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Disclosing Gender-Based Violence During Health Care Visits: A Patient-Centered Approach

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Abstract

The purpose of this study was to better understand victims' perspectives regarding decisions to disclose gender-based violence, namely, intimate partner violence (IPV) and human trafficking, to health care providers and what outcomes matter to them when discussing these issues with their provider. Twenty-five participants from racially/ethnically diverse backgrounds were recruited from a family justice center located in the southeastern United States. Two fifths had experienced human trafficking, and the remaining had experienced IPV. Upon obtaining informed consent, semistructured, in-depth interviews were conducted. Interviews were audio recorded and transcribed verbatim. Qualitative content analysis was used to examine interview data. Five primary themes emerged. Three themes focused on factors that may facilitate or impede disclosure: patient–provider connectedness, children, and social support. The fourth theme was related to ambiguity in the role of the health care system in addressing gender-based violence. The final theme focused on outcomes participants hope to achieve when discussing their experiences with health care providers. Similar themes emerged from both

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IPV and human trafficking victims; however, victims of human trafficking were more fearful of judgment and had a stronger desire to keep experiences private. Cultural factors also played an important role in decisions around disclosure and may interact with the general disparities racial/ethnic minority groups face within the health care system. Recognizing factors that influence patient engagement with the health care system as it relates to gender-based violence is critical. The health care system can respond to gender-based violence and its associated comorbidities in numerous ways and interventions must be driven by the patient's goals and desired outcomes of disclosure. These interventions may be better served by taking patient-centered factors into account and viewing the effectiveness of intervention programs through a behavioral, patient-centered lens.

Keywords
disclosure of domestic violence, domestic violence, domestic violence and cultural contexts, prostitution/sex work

Introduction

Gender-based violence, defined as violence targeting individuals based on biological sex, gender identity, or social gender norms, is a critical global health concern (U.S. Agency for International Development, 2016). Common forms of gender-based violence include intimate partner violence (IPV) and human trafficking. Victims of gender-based violence, such as IPV and human trafficking, are significantly more likely to experience adverse health outcomes compared with the general population, including chronic gynecological, central nervous system, and stress-related health problems, as well as depression, posttraumatic stress disorder, substance abuse, and suicidality (Bonomi, Anderson, Rivara, & Thompson, 2007; Campbell et al., 2002; Hegarty et al., 2013; Lagdon, Armour, & Stringer, 2014; Ottisova, Hemmings, Howard, Zimmerman, & Oram, 2016). They are also more likely to seek health services compared with those with no history of victimization (Ford-Gilboe et al., 2015; Plichta, 2007; Ross et al., 2015). As such, health care visits provide an opportune time to identify and intervene in these situations. Identifying experiences of gender-based violence among patients can also help health care providers tailor care to better meet their unique needs.

Numerous barriers exist, however, in screening and responding to gender-based violence within health care facilities. Several studies have highlighted the difficulties health care facilities face in implementing IPV programs including unwillingness of patients to disclose (Spangaro et al., 2016; Sprague et al., 2012). Patients may not be comfortable disclosing traumatic experiences due to feelings of embarrassment, belief that the provider may pass judgment, and fear for one's own safety. The severity of abuse may also influence disclosure as these are likely to contribute to an individual's perceived susceptibility to adverse consequences and severity of the situation (Cheng & Lo, 2016). As such, it is important to examine the perspectives of individuals who have experienced different forms of gender-based violence.

In addition, controversy exists regarding the role health care providers should play in actively screening patients for experiences of gender-based violence. Studies examining the effectiveness of IPV screening have found mixed results regarding outcomes such as utilization of support services (e.g., shelters) and reduction of IPV (Nelson, Bougatsos, & Blazina, 2012; Wathen, Macgregor, Sibbald, & Macmillan, 2013). These mixed findings have led some to criticize the utility of IPV screening in health care settings. The current health care landscape calls for expanding our understanding of effectiveness to include outcomes related to the patient experience of care (e.g., satisfaction, quality), in addition to more traditional health outcomes (Berwick, Nolan, & Whittington, 2008). Few studies have examined the patient's experience of care as it relates to IPV screening and response. To examine the effectiveness of screening on the patient's experience, a better understanding of what outcomes patients desire when disclosing traumatic experiences to their health care provider is needed.

The purpose of this study is to better understand victims' perspectives regarding decisions to disclose gender-based violence, namely, IPV and/or human trafficking, to health care providers and what outcomes matter to them when discussing these issues with their provider. The results of this study fill several knowledge gaps regarding why victims of IPV and human trafficking decide to disclose experiences of abuse to health care providers and their expected outcomes from disclosure. This study contributes to limited research examining perspectives related to the role of the health care system in addressing gender-based violence among individuals who have experienced different forms of gender-based violence (i.e., IPV and human trafficking). In addition, this is one of the first studies to specifically examine patient-desired outcomes related to gender-based violence. Through a better understanding of these factors, interventions can be developed to support both victims and providers through the process of screening and response to IPV and human trafficking in a systematic and patient-centered way.

Method

Design

A qualitative descriptive research design was used to guide the conduct of this study (Sandelowski, 2000). Individual in-depth interviews were conducted with individuals who identified as being a victim of IPV or human trafficking and agreed to participate in an individual, face-to-face interview with a study team member.

