PATIENT-CENTERED PROVIDER BEHAVIORS AND DISCLOSURE OF INTIMATE PARTNER VIOLENCE IN A PSYCHIATRIC EMERGENCY SETTING

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Violence and Injury Prevention has risen to the top of the nation's list of important public health mandates. As one of the most pervasive forms of violence facing our country today, Intimate Partner Violence (IPV) constitutes a significant public health concern. Although screening for IPV with women by healthcare providers offers opportunities for intervention and treatment, little is known about screening for IPV in emergency psychiatric settings. This descriptive study was aimed at identifying women presenting for psychiatric emergency treatment who had been exposed to IPV and the demographic characteristics, clinical factors and/or patient-centered provider behaviors that were associated with disclosure of the abuse in this setting.

The subjects for this study consisted of 216 women presenting to an emergency psychiatric setting. A self-report questionnaire elicited demographic information, history of mental illness, exposure to abuse, and screening by the provider. Respondents also scored providers on four patient-centered behaviors, including measures of trust, interpersonal interactions, communication, and knowledge of them as a person.

The findings indicated that 75% of the respondents reported exposure to IPV. Those exposed to IPV attested to varying types of IPV abuse, including psychological, physical and sexual abuse. They also reported higher rates of depression, anxiety, post-traumatic stress disorder (PTSD), and bipolar disorder.

The rate of abuse disclosure was then determined among the group of female abuse victims. Respondents were more likely to disclose abuse when screened by clinical staff. Other factors associated with an increase in disclosure included being unmarried and having PTSD, as well as the perception of a provider as being knowledgeable about the patient on a personal level.

Emergency psychiatric providers should be alert to the potential for IPV among their patients. Additional research is needed into the factors that improve disclosure of IPV.

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1.0 INTRODUCTION

1.1 SIGNIFICANCE

Intimate Partner Violence (IPV) represents one of the nation's most pressing public health concerns. Healthy People 2010 cites injury and violence as one of the ten Leading Health Indicators and identifies the reduction of the rate of physical assault by intimate partners as a specific target objective *(Healthy People 2010: Objectives for Improving Health)*. Screening for IPV is typically conducted during visits to emergency room settings or primary health care settings when IPV victims present with acute injuries. As with any screening program, the goal of positive detection is immediate intervention and treatment aimed at the reduction of IPV and corresponding threats to the victim's emotional and physical well being.

However, studies have shown that screening efforts result in the detection of only small numbers of women who are victims of IPV, for myriad possible reasons related to characeteristics both of the victims and the health care providers conducting the screening (Bowker & Maurer, 1987; Burge, 1989; Drossman et al., 1990; Gondolf, 1998; Jacobson & Richardson, 1987; Plichta, Duncan, & Plichta, 1996). As a result, in recent years attempts have been made to determine clinical approaches that enable victims of IPV to safely and consistently disclose abuse to health care providers. In this literature, there is a dearth of research related to how IPV affects the population of women with psychiatric disorders, and whether there are important differences in how to screen for IPV in these women when they present for emergency medical or psychiatric treatment. Unfortunately, it is widely agreed that this population is at heightened risk for experiencing IPV as well as less likely to be screened by a health care provider for IPV due to a variety of factors, such as clinician bias, no apparent physical injuries and acuity of psychiatric presentation (Briere, Woo, McRae, Foltz, & Sitzman, 1997; Gondolf, 1998; Larkin, Hyman, Mathias, D'Amico, & MacLeod, 1999; Larkin, Rolniak, Hyman, MacLeod, & Savage, 2000; Matevia, Goldman, McCullough, & Randall, 2002). Subsequently, we lack information as to how best to prepare health care providers to screen women for IPV in the psychiatric emergency room setting.

1.2 STATEMENT OF PROBLEM

Intimate partner violence (IPV) has many other commonly used names, associated with the same phenomenon: wife abuse, marital abuse, wife battering and perhaps the most recognizable, domestic violence. Women are far more likely to experience IPV as well as resulting serious medical and psychological injury than men (Tjaden & Thoennes, 2000) and therefore are the focus of this study. The National Center for Injury Prevention and Control, an arm of the Centers for Disease Control and Prevention (CDC) uses the following parameters to describe the concept of Intimate Partner Violence (Saltzman, Fanslow, McMahon, & Shelley, 1999): "…actual or threatened physical or sexual violence or psychological and emotional abuse directed toward a spouse, ex-spouse, current or former boyfriend or girlfriend, or current or former dating partner". The importance of recognizing the role of nonviolent abuse is essential. This type of abuse is characterized by attempts to control, coerce or humiliate the victim and includes the implicit threat of the loss of something of extreme value to the victim, such as children, pets or jobs

(Goodman, Koss, Fitzgerald, Russo, & et al., 1993). One study of male batterers and their wives found that emotionally abusive behaviors may serve as a proxy for physical assault. Over time, the woman begins to associate the emotional abuse with impending assault and the batterer can achieve the same degree of terror and subjugation of his partner without the actual physical violence occurring (Jacobson & Gottman, 1998).

1.2.1 Etiology

A functional analysis approach to understanding IPV reveals a multi-layered, complex interaction among social, economic, cultural and gender-based factors. Understanding these issues is crucial to any efforts to understand the victim's perspective and, hence, allow for more effective interventions. According to Walker (1999) the societal conditions that contribute to the occurrence of domestic violence against women are multifold and to some degree universal in nature, crossing national and cultural boundaries:

> Although each country has unique factors that determine the services and resources available to battered women, children exposed to domestic violence, and abusive partners, it is the interaction among gender, political structure, religious beliefs, attitudes toward violence in general and violence toward women, as well as state-sponsored violence, such as civil conflicts and wars, and the migration within and between countries that ultimately determine women's vulnerability and safety (p.21).

1.3 THEORETICAL BASES OF IPV

Multiple theories exist across the disciplines of sociology, biology, economics, psychological and other fields that attempt to explain the origins IPV. The socioeconomic theory of domestic violence is related to traditional views of marriage, e.g., as that of a primarily economic transaction in which the man is seen as acquiring the wife as property. In this model, men are seen as superior and are expected to retain all financial power, while women are seen as inferior and therefore subject to mistreatment (Robinson, 2003). This forced compliance is also seen in other matters which highlight the elements of power and control and ensure the wife's compliance with and dependence on the husband or paramour's autocratic control. This can include prohibitions against the woman earning an advanced education, having an occupation outside the home, or owning property or a business. This economic model of marriage also provides the rationale for the inability of the woman to leave the relationship by herself or with her children (Loue, 2001). Aside from lacking resources for basic food, shelter and other needs, she may fear legal difficulties in achieving primary custody of her children from the abusing partner.

1.3.1 Organizational theory

Hearn (1996) discusses the role of violence as a subset of the culture of dominance and power that is seen in most organized institutions, without which organizations could not exist. In these institutions, violence may be explicitly, or, as in the case of IPV, implicitly endorsed. Hearn suggests that attempts to separate the role of violence towards women from the worldview of men as the superior gender, with continued dominance, power and control over most institutions, is problematic, since the one is derived from the other. Examples are given of cases of IPV being discussed in institutions that remain largely patriarchal in nature, such as law enforcement, where the topic of violence is avoided, thereby allowing it to perpetuate itself. This organizational view of violence towards women becomes especially relevant when discussing interventions aimed at reducing women’s fear of disclosure to men in positions of authority, like policemen or physicians.

1.3.2 Evolutionary theory

Loue (2001) summarizes the view of IPV through the lens of evolutionary theory as a result of the growing complexity of our social systems:

> Obedience, it has been argued, is valued in societies which maintain a hierarchically organized social structure and in which a large amount of activity occurs in the context of formal social encounters outside the home. It can be hypothesized, then, that if such high value is placed on obedience, obedience may be demanded …where such obedience is not forthcoming, violence may be used as a means to secure it (p.23).

Evolutionary theories of domestic violence highlight the importance of a woman’s reproductive status as the stimulus behind the male partner’s controlling, abusive and violent behaviors. Specifically, the behavior is seen as stemming from the male’s need to establish certainty related to his paternity for any offspring, or the potential conception of offspring in an attempt to ensure his genetic succession or access to resources (Buss, 1989). The relationship of this sexual territoriality to IPV was tested by Peters, Shackelford, and Buss (2002) in an urban community to determine the association between women’s reproductive status and age and their risk of IPV. The authors dispute the contention that the risk of IPV decreases with age because the male partners are aging as well. They found that younger women of viable reproductive age are ten times more likely to experience IPV and that this is not only attributable to a younger male partner; in this study, the women at highest risk for IPV were those married to men who were significantly older than they by an average of twenty years.

The focus on the role of power in gender relations and its influence on IPV appears especially relevant in examining what is known about cultural differences in abusive practices and societal response. The Latino culture provides a model for examination of IPV through a sociological framework (Harris, Firestone, & Vega, 2005). In this culture, *machismo* is a set of behaviors and attitudes valued among men where the emphasis is placed on the physical domination of women and the control of female behavior. In contrast, the attitudes consistent with *marianismo* can be internalized by women in the Latino culture. Marianismo calls for women to be dependent, desexualized, subservient, and to avoid asking for help or discussing problems outside the home.

