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Shelter Staff Perceptions of Physicians Seeking Services for Intimate Partner Violence

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by

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Each person whose signature appears below certifies that this doctoral project in her opinion is adequate, in scope and quality, as a dissertation for the degree Doctor of Psychology.

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CONTENT

ABBREVIATIONS

DV	Domestic Violence
IPV	Intimate Partner Violence
NPR	National Public Radio
SES	Socioeconomic Status

ABSTRACT OF THE DOCTORAL PROJECT

Shelter Staff Perception of Physicians' Seeking Services for Intimate Partner Violence

by

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Research indicates there are a significant number of instances of intimate partner violence (IPV) in the United States, with current prevalence rates impacted by a substantial amount of underreporting due to stigma, difficulty disclosing, and complex love and fear of abusive partners (Breiding et al., 2014; Ellsberg & Heise, 2005; Overstreet & Quinn, 2013). A large body of IPV research exists more generally, but there is little understanding about the help-seeking behaviors of high socioeconomic status (SES) individuals within IPV shelter systems. While several studies have demonstrated the equal impact of abuse across demographic contexts (Satyen, Rogic, and Supol, 2018; Haselschwerdt & Hardesty, 2017), a larger body of research indicates lower SES and minority communities are impacted by abuse at disproportionate rates (Cunradi, Caetano, & Shafer, 2002; Panchanadeswaran & McCloskey, 2007). Most of the literature focuses on these populations, leading to a gap in understanding IPV in higher SES individuals, specifically alternative sources of support and potential barriers (Tolman & Raphael, 2000). This study aims to identify the unique needs, experiences, and assumptions of higher SES individuals, with a particular emphasis on physician survivors of IPV. A unique interplay of physician characteristics, hospital culture, and needs and challenges of these individuals serves as the backdrop for a qualitative study utilizing interview data

collected from shelter staff. While this study is exploratory, the authors held the *a priori* assumption that few physicians would utilize services due to significant barriers impeding help seeking, including shame, stigma, and culture of the healthcare environment.

CHAPTER ONE

INTRODUCTION

Current Literature on Intimate Partner Violence

Intimate partner violence (IPV) shelters nationwide reported serving 4,183,893 individuals over the 2018 calendar year ("Number of People Using Domestic Violence," 2019). Intimate partner violence affects individuals across genders, lifestyles, education-levels, races and ethnicities, marital status, and career trajectory (Avdibegovic, Brkic, Sinanovic, 2017; Black et al., 2011). This study explores shelter staffs' personal experiences with survivors of IPV that have sought services through the various social service agencies with which they work. More specifically, the goal of this study is to better understand the patterns of help-seeking demonstrated by high socioeconomic status individuals, and more specifically, those that are physicians. Through the use of semi-structured interviews and focus groups, we asked shelter staff about their perceptions or personal experiences with this population; asking them to reflect on the unique experiences that a high-income client might have when choosing to leave their abusive partner and seek shelter. We asked that they reflect about difficulties disclosing more broadly, as well as what a shelter environment experience might be like for those individuals. Added emphasis is placed on the experience of a physician seeking services, asking the participants to expand on the unique reality of a healthcare provider who both offers treatment for others experiencing IPV, while also potentially experiencing that kind of abuse themselves.

Overview of Intimate Partner Violence

Intimate partner violence, also referred to as domestic violence, domestic abuse, or relationship abuse interchangeably in the literature and throughout this text, is a pervasive public health crisis throughout the world (CDC, 2018). The National Domestic Violence Hotline defines domestic violence as a pattern of behaviors used by one partner to maintain power and control over another partner in an intimate relationship ("Abuse Defined," 2018). A more specific definition of IPV incorporates "any behavior within an intimate relationship that causes physical, sexual, or psychological harm, including acts of physical aggression, sexual coercion, psychological abuse and controlling behaviors" (WHO, 2010). Much of the initial research on IPV focused on explicit acts of physical violence between partners, including murder, rape, sexual assault, robbery, aggravated assault, and simple assault (Rennison & Welchans, 2002). A more current theoretical understanding of the power dynamics involved in instances of domestic violence broaden that definition to include coercion and threat, emotional abuse, isolation, minimizing, denying, blaming, children as a tool for guilt, male privilege, or economic abuse ("Abuse Defined," 2018). This more inclusive understanding of abuse within intimate partnerships encompasses a much wider array of violence and control that is inclusive of far more relationships than many survivors are able to realize while they are experiencing the abuse. While overt acts of physical or sexual aggression are more widely understood as abusive, some are still perceived as culturally "acceptable," leaving many survivors trapped in a cycle of fear and shame that often isolates and silences those who are experiencing it (Kasturirangan, Krishnan, & Riger, 2004). These cultural underpinnings

play a particularly significant role in not only awareness and perception of patriarchal norms as abusive, but a desire and willingness to help seek.

As domestic violence incidence rates began to rise, national survey research at the turn of the century indicated that approximately 4.8 million intimate partner rapes and physical assaults against women and 2.9 million physical assaults against men were committed annually in the U.S. alone (Tjaden, & Thoennes, 2000). Surveys at this time compiling lifetime prevalence rates indicated that between 33% and 37% of women report having experienced one or more act of physical or sexual abuse from their partner in their life (Tjaden & Thoennes, 2000). More recent numbers demonstrate that annual prevalence rates have increased to over 10 million women and men experiencing some type of physical assault by their current or former intimate partners (Breiding et al., 2014). These statistics are the current best estimates of violence prevalence, but the historical phenomenon of underreporting abuse is important to consider when evaluating these estimates (Anderson, 1997). This is supported by evidence suggesting that women in abusive relationships will experience some type of violence perpetrated by their partner an average of 35 times before they report it to the police (Truman & Morgan, 2014). While patients may find it difficult and uncomfortable to disclose instances of domestic violence, it has also been established that physicians interacting with survivors of obvious physical abuse find it uncomfortable and inappropriate to address in an acute care setting (Davis et al., 2003). This bidirectional discomfort in addressing the topic of IPV leaves both care providers and survivors without feasible options for open conversation regarding this sensitive and critical issue.

Aside from the personal impact that each act of IPV has on the life of the survivor, there are also incredible costs to society as a whole. It is estimated that medical, mental health, and lost wages due to physical and emotional ramifications of IPV cost an excess of 8 billion U.S. dollars per year, excluding the cost of survivors' services, criminal justice costs, and police response (Centers for Disease Control and Prevention, 2003). Research also indicates that 43% of families in which an act of IPV has occurred also have children present in the home (Rennison & Welchans, 2002). Exposure to this kind of violence in childhood serves as one of the most prominent risk factors for poor adolescent outcomes, including internalizing and externalizing behaviors such as psychological symptoms of anxiety and depression, delinquency, and continuing to engage in and perpetrate the cycle of violence (Moylan et al., 2010). This emphasizes the imperative need to address effective solutions to combat IPV and continue to support survivors and the families that also experience the ramifications of violence.

Services Available for Survivors of Intimate Partner Violence

According to 2017 census data, there are currently 1,873 active and identified programs serving survivors of domestic violence in the United States (National Network to End Domestic Violence, 2017). Survivors seeking services report needing assistance with housing insecurity, difficultly managing financings and paying bills, and lack of access to consistent meals (Baker, Cook, & Norris, 2003). On one evening in the month of September every year, a census is conducted by the National Network to End Domestic Violence that hopes to capture the typical number of survivors seeking services on any given day at shelters throughout the U.S. Data collected on this day, September

14th, looked at the most frequently used services in a 24-hour period in shelters across the nation. Shelters reported the most frequently used services to include children's support and advocacy, emergency shelter, transportation, court advocacy, prevention or education programming, transitional and other housing resources, and therapy or counseling services (National Network to End Domestic Violence, 2017). The National Network also reported that although 72,245 survivors were served throughout this 24-hour period, 11,441 requests for various services (predominantly housing) went unmet due to lack of adequate resources to meet the immense need within this population (National Network to End Domestic Violence, 2017). This census is one example of the incredible strain that is put on social service agencies, like domestic violence shelters, to meet the needs of clients with a lack of effective access to resources to keep up with demand. Alongside this inability to serve those who are requesting aid in various ways, there is the significant aforementioned number of individuals who do not seek services at all, leaving an immense number of survivors without adequate support to break out of the cycle of violence.

Shelter programs are often viewed as a last resort by many survivors, frequently marred by the fear of coexisting in a space with many individuals who are also in crisis, and living in a communal environment (Grossman & Lundy, 2011). Research suggests that survivors enter into shelters with a variety of past histories, experiences, cultural narratives and purposes for seeking shelter (Few, 2005; Liang et al., 2005; Ogulmus & Keskin, 2017). Some individuals come to a shelter seeking support after having made the choice to permanently leave a relationship, while others take time in a shelter as a temporary relief from a relationship they still hope to work out, or a safe alternative to an

unhealthy ex-partnership that cannot be escaped despite no longer identifying oneself as "being in a relationship" with that individual (Sullivan, 2012; Fleury, Sullivan, & Bybee, 2000; Hardesty & Chung, 2006). Qualitative research illuminating the voices of staff and survivors in existing shelter systems within the United States demonstrates that both populations, those who work at shelters and those who are receiving services, perceive enhanced IPV services when shelters provide empathy, supported empowerment, individualized care, and maintained ethical boundaries. Additionally, this qualitative work notes that inadequate organizational resources, staff burnout, lack of training, and poor integration with other community resources hinders the quality of services (Kulkarni, Bell, & Rhodes, 2012). Cross-sectional survey research suggests that although many traditional shelter services, such as law enforcement and legal assistance, domestic violence counseling, and emergency shelter, are available to survivors - participants expressed preferring increased access to economic and health support services that help to facilitate long-term solutions to the consequences of IPV (Rhodes & Dichter, 2011). This information provides a better understanding of the success and pitfalls of services offered within the shelter system from the perspective of individuals working within it every day, and continues to inform research and intervention strategies about best practice in the field.

Barriers to Help Seeking Following Intimate Partner Violence

While understanding the most effective resources to offer and referral sources to pull from in order to address the needs of this population is crucial, evaluating barriers to this population actually seeking care is a fundamental first step in understanding the

complex phenomenon of safety-seeking in IPV. Current literature indicates that women who utilize help-seeking services are experiencing violence to the same degree of severity that non-help seekers are, but there are significant barriers to accessibility and psychosocial variables impacting choices to seek safety for many women (Dufort, Gumpert, and Stenbacka, 2013). Qualitative research focusing on internalization of violence and abuse found that women often describe reactionary psychological processes as barriers to help seeking. This includes feelings of self-blame, powerlessness, hopelessness, the need to protect family, and the need to keep such abuse a secret (Beaulaurier et al., 2008). Women in these relationships characterized by strong power-differentials may often feel powerless to make a change in their lives, which is indicative of a significant variable for interventions to aim toward enhancing in IPV survivors.

An effective theoretical framework for understanding the demonstrated pattern of help-seeking in this population is based on a cognitive understanding of a three-step response to the experience of stigmatization related to incidences of domestic violence. This theory suggests that these stepwise processes include first defining the problem, deciding to seek help, and finally selecting a source of support (Liang et al., 2005). The socio-cultural context in which these individuals exist while they are making the choices of whether or not to disclose their experience of abuse and subsequently pull from potential sources of social support versus engage with community services serve as a crucial backdrop to the decisions that individuals experiencing IPV have to make.

Cultural Factors Impacting Help-Seeking Behaviors

Specific cultural variables play a role in creating barriers to help-seeking. For Latina women, research demonstrates that low acculturation serves as a significant barrier to help-seeking behavior, specifically referring to the preference of communicating in the Spanish language (West, Kantor, & Jasinski, 1998; Garcia, Hurwitz, and Kraus, 2005). This could indicate that there are not enough adequate Spanish-speaking resources to address the needs of this specific subgroup of IPV survivors. It has also been demonstrated that Latino immigrants are less likely to seek services than non-immigrants, indicating that there are both language and education gaps in awareness of IPV support (Ingram, 2007). Latinas' experiences with relatively lower levels of income, employment, and education compared to their non-Latino counterparts also serve as significant impediments to help seeking. Lack of education and cultural norms of toleration of abuse feed into the process of cultural isolation that can exist in specific communities, particularly those with higher recent immigration status, which decreases overall awareness of and decisions to seek resources and support services beyond their insulated community (Lewis et al., 2005). Literature demonstrates that although IPV is experienced across cultures, Caucasian women are more likely to seek formal survivor services like shelters, while Latina and African American women are more likely to utilize hospitals and law enforcement (Satyen, Rogic, and Supol, 2018). Future studies in this area are necessary to determine if this phenomenon is a function of education about the existence of services across racial and ethnic groups, or mediated by cultural beliefs about appropriate places to seek care. Cultural experiences of stigma also play a role in perceptions about abuse and subsequent help-seeking behavior. The internalization of

assumed stigma about the de-legitimization of people who experience abuse and a fear about the anticipated treatment following disclosure, severely inhibit conversations about IPV (Overstreet & Quinn, 2013). Feelings of stigma and shame rooted in cultural narratives can work to further isolate survivors of IPV, leaving them feeling stuck to suffer in silence rather than face potential backlash of coming forth with their experience of abuse.

