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Rural Appalachian Health Care Providers' Perceived Barriers to Intimate Partner Violence
Screening in Primary Care

A thesis

presented to

the faculty of the Department of Psychology

East Tennessee State University

In partial fulfillment

of the requirements for the

Master of Arts in Psychology

by

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ABSTRACT

Rural Appalachian Health Care Providers' Perceived Barriers to Intimate Partner Violence Screening in Primary Care

by

Jamie A. Tedder

Intimate Partner Violence (IPV) is a major problem in the United States. There are many health concerns associated with IPV (e.g. chronic pain, gynecological problems), leading researchers to examine the detection and management of IPV in primary care settings. However, a disproportionate amount of this research has focused on the detection and management of IPV in urban primary care clinics, with the detection and management of IPV in rural primary care being largely understudied. The current study addresses this gap in the literature by describing the screening practices and barriers to screening reported by rural providers as well as differences in rural and urban providers in regards to amount and type of barriers reported. Eighty-seven primary care providers (47=Rural) were surveyed about IPV screening practices and barriers to screening. Providers identified barriers related to both professional issues and personal beliefs. There were no significant differences in rural and urban providers in regards to number and type of reported barriers. Implications for the management of IPV in rural primary care settings are discussed.

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CHAPTER 1

INTRODUCTION

Intimate Partner Violence (IPV), especially against women, is a major problem in the United States, with lifetime prevalence for IPV between 21.4% and 53.6%, depending on how IPV is defined (e.g. Coker, Smith, Bethea, King, & McKeown, 2000; McCauley et al., 1995).

There are many health concerns associated with IPV, including gynecological problems, chronic pain problems, depression, suicidal ideation, and substance abuse (Coker et al., 2000; McCauley et al. 1995; Mechanic, Weaver, & Resick, 2008; Pico-Alfonso, 2005). Given these health concerns, many researchers have examined the detection and management of IPV in primary care settings. However, a disproportionate amount of this research has focused on the detection and management of IPV in urban primary care clinics (e.g. McCauley et al.,1995; Richardson et al., 2002). The detection and management of IPV in rural primary care has been largely understudied.

Definition of IPV

Several definitions exist for IPV, with no single definition used consistently throughout the research (Saltzman, Fanslow, McMahon, & Shelley, 1999; Tjaden & Thoennes, 2000). The primary difference between definitions used in the research concerns what forms of violence to include in the definition. Some studies have only included physical and/or sexual abuse when defining IPV (e.g.; Breiding, Black, & Ryan, 2008; Buehler, Dixon, & Toomey, 1995; McCauley et al.,1995; Schafer, Caetano, & Clark, 1998; Tjaden & Thoennes, 2000). However, other studies have expanded on this definition to include psychological or emotional abuse (e.g. Caralis & Musialowski, 1997; Coker et al., 2000; Thompson et al., 2006).

Varying definitions of IPV have led to differing estimates of IPV prevalence, with studies including psychological or emotional abuse finding higher rates of IPV (40%-44%, e.g. Caralis & Musialowski, 1997) than studies that only include physical and/or sexual abuse (23.3%-30%, e.g. Tjaden & Thoennes, 2000). A lack of a universal definition of IPV also makes comparing results across studies difficult.

The lack of coherence among definitions has led several organizations including the Centers for Disease Control (CDC) and World Health Organization (WHO) to organize work groups around developing a uniform definition of IPV that could be used for more consistent research. According to the CDC's *Intimate Partner Violence Surveillance: Uniform Definitions and Recommended Data Elements*, IPV can be defined as a harmful act committed by a former or current partner (Saltzman et al., 1999). Harmful acts as defined in the report can include physical violence (e.g. punching, shoving), sexual violence (e.g. forced intercourse, unwanted touching), threats of violence (e.g. verbal threats of physical harm), and psychological abuse (e.g. humiliation, controlling partner's behaviors).

In their *World Report on Violence and Health* (2002), the WHO offered a similar definition of IPV, describing it as "any behavior within an intimate relationship that causes physical, psychological, or sexual harm to those in the relationship" (p. 89). The report further defined IPV by categorizing four types of abusive behavior: physical abuse, psychological abuse, sexual assault, and controlling behaviors (e.g. physical isolation) (Krug, Dahlberg, Mercy, Zwi, & Lozano, 2002). However, researchers continue to use varying definitions and methods for defining and identifying IPV in their samples, including the use of various measures such as the Revised Conflict Tactics Scale (e.g. Shorey et al., 2011) and the Abuse Assessment Screen (e.g. Nicolaidis, McFarland, Curry, & Gerrity, 2009). The wide variety of methods and measures used

to assess IPV make drawing comparisons and conclusions from the IPV literature difficult, and determining a universal definition of IPV should be a goal of future research.

Prevalence of IPV

General prevalence. Despite varying definitions incidence of IPV in the general population tends to be fairly consistent across studies. *The National Violence against Women Survey* reported that the lifetime prevalence for IPV was 25.5% for women and 7.9% for men. The study also found that 1.8% of women and 1.1% of men had experienced IPV within the past year (Tjaden & Thoennes, 2000). A recent study conducted by Breiding et al. (2008) analyzed data collected from 18 different U.S. states (N=70,156) and found a lifetime IPV prevalence rate of 23.6% with an annual prevalence rate of 1.4%. The Georgia Women's Health Survey (1995) found a lifetime prevalence of 30% among a sample of women (Buehler, Dixon, & Toomey, 1995). Schafer et al. (1998) found that one in five (i.e., 20%) U.S. couples have had an incident of IPV.

Not surprising, studies that include psychological abuse in the definition of IPV report higher incidence of IPV than studies that only include physical and/or sexual assault. Caralis and Musialowski (1997) defined IPV as having experienced stress or physical injury from a partner. Using this definition, a lifetime prevalence of 44% (N=3,429) was reported. Thompson et al. (2006) also included psychological violence in the definition of IPV and found a lifetime prevalence of 40% (N=406).

Prevalence by ethnicity. *The National Violence Against Women Survey* found that men and women identifying as American Indian or Alaskan Native reported the highest rates of IPV while men and women identifying as Asian Pacific Islander reported the lowest rates of IPV. Caetano, Field, Ramisetty-Mikler, and McGrath (2005) reported that African American and

Hispanic couples reported higher rates than White couples. However, MacFarlane, Groff, O'Brien, and Watson (1995) found that in a sample of 7,443 African American, Hispanic, and White women, White women reported higher rates of IPV than African American and Hispanic women.