1.3.3 Psychological Theory

In contrast to these etiological theories of IPV, which assign causality for the behavior on the part of the abuser to a broader sociocultural, biological, or evolutionary basis, the psychological constructs related to the basis of IPV as it occurs in male perpetrators focus on the individual themselves. After reviewing the existing literature on characterological factors in abusive men, Holtzworth-Munroe and Saunders (1996) developed three main typologies: family- only abusers, abusers with predominant mood disorders and personality disordered presentations, and abusers with global violent, antisocial tendencies. In addition, the range of potential factors contributing to the development of abusive behaviors in these men was identified. This includes developmental factors such as exposure to abuse or attachment difficulties as children, impulsivity problems as an adult often associated with drug and alcohol abuse, social skills deficits, and firmly held attitudes towards women characterized by rigid gender role beliefs. These typologies were validated in a study by Hamburger, Lohr, Bonge, and Tolin (1996).

In a study of married couples with a history of battering, Jacobsen and Gottman (1998) detected two distinct subtypes of batterers, which they termed “Cobras” and “Pit Bulls”. The Cobras, comprising approximately 15% of the total group, were emotionally distant men, some of whom had sociopathic tendencies, who actually became calmer and more focused during episodes of abuse, hence the Cobra reference. These men also had a higher likelihood of having a criminal background. The Pit Bulls tended to be emotionally dependent on their wives and overall insecure and rejection-sensitive as a group. They tended to experience steadily escalating levels of expressed emotion during abusive encounters. Most batterers are believed to fit into this sub-grouping. Boyle and Vivian (1996) found that non-specific heightened levels of aggression and hostility were not associated with increased risk of spousal abuse, but that in men classified as severely violent the more accurate predictors of abuse were anger specifically directed at the spouse, spousal conflict and poor problem-solving skills.

Other studies offer support for these perspectives on the risk factors for abusive behavior. Dutton (2002), after completing a survey of studies exploring the rage generated by the intimate attachment of the abuser with his partner, posits that this “intimacy-anger” pattern results from poorly-formed attachments in the early developmental years of the abuser. As adults, these men develop “fearful” attachments characterized by anxiety, fear of abandonment and resulting episodes of rage toward the object of attachment. Cohen, Rosenbaum, Kane, Warnken, and Benjamin (1999) found a relationship between neuropsychological deficits, including poor problem-solving skills related to minor cognitive impairments, and an increased risk of battering behaviors. The risk of injury increases for women who are abused by their intimate partners when the abuser has had a romantic history with the victim as well as a history of drug and alcohol abuse, unemployment, and less than a high-school education (Coker, Smith, McKeown, & King, 2000; Krishnan, Hilbert, & Pase, 2001).

In summary, there are wide-ranging views regarding the etiology of IPV as manifested in the perpetrator. These views take on additional significance as the phenomenon of failure to disclose the abuse is examined in Chapter II and provide important background to a review of the history of social responses to IPV.

1.4 HISTORY

It is only relatively recently in the history of the United States that social prohibitions, mostly in the form of changes to law enforcement, have been attached to the battering husband. However, domestic violence is evident throughout recorded history and across many cultures. Roman laws from 753 BC gave men permission to physically punish their wives, and the commonly used phrase “Rule of Thumb” can be attributed to the English law which limited men to beating their wives with sticks that did not exceed the width of a thumb (Buzawa, 2003). The 1880s marked the beginning of social action against domestic violence; The Chicago Protective Agency for Women, opened in 1885, is believed to be the first of its kind, aimed at helping women who were victims of physical abuse; the program provided shelter as well as legal advocacy (Burgess, 2002).

In 1978 the National Coalition Against Domestic Violence was formed and use of the phrase “domestic violence” entered into the vernacular (Jones, 1998). Legislation in the form of The Domestic Violence Act of 1985 brought relief for victims of abuse by supporting the creation of safe housing and related services at the state level. In 1994, the United States

Congress passed the Violence Against Women Act (VAWA) which federalized the support for several domestic violence programs such as the National Domestic Violence Hotline (Buzawa, 2003). In addition, the act mandated financial support for programs aimed at helping victims of domestic violence and the creation of the National Domestic Violence Hotline and Office on Violence against Women, part of the Department of Justice. In 2000, VAWA was extended by Congress as well as strengthened by additional laws related to issues such as protecting the custodial rights of victims.

1.5 NATIONAL SCOPE OF PROBLEM

In order to gain a comprehensive grasp of the scope of IPV in the United States, in 2000 the CDC, along with the National Institute of Justice, commissioned and published an exhaustive overview of the findings from the National Violence Against Women survey (Tjaden & Thoennes, 2000). This survey describes how Intimate Partner Violence occurs in this country as well as outlines the prevalence, incidence and sequelae:

- -22.1% of women surveyed stated they had been raped or physically assaulted by an intimate partner in their lifetime
- -1.5% of these respondents reported they had been victimized as such in the past 12 months.

The authors extrapolate to estimate that in the U.S. 1.5 million women annually are victims of IPV, experiencing almost five million actual discrete episodes of IPV among this group. Approximately two million of these will require some type of medical intervention. Finally, the findings confirm that the majority of women experiencing IPV do not report these incidents to the police: less than one-fifth of the victims of marital rape and less than one-quarter of the physically assaulted notify law enforcement. These data confirm that opportunities for intervention and assistance to victims of IPV are more likely to occur via the medical health care arena than through the criminal justice system. Prevalence and incidence estimates with wider ranges are available from smaller scale studies (Bauer et al., 2002; Coker et al., 2000; McCauley et al., 1995).

1.6 INTERNATIONAL SCOPE OF PROBLEM

The World Health Organization (WHO) has identified IPV as a high priority global public health concern, given the threat that it poses to women's health at the international level (Krug, 2002). In a review of 48 population-based surveys of women from a variety of African, North and South American, Asian, and European countries, the WHO reports that 10% - 69% of women surveyed admitted to being victims of IPV in their lifetimes, specifically with regard to physical assault, and an incidence of 3% - 27% in the previous 12 months (Krug, 2002). As with the findings from the Violence against Women survey completed in the United States, this WHO review of surveys supports the finding that most of the participants acknowledged that the acts of IPV were not limited to one act, but instead were associated with multiple acts of physical aggression over time, coupled with psychological and sexual abuse and coercion. It should be noted that the WHO identifies several issues with relation to the quality of data being compared in these study reviews, including issues related to lack of full disclosure by participants secondary to concerns about personal safety and cultural pressures, which may affect the comparability of the findings. Data related to prevalence and incidence of IPV may be subject to underreporting by victims due to factors such as fear of retribution, lack of appropriate response and cultural pressures. The low rates of reporting of domestic violence as compared to the known prevalence has been called the "iceberg" of domestic violence (Gracia, 2004).The WHO has established guidelines for researchers to aid in developing study designs that are sensitive to these issues so that respondents are not placed in danger as a result of their participation.

Accordingly, the WHO has been working to typify intimate partner violence across international and cultural boundaries. In 1997 the WHO began a worldwide study of IPV, the WHO Multi-Country Study on Women's Health and Domestic Violence Against Women (2004), aimed at comprehensively identifying all aspects of IPV as it occurs in participating nations. The study's scope ranges from examining IPV prevalence and incidence data, exploring culturally–related risk factors, and identifying appropriate intervention and protection for victims to allowing for the development of international efforts aimed at reducing the occurrence of IPV. The WHO does recognize that Intimate Partner Violence as it occurs across the globe shares the same basic elements constituting the abusive pattern, including physical and sexual aggression, psychological abuse, coercion and control (Krug, 2002).

Defining what constitutes a perpetrator of IPV may vary across sources. However, in general, this term refers to a co-habiting spouse, paramour, or romantic interest of the victim. IPV is not relegated simply to heterosexual relationships nor to male-on-female abuse. However, as previously noted, because the mortality and morbidity associated with IPV is predominantly seen in female victims of male perpetrators (Tjaden & Thoennes, 2000), IPV as it applies to female victims and male perpetrators will be the topic of focus for this study.

1.7 MORTALITY AND MORBIDITY

Mortality and morbidity estimates related to IPV are subject to problems with underreporting and lack of appropriate identification of abuse (Dannenberg et al., 1995; Sorenson, Upchurch, & Shen, 1996). Morbidity related to IPV is related to accidental deaths from injuries inflicted during an abusive event and homicidal acts, in which the fatal injury occurred from an act by the perpetrator with the intent to murder the victim. The U.S. Department of Justice, Bureau of Justice Statistics (B.J.S.), Crime Data Brief on IPV from the B.J.S. National Crime Victimization Survey conducted in 2001 (Rennison, 2003) indicates that 588,490 violent crimes against women occurred, including rape and simple and aggravated assault, or a rate of 5 per 1,000 females. In addition the survey results showed that for the year 2000, 1, 247 women were murdered by their intimate partners; and that 33% of all homicides of women were IPV-related, an increase of approximately 10% from 1994 estimates (Dannenberg, Baker, & Li, 1994).

Women who are victims of IPV often experience a common set of physical and psychological traumas. Injuries may often be repeated and left untreated, thereby producing a hallmark grouping of medical conditions secondary to abuse. Women are more likely to sustain acute serious physical injury from an assault by an intimate partner than women who experience violence outside of an intimate relationship (Thompson, Simon, Saltzman, & Mercy, 1999). Chronic physical ailments and psychological dysfunction are common as well (Coker et al., 2002). In a study of women presenting for emergency treatment in rural communities, Krishnan et al. (2001) found that 29% admitted to being abused by their current intimate partner.

Resnick, Acierno, and Kilpatrick (1997) identify the potential for acute physical injury as well as chronic health problems resulting from violent assaults. They propose an interactive model that demonstrates how common responses to assaultive behavior (physical and psychological trauma and stress) may combine to produce additional negative health outcomes such as poor utilization of health care services or neglect of personal health, impaired immune system function and susceptibility to additional illness, and mental health disorders such as PTSD and depression.