Sociological research has aimed to explore the role of not only ethnic and racial variations in culture, but collectivist versus individualist ideals about patriarchal societal structure as a potential barrier to help seeking and a contributor to cycles of violence. This research theorized that an underlying emphasis on dominance, gender, and power when conceptualizing violence through a more patriarchal lens can contribute to the stigma around survivors seeking help. An understanding of violence as a biproduct of a gendered, male-dominant power struggle over female survivors could contribute to a belief in these survivors that they exist in an assumed and imposed power structure that there may never be an alternative to (Hunnicutt, 2009). Similar research using perceptual experiences of IPV in women in a heavily hierarchical Ugandan society contributed to the theory that patriarchal structures normalize violence through the process of subordinating women and children via negative role modeling and displaced aggression (Namy et al., 2017). Conceptualizing violence in this way reinforces the ideals that women may never be able to step out of this male-dominated narrative in a society that emphasizes this hierarchy, leaving them feeling stuck in a cycle of violence in which no end is visible, regardless of the partner.

While much of the research explores heteronormative relational experiences of violence perpetrated by men against female partners, this is by no means the only experience of IPV that exists within romantic relationships. While research demonstrates that 1 in 10 men have experienced rape, physical violence, and or stalking by a partner, a 2017 National Public Radio (NPR) interview reports that at the time only two emergency service shelters existed in the United States that serve an entirely male population (Black et al., 2011; Simon, 2017). With so few shelter services available for male survivors, this begs the question of what beliefs about these populations as survivors exist within society, and what can these male survivors do following an experience with violence? Perceptions of violence enacted in same- and opposite-sex relationships have been demonstrated to reflect traditional gender stereotypes, with male-against-female violence considered the most serious and deserving of legal intervention (Seelau & Seelau, 2005). These socially held beliefs about partner violence invalidate the experience of male survivors of IPV and female partners in same-sex relationships, perpetuating an increased lack of help-seeking by these specific populations above and beyond the stigma and challenges already experienced by survivors of IPV more broadly.

Survey research of male survivors of IPV has demonstrated that their lack of reporting of their experience with violence is rooted in fear that their experience will not be taken seriously by authorities (Drijber, Reijnders, & Ceelen, 2013). Studies examining the interrelated themes between male and female perpetrated domestic violence has demonstrated that similar patterns of abusive behavior are visible across genders, with psychological symptoms of Cluster B personality traits as well as a history of multigenerational abuse and violence experienced by the perpetrators being common

amongst both male and female perpetrators (Bernardi & Steyn, 2019). This research points toward the significant gap in services for a broad spectrum of IPV survivors, and may contribute to the lack of research and understanding about help seeking in these populations due to lack of accessibility and availability of proper resources to service them.

Literature like this contributes to a greater understanding of the processes underlying violent behavior across populations that experience and perpetrate violence, and allows for an integration of theory and intervention that are informed by the complex nature of cycles of violence. Understanding the multiple ways that violence plays out across cultures and the variables that contribute to its perpetuation is critical. This understanding will pave the way for more well-informed intervention and support services that aim to successfully bridge the gap between experiencing IPV and seeking services to help remove oneself from the continued cycle of violence.

Socioeconomic Disparities in Seeking Services for Intimate Partner Violence

Intimate Partner Violence in Low Socioeconomic Status Individuals

Most frequently, women who do not have the means to take advantage of alternative options to a shelter environment, like staying with friends or financially providing for their own housing, find themselves seeking domestic violence shelter services (Panchanadeswaran & McCloskey, 2007). Research has demonstrated that individuals who exist in lower income brackets, specifically women and children, suffer the most from the impacts of IPV (Tolman & Raphael, 2000). Not only do survivors in

this level of socioeconomic status face a greater impact following an experience of abuse, but research demonstrates that they are actually at a more significant risk of abuse, even more so when survivors in this population are also members of minority ethnic groups, especially African American and Hispanic women (Frias & Angel, 2005). Instances of IPV have had significant negative effects on job stability and economic well-being for this population, well beyond the years during which the violence was experienced (Adams et al., 2013). Women in economically disadvantaged positions often report remaining in abusive relationships because of financial dependence on their partner, furthering the cycle of violence beyond physical or emotional abuse to include financial abuse as well (Purvin, 2007). While those that have no other viable alternatives are most frequently the ones utilizing social service agencies, they are by no means the only population in need of these supports or who could benefit from the safety of these services.

Intimate Partner Violence in High Socioeconomic Status Individuals

A study aimed at understanding the role of a myriad of demographic characteristics on incidence rates of IPV in Caucasian, African American, and Hispanic couples found that education levels collapsed across race did not significantly contribute to number of reported incidents of IPV (Cunradi, Caetano, & Shafer, 2002). This suggests that those with higher education, who may be assumed to have greater access to alternative resources aside from shelter services, are just as susceptible to experiencing IPV as those that have less education.

Qualitative research capturing the reality of secrecy and the threats to disclosure in high-income populations demonstrates the difficulties surrounding acknowledging the existence of intimate partner violence and subsequent help-seeking within this population (Haselschwerdt & Hardesty, 2017). The minimal research addressing this specific community highlights that much of the IPV research relies on sample groups pulled from service agencies more likely to be frequented by individuals of lower socioeconomic status, therefore potentially conflating the generalizability and accuracy of the population being researched overall (Davies, Ford-Gilboe, & Hammerton, 2009; Weitzman, 2000). Davies et al. (2009) also suggest that beyond the reality that IPV does exist in this community, they also experience unique continued abuse post-separation in the form of financially and emotionally costly custody battles made possible by wealthy abusive partners who have the means to engage in lengthy court-related encounters.

A study of 1,077 women who had experienced IPV demonstrated that SES did not play a role in the use of some resources, like hotlines, but did dictate the use of other, more wrap around services like domestic violence shelters. This survey research also found that higher income women were more likely to reach out to law enforcement to step in following an instance of IPV if there was a high degree of physical violence, while the threshold for police intervention was not predicted by severity of violence for lower socioeconomic participants (Cattaneo & DeLoveh, 2010). These findings may go hand in hand with research surrounding the experience of shame, secrecy, desired privacy, and isolation within higher income communities that leave survivors in these populations feeling as though disclosure would shatter the perceptions held about them and their families within their social circle (Cashman & Twaite, 2009; Haselschwerdt &

Hardesty, 2017; Weitzman, 2000). Beyond the assumption that IPV does not exist in this population, Weitzman's (2000) qualitative work with 14 women of affluence who experienced IPV illuminated that those within their communities, as well as professional, media, and academic communities at large, hold the belief that if IPV were to occur in a high socioeconomic status relationship, the survivor would have the financial means necessary to manage it on their own. These assumptions do not take into account the costs that come with leaving an abusive relationship across socioeconomic strata, including physical danger and abuse escalation, lack of personal resources, and perceived quality of alternatives (Stork, 2008). High socioeconomic survivors' awareness of these challenges and widely-held stereotypes impact their ability to disclose an IPV experience and openly utilize community resources, further contributing to the lack of effective research on this sensitive population.

However, there is a significant amount of research that indicates IPV incidence rates are fewer in populations with higher incomes (Cunradi, Caetano, & Shafer, 2002; Field & Caetano, 2004). Poverty and IPV have been demonstrated to co-occur at high rates, contributing to intensified adverse mental and physical health outcomes associated with each experience that increase collectively as they co-occur (Goodman et al., 2009). In a survey of 5,994 urban couples followed longitudinally over the span of two years, IPV rates were highest in neighborhoods that were the most economically disadvantaged, replicating previous studies that have exhibited a connection between neighborhood poverty and domestic violence rates (Bonomi et al., 2014; Fox & Benson, 2006). While low socioeconomic status may serve as a predictor for greater likelihood of abuse, emerging literature focusing on higher-income populations more so than ever before may

indicate that there are far more mechanisms contributing to this significant difference in abuse reporting statistics that exceed far beyond prevalence rates.

Despite disparities noted above in incidence rates between low and high-income populations, emerging qualitative and quantitative research in this area may demonstrate that there are other mechanisms at work contributing to perceived lower incidence rates beyond increased affluence (Hernandez et al., 2016, Haselschwerdt & Hardesty, 2017). Specifically, for those higher income populations, such as physicians or other healthcare providers, these influencing mechanisms may include physician victim stigma due to perceived affluence, a culture of secrecy, assumptions about financial resources to personally manage consequences of abuse, and unrealistic expectations of those holding these professional caregiving roles in a healthcare environment (Hernandez et al., 2016; Haselschwerdt & Hardesty, 2017; Weitzman, 2000). This emerging literature indicates there is an increased need for future research to address how IPV is operating in this population that was previously understood as simply having less incidence of violence, but may in fact be just as vulnerable and feel even more unable to disclose.

CHAPTER TWO

INTIMATE PARTNER VIOLENCE WITHIN PHYSICIAN POPULATIONS

Disclosure of Intimate Partner Violence in Primary Care Settings

Survivors of IPV often find themselves in primary care settings for appointments unrelated to their experience of relational violence (Morse et al., 2012). Studies of patient demographics in diverse community-based populations have indicated that 1 in every 20 women presenting to a primary care setting have experienced an incidence of domestic violence in the last year (McCauley et al.,1995), with those incidence rates upholding over time throughout modern studies focusing on IPV survivors presenting to emergency room settings (Hackenberg et al., 2019). The overwhelming presentation of this population to primary care settings indicates that physicians play a critical role in initially detection abuse, but previous research has demonstrated mixed results with regards to their openness to discussing IPV with their patients (Brown et al., 2000). Some survey research indicates that although IPV is a frequent source of trauma in patients presenting to Emergency Departments, questions about experiences of IPV from physicians during routine assessments are not often documented (Sims, et al., 2011). This implies that there is a gap between the frequency of experience of IPV as a precursor to emergency room visits and physicians' assessing for these instances as a part of routine information collection.

Further support for the primary care context as the most appropriate place to intervene and address experiences of IPV comes from research denoting the significant physical health consequences of domestic violence. Studies of both men and women

indicate that those who identify as survivors of IPV have poorer health outcomes following their experiences of violence, including depressive symptoms, substance use, higher instances of chronic disease and chronic mental illness, and acute injury (Coker et al., 2002). Research also indicates higher incidences of gastrointestinal symptoms, gynecological signs related to sexually-transmitted diseases, and symptoms of post-traumatic stress disorder in women who experience IPV, with those who are exposed to violence during pregnancy at higher risk for physical trauma impacting both themselves and the fetus in-utero (Campbell, 2002). With the high prevalence of physical ramifications leading to seeking healthcare, this serves as the ideal intersection for research and intervention for this population.

Although police-identified survivors of IPV use the healthcare system at an increased rate, they have been shown to usually result in lack of identification as a survivor of IPV with no follow ups or referral services offered (Kothari & Rhodes, 2006). Many women who do chose to disclose their experience with IPV to their healthcare provider report being told to leave the relationship, with only 31% of women indicating that their physician also provided safety planning alongside advice to end the relationship (Morse et al., 2012). Previous literature focusing on physician input on intervention improvement with IPV indicates that there is a desire for reliable screening as a solution to under-identification, providing an outlet for discussing IPV and providing concrete alternatives (Brown, Sas, & Lent, 1993). Conversely, several studies indicate that there is a comfort level with disclosing to physicians, and reveal a pattern of cultural norms indicate that many deem the healthcare setting to be the most appropriate space to talk about instances of violence (Usta & Taleb, 2014). Survey research of survivors of

domestic violence indicate that formal help-seeking after instances of abuse most commonly occurred within the context of a healthcare setting (i.e. with physicians, nurses, etc.), especially as the severity of violence experienced at the hands of perpetrators increased (Ansara & Hindin, 2010). This evidence suggests that physicians not only serve as the first line of defense for most medically-related concerns, but provide an emotionally supportive role for their patients above and beyond addressing their physical needs that may or may not be rooted in an experience of trauma or violence.

Physicians' Role in Responding to Intimate Partner Violence

Physicians as Care Providers for Survivors of Intimate Partner Violence

While primary care settings serve as the space in which many survivors may be disclosing their experience with IPV, the impact that these disclosures, or lack thereof, have on physicians, is less considered in the literature. Physicians serve as a unique bridge between acting as healthcare providers, while also at points in their life needing to interact with the healthcare system as a patient themselves (Perez-Alvarez et al., 2019). The impact that an incidence of IPV may have on the workplace and personal functioning of physicians is critical, given the disconnect between women that are reporting abuse and seeking services and the inferred numbers of individuals that may actually be experiencing it. Alongside these mental health and workplace challenges, societal norms related to expectations about the role physicians should play contribute both to difficulty disclosing abuse and making the decision to seek domestic violence services (Brown, 2018). Physicians tend to be highly self-critical and perfectionist. These traits function in

such a way that, in order to maintain this perception within the field both for themselves and in front of their colleagues, physicians may withhold from disclosing experiences that go against this forced narrative, thereby harming their professional success (Bright & Krahn, 2011). This may contribute to the reinforcement of a fear of disclosure within the work environment for physicians that limits prevalence rates within this demographic.

