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Health Worker Attitudes to Intimate Partner Violence on the Tibetan Plateau: A Qualitative Assessment of Cultural and Material Factors Behind Non-Interventionist Attitudes

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Abstract

Qualitative interviews with a small number of health care providers and nongovernmental organization (NGO) staff members were conducted to understand providers' attitudes to intimate partner violence (IPV) on the Tibetan plateau and the link between these attitudes and prevalent social norms. NGO members have received gender awareness training and tended to consider prevalent gender norms and roles to blame for IPV. Health care providers, on the other hand, tended to endorse these norms. Providers did not appear to conceptually separate abusive and nonabusive conflict, giving rise to perceptions that abuse is commonplace and without traumatic effects. In general, providers did not consider that assisting cases of IPV was part of their professional responsibility. When asked what type of help victims need, health workers focused on reconciliation with perpetrators or emotional support. Providers said they would advise victims to avoid conflict and react to perpetrators with less anger. Respondents also expressed beliefs that victims are sometimes the guilty party responsible for conflict. Respondents felt separation from an abusive partner is generally not an option, because divorce is considered to cause concerns for children, difficult financial circumstances, and a negative reputation for wom-

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en following divorce. Perceptions that divorce is usually the worst option for women and lack of awareness regarding the difference between abusive and nonabusive conflict should be addressed in health worker training programs and community interventions. Our findings are relevant to other regions of the world in which IPV is not considered extraordinary or serious and in which heavy social and material constraints can act as a barrier to divorce for women.

Keywords

domestic violence; intimate partner violence; gender violence; gender-based violence; health worker; health care; doctor; nurse; health professional; Tibet; China; Asia; gender; women

Intimate partner violence (IPV) in heterosexual relationships has been defined as a process by which a man uses physical violence as well as psychological, emotional, and financial abuse in a malicious attempt to assert power and control over his female partner (Gilchrist & Kebbell, 2004; Kilpatrick, 2004; Krug, Dahlberg, Mercy, Zwi, & Lozano, 2002; Pence & Paymar, 1993; Stark, 2007). Stark (2007), for example, argued that domestic violence is more accurately termed coercive control and draws parallels between tactics used by abusive men to control heterosexual partners and capture crimes, such as kidnapping, the taking of hostages, or the internment of prisoners of war. This bears similarities to the argument of Sloan-Lynch (2012), who asserted that domestic abuse is not a series of "isolated acts of violence" but is instead "a source of brutal oppression" and characterized by "a miasma of fear" (p. 787). As Stark explained, victims often have a sense that perpetrators' excessive anger and violence are possible at any moment and unpredictable, regardless of what the victim says or does. Abusers regulate and restrict victims' daily activities; often engage in stalking and surveillance of their partners' belongings, phone calls, and activities; work to deprive victims of "money, food, access to communication or transportation"; and work to cut victims off from social support, such as family and friends (Stark, 2007, p. 5). IPV is usually distinguished from nonpartner violence in surveys (Fulu, Jewkes, Roselli, & Garcia-Moreno, 2013; Jewkes, Fulu, Roselli, & Garcia-Moreno, 2013) and measured separately.

A large body of evidence lists adverse health effects associated with IPV (Black et al., 2011; Campbell, Abrahams, & Martin, 2008; Dillon, Hussain, Loxton, & Rahman, 2013; Stockl et al., 2013; Woods, Hall, Campbell, & Angott, 2008; World Health Organization, 2013). Studies show that survivors use health services more often than the general population (World Health Organization, 2012), and researchers have noted the importance of health care settings for identifying and responding to IPV survivors. Survivors often do not approach police or legal services and are therefore likely to be left without

institutional support unless identified in the health care setting (Colombini, Mayhew, & Watts, 2008; Odero et al., 2014). Investigators have likewise noted that because health workers[1] are often the first professionals approached by survivors, they can play a key role in intervening and providing support (Husso et al., 2012; Morrison, Ellsberg, & Bott, 2007). However, research suggests that health care providers in many settings are often ill-equipped and/or unwilling to address IPV (Beynon, Gutmanis, Tutty, Wathen, & MacMillan, 2012; Colombini, Mayhew, Ali, Shuib, & Watts, 2013; Kirst et al., 2012; Roelens, Verstraelen, Van Egmond, & Temmerman, 2006). For health workers who learn of or suspect abuse, research has suggested they may minimize survivors' experiences, ignore the abuse, or blame the victim as responsible for the perpetrator's actions (Beynon et al., 2012; Colombini et al., 2013; Corbally, 2001; Haggblom, Hallberg, & Moller, 2005; Kim & Motsei, 2002; Odero et al., 2014; Rodriguez, Bauer, Flores-Ortiz, & Szkupinski-Quiroga, 1998; Rodriguez, Quiroga, & Bauer, 1996). This negative response can cause survivors to lose faith in health care providers, to feel that their relationships with providers have deteriorated, or to believe that services provided in health care settings have lost much of their value (Hathaway, Willis, & Zimmer, 2002; Rodriguez et al., 1998; Rodriguez et al., 1996).