IPV-related physical assaults on women occur in a myriad of forms. Weapons are used in a minority of episodes of physical assault. According to a Bureau of Justice Statistics (BJS) survey from 1993-1999 (Rennison, 2003), only 15% of the episodes of assault associated with IPV involved weapons including firearms, knives or other objects. According to the BJS survey, 50% of the reported IPV incidents resulted in injury; 5% were considered serious injuries involving gunshots, stab wounds, broken bones, loss of consciousness, and injuries to internal organs or other serious injury. Minor injuries were reported as cuts and bruises. Rape and sexual assault without related injuries accounted for 4%.

The increased utilization of inpatient medical treatment by abused women has been noted (Bergman & Brismar, 1991). In a study of women presenting to emergency departments with injuries inflicted by male partners, the injuries were most commonly characterized by contusions and abrasions, followed by lacerations and finally fractures and dislocations (Kyriacou et al., 1999). In another study, women in abusive relationships were found to have an increase in hospitalizations rates of 50% compared to non-abused women. Among these women the relative risk was 3.6 for a psychiatric hospitalization (Kernic, Wolf, & Holt, 2000). Dearwater et al. (1998) found a prevalence of 14.4% for abuse in the past year among women presenting to an emergency department and a lifetime history in 36.9%. In a study of Mexican-American women, Lown and Vega (2001) found that 10.8% of the participants reported abuse within the previous 12 months. Among these IPV victims, 26% reported health problems and six times as many somatic complaints compared to the non-abused women. In women with HIV, Liebschutz et al. (2000) found that 68% had experienced physical and sexual abuse. In addition, the abused women from this group were more likely to experience periodic and chronic illness and injuries, and to present for acute medical treatment.

1.8 PSYCHOLOGICAL IMPACT

The negative health consequences of IPV also extend to the emotional well being of abused women. IPV has been lined with findings of increased rates of depression and other mental disorders among female abuse victims. However, research is still ongoing to separate out these factors for their directional relationship to IPV. Women with certain mental disorders may have a higher risk of being victims of IPV because of related factors such as poor judgment, low self-esteem or earlier childhood experiences which predispose them to inadvertently choose or remain with violent or abusive adult male partners. Conversely, IPV itself may be the cause or trigger for the development of the mental disorder. McCauley, Yurk, Jenckes, and Ford (1998) suggest there may be a dose-dependent pattern to the relationship of physical abuse and the development of depression or substance abuse. In their study of women seen in primary care clinics, women with exposure to less traumatic types of physical abuse (characterized by no injury or minor injury) had higher levels of depressive symptoms than women who denied ever being victims of physical assault, but not as high as women who admitted to severe physical abuse (abuse which had high potential for serious injury). In addition, the subjects in the group experiencing severe abuse had a higher likelihood of a suicide attempt at some point prior to the study.

Bauer, Rodriquez and Perez-Stable (2000), in a survey of women receiving treatment at primary care clinics, found reports of depressive symptoms significantly higher among women who admitted to past (prior to previous 12 months) and current partner abuse. Scholle, Rost and Golding (1998) reported a 55% prevalence of physical abuse among depressed women, findings which are higher than the prevalence rates reported for the general population. Danielson, Moffitt, Caspi and Silva (1998), in a study of young adults, found that over half of the women with positive histories of partner violence also reported symptoms meeting criteria for a variety of psychiatric conditions ranging from anxiety and other mood disorders to eating disorders, substance abuse disorders, and personality disorders.

This co-morbidity of psychiatric disorders and involvement in abusive relationships has been identified elsewhere in the literature: depression and suicidality (Briere et al., 1997; Krishnan et al., 2001; Porcerelli et al., 2003), personality disorders (Zanarini et al., 1999), post-traumatic stress disorder (Astin, Ogland-Hand, Coleman, & Foy, 1995), substance abuse (Kilpatrick, Acierno, Resnick, Saunders, & Best, 1997), substance abuse and schizophrenia (Gearon, Kaltman, Brown, & Bellack, 2003), and substance abuse, suicidality and depression (Bergman & Brismar, 1991). Briere et al. (1997) conducted one of the few identified studies of women presenting for treatment to emergency psychiatric treatment centers in which they found that 42% of the women interviewed reported positive histories of violence in an adult relationship.

One of the most devastating aspects of IPV relates to the infliction of psychological abuse on the victim by an abusive partner. Sackett and Saunders (1999) identified four major types of psychological abuse as reported by IPV victims: criticism, ridicule, systematic ignoring and finally, rigidly controlling the woman’s activities and relationships. They also found that these behaviors were more highly correlated with damaging psychological effects such as low self-esteem, fear, and depression than was physical abuse. Jacobsen and Gottman (1998) studied four particular forms of emotional abuse and their impact on the victim's psychological status. Behaviors such as damaging property or harming pets, sexual bullying, forced isolation and humiliation were all associated with the victim's feeling intimidated, guilty, ashamed, degraded and isolated.

1.9 IMPACT ON CHILDREN

The impact of IPV on children in the abusive household can be devastating as well. In the U.S. Department of Justice, Bureau of Justice Statistics, Special Report on Intimate Partner Violence, it is noted that 43% of IPV victims have children 12 years of age or younger living in the household (Rennison & Welchans, 2000). Grych, Jouriles, Swank, McDonald and Norwood (2000) identified levels of adjustment difficulties in a sample of children who had lived in homes where IPV was occuring. Over half of the children studied exhibited some type of clinically significant behavioral and/or cognitive changes attributed to the prior abusive living situation. Studies also indicate that children who witness IPV are at higher risk for developmental problems (Fantuzzo, Boruch, Beriama, Atkins, & Marcus, 1997). Jouriles et al. (2001) found that impairments in functioning and adjustment in this population of children of mothers who were victims of IPV did not improve over time, even after extended periods away from the violent environment.

1.10 ADDITIONAL FACTORS

The risk factors associated with IPV vary across demographic lines as well as with regard to individual victims’ personal histories. Marital status has been associated with increased risk of IPV, specifically in women who were currently divorced or separated (Bergman & Brismar, 1991; Coker et al., 2000). According to the BJS Special Report on Intimate Partner Violence for the years 1993-1998 (Rennison & Welchans, 2000) women falling into each of the following demographics experienced higher rates of IPV: young, black, divorced or separated, of lower socioeconomic status, and living in rental housing and in urban areas.

Black women are deemed to be at higher risk overall as well as women in lower socioeconomic groups; Latino women appear to be at lower risk, while risk appears to decline with the age of the woman (Sorenson et al., 1996). Although white women appear to be at lower risk, this subgroup appears to be experiencing an increase in the rates of IPV (Rennison & Welchans, 2000). Unemployed women (Coker et al., 2002) and women with histories of childhood abuse are also at higher risk for IPV (Crandall, Nathens, Kernic, Holt, & Rivara, 2004). In a study of women presenting for emergency treatment (Larkin et al., 1999), it was found that women who were victims of IPV were more likely to be younger, non-white, unemployed, unmarried, and uninsured.

In a meta-analysis of 13 studies, Gazmararian et al. (1996) found a prevalence of violence towards pregnant women of 0.9- 20.1%, including emotional and sexual as well as physical abuse. Homicide was identified as a leading cause of death among pregnant women in an urban area, most likely attributable to IPV, according to the authors (Dannenberg et al., 1995). In addition, women who experience IPV during their pregnancy are more likely to deliver infants with low birth weights (Murphy, Schei, Myhr, & Du Mont, 2001).

The undue burden that IPV places on society is not limited to its impact on the well-being of the victims and their children. The phenomenon of IPV has economic consequences that affect both the individual victim and larger American institutions as well. As part of the WHO's ongoing focus on the issue of interpersonal violence, a comprehensive review of the existing literature related to the economic impact of all forms of violence was conducted (Waters, Hyder, Rajkotia Y, Rehwinkel, & Butchart, 2004). The authors note the difficulties associated with capturing the true costs of intimate partner violence given the serious underreporting that occurs and the importance of calculating costs. This includes direct costs such as medical expenses for injuries sustained or the costs for law enforcement to respond to calls for help, along with indirect costs, such as the lost earning potential for women who are too injured to work or lost productivity related to dealing with the sequalae to the abuse. A study by Women's Advocates Inc. (2002) estimates an annual loss to the United States economy of 12.6 billion dollars, secondary to IPV related costs. Wisner, Gilmer, Saltzman, and Zink (1999) estimated the costs to individuals and found that women in one health plan who were victims of IPV had average health care costs over $2,100 higher than non-abused women. Ulrich (2003) found that victims of IPV have medical costs 1.6 times higher than non-victims.

Given the widespread nature of IPV and the serious impact of this type of family violence on the physical and emotional well-being of women, as well as related impacts on their children and the social and financial burden to society, detection of IPV must be a priority in health care settings. One setting with particularly complex challenges in the screening for IPV is the psychiatric setting. There is scant information available in the literature describing female abuse victims presenting for emergency psychiatric care and there are no guidelines to best practice methods for screening patients for IPV in this arena.