Prevalence by gender. Though both men and women perpetrate and are victims of IPV, women are disproportionately affected (Tjaden & Thoennes 2000). A report issued by the Bureau of Justice Statistics (2000) found that women experienced IPV five times more often than men (Rennison & Welchans). However, some research has shown that violence perpetration rates are not as disproportionate as previously reported. Archer (2000) found that while males were more likely to injure their female partners, females were more likely to engage in single or multiple acts of physical aggression. Kelly and Johnson (2008) identified four types of IPV including Coercive Controlling Violence and Situational Couple Violence. Coercive Controlling Violence refers to acts such as intimidation, isolation, and threats, while Situational Couple Violence refers to interactions that occasionally result in physical violence between partners. While most Coercive Controlling Violence is perpetrated by men, Situation Couple Violence is perpetrated by both men and women (Kelly & Johnson, 2008). Williams and Frieze (2005) found in a nationwide sample the most commonly reported type of violence was mutually mild, meaning both partners perpetrated acts of violence.

Prevalence in primary care. McCauley et al. (1995) found a lifetime prevalence of 21.4% in a sample of 1,952 women reporting to a primary care clinic. A similar estimate (27%) was found by Soglin, Bauchat, Soglin, and Martin (2009) in their study of 306 women presenting in an urban primary care clinic.

However, two other studies found much larger lifetime prevalence rates in their primary care samples. Richardson et al. (2002) found that 41% of women seeking care at primary care clinics in the United Kingdom had experienced physical abuse in their lifetime. Coker et al. (2000) found a lifetime prevalence of 53.6% in a sample of 1,152 women presenting at primary care clinics in South Carolina. In the study Coker noted that had psychological abuse not been included in the definition of IPV, one fourth of abused women would not have been identified. In fact, how IPV was defined and assessed could explain the wide range of lifetime prevalence rates found in these studies. Soglin et al. (2009) and McCauley et al. (1995) both used the AAS to assess abuse in their samples, while Richardson et al. (2002) and Coker et al. (2000) used broader measures (e.g. Women's Experience with Battering (WEB) scale).

In their samples of primary care patients Soglin et al. (2009) found that 4.2% of women reported currently experiencing abuse, whereas Coker et al. (2000) found that 13.6% of women reported currently or recently being in an abusive relationship. A study conducted in a primary care clinic in Madison, Wisconsin, found that 44.3% of 399 women sampled had experienced either physical or psychological violence in the last 90 days (Peralta & Fleming, 2003). Finally, McCauley et al. (1995) and Richardson et al. (2002) found an annual prevalence rate of 5.5% and 17% respectively. Again, differences in how IPV was assessed across different studies (e.g. different screening measures, varying sample sizes) may help to explain the varying prevalence rates reported for current or recent abuse.

Prevalence in rural areas. Research findings describing the prevalence of IPV in rural areas are mixed. Shannon, Long, Cole, and Medley (2006) found that women living in rural areas reported significantly more severe physical abuse as well as more annual incidences of physical and psychological abuse than women living in urban areas. In contrast, a report released

by the Department of Justice, Bureau of Justice Statistics (2007) based on data from the *National Crime Victimization Survey* showed that, on average, more women living in urban areas reported IPV than women living in rural areas. Interestingly, however, the percentage of homicides involving an intimate partner was higher in rural areas (Catalano, 2007). Another study that sampled 15,598 women across 16 states examined the prevalence of IPV in rural areas using the IPV module of the *Behavior Risk Factor Surveillance System* (BRFSS). The BRFSS is a survey distributed by the CDC to monitor health behaviors among adults. In contrast to the results found by Shannon et al. (2006), this study found no significant differences in IPV prevalence between rural and urban areas. Breiding, Ziembroski, and Black (2009) report a lifetime prevalence of 26.7% for women living in rural areas compared with 26.8% for women living in urban areas.

However, the studies described above differ on two important dimensions. First, the results put forth by Breiding et al. (2009) and the Department of Justice, Bureau of Statistics are based on much larger samples than those published by Shannon et al. (2006) (N= 378). Second, the IPV module of the BRFSS used by Breiding et al. and the *National Crime Victimization Survey* did not include items related to emotional abuse. On the other hand, Shannon et al. used items from both the CTS and Tolman's Psychological Maltreatment of Women Inventory to assess four categories of abuse: psychological, sexual violence, physical violence, and severe physical violence. The more encompassing definition of IPV used by Shannon et al. may have identified a wider variety of women experiencing abuse, thereby explaining the differences.

The results of these two latter studies highlight the need to include psychological abuse in definitions of IPV in order to better differentiate prevalence estimates between rural and urban areas. Murty et al. (2003) found that 2.9% of women living in a rural county reported

experiencing severe physical abuse by their partner, but that 46.7% reported experiencing emotional abuse.

Prevalence in rural primary care. Little research has examined the prevalence of IPV in rural primary care. Rates for annual prevalence range from 8% (Johnson & Elliott, 1997) to 21% (Kershner, Long, & Anderson, 1998) in primary care settings. Coker et al. (2007) found that 13.3% of women reported currently being in an abusive relationship and 25.6% reported having experienced IPV within the past 5 years in their sample of women presenting in a rural primary care clinic.

IPV and Well-Being

Physical health effects. Research has shown that IPV can have serious effects on an individual's physical and mental health. A robust finding is that women with a history of physical and/or sexual abuse report their health as fair or poor more often than women without a history of abuse (Bonomi, Anderson, Rivara, & Thompson, 2007; Campbell et al., 2002). Specifically, women with a history of abuse were significantly more likely to experience gynecological problems such as sexually transmitted diseases (STDs), vaginal bleeding and infection, pelvic pain, painful intercourse, and urinary tract infections as well as headaches, back pain, digestive problems, abdominal pain, and a loss of appetite. Coker et al. (2000) obtained very similar findings. McCauley et al. (1995) found similar physical complaints in women with a history of physical and/or sexual abuse but added that broken bones, serious cut, sprains, diarrhea, and vaginal discharge were the complaints most often correlated with abuse.

Mental health effects. In addition to the harmful effects of partner violence on physical health, there is considerable empirical evidence of the negative effects of IPV on mental health. Abused women report having more symptoms of depression (Bonomi et al. 2007; Coker et al.,

2002; McCauley et al., 1995; Mechanic et al. 2008; Pico-Alfonso et al., 2006; Plichta & Falik, 2001) and anxiety (McCauley et al., 1995; Pico-Alfonso et al., 2006; Plichta & Falik, 2001) than women who have no experience of abuse. IPV has also been linked to Post-Traumatic Stress Disorder (PTSD) (Hedtke et al., 2008; Mechanic et al., 2008).

