

ORIGINAL ARTICLES

Abused Women Disclose Partner Interference with Health Care: An Unrecognized Form of Battering

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BACKGROUND: Some providers observe that partners interfere with health care visits or treatment. There are no systematic investigations of the prevalence of or circumstances surrounding partner interference with health care and intimate partner violence (IPV).

OBJECTIVE: To determine whether abused women report partner interference with their health care and to describe the co-occurring risk factors and health impact of such interference.

DESIGN: A written survey of women attending health care clinics across 5 different medical departments (e.g., emergency, primary care, obstetrics-gynecology, pediatrics, addiction recovery) housed in 8 hospital and clinic sites in Metropolitan Boston.

PARTICIPANTS: Women outpatients ($N=2,027$) ranging in age, 59% White, 38% married, 22.6% born outside the U.S.

MEASUREMENT: Questions from the Severity of Violence and Abuse Assessment Scale, the SF-36, and questions about demographics.

RESULTS: One in 20 women outpatients (4.6%) reported that their partners prevented them from seeking or interfered with health care. Among women with past-year physical abuse ($n=276$), 17% reported that a partner interfered with their health care in contrast to 2% of women without abuse (adjusted odds ratios [OR]=7.5). Further adjusted risk markers for partner interference included having less than a high school education (OR=3.2), being born outside the U.S. (OR=2.0), and visiting the clinic with a man attending (OR=1.9). Partner interference raised the odds of women having poor health (OR=1.8).

CONCLUSIONS: Partner interference with health care is a significant problem for women who are in abusive relationships and poses an obstacle to health care. Health care providers should be alert to signs of patient noncompliance or missed appointments as stemming from abusive partner control tactics.

KEY WORDS: intimate partner violence; partner interference with health care; abused women; domestic violence; women's health.

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As many as 30% of American women face the threat of intimate partner violence (IPV) during their lifetime.¹ Prevalence rates are even higher within patient populations and highest in emergency departments where 11-19% of women report IPV within the past year and between 22-54% report lifetime exposure.²⁻⁵ Most research on IPV within patient populations focuses on physical and sexual assault. Yet the American Medical Association advances a wider definition, spanning "a pattern of coercive behaviors that may include repeated battering and injury, psychological abuse, sexual assault, progressive social isolation, deprivation, and intimidation".⁶ IPV, therefore, encompasses nonphysical behaviors that restrict women's freedom, although the nuances of IPV are only occasionally measured or examined in patient populations. The diverse scope of such abuse, particularly as it may affect women's autonomy to seek health care, is critical to recognize because of its potentially profound impact on women's health. Abused women tend to have more health problems than non-abused women and frequently present to medical settings with both acute and chronic health sequelae, such as injuries, gastrointestinal problems, pain, and arthritis.^{1,7,8}

It is uncertain whether abusive partners obstruct women's health care. They do hinder their partners in other domains such as work and education. Women experiencing recent IPV work fewer hours, at lower wages, and have unstable work patterns (defined as more time unemployed).⁹⁻¹¹ In 1 qualitative study, over 90% of battered women interviewed had resigned or been terminated from a job in the last 2 years

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because of domestic violence.¹² Women reported that their partners used several tactics to prevent them from going to work, including physically restraining them or not making a shared car available. Abusive men could apply similar forms of intimidation to prevent women from going to a doctor's appointment.

The dynamics of IPV might intrude upon a woman's relationship with her doctor, ultimately affecting her health care, although research in this area is limited. Researchers investigating the determinants of delayed entry into prenatal care found that pregnant women who reported 12-month IPV were almost twice as likely to enter prenatal care late after the first trimester.¹³ Other researchers found that, on average, women who were abused entered prenatal care 6.5 weeks later than non-abused women.¹⁴ The reasons for delay in prenatal care remain to be fully explored, but the obvious possibility is that the partners isolated the women from institutional contacts including clinics. Such an insidious pattern could extend to other types of health care, although there may be unique dynamics specifically surrounding men's control of women's reproductive health and pregnancy. In any event, abused women might appear to clinicians as noncompliant with missed appointments and interrupted care.

Our study is the first to examine in a large sample of outpatients whether abused women report that their partners directly infringing on their health care across different medical settings. More than 2,000 women in various medical settings were surveyed about exposure to IPV and their partners' interference with health care. If abused women are blocked from accessing treatment, their health conditions are likely to worsen, and we test this hypothesis by examining the role of violence, partner interference, and health status derived from a single question about overall well-being.

