"I just keep my antennae out" - How Rural Primary Care Physicians (PCPs) Respond to Intimate Partner Violence (IPV)

Jennifer McCall-Hosenfeld, MD, MSc, FACP
Pennsylvania State University College of Medicine
Departments of Medicine and Public Health Sciences

National Conference on Health and Domestic Violence
San Francisco, CA 3.30.2012

Disclosures

- None.

Primary care may be an important site for rural women seeking care for IPV

- 2011 IOM guidelines support screening and counseling for IPV in healthcare settings
- Prevalence of IPV in primary care settings exceeds community-based samples
- Identifying IPV in healthcare can improve health outcomes for women
- Enhanced role for primary care in rural settings

Rural primary care is a missed opportunity for responding to IPV

- In rural communities, there are significant barriers to IPV-related care (scarce referral services, poverty, social isolation, fear of disclosure)
- Rural PCPs were unsure how to properly screen and counsel patients
- Numerous barriers to IPV-related care exist in rural communities
- Little prior work has investigated IPV-related care from the rural PCP's perspective
  - The Rural Women's Healthcare Project

Methods – sample selection in the Rural Women's Healthcare Project

- AMA Masterfile, 28 county region in central Pennsylvania
- PCPs – family practice, internal medicine, obstetrics and gynecology
- Rural Urban Commuting Area (RUCA) codes used to determine rural or rural-adjacent location

Data collection – interview guide

- Explore PCPs' opinions and practices regarding primary care to rural adult women.
- Wording optimized via pilot testing and sequential revision
- After demographics, questions focused on four main topic areas:
  1. cancer screening
  2. preventive reproductive health
  3. intimate partner violence (IPV)
  4. mental health

Interview guide – IPV themes

- Defined IPV
- IPV screening in the PCP's practice
- Perceptions of IPV as a health problem
- Current practices for responding to identified IPV
- Perceived barriers to care for victims of IPV unique to rural communities.

Data analysis

- Interviews professionally transcribed.
- Three members of the research team independently analyzed each transcript.
- Inductive codes were developed using modified grounded theory.
- Iterative process used for coding.
- Using NVivo8 software, quotes illustrating themes were selected.

Sample description

Primary Care Physician Characteristics, N=19	
Female	47% (9)
Specialty Family Medicine Internal Medicine Obstetrics-Gynecology General Practitioner	 63% (12) 27% (5) 5% (1) 5% (1)
Years in Practice—median (range)	21 (1-38)
Rural Location	42% (8)
In-person Interview	53% (10)

Routine screening for IPV in rural practice is not commonly performed

- Lack of time, competing priorities, lack of training and discomfort with IPV
- Screening for IPV could harm the patient-doctor relationship
- Lack of effective resources for referral and follow-up

Routine screening for IPV in rural practice is not commonly performed

"If you don't have the resources...if you don't feel like you can do anything effective to help a person, sometimes it makes you reluctant to screen for it. Sometimes you'd rather not know."

"If you're going to ask every single female, 'Are you getting abused at home?' and they might get mad at you and walk out of here."

IPV is suspected in clinical practice when alarm is raised

- ED referrals, broken bones, bruises uncommon
- Mental health problems common presenting symptom
- Partner control tactics may trigger IPV assessment
- "I just keep my antennae out."

IPV is suspected in clinical practice when alarm is raised

"I think the more common thing as you would expect, is more psychological. We see anxiety and depression as a very understandable result of that. We see non-compliance. We see lots and lots and lots of overutilization of services for reasons you can't figure out why they're coming in."

"If the partner is always back with them for every visit and won't let them be alone in the visit. You sort of start to get a little suspicious."

Rural PCPs often use appropriate practices for counseling and referral

- Validation
- Danger assessment
- Safety planning
- Referral to services
- Creating a follow-up plan

Rural PCPs often use appropriate practices for counseling and referral

"I'll remind them that what they say to me is confidential, that I won't disclose anything without their permission, and make some general statements like, 'nobody deserves to be hurt'."

"Number one, assuring their safety and letting them know as far as areas where they can in the community, if they need to be moved out—where they can move to safely, as far as a safe house."

Rural communities present unique challenges PCP caring for IPV

- Acceptance of traditional gender roles prevent rural women from seeking help.
- Lack of resources (financial, educational, transporation, referral) in rural communities prevents women from accessing care for IPV.
- Lack of privacy in rural communities is an important barrier for women to access care for IPV.

Rural communities present unique challenges PCP caring for IPV

"This is a little bit of a male-dominated kind of society here, more so than probably some other places and I think a lot of women are afraid to come forward."

