
 INNOVATIONS IN EDUCATION AND CLINICAL PRACTICE

The Voices of Survivors Documentary

Using Patient Narrative to Educate Physicians About Domestic Violence

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This article describes a method of developing physician education materials using analysis of domestic violence patient experiences and patients' descriptions of their experiences. The process began with interviews of 21 domestic violence survivors, focusing on what they wanted to teach physicians. Qualitative analysis of these interviews identified 4 main themes regarding what survivors wanted physicians to understand about life in an abusive relationship: that domestic violence is universal, that it is more than just physical assaults, that it is all about power and control, and that it affects the entire family. Because what survivors wanted from physicians differed depending on where they were in their abusive relationships, recommendations were developed for each of 5 common situations: when a patient may not yet recognize the abuse, when s/he may not be ready or able to disclose the abuse, when s/he chooses to remain in an abusive relationship, when s/he is seeking care for an acute assault, and when s/he has left the relationship but not yet healed. Interview excerpts representing each of the identified themes are used to create a 30-minute educational documentary. A written companion guide covers the traditional aspects of domestic violence education. In teaching about domestic violence or other health problems where it is difficult for physicians to understand their patients intuitively, an educator's most important role may be to direct learners to listen to the experience and wisdom of patients.

KEY WORDS: domestic violence; intimate partner violence; spouse abuse; medical education; multimedia; qualitative methods; patient-centered care; patient narrative.

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"And I picked up the phone, and I started to dial 911, and he started crying, so then I felt bad again and I put down the phone. 'Oh I'm so sorry, I'm so sorry. I don't want to grow up to be like my dad.' And he ended up cleaning all my cuts and all that that night."—Stacey

Domestic violence is a major health problem in the United States. Numerous studies document the high morbidity, mortality, and health care costs attributable to domestic violence,¹⁻²³ with an estimated lifetime prevalence of 13% to 30% in population-based samples of women,¹⁻⁴ or 26% to 55% in women in health care settings,⁵⁻⁹ and an estimated 92% greater annual cost to the health care system per patient experiencing domestic violence.²³ Still, statements such as the quote from Stacey, a bright, attractive college student who was repeatedly beaten by her boyfriend, can leave physicians baffled and frustrated, as evidenced by studies highlighting physicians' failure to adequately respond to victims of domestic violence.^{7,14,24-28} For example, studies have found that less than 20% of victims were asked by their providers about domestic violence,^{7,14} and that less than 6% of internists stated that they routinely screen new patients for it.²⁶

In searching for the etiology of this failure, researchers have uncovered many barriers to the identification and treatment of domestic violence victims within the health system.^{25-27,29-32} Some barriers, such as limited time and resources, are institutional in nature and need to be addressed by organizational changes. The attitudes and skills of physicians themselves, however, can be major impediments in the delivery of care to patients in violent relationships.^{25,29-31} Physicians often waver between underestimating the impact of violence on their patients' lives and feeling overwhelmed by their inability to fix what appears to be a hopeless situation.^{29,30}

Understandably, the literature has many calls for improved educational efforts to address this physician skills gap.^{25,32-40} These efforts have traditionally focused on statistics, theories, and expert recommendations to improve knowledge about domestic violence. Such expert-driven instruction does not adequately address the inherent difficulty in understanding what victims of abuse are experiencing. Testimony from individual survivors has been successfully included in workshops about domestic violence.⁴¹ Still, coordinating such guest visits can be

difficult. It is impossible for one or two people to exemplify all the important lessons, and survivors' stories may be seen only as colorful anecdotes supplementing an expert's lecture. The goal of this project was to create an easily distributed tool that would allow survivors themselves to act as the teachers, explaining both what it is like to live in an abusive relationship, and what they want from physicians.

The author worked in collaboration with a variety of domestic violence experts, survivors, and advocates to interview survivors about what they would like physicians to understand and do about domestic violence. This team, along with a group of volunteer artists, then used representative excerpts from the interviews to create an educational documentary aimed at physicians. The documentary aims to improve physicians' awareness and empathy, to increase detection, and to reinforce responses that survivors find helpful. This article describes a method of combining qualitative research with documentary production to create innovative educational materials that allow physicians to learn from the experiences of patients.