Sample and Setting

Participants were recruited from a family justice center in a large urban area located in the southeast United States. This center provides coordinated, comprehensive, and compassionate services to victims of IPV, sexual violence, and human trafficking, their children, and the general community. Participants were recruited using flyers. These flyers were handed to individuals in person as well as posted in visible areas at the center. Individuals interested in participating were screened for eligibility. To be eligible, an individual needed to be 18 years of age and older, have a history of IPV and/or human trafficking, and have received care from a health care provider since experiencing IPV and/or human trafficking. Participants were purposively selected so two fifths of the sample had experiences with human trafficking and about half had spoken with a health care provider about their experience with gender-based violence. A total of 25 individuals participated in this study.

Procedures

This study was approved by the local Institutional Review Board. After eligibility screening, a study team member described in further detail the purpose of the study, assessed continued interest, and scheduled a time for an interview. At the beginning of each interview, the interviewer reviewed the informed consent form and interview procedures with the participant. During this process, the interviewer explained the voluntary nature of the study, the participant’s right to discontinue participation at any time, and the right to request that data not be used retrospectively. It was also made clear to participants that their decision to participate, not participate, or discontinue participation will not affect any services that they receive from the organizations involved in conducting the study. Participants were notified before the interview that they would be compensated US$50 for their time. This amount was based on living wage estimates for a family of four in the county where the study was conducted (Glasmeier & Massachusetts Institute of Technology, 2017). Procedures were put in place to assist participants if they became distressed during the interview. The interviewers were all licensed health professionals, trained to recognize signs of distress or retraumatization. If a participant became distressed, the interviewer was to stop the interview and refer her to a licensed psychologist or mental health worker on-site at the interview location.

After obtaining written consent, basic demographic data were collected from each participant through a brief questionnaire. Then, a semistructured interview guide was used to elicit information regarding decisions to disclose IPV and/or human trafficking to health care providers and desired outcomes of this disclosure. This guide was based partly on the Decisional Needs Assessment Interview Guide developed by Jacobsen, O'Connor, and Stacey (1999/2013). Interviews were conducted face-to-face by a trained study team member in the participant's preferred language (i.e., English or Spanish). All interviews were conducted in a private location, audio recorded, and lasted approximately 1 hr long.

Data Analysis

Demographic data were analyzed through descriptive statistics. Qualitative content analysis was used to examine the interview data. Analyses were conducted independently by two members of the research team. Each transcribed interview was read in its entirety to get a sense of its essential features, underlining key statements and writing a brief abstract of the distinctive elements (Sandelowski, 1995). The data were examined and coded using in vivo codes that emerged from the data (Marshall & Rossman, 2011). The codes were then grouped into conceptual categories and themes generated from the data. A codebook was maintained to detail the codes and definitions. An audit trail of the coding process was kept as a running record of procedures for data collection and analytic strategies (Marshall & Rossman, 2011). Credibility of data was addressed through the use of double coding, in which all text was double coded and compared for consistency. Discrepancies were reviewed by both coders until consensus in major themes was achieved.

Results

Demographic characteristics of participants are presented in Table 1. Participants were from diverse racial/ethnic backgrounds with 88% identifying as Black, Hispanic/Latino, or both and 36% indicating they had been born outside of the United States. Ages ranged from 18 to 43 years, with a

Table 1. Demographic Characteristics of Participants (*n* = 25).

Characteristic	*M* (*SD*) or *n* (%)
Age	32.1 (8.3)
Type of violence	
Intimate partner violence	15 (60.0)
Human trafficking	5 (20.0)
Both	5 (20.0)
Race/ethnicity	
Black, non-Hispanic, or Latino	12 (48.0)
Black, Hispanic, or Latino	1 (4.0)
White, Hispanic, or Latino	9 (36.0)
White, non-Hispanic, or Latino	3 (12.0)
Preferred language	
English	21 (84.0)
Spanish	4 (16.0)
Place of birth	
United States	16 (64.0)
Outside of the United States	9 (36.0)
Health insurance	
Yes	17 (68.0)
No	8 (32.0)
Last visit to health care provider	
<1 month	7 (28.0)
1-3 months	7 (28.0)
4-6 months	7 (28.0)
7-12 months	4 (16.0)
Number of visits to health care provider per year	
1 time per year	4 (16.0)
2-5 times per year	13 (52.0)
6-10 times per year	6 (24.0)
>10 times per year	2 (8.0)
Spoken with health care provider about experiences with gender-based violence	
Yes	14 (56.0)
No	11 (44.0)

mean of 32.1 years (*SD* = 8.3 years). A majority of participants had health insurance (68%) and all had visited a health care provider in the past year. Health care utilization was high with 32% reporting visiting a health care provider over five times per year and 52% reporting two to five visits per year.