Pico-Alfonso (2005) found that 58.7% of physically and psychologically abused women reported having suicidal thoughts compared to 7.7% of women who were not abused; and 34.7% of abused women reported having attempted suicide, compared to 1.9% of women who were not abused. Similarly, McCauley et al. (1995) found that 21.5% of women who were currently experiencing abuse reported attempting suicide compared to only 5% of women not currently experiencing abuse. McCauley et al. also found that 46.3% of abused women reported drug or alcohol abuse compared to 15.3% of women who were not abused.

Increased health care utilization. In addition to the research directly linking IPV to negative physical and mental health outcomes, the adverse effects of IPV are also evident when health care use and cost of health care is compared between abused women and women who have not been abused. Researchers found that 86% of women reporting abuse had visited their primary care provider within the past year (Willson et al., 2001).

Rivara et al. (2007) found that women with a history of physical, sexual, or psychological abuse were more likely to use health care services such as emergency departments and mental health services than women who had no history of IPV. Women with a history of abuse visited primary care offices 17% more often than women who had not been abused, and abused women's health care costs were 19% higher than women with no history of abuse.

Bergman and Brismar (1991) compared health care use between samples of women reporting or not reporting abuse and found that over a 15- year span, the sample of women

reporting abuse had significantly more hospital admissions and had made more visits to outpatient clinics. Abused women were also more likely to have visited a psychiatric facility, with the sample of abused women reporting 69 visits within the last 15 years compared to only one visit in the control group. Interestingly, Sansone, Wiederman, and Sansone (1997) found that emotional abuse, more so than physical abuse, was associated with an increase in health care use. These findings have led organizations such as the American Medical Association (AMA) to recommend that physicians include questions that screen for IPV (Flitcraft et al., 1992).

IPV experiences unique to rural women. Although research is mixed regarding an increased prevalence of IPV in rural areas, there is some evidence to support the idea that the IPV experience for rural women is different from that of their urban counterparts. Barriers unique to rural women that either prevent help-seeking or aid in perpetuating violence include increased social and physical isolation, decreased access to resources (e.g. women's shelters), and limited financial resources (Annan, 2008; Clifford, 2003).

Most of the research that has focused on rural women's experiences with IPV has been gathered via focus groups or interviews with the women themselves. Wendt and Cheers (2002) found that women reported various aspects of rural culture that had impacted their experiences. These components included religion, strong societal and familial ties, a need to belong in the community, and the need to balance upholding social norms with preserving the safety of themselves and their children.

IPV Screening in Primary Care

Given the many negative health consequences associated with partner violence, some researchers believe the primary care environment provides the ideal opportunity to screen for IPV. According to Hamberger (1993) the long-term relationship between the primary care

physician and the patient allows for the development of a trusting relationship that might be more conducive to IPV disclosure. In fact, women have reported being more likely to disclose abuse if there is more familiarity with the physician (Liebshutz, Battaglia, Finley, & Averbuch, 2008). Physicians can take advantage of this long-term relationship by scheduling routine follow-up visits with the patient to develop courses of action and to monitor the patient's safety. Primary care physicians also see a wide variety of patients in their everyday practice, which would ideally increase the likelihood of IPV detection (Hamberger, 1993).

There are several issues primary care physicians must consider when preparing to implement IPV screening into their practices. First, providers must determine the screening method (e.g. type of screener) and how screening will be implemented (e.g. computerized, in-person). Physicians must determine who in their patient population will be screened and how often. IPV screening might occur at every visit, during annual exams, or only if abuse is suspected. Physicians must also determine who in the practice will be responsible for screening patients for IPV (e.g. the physicians themselves, nursing staff) and how those professionals will be trained to manage partner violence issues (Falsetti, 2007).

There is some research available to guide primary care providers in implementing a screening protocol. Several IPV screening methods and measures have been developed for use in primary care. One literature review yielded 33 available IPV screening measures (Waltermaurer, 2005). These methods for screening identified in the literature include personal interviews, written questionnaires, and computerized questionnaires. In a review of the IPV literature Phelan (2007) compiled a list of the most commonly used IPV screening tools. Examples of measures that have been tested within primary care or family practice include the Partner Violence Screen (PVS), the Abuse Assessment Screen (AAS), and the Woman Abuse Screening Tool (WAST).

These tools ask questions related to physical, psychological, and/or sexual abuse (Phelan, 2007). For example, the PVS asks questions regarding physical abuse (e.g. if the person has been hit, punched, etc.) and perceptions of personal safety (Feldhaus et al., 1997). Other options for screening available to physicians include informal questioning and observation (Falsetti, 2007).

Frequency of screening for IPV in primary care. Although the AMA recommends that physicians screen for IPV (Flitcraft et al., 1992), IPV screeners are available, (Phelan, 2007), and IPV reporting is fairly prevalent in health care settings (e.g. McCauley et. al., 1995), research has shown that physicians often do not screen their patients for partner violence. Rodriguez, Bauer, McLoughin, and Crumback (1999) found that although 79% of physicians surveyed asked patients specific questions pertaining to partner violence when the patient was injured, only 10% screened during patients' initial visits to the office and only 9% screened during regular checkups. However, a study conducted by Chamberlain and Perham-Hester (2002) of Alaskan physicians found that screening practices were even lower. This particular study found that only 2.3% of physicians surveyed always screened for violence on a patient's initial office visit and only 1.2% always screened during an annual check-up.

Edwardsen, Pless, Fiscella, Horwitz, and Meldrum (2004) and Willson et al. (2001) both found that only 24% of patients reported being asked questions about IPV by their primary care physician. Caralis and Musialowsky (1997) surveyed women in a primary care clinic in Miami, Florida, and found that although 68% of women felt comfortable disclosing abuse to their physician, only 12% of participants were asked about partner violence by their physician. Plichta and Falik (2001) found that 74% of women who had talked about IPV with their physician had brought up the topic themselves. Gielen et al. (2000) found that 74.5% of women experiencing

IPV thought that talking to their physician about abuse was helpful and 86.1% reported that screening for partner violence would help women experiencing IPV get help.

Frequency of screening in rural areas. As with urban primary care clinics, several researchers have found that IPV screening rates are relatively low in rural settings. A sample taken from physicians practicing in rural West Virginia revealed that only 16% regularly asked their patients if they had been hurt or threatened in the past year, and only 43% asked patients if their somatic complaints could be attributed to partner violence (CDC, 1998). Kershner and Anderson (2002) found that only 15.2% of rural women surveyed had ever been asked about abuse (physical, sexual, or emotional) by a health care provider. Despite low screening rates in primary care, researchers have demonstrated the successful implantation of an IPV screening measure into rural primary care practices (Johnson & Elliott, 1997).

