ABSTRACT

MARAS, SHELLY ANN. Healthcare as an Institution of Social Control: Intimate Partner Violence Survivors’ Experiences of Medicalization, Safety, and Punitive Care

Intimate partner violence (IPV) is considered a public health crisis due to the short and long-term health problems that abuse creates for women. According to the Centers for Disease Control and Prevention (2021), IPV is a pattern of coercive behaviors used by a current or former partner via physical, sexual, or psychological violence. It is estimated that 1 in 4 women in the United States experience IPV, which puts women at risk for physical, sexual, and mental health problems and injuries (National Coalition Against Domestic Violence 2020).

This dissertation contributes to sociological literature on medicine as a social control apparatus for the state. I draw from in-depth interviews with 20 women who have experienced IPV to show how abuse is socially controlled in healthcare settings. Specifically, I contribute to bodies of literature related to medicalization, patient safety, and punitive care.

My findings create a deeper understanding of IPV survivors’ experiences seeking health care, particularly how the healthcare system controls abused women’s experiences of health and violence. In Chapter 3, I extend the work of medical sociologists to show how clinicians utilize the clinical gaze to medicalize abuse. In Chapter 4, I contribute to the literature on patient safety. Drawing on sociologists’ conception of safety, I argue that providers fail to assess for violence and safety. Therefore, I argue that safety does not emerge between patients experiencing violence and providers. In Chapter 5, I add to growing literature that addresses how IPV survivors are clients of many different state institutions at once, but how each system provides fragmented and punitive care. I focus on both healthcare and criminal justice systems in this chapter. Finally, in Chapter 6, I argue that the healthcare system acts as an apparatus of social control for the state through the mechanisms of medicalization, patient safety, and punitive care.
Although I recognize that institutional changes will not prevent violence from occurring, I argue for a systems-based approach to healthcare to improve the healthcare system’s response to IPV.
Healthcare as an Institution of Social Control: Intimate Partner Violence Survivors’ Experiences of Medicalization, Safety, and Punitive Care

by
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A dissertation submitted to the Graduate Faculty of North Carolina State University in partial fulfillment of the requirements for the degree of Doctor of Philosophy in Sociology

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DEDICATION

To the women whose stories are told here, and all the women who have a story to tell.

Your strength inspires me.
BIOGRAPHY

Shelly Ann Maras was born on August 26th, 1993 in Erie, Pennsylvania to Sherrie and Dave Maras. Shelly attended Iroquois High School and graduated in 2011. Upon graduating from high school, she attended Indiana University of Pennsylvania where she earned both a Bachelor’s (2015) and a Master’s degree (2018) in Sociology. From there, Shelly moved to Raleigh, NC to pursue a PhD in Sociology at North Carolina State University. Her research primarily focuses on intimate partner violence survivors’ experiences seeking health care. Although she is also interested in research related to women’s health more generally and medical sociology. She hopes to pursue an applied research career in public health before eventually going into academia.
ACKNOWLEDGMENTS

First, I would like to thank my support system – my family and my friends. To the two strongest women in my life, my mom and my grandma, I would not be who I am or where I am today without your unwavering support and belief in me to do anything I set my mind to. To my brother who is always in my corner rooting for me. I am also grateful for my friends near and far who have always shown up for me and encouraged me to reach the finish line – you are my chosen family; you know who you are. And a big thank you to my friends I made in this graduate program, particularly Marissa and Sierra, for always lending a listening ear and helping me to edit any document I send your way.

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I am also grateful for all the sociologists whose work has inspired me to become a sociologist and fight for social justice. I believe our work has a purpose to make the world a better place, even on the days where the world seems dark and heavy.
Finally, I want to thank all the women who shared their stories with me – my work would not exist without each of you. Thank you for sharing your stories with me, stories that were not easy to tell; I recognize that and am so grateful for your willingness to share. I know you all agreed to participate because you want to spread awareness about intimate partner violence. I hope that you feel heard and that this project makes you proud. I intend to continue to stand by your side and fight for improved policies related to intimate partner violence.
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CHAPTER ONE
INTRODUCTION

Intimate partner violence (IPV), commonly referred to as domestic violence, is a pattern of coercive behaviors used to control a current or former romantic partner through physical violence, sexual violence, stalking, and psychological abuse (Centers for Disease Control and Prevention 2021). In the United States, it is estimated that 1 in 4 women experience IPV, and women between the ages of 18 and 24 are most abused by an intimate partner (National Coalition Against Domestic Violence 2020). IPV is also a racialized issue as the rates of IPV experienced by black, American Indian or Alaska Native, and multiracial non-Hispanic women is 30-50% higher than those experiences by non-Hispanic white women (National Center for Injury Prevention and Control 2010). The World Health Organization (2021) estimates that 27% of women aged 15-49 worldwide have be subjected to some form of violence by an intimate partner. In severe cases, women are killed by intimate partners – as many as 38% of women murdered are committed by an intimate partner globally (World Health Organization 2021).

IPV is considered a public health crisis because it causes serious short and long-term physical, mental, and sexual health problems for women. As violence increases in frequency and severity, health problems become more severe (Black et al. 2011). As result, abused women seek health care services often. In fact, it is estimated that abused women seek health care services almost twice as much as women who do not experience IPV (Ulrich et al. 2003).

This study contributes to a growing body of literature that focuses on abused women’s experiences seeking health care. Existing research documents the ways in which the healthcare sector fails to appropriately detect women experiencing violence and referring them to crucial social resources to support and help them leave abusive relationships (Tower et al. 2006; Tower
et al. 2012; Williamson 2009). However, much of the existing research does not provide a sociological or feminist analysis of how the healthcare system is a social control apparatus used to control abused women’s lives. This study addresses this by conducting in-depth interviews with women who have experienced IPV and sought health care for IPV-related symptoms. Understanding IPV survivors’ experiences is crucial to understanding how the healthcare system continues to work as a social control apparatus over women seeking help for violence.

STATEMENT OF THE PROBLEM

Women who experience IPV are at risk for physical health problems and injuries. Women who experience IPV may have headaches, back pain, chronic pain, vaginal infections, depression, and digestive problems (Campbell et al. 2002; Chang et al. 2005; Coker et al. 2004). Moreover, many abused women sustain minor and severe physical injuries. About 1 in 3 women have been slapped, pushed, or shoved by an intimate partner (Black et al. 2011), and around 42% of women report an injury because of violence (World Health Organization 2021). According to Sheridan and Nash (2007), injuries most commonly occur on women’s face, neck, and head, and less commonly on women’s abdomen, back, and genitals. Women are also at risk for more severe injuries, such as mild traumatic brain injuries caused by external force, strangulation, and/or punching to women’s head or neck (Davis 2014; Haag et al. 2019; Ivany et al. 2018). Mild traumatic injuries lead to further complications such as fatigue, confusion, aggression, memory loss, dementia, and depression (Haag et al. 2019). Finally, IPV can lead to fatal outcomes like homicide or suicide (World Health Organization 2021).

IPV also predisposes women to sexual health issues – gynecological problems, sexually transmitted diseases, and induced abortions (World Health Organization 2021). Sexual violence occurs in many cases of IPV – as many as 1 in 10 women have been raped by a partner (Black et
al. 2011; Dutton et al. 2015). Women who are pregnant are especially in a vulnerable state, and those that experience IPV are at risk for miscarriage, stillbirth, preterm delivery, and low birth weight babies (World Health Organization 2021). Thus, abuse can lead to both immediate and long-term negative health consequences for women, and physical and sexual violence may exacerbate women’s risk of mental health problems.

Research finds that IPV places women at risk for depression, anxiety, post-traumatic stress disorder, eating disorders, sleeping problems, and suicidal ideation (National Coalition Against Domestic Violence 2020; World Health Organization 2021). According to the World Health Organization (2021), women who have experienced IPV are twice as likely to experience depression, and almost twice as likely to experience alcohol use disorders than women who do not experience IPV. There is further evidence that women who are abused experience fear, self-blame, and guilt (Martin 2009). Negative mental health consequences may lead to suicidal ideation, and it is estimated that as many as 35-40% of abused women attempt suicide in the United States (Haesler 2013).

Due to the physical, sexual, and mental health effects of IPV, many abused women seek out health care services, such as mental health, substance abuse, and emergency departments, which leads to high health care costs for survivors of IPV (Black et al. 2011; Rivera et al. 2017). It is estimated that women who experience IPV incur 2-2.5 times the costs of non-abused counterparts and incur more than $5.8 billion in health care costs per year (Bonomi et al. 2009; Chang et al. 2005). The more severe abuse is, the higher the costs of care, too. For example, over a 3-year period, Snow Jones et al. (2006) find that women who experience physical, sexual, and mental abuse have the highest health care costs averaging $9,673, followed by women with physical and mental abuse averaging $9,210, followed by women with only mental abuse
averaging $6,931. Meanwhile, the average health care cost for non-abused women is only $4,826 (Snow Jones et al. 2006). Just as health problems may continue after abuse has ended, so can health care costs. Bonomi et al. (2009) find that survivors who have suffered from physical violence for 5 or more years spend 19% more on health care per year post-abuse than women who have never experienced IPV.

The healthcare sector is often the first point of formal help-seeking for many women experiencing IPV, placing health care providers in a unique position to respond to abuse (Bacchus et al. 2003). Nonetheless, the healthcare sector’s response to IPV has been described as negative and inadequate (Tower et al. 2012; Williamson 2009). Research suggests that women seeking health care for IPV experience inadequate assessments, which may lead women to feel punished and undeserving of health care, resulting in disengagement from health care professionals and further isolation (Tower et al. 2006).

Improving care is essential for connecting women to critically needed resources. Black et al. (2011) argue that the “healthcare system’s response must be strengthened and better coordinated for sexual violence, stalking, and intimate partner violence survivors to help navigate the healthcare system and access needed services and resources in the short and long term” (90). More importantly, if abuse is undetected within healthcare settings, health-related conditions can worsen (Chrisler and Ferguson 2006).

It is then essential to understand abused women’s experiences in the healthcare system. However, we need to understand abused women’s experiences from a sociological lens. A sociological framework uncovers larger, structural issues that may be leading to poor outcomes in healthcare settings. This is the goal of this dissertation, and I show how medicine acts as a
social control apparatus of the state. It is the inherent nature of healthcare that continues to create poor outcomes for survivors seeking health care.

RESEARCH PROBLEM AND QUESTIONS

Existing literature has documented abused women’s experiences in health care; however, many of these studies are outdated (Bacchus et al. 2003; Chang et al. 2003; Chang et al. 2005; Haesler 2013; Spangaro et al. 2010; Tower et al. 2006). Additionally, much of the existing research is done from a public health standpoint and is lacking a conceptual and theoretical lens for understanding IPV survivors’ help-seeking experiences, particularly from sociological and feminist frameworks. Sociological research has extensively examined both IPV and healthcare as an apparatus of social control separately. However, no studies to date examine the how the healthcare system is a control apparatus of the state when it comes to gender-based violence. I address this gap by examining how healthcare controls IPV survivors’ experiences via medicalization, patient safety, and punitive care.

Grounded theory is a way of thinking about and conceptualizing data (Strauss and Corbin 1998). Under this approach, what is studied emerges from the data via an analytic process, rather than being decided upon before data is collected (Clarke 2012). Grounded theory is also a way of analyzing actions and making connections between actions (Charmaz 2014). In studying human action, grounded theorists develop theories about social processes that occur in the data. Therefore, grounded theory is essential for addressing the process by which survivors of IPV seek health care.
Research Questions

The main overarching question guiding this research was, *what is the process for seeking health care for survivors of intimate partner violence?* Related to this broad, overall question, I had more focused questions. Part of understanding the process of seeking care is understanding women’s experiences, *how do women who have experienced IPV describe, make sense of, and perceive their experiences seeking care within the healthcare system?* Along with understanding abused women’s experiences seeking help, I was also interested in issues of safety within the healthcare sector, *how is safety sought by women within healthcare settings and is it achieved?* And finally, related to women’s experiences seeking care and safety, I wanted to understand the overall process of navigating the healthcare system, *what is the process that abused women go through navigating the healthcare sector?* These three sub-questions guide the main findings presented in this dissertation, in that order.

LITERATURE REVIEW

In this section, I detail literature that is relevant to the overall contents of this dissertation. First, I detail what previous studies have found regarding abused women’s experiences seeking health care. Second, I cover the rise of the anti-violence movement that began in the 1970s and how this movement incorporated social control apparatuses into the movement. Third, I highlight intersectionality, and the importance of utilizing intersectionality to understand abused women’s experiences. These bodies of literature contextualize my overall research topic and frame the findings presented in the ensuing chapters of this dissertation.

Survivors’ Experiences Seeking Health Care

Contrary to beliefs about abused women being helpless, many women actively engage in a range of strategies to deal with victimization – like seeking health care (Barrett and St. Pierre
Seeking help is essential for women to leave abusive relationships but is also a very dangerous time for survivors. Extant literature has documented the barriers women face disclosing abuse to health care professionals (Bacchus et al. 2003; Chang et al. 2003; Chang et al. 2005; Spangaro et al. 2010; Spangaro et al. 2011), instances where women have been revictimized by health care professionals after disclosure (Anderson and Aviles 2006; Bybee and Sullivan 2005; Spangaro et al. 2020; Tower et al. 2015), and what abused women desire in their interactions with health care professionals (Chang et al. 2005; Spangaro et al. 2020), which I detail in this section.

Very few women voluntarily disclose abuse to health care professionals because they are too embarrassed or afraid to do so (Bacchus et al. 2003). Further research suggests that women may not disclose due to shame, fear of their abuser, belief that health care professionals will not understand their situation, or fear of being reported to statutory officers (Bacchus et al. 2003; Spangaro et al. 2010; Spangaro et al. 2020). While women may not voluntarily disclose abuse, research suggests that women are more likely to do so if directly asked about abuse by health care professionals (Bacchus et al. 2003; Chang et al. 2005). Moreover, even when women are not ready to disclose abuse, they support screening practices and prefer to receive resources about IPV, such as brochures or informational cards, rather than not to (Chang et al. 2005; Spangaro et al. 2020).

For women who do disclose, studies show that women report anger, embarrassment, and frustration when health providers blame, pity, or misunderstand their situation (Anderson and Aviles 2006; Tower et al. 2015). Other times, health care providers may do nothing about abuse disclosures, or offer unhelpful advice. For instance, in Bacchus et al.’s (2003) study abused women were advised by their general practitioners to take a rest or a vacation – advice that
women were generally unhappy with. When health care professionals do not properly address abuse disclosures, women lose opportunities to receive referrals to specialized services, such as social services, and women’s distress remains uninterrupted after disclosing (Spangaro et al 2020). Thus, after disclosing and nothing being done about abuse, women feel invalidated by health professionals – revictimizing women experiencing IPV (Bybee and Sullivan 2005). These negative interactions with health care professionals exhibit that the healthcare system needs to improve its response to IPV. Even worse, it shows how the healthcare system’s practices and policies control women’s experiences of health care and violence.

The Anti-Violence Movement and the Rise of Social Control

Following anti-violence feminist movements, the 1970s through the 1990s ushered in successful policy reforms (Stark 2012; Sweet 2021). By the end of the 1990s, federal and state laws defined domestic violence as a criminal offense, provided victims Protection from Abuse Orders (PFAs), and funded a range of programs, such as shelters, legal assistance, and intervention programs for abusers (Stark 2012). During this same time, domestic violence was framed as an epidemic, or a public health crisis in need of treatment (Sweet 2021). These reforms created new roles for criminal justice and health care workers alike when dealing with IPV; they now had a duty to identify and respond to cases of IPV, rather than regarding abuse as a “private” family matter. However, the criminal justice and healthcare systems’ involvement in violence gave each institution the power to manage social problems via social control.

During the anti-domestic violence movement of the 1970s, agents of crime control began to occupy the social movement, which was once devoid of carceral involvement (Kim 2020). The anti-violence movement turned to criminalization as a tool for social justice (Simon 2007). Kim (2020) argues that the domination of crime control within the feminist, anti-violence social
movement is a process called the carceral creep. The progressive movement demanded law enforcement protections and punishments. Consequentially, the movement successfully criminalized gender-based violence, strengthened penalties, and created new policies, such as mandatory arrests (Kim 2020). Kim (2020) argues that this process led the feminist, social movement to become submissive to the masculine, punitive state.

In fact, many social movements follow this progression as they seek out neoliberal solutions to social problems (Bernstein 2010). Bullimer (2008) demonstrates how feminist movements often become infected by neoliberal strategies of social control. In the 2000s, feminist sexual violence agendas were marked by neoliberal strategies of criminalization (Bullimer 2008). For example, in antitrafficking campaigns, perpetrators and victims are criminalized; pimps may be arrested as sex traffickers and sex workers are arrested for their own protection (Bernstein 2007). This is an intentional consequence of the movement adopting neoliberal social control tactics (Bernstein 2010).

Not only did the anti-violence movement redefine the role of law enforcement, but reforms relied on a model of abuse that defines domestic violence as discrete assaults or threats. Stark (2012) refers to this as the “violent incident model (200)” because it implies that abuse is dependent on physical injuries and incidents. This model is problematic because it does not represent the nature of most domestic violence cases; most survivors experience prolonged patterns of isolation, exploitation, manipulation, and control (Stark 2012). Thus, there is a gap between the reality of IPV and official definitions of it.

As with the criminal justice system, the healthcare system acts as an institution of social control. Since the late 1950s, medical sociologists have conceptualized healthcare as a social control apparatus. Parsons (1951) was the first sociologist to conceptualize medicine as a form
of social control. Parsons (1951) argued that sickness is a form of deviance and people must adhere to the sick role as a mechanism of social control. Extending on this analysis, Waitzkin (1979) argues that medicine is a repressive state apparatus, like the army, police, prisons, and other institutions. Furthermore, Conrad (1979) argues that “medical social control is the acceptance of a medical perspective as the dominant definition of certain phenomenon. When medical perspectives of problems and their solutions become dominant, they dimmish competing definitions” (2).

Influential medical sociologist, Peter Conrad (1992), has argued that healthcare system has gained control over people’s lives via medicalization. Through medicalization, the healthcare system has the greatest social control power to define what is and is not a valid medical concern (Conrad and Schneider 1980). The process of medicalization has been applied to both deviant behaviors and conditions and “natural processes” (Conrad 1992). As a result, the boundaries of medicine are flexible and expansive (Conrad 1979). According to Conrad (1992), medicalization precedes and facilitates medical social control, which leads the way to medical authority and powerful medical technology. Medicalization leads to social control via physician collaboration, technology, ideology, and medical surveillance (Conrad 1979; Conrad 1992).

First, clinicians collaborate in the process of medicalization by acting as agents of social control (Maynard 1991). Physicians are information providers, gatekeepers, and institutional agents (Conrad 1992). Zola (2009) argues that the healthcare system makes final judgements over people’s lives via objective experts that are morally neutral. Healthcare institutions maintain dominance over laypeople’s lives because the nature of scientific knowledge is inaccessible to most people. Thus, laypeople typically submit to medical authorities. There is an inherent power imbalance in patient-provider interactions, which enables social control within
and outside of medical institutions (Waitzkin 1979). Ultimately, medical authority figures, like doctors, often act in the interest of the capitalist class, which creates and maintains a class structure in society (Waitzkin 1979).

Second, medical technology creates many vehicles for social control. Drugs, surgery, genetic screening, and other screenings are used as a form of social control (Conrad 1992). For example, psychoactive medications are used to control behavioral deviance, such as valium for anxiety (Conrad 1979). Genetic screening may be used to discourage parents from having children if there is a high risk of genetic impairment (Conrad 1979). Thus, medical technologies are used as a means for social control.

Third, medical ideology imposes a medical model based on social and ideological beliefs (Conrad 1992). According to Waitzkins (1979), ideologic state apparatuses are institutions that instill ideologies in the population. Science is a perfected ideology because its claims to go beyond beliefs; science is objective and value-free (Habermas 1970). Furthermore, medical science excludes laypeople from obtaining expertise, which maintains medical dominance (Waitzkins 1979). Patient-physician interactions reinforce ideological production and social control (Waitzkins 1979).

Fourth, through medical surveillance, clinicians lay claims to activities concerning certain behaviors or conditions (Conrad 1992). Foucault’s (1963) work on the clinical gaze shows how medical professionals are trained to look at the body objectively and to provide medical surveillance. For instance, Conrad (1992) argues that childbirth is an example of increased medical surveillance. Despite medical innovations, clinicians monitor all activities related to childbirth. In fact, clinicians have extended surveillance to extend to prenatal lifestyles, infertility, and postnatal interaction with babies (Arney 1982; Conrad 1992).
Nonetheless, institutions may experience changes in social control, and social control mechanisms are subject to change (Conrad 1992). Clinical social control cannot be expected to replace earlier forms of social control. For instance, although drug abuse has been medicalized, it remains largely controlled by the criminal justice system, rather than the healthcare system (Conrad 1992). Therefore, Conrad (1992) argues that it is not surprising that we see social issues controlled by both criminal and medical institutions.

Although we know that medical institutions are agents of social control, rarely do sociologists investigate how the healthcare system controls gender-based violence, and more specifically IPV. In this dissertation, I investigate the case of IPV to understand how the medical system controls IPV survivors’ lived experiences, and to a certain extent, how the criminal justice system does as well. In other words, I examine how both institutions control IPV simultaneously. However, I place a larger emphasis on the healthcare system because this was the gap in the literature that I sought out to investigate.

Intersectionality

Issues related to IPV are compounded when women’s race, culture, and socioeconomic status are considered (Bent-Goodley 2007). Crenshaw (1991) argues that the intersectionality of abuse warrants greater attention. Black feminists created the concept of intersectionality to problematize categorical analyses and social identities (Barrios et al. 2020; Crenshaw 2015). Bent-Goodley (2007) states that when only one aspect of abuse is considered, researchers develop an incomplete analysis of abuse (Bent-Goodley 2007). Therefore, an intersectional framework is useful in research. Intersectionality allows researchers to contextualize participants’ narratives to account for the interconnections among social identities and develop complex explanations for people’s experiences (Barrios et al. 2020; Crenshaw 2015).
Violence disproportionately affects racial and ethnic minority women. Cho (2012) finds that black women experience disproportionately higher rates of IPV. Black women are also more likely to be victimized by multiple forms of violence within a relationship (Breiding et al. 2014). Golden et al. (2013) find that rates of IPV are higher among foreign-born women, especially among noncitizens that have recently arrived in the United States.

Research documents racial and ethnic disparities among women’s help-seeking behaviors (Lipsky et al. 2006). Women of color experience disproportionately high rates of unemployment, which makes women less able to depend on friends and family for temporary shelter (Crenshaw 1991). When it comes to health care, black and Hispanic women face financial barriers accessing physical and mental health care services (Vega and Alegria 2001). Additionally, Hispanic and Asian women face unique barriers related to fear of deportation, dedication to family, and a cultural stigma related to divorce (Bauer et al. 2000). Immigrant women also face language barriers that impedes their ability to seek help (Crenshaw 1991).

Socioeconomic status also limits abused women’s ability to seek help. Women in abusive relationships experience a decline in resources as abuse becomes more extreme (Davies et al. 2015), which impacts their ability to seek help. Bybee and Sullivan (2005) find that women with low socioeconomic status report fewer social supports. Barrett and St. Pierre (2011) support this finding; they find that women in Canada with an income below $30,000 are less likely to access formal support services compared to women with incomes above $30,000.