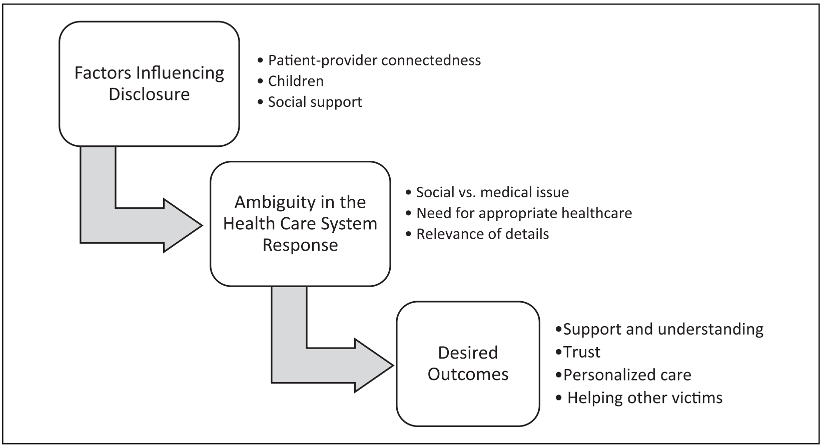

Figure 1. Patient perspectives regarding decisions to disclose gender-based violence to health care providers and desired outcomes (*n* = 25).

Five primary themes emerged from the interviews. Three themes focused specifically on factors that may facilitate or impede disclosure of gender-based violence to health providers: patient–provider connectedness, for the children's sake, and social support. The fourth theme emerged when examining text across interviews and is related to ambiguity in the role of the health care system in addressing gender-based violence. The final theme focused on outcomes participants hope to achieve when discussing their experiences of violence with health care providers. A visual representation of these factors that influenced disclosure and desired outcomes are presented in Figure 1.

Patient–Provider Connectedness

Feeling connected to one's provider was critical for facilitating disclosure of traumatic experiences. Participants used terms such as comfort, support, and respect when describing positive relationships with providers. As stated by one participant describing how she first told her doctor about her experience with human trafficking,

> He was shocked. And then he spent time, and he stopped what he was doing to actually listen. He just earned my respect. I like that. It was so cool how he did it though. Like he had closed the door and everything, and then he was just with me. As I was talking he was holding my hand. He was, like, I'm here with you. (Human trafficking, Black, non-Hispanic/Latino, 19 years)

Personal characteristics of the provider can play a role in feelings of connectedness. Participants often stated that they felt more comfortable with a provider who shared some of the same personal characteristics as them such as being female, of a similar race or culture, or also had a history of gender-based violence. As illustrated by one participant, “She was being a friend. I don’t know, I could relate to her because of her culture. And she reminded me, at the time, of a mother. And that’s what I needed there at the time was a mom” (IPV, Black, non-Hispanic/Latino, 31 years).

Confidentiality and trust were also important factors in feeling connected enough with a health care provider to disclose gender-based violence. Participants often indicated they were comfortable talking with their provider because they know he or she can be confidential. In describing why she disclosed abuse to her provider, one participant stated,

> So I did that and it felt really good just—to talk to people and medical professionals. And you feel like you’re safe, like you could talk to somebody and not worry that person is gonna break your confidentiality and go back and tell your mom or your husband or somebody that you don’t want to know, but you have all these questions. (IPV and human trafficking, White, non-Hispanic/Latino, 43 years)

A few participants, however, had concerns about confidentiality, especially if the perpetrator was there or other nonhealth professionals were involved. For example, one participant described why she did not disclose to her doctor stating,

> Because you can’t take it back. It’s there. It’s a negative if the doctor tries to approach the pimp or that could definitely be a negative. I never personally experienced that, but I know other people who have because their pimp was with them, and they tried to call the cops on them while they’re in the office. And that would be very intimidating and negative. (IPV and human trafficking, White, non-Hispanic/Latino, 24 years)

Finally, participants stressed the importance of having enough time to work up to disclosing abuse and not feeling rushed during this process. One participant stated,

> Some doctors just—I guess you need to see a thousand patients in a day so you don’t really have time. That’s what pretty much held me back because when I go in the doctor’s office, it’s so rushed and you kinda just feel like he doesn’t care. He just wants to get to the next patient. That’s kinda what took me so long to open up and talk about it. (IPV, Black, non-Hispanic/Latino, 33 years)

For the Children's Sake

Children were often described as the number one influencer of the decision to disclose to a health care provider. However, some participants viewed children as an important reason to disclose, whereas others felt they were an important reason not to disclose. Those who identified children as an important reason to disclose reported needing to get help to be there for their children. They also feared that their children would be harmed and that it was their responsibility as a parent to protect them from abuse. As one participant stated, "Because looking at my kids and then having to think about them having to go through it, well kind of freaked me out, so I wanted to talk to somebody" (IPV, Black, non-Hispanic/Latino, 25 years).

However, some participants felt that disclosing to a health care provider would have negative consequences on their children. Participants described fear of their children being harmed by the perpetrator if they found out the participant disclosed. Some participants preferred to remain silent and sacrifice their own health to prevent their child from being harmed, especially if their children were not being physically abused, directly. As stated by one participant,

> Well, it's mainly just being scared to discuss that with anybody, or the outcome of him, the aftermath . . . Because you don't want him to get mad; you just want everything to be, even though you're walking on eggshells, you just want everything to be like, all right, there's no yelling today, there's no screaming, there's no hitting. Okay, it's gonna be good night . . . I used to work overnight, so my kids were home with him at night. So that would be, okay, I have to make sure life is nice and quiet before I got to work and everybody's happy. Because then it's him dealing with them, and then him doing the abuse towards them. (IPV, White, Hispanic/Latino, 38 years)

Participants also feared being reported to the Department of Children and Family (DCF) and having their children taken away from them. This is illustrated by one participant who stated,

> I'm just scared . . . they [health professionals] might think, "Oh my God, you put your kids through 12 years of hell." I don't know. I don't know. That's what I—like when DCF got involved and I was like, "Please don't take my kids." (IPV, White, Hispanic/Latino, 34 years)

Social Support

Participants identified a lack of social support as leading to disclosure of gender-based violence. They indicated that disclosing to a provider provided an opportunity to talk to someone in a confidential manner. In disclosing, they were often looking for support that they otherwise did not have. Receiving this support led to feelings of relief. As stated by one participant, “I don’t know, everything was going crazy. No family support, no friend support, nothing. And I just—she [health provider] was there, and we spoke. And that’s when I was able to express myself at the time” (IPV, Black, non-Hispanic/Latino, 31 years).