Johnson and Elliott (1997) introduced a five-item IPV screening measure into the routine intake process of a rural primary care site. Participants were asked to complete the questionnaire, and if abuse was indicated the physician was to follow-up with the patient during her appointment. Implementation of the screen was well-received by clinic staff, with physicians spending approximately 1 minute to address the screen with each patient. Although more time was spent with patients whose responses on the screen indicated abuse, the participating physicians rated this additional time discussing available resources and nature of the abuse as beneficial for the patient.

Barriers to IPV Screening in Primary Care

Many of studies have found that IPV screening rates are relatively low in primary care offices (e.g. Rodriguez et al., 1999) despite the fact that patients feel screening would be helpful and most would disclose IPV if asked (e.g. Caralis & Musialowsky, 1997; Gielen et al., 2000).

Given the relatively low screening rates, researchers have begun to examine what factors prevent physicians from screening for IPV in their offices (e.g. Molliconi & Runyan, 1996).

Understanding the barriers to IPV screening experienced by primary care providers might be useful in developing more valid and efficient IPV screening tools.

Researchers have identified several barriers to screening for IPV. Personal barriers include any attitudes, beliefs, or ideas that the physician might hold that would influence whether or not the physician screened for IPV (Gremillion & Evins 1994). One such barrier is the belief or idea that the patient will not leave the abusive relationship or seek help (Brown & Sas, 1994; Love et al. 2001; McGrath et al., 1997; Molliconi & Runyan, 1996). Accordingly, physicians might feel a sense of helplessness or not being able to help the patient if he or she did screen positive for IPV (Gremillion & Evins, 1994; Molliconi & Runyan, 1996).

Physicians also might believe that asking questions related to partner violence will offend or embarrass the patient (Elliot, Nerney, Jones, & Friedmann, 2002; Love et al., 2001; Molliconi & Runyan, 1996) or infringe on the patient's privacy (Gremillion & Evins, 1994; McGrath et al., 1997; Molliconi & Runyan, 1996). Physicians might feel that offending the patient or intruding on the patient's privacy will cause the patient to become uncomfortable, potentially straining the patient-physician relationship. Furthermore, physicians may fear that the patient will stop seeking services at the practice altogether (Brown et al., 1993). Similarly, physicians themselves might find discussing partner violence with the patient to be uncomfortable or embarrassing (Love et al., 2001; McGrath et al., 1997). For instance, a personal history of abuse (Gremillion & Evins, 1994) or gender differences between the patient and physician (Brown et al., 1994) might lead the physician to avoid screening.

Another possible barrier is that physicians lack confidence in their ability to handle IPV cases (Chiodo, Tilden, Limandri, & Schmidt, 1994; Ferris, 1994; Rodriguez et al., 1999). Physicians might not feel they can trust their own judgment (Limandri & Tilden, 1996) or that their assessment of the situation will be incorrect (Limandri & Tilden, 1996; McGrath et al., 1997). Fear for their own safety is another barrier faced by physicians. The physician might fear that becoming involved in cases of IPV will put him or her in danger of being retaliated against by the abuser (Brown et al., 1993; Limandri & Tilden, 1996; McGrath et al., 1997). Physicians may also fear that getting involved will only make the situation worse for the patient (Limandri & Tilden, 1996). Finally, physicians may feel that it is not their responsibility to be concerned with IPV (Love et al., 2001), and that is the sole responsibility of the patient to get out of the abusive relationship (Molliconi & Runyan, 1996). The complexity of partner violence might also deter physicians from screening for IPV (Molliconi & Runyan, 1996).

Professional and institutional barriers are problems that arise when screening for IPV conflicts with the organization, policies, or handling of the practice (Gremillion & Evins, 1994). The most common of these barriers include a lack of time available to screen (Brown et al., 1994; Gremillion & Evins, 1994; Love et al., 2001; McGrath et al., 1996; Molliconi & Runyan, 1996; Rodriguez et al., 1999) and a lack of knowledge or training in dealing with partner violence issues (Brown et al., 1994; Gremillion & Evins, 1994; Limandri & Tilden, 1996; Love et al., 2001; Rodriguez et al., 1999). Research has found that most medical schools do not offer any form of extensive training in partner violence issues. The Task Force on Violence Education and Awareness (1996) surveyed residency programs at three medical schools in Virginia to assess the curriculum on family violence. Only 27% of responding programs offered domestic violence curriculum (Hendricks-Matthews, 1996).

Another factor that might prevent the physician from screening for IPV is that the patient is not alone during the appointment. The patient might be accompanied by the partner (Love et al., 2001; Molliconi & Runyan, 1996) or their children (Love et al., 2001). The physician might feel that asking the patient questions regarding partner violence while in the presence of a partner or child will limit the patient's responses or further endanger the patient. The physician might also have a personal relationship with the patient (Molliconi & Runyan, 1996), or the abuser might also be a patient of the physician (Gremillion & Evins, 1994). These relationships might pose a conflict of interest for the physician.

Finally, the physician might not know how to help the patient if he or she does screen positive for IPV (Gremillion & Evins, 1994). For instance, the physician might not know who to refer the patient to in order to seek help (Molliconi & Runyan, 1996). There might not be any form of social service support in place for the patient to use (McGrath et al., 1997).

Waalén, Goodwin, Spitz, Peterson, and Saltzman (2000) conducted a literature review of the research on barriers to IPV screening and found that the most commonly cited barriers in previous studies were a lack of time, lack of education about IPV, lack of effective treatments or interventions for IPV, fear of offending the patient, the patient was noncompliant, and patient nondisclosure. Other barriers cited included the belief that IPV is not a medical condition and the fear that screening would put the physician's safety at risk.

Barriers to IPV screening in rural primary care. In addition to the factors present in urban clinics, several factors unique to rural areas might affect whether a primary care provider decides to screen his or her patients for IPV. One such factor might be decreased access to resources geared toward helping women experiencing IPV. Rural physicians have identified a lack of resources (e.g. shelter services, counseling services) available to meet the needs of the

community as problems in managing IPV (Eastman & Bunch, 2007; Ferris, 1994). Further, in a nationwide survey of IPV service providers rural providers were more likely to report having to turn individuals away because of a limited availability of shelter and counseling services (Iyengar & Sabik, 2009).