PROJECT DESCRIPTION

The Collaboration

At the start of the project, senior researchers and domestic violence activists cautioned that the domestic violence community has historically had negative feelings toward researchers, the perception being that researchers do not value their expertise, that they do not adequately protect their clients, and that they do not give back to the community. To address these concerns, the author created an advisory council, which included representatives from the state coalition against domestic violence, local domestic violence agencies, health system domestic violence projects, survivor activists, the district attorney's office, and the state medical association. (See Appendix A) This group facilitated recruitment and provided expertise and recommendations throughout the project. The use of the first person plural in this article refers to the author and the members of this advisory council.

Research Methods

We conducted a qualitative research study, focusing on what domestic violence survivors wish to teach physicians. The author held private, audio-recorded, semistructured interviews, each lasting 45 minutes to 2 hours. Participants were recruited via announcements and brochures distributed to clinics and domestic violence agencies, including ones targeting ethnic and sexual minorities. Participants were first asked an open-ended question to "tell their story" about the abusive relationship. After allowing participants to describe their situation for approximately 20 to 30 minutes and asking for needed clarifications, the interviewer focused on specific ques-

tions about interactions with the health care system, including what actually happened and how they felt about each interaction. Participants were then directed to give specific advice to physicians as to what they could do for a patient in a similar situation.

We analyzed the interviews for common themes using QRS-NUD*IST software (Sage Publications Software, Thousand Oaks, Calif). To meet the educational needs of viewers, we formulated a structure for the documentary from preliminary review of the interview scripts. For the first section, which describes what survivors want physicians to understand about domestic violence, we chose the 4 most common themes expressed by participants. When creating the second section, which describes what physicians can do to help patients, we found that participants' recommendations depended on where they were in their relationships. Thus, we identified the 5 most common situations affecting their interactions with physicians. For each one, we chose themes or advice expressed by a majority of participants who had described being in such a situation.

We used the ethnographic technique of reviewing identified themes with participants, but also showed the preliminary themes to the members of the advisory council and to approximately 15 physician colleagues. All of the above individuals, as well as members attending a national conference, later had the opportunity to watch and comment on the preliminary version of the documentary. Changes were made based on their comments.

Documentary Production

Although the themes that emerged from the ethnography are interesting in their own right, we felt that few physicians would change their attitudes or practices simply by reading through a list of them or hearing an expert describe them. We hoped that by using the survivors' own voices and examples, and coupling them with vivid images, the documentary would have a greater impact on physicians than traditional teaching methods. The soundtrack of the documentary consists of interview excerpts representing each identified theme. Participants chose whether or not to have their portraits included. Local artists volunteered to provide photography, music, artistic guidance, and video editing expertise (Appendix B).

Based on comments from physician viewers requesting written materials, we created a companion guide that supplements each identified theme with traditional aspects of domestic violence training, such as statistics, screening questions, clinical indicators, and documentation guidelines. Information in the companion guide was adapted from current training materials in use by the Family Violence Prevention Fund and the Providence Health System, as well as a review of the literature and discussions

with a deputy district attorney specializing in domestic violence.

RESULTS

Participants

Twenty-one self-identified domestic violence survivors, aged 22 to 64 years, participated in the interviews. Nineteen women experienced the abuse in heterosexual relationships; 1 woman and 1 man experienced it in same-sex relationships. Although special effort was made to recruit participants from diverse racial and ethnic groups and to provide interpreters for non-English speakers, all were English speakers, 19 were white, 1 was African American, and 1 was Native American. The abusive relationships ranged in duration from 3 months to 23 years. Time since last episode of physical violence ranged from 1 week to 20 years. Six women were living in shelters or transitional housing at the time of the interviews.