IPV is a common occurrence in China, with studies indicating between 17% and 30% prevalence of gender-based violence in families or of IPV (Human Rights in China, 2006; Jolly & Ying, 2003; Merry, 2005; Parish, Wang, Laumann, Pan, & Luo, 2004; Tam et al., 2015). However, there is a dearth of information on health worker attitudes and practices toward IPV on the Chinese mainland (Kamimura et al., 2015). In addition, evidence regarding violence against women among Tibetan populations, in particular in Tibetan regions of China, is scarce. Most important, a clear gap in the public health literature exists with regard to a deeper probing of why and how providers adhere to non-interventionist, minimizing, and victim-blaming attitudes (Colombini et

[1] Health workers/health care providers are defined here as current or former full-time staff members of hospitals or clinics as well as those who have completed a medical internship. The length of work experience among providers interviewed in this study ranged from 3 to 19 years. In the study region, many rural and remote areas have a village clinic located relatively near residents' homes. Village clinics, however, often provide only very basic services; care needs beyond this level usually require travel to the nearest town or city. Recent studies have found the coverage rate of rural medical institutions in Western China is high, but lower than the coverage found in Eastern and Central China (Wang et al., 2015). One study found there are approximately 23 health workers per 1,000 people in rural areas of the study region, but noted that township and village health care workers were responsible for residents of much larger areas of land than was found in eastern parts of the country (Han et al., 2012).

al., 2008; Cronholm, Singh, Fogarty, & Ambuel, 2014; Goicolea et al., 2015; Morrison et al., 2007).

This study was an analysis of interviews with health workers and nongovernmental organization (NGO) staff members residing on the Tibetan plateau. This was an exploratory study of health worker attitudes and practices to IPV and of the cultural and societal context affecting IPV response. Similar to findings from other low and middle income country settings, such as parts of sub-Saharan Africa, Latin America, and Asia (Colombini et al., 2008; Mitchell, Parekh, Russ, Forget, & Wright, 2013; Odero et al., 2014), this study also revealed a lack of workplace protocols or regulations on IPV, a tendency among providers to ignore abuse to focus on treating physical ailments alone, and provider attitudes generally disparate from supportive or positive interventionist responses. The attitudes and practices of health workers in one part of the Tibetan plateau, as revealed by our findings, present a valuable case study for two reasons. First, this is one of the poorest regions of China with consistently low human development indicators (Li & Wei, 2010; Liu & Griffiths, 2011) and a region in which household farming and animal husbandry make up a large proportion of economic activity (Fang, 2013; "Tibetan nomads," 2009). The study area is a region with important similarities to many other low and middle income country settings. Second, and primarily, this study looked closely at the cultural and material factors and rationales behind providers' attitudes. Such an investigation is necessary if training programs for health workers are to be effective.

Theoretical Framework

This study used Heise's (1998) ecological model of IPV, in which violence is seen "as a multifaceted phenomenon grounded in an interplay among personal, situational, and sociocultural factors." This model relies on a "notion of embedded levels of causality" (pp. 263–264), in which personal history factors are embedded within a microsystem environment. The microsystem level, in turn, is embedded within the exosystem, which is embedded within the macrosystem (see Figure 1). The individual level encompasses "those features of an individual's developmental experience or personality that shape his or her response to microsystem and exosystem stressors" (Heise, 1998, p. 266) and can include elements such as witnessing marital violence as a child, being abused as a child, and having an absent or rejecting father. The microsystem encompasses situational factors and "refers to those interactions in which a person directly engages with others as well as to the subjective meanings assigned to those interactions" (Heise, 1998, p. 269). This level can include male dominance in the family, male control of wealth in the family, frequency of marital conflict, and use of alcohol. The exosystem encompasses the immediate social environment of individuals and includes elements such as unemployment or low socioeco-

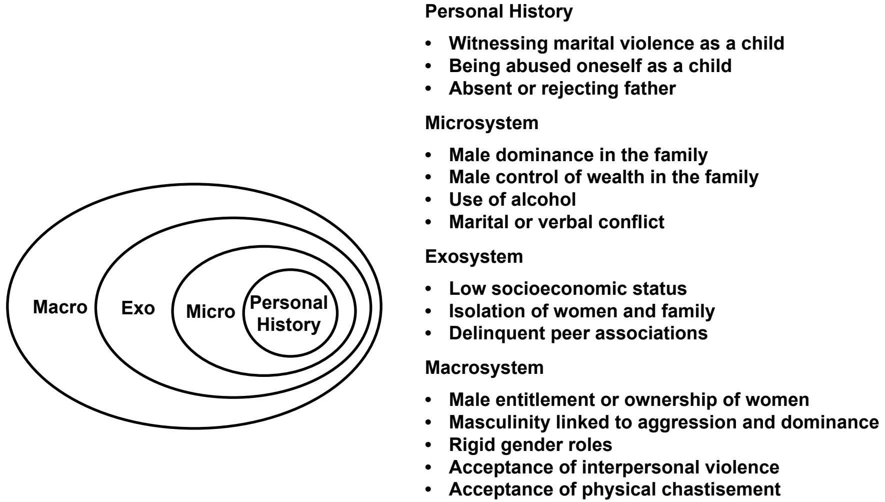

Figure 1. Heise's ecological model. From "Violence Against Women: An Integrated, Ecological Framework," by L. L. Heise, 1998, *Violence Against Women, 4,* p. 265.

