“I was always on guard”—an exploration of woman abuse in a group of women with musculoskeletal pain

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Hamberg K, Johansson EE and Lindgren G. “I was always on guard”—an exploration of woman abuse in a group of women with musculoskeletal pain. *Family Practice* 1999; 16: 238–244.

**Objectives.** We aimed to explore experiences of abuse of women, and the way it was described and hinted at, in a group of women suffering from biomedically undefined long-term musculoskeletal pain (UMSD).

**Method.** Twenty women patients participated. Data were gained through repeated semi-structured interviews conducted over 2 years and qualitatively analysed according to grounded theory.

**Results.** Eleven participants had experienced abuse. Abuse was difficult to disclose due to shame, fear of the listener's preconceptions and fear of the abuser. In the interviews it was diminished, 'sugar-coated' and renamed. However, the women gave hints of abuse before avowing it. ‘An understanding listener’, who was expected to apprehend the hints, ask about abuse and confirm that it was valid to talk about it, was described as a precondition for disclosure.

**Conclusion.** This study suggests that it is important to explore woman abuse when investigating and treating UMSD. When there are hints of abuse, one should avoid blaming, stand by, be patient and ask about abuse even if the woman has once negated it. Fear of the abuser permeated the narratives and it is therefore suggested that doctors must consider carefully the danger involved.

**Keywords.** Consultation, musculoskeletal pain, undefined disorders, woman abuse, women’s health.

Introduction

Throughout the world, the abuse of women is a significant public health problem, cutting across all ethnic, racial and socio-economic distinctions. Research has shown that abused women are heavy consumers of somatic as well as psychiatric health care. Physical trauma in the form of severe or small injuries are the visible results of abuse, but several other negative effects on health have been reported. Headache, chronic pain, pelvic pain, gynaecological problems, pregnancy complications, anxiety, depression, suicide, back and limb problems, frequent colds, dizziness, and gastrointestinal, lung, skin, heart and blood-pressure problems are all shown to be common among abused women. Most research on medical aspects of woman abuse is conducted at emergency and psychiatry departments, but, obviously, health effects following abuse concern the whole medical field.

Abused women often come to the family physician with vague symptoms and complaints. These women are reluctant to acknowledge spontaneously the violence and threats to which they have been subjected, and the abuse is rarely recognized. This calls attention to how woman abuse is presented in primary care, in order to improve the identification and treatment of the affected women.

In a research project conducted in primary care we interviewed women patients suffering from biomedically undefined musculoskeletal pain disorders (UMSD). Such patients are often perceived as problematic by their doctors, and our aim was to acquire a deeper understanding of the patients’ daily lives and their experiences with health care. As part of this larger project, this...
paper focuses on abuse suffered by the participants. We explored the women's experiences of abuse, the way abuse of women was described and hinted at, and the preconditions for disclosure. In this paper 'woman abuse' is defined as physical and sexual violence and threats from an intimate partner or other male.

Method

Setting and participants
The study took place at an urban health centre in northern Sweden. Women patients seeking consultation for UMSD, i.e. the cause of pain had been carefully investigated but no biomedical diagnosis had been found that could explain the symptoms, were eligible for recruitment. Twenty-two of the women were asked to participate, strategically selected to include women of different ages and duration of symptoms. Twenty agreed to participate. Two of the researchers (KH and EJ) were also the women's family doctors.

The participants were all born in Sweden and between 21 and 61 years of age. They each had a job, mainly physically demanding, low-paid work. All had experiences of marriage or cohabitation, and 12 were living with a man at the beginning of the study. Thirteen had gone through divorce, two more divorced during the study and five, living alone when the study started, entered new marital relationships. All except one had children. Most of the patients were frequent attenders of medical care. Two were acknowledged as abused by their family physician when recruited.

Data collection and analysis
The participants were followed up over a 2-year period by way of repeated semi-structured interviews, conducted by one of the researchers (KH or EJ). The women were interviewed when included, after 6–8 months and at the end of the study. The first interviews were conducted at the health centre, the later ones at the health centre or in the participant's home. One woman was interviewed only twice, due to practical circumstances. One woman withdrew after the first interview.

In the interviews, the women were encouraged to describe their experiences in their own words. The only guideline was to cover broad topics and use open questions concerning family life, paid work, health and experiences in health care (for a full list of themes see Appendix 1). The researchers tried to ease the narrative flow with probing questions like “Can you tell me more?” or “Would you give an example of that?”