METHODS

Sampling Procedure

Data were collected with Institutional Review Board consent from a convenience sample of 7 metropolitan area hospitals (4 community hospitals and 3 tertiary care hospitals) and 1 freestanding gynecology clinic in the Boston Metropolitan area. We surveyed at randomly distributed time points in the following departments: emergency ($n=4$), obstetrics-gynecology ($n=5$), primary care ($n=2$), pediatrics ($n=2$), and addiction recovery ($n=1$).

Trained research assistants surveyed women patients across sites, and data collection in any 1 department averaged 7.6 months ($SD=4.7$). At least 2 research assistants distributed surveys and collected observational recordings in each department. Research assistants observed and coded features of the women such as whether they were seated with a companion and the sex of the companion; the surveys were prenumbered to match the coding sheets and distributed to women who self-identified as patients in the waiting rooms of each department. Research assistants noted at the time of the survey whether a woman was accompanied by another person in the waiting room, particularly a man. All women were approached in the same manner, regardless of their companions. However, it was left to the discretion of the research assistant to not approach an individual woman if it seemed

that to do so would be problematic (either for safety reasons or because of severe illness).

Surveyors explained to each woman that the questionnaire was: (1) about stress and health; (2) anonymous unless they volunteered for further follow-up; (3) confidential and information would not be shared with their health care providers. Although no verbal mention was made that the survey was about IPV, a cover sheet further explained that the survey contained questions about IPV. Completed surveys were placed in a locked box located in the waiting room. Surveying occurred during predesignated blocks of time lasting an average of 3 hours, spanning mornings through night hours, each day of the workweek, and some weekends. All periods of the day were covered while clinics were open, and the blocks of time were randomly distributed over the course of several months for each site. Data collection was completed by the end of 2002.

Patient Survey

Women received a 3-page survey that included questions about demographics, IPV, health and well-being, and social support. The survey was offered in several languages including English, Spanish, Chinese, and Russian, although 97% were completed in English, and women wrote their responses.

Women were coded as having experienced IPV in the past year if they endorsed at least 1 of 10 items assessing experiences with IPV within the previous 12 months (Appendix). These items included 6 questions from the Severity of Violence Against Women Scale (SVAWS),¹⁵ 2 questions from the Abuse Assessment Scale,¹⁶ and 2 questions from another screening instrument validated in emergency departments.² The last 4 questions were also used to determine past experiences with IPV. The 6 items chosen from the Severity of Violence Against Women Scale represented 3 different types of abuse that women may face—threats, physical assault, and sexual assault. The 4 other items used to assess patients' experiences with IPV came from 2 scales that each have been used in studies conducted in medical settings. The alpha coefficient for these 10 items was high (0.85) indicating internal consistency.

Participants were asked 2 questions about partner interference with health care *during the past year*: (1) "How many times has a partner prevented you from going to a clinic or seeing a doctor or nurse when you wanted to?" and (2) "How often has a partner tried to interfere with your health care?" These items were developed for this study because no validated measure of partner interference with health care currently exists. A dichotomous variable of partner interference was created with patients classified as having an interfering partner if they answered either question with a value greater than 0. There was high concordance on the 2 partner interference questions with 70% of women whose partners prevented them from going to a clinic also stating that their partners interfered with their health care on at least 1 occasion in the past year.

Self-rated health status was assessed with 1 question: "In general, would you say your health is: excellent; very good; good; fair; poor?" This item from the SF-36 has been used in multiple studies, including in at least 2 studies looking at the impact of IPV on health.^{17,18} As has been done previously, this item was dichotomized into "fair/poor" versus "excellent/very good/good."

The survey also included questions about household annual income, unemployment, education, race/ethnicity, country of birth origin, age, marital and relationship status, and pregnancy.

Data Analyses

Analyses were conducted for 2,027 women with complete survey information on partner interference with health care and information on the woman’s companions at the time of survey. Data were missing for several variables such as income (14%) and employment (6%); most of the other variables had missing data points for less than 2% of the subjects. Cases with missing data were excluded in the multiple regression models.

Associations between partner interference and the demographic characteristics, IPV, and presence of a man at survey were tested using Pearson’s χ^2 tests. To examine the first objective, adjusted odds ratios (OR) and 95% confidence intervals (95% CI) were estimated using logistic regression analysis to examine the relationship between each independent variable, including IPV, and partner interference. Logistic regression analysis was also used to examine the second objective of the relationship between partner interference and the outcome of poor health, controlling for IPV and demographic characteristics. Thirty-one women had missing data on self-reported health and were also excluded from this model.

