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Original Research

Intimate partner violence screening and the comparative effects of screening mode on disclosure of sensitive health behaviours and exposures in clinical settings

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A R T I C L E I N F O

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A B S T R A C T

Objective: Detecting sensitive health information in clinical settings is of scientific and practical importance. The purpose of this study was to determine whether mode of screening influenced disclosure of intimate partner violence (IPV) in patterns similar to other forms of sensitive information.

Study design: This cross sectional study was designed to compare effects of face-to-face vs computer self-assessment for sensitive health information on disclosure rates. Multivariate logistic regression was used for the analysis.

Methods: Data were collected in 2012 from 639 eligible African American consenting women receiving services in women, infants and children (WIC) clinics. Women were randomized to complete assessments of sensitive exposures via computer-assisted self-interview (CASI) or face-to-face interview (FTFI). Those with complete information were included in the analysis ($n = 616$).

Results: Of 39 sensitive health exposures, reporting was higher for FTFI than CASI for exposure to IPV (7 of 7 outcomes), tobacco use (2 of 3 outcomes) and reproductive health care (2 of 3 outcomes). For example, face-to-face improved disclosure of IPV in the last year (adjusted odds ratios [aOR] = 2.27; 95% CI = 1.60–3.21) and any drug, tobacco or alcohol in the last week (aOR = 1.39; 95% CI = 1.00–1.93).

Conclusion: Trained personnel may enhance disclosure above computer-based assessments for IPV for African American women receiving public assistance through The Special Supplemental Nutrition Program for Women, Infants and Children (WIC) Propensities to disclose sexual health behaviour and drug use by CASI may not apply to IPV in this population. The context and personal motivations influence women's decision to disclose IPV.

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Introduction

In the last decade, the burden of intimate partner violence (IPV) has been enumerated for the health and well-being of families and individuals in the US and abroad. From the economic cost[1,2] to the toll exposure takes on individual life quality, IPV has a wide-ranging and detrimental impact that ripples through child development,[3–6] maternal health and family welfare.[7] The US Department of Health and Human Services, The American Congress of Obstetricians and Gynecologists, The US Services Prevention Task Force, and many other clinical and public health organizations have long supported the need to screen systematically for IPV.[8–10] Despite evidence and organizational support for IPV screening, questions about best practices and particularly mode of screening, are disputed

Pregnancy and early parenthood are periods of potential risk and change in exposure to IPV. Comparing IPV trends across studies is difficult because there is no gold standard in IPV detection. Increases in disclosure and reductions in IPV have been observed during pregnancy.[11–13] While more work understanding IPV risk during this time is needed, pregnancy and early parenthood are times of increased contact with clinical health care providers. This offers a potential window to detect and to intervene with cases of IPV.

Despite this window of opportunity for detection and intervention, both the clinical setting and the participants themselves have several constraints that make screening for IPV difficult.[14] Constraints of the clinical setting include the type of facility (e.g. emergency room vs outpatient clinic), as well as the clinician's caseload, limitations of time, extent of training to screen for IPV and preparation for the complex family dynamics involved if disclosure occurs.[15]

Beyond IPV, disclosure of sensitive information in general is challenging. Participants may be motivated to answer based on the most socially desirable or acceptable response for a given behaviour or exposure. Newman et al.[15] (2002) assessed the effects of face-to-face and computer-based screening modes on various health outcomes across genders, and found that patterns of disclosure depended on the behaviour or exposure about which questions were asked. Stigmatized behaviours, such as HIV-related risks, tended to be reported in the face-to-face interview (FTFI), vs the computer-assisted self-interview (CASI), based on the most socially desirable response. This pattern, however, was not generalizable across all behaviours and exposures. Exposures resulting in high psychological distress were reported significantly more often in FTFI than CASI.[15] Yet, some research on the effects of clinical screening mode for IPV suggest that CASI's tendency to improve disclosure was attributable to its greater anonymity, convenience and time savings.[16–18] Audio-CASI further addressed the barrier of low literacy for self-administered screening.[19]

Newman et al.[15] did not assess exposure to IPV, but other qualitative studies have considered the factors that may affect disclosure of IPV. Women who have chosen to disclose IPV have stated that privacy, clinician time, gender and elements of the environment that created a feeling of safety enabled them to disclose experiences of IPV. Many of the studies that have supported CASI methods have not explicitly taken these factors into consideration.[20–22]

Race and socio-economic status are two other factors included in this work. Complexities in racial dimensions of IPV make this population interesting. While evidence is mixed on the relationship between race and risk for IPV,[6,23,24] African American women exposed to IPV seem to have greater challenges in seeking or obtaining help.[25] Racial inequities in pregnancy health care encounters[26] and decreased provider trust[27] during pregnancy have been well documented. These inequities and trust issues suggest that the general challenges of IPV disclosure might be compounded in African American women by additional dimensions within the patient-provider interaction.

Poverty is another point of intersection that impacts IPV disclosure. Pregnant women in poverty may experience more concern about safety,[28] lower access to needed care for children and for self,[29,30] more emotional strain due to shallow social support networks[31] and increased physical risks associated with violence in the home.[30] The intersecting challenges of racial inequities and poverty, during pregnancy and the post partum period, drove our interest to assess how mode of screening influenced disclosure of IPV among African American women receiving income-based public assistance through the state-level supplemental nutrition program for women, infants, and children (WIC) programme in Atlanta, Georgia. In this study, we critically consider face-to-face screening (FTFI), and compare this method with the potential utility of computer-based forms of screening. In this context, we compare women's disclosure of experiences of IPV with their reports of other sensitive health information, such as sexual behaviours, HIV, drug use and other high-risk or highly stigmatized experiences. We make this comparison in the context of pregnancy and early parenthood.

Methods

Setting and study population

The data for this study were collected at two WIC clinics in Fulton County, Georgia, between May and July of 2012. To be eligible for WIC, families must fall below 185% of the US Poverty Income Guidelines.[32] In Fulton County (population 984,293) 60.8% of African American women receiving WIC services.[33] Proportionally, African American women are not poorer (Fulton County: 25.9% below the poverty line are African American women, nationally: 25.7% below the poverty line are African American women), but the population of African American women in this county is high relative to other counties. The Emory University Institutional Review Board and the Division of Health and Wellness of the Fulton County Health Department approved the study.

Sample inclusion and exclusion criteria

This sample included African American women who were a part of a larger study. To be enrolled in the larger study, a woman had to be at least 18 years old, eligible to receive WIC services and English speaking. Literacy was not an inclusion criteria but basic reading literacy was needed to navigate the WIC clinic. A total of 704 participants were recruited between