Normative Feedback and Resulting Changes

All 21 participants received copies of the themes and a preliminary "script" of the soundtrack. They were surprised at how much their own experiences resonated with those of others. Changes were made based on survivors' comments to include a greater emphasis on the fact that domestic violence can affect anyone regardless of age, race, socio-economic status, sexual preference, or gender. The members of the advisory council received similar materials, and made changes to the wording of the narration, both to avoid any "victim-blaming" language and to make a stronger parallel between the controlling behavior of the batterer and of some physicians. Based on comments from physicians, we added a section pointing out that this does not have to be a hopeless or "terminal" situation for most patients, and shortened the video from 45 to 30 minutes.

Final Themes and Documentary Structure

The documentary is structured around the themes in Table 1. The sound track consists primarily of actual audio-recorded interview excerpts, edited for clarity. A narrator briefly names each major theme and the survivors' voices elaborate upon it with representative quotes. Animated text phrases appear during the narration, and black and white photographs, either of the survivors or of other vivid images, accompany the survivors' voices. Subthemes are identified with a text phrase that fades into the still photographs.

Part I: Understanding Domestic Violence. Four themes emerged around what survivors want physicians to understand about domestic violence. First, survivors wanted physicians to know that domestic violence is universal—that is, anyone can become a victim of domestic violence—and that they should discuss it with all

Table 1. Identified Themes and Documentary Structure

Part I: Understanding domestic violence
1. Domestic violence is universal. <ul style="list-style-type: none"> • Physicians should address it with all patients, not just those that fit their stereotypes.
2. Domestic violence is more than just physical assaults.
3. Domestic violence is all about power and control. <ul style="list-style-type: none"> • Batterers commonly used stalking, social isolation, physical and economic limitation, and threat of violence as other ways to establish control over their partners' lives.
4. Domestic violence has negative effects on the whole family.
Part II: Understanding your patients and what they need from you
1. The patient may not recognize the abuse. <ul style="list-style-type: none"> • Barriers to recognition include the patient's own stereotypes about victims or abuse, the complexities of relationships, or being in love. • To help a patient recognize the abuse, ask detailed screening questions and provide information on domestic violence to all patients, not just those who disclose abuse.
2. The patient may not be ready or able to tell a physician about the abuse. <ul style="list-style-type: none"> • Barriers to disclosure include a lack of privacy, as well as shame, embarrassment, or a feeling that doctors don't want to know. • To help a patient disclose the abuse, interview the patient alone, display compassion, express interest, and discuss your clinical suspicion with the patient.
3. The patient may be choosing to remain in the abusive relationship. <ul style="list-style-type: none"> • Reasons include a commitment to the relationship, belief of excuses or apologies, erosion of self-esteem, lack of options, or the danger associated with leaving an abusive relationship. • To support the patient while they choose to remain in the relationship, use care not to blame the victim, tell the patient he or she does not deserve to be abused, offer resources and referrals, and leave the ultimate decision to the patient.
4. The patient may be presenting due to acute physical abuse. <ul style="list-style-type: none"> • Interactions with the health care system can add to the already severe emotional trauma the patient has just experienced. • Offer support, ensure privacy, and provide careful documentation.
5. The patient may have left the relationship, but not fully recovered. <ul style="list-style-type: none"> • It takes a long time to heal. • Make sure that you do not replicate the controlling behavior of the batterer.
Epilogue
1. Domestic violence is life threatening, not terminal
2. Physicians can play an important role in the lives of patients experiencing domestic violence.

their patients. Stacey describes why she believes her doctors never questioned her false excuses for repeated injuries:

I mean, I'm not poor. I'm not married. And I just don't think any doctor would have ever approached me to think that I would lie, or that I really was going through this.

Second, survivors felt that domestic violence was more than just physical assaults. Joan notes:

He held me hostage in that room and screamed at the top of his lungs and yelled at me and berated me and absolutely tore me apart to, you know, the deepest extent that he could. It was like one of the worse beatings I think I've ever gotten.

Third, survivors wanted physicians to understand that domestic violence is all about power and control. Their batterers used violence as one of many means to establish control. Other ways of establishing control included stalking, social isolation, physical and economic limitations, and the threat of violence. Cindy explains how her partner used jealousy to excuse constant stalking:

I would go to the grocery store and he would follow me to the grocery store. And I would have in the back of my mind, okay, he might show up. So when I go to pay for these groceries, I need to go to a checker that's a female. 'Cause if I'm standing in line when he gets here, at a checker where there's a male, he's going to say, "Oh, so that's your boyfriend."