Systems of race, gender, and class converge, which affects abused women’s experiences of violence (Crenshaw 1991). Abused women experiencing multiple forms of oppression are hyper-marginalized. Hyper-marginalized groups experience multiple inequalities that affect their everyday experiences (Comfort et al. 2015). For instance, Golden et al. (2013) find that
economic hardship, low educational levels, and lack of control over household finances converge to increase women’s risk of emotional abuse and coercion. Additionally, Cho (2012) finds that blacks experience higher rates of IPV victimization; however, when controlling for income, rates tend to be similar to white and Hispanic women.

Therefore, successful violence intervention strategies must consider intersectional experiences to account for the hardships faced by minority and lower-class women (Crenshaw 1991). In this dissertation, I account for how gender, race, and class intersect to suggest ways in which we might improve formal help resources, particularly within the healthcare system, that account for intersectional experiences.

GAP IN THE LITERATURE AND CONTRIBUTIONS

The findings presented in this dissertation contribute to existing literature regarding healthcare as a social control apparatus. I add to the literature in three keyways. First, I build on the work of Foucault and others to argue that the healthcare system utilizes the clinical gaze to medicalize abuse. As a result, I argue that abused women become disenfranchised from the healthcare system. Second, I build on sociological literature regarding patient safety. Contributing to Rhode et al.’s (2016) conceptualization of safety, I argue that clinicians fail to acknowledge safety from violence in interactions with patients. Third, building on Haney (2018) and Comfort et al.’s (2015) work, I show how institutions that are meant to help IPV survivors intersect in important ways. At the same time, institutions provide fragmented and punitive care to IPV survivors seeking help and safety.

Altogether, I show how issues of medicalization, patient safety, and punitive care converge to maintain healthcare as a social control apparatus of the state. While this dissertation
mainly focuses on the healthcare system, I also highlight how the criminal justice system works as a control apparatus in chapter 5.

I conclude this dissertation with a way forward to address some of the barriers and negative experiences women have had within the healthcare system. I argue for a systems-based approach, which would help link healthcare systems to community resources and provide a conscientious approach to IPV in healthcare settings. Ultimately, this dissertation contributes to sociological literature on medicalization, patient safety, and punitive care. I use the knowledge gained from this study to suggest more beneficial policies and practices in healthcare settings.

PREVIEW OF DISSERTATION

This dissertation is organized in 6 chapters as follows.

In Chapter 2, I outline the methodological approach I took for this study. Specially, I explain the research approach, sampling strategies, key demographics, data collection, and data analysis.

In Chapter 3, extending on work done by medical sociologists, I describe how health care providers evoke the clinical gaze to medicalize IPV survivors’ health care seeking experiences. Further, I show how providers rely on controlling images of women to pathologize women’s bodies. In interactions with IPV survivors, I find that health care providers evoke paternalism to control patient-provider interactions. I explain how processes of medicalization and pathologization disenfranchise abused women from seeking future health care.

In Chapter 4, I contribute to medical sociologists’ work on patient safety. More specifically, I extend on Rhodes et al.’s (2016) conceptualization of patient safety. According to Rhodes et al. (2016), safety emerges between people, and between people and their environments. Therefore, I use the case of IPV to examine how safety emerges among providers
and patients seeking care for violence. I argue that providers often fail to assess for safety, so safety typically does not emerge between providers and patients.

In Chapter 5, I add to sociological literature on institutional intersectionality, which explains how survivors of IPV are required to become clients of many institutions as they seek safety (Haney 2018). Participants describe seeking care from criminal justice and healthcare institutions at the same time, and how each failed them simultaneously. Institutional intersectionality explains how institutions intersect to impact survivors’ experiences seeking care. However, I also build on work of Comfort et al. (2015) to argue how institutions provide fragmented and punitive care to IPV survivors.

In Chapter 6, I explain how the healthcare system weaponizes medicalization, safety, and punitive care to control abused women’s health care seeking experiences. I also highlight a potential way for the healthcare system to improve its response to IPV survivors. I conclude with limitations and areas for future research.
CHAPTER TWO
RESEARCH METHODS

For this study, I conducted a qualitative in-depth interview study with survivors of IPV to investigate their experiences seeking health care. In this chapter, I explain the qualitative approach I employed in this study. I begin by outlining my research question. Then, I explain and provide a rationale for my research approach. Next, I explain how I recruited my sample and provide information about my sample and their key demographics. Following this, I provide details about data collection, analysis, and management. Finally, I end with a note on researcher reflexivity and positionality.

RESEARCH QUESTION

As outlined in the previous chapter, the main overarching question guiding my research was: what is the process for seeking health care for survivors of intimate partner violence? By asking this question, I wanted to discover how IPV survivors described, made sense of, and perceived their experiences seeking care within the healthcare system. Existing literature suggests that the healthcare system’s response to IPV is inadequate, and at times, harmful to survivors (Tower et al. 2012; Williamson 2009). However, existing literature is missing a conceptual and theoretical lens for understanding abused women’s experiences, so this study uses a grounded theory approach to theorize IPV survivors’ health care seeking experiences via a sociological lens. Using a grounded theory, I discover themes about how the healthcare system works as a system of social control over survivors’ experiences.

This study takes a qualitative approach to deeply understand women’s lived experiences seeking health care for IPV-related health concerns; a qualitative approach is conducive to richer,
more in-depth data. Lawless (2001) argues that listening to respondent’s stories tells us more about lived experiences than quantifiable data can. For example, quantifiable data can tell us the association between abuse and health care usage, but it can’t tell us about the specific experiences seeking care and interacting with health care professionals. Obtaining this knowledge is important if we are to reform and improve the healthcare system’s response to IPV to better serve survivors’ needs. Thus, I used interviews to elicit in-depth responses about survivors’ experiences, perceptions, and knowledge seeking health care. Additionally, I took an inductive, rather than a deductive approach, because I aimed to discover new information about IPV survivors’ experiences navigating the healthcare system. Employing this method, I also discovered new information that I did not set out to find, such as women’s experiences interacting with law enforcement officials that was an important part of many women’s stories seeking help.

RESEARCH APPROACH

This study utilizes a grounded theory methodological approach. Methodologically speaking, grounded theory consists of “systematic, yet flexible guidelines for collecting and analyzing qualitative data to construct theories from the data themselves” (Charmaz 2014:1). In other words, rather than testing an existing theory, grounded theory strives to build theory (Patton 2015). This approach encourages researchers to move past description, and to construct theoretical explanations for social processes (Charmaz 2014). Allen (2011) argues that feminist researchers can use grounded theory to develop an empowering strategy to help abused women. Ultimately, I wanted to ground new theoretical and conceptual information about survivors’ experiences navigating the healthcare system to theorize about the unique struggles they faced in order to develop new ways forward to improve health care.
Grounded theory aligns with a constructivist approach. Social constructionism challenges positivism and assumes that people create their realities by interacting in a network of relationships (Patton 2015). Charmaz (2014) states that constructivist grounded theorists take an inductive, emergent, and open-ended approach. Because I was not seeking to test any existing theory, but to reconceptualize abused women’s experiences seeking healthcare, I took this type of approach.

Allen (2011) argues that constructivist grounded theory is useful for studying women’s experiences of IPV to account for both the structural aspects that limit women’s freedom and choices and their individual constructions of abuse and responses to it. For this research, I took this approach to understand the structural constraints abused women face when seeking care and navigating the healthcare system, as well as to understand their individual experiences and meanings they ascribed to interacting with health care professionals and the overall process of seeking health care.

Within constructivist grounded theory, it is understood that researchers produce constructions of the world based on their own interpretations (Charmaz 2014). It is often assumed that researchers utilizing grounded theory approach research from a blank state of mind, as if they do not have any preconceived notions of a given topic. However, Clarke (2005) argues that this is problematic because researchers are always influenced by the findings and insights of previous work. Charmaz (2003) refers to this as the background ideas that inform research questions and problems. Therefore, the goal is to recontextualize a research topic. Using grounded theory, I was able to reconceptualize abused women’s health care seeking experiences by allowing new themes and patterns to emerge from participants’ narratives. As a result, my
research aligns with previous knowledge about this topic, but I add knowledge about processes that affect abused women’s experiences navigating the healthcare system.

According to Charmaz (2014) grounded theory research should extend beyond description and analyze processes that occur within a given phenomenon. Studying processes allows one to construct theory by focusing on the main processes and then developing the relationship between them (Charmaz 2014). In this dissertation, I focus on one process that affects women’s experiences seeking help in each chapter; in the conclusion, I describe how each separate process is related to one another to maintain healthcare as a social control apparatus for the state.

Social constructionists reject ideas about one objective truth about the world, but instead assert that people create multiple truths. In this study, I wanted to understand IPV survivors’ “truths.” In other words, I believe the narratives that women shared with me were truthful accounts of the incidences they have experienced from their position and their subjectivity within a given experience (Lawless 2001). Furthermore, I am cognizant of my interpretation of participants’ realities and the scientific conclusions I have constructed from them. The findings presented in this dissertation are not a universal truth, but a construction of participants’ truths. Said differently, the experiences of women seeking health care presented in this dissertation may not be true for all survivors of IPV, but they are true for the survivors that I interviewed.

RECRUITMENT AND SAMPLE

I began recruiting participants in September 2020, during the COVID-19 pandemic, upon receiving Institutional Review Board (IRB) approval, and recruitment ended in March 2021. I originally intended to recruit and interview participants in-person. However, the nature of the
pandemic changed my recruitment plans. Therefore, all participants were recruited virtually, through social media, and all interviews took place virtually as well.

I implemented a convenience sampling strategy to recruit participants because I was trying to locate a vulnerable population that is hard to reach. Convenience sampling is a strategy whereby participants are selected based on their availability (Patton 2015). Past research finds that convenience sampling is the best sampling method to use when interviewing women who have experienced IPV due to the sensitivity and intensity of the subject (Renzetti et al. 2018; Maras 2018). Following convenience sampling techniques, I utilized social media – Facebook and Reddit – to recruit participants by sharing my IRB-approved research flyer on both platforms. To see the recruitment flyer, see Appendix A.

I located pages on Facebook and Reddit that were for survivors of IPV. I found both private and public pages for survivors. To keep social media groups for survivors confidential, I will not name them here. When sharing the recruitment flyer on social media, I asked page administrators to post the flyer, or I posted it directly on pages – depending on whether pages were private or public.

Additionally, I recruited women via respondent-driven sampling, which is a strategy that involves asking initial participants to recruit others in their social networks (Patton 2015). Not only were survivors willing to contact others in their social networks, but they also recommended other social media pages for me to use for recruitment. In fact, the most useful
Facebook group I found (run by DomesticShelters.org\textsuperscript{1}) was recommended to me through respondent-driven sampling. This site posted the recruitment flyer multiple times throughout recruitment, and most respondents were recruited through this site.

In all, 33 IPV survivors indicated interest participating in this research. Out of the 33, 2 did not show up for a scheduled Zoom interview, 3 cancelled their scheduled interview and never rescheduled, 4 showed initial interest but never followed up, and 4 were excluded because they did not fit the study criteria – ex-boyfriend was abusive post-relationship, did not seek any health care for abuse-related symptoms, experienced parent’s violent relationship, and one was currently still in an abusive relationship. Therefore, the sample consisted of 20 IPV survivors total\textsuperscript{2}.

\textit{Study Criteria}

In order to participate, IPV survivors had to meet certain requirements. Participants had to: (1) be 18 years or older; (2) identify as women; (3) have been in an IPV relationship and have left abusive relationships 6 months ago or longer; (4) have sought health care; and (5) agree to be audio recorded.

First, participants had to be 18 years or older. I only wanted to include adults in this study for ethical and safety reasons, and to protect minors.

\textsuperscript{1} This Facebook page asked to be named in my study, which is why I name that one and not any of the others.

\textsuperscript{2} More on my sample size below.
Second, participants had to identify as women. While men also experience IPV, research shows that women are 5 to 8 times more likely than men to be survivors of IPV (Family Violence Prevention Fund 2004). Not only are women more likely to experience violence, but their experiences as victims are vastly different than men’s. For example, women are more likely to experience severe injuries from violence (Cantos et al. 1994). Moreover, men are less likely to seek help or report abuse, due in part because of challenges to masculinity (Drijber et al. 2013; Huntley et al. 2019).

Third, women interested in participating had to have personally been in an IPV relationship and left that abusive relationships 6 months ago or longer. Women currently in abusive relationships need to put their safety concerns above participating in research as they risk retaliation from partners for participating in research and disclosing abuse (Maras 2018). Moreover, Lawless (2001) asserts that women who have just recently been out of violent relationship tend to provide fragmented and incoherent stories, understandably, whereas women that are further from violence have more thoughtful reflections about violence they endured. I chose 6 months as the limit because I wanted to give women enough time to recover from their relationship and secure safety, but I did not want to exclude too many survivors who wanted to participate. As Beauchamp and Childress (2009) argue, excluding abused women completely from research due to fear of harm is paternalistic thereby denying women the opportunity to share their experiences so that future violence may be prevented. Previous research also finds that risks to IPV survivors in research participation are modest, with few exceptions such as people who may feel distress or regret participating. Rather, most survivors report that participating in research is beneficial due to the therapeutic nature of disclosing abuse (Birch and Miller 2000; Burgess-Proctor 2015; Clark and Walker 2011). Thus, I limited my sample to
survivors who left at least 6 months ago to protect the most vulnerable survivors of IPV but allowed survivors who wished to participate to do so.

Fourth, women had to have sought health care while they were in the abusive relationship. Because I was interested in learning about survivors’ experiences seeking health care, I ensured women sought health care for IPV-related symptoms, or at least sought health care while they were in their abusive relationship. Women typically seek routine health care, whether for gynecological visits or physical exams, which means that health care professionals can still address abuse for women during routine visits.

As for the fifth and final criterion, survivors had to agree to be audio recorded to ensure the integrity of the data, rather than depending on jottings during the interview, which are subject to misinterpretations or mishearing participants. Only participants who met all five inclusion criteria were included.

Sample Size and Characteristics

The sample consisted of 20 women. While this is a small sample size, it is not small for qualitative studies investigating survivors of IPV because this population is hard to reach and vulnerable. Qualitative studies with survivors often include sample sizes smaller than 20 (Bacchus et al. 2003; Bostock et al. 2009; O’Doherty et al. 2016; Othman et al. 2014). Due to the sensitive nature of IPV, recruiting survivors to participate in an interview is difficult, especially without being able to provide an incentive for participation, such as a gift card or another form of payment.

I conducted in-depth interviews with all 20 IPV survivors. Within grounded theory, the size of the sample does not matter as much as the quality of data (Charmaz 2014). The goal of
this research was not to generate generalizability among all IPV survivors seeking health care, but to generate a deep comprehension of survivors’ experiences and processes navigating the healthcare sector via in-depth interviews from a smaller sample size.

The women who participated in my research ranged in age from 29-65, with an average age of 46. Women were located all over the US in different time zones, from California to Maine. One participant lived in the UK but spent half her time in the US. The sample is not very racially diverse; 14 identified as White (70%), 3 identified as Hispanic or Mexican (15%), 2 identified as mixed race (10%), and 1 identified as Black (5%). Participants’ education ranged from high school/GED to a master’s degree. Most women in the sample were mothers, 19 out of 20 had children. Refer to Table 1.1 for demographic information.
<table>
<thead>
<tr>
<th>Name</th>
<th>Age</th>
<th>Gender</th>
<th>Race</th>
<th>Education</th>
<th>Sexual Orientation</th>
<th>Location</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alyssa</td>
<td>52</td>
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<td>White</td>
<td>Bachelor's in Elementary Education</td>
<td>Heterosexual</td>
<td>Florida</td>
</tr>
<tr>
<td>Celine</td>
<td>59</td>
<td>Woman</td>
<td>White</td>
<td>Master's in Nursing</td>
<td>Heterosexual</td>
<td>Unknown - CST time zone</td>
</tr>
<tr>
<td>Christian</td>
<td>62</td>
<td>Woman</td>
<td>Black</td>
<td>High School</td>
<td>Heterosexual</td>
<td>Pennsylvania</td>
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<tr>
<td>Fiona</td>
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<td>Woman</td>
<td>Hispanic</td>
<td>Bachelor's in Fine Arts and Design</td>
<td>Bisexual</td>
<td>Texas</td>
</tr>
<tr>
<td>Lauren</td>
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<td>White</td>
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<td>Heterosexual</td>
<td>South Carolina</td>
</tr>
<tr>
<td>Lily</td>
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<td>White</td>
<td>High School</td>
<td>Heterosexual</td>
<td>North Carolina</td>
</tr>
<tr>
<td>Holly</td>
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<td>White</td>
<td>Bachelor's Degree in Nursing</td>
<td>Heterosexual</td>
<td>North Carolina</td>
</tr>
<tr>
<td>Louisa</td>
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<td>White</td>
<td>Master's in Social Work</td>
<td>Heterosexual</td>
<td>Unknown - EST time zone</td>
</tr>
<tr>
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<td>White</td>
<td>Bachelor's Degree in Human Services</td>
<td>Heterosexual</td>
<td>Arizona</td>
</tr>
<tr>
<td>Lindsay</td>
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<td>White</td>
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<td>Heterosexual</td>
<td>UK/Florida</td>
</tr>
<tr>
<td>Roxanne</td>
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<td>Hispanic</td>
<td>Some College</td>
<td>Bisexual</td>
<td>Texas</td>
</tr>
<tr>
<td>Meagan</td>
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<td>Woman</td>
<td>White</td>
<td>Some College</td>
<td>Heterosexual</td>
<td>Colorado</td>
</tr>
<tr>
<td>Rhonda</td>
<td>52</td>
<td>Woman</td>
<td>White</td>
<td>Associates Degree in Computer Science</td>
<td>Heterosexual</td>
<td>CST time zone</td>
</tr>
<tr>
<td>Tina</td>
<td>65</td>
<td>Woman</td>
<td>White</td>
<td>Master's Degree</td>
<td>Heterosexual</td>
<td>Maine</td>
</tr>
<tr>
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</tr>
<tr>
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<td>Mexican</td>
<td>Some College</td>
<td>Bisexual;</td>
<td>Oregon</td>
</tr>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Polyamorous</td>
<td></td>
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<td>Heterosexual</td>
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<td>Mixed - Hispanic and Asian</td>
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<td>Bisexual</td>
<td>California</td>
</tr>
<tr>
<td>Krystal</td>
<td>56</td>
<td>Woman</td>
<td>White</td>
<td>GED</td>
<td>Heterosexual</td>
<td>Texas</td>
</tr>
</tbody>
</table>
DATA COLLECTION

When collecting data, interviews lasted from 36 minutes to 1 hour and 40 minutes; the average duration was 1 hour and 2 minutes. Due to the covid-19 pandemic, all interviews were conducted over the phone or Zoom, with 10 on the phone and 10 on Zoom. Participants could choose between the phone or Zoom, as we were discussing a very vulnerable and often traumatic subject. All interviews were recorded on Zoom, so they were securely recorded and saved to my Zoom cloud. To record phone interviews, I talked in a private space with participants on speaker phone and recorded the interview via Zoom on my computer close by.

**Phone and Zoom Interviews**

Within qualitative research, face-to-face interviews are regarded as the gold standard for data collection, as opposed to virtual or phone interviews. Most qualitative research generates data face-to-face (Gray et al. 2020). Nonetheless, studies do not find significant differences between phone, virtual, and in-person interviews; they find that phone and virtual interviews produce quality data that is rich and vivid with details (Gray et al. 2021; Sturges and Hanrahan 2004; Sweet 2002). Research suggests that both phone and Zoom interviews are conducive to in-depth interviewing techniques in qualitative research (Reñosa et al. 2021; Sturges and Hanrahan 2004; Sweet 2002).

According to previous research, there are certain advantages of using the phone to conduct interviews. Sweet (2002) argues that telephone methods can reach participants who are geographically distant. Additionally, phone interviews may improve research participation because the level of anonymity associated with talking over the phone (Sweet 2002). In other qualitative studies, participants requested to discuss sensitive information over the phone rather
than in person (Kavanaugh and Ayers 1998). Therefore, because survivors of abuse are traditionally difficult to recruit for research studies (Maras 2018) and are being asked to discuss sensitive information, phone interviews are a viable and effective approach.

Similarly, recent research highlights the advantages of utilizing Zoom Video Communications Inc. (Zoom) to conduct in-depth qualitative interviews, such as the convenience and ease of use for participants, a personal interface to discuss personal subjects, accessibility, and cost and time saving because it eliminates the need for travel (Gray et al. 2020). Further, Zoom offers an opportunity to connect with participants who are geographically dispersed. Regarding the quality of remote interviews, Reñosa et al. (2021) conclude that they evoke a meaningful level of depth with enough nuance and conviction for researchers to meet their objectives. Like phone interviews, research suggests that remote interviews produce quality data, which is also why I used this option, and I wanted the opportunity to meet participants as close to in-person as possible by using Zoom.

Importantly, there was a difference between Zoom and phone interviews, namely that Zoom allowed an opportunity to observe participants’ body language and emotional cues. While Gray et al. (2020) note there is a missed opportunity to observe the participant’s physical space and respond to body language and emotional cues during Zoom interviews, this was not the case in my research – Zoom allowed me to gauge these. Nonetheless, I believe half of participants chose to do phone interviews because of the level of anonymity it offered when discussing sensitive information, as Sweet (2002) and Kavanaugh and Ayers (1998) suggest is a benefit of phone interviews. However, I was not able to accurately gauge how participants were feeling during phone interviews, as I could only rely on the sound of their voice. If I suspected participants were getting uncomfortable or upset, I verbally checked in if they were okay and
asked if they wanted to continue. In all, I did not observe a significant difference among the quality of data produced vis-à-vis the phone or Zoom; I found both produced quality data to answer my research questions, especially given the circumstances of collecting data during a pandemic.

_In-Depth Interviews_

According to Morris (2015), during in-depth interviewing, researchers ask participants a series of questions and follow up questions to elicit as much information as possible from an interviewee. It is an effective method for collecting detail-rich data for qualitative research (Morris 2015). Within grounded theory, this interviewing method is also referred to as intensive interviewing, which is a gently guided discussion that focuses on an interviewee’s expertise on a topic (Charmaz 2014). Furthermore, according to Hesse-Biber and Leavy (2007) in-depth interviews are also a valuable method in feminist research. Interviews allow feminist researchers to gain new perspectives on the lives of women in a particular society or social group (Hesse-Biber and Leavy 2007). I utilized interviews to evoke in-depth responses about survivors’ experiences navigating the healthcare system,

Originally, my interviews were guided by a semi-structured interview guide; to view the guide please see Appendix B. Interview guides help researchers prepare for their interviews (Charmaz 2014). A semi-structured interview guide documents particular questions the researcher wants to ask but leaves room for digression and for the interview to be more conversational (Morris 2015). Semi-structured interview guides typically require modifications, however, and researchers often fine-tune their questions as they gain a better understanding of how and when to ask questions during their conversations with interviewees (Charmaz 2014).
As I continued to interview IPV survivors, interviews strayed from the semi-structured interview guide and became more unstructured. According to Hesse-Biber and Leavy (2007) unstructured interviews tend to “go with the flow” of the interview; there are specific ideas that a researcher wants to address, but the questions are more unstructured. Often, the women I interviewed began to take the conversation in a different direction, to discuss things that were important to them, but weren’t necessarily part of my original interview guide. I would allow women to talk about these things and ask follow-up questions. However, if the conversation began to stray too far from experiences seeking health care, I would return to my interview guide for guidance to bring women back on topic.