Each interview lasted 1–2 hours and was audiotaped and transcribed. Before the second interview, the woman read ‘her’ first interview in order to make comments and correct misunderstandings. At the same time it was possible for the researcher to discuss themes that needed further elaboration. When the third interview was conducted, the preliminary analysis of the texts was presented to the woman for her reactions and comments.

The data analysis was based on grounded theory by “repeated comparisons to find similarities and differences”. The researchers first examined and coded the transcripts independently. The codes were then compared, scrutinized and categorized by the researchers together. The analysis of the transcripts was conducted parallel to the interview process, in order to collect and interpret data, and to identify emerging themes important for further analysis. One of these themes was the patient’s experiences of abuse and the way those experiences were communicated in the interviews.

For the purpose of this paper, interview segments concerning abuse and marital interaction were systematically compared and explored. Questions were posed to the data, such as ‘Why is she afraid? Why does she tell us her story in this way? Is there another participant who has had similar experiences and what does she tell us? Is there a participant who has contradictory experiences?’ Tentative findings and concepts were tested and recontextualized by way of reading through the entire interviews again. The analysis was completed as different drafts were discussed by all the authors.

Findings

(i) Experiences of violence
Our main impression was that violence was a delicate matter to discuss, despite our efforts to create a close and intimate interview situation. The women hesitated to speak about abuse and showed by sighing and pausing that it was hard for them. Still, as many as 11 of the 20 participants described different experiences of violence and/or threats (Table 1).

Ten had been abused by a former and/or present intimate partner. They described various kinds of physical violence, threats, fear and being constantly on guard. They underlined that threats were just as hard to survive as the physical violence.

“In the end, I was afraid all of the time and then I had to accept it all the time because it was always my fault, of course … You never got to say anything. Wasn’t allowed to have my own opinions, because he saw them as insults … I wasn’t allowed to vacuum, but the house had better be clean … You never knew what you were supposed to do. Sometimes, he would kick me out of the bed in the middle of the night. Once he jumped on me and grabbed me by the hair and pulled and banged my head against the floor and spit on me” (No. 2).

Eight women had experienced abuse in their present situation. Four had experienced violence in their childhood, against themselves and/or as witnesses to abuse.
towards their mothers: “I was ten years old... He lay my mother up on the kitchen table and was strangling her” (No. 6). Four had experienced violence towards their children, and this was an ultimate reason why they left their partner. Two had been abused outside the family. They were raped: “When I was thirteen years old I was raped by six men and was hospitalised for a month... I'm still afraid of them” (No. 4). Nos 12–20 negated any personal experiences of abuse.

(ii) Violence and pain
Eight women described abuse as one root of their pain and ill health. One had chronic sinusitis and facial pain which she described as a consequence of a severe battering. More common was that tensions and anxiety due to fear and threats were given causality:

“When I feel sick mentally I get all tensed up and when I am tense my back hurts... The reason that I don’t feel well nowadays has nothing to do with my daily life but it’s things that remind me of things that happened then... And so, if you could only... just erase them, everything but the last two years, then you’d have a pretty ideal life” (No. 3).

Years after having left the abuser some still referred to the violence as a cause of their present health problems:

(1) Difficulties in telling
Some participants had told a friend, social worker or health care professional. However, all underlined that it was on the whole hard to tell: “Twenty years, and I haven’t even told my parents” (No. 1). Some denied abuse at the beginning of the study: “No, never any fights” (No. 7), but acknowledged it in later interviews: “I was harassed all the time. When he hit the boy, I moved out” (No. 7). Contradictory narratives challenged us to explore the difficulties of and the conditions for disclosing the violence.

Shame. Abuse was closely allied to feelings of shame:

Even today, I can’t understand how I could accept being

TABLE 1 Experiences of abuse among the participants

<table>
<thead>
<tr>
<th>Participant</th>
<th>Age (years)</th>
<th>Experiences of abuse</th>
<th>Abused in an intimate relationship</th>
<th>Ongoing abuse</th>
<th>Her children abused</th>
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(x)* She is still adjusting her life to avoid contact with a former abuser, considering it in everyday life.