1.11 RESEARCH PURPOSE

This study defines the experience of disclosure of IPV by female abuse victims to an emergency psychiatric health provider and describes related factors that affected disclosure. The study seeks to inform the larger questions related to the phenomenon of IPV in female psychiatric patients. For instance, if women with acute psychiatric illnesses are at high risk for IPV, are emergency psychiatric providers adequately sensitized to this significant risk and are they successfully screening for IPV in the psychiatric emergency setting? What are the variables that impede or promote successful screening? Is the abuse victim's experience of the provider as patient-centered a major factor in predicting disclosure, or are other factors, such as demographics, previous treatment experience, chief psychiatric complaint or being asked about abuse equally or more important in determining disclosure. The research questions posed by this study are available for review in Chapter IV.

2.0 CONTEXT OF THE STUDY

2.1 INTIMATE PARTNER VIOLENCE

Clinical interventions to increase the detection of IPV and provide subsequent opportunities for treatment and support are an important arena of clinical practice and research. In response to the need for structured clinical IPV program design, The Agency for Healthcare Research and Quality (AHRQ) developed a program for hospitals and healthcare systems to systematically evaluate their own IPV screening and intervention practices using a specially designed quality measurement tool (*Evaluating Domestic Violence Programs*, 2002). However still more research is required to determine what constitutes effective interventions with IPV victims in the psychiatric emergency setting. It is currently unclear from the literature what modifications to screening processes and supportive interventions are warranted to improve the likelihood of IPV disclosure and subsequent treatment in this specialized setting.

2.1.1 Disclosure

The issues that affect a victim’s willingness to notify health care professionals inquiring about the occurrence of IPV are complex and variable. The elements of disclosure are particularly relevant to the concept of IPV disclosure in a health care setting. Unlike other types of illness or challenges to a patient’s well-being, the provider is dependent on patients to disclose that they are experiencing IPV. The provider may suspect that physical injuries or emotional difficulties are caused by IPV, but a patient must verbally confirm their cause. The challenges to the provider in the medical setting are considerable. Blood tests, imaging, and basic physical evaluation can produce enough information to proceed with providing diagnosis and treatment for most other presenting problems regardless of patient report; indeed for many patients who present in an impaired state of consciousness, this is how diagnosis and treatment take place.

But in the circumstance of IPV, there is a set of unique obstacles that affect the patient's willingness to openly share this information outright in a medical setting. These obstacles include both individual patient and provider factors as well as the interactive effect between the two parties.

2.1.2 Patient Issues

There is an important distinction between the act of disclosing the experience of abuse and actually leaving the abusive situation that is crucial for health care providers to understand. The act of leaving the abusive situation holds many threats to the woman's safety, her children's safety and their economic future (Jenkins & Davidson, 2001). It is an act that may take the woman years to plan for, or the decision to leave may occur impulsively. However many health providers equate the act of disclosing abuse as synonymous with readiness to leave the situation and may take action on the victim's behalf, such as notifying shelter staff or law enforcement. While in some instances women may indeed be ready to leave the perpetrator, in many situations it is the first time they have admitted to another person what is happening to them. At this critical juncture, what they require is validation that they do not deserve to be treated in such a way and that the provider can help them with whatever information or support they need at that moment, regardless of the outcome, including returning to the abusive situation. This is why the emphasis on intervening in IPV cases in medical settings focuses on the identification of the abuse by disclosure as the stepping stone to opportunities to provide treatment and support (Jenkins & Davidson, 2001).

The missed opportunities for women suffering from abuse to disclose their experiences to their health care provider exist on two levels: the first, the spontaneous sharing of information with the provider and the second, the ability to respond to direct inquiry by the provider. That women rarely disclose IPV spontaneously and only slightly more frequently in response to inquiry is well documented in the literature (Bowker & Maurer, 1987; Burge, 1989; Drossman et al., 1990; Gondolf, 1990; Jacobson & Richardson, 1987; Plichta et al., 1996). Nonetheless, because rates of disclosure increase when health care providers actively screen for IPV, most advocacy agencies and medical groups have come out in favor of routine screening for IPV in all medical settings, from routine primary care visits to acute or emergency presentations.

The American College of Obstetricians and Gynecologists (ACOG) (2004) recommends that physicians screen all patients for IPV and provides scripts to physicians to guide their screening questions. The American Medical Association (AMA) (2003) has published a seven point list of guidelines for physicians related to screening for and intervening in the event of IPV. These guidelines recommend routine inquiry to all patients regarding IPV, and call for including in medical school and residency training curricula ongoing training requirements in IPV detection and intervention. The Joint Commission for the Accreditation of Health Care Organizations (2005) requires health care providers to have systems in place to universally screen for and intervene in cases of abuse. IPV researchers (Gerbert, Caspers, Bronstone, Moe, & Abercrombie, 1999; Warshaw & Alpert, 1999) note the importance of the act of universally screening for IPV and that this act in and of itself constitutes an intervention. The clinician is essentially communicating to the patient her concern and that assistance is available when needed so that even if the patient is not ready to disclose at that moment, groundwork is laid for possible future disclosure and intervention. In a study of a group of ethnically diverse abused women (Rodriguez, Sheldon, Bauer, & Perez-Stable, 2001), those who were surveyed reported that clinician inquiry was one of the factors most strongly associated with dislosure to a clinician the experience of abuse. A recent study confirmed that screening for IPV by healthcare providers is associated with improved health outcomes for women (McCloskey et al., 2006).

Clinical staff seeking to screen for and intervene with IPV in the medical setting must overcome powerful influences that compel victims to keep their abuse a secret. Several of the factors that negatively affect an IPV victim's willingness to disclose to health care providers lie in realistic fears given the nature of the abusive partner's behaviors and related fears of law enforcement involvement; specifically, fears of retaliation from the abuser, failure of the clinician to maintain confidentiality, and forced involvement with police (Gerbert et al., 1996; Rodriguez et al., 2001) .

The experience of IPV may produce psychological changes in the survivor that also decrease the likelihood of disclosure to health care providers. The "Stockholm Syndrome" is a term that has been coined for the phenomenon that occurs when hostages begin to align with their captors (Auerbach, Kiesler, Strentz, & Schmidt, 1994). This syndrome has been used by IPV researchers to explain why some women stay in abusive relationships or avoid revealing what is happening to them to others (Brookoff, O'brien, Cook, Thompson, & Williams, 1997). On the other hand, Graham et al. (2001) theorize that this response is actually a focus on survival brought on by the perceived lack of escape from the abusive situation, and is characterized by the development of cognitive distortions which enable the victim to minimize or in other ways rationalize the abuse. One study of abused women (McCauley et al., 1998) found they self-reported the following attitudinal factors as preventing them from disclosing their abuse to their health care providers: fear of friends', family or health care providers' reaction to the disclosure; shame; unwillingness to leave the abuser; and fear of retribution to self or children. Some of the women described feeling that they had to endure the abuse and some degraded themselves as "stupid" for staying in the relationship. Another interesting finding was that some of the women were embarrassed to disclose the abuse because they associated it with inferior social status (McCauley et al., 1998).

2.1.3 Provider Issues

Given the tremendous psychological and societal pressures on women who are victims of IPV to not disclose what they are experiencing to health providers, clinicians in health care settings where women present for treatment must be extraordinarily skilled in the art and science of building rapport so that these women may safely disclose their experience of IPV. However, there are also pressures on these health care providers that have produced an unfortunate dynamic with regard to the screening and assessment for IPV. The victims may be tentative and wary regarding disclosure and when they encounter health care providers who are rushed, personally uncomfortable with the topic, and/or lack expertise in IPV and related interventions, the results are low rates of disclosure and missed opportunities to intervene and offer help.

In addition, the current design of the health care system places a premium on physician and clinician productivity. In this model, time is of the essence. As a result, health care providers, in an attempt to be efficient, have modified their assessment practices in ways that may have an adverse effect on the accuracy of the information being obtained and as a result, delay appropriate intervention and treatment. In a study of patients presenting to a family practice (Marvel, Epstein, Flowers, & Beckman, 1999), the physicians on average interrupted the patient's opening presentations of their chief complaint after an average of 23.1 seconds. However, patients who were not interrupted and allowed to give a full description of their complaint used only an additional six seconds. Additionally, the study found that in patients who were interrupted, there were often additional medical concerns that were mentioned towards the end of the examination, thus prolonging the sessions, as these new concerns required investigation. Rodriguez et al. (2001) found in a study of women who reported being victims of IPV that the perception of the clinician as being rushed and not giving enough time to the patient was one of several barriers to IPV disclosure by patients. Plichta, Duncan and Plichta (1996) found that abused women were more likely to report decreased satisfaction with their physicians especially in relation to how much time they spent with them during their examinations and whether the physician made efforts to explore in depth their concerns and issues. Warshaw (1996) describes the socialization of medical trainees to maintain a detached, objective presentation with patients and the push to primarily use the provider-patient interview to derive diagnostic categories, especially in the mental health setting, instead of focusing on building the therapeutic alliance with patients.

Failure by clinical staff to inquire about IPV was identified by IPV victims as one of several barriers (Rodriguez et al., 2001) to communication regarding the abuse . Tilden et al. (1994) found that a proportion of health professionals surveyed felt that asking about and dealing with abuse issues was outside their discipline's purview. In Sugg and Inui's (1992) seminal study identifying the reasons why physicians avoid screening for domestic violence, many of the physicians used the phrase "opening Pandora's box" to describe their reluctance to enter into conversations with their patients on this sensitive issue. Specific concerns noted were: the fear of offending their patients (given the stigma associated with abuse); close identification with patients that prevented them from seeing them as possible abuse victims; a sense of hopelessness and inability to intervene; and the belief that, given their busy schedules, having to ask questions related to abuse and deal with the responses would take too much time. McCauley (1998) summarized several studies aimed at identifying barriers to physician discussions with patients regarding abuse. There were several common themes: shame, embarrassment and fear of reaction of others including the abuser. This particular barrier included physician discomfort with the topic of IPV as well as concerns for their own safety if the abuser became aware of their knowledge of the abuse. Many physicians noted their avoidance of the topic being related to an inability to help their patients who disclosed, specifically their frustration with a lack of financial resources to get medical care for IPV victims and /or housing without the abuser's support and the lack of readiness of patients to change the relationship with the abuser.

