Factors Affecting Patient-Physician Communication for Abused Latina and Asian Immigrant Women

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BACKGROUND. Domestic violence is one of today's most serious health issues. Abused Latina and Asian immigrant women face unique barriers to the discussion of abuse with health care providers. This research was undertaken to identify any provider-related factors that may affect patient-provider communication for these women.

METHODS. Qualitative data were collected using semistructured focus group interviews with abused Latina and Asian immigrant women. Participants were recruited through urban community-based organizations. Twenty-eight immigrant women with histories of domestic violence participated in four focus groups: two groups of Latina women and two groups of Asian women. Iterative readings by independent researchers identified provider-related factors affecting patient-provider communication.

RESULTS. The study participants identified the provider behaviors that demonstrate trust, compassion, and understanding as elements that improve patient-provider communication. In addition, participants wanted providers to initiate discussions about partner abuse.

CONCLUSIONS. Improved understanding of factors that may affect abused immigrant patients' communication may assist health care providers in offering meaningful support and assistance to these patients. Providers, administrators, policy makers, and educators should consider these factors when developing policy, protocols, and educational curricula for a variety of health care settings.

KEY WORDS. Domestic violence; Hispanic Americans; Asian Americans; immigration; communication barriers. *J Fam Pract 1998; 47:309-311.*

Submitted, revised, July 27, 1998.
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Domestic violence is one of the most serious social and public health issues of our time. Abused women make up a significant proportion of primary and acute care patient populations.[1-7] Although these women have significant associated physical and mental health problems,[7, 8-12] they have less access to health care services[13-15] and may be more likely to be dissatisfied with their medical care.[16] Previous work has been conducted to identify and address the needs of patients and providers regarding domestic violence, but few studies have addressed the specific issues faced by abused immigrant women when seeking help from the US health care system. This work focuses on abused immigrant Latina and Asian women and provides an analysis of their experiences, perceptions, and expectations when communicating with medical providers.

Methods

Qualitative data were collected through semistructured focus group discussions with abused women as participants. Participants were asked to discuss provider behaviors affecting communication about abuse with health care providers. This study was approved by the Human Subjects Review Committee at Stanford University, and informed consent was obtained from all participants.

Recruitment

Women residing in the San Francisco Bay area were recruited through a variety of community-based organizations, including women's advocacy groups and abused women's resource centers and shelters. Eligible participants were 18 to 64 years of age and had been the victims of domestic abuse within the previous 2 years. Each of the four focus groups was composed of women with the same ethnic identity, and discussions in each group were facilitated by two moderators, at least one of whom was female and of the same ethnicity as the group. The two focus groups of Latina women were conducted in Spanish. One focus group of Asian women was conducted in both Mandarin and Cantonese; the other was conducted in English. Discussions were audiotaped, transcribed verbatim, and translated into English.

Demographics

The study population included 14 Latina women from Mexico, El Salvador, Guatemala, and Colombia who had lived in the United States for 1 to 15 years; and 14 Asian women from China, Vietnam, Korea, the Philippines, and Taiwan who had lived in the United

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States for 1 to 22 years. Median participant age was 35 years. Formal educational background ranged from none to university level. Eighty-five percent of participants (23 of 27) had children, and 85% were divorced, single, or separated.

Data Analysis

On the basis of iterative transcript readings by multiple independent readers familiar with domestic violence issues, a list of common codes was developed to encapsulate the major topics discussed in the focus groups. Transcript coders included professionals from various disciplines (medicine, public health, psychology, medical anthropology, law, and social work) working in academic, legal, and domestic violence advocacy organizations. Each transcript was coded by persons of the same ethnicity of the participants, as well as by persons outside the culture. All coders were systematically trained to maximize objectivity. Coded data were organized using Ethnograph 4.0 (Qualis Research Associates, Amherst, Mass). All tapes and transcripts were initially analyzed in their original language with the exception of the one focus group conducted in Chinese. Preliminary conclusions were reviewed by abused Latina and Asian immigrant women, domestic violence advocates, and professionals from various disciplines. In this report, we present major provider-related factors that affected patient-provider communication among the abused immigrant Latina and Asian women.