*Rape.
hit and humiliated like that” (No. 6). The women feared that they would tarnish their reputations: “Well, that there should be something wrong (in the family) and that things aren't as fine and dandy as they look, you know?” (No. 1). For a couple of women, the shame of having been abused was connected to guilt-feelings about over-consumption of alcohol and tranquilizers. To talk about the abuse was to also acknowledge the drug addiction.

Fear of the listener's preconceptions. Seeking help for chronic and recurrent problems, still undefined after several examinations, made the participants afraid that they would be labelled as “neurotics” or “malingeringers” if something problematic in their private life was detected.

“I don’t think you say straight out that you need help. You want it to be something physical” (No. 2).

Several participants were afraid that the doctor would consider them as suffering from a psychiatric illness, as the abuser had often defined them as a ‘psycho’:

“. . . he says that I’m so complicated, that I’m sick in the head and must be mentally ill . . . it went so far that I started believing that I was” (No. 8).

One woman had been married to an immigrant, and had experienced prejudices against foreigners for many years. She opposed the doctor’s attitude:

“Yes, but I flatly denied it . . . The doctor said ‘well, you know that they can become sort of serious and hit their wives and lock them in the cupboard and things like that. No, mine isn’t like that, I said . . .’” (No. 1).

Her efforts of protecting her husband against prejudice were intertwined with her shame about being abused.

Fear of the abuser. Fear of the abuser was pertinent. A couple of women had changed the locks on their doors to feel safer; one changed identity; another said she used to sit in the darkness and seldom answered the phone—avoiding the abuser. A couple of women did not want us to send the transcribed interview by post and some refused to allow us to come to their homes. One of them later disclosed being abused.

Betraying the abuser, risking revenge, was a common reason for not revealing abuse: “Well, he might come here and he might kill me, because he’s dangerous when he’s been drinking” (No. 5).

The abuse diminished and ‘sugar-coated’. The shame, fear for the doctor’s preconceptions and the abuser’s revenge influenced the way the women talked about violence. It was diminished, ‘sugar-coated’ and renamed.

Describing the abuse as a mere episode was a way of diminishing it. Although living under threats and fear for many years, these women did not describe it as a pattern or a continuous pressure: “Actually, he only hit me twice . . .” (No. 2).

Excusing the abuser was reducing the cruelty of the abuse. Some described extenuating circumstances: “I mean, I understand him . . . He has not gotten any help from the unemployment agency or anything . . .” (No. 10). Others expressed feeling sorry for him: “I know that he has had a tough childhood, so mostly I feel sorry for him” (No. 2). Very common was saying he was actually nice: “Yes, he has hit me a lot, many times. But he’s so terribly nice when he’s sober . . .” (No. 5).

Renaming the abuse, or being uncertain if their experiences really could be considered abuse, made it difficult for the listener to grasp and identify what was going on.

Jill: “. . . For him to leave me alone he forced me to have sex with him. You know, so that I could go to bed and sleep in peace.”

Dr: “So it was more or less under the threat of violence?”

Jill: “So that he would leave me alone. And so that I would have the energy to cope. Because I was tired, I . . . he didn’t leave me alone, he was very demanding . . . sigh” (No. 3).

Jill did not classify the forced intercourse as abuse.

Hints of violence. The women who denied abuse at the beginning and later admitted it gave us the opportunity to explore an important question: had they hinted at abuse while they were denying it? The answer was ‘yes’, but the hints were made in a variety of manners.

Participants providing inconsistent narratives, scanty and short answers, avoiding our eyes or showing signs of discomfort when questioned about abuse left us with feelings that they in fact might be abused. In several cases our presentiments were later confirmed.

Expressions such as “He is aggressive” or “I dare not . . .” were easy to identify as hints of abuse, and it was necessary to follow up with questions like, “In what way is he aggressive?” and “Why don’t you dare?” ‘Jealousy’ was described as a reason for the woman to be careful and to adjust herself to her partner’s demands, and saying “He is jealous” was identified as a hint of abuse.

Depicting the partner’s drinking habits as a problem, using expressions like “he drinks too much”, was also a cue. Still, it is important to emphasize that six women described violence that had no connection with the use of alcohol.

Vague expressions when answering questions about abuse were also hints:

Dr: “Did he never threaten you?”

Lena: “No, I don’t think so. He’s so big, too, you know, so that you watch what you say around him, because
he gets angry. Because you never know, you can’t bug a person until they explode, can you . . .” (No. 9).

