Women's experiences with healthcare professionals after suffering from gender-based violence: An interview study.

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Women's Experiences with Healthcare Professionals after Suffering from Gender-Based Violence: An Interview Study

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ABSTRACT

Aim and objectives: This study sought to describe how women in Mexico who have suffered from gender-based violence experience their encounters with healthcare professionals.

Background: Gender-based violence is a worldwide problem. Previous studies have described that women feel they are not being cared for appropriately during their encounters with healthcare professionals. This study was conducted in Mexico, which has a high rate of gender inequality.

Design: A descriptive, qualitative study was conducted.

Methods: Face-to-face interviews were conducted with seven women. An inductive content analysis was used to analyse the interviews.

Results: The analyses resulted in four categories: *Feelings of guilt about being abused*, *Feelings of being unimportant*, *Feelings of taking time* and *Feelings of being insecure/secure*. The women emphasised the importance of healthcare professionals taking time out of their busy schedules for them. When they treated the women with respect and genuine interest, the women felt secure. When the healthcare professionals did not meet these expectations, feelings of frustration and mistrust were elicited.

Conclusions: Feelings of being listened to and safety were considered important aspects in a positive encounter, whereas feeling a lack of time or interest often led to negative experiences such as frustration with and distrust of the healthcare system. These results imply that healthcare professionals may have deficiencies with regard to how these women are treated because these women do not feel that they receive the proper support.

Relevance to clinical practice

Education regarding how to approach women who have suffered from gender-based violence is essential for healthcare professionals to establish respectful encounters. The findings of this study stress that relatively simple efforts such as listening to these women's stories and providing them with genuine attention might substantially improve care.

Keywords: Encounters; Gender-based violence; Healthcare professionals; Women's experiences

What does this paper contribute to the wider global clinical community?

- The healthcare professionals' behaviour during encounters with women who have experienced gender-based violence is of great importance for women's trust in healthcare professionals.
- Healthcare professionals need to establish respectful encounters where women feel secure to talk. Showing respect, taking time to listen, giving the woman undivided attention, showing genuine interest in her story and not judging or questioning her actions are helpful aspects to create such trust and encounters.

INTRODUCTION

The World Health Organization found that one-third of all women who have been in an intimate relationship report having suffered from physical violence committed by their partner (World Health Organization 2013). Globally, 38 per cent of all homicides of women are committed by an intimate partner (Garcia-Moreno *et al.* 2006). Previous research has shown that victims of gender-based violence feel that they do not receive the support they are entitled to when reaching out to healthcare professionals (Peckover 2003, Pratt-Eriksson *et al.* 2014, Wendt & Enander 2013).

Domestic violence can be defined as physical, sexual, psychological, and economic abuse carried out by an intimate partner or other family member against another (UNICEF 2000), often this is repeated abuse (Garcia-Moreno *et al.* 2006). A common problem in many countries is that domestic violence laws apply to only individuals who are involved in intimate relationships, specifically, married and cohabiting couples. However, these laws should also apply to violence performed by other family members, as well as less formal intimate relationship partners (Vives-Cases *et al.* 2010)

Gender-based violence can be defined as physical, sexual or psychological abuse, and the perpetrator can be anyone of the opposite sex (Wilson & Miller 2016). The present study uses the term “gender-based violence” when referring to the different types of violence that the women of the current study had suffered, whether in their private (domestic) or public lives (Garcia-Moreno *et al.* 2006, World Health Organization 2012).

Mexico has a high rate of gender inequality, and gender-based violence is a complex issue in this country (Frias 2008, Frias & Angel 2013). Gender inequality is one of the major risk factors for

intimate partner violence, and the dominant gender is likely to use power to coerce the submissive gender (Conroy 2014, Gomez *et al.* 2011). A national survey (Incháustegui *et al.* 2012) showed that more than ten per cent of all women in Mexico over the age of 15 years old have been physically assaulted by their partner, and six per cent have suffered sexual violence within a relationship. Thirteen per cent of men and nine per cent of women believe that the physical abuse of a woman is either partly or completely justified. Twelve per cent of the population believes that domestic violence is a private matter in which neither the government nor the legal system should interfere (Incháustegui *et al.* 2012).