Results

Participants described several provider-related factors that facilitated or undermined communication with their providers about domestic violence, including open and supportive patient-provider relationships, encouragement by providers to discuss abuse issues, and continuity of care.

Latina women often used the Spanish term *confianza* to describe the constellation of trust, confidentiality, support, comfort, and safety that was essential for facilitating discussions about domestic violence. Listening attentively, offering advice and support, and providing referrals were all identified as ways providers can create personal relationships and a supportive atmosphere.

> *I felt comfortable because he saw that the problem wasn't that [I was ill]. He said, "a problem, tell me." He helped me because he gave me a list of places I could stay, another list of places I could get food, another list about support groups . . . until I felt very comfortable because I trusted him. He listened to me as if he were a brother.* — Latina woman

A compassionate and supportive environment was also important to Asian participants. Many were apprehensive in their interactions with health care providers and desired a particularly caring approach that demonstrated an understanding of domestic violence. Several participants described providers who were "kind-hearted" and "concerned," facilitating open communication about problems related to domestic violence.

> *If you meet a doctor who doesn't start with a concerned approach, you are afraid that he or she is laughing at you, and you feel that maybe your situation is not worth attention.* — Asian woman

Both Latina and Asian participants expressed a desire for providers to initiate discussions about domestic abuse. Several participants discussed the difficulty of disclosing abuse and asking for help, particularly in situations where providers did not ask directly. Some women attributed this lack of inquiry to the provider's discomfort with the issue, which exacerbated their own discomfort about disclosure.

> *I went. They took x-rays and the doctor told me I only had blows. The doctor asked, "Does it hurt here? Does it hurt there?" I had already told him many places, but I didn't tell him about the violence because he didn't ask. Maybe it was because of his embarrassment or my shame of not telling all that I had.* — Latina woman

> *It usually happens that you see the same doctor regularly so the next time you go, she should ask. Because the color of your face [your expression] is different if you are injured from falling down than from being beaten . . . by your husband. So she should ask.* — Asian woman

Some Latina participants reported encountering providers who focused only on physiological problems and ignored their social and psychological problems. These participants believed that treating only the physical injuries and illness or prescribing sedative and pain medication undermined the patient-provider relationship. This emphasis on medication resulted in some participants losing faith in their providers and contributed to a decreased regard for health care services.

> *I saw the doctor that night, and when he arrived, he examined me: "You're fine, only a little bit agitated. So that you can sleep, here is a little pill to calm you down and a little pill for the pain so that you feel better." This is lack of professional ethic. I was disappointed. I will never visit a doctor; I better cure myself.* — Latina woman

Several Asian participants emphasized the benefit of long-standing relationships with their providers, and many required multiple interactions with the same provider to establish enough trust and rapport to disclose their abuse.

Every time I went to the doctor it was the same doctor, so we became familiar. Could it be that I was that clumsy to fall all the time? So the second time I saw the doctor, he asked me. We knew each other better so I wasn't scared or shy anymore, and I didn't know what else to do, so I told him.
— Asian woman

DISCUSSION

Our research is the first we are aware of to explore in depth the experiences and perspectives of abused immigrant Latina and Asian women regarding health care provider behaviors affecting discussions of abuse. The Latina and Asian immigrant participants wanted compassionate, respectful, and attentive medical providers to facilitate discussions of abuse. While many of the women's perspectives were expressed in culturally distinct ways, both Latina and Asian participants were reluctant to initiate discussions about their abuse and preferred that providers ask directly and sensitively. Medical providers should facilitate communication about domestic violence through their understanding, sensitivity, and willingness to initiate discussions about domestic abuse in the context of a supportive relationship.