nomic status, a woman's or family's social isolation, and male peer groups that encourage gender-based violence. Finally, the macrosystem encompasses "the broad set of cultural values and beliefs that permeate and inform the other three layers of the social ecology" (Heise, 1998, p. 277). In this study, by looking at survivors' interactions with health care workers, and by exploring broader gender norms as they affect IPV, we focused on the exosystem and macrosystem levels.

This study additionally drew on Esser and Kroneberg's (2015) theory of behavioral motivation. Pulling together evidence from experimental and theoretical work in psychology, neuroscience, sociology, and economics, Esser and Kroneberg proposed a theory of individual action that accords with the contention of IPV scholars that perpetrators' actions often derive from prevalent and readily accessible social scripts. Stark (2007), for example, described how perpetrators draw heavily on readily accessible and gendered social scripts when they abuse female partners. He described, for example, that perpetrators sometimes use social scripts associating the feminine with emotionality to decry their female partners as crazy and associating the masculine with rationality or femininity with moral degradation to show disdain for female partners. Esser and Kroneberg likewise described humans' choice of actions and responses as a matter of first defining a situation. If the situation in question resonates with strongly held norms and mentally held conceptions of prototypical scenarios believed to warrant a particular response, a response is automatically enacted.

If the response involves high stakes and potentially severe consequences, a more deliberative response ensues in which an actor first weighs the pros and cons of different actions prior to responding. This model of frame selection asserts that social norms are highly salient factors in individual behavior. Rather than being endowed with absolute power, however, these norms are tempered by the situations an actor encounters (Esser & Kroneberg, 2015).

This theoretical background led to our focus on social norms, definitions, and conceptions of abuse. Our theoretical framework also gave rise to our interest in investigating the attitudes and practices of health providers, as this is an important component of the broader environment described in Heise's ecological model.

Study Purpose

As there is no literature on the attitudes and responses of health workers toward IPV and IPV survivors in the study region, this study aimed to fill a gap in the literature. Specifically, this study aimed to fulfill four purposes:

1. Explore health care providers' knowledge and beliefs regarding the nature and causes of IPV, IPV's effect on health, prevalence of IPV, and severity of the problem in the study region.
2. Explain whether providers have come into contact with IPV survivors through their contact with patients, family, or friends; explain how providers learned of the IPV and the manner in which providers responded to these cases.
3. Gain from providers a description of common or prevalent responses by the community and the authorities to incidences of IPV; understand whether providers' own responses reinforce those of the community.
4. To further understand whether providers' responses reinforce or counteract those of the community, obtain from NGO staff a description of community and authority responses to IPV as well as the gender norms, roles, and relationships that may give rise to IPV; NGO staff members should be individuals who have received gender awareness training and who work on social problems affecting women.

Method

Health care providers' knowledge and beliefs about IPV as well as their contact with IPV through patients, friends, or family were explored through qualitative, semistructured interviews conducted in April 2009 in a region of Western China located on the Tibetan plateau. Providers were also asked to discuss their impressions of community and authority responses. Qualitative, semistructured interviews were conducted on similar topics with staff (current or previous) of NGOs (see Appendix for a partial list of interview questions).

Most of the NGO staff members have received gender awareness training and have worked on projects related to women's health or women's needs. NGO members' gender awareness training included discussion of IPV and rape; gender stereotypes; gendered opportunities and constraints found in education, professional areas, and the family; representations of gender in local religious practices; and prominence of women in contemporary society as well as within histories and hagiographies. In their professional work, NGO members have worked to improve women's health in the areas of family planning and sexually transmitted infections. NGO members have also worked to reduce the household labor burden of women and to change common gender-unequal community opinions.

In their professional work, NGO staff members have traveled to remote villages and nomadic settlements to assess and deal with local needs. Health care providers, on the other hand, were based in clinics or hospitals in cities or small towns. NGO members' professional work and gender awareness training, including their awareness of rural women's struggles, meant NGO members were likely to have a more comprehensive understanding of local gender norms and of community responses to IPV, including responses among the large proportion of the population living in rural areas. NGO interviews thus complemented the health provider interviews by offering a wider contextual understanding of IPV in this region.

The interview topic guide was developed based on a literature review of provider attitudes to IPV in China and worldwide, the principal researcher's personal knowledge of local culture and practices, previous qualitative research with IPV survivors in Cambodia (Zimmerman, 1995), and the World Health Organization (2005) Multi-Country Study on Women's Health and Domestic Violence Against Women.