BACKGROUND

Women who have suffered from gender-based violence often feel they do not receive the respect or interest that they think they deserve from healthcare professionals. These women commonly experience feelings of guilt and shame. Furthermore, previous studies show that feelings of responsibility for gender-based violence are common among these women, and many of them feel that healthcare professionals blame them, which makes it much more difficult to create a positive relationship (Peckover 2003, Pratt-Eriksson *et al.* 2014, Wendt & Enander 2013).

Clearly, healthcare professionals play an important role in the well-being and recovery of women who have suffered from gender-based violence (Bradbury-Jones *et al.* 2011, Peckover 2003). In her Human-to-Human Relationship Model, theorist Joyce Travelbee defines nursing as an interpersonal process in which the nurse works with an individual to prevent or cope with an experience of suffering or illness (Meleis 2011, Travelbee 1971). Travelbee indicates the importance of communication in the process of nursing; in other words, it is essential to establish a mutual understanding with the patient (Travelbee 1971). However, various studies (Beynon *et*

al. 2012, Gutmanis *et al.* 2007, Taylor *et al.* 2013) show that healthcare professionals do not want to discuss domestic violence with patients. One common reason is to avoid offending the patient by asking such private questions or not feeling confident asking these types of questions because of a lack of education/knowledge in this specific area. The amount of time such a discussion would take is also highlighted as a problem (Bradbury-Jones *et al.* 2011, Peckover 2003).

In Mexico, healthcare professionals are legally responsible for reporting suspicions of violence against women, and each case of confirmed violence is reported to the district attorney's office and the Ministry of Health, where all confirmed cases must be registered. Certain regulations exist that healthcare professionals must follow in all cases of violence against women. These regulations include promoting, protecting and re-establishing the highest level of mental and physical health possible (Norma Oficial Mexicana 2009).

The literature review has attempted to provide insights into the global extent of gender-based violence. Studies from various countries describe how many women feel that they are not received appropriately in their encounters with healthcare professionals (Beynon *et al.* 2012, Gutmanis *et al.* 2007, Peckover 2003, Pratt-Eriksson *et al.* 2014, Taylor *et al.* 2013, Wendt & Enander 2013). The present study was conducted in Mexico, which has a high rate of gender inequality (Frias 2008); furthermore, gender-based violence is a widespread issue in this country (Incháustegui *et al.* 2012). According to Travelbee (Meleis 2011, Travelbee 1971), establishing a human-to-human relationship between the nurse and the patient is crucial for the ability to identify, understand and meet a patient's needs. In Mexico, numerous studies have focused on the experiences of the victims of gender-based violence (Incháustegui *et al.* 2012, Norma Oficial Mexicana 2009); to the best of our knowledge, however, no study has examined how women in Mexico experience their encounters with healthcare professionals after having suffered from

gender-based violence Therefore, the current study describes how women in Mexico who have suffered from gender-based violence experience their encounters with healthcare professionals.

METHODS

Design

The study was conducted as a minor field study (MFS Swedish Council for Higher Education 2017), an independent project funded by the Swedish International Development Cooperation Agency (SIDA). In this study, the descriptive qualitative method of Elo and Kyngas (2008) was used to achieve an understanding of how women in Mexico who have suffered from gender-based violence experience their encounters with healthcare professionals. Face-to-face interviews were conducted, and the interviews were analysed using an inductive content analysis (Elo & Kyngas 2008).

Setting and participants

Because the study was conducted at a public hospital in an urban area of central Mexico, preparations were required to assure a sufficient number of participants as well as permission from the state government and the hospital where the interviews would take place. The hospital was initially contacted via e-mail: A letter was presented to the director of the hospital in which the authors requested permission to conduct the study. A meeting was then arranged with the director and the head of the hospital's department of violence against women to discuss the details of the study. The director provided his verbal approval and arranged all necessary permits from the state government.

Purposeful sampling was employed to ensure information-rich cases (Patton 2015). The inclusion criteria were that the women had to be Mexican citizens, speak Spanish as their native language

and have been victims of gender-based violence. In addition, all participants must have had contact with a healthcare professional at the hospital with regard to gender-based violence over the past two years. Specific criteria regarding age were not employed.

