



Intimate partner violence discussions in the healthcare setting: A cross-sectional study

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ABSTRACT

In 2013, the United States Preventive Services Task Force recommended routine intimate partner violence (IPV) screening for reproductive-age women. Given the increased attention paid to IPV on a national scale, and broader recognition of its social and physical implications, we sought to characterize the discussions resulting from routine IPV screening—specifically regarding provider response and patient perceptions. In a cross-sectional analysis, we implemented a survey to examine outcomes of IPV screening, including use of guideline-concordant discussion topics and interventions, as well as patient perception of the encounters. Women aged 18–65 with lifetime history of IPV and a past-year healthcare appointment were recruited from clinics and women's shelters in Pennsylvania. Data collection took place from May 2014–January 2015. Of 253 women, 39% were screened for IPV at a healthcare visit in the year prior to survey administration. Of women who were screened, guideline-concordant discussion topics were employed in 70% of encounters and guideline-concordant interventions were offered in 72% of encounters. 58% of women reported being “extremely” or “very satisfied,” and 53% reported being “extremely” or “very comfortable” with IPV-related discussions. The low rate of screening in this population reiterates the importance of focusing efforts on educating providers on the importance of screening, promoting the availability of community resources, and developing systems-based practices that foster IPV screening, discussion, and referral following disclosure.

1. Introduction

Intimate partner violence (IPV) is psychological, physical, or sexual abuse occurring in an intimate relationship (Flitcraft et al., 2009). Centers for Disease Control (CDC) estimates from 2011 suggest that IPV is highly prevalent within US society, with 19% of women experiencing rape within their lifetimes, and 44% of women experiencing other sexual violence (Breiding et al., 2014). IPV has been identified as an etiological risk factor in the development of numerous physical and psychological comorbidities (Campbell and Lewandowski, 1997), and accounts for significant healthcare expenditure annually (Rivara et al., 2007). Thus, healthcare providers are poised to be powerful resources for women by addressing safety concerns and connecting women to resources, with the aim of preventing future violence and reducing morbidity and mortality.

While numerous organizations have issued recommendations for IPV screening, such recommendations, until recently, have not been codified at the federal level. Recognizing the substantial impact of IPV

on health, the Institute of Medicine (IOM) determined in 2011 that a substantial preventive service deficit exists in the detection of and intervention in IPV-related morbidity and mortality. Accordingly, the IOM recommended that all women should be screened and counseled for IPV in the healthcare setting, stating “screening for risk of abuse is central to women's safety” (Institutes of Medicine, 2011). In 2013, the United States Preventive Services Task Force (USPSTF) recommended that healthcare providers screen all women of reproductive age (18–46) for lifetime exposure to IPV, and provide appropriate follow-up (Moyer, 2013).

Numerous organizations, including Futures Without Violence, the American Medical Association (AMA), and the American College of Obstetricians and Gynecologists (ACOG), have proposed best-practice guidelines for IPV screening, as well as recommendations for counseling following disclosure. These recommendations address the context and content of screening and provide suggestions for navigating follow-up discussions if a woman discloses abuse (Flitcraft et al., 2009; Anon., 2002; ACOG, 2012).

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Evidence-based guidelines regarding the context of IPV screening focus on periodic screening that addresses recent and past IPV exposure. Research shows that women who were previously exposed to IPV are more likely to be re-exposed in the future, and thus comprise a high-risk population (McCall-Hosenfeld et al., 2013). Additionally, women should be screened in private in order to maximize disclosure, and more importantly, decrease the risk of retaliation should their partner become aware of the disclosure (Flitcraft et al., 2009; Anon., 2002; ACOG, 2012).

Guidelines regarding the content of IPV screening and counseling discussions include both discussion topics and provider interventions (Anon., 2013). Given the sensitive nature of IPV-related discussions, the healthcare provider's initial response has potential to influence further discussion as well as the patient's course of action once she leaves the office (Overstreet and Quinn, 2013; Liebschutz et al., 2008). Disclosure of IPV warrants an immediate in-depth conversation. The provider's initial response should focus on validation of the patient's experience, thus establishing a sense of solidarity against IPV (Anon., 2013). Further discussion should consist of assessing the safety of the patient and other household members, the pattern and severity of abuse, and should include development of a safety plan if abusive behavior escalates (Flitcraft et al., 2009; ACOG, 2012; Anon., 2013). Likewise, the provider should assess the impact IPV is having on the woman's physical health, mental health, and interpersonal relationships to determine how best to approach further discussion and intervention (Flitcraft et al., 2009; Anon., 2002; ACOG, 2012).

To date, relatively little research has addressed the nature of the discussions that take place following screening or patient perceptions of these encounters; however, women who discuss IPV with their healthcare providers are more likely to pursue other safety measures, such as contacting community-based domestic violence services (Bair-Merritt et al., 2014; Coker et al., 2002). Barriers to discussing IPV with patients commonly cited by healthcare providers include time constraints, provider discomfort with IPV screening questions, and lack of provider knowledge of referral resources (McCall-Hosenfeld et al., 2014). Sutherland et al., in 2014 found that, of clinicians who screened patients for IPV, 13% did not document any follow-up discussion, and the vast majority (81.5%) did not offer an action-oriented response, such as offering a follow-up appointment or making a referral to domestic violence services (Sutherland et al., 2014).