“I don’t think” indicates that it was a ‘matter of opinion’ whether her experiences were to be defined as threats or not. The ambiguous negation is followed by her establishing the fact that her partner was “so big” and that was a reason for her to be careful. Later on this woman disclosed having been severely abused for several years by her husband.

Most of the identified difficulties implied that it was especially hard to admit being abused while still living with the abuser.

(iv) Preconditions for disclosure

An understanding listener was a crucial precondition for being able to speak about abuse, according to most of the women studied:

“You have to have a doctor who understands. Who understands that the cause might be something else. And I didn’t have one then. She didn’t bother to check, like, where the pains could have come from. She was just satisfied with the explanation that I got pain when I used a typewriter” (No. 6).

This way of describing the conditions for telling was common and an important finding in our analysis: abuse was not mentioned and spoken about openly, but rather treated as a ‘given’ that the interviewer should grasp if he or she had the requisite tacit knowledge. Thus a good listener was expected to ask about violence, apprehend the hints and confirm that abuse was valid to talk about. Furthermore, an understanding doctor was supposed to avoid aggravating the conditions that made disclosure so difficult. This implied not blaming or questioning her, in order not to increase her guilt; to be impartial and careful not to neglect her somatic symptoms; and at the same time tend to her psycho-social needs and fears. What kind of protection did she need if she was still living with or threatened by the abuser?

Women identifying violence as illegitimate had less difficulty in disclosing it. One woman described being threatened by her husband on a couple of occasions. When identifying his violent behaviour as a threat, and declaring that she did not accept it, she found a way to handle and change the situation. She was proud of herself, had asserted her self-esteem and was not ashamed.

“Seeing when he kicked in a cupboard door or slammed the car door, this was like I had something on him . . . Because I saw it with my own eyes, and so it gives me some power, you know? . . . We talked a lot about it later” (No. 11).

Discussion

On method

The purpose of this study was to discover and explore. Even so, validity problems cannot be neglected. The participants’ involvement in the analysing process, through their reading their own interview transcripts and commenting on interpretations, was done in order to increase dependability and confirmability. For the sake of trustworthiness, we attributed abuse of women only to participants who themselves acknowledged abuse or confirmed it in descriptions of lived events. Confirmability was also tested by asking researchers not involved in the study to scrutinize transcripts and codings. That the interviewing researchers were also the participants' family physicians was an important feature of the study, and caused considerable concern, which we have discussed in more detail in another paper. What did she tell us, what did she hide, and why? To be aware of those questions was important in the analysis. The setting might have restricted the data collection, but, on the other hand, the findings are grounded in a doctor–patient relationship which might increase their applicability in clinical practice. The difficulties we experienced in talking about abuse in the interviews were probably of a similar nature to the difficulties encountered in ordinary patient–doctor consultations.

The study was conducted on a restricted patient group, 20 women with UMSD at one health centre in Sweden, 11 of whom had experienced abuse. The reader is advised to keep that in mind when evaluating the findings. Still, because the research was conducted in a clinical context and the women were recruited to the study due to their UMSD, not because it was acknowledged that they were abused, we suggest that the applicability of the finding, and the conditions for identifying and talking about abuse, might be of considerable significance in patient–doctor communication.

On findings

We were surprised by the fact that as many as 55% (11 women) of the participants reported experiences of abuse. Only 10% (two women) were known by their family physicians to have been exposed to abuse when the study started. However, the high frequency of abuse in patients with chronic pain disorders is supported by others. In a study of female patients with chronic pain, referred to a pain centre, 53% of the women were physically and/or sexually abused. Similarly, 66% of women suffering from chronic headache, and presenting at a pain centre, were identified as victims of physical and/or sexual abuse. Without stating anything about causality, research shows that it is necessary to reflect on and ask about abuse in women patients suffering from chronic pain. Furthermore, these results indicate that the known abuse in health care is only the tip of the iceberg.
That shame, fear of preconceptions and fear of the abuser make disclosure difficult are confirmed by others. Less described in medical research are the obstacles to talking about abuse due to renaming and women’s uncertainty as to whether their experiences really can be defined as abuse. This ambivalence made it necessary for the interviewer to try different concepts, expressions and words in order to facilitate disclosure. In the process of telling, the woman wanted to have some control over definitions and interpretations. For us, what to call it was not the primary issue under discussion, but rather what had actually happened.