The participants were recruited using an internal register that included all woman victims of violence who had been cared for at the hospital. These women, who agreed to be contacted after leaving the hospital to participate in research, comprised a specific category in this register. The authors initiated the recruiting process after they were given the e-mail addresses of all the women ($n = 212$). The 40 women who met the inclusion criteria received an e-mail concerning this study. A total of 21 women responded to the e-mail; 13 of them were unable to participate during the study's time frame, leaving eight women to be interviewed for the study. The time and place for the interviews were decided through further e-mail contact. One woman did not show up for her interview.

Data collection

The data were collected through semi-structured face-to-face interviews during April 2015. An interview guide with open and neutral questions and possible follow-up questions was designed to explore the experiences of each participant. The main goal was to illustrate the experiences of these women with regard to their encounters with healthcare professionals. The questions were discussed with a native Spanish-speaking expert in the field to ensure the relevance of the interview guide. Thereafter, a proof-reader reviewed the questions to avoid misunderstandings (Brislin 1970).

In accordance with Green and Thorogood (2013), a pilot interview was performed to test the interview guide and ensure that the questions being asked were relevant and would provide

narrative answers in relation to the aim of the study. The pilot interviewee answered all of the questions in a relevant manner; therefore, no changes were necessary. The pilot interview was included in the study's results, which is considered as appropriate in qualitative studies (Patton 2015). The interviews took between 15 and 45 minutes, with an average length of 35 minutes, and were performed entirely in Spanish by the third author who speaks the language fluently. The audio of the interviews was recorded with permission from the women. To ensure a feeling of safety, the interviews were held in a conference room connected to the hospital.

Analysis

Each interview was transcribed verbatim in Spanish shortly after being conducted to ensure that all information was as recent as possible. All pauses, sighs, emphases, and so on were included in the transcriptions. Each transcription was made after listening to the recorded material several times to ensure that no information was missed and that no mistakes were made due to language difficulties. The transcripts, originally in Spanish, were translated into English according to the method described by Chen and Boore (2010).

The data were analysed in accordance with the content analysis process of Elo and Kyngas (2008); thus, the text was examined using a qualitative, inductive content analysis method including open coding and the creation of categories. The analysis began with several readings of the translated text to search for meaning and a deeper understanding of the entire dataset. All authors read the transcripts separately because important insights can emerge from the different ways that people consider the same data (Sandelowski 1998). Thereafter, the authors coordinated their separate analyses to obtain an understanding of the entire dataset based on the aim of the study. All of the content that responded to the study's aim was divided into different units of analysis according to their specific topic using different colours. Each unit was then condensed

into meaning units; in other words, all units were broken down into smaller units preserving only the most essential information presented (Elo & Kyngas 2008). These meaning units were then labelled with a code and organised into categories based on similarities in content of the text (Table 1). The interpretation of the data and the abstraction process continued as far as it was reasonable and possible to express the content of the text (Elo & Kyngas 2008). To assess trustworthiness, the authors reviewed the credibility, dependability, conformability and transferability of the study according to the method of Elo *et al.* (2014). Moreover, four of the transcript categories were compared via a peer review (i.e., inter-rater reliability; (Burnard *et al.* 2008) by the authors. The categories were discussed extensively between the authors. When disagreements emerged, they were discussed until consensus was reached to achieve trustworthiness (Table 1). To assess credibility and trustworthiness, the authors provided a full description of the content analysis process and the presented results from original data to allow readers to draw their own conclusions of the results according to the method of Elo *et al.* (2014).

Ethical considerations

The research ethics council at Sophiahemmet University, Stockholm, Sweden, approved this study. Permissions were also received from the state government and the hospital where the interviews were performed. In Mexico, approval is not necessary from an ethics committee for a study with the present design (i.e., interviews with women who had been discharged from the hospital). Nevertheless, the guidelines for research on domestic violence outlined by the Department of Gender and Women's Health at the WHO were followed to diminish the possibility of putting the women or researchers at risk (World Health Organization 2001). In addition and in keeping with the ethical guidelines of the Declaration of Helsinki (Ndebele 2013, World Medical Association 2013), all participating women were informed about the study in

advance. They were given verbal and written information outlining the study, the voluntary nature of their participation, their right to withdraw at any time without a reason, and their right to refuse to answer any question. They were also made aware that the confidentiality of their answers would be preserved and that any quotations from the interviews would protect the participants from identification.