Maheux, Haley, Rivard and Gervais (1999) studied physicians in general practice and obstetric-gynecologists with regard to the frequency with which they screened for lifestyle-related risk factors to health. Only 3.2% of the physicians surveyed routinely assessed their patients for family violence; 86.5% of the general practitioners and 93% of the obstetricians/gynecologists admitted they had difficulty assessing for this risk factor, and 12.7% and 31.6% respectively reported they had inadequate training to perform this screening. In a survey of 2,400 physicians (Elliott, Nerney, Jones, & Friedmann, 2002) one third of the group worried that asking patients about domestic violence would be offensive and 41% admitted they typically forgot to inquire about domestic violence. Taft, Broom and Legge (2004) found a pattern of avoidance of IPV assessment in patients by a group of general practitioners, as well as both a failure to practice within recommended guidelines for managing IPV and a lack of support referrals when indicated. Dickson and Tutty (1996) found in a survey of public health nurses that although as a group they expressed interest in and desire to identify and intervene with abused women, that 55% were unsure of how to respond to issues of abuse.

This reluctance on many clinicians' part to avoid inquiry into IPV is unfortunate given that patients support this inquiry. Friedman, Samet, Roberts, Hudlin, and Hans (1992) studied a group of patients with and without abuse histories about their preferences related to being asked about sexual or physical abuse by their physicians. They found that the majority of patients, regardless of whether they had been abused or not, were in favor of their physician asking them about abuse during their medical visits. Failure to assess for IPV is an issue even among physicians who are considered highly trained in and experienced in this area. Gerbert, et al. (1999) surveyed such a group of IPV physician experts and found that fear of mandatory reporting laws, concerns about time, low yield in terms of positive response to direct inquiry, and subsequently deferring direct inquiry and/or forgetting to universally screen were commonly cited issues affecting whether they screened for IPV.

2.2 IMPLICATIONS FOR EMERGENCY SETTINGS

Issues related to the avoidance of inquiry into IPV by medical staff become additionally problematic in emergency settings. Ellis (1999) found in a survey of emergency room nurses that two of the most commonly cited barriers to inquiry regarding IPV were lack of time and lack of knowledge about how to conduct the inquiry. Heinzer and Krimm (2002) found that in a large urban emergency department (ED), despite preparatory training for staff which included use of video as well as written educational guides and a systematic process for screening and documentation, compliance with conducting screenings for IPV was inadequate. The staff involved in this study cited a variety of reasons for their failure to conduct the screenings, including discomfort with the topic and fear of family members' reactions. In a study of women presenting to emergency rooms (Abbott, Johnson, Koziol- McLain, & Lowenstein, 1995), only 13% disclosed or were asked about IPV although the incidence of IPV reported was 11.7% and the lifetime prevalence for the group was 54.2%.

In a study of women who were victims of IPV related homicides, over half were found to have presented to emergency rooms within the two years prior to their death with injuries consistent with physical abuse (Wadman & Muelleman, 1999). In this study, although IPV was suspected in some of the cases, none of the women were offered IPV related interventions that may have averted their eventual demise. Yam (2000) found that a group of abused women who had presented to an emergency department reported dissatisfaction with the way they were treated by staff, especially with regard to their abuse. These women described the clinical staff in the emergency rooms they visited as rushing them during their examination, lacking in compassion and being dismissive of their abuse issues and some reported that this contributed to their choice not to disclose their abuse.

There may be elements of bias inherent in some clinicians failure to assess for or respond to the disclosure of abuse. Olshansky (2002) found in a study of emergency department staff, that identification of abuse was obstructed by attitudinal barriers. Staff patterns of ignoring or minimizing abuse in their patients were openly justified by their value judgments related to the woman's inability to leave the abusive situation, the involvement of substance abuse issues, and the perception that the emergency services were being inappropriately utilized. Conversely, other women who were perceived as more deserving because of their type of injury or as possessing social status were offered more choices by staff and were assisted to disclose the abuse or obtain additional assistance. Kurz (1987) noted similar findings in a sample of women presenting for emergency treatment; 89% of the cases of women with identified abuse received either an incomplete response or no response at all to their abuse disclosure by the clinical staff. The authors identified moral judgments of the abused woman as unworthy as partially driving this response. In addition, women who were perceived as cooperative or friendly were more likely to have staff follow through with them on their report of abuse than women who were perceived by staff as uncooperative or unfriendly.

2.2.1 Implications for Emergency Psychiatry

Unfortunately, these issues identified as negatively affecting the likelihood of an IPV survivor disclosing IPV in an emergency setting are compounded by another set of factors when the emergency setting is psychiatric in nature. As noted previously, women with mental health difficulties are at risk for experiencing IPV. Briere et al. (1997) reported that four-fifths of a sample of women presenting to a psychiatric emergency room had some history of victimization of a sexual, physical or psychological nature. However, Matevia, Goldman, McCullough and Randall (2002) noted there was no evidence of IPV screening practices specifically geared towards behavioral health care settings available in the literature. Larkin et al. (1999) found in their study of patients presenting to an emergency department that although women with psychiatric presentations were at higher risk for IPV than patients with non-psychiatric presentations, they were 50% less likely to be screened for IPV by clinical staff than women with non-psychiatric presentations.

Gondolf (1998) has studied the interface of domestic violence advocacy and the mental health system extensively and has identified key structural and philosophical issues present in the mental health system, including emergency psychiatric services, that are associated with inadequate care for women experiencing IPV. These issues include a focus on the medical model which emphasizes diagnosis and medical treatment and which often minimizes social issues affecting the patient. The danger of this approach is that the subsequent focus is on identifying distinct psychiatric symptomatology and diagnosis instead of viewing the woman's overall history and presentation. An example of the potential errors resulting from the medical focus would be that of a woman presenting to a psychiatric emergency setting as withdrawn, uncommunicative, and somatizing and subsequently receiving a diagnosis of a mood disorder or personality disorder, when in fact, undisclosed to the psychiatric care provider, the woman may be living in a dangerous, abusive situation and her "symptoms" are consistent with coping reactions normally seen with abuse. This labeling and medicalization of a social problem lies at the heart of domestic violence advocates' complaints about the mental health system.

According to Gondolf (1998), other issues unique to the psychiatric emergency setting that prevent the likelihood of disclosure include an interrogative, authoritarian style of interviewing on the part of some psychiatric clinical providers. Such an approach, coupled with fears of loss of control related to a locked inpatient hospitalization may trigger the abused woman's self-protective response of avoidance and withholding of information, especially if the interview is conducted by a male clinician. Warshaw (1996) discusses similar issues that may affect the patient's response to the discussion of IPV. For some patients the locked environment of a psychiatric emergency setting, the physical search and confiscation of belongings and, as previously noted, the interrogative nature of the examination may retraumatize the patient.

Gondolf (1990) observed the assessment of women for IPV in a large urban psychiatric emergency setting and found a pattern among the clinical staff's interviews with abused women of: minimization of reports of abuse, failure to differentially diagnose symptoms consistent with abuse (such as depression , anxiety, avoidance and flashbacks consistent with Post-Traumatic Stress Disorder (PTSD)), and failure to consider safety planning. The staff tended to treat the abuse as a stressor that was exacerbating the primary psychiatric diagnosis instead of being seen as a potential source of the symptoms. In some of the cases, couples counseling was recommended and in four cases, the abused woman was discharged to home with the battering spouse, all actions that placed the woman at increased risk as well as invalidated the seriousness of the abuse. Gondolf recommends a two-pronged approach for improving the odds of successful identification and treatment of abused women in psychiatric settings that consists of education combined with administrative interventions.

Applying these findings to the psychiatric emergency room, it becomes apparent why disclosure by IPV victims would be difficult. In addition, as with personnel in medical settings, psychiatric emergency providers describe varying degrees of comfort in assessing for and asking questions related to abuse. The pace of the busy emergency setting may preclude many providers from communicating with or demonstrating a degree of accessibility to the client. Making the patient feel cared for may also be a special challenge in the emergency setting; in a study by Battaglia, Finley, and Liebschutz (2003), IPV victims reported an increase in trust when a provider spent extra time with them talking and sharing personal experiences, continued to question them and ask them to discuss their experiences and, finally, made kind gestures such as pats on the back, reassuring comments and empowering statements. Providers who are typically rushed as they provide emergency patient care may not value these behaviors. In addition, the concept of emotional equality is of special concern in the psychiatric setting where traditional training teaches clinicians to maintain strict boundaries between themselves and their patients. As a result, a clinician in the psychiatric setting may feel restricted in making comments to a patient regarding personal experiences or feelings, which may in turn prevent the development of a connection with the patient such that she would disclose IPV.