"A lot of the women can't afford to leave the situation they're in because they don't have jobs and they don't have money and they don't have cars and so they feel stuck."

Strengths and Limitations

- Limitations
  - Limited racial and ethnic diversity
  - No patient data
- Strengths
  - Thematic saturation
  - Stratifed analysis – PCP's gender, interview type
  - Robust findings

PCPs felt training not sufficient despite overall appropriate care

- All of the PCPs reported providing some aspects of guideline-concordant IPV care.
- PCPs may be underestimating their ability to provide appropriate care for women exposed to IPV.
- Improving PCPs confidence in providing effective IPV-related care could help to overcome an important barrier.

PCPs identified rural culture as a factor that mitigates effective responses to IPV.

- PCPs implied that rural women are less able to respond effectively to IPV.
- This perception might make IPV more difficult for the physician to address.
- Directive counseling may be more effective.

Multi-level interventions are necessary

- Provider education and training is necessary but will be insufficient.
- Competing time demands and scarce resources in rural communities remain significant barriers to optimizing IPV-related primary care
- Competing time demands and scarce resources in rural communities remain significant barriers.

Acknowledgements

- Cynthia H. Chuang, MD, MSc
- Carol S. Weisman, PhD
- Amanda Perry, BA
- Marianne Hillemeier, PhD, RN, MPH

- Penn State BIRCWH Program, NIH Office of Research on Women's Health BIRCWH career development award, K12 HD05582
- The Rural Women's Healthcare Project was supported by a grant from the Penn State CTSI, UL1RR033184
- Thanks to Sara A. Baker, MSW and Lara Rosenwasser, BA

- Contact: jmccallhosenfeld@hmc.psu.edu.

BIBLIOGRAPHY

Averill, J. B., Padilla, A. O., & Clements, P. T. (2007). Frightened in isolation: unique considerations for research of sexual assault and interpersonal violence in rural areas. *Journal of Forensic Nursing, 3*(1), 42-46.

Basile, K. C., Hertz, M. F., & Back, S. E. (2007). *Intimate Partner Violence and Sexual Violence Victimization Assessment Instruments for Use in Healthcare Settings* (Vol. 1). Atlanta, GA: Centers for Disease Control and Prevention, National Center for Injury Prevention and Control.

Black, M. C., Basile, K. C., Breiding, M. J., Smith, S. G., Walters, M. L., Merrick, M. T., . . . Stevens, M. R. (2011). The National Intimate Partner and Sexual Violence Survey (NISVS): 2010 Summary Report. Atlanta, GA: National Center for Injury Prevention and Control, Centers for Disease Control and Prevention.

Bonomi, A. E., Anderson, M. L., Reid, R. J., Rivara, F. P., Carrell, D., & Thompson, R. S. (2009). Medical and psychosocial diagnoses in women with a history of intimate partner violence. *Archives of Internal Medicine, 169*(18), 1692-1697.

Bosch, K., & Schumm, W. R. (2004). Accessibility to resources: helping rural women in abusive partner relationships become free from abuse. *Journal of sex & marital therapy, 30*(5), 357-370.

Breiding, M. J., Black, M. C., & Ryan, G. W. (2008). Prevalence and risk factors of intimate partner violence in eighteen U.S. states/territories, 2005. *American Journal of Preventive Medicine, 34*(2), 112-118.

Breiding, M. J., Ziembroski, J. S., & Black, M. C. (2009). Prevalence of rural intimate partner violence in 16 US states, 2005. *Journal of Rural Health, 25*(3), 240-246.

Campbell, J., Jones, A. S., Dienemann, J., Kub, J., Schollenberger, J., O'Campo, P., . . . Wynne, C. (2002). Intimate partner violence and physical health consequences. *Archives of Internal Medicine, 162*(10), 1157-1163.

Campbell, J. C., & Lewandowski, L. A. (1997). Mental and physical health effects of intimate partner violence on women and children. *Psychiatric Clinics of North America, 20*(2), 353-374.

CDC. (2012). Understanding Intimate Partner Violence, Fact Sheet 2012 Retrieved Jan. 25, 2012, from http://www.cdc.gov/ViolencePrevention/pdf/IPV_Factsheet-a.pdf.

Chuang, C. H., Hwang, S. W., McCall-Hosenfeld, J. S., Rosenwasser, L., Hillemeier, M. M., & Weisman, C. S. (2012). Primary care physicians' perceptions of barriers to preventive reproductive health care in rural communities. *Perspectives on sexual and reproductive health, in press.*

Clinical Preventive Services for Women: Closing the Evidence Gaps. (2011). Washington, DC: National Academies Press.