A quote from Pat addresses the physical and economic limitations her batterer imposed upon her:

He would push the couch up against the door, the couch. Not the loveseat, the couch. He took my ID, and my bank book, my Social Security card. "You can't go cash your check unless I'm there."

Similarly, James describes how the threat of violence controlled his life:

If he was having a good day, I could have a good day. If he was having a bad day, then it was like I had to dance around, walk on eggshells, do whatever it took to try to get him back in a better place. So I kind of felt like I was just a marionette.

Finally, survivors wanted physicians to understand that domestic violence affects the entire family. Every participant who had children showed great concern for the effects it had on them. Patti describes:

And for as young as he was, it's amazing how much he picked up, because immediately following the assault, and sometimes even now, he has to hurt me, and then he'll tell me he loves me. He'll either just pinch my hand or push my knuckles in and hurt me, or he'll come up and pound on the back of me, and then he goes "I love you!"

Part II: How Physicians Can Help. Survivors made it clear that domestic violence is a chronic problem and needs to be treated as such. They did not expect to resolve their problems in one office visit, and were frustrated with physicians who thought they could "fix" the situation immediately. What they wanted physicians to do depended on where they were in their lives and relationships, either because of their own readiness or because of obstacles imposed upon them by their partners. As such, this section of the documentary is divided into what physicians can do for patients at different times in their patients' lives. Each

section starts with survivors' descriptions of how they felt during that time. It then offers recommendations from the survivors as to what physicians should do for patients in that situation. Of course, not every patient experiences each of these scenarios, but this format allows physicians to target efforts to what patients may need at different times.

Many survivors felt there was a time they could not yet recognize the abuse as domestic violence, be it due to their own stereotypes of victims or abuse, the complexities of relationships, or the fact they were in love with their partner. Connie Sue explains:

I didn't associate my situation with domestic violence. [Interviewer: "Why not?"] Because I wasn't all tattered and torn. The images that we see of women who are battered are those that end up in the emergency room. And I didn't look like that.

Patti adds:

As much as he was extreme in his violence, he was extreme in his love. Red flags should have been going off. Denial! Denial! These are all things, now, I see, but at the time I didn't, okay? So as much as he beat me or was violent with me, he was also...no one had ever loved me like he loved me.

These and other examples of barriers to recognition are followed by the relatively obvious recommendations that physicians should ask questions about the specific components of abuse, and that they should provide domestic violence information to all their patients, not just those that disclose it. Certainly this is not the first time physicians have been told to do so, but the survivors show why these recommendations matter.

On intake, I was asked all these screening questions and I was amazed and horrified to find myself answering "yes," "yes," "yes," "yes" to question after question. And it was then, at that moment, that I realized, "My God, this does apply to me!"

Survivors described a time where they were not able or ready to disclose the abuse to physicians, be it due to a lack of privacy, shame, embarrassment, or a feeling that doctors don't want to know about it. Yvonne explains:

I didn't trust the doctors, it's like, I felt like I was wearing a sign on my head that said, "I'm abused. You know, my husband hates me," but it was just ignored. And so I didn't feel that I could go to anybody and be helped.

Survivors suggested that physicians interview the patient alone, display compassion, express interest, and openly discuss their clinical suspicion.

Many survivors also described a time where they recognized the abuse, but still chose to remain in the relationship. Reasons included a commitment to the relationship, belief in excuses or apologies, erosion of self-esteem, lack of options, or the danger associated with leaving an abusive relationship. Patti describes her frustrations with the system's response to her call for help:

They basically told me to leave. And it wasn't as simple as that. You know, I had other children. I was isolated in

a trailer. I was pregnant. I really felt kind of trapped. And so I said, "Well, then I guess I can't do anything." So I decided to stay, and I just let it go.