Questions and informed consent forms were translated from the original English into Chinese and Tibetan. Translations were cross-checked to ensure clarity and accuracy of meaning. Some questions were modified after the first interviews, making the interview process iterative. The majority of interviews lasted for approximately 1 hour 20 min and were conducted in Tibetan, Chinese, or English, according to the participant's preference. Interviews were tape-recorded and were either fully transcribed or partially transcribed to capture all statements related directly or indirectly to the subject of IPV. Partial transcription was at times conducted because some recordings included content unrelated to IPV and therefore did not constitute data requiring analysis. Two individuals refused to be tape-recorded. Notes taken by hand during these two interviews were typed and elaborated upon within 48 hr of interview completion. When conducting data analysis, we employed thematic analysis, a process by which recurrent themes and links between respondent statements are assessed (Green & Thorogood, 2005; Miles & Huberman, 1994).

Participants were a convenience sample introduced via the principal investigator's local contacts. Five health care providers were interviewed including nurses, doctors, and individuals not currently working in a clinical capacity but who have completed a medical internship. Most worked in obstetrics, gynecology, or family planning. Providers were all female. NGO staff members were identified through a similar process. Four individuals who have worked in a significant capacity on nonprofit development or health projects were interviewed. As noted, all of the NGO participants have worked on activities that included a focus on women's health or women's issues. The majority have also received gender awareness training. All NGO members were also female. Unfortunately, further details on respondent work activities and characteristics cannot be provided because of the small sample size and confidentiality concerns. Health care providers were between 25 and 45 years old, and NGO staff members were between 20 and 30 years old.

Many of the ethical concerns common to IPV research projects, such as worries for victims' safety in the event that the perpetrator discovers the victim has been speaking to researchers about abuse, did not apply to this study, because we did not seek to interview victims directly or ask respondents about their own experiences of violence. As only five health care providers and four NGO staff members were interviewed, neither the respondents' names or work locations nor the specific site of interviews is listed here because of ethical concerns. Ethical approval was obtained prior to conducting interviews through the London School of Hygiene and Tropical Medicine, and local ethical review was conducted by a prominent women's NGO in the study area.

Results

Concept of IPV

Participants' definitions of IPV and abuse were broad and included much more than physical violence alone. Health care providers stated IPV includes causing bodily harm, beating and scolding, and one participant included extramarital affairs. Health care providers said that in addition to physical hitting, the term *abuse* includes mental harm, such as not talking to one's partner; curtailed freedom; or a situation in which a husband does not pay attention to his wife, leaves her at home, and spends a lot of time outside. NGO staff members listed similar acts and added other behaviors, such as insulting; not allowing one's partner to attend events outside the home; withholding needed money from one's partner; disrespecting one's partner by being unfaithful; and a situation in which a woman is treated like a servant, has few rights in the family, or is viewed as the source of bad luck. The inclusion of extramarital affairs, not talking to one's partner, and spending a lot of time outdoors while leaving one's

wife at home in respondents' definitions indicates a broad conceptualization of IPV and abuse.

When responding to questions regarding the definition of abuse, many providers focused more on the causes of marital conflict than on describing the parameters of abuse as such. This likely indicates a lack of a strong conceptual separation between abusive and nonabusive intimate partner conflict. For example, one provider stated,

> Q: *What is the meaning to you of the term "domestic violence"?*
>
> A: I think domestic violence primarily includes husbands and wives not getting along. Also like when the husband says he needs something, but the wife doesn't go [to get it], and then the husband says, "you didn't go" and then hits her. Also, sometimes when the husband and wife generally get along, but they have a disagreement about some work that is to be done or relationship—this happens a lot.

Similarly, an exchange with another provider was as follows:

> Q: *What is the meaning of the term "domestic violence"?*
>
> A: I don't know.
>
> Q: *What is included in domestic violence? Does it include a husband hitting his wife?*
>
> A: Yes.
>
> Q: *And besides hitting, anything else?*
>
> A: When a man sleeps with another woman. Many people have disagreements because of this.

These responses appear to indicate that physical violence was considered to be part and parcel of marital disagreement more generally. Violence and abuse were not distinguished as qualitatively different from nonabusive marital disagreement. This likely underpins respondents' broad definitions of abuse.

Effect of IPV on Health

Respondents' broad definitions of IPV and abuse were replicated in assessments of the health effect of IPV, with providers focusing on the emotional damage of IPV. Some providers also spoke of bodily harm and danger to the fetus of a pregnant woman. One provider linked the emotional harm of IPV to bodily health: "One's emotional state is not good [when you suffer IPV], and then because of this you have a lot of illness, like not being able to sleep at night, you cry a lot, and your body really has illnesses."