A study conducted in the Southeastern United States in the year 2000 surveyed physicians about their beliefs related to spousal abuse and their subsequent treatment of survivors of domestic violence. Of 76 total respondents, 97% believed it was their role to aid in the care of victims of domestic violence. However, 30% of the participants also simultaneously held victim-blaming attitudes towards survivors, and 70% did not believe they had adequate resources to address the needs of this population (Garimella et al., 2000). This perceived lack of education about how to offer resources to survivors of domestic violence, coupled with the potentially biased attitudes about the experiences of survivors, may work together to foster a negative context around conversations about and care provided to survivors of IPV.

Physicians as Survivors of Intimate Partner Violence

Physicians may often find themselves in the distinctive role of screening for a significantly traumatic experience while also having to deal with the potential of having experienced that very same trauma themselves. While there is little literature about the prevalence of IPV in this population, estimates of incidence rates of this type of violence in the general population allow for inferences about the rates at which IPV occurs for physicians and the general public alike. According to a systematic review of IPV within a

physician population utilizing census information from 2012, of the 878,194 practicing physicians in the US at the time, up to 395,000 of those individuals may have experienced IPV at a rate equivalent to that of survivors across socioeconomic and other demographic categories (Hernandez et al., 2016). Broadening the issue to a global context, a study conducted in 2018 in Australia demonstrated that medical staff, defined as nurses, doctors, and other healthcare providers, actually have prevalence rates of intimate partner and family violence in the last year at rates exceeding 11.5%. Furthermore, that percentage drastically increased to 45.2% of this sample indicating that they had experienced violence at the hands of a partner or family member when that timepoint was expanded to at some point throughout their life (McLindon, Humphreys, & Hegarty, 2018). Much of the research into the experiences of this population is new and currently being conducted, pointing toward the need for continued understanding of the experience of this unique population within the context of the greater experience of IPV across cultural and demographic contexts.

While a significant amount of the research surrounding IPV aims to understand the experience of survivor and perpetrator populations more broadly, including both the needs and barriers to seeking effective care, the specific position of highly educated providers of care who are also experiencing violence themselves is less understood. Hernandez and colleagues' 2016 systematic review on the literature specifically addressing physician survivors' incidences of abuse yielded only 17 publications, including first-person accounts, qualitative studies, case studies, and anecdotal references in trade books (Hernandez et al., 2016). The authors identified several concerns with mixed methodologies that have been utilized for research within this population up to this

point, including threats to validity such as a lack of clear qualitative descriptions and definitions of violence experienced, a failure to effectively address financial abuse and functional poverty specifically impact physician survivors, and a need for prevalence studies that give an accurate depiction of the issue and what it means to exist in a society that views physicians as the "helpers" rather than those who may need help (Hernandez et al., 2016; Weitzman, 2000). This lack of clarity in variable definitions, stigma around accurate self-reporting, and a lack of information from the survivors themselves about their reality contributes to the little understanding about this population's experience, and call for a greater need in the literature for qualitative research that can provide direction for future intervention and support for physicians experiencing intimate partner violence.

Survey research that does sample from this population pulled from national data of 4,501 female physicians assessed rates of domestic violence and sexual abuse alongside other personal, health, and work-related factors. The history of domestic violence among this group was estimated to be 3.7%. These participants were significantly more likely to report histories of depression, past suicide attempts, substance abuse, current or past cigarette smoking, severe daily stress at home, chronic fatigue syndrome, and DV experienced by their mothers. The portion of physician participants who endorsed domestic violence histories also reported less career satisfaction, high rates of severe daily stress at work, and more days of poor mental health in the month prior to completing the questionnaire (Doyle et al., 1999). As mentioned above, if the same numbers of prevalence rates of IPV for the general population are applied to physicians, this reported incidence value is considerably below expected. More recent survey research in the last year attempted to estimate prevalence rates of IPV in physicians,

nurses, and nursing assistants in the Spanish Health Service. This sample consisted of 1071 professionals, including 49.9 % physicians, 46.9% nurses, and 3.3 % nursing assistants. 26.6% reported experiencing some form of abuse, with 73.3% of those who endorsed past abuse experience indicating that they had not reported or spoken about this experience with anyone else (Carmona-Torres, Recio-Andrade, & Rodriguez-Borrego, 2018). These identified rates are more consistent with expected prevalence within this population based on overall incidence rates of IPV. The existence of up and coming research supporting higher rates in a population that was previously believed to not experience this type of violence serves as a jumping off point for more information in the field that accurately depicts the existence of IPV in populations of those working in the healthcare field. This disconnect between Carmona-Torres et al.'s (2018) emerging research findings and previous prevalence and reporting rates indicates a lack of universal understanding across healthcare professionals about whether or not rates of IPV are in fact lower than that of the general population, or if there are mediating factors contributing to their lack of reporting and seeking services that need to be better understood.

While physicians that have their own personal experience surviving IPV face a significant number of challenges related to disclosure, they also have a unique and critical ability to provide empathic care within a diagnostic context that they are intimately involved with. A study surveying 500 California physicians across multiple specialties demonstrated that neither physical abuse during childhood or adulthood had a significant effect on IPV screening practices (Rodriguez et al., 1999). Another study of Massachusetts family practice physicians found that those 42.4% of female and 24.3% of

male physicians who had personal experiences with trauma in the form of some type of violence or abuse, felt more confident screening for abuse overall and were less likely to see time as a barrier to screening completion (Candib et al., 2012). These studies demonstrate that increased comfort discussing IPV, due to intimate awareness or personal experience of abuse, may serve to positively buffer physician care-providing for survivors of IPV.

Impact of Culture on Physicians' Healthcare Delivery

Workplace culture within hospital and primary care environments is not only dependent on personal beliefs held by physicians, but the cyclical nature of norms created within the medical system to discourage openness related to mental health and personal wellbeing. Renewal of medical licensure dissuades truthful disclosure of mental health experience due to concerns about perceived acceptability to continue to practice, often reinforcing the belief that challenging emotional experiences or struggles in mental health should not be discussed within the physician population (Schroeder et al., 2009). Original research on the topic of seeking support and services within peer groups of physicians also noted that when a physician seeks help from another colleague, both parties tend to underestimate the severity of the crisis (Robbins, Macdonald, & Pack, 1953). Updated research in the field indicates that beyond the peer environment created amongst physicians, individuals also reported a sense of shame related to feelings of personal fault due to the fact that they are trained to screen for violence and still found themselves in a relationship in which they were experiencing it (Hernandez et al., 2016). When asked about maintaining their physical health, physicians in a British study reported that they

are aware that they do not take care of themselves, often working despite feeling sick and having an expectation that their collogues will also do so, even though this is advice they would not provide to their patients. The same study also identified that physicians feel a pressure to perform well despite typical human imperfection because they believe their health is a direct reflection of their professional competency toward their patients (Thompson et al., 2001). A more recent study addressing the experience of burnout and compassion fatigue in practicing physicians demonstrates that beyond a lack of addressing or downplaying their own needs, physicians also experience burnout that leaves them with diminished emotional energy to care for their patients and themselves (Sanchez-Riley et al., 2013). This culture amongst physicians that discourages the discussion of hardship and downplays the significance of personal crises may contribute to this perceived pattern of underreporting and underutilization of shelter services within the physician population.

Further, culturally informed research with physicians attempts to understand the ways in which witnessing or experience IPV can change overall beliefs about violence. A survey of Palestinian physicians aimed to understand not only the mental health consequences of experiencing IPV for the physicians, but the cultural narrative that this experience creates in the minds of this demographic population. This study demonstrates that witnessing parental violence as a child correlated with increased attitudes about the acceptability of "wife beating" as well as internalized patriarchal norms about victim-blaming and justification of abuse in a significant number of respondents. Roughly a third of these physicians also reported wanting to help survivors of these experiences, but these previously held beliefs about this experience of violence contributes to the interactions

that physicians with personal abuse experience have with their patients (Haj-Yahia et al., 2015). These types of culturally-based beliefs about domestic violence intensify the challenges of approaching the conversation of IPV with patients as a physician who is experiencing domestic violence themselves.

Beyond the cultural beliefs developed within ethnic and social communities, the community of healthcare professionals more broadly also holds a certain set of standards and norms about being a member of the medical community that impede patterns of help-seeking for professionals within the field. The implicit rulebook informed by this cultural narrative, referred to in the literature as the "hidden curriculum," can be defined as the socialization process in medical training that exists outside of the classroom, and can often conflict with the curriculum that is formally taught to students (Hafferty, 1998; Hendelman & Byszewski, 2014). Qualitative research conducted with current medical students has revealed their perceptions of how the hidden curriculum plays out in their educational lives. Students report that as they go on in the program, this curriculum shift introduces a perceived lack of sensitivity, increased student cynicism, and a level of arrogance within the student body as mirrored by the faculty they interact with (Beaudoin et al., 1998; Szauter et al., 2003; Wear & Zarconi, 2008). Further qualitative interviews illuminate the idea that the medical hierarchy in place within a healthcare setting teaches students that there is a time and place to speak and a necessary respect imbedded within roles in the professional community, as well as a need to go above and beyond excelling as a clinician and to contribute to the field as a researcher (Bandini et al., 2017). This curriculum also de-emphasizes the empathy and compassion that often comes with beginning medical students, shifting instead to a more "jaded" cynicism toward

dehumanizing patients and instead "going through the motions" (Bandini et al., 2017). The influence of the hidden curriculum teaches physicians to devalue the emotionality of the medical experience and instead forces a mentality of doing more and pushing beyond typical workplace expectations. The influence of this culture not only impacts the care physicians deliver to patients, but also contributes to how physicians view themselves and their own medical and emotional care.

This research points to a need to actively address the societal and cultural beliefs around IPV experiences in a healthcare context specifically for providers who have survived IPV. If those that have experience with trauma of this nature were able to be more open with their peers, it is possible that they may encounter the same empathy and support that they will then be able to offer to their patients. A process of de-stigmatization around the conversation of IPV in healthcare for survivors and providers alike may aid in altering the workplace culture to create a safer space for physicians and their clients to affectively offer empathically-informed and educated care.

Current Study

A single focus group (n = 8) and several semi-structured individual interviews (n = 4) with administrators and staff members at domestic violence shelters were conducted in order to better understand shelter staffs' beliefs about the experience of high socioeconomic status survivors of IPV more broadly, and specifically that of physicians who are also survivors themselves. Due to the aforementioned research that describes a high level of secrecy and difficulty with disclosure in high socioeconomic populations, this study's effort to target shelter staff as reliable sources of information about any

experience with survivors of this nature captures the reality of these stereotypes and challenges at play in current shelter settings. This study aims to add to the literature addressing the unique needs and barriers impacting this population's decisions about help-seeking with regards to instances of IPV. As the research suggests, there is little understanding about how a healthcare provider, who actively interacts with survivors in a professional capacity on a daily basis, may respond to their own needs while existing in an abusive relationship. The specific culture of the medical profession, the high-income experience, and the reality of emergency shelter systems and long-term social services interact to inform the decisions these survivors make, and this study aims to further understand this interaction from the perspective of professionals at the grassroots level.

While this is a significant area of growth needed in this field of research, the literature suggests that it may be challenging to fully understand the experience of survivors in this population due to their lack of help-seeking behaviors within a shelter context. This study may illuminate these challenges even further, contributing to the current body of research that suggests many high SES and physician survivors engage in other behaviors related to their experience of IPV and help-seeking that do not include the utilization of community-based resources. Shelter staff provide a unique window into the day to day operations of a shelter, and provide an expertise about the experience of help-seeking and the dynamics amongst populations in the shelter system that would be a critical perspective to understand the patterns of various demographics of IPV survivors. These staff members would also be able to draw on their professional experience to illuminate the specific considerations that may be necessary for a physician client seeking shelter. The current study asks shelter staff to describe the distinctive environments of the

shelters in which they serve, providing in depth demographics about populations that utilize their services and resources being offered. Additionally, the semi-structured interviews and focus group address vignettes of specific high-income clients, and then more explicitly physicians, to gain a better understanding about this population's experience of intimate partner violence. While this qualitative study is exploratory in nature, the gaps in previous literature addressing the unique experience of physician survivors of intimate partner violence suggests that few physicians seek help due to barriers including shame, stigma, and the culture of the healthcare environment. With this understanding of the literature as a backdrop to the current study, the *a priori* assumptions held by the authors would be that few physicians utilize services due to the aforementioned barriers impeding their ability to help-seek.