The survivors suggest that physicians should 1) use care not to blame the victim, 2) tell the patient he or she does not deserve to be abused, 3) offer resources and referrals, and 4) leave the ultimate decision to the patient. Monica explains:

Yes there's something that you cannot fix. But as long as you're there, and you can give the help, or let them know that there is help out there, you've done your job. Because you're not completely powerless in the fact that you have given them options. And that's the most amazing thing, to be given a choice.

Many participants who had presented to a health care setting as a result of an acute physical attack felt that interactions with the health care system often added to the emotional trauma they had experienced. Kathy describes her hospital stay:

It was like I was on display at a freak show. That's how I felt. I had doctors, swarms of doctors, that would come in, you know, doing their rounds.... All these doctors standing around looking at me, inspecting me.... It just did not feel very supportive.

Survivors suggest that physicians offer support, either themselves or by calling in an advocate or friend, ensure privacy, and provide careful documentation.

Finally, many survivors described a period of time in which they had left the abusive relationship but had not yet healed. They wanted to remind physicians that it takes a long time to heal, and that they should not replicate the controlling behavior of the batterer. Kathy suggests:

Don't be this, "I'm the doctor, you're the patient" kind of attitude. Have a softer presence. Realize that you're dealing with a woman that might be being abused, or have been abused.

The documentary ends with an epilogue that conveys two messages: that domestic violence is life threatening, but not terminal, and that physicians can make a difference. As Joan states:

I really think that it's the compassion, the screening, the referral which can happen in a matter of minutes, which can be the hinge, the gateway to the way out.

Distribution

The American College of Physicians – American Society of Internal Medicine and the Family Violence Prevention Fund are distributing the documentary. It is being used regularly in workshops aimed at students, residents, and practicing physicians. The companion guide includes many topics covered by traditional training courses, as well as sections aimed at physician preceptors and domestic violence advocates wishing to use the video as part of their teaching efforts. Table 2 lists the topics covered in the companion guide.

Table 2. Contents of Companion Guide

Part I: Understanding domestic violence
1. Domestic violence is universal
• Some basic statistics
• Special issues for gay, lesbian, and bisexual patients
• Special issues concerning race, ethnicity, or disability
2. Domestic violence is more than just physical assaults
• Definitions of domestic violence
3. Domestic Violence = power and control
• Power and control wheel
4. Domestic violence affects the entire family
• Facts about the effect of domestic violence on children
Part II: Understanding your patients and what they need from you
1. Your patient may not recognize the abuse
• Recommended screening questions
• A note about patient information
2. Your patient may not be ready or able to tell
• Clinical indicators that may raise your index of suspicion
3. Your patient may be choosing to remain in the abusive relationship
• Accessing domestic violence resources
4. Your patient may be seeking care just after an acute assault
• Documentation issues
5. Your patient may have left the relationship, but not fully recovered
• Medical power and control wheel
Epilogue
1. Domestic violence is life threatening, not terminal
2. Physicians can make a difference
• Medical advocacy wheel
3. A note to physician preceptors
4. A note to domestic violence advocates

Evaluation

Evaluation of this project was divided into 3 parts: a normative evaluation process during qualitative analysis and video production; pilot testing of the educational value of the videotape with a national audience; and ongoing evaluation by current users. Formal studies of the effectiveness of the documentary in changing physician attitudes and behavior are underway.

The author presented a preliminary version of the documentary at the 1999 Society of General Internal Medicine meeting. When asked to describe the most important lessons they learned from the videos, physicians at SGIM wrote comments such as: "This could actually happen to a well-adjusted person," "Belief by provider that they know what's best can be a barrier," and "Survivors would want to discuss this issue with their physician." Since completion and distribution of the final version in early 2000, we have received unsolicited feedback from over 100 physicians, advocates, and educators, all of which has been extremely positive. The most common theme in this feedback is the "powerful" or "compelling" nature of

the documentary. In the words of one facilitator, "The voices ... touch our intellect, heart, and soul." The Family Violence Prevention Fund recently reviewed available training videos, and chose the *Voices of Survivors* as the one to promote in conjunction with "Health Cares About Domestic Violence Day."