Similarly, participants reported that having a social support network may lead to nondisclosure to providers. Participants stated they would rather talk to family or friends first. If family or friends suggested talking with a provider, they would consider it. For example, one participant stated,

> I would feel more comfortable talking to a friend or a family member first and then I would listen to their advice. If they say, well, you know, this is something you need to discuss with your doctor or just to have a checkup or see if there’s any kind of help that your doctor could maybe help you with, maybe some type of trauma counselling, so then I would probably go to my doctor then and I would talk to him because I do value their opinions. (IPV, Black, non-Hispanic/Latino, 42 years)

Ambiguity of the Role of the Health Care System in Addressing Gender-Based Violence

Throughout the interviews, there was clear ambiguity regarding the role of the health care system in addressing gender-based violence. This was often related to whether participants viewed their experiences as a pure social issue or medical issue, as well. One participant described why she spoke with her provider about her experiences of abuse stating, “What’s more important? My health, for one thing, because me not talking to nobody, it was really taking effect on me. My health was getting bad. I was stressed, and stressed out, and stressed out bad” (IPV, Black, non-Hispanic/Latino, 40 years). Some participants felt their provider did not need to know about their trauma history if they were simply there for health reasons. For example, when asked about whether she had ever discussed experiences of abuse with her provider, one participant stated,

> This is my first time hearing about reaching out to a health care provider about domestic violence. Never in a million years would I have thought that I need to speak to my doctor about a situation that’s going on at home. (IPV, Black, non-Hispanic/Latino, 32 years)

Others reiterated this stating they did not understand the provider’s role in assisting with issues of abuse and did not know what a provider could do if they did disclose. This uncertainty is illustrated through the following quote,

> If you cannot help me, why am I talking to you about it? So maybe if there is something that my health care provider can do or any help your provider can do for an individual in a domestic violent situation, and people are made aware of this, then maybe they will talk to them. But if you don't know that, hey this individual can help me or there's something that they can do, why would you talk to them? (IPV, Black, Hispanic/Latino, 23 years)

Others felt it was important to disclose to receive appropriate care for health concerns (e.g., injuries, HIV, anxiety, flashbacks) and there could be negative effects of not disclosing, such as inappropriate treatment. Participants who felt this way were more likely to understand the effects of violence on health. For example, one participant stated, "I was scared because I was sexually abused also, so when I understood what that type of abuse was, I thought, 'I need to tell the doctor because, I don't know if I have AIDS'" (IPV, White, Hispanic/Latino, 42 years). However, participants also said that the level of detail they provided regarding their abuse experiences depended on necessity or need to know basis. They often would not tell the whole story, only details they felt were related to a particular health concern or a desired outcome. As stated by one participant,

> I didn't know how much to tell, how much not to tell. And some things I still didn't tell because I just didn't feel that it was quite necessary for me—I think that I pretty much painted the picture without the gory details. A lot of stuff I did withhold . . . I don't know if it woulda helped or not [to tell the provider]. Whatever I said, it was enough for him to point me in the direction of seeing a psychiatrist, so what I did say was enough for him to react to it as an emergency situation. (IPV, Black, non-Hispanic/Latino, 33 years)

Desired Outcomes of Disclosing Gender-Based Violence to Health Care Providers

Participants provided information regarding what they would like to see as a result of speaking with a health care provider about gender-based violence. In discussing these issues, participants identified what they wanted for themselves, as well as what would be helpful for others in similar situations. Many participants related desired outcomes back to patient–provider connectedness. Participants stated that they wanted to feel supported and understood when disclosing experiences of gender-based violence to their health care provider. They said they wanted their provider to "be there" and to "not be treated as a statistic." Specifically, participants stated that when their provider demonstrates empathy and concern, they are more likely to trust that their provider is looking out for their best interests. For example, in describing what she would want when disclosing to her provider, one participant stated,

> I would want him to understand where I'm coming from. I don't want him just listening to me, and be like, okay, here, he goes to refer. I want him to sit down and explain like this is what you got to do. I would trust that. (IPV, Black, non-Hispanic/Latino, 25 years)

A provider's ability to provide explicit referrals to "services that actually work" also increases trust in the provider's ability to actually help. As one participant stated,

> I would like her to direct me to some services that actually work. That are compatible to what I'm seeking and that are effective. Because I've dealt with the system and it's just closed door, closed door, closed door and you start to create, like I said, mistrust. You start to close down and just isolate yourself as far as from letting people in. Because I'm not gonna just extend myself and it's just the same, same outcome. Nothing is being resolved and that makes me feel like I'm the only person that can really resolve it at this point. But if I was the only one to resolve it I wouldn't be in this situation. (Human trafficking and IPV, White, non-Hispanic/Latino, 32 years)

Participants wanted to receive care that was personalized to their needs, and disclosure was viewed as a necessary to "get the right treatment." This care was viewed as consisting of medical treatments, psychological support, education, social services, and referrals that were responsive to their unique abuse experiences. Common services requested were counseling services, support groups, immigration assistance, and help obtaining health insurance.