CHAPTER THREE

METHODS

Participants

Shelter Administrators

A total of twelve shelter administrators and staff members participated in the focus group and individual interviews for this study. The initial focus group was held at a county-wide meeting for professionals working with various populations of IPV survivors, while the individual interviews were conducted by telephone following a snowball sampling model with administrators from shelters located on the West Coast and in the Midwest of the United States (Noy, 2008). They were employed by various organizations dedicated to providing shelter services and extensive intimate partner violence resources to survivors in their individual communities. Staff members' years of experience in the shelter system ranged from 2 to 37 years of employment with an intimate partner violence-related organization, with the mean number of years working in this field across participants being 11 years. Background educational and vocational expertise prior to serving in their shelter role included business management, marriage and family therapy, childcare, legal counseling, and banking. Roles that participants in the group performed in their current shelter environment included executive and operations director, fiscal and office manager, program coordinator, and founders of individual shelter programs who also identified as survivors themselves.

Shelter Context

The participating staff members served in a myriad of shelter environments, including differing geographical locations across multiple states, community dynamics, and types of services offered. Shelters within which participating staff members worked included those that are county-based, affiliated with a military base, rural, mountain, city, and hospital-based shelter environments, as well as a larger network of shelters that spanned multiple locations. Participating shelters were identified as including both larger, more long-term stay options extending beyond 180 days to smaller, short-term emergency housing to stabilize survivors in crisis and offer referral and resource options in the community to maximize ability to address client need. Alongside housing services, resource availability reported by staff included community engagement, educational opportunities, legal assistance, and mental health services.

Materials and Procedures

Following approval from the shelters' directors and the university's Institutional Review Board, participants were recruited via email announcements targeting administrative staff at local shelters within Southern California. Subsequently, recruitment announcements were also made at monthly meetings for executive administrators at domestic violence shelters in the surrounding area. Staff members from this initial recruitment process composed the original focus group. Snowball sampling was then used to establish connections with other shelter agencies in order to obtain further shelter directors to serve as participants in the individual semi-structured interviews.

Semi-Structured Individual Interviews

A semi-structured interview process was designed and conducted to elicit various shelter demographics, populations served, and services offered across a wide variety of community-based settings (n = 4). The goal of these interviews focused on addressing the unique characteristics and needs of a higher socioeconomic status client, focusing on staff's perceptions of the experience of a physician as a survivor seeking shelter services. Individual interviews were conducted over the phone by Barbara Hernandez, PhD, LMFT, who serves as the director of Physician Vitality for Loma Linda University Health. The use of snowball sampling through a widely accessible communication medium allowed for the ability to interview several shelter administrators across multiple states within the US (including participants from states across the Western and Midwestern portions of America, deidentified for the safety and confidentiality of participants). These interviews intended to span 30 minutes of conversation across both general and more specific questions related to their individual shelter and a physician's experience within this environment. Additional time at both the beginning and end of the interviews was allotted for general introductory topics, information and background about the purpose of the study, and follow-up conversation about potential significance of findings and future directions for physicians as clients in shelter.

Interview questions began by asking each staff member to describe themselves and their role, the types of clients seeking services at their shelter, the environmental factors and geographic specifics of their community, and the types of services offered. Following the a priori assumptions held by the authors about the nature of help-seeking in physician populations, participants were then asked to consider a short vignette about a

specific type of client who might present to their shelter, “Let’s say a woman pulls up to the shelter in a Lexus station wagon and she asks for help. Her hair and nails are done and she’s dressed in a matching athletic outfit and she has a leather carry-on bag with her things in it. She tells you that her partner has been beating her up and she can’t take it anymore, and she looks pretty nervous and she’s got a little girl with her. Do you have any thoughts about challenges that you might have working with her, or specific needs that she might have?” After receiving participants’ perspective on this issue, the interviewer then asked more specific questions about the population of interest, including, “Let’s say a physician is being abused by their partner. How do you think their life or their experience could be similar or different from clients who are not physicians?” Participants are asked to comment specifically on their perspectives about working with physicians in a shelter, the barriers that might be unique to this population and their specific expertise as members of the medical field, challenges staff and other shelter clients may have with this population, and characteristics of a physician that might conflict with assuming the identify of a survivor or client at a domestic violence shelter. Two graduate students (KV and GB) transcribed the audio recordings. The second graduate student (GB) reviewed all transcriptions after the fact and checked them for accuracy.

Focus Group

The focus group consisted of eight participants and one facilitator, Ellen Reibling, PhD, who serves as the director of research for the Emergency Department at Loma Linda University Health. The facilitator began the hour-long discussion by introducing

themselves and the purpose of the study, alongside her role a professional and researcher interested in the experience of physicians within the context of their experience as survivors of intimate partner violence. The facilitator also introduced other researchers involved in the project to the group and addressed any questions participants may have had before beginning the discussion. Participants were encouraged to begin by going around the group and speaking one at a time for introductions, and then to respond freely when they wanted to contribute to a particular question or topic. After introductions, there was no maintained order of participant response and participants contributed at their discretion, guided by the facilitator's questions which were later mirrored in the individual interviews. At the end of the focus group, participants had time to debrief on their experience sharing with other staff members about their understanding and experience with survivors of intimate partner violence, and the role that research of this nature can play in expanding knowledge about unique populations, like that of physician and high-income clients discussed throughout the focus group.

Similar to the structure of the previously mentioned individual interviews, shelter staff members were asked to identify themselves and their experiences working in a shelter environment before continuing with the more directed part of the group discussion. Participants provided demographic information about the types of clients they often interact with in their communities, as well as the services and resources provided by their individual shelters. Staff were then asked to speak on topics related to their experience with physicians and high socioeconomic status individuals as clients, the unique needs this population might have, barriers that they may face in seeking shelter services, and the approach staff might take in specifically interacting with a client from

this population. The authors that facilitated participant recruitment for and conducted the focus group transcribed the audio recording. A graduate student reviewed the transcription and checked it for accuracy.

Data Analysis

Several steps were taken to adhere to the quality standards set by foundational qualitative researchers Lincoln and Guba (1985) to enhance the trustworthiness of this research and to establish and increase credibility, transferability, dependability, and confirmability to the best of our ability given the study design. Strategies such as prolonged engagement, developing a coding system, and clarifying researcher bias were utilized throughout in order to increase the measure of validity and reliability in this rich, interview-based study that is often seen in more standardized quantitative research (Morse, 2015). Extended interviews with subjects were preceded by detailed explanation of the study and an effort to build rapport throughout, followed by semi-structured questioning that gave participants a chance to provide as much detail as possible about their experiences. Investigators utilized a structured coding strategy and remained objective throughout the process of data transcription, coding, and analysis. Further details about the coding and thematic analysis process are described below.

Transcripts were coded to identify emergent themes. Following grounded theory and the axial coding method outlined in previous qualitative research (Akers et al., 2011), coding procedures began with open coding during which two independent coders reviewed each transcript line by line to identify words or phrases related to both general shelter demographics, and then the overall theme of shelter staff perceptions of the

experience of high-income clients, more specifically those whose careers were in the medical field as physicians, who identified as survivors of intimate partner violence themselves. The goal of addressing shelter services more broadly, and then focusing in on the specific challenges and realities for physician clients, was to better understand the general shelter context before understanding how a physician may fit into this context.

Following this initial coding process, both coders then met to compare codes to ensure all relevant phrases were captured and none were missed. The second step involved axial coding during which the same two coders reviewed their separate lists of initial words to identify and organize common patterns that were present throughout all reviewed transcripts. They subsequently synthesized their original lists into a set of organized hierarchical categories to create a codebook (See Appendix A). Codes were created to address both the overall demographic questions related to the shelter environment and subsequent questions addressing specific topics related to high-income and physician clients the staff may have encountered. Use of each set of codes related to the appropriate questions throughout the transcripts was delineated within the codebook instructions as well as emphasized throughout training of the coders. Next one of the coders tested the codebook on one of the transcripts, to ensure its feasibility and appropriateness to code the data. Once the codebook was finalized, two new, independent, graduate student coders were trained on the codebook before participating in consensus coding for all individual interview and focus group transcripts. All coding activities were done using Dedoose, a qualitative coding software. The coders coded all the focus group and semi-structured interview transcripts according to the codebook independently, and then met with the first author, who served as a third coder to review

all codes and address any discrepancies. This coder resolved any inconsistencies and acted as a tiebreaker in instances in which the first two coders disagreed on a particular excerpt.

CHAPTER FOUR

RESULTS

Thematic Overview

A total of five transcripts were coded, representing four individual interviews and one focus group transcript consisting of eight participants. These codes were applied to 402 total excerpts across all transcripts, with a range of 23 to 93 excerpts per individual transcript (M = 57.27, SD = 55.87) and 177 excerpts in the single focus group transcript. Excerpts were compiled of direct and complete quotes from the participants, and were organized into several themes (shelter environment, high-income experience within the shelter, etc.) that were subsequently organized into a codebook divided into two categories based on the major discussion topics of the interviews that the coders felt stood alone as relevant discussion topics throughout the interviews (facility demographics and high-income experience). These larger umbrella sections were then broken down through the process of axial coding into six higher-order facility demographics categories (including populations served, characteristics of batterers, referral source, services provided, community outreach, and characteristics of shelter) and twelve higher-order high-income experience categories (including real experience of high SES or physician clients, barriers to seeking services, lack of belonging in shelter environment, common ground among survivors, financial control, staff response, other survivors' responses, available alternatives to shelter, independent access to finances, emotions experienced, isolation, and unique considerations for physicians). Codes falling under the Facility Demographics section of the codebook were used throughout the interviews, while the

specific Higher-Income Experience codes were only applied after the introduction of this topic by the interviewer, marked by questions such as "what kind of needs or challenges do you believe a woman from a higher socioeconomic status would face upon entering your facility, and how would you address those needs? Are there any unique challenges that would particularly affect physicians?" and the description of a vignette of a well-dressed woman in a luxury car presenting to the shelter for services.

After the initial code pulling process, the coders collectively agreed that separating the codes into the two overarching umbrella categories spoke to the natural shift in conversation experienced throughout each of the transcripts. This separation allowed for a better understanding of the general characteristics of each shelter, and thus the specific needs and realities of what a high-income individual would face seeking safety in shelters of this nature. Below the most frequently coded themes from each of the two umbrella categories (Facility Demographics and High-Income Experience) are elaborated on further. Themes that were observed in over fifty percent of the codes applied are noted in detail as representative of the main takeaways from the transcripts.

Facility Demographics Section

Shelter administrative staff endorsed a variety of geographical and structural specifics that were particular to the environment they served in. Most commonly discussed were the career status and socioeconomic background of the population, the experience of shame, stigma, and denial, location of the shelter, community engagement, characteristics of batterers, services provided, safety and confidentiality, mental health and well-being, family issues and dynamics, other resources, shelter and housing,

characteristics of shelter, living environment, physical or sexual abuse and violence, and referral sources. The themes detailed below expand on the most highly applied codes throughout the interview transcripts, with each theme represented in at least fifty percent of the codes identified throughout the interviews. These particular codes capture each participant's shelter environment, the services they offer to the particular population they serve, and the surrounding community they exist in.

Category 1: Populations Served

Theme 1.1 Career and Socioeconomic Status (N = 40 excerpts)

The topic of career and socioeconomic status of survivors permeated a significant amount of discussion in each interview due to the nature of the research questions themselves. Participants reflected on the fact that many of the guests that utilize their shelter services are from low socioeconomic status populations, but that domestic violence is pervasive, and that "any person can experience domestic violence, so we have all walks of life, all nationalities, all ages, also socioeconomic classes." The frequency of this theme emphasizes how much participants believe that this demographic variable serves as the most significant defining factor in who is utilizing shelter services and what separates those that do seek help in this population versus those that do not.

Theme 1.2 Shame and Stigma (N = 40 excerpts)

The experience of emotions like shame, stigma, fear, and denial on the part of survivors of IPV are pervasive, often leading to a lack of help-seeking cited throughout

the literature. This pattern was also observed in this qualitative study, with the second highest coded item reflecting the negative emotions that disclosure of this experience can carry for survivors, often inhibiting them from seeking services at all. Participants reflected on the role that shelter services can provide to eliminate some of these negative feelings through empathic, culturally informed service providing that bridge the gap between what survivors have experienced in the outside world and what a safe shelter space can provide them. As one participant described:

> "You know victims of domestic violence feel very alone, they feel very ashamed. Just being able to talk through some of those things, being reassured that they aren't the only person experiencing this, that the things he's doing or saying that make you feel crazy are because that's what he's good at, he's manipulative, and all those things. So just helping them understand what they are experiencing and how, and just validating that."