In all, the stories that interviewees tell are rich sources of knowledge production. The level of detail and data produced from my interviews gave me a lot of data to answer my research questions and produced new theoretical and conceptual ideas about abused women’s health care seeking experiences as I analyzed my data.

DATA ANALYSIS

The first step in analyzing my data was transcribing all recorded interviews. All interviews were recorded using Zoom. From there, I transcribed all audio files, and I replaced all interviewees’ names with pseudonyms that I generated by Googling a list of random women’s names. I imported each interview transcript into the software Dedoose to code my data.

Data analysis was an ongoing process as I conducted my research. I utilized grounded theory techniques to analyze data, which include simultaneous involvement in data collection and analysis, constructing analytic codes and categories from the data, memo-writing to elaborate categories, and advancing theory at every step of the process (Glaser and Strauss
Therefore, I analyzed my data as I was collecting it; in other words, I did not wait until I collected my entire sample to analyze my data, but data analysis happened simultaneously as I collected my data. To analyze my data, I utilized grounded theory coding strategies, which involves two steps – initial coding and focused coding (Charmaz 2014).

I began analyzing my data with initial coding. Coding refers to the process of categorizing segments of data with a short name, or a code, that describes and summarizes what is occurring in each piece of raw data to raise the data to a conceptual level (Charmaz 2014; Corbin and Strauss 2008). During initial coding, researchers closely examine fragments of data, such as words, lines, and segments, to determine their analytic importance (Charmaz 2014). The goal of initial coding is to remain open to all theoretical directions that may emerge from the data, but to stick close to the data – initial coding is grounded in the data. Rather than applying pre-existing codes to the data, I developed codes as I analyzed segments of data. As I coded, I also took memos regarding each code and its analytical importance and implication.

After initial coding, I engaged in focused coding, which involves using the most significant codes developed during initial coding to examine large amounts of data (Charmaz 2014). Focused coding requires making decisions about which initial codes hold the most analytic weight, and how to code data incisively (Charmaz 2014). During focused coding, I elaborated on the most significant analytical codes that I developed during initial coding and refined and reorganized the data by analyzing these codes.

During both initial and focused coding, I wrote memos on emerging themes within the data. Memos are a form of written record where preliminary analysis of the data takes place (Charmaz 2014; Corbin and Strauss 2008). According to Corbin and Strauss (2008) every researcher develops their own memo writing styles; for me, this meant recording memos while I
was initially coding in Dedoose, and then recording more in-depth memos and outlines in Word as I engaged in focused coding. Memo writing enabled me to elevate codes into conceptual themes and patterns.

However, while seeking meaning in women’s words, Allen (2011) reminds us that the goal of the researcher is to present participants’ words and experiences as faithfully as possible to the meanings they have constructed. While coding and writing memos, I wanted to stick as close to women’s actual experiences as possible, while also elevating codes to a more theoretical understanding. In all, through an iterative process of data collection, coding, and memo-writing, I advanced the data to a conceptual and theoretical level and constructed the analysis and the findings that I present within the ensuing chapters of my dissertation.

DATA MANAGEMENT

To protect participants and the data I took several steps to securely manage the data: (1) I gained informed consent from participants; (2) I concealed participants’ identities; and (3) I securely stored data. All three processes were approved by NC State’s IRB. First, I gained and recorded oral consent from all participants at the beginning of the interview. Consent was recorded via Zoom, and then securely stored in an encrypted volume in VeraCrypt on my NCSU desktop computer. Second, while I collected direct identifiers related to participants, such as their name, phone number, email, and audio recording, I protected their identity by keeping a record, or a master list that I stored on my NCSU desktop computer in an encrypted volume on VeraCrypt. The master list connected participants’ identifying information to their pseudonyms. I assigned each participant a pseudonym and refrained from reporting on any unique identifiers about participants in the write-up of my study. Third, I safely stored all data in a secure volume in VeraCrypt on my NCSU desktop computer, which only I had access to.
RESEARCHER REFLEXIVITY AND POSITIONALITY

Traditionally, positivist research assumes that the researcher is an objective actor, and that knowledge exists independently of the researcher. Meanwhile, constructivist research, like grounded theory, acknowledges the active role that researchers play when constructing knowledge. Charmaz (2014) states this best in saying that researchers “are not passive receptacles into with data are poured. We are not scientific observers who can dismiss scrutiny of our values by claiming scientific neutrality and authority” (27). This is precisely why researchers must evoke reflexivity when conducting qualitative, constructivist research studies.

Reflexivity refers to the way a researcher examines how their own interests, positions, and assumptions influence their research decisions and interpretations (Charmaz 2014). Reflexivity urges researchers to be cognizant of the cultural, political, social, linguistic, and economic background of one’s own perspective and of the interviewee’s perspective (Patton 2015). Allen (2011) writes that despite efforts to reduce power imbalances between researcher and participant, there is an implicit power imbalance, which researchers must reflect on as they interpret their participants’ stories. Therefore, I was mindful of my position as a white, middle-class, woman, graduate researcher during this project. While there were some cultural, political, social, and economic similarities between participants and I, there were other areas where we differed. I reflected on my own biases throughout my research project to avoid “othering” participants.

It is important to note here that while I have never been in an intimate partner violence relationship myself, I did witness emotional and physical violence among my parents growing up. Having lived through traumatic experiences is what drew me to this research topic. As Lawless (2001) writes, we are drawn to work that has meaning to us and to study topics that have
no relation to us seems futile. Participants would often ask me why I was conducting this study prior to our interview, and I would share with them parts of my personal interest in this study from my childhood. I believe that this helped to build rapport with participants and allowed them to feel comfortable opening to me and sharing intimate details with me.

Moreover, I have worked as a sexual assault response advocate at a women’s domestic violence shelter in North Carolina for 3 years. My work as a sexual assault response advocate has also allowed me to build rapport with participants because I am familiar working with vulnerable populations that have experienced trauma. My work as an advocate prepared me to be mindful of how and when I asked participants certain questions. If I noticed that participants were getting overwhelmed, emotional, and/or crying, I was able to pause the interview and ask if they were okay or skip any interview questions that I thought might be too triggering. Additionally, I actively listened to what participants were saying, and I periodically checked to ensure participants wanted to continue our interview. Moreover, at the end of every interview I asked if participants were okay, if they had a support system, and if they needed any additional resources. Thankfully, all participants were in a place where they had support systems in place and declined additional resources, but they were thankful that I asked them.

I was cognizant of my personal experiences with IPV as I conducted this research. I listened to women’s stories and learned from them firsthand what being in a violent relationship was like, and what seeking health care for IPV-related symptoms was like. In other words, I was aware of my status as both an “insider” and an “outsider” when it comes to IPV (Hesse-Biber and Leavy 2007). I have witnessed IPV as a child and I have worked with women recovering from sexual assault, but I have never been in an abusive relationship myself. I have also never claimed to be an expert on this topic from my own experiences, but rather from research
investigating IPV, such as this study. As Lawless (2001) writes, she does not consider herself to be an authority on domestic violence, but an educated guide as she shares the voices of women she has studied.

While conducting interviews, I realized that participants were often grateful to have an opportunity to have a voice on this topic and to share their experiences with me. According to Lawless (2001), sharing stories is a powerful process for understanding women’s lived experiences of violence, survival, and healing, and making women feel heard. Storytelling can empower groups, like abused women, that have been historically silenced. In fact, Birch and Miller (2000) argue that qualitative interviewing provides some of the same benefits as therapy – it allows participants to reflect and reorder difficult past experiences while creating new meanings, much like what is done in therapy.

I originally thought survivors might be unwilling to share examples of the horrific things they endured, and sometimes they were, but participants were mostly very vulnerable and open about these experiences. Participants were also committed to improving care and services for future survivors, which is why they agreed to participate in the first place. Like Birch and Miller (2000) suggest, I noticed how therapeutic some of the interviews were for survivors; they got to vent about their frustrations with systems meant to help them and about being victim-blamed by others in society. However, I also heard about how proud survivors were for the struggles they had overcome, despite their exhaustion. Interviews provided an opportunity for them to be heard and listened to.

In turn, I learned so much from survivors’ stories, more than I could have ever anticipated. The stories from the abused women I listened to are much more than data to me as a researcher. I was moved by each women’s story, and I will continue to use women’s voices to
fight for justice and to combat misconceptions about their lived experiences. In the following chapters, I tell their stories, and the conceptual and theoretical knowledge I gained and constructed from them via grounded theory.
CHAPTER THREE

“IT STARTED AVOIDING IT, WHAT’S THE POINT?”: THE CLINICAL GAZE, MEDICALIZATION, AND MEDICAL DISENFRANCHISEMENT

Scholars define intimate partner violence (IPV) as a public health crisis because women exposed to violence suffer from a range of health problems (Plichta 2004; Riemann 2019). Although intimate partner violence (IPV) creates many health problems for women, defining abuse as a medical condition can also be problematic. Research finds that the biomedical framework, premised on objectivity and detachment, has led to medical inaccuracies and mistreatment when it comes to gendered violence (Wade and Halligan 2017; Wilkerson 2019). Critics argue that the biomedical model invalidates patients’ lived experiences of abuse, leading to further stigma and harm for survivors of violence. The process of medicalizing abuse transforms the survivor into the disease or condition to be treated with medical interventions, rather than abuse (Sweet 2015). Even more problematic, Durazo (2016) argues that the healthcare industry has used medicalization as a tool to increase profits, legitimate the state, and maintain medical dominance. In short, medicalization can obscure the social forces that affect people’s health and well-being and is often based on an assumption that medical treatment is the only and/or the best option to alleviate symptoms (Barker 2010). Instead, to eradicate and adequately respond to violence, society needs political, economic, or social changes (Barker 2010).

Michel Foucault’s work on the clinical gaze has been very influential within sociological research on health and illness. However, few studies have explored how his work applies to IPV survivors’ experiences in healthcare settings. This study addresses that gap by examining how the clinical gaze, as described by Foucault (1963) and others, influences IPV survivors’
interactions with health care professionals. In this chapter, I investigate participants’
descriptions of their experiences seeking health care to understand how clinicians diagnose and
treat IPV survivors utilizing the clinical gaze to medicalize abuse.

I find that medical professionals evoke the clinical gaze to isolate IPV survivors’ injuries
and symptoms from the context in which they occur – abuse. Operating under the clinical gaze,
medical professionals simultaneously medicalize abuse and pathologize bodies, which results in
negative experiences seeking health care for IPV survivors. Consequentially, IPV survivors start
to avoid future health care and feel disenfranchised from the medical system.

LITERATURE REVIEW

Medicalization, The Clinical Gaze, and Paternalism

Sociologists are concerned with how a wide range of human experiences have become
defined as medical conditions through a process called medicalization (Barker 2010). Conrad
(2007) argues that medicalization is a process in which nonmedical conditions are redefined in
terms of illnesses and disorders. Social problems and conditions like obesity, antisocial
personalities, drinking alcohol, and gambling, have become medicalized. The medical
community redefines social problems as medical conditions to be treated via medical
interventions. By defining a biological disruption within, or variation of the human body as a
disease, medicalization gives the medical community undue authority over people’s bodies and
minds. The biomedical model is assumed to operate under scientific objectivity and detachment,
which means that clinicians typically disregard social determinants of disease (Wilkerson 2019).

There are benefits and drawbacks to medicalization. The case of anorexia is one instance
in which medicalization leads to positive outcomes. For instance, Saguy and Gruys (2010) argue
framing anorexia as a medical problem shifts the blame from the individual to genetic and/or social factors. Therefore, women suffering from anorexia need medical interventions, such as hospitalization and medical supervision, and anorexic women are not expected to “pull themselves up by their bootstraps” (Saguy and Gruys 2010). While the medicalization of anorexia shifts the blame from an individual to a biological or social problem, this does not always happen for other social problems, like abuse.

Through medicalization, the healthcare system diagnoses and treats incidences of IPV, but clinicians do not acknowledge how symptoms are caused. As a result, health providers may treat physical symptoms, such as injuries, gynecological problems, or digestive issues, without addressing the underlying cause of symptoms (Sutherland, Sullivan, and Bybee 2001). Health care professionals do not address how abuse is a social problem, and women do not receive necessary social resources to address abuse. The process of medicalization does not shift the blame from women to biological or social factors; rather, women’s bodies are scrutinized as health care professionals attempt to locate malfunctioning body parts for which women are blamed. When health care professionals only address isolated body parts, they are evoking the clinical gaze.

Michael Foucault coined the term the “clinical gaze” in his seminal book, The Birth of a Clinic, in 1963. During this time, physicians stopped asking “what is the matter with you?” and started asking “where does it hurt?” (Bourgois 2013:124). The clinical gaze transformed patient-physician interactions. Prior to the 1950s, patients expected physicians to listen to them describe their experience of illness. However, by the 1950s, physicians began to focus on isolated, diseased organs and ignored the social and personal realities of the patient (Bourgois 2013). Medical students learn how to isolate body parts and organs by dissecting cadavers in medical
school, which teaches them how to look at the body objectively and with clinical detachment, or to strip the body of its personhood (Walter 2004). As a result, students learn to interact with patients via the clinical gaze – to objectify patients rather than to build interpersonal relationships with them (Bourgois 2013). Consequentially, physicians may make diagnoses of the body that undermine the underlying social contributors to poor health (Lavis et al. 2015).

The arrival of modern positivistic science created another fundamental shift in medicine, the arrival of the biomedical model. The biomedical model values objective observation of symptoms and professional detachment (Wade and Halligan 2004; Walter 2004). According to the biomedical model, experts develop treatment trajectories that span diagnosis, treatment, and recovery (Tower et al. 2012). To follow this model, health care professionals attempt to medicalize social issues into manageable and treatable health problems, such as a fracture or an overdose (Lavis et al. 2015; Tower et al. 2012; Warshaw 1989). This process shifts problems away from the social context in which they occur, which effectively works to distance and protect health care professionals (Lavis et al. 2015). Patients’ concerns about their needs, relationships, and circumstances are dismissed and constructed as non-medical concerns (Wilkerson 2019).

However, IPV leads to health issues that are more complex than most because they are caused by abuse, rather than a disease, virus, or accident. Therefore, many health professionals regard IPV as a “wicked problem” that is a difficult, complex, stigmatized, and seemingly unmanageable condition (Young-Wolff et al. 2016). There is not a straightforward treatment trajectory or medical solution for IPV-related health problems, which challenges medical professional’s ability to treat it.
Survivors’ behavior was first elevated to a medical problem, or a psychiatric disorder, in 1979 when Lenore Walker suggested that Battered Women’s Syndrome was a psychological explanation for IPV survivors’ compliant and submissive behavior. Under this “syndrome,” women were pathologized for their passive and masochistic personalities (Walker 1979; Sweet 2014). While the Battered Women’s Syndrome is no longer a favorable explanation for IPV, its legacy still manifests itself in provider-patient interactions whereby health care providers may diagnose survivors experiencing trauma with psychiatric disorders.

Sweet (2014) argues that pathologizing women’s bodies in this way is a form of victim-blaming. When clinicians project pathologies deep into women’s bodies, women are subjected to victim-blaming attitudes, and they are blamed for having poor health. As Sweet (2014) describes, “under the logic of health, those who cannot properly manage themselves as healthy subjects are called out for being expensive and detrimental to the system” (50). The medial system frames women’s bodies as the problem to be addressed and labels women who are suffering from abuse as pathological, sick, or crazy (Stark et al. 1979). As a result, the health care system deflects attention away from social inequalities and oppression by constructing survivors of IPV as the problem (Durazo 2016).

While the biomedical model is assumed to be rooted in “science” and “objectivity,” research shows that health care recommendations and treatments may rely on stereotypes about women (Anspach 2010; Wilkerson 1998). For thousands of years, society believed that women suffered from hysterical disorders that were caused by reasons such as, but not limited to, the uterus moving throughout a woman’s body or from women being too sexual (Tasca et al. 2012). In Foucault’s (1963) analysis of the Charcot and Salètrière Clinic, he describes how psychiatric trainees were taught to examine women for hysteria using the clinical gaze by objectifying
women’s bodies. Trainees were instructed to touch women’s sexual reproductive areas, and if they became sexually aroused, women were taken away. Thus, trainees objectified women’s bodies and denied women’s personhood (Bourgois 2013), and treatment was based on subjective perceptions and stereotypes about women.

The DSM-III removed the concept of hysterical neurosis in 1980 (Tasca et al. 2012), but recent analyses show how the medical community treated women impacts care today. For instance, Davis (1988), a medical sociologist, documents the paternalistic nature of clinicians whereby they make moral judgements about women as wives and mothers, pathologize women’s problems, dismiss women’s complaints, and prescribe women tranquilizers. Additionally, research documents how physicians stereotype women to be more emotional and weaker than men, resulting in unequal treatments (Anspach 2010). Medicine enforces its own definition of reality over women’s experiences and perceptions by enforcing a “for her own good” approach to health care (Wilkerson 1998).

Furthermore, when considering race, we see how the healthcare system implements sexist and racist policies and practices when treating black women. Thomas (2022) argues that maternal and reproductive health institutions have not been objective or free from racist ideologies throughout history. The United States has historically viewed unregulated black reproduction as dangerous, and social policies have been developed to monitor and restrain black motherhood (Roberts 2017). Thus, the healthcare system’s ideas about black women impact the care they receive. For instance, Cottom (2019) argues that black women are assumed to be incompetent and therefore underserving of healthcare. Health care providers’ assumptions of black women are compounded by both gender and race, and medicine can control black women’s bodies as a result.
Nonetheless, recent scholars have challenged and critiqued the clinical gaze and the biomedical approach to medicine (Wade and Halligan 2017). Scholars such as Wilkinson and Pickett (2010) have shown how social determinants like income, education, and social support are related to increased morbidity rates and premature mortality. As a result, the healthcare system now recognizes social determinants of health as an important influence on health outcomes (Andermann 2018). However, the healthcare system has not easily adopted screening practices for social determinants of health. For instance, researchers are at odds about the necessity and usefulness of universal screening for IPV (Miller et al. 2015). Some studies find that screening leads to positive results and that adverse effects are minimal (McCloskey et al. 2006; O’Doherty et al. 2014), while others find that there is not enough empirical support of positive screening outcomes (MacMillen et al. 2009).

Regardless of the debate over screening, healthcare systems have attempted to improve their response to IPV. For example, many organizations have launched programs to help improve the healthcare system’s response to IPV\(^3\). Nonetheless, IPV remains underreported and underrecognized by health care professionals (Dicola and Spaar 2016). This suggests that the biomedical model remains the dominant approach to health care (Wade and Halligan 2017), especially when treating IPV.

Drawing from literature on the clinical gaze and medicalization, I investigate IPV survivors’ descriptions of their experiences seeking health care. Utilizing these concepts allows

us to understand how clinicians diagnose and treat IPV survivors operating under the biomedical model of health care. Scholars studying IPV survivors’ help-seeking experiences in health care rarely apply the clinical gaze and medicalization to contextualize women’s help seeking experiences, and this chapter addresses that gap.

FINDINGS

Based on my interviews, I find that survivors’ experiences seeking health care are medicalized and pathologized by healthcare professionals, which leads to medical disenfranchisement. In what follows, I detail this process in four processes. First, health care professionals evoke the clinical gaze to medicalize abuse by treating only physical manifestations or prescribing medication as a quick fix. Second, health care professionals pathologize survivors when they reframe survivors’ concerns as psychiatric disorders and/or respond to survivors as if they are hypochondriacs. Third, health care professionals evoke paternalism in patient-provider interactions to question women’s competency and make claims over women’s experiences. Fourth, the health care system disenfranchises IPV survivors from seeking future health care for both IPV and general health concerns.

Medicalization

Survivors’ narratives show how the abuse is medicalized in two main ways. First, health care providers treat survivors’ physical injuries and symptoms while avoiding the cause of them. Second, providers are quick to medicate patients as a quick “fix” for the symptoms they experience related to IPV. In both cases, I argue that health care professionals evoke the clinical gaze to medicalize abuse into individualized, manageable conditions and injuries.
Treating only the physical

IPV survivors described how health care professionals fixed or treated their physical injuries without addressing how women’s injuries were caused. Many survivors had experienced severe physical injuries from abuse. For example, in Lily’s case, her husband strangled her until she lost consciousness and he knocked her teeth out. When Lilly regained consciousness, her husband said, “Oh, you’re alive. Thank God. I thought you were dead.” Lily had to have her mouth wired shut at the hospital following this incident, but she described how health professionals left her to deal with the emotional aftereffects on her own, “I think they are so focused on like that crisis moment and the, her jaw is broken let’s wire it shut, and let her deal with her emotional mess. I don't know.” Using the clinical gaze, medical professionals focused on Lily’s jaw, and they did not address the cause of Lily’s injury. Although Child Protective Services (CPS) visited Lily in the hospital following this incident, she could not recall health care providers giving her any additional resources about domestic violence support.

Similarly, Roxanne suffered severe injuries after her boyfriend attacked her, punching her repeatedly in the face and choking her. Like in Lily’s case, health care professionals responded to Roxanne’s physical needs in her moment of crisis but did not ask what she needed beyond physical help. She recalled:

I don't remember a doctor or physician talking to me about what happened and what I was feeling at that point. I think they were just trying to, since I wasn't very coherent, they were just trying to figure out what injuries I had, internal if any.

Once again, health care professionals medicalized abuse via the clinical gaze. Medical personnel effectively stripped women’s symptoms away from the context in which they occurred to treat body parts and isolated injuries.
Additionally, I find that health care professionals evoke the clinical gaze when women seek care for other symptoms, like stress and heart problems too. When this occurs, health professionals assess physiological functions, but do not assess stressors beyond the body. Celine explained:

I don’t know if I told [my doctor] about the abuse, he was a cardiologist and he was kind of, that was his zone that he stayed in, he didn’t really go outside of that… these doctors, I don’t think they go outside of their specialty field or feel comfortable doing that.

Celine describes how her cardiologist evoked the clinical gaze to “stay in his zone.” In other words, her doctor objectively examined an isolated body part – her heart – and did not try to understand how life stressors, like abuse, could be affecting her heart health.

Although survivors recognized that a doctor’s job is to treat their physical, medical needs, survivors expressed that doctors should understand how abuse has affects their overall health.

For example, Yasmin told me:

I think they probably should have asked, maybe tried to put two and two together. I saw a new doctor yesterday, which is a neurologist, and I told her [about] the domestic violence situation, assaults, so on and so forth. And the reason I told her that is because she asked me if I had been under stress, and I said yes, doctor, I've been under severe stress, severe stress. Why I did not have a stroke is beyond me. And I made a joke, and I said, I guess it's not my time to go, she was very stiff, she was good, but she was stiff, you know, you can't go beyond that.

Yasmin’s doctor responded in a “stiff” manner because healthcare systems do not train providers to look at a patient’s personal history. Rather, neurologists, and other doctors, and trained to look at specific body parts objectively (Wade and Halligan 2017; Walter 2004). As Yasmin’s narrative indicates, women’s admission of violence may make clinicians uncomfortable in patient-provider interactions.