In addition to a lack of resources available to offer rural victims of abuse, rural physicians also report a lack of training regarding IPV-related issues (Eastman & Bunch, 2007). Research conducted by the CDC (1998) found that in a sample of rural primary care physicians, 29% reported being unsure of how to screen for IPV and only 50% had received IPV training within the past 2 years. This is problematic considering research has shown provider preparedness to be related to whether he or she asked patients about abuse (Gutmanis, Beynon, Tutty, Wathen, & MacMillan, 2007).

Eastman and Bunch (2007) found that providers practicing in rural areas were more likely to report threats to their sense of personal safety, indicating the experience of managing IPV is different for rural physicians as well as their patients. Finally, a recent study conducted in emergency departments (EDs) found that rural EDs were less likely to have standard screening policies and instruments for IPV in place, less likely to provide IPV training to staff, and less likely to offer IPV-related resources to patients (Choo, Newgard, Lowe, Hall, & McConnell, 2011).

The CDC (1998) found that rural physicians cited many patient-centered barriers to IPV detection (e.g. patient denies abuse, patient fears consequences of disclosure, patient doesn't feel experience should be classified as abuse). These barriers could be reflective of the cultural and familial norms often cited by rural women as barriers to help-seeking and disclosure (e.g. Wendt & Cheers, 2002). Ferris (1994) reported that rural physicians were more likely than urban

physicians to cite not having community resources to refer women to as a barrier to IPV identification. More research is needed to better understand the unique challenges faced by rural physicians in screening and managing IPV.

Study Rationale

IPV, especially among women, is a major problem in the United States. IPV is both a prevalent and persistent problem disproportionately affecting women (e.g. Breiding et al., 2008). Further, IPV has been shown to have negative consequences on well-being, including both physical and mental health (e.g. Coker et al., 2000; McCauley et al., 1995). Consequently, researchers have suggested the primary care environment to be an ideal place to screen and manage IPV cases due to the high prevalence of IPV reporting in primary care (e.g. McCauley et al., 1995) and increased primary care service use by women experiencing IPV (e.g. Rivara et al., 2007). However, research has shown that many primary care physicians do not screen their patients for IPV and report several barriers to screening. Further, the vast majority of research on IPV screening and management in primary care has largely been conducted in urban settings. The unique challenges and IPV-related experiences of rural physicians and their patients have been understudied, particularly in the Appalachian region.

This study fills in these research gaps by examining the most common barriers to IPV screening and management in primary care as reported by rural Appalachian primary care providers. Differences between rural and urban providers on amount and type of barriers reported were examined in order to isolate issues that might be unique to rural providers. Because of the unique challenges facing rural primary care providers identified in prior research (e.g. Eastman & Bunch, 2007; Ferris, 1994), it was expected that rural primary care providers,

compared to urban primary care providers, would report more perceived barriers to IPV screening.

The current study served as the first phase of a larger project that involves the development of a protocol for detecting and managing IPV in primary care settings within the rural Appalachian region. Findings from this study, including perceived barriers to IPV screening and current screening practices, will be used to design a protocol that will address the specific concerns of primary care providers practicing in rural Appalachia. For a diagram of the proposed project implementation, see Appendix B.

CHAPTER 2
METHODS

Participants

Participants enrolled in the study (N=87) were recruited from five sites: an annual conference for rural primary care providers, a university-affiliated student health clinic, and family medicine residency training clinics located in Northeastern Tennessee. Participants included primary care physicians, nurse practitioners, family medicine residents, and family medicine faculty. Within this sample, 46 (54.8%) participants self-identified as rural practitioners. The mean age for rural participants was 41.8 (SD=13.41) and 54.3% identified as female. The mean age for urban participants was 38.6 (SD=11.05) and 34.2% identified as female. Detailed demographical information for the various data collection sites can be found in Table 1.

Table 1. Participant Demographics by Site

	Family Medicine Residency Training Clinics	Student Health Clinic	Conference for Rural Providers
N=	42	4	39
Age M(SD)	31.2(4.9)	56(6.6)	48(11.6)
Male	53.5%	0%	64.1%
Female	46.5%	100%	35.9%
Practice in Rural Area	47.5%	20%	66.7%

Measure

Participants were given a pencil and paper questionnaire consisting of four sections. The first section consisted of the informed consent document and explained the purpose and voluntary nature of the survey. The second section contained general questions related to both physician and practice demographical information (e.g. age of physician, types of providers currently in the practice). The third section of the survey pertained to IPV screening practices used by the participant and other health care providers in his or her practice setting. Specifically, participants were asked to identify which (if any) health care providers within the practice currently screen for IPV.

The final section of the survey contained a list of potential barriers to IPV screening previously identified in the literature. In addition to barriers cited in IPV-related work, barriers found in the literature on depression, anxiety, suicide, and substance abuse screening were also included in the list of potential barriers. Potential barriers included both physician-oriented barriers (e.g. “I do not feel confident dealing with this issue”) and practice-oriented barriers (e.g. “I do not have time to assess this problem”). Participants were asked to rate the extent to which each issue was a barrier on a 4-point Likert scale ranging from 0 (Not at all a barrier) to 3 (A lot). The questionnaire took approximately 8-10 minutes to complete.

To determine rural and urban differences in barriers reported, three scale scores were created from respondents’ ratings of the potential barriers. To quantitatively assess the number of barriers reported, a Composite Barriers Scale Score was created for each participant. In order to determine differences in the type of barriers reported by each group, a Professional Barriers Scale Score and a Personal Barriers Scale Score were created.

Composite Barriers Scale Score. Respondents' ratings of all 24 barriers were averaged to create a Composite Barriers Score for each participant. Barriers used to create this scale were previously cited in research on barriers to depression, anxiety, suicide, IPV, and substance abuse screening. Internal consistency for this formulated scale was found to be good ($\alpha=.88$).

Professional Barriers Scale Score. Nine of the 24 barriers were grouped by the investigators as professional barriers based on Gremillion and Evins's (1994) qualitative categorization of professional and personal barriers to IPV screening. Any ambiguity in regards to the classification of barriers was discussed among research staff until a unanimous decision was determined. Examples of professional barriers included lack of time available to screen and a lack of effective interventions. Respondents' ratings of these nine professional-related barriers were averaged to create a Professional Barriers Scale Score. Internal consistency for this scale was found to be acceptable ($\alpha=.74$).