Theme 1.3 Shelter Context (N = 99 excerpts)

Each interview began by asking the participants to describe the environment that their shelter existed in. This often led to participants emphasizing the specific culture surrounding the geographic location they existed in, highlighting this as an important factor contributing to how domestic violence and seeking help for experiencing it was viewed in their community. Participants spoke about steps taken to ensure safety, such as undisclosed locations and unmarked buildings, as well as more descriptive information about the physical environment within the shelter itself. Most shelters described their locations as "living simply," often relying on donations to fund support for their services and providing an environment potentially very different from the lives that many high-income individuals may be coming from. In the same vein, several interviewees described the challenges that can come from a mixture of individuals suffering from mental illness, substance abuse, and a deep-seeded sense of protection over what little

property they may have left. Important consideration was given to the fact that shelters can often be described as "chaotic environments," with many participants emphasizing the fact that they are trying to further foster a sense of safety, community and home within their walls. One individual clearly spoke to the challenges of the dynamic between the survivors' adjustment to a shelter environment in this way, stating:

> "Women will share about their birthing experience, their gallbladder surgery, their experience about who has been molested by somebody, but they don't share kitchens and bathrooms well."

Theme 1.4 Services Provided (N = 101 excerpts)

The types of services that each shelter provided emerged as a common theme of conversation for participants to discuss what they were able to offer those they severed. Most commonly, services included emergency shelter, longer-term temporary housing, counseling and mental health, legal aid (including restraining orders), other general resources, and skills classes (including parenting, financial management, etc.) Participants emphasized that those utilizing these services may be both overnight guests as well as survivors who have stable shelter, but who may need assistance with other aspects of their lives.

Theme 1.5 Family Dynamics (N = 25 excerpts)

The contribution that family culture and the dynamics that a culture of domestic violence bring to a household was a frequently discussed theme with relation to parenting after experiencing abuse. Interviewees spoke to the fact that parenting as a survivor of abuse can be particularly challenging, with parents having often been undermined by their perpetrating partners. Additionally, survivors also have to manage what may be a custody battle between themselves and their ex-partners, as well as what it might mean to

have to parent on their own for the first time. All of these challenges are exacerbated by an experience of homelessness or fear of safety and financial security for both themselves and their children, adding to the high need for services that address these concerns within a shelter context. When speaking about the experience of parenting as a survivor of violence and the impact that that violence may have had on any children, one participant said:

> "This is maybe the first time they're parenting on their own if they are leaving that abuser, and so that's overwhelming in and of itself. If they have children and they've lived in this home where there's been domestic violence, the kids are obviously in crisis and have experienced a lot of things as well, so just helping them process through that with the kids. Or even, just, you know, kids often times, you know, act out what they've seen. So, we see lots of little boys who treat their mothers very poorly and moms don't know how to handle that, and so we can help them with that a little bit."

Theme 1.6 Types of Intimate Partner Violence (N = 17 excerpts)

While the most current understanding of intimate partner violence encompasses far more than just physical confrontation between a victim and a perpetrator, the highest endorsed code related to the kinds of abuse experienced by those seeking shelter was that of physical or sexual abuse and violence. This suggests that survivors that do seek shelter services are most often experiencing physical or sexual violence, with the severity of this type of abuse potentially serving as the catalyzing factor to disclose and reach out for help.

Theme 1.7 Community Engagement (N = 29 excerpts)

Alongside providing direct services to those who have survived IPV, shelter staff viewed their responsibility to the greater community as a large part of their responsibilities as well. Community engagement and education about IPV and the

existence of support to serve this population was a frequently discussed theme, described as a "key role" of shelter staff. This perspective emphasizes the role that shelters play in contributing to the overall domestic violence education of individuals, organizations, and communities about signs of violence. Presentations in the community about the existence of these services may be survivors' only chance to interact with and become aware of the help that is out there, bridging the gap between those that may be isolated and the services that they need to be engaged with.

Category 2: Characteristics of Batterers

Theme 1.8 Factors Related to Those Who Perpetrate (N = 29 excerpts)

While the experience of IPV survivors is a major overall focus of the transcripts, the theme of characteristics that perpetrators often present with was also repeatedly addressed. These shared characteristics, including trauma and an environment of violence in their upbringing, may contribute to their perpetuation of continued violence in their own adult romantic relationships. A rehabilitative approach to providing services to perpetrators is scarce throughout the current punitive structure of punishment in place for violence of this nature. Instead of focusing on alternative outlets for aggression and a strengths-based approach, many perpetrators are thrown back into a system that reinforces their tendencies toward violence. Additionally, survivors are forced to navigate the legal system in an effort to keep themselves safe in ways that are emotionally scaring, fear-inducing, and arduous. In describing the lack of effective strategies to address this process, a participant mentioned:

> "Our society is not really geared toward helping the batterer. We put them in punitive situations because the whole thing about battering is that the whole reason behind it is to get power and control. So, we put them in situations where they are under somebody else's power and control, which only makes it worse. And we don't try to help them, understanding that, in all likelihood, they were watching victimization of a parent when they were growing up. So, um, it's got to be a cultural attitude change and we're not, you know, I don't know that, don't know that in a male dominant society, that we're ready to do that yet."

Category 3: Referral Source

Theme 1.9 Referring Agency (N = 15 excerpts)

Participants from a variety of shelter contexts described a myriad of referral sources that bring survivors into the shelter to seek services. Previous research suggests that hospitals and primary care physicians are often the first people that survivors disclose violence to, and participants in this study reinforced the idea that they are often interacting with emergency room staff and physicians to educate them about shelter services in order to provide referrals to patients that they see (Morse et al., 2012; Coker et al., 2002). Community presentations, taking place in schools, community centers, and other local agencies also serve as connection points for survivors to the services they need. Participants also described that Child Protective Services, law enforcement, and crisis hotlines often serve as referring agencies as well.

High Income Experience Section

Participants' reflections on the experience of high-income clients more broadly, and then specifically on the experience of physicians, speaks to the current literature findings of minimal consistent staff interaction with these specific populations due to lack

of utilization of shelter services. Of the five coded transcripts, four were able to draw on some level of experience with a higher-income survivor seeking shelter services, but actual interaction with a survivor who was also a physician was not an experience that any participant had at the time of interviewing. This led to the participants extrapolating based on their expertise and experience about what a physician might experience if they were to seek services, and namely the reasons that they might not be utilizing the services at all. There was a unanimous understanding amongst participants that IPV exists across cultural contexts and socioeconomic strata, but they often spoke to the psychological and cultural barriers to disclosure and financial circumstances that may be at play in keeping them from a shelter context. Therefore, the most represented themes, in the upper 50% of represented codes, throughout the latter portion of the interviews speak to the shelter staffs' perception about unique challenges and considerations that may be informing the help-seeking patterns of high-income survivors, namely physicians. The themes detailed below expand on highly represented themes including physician education, real experiences of high socioeconomic status or physician clients, unique considerations for physicians, preparing to leave their current lives, common ground among survivors, open-mindedness and ability to address diverse needs, available alternatives to shelter services, independent access to finances, discomfort and lack of belonging in a shelter environment, and staff response to this population.

CHAPTER FIVE

CONCLUSIONS

Discussion

Shelter administrative staff with years of experience providing services to s urvivors of domestic violence serve as a critical starting point for beginning to understand help seeking patterns of the population that they serve. Their experience with the culture of shelter systems and the services that they are able to provide both to survivors and the community at large allows for a unique perspective on dynamics amongst survivors and any unique challenges that may come into play for members of this population. Due to the exploratory nature of this qualitative study, few assumptions were held about the outcomes of the interviews and focus group with shelter staff, but there was an *a priori* assumption based on previous literature that few physicians would have sought shelter services and interacted with our participants. This assumption was upheld following analysis of the data, confirming that no shelter administrators in our sample had any professional experience engaging with a physician seeking services after experiencing domestic violence. However, several participants endorsed limited past interactions with providing care and resources to higher income survivors. This past experience served as a backdrop for their reflections on the potential challenges that would face these individuals more broadly, and then specifically those physicians whose careers are devoted to helping others, but who are in a circumstance in which they are seeking help themselves.

In analyzing the transcripts from the semi-structured individual and focus group interviews, shelter staff spoke more generally to the culture and environment of the shelters they work in, and then more directly addressed the specific considerations that would be relevant for a higher income or physician survivor in seeking services. Participants reported that those utilizing their services often came from low socioeconomic status backgrounds, reflecting a large portion of the literature that endorses this population as the highest subset of those experiencing IPV and most frequent utilizers of shelter services (Panchanadeswaran & McCloskey, 2007; Tolman & Raphael, 2000). In detailing the services they provide, participants endorsed emergency shelter, longer-term temporary housing, counselling, legal aid, and skills classes as the most frequently used resources, and noted that these are often the most necessary for survivors who are leaving relationships with no support system or safety net beyond their perpetrating partner. Previous research within this population points toward these services reflecting those most commonly sought by survivors (Baker, Cook, & Norris, 2003; National Network to End Domestic Violence, 2017), indicating that shelters sampled in this study are providing care consistent with the needs most often experienced by survivors across study samples.

In addition to the types of services provided, physical shelter environments were discussed as often lacking financial support to upgrade their buildings or offer the most up-to-date personal resources such as televisions or phones, leading to certain stereotypes about what shelter in this environment might be like. Staff noted that this may be a deterrent for individuals whose lifestyles have up until this point looked very different from what a shelter may be able to offer. Alongside space concerns, the dynamics of

stereotypes about income and privilege that may be held by both high- and low-income guests in shelter could contribute to a sense of discomfort, exclusion, and animosity amongst survivors. Our findings that reference these perceptions about what it would mean to live in this space may serve as a further contributing factor to why previous studies have suggested DV shelters serve as a "last resort" in the minds of many individuals experiencing violence (Grossman & Lundy, 2011). Fear about the lifestyle changes that may accompany leaving an abusive partner may serve as mediating factor in survivors' choices to abandon their current life.

Beyond what the shelter environment is like more generally, concerns about even disclosing the experience of domestic violence are cited throughout the literature as often the biggest barrier to engaging with survivors to offer resources and support (Overstreet & Quinn, 2013; Beaulaurier et al., 2008; Liang et al., 2005). Participants further reiterated this difficulty by endorsing feelings of shame, stigma, fear, and denial as frequently at play in keeping abuse a secret from others, and even denying the existence of abuse to themselves. The cultural taboo around this topic limits shelter staff's ability to provide resources and extend support due to the lack of comfort in addressing this issue. When shifting the conversation toward high income, and specifically physician survivors seeking shelter, the cultural narrative of secrecy became even more apparent due to the cultural "rulebook" of control and competence (Hafferty, 1998; Hendelman & Byszewski, 2014; Beaudoin et al., 1998; Szauter et al., 2003; Wear & Zarconi, 2008) experienced by the physician as a career necessity, and the lifestyle they are accustomed to living.

Our findings specific to shelter staff perceptions about the experience of high-income physician survivors suggest that there are multiple influences that may be at play which contribute to the continued evidence pointing toward their lack of service utilization (Hernandez et al., 2016; McLindon, Humphreys, & Hegarty, 2018). Themes such as access to alternative means of support including friends, independent finances, and alternative housing, as well as fear of peer and patient awareness of violence, discomfort in a shelter environment, and shame about their training experience in light of their status as a survivor emerged throughout the current findings as barriers to disclosure and help seeking in a physician population. Participants noted that most often their assumption about the gap in service-seeking was directly related to usage of alternative means, such as a hotel or independent apartment that would likely provide a space much more similar to the lifestyle a physician or high-income survivor may be accustomed to pre-separation from their abuser. This finding speaks to previously discussed discrepancies in the assumed number of survivors of IPV in the physician and high-income population versus the number of individuals who are actually disclosing and seeking services (Cunradi, Caetano, & Shafer, 2002; Field & Caetano, 2004; Carmona-Torres, Recio-Andrade, & Rodriguez-Borrego, 2018). While participants were able to draw on personal and professional knowledge and experience to extrapolate assumptions about the role these factors play in help seeking, their lack of individual interaction with survivors in this population also serves as a data point to speak to the reality that there are mechanisms at play deterring them from stepping into a shelter environment.

Limitations

These results should be interpreted with the following limitations in mind. First and foremost, due to the sensitive nature of this population and the realities of qualitative research, the sample used for this study was small and only represents a limited number of experiences related to the topic of intimate partner violence with physicians in a shelter setting. The snowball sampling technique created an inherent bias in the selection process for participants, but we believe was the best step to gain trust and confidence with this high-needs population while continuing to maintain safety and confidentiality and build relationships upon which further research can be done. Although there were a smaller number of overall individual interviews alongside the focus group, those interviewed were able to capture experiences across multiple varying geographic areas, allowing for a wider variety of cultural values held by participating staff and shelter environments to be accounted for. The semi-structured interview technique and empirically supported coding techniques utilized throughout this study allowed for participants to more fully detail their own experiences working directly with this population while maintaining trustworthiness and accuracy during data analysis. While these individuals represent only a few perspectives in shelters throughout the United States, this more in-depth qualitative data provides a backdrop for future study of the experience of physicians from a shelter administration standpoint, providing further literature to a topic that is not well researched up to this point.