These issues may explain why other screening measures for abuse have been more successfully systematized in medical evaluation settings. IPV identification by clinical staff and the resulting need to intervene appears to have a unique set of challenges associated with it, which extend beyond the usual modes of training and education that are used to teach clinicians how to screen for child abuse or elder abuse. Indeed, there is evidence in the literature that training and education of providers regarding the phenomenon of IPV and its clinical presentation as well as the medical, symptomatic assessment of IPV alone does not produce significant improvements on identification rates (Deinemann et al., 1999; Larkin et al., 1999; Olson et al., 1996; Waalen, Goodwin, Spitz, Petersen, & Saltzman, 2000). While IPV shares similar issues with child abuse and elder abuse related to the victim's reluctance to disclose to health care providers (Rudolph & Hughes, 2001), the addition of barriers to clinician inquiry regarding abuse results in the poor likelihood of identification and disclosure in the emergency psychiatric setting. Research is needed into clinician behaviors that can overcome the IPV victim's realistic fears and facilitate the disclosure of the abuse so that intervention can take place.

3.0 CONCEPTUAL FRAMEWORK: PATIENT-CENTERED BEHAVIORS IN PROVIDER RELATIONS

3.1 PATIENT CENTEREDNESS IN PROVIDER RELATIONS

The importance of the quality of the relationship that is established between caregivers and patients in determining the outcomes of care is clearly evident. As has been noted, it is a defining variable in terms of IPV victims' ability to share their experiences with a health care provider. Given that relationship-building skills are so crucial to the provider-patient interaction in medical settings, the need for continued attention to the standardization and prioritization of these approaches in daily practice is vital to our health care system. Indeed, the Institute of Medicine's (IOM) Quality of Health Care in America Project cites Patient-Centeredness as one of six aims for improvement. Patient-centeredness is broadly defined by the IOM as encompassing "qualities of compassion, empathy, and responsiveness to the needs, values, and expressed preferences of the individual patient" (2001). Berry, Seiders, and Wilder (2003) promote the IOM's Patient-Centered Approach as an integrated philosophy of the provision of health care, and highlight three overarching principles pertaining to the six aims for improvement. Broadly, these three principles are the following: work should be performed to the highest degree of skill; and care should be balanced for both patient preference and need and provided at the moment in time it is required. Quill and Brody (1996) recommend moving away from archaic paternalistic approaches to the doctor-patient relationship and encourage instead a collaborative effort that includes sharing opinions, negotiating decisions and sharing medical decision making.

The concept of patient-centeredness is not a new one to medicine. Carl Rogers' (1961) theory of the client-centered approach to working with patients was developed in the 1940s and contributed important foundational concepts regarding clinician and patient relationships. Central to Rogerian theories are three elements that are felt to be crucial to building rapport with the patient, specifically the clinician's use of self, unconditional positive regard and use of empathic communication. The use of self refers to the ability to be genuine during encounters with patients, including the sharing of relevant experiences and feelings when it will assist in building the relationship with the patients. Unconditional positive regard is one of the most recognizable Rogerian concepts and encourages clinicians to not only avoid judgment of the patient's behaviors or choices but to actively communicate acceptance of the patient. Finally, empathic understanding involves the clinician's ability to sense the patient's internal experience during interactions and articulate this understanding to the patient.

Laine and Davidoff (1996) discuss the evolution in medicine towards a more patient-centered approach. This approach includes medical decision making practices where the patient, not the physician, is the final arbiter of treatment choice and patient-physician relationships are characterized by a mutual respect and sharing of information. Roter (2000) conceptualizes the importance of power in the patient-physician relationship by suggesting several patient-physician relationship prototypes. In one prototype, physician power is prioritized, resulting in interactions with patients characterized by a paternalistic approach, in which the physician sets the agenda for the interaction and makes unilateral decisions regarding treatment, or "the doctor knows best." This approach is contrasted with one from the other end of the spectrum, a consumeristic approach in which the patient is seen as purchasing medical care and related elements of care from a vendor, in this case the physician. There is little personal interchange in this model as the physician's role is to respond to the purchaser's request. Between these two polarities, Roter conceptualizes the collaborative model of the patient-physician interaction characterized by mutual agenda and goal setting, in which attention to the psychosocial and emotional experience of the patient through careful discussion and use of empathic communication are emphasized.

Mead and Bower (2002) propose a structure for the conceptual framework of patient-centeredness in the physician-patient relationship in which key elements are defined. They include: visualizing patients in a holistic fashion, with regard to their social, psychological as well as biological make-up; seeing the patient as a person and connecting with the patient's view of his or her own illness and allowing the physician's personal experiences and attributes to enter into the relationship; and finally forming a collaborative alliance in which control and decision making are shared within the treatment relationship. It appears that the converse of this approach may have a detrimental impact on the patient-provider relationship. Keating et al. (2002) found that patients who later reported certain problematic experiences that occurred during their visits with their physicians were also less likely to trust these physicians. The problematic behaviors on the part of the physicians included: not asking patients about their personal lives or any related health problems; not giving enough patients enough time for discussion and questions; and not including patients in the decision making related to treatment.

Although widely held to be an important element of the patient-provider relationship, trust as a concept is still being studied for its role in outcomes such as patient satisfaction, compliance with recommended treatment and a variety of other factors. Anderson and Dedrick (1990) describe two studies aimed at the development of a scale to test a reliable measure of trust in physicians and the subsequent determination of this measure's validity. The resulting Trust in Physician scale used three dimensions: dependability, confidence in competence of physician, and confidentiality. This scale's validity and predictive ability were retested by Thom, Bloch and Segal (1999), who found the scale to have construct and predictive validity. This study found that trust was a significant predictor of continuity, adherence and satisfaction. These findings have been reflected in the results of other studies on the role of patient trust in physicians (Safran et al., 1998). This inquiry into the actual behaviors that are indicative of a shift in a provider's practice pattern towards a more patient-centered approach is especially relevant to the process of screening for IPV by the provider; simple changes in the relationship between the provider and patient can produce significant improvements in the outcomes of care, specifically with regards to the disclosure of IPV.

Thom and Campbell (1997) found seven types of physician behavior to be correlated with the development of patient trust in the physician. Their study identified two categories related to expertise in assessment and intervention, and five other categories related to interpersonal competence, specifically: attempting to understand a patient's personal history, caring behavior, comprehensive and clear communication, building relationships based on equality of decision making, and respectful interactions with the patient. An additional study finding was patients' report that they were more inclined to follow the treatment recommendations from physicians whom they trusted.

A subsequent Thom study (Thom & Stanford Trust Study, 2001) of adults presenting to community-based family practices sought to build on these findings. They attempted to identify the strength of the relationships between the specific physician behaviors which were determined to be essential to building trust from their 1997 study. Among all the positive physician characteristics noted by the patients in the study, an ability to communicate a sense of expertise, caring, and attempts to comfort the patients as well as sharing information were most strongly correlated with patient trust.

A group of studies suggests that gender may play a role in the degree to which a clinician practices patient-centered communication. Bylund and Makoul (2002) found that female physicians were more likely to effectively use empathic communication in their patient encounters. Street (2002), in a review of literature examining the impact of gender differences on physician communication style, notes that while there are recent research findings demonstrating that female physicians tend to use more patient-centered types of communication, these are skills that may be practiced by male physicians as well Hence, while patient-centered communication may be style more commonly found among the female gender, it is not gender-specific, and as such can be taught to all physicians.

3.2 IMPACT ON DISCLOSURE

Patient-centered provider behaviors play an even more significant role in the patient-provider relationship when there is a question of IPV history and can promote the increased likelihood of disclosure. McCauley et al. (1998) found that, in a study of women receiving group therapy for domestic violence, participants reported they would be more likely to disclose abuse to a provider if that provider possessed a caring, “easy to talk to,” protective persona or if he or she provided a follow-up to treatment. Gerbert et al. (1999) conducted a qualitative study of physicians who were considered expert in assessment of domestic violence for information on how to guide other physicians in identifying IPV patients. Five major themes were derived:

framing screening questions to reduce patient discomfort and fear; tuning in to patient signs and symptoms that alerted the physician to IPV, such as a pattern of injuries, certain types of injuries or explanations for injuries that were not consistent; using direct and indirect approaches to identification of IPV; and asking without necessarily getting positive affirmation of the abuse. The last factor may set the stage for future disclosure given additional interactions with caregivers perceived as compassionate. Physicians were able to use more indirect methods if they had more time in the examination, and that indirect methods helped build patient trust as well as communicate a nonjudgmental atmosphere. Most importantly, some of the physicians reported that making caring statements or observations to the patients produced the most disclosures of IPV over time.

This set of clinical behaviors associated with building positive provider relationships with women experiencing IPV appears to cross cultural lines as well. A study of Latina and Asian women with a history of domestic violence found that relationships with providers characterized by open, supportive, encouraging behaviors and continuity of care improved patient-provider communications (Rodriguez, Bauer, Flores-Ortiz, & Szkupinski-Quiroga, 1998). The authors noted the Spanish term *confianza* was used by Latina participants to describe interpersonal interactions characterized by comforting, warm and caring behaviors that facilitated communication. Among Asian participants, a compassionate environment and caring approach combined with knowledge of domestic violence were deemed especially important.

In a qualitative study of IPV survivors (Battaglia et al., 2003), five key behaviors were identified that promoted the development of trust between the abuse victim and the provider: 1) provider communication about abuse, including an openness towards discussing abuse, as well as offering information and listening respectfully to the abuse victim; 2) professional competency, including appearing knowledgeable, conducting comprehensive history taking and asking about the patients' personal lives, as well as, in some cases, having some relationship over time with the patient; 3) accessibility of the provider in that the respondent could reach him or her easily and quickly, including behaviors that led the patient to believe that information shared with the provider would be maintained with confidentiality and that decisions about care would be made in a collaborative fashion; 4) caring, including nonverbal behaviors that conveyed warmth and attention to the patient, nonjudgmental and validating statements about the abuse, and respectful but persistent questioning and discussion of the abuse; 5) emotional equality, developed between the provider and patient when the provider shared aspects of his or her personal life or emotions with the patient, especially when there was a perception of a common shared experience. The authors suggest that this particular behavior is especially effective in promoting trust as it may eliminate the power imbalance between the provider and patient and reduce the perception of the provider as an authority figure, which may trigger avoidance and withdrawal in abuse victims.