Personal Barriers Scale Score. Fifteen barriers were grouped by the investigators as personal barriers based on Gremillion and Evins's (1994) qualitative categorization of professional and personal barriers to IPV screening. Any ambiguity in regards to the classification of barriers was discussed among research staff until a unanimous decision was determined. Examples of personal barriers included a lack of confidence in managing IPV-related issues and fear of offending the patient. Respondents' ratings of these 15 personal-related barriers were averaged to create a Personal Barriers Scale Score. Internal consistency for this scale was found to be good ($\alpha=.83$).

Procedure

The first phase of data collection occurred during the Rural Health Association of Tennessee's 2008 Annual Conference in Gatlinburg, Tennessee. During the conference

announcements were made requesting that providers complete the questionnaires, which were located on a table in the back of the conference room. Participants were instructed to return the surveys to the table upon completion. Informed consent was implied by the participant's returning of the survey to researchers.

The second phase of data collection occurred at three family medicine residency training clinics and a student health clinic located in Northeastern Tennessee. Family medicine residents, faculty, and nurse practitioners were approached during a typical workday and asked to complete the survey by a member of the research team. Informed consent was implied by the participant's returning the survey to the research assistant.

Analyses

IPV screening rates among rural primary care providers. Screening rates for rural primary care providers was determined by calculating what percentage of participants indicated they or another provider in their practice (i.e. a medical resident, social worker, physician assistant, nurse practitioner, psychiatrist, psychologist, licensed counselor, registered nurse, or other provider) currently screens patients for IPV. Because limited data exist on the IPV screening rates among rural Appalachian primary care providers, the purpose of this analysis was exploratory in nature.

Commonly cited barriers to IPV screening. Frequency analyses were conducted in order to determine the most and least commonly cited barriers to IPV screening as perceived by rural primary care providers. As noted above, barriers were rated on a 4-point Likert scale ranging from 0 ("Not at All) to 3 ("A Lot"). The barriers that had the *least* percentage of respondents citing that particular issue as "Not at All" a barrier (i.e. participants endorsed a rating of "1", "2", or "3" on the Likert scale for these barriers) determined the most commonly

cited barriers. The barriers that had the *greatest* percentage of respondents citing the particular issue as “Not at All” a barrier (i.e. participants endorsed a rating of "0" on the Likert scale for these barriers) determined the least commonly cited barriers. The outcome of interest will be the five most commonly cited barriers and the five least commonly cited barriers. Because little research has been conducted in regards to rural providers' perceived barriers to IPV screening, this analysis will be exploratory in nature.

Rural-Urban differences in barriers reported. Independent Samples t-tests were used to determine statistical differences between rural and urban providers in Composite Barriers Scale Score, Professional Barriers Scale Score, and Personal Barriers Scale Score.

CHAPTER 3

RESULTS

Screening Practices

Frequency analyses were conducted to determine what percentage of rural primary care providers reported screening patients for IPV. Results show that 93.5% of providers surveyed indicated that at least one health care professional in his or her practice screened for IPV. A more thorough description of screening practices can be found in Table 2.

Table 2. Description of Respondents' Screening Practices

Screening Practice	Percentage of Respondents
Only Physician Performs Screening	32.6%
Nursing or Nonmedical Staff Perform Screening	2.2%
Both Physician and Staff Perform Screening	58.7%
No Screening	6.5%

Most Commonly Cited Barriers to IPV Screening

The most commonly cited barrier in the current study was the belief that the patient would be noncompliant with recommendations. Other commonly cited barriers included a lack of confidence in dealing with IPV-related problems, other people being in the exam room with the patient at the time of appointment, the demand to address other health problems, and a lack of effective treatments or interventions for IPV-related issues (Table 3).

Table 3. Most Commonly Cited Barriers to IPV Screening

Barrier	Percentage of Respondents Citing Issue as a Barrier
I feel the patient would be noncompliant with recommendations	89.1%
I am not confident in dealing with these types of problems	84.8%
There are other people with the patient at the time of the appointment	77.8%
Other health problems are competing demands	77.8%
There is a lack of effective treatments/interventions	75.6%

Least Commonly Cited Barriers to IPV Screening

The least commonly cited barrier in the current study was the belief that the provider might make the problem worse by talking about it. Fear of the patient not returning to the practice, fear of infringing on patient's privacy, costly screening, and the belief that it is the patient's responsibility to bring up IPV were also infrequently cited as barriers to IPV screening (Table 4).

Table 4. Least Commonly Cited Barriers to IPV Screening

Barrier	Percentage of Respondents Citing Issue as a Barrier
I think I might make the problem worse by talking about it	26.7%
I fear the patient may not return to my practice	30.4%
I feel I would Infringe on the patient's privacy	32.6%
Screening would be too costly	33.3%
I think it should be up to the patient to bring up the topic	40.0%

Rural-Urban Comparisons of Barriers Score

Composite barriers score. An independent samples t-test was conducted to determine rural-urban differences in composite barriers score. Results indicate that, on average, the composite barriers score for urban primary care providers (M=1.03, SD=.51) was greater than the composite barriers score for rural primary care providers (M=.99, SD=.48). However, this result was not significant $t(70) = .379, p > .05$. Thus, the hypothesis that rural primary care providers would report more barriers to IPV screening than urban primary care providers was not supported.

Professional barriers score. An independent samples t-test was conducted to determine rural/urban differences in professional barriers score. Results indicate that, on average, the professional barriers score for urban primary care providers (M=1.08, SD=.55) was greater than the composite barriers score for rural primary care providers (M=1.06, SD=.57). However, this

result was not significant $t(71) = .181, p > .05$. Thus, the hypothesis that rural primary care providers would report more professional barriers to IPV screening than urban primary care providers was not supported.

Personal barriers score. An independent samples t-test was conducted to determine rural/urban differences in professional barriers score. Results indicate that, on average, the professional barriers score for urban primary care providers ($M=.99, SD=.54$) was greater than the composite barriers score for rural primary care providers ($M=.93, SD=.48$). However, this result was not significant $t(77) = .561, p > .05$. Thus, the hypothesis that rural primary care providers would report more personal barriers to IPV screening than urban primary care providers was not supported.

CHAPTER 4

DISCUSSION

Findings indicate that an overwhelming amount of participants (93.5%) indicated screening for IPV in his or her practice. Despite the high screening rate found in the present study, results indicated that participants did perceive some barriers to IPV screening in primary care. Rural providers reported both professional barriers and personal barriers to detecting and managing IPV. However, there were no significant differences between rural and urban providers on self or other reported screening or type (i.e. professional or personal) of barriers reported.