Secondly, another limitation to be aware of is the frequency with which participants pulled from hypothetical assumptions about what the experience of a physician may be like in their shelter system due to the fact that many individuals had not

directly worked with this population. As previously mentioned, this lack of interaction with high socioeconomic clients further replicate the challenges discussed in the literature that limit the utilization of these shelter resources by this specific population. Although this is consistent with previous studies' finding related to little use of shelter services, this does in turn require the participants to extrapolate about the potential realities of physicians in a domestic violence shelter setting rather than speak from personal experience working with these individuals. However, the years of expertise and experience held by each of the participants increases their understanding of the dynamics within the shelter system and allows them to surmise based on their knowledge of this population.

Future Directions

Although prevalence rates for high-income populations experiencing domestic violence, specifically physicians, are presented as fewer than the rest of the population, burgeoning studies have demonstrated that this is due to several mediating factors that cause these numbers to not accurately reflect IPV instances in this population. Despite new understanding in the field that those with more perceived resources are just as vulnerable to experiencing IPV, little research currently exists to better understand why these individuals may not be reporting these experiences or seeking traditional domestic violence services at a rate consistent with their lower socioeconomic status peers. This gap in understanding reflects a greater gap in grassroots knowledge about creating comfort around disclosure for these communities and tailoring services provided to meet their unique needs. When speaking particularly about survivors who are also healthcare

providers, specifically physicians, the literature is even less available on the interplay between the complex emotions around professional training in the field of IPV detection and being a survivor of IPV themselves.

Results from this study mirror previous research evidencing a lack of experience with this population on the behalf of shelter staff and administration, leaving those serving these populations ill-equipped to engage with physicians or higher SES survivors if they were to present at their facilities. The fact that those who are members of these careers are not seeking services may be due to several extraneous factors presented in this study, such as independent access to finances and social support, but a lack of direct reporting from the population in question leads to an inability to clearly understand this pattern of underutilization of services. Future research should be done to collect individual self-report from physicians and high SES survivors to gain more complete knowledge about why they are not presenting to shelters. This research could inform future community engagement and clinical training to specifically target the needs and concerns of physician and other high SES populations, and bridge the gap between their experience of violence and appropriate services that meet their needs.

REFERENCES

Abuse Defined. (n.d.). Retrieved October 28, 2018, from https://www.thehotline.org/is-this-abuse/abuse-defined/

Adams, A. E., Tolman, R. M., Bybee, D., Sullivan, C. M., & Kennedy, A. C. (2012). The Impact of Intimate Partner Violence on Low-Income Women's Economic Well-Being: The Mediating Role of Job Stability. Violence Against Women, 18(12), 1345–1367. https://doi.org/10.1177/1077801212474294

Akers, A. Y., Yonas, M., Burke, J., & Chang, J. C. (2011). "Do you want somebody treating your sister like that?": Qualitative exploration of how African American families discuss and promote healthy teen dating relationships. *Journal of Interpersonal Violence, 26*, 2165–2185. https://dx.doi.org/10.1177/0886260510383028

Anderson, K. L. (1997). Gender, Status, and Domestic Violence: An Integration of Feminist and Family Violence Approaches. *Journal of Marriage and the Family,59*(3). doi:10.2307/353952

Avdibegovic, E., Brkic, M., & Sinanovic, O. (2017). Emotional Profile of Women Victims of Domestic Violence. *Materia sociomedica*, *29*(2), 109–113. doi:10.5455/msm.2017.29.109-113

Baker, C. K., Cook, S. L., & Norris, F. H. (2003). Domestic Violence and Housing Problems: A Contextual Analysis of Women's Help-seeking, Received Informal Support, and Formal System Response. *Violence Against Women*, *9*(7), 754-783. https://doi.org/10.1177/1077801203009007002

Beaudoin, C., Maheux, B., Cote, L., Des Marchais, J. E., Jean, P., & Berkson, L. (1998). Clinical teachers as humanistic caregivers and educators: perceptions of senior clerks and second-year residents. *Cmaj*, *159*(7), 765-769.

Beaulaurier, R. L., Seff, L. R., Newman, F. L., & Dunlop, B. (2005). Internal Barriers to Help Seeking for Middle-Aged and Older Women Who Experience Intimate Partner Violence. *Journal of Elder Abuse & Neglect,17*(3), 53-74. doi:10.1300/j084v17n03_04

Bernardi, D. A., & Steyn, F. (2019). A Model for Female-Perpetrated Domestic Violence. *Victims & Offenders*, 1-21.

Black, M.C., Basile, K.C., Breiding, M.J., Smith, S.G., Walters, M.L., Merrick, M.T., Chen, J., & Stevens, M.R. (2011). The National Intimate Partner and Sexual Violence Survey (NISVS): 2010 Summary Report. Atlanta, GA: *National Center for Injury Prevention and Control,* Centers for Disease Control and Prevention.

Bonomi, A. E., Trabert, B., Anderson, M. L., Kernic, M. A., & Holt, V. L. (2014). Intimate partner violence and neighborhood income: a longitudinal analysis. *Violence against women*, *20*(1), 42-58.

Breiding, M. J., Smith, S. G., Basile, K. C., Walters, M. L., Chen, J., & Merrick, M. T. (2014). Prevalence and characteristics of sexual violence, stalking, and intimate partner violence victimization—national intimate partner and sexual violence survey, United States. *2011. Morbidity and Mortality Weekly Report. Surveillance Summaries*, *63*(8), 1–18.

Bandini, J., Mitchell, C., Epstein-Peterson, Z. D., Amobi, A., Cahill, J., Peteet, J., ... & Balboni, M. J. (2017). Student and faculty reflections of the hidden curriculum: How does the hidden curriculum shape students' medical training and professionalization?. *American Journal of Hospice and Palliative Medicine®*, *34*(1), 57-63.

Bright, R. P., & Krahn, L. (2011). Depression and suicide among physicians. *Current Psychiatry*, *10*(4), 16.

Brown C. (2018). Physicians not immune to intimate partner violence. *Canadian Medical Association Journal*, *190*(46), E1372-E1373.

Brown, J. B., Lent, B., Schmidt, G., & Sas, G. (2000). Woman Abuse Screening Tool. *PsycTESTS Dataset*. doi:10.1037/t04577-000

Brown, J.B., Sas, G., Lent, B., (1993). Identifying and Treating Wide Abuse. *Journal of Family Practice*, 36(2), 185-191.

Campbell, J. (2002). Health Consequences of Intimate Partner Violence. *The Lancet*,*359*(9314), 1331-1336. doi:10.4135/9781412963923.n217

Candib, L. M., Savageau, J. A., Weinreb, L. F., & Reed, G. W. (2012). Inquiring into our past: when the doctor is a survivor of abuse.

Carmona-Torres, J. M., Recio-Andrade, B., & Rodríguez-Borrego, M. A. (2018). Violence committed by intimate partners of physicians, nurses and nursing assistants. *International nursing review*, *65*(3), 441-449.

Cashman, O., & Twaite, J. A. (2009). Toxic wealth: How the culture of affluence can harm us and our children. Santa Barbara, CA, US: Praeger/ABC-CLIO.

Cattaneo, L. B., & DeLoveh, H. L. (2008). The role of socioeconomic status in helpseeking from hotlines, shelters, and police among a national sample of women experiencing intimate partner violence. *American Journal of Orthopsychiatry*, *78*(4), 413-422.

Centers for Disease Control and Prevention. (2003). *Costs of intimate partner violence against women in the United States*. Atlanta, GA: National Center for Injury Prevention and Control.

Coker, A. L., Davis, K. E., Arias, I., Desai, S., Sanderson, M., Brandt, H. M., & Smith, P. H. (2002). Physical and mental health effects of intimate partner violence for men and women. *American Journal of Preventive Medicine, 23*(4), 260-268.

Cunradi, C. B., Caetano, R., & Schafer, J. (2002). Socioeconomic predictors of intimate partner violence among White, Black, and Hispanic couples in the United States. *Journal of family violence, 17*(4), 377-389.

Davies, L., Ford-Gilboe, M., & Hammerton, J. (2009). Gender inequality and patterns of abuse post leaving. *Journal of Family Violence, 24*(1), 27.

Dichter, M. E., & Rhodes, K. V. (2011). Intimate partner violence survivors' unmet social service needs. *Journal of Social Service Research, 37*(5), 481-489.

Doyle, J. P., Frank, E., Saltzman, L. E., Mcmahon, P. M., & Fielding, B. D. (1999). Domestic Violence and Sexual Abuse in Women Physicians: Associated Medical, Psychiatric, and Professional Difficulties. *Journal of Womens Health & Gender-Based Medicine,8*(7), 955-965. doi:10.1089/jwh.1.1999.8.955

Drijber, B. C., Reijnders, U. J., & Ceelen, M. (2013). Male victims of domestic violence. *Journal of Family Violence, 28*(2), 173-178.

Dufort, M., Gumpert, C. H., & Stenbacka, M. (2013). Intimate partner violence and help-seeking – a cross-sectional study of women in Sweden. *BMC Public Health,13*(1). doi:10.1186/1471-2458-13-866

Ellsberg, M., & Heise, L. (2005). *Researching violence against women: A practical guide for researchers and activists*. Washington, DC: World Health Organization.

Few, A. L. (2005). The Voices of Black and White Rural Battered Women in Domestic Violence Shelters. *Family Relations,54*(4), 488-500. doi:10.1111/j.1741-3729.2005.00335

Fleury, R.E., Sullivan, C.M., & Bybee, D.I. (2000). When ending the relationship doesn't end the violence: Women's experiences of violence by former partners. *Violence Against Women, 6,* 1363-1383.

Frias, S. M., & Angel, R. J. (2005). The Risk of Partner Violence Among Low-Income Hispanic Subgroups. *Journal of Marriage and Family,67*(3), 552-564. doi:10.1111/j.1741-3737.2005.00153

Fox, G. L., & Benson, M. L. (2006). Household and neighborhood contexts of intimate partner violence. *Public health reports (Washington, D.C.: 1974), 121*(4), 419-27.

Garcia, L., Hurwitz, E. L., & Kraus, J. F. (2005). Acculturation and Reported Intimate Partner Violence Among Latinas in Los Angeles. *Journal of Interpersonal Violence*, *20*(5), 569–590. doi: 10.1177/0886260504271582

Garimella, R., Plichta, S. B., Houseman, C., & Garzon, L. (2000). Physician Beliefs about Victims of Spouse Abuse and about the Physician Role. *Journal of Women's Health & Gender-Based Medicine,9*(4), 405-411. doi:10.1089/15246090050020727

Goodman, L. A., Smyth, K. F., Borges, A. M., & Singer, R. (2009). When Crises Collide: How Intimate Partner Violence and Poverty Intersect to Shape Women's Mental Health and Coping? *Trauma, Violence, & Abuse*, *10*(4), 306–329. https://doi.org/10.1177/1524838009339754

Grossman, S.F. & Lundy, M. (2011). Characteristics of women who do and do not receive onsite shelter services from domestic violence programs. *Violence Against Women, 17*, 1024-1045.

Hackenberg, E. A. M., Sallinen, V., Handolin, L., & Koljonen, V. (2019). Victims of Severe Intimate Partner Violence Are Left Without Advocacy Intervention in Primary Care Emergency Rooms: A Prospective Observational Study. *Journal of Interpersonal Violence*, 088626051983764. doi: 10.1177/0886260519837649

Hafferty, F. W. (1998). Beyond curriculum reform: confronting medicine's hidden curriculum. *Academic medicine: journal of the Association of American Medical Colleges*, *73*(4), 403-407.

Haj-Yahia, M. M., Sousa, C., Alnabilsy, R., & Elias, H. (2015). The Influence of Palestinian Physicians' Patriarchal Ideology and Exposure to Family Violence on Their Beliefs about Wife Beating. *Journal of Family Violence*,*30*(3), 263-276. doi:10.1007/s10896-015-9671-4.

Hardesty, J. L., & Chung, G. H. (2006). Intimate partner violence, parental divorce, and child custody: Directions for intervention and future research. *Family Relations*, *55*, 200-210.

Haselschwerdt, M. L., & Hardesty, J. L. (2017). Managing Secrecy and Disclosure of Domestic Violence in Affluent Communities. *Journal of Marriage and Family*, *79*(2), 556-570. https://doi.org/10.1111/jomf.12345

Hendelman, W., & Byszewski, A. (2014). Formation of medical student professional identity: categorizing lapses of professionalism, and the learning environment. *BMC medical education*, *14*(1), 139.

Hernandez, B. C., Reibling, E. T., Maddux, C., & Kahn, M. (2016). Intimate partner violence experienced by physicians: a review. *Journal of Women's Health*, *25*(3), 311-320.

Hunnicutt, G. (2009). Varieties of Patriarchy and Violence Against Women. *Violence Against Women,15*(5), 553-573. doi:10.1177/1077801208331246

Ingram, E. M. (2007). A Comparison of Help Seeking Between Latino and Non-Latino Victims of Intimate Partner Violence. *Violence Against Women*, *13*(2), 159–171.

Intimate Partner Violence -Violence Prevention-Injury Center, CDC. (2018, October 23). Retrieved October 26, 2019, from https://www.cdc.gov/violenceprevention/intimatepartnerviolence/index.html.