Another provider stated,

> Patients [who have experienced IPV] . . . are feeling emotional pain. Other patients have pain and illness that's a bit more common, but

> [patients who have suffered IPV] have emotional wounds. Even if their body is healed, they will still be angry in their heart.

Acceptability of Abuse and Placement of Blame

NGO members' descriptions of prevalent norms and practices that aggravate or give rise to IPV were at times directly replicated in the health care workers' accounts. Thus, NGO staff described local gender roles and norms that contribute to IPV, such as women's heavy workload, men's powerful position within the family, conflicts between a wife and her husband's family, men's drinking of alcohol, and men's infidelity. Health care providers listed many of these factors as well. Several NGO respondents explained that gender socialization and norms are to blame for IPV. An important gender norm in this regard is men's position of authority within the family. NGO staff members explained that men tend to believe that they have a right to hit their wives and no one can interfere. A man's violence against his partner is considered to be "like [the perpetrator is] breaking [his] own property," explained an NGO member. Many NGO members described these norms, but they did not endorse these views.

Health care providers, on the other hand, replicated the NGO members' descriptions, but did so by endorsing such views. Thus, reflecting the norm that men's place is one of authority within the household, many health care providers implied a wife's rightful place is to defer to others' authority, by implying that a wife's rightful place is one of silence, understanding, little anger, and hard work. Providers expressed the notion that the victim should be more conciliatory or understanding toward the perpetrator to prevent abuse. In the event of IPV, therefore, providers would advise victims to avoid conflict and be understanding. Following a perpetrator's threat to kill his wife, for example, one provider urged the perpetrator to stop his violent behavior and then told the victim that a bit of hitting is "not a problem" and instructed the victim to refrain from talking back. One health care provider noted that men have the right to verbally discipline their wives, explaining the situation of her own parents:

> Sometimes [my father] would say really bad things [to my mother], like "You're stupid," "You don't know anything." . . . When he talked like this, my mother felt really bad. When she felt bad, . . . [I] would feel angry at my father . . . When I was young, I didn't know . . . whether it was my father or mother who was right, but my father was the harsh one . . . But now that I've grown up . . . I know how to think through things, and I think my father's behavior was understandable. When he scolded my mother, it was because she didn't understand something, and so he scolded her.

She assessed that if her mother had done something wrong or "didn't understand something," the husband had the right to put his wife in her place using a disproportionate severity of language.

Although most health care providers stated hitting one's wife is a crime or generally unacceptable, a number of providers also indicated that in some instances beating is acceptable. According to these participants, instances in which abuse might be acceptable include if the wife has done something wrong, if weapons are not used, if the hitting is not serious, or if the wife will engage in bad behavior unless she is beaten. Some providers suggested that if beating is not too serious, it can or should be endured. A number of providers and one NGO member indicated that the victim is sometimes the guilty party responsible for conflict. One provider stated,

> If the husband beat his wife, he should think, "I beat my wife today. That wasn't right" and regret it . . . Afterwards, the wife should also think, "This time he hit me. But even if he hit me, he regretted it and apologized. He's gotten better. In the future, I will not do these bad things and will change." This kind of thinking is needed. Both people should try hard regarding their respective problems. If they do this, then violence won't occur.

In this case, the speaker assumed the wife had done something wrong to cause the beating. This same provider said that sometimes wives "should stay quiet. If you'll just properly be, then violence won't occur . . . if the wife still tries to say the other person was wrong . . . even though the other person was not wrong . . . then [violence] will occur."

Reconciliation as Response

In the cases of real and hypothetical occurrences of IPV to friends, family, and patients of providers, advising divorce was generally not considered an option, unless cases were severe. According to one provider, if a wife is not treated "like a person," she does not have freedom, or her life may be in danger, she should divorce. Several NGO respondents would only interfere in a case of IPV or recommend that a victim leave her perpetrator in serious or repeated situations.

When asked what type of help victims need, the health workers focused on reconciliation or emotional support. For example, one health care provider spoke of telling a woman to be more open-minded and not rush to divorce in anger. One health worker would advise patients to endure the extramarital affairs of their husbands, telling them "if you're truly in his heart . . . then it's not such a big problem." One provider conveyed that informing victims they do not deserve their partners' violence is incorrect.

Health care providers stated that they cannot interfere in patients' personal lives or that IPV is not a part of doctors' responsibilities. One provider stated, "We as doctors don't have the option of interfering in these matters. Patients never tell doctors directly about domestic violence." That victims will not speak honestly to health workers was also listed as a barrier providers would face if they attempted to help a victim. Several respondents believe providers' professional role in treating IPV survivors is only to treat survivors' physical injuries and illnesses.

Many health care providers have never come across patients they knew to be suffering IPV, and no provider has ever directly asked patients about IPV. Most health care providers said their workplace has no rules around IPV or none that they know of. No provider has ever received IPV-related training. Only one provider has come into contact with many known victims of IPV in her work. She explained her response to patients suffering IPV:

> With patients [who have suffered IPV], for example I would say, "You're in pain. All animals and people have pain. We also have pain. It's not a problem. It'll get better if you take medicine. It'll get better if you get an IV. It's not a problem. This is nothing . . . Is it only you? Go and watch TV." I talk to them like this, and like, "Oh! He hit you. This is not right"—you can't talk like this. If you say this, then they cry and feel bad, and you feel bad for them.