Previous studies find that health care professionals use metaphors such as “opening pandora’s box” or “opening a can of worms” to describe asking about IPV because abuse is
perceived as a seemingly difficult, complex, stigmatized, and unmanageable condition (Lavis et al. 2015; Sweet, 2015; Williston and Lafreniere, 2013; Young-Wolff et al. 2016). Participants in this study recognized how uncomfortable their physicians became upon disclosing abuse, and they often utilized the clinical gaze to frame abuse as outside of their scope of work (Lavis et al. 2015). For example, Lindsay explained, “I told my doctor I was being abused in about 2015 [or] 2016. And he told me it was a private matter.” Likewise, Christian expressed how she felt upon disclosing abuse, “It was like, okay, that's between a husband and a wife, a man and a woman, or she's going to go back to him. So alright, we're listening to your story, we understand, but you got to go.” Thus, providers evoke the clinical gaze to detach themselves from IPV survivors’ lived experiences, and as a result they diminish the effect that abuse has on women’s health.

While women acknowledged that health professionals did their jobs in terms of treating physical issues or symptoms, they expressed that they needed more than physical care at that time. For example, when I asked Meagan how her experiences were overall seeking care for abuse, she told me:

Um, I wouldn't call it a good experience. Because I honestly didn't get the help that I needed. Yes, I got a splint put on my arm that I took off myself six weeks later because I didn't want to go back. And that's basically all I got out of it. So, and I really needed more, I needed more help than that.

Therefore, while IPV survivors may be seeking help for physical injuries or symptoms, they often express needing more than the physical care they receive. Survivors need additional resources to help them leave abusive relationships and ensure safety. However, when clinicians medicalize abuse via medical treatments, women do not receive the resources they need to escape violence. Health care professionals evoking the clinical gaze to break abusive symptoms into isolated injuries is one way in which abuse is medicalized then; this also occurs when health care professionals treat abusive symptoms with medicine.
Medicating survivors

As evident from survivors’ stories, health care professionals are quick to prescribe women medication for IPV related symptoms. Previous research echoes this sentiment; for example, in their study of the prevalence of abuse in ERs, Stark et al. (1979) find that nearly 1 in 4 abused women received minor tranquilizers or pain medication. Stark et al. (1979) argue that is a dangerous solution for abuse, especially for women who have suicidal ideations. Medicalizing abuse ignores the context of the participants’ situation by assuming that medication is a quick fix to a social issue.

While Stark et al.’s (1979) study is outdated, many of the women in my study reported receiving medication for abuse related symptoms, typically anxiety or depression, without medical personnel taking the time to understand why women were experiencing these symptoms. For example, Lindsay, a white woman, was dismissed by her doctor when she tried to disclose abuse but was prescribed mediation anyways. She told me, “I'd gone for antidepressants, I think, and I broke down in tears. And I said, I'm living through some domestic abuse. And he said, well, that's none of my business and he gave me some anti-depressants.”

Similarly, when Rhonda, a white woman, was experiencing some health issues during her abusive relationship, doctors could not figure out what was wrong with her, so they prescribed her some medications anyways. As she explained:

That's probably why [the doctors] never found anything is because it was just because your body is in such stress, constantly. You're living in constant stress mode all the time, just to survive. And so, you know, it was probably bad, but no one, no one ever asked me [about abuse], that I remember. They just essentially said, it's in your head, I don't know why you're doing this. And then I had doctors that would, they would prescribe some medicine.

Once again, by using the clinical gaze to examine individual symptoms, clinicians detach women’s health problems from the context in which they occur. Under the clinical gaze,
clinicians avoid asking women about their social and personal realities (Wade and Halligan 2017; Walter 2004), which might help them to better understand women’s overall health.

Nonetheless, many survivors acknowledged the limitations of medication. For example, Natasha told me about how her emotional support dog was more beneficial to her than some of the medication she had been prescribed:

I guess, one therapist I seen was more positive. I mean, she was shocked at the things I told her about the courts and the police, but she was more positive. And she did help me to get an emotional support dog, which she wrote me a letter so that when I was living in places that don’t allow pets, I was able to get my dog and she’s, she’s a Pit Bull Terrier. She’s, she’s very friendly, but she makes me feel safer. That was, that was definitely helpful, you know, more helpful than medication really.

Therefore, medication is helpful to a certain extent. What is more helpful is listening to survivors’ stories and offering other solutions – like an emotional support dog – to help women feel heard, understood, and safe. However, there were also instances where IPV survivors actively sought medication to help alleviate some of their symptoms.

I do not intend to suggest that medicalization does not have any benefits. Rather, when health care professionals take the time to listen to women’s stories, they can provide appropriate treatments. Thus, receiving medication is not always a bad thing, it can be beneficial for some survivors. Fortunately, some of the women in this study had positive experiences seeking medication for mental health symptoms when their doctors took the time to listen to them and understand why they were seeking medication. Roxanne explained:

Once I actually told my doctor, my primary care physician, what had happened and everything, he was the best, like, he found something that worked for me, an anti-depressant. I have horrible anxiety, or had horrible anxiety, I still have anxiety to this day. But you know, he got me right, you know, to where I could go to therapy, to where I could, you know, talk about this, and it's kind of lessened the anxiety, and I feel more comfortable talking about it.
For Roxanne, prescribing medication was not a quick fix her abuse-related symptoms but was a stepping-stone in her healing process. With the medication, she was able to seek out therapy and talk about abuse. Therefore, the process of medication can in fact help survivors if health care providers take the time to understand patients’ social and personal realities, which requires providers to abandon the clinical gaze. It is problematic when providers evoke the clinical gaze and do not take the time to listen to survivors, but prescribe medication anyways, as was the case for Lindsay and Rhonda.

In all, I observed that medicalization occurred when clinicians used the medical gaze to isolate specific injuries and symptoms. In doing so, providers diagnosed and treated body parts void of abused women’s entire body or illness experience. As a result, I found that health care professionals dealt with physical injuries and symptoms, or provided medication for health concerns, without addressing abuse, resulting in a lack of referrals to social resources.

Pathologization

Aside from medicalizing abuse, evoking the clinical gaze is also problematic because it pathologizes bodies as the site of illnesses and disorders. When women stay in abusive relationships, they are pathologized for their presumed weak behavior (Sweet 2014). Society has constructed survivors of domestic violence as “sick,” “helpless,” or “masochistic” for remaining in abusive relationships – pathologizing survivors’ behavior, rather than their abusers’ (Stark et al. 1979). In doing so, the medical community attempts to fix women, rather than address abuse. In this study, I find that IPV survivors are pathologized two ways. First, I find that survivors are diagnosed with psychiatric disorders. Second, I find that health care professionals tell survivors their physical symptoms are “in their head,” making survivors feel crazy and/or like hypochondriacs.
Abuse as a psychiatric “disorder”

The pathologization of survivors transforms their experiences into a “sickness.” Most notably, I found this to be true in Tina’s story. Health care professionals incorrectly diagnosed Tina with Bipolar Two Disorder. Tina explained to me how she tried to kill herself because she could not endure anymore abuse in her relationship. When this happened, Tina was escorted to a hospital, and then sent to a mental health living facility. During her time in the mental health facility, Tina recounted:

I was sent to a counselor. And for six months, I had to see her, and I never said a word to her – didn’t say a word. I’d go in her office and sit down and stare at the floor, three days a week. Then it went down to two, then it went down to one. And one day I sat in her office and just started to cry. She cancelled all of her appointments for the day. And I sat in her office for seven hours. And all I could do was ball. And I finally started to talk about what happened to my life and all that stuff. But in the meantime, they still had me see psychiatrists, psychologists, and all that stuff. So, they diagnosed me with bipolar two. But I never went on bipolar medication except for two months. They gave me lithium, and it destroyed my thyroid. What they did do is put me on very high doses of anti-anxiety and depression medication.

As evident in Tina’s narrative, mental health care providers transformed Tina into the issue that needed to be “fixed” via diagnosis and treatment. When Tina was unable to talk about her trauma from abuse, both in her marriage and in her childhood, mental health providers pathologized Tina as suffering from a bipolar disorder. To treat her, health care providers gave Tina strong medication. The treatment led to more physical health complications for her when they destroyed her thyroid. Later in Tina’s narrative, she explains that health providers eventually diagnosed with Post-Traumatic Stress Disorder (PTSD), and she was originally misdiagnosed with Bipolar Two Disorder.

Using the clinical gaze, health care providers disregard abuse as a social determinant of health; rather, they locate the source of issues within the body. Consequentially, health care professionals diagnose abusive symptoms as a psychiatric problem for the victim – most
commonly to anxiety (Elderkin-Thompson and Waitzkin 1997; Stark et al. 1979). In fact, many of the survivors I interviewed were diagnosed with anxiety while seeking health care. Following an abusive episode, Alyssa sought health care, and this is what happened:

So I went to the doctor, to you know, just to go to the doctor, and they're like, are you okay? Do you think he'll hurt you? And I'm like, no, I don't think so. So, they gave me Klonopin for my anxiety. And again, I was like absolutely hysterical in your office, couldn't you ask me more questions?

Alyssa went to the doctor for help, doctors reduced her concerns to her own pathology – anxiety. She wanted doctors to understand her situation and assess how it was affecting her overall health. Later in Alyssa’s story, she explained how she began seeing a counselor who knew a family doctor she had started seeing, and coordinated her care, which led to improved outcomes. She said, “[Doctors] started hearing me and things started to get better. Like I was getting actual care for the things I really needed. Not just like, oh it's anxiety.”

Alyssa’s story highlights the importance of listening to survivors to avoid pathologizing them and reducing their trauma to a psychiatric disorder. When clinicians label psychological symptoms of violence as a disorder, this does not help to address abuse. Rather, health providers frame women as the problem to be fixed through medical interventions.

Women as crazy, hypochondriacs

Although clinicians pathologize women’s bodies and may be quick to prescribe medication, research also suggests that medical professionals may not take women seriously when there is not a clear biomedical diagnosis. In the absence of a diagnosis, providers tell women that their symptoms are “all in their head” and stereotype that women take up physician’s time with host of vague and endless complaints (Davis 1988). In searching for medical explanations for their symptoms, such as stomach pain, sleeplessness, and weight loss, patients suffering from unexplainable symptoms are often told there is nothing medically wrong and feel
as if they are crazy (Barker 2010). In this study, I find that providers rely on controlling images of women, and survivors who seek frequent care for IPV-related symptoms risk being labeled as hypochondriacs, or plain crazy.

This was the case for Rhonda who experienced a host of physical symptoms during and following her abusive relationship:

I went through a time from, like, 2008 to 2016, where I was having problems, and I didn't know what the cause was, but I was losing weight. I had all these symptoms. I had joint pain. My stomach hurt when I ate. We did all these tests, and the first doctor I saw, she's like, it's all in your head. Um, she never asked me about any, you know, if my marriage was good, nobody did.

Health care providers attempted to locate a specific body part that was malfunctioning by conducting a series of biomedical tests, but they could not provide a clear diagnosis. As Davis (1988) suggests, unexplainable and endless symptoms may lead health professionals to think that women are hypochondriacs or crazy. In Rhonda’s case, providers told her that all her symptoms were in her head – invalidating her experiences.

Wilkerson (2019) argues that the process of labeling women as hypochondriacs nullifies the healthcare system’s institutional responsibility to acknowledge assault. This exemplifies how the biomedical approach to violence fails women and contributes to systemic violence against women (Wilkerson 2019). I argue that this process occurs because medical students are not trained to understand how social determinants of health affect patients’ overall health; rather, they are trained to diagnose and treat individual body parts. As a result, health care providers do not understand how IPV affects health, and they often dismiss women’s complaints when they cannot offer a diagnosis. In doing so, they pathologize survivors and their bodies.

The biomedical model effectively diminishes the issue of gender-based violence by reframing survivors’ bodies as the site where disease and chronic illnesses exist. In diminishing
violence, the healthcare system holds women responsible for managing the symptoms associated
abuse – a “wicked” issue that does not concern medical professionals (Lavis et al. 2015). Rather,
health care providers rely on controlling images of women as crazy and dramatic to dismiss
abused women’s health concerns. The health care system uses its authority over bodies to
reframe abuse as a non-medical issue while simultaneously treating the symptoms created by
abuse. Often, clinicians provide medical recommendations and treatments that are paternalistic
in nature.

**Paternalism**

From survivors’ narratives, I find that providers evoke paternalism in interactions with
abused patients. Davis (1988) argues that paternalism occurs in medical interactions when
providers limit patients’ freedom and take a “for their own good” approach to medicine. Davis
(1988) finds that when women seek medical expertise, health care professionals may trivialize
their complaints and suggest that their own behavior is the result of their suffering. As a
solution, medical experts may give advice about how women should manage their lives,
suggesting that women do not know what is best for themselves (Davis 1988). Health
professionals may evoke their authority to dismiss women’s explanations of their health concerns
and provide their own explanation. The findings in this study echo those found by Davis. When
women sought out medical expertise for IPV-related symptoms, health care professionals used
their authority to provide explanations that blamed women and/or questioned women’s
competence over their own bodies.

This occurred when health care professionals attributed survivors’ symptoms to the stress
of being mothers. After leaving her abusive husband, Holly became a single mother of four. In
her marriage, she experienced severe trauma that affected her health both during and after her
divorce. When Holly sought medical care for her concerns, medical personnel insisted her experiences were solely due to being a mother of four children. Holly felt as though health care professionals were not listening to her and did not understand the trauma she went through:

I wish they would have listened to me more, like I wish they would have like, just stopped saying I was a mom of four children. Like, they just kept saying, even before I became a single mom, they were just kept saying, well, you have got a lot of stress. You have four kids under six... And they weren't listening to the fact that I was going through a lot of trauma and I had a lot of trauma done to me, emotionally and physically. And they just kept saying, well, you're just a mom of four kids.

Health care professionals disregarded abuse and proclaimed that Holly’s health concerns were because of her own choices – being a mother of four children. Rather than listening to Holly’s explanation of her health, they used authority to provide their own explanation – invalidating Holly’s own understanding of her life and her experiences.

Similarly, when Alyssa found out she was pregnant at the doctors’ office, she became extremely emotional. This was because of the abuse she endured the first time she got pregnant with her abuser. Alyssa was seeking care for dysplasia when she found out she was pregnant. She recalled:

And I'm going through dysplasia, and I was having a hard time because I'd had a number of different procedures to get rid of it. And [the doctor is] sitting there, and he's like, oh, you're pregnant! ... Oh, I lost it! I was sobbing in his office going, I can't have this baby! He never asked why. He's like, oh, you'll be okay, you'll get excited about it, it's just a shock because you didn't realize. I wish that he would have said like, you know, why is this so distressing to you? I probably would have said because my husband was physical with me when I was pregnant the first time! I can't be pregnant again.

Evoking paternalism, Alyssa’s doctor provided an explanation to her why she was so upset – she was simply shocked. Had he asked Alyssa why she was so upset, he would have learned that it was because she feared her husband would be violent with her during her pregnancy, like he was during the last. Rather, he assumed that she would get excited about the pregnancy once the “shock” wore off because it is a cultural expectation that all women want to be mothers.
Providers also use paternalism in interactions with survivors to question survivors’ competency over their own bodies. This was true for Louisa when she tried to explain to health care professionals how her head trauma was related to her memory loss. She told me:

I had talked to them about, you know, how can I put it, like just having been punched in the head so many times, or into brick walls, like there was a lot of physical stuff. And I've kind of said, you know, with my memory kind of shot, I kind of wonder [if it's related to abuse], and rather than them like taking time to ask, it's always kind of switched over to, oh, it could just be anxiety. Well, it could be, but it also could be something else… I think that's something that when people are trying to talk about something, you need to shut your mouth and listen, that's you know, it's helpful. It can help.

Once again, health professionals provide their own explanations for survivors’ health concerns without listening to their own explanations. The clinical gaze encourages providers to find a specific body part that is malfunctioning, so it is more likely for them to attribute symptoms to anxiety, than to validate survivors’ explanation of how abuse has caused symptoms.

As a result, the lack of recognition and understanding of abuse can lead medical experts to give advice that is unhelpful:

And [my doctor] kind of gave me like, some off things that I felt were just not helpful. Like, he told me, I should go for a walk every day, even though I'm exhausted from work and have four kids to take care of, you know, it's like, that's not helpful. And just kind of ignores the problem. And like, kind of said in a way that it was all in my head. And if I just make myself happier and stuff, you know, I'll just feel better. So, he just didn't get it, obviously, and I won't be going back to that doctor.

Taking a paternalistic approach, Natashia’s doctor blamed her situation – being a mother of four kids – for her health problems. To address her problem, Natashia’s doctor told her to take more walks and make herself happier. Natashia was terrified of her ex-husband showing up at her house, which is why she could not sleep at night, but her doctor disregarded this explanation.

Thus, gendered expectations lead health care providers to assume that women are incompetent when it comes to their health. However, this issue is further problematized when we consider race. While the sample in this study is mostly white, it is reasonable to assume that
Clinicians would question black women’s competency over their realities of IPV even more than the white women’s stories presented here. Cottom (2019) writes that healthcare is a bureaucracy, and that people in bureaucracies make decisions for other people. In healthcare systems, experts make decisions about patients based on the perceived competency of patients. Cottom (2019) argues that black women are assumed to be incompetent and therefore underserving of reasonable healthcare. This same experience would likely apply to black IPV survivors whereby their experiences are dismissed even more than white women. Health care professionals assume that white women are at least somewhat competent over their own health to begin with.

By evoking paternalism, health care providers exert control over patient-provider interactions, including diagnoses and treatments. Medical professionals hold power and authority to define the cause of survivors’ suffering and how women should “fix” their issues. In this study, patients often received unhelpful solutions, advice they did not ask for, and/or inadequate assessments of their health problems. Essentially, survivors were blamed for their own poor health and disempowered in patient-provider interactions, which dissuaded women from seeking future health care.

Disenfranchisement

I argue that health care professionals trained to use the clinical gaze medicalize and pathologize survivors’ health concerns. Additionally, health care providers evoke paternalism to define survivors’ situations, which minimizes women’s trauma and abuse. Consequentially, women become disempowered in medical interactions and they begin to avoid seeking health care — a process I am coining medical disenfranchisement. In this study, I find that medical disenfranchisement transpires via three main outlets: (1) women fail to disclose abuse to health care professionals; (2) clinicians stigmatize survivors; and (3) women avoid future health care altogether.
First, women fail to disclose abuse to providers because they do not have power in patient-provider interactions to do so. Research suggests that physicians’ authority in medical encounters dissuades survivors from disclosing abuse during patient-provider interactions (Wilkerson 2019). As previously highlighted, when health care professionals use paternalism to define patients’ experiences, women feel powerless in providing their own explanations, such as abuse. Moreover, survivors express frustration when health care providers do not try to understand the complexity of violence (Nicolaidis et al. 2008):

And when I told [my doctor about the abuse], I was alone, they could have pressed or asked me more questions. They did not. Like and I had to make a choice, do I keep babbling – blah, blah, blah? Just tell them, you know, more information that is going to go nowhere and waste of my time?

Upon disclosing abuse, Yasmin’s doctors did not validate her experiences. Her doctors’ reaction and lack of interest led her to believe that further disclosure was a waste of her time, so she withheld further information. Yasmin was disenfranchised to talk about abuse any further.

Second, health care providers may stigmatize survivors as they are seeking help, which blames women and makes them feel unworthy of help. For example, when I asked how health professionals made her feel, Nikki responded, “Gosh it's hard, like I didn't matter and that I must have deserved it and there was no fixing me, that I was too broken. That it was my fault.” Health care providers stigmatized Nikki by making her feel like she was the problem, and it was her fault for her health issues. Katy expressed these same sentiments as she was seeking help and how health providers exacerbated the shame she felt:

So, I feel as a survivor, as a victim, you just feel like it's not important. It's not a big deal. And it shuts you into more, it just puts you into more shame. Or, like, it's not important, like, oh, well, you know, they didn't, they didn't really ask about it, so it doesn't matter.

When providers stigmatize survivors in medical interactions, survivors are disempowered from their own experiences with violence and how it affects their well-being. By ignoring abuse,
especially when survivors try to talk about it, health care providers shame and disempower women. They also disempower survivors when they challenge survivors’ competence over their own bodies and experiences, which relates to Louisa’s case mentioned previously, in which providers would not listen to her about how her head trauma from violence was related to her memory issues. Rather, health care providers relegated her concerns to anxiety. When health care providers shut down survivors’ disclosure of abuse, this leads women to avoid health care.

Third, IPV survivors stop seeking future health care after negative encounters with medical professionals. Survivors become disenfranchised from the healthcare system when they lose trust in health care professionals and feel marginalized during patient-provider interactions. As Rhonda was telling me about a health care professional that would not listen to her concerns about a medication, she went on to say, “She was just very dismissive. And so that really turned me away, for many years, and it still does to this day, I don't like going to anybody.” From survivors’ stories, it is evident medical providers dismissed women’s concerns, which eroded trust. Medical trust is typically measured by patients’ belief that a doctor will put patients’ needs above all else (Stepanikova et al. 2006). Distrust also occurs when there is a lack of patient-centered communication and poor quality of care (McAlearney et al. 2012). Having trust in medical professionals is important because it facilitates health care seeking behaviors (Jacobs et al. 2006). When survivors lost trust that a medical provider is going to help, they stop seeking care:

[T]hat day when I went in with a broken rib, I mean, it was super obvious. I mean, I was covered in bruises. And no one asked me, no one asked me anything. So, it was just, I think women choose not to seek health care, because why? Nothing will be done (Lauren).

It is clear from survivors’ stories that health providers diminish trust when they do not address abuse or listen to survivors’ concerns. When women begin to lose trust in health care providers,
they become disenfranchised from health care altogether. As Krystal, a white woman, sums this up, “I started avoiding it, what’s the point?”

CONCLUSION

In conclusion, I argue that health care providers operate under the biomedical model of health, which encourages providers to utilize the clinical gaze. Using the clinical gaze, providers medicalize abuse and pathologize women’s bodies, which disenfranchises survivors from the healthcare system. This harms women who are being abused because they stop seeking care for injuries and symptoms related to abuse, even when they need it. While medicalization has proven to be effective in treating some social problems, like anorexia (Saguy and Gruys 2010), I find that medicalization leads health care professionals to disregard how abuse affects women’s health. On the one hand, medicalizing abuse enables health care professionals to treat physical manifestations of IPV and prescribe medication to help alleviative symptoms. On the other hand, medicalization leads health care professionals to address individual injuries and symptoms without acknowledging how abuse affects abused women’s overall health. As a result, survivors feel as though their situations do not matter and they do not receive needed social resources to help them address the real cause of their symptoms – abuse.

Building on Foucault’s (1963) work, I find that providers rely on the clinical gaze to isolate injuries and symptoms from the context in which they occur. Health care professionals have the expertise to define what is and is not a valid medical concern. Therefore, providers only attend to physical and mental manifestations of abuse regardless of the social context in which they occur. Moreover, I find that providers objectify women’s bodies as the site of intervention. Providers transform women’s bodies into the problems to be fixed, as Wilkerson (2019) and Sweet (2014) also find. Clinical detachment marginalizes patients’ lived experiences
(Walter 2004), so when health care professionals do not adequately address abuse and its implications on women’s overall health, women become disenfranchised from seeking health care, not just for abuse, but for other health concerns once they leave their relationships.