RESULTS

The results presented are based on seven interviews with women in Mexico between 21- 49 years old. The participants are referred to as the women or the victims. The amount of experience the women had with healthcare professionals (nurses and physicians) because of gender-based violence varied between three occasions and 13 years of encounters across different healthcare contexts. All of the women interviewed had suffered gender-based violence within a heterosexual relationship, and none were still involved with the same partner. The results are presented through four categories (Table 1), and each category is illustrated with quotations.

(Insert Table 1 about here)

Feelings of guilt regarding being abused

Most of the women expressed having experienced feelings of guilt for being abused by their significant others and that these feelings were reinforced by the attitudes of the healthcare professionals on various occasions, especially in terms of psychological violence.

I still feel [that] many do not take it seriously, not even the medical staff /.../ If you are not left black and blue or [do not] have physical injuries, [then] it feels that it does not count. As if you should be able to take a few bad words or insults because it is normal, not even they [the medical staff] help you understand [that] it is not your fault. (Participant 3)

The women described the healthcare professionals as inflicting feelings of guilt not primarily through verbal accusations but by questioning their actions. For example, asking why they did not speak up earlier about the violence or how they were able to maintain a relationship with someone who abused them. One woman expressed herself when she more than once felt that healthcare professionals accused her of provoking her husband into violence:

Many times, they [the healthcare professionals] make you feel guilty saying things out loud or sometimes it is even the way they look at you.... Once they even told me it was my own fault [that] he beat me up; that in one way or another, I deserved it. (Participant 2)

Feelings of being unimportant

One reoccurring subject in several interviews was experiencing a lack of interest from the healthcare professionals. This feeling arose for various reasons, but the most common were not receiving the healthcare professional's undivided attention or being interrupted in the middle of a medical visit.

You tell a story that is so hard to tell; it is so difficult and ugly, and they [the healthcare professionals] do not even respect you enough to give you their undivided attention. They answer the telephone or keep looking at their watch; you can see it in their eyes that they are thinking about something else. (Participant 6)

The women shared that they had expected the healthcare professionals to act in a certain manner (e.g., inquiring about violence) and, if the violence was confirmed, having conversations aimed at strengthening and supporting the women. Furthermore, most of the women expressed feeling less important than other patients or that their traumatic experiences were not taken seriously,

especially when the healthcare professionals were stressed or talked about not having enough time.

They have even said it straight to my face that they don't have time, as other patients who are sicker than me need their time. Since I'm not dying, I should just hold on for a while. When they treat you like that, you don't feel like telling them when they do have time, even if it is only ten minutes later. (Participant 1)

Feelings of taking time

All of the women emphasised the importance of time. Some of them explained how they had felt guilty for taking up the healthcare professional's time after having been told they were busy and did not have time to walk around guessing which patients had problems about which they did not speak up. The women felt as though they were a burden while trying to catch the healthcare professional's attention without saying that they were victims of violence out loud.

In contrast to the negative experiences due to an insufficient amount of time, when the women felt like the healthcare professionals were not rushing through their visit, they felt comfortable enough to open up and share their experiences. One woman explained it this way:

You often feel stressed when talking during a medical appointment because the staff keeps looking at their watches and you know [that] they have many patients waiting. But with her I never felt that way /.../ she made me feel [that] I mattered. (Participant 4)

Almost all the women emphasised that it was not as much about talking to the healthcare professionals for an hour or telling them their whole story during the first encounter; rather, it

was about them feeling that their issues were considered as important enough for the healthcare professionals to take the time to sit down and listen to what they had to say.

Feelings of being insecure/secure

The importance of feeling secure with the healthcare professionals was broached in the interviews. Most of the women talked about not feeling secure enough to talk to anyone but healthcare professionals, whereas others stated that many times they had not felt secure enough to tell even them because of either their own negative experiences or those of friends or acquaintances. One woman stated,

I came to talk to a male nurse for some time, but he would always reprimand me. It was like he got angry when I did not do the things he told me to do; it was like the situation felt oppressive. On top of that, he told my mother everything, and that did not seem ethical to me.... How could I trust him? (Participant 3)

Whether the women felt secure enough to share their problems with the healthcare professionals depended on many different factors; however, the women agreed on the importance of the first impression. If the women, for whatever reason, came to doubt the intentions of the healthcare professionals during their first meeting, then they were unlikely to regain confidence later. However, most of the women believed that their relationship with the healthcare professionals would not be perfect from the beginning.