This provider gives similar advice to patients and friends, believing that by minimizing victims' experiences she is helping them focus less on their suffering, so as not to aggravate their pain. In the event that she came across a patient suffering IPV, one provider, likewise, said she would "teach [patients] that they can't be [sad/angry] like this; if you keep feeling like this, it will only get worse." Like the provider who prefers to minimize patients' abuse, this provider believes helping victims to focus less on their suffering is a positive response to IPV.

That providers focused on encouraging victims to manage better within abusive situations implies divorce is often considered an unacceptable option. This view may be driven by beliefs that divorce often places women in especially constrained and trying circumstances. Respondents mentioned a number of barriers preventing many women from divorce, such as concerns for the postdivorce welfare of children, the stigma to one's reputation that results from divorce, worries that remarriage after divorce would be difficult or impossible, and, perhaps most important, concerns around women's lack of independent material or economic assets.

In line with some respondents' predominant motive of reconciliation, advising the perpetrator to stop his violent behavior was a commonly mentioned response to IPV. One provider stated, "Somebody should talk to the husband

nicely" so the couple can get along once again, and she also spoke negatively of those who encourage divorce. Several NGO members said they would respond to IPV by talking to the perpetrator, threatening the perpetrator with legal consequences, or convincing the couple to get along. Among health care providers, the notion that the perpetrator should be punished for his behavior beyond mere scolding or exhortations to change his behavior was largely absent.

When asked whether IPV would prompt health care providers to call the police, providers' answers were negative. Providers indicated that they would not call the police at all or would only call in the case of a threat to life or serious bodily harm. One provider stated that it is wrong to call the police as "the two of them can decide their own things themselves," and another voiced a fear that calling the police would aggravate the situation for the victim at home. All NGO staff members were likewise generally unwilling to call the police. NGO members stated that the police would not come quickly, would only come if the situation is serious, or would only come if given a bribe, and some feared calling the police would incite greater anger in the perpetrator. One NGO respondent spoke disparagingly of the police, stating the police would do nothing if called. Some NGO respondents implied IPV is usually not severe enough to warrant calling the police or to warrant either the perpetrator's arrest or a response by the authorities.

Discussion

Our findings provide exploratory insight into health care providers' attitudes and behaviors toward IPV in a region of Western China located on the Tibetan plateau, with background information on IPV and gender dynamics in this region provided through interviews with NGO staff. When asked about the causes of IPV, NGO staff members, most of whom have received gender awareness training, focused more on gender inequality and the prevalent societal view that IPV is often acceptable. They were also more likely to blame conflict and IPV on gender inequality than on individual personality conflicts. Health care providers, on the other hand, tended to imply that a husband and wife were equally to blame for male-perpetrated IPV.

Providers defined abuse in extremely broad terms. The broad definitions of IPV cited by health care providers and NGO staff members in this study included scolding, extramarital affairs, curtailed freedom, or abuse in addition to beating. The inclusion of extramarital affairs in the concept of abuse indicates a broad definition indeed. Moreover, when responding to the principal investigator's questions regarding the definition of abuse, some respondents focused more on the general causes of marital conflict than on describing the parameters of abuse. This appears to indicate a lack of strong conceptual separation between abusive and nonabusive intimate partner conflict. Feminist author Gloria Steinem, speaking of her upbringing and activism in 1950s, 1960s, and

1970s America, stated that in those decades, "we didn't even have a word for domestic violence. It was just called life . . . now we understand that it's not natural, it's not normal, it's not inevitable" (*Gloria Steinem,* 2013). Others have also written about processes by which feminist movements in a number of settings around the world have played a major role in adopting a public understanding of IPV as a social problem requiring active intervention and protection of victims' welfare and rights (Heo, 2010; Pleck, 1987; Walker, 1990; Yoshihama, 2002; Zhang, 2009). Thus, in settings in which such activism has not occurred or in which historical and social circumstance have not led to abuse or IPV to be viewed as something extraordinary or serious, something beyond "just life" and beyond the "normal and inevitable," as Steinem describes, a strong conceptual separation between abusive and nonabusive couple conflict may not be seen. This lack of a stark conceptual separation may be behind respondents' broad definitions of abuse, such that abuse is deemed to include behaviors such as extramarital affairs and husbands leaving home often.