In recent years, scholars have criticized the clinical gaze and argued there are newer, more useful models for understanding health, such as the social model of health (Wade and Halligan 2017; Walter 2004). However, it is clear from survivors’ stories that the biomedical model and the clinical gaze are still the dominant modes that health professionals use to examine, diagnose, and treat women’s bodies. From survivors’ stories, health care providers used the clinical gaze to treat isolated body parts or isolated symptoms, like anxiety or sleeping issues, but did not address the cause of the problems. Therefore, despite efforts in some healthcare systems to increase efforts to detect and address abuse, this was not the experience of the survivors I interviewed in this study. For them, most health care professionals operated under the biomedical model of medicine.

Additionally, previous research finds that the healthcare system is still marked by years of treating women for hysteria where women’s bodies are pathologized and diagnoses and treatments are made based on assumptions and stereotypes about women (Anspach 2010; Davis 1988; Tasca et al. 2012). My research adds to these findings by examining IPV survivors’ experiences specifically. I find that medical professionals evoke controlling images of women as mentally ill and as single mothers when treating survivors of IPV. Their treatment options are then based on these assumptions, which include things like medication or suggesting women “take care of themselves” by taking walks.

It should be noted that white women’s experiences are mainly represented in this chapter. The voices of women of color are largely missing and their experiences of medicalization,
pathologization, and medical disenfranchisement are likely very different. For example, while I found that clinicians were quick to prescribe medication to alleviate abusive symptoms, this likely only applies to white women. Research shows that medical professionals are less likely to prescribe blacks pain medication because of stereotypes of them as drug abusers (Badredlin et al. 2019). Further, Cottom (2019) argues that the healthcare system denies the existence of black women’s pain, underdiagnoses pain, and refuses to treat pain. While the white IPV survivors in this study were mainly prescribed anxiety and depression medication, black women may also be denied this help, but more research needs to be done.

Health providers assume that black women are incompetent and underserving of health care (Cottom 2019). Therefore, their experiences seeking care is likely drastically different than the women’s stories noted here. First, health care providers are unlikely to conduct biomedical tests to assess what is causing somatic symptoms for black IPV survivors. Second, black women’s understanding of how abuse has affected their health is also much more likely to be denied, as black woman are already assumed to be incompetent (Cottom 2019). Future researchers need to address how race impacts health professionals use of the clinical gaze and the process of medicalization.

Also, the process of medical disenfranchisement presented in this chapter is likely only representative of white women who have trust in the medical system in the first place. It is widely documented that black people are more distrustful of the healthcare system compared to whites due to limited access to the healthcare system, historical segregation, and mistreatment and maltreatment by health care professionals (Boulware et al. 2003; Brandon et al. 2005; Byrd and Clayton 2002). The healthcare system has subjected minority women to harm through forced sterilization and other controlling reproductive tactics throughout history (Luna 2020;
Roberts 2017), which leaves them with little trust in the healthcare system to begin with. Therefore, black women seeking care for IPV likely already have distrust in the medical system and are already disenfranchised from it; they likely do not become disenfranchised due to medical interactions with health professionals while seeking help for IPV.

I would be remiss if I did not add a caveat to my findings – despite the largely negative interactions with health care professionals, participants recounted some positive interactions with health professionals, which led to much different outcomes for them. Often, women had a combination of negative and positive experiences seeking care from different health care providers. For survivors that had positive experiences seeking health care, health care professionals listened to them and validated their experiences – they did not take detached and objective approaches to medicine. For instance, Sarah sought health care previously from the Department of Veteran Affairs (VA) for her health concerns, but then she switched to a civilian health care provider. Sarah had a more positive experiences with her civilian health care provider who was highly supportive when she left her abusive relationship. She explained:

> When I told [my doctor] what had happened, she was amazing. And she's pretty much kind of been there since this all happened, you know, asking how me and [my daughters] are doing when I go in for my appointment, you know, making sure we're okay. Just being supportive in that aspect. Even though she is just my primary care physician. She will go above and beyond to make sure that my referrals are correctly submitted, so there's no issue for me receiving the care that I need.

I provide this caveat to stress the importance of health care professionals taking a well-informed, supportive, and comprehensive approach to treating survivors of IPV, which requires them to take the time to listen and understand patients, detect IPV, and make the appropriate referrals to social services. In other words, when providers do not assess survivors’ situations using the clinical gaze, survivors have much more positive outcomes seeking health care.
I began this chapter by detailing how IPV has been constructed as a public health concern. While the public health paradigm accurately highlights the health concerns experienced by many IPV survivors, it also shifts the burden of care onto health care professionals who are not always trained or prepared to respond to IPV adequately. As Bourgois (2013) argues, the neoliberal state of our healthcare system places medical professionals in a double bind – “either they spend the time and energy necessary to listen to and fully treat the patient and put their job and clinic in economic jeopardy, or they move at a frenetic pace to keep their practice afloat and only partially attend to the patient in their presence” (33). Unfortunately, unless the healthcare system changes how it approaches medicine, improved outcomes for IPV survivors are unlikely to occur.
CHAPTER FOUR

“YOU JUST WANT TO FEEL SAFE WHEN YOU GO TO A HEALTH CARE PROFESSIONAL:” INTIMATE PARTNER VIOLENCE AND PATIENT SAFETY

Beginning in the early 1990s, the healthcare system began to recognize clinical risk and patient safety as major system-level priorities (Jensen 2008; Waring et al. 2016). Following the 2000 American Institute of Medicine’s report titled To Err is Human: Building a Safer Health System, the medical community reconceptualized healthcare as a system that is unsafe due to human error (Jensen 2008; Zuiderent-Jerak et al. 2009). Upon this reconceptualization, social scientists began to argue that healthcare systems have a responsibility to ensure patient safety and that a lack of safety can be fixed through policy initiatives (Zuiderent-Jerak et al. 2009). As a result, many social scientists have focused their research agendas toward improving safety in healthcare systems. Medical sociologists, for instance, study how safety is understood, how it should be measured and analyzed, and how it should be addressed in healthcare settings (Waring et al. 2016).

Social scientists and policy makers broadly define patient safety as health care that is free from medical error and patient harm (Rhodes et al. 2016). Runciman et al. (2009) provide another definition of patient safety, “the reduction of risk of unnecessary harm associated with healthcare to an acceptable minimum” (19). However, many medical sociologists argue that patient safety is broader than absence of medical error or harm (Rhodes et al. 2016). Rhodes et al. (2016) argue that patient safety is contestable and negotiable – safety emerges from interactions between people, and between people and their environments (Rhodes et al. 2016). Thus, more recently, medical sociologists argue that we cannot take the concept of safety for granted (Zuiderent-Jerak et al. 2009). We need to understand how patient safety is multi-
dimensional and how dimensions may complement or conflict with one another based on the situation (Rhodes et al. 2016).

Empirical research studies argue that safety is achieved through routine feedback and monitoring or statistical data, strategic improvement in quality improvement, and attention to governance systems (Freeman et al. 2015). I argue that achieving patient safety is more complex than addressing safety within healthcare institutions through statistical monitoring and governance systems. The healthcare system creates adverse patient outcomes through more complex processes than medical error; patient-provider interactions, for example, can also jeopardize safety and outcomes. Following Rhodes et al.’s (2016) conceptualization of patient safety, I use the case of IPV to investigate how safety emerges from interactions between IPV survivors and the healthcare system. Sweet (2019) argues that health and legal systems are presumed to be “safe” spaces for victims of IPV; however, few research studies assess how patient safety is achieved in healthcare spaces for vulnerable patients. My study addresses that gap, and I answer the question: “how does patient safety emerge in interactions between IPV survivors, health care professionals, and the healthcare system?”

LITERATURE REVIEW

During the last two decades, numerous reports have exposed adverse patient outcomes in healthcare settings (Iidema 2009). Healthcare facilities create harm via medical errors, injury from medical devices, infections, and patient falls (Iidema 2009). Therefore, many social scientists have focused on system-level analyses to improve adverse patient outcomes (Allen et al. 2016; Runciman and Merry 2007). Since the publication of To Err is Human, policy makers, governments, and health care services have prioritized agendas regarding patient safety to improve health outcomes (Iidema 2009; Scott et al. 2012).
Medical sociologists differ regarding which definition of patient safety they embrace. Some use the general understanding of patient safety – health care that is free from harm and medical errors. Whereas others argue that we need to complexify our understanding of patient safety (Zuiderent-Jerak et al. 2009). Recently, sociologists began to consider patient definitions of safety (Scott et al. 2012). Ricci-Cabelo et al. (2017) argue that patients are ideally suited to reflect on the health care they receive to improve safety. However, patients’ conceptualization of safety may be in tension with physician and healthcare system’s definition of safety (Rhodes et al. 2016). For example, Scott et al. (2011) find that aside from traditional medical errors, patients value communication and patient centeredness in making people feel safe. Whereas Waring (2009) finds that clinicians often minimize risks into abstract, quantitative, and explicit variables to be managed. However, there is growing interest surrounding patients’ contributions to their own safety in healthcare settings (Allen et al. 2016). For example, recent sociologists look at how patients and service users can be involved in improving safety measures in healthcare settings (Allen et al. 2016). Patients can see things that healthcare workers may not and have a valuable perspective to contribute to patient safety.

Sociologists also debate where responsibility for patient safety resides – among patients or clinicians (Heavey et al. 2019). Only recently has the concept of responsibility been applied to medical sociological studies of patient safety. Individuals acting within institutions are responsible when they adhere to moral norms and institutionalized obligations (Giddens 1984; Heavey et al. 2019; Heimer and Staffen 1998). Typically, health care systems allocate responsibilities to health care professionals, but a growing body of literature suggests that patients are also responsible for maintaining safety (Evans 2007; Heavy et al. 2019). Therefore, scholars argue that responsibility for patient safety is complex. For instance, Heavey et al.
(2019) find that patients attribute the responsibility of safety to themselves, to health care professionals, and to a mix of both.

Previous research finds that the healthcare sector plays a vital role in ensuring IPV survivors’ safety as survivors seek health care for IPV-related concerns frequently. In fact, Campbell (2004) finds that most women in abusive relationships who are killed by their partners can be identified in healthcare settings prior to their death. This means that women seek out health care services before their partners kill them. Even though IPV survivors seek health care often, health care providers often fail to detect abuse in healthcare settings (Plichta 2007; Stark et al. 1979; Warshaw 1989). However, health care professionals’ failure to detect abuse can be fatal. Therefore, health care professionals have a responsibility to intervene in abusive relationships to help patients achieve safety.

Given the critiques of scientific conceptualizations of patient safety, recent sociological studies complicate safety by investigating the people-people interface of safety (Iidema 2009). In other words, sociologists study how safety is constructed and emergences from interactions between people, and how safety is performed into being by actors in institutions (Gherardi and Nicolini 2002; Rhodes et al. 2016; Waring 2009). For instance, Rhodes et al. (2016) argue that safety is accomplished through interactions between people, and between people and their environment. To study how safety is understood, many sociologists have turned to narrative studies to understand how people conceptualize safety through storytelling (Waring 2009). This study contributes to this line of inquiry. Building on Rhode et al.’s (2016) definition of safety, I examine how safety emerges between IPV survivors and health care professionals within healthcare systems via survivors’ narratives.
Although sociologists are critical of the definitions that are used to conceptualize safety, sociologists have also been criticized for providing analyses that are too critical and laden with doom (Allen et al. 2016). Thus, policy makers and social scientists view sociological critiques of patient safety as problematic when they do not provide alternatives for achieving patient safety (Latour 2004). Zuiderent-Jerak et al. (2009) state that there is a plea for medical sociologists to “get real” and to offer solutions to the problems they critique. Although not all sociologists agree with this standpoint, I argue that it is important to offer some solutions for the problems we critique, especially when they affect vulnerable populations. Therefore, I also describe IPV survivors’ suggestions to improve safety in healthcare settings.

FINDINGS

Safety Concerns

To start, I think it is important to contextualize IPV survivors’ safety concerns during and after abusive relationships. Previous research finds that women who experience violence live in fear (Ivany et al. 2018). Respondents in this study echoed this; they reported living in constant fear during the relationship, while they were estranged from their partners, and even after they left the relationship completely. Many women feared being killed by their partners. For instance, Alyssa told me:

I mean, literally, I would lay there thinking he literally would kill me, like it was a reality. In fact, when I left him, I didn't find this out until a few years later, but when I left him, he drove to a mutual friend of ours with the shotgun in the car and said that he was going to go to New York where my parents lived. He was going to find me and kill me.

After Alyssa left, her husband tried to find her with a shotgun in his car and threatened to kill her if he found her.
Holly recalled a similar experience. Holly moved states to get away from her husband. Before Holly moved, her husband had threatened her, telling her that he was going to hire a hitman to kill her. After she moved, Holly visited the ER because she was sick from the trauma she incurred.

I did end up having to go to the emergency room when I was really, really sick, and I thought I was dying... I wasn't dying, but I thought I was because of my trauma... I was literally like, going hysterical, I thought he was gonna come and kill me.

Many women’s fears are heightened when they are leaving their partners and attempting to seek safety, as evident in Holly’s and Alyssa’s stories.

Many participants expressed how dangerous leaving the relationship can be. Given the danger associated with leaving, women explained that leaving was not always the best option for them at one time. For example, Lily explained her frustration with the common narrative in our society that abused women should “just leave.” She said, “I think so many people say like, just leave, just leave, you need to leave, you need to leave, and that's not always the best option. And it’s not always the safest option, and not everybody's ready to do that.” Many people do not understand the danger associated with leaving an abusive partner, which means that women may be blamed for staying in abusive relationships.

Nonetheless, most women do leave, or try to, as abuse escalates (Barrett and St. Pierre 2011). Women do not stop fearing abusers after they have left, however, and may remain fearful for many years after leaving. Christian explained,

Here I am, I left my ex-husband, let’s say 89-90, and let’s say the marriage was finally over by 93, I didn’t write my book until 2007... My children told me, at the time, if you don’t write that book, you’re still afraid of him. So, I was still afraid in 2007 after leaving him in 1989.
For Christian, and many other women, they remain afraid of their abusers many years after leaving. Therefore, women continue to experience safety concerns. However, the institutions that are meant to help women achieve safety, often fail them. This includes many institutions, but I focus on the health care system in this chapter because it is often overlooked as a sight where IPV survivors’ safety should be prioritized. Therefore, I explain women’s conceptualization of patient safety and investigate how safety emerges through interactions with health care professionals.

*Health Care’s Responsibility to Patient Safety*

Despite the debate within sociological literature regarding where patient safety resides – among patients or providers (Evans 2007; Heavey et al. 2019) – IPV survivors indicate that healthcare systems have a responsibility to ensure their safety. Christian explained this to me and said, “You just want to feel safe when you go to a health care professional because really that is the only place you can feel safe.” When I asked Christian to elaborate on what she meant, she explained:

I guess I feel like, if you step into a hospital, where you know, you are going for treatment and to be taken care of, and back to your optimal health, it just seems to me, that even more than the police, is the place where you should be comforted. I don’t mean like hugs and kisses comforted, but where you should be healed, and that’s where the healing process should begin. Just like the things for cancer patients, and breast cancer patients especially, and all those other things.

Christian related IPV to cancer to show how healthcare is a space where survivors should be able to go and feel like they are safe and are going to be taken care of. As Christian stated, healthcare is a place where the healing process should begin.

Other participants elaborated on this belief and argued that medical institutions may be one of the only places women will be allowed to seek help, so they want to feel safe there. For
example, when I asked Meagan if health care was an ideal space to seek help for IPV, she responded:

The reason I think health care would be the best place is first, a woman will go there because she needs medical attention. And the man that she's with knows that she needs medical attention, so he's gonna allow her to go there, as long as, even if she has a fake story to tell, or as long as she promises not to tell them the truth or whatever – it doesn't matter what she tells them. I think that a man will allow a woman to go to a place like this. A lot of women are stuck in this situation. They can't, they're not allowed to go anywhere, or do anything. But if she needs medical attention, she's going to be allowed to go to the hospital, so I think that's like an in-between place that's safe.

As Meagan suggests, women often seek out health care services as their first form of formal help-seeking (Bacchus et al. 2003). Therefore, Meagan argued that healthcare is an ideal place to go because abusers are likely to allow women to seek medical care for their injuries or other medical concerns. Healthcare is a space where women should be able seek help and safety.

Viewing healthcare as a safe space to seek help, many participants believed that health care professionals have a responsibility to ensure patient safety. In fact, survivors who had worked in healthcare previously as nurses argued that it was health care professionals’ job to assess safety. For example, I asked Holly, a former nurse, if it was health care professionals’ role to ask about abuse, and she responded:

Oh, for sure. Yeah. Because even when I was in the ICU, if I would see bruises on people, I would ask them how they got them. I mean, I wouldn't be like out there with it. But I'd be like, ‘Oh, it looks like you got hurt here. Did you fall?’ Because it is our job, even with adults… I think health care professionals really do need to have that domestic violence assessment. I mean, especially if at one point that woman or man says yes, they should just have a whole write-up for them. And then the solution to all of it to help them.

Therefore, providers can assess for patient safety in interactions with patients. Health care providers should ask women about abuse to assess for safety and help women achieve safety.
Similarly, Celine used to be a nurse and I asked her if she thought it was health care professionals’ job to help maintain the safety of survivors in healthcare settings, to which she responded:

Oh yeah, yeah… In the hospital, that is a more controlled place, unless [health professionals] think you’re at risk of being revealed and somebody might come after you, I don’t know. I would think that there would be a way to have privacy and confidentiality if that patient needs you, without worrying about a dangerous situation. Celine frames health care as a controlled space whereby health professionals have authority to protect women’s privacy, confidentiality, and safety. Therefore, patients argue that safety can emerge through interactions with health care professionals if health professionals assess for patient safety. However, this was not the case for all respondents, in some cases, providers threatened women’s safety.

*Health Care Can Endanger Women’s Safety*

Trevillion et al. (2013) argue that health care professionals prioritize the safety of IPV survivors, and that health care providers should ask if it is safe for patients to return home. However, none of the women in this study experienced this type of action planning from health care professionals. In fact, I find that some participants experienced situations where providers put survivors in unsafe situations. I provide their stories to show the importance of ensuring that there are practices in place that protect patients’ safety, particularly for women who are already experiencing a lot of fear and danger.

Health care professionals jeopardized Christian’s, a black woman’s, safety while she was seeking health care following an abusive incident. She recounted:

Another time, when I had my collarbone broken, and [my partner] was chasing me through the street. Well, he broke my collarbone in the house, and then he ran out the house, he chased me through the street. And finally, the cops were like, circling the
block, they found me. So they put me on a stretcher, EMTs, and then the cops are trying to grab him. And then they're letting him come over to say something to me, and I'm like, what the fuck? So they get me to the hospital, I tell them everything, the EMTs are telling them everything, you know, I'm scared to death that he's going to come in there, right? And I'm telling [the health care professionals], keep him away from me, keep him away, and then when he calls the hospital, they bring me the phone. And I lose it. It's like, do you not get it? And maybe I didn't totally get it, I didn't talk to him. Then they're like, oh, we're sorry. It's so, it's just crazy.

Despite Christian’s pleas to keep her abuser away from her, health care professionals brought her the phone when her abuser called. Not only did this notify her abuser where she was, but it heightened her fear that he was going to come there. Christian justifies this situation by concluding that health care professionals did not understand what she was going through. However, they ultimately put her in more danger and did not ensure patient safety.

Holly, a white woman, had a similar experience where her safety and privacy were threatened. Holly’s ex-husband was a physician where she sought care, and he could access her medical charts. Holly was fearful that her husband would infringe on her privacy by accessing her charts without her consent. To make matters worse, Holly’s health providers failed to do anything to help protect her. Holly explained:

I wish that they would have just protected my privacy without me having to protect my privacy… [My ex-husband] was getting into my chart. And, you know, at first, I asked them, I said, do you have my chart under like a lock? Like he can't get [access to it]? Because, you know, it's illegal for him to do that, and I knew he was doing it, but they didn't really listen to me that he was. So, then they said, well, what we can do is put on break the glass so that even if he looks at it, we'll be notified. But then again, I was thinking, well, even if they're notified, are they even going to do anything?

Because Holly’s ex-husband was in the same network as her personal health care providers, Holly felt that her providers were not protecting her privacy and medical information. Rather, Holly felt like her providers would cover-up a breach in confidentiality for her ex-husband. Not only was her privacy not being protected, but Holly was also unable to disclose abuse because
she feared her husband would view her medical records. Altogether, her health care providers placed Holly in an unsafe position.

Although health care systems have implemented policies meant to protect patients’ information, such as The Health Insurance Portability and Accountability Act (HIPPA) of 1996, health care providers may not always be enforcing it. However, patients benefit from policies like HIPPA because abusers could much more easily access information about their partners before 1996. This was the case for Tina when she was in an abusive relationship before HIPPA. Tina recalled how easily her ex-husband could access her information or find out when her appointments were.

And with [my ex-husband], the medical profession used to, if your spouse called, and says, does so and so have appointments, when are they? They used to get those out. They can't do that anymore because of HIPPA, don't let them, unless I gave them permission. So you know, they can always show up and you know, they don't leave the room no matter what your doctor's appointment is for, and the doctors never told him he had to leave.

Once again, safety did not emerge via patient-provider interactions. Although HIPPA impedes abuser’s ability to access patient information, Tina brings up another good point — abusers may still accompany their partners to their doctor appointments, and abusers are not always asked to leave the room. In fact, survivors suggest that health professionals ask men to leave examination room to increase women’s safety. It is imperative for policymakers to listen to women’s suggestions to increase patient safety so other survivors are not put in dangerous experiences seeking care, like Christian, Holly, and Tina. Therefore, I describe women’s suggestions to increase patient safety next.
SUGGESTIONS TO INCREASE SAFETY

Jensen (2008) argues that the goal for medical sociologists is to help articulate new patient safety research agendas, rather than to provide answers. Setting new agendas allows medical sociologists to critically engage with patient safety rather than offering a purely critical stance (Zuiderent-Jerak et al. 2009). Although the goal of sociological research is not to provide “answers,” I think it is important to allow patients to have a say in how to improve their safety. Therefore, I include IPV survivors’ suggestions for how to improve safety within healthcare settings, which should be at the forefront of policy recommendations to increase survivors’ patient safety in healthcare settings.

Policies and Procedures

Although it may seem like an obvious suggestion, survivors brought up the need for clear policies and procedures to help protect women in healthcare settings. Louisa, a survivor, who provides training for health care professionals about IPV, emphasized the need for this. She said,

Maybe one thing would be to have policies and procedures in place for, especially in a medical facility. You know, you have that for a suicidal patient, you have it for a homicidal patient, or for, you know, someone under the influence. Have a policy for, you know, [IPV survivors]. Who would be in charge of this, if we need to call the police? Who can sit with the client, and help her feel safe? Or, you know, is there a room we can designate as a safe space? That kind of thing.