If I, for some reason, did not feel safe, [or] if I thought I should not be telling this [my story of abuse], [or] if he or she looked at me [in] a certain type of way or if I felt judged with words or in silence, [then] I would not go back. Maybe I would go back [to] pretending [that] everything

was fine and not tell him or her my story. If something tells me not to trust this person, [then] I follow that instinct. (Participant 5)

The women initially expressed being afraid to speak up about their experiences to the healthcare professionals. Their underlying reasons varied from fearing that the perpetrator would find out and harm them to the healthcare professionals telling other people about the women's experiences without permission. Being able to feel secure when reaching out to healthcare professionals was highlighted as important. The first impression played a significant role in the relationship between the victims and the healthcare professionals. Many of the women were unable to say exactly what made them feel secure; however, they described it as a feeling or hunch that the person they were talking to was there to help

It was as if I was telling my story to my mother or to someone [who] I trust very much; I never felt like I was being judged. She [the healthcare professional] always inspired confidence, even just by looking at me. I felt like she understood me and that this was a place where I could drain all my suffering. (Participant 4)

When the women's expectations were not met during their encounters, they felt frustration with and distrust towards all healthcare professionals. These feelings made them decide to never reach out for medical help in the future unless they had other physical problems. One woman felt that her story and her issues were not interesting enough for a nurse in whom she tried to confide because they were only psychological:

She looked at me, and you could see it in her eyes. She even sighed; you could see it in her eyes and in her body language. This nurse did not want to hear about my psychological problems; she wanted blood and surgery and all that. I was just a poor lady who let herself get beaten up by her

worthless husband. In that moment, I decided to only request medical help when I have real, physical problems. (Participant 6)

DISCUSSION

This study described how women in Mexico who have suffered from gender-based violence experience their encounters with healthcare professionals. The results revealed that women expressed feelings of *guilt about being abused, being unimportant, taking time and being insecure/secure* in their encounters with healthcare professionals.

The women in this study described situations in which healthcare professionals inflicted feelings of guilt that made them feel less important than other patients. Furthermore, the professionals ignored the women when they reached out for help. Victims of gender-based violence might feel guilty about their situations, and women in previous studies declared having these feelings increased by healthcare professionals (Beynon *et al.* 2012, Gutmanis *et al.* 2007, Peckover 2003, Pratt-Eriksson *et al.* 2014, Wendt & Enander 2013). Travelbee (1971) concurred with this result when she described how professionals tend to inflict feelings of guilt in their patients by blaming them for their own suffering or illness. This style of communication is an effective manner to block communication between healthcare professionals and patients (Meleis 2011). This type of relationship coincides with the descriptions of the women in this study because several of them described negative experiences in relation to being accused by healthcare professionals of causing their own suffering.

The women of this study concurred that their healthcare professionals lacked an interest in their problems, and several women claimed that they felt as though their problems were not interesting enough to be acknowledged. Wendt and Enander (2013) described how victims of gender-based

violence often experience feelings of being unimportant. These feelings are primarily due to the lack of inquiring about the violence or the signs of violence are ignored. Furthermore, victims of gender-based violence often feel that they are not taken seriously or shown the amount of respect that they feel they deserve, especially compared with other patient groups (Peckover 2003, Pratt-Eriksson *et al.* 2014, Wendt & Enander 2013).

Each woman in this study discussed the aspect of time. Time is subjective, and the exact amount of time a patient requires for her needs to be fulfilled cannot be determined (Jones 2001, McCormack & McCance 2011, Wiig *et al.* 2014). However, time is an important component in nursing, and healthcare can become more person-centred by improving time management. Most of the women in this study emphasised the importance of the healthcare professionals taking time out of their busy schedule for them and making them feel like their problems were worth hearing. The women described positive experiences when the healthcare professionals took the time to sit down and listen to them, if only for a few minutes, and did not show signs of stress.