Nonsignificant variables that were not confounders were removed from the model because of limited statistical power in both multiple logistic regression models. Confounding was established if the addition of a variable to the model changed in the coefficient of the main exposures of interest (i.e., IPV, partner interference) by more than 10%.¹⁹

RESULTS

Of the 4,857 eligible women patients who were present at the 14 survey sites, 87.4% (n=4,245 women) were approached. Of those who were approached, 62.4% agreed to complete the survey. Within each department, there were no statistical differences in acceptance rates between those women who were with a man and those who were not. Detailed information about the acceptance rates is presented elsewhere.⁵

Overall Sociodemographic Characteristics

Over half (59%) of the respondents were White and 77% were born in the United States. Women’s ages ranged widely from 18 to over 60 years (mean=34.1 years, SD=12.9). Approximately one-third of the participants reported incomes less than \$20,000 and another one-third reported incomes more than \$50,000. Over 40% of the sample had some college or graduate education. Only 13% had no partner within the past 12 months and 38% were married.

Partner Interference with Health Care

Approximately 2% of the sample reported that a partner had prevented them from going to a doctor and almost 4% of women reported that a partner had interfered with their health care. Overall, nearly 5% of all women surveyed disclosed some form of partner interference with health care (Table 1).

Table 1. Prevalence of Partners Interfering with Health Care

	Percent (number)
Number of times partner prevented from going to doctor	
None	97.6 (1,958)
1–3	1.5 (30)
4–6	0.4 (8)
6 or more	0.6 (11)
Any	2.4 (49)
How often partner interfered with health care	
Never	96.1 (1,919)
Once or twice	2.5 (50)
A few times	0.8 (16)
Very often	0.6 (11)
Any	3.9 (77)
Partner interference with health care	
None	95.4 (1,933)
Any	4.6 (94)

Characteristics of Women Whose Partners Interfered

Table 2 shows the demographic characteristics of women with and without an interfering partner. Women with interfering partners differed from the other participants on most demographic features based on bivariate χ^2 tests, except for age and marital status. Almost 60% of women with interfering partners reported incomes less than \$20,000 compared with 30.3% of women with no partner interference. Women with less than a high school education were overrepresented among those with interfering partners (19.6% vs 6.7%). Partner interference with health care was highest among Latina women (23.4%). Women with interfering partners were also less likely to be born in the United States (65.2% vs 77.9%) and were more likely to be unemployed (51.7% vs 33.9%). Partner interference was much higher if the woman was pregnant (20.7% vs 11.5%) or uncertain about being pregnant (6.5% vs 3.5%). Women reporting an interfering partner were also more likely to be with a man when they completed the survey in the waiting room (25.0% vs 15.3%).

The Relationship of IPV to Partner Interference

Nearly 14% of the women patients disclosed recent IPV and 37% confirmed *ever* being in a violent relationship. Detailed information about the nature and correlates of the women’s experience with partner violence is presented elsewhere.⁵ Over half of women with an interfering partner were abused during the past year (54.4%) and 75% had experienced IPV at some point during their lifetime, including in the past year (see Table 2). Overall, 17% of women with 12-month IPV also disclosed that their partner interfered with their health care, in contrast to about 2% of women without recent abuse (Table 3).

Table 3 displays a multiple logistic model designed to examine whether women patients currently experiencing IPV and those who were accompanied by a man in the waiting room at the time of the survey were more likely to report partner interference with health care, controlling for other influences such as women’s educational background, race, and immigration history. Even with these controls, experiencing IPV in the past year was highly related to their interfering behavior (OR=7.5, 95% CI=4.7–11.9). Women who were with a

Table 2. Demographics of the Sample by Partner Interference

	Overall	Partner interference with health care		χ^2	P value
		No	Yes		
Violence history					
IPV (past year)	13.7 (276)	11.8	54.4	134.9	<.0001
IPV (lifetime)	37.5 (755)	35.7	75.0	58.0	<.0001
Income					
<*\$20,000	31.5 (550)	30.3	59.5	28.3	<.0001
\$20,000– \$50,000	35.0 (612)	35.6	23.0		
>*\$50,000	33.5 (585)	34.2	17.6		
Unemployed	34.7 (659)	33.9	51.7		.0006
Education					
Less than high school	7.3 (147)	6.7	19.6	27.8	<.0001
High school education	50.9 (1,025)	50.7	56.5		
College/post grad	41.8 (840)	42.6	23.9		
Race/ethnicity					
White	59.0 (1,182)	60.0	39.4	29.1	<.0001
Black	21.0 (421)	20.9	23.4		
Hispanic	11.0 (220)	10.4	23.4		
Asian	3.7 (75)	3.8	2.1		
Other	5.2 (105)	4.9	11.7		
U.S. born	77.4 (1,561)	77.9	65.2	8.1	.0044
Age (years)					
18–23	23.6 (468)	23.4	28.7	4.4	.6284
24–29	22.7 (450)	22.7	23.0		
30–34	13.0 (257)	12.9	13.8		
35–39	12.4 (245)	12.5	10.3		
40–49	14.8 (293)	14.9	12.6		
50–59	8.8 (175)	8.8	10.3		
60+	4.7 (94)	4.9	1.2		
Marital status					
No current partner	12.4 (247)	12.6	9.9	6.5	.0916
Dating partner	27.3 (542)	27.5	23.1		
Cohabiting partner	22.2 (442)	21.7	33.0		
Married	38.1 (757)	38.3	34.1		
Pregnancy status					
Not pregnant	84.5 (1,689)	85.3	72.8	10.7	.0047
Pregnant	11.9 (237)	11.5	20.7		
Unsure if pregnant	3.4 (67)	3.2	6.5		
With a man at survey	15.7 (317)	15.3	25.0	6.2	.0124