Louisa argued that health professionals need specific policies in place to ensure that survivors’ needs and safety concerns are being addressed. An example of this type of policy would cover safety assessment and planning.
According to survivors, health care professionals should be conducting safety assessments. Police officers are required to do domestic violence assessments, so survivors suggested that health care professionals conduct them too. Without an evaluation, women could be at risk for death (Campbell 2004). For example, Roxanne explained how women could be killed without a safety evaluation. She explained:

I mean, I feel like when I was in that situation, I was waiting for somebody to ask me, you know, so I could say something about it, because you don't want to ever bring up the subject… Gently poke and prod [survivors] because sometimes they don't want to talk about it and they're scared. But I mean, I think that early on, you know, just getting that, that evaluation, trying to figure out what the situation is, how dangerous it is, is key. Because I mean, it could get so much worse in just a matter of hours.

Roxanne acknowledges how sometimes it may require that health care professionals gently probe women about their safety, but that it is vital for their security.

Similarly, Celine acknowledged how safety assessments are crucial for ensuring women’s security. Celine argued that health care professionals need to ask questions and assess safety, so they do not send a woman who is in danger home to be killed. She said health care professionals need to ask questions like, “Do you feel safe going back home? If you don’t feel safe, we need to do something about it now. Do you have a family member you can go to?” She then went on to explain, “That’s when you have to dive deeper because what health care provider would want to send someone back and then that evening, find out they’re dead? It could happen, it probably has.”

In addition to safety assessments, survivors emphasized that assessments need to co-occur with solutions, such as safety planning. Meagan explained this and the types of solutions that health care professionals could offer women.
Ideally, I would hope that a woman could go, like, if you're bad enough that you need to go to a hospital, you should feel safe doing so. And I think that there needs to be something in place that when the woman goes there, she can tell them that she's in a bad situation, and then they can have the resources to help her get out of that. Then they should be able to take pictures of wounds for her and help her get her children out of the house. Like if she's in the hospital, and her children are there with that man alone, they should be able to help her get her children out. They should be able to help her find a safe place to go away from him and he should go be arrested and he should stay in jail until it's figured out.

Meagan argued that providers should have the resources to help women achieve safety, such as taking pictures of wounds, helping children out of the home, and connecting women with a safe space. However, this also requires that health care providers coordinate with other organizations, like police and social services, to help women achieve safety, which does not always happen. Nonetheless, women want health care professionals to help them come up with a solution, mainly because health care may be one of the only places women can seek care.

*Keeping Abusers out of Examination Rooms*

Another way in which health care professionals can help IPV survivors achieve safety, is by keeping their abusers out of examination rooms. Women frequently mentioned that their abusers accompanied them to doctors’ appointments. Therefore, they suggest that health care professionals remain cognizant of this and try to keep abusers out of examination rooms to enhance their safety.

While survivors did not always recognize their partner’s presence at doctors appoints as problematic at the time, many looked back and framed it as unusual, or as a sign of abuse. Bianca, for instance, framed her partner’s presence at all her appoints as “weird” – “He insisted on going with me to all of my appointments when I was pregnant, and the health care providers would be like, looking at me, like, why is he here with you? It was kind of weird. Like he wanted
to be a chaperone or something.” Fiona had a similar experience with her ex-boyfriend and now frames his behavior as a red flag:

I can't remember when this happened. But at one point, my ex went to an appointment with me, which is weird, like, looking back, I'm like, what the fuck? I can't remember why he did… But looking back, it's like, that's a red flag. It's one thing if someone's in the waiting room, or if you have one car, you know, there's instances where that's not super weird. But he was like, in the appointment with me. And so I think that's really strange and not appropriate.

As Fiona suggests, this type of behavior, abusers accompanying their partner in the examination room can be intrusive, and a behavior that health care professionals should look out for.

When abusers attend women’s doctor’s appointments, women are not given the opportunity to disclose abuse to health care professionals. Katy explained how she was finally able to disclose abuse to her doctor during one visit when her abuser was not there.

Every time I would go to the doctor, like he would go to the doctor with me. I couldn't ever say anything. But there was one time that I went to the doctor, and I actually disclosed to the doctor that I was being physically abused, but that was the only time. I had a good relationship with my doctor, that I felt comfortable enough to disclose that to him. I just couldn't do it before because the abuser would never let, like I couldn't even go in the room by myself, so it just really it, it like made things so much more difficult.

For Katy, her abuser’s presence was a barrier for her to disclose abuse to her doctor. However, if her doctor kept her abuser out of the examination room, she may have been able to disclose sooner. Health care professionals have authority in medical spaces, so they can use that authority to ensure that examination rooms are private and confidential.

Nonetheless, ensuring patient safety can be complex and dependent on the situation.

Celine explained the complexity of this:

I realize [health care professionals] probably can’t keep [abusers] away unless the patient says so. That’s where the tough part comes in because the patient or domestic victim has to say that they don’t want them there, and sometimes they are too scared of them to do
that. It’s a problem, I mean, I think the biggest part of it is getting them out, how do you do that? And do they really want to get out?

Therefore, patient safety can depend on the situation. The concept of patient safety is contestable and not always straightforward.

Additionally, if clinicians ask abusers to step out of examination rooms, this could cause retaliation for survivors. For example, in Yasmin’s case, there was a time where a health care professional asked Yasmin’s abuser to step away, which Yasmin appreciated, but was also fearful of what her abuser would do. She tells me:

Something did happen on a different ER visit unrelated to physical assault, where I was there for another reason. And my wrist was wrapped, okay, from an injury, right? And a female doctor came into the ER, and she looked at me, she looked at [my partner], and she probably sensed something. So she says, why are you here? And he was there, right? And I said, oh, because I'm not feeling well. And I gave her this stare, and she picked up on it. She was very smart, so she asked him to step away, so she could talk to me in private. And I liked that, but at the same time, it put such fear in me because I knew that all hell was gonna break loose afterwards. Number one, because he was afraid I might tell the truth. Number two, he wanted complete control on everything - conversations - even though this man has zero medical knowledge.

Yasmin’s narrative shows the complexity of achieving patient safety via patient-provider interactions. There are both benefits and drawbacks when providers ask abusers to step aside.

Nonetheless, health providers could keep abusers out of rooms if there is a policy and/or procedure in place for all doctor visits. For example, a policy could require that all women be alone with the physician for at least five minutes at the beginning of every single appointment. Louisa stressed the importance of this:

The other thing that's super important that most people don't think about is, no one should be in that appointment with her. So I tried to implement that at our clinic where I said, partners should not be allowed in the appointment, you know, at least have a few minutes alone with the patient, ask if everything’s safe, ask how they are with their partner, do they feel safe?
When health care professionals have time alone with patients, they can conduct a safety assessment while providing protection momentarily. This situation gives women a chance to disclose abuse and any safety concerns and gives providers the chance to help women safety plan, such as providing women with an escort service to get their belongings.

Providing escort services

Survivors suggested that health care professionals provide escort services to help women achieve safety. Oftentimes, survivors may be reluctant to disclose abuse to health care professionals because they believe health care professionals will not do anything about it, which means that survivors lose opportunities to receive referrals to social services (Spangaro et al. 2020). However, survivors want health care professionals to provide help. Respondents suggested that health care professionals help women get away from their abusers. Meagan explained,

What might have been nice would be if I knew that I could go to the hospital and say, this man is doing this to me, and like, or if I would have went to get stitches on my arm, I could have said, he did this. He's been abusing me for years and years. And if they could have, at that point, helped me get away, like maybe then put me in a safe house or somehow to get my daughter out of there with me, and guarantee our safety — like that would be the ultimate thing.

Like Meagan, Yasmin also indicated that she would have liked for health care professionals to provide escort services to help her achieve safety during her health care visit. Yasmin talked hypothetically about what she should have done during her doctor visit:

And I'm not leaving here until you get me some help — call NYPD, call domestic violence unit — because they do have them all over the precinct. I'm not leaving. I want an escort to the house, so I could get my belongings and so on and so forth. That's what I think doctors and nurses should do.
Meagan and Yasmin both indicated that health providers should directly connect survivors with resources to get them to safety.

Finally, Louisa suggested that escort services would ideally connect women with whatever she needed at that time. She suggested that health care professionals say to IPV survivors:

If you need me to call a domestic violence hotline and figure out where we can take you. If you need to go to the hospital, and you're in the doctor's office, we can coordinate something. If you need to, you know, if he's outside waiting, and we need to call the police to escort you to safety, we can do that.

Thus, health care professionals can increase IPV survivors’ safety by offering escort services. As mentioned previously, when health care professionals learn women are being abused, they need to offer some sort of solution for women, and not send them back to their homes that are dangerous.

CONCLUSION

Rhodes et al. (2016) state that patient safety emerges from interactions between people, and between people and their environments. In this study, I use the case of IPV to build on Rhodes et al.’s (2016) conceptualization of patient safety to assess how safety emerges between IPV survivors and clinicians. I find that patient-centered interactions are critical to establishing patient safety for IPV survivors. However, I find that providers often fail to assess survivors’ safety, which I argue is a form of medical harm that is not recognized by medical sociologists. Therefore, safety does not emerge between patients and providers when health care providers fail to assess patients for abuse. Ricci-Cabello et al. (2017) argue that when providers do not engage in patient-centered communication, patients receive delayed referrals, which can lead to harm.
Patients’ understanding of safety is often multi-dimensional and situational – what may be considered safe in one situation could be unsafe in another (Rhodes et al. 2016). Survivors often described situations in which assessing patient safety could be beneficial, such as when survivors are alone, but assessing patient safety could be detrimental, such as when abusers are at appointments with survivors. Therefore, patients’ conceptualization of safety in dependent on the situation. Patient safety for IPV survivors is extremely complex and not always easily defined.

Sweet (2019) argues that health systems are presumed to be safe spaces for IPV survivors. I find that this is not always the case. Although the United States Preventative Task Force recommends screening for IPV (Moats, Edwards, and Files 2014), this seems to be more of a suggestion, rather than a practice that is routinely implemented. Rather, participants did not report stories of being adequately screened for IPV, nor did they disclose stories of safe health care spaces. While respondents argued that health care spaces should be safe, this does not mean that safety emerges within them.

I report on conceptualizations of safety that are largely reflective of white women’s safety concerns. Black women face unique safety issues within the healthcare system. Ross et al. (2001) argue that the United States lacks a legal framework that guarantees women of color safe health care. Throughout history, minority women have been subjected to harmful healthcare practices via forced sterilization and other controlling reproductive tactics (Luna 2020; Roberts 2017). Roberts (2017) argues that the state’s regulation of black women’s bodies is marked by reproductive regulation and stereotypes of maternal responsibility. Minority women’s safety has been routinely threatened within healthcare settings, heightening their sense of insecurity.
Due to a lack of diversity in my sample, I cannot make substantial claims about how safety emerges between women of color and healthcare professionals. However, Christian, a black woman, argued that healthcare settings should be safe spaces for IPV survivors seeking health care. While seeking care, health care providers threatened Christian’s safety by bringing her the phone with her abuser on the other end. Therefore, health care professionals clearly do not always protect black IPV survivors’ safety. However, more research is needed to understand how safety does or does not emerge between women of color experiences violence and health care providers.

Finally, I conclude with a caveat, health care professionals alone cannot increase survivors’ safety. A single actor or institution cannot be responsible for survivors’ overall safety and well-being because women require help from many outlets simultaneously, like police, social services, and mental health care services – there needs to be a coordinated effort among many different actors to achieve safety (Haeseler, 2013; Vinton & Wilke, 2014). For example, health care professionals need to be able to call the local police to escort women to safety, and/or they need to coordinate with the local domestic violence shelter to be able to send women there if they need immediate safety.

Therefore, policy implications matter. Healthcare systems need to work with other institutions, such as police, mental health facilities, and social services, to ensure they are doing everything they can to increase women’s safety. The health care system must adopt policies that connect survivors to multiple services. Health professionals must conduct safety assessments and help survivors create a safety plan. Additionally, clinicians must listen to survivors’ experiences of safety and/or threats to their safety. Ultimately, policymakers can listen to survivor’s stories to develop policies that benefit and improves survivors’ patient safety within
the healthcare sector. In the next chapter, I explain how systems are fragmented in their responses to IPV survivors, which makes a system-based approach to healthcare that much more necessary.
CHAPTER FIVE
“IT ALWAYS FELT LIKE THEY TRANSFERRED ME TO SOMEONE ELSE... LIKE I WAS SOMEBODY ELSE’S PROBLEM” – FRAGMENTED AND PUNITIVE SYSTEMS OF CARE

Intimate partner violence (IPV) is regarded as a social, public health, and criminal justice problem. For IPV survivors to leave abusive relationships, they often need help from multiple service providers – protection, legal help, housing, health care, mental health care, childcare, and job training and/or education (Haesler 2013; Vinton and Wilke 2014). In other words, women require a network of support to meet their needs (Merrell 2001). However, scholars often fail to investigate the connections among various state systems (Haney 2018). Only recently, sociologists have begun to explore the intersection between criminal justice and institutions of health care, education, family, and social services. The relationship between various state systems is what Haney (2018) calls institutional intersectionality.

Sociologists and anthropologists are particularly interested in how multiple vulnerabilities intersect to affect health outcomes (Whittle et al. 2020). Although we know that vulnerable groups have multiple material needs, social scientists are just beginning to understand how institutions of help provide resources to marginalized groups that are fragmented and punitive in nature (Comfort et al. 2015). I contribute to the growing body literature on institutional intersectionality by examining how IPV survivors navigate the criminal justice and healthcare systems, and how these systems work together to control IPV survivors’ experiences. IPV survivors seek care from both criminal justice and healthcare systems, which is indicative of the systems’ overlap, or their institutional intersectionality (Coulter et al. 1999; Duterte et al. 2008; Kothari and Rhodes 2006).
Building on the work of Comfort et al. (2015), I use the case of IPV among women to understand how criminal justice and healthcare systems provide fragmented and punitive care. I ask, how do IPV survivors navigate intersecting institutions of help? I find that criminal justice and healthcare institutions fail to protect and help women, and they provide fragmented services to survivors of IPV. I also find that women are subject to discipline from these state institutions. I argue that state systems function as social control apparatuses that are designed to fail IPV survivors.

LITERATURE REVIEW

Institutional Intersectionality

Survivors of IPV often navigate many different systems of help simultaneously. Haney (2018) argues that state systems, such as healthcare, criminal justice, and social services affect people’s experiences through institutional intersectionality. Institutional intersectionality requires that people become clients of multiple systems at the same time (Haney 2018; Sweet 2021). IPV survivors may become clients of the criminal justice system, welfare, health care, and child services.

Research documents the interconnection of medical and criminal justice help seeking. Kothari and Rhodes (2006) examine emergency department utilization by IPV survivors identified by police. In 2000, of the 964 women in the prosecutor’s IPV database, 601 (63.9%) received care in at least one emergency department (Kothari and Rhodes 2006). Additional research suggests that rates of medical and legal help seeking increase as physical abuse increases in severity (Duterte et al. 2008). Although not all women reach out to police for help, Coulter et al. (1999) find that more than half of women in a shelter contacted police for physical,
emotional, or other forms of abuse. This literature suggests that women are often seeking health care and help from criminal justice at the same time.

**Fragmented and Punitive Care**

Research finds that hyper-marginalized populations have extremely high and interconnected needs, but the institutions that are meant to serve these needs are fragmented and punitive, which furthers marginality (Comfort et al. 2015). Hyper-marginalized populations are those that experience multiple inequalities that shape everyday experiences, such as homeless drug users with acute health problems (Comfort et al. 2015). For instance, Whittle et al. (2020) find that food insecure, HIV positive women face overlapping, interconnected insecurities in food, housing, and health care. However, the women in Whittle et al.’s (2020) study believed the US economy and social safety net was designed to keep women insecure and impoverished. Additionally, Lopez et al. (2018) find that HIV-positive people using drugs face exclusionary practices and punitive tactics while they are navigating the Supplemental Security Income (SSI) application process. Lopez et al. (2018) argue that institutional procedures are a form of structural violence that deepen vulnerabilities among already marginalized groups.

Women experiencing violence are another group that may be hyper-marginalized, especially among the poor and women of color. Although the criminal justice and health care system serve survivors of IPV, both institutions leave the “social” aspect of violence to other organizations to deal with. In other words, service providers delegate the “problem” of IPV to another agency or organization, which leads to fragmented care. For example, Monckton-Smith et al. (2014) argue that paramedics often view IPV as a police responsibility, and police view it as a social work responsibility. In another study, health providers argue that IPV is a “social”
problem outside their scope of work, despite the health complications that health providers address that are caused by abuse (Lavis et al. 2015).

Service providers may rely on others, mainly social workers, to address IPV because they feel incompetent to do so. For example, Tower et al. (2012) find that nurses often pass IPV survivors’ care along to other service providers deemed more appropriate because they are not trained to do it – “have the nurse not really do any intervention ‘cos I don’t think these days we’re trained for that … and then just wait ‘til services kick-in in the morning and get Social Work involved and what not then” (Tower et al. 2012:220). In another study, a clinical trauma worker in a domestic violence shelter explained that she did not know how to “do” systems-based advocacy, which includes connecting survivors to food stamps or housing, but instead was only able to provide emotional therapy to clients (Sweet 2021). While therapy is important for survivors’ recovery and safety, so is connecting women to resources. Across service providers, responsibility for responding to IPV is displaced to others and deemed as “someone else’s” responsibility.

In addition to the overall lack of responsibility to respond to IPV, first responders also indicate that IPV is a problem of the victim’s behavior (Monckton-Smith et al. 2014). In assessing police officers’ attitudes of domestic violence calls, Monckton-Smith et al. (2014) find that many officers considered victims to be untruthful, ungrateful, and often hostile. Similarly, Horwitz et al. (2011) find that police officers frequently express frustrations with victims of domestic violence rather than the perpetrators, especially when victims do not follow through with legal cases. Health care providers echo similar sentiments by expressing frustration when they make referrals to social services, but patients do not follow through or seek additional help (Minsky-Kelly et al. 2005). Therefore, not only do service providers delegate the care of IPV to
someone else, but they also do not feel a responsibility to help non-compliant or “difficult” victims. In this way, they are punishing survivors of IPV.

Haney (2010) refers to various state systems, like healthcare and criminal justice systems, as “satellite states” that circle and hover over the centralized U.S. State. Through satellite states, governance is decentralized, which expands governance into more spaces; governance cuts across and loops through diverse state institutions (Sweet 2021). Satellite states are intricately interconnected and provide increased governance over IPV survivors. One institution may require that survivors become clients of another institution to receive the care that the state deems is necessary. For example, domestic violence agencies pay legal advocates who work in courthouses. Courthouse personnel, such as judges and lawyers, often recommend that women attend domestic violence agencies for counseling (Sweet 2021).

Many state institutions provide governance via social control. Wacquant (2010) argues that a diligent carceral system is an integral element of a neoliberal state. In fact, even anti-violence efforts have included neoliberal solutions of social control (Bernstein 2010; Bullimer 2008). Bernstein (2012) argues that feminist advocacy movements have facilitated “the carceral controlling arm of the neoliberal state” (235). Therefore, feminist agendas have prioritized a carceral agenda (Bernstein 2012).

There is a controversy over the turn to a carceral state. Coker (2001) explains how on the one hand, women’s advocates want to hold police accountable to protect women because the police are an agent of the state. However, on the other hand, feminists recognize that the police expert power in ways that disadvantage women, especially women in poor and minority communities.
Nonetheless, the turn to a carceral state has severe implications for IPV survivors. The institutions that are meant to help IPV survivors control them through neoliberal means. As Coker (2001) argues, crime control anti-domestic violence strategies lead to greater state control over women. In this chapter, I investigate how criminal justice and healthcare institutions control IPV survivors’ experiences by failing to provide help and protection. I argue that fragmented and punitive care within institutions punishes, controls, and marginalizes IPV survivors.

FINDINGS

Survivors seek help from multiple institutions simultaneously, such as from law enforcement, the courts, health care, and mental health. When I began this study, I was interested in women’s experiences seeking help in health care. However, through survivors’ stories, it became evident that health care was only one piece of women’s help-seeking experiences. As women told me about their experiences seeking help within other institutions, I learned how the criminal justice and healthcare systems failed survivors seeking care. In this section, I document how institutions of help have routinely failed survivors when they reach out for help. Additionally, I explain how organizations displace the responsibility to address IPV onto other organizations, making IPV “nobody’s” problem. In all, I find that the criminal justice and healthcare systems provide fragmented and punitive care to IPV survivors, which controls IPV survivors’ experiences.

The Criminal Justice System

I never asked women directly about their experiences seeking help from the police, but it inevitably came up in many respondents’ stories, which highlights the crucial role of this institution in women’s help-seeking behaviors. Ultimately, I found that the criminal justice
system fails to protect and help IPV survivors. This transpires in three main ways. First, the criminal justice system fails to protect women’s safety when calling for help because police do not take women’s accounts of abuse seriously. Second, the criminal justice system criminalizes and/or re-victimizes women reaching out for help. Third, the criminal justice system fails to hold perpetrators responsible for their actions. Together, these led women to feel resentment towards the system and a lack of faith in its ability to help them. Although survivors may rely on the criminal justice system for help, I argue that the criminal justice system is not organized in a way that is conducive to prevention and protection from abuse.

First, participants shared stories about calling for help and feeling as though police failed to protect their safety. For instance, Lauren recalled a time when she called the police to escort her husband off her property. The police refused to do so because Lauren was married to her abuser, even though he did not live with her at the time.

A week prior to holding me hostage, he had pulled into my driveway, and I called the police, and they wouldn't make him leave because we were married. And I said, you know, we've been estranged for a year and a half. He doesn't live here. He's not on the lease. He doesn't even have, you know, a driver's license in the state. I had all these police reports, my two daughters are inside, and they still didn't make him leave.

Legally, Lauren’s husband was trespassing – the act of knowingly entering another person’s property without permission (Legal Information Institute). Not only was he trespassing, but Lauren made numerous police reports against him previously. Despite this, police failed to arrest Lauren’s husband, or at the very least, escort him off her driveway. Police failed to ensure Lauren’s safety, and a week later, Lauren was held hostage by her abuser.

Another participant, Lily, experienced a comparable situation with the police. In Lily’s case, her abuser called the police and told them he was going to kill, so he was calling to have her removed from the home. Upon arriving at the scene, the police found no physical violence...
had unfolded, and that “nothing happened.” Therefore, police did not remove either of them from the home, despite the death threat her husband called and made.

He had called the police and told them, like I'm going to kill her. You need to come get her, and a deputy showed up and nothing like happened but, [the police officer] came in, and we were talking about what we could do, and he's like… well, nothing's happened, so I can't make you leave. And I was like, well, he said he was gonna kill me. So, if he does that, will you come back and arrest him then? And he was like, ‘oh yeah, yeah, definitely!’ I’m like that is so reassuring, *thank you.*

The law in North Carolina, where this incident occurred, classifies communicating threats as a Class 1 misdemeanor (North Carolina General Assembly 2020). Moreover, when abusers threaten to kill victims, the odds of homicide increase by five times or more (Klein 2009). In Lily’s case, law enforcement failed her by refusing to take any action to protect her. Police could have arrested her husband, helped her to secure a protective order, or made follow-up visits after he threatened to kill her (Klein 2009) — none of which occurred.