The difficulties in disclosing and naming become understandable in light of the theory of “the process of normalisation of violence”. This theory implies that an abused woman is successively accustomed to see aggressive behaviour, threats, and physical and sexual violence as parts of a normal intimate relationship. The abuser’s criticism of her person and behaviour are internalized and she thinks that she deserves the battering. She perceives herself with the concepts and demands of her abuser. The process of normalization can explain why some participants did not define even severe physical violence as abuse, and why several were afraid that they suffered from a psychiatric illness.

In another paper, we analysed the participating women’s consultation experiences. They had felt ignored, disregarded and rejected by doctors, and had worked out strategies to maintain medical attention in their search for help and a diagnosis. The participants’ fear of preconceptions that the doctor might have concerning violence against women were probably reinforced by this atmosphere of distrust.

When we initiated this study, we knew that abuse of women was dangerous, even leading to murder. Still, when reflecting on the research, we realize that fear of the abuser had a far stronger impact on the process of disclosure than we had imagined. Research on the medical response to abuse of women supports our suspicion that doctors might underestimate the danger and fear involved. We therefore suggest that doctors in clinical work might consider this aspect more carefully. What kind of danger is involved? What are the consequences of alternative measures for her safety? What kind of protection does she need?

The women described an understanding listener as a precondition for disclosing abuse, which is in line with earlier research. Our participants wanted the listener to be interested in, have a tacit knowledge of and take responsibility for asking questions about abuse. This implies that a great responsibility is put on the listener. Though the question of how to become an understanding listener with tacit knowledge still remains.

We experienced part of the answer in the third interviews. Describing our impressions that violence was often present, giving examples from the study, we required a lot of new information on violence. It was as if some women then thought that we might have enough experience to be able to understand their conditions. Therefore, we suggest that providing information and examples of abuse is one way for doctors to facilitate disclosure.

From the perspective of becoming an understanding listener an important finding was that the women gave hints of abuse before admitting it. The hints might be rather obvious, such as “He is aggressive”, or more veiled, such as “He is big”. We are tempted to say that by using hints, the women ‘tested’ our tacit knowledge. In a study of stigmatizing conditions, Limandri described a similar process. She calls it “invitational disclosure”, wherein the discloser provides sufficient cues that ‘something is wrong’ to invite the listener to notice. If the listener then picks up on the cue and asks, but in a way that the discloser is not comfortable with, he/she still has the opportunity to retract without too much having been made known. Further research about disclosure of woman abuse is a task for general practice research, and we suggest that the concepts ‘hints’, ‘testing’ and ‘invitational disclosure’ might be rewarding when utilized.

One shortcoming in this study was the fact that we did not receive much data on what the abused women wanted doctors to do to help them, besides being an understanding listener. Why was this so? These women had not turned to health care in a conscious effort to get help as a victim of abuse. On the contrary, they were afraid of revealing the violence and threats. This fact might explain why they had difficulty expressing any concrete demands or suggestions as to what doctors actually ought to do. In order to explore what actions abused women want doctors to take, we suggest studies on abused women who have already acknowledged the abuse and consciously tried to get help from doctors. They are probably in a position in which they have reflected upon their experiences and needs. This study explores other aspects of communicating woman abuse—the difficulties in disclosing abuse in the first place.

This study concludes that in clinical practice it is important to look for hints of abuse in women suffering from UMSD. When there are hints of abuse, avoid blaming and doubting, stand by, be patient, keep abuse in mind and ask about it, even if the woman has once negated it. Furthermore, don’t forget that the woman might be in real danger.

Acknowledgement

This study was supported by grants from the Umeå Medical District, the County Council of Västerbotten, Sweden (Primärvårdens FOU-anslag i Umeå Sjukvård) and the Board of Research in Health Care in Northern Sweden (Samverkansnämnden för anslag till forskning för hälso- och sjukvården i norra regionen).
Appendix

The following interview guide was used as a check-list to guarantee that all themes were treated.

- education and occupation
- working conditions
- family situation—husband, child care and other caring duties, housework
- sexuality
- economy
- housing
- experiences of violence and threats
- family members' health situation
- voluntary work, political and/or trade-union activities
- reason for being sick-listed
- what did they think had caused the present situation
- consequences of the illness
- impediments to returning to work
- how did they spend their days
- what kind of assistance did they require
- experiences of health care
- personal strengths and weaknesses
- views of the future

References