man in the waiting room were also more likely to report partner interference with health care (OR=1.9, 95% CI=1.2–3.3).

The Impact of Partner Interference on Women's Health

Table 4 displays the model investigating whether partner interference relates to the women's health status. Recent IPV (OR=2.1, 95% CI=1.4–3.1) and whether the woman was with a man at survey (OR=1.7, 95% CI=1.2–2.5) were associated with poorer health. Controlling for violence and whether the woman was with a man at survey, women with interfering partners were significantly more likely to report having poor health status (OR=1.8, 95% CI=1.0–3.2).

DISCUSSION

Overall, partner interference in a patient population is a fairly rare event (~5%) and may be unlikely to surface notably in small samples of the general population. However, the results reported here demonstrate that nearly 1 in 5 women reporting IPV during the preceding year had partners who interfered with their health care, and conversely, over half of women with an interfering partner were abused in the preceding year. Such a finding illustrates how partner violence may affect health care access and patient compliance.

This study does not directly assess the reasons for the observed obstruction. Abusers may obstruct access to health care because they fear detection of the violence. In these cases, the interfering partner could also be more likely to accompany a woman to doctors' appointments to extend their control. Physicians may then be unable to ask about IPV and refer a patient appropriately for services that could help her.

This finding of partner interference with health care is consistent with forms of control and intrusion in other domains such as employment and education, and deserves additional attention. Women reporting interfering partners were more likely to be in poorer health than those who did not. Doctors and nurses who are aware of this problem might be able to address better the needs of their patients who are experiencing partner interference with health care. Indeed, if they note recurrent missed appointments even when following-up with serious disease conditions or injuries, IPV and partner interference should be considered; certainly if women patients have disclosed abuse, questions about partner interference with health care should be posed. In the most recent review of qualitative research on patient disclosure of abuse in health care settings, the authors conclude that women patients, especially in chronic abusive relationships, welcome inquiry from health care providers, especially if providers appear sensitive to the "complexity of partner violence".²⁰

Table 3. Adjusted Logistic Regression Analysis of Potential Risk Markers of having a Partner who Interferes with Health Care (N=1,961)

Characteristic	% with interfering partner	Adjusted OR	95% CI
IPV (past year)			
No	2.4	Ref	–
Yes	17.0	7.5	4.7–11.9
With a man at survey			
No	3.8	Ref	–
Yes	7.6	1.9	1.2–3.3
Education (%)			
Less than high school	12.1	3.2	1.5–6.9
High school education	5.0	1.5	0.8–2.7
College/postgrad	2.3	Ref	–
Race/ethnicity (%)			
White	2.8	Ref	–
Black	4.6	1.0	0.5–1.9
Hispanic	10.4	1.9	1.0–3.6
Asian	2.8	0.7	0.2–3.3
Other	9.7	2.4	1.1–5.6
Immigrant status			
Immigrant	6.9	2.0	1.2–3.4
U.S. born	3.7	Ref	–

OR=odds ratio, CI=confidence interval

Table 4. Adjusted Logistic Regression Analysis of Potential Risk Markers for Fair or Poor General Health Rating (N=1,837)