Kasturirangan, A., Krishnan, S., & Riger, S. (2004). The Impact of Culture and Minority Status on Women's Experience of Domestic Violence. *Trauma, Violence, & Abuse*, *5*(4), 318–332. https://doi.org/10.1177/1524838004269487

Kothari, C. L., & Rhodes, K. V. (2006). Missed Opportunities: Emergency Department Visits by Police-Identified Victims of Intimate Partner Violence. *Annals of Emergency Medicine,47*(2), 190-199. doi: 10.1016/j.annemergmed.2005.10.016

Kulkarni, S. J., Bell, H., & Rhodes, D. M. (2012). Back to Basics: Essential Qualities of Services for Survivors of Intimate Partner Violence. *Violence Against Women*, *18*(1), 85–101. https://doi.org/10.1177/1077801212437137

Lewis, M. J., West, B., Bautista, L., Greenberg, A. M., & Done-Perez, I. (2005). Perceptions of Service Providers and Community Members on Intimate Partner Violence Within a Latino Community. *Health Education & Behavior*, *32*(1), 69–83. https://doi.org/10.1177/1090198104269510

Liang, B., Goodman, L., Tummala-Narra, P., & Weintraub, S. (2005). A Theoretical Framework for Understanding Help-Seeking Processes Among Survivors of Intimate Partner Violence. *American Journal of Community Psychology,36*(1-2), 71-84. doi:10.1007/s10464-005-6233-6

Lincoln, Y. S., & Guba, E. G. (1985). Naturalistic inquiry. Newberry Park.

McCauley J, Kern DE, Kolodner K, Dill L, Schroeder AF, DeChant HK, et al. (1995). The "Battering Syndrome": Prevalence and Clinical Characteristics of Domestic Violence in Primary Care Internal Medicine Practices. *Annals of Internal Medicine*, 123:737–746. doi: 10.7326/0003-4819-123-10-199511150-00001

McLindon, E., Humphreys, C., & Hegarty, K. (2018). "It happens to clinicians too": an Australian prevalence study of intimate partner and family violence against health professionals. *BMC women's health*, *18*(1), 113.

Morse, D. S., Lafleur, R., Fogarty, C. T., Mittal, M., & Cerulli, C. (2012). "They Told Me to Leave": How Health Care Providers Address Intimate Partner Violence. *The Journal of the American Board of Family Medicine,25*(3), 333-342. doi:10.3122/jabfm.2012.03.110193

Morse, J. M. (2015). Critical analysis of strategies for determining rigor in qualitative inquiry. *Qualitative health research*, *25*(9), 1212-1222.

Moylan, C. A., Herrenkohl, T. I., Sousa, C., Tajima, E. A., Herrenkohl, R. C., & Russo, M. J. (2010). The effects of child abuse and exposure to domestic violence on adolescent internalizing and externalizing behavior problems. *Journal of family Violence*, *25*(1), 53-63.

National Network to End Domestic Violence. (2017). *2017 National Summary*. Retrieved from https://nnedv.org/mdocs-posts/2017-national-summary/

Noy, C. (2008). Sampling knowledge: The hermeneutics of snowball sampling in qualitative research. *International Journal of social research methodology*, *11*(4), 327-344.

Number of people using domestic violence shelters by state. (2019). Retrieved April 1, 2019, from https://www.domesticshelters.org/data-center/state-reports-and-rankings/people-using-domestic-violence-shelters-by-state

Ogulmus, S., & Keskin, A. (2017). Investigating the socio-demographic properties of women in shelters and the characteristics of violence that they are exposed. *Biomedical Research,28*(6). Retrieved March 6, 2019.

Overstreet, N. M., & Quinn, D. M. (2013). The Intimate Partner Violence Stigmatization Model and Barriers to Help Seeking. *Basic and Applied Social Psychology,35*(1), 109-122. doi:10.1080/01973533.2012.746599

Panchanadeswaran, S. & McCloskey, L.A. (2007). Predicting the timing of women's departure from abusive relationships. *Journal of Interpersonal Violence*, 22, 50-65.

Pérez-Álvarez, C., Gallego-Royo, A., Marco-Gómez, B., Martínez-Boyero, T., Altisent, R., Delgado-Marroquín, M.-T., & Astier-Peña, M. P. (2018). Resident Physicians as Patients: Perceptions of Residents and Their Teaching Physicians. *Academic Psychiatry*, *43*(1), 67–70. doi: 10.1007/s40596-018-0981-8

Purvin, D. M. (2007). At the crossroads and in the crosshairs: Social welfare policy and low-income women's vulnerability to domestic violence. *Social Problems*, *54*(2), 188-210.

Rennison, C. M., & Welchans, S. (2002). Intimate Partner Violence. *Bureau of Justice Statistics,6*(1), 111-136. Retrieved October 28, 2018.

Robbins, G. F., Macdonald, M. C., & Pack, G. T. (1953). Delay in the diagnosis and treatment of physicians with cancer. *Cancer,6*(3), 624-626. doi:10.1002/1097-0142(195305)6:33.0.co;2-0

Rodriguez, M. A., Bauer, H. M., Mcloughlin, E., & Grumbach, K. (1999). Screening and Intervention for Intimate Partner Abuse. *Jama,282*(5), 468. doi:10.1001/jama.282.5.468

Sanchez-Reilly, S., Morrison, L. J., Carey, E., Bernacki, R., O'Neill, L., Kapo, J., … Thomas, J. (2013). Caring for oneself to care for others: physicians and their self-care. *The journal of supportive oncology*, *11*(2), 75–81.

Satyen, L., Rogic, A. C., & Supol, M. (2018). Intimate Partner Violence and Help-Seeking Behaviour: A Systematic Review of Cross-Cultural Differences. *Journal of Immigrant and Minority Health*. doi:10.1007/s10903-018-0803-9

Schroeder, R., Brazeau, C. M., Zackin, F., Rovi, S., Dickey, J., Johnson, M. S., & Keller, S. E. (2009). Do State Medical Board Applications Violate the Americans With Disabilities Act? *Academic Medicine,84*(6), 776-781. doi:10.1097/acm.0b013e3181a43bb2

Seelau, S. M., & Seelau, E. P. (2005). Gender-role stereotypes and perceptions of heterosexual, gay and lesbian domestic violence. *Journal of family violence*, *20*(6), 363.

Simon, S. (Producer). (2017, July 15). More Domestic Violence Shelters For Men Opening [Transcript, Radio series episode]. In *Weekend Edition Saturday*. National Public Radio.

Sims, C., Sabra, D., Bergey, M. R., Grill, E., Sarani, B., Pascual, J., . . . Datner, E. (2011). Detecting Intimate Partner Violence: More Than Trauma Team Education Is Needed. *Journal of the American College of Surgeons,212*(5), 867-872. doi:10.1016/j.jamcollsurg.2011.01.003

Stork, E. (2008). Understanding high-stakes decision making: Constructing a model of the decision to seek shelter from intimate partner violence. *Journal of Feminist Family Therapy*, *20*(4), 299-327.

Sullivan, C.M. (2012, October). *Domestic Violence Shelter Services: A Review of the Empirical Evidence,* Harrisburg, PA: National Resource Center on Domestic Violence. Retrieved March 5, 2019, from: http://www.dvevidenceproject.org.

Sullivan, C.M., Campbell, R., Angelique, H., Eby, K.K., & Davidson, W.S., 2nd (1994). An advocacy intervention program for women with abusive partners: six-month follow-up. *Am J Community Psychol,* 22, 101-122.

Szauter, K., Williams, B., Ainsworth, M. A., Callaway, M., Bulik, R., & Camp, M. G. (2003). Student perceptions of the professional behavior of faculty physicians. *Medical Education Online, 8*(1), 4338.

Thompson, W. T., Cupples, M. E., Sibbett, C. H., Skan, D. I., & Bradley, T. (2001). Challenge of culture, conscience, and contract to general practitioners' care of their own health: qualitative study. *BMJ: British Medical Journal, 323*(7315), 728.

Tjaden, P., & Thoennes, N. (2000). Extent, nature, and consequences of intimate partner violence. *PsycEXTRA Dataset*. doi:10.1037/e300342003-001

Tolman, R. M., & Raphael, J. (2000). A review of research on welfare and domestic violence. *Journal of Social Issues, 56*(4), 655-682.

Truman, J., & Morgan, R. (2014). Nonfatal Domestic Violence, 2003-2012. *Bureau of Justice Statistics*. Retrieved October 29, 2018.

Usta, J., & Taleb, R. (2014). Addressing domestic violence in primary care: what the physician needs to know. *The Libyan journal of medicine, 9*, 23527. doi:10.3402/ljm.v9.23527

Wear, D., & Zarconi, J. (2008). Can compassion be taught? Let's ask our students. *Journal of General Internal Medicine, 23*(7), 948-953.

Weitzman, S. (2000). *Not to people like us: Hidden abuse in upscale marriages*. Basic Books.

West, C. M., Kantor, G. K., & Jasinski, J. L. (1998). Sociodemographic Predictors and Cultural Barriers to Help-Seeking Behavior by Latina and Anglo American Battered Women. *Violence and Victims,13*(4), 361-375. doi:10.1891/0886-6708.13.4.361

WHO. (2010). Preventing intimate partner and sexual violence against women: Taking action and generating evidence. Geneva: WHO and London School of Hygiene and Tropical Medicine.

APPENDIX A

CODEBOOK

Coding Instructions

You will be coding transcripts of a single focus group and four semi-structured individual interviews. These transcripts will focus on responses to the following two sections of the semi-structured interview: (1) Tell me a little bit about your facility and the kind of services that you offer (2) What kind of needs or challenges do you believe a woman from a higher socioeconomic status would face upon entering your facility, and how would you address those needs? Are there any unique challenges that would particularly affect physicians? The following code structure will be broken into two sections in accordance with the aforementioned topic structure. Codes from section one, referred to as the *Facility Demographics Section*, may be used throughout the entire interview transcript. Codes from the section two, referred to as the *High-Income Experience Section*, may only be used after the topic of unique challenges directed at high socioeconomic individuals or individuals that are physicians has been brought up by the interviewer. Have your coding manual in front of you and reference it often as you code the interview transcripts. Transcripts should be coded using Dedoose, an application for analyzing qualitative research.

Transcript Excerpts

Transcript excerpts will be predetermined by the lead coder. Transcript excerpts will only feature provider responses. Examples of excerpts:

- "And as you know, any person can experience domestic violence, so we have all walks of life, all nationalities, all ages, also socioeconomic classes—you know, a wide variety in that way."
- "And I guess just, um, giving them permission to not be ashamed by that, or reach out for the help themselves."
- "The physicians that I worked with, which was over thirty years ago on the East Coast, I learned that, um hospitals have separate waiting rooms for, um, victims of domestic violence who were married to attorneys, doctors, judges, and police."

Although only transcript excerpts should be coded, coders must read the entire transcript as other parts of the transcript may provide important context for assigning codes. Portions of the transcript that should not be included in excerpts for coding have been italicized and greyed out for the convenience of the coders.

Code Assignment

Each transcript excerpt should be assigned at least one Topic code, although more than one Topic code may be assigned to the same excerpt. Coders should focus on capturing the content of the excerpt with the most relevant code(s). Many times, one Topic code will be sufficient for characterizing an excerpt. Coders can assign codes to excerpts by right-clicking the excerpt and selecting "Add Code(s)" or by selecting the excerpt and dragging and dropping code(s) into the "Selection Info" pane on Dedoose.

Each transcript excerpt should be assigned the highest level code possible.

Time Considerations

Coding one transcript should take approximately 45 minutes. Please try to only begin coding a transcript if you know that you will have time to finish it. Rushing may

compromise the reliability of coding, so do not rush. In addition, coding for too long continuously, or while very tired may compromise reliability. We recommend that coders take at least a short break between coding separate transcripts and do not code more than two transcripts in one sitting.