Coker, A. L., Davis, K. E., Arias, I., Desai, S., Sanderson, M., Brandt, H. M., & Smith, P. H. (2002). Physical and mental health effects of intimate partner violence for men and women. *American Journal of Preventive Medicine, 23*(4), 260-268.

Coker, A. L., Smith, P. H., Bethea, L., King, M. R., & McKeown, R. E. (2000). Physical health consequences of physical and psychological intimate partner violence. *Archives of Family Medicine, 9*(5), 451-457.

Colarossi, L., Breitbart, V., & Betancourt, G. (2010). Barriers to screening for intimate partner violence: a mixed-methods study of providers in family planning clinics. *Perspectives on sexual and reproductive health, 42*(4), 236-243.

Corbin, J., & Strauss, A. L. (2008). *Basics of qualitative research: Techniques and procedures for developing grounded theory*. Thousand Oaks, CA: Sage.

Derk, S. (1998). Rural health-care providers' attitudes, practices, and training experience regarding intimate partner violence--West Virginia, March 1997. *MMWR - Morbidity & Mortality Weekly Report, 47*(32), 670-673.

de Haes, H. (2006). Dilemmas in patient centeredness and shared decision making: a case for vulnerability. *Patient Educ Couns, 62*(3), 291-298. doi: S0738-3991(06)00194-7.

Eastman, B. J., & Bunch, S. G. (2007). Providing services to survivors of domestic violence: a comparison of rural and urban service provider perceptions. *Journal of Interpersonal Violence, 22*(4), 465-473.

Family Violence Prevention, F. (2004). National Consensus Guidelines on Identifying and Responding to Domestic Violence Victimization in Health Care Settings. San Francisco, CA.

Freund, K. M., Bak, S. M., & Blackhall, L. (1996). Identifying domestic violence in primary care practice. *Journal of General Internal Medicine, 11*(1), 44-46.

Gutmanis, I., Beynon, C., Tutty, L., Wathen, C. N., & MacMillan, H. L. (2007). Factors influencing identification of and response to intimate partner violence: a survey of physicians and nurses. *BMC Public Health, 7*, 12.

Jaffee, K. D., Epling, J. W., Grant, W., Ghandour, R. M., & Callendar, E. (2005). Physician-identified barriers to intimate partner violence screening. *J Womens Health, 14*(8), 713-720. Logan, T. K., Evans, L., Stevenson, E., & Jordan, C. E. (2005). Barriers to services for rural and urban survivors of rape. *Journal of Interpersonal Violence, 20*(5), 591-616.

McCloskey, L. A., Lichter, E., Williams, C., Gerber, M., Wittenberg, E., & Ganz, M. (2006). Assessing intimate partner violence in health care settings leads to women's receipt of interventions and improved health. *Public health reports,* 121(4), 435-444.

Nelson, H. D., Nygren, P., McInerney, Y., Klein, J., & Force, U. S. P. S. T. (2004). Screening women and elderly adults for family and intimate partner violence: a review of the evidence for the U. S. Preventive Services Task Force. *Annals of Internal Medicine, 140*(5), 387-396.

Peek-Asa, C., Wallis, A., Harland, K., Beyer, K., Dickey, P., & Saftlas, A. (2011). Rural disparity in domestic violence prevalence and access to resources. *J Womens Health, 20*(11), 1743-1749. doi: 10.1089/jwh.2011.2891

Richardson, J., Coid, J., Petruckevitch, A., Chung, W. S., Moorey, S., & Feder, G. (2002). Identifying domestic violence: cross sectional study in primary care. *BMJ*, 324(7332), 274.

Rural Health Research Center. Retrieved April 26, 2011, from http://depts.washington.edu/uwruca/.

Sofaer, S. (1999). Qualitative methods: what are they and why use them? *Health services research,* 34(5 Pt 2), 1101-1118.

Trabold, N. (2007). Screening for intimate partner violence within a health care setting:a systematic review of the literature. *Soc Work Health Care, 45*(1), 1-18.

Van Hightower, N. R., & Gorton, J. (1998). Domestic violence among patients at two rural health care clinics: prevalence and social correlates. *Public Health Nurs, 15*(5), 355-362.

Waalen, J., Goodwin, M. M., Spitz, A. M., Petersen, R., & Saltzman, L. E. (2000). Screening for intimate partner violence by health care providers. Barriers and interventions. *Am J Prev Med, 19*(4), 230-237.

Weisman, C. S. (1998). *Women's Health Care: Activist Traditions and Institutional Change*. Baltimore, MD: The Johns Hopkins University Press.

Women's health research: Progress, pitfalls, and promise. (2010). Washington, DC: National Academies Press.