DISCUSSION

The *Voices of Survivors* documentary adds to traditional expert-driven domestic violence interventions by allowing physicians to see domestic violence from the perspective of those who have lived through it. It also improves upon the practice of inviting a single survivor to speak at a conference by drawing upon the experiences of a wide range of people, and focusing on common themes in a structured manner.

This project has some important limitations. Certainly these 21 survivors cannot speak for every person who has experienced domestic violence. Our sample consisted of primarily white volunteers from the Seattle area who had already left their relationships, who were interested in educating physicians, and who were comfortable discussing their experiences on audio tape. In trying to limit the documentary to 30 minutes, we had to focus on the similarities in survivors' experiences, and could not include important cultural, socioeconomic or personal differences that may impact a patient's experience. We left much of the traditional information such as statistics, clinical indicators, or documentation guidelines to the written companion guide, and thus must rely either on a learners' motivation to read through the material or on a preceptors' skill in addressing those areas. We also focused the documentary on what may more accurately be termed "intimate partner violence." Other aspects of domestic violence such as child abuse or elder abuse are beyond the scope of the documentary and would need to be addressed separately.

Another important limitation is the lack of formal evaluation data on the effectiveness of the documentary as an educational intervention. A pilot randomized control trial is underway with 42 internal medicine residents. We are starting a larger randomized control trial with 500 primary care providers in Oregon. The former study uses a pre- and post- intervention survey addressing participants' knowledge, ability to empathize with victims, acceptance of appropriate responsibility, confidence in treating patients, and self-reported behavior. Psychometric testing of the questionnaire is in progress. The latter study uses the same survey as well as pre- and post-intervention patient questionnaires addressing patients' report of providers' behavior and patients' satisfaction with the interactions. Such data will be critical to assessing the effectiveness of this educational intervention.

This article describes a method of developing physician education materials using analysis of patient experiences, and patients' descriptions of their experiences. Educators, whether or not they consider themselves to be experts in

domestic violence, are encouraged to use the documentary and companion guide as part of their teaching on domestic violence. Similar projects would be useful in other areas in which it is hard for physicians to intuitively understand what their patients are experiencing. Examples would include patients struggling with substance abuse, chronic pain, or terminal illness. As qualitative methods become more widely used in the research arena, educators should take advantage of the power of narrative to create innovative teaching tools. In many areas, an educator's most crucial role may be to direct learners to listen to the experiences and wisdom of patients.

CONCLUSIONS

Domestic violence survivors choosing to participate in our project wanted physicians to understand that domestic violence is universal, that it is more than just physical assaults, that it is all about power and control, and that it affects the entire family. What they wanted from physicians depended on where they were in their abusive relationships. They provide recommendations to physicians who may be seeing a patient at a time when he or she may not recognize the abuse, when the patient is not ready or able to disclose the abuse, when the patient chooses to remain in the abusive relationship, when the patient is presenting for care as a result of an acute physical assault, or when the patient has left the relationship but not yet healed. By coupling qualitative research with documentary production, one can create powerful educational materials that allow physicians to learn from the voices of patients.

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APPENDIX A

Voices of Survivors Advisory Council

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- Mirian Hilfrink, MSW, CCDC, Clinical Director, Family Services Family Violence Program
 - Leigh Nachman Hofheimer, MA, Education Coordinator, Washington State Coalition Against Domestic Violence
 - Ellie Rose, Domestic Violence Activist
 - Robin Fox, JD, Senior Deputy Prosecuting Attorney, King County Prosecutor's Office
 - Patti Bland, MA CCDC, Advocate, New Beginnings
 - Connie Burke, Executive Director, Advocates for Abused and Battered Lesbians
 - Andrea Carlson, Advocate, Domestic Violence Abuse Network
 - Candice Cardinal, MPA, Domestic Violence Specialist, Evergreen Community Health Care
 - Pamela Rhoads, Trainer, Providence Health System Family Violence Program
 - Roy Farrell, MD, Chair, Violence Prevention Committee, Washington State Medical Association
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APPENDIX B

Documentary Production Staff

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 - Sound Editing: Joseph Wilmhoff, University of Washington Educational Resource Center
 - Music: Alicia Healey
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