Thus, in our study, broad definitions appear to be indicative of a lack of strong conceptual separation between abusive and nonabusive couple conflict, thereby giving rise to attitudes that do not consider IPV to be a serious problem. This is counterintuitive because narrow rather than broad definitions of abuse tend to be associated with victim-blaming or non-interventionist attitudes to IPV within the literature. In other words, as stated by Flood and Pease (2009), IPV studies usually reveal the following:

> The more that people maintain egalitarian gender attitudes, the better are their attitudes toward violence against women. They are more likely to see violence against women as unacceptable, *to define a wider variety of acts as violence or abuse* [emphasis added], to reject victim blaming, to support the victim, and to hold accountable the person using violence. (p. 128)

Those who define IPV as physical violence in addition to demeaning a victim through verbal insults, depriving a victim of money, or isolating the victim from family and friends are therefore more likely to display attitudes that are supportive to victims and favorable toward professional intervention in IPV. Those who define IPV as physical violence or severe physical violence alone, on the other hand, are less likely to hold to these supportive attitudes (Flood & Pease, 2009; Kim & Motsei, 2002). Unlike the literature, however, we found providers held to broad definitions of abuse, but this did not correlate in the study setting with interventionist or supportive attitudes that refrained from blaming victims.

When IPV is not viewed as a serious problem, it is likely to be understood as just another aspect of intimate partner conflict. In many settings around the world, then, it is likely that, in the absence of widespread feminist activism,

prevalent notions by which a stark conceptual separation is made between abusive and nonabusive couple conflict do not exist. Instead, all conflict is likely to be understood as mundane and often as relatively trivial. This lack of a conceptual separation is likely to lead to attitudes toward IPV that are similar to attitudes toward nonabusive marital conflicts. The result, therefore, is perceptions of conflict as gender-symmetrical rather than a product of power imbalances between men and women, with blame equally apportioned to husbands and wives (Leung, 2011). This finding is likely to be relevant to other settings in which prominent and successful feminist movements specifically around the topic of violence against women have not occurred or to populations that have not been affected by feminist understandings of abuse as extraordinary and serious. Our findings are relevant to the study region as well as other settings in which abuse does not appear to encounter a strong conceptual divide differentiating abuse as significantly and qualitatively distinct from nonabusive intimate partner conflict. Our findings are relevant for IPV-related training programs provided to health workers and for other IPV interventions.

Our study is unique in that it includes interviews with NGO staff members, most of whom have received gender awareness training, unlike the health care providers. NGO staff descriptions of the broader social and cultural context within which IPV occurs, combined with providers' accounts, reveal that perceptions of women's difficult circumstances following divorce are an important factor reinforcing providers' responses to victims because they revolve around the notion that, in many cases, advising divorce is not an option. Some participants implied that the first order of response to IPV is always to attempt to reconcile the couple, with divorce being advised only if reconciliation proves impossible. Descriptions of women's or families' difficult circumstances following divorce reveal that preserving family unity is promoted not only for its own sake, because this is considered of greater import than women's rights or welfare, but also at times *for* women's welfare. That is, we reveal that providers do engage in victim-blaming, but respondents also commonly implied that divorce can be worse for women and families than remaining in abusive situations. This finding may be relevant to other parts of the world where significant barriers prevent women from divorcing their partners because of, for example, the prospect of poverty or social stigma. Such perceptions are therefore a point that may need to be addressed in training provided to health care workers or in IPV-related community interventions, in the study site and in other settings where similar perceptions are found.

NGO staff and health care providers appeared to believe that divorce or intervention by authorities is only warranted in serious situations. Providers' responses included minimization of abuse, and abuse was often seen as an inevitable or trivial fact of everyday marital life. Reconciliation, emotional support, and advice, often to change one's behavior so conflict does not arise, were the

favored responses to IPV victims. Thus, acceptance of IPV, minimizing victims' suffering, and focusing on reconciliation without strong prior focus on victims' own desires were common interventions in IPV cases, although some have advocated divorce in some instances with friends or relatives. Scolding the perpetrator or exhorting him to stop his abuse were also mentioned as responses.

Most health care providers believed that dealing with IPV was not part of their professional responsibilities or that it was not their place to intervene in patients' private matters. Some providers felt providing medical treatment was their only responsibility in the case of IPV. In addition, most providers were unwilling to call the police or would only call in serious or life-threatening situations.

Studies from Western countries indicate the types of provider responses found in the study region do not meet the wishes of survivors. For example, IPV survivors in several North American studies stressed the importance of direct and provider-initiated questioning about IPV (Hathaway et al., 2002; Rodriguez et al., 1998; Rodriguez et al., 1996; Kelly, 2006). A minority of survivors in one study also voiced a preference for indirect questioning (Hathaway et al., 2002). Minimizing abuse, ignoring abuse to provide only medical treatment, and blaming the victim as responsible for the perpetrator's actions have been found to affect survivors negatively (Campbell, Pliska, Taylor, & Sheridan, 1994; Corbally, 2001; Hathaway et al., 2002; Hattendorf & Tollerud, 1997; Rodriguez et al., 1998; Rodriguez et al., 1996). Additionally, studies conducted in the United States, Australia, and the United Kingdom have found survivors want health professionals to respect their wishes and engage in joint decision making with them. Survivors were dissatisfied when their autonomy was not respected in this way (Feder, Hutson, & Taket, 2006). Survivor wishes in the current study area are unavailable, but if these wishes are similar to those in other settings, providers' responses are inadequate. When telling victims to keep quiet or change their behavior, providers in the current study have in effect blamed victims for the abuse they suffered. Moreover, when providers do not address the underlying causes of women's health complaints, women may continually return to health facilities with a similar set of unresolved health issues. In addition, our findings indicate a lack of clear workplace protocols or professional guidelines on assisting IPV victims. Instead of informing women of available options and supporting them in the decision-making process, therefore, professionals may further isolate victims and contribute to the perpetuation of violence.