Participants also identified several things providers could do to help other patients who may be experiencing gender-based violence. First and foremost, participants stated there is a need for more pamphlets, signs, posters, and so forth related to gender-based violence in health settings. Several also suggested that these resources provide more information about how health providers are a resource for gender-based violence and the specific health risks related to abuse. As a general point, participants felt that it was important to encourage people to get help sooner rather than later. It was a common sentiment that abusive situations only get worse as time goes on and the sooner you open up and get help, the better. This is summarized by one participant who stated,

> I never identified that I was abused. Never. To me—I come from a very conservative Latino family, which the first one you marry, you stay with him

> for life, and that's the parameter, and that's the way you have to keep your household . . . But if you, for example—I go to my son's pediatrician, and I see a booklet in the pediatrician's office which catches my attention, and I can look at it while I'm sitting. There is a nice one here [at the family justice center], which has a circle. And in that circle it identifies what kind of man is an abusive man. When I read that the first day, I said, "I have all of that," and I didn't know I was abused. So if you see in the doctor's office those little things—how many women go to take their children, and could identify, "This happens to me." And they might have some numbers in the back that say, "Don't worry, there are people here who can help you. You will not be deported," there obviously has to be something that links you directly in a doctor's office that can help you. (IPV, White, Hispanic/Latino, 42 years)

Finally, participants wanted their stories to be heard by other victims in the health care system. They felt that by telling health care providers about their experience, the health care provider could help other patients experiencing gendered-based violence. They hoped their provider could use their own story to help other patients feel like they were not alone. As stated by one participant,

> I'm telling them [health providers] my story, and hopefully they tell someone else my story, and hopefully that person could relate and actually think and wake up. Because it happened to me and it can happen to someone else. (Human trafficking, Black, non-Hispanic/Latino, 19 years)

Comparison of Victims of IPV and Human Trafficking

Similarities and differences were seen among participants who had experienced IPV and those who had experienced human trafficking. Overall, the same themes emerged from both groups; however, different factors were emphasized within each theme. Regarding patient–provider connectedness, victims of human trafficking were generally more concerned with being judged poorly by their provider due to the sexual nature of their victimization (e.g., multiple sex partners, forced prostitution). This fear of judgment is illustrated by one participant, who stated,

> For me, judgment, you know criticizing me because I don't need any more criticism. I didn't really want to tell her, because she would sort of act a different way. At first, I look normal and then it's different when you tell them. They just treat you in a different manner if you are not able to do things the same. (Human trafficking, White, Hispanic/Latino, 18 years)

Victims of IPV and victims of human trafficking both discussed the importance of social support in assisting with recovery. Those who had experienced

IPV felt that in disclosing, they could achieve social support directly from their provider. Those who had experienced human trafficking did not feel they would receive social support from their provider, but rather that their provider might connect them to social support groups. The importance of groups for victims of human trafficking is reflected by the following participant statement,

> You've been there; you know how I feel. And I think that's gets people to open up or to actually be more at ease and to unify, and to heal as a whole, more than separately. That's why I suggest a lot of group you know, group setting therapy or support groups type of setting. Because every time I'm in a group setting and we're all sharing about the same thing, then it doesn't feel so this disgusting or weird or awful. (IPV and human trafficking, White, Hispanic/Latino, 40 years)

Both victims of IPV and human trafficking expressed ambiguity about the role of health care providers in addressing gender-based violence. Victims of human trafficking, however, felt more strongly that their experiences were none of their provider's business, whereas, victims of IPV were more unsure about what their provider could do to help. As stated by one participant who had experienced human trafficking, "Because I think it's not his [health care provider] business. Because his job is to test me and to find out if I'm sick, not to be social" (Human trafficking, Black, non-Hispanic/Latino, 18 years).

In describing desired outcomes of disclosure, both victims of IPV and human trafficking identified factors that would lead to improved connectedness with their provider (e.g., support, active listening) as well as direct services (e.g., medical treatments, education). Those with a history of IPV, however, tended to focus more on support needs, whereas those who had experienced human trafficking tended to focus on service needs. In addition, victims of human trafficking were more likely to see disclosure as a way to teach providers and/or others about how to prevent human trafficking. For example, one participant stated,

> So if that experience is gonna help her [the provider] in how to deal with the next person, or maybe to be more open, or as far as to automatically bring that up if she feels like she needs to. You know, that you can break the ice that way. The person, like I said, is not gonna just come out and tell you, I think. Unless there's something like that severe. (IPV and human trafficking, White, non-Hispanic/Latino, 32 years)

Discussion

This study provides insight about perceptions regarding disclosure of gender-based violence and desired outcomes of disclosure among a diverse sample of individuals who have experienced IPV and/or human trafficking. Experiences of gender-based violence are rarely the result of one factor, but rather the interplay of factors occurring across multiple levels, including individual, family, community, and societal levels (Centers for Disease Control and Prevention, 2015). As such, the patient perspective is critical for the development of effective interventions.

