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Comparison of Modes of Administration of Screens to Identify a History of Childhood Physical Abuse in an Adolescent and Young Adult Population

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Abstract

BACKGROUND Childhood physical abuse is a major public health issue with negative consequences to health and well-being manifested in childhood and adolescence, and persisting into adulthood. Yet much childhood physical abuse is not identified when it occurs and little is known about how to screen for it.

METHODS To address this gap, the effectiveness of 4 modes of administration of screens to identify childhood physical abuse were compared in a sample of 506 adolescents and young adults aged 12-24 years seeking general health services at a primary care clinic. Comparisons were made between paper and pencil screen, audio computer-assisted self-interview screen, face-to-face structured screen (all 3 using the same measure), and face-to-face unstructured interview.

FINDINGS Overall, 44.5% of the sample disclosed that they had been physically abused. Compared to paper and pencil screen, the odds of reporting physical abuse were 1.5 (95% confidence interval [CI]: 0.92, 2.58) and 4.3 (95% CI: 2.49, 7.43) higher among participants using face-to-face structured screen and face-to-face unstructured interview methods, respectively. The face-to-face unstructured interview identified significantly more reports than the paper and pencil screen.

CONCLUSIONS Although the unstructured interview was the most effective mode for screening for childhood physical abuse, additional research is needed to confirm whether this holds true in other health care settings. Further research should examine how a health provider's training, experience, and comfort level might influence the identification of physical abuse disclosure in primary care settings using face-to-face unstructured interview.

KEY WORDS adolescents, childhood physical abuse, mode of administration, screening tool, young adults.

INTRODUCTION

Childhood physical abuse is a major public health issue with tremendous emotional and financial burden.[1] Though much abuse goes unreported,[2] the number of reported cases among children and adolescents nationally is high: In 2013 there were 3.5 million reports of child maltreatment involving 6.4 million children, of which 18% were for physical abuse.[3]

Childhood physical abuse has both short- and long-term negative consequences that affect all aspects of functioning throughout the victim's life course.[2,4,5] In adolescents the problems associated with abuse include teen pregnancy,[6] high stress, poor self-esteem, cigarette smoking, drug and alcohol abuse,[7,8] and depression and suicidality.[9] These negative effects can be diminished through treatment interventions if the abuse is identified by a health care provider.[1,2,10,11] Although most victims do not spontaneously disclose a history of childhood physical abuse, they are likely to disclose if asked in a medical setting as part of a comprehensive health history.[12-14] Unfortunately most

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health care providers do not ask about abuse when there are no obvious signs or symptoms, as is most commonly the case.[15] Though very few studies have focused on understanding why providers do not assess for childhood abuse,[16] there is evidence that they feel ill prepared and lack the knowledge of effective methods for identification.[17,18]

A number of modes of administration of screens have been used to identify a history of childhood abuse including paper and pencil questionnaires, interviewer-conducted questionnaires, computer-assisted questionnaires, and face-to-face interviews.[18] Each has its merits. The paper and pencil questionnaire is easy to administer but depends on the reader understanding and correctly interpreting questions.[19] In contrast the audio computer-assisted self-interview (ACASI) has an audio component that speaks the questions to the participant and does not require the same level of reading skills.[20] Structured screens, such as the Childhood Maltreatment Interview Schedule—Short Form (CMIS-SF)[21] or the Computer Assisted Maltreatment Inventory (CAMI),[22] use a defined set of questions. In contrast, the face-to-face unstructured interview allows the give and take of a conversation,[20,23] allowing the interviewer to probe. Thus an experience of physical punishment that a participant might initially define as nonabusive might, on further probing, become redefined as abuse. ACASI, which has not previously been studied in childhood abuse per se, has been found to be more effective than other modes of inquiry in research on highly sensitive issues in adolescents and young adults[24-29] because it has also been found to enhance the participants' sense of privacy and to reduce the influence of social desirability in shaping participants' responses.[30]

Our aim was to compare the effectiveness of 4 modes of administration of screens—paper and pencil screen, ACASI screen, face-to-face structured screen, and face-to-face unstructured interview—to identify a history of childhood physical abuse during a clinical visit.

METHODS

Study Population. The study sample was recruited from English-speaking youth ages 12-24 years, seeking general health services, between December 5, 2005, and April 13, 2007, at a New York City primary care clinic specifically designed for young people. A total of 532 young people were screened for history of childhood physical abuse.

Study Recruitment. Institutional Review Board approval was obtained from the Icahn School of Medicine at Mount Sinai along with a waiver of parental consent to allow consent from adolescents younger than age 18. A certificate of confidentiality was obtained to protect participants' privacy.

While waiting to see their medical provider, patients were approached by a research assistant who described the project as a confidential study on how to best take a psychosocial history from young people. Patients were told that they could decide against participation at any time without this affecting their care. Those who had difficulty understanding the study materials and consent form were not enrolled. No formal sampling or selection protocol was used. Patients who agreed to participate, once they provided consent, were randomly assigned within clinician and nonclinician arms to 1 of 4 modes of administration of screens to identify a history of childhood physical abuse. Participants received 2 movie tickets on completion of all the study instruments. Safety protocols were put in place to ensure an immediate assessment for any participant who disclosed childhood abuse or suicidality. For those younger than 18 years who disclosed abuse, child protection reporting protocols were followed.

Study Randomization. The study was limited by the fact that only 1 clinician was assigned to conduct the 2 face-to-face screening groups. Therefore, random allocation was stratified based on clinician's availability. When the clinician was not available, participants were randomly assigned to paper and pencil screen versus ACASI screen, and when the clinician was available participants were randomly assigned to face-to-face structured screen versus face-to-face unstructured interview.

Outcome. The study outcome was self-reported history of childhood physical abuse occurring before 17 years of age disclosed during any of the 3 structured screening methods (paper and pencil, ACASI, or face-to-face structured screens) or a face-to-face unstructured interview. The outcome was specified as childhood physical abuse or no childhood physical abuse regardless of the screening method used. For all 3 structured methods, childhood physical abuse was identified using the CMIS-SF (see Appendix) modified to better fit the speech used by the study population.

Predictors. Once participants completed the history of childhood abuse using 1 of the 4 randomly assigned modes of administration of childhood abuse screens, the participants completed a demographic questionnaire and the Beck Depression Inventory for Primary Care—Fast Screen (BDI-FS)[31] using ACASI.