The broader social and institutional context of the region significantly informed respondents' views and responses to IPV victims. Thus, for NGO respondents, a barrier to approaching the police was the belief that police responses would be inadequate. In addition, health care workers and NGO members spoke of difficulties that often result in divorce becoming a nonoption

for women. These barriers included women's lack of independent material or economic assets, concerns around stigma and poor reputation that follow divorce, the inability of some women to remarry following a divorce, and concerns for children's welfare in postdivorce situations. These barriers may not be insurmountable in every case, but respondents appeared to feel they were insurmountable in many cases. This reveals that providers' focus on mediation of the marital relationship and the advice they provided to victims to find ways to prevent or minimize abuse while remaining within their marriages were informed not only by victim-blaming attitudes and by a view that IPV is not always a serious problem, but also by concerns for women's welfare.

In the study setting and in other settings where similar perceptions are found, training programs should address that providers perceive divorce as causing women and families to be worse off than remaining within abuse. Trainers should also emphasize conceptually separating abusive from nonabusive conflict and should build upon this conceptual separation to emphasize victims' welfare and refraining from victim-blaming rather than mediation alone as a response to IPV. Without a prior understanding of providers' broad definitions of abuse, training programs are likely to be ineffective. Our findings are therefore relevant to other settings where feminist movements have not engendered a notion of IPV as a serious social problem requiring external intervention.

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Appendix

Abbreviated Sample of Interview Questions for Health Workers

What is domestic violence? Please explain what you understand by this term.

Have you ever suspected patients of experiencing domestic violence?

> How did you come to suspect her/him of experiencing domestic violence? How did you react/respond? Can you describe the situation and your response?
>
> What kind of injuries or illnesses did they have? What are the most severe injuries that you have seen?
>
> Was the manner in which you spoke with, diagnosed, or provided treatment to suspected domestic violence victims different than that given to other patients? If so, how?
>
> Is there any special advice or suggestions you give to suspected victims of domestic violence? Do you ever advise them not to return to their husbands?

Has a patient ever told you about or have you ever suspected a patient of being raped by a husband or boyfriend?

Have you ever suspected that a patient's husband or boyfriend has used a weapon against her?

Among those patients you suspected or confirmed were experiencing domestic violence, why do you think the violence was occurring?

Would you ever or have you ever called the police on behalf of a patient? Why or why not?

In attempting to help a victim of domestic violence, what barriers do you think you might face (or have you faced)?

If you wanted to report an incident or situation of domestic violence, whom would you report to? What would likely happen?

Are there any hospital rules or policies regarding domestic violence?

What are your views on domestic violence? Why does it happen?

In general, who or what do you think is to blame for domestic violence?

In your opinion, when can a woman be called "abused"?

Are there other types of abuse besides hitting? If so, what type of abuse is okay and what is serious?

Have you ever had a family member or friend who was experiencing domestic violence? If so, how did you respond? How did this experience impact you?

Abbreviated Sample of Interview Questions for NGO Staff Members

Tell me a bit about the kind of work that you do and your work-related responsibilities. What kinds of projects or activities have you been involved in?

What benefits do you think women have gained from your work?

What is domestic violence? Please explain what you understand by this term.

Are there other types of abuse besides hitting?

> Do these other types of abuse fall within the realm of "domestic violence"?

Have you ever known anyone who was or is experiencing domestic violence? Can you describe any of these situations?

> How did you respond to this situation? How did this experience impact you?

What are your views regarding domestic violence? Why does it happen?

In your opinion, what are some common causes of conflict between husbands and wives?

In your opinion, when can a woman be called "abused"?

Who do women experiencing domestic violence tell about their problem?

Do women themselves go to the police for help with domestic violence? How do the police usually respond?

In your opinion, what type of help do women experiencing domestic violence want? Is there any help available to them?

What barriers might a woman face when trying to escape from a violent partner? Are these barriers the same for women escaping a single episode of violence and those wishing to leave a partner for good?

What or who might offer help and support to a woman trying to escape from domestic violence?

What more can/should the government do to deal with the problem of domestic violence?

Do you believe the police should ever be called regarding abuse within the family? In what types of situations should they be called?

Do you believe that any aspect of domestic violence or how it is dealt with in society will change in the future?

What can local people/Tibetans do to stop the problem of domestic violence?