Results from this study indicate that patients may be motivated or dissuaded to disclose experiences of violence for a number of reasons. These include feeling connected with their provider, perceptions about how disclosure would affect their children, current level of social support, and thoughts about the role of the health care system in addressing gender-based violence.

The role of patient–provider connectedness in disclosure of gender-based violence is a consistent finding throughout the extant literature (Feder, Hutson, Ramsay, & Taket, 2006; Robinson & Spilsbury, 2008; Spangaro et al., 2016). Women want to feel safe, supported, and validated when discussing experiences of violence and are less likely to disclose these experiences if this connectedness is absent. In fact, an unsupportive or inappropriate response to disclosure by a provider can lead to retraumatization among patients and a reduction in future help-seeking behavior. Retraumatization can occur when an individual reexperiences traumatic stress as a result of being in a situation that is similar to prior traumatic experiences (Substance Abuse and Mental Health Services Administration [SAMHSA], 2014). The integration of trauma-informed services into routine health care practice is a promising method for supporting individuals with a history of gender-based violence and avoiding retraumatization (SAMHSA, 2015). Additional research is needed to examine the impact of trauma-informed care on the patient experience of care and rates of disclosure.

The role of children was also identified as a particularly important consideration when making decisions about disclosure of gender-based violence. Some participants were motivated to disclose because of their children, whereas for others, children were a reason to not disclose. Participants were often reluctant to disclose out of fear of losing their children and this is consistent with other research (Robinson & Spilsbury, 2008). There is wide variation in laws around children witnessing IPV in the home, particularly when the child is not experiencing abuse or neglect. Resources to assist victims and children also vary in communities. Providers need to be aware of the laws and resources within their particular jurisdiction and educate patients about these. A better understanding among patients about the implications of disclosing on children can help dispel myths and encourage disclosure.

Ambiguity about the role of the health care system in addressing gender-based violence was also evident in the results of this study. Often, this was due to whether participants viewed gender-based violence as a social issue or recognized the health implications, as well. This lack of recognition among some participants indicates that additional work is needed to raise awareness among victims about the health implications of trauma.

It is also important to acknowledge the role of culture in this area of inquiry. This study was conducted with a racially and ethnically diverse sample of women. Results from this study, as well as previous research, show that disclosure of gender-based violence may be influenced by cultural factors such as cultural congruency with the provider, immigration issues/fear of deportation, children, cultural traditions, language barriers, and family values (Alvarez & Fedock, 2018; Crandall, Senturia, Sullivan, & Shiu-Thornton, 2005; Montalvo-Liendo, 2009; Nash, 2005). There is awareness of the need for culturally tailored interventions to address gender-based violence within the health care setting (Alvarez, Davidson, Fleming, & Glass, 2016; Cheng & Lo, 2016), but there is also a need for culturally tailored messaging to address these culturally specific barriers to disclosure.

In addition, victims are concerned with issues related to trust, stigma, support, and confidentiality, which may be affected by race/ethnicity (Chang et al., 2005; Robinson & Spilsbury, 2008; Zeitler et al., 2006). Racial/ethnic disparities in patient experiences of health care are well documented and can lead to distrust and lower engagement in services (Blanchard & Lurie, 2004; Trivedi & Ayanian, 2006). Additional research is needed to better understand how race and victimization may interact to influence disclosure of violence and engagement in health care services.

Factors that influence disclosure not only include a patient's personal characteristics, experience with providers, and perceptions of the role of the health care system, but also their desired outcomes of this encounter. Participants in this study identified several outcomes they desired when disclosing experiences of abuse to their provider including support, empathy, effective and personalized services, and the ability to help others by sharing their story. This variation in desired outcomes may reflect differences in individual experiences (e.g., type of gender-based violence) and readiness for change. A thorough understanding of these patient-centered outcomes and individualized approach is critical for ensuring the delivery of safe, effective, and meaningful interventions. The health care system can respond to gender-based violence in numerous ways and interventions must be driven by the patient's goals and desired outcomes of disclosure. Screening and response interventions for gender-based violence may be better served by taking these patient-centered factors into account by viewing the effectiveness of these programs through a behavioral, patient-centered lens.

Finally, this is the first study to examine patient perspectives of the health care system among individuals who have experienced different forms of gender-based violence, namely, human trafficking and IPV. Results indicate that although similar themes exist, there are notable differences. Individuals who experienced human trafficking tended to be more fearful of being judged by their provider and had a stronger desire to keep their experiences private. They did not see their provider as a source of support, but rather someone who could connect them to more acceptable support networks, such as a support group for those who have experienced human trafficking. This reluctance to be vulnerable with others is also reflected in the desired outcomes of those who have experienced human trafficking. Whereas victims of IPV focused on connectedness with their provider as a desired outcome of disclosure, victims of human trafficking focused on direct service needs. These feelings may be due, in part, to the fact that human trafficking continues to remain largely hidden and there are often fewer resources and less media attention given toward addressing this type of gender-based violence (Clawson, Dutch, Salomon, & Grace, 2009). Recently, several national and international organizations have increased efforts to improve awareness of the issue of human trafficking (Cronk, 2015; United Nations Global Initiative to Fight Human Trafficking, 2016). It is critical that these efforts continue and include the role of the health care system as a resource in addressing human trafficking to address the barriers to disclosure seen among human trafficking victims. Future research should examine the impact of these efforts on improving help-seeking behavior among victims.