This study had several limitations. The sample was small and is not representative of all abused immigrant Latina and Asian women in the United States. Because of the method of recruitment, women in our study were likely to have greater resources and community involvement than many immigrant women. In addition, the high percentage of divorced, single, or separated participants likely indicates a high level of acculturation. Thus, our results may not be generalizable to these populations as a whole. Additionally, because of the open-ended nature of questions, important issues may have been omitted from the focus group discussions.

The goal of this research was to give abused immigrant women a voice in the education of medical providers and policy makers regarding the needs of this group of patients. Through focus group discussions, these participants were able to express and elaborate upon health care provider behaviors affecting patient-provider communication. Further research is needed to identify other social, political, and cultural factors that may also affect patient-provider communication, and to determine whether these issues are generally shared by abused Latina, Asian, or other cultural groups of women. Given the growing immigrant population in the United States, greater consideration of ethnicity and culture is needed in health care policy, research, and education to more effectively address domestic violence.

ACKNOWLEDGMENTS

Funding for this project was provided by the Robert Wood Johnson Clinical Scholars Program, Stanford University. We are indebted to the staff of the following agencies in San Francisco, California, without whose help this study could not have been possible: The Family Violence Prevention Fund, Mujeres Unidas Y Activas, Asian Women's Shelter, Cameron House, and Casa de Las Madres. We also thank Marlene Marin, Clara Luz Navarro, Maria Olea, Karen Rosen, Wendy Sheldon, and Jackie Campbell for their assistance and feedback throughout the project.

REFERENCES

1. Helton A, McFarlane SJ, Anderson ET. Battered and pregnant: a prevalence study. Am J Public Health 1987; 77:1337-9.
2. Rath GD, Jarratt LG, Leonardson G. Rates of domestic violence against adult women by men partners. J Am Board Fam Pract 1989; 2:227-33.
3. Gin NE, Rucker L, Frayne S, Cygan R, Hubbell FA. Prevalence of domestic violence among patients in three ambulatory care internal medicine clinics. J Gen Intern Med 1991; 6:317-22.
4. Hamberger LK, Saunders DG, Hovey M. Prevalence of domestic violence in community practice and rate of physician inquiry. Fam Med 1992; 24:283-7.
5. McFarlane J, Parker B, Soeken K, Bullock L. Assessing for abuse during pregnancy: severity and frequency of injuries and associated entry into prenatal care. JAMA 1992; 267:3176-8.
6. Abbott J, Johnson R, Koziol-McLain J, Lowenstein SR. Domestic violence against women: incidence and prevalence in an emergency department population. JAMA 1995; 273:1763-7.
7. McCauley J, Kern DE, Kolodner K, et al. The "battering syndrome": prevalence and clinical characteristics of domestic violence in primary care internal medicine practices. Ann Intern Med 1995; 123:737-46.
8. Drossman DA, Leserman J, Nachman G, Li Z, Gluck H, Toomey TC, Mitchell CM. Sexual and physical abuse in women with functional or organic gastrointestinal disorders. Ann Intern Med 1990; 113:828-33.
9. Bergman B, Brismar B. A 5-year follow-up study of 117 battered women. Am J Public Health 1991; 81:1486-9.
10. Cascardi M, Langhinrichsen J, Vivian D. Marital aggression: impact, injury, and health correlates for husbands and wives. Arch Intern Med 1992; 152:1178-85.
11. Koss MP, Heslet L. Somatic consequences of violence against women. Arch Fam Med 1992; 1:53-9.
12. Plichta S. The effects of woman abuse on health care utilization and health status: a literature review. Women Health Issues 1992; 2:154-63.
13. Warshaw C. Limitations of the medical model in the care of battered women. Gender Soc 1989; 3:506-17.
14. Loring MT, Smith RW. Health care barriers and interventions for battered women. Public Health Rep 1994; 109:328-38.
15. Plichta SB, Weisman CS. Spouse or partner abuse, use of health services, and unmet need for medical care in US women. J Women Health 1995; 4:45-53.
16. Plichta SB, Duncan MM, Plichta L. Spouse abuse, patient-physician communication, and patient satisfaction. Am J Prev Med 1996; 12:297-303.