



## Original article

## Intimate Partner Violence Detection and Care in the Veterans Health Administration: Patient and Provider Perspectives



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### A B S T R A C T

**Background:** Women veterans experience high rates of intimate partner violence (IPV), with associated negative health impacts. The Veterans Health Administration (VHA) has recently developed plans to implement routine IPV screening and provide IPV-related follow-up services for VHA patients. Previous research has examined barriers and facilitators to health care provider screening for IPV. The next step is to examine patients' disclosure of IPV experiences to health care providers and effective response to such disclosures. We sought to identify VHA patients' and providers' perspectives on how to facilitate effective IPV detection and care in VHA.

**Methods:** We conducted semistructured, qualitative interviews with 25 female veteran patients and 15 VHA health care providers. We used an inductive approach to analyzing interview transcripts and identifying themes that constituted study findings.

**Results:** Themes fell in to two broad categories: 1) barriers to disclosure and 2) barriers to an adequate response to disclosure and providing follow-up care. Barriers to disclosure of IPV to health care providers included lack of provider inquiry, lack of comfort, and concerns about the consequences of disclosure and lack of privacy. Patients and providers both indicated a need for expanded resources to respond to IPV in VHA.

**Conclusions:** Findings support current plans for IPV program implementation in VHA and point to recommendations for practice and implications for further research.

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Experience of intimate partner violence (IPV) is associated with a wide range of physical, psychological, and social health consequences, including injury; musculoskeletal, gastrointestinal, and reproductive health problems; infection with the human immunodeficiency virus and other sexually transmitted infections; mental and behavioral health concerns;

homelessness; and death (Bonomi et al., 2006; Bonomi et al., 2009; Campbell, Glass, Sharps, Laughon, & Bloom, 2007; Coker, Smith, Bethea, King, & McKeown, 2000; Coker et al., 2002; Pavao, Alvarez, Baumrind, Induni, & Kimerling, 2007). The U.S. Preventive Services Task Force recommends that health care providers screen all women of childbearing age for IPV to identify patients who may be in need of health or social services related to IPV experience (Moyer, 2012). Recent research has begun to examine the prevalence and correlates of IPV experience among the growing population of women veterans (Gerber, Iverson, Dichter, Klap, & Latta, 2014). Although more population-based research on IPV experience among female veteran populations is needed, one recent study using national health surveillance data suggests that women who have served in the military may face increased risk of lifetime IPV experience (Dichter, Cerulli, & Bossarte, 2011). Studies have also identified adverse health outcomes associated with IPV experience among female patients in the

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Veterans Health Administration (VHA; Dichter & Marcus, 2013; Dichter, Marcus, Wagner, & Bonomi, 2014; Iverson et al., 2013a). In 2013, the U.S. Department of Veterans Affairs established a program to identify and address IPV in VHA clinical practices (Broomfield, 2014).

Prior research has examined the impact of, preferences for, and barriers and facilitators to, IPV screening in the health care setting (for reviews see Nelson, Bougatosos, & Blazina, 2012; Taft et al., 2013). Recent literature has also identified barriers and facilitators to IPV screening specifically in the VHA setting (Iverson, Wells, Wiltsey-Stirman, Vaughn, & Gerber, 2013b; Iverson et al., 2014). Screening is useful for provider detection of IPV experiences because patients are unlikely to spontaneously disclose IPV in the absence of direct inquiry (Gerbert et al., 1999). However, even when asked about IPV, patients do not always disclose such experiences (Spangaro, Zwi, Poulos, & Man, 2010). Studies with women who have experienced IPV (Battaglia, Finley, & Liebschutz, 2003; Chang et al., 2005; Liebschutz, Battaglia, Finley, & Averbuch, 2008; Spangaro, Zwi, & Poulos, 2011) and veterans (Jeffreys, Leibowitz, Finley, & Arar, 2010) have identified factors inhibiting disclosure of experiences of violence and trauma to health care providers, including perceptions of clinicians as uncaring or insensitive and concerns about the repercussions of disclosure.