Characteristic	% with poor health	Adjusted OR	95% CI
Partner interference			
No	13.6	Ref	–
Yes	30.7	1.8	1.0–3.2
IPV (past year)			
No	13.0	Ref	–
Yes	23.1	2.1	1.4–3.1
With a man at survey			
No	13.2	Ref	–
Yes	20.3	1.7	1.2–2.5
Income (%)			
<*\$20,000	20.8	1.4	0.9–2.0
\$20,000–\$50,000	12.3	1.0	0.7–1.5
>*\$50,000	8.3	Ref	–
Education (%)			
Less than high school	35.4	5.0	2.9–8.5
High school education	16.5	1.9	1.3–2.6
College/post grad	8.3	Ref	–
Age (years)			
18–23	10.4	Ref	–
24–29	9.6	1.1	0.7–1.8
30–34	9.8	1.3	0.7–2.3
35–39	14.2	2.3	1.3–3.9
40–49	19.4	2.7	1.7–4.5
50–59	24.7	4.6	2.6–8.1
60+	35.6	7.0	3.7–13.2
Race/ethnicity (%)			
White	11.8	Ref	–
Black	17.5	1.4	0.9–2.0
Hispanic	21.5	1.4	0.9–2.3
Asian	8.8	0.8	0.3–2.0
Other	19.4	1.6	0.9–3.0
Pregnancy (%)			
Not pregnant	15.8	Ref	–
Pregnant	5.7	0.3	0.2–0.6
Unsure	9.4	0.5	0.2–1.1
Marital status			
No current partner	26.2	2.1	1.3–3.2
Dating partner	10.5	1.1	0.7–1.7
Cohabiting partner	15.6	1.5	0.9–2.2
Married	12.9	Ref	–
Immigrant status			
U.S. born	13.4	Ref	–
Immigrant	17.7	1.5	1.1–2.2

OR=odds ratio, CI=confidence interval

IPV has been shown to cost approximately \$8 billion in the United States each year.²¹ This estimate only reflects the costs and lost productivity associated with injury and premature death. The economic impact would be even greater if partner interference with health care led to poorer health outcomes generally because of delayed entry into care or lack of appropriate follow-up that could lead to more severe disease. Indeed, just such a narrative might apply to abused women's long-term health outcomes. Researchers in Seattle, for instance, have recently illuminated the long-term, broad impact that violence has on women's health in various domains and the staggering costs to the health care system.²²

Limitations

The current study is the first that we are aware of that surveys women about partner interference with their health care. Certain limitations are inherent in the design of this study.

First, it was cross-sectional, so we were unable to establish the direction of the relationship between partner interference and poorer health: it may be, as we hypothesized, that partner interference results in medical neglect that in turn exacerbates poor health conditions, but it could also be that the women who are in poor health may require more contact with a physician. Therefore, there are more opportunities for a partner to obstruct efforts to seek care.

Interpreting the low prevalence of partner interference in this study must be tempered by the fact that only women who had actually arrived at a health care site were surveyed. We would predict that abused women surveyed in nonmedical settings would almost certainly report higher rates of partner interference with health care because all of the women in this study were able to access health care despite partner interference. Although these women successfully accessed health care, it is possible that the regularity of their care and their adherence to treatment may also be hampered by their partner's abuse. It is therefore critical to realize that although this study examined partner interference only among women who successfully obtained care, physicians must be aware of barriers their patients may face to obtain indicated follow-up care and treatment.

It is also important to note that the survey was issued in waiting areas rather than private settings within the clinics. This may have limited women's disclosure of IPV. To reduce this bias, the survey was written instead of orally administered and it was anonymous. One specific bias might occur when abused women filled out the survey with their partner sitting next to them. We did not find lower rates of reported IPV when we compared women who were accompanied in the waiting room by a man compared to women who were unaccompanied.⁵

CONCLUSION

This study addresses the issue of partner interference with health care. A topic that has not yet been explored in the literature of IPV and health. Partner interference with health care appears to be a fairly common spoke in the cycle of relationship violence. Women's autonomy and self-care is undermined by such interference. Physicians should be aware of IPV not only as a possible source of women's health problems, but also as a mechanism in the patient profile of interrupted care or apparent noncompliance with fidelity to treatment and follow-up visits. At the organizational level, clinic managers could promote the policy that all patients be seen alone at some point during each health care visit, given that men are accompanying abused women to medical appointments at a high rate and that such accompaniment relates to women's disclosure of partner interference.

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Conflicts of Interest: None disclosed.

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APPENDIX

1. In the last 12 months, has a partner:
 - A. Threatened to hurt you?
 - B. Pushed or shoved you?
 - C. Slapped you around your face and head?
 - D. Punched you?
 - E. Threatened you with a gun?
 - F. Physically forced you to have sex?
2. At any time in your life has any partner:
 - G. Hit, slapped, kicked or otherwise physically hurt you?
 - H. Forced you to have sexual activities?
 - I. Made you feel stressed or afraid through threats or violent behavior?
 - J. Made you fear for your safety during arguments?

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