Previous research suggests that police officers may overlook signs of IPV if there are no physical injuries or property damage present, which may inadvertently trivialize survivors' concerns due to misconceptions about the dynamics of IPV (Maple and Kebbell 2021; Myhill and Johnson 2016). This was the case in both Lauren’s and Lily’s case as there were no physical injuries or property damage; officers in both situations were operating under the “violent incident model” of abuse (Stark 2012). Nonetheless, the incidents described are obvious signs of abuse. Later, Lauren’s and Lily’s abusers acted on threats and harmed them following the incidents described. Lauren’s abuser held her hostage. Lily’s abuser choked her unconscious and she sustained other severe injuries. Police may have prevented these occurrences had they acted initially.
In many IPV cases, violence escalates over time (Aldarondo 1996; Boxall and Lawler 2021), which is why police need to act immediately. Another participant, Lindsay, expressed her belief that law enforcement needs to remove violent men from the situation before it turns fatal:

I think [police] need to, you know, do something, and do it quick before the man escalates to actually killing the woman because the most dangerous time is when you're looking to leave. The man needs to be taken out of the situation and have the restraining order slapped on him immediately… Address the problem, not take the woman away from her children or animals and all rest of it, you know, take the offender, that's the trouble, they're not dealing enough with the offenders.

Research has shown that when women are estranged from their abusive partners, this is the most dangerous time for them (Campbell et al. 2003; Dawson and Gartner 1998), and Lindsay felt like law enforcement needed to do more to protect women, such as remove abusers from the home and grant a restraining order. However, Loftus (2009) argues that police often hold negative attitudes toward domestic dispute calls; officers regard calls as burdensome and unimportant, which is likely one reason police failed to protect participants’ safety in this study. Other research suggests that criminal justice systems are incompatible with preventing violence and ensuring safety (Bernstein 2010; Bernstein 2012; Goodmark 2004).

Unfortunately, the criminal justice system fails to provide safety in many situations. For instance, Rhonda explained how she feared appearing in court because she would be so close to her abuser in the courtroom:

I think that part of the system has to change as well. Because when you're so scared of your abuser, even if you're supposed to be in court, you don't want to show up… I did call the police, I did. I did have him arrested. I did go to court through that. You know, we went through the whole thing. He was on probation for a year, and yeah, he stopped [abusing me] for a little bit, but it doesn't work. It does not work. And there's just no protection for, for women or, you know, men if they're being abused, either. I mean, there's just not.

In Rhonda’s case, the criminal justice system failed to make sure that she felt safe in the courtroom with her abuser. While her abuser did receive one year of probation, she still felt as
though this was not enough to keep her safe. The court system failed to serve a sanction that continued her safety past the one-year probationary period.

Second, the criminal justice system criminalizes and re-victimizes survivors of violence (Bumiller 2008; Bernstein 2010). For example, a lot of states have passed mandatory arrest laws for domestic violence, whereby police must arrest if there is probable cause that domestic violence has occurred (Coker 2001). This was the case for Sarah, a mixed Korean, white woman who recalled, “Before I went to jail, they had me get medically cleared because, so in the state of Arizona, when domestic violence happens, everybody goes to jail.” Following a domestic violence incident, Sarah sprained her ankle, and after receiving a boot from the hospital, she spent the night in jail.

The mandatory arrest law in Arizona mandates that an arrest be made in domestic violence incidents that include, “physical injury or a weapon and allows an arrest, with or without a warrant, when the law enforcement officer has probable cause to believe that an incident of domestic violence has been committed and that the person to be arrested has committed the offense” (Hale 2000). In Sarah’s case, she was the victim of violence but was arrested along with her abuser. It is important to note that Sarah was a woman of color that was arrested, which suggests racial dynamics may have been at play in this case as well. Nonetheless, this incident highlights how police use discretion in IPV cases, which may be based on misconceptions about IPV and racism, to punish survivors of violence. The criminal justice system criminalized and re-victimized Sarah.

Third, participants shared an overwhelming sentiment that the criminal justice system does not hold perpetrators responsible for their actions. Repeatedly, women expressed how perpetrators of abuse are not sanctioned. To provide some examples, Tina stated, “I mean, the
perpetrators get off almost scot-free.” Sarah echoed this: “What I've noticed is, abusers can pretty much do and say whatever they want.” Yasmin highlighted the lack of accountability for abusers’ actions – “And men like [my ex-husband], people like him, need to be held accountable. It's as simple as that.”

Given the failure of the criminal justice system, the women in this study expressed resentment towards it. Based on survivors’ interactions with police and the court system, they lost faith in the criminal justice system’s ability to protect them. Rather, women began to view policies and practices as useless. For example, when discussing protective orders, Rhonda stated matter-of-factly – “It's just papers. It's nothing. The protective orders do nothing.” Survivors lack faith in restraining orders and other protective measures because the people working in these institutions do not enforce them, leading women to continue to live in fear and danger. Because the women in this study lacked trust in law enforcement, the main institution intended to protect women, it is not surprising that women also lacked faith in other formal institutions for help-seeking, like health care.

The Healthcare System

From survivors’ narratives, healthcare fails women too. This occurs in two main ways. First, the healthcare system fails to train health care professionals to detect signs of abuse. Second, the healthcare system fails to make health care accessible to women without financial resources. I explain both themes in detail in this section.

First, the healthcare system does not train health care professionals to respond to abusive situations, nor does it have an IPV protocol in place. Participants often expressed that health
care professionals ignored blatant signs of abuse. Participants attended healthcare facilities with clear signs of abuse, but health care professionals never asked them about abuse:

I would have given my eye, teeth, if they had asked me, is your spouse yelling, hitting, anything with you? You know, the doctors could see bruises. And I guess they knew I was lying about them, but they never questioned me about it. I had fingerprint bruises on my arms and my legs, everything, they never asked about them (Tina).

I remember while I was going for my prenatal checkups, there had been a day where he had grabbed me and put me up against the wall. And because he had me so hard, the shirt made marks on my neck, and I was hoping someone would notice, so I wore my hair up that day, and like, nobody asked me about it. I don't know why I didn't reach out for help, but I was so scared. And I just remember thinking if someone just asked me, I'm going to be honest. And no one asked me why I had that, you know, mark around my neck. Like it was this red mark around my neck (Alyssa).

Even when I would fill out the renewal forms for my [State] Health Plan packet, there's a little box that says, do you feel unsafe in your relationship? Yes or no. And I would always leave that blank, hoping someone would ask me (Nikki).

Existing literature argues that health care professionals need to be trained to detect signs of IPV (Hamberger et al. 2004; Minsky-Kelly et al. 2005). However, even when providers are trained, many still feel ill-prepared to ask about abuse because they do not have enough time to establish rapport, there is a lack of privacy, and/or they hold the belief that asking about IPV is a personal question (Minsky-Kelly et al. 2005). These studies highlight institutional barriers that impede health care professionals’ ability to address blatant signs of abuse.

Despite providers’ lack of training, survivors want to be asked about abuse. Roxanne explained how she wanted health care professionals to ask her about abuse:

I feel like when I was in that situation, I feel like I was waiting for somebody to ask me, you know, so I could say something about it, because you don't want to ever bring up the subject. It takes somebody to ask you, what are you going through? Is it, you know, is there something that we should probably know about?

According to previous research, many women will not openly disclose abuse in the absence of direct questioning because they are scared (Bacchus, Mezey, & Bewley, 2003). In a way,
participants were crying out for help in doctor’s appointments to be asked about abuse.

Survivors were not trying to hide abuse, but they wore it openly, hoping someone would ask them about it. Healthcare systems need to train providers to detect and ask about abuse so they can connect women to other appropriate services (Hamberger et al. 2004).

While women acknowledged that providers should do more to screen women for abuse, some also acknowledged that our healthcare system systematically avoids the problem of abuse. I interviewed one survivor that now works on training health care providers, and she remarked:

I try and teach providers to be comfortable asking [about abuse], don't be afraid to ask it. And I understand why people are afraid. And the reality is sad because our system is not equipped to help these women, and so it's a very hopeless and helpless feeling when you can't help someone who needs help (Louisa).

As Louisa indicates, failing to acknowledge and respond to women experiencing IPV is a failure of the healthcare system itself, rather than individual providers that lack empathy or compassion. Our system does not train providers to ask about abuse or to successfully help survivors maintain safety and well-being, which leads providers to avoid it and survivors to believe that health care professionals do not care or do not want to help.

When health care professionals deny the reality of abuse, they punish victims and control women’s realities. The lack of institutional procedures in most healthcare settings to screen and detect violence is a form of state control. The healthcare system invalidates the existence of IPV and reinforces gender inequality.

Second, the healthcare system denies many survivors without financial resources access to health care. As a result, many participants avoided health care or prolonged health care because they could not afford it. This affected survivors in my study who did not have health insurance or were on Medicaid.
For Lauren, she did not have health insurance and she did not seek care for broken ribs when she knew it was going to come out of her own pocket,

And the last attack, when he held me hostage, he broke another rib. And I should have gone [to the hospital] then, but I didn't because I learned the first time that there's nothing they can actually do for a broken rib, so it's just 1,000 bucks for nothing. And I knew that would come out of my own pocket, so I chose not to.

Similarly, Roxanne, a Hispanic woman, did not have health insurance, and when I asked her if that prevented her from seeking care sooner, she responded,

Absolutely. I mean, if I wouldn’t have had, you know, co-pays or things it would have been so much easier. I was cash paying. And I mean, how many times can you pay $150 or $500 to get the help you need? It's just not practical. We can't, it's not long term, it's not a solution for long term. I needed that [financial] backing to help me. I didn't have it.

Survivors with Medicaid also faced barriers accessing health care providers that accepted their health insurance. For example, Nikki, a Mexican woman and a Medicaid recipient, explained that very few therapists accepted her insurance – “I had a list of therapists mailed to me, and out of the two pages, three people took Medicaid. I don't even know if they have openings right now. You know, those are just the three people in this city that accept my insurance.” Because not all health providers, including therapists, will accept Medicaid, Nikki was unable to access the therapy she needed.

It is important to note that Roxanne and Nikki both lacked access to care, identified as non-white, and lacked formal education. Therefore, we begin to see how the healthcare system controls poor, abused, women of color. While Nikki was granted state assistance, the assistance was not enough to help her access mental health services. Intersectionality allows us to understand how hyper-marginalized groups face increased difficulties accessing care.
Nonetheless, both uninsured women and women with government insurance were denied access to healthcare. In this way, the state punished victims of IPV by denying them accessible care. Not only are women punished by being denied care, but many women who lacked financial resources did not qualify for government assistance because poverty thresholds\textsuperscript{4} are so low. Katy, a white woman, explained, “Well, if you don't have insurance, and you don't have money, then how are you going to get help? And when you don't meet criteria for government assistance, then you're just stuck. You can't afford to go to the doctor because you don't have the money.”

Access to health care is a systemic issue within our healthcare system. Cohen et al. (2020) estimate that 31.2 million adults under 65 are uninsured, and only 26.4\% of adults under 65 are on public insurance. This affects survivors of abuse as well; in a previous study, most participants cited cost of care as the largest barrier to seeking and receiving care (Wilson et al. 2007).

Survivors are typically already experiencing financial abuse, which poses a problem in accessing care – survivors should be able to receive free care.

If [you’ve] left an abusive relationship, and you're starting over, you're already so financially abused, that health care should be the absolute last thing that should be on your mind. And, you know, [abuse] should be part of the qualifications for Medicare (Lauren).

\textsuperscript{4} See the current federal poverty threshold here: https://aspe.hhs.gov/topics/poverty-economic-mobility/poverty-guidelines
The healthcare system controls who can and cannot afford healthcare. As a result, it reinforces ideas about who is and who is not worthy of receiving health care. For hyper-marginalized populations, such as women experiencing violence, the healthcare system denies women proper care – reinforcing inequality and controlling women’s lives. In a neoliberal society, society expects women to maintain individual responsibility to pay for their health care, and the state punishes poor women through an emerging government of social insecurity (Wacquant 2010).

Although most women in this study had difficulties accessing care, some women were able to access health care when programs were put in place to address structural barriers. For instance, one survivor, Meagan, was able to access care after her husband broke her arm because a local university hospital offered a reduced “day rate:”

I had to go to the hospital [when he broke my arm], so I went to the emergency room. I didn't have any [insurance], I was doing home health and working for an agency at the time, so I didn't have any insurance. They don't provide it. So, I just went to the emergency room at university hospital, they have a thing where if you don't have insurance, they'll let you go - they call it a day rate. And then they make what you pay based off what you make, so you can pay like, I think it was like $50 for me to go to the emergency room... If I wouldn't have known about the day rate at University Hospital, then I really wouldn't have known where to go for that either. And a lot of people don't know that they offer that. So, there might be a lot of women who don't have health insurance that don't go to the hospital just because of the whole health insurance part of it.

Programs like the day rate that Meagan experienced can help reduce structural barriers to accessing health care. Unfortunately, most participants had different experiences than Meagan, and many avoided or prolonged care because of perceived costs of care. This points to the importance of making health care more accessible to survivors of IPV. In all, the healthcare system needs to increase training among providers to detect IPV and make appropriate referrals and ensure that survivors can access the care they need when they need it.
Fragmented Care Among Service Providers

As survivors sought help from the criminal justice system and the healthcare system, they experienced fragmented care both within each institution and across them. Survivors were often transferred from one service provider to next, and they were repeatedly denied help. As a result, survivors expressed the belief that service providers viewed survivors as a burden. Consequently, survivors believed that no institution truly intended to help them, like they were “somebody else’s problem.”

The belief that institutions would not help them often stemmed from providers giving women other resources to reach out to. When reaching out to a service provider, survivors were told that the institution could not help them, so they gave them another number to call. For example, Krystal explains:

They just kept saying, they kept giving me another number I had call for that, and it was just like nobody would even bring up the fact, about a place for me to go to. It was just like they avoided it, like okay, here's some resources you can call this place, that place, this place, that place. Bitch, I'm not in a safe place, and I'm certainly not in my head, I'm needing you to take the wheel. I'm finally reaching out, but nobody's grabbing my hand back, and I'm searching desperately. I've given up more hope, and it was me that did it. It was me because I wanted to live!

Women were routinely passed on from one service provider or another because the providers they initially reached out to were unable to help them. While service providers were successfully referring women to other organizations, they were setting them up for failure by referring them somewhere that also could not provide help. This is problematic as it indicates that service providers are not regularly communicating with one another, which leads to a fragmented system of care for survivors.

Therefore, when reaching out to various service providers, women described hitting a dead-end, or a wall:
And then once I did start looking through these resources, and you know, I was calling different places – ‘Oh, we don't have the funding right now,’ – or – ‘oh, we don't, you know – I was just hitting wall after wall after a while. It was very frustrating (Roxanne).

A lot of people try to tell me to go to Blue Fish here, [which] is the free clinic for homeless and super crazy people, and I've tried to call them because I was like, sure, you know, I could use help. And they're supposed to give it, you know, but I was on too many different kinds of medications for them. So, they said no, you need like a primary care physician and a mental health professional. Even the people that they tell me to call, they told me to call [this one place], which is like a complete behavioral unit. And when I called them, they said, nope, you must have referral from your primary care physician to come in here. It's just brick wall, after brick wall, and call somebody else, you know, it's frustrating (Nikki).

Like Krystal, Roxanne and Nikki were left to navigate different resources, like the homeless shelter and the healthcare system, on their own. Unfortunately, service providers may not have been able to help Roxanne or Nikki because they lacked resources, which highlights another structural issue at play both within and between services.

Nonetheless, navigating resources independently led to frustration as various providers displaced the responsibility to help survivors onto another provider, which left survivors feeling like a burden. Nikki later expressed this to me stating, “It always feels like they transferred me to other people like, sorry, we can't help you because of this and then they all transfer me to somebody else. Like I am somebody else's problem.” Nikki’s quote highlights how fragmented care is for survivors across institutions. Rather than providing a comprehensive approach to care, women are left to navigate various resources on their own, which signifies the need for a systems-based, or a coordinated community response to IPV.

CONCLUSION

I find that IPV survivors are often clients of many institutions simultaneously, mainly the criminal justice and health care systems. Haney (2018) refers to the interconnectedness of these spaces as institutional intersectionality. Essentially, satellite states, such as criminal justice and
healthcare systems, extend state surveillance in other domains, which ensures that IPV survivors remain oppressed (Haney 2018, Sweet 2021). Drawing on Haney’s (2018) work, I find that institutions intersect to control IPV survivors’ experiences.

Extending on Comfort et al.’s (2015) work, I argue that criminal justice and healthcare systems provide fragmented and punitive care. The criminal justice system controls and punishes women by failing to protect IPV survivors, criminalizing survivors, and refusing to hold perpetrators accountable. The healthcare system controls and punishes women by failing to train health professionals to detect violence and by denying access to affordable health care services. Criminal justice and health care systems intersect as control apparatuses to punish IPV survivors.

The findings in the study corroborate existing sociological and feminist research regarding the criminal justice system. First, existing research documents that the criminal justice system’s definition of IPV relies on physical assaults and property damage (Goodmark 2004; Stark 1979). While many women do experience physical violence, this is not the reality of most IPV survivors’ experiences. Therefore, the criminal justice system refuses to recognize how other forms of violence, such as psychological forms, affect IPV survivors’ ability to function as people (Goodmark 2004). The participants in this study reaffirm that the criminal justice system relies on the violent-incident model of abuse. Lily and Lauren’s abusers were not removed or arrested following abusive incidents because police determined that there was no physical assault that occurred. Thus, the criminal justice system denies the reality of abuse for many women, which works to re-victimize women seeking protection from the system.

Second, existing research documents how the criminal justice system fails to keep its promise to protect IPV survivors (Goodmark 2004). Respondents in this study argued that the
criminal justice system did nothing to help protect them, and in fact, it failed to protect them in
many cases. Not only does the system fail to protect women, but it is an apparatus that works to
re-victimize women. Goodmark (2004) argues abusers use the criminal justice system to further
victimize IPV survivors. Abusers utilize the system to file retaliatory motions, make false claims
about survivors in court, and manipulate the courts to try to gain custody of children (Goodmark
2004). Thus, abusers continue to abuse women by manipulating the court system. Many
participants also experienced this whereby they sought legal help, but their abusers were not held
responsible for their actions, or women were harassed by their abusers via the legal system.

Just as scholars critique the criminal justice systems’ ability to prevent violence, they
critique the health care systems’ ability to as well. Although some scholars argue that healthcare
systems can prevent violence by raising awareness, identifying violence, and providing support
services (García-Moreno et al. 2015; Spangaro 2017), others disagree. Jewkes et al. (2015)
argue that systems of help were originally intended to respond to violence, not to prevent it.
Nonetheless, other scholars argue that the healthcare system should improve its response to
violence against women (Ghandour et al. 2015)

Therefore, scholars argue that institutions are working as they are intended to — they
were never organized to prevent violence or ensure IPV survivors’ safety. Social control
systems’ goal of punishment is incompatible with prevention and safety. In the United States,
we have relied on the criminal justice system to reduce violence; however, the criminal justice
system is the wrong instrument to rely on to stop the ongoing cycle of abuse within intimate
relationships (Buzawa et al. 2015). Other scholars argue that we also cannot rely on the
healthcare system to accomplish justice for IPV survivors either (Kapilashrami 2021).
Institutional intersectionality also shows us how various systems work together to oppress hyper-marginalized groups. Crenshaw (1991) argues that black women are reluctant to call police because police are often hostile towards the black community. While it is believed that policies, such as mandatory arrests, work to deter racist policing, police must still make decisions about probable cause, which are not colorblind (Fedders 1997). Furthermore, immigrant women that seek out legal protection are subjected to deportation (Goodmark 2004). While the criminal justice system works to oppress women of color, the healthcare system does at the same time. Research shows that people of color are more likely to be uninsured than whites, even after the advent of the Affordable Care Act (Buchmueller and Levy 2020). Thus, they may be denied accessible healthcare.

My research begins to support these findings. As shown by Sarah’s, Roxanne’s, and Nikki’s stories, IPV survivors of color are more likely to be punished by state systems. Not only were all three women of color, but they all lacked higher education. Therefore, I show how state systems punish poor, women of color. Furthermore, it is reasonable to assume that poor, women of color are likely to be oppressed by multiple systems at the same time, which includes the criminal justice and healthcare systems, among many more.

Kapilashrami (2021) argues that traditional intervention models fail to challenge structural inequalities that underpin violence and gender oppression. Although scholars are critical of social control institutions’ ability to prevent violence and establish safety, survivors believe that police and health care professionals should be doing more to protect their safety. Women seek out criminal justice and healthcare institutions for help and rely on them for safety when they have nowhere else to turn. While I agree with scholars that institutional interventions are not the end-all solution to structural violence in society, I also agree with IPV survivors that
institutions should be doing more to try to help them when they are in vulnerable positions. IPV survivors must navigate many services simultaneously during and after an abusive relationship, many of which fail them. In the process of seeking help, women feel as though individual systems provide fragmented care and they are left to navigate and seek help alone.

Therefore, considering mounting evidence that individual systems are not equipped to deter violence and offer protection, many scholars advocate for a cross-sector response to violence (Buzawa et al. 2015). While this will not work to end violence in society, a cross-sector approach could help women navigate multiple services at once. In the next chapter, I detail a systems-based approach that could be implemented in the healthcare system to help create a cross-sector collaboration among healthcare and other institutions that serve women experiencing violence.
CHAPTER SIX
CONCLUSION

I began this dissertation by considering how IPV is commonly framed as a public health crisis due to the short and long-term physical, mental, and sexual health problems that arise. Despite the health complications of IPV, the healthcare system has been criticized for failing to detect IPV in encounters with abused women, and thereby failing to appropriately respond to cases of IPV or offer social service referrals (Tower et al. 2006; Williamson 2009). Therefore, I sought out to understand survivors’ experiences navigating the healthcare system. I argue that the healthcare system is operating as it is intended to – it was never designed to prevent abuse, which is why it is criticized for failing women experiencing violence. I find that medicine operates as a system of social control through medicalization, safety, and punitive care. Therefore, this dissertation offers three theoretical contributions to medical sociological literature.

First, I contribute to medical sociology by investigating how the clinical gaze facilitates the process of medicalization for IPV survivors. Healthcare professionals utilize the medical gaze by objectively examining the body to isolate specific injuries and symptoms (Foucault 1963; Walker 2004). In diagnosing individual body parts, providers often treat abused women via surgeries or medications (Stark 1979; Tower et al. 2012). I find that providers medicalize abuse by treating physical manifestations of abuse and medicating survivors. In doing so, I argue that providers pathologize women’s bodies. Pathologies are projected deep into women’s bodies, and women are blamed for having poor health (Sweet 2014). Further, providers evoke paternalism in patient-provider interactions to deny the realities of abuse and how it affects
women’s overall health. Often the implication of medicalization is overlooked, but I find that providers disenfranchise women from the healthcare system by medicalizing abuse.

Second, I extend Rhodes et al.’s (2016) conceptualization of patient safety by examining patient safety for IPV survivors. Rhodes et al. (2016) argue that safety emerges in healthcare systems through interactions between people, and between people and their environment. I find that health care providers fail to establish safety for IPV survivors. For example, abused women are rarely asked about safety in a meaningful way. Furthermore, providers fail to increase safety in patient-provider interactions when they do not ask abusers to leave examination rooms, or when they fail to establish safety planning with survivors. Thus, I find that safety does not emerge between abused patients and providers, and the healthcare system fails to establish patient safety for IPV survivors.