Facility Demographics Section
Basic Structure of Codes

Topic	Specifier	Sub-codes
Populations Served	Race/Ethnicity/Nationality/Immigration Status	N/A
	Family Issues and Dynamics	N/A
	Gender and Sexual Orientation	N/A
	Cultural Norms	Religious Values
		Stigma/Fear of Judgement/Concerns of Confidentiality
		Cultural Expectations
	SES/Career Status and Educational Background	N/A
	Military	N/A
	Transient	N/A
	Characteristics of Populations Served	Shame/Fear/Stigma Denial
		Isolation/Alone/No Family Support
		Other
	Other	N/A
Characteristics of Batterers	N/A	N/A
Referral Source	N/A	N/A
Services Provided/Needed	Mental Health and Well Being	N/A
	Shelter and Housing	N/A
	Career Counseling	N/A
	Advocacy and Referrals	N/A
	Legal Counseling and Advisory Services	N/A
	Other Resources	N/A
	Types of Abuse	Physical and or Sexual Abuse and Violence
		Emotional/Psychological Abuse and Stalking
		Financial Abuse and Control
Community Outreach	Marketing	N/A
	Engagement	N/A
Characteristics of Shelter	Location	N/A
	Safety/Confidentiality	N/A
	Living Environment	N/A

High Income Experience Section
Basic Structure of Codes

Topic	Specifier	Sub-codes
Real Experience of High SES/Physician Clients	N/A	N/A
Barriers to Seeking Services	Not Believed/Victim Blaming	N/A
	Difficulty Disclosing	
	Lack of Insight into Experience of Violence/Denial	
	Preparing to Leave Current Life	
	Confidentiality Concerns	
Discomfort/Lack of Belonging in Shelter Environment	N/A	N/A
Common Ground Among Survivors	N/A	N/A
Financial Control	N/A	N/A
Staff Response	Open-Mindedness and Ability to Address Diverse Needs	N/A
	Lack of Training/Exposure and Assumptions about High SES Clients	N/A
Other Survivors' Responses	N/A	N/A
Available Alternatives to Shelter	N/A	N/A
Independent Access to Finances	N/A	N/A
Emotions Experienced	N/A	N/A
Isolation	N/A	N/A
Unique Considerations for Physicians	Peer Support Amongst Physicians	N/A
	Physical Education	N/A
	Culture of Workplace	N/A
	Physician Other	N/A

Facility Demographics Section
Code Definitions

Topic	Specifier	Sub-codes
Populations Served: Comments that describe demographic descriptions of clients seeking services at various represented shelters.	***Race/Ethnicity/Nationality /Immigration Status:*** Comments about an individual's race, ethnicity, nationality, or immigration status.	N/A
	Family Issues and Dynamics: Comments about topics addressing parenting challenges, discipline and communication issues, parental emotional experiences, and violence witnessed by and exhibited by children. These excerpts may include both the experience of the survivor and the child following abuse in the home, as well as family dynamics stemming from a household in which violence was experienced.	N/A
	Gender and Sexual Orientation: Comments about individuals gender identify and various sexual orientations, including members across the LGBTQIA+ community.	N/A
	Cultural Norms: Comments about experiences related to specific cultural values that influence individual characteristics of survivors' experiences, often related to perceptions of others and societal values that influence the experience of abuse, like conceptual understanding of intimate relationships, parenting, and violence.	***Religious Values:*** Comments related to faith-based influences in survivors' understanding of their cultural experience, including examples like a religious framework for approaching family structure or marital dynamics.
		Stigma/Fear of Judgement/Concerns of Confidentiality: Comments that address clients' experiences of shame, stigma, or judgement related to victimization and expressed fear of being known

		as a survivor of some type of violence or abuse in the community.
		Cultural Expectations: Comments addressing values that influence individual perspectives on topics like marriage, parenting, and use of violence, like the use of corporal punishment in disciplining children.
	SES/Career Status and Educational Background: Comments about individuals of a specific socioeconomic status, education background, or particular type of career.	N/A
	Military: Comments about individuals who are active or retired members of the armed forces.	N/A
	Transient: Comments about individuals who do not have a permanent residence or who may travel to various locations of residence throughout the year.	N/A
	Characteristics of Populations Served: Comments about the emotions and psychological experiences of survivors that often seek shelter following violence that may contribute to continued victimization and inability to escape violence through means other than shelter services.	***Shame/Fear/Stigma/Denial:*** Comments related to emotions often experienced by survivors that encompass and are influenced by the negative connotations surrounding the experience of victimization.
		Isolation/Alone/No Family Support: Comments addressing traits of clients that are specific to their experience of social support in relation to their abuse.
		Other: Comments about specific traits of clients seeking services that do not fit in the above codes.

	Other: Comments about individuals belonging to a specific population category that does not fit within the above codes (e.g., marital status).	N/A
Characteristics of Batterers: Comments that address topics related to individual psychological factors that often influence abusers' acts of violence, including social status, personal experience with abuse, and beliefs about power differentials within intimate relationships, like well-known, power, control, manipulation, personal experience with violence.	N/A	N/A
Referral Source: Comments that describe various resources and emergency services that often interact with survivors firsthand and offer information to survivors about shelter services that often encourage them to seek help	N/A	N/A

and offer contact information.		
Services Provided/Needed: Comments related to introductory descriptions of available services offered to clients through the shelters mentioned as well as the various needs that staff have come to understand clients often have when entering a shelter environment following abuse.	***Mental Health and Well Being:*** Comments related to services including counselling, therapy, substance abuse treatment, stabilization, support groups, and educational classes.	N/A
	Shelter and Housing: Comments related to services addressing housing security, including emergency, short-term, and long-term shelter within the facility as well as resources and aid finding secure housing options, like a house or apartment.	N/A
	Career Counseling: Comments related to shelter services addressing employment security and career options for clients, like resumé editing and assistance with the job search process.	N/A
	Advocacy and Referral to Outside Services: Comments related to services providing support navigating the shelter system and available resources for low-income individuals and survivors of violence, as well as information provided to other agencies offering services the shelter facility may not be able to.	N/A
	Legal Counseling and Advisory Services: Comments related to services addressing clients' potential legal avenues after experiencing abuse,	N/A

	including navigating the court process and completing any necessary legal documentation if the decision to report an abuser is reached.	
	Other Resources: Comments related to any other services sought after by clients or offered by shelter facilities that have not been addressed in the aforementioned codes.	N/A
	Types of Abuse: Comments related to services offered to survivors experiencing a variety of abuse beyond physical violence within a committed intimate relationship, including dating violence, abuse affecting both the physical and mental health of victims, withholding of individual access to finances or basic needs, manipulation of children shared with the abusive partner, and other acts of aggression or exploitation.	***Physical and or Sexual Abuse and Violence:*** Comments addressing abuse and victimization of a physical or sexual nature, including violence like hitting or punching, non-consensual sexual encounters or rape, or instances of human trafficking or exploitation.
		Emotional/Psychological Abuse and Stalking: Comments addressing abuse of an emotional nature, including verbal abuse, manipulation, demeaning language, isolation, stalking, or verbal threats.
		Financial Abuse and Control: Comments addressing abuse related to financial control, including withholding of money, limiting financial access, or reliance on abusive partner for any financial security.

Community Outreach: Comments related to educational opportunities shelters offer to various community-based organizations and services by the shelter staff to increase awareness about the prevalence of domestic violence, the ways to screen for and ask about it, and how to encourage help-seeking behavior in survivors.	***Marketing:*** Comments related to spreading awareness of the existence of shelters and services offered within the community at large.	N/A
	Engagement: Comments related to shelter staff expanding community knowledge about domestic violence through demonstrations and presentations in educational environments like schools or hospitals.	N/A
Characteristics of Shelter: Comments that include descriptions of the geographic area the shelter is located in, the security of the building and process of seeking shelter itself, the knowledge of the shelter within the greater community,	***Location:*** Comments related to the physical nature of the shelter, including descriptions of the surrounding area and location of the shelter relative to the rest of the community (i.e. urban or rural, in the center of town).	N/A
	Safety/Confidentiality: Comments related to the security of the shelter, the process of gaining knowledge about the location and entering into the shelter as an individual seeking services, and efforts made to maximize confidentiality of clients.	N/A

and the experience of existing within the shelter as a client interacting with staff and other survivors.	***Living Environment:*** Comments related to the experience of staying in the shelter, which may include the size and layout of the shelter overall as well as the general pace of day to day existence within that environment (i.e. hectic, peaceful, etc.).	N/A

High Income Experience Section
Code Definitions

Topic	Specifier	Sub-codes
Real Experience of High SES/Physician Clients: Comments referring to shelter staff's retelling of an experience with a high SES or physician client that they have actually had while working in the shelter system. Otherwise, all comments related to physician or high SES experiences will be assumed to be the staff's perception of what may happen if an individual in this demographic category was seeking services, rather than personal experience with a client of this nature.	N/A	N/A
Barriers to Seeking Services: Comments related to topics that address various psychological, physical, and logistic challenges survivors face in seeking help to leave an abusive relationship, including often being unable, unwilling, or unaware of the abuse they are experiencing and acknowledgement of the extreme sacrifices that leaving that relationship might require.	***Not Believed/Victim Blaming:*** Comments related to the experience of survivors being blamed in some way for the abuse that they have endured, including assuming they should have known better or been able to get themselves out of the abusive situation before it escalated, as well as not believe those that come forward and disclose an experience of violence because they or their abusive partner belong to a certain demographic category.	N/A
	Difficulty Disclosing: Comments related to the challenges that come with trying to choose if one should speak out about having experienced abuse, often related to perceived embarrassment or judgement from others.	
	Lack of Insight into Experience of	

	Violence/Denial: Comments related to the survivor's inability to acknowledge that they are in an abusive relationship, often due to denial, a lack of understanding about what constitutes abuse, cultural norms, or belief about individual worth that perpetuates the cycle of victimization.	
	Preparing to Leave Current Life: Comments related to fear or anxiety on the part of the survivor surrounding having to leave behind everything that they have in their life to escape their abuser, difficultly letting go of an emotional or long-term relationship, the complex interplay of emotions like love and duty with pain and abuse, losing job or interpersonal ties, or having to navigate child safety alongside personal need to leave an abusive environment.	
	Confidentiality Concerns: Comments related to the unique experience of this population related to concerns about knowledge in the community, shame and embarrassment surrounding their status and their abuse experience, and potential knowledge of other clients staying in shelter in a more professional role.	
Discomfort/Lack of Belonging in Shelter Environment: Comments about the specific experience of a higher SES client who may be utilizing a social service agency for the first time, facing the challenge of judgement and feeling out of	N/A	N/A

place in an environment that is often more heavily populated with individuals from very different life circumstances, and requiring the higher SES individual to leave many of the comforts they may be used to.		
Common Ground Among Survivors: Comments related to topics such as the idea that clients from diverse cultural backgrounds (including SES, race, etc.) being able to relate to the experience of abuse and connect with survivors they may otherwise have nothing in common with.	N/A	N/A
Financial Control: Comments related to the more unique experience of potentially living a life of very privileged economic status, either through personal or joint financial success, but having limited or no access to the fund separate from your abuser's control, leaving the clients with no real economic security once they have left their abusive partner.	N/A	N/A
Staff Response: Comments about perceptions of higher SES clients from the point of view of shelter staff, who may have little previous experience. with this demographic, including both positive and negative ideas about how staff members would interact and be equipped to respond to survivors in this population category.	***Open-Mindedness and Ability to Address Diverse Needs:*** Comments addressing shelter staff's ability to adjust expectations related to high income clients they may have little experience working with, including their strength in understanding that abuse can happen to anyone, and their ability to tailor their approach to the presenting needs of the client, regardless of assumptions about or past experience with individuals from these higher education and income categories.	N/A
	Lack of Training/Exposure and Assumptions about High	N/A

	SES Clients: Comments related to shelter staffs' lack of frequency in encountering clients of higher SES demographic categories, implying they may be less aware of and trained to meet their needs, and may hold several assumptions about their experience as a member of a higher social or financial class that may influence their beliefs about their needs as shelter clients.	
Other Survivors' Responses: Comments related to lower SES clients' perceptions and assumptions about life experiences and privileges experienced by higher SES clients, including legitimacy of need for shelter services and reality of abuse.	N/A	N/A
Available Alternatives to Shelter: Comments related to the discussion of utilization of alternative resources often available to higher SES clients beyond seeking emergency shelter that often limits the number of individuals from this population that actually stay in shelter communities (like hotel, relatives, friends, therapists).	N/A	N/A
Independent Access to Finances: Comments that include descriptions about higher SES individuals' access to personal finances from their own employment or alternative resources that may allow for a more feasible separation from their abusive partner that would decrease a need for long-term shelter services.	N/A	N/A

Emotions Experienced: Comments touching on topics including the psychological experiences unique to this higher SES demographic of survivor that may be related to the cultural values and norms experienced by this group specifically, for example resistance, shame, pride.	N/A	N/A
Isolation: Comments related to the emotional experiences of lack of social belonging or community due to abuse experience that may often remove these individuals from being able to be open and interact with their social circle, either from intentional isolation by the abuser or shame and embarrassment from the survivor.	N/A	N/A
Unique Considerations for Physicians: Comments that specifically address the realities and challenges a physician might face within the shelter system, separate from a higher SES client more generally.	***Peer Support Amongst Physicians:*** Comments that address the encouragement of training and awareness of domestic violence within the physician community to strengthen support for those who are survivors themselves to feel empowered to acknowledge their abuse experience and seek help.	N/A
	Physician Education: Comments that emphasize a need for greater training, safety planning, and personal and professional development within physician curriculum to handle the unique needs of survivors that may be relevant to their patients, their collogues, or themselves, as well as a discussion around greater domestic violence awareness and resourcing in the healthcare setting more broadly.	N/A

	Culture of Workplace: Comments that address characteristics of workplace culture that contribute to openness to discussing and dealing with abuse, including negative factors that perpetuate violence and often protect abusers, like employment restrictions (restraining orders) and safety concerns.	N/A
	Physician Other: Comments from all other dialogue related to the experience of physicians that does not fit into the aforementioned thematic codes.	N/A