The high screening rate found in the present study is not consistent with lower rates found in prior research conducted in rural areas (e.g. CDC, 1998; Kershner & Anderson, 2002). One explanation for this inconsistency could be that the term "screening" was not operationally defined for participants. Participants only indicated whether they or other professionals in the office screened for IPV. Therefore, it cannot be inferred from the present results how often providers screen (e.g. routinely, only if suspicious) or screening method. Kershner and Anderson (2002) and the CDC (1998) used more precise questions about frequency of screening, which might account for the discrepancy between their findings and the current results. Future research should continue to use a more precise line of questioning for assessing screening frequency among primary care providers. For instance, researchers might ask providers about the specific screening measure being used (e.g. PVS, AAS) or whether screening is in-person or computerized.

Also, the majority of participants were sampled from three family medicine residency training clinics in Northeastern Tennessee. These clinics may have procedures for IPV screening in place that increase screening among providers. Also, because these sites are training clinics,

there might be more awareness of IPV screening recommendations. Therefore, this sample might be less representative of typical rural primary care providers. As such, future research might examine screening frequency among rural primary care providers using a larger, more diverse sample.

The most commonly cited barriers to IPV screening reflect a variety of both professional and personal barriers. Professional barriers cited include the competing demands of other health problems and a lack of effective interventions for IPV-related issues. Personal barriers cited include the belief that the patient would be noncompliant with recommendations made by the provider, lack of confidence in managing IPV-related issues, and the presence of other people in the exam room at the time of the appointment.

Results of the current study parallel some findings of prior research. In 2000 Waalen et al. conducted a literature review to identify barriers to IPV screening found in previous research. Researchers compiled a list of the most commonly reported barriers in each of 12 empirical studies. There were some consistencies between the literature review and the findings of the present study. Both cited a lack of effective interventions and the belief that the patient would be noncompliant with recommendations as significant barriers. Someone being with the patient in the exam room at the time of the appointment is also consistent with prior research (Love et al., 2001; Molliconi & Runyan, 1996), as is a lack of confidence in managing IPV-related issues (Chiodo, Tilden, Limandri, & Schmidt, 1994; Ferris, 1994; Rodriguez et al., 1999;), and the competing demands of other health problems (Burman, McCabe, & Pepper, 2005).

Interestingly, many of the barriers cited in prior research on screening in rural primary care were not among the top five barriers found in the current study. Specifically, the fear that the patient (or perpetrator) would retaliate against the provider (Eastman & Bunch, 2007) and a lack of training (CDC, 1998) were not among the most commonly cited barriers. However, lack

of training was still cited as a barrier by 71.1% of respondents, indicating this issue is a concern for providers. Future research should be designed to precisely examine the training experiences of rural primary care providers as well as mechanisms for improving training in this area.

Given the perceived lack of resources for managing IPV in rural areas found in prior research (e.g. Eastman & Bunch, 2007; Ferris, 1994), it is surprising that a lack of mental health professionals to make referrals was only cited as a barrier by 46.7% of participants. One explanation for this finding is that many of the participating clinics did have a mental health professional on-site. Future research should examine the prevalence of this barrier in a more diverse sample of practitioners.

The competing demands of other health problems could reflect the time pressures felt by primary care providers in trying to address a wide range of presenting problems in a limited time frame. Abbo, Zhang, Zelder, and Huang (2008) found that the average time spent addressing individual clinical items in primary care was 3.8 minutes. This issue could potentially be addressed through an Integrated Care system, such as the model proposed by Strosahl (1998). In this model, a mental health professional is located within the primary care clinic and is available to address mental health concerns as they arise. If a patient presents with a mental health issue such as IPV, the physician could bring in the mental health professional to address the issue of abuse, thus giving the provider time to address other presenting health problems.

The lack of IPV interventions cited by providers could highlight the need for the development of more effective strategies for managing IPV in rural primary care settings. Physicians might feel that screening for IPV would be purposeless because there are no interventions available to offer patients who do screen positive for abuse. However, the issue of IPV intervention efficacy is a complex one. For instance, intervention inefficacy could be caused by a true lack of effective interventions or by the physician's lack of awareness about available

interventions. Frank et al. (2006) found that only 20% of medical school students surveyed had received extensive training in IPV-related issues. A perceived lack of interventions as well as a lack of training could explain providers' reported lack of confidence in managing IPV-related problems. Future research should explore the effectiveness of available interventions for IPV as well as how those interventions are distributed to providers practicing in rural areas.

The belief that patients will be noncompliant with recommendations could reflect a variety of underlying issues facing primary care providers. For instance, it might be that physicians feel patients would not be compliant with recommendations because of the stigma associated with mental health care in rural areas (Jameson & Blank, 2007). Also, if physicians do perceive a lack of intervention strategies for IPV, it might be that physicians do not feel they have recommendations to give patients. Prior research has also shown that the time frame from entering an abusive relationship to seeking help can be extensive. Wingood, DiClemente, and Raj (2000) found that, depending on type of abuse experienced, the average time from initial assault to a shelter visit ranged from 43.1 to 58.7 months. Physicians might feel that patients would not leave the abusive relationship, even if he or she were asked about abuse or offered an intervention. Any future protocol designed to manage IPV in rural primary care should contain an educational component designed to inform providers as to the practices and strategies used by rural women to leave abusive relationships.

Having someone with the patient at the time of the appointment might also reflect an issue of stigma. The primary care provider might feel that screening for abuse in the presence of other people might be embarrassing or offensive to the patient. The provider might also be concerned about the patient's privacy. Or, if the abuser is with the patient at the time of the appointment, the provider might feel that screening for abuse will further endanger the patient's

safety. A protocol for managing IPV in rural primary care should contain alternative options for abuse assessment when there are other people with the patient in the exam room.

Most of the least commonly cited barriers to IPV screening and management were related to personal beliefs (i.e. I think I might make the problem worse by talking about it, I fear the patient may not return to my practice, I feel I would infringe on the patient's privacy, and I think it should be up to the patient to bring up the topic). While participants did indicate a lack of confidence in managing IPV-related issues, the minimal endorsement of barriers such as fear of making the problem worse, infringing on the patient's privacy, and the belief that the patient should bring up the topic may indicate that physicians are at least somewhat comfortable discussing IPV with patients. The cost of screening was also not perceived to be a significant barrier. This finding provides some evidence that rural primary care providers do see IPV screening as financially feasible within their practices.

There were no significant differences between rural and urban providers in both number of barriers reported, as indicated by Composite Barriers Score, or type of barrier reported. Given the unique challenges potentially facing rural providers (e.g. lack of mental health resources, lack of domestic violence shelters), it was expected that rural providers would perceive significantly more barriers (both professional and personal) than urban providers. It is possible that urban and rural providers experience similar barriers to IPV screening and intervention. Therefore, protocols previously established for managing IPV in urban primary care clinics could be adapted for use in rural clinics.