These results are especially significant given what we know about existing attitudes and typically distant stance that are the norm among providers in a variety of health care settings. Indeed, clinicians are traditionally trained to maintain strict interpersonal boundaries with their patients in psychiatric settings where the sharing of the clinician's personal experiences would be discouraged. Battaglia's findings point out that traditionally held beliefs and practice patterns of health care providers are at odds with what we now know to be effective in helping women who are experiencing IPV.

3.3 PROSPECTS FOR TRAINING

The need for building better curricula aimed at educating health care providers in the prevention, exploration of and treatment of family violence, including IPV, has been identified in the literature (Albright, 1997; Alpert, Sege, & Bradshaw, 1997; Brandt, 1997; Dickstein, 1997; Rosenberg, Fenley, Johnson, & Short, 1997). Warshaw (1997) notes the importance of incorporating three concepts into any educational intervention with clinicians regarding abuse: 1) an understanding of the dynamics of the abusive situation from the patient's perspective; 2) understanding the individual woman's life experiences and living situation; and 3) the interactive effect among the victim, the individual health care provider and the system in which they practice.

Studies exploring the positive benefits of incorporating IPV-specific information and skill building into the curricula of training programs for health care providers are also available (Belknap, 2003; Short, Cotton, & Hodgson, 1997). Smith et al. (1998) found that residents in a primary care residency exposed to training to improve their patient-centered interviewing skills experienced a greater sense of confidence and expertise especially with regard to their ability to connect with their patients' psychological and emotional concerns. These skills included encouraging the patient to steer the interview, and responding to psychosocial and emotional cues from the patient.

Encouraging evidence shows that the use of patient-centered approaches by a physician or clinician can be systematized into a training curriculum (Kaplan, Siegel, Madill, & Epstein, 1997; Novack et al., 1997). McCauley, Jenckes and McNutt (2003) found an improvement in attitudes and knowledge base related to abuse in groups of clinicians (including nurses, social workers and physicians) after exposure to targeted trainings on the subject. In a review of studies aimed at improving rates of disclosure of IPV by women to health care providers, Waalen et al. (2000) found that interventions that combined both educational elements and supportive system design changes, such as administrative protocols, resulted in the most improvements in disclosure rates.

However there is a dearth of literature regarding IPV training for health care professionals working in the psychiatric setting. Warshaw, Gugenheim, Moroney, and Barnes (2003) describe preliminary results of an innovative program aimed at improving the collaboration between domestic violence agencies and the mental health community, in which 94% of the program participants integrated IPV targeted clinical approaches into their existing practice as did 67% of the mental health agencies involved. There are no known studies examining provider trainings targeted to the emergency psychiatric setting.

Clearly, information is needed to determine which clinical approaches are most effective in building trust between psychiatric emergency providers and their female patients who are experiencing IPV with the goal of encouraging disclosure of abuse. Given the existing literature that identifies promising approaches in other medical venues, this study contributes to our understanding of IPV by asking female abuse victims who are seeking emergency psychiatric care what provider behaviors, if any, helped them to disclose their abuse or prevented them from disclosing. The study contained herein identifies these behaviors, using the conceptual framework of Patient-Centeredness in Patient-Provider Relations as the basis for inquiry. The elements of patient-centeredness are applied and tested to determine whether such characteristics increase the likelihood that a patient experiencing IPV will disclose her experience. Four main domains/behavior sets of patient-centered care derived from the work of Battaglia et al. (2003) are tested: trust, interpersonal treatment, communication, and knowledge of the patient. These behaviors were identified and their relationship to disclosure determined. These results will guide the development and implementation of education and training programs accordingly to build these skill sets in emergency psychiatric providers.

4.0 METHODOLOGY

4.1 RESEARCH PURPOSE

This study explores the relationship between the perception by female abuse victims of patient-centeredness in health care providers in a psychiatric emergency setting and the resulting frequency of disclosure of IPV history. The guiding conceptual framework for the study is derived from the body of work surrounding the concept of Patient-Provider Relations, with an emphasis on the phenomenon of patient-centered provider behaviors. The data collection methodology was a self-administered instrument with two specific purposes: 1) to assess provider behaviors associated with establishing a sense of patient-centeredness, as perceived by the respondents, and 2) to ascertain respondents' exposure to IPV and, if affirmative, whether they disclosed this information to the provider. The resulting data were analyzed to determine whether the degree to which a provider is seen as patient-centered impacts the outcome of disclosure of IPV and if other related factors, such as demographics, previous treatment experiences, chief complaint or direct inquiry, affect disclosure as well. The research questions for this study are outlined below.

4.2 QUESTIONS

1. Among a sample of women seeking psychiatric emergency treatment, what percentage have experienced IPV by history and/or in the past 12 months? In addition, among this group, what other demographic, diagnostic or treatment related factors are present?

The proportion of women seeking treatment in the emergency setting who had been exposed to IPV was determined; this is the subset of interest to which additional analyses were applied. In addition, information regarding the demographic make-up of the respondent group, the respondents' experiences with and expectations for treatment, and their chief complaints were determined and used as a baseline for comparison purposes.

2. Among those with a positive reported history of IPV, what percentage disclosed this history directly to a clinician during the psychiatric evaluation process?

Disclosure, defined for this study as a patient informing a clinician directly and verbally of a history of IPV during a psychiatric evaluation, is the dependent variable being explored in this question. The rate of screening for IPV by ER staff was determined by asking respondents to indicate whether they had been asked about their abuse history by a clinician.

3. How did the respondents in the group that disclosed their IPV history rate the clinician(s) that they interacted with in terms of patient-centered behaviors, as compared with the group that did not disclose? In addition, among this group, what other demographic, diagnostic or treatment related factors are present?

Respondents with a history of IPV were divided into two groups, one that disclosed abuse in the face-to–face portion of the evaluation, and another group that did not disclose their IPV history. The ratings on the study instrument by the respondents across the four independent variables of interest, or areas of patient-centered provider behaviors, were compared by group and analyzed to determine the presence of any relationships between the provider behaviors of interest and the outcome of disclosure of IPV. Using an adaptation of a previously validated instrument, the providers were rated by the respondents on: (1) their ability to effectively communicate, (2) the patient's sense that the provider came to know them as a person, (3) the quality of the interpersonal interactions they experienced with the provider and finally, (4) the provider's overall trustworthiness as rated by the patient. In addition, information regarding the demographic make-up of the two groups (disclosing and nondisclosing), the respondents' experiences with and expectations for treatment, their chief complaint and whether they were asked about abuse, were examined to determine if these factors were related to disclosure.

4.3 RESEARCH DESIGN

This study has descriptive and exploratory as well as predictive design elements. The primary data collection instrument is a self-administered questionnaire created from two pre-existing questionnaires and modified by this author to meet the study needs. Three distinct areas of information collected by the questionnaire that were examined separately as well as in conjunction with each other. Demographic questions elicit the respondent's age, race/ethnicity, marital status, number of children, educational attainment, and an estimation of socioeconomic status (SES) based on health insurance status. The second set of questions captured key clinical information, including the patient's chief psychiatric complaint and reason for the emergency room visit, as well as her previous treatment experiences at WPIC, her history of exposure to abuse as a child and adult, and whether she disclosed a history of IPV to a clinician or physician during the examination.

Finally, the third set of questions asked the respondent to rate the clinician or physician treating her in the emergency department on a series of scales measuring the provider’s interpersonal skills, communication skills, knowledge of her as a patient and trustworthiness.

Basic descriptive statistics regarding the respondent group’s demographic makeup are reported. The clinical data were analyzed to determine the sample’s overall exposure to IPV as well as the percentage of respondents who disclosed to clinical staff. Finally, the ratings of clinical staff on measures of patient-centeredness were examined.

The disclosure of IPV history to a clinical staff is considered the major dependent variable of interest, and the demographic data, clinical data and measures of patient-centeredness for each case were treated as independent variables. These concepts are presented graphically in the conceptual framework shown in Figure1.