Similarly, providers historically have expressed concern that screening for IPV may harm the patient-provider relationship; however, these concerns have been largely unfounded in analysis of real-world screening programs (Renker and Tonkin, 2006). Patients who have been exposed to IPV tend to view counseling discussions with their healthcare providers as a strategic response (Swailes et al., 2016). Indeed, patients who receive preventive services such as IPV screening are more likely to report being satisfied with the encounter (Weingarten et al., 1995).

While many previous studies have addressed screening rates, very little data exists regarding the content of discussions that follow screening. Likewise, little data exists regarding the acceptability of IPV-related discussions from the patient's perspective—especially those previously exposed to IPV—as most studies focus on provider-perceived barriers to screening. This study seeks to examine screening rates following the 2013 USPSTF recommendation for universal IPV screening, as well as to add insight into the context and content of the discussion that takes place surrounding IPV screening. Finally, we seek to provide a more robust idea of the opinions of women regarding IPV-related discussions. In accordance with guidelines proposed by Futures Without Violence, as well as recommendations by AMA and ACOG, we developed a survey to examine the context and content of IPV-related discussions in the healthcare setting, and to characterize patients' comfort and satisfaction with the encounter. The conceptual framework of the study is included in Fig. 1. We underscore the importance of characterizing these clinical encounters, so as to better understand the areas

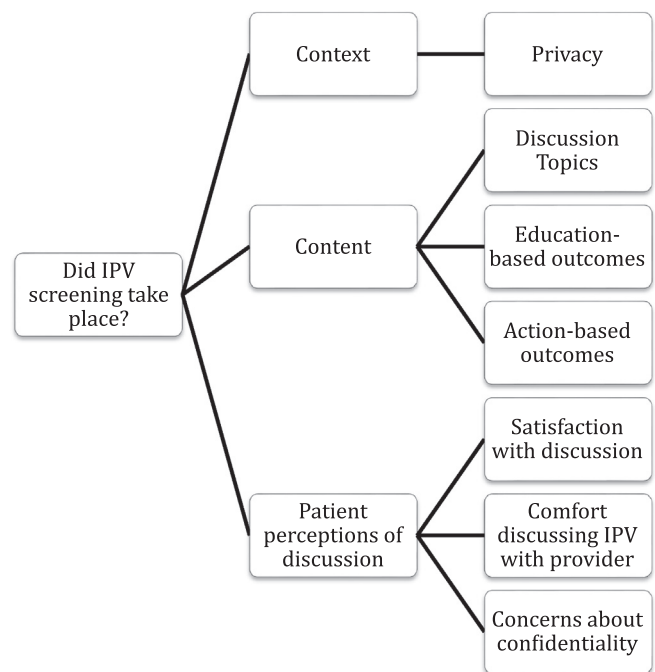


Fig. 1. Conceptual framework for IPV discussions in clinical setting. Data collected May 2014–January 2015, Central PA.

for improvement in healthcare provider-based preventive screening, counseling, and intervention for IPV-exposed women.

2. Methods

Surveys were administered as part of a longitudinal study of women's health issues in a population with lifetime exposure to IPV. Inclusion criteria included: 1) female gender, 2) age 18–64, 3) a healthcare appointment in the preceding year, and 4) history of lifetime IPV, measured by a modified HARK screening instrument (Sohal et al., 2007) (The original language of the HARK instrument asks women “Within the last year, have you [been exposed to “X”]?” We modified this to form a two-level question in which participants were asked “Within your lifetime, have you [been exposed to “X”].” If the response was affirmative, they were then asked about exposure in the preceding year). Consent to participate in this research study was obtained from all participants. Study documents and protocols were reviewed and approved by the Institutional Review Board of the Pennsylvania State University. A Certificate of Confidentiality was obtained from the National Institutes of Mental Health (CC-MH-12-204) prior to the conduct of this research.

The primary source for recruitment was the Penn State Ambulatory Research Network (PSARN), a group of outpatient primary care clinics in Central Pennsylvania affiliated with the Penn State Health Milton S. Hershey Medical Center. PSARN-associated clinics are comprised of approximately 125 providers, and encompass the specialties of Family Medicine, Internal Medicine, and Pediatrics. The mission of PSARN is to provide a platform from which to conduct primary care research.

From 24,338 eligible women with an appointment at a PSARN facility in the 12 months prior to recruitment, a randomized, rurality-stratified subsample of 2500 women was constructed. Stratification based on rurality was performed to over-sample rural residents, as the parent study was designed to examine strategies and mental health outcomes in rural women exposed to IPV. These women were sent screening questionnaires with a \$2 incentive. Participants had the option of completing screening questionnaires online, by phone, or by mail. Participants were considered to screen positive for IPV exposure if they reported any lifetime exposure to emotional, physical, or sexual

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