Limitations

In the current study, participants were recruited from a domestic violence service agency. Thus, the results reflect the perspectives of individuals who have engaged in help seeking for issues related to gender-based violence. Views on disclosing experiences of violence to health professionals and desired outcomes of this disclosure may differ among those who have not engaged in help seeking. In addition, participants must have received care from a health provider since experiencing IPV and/or human trafficking to be eligible for the study. As such, the views of individuals who have limited or no access to health care services are not reflected in this study. Additional research is needed to better understand the role of health care access on patient experiences. Finally, the interview guide used in the study was based in part on the Decisional Needs Assessment Interview Guide to elicit information related to decisions around disclosure (Jacobsen et al., 1999/2013). The structuring of this interview guide may have influenced responses in unintended ways. Despite these limitations, results increase understanding of patient perspectives around disclosing gender-based violence to health care providers and desired outcomes of disclosure.

Conclusion

Numerous factors influence an individual's likelihood of disclosing experiences of IPV to their provider and wide variation exists in the desired outcomes of this disclosure. Recognizing the factors that influence a patient's engagement with the health care system as it relates to gender-based violence is critical for understanding the true effectiveness of screening and response efforts and improving the role of the health care system in addressing gender-based violence and its associated comorbidities. Health care providers must recognize how different factors may influence a patient's engagement with the health care system and adopt a victim-centered approach when providing services.

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References

Alvarez, C., Davidson, P. M., Fleming, C., & Glass, N. E. (2016). Elements of effective interventions for addressing intimate partner violence in Latina women: A systematic review. *PLoS ONE*, *11*, e0160518. doi:10.1371/journal.pone.0160518

Alvarez, C., & Fedock, G. (2018). Addressing intimate partner violence with Latina women: A call for research. *Trauma Violence, & Abuse*, *19*, 488-493. doi:10.1177/1524838016669508

Berwick, D. M., Nolan, T. W., & Whittington, J. (2008). The triple aim: Care, health, and cost. *Health Affairs*, *27*, 759-769. doi:10.1377/hlthaff.27.3.759

Blanchard, J., & Lurie, N. (2004). R-E-S-P-E-C-T: Patient reports of disrespect in the health care setting and its impact on care. *The Journal of Family Practice*, *53*, 721-730.

Bonomi, A. E., Anderson, M. L., Rivara, F. P., & Thompson, R. S. (2007). Health outcomes in women with physical and sexual intimate partner violence exposure. *Journal of Women's Health*, *16*, 987-997. doi:10.1089/jwh.2006.0239

Campbell, J., Jones, A. S., Dienemann, J., Kub, J., Schollenberger, J., O'Campo, P., . . . Wynne, C. (2002). Intimate partner violence and physical health consequences. *Archives of Internal Medicine*, *162*, 1157-1163. doi:10.1001/archinte.162.10.1157

Centers for Disease Control and Prevention. (2015). *Intimate partner violence: Risk and protective factors*. Retrieved from http://www.cdc.gov/violenceprevention/intimatepartnerviolence/riskprotectivefactors.html

Chang, J. C., Cluss, P. A., Ranieri, L., Hawker, L., Buranosky, R., Dado, D., . . . Scholle, S. H. (2005). Health care interventions for intimate partner violence: What women want. *Women's Health Issues*, *15*, 21-30. doi:10.1016/j.whi.2004.08.007

Cheng, T. C., & Lo, C. C. (2016). Racial disparities in intimate partner violence examined through the multiple disadvantage model. *Journal of Interpersonal Violence*, *31*, 2026-2051. doi:10.1177/0886260515572475

Clawson, H. J., Dutch, J. M., Salomon, A., & Grace, L. G. (2009). *Study of HHS programs serving human trafficking victims: Final report*. Washington, DC: Office of the Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services.

Crandall, M., Senturia, K., Sullivan, M., & Shiu-Thornton, S. (2005). Latina survivors of domestic violence: Understanding through qualitative analysis. *Hispanic Health Care International*, *3*, 179-187.

Cronk, T. M. (January, 2015). Official reports progress in awareness of human trafficking. *DoD News, Defense Media Activity*. Retrieved from http://www.defense.gov/News/Article/Article/603878

Feder, G. S., Hutson, M., Ramsay, J., & Taket, A. R. (2006). Women exposed to intimate partner violence—Expectations and experiences when they encounter health care professionals: A meta-analysis of qualitative studies. *Archives of Internal Medicine*, *166*, 22-37. doi:10.1001/archinte.166.1.22

Ford-Gilboe, M., Varcoe, C., Noh, M., Wuest, J., Hammerton, J., Alhalal, E., & Burnett, C. (2015). Patterns and predictors of service use among women who have separated from an abusive partner. *Journal of Family Violence*, *30*, 419-431. doi:10.1007/s10896-015-9688-8

Glasmeier, A. K., & Massachusetts Institute of Technology. (2017). *Living wage calculation for Miami-Dade County, Florida*. Living Wage Calculator. Retrieved from http://livingwage.mit.edu/counties/12086