Third, I contribute to sociological literature on institutional intersectionality. According to Haney (2018), the state often requires that abused women become clients of many institutions simultaneously. The participants in this study discussed seeking care from criminal justice and health care systems. In doing so, participants explained how each institutional failed them. Therefore, I draw on the work of Comfort et al. (2015) to explain how institutions provide fragmented and punitive care for IPV survivors. I find that the criminal justice and healthcare systems are fragmented in their response to IPV, and they both provide care that is punitive in nature and works to re-victimize survivors of IPV.

Altogether, I argue that medicalization, lack of patient safety, and punitive care converge to maintain healthcare as a violence social control apparatus of the state. I also provide evidence of how the criminal justice system maintains social control based on findings from chapter 5. Therefore, I turn to these broader implications next.
MEDICAL SOCIAL CONTROL

As I explained in the introduction, the anti-violence movement of the 1970s turned to agents of social control to achieve social justice (Kim 2020). As a result, criminalization became a vehicle for justice whereby the movement worked to criminalize gender-based violence, strengthened policies, and created new policies, like mandatory arrests (Kim 2020; Simon 2007). While it is clear how the criminal justice system became an apparatus for social control over violence, it is less clear how the medical system became a vehicle for social control over IPV survivors’ experiences. This dissertation addresses that gap.

Sociologists have conceived of the healthcare system as a social control apparatus since Parson’s work in the 1950s. Adding to Parson’s work, Peter Conrad (1992) has argued that the healthcare system has gained control over people’s lives through the process of medicalization. According to Conrad (1979; 1992), medicalization exerts power via physician collaboration, technology, ideology, and medical surveillance. This dissertation corroborates this argument. However, for survivors of IPV, I find that the medical system exerts control by medicalizing abuse, denying safety, and providing fragmented and punitive care to survivors.

Building on Conrad’s (1979; 1992) work, I find that the medical system exerts control over IPV survivors through medicalization. I find that this occurs through physician collaboration and medical surveillance. For instance, I find that clinicians are complicit in medicalization of abuse by maintaining professional dominance and evoking paternalism when interacting with patients. In paternalistic encounters, providers maintain that abused women do not have anything biomedically wrong with their health. As a solution for women’s problems, providers suggest that women simply take better care of themselves, or take more walks, effectively diminishing how abuse impacts women’s health. As Davis (1988) argues, providers
take a “for their own good” approach to medicine with women. I argue that medical experts control women’s experiences and conceptions of their health. Providers rely on controlling images of women to blame them for their poor health and frame women’s bodies as the issue that needs to be fixed, rather than abuse (Barker 2010; Davis 1988).

Additionally, through medicalization, the healthcare system surveillances abuse. Contributing to the work of Foucault (1963), I show how healthcare providers operate under the clinical gaze to medicalize abuse. Under the clinical gaze, providers isolate individual injuries and symptoms (Bourgois 2013). Participants in this study demonstrate how clinicians did this while ignoring how injuries and symptoms were caused. When physicians only attend to singular body parts, this diminishes and trivializes the impact that abuse has on women’s health. Therefore, the medical community socially controls women’s experiences of abuse by laying claims over issues related to violence. I argue that the healthcare system diminishes the impact that abuse has over women’s health as providers evoke the clinical gaze to medicalize abuse.

Another way in which the healthcare system denies experiences of violence is by refusing to acknowledge violence as a patient safety concern. Rhodes et al. (2016) conceptualize patient safety as a fluid concept that is situation-dependent and emerges between people. However, I find that the healthcare system does not prioritize violence from safety. For instance, participants described how healthcare should be a safe space for IPV survivors, but it often is not. Health systems do not train providers to assess for violence or to implement strategies to minimize violence, like keeping abusers out of examination rooms. Thus, in denying the importance of safety, the healthcare system controls what is and is not in the realm of patient safety. Based on participants’ narratives, the healthcare system frames safety from violence as irrelevant, which impacts survivors’ experiences seeking care and experiences of violence.
Finally, the healthcare system controls women’s experiences by providing fragmented and punitive care. As I highlight in chapter 5, women often are clients of many institutions simultaneously, a process Haney (2018) calls institutional intersectionality. Participants in this study sought care from healthcare and criminal justice systems. However, in doing so, survivors explained how each institution provided fragmented care. Institutions did not work together to make useful referrals or to coordinate care. Moreover, both institutions provided punitive care. The criminal justice refused to protect women’s safety and re-victimized survivors. The healthcare system refused to acknowledge violence and made healthcare inaccessible to survivors. Thus, punitive care re-victimizes and criminalizes survivors of IPV. As systems of social control, each system punishes abused women.

INTERSECTIONALITY

Crenshaw (1991) argues that studies of IPV warrant an intersectional analysis. Echoing this, Bent-Goodley (2007) states that when researchers only investigate one social identity or characteristic, they miss the full picture. Unfortunately, this dissertation does not capture the full picture regarding how healthcare and criminal justice systems act as social control apparatuses for abused, minority, poor women. My sample is predominantly white and therefore, mainly represents the experiences of white, abused women.

Research suggests that white women experience a different process leaving violent relationships that women of color (Lacey et al. 2011). Therefore, it is reasonable to assume that women of color have vastly different experiences seeking help from healthcare and criminal justice systems. As I have shown throughout this dissertation, findings related to medicalization, patient safety, and punitive care are representative of white women.
First, healthcare providers are more likely to rely on controlling images of black women. While I have shown that healthcare providers may stereotype when to be crazy and/or hypochondriacs, black women are assumed to be incompetent and underserving of healthcare (Cottom 2019). Therefore, healthcare providers may rely on controlling images based on race and gender while interacting with abused women of color. Furthermore, black women are not likely to experience medical disenfranchisement as I described in Chapter 3. Research demonstrates that black women distrust the medical system already (Boulware et al. 2003; Brandon et al. 2005; Byrd and Clayton 2002). Black women do not trust the healthcare system to begin with, so there is no trust to be lost.

Second, minority women face unique safety concerns within the healthcare system. Women of color have been subjected to controlling healthcare practices throughout the United States’ history (Luna 2020; Roberts 2017). Therefore, minority women have faced safety concerns that white women have not. This has important implications for abused minority women. Therefore, for safety to emerge among minority women in healthcare settings, providers must account for both race and gender.

Third, minority women risk harsher punitive care than white women. For example, black women are much more likely to be criminalized by the criminal justice system (Goodmark 2004) and denied accessible health care (Buchmueller and Levy 2020). Institutional intersectionality allows us to speculate how minority women who are clients of multiple systems of care risk being criminalized and re-victimized by many institutions simultaneously. Therefore, the criminal justice and healthcare systems are likely to control and oppress women of color more intensely than white women.
Nevertheless, this dissertation begins to highlight how gender, race, and class intersect in complex ways for IPV survivors. Although most participants in this study were white and highly educated (10 out of 20 women had bachelor’s degrees or higher), women of color with lower educational levels tended to have some of the worst experiences seeking help. For instance, in chapter 5, I provide Sarah’s account of being arrested for violence. Sarah identified as half Korean, half white and had an associate degree. In the same chapter, I present Roxanne’s and Nikki’s accounts of avoiding care due to lack of insurance and paying out of pocket. Roxanne, a Hispanic woman, and Nikki, a Mexican woman, both have some college as their highest level of education. Therefore, intersectionality allows us to understand how state systems control and punish poor, women of color even more than white survivors of IPV. Overall, hyper-marginalized women face greater consequences seeking help from formalized institutions of help.

A SYSTEMS-BASED APPROACH

Given individual system’s failure to address abuse and the disconnect among systems, I argue for a systems-based response to care. Systems-based approaches to care evoke a cross-sector collaboration in which healthcare systems are connected to other community services and advocacy providers (Miller et al. 2015). Further, systems-based approaches have effective screening protocols, ongoing training for providers, and access to onsite or offsite referrals (O’Campo et al. 2011). There is evidence that systems-based approaches lead to better outcomes than organizations that do not take this approach (O’Campo et al. 2011).

One organization that takes a systems-based approach, Kaiser Permanente, has made IPV inquiry, recognition, and intervention part of their everyday care (Young-Wolff et al. 2016). Kaiser Permanente’s model has 5 interdependent components: (1) create a safe environment by
posting visible messaging about IPV throughout the healthcare settings; (2) routine clinician inquiry, intervention, and referral; (3) provide on-site behavioral medicine, social services, and mental health services; (4) partnerships with crisis services, emergency shelter, law enforcement, legal assistance, and other advocacy services; and (5) leadership and oversight (Kaiser Permanente n.d.; Young-Wolff et al. 2016). This system demonstrates that a systems-based approach can yield better outcomes for IPV survivors as identification of abuse since 2000 has increased eighteenfold (Young-Wolff et al. 2016).

As shown by Kaiser Permanente’s Family Violence Prevention Program, a systems-based approach helps to circumvent some of the issues that survivors shared with me during this study – medicalization, patient safety, and fragmented care. By encouraging providers to implement IPV efforts in their everyday practice, they are discouraged from treating physical symptoms without understanding the underlying factor of abuse that is causing symptoms. Further, Kaiser Permanente makes a concerted effort to create a safe space for survivors. They post visible messaging around the facility to encourage disclosure and safety. They also make enact safety planning with patients as part of the behavioral medicine and social services. This helps to ensure that safety can emerge between patients and providers. Finally, Kaiser Permanente has partnerships with other organizations, like law enforcement, to help establish cross-sector collaboration and ensure women receive help from all the services they need.

Unfortunately, a systems-based model is not widely implemented across healthcare delivery systems. As evidenced from participants’ narratives, most survivors do not receive this type of response to IPV when seeking health care. Developing a sustainable systems-based approach to IPV requires healthcare priorities of patient safety, care coordination, and patient
outcomes (Young-Wolff et al. 2016). Without these commitments, healthcare systems are not likely to adopt such approach.

Additionally, a systems-based approach to health care is unlikely to happen in the absence of institutional backing. Institutional theory helps to explain if organizations will engage in expensive and difficult adaptations in the absence of evidence that it will lead to improved outcomes (Flood and Fennell 1995). Institutional pressure, such as coercive, normative, or mimetic pressure, are essential to implement changes in organizations (DiMaggio and Powell 1983). Coercive pressure refers to pressures to comply with the dictates of policies of other organizations, particularly the government (Flood and Fennell 1995). Normative pressure refers to the pressures to comply with the expectations and values of a powerful interest group, such as physicians or society at large (Flood and Fennell 1995). Finally, mimetic pressure is the pressure to mimic other, successful, organizations. More research on various systems is needed to assess whether organizations feel any pressure, whether coercive, normative, or mimetic to develop a systems-based approach to IPV. In the absence of governmental, societal pressure, or institutional pressure, organizations are unlikely to reorganize themselves to become more collaborative as it costs resources to do so. Therefore, future research needs to examine whether there is a need for this type of collaboration from an organizational standpoint, as that will be the driving force of change.

I do not mean to suggest that a systems-based approach will prevent violence from occurring. As Kapilashrami (2021) argues, “health systems are social institutions embedded in prevailing gender norms and power relations that must be tackled alongside addressing imminent needs of women victims of abuse” (5472). To prevent violence, our society needs to transform gender and power relations, enacting changes within institutions will not be enough. However,
in lieu of structural changes, institutions can do something to improve their response to violence and challenge institutional norms. However, this also means that medical systems need to move away from the biomedical model that encourages the clinical gaze to avoid socially controlling survivors’ experiences.

LIMITATIONS AND FUTURE RESEARCH DIRECTIONS

This research has its limitations. First, because this project has a sample of 20 IPV survivors, findings are not generalizable to all IPV survivors across the United States. The purpose of this research though was not meant to be generalizable, but rather to allow for a deeper understanding of IPV survivors’ experiences navigating the healthcare sector.

Second, I faced barriers recruiting IPV survivors for this research. Many abused women showed initial interest in participating in an interview, but ultimately did not follow through. Of the 33 survivors that expressed interest, 9 never followed through and 4 were excluded, leaving me with a sample of 20 participants. It is reasonable to assume that I likely missed some information from women that chose not to participate that would have added more nuance to the processes I uncovered within this research. For example, those who did not participate likely did not because they did not want to risk bringing up traumatic events that happened to them or were not ready to share those experiences in their healing process. The women that did participate likely had enough distance from their abusive relationship and/or strong feelings about the healthcare sector’s response to IPV compared to those that did not participate. Nonetheless, sampling barriers limit my ability to fully understand how IPV survivors navigate the healthcare sector.

Third, the COVID-19 pandemic also limited how and who I was able to recruit for this study. I originally wanted to hand out flyers in public spaces such as grocery stores, hair salons,
or shopping centers, but I was not able to during the height of the pandemic. I also was not able to attend any support groups for survivors, which also limited my recruitment strategies. Additionally, COVID-19 likely impacted who was able to participate in my research. Hawkins (2020) finds that people of color were more likely to work in occupations deemed essential during COVID-19. Therefore, women of color were likely working in essential industries while I was recruiting. Moreover, they likely experienced heightened levels of stress during this time, which may have prevented their participation.

Fourth, my sample comprises of mainly white women. By recruiting online, I was hoping to target a much more diverse range of women. However, my sample ended up consisting of predominantly white, cis-gender women (70%), which is a limitation for analyzing other abused group’s experiences seeking care. First, more research is needed to understand men’s experiences seeking health care for IPV-related symptoms. Second, more research is also needed to understand if there are other important racial differences seeking health care for IPV. My research did not uncover significant racial differences, but that is likely due to the lack of diversity in my sample. Future research in this area should strive to obtain a more diverse sample – research needs to be done with men, the LBGTQ community, racial minorities, and disabled people.

Finally, my research is limited to women’s experiences navigating the healthcare system. When it comes to understanding the healthcare system, researchers have many perspectives to consider, but this study only focuses on women’s experiences. Research exploring other facets of this would be useful to help improve healthcare responses to IPV; for example, exploring existing structural policies and practices. Additionally, researchers should investigate personnel in managerial positions within healthcare organizations to understand if organization leaders feel
any pressure, whether coercive, normative, or mimetic to implement a safety protocol or develop a systems-based approach to IPV. Therefore, additional research is needed within organizations to assess whether there is a movement to help improve IPV responses, and if there is not, why not.

CONCLUDING THOUGHTS

Building on existing theories of medicalization, patient safety, and punitive care, this study examines how healthcare and criminal justice systems act as social control apparatuses of the state. I argue that healthcare, like the criminal justice system, works to control, re-victimize, and punish women experiencing violence. Ultimately, the healthcare system fails to recognize how abuse affects women’s overall health and well-being. This is problematic because medicine re-victimizes abused women by insinuating that women have caused their own suffering, rather than their abusers. Furthermore, by failing to address safety, the healthcare system contributes to growing danger among women in abusive relationships. The system’s overall response punishes those experiencing violence.

The overall process of navigating the healthcare system is complex and may not look the same for every survivor of IPV. Further, this process is not linear; rather, multiple processes occur simultaneously, and may not occur in the same order for every survivor. Therefore, I do not mean to argue that there is a linear process by which women navigate the healthcare system, but a multifaceted, complex process. To improve healthcare responses to IPV then, this requires a systematic, conscientious approach to help survivors wherever they may be in their help-seeking journey – from early-on thinking about leaving an abusive relationship to actively leaving and seeking safety. One proposed solution to this is a systems-based approach to health care.
Although I argue that the healthcare system may improve its response to IPV by adopting a systems-based approach, I recognize that the neoliberal nature of healthcare makes adopting this approach unlikely. In other words, the current for-profit state of our healthcare system is fundamentally incompatible with supportive IPV policies and procedures. Existing sociological research shows that our healthcare system draws resources away from sectors of the healthcare system that are crucial, but less profitable (Wright and Perry 2010). Rather, healthcare organizations have become more highly specialized and technologically oriented (Wright and Perry 2010). Thus, we need healthcare systems to understand the costs associated with IPV, such as that abused women incur 2-2.5 times the cost compared to non-abused women and incur more than $5.8 billion in health care costs per year (Bonomi et al. 2009; Chang et al. 2005), for them to invest resources toward improving IPV responses.

Nevertheless, improving healthcare responses to IPV is crucial to help abused women get the help they need. We need health care professionals to detect abuse and connect women to critical social resources. We need health care professionals to improve patient safety and ensure that abused women are safe and secure within healthcare settings. We need healthcare organizations to collaborate with other institutions to provide holistic care. Research that aims to understand women’s experiences navigating the healthcare system is one step towards the right direction, but we need healthcare systems to implement policies and procedures too.
REFERENCES


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Appendix A

Request for study participants in a confidential recorded interview

HAVE YOU EXPERIENCED RELATIONSHIP VIOLENCE?

- ARE YOU 18 YEARS OR OLDER?
- DO YOU IDENTIFY AS A WOMAN?
- ARE YOU A SURVIVOR OF INTIMATE PARTNER VIOLENCE?
- HAVE YOU SOUGHT HEALTH CARE FOR SYMPTOMS RELATED TO ABUSE?
- ARE YOU WILLING TO DISCUSS YOUR EXPERIENCES SEEKING HEALTH CARE FOR ABUSE?

If you answered yes to all of these questions, you may be eligible to participate in a study to better understand women’s experiences seeking health care for intimate partner violence related health issues. Your voice could help others.

Researcher: Shelly Maras, PhD Student at North Carolina State University, Department of Sociology and Anthropology

Contact Info: Shelly Maras at 919-590-9022 or samaras2@ncsu.edu for additional information.

Researcher’s Advisory Contact: Celeste Curbington, ccuring@ncsu.edu

If you are currently experiencing abuse or want to talk to someone, call the national domestic violence hotline at 1-800-799-7233
Appendix B

Semi-Structured Interview Guide

Pre-Interview Protocol:
Before we get started, I just want to double check and make sure this is still a safe time for you to be talking to me.

• Is this still a safe time? Do you feel comfortable talking to me?
• (If interview is on Zoom or over the phone) Are you in a safe space to talk? Do you have anyone around you that can overhear?

Go through the informed consent with participant. Ensure that they understand what re-identifiable information is, especially for the broad consent.

• Re-identifiable. Re-identifiable data is information that I can identify you indirectly because of my access to information, role, skills, combination of information, and/or use of technology. This may also mean that in published reports others could identify you from what is reported, for example, if a story you tell us is very specific. If your data is re-identifiable, I will report it in such a way that you are not directly identified in reports. Based on how I need to share the data, I cannot remove details from the report that would protect your identity from ever being figured out. This means that others may be able to re-identify from the information reported from this research.

• Explain that I will store identifiable information, such as their email and phone number, if they provide broad consent so that I may reach out to them in the future, but that I will not share their identifiable information with anyone else.

I just want to remind you that you can stop our interview at any time during the interview. It is okay if you wish to stop at any time and it is your right to do so. I can also provide you with community or national resources at any time throughout the interview.

Would you like to create a safe word for our interview? You can use this safe word at any time during the interview if you wish to stop the interview.

• What safe word would you like to use?

I would just like to ask you not to use yours or anyone else’s real names as you answer the questions I am about to ask you today. If you are telling me about a hospital visit, just refer to the hospital as “hospital.” Similarly, if you are telling me about an experience with a specific doctor, just refer to that person as “doctor.” This will help protect the confidentiality of other people as you tell me your story.

Do you have any other questions for me before we get started?

Interview Protocol:
To start, I would like to collect some basic information about you.

1. Do you mind starting by telling me a little bit about yourself – your age, about your job, things like that?
2. What gender do you identify as?
3. What race do you identify as?
4. How would you describe your sexual orientation?
5. What is the highest level of education you have received?
To begin this interview, I’d like to ask you some broad questions about your views on relationships.

6. First, can you tell me a little bit about your family growing up. What was it like growing up?
7. What did you think about relationships as a kid? Has that changed as an adult?
8. Can you tell me about what a healthy relationship looks like to you?

Next, would you mind telling me a little bit about the relationship that you were in that you were thinking about when you signed up to participate in this study?

1. How long ago was the relationship?
2. How long did the relationship last?
3. Can you tell me a little bit about the progression of your relationship from start to finish?
4. I know this may be hard to share, but can you tell me what kind of abuse you experienced?
   a. Standardized List to choose from:
      i. Physical – slapping, pushing, shoving, kicking, cutting, choking, punching, hitting.
      ii. Mental – being put down, feeling bad about yourself, being called names, being made to think you were crazy, being humiliated, being manipulated, being made to feel guilty
      iii. Sexual – being coerced into sexual acts you did not want, being raped
      iv. Financial – were your finances controlled, were you denied access to assets and bank accounts, given an allowance each week, denied the right to work, your partner controlled how money was spent, partner ruined your credit score or created debt using your name, partner sabotaged work opportunities or harassed you at work.

5. How did you feel during this time?
6. Do you remember anything about your emotional state that you can share?
7. Were you working in the same job then as you currently are?
8. How would you describe your financial situation personally at the time of the relationship? Is it different than it is now?

Now, I would like to know more about your experiences in health care. As I mentioned before, I am interested in learning more about your experiences seeking health care for issues related to the violence you experienced.

First, can you give me some examples of times you sought out health care at a doctor’s office, hospital, or clinic?

   a. Can you tell me about your reasons for seeking health care?
   b. Can you tell me about the health care facilities you went to? Did you see a gynecologist, family doctor, ER physician? Etc.
   c. Who mainly treated you when you sought health care? Doctors? Nurses?
   d. When seeking care, did you typically see the same health care professionals each visit, or were you seen by new nurses and/or doctors each time?
   e. Can you tell me about the gender of the health care professionals you saw?
i. Do you think seeing a male or female health care professional affected the care you received?

ii. Did seeing a male or female health professional affect how you felt during these interactions?

f. How frequently would you say you sought health care for symptoms related to violence in your relationship – which can be physical, mental, or sexual symptoms?

g. Is there anything else that stands out about your interactions with health care professionals that you would like me to know?

9. When seeking health care, can you recall being asked about a history or domestic violence?
   a. Can you tell me what that situation was like and what happened?
   b. What do you think healthcare professionals should have asked you when it comes to abuse?

10. Overall, how would you describe your experiences seeking health care because of violence?
   a. Did you experience any obstacles or challenges seeking health care for domestic violence related issues?
   b. Did you have any positive experiences seeking health care for domestic violence related issues?
   c. What do you wish health professionals would have done differently for you when you were seeking health care services?

11. Can you tell me about any needs that you were looking to meet beyond your immediate health care needs when seeking health care?

12. Can you tell me about your state of safety when you were seeking health care for health care services?

13. How do you think your financial standing at the time of your relationship impacted your health care seeking experiences?
   a. Did you face any financial challenges obtaining or seeking health care?
   b. If no, did you have a good insurance plan to seek care? Was this insurance through your work? Your partners? Other?

To conclude, I would like to ask you some questions about what health care would ideally looking like for domestic violence survivors.

14. In an ideal situation, what do you think is the best way for doctors and nurses to ask women about domestic violence?

15. Let’s say that a doctor or nurse asks a woman about domestic violence and she tells them that she is currently in a violent relationship, how do you think health professionals should respond to this?

16. Okay let’s take another hypothetical situation, let’s say a woman is in a violent relationship and a doctor or nurse asks her about it. However, she is not ready to leave the relationship yet, so she tells the health professional she is not in a violent relationship. How do you think a doctor or nurse should respond in this situation?
17. In an ideal situation, how should health care professionals respond to women experiencing abuse?

18. When it comes to experiences seeking help in healthcare, is there anything that I haven’t asked you that you think I should know?

National Domestic Violence Hotline, 1-800-799-7233