The women described feelings of vulnerability and exposure when reaching out for medical help and that the healthcare professionals did not show them enough respect. This behaviour made the women lose their trust in the healthcare professionals and caused a reluctance to share their stories. Travelbee (1971) defined trust as the “assured belief that other individuals are capable of assisting in times of distress and will probably do so” (Travelbee, 1971, p. 80). Peckover (2013) also emphasised the importance for these victims to be able to confide in healthcare professionals and suggested that these women cannot actually be helped before they establish a positive relationship with the healthcare professionals. The women in this study expressed difficulty determining exactly what made them trust and feel secure with the healthcare professionals;

however, the majority agreed that the staff treating them with respect and showing a genuine interest in their stories played a role.

Not all individuals are able or willing to request help, which increases the responsibility of healthcare professionals to offer help in any possible way. If a woman has been denied help or feels as though she has been denied help, it is likely that she will lose trust in the healthcare professionals and conclude that there is no use in continuing to ask for help (Travelbee 1971).

The women in this study described similar experiences in terms of trust and help-seeking behaviour. Most of the women expected to receive questions about violence followed by conversations aiming to support and strengthen them. When healthcare professionals failed to meet their expectations, the women illustrated feelings of frustration with and distrust for the healthcare system.

Many of the encounters described by the women seemed to lack sufficient communication, making it nearly impossible to establish an adequate relationship between them and the healthcare professionals. They described situations where healthcare professional inflicted guilt towards being abused. Furthermore, women felt ignored and unimportant during these encounters, guilty for taking up time and insecure leading to feelings of distrust towards the healthcare staff. Travelbee accentuates the significance of the healthcare professionals with regard to possessing an accepting attitude towards the patients and aspiring to change the patient's situation by reducing her suffering (Meleis 2011, Travelbee 1971). According to Travelbee (1971), our interpretation is that the feelings described by the women in the present study are related to healthcare professionals' attitudes in the encounters and how they approach these women. One of the main issues is the lack of appropriate education in this area, which previous research confirmed by focusing on the healthcare professionals' views of treating

women who have suffered from violence (Beynon *et al.* 2012, Gutmanis *et al.* 2007, Taylor *et al.* 2013). Sundborg, Saleh-Stattn, Wandell, and Tornkvist (2012) also demonstrated that healthcare professionals (i.e., nurses) lack preparedness to care for women exposed to intimate partner violence. In their study, nurses were lacking organisational support such as guidelines, collaboration with others and knowledge regarding the extent of intimate partner violence. Furthermore, nurses had difficulties with knowing how to ask, and half of the participants in the study did not ask about violence, even when a woman was physically injured (Sundborg *et al.* 2012). This finding is in line with the results of the current study in which many women expected inquiries regarding violence but received no questions. Sundborg, Tornkvist, Saleh-Stattn, Wandell, and Hylander (2017) suggested that the factors that facilitate nurses asking questions of women exposed to violence are having strategies for asking, knowing how to deal with the answers, and having a supportive environment (Sundborg *et al.* 2017). When asking about gender-based violence, questions should be posed in an empathic, sensitive and non-judgemental way (McCormack *et al.* 2011, Mørk *et al.* 2014).

Screening tools might be one way to identify women who are exposed to violence. Taft and co-authors (Taft *et al.* 2013) have discussed whether screening is justified in healthcare settings. Screening increases the identification of women experiences of intimate partner violence, but more evidence is needed to show whether screening increases refereeing and women's engagement with supportive services, reduces violence or positively affects women's well-being (Taft *et al.* 2013). Interestingly, training healthcare professionals on how to speak to women exposed to violence, give them support and information, and plan for their safety seems to be more effective than using screening tools (Taft *et al.* 2013). However, when healthcare professionals feel confident in their strategies to speak to these women, to provide support or

refer them to specialist help, screening tools might be helpful. In addition, healthcare professionals need enough time and confidence to screen. Otherwise, different barriers remain for healthcare professionals regarding how to approach and to support women exposed to violence. Women will most likely not receive the care and support they need, when healthcare professionals are lacking training or strategies regarding when and how to use screening as well as how to approach and support these women (Burton & Carlyle 2015, Ramachandran *et al.* 2013, Taft *et al.* 2013, Williams *et al.* 2016).