Hegarty, K. L., O'Doherty, L. J., Chondros, P., Valpied, J., Taft, A. J., Astbury, J., & Gunn, J. M. (2013). Effect of type and severity of intimate partner violence on women's health and service use: Findings from a primary care trial of women afraid of their partners. *Journal of Interpersonal Violence*, *28*, 273-294. doi:10.1177/0886260512454722

Jacobsen, M. J., O'Connor, A. M., & Stacey, D. (2013). *Decisional needs assessment in populations: A workbook for assessing patients' and practitioners' decision making needs*. Ottawa, Ontario, Canada: University of Ottawa. (Original work published 1999)

Lagdon, S., Armour, C., & Stringer, M. (2014). Adult experience of mental health outcomes as a result of intimate partner violence victimization: A systematic review. *European Journal of Psychotraumatology*, *5*, Article 24794. doi:10.3402/ejpt.v5.24794

Marshall, C., & Rossman, G. B. (2011). *Designing qualitative research* (5th ed.). Thousand Oaks, CA: Sage.

Montalvo-Liendo, N. (2009). Cross-cultural factors in disclosure of intimate partner violence: An integrated review. *Journal of Advanced Nursing*, *65*, 20-34. doi:10.1111/j.1365-2648.2008.04850.x

Nash, S. T. (2005). Through black eyes: African American women's constructions of their experiences with intimate male partner violence. *Violence Against Women*, *11*, 1420-1440. doi:10.1177/1077801205280272

Nelson, H. D., Bougatsos, C., & Blazina, I. (2012). Screening women for intimate partner violence: A systematic review to update the U.S. Preventive Services Task Force recommendation. *Annals of Internal Medicine*, *156*, 796-808,W-279, W-280, W-281, W-282. doi:10.7326/0003-4819-156-11-201206050-00447

Ottisova, L., Hemmings, S., Howard, L. M., Zimmerman, C., & Oram, S. (2016). Prevalence and risk of violence and the mental, physical and sexual health problems associated with human trafficking: An updated systematic review. *Epidemiology and Psychiatric Sciences*, *25*, 317-341. doi:10.1017/S2045796016000135

Plichta, S. B. (2007). Interactions between victims of intimate partner violence against women and the health care system: Policy and practice implications. *Trauma Violence Abuse*, *8*, 226-239. doi:10.1177/1524838007301220

Robinson, L., & Spilsbury, K. (2008). Systematic review of the perceptions and experiences of accessing health services by adult victims of domestic violence. *Health & Social Care in the Community*, *16*, 16-30. doi:10.1111/j.1365-2524.2007.00721.x

Ross, C., Dimitrova, S., Howard, L. M., Dewey, M., Zimmerman, C., & Oram, S. (2015). Human trafficking and health: A cross-sectional survey of NHS professionals' contact with victims of human trafficking. *BMJ Open*, *5*(8), Article e008682. doi:10.1136/bmjopen-2015-008682

Sandelowski, M. (1995). Qualitative analysis: What it is and how to begin. *Research in Nursing & Health*, *18*, 371-375.

Sandelowski, M. (2000). Whatever happened to qualitative description? *Research in Nursing & Health*, *23*, 334-340.

Spangaro, J., Koziol-McLain, J., Zwi, A., Rutherford, A., Frail, M.-A., & Ruane, J. (2016). Deciding to tell: Qualitative configurational analysis of decisions to disclose experience of intimate partner violence in antenatal care. *Social Science & Medicine*, *154*, 45-53. doi:10.1016/j.socscimed.2016.02.032

Sprague, S., Madden, K., Simunovic, N., Godin, K., Pham, N. K., Bhandari, M., & Goslings, J. C. (2012). Barriers to screening for intimate partner violence. *Women & Health*, *52*, 587-605. doi:10.1080/03630242.2012.690840

Substance Abuse and Mental Health Services Administration. (2014). *Treatment Improvement Protocol (TIP) Series: Vol. 57. Trauma-informed care in behavioral health services* (HHS Publication No. (SMA) 13-4801). Rockville, MD: Author.

Substance Abuse and Mental Health Services Administration. (2015). *Trauma-informed approach and trauma-specific interventions*. Retrieved from http://www.samhsa.gov/nctic/trauma-interventions

Trivedi, A. N., & Ayanian, J. Z. (2006). Perceived discrimination and use of preventive health services. *Journal of General Internal Medicine*, *21*, 553-558. doi:10.1111/j.1525-1497.2006.00413.x

United Nations Global Initiative to Fight Human Trafficking. (2016). *About*. Retrieved from http://www.ungift.org/knowledgehub/en/about/index.html

U.S. Agency for International Development. (2016). *Addressing gender-based violence*. Retrieved from https://www.usaid.gov/sites/default/files/GBV-Infographic.pdf

Wathen, C. N., Macgregor, J. C., Sibbald, S. L., & Macmillan, H. L. (2013). Exploring the uptake and framing of research evidence on universal screening for intimate partner violence against women: A knowledge translation case study. *Health Research Policy and Systems*, *11*, Article 13. doi:10.1186/1478-4505-11-13

Zeitler, M. S., Paine, A. D., Breitbart, V., Rickert, V. I., Olson, C., Stevens, L., . . . Davidson, L. L. (2006). Attitudes about intimate partner violence screening among an ethnically diverse sample of young women. *Journal of Adolescent Health*, *39*, 119.e111-119.e118. doi:10.1016/j.jadohealth.2005.09.004

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