There are some limitations to the present study. As described earlier, it is possible that an effect of rurality on barriers score or type of barriers cited could not be detected in the study's small sample size. Also, participants self-identified as practicing in a rural setting. It is possible that participants' perceptions of rurality are not congruent with the true geographic classification

of their practice location. Thus, results are not entirely representative of rural primary care providers. Because the term “screening” was not operationally defined for participants, method and frequency (e.g. routinely, only when suspicious) of screening cannot be determined from the current study. Finally, because participants were only sampled from the Southeastern United States, results cannot be generalized to other rural areas. It is possible that the experience of rural providers in the Southeast is different from rural providers practicing in other regions.

Results of this study have important implications for future research as well as the clinical management IPV in rural primary care clinics. Findings highlight a variety of both personal and professional barriers that might deter providers from screening for IPV. Although findings did not support the hypothesis that the amount and type of barriers reported would be different for rural providers, future research should continue to examine any rural-urban differences in amount and type of barriers reported in a larger sample size. As previously discussed, information gathered from this study on rural Appalachian primary care providers' perceived barriers to screening for IPV will be used in the development of a protocol for the detection and management of IPV in rural primary care. Ideally, addressing the specific barriers raised by rural Appalachian primary care providers will make the implementation of a protocol more successful in this particular population.

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APPENDIXES

Appendix A: Complete List of Barriers

Table 1. Barriers to IPV screening in rural primary care

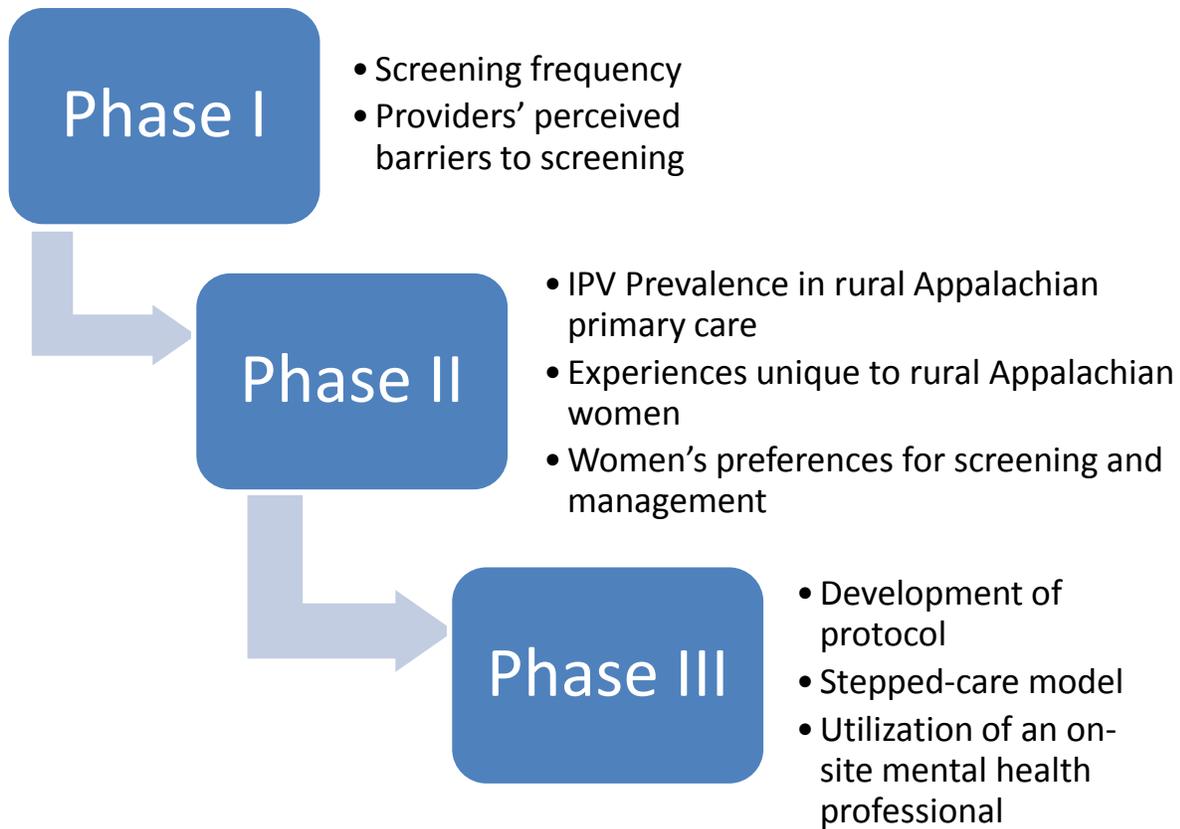
<u>Barrier</u>	<u>% of Respondents Citing Issue as a Barrier</u>
I feel the patient would be non-compliant with recommendations	89.1%
I am not confident in dealing with these types of problems	84.8%
Other health problems are competing demands	77.8%
There are other people with the patient at the time of the appointment	77.8%
There is a lack of effective treatments/interventions	75.6%
I feel that I cannot provide effective intervention in this area	73.9%
I feel patients will not cooperate with assessment	71.7%
I lack training in diagnosing this problem	71.1%
Patients' health insurance would not adequately reimburse	71.1%
I do not have the time to assess this problem area	67.4%
There is not an adequate screening measure	63.6%
I fear that I will offend my patient if I question them in this area	63%
I would not want to misdiagnose the patient	62.2%
I know my patients personally	59.1%
I fear that I may be wrong in assessing this area	54.3%
The emphasis of the practice is not on mental health	48.9%
I would not feel comfortable in dealing with the issue	46.7%
I do not know a mental health consultant to whom I can make referrals	46.7%
I fear that the patient (or family member) will retaliate against me	43.5%
I think it should be up to the patient to bring up the topic	40%
Screening would be too costly	33.3%
I feel I would infringe on patient's privacy	32.6%
I fear the patient may not return to my practice	30.4%

I think I might make the problem worse by talking about it

26.7%

Appendix B: Proposed Protocol Development

Figure 1. Proposed protocol development for detecting and managing IPV in rural primary care



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 (2011, October). *Barriers to screening for common mental health
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 Tedder, J. A. & Williams, S. L. (2010, June). *Perceived
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 Tedder, J. A., Chandler, S. L., & Williams, S. L. (2010, March).
 *Low perceived control and physical health limitations among
 women reporting sexual assault*. Poster session presented at the
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