When patients do disclose IPV to health care providers, there is wide variation in clinicians' responses (Dichter et al., 2013; Gerber, Leiter, Hermann, & Bor, 2005; Liebschutz et al., 2008; Rhodes et al., 2007). Responses range from those that patients may find unhelpful, alienating, and/or distressing (Liebschutz et al., 2008), such as not acknowledging a disclosure or telling patients that they must report the violence and/or leave the relationship, to those that meet the standards of best practices (Family Violence Prevention Fund, 2004), including validation, further assessment, safety planning, and link to needed health care and social services (Liebschutz et al., 2008; Rhodes et al., 2007).

As an integrated health care system providing both primary and specialty care for medical and mental health needs, as well as a range of social services and VA-related benefits, there may be unique characteristics of the VHA system that influence IPV detection and response. The aim of this study was to explore VHA patients' and providers' perspectives on identifying and addressing IPV in the VHA setting. Extending prior work on barriers and facilitators to IPV screening (Iverson et al., 2013b; Iverson et al., 2014), we focus here on barriers to—and recommendations for facilitating—patient disclosure of IPV and health care provider and system response to disclosures, within the VHA.

## Methods

In this qualitative study, we conducted semistructured interviews with female veteran patients and VHA clinicians providing care to female veteran patients to identify perspectives on IPV screening and response in VHA. Interview guides were developed specifically for this study by the first author, with input from clinical staff at the Philadelphia VA Medical Center, and focused on experiences with and perspectives on talking with patients/providers about stress, violence, or abuse in intimate relationships. Interviews were audio recorded and transcribed verbatim. This study was approved by the medical center's Institutional Review Board.

## Participant Recruitment and Data Collection

### Patient interviews

As part of a larger mixed-methods study, women veteran patients, ages 18 to 64, were recruited from the waiting room of the Women's Health Clinic at the Philadelphia Veterans Affairs Medical Center (VAMC) to participate in structured interviews about women's personal health needs. A subset ( $n = 25$ ) of the structured interview participants, selected on the basis of demographic diversity and willingness to participate, then participated in in-depth semistructured qualitative interviews about military experiences, experiences with IPV, and perspectives on health care system response to IPV. Qualitative interviews were conducted in-person between December, 2012, and April 2013, by one of two trained and experienced qualitative interviewers. Participants completed written informed consent and received \$25 in compensation.

### Clinician interviews

Clinicians serving women patients in a regional area identified as Veterans Integrated Service Network (VISN) 4, which includes 10 VAMCs and 43 community-based outpatient clinics in Pennsylvania, West Virginia, Delaware, New Jersey, New York, and Ohio, were recruited via email and telephone to participate in semistructured interviews about care for women patients who have experienced IPV. We used purposive sampling methods to recruit 15 participants (at least 1 from each of the 10 VAMCs in VISN 4) who reflected diversity in role and discipline. We felt it important to include a range of disciplines because IPV screening and follow-up care in VHA would likely be addressed by providers of many disciplines and existing research with health care providers has tended to rely heavily or exclusively on physician participants. All interviews were conducted between June and August 2013 by trained qualitative interviewers using a semistructured interview guide that included open-ended questions about experience with serving patients who had experienced IPV and recommendations for IPV response in the VHA setting. One interview was conducted in person; the other 14 interviews were conducted via telephone. Participants provided informed consent and did not receive financial compensation for their participation.

### Data Analysis

We used an inductive approach to data analysis, developing a coding scheme and identifying dominant themes through a close reading of the data (Thomas, 2006). Three members of the research team, including the first author, each read over the transcripts and noted common themes related to IPV disclosure and response. The research team together developed a preliminary coding structure based on the identified themes. Two members of the research team then coded each of the transcripts, using NVIVO software, with codes added and refined as appropriate to the data and agreed upon by the research team. The research team then reviewed the coding reports to come to consensus about themes identified in the data. The team selected examples from transcripts that reflected each of the themes described.

## Results

### Participant Characteristics

Patient participants ranged in age from 22 to 58 (mean, 44.6). More than one-half (56%) identified as Black/African American;

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