Methodological considerations

The study involved two languages: Spanish and English. The study was written entirely in English, whereas the interviews were performed in Spanish by the third author who speaks the language fluently. The transcripts were translated into English. One weakness of this study might be that Spanish was not the native language of either author. This limitation, as well as the translations between English and Spanish, augment the risks of misunderstandings and misinterpretations. However, the third author (who speaks both languages fluently) performed all interviews and translations from Spanish into English. To further diminish the risk of linguistic errors, a proof-reader reviewed all interview questions before performing the interviews. Furthermore, the questions were discussed with a native expert to ensure their relevance in relationship to the study's aim, which further increased the dependability of the interview questions. The third author, an external and objective person who was not involved in the healthcare of the participating women, performed all of the interviews. More participants would have increased the study's transferability; however, qualitative studies that obtain purposeful samples are more likely to provide the type of in-depth information that is well suited to the aim of the study (Patton 2015). Because of these circumstances, seven participants were considered as

a sufficient number to obtain a satisfactory amount of information to meet the study's aim.

However, the findings must be considered in the context of the limitations of this study. On the other hand, our intention was to extend knowledge about issues of relevance and not to explain or present generalisable knowledge.

Relevance to clinical practice

Women who are victims of gender-based violence tend to perceive their encounters with healthcare professionals as negative, mainly because of their approaches and attitudes. This finding might be related to the uncertainty among healthcare professionals regarding how to approach women exposed to violence. Education concerning how to approach these women including when and how to ask about violence is likely essential; furthermore, this education might provide personal strategies for asking and knowing how to address the answers. This knowledge might lead to respectful encounters in which women are able to feel secure. Such positive experiences might increase their trust in healthcare, which in turn might provide women with the self-confidence and courage needed to seek medical or psychological help if they are exposed to physical or psychological violence in the future. The results of the current study demonstrate what women who have suffered from gender-based violence consider as important in encounters with healthcare professionals. These findings stress that relatively simple efforts such as listening to their stories and providing genuine attention might improve care substantially.

Conclusions

Women who have suffered from gender-based violence experience both negative and positive encounters with healthcare professionals. The positive experiences were primarily associated with healthcare professionals taking time out of their schedules to sit down with the women and

make them feel safe. Being listened to and feeling safe were considered as important aspects in a positive encounter. The negative experiences of the victims were primarily caused by the healthcare professionals' inflicting guilt related to the abuse. In addition, a lack of time or interest from the healthcare professionals led to negative experiences in the encounters (e.g., frustration and mistrust). These results indicate that healthcare professionals have deficiencies with regard to how these women are treated because the women did not feel that they received the proper support from these professionals.

Contributions

Study design: IWL, LE, FB, MW. Data collection: FB. Data analysis: IWL, LE, FB, MW.

Manuscript preparation: IWL, LE, FB, MW. Manuscript review: IWL, LE, FB, MW.

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Table 1. Categorization matrix: An overview of the systematic qualitative data-coding scheme for the abstraction process

Meaning unit	Condensed meaning unit	Code	Category
<i>Many times, they [the healthcare professionals] make you feel guilty [by] saying things out loud or sometimes it is even the way they look at you.... Once they even told me [that] it was my own fault [that] he beat me up; that in one way or another, I deserved it.</i>	It was my own fault, and I deserved it	Guilt	Feelings of guilt about being abused
<i>You tell a story that is so hard to tell, it is so difficult and ugly, and they [the healthcare professionals] do not even respect you enough to give you their undivided attention. They answer the telephone or keep looking at their watch; you can see it in their eyes that they are thinking about something else.</i>	They do not give you their undivided attention	Lack of interest	Feelings of being unimportant
<i>You often feel stressed when talking during a medical appointment because the staff keeps looking at their watches, and you know they have many patients waiting....</i>	Feeling stressed while talking during a medical appointment	Lack of time	Feelings of taking time
<i>It was as if I was telling my story to my mother or to someone [who] I trust very much; I never felt like I was being judged. She [the healthcare professional] always inspired confidence, even just by looking at me. I felt like she understood me and that this was a place where I could drain all my suffering.</i>	Feel trust and never judged.	Secure	Feelings of being insecure or secure