CONCEPTUAL FRAMEWORK: PATIENT-CENTERED PROVIDER BEHAVIORS AND DISCLOSURE OF INTIMATE PARTNER VIOLENCE (IPV) IN PSYCHIATRIC EMERGENCY SETTING

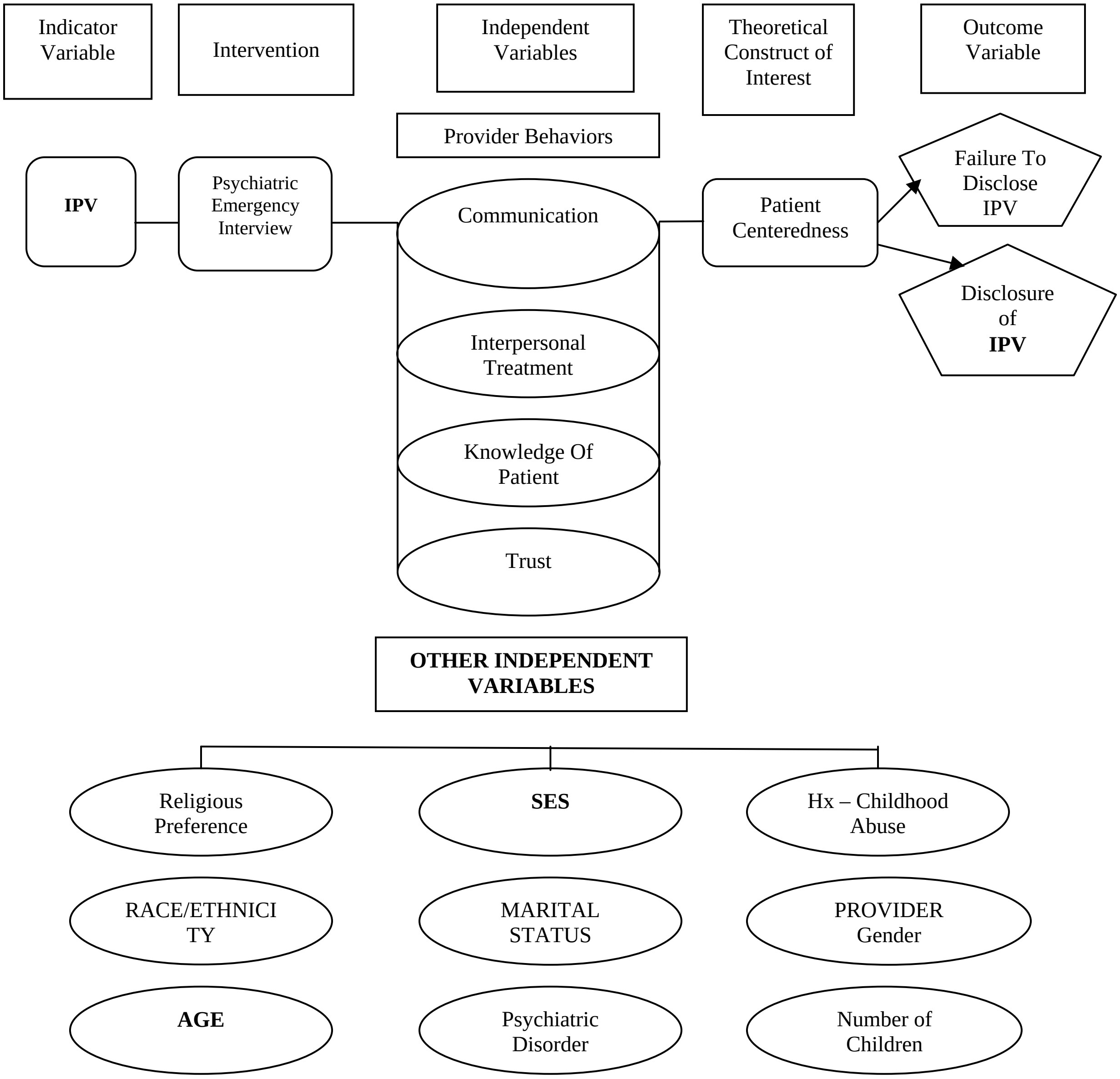

Figure 1 CONCEPTUAL FRAMEWORK: PATIENT-CENTERED PROVIDER BEHAVIORS AND DISCLOSURE OF INTIMATE PARTNER VIOLENCE (IPV) IN PSYCHIATRIC EMERGENCY SETTING

4.4 SETTING

The setting for this study is an urban, psychiatric emergency clinic with patient volumes exceeding 13,000 visits per year. This emergency service is located in a large, teaching psychiatric facility with inpatient, ambulatory and research programs located within the building, including 289 licensed inpatient beds with annual occupancy of over 85, 000 bed days a year. This program operates 24 hours a day, seven days a week. On average, roughly 50% of the patients seen require inpatient admission while the other half are seeking and require outpatient treatment in ambulatory settings. Patients range in age from three years old to >90 years of age. Male and female patients are seen in approximately equal proportions.

Patients may present for treatment in a variety of ways. While most patients “walk in”, i.e. transport themselves to the program, significant numbers are also brought in by the police, or Emergency Medicine Service (EMS) providers, or are referred from other area hospitals’ emergency or inpatient programs. The majority of patients willingly present for evaluation but some are involuntarily committed by another person based on concerns that they are in danger of harming themselves or others, or are dangerously impaired in their judgment or ability to attend to basic self-care needs.

The program features two distinct patient care areas with large waiting rooms surrounded by smaller interview rooms; these two areas are joined by locked doors. The entrance to the main waiting area is generally left unlocked but is monitored continuously by safety specialists and may be automatically locked using electronic mechanisms at a moment’s notice, in the event that a patient who is involuntarily committed should try to leave without authorization. The second space of the program contains several interview rooms, a waiting area, an enclosed nursing station, two rooms specifically designed for the seclusion or restraint of patients, a room specially designed for use as a smoking area, two rooms used to conduct physical examinations and triage, a medication storage and preparation room and the ambulance loading area. Entries and exits from this second program space are restricted and can be accessed only by program staff must physically or electronically unlock the doors to the ambulance bay or to the adjoining waiting room. This area is also manned continuously by safety specialists. These space configurations and safety considerations are important for the study given the potential dangers to women with IPV from their partners, especially in situations when the partner suspects disclosure of abuse to health care providers.

This program is staffed with attending psychiatrists and resident psychiatrists 24 hours a day. In addition, the program is staffed with nurses, evaluator clinicians, safety specialists, patient service coordinators (PSCs), reception, registrationists, primary care providers, and trainees in medicine, psychiatry, nursing, psychology and social work. Patients seeking services in the ER will be seen by a variety of these staff. For the majority of patients who present willingly for evaluation and treatment, the flow of their visit through the ER proceeds as follows: initially, they are screened by safety specialists for contraband and weapons; they then sign in with reception and are triaged by a nurse. This triage is brief and aimed at assessing whether there are any medical or psychiatric concerns that must be addressed immediately, including the presence of any lethality towards self or others. If the outcome of the triage indicates that a comprehensive psychiatric evaluation is warranted, it will be completed with the patient. Patients are seen by an evaluator clinician (staff with bachelor or master's degrees in counseling, nursing, social work, psychology or related fields), along with a resident and /or psychiatrist. For some patients, there may be more urgent medical problems detected which require assessment and stabilization and for those patients, transfer to a medical facility is arranged. Other patients may decline the comprehensive evaluation and, if there are no grounds for involuntary commitment, they will be allowed to leave with a referral from the clinical staff for mental health services. The discipline of the primary clinician or “doctor or mental health professional” as they will be referred to on the questionnaire, is defined as the clinician who is identified to the patient as the case coordinator and who performs the bulk of the psychiatric evaluation.

The comprehensive psychiatric evaluation consists of an assessment of the presenting problem from the patient’s perspective. The clinician then assesses the history of the current illness as well as past psychiatric history. The patient’s developmental history and medical history are also solicited. A complete psychosocial history is obtained including housing, social supports, financial supports. A mental status examination is conducted and if the patient is to be admitted for inpatient treatment, a full medical examination is completed. It is important to note that though the patient will be asked about abuse during the psychiatric evaluation, any clinician may ask a patient about current or past abuse at any time during the entire examination if the patient’s condition or behavior warrant, providing multiple opportunities for the patient to disclose a history of IPV. Among the group of possible primary clinicians are physicians and evaluation staff from nursing, social work, psychology and other mental health related disciplines, depending on the patient’s presentation and availability of clinical staff. Based on the results of the evaluation and recommendations for treatment and disposition, patients may also receive additional medical work-ups, medication, or referrals to additional providers. Patients are then discharged from the program to inpatient care, transferred to other less restricted levels of care, or discharged to home with referrals to ambulatory services.

4.5 POPULATION

Intimate Partner Violence (IPV) poses a danger to the well being of many women, with certain subgroups of the female population being at higher risk than others, including the population of women with mental illness. The population of interest for this study is adult females ranging in age from 19-60+ who are presenting for emergency psychiatric evaluation. Although IPV is seen in the adolescent population, the phenomenon is not as well-articulated in the literature as with the adult population. Therefore, the decision was made not to include adolescents in this study. In addition, although studies of IPV do show a decreasing risk of occurrence with age, older adults do experience the phenomenon and are included in this study. The target subgroup of interest is adult women who have experienced IPV at some time in their life. As the comprehensive review of the prevalence, incidence and risk factors associated with IPV reveals (see Chapter 1), the proportion of women in the general population who have experienced IPV is high. According to a national survey (Tjaden & Thoennes, 2000), 22.1% of adult women reported being physically or sexually abused by a partner in their lifetime and 2.1% within the past year.

Mortality and morbidity for IPV victims is extraordinarily high as well, with one study indicating 33% of reported homicides being IPV-related (Dannenberg et al., 1995) and another reporting that 50% of IPV incidents are believed to result in some kind of physical injury (Rennison & Welchans, 2000). Finally, a strong relationship exists between IPV and psychiatric illness. Women with histories of IPV have shown an increased risk of various psychiatric disorders (Astin et al., 1995; Bauer et al., 2000; Bergman & Brismar, 1991; Danielson et al., 1998; Gearon et al., 2003; Kilpatrick et al., 1997; Scholle et al., 1998), as well as an increased risk for psychiatric hospitalizations (Kernic et al., 2000). Therefore, women presenting for psychiatric evaluation have an elevated risk of having experienced IPV in their lifetime. Indeed, Briere et al. (1997) found that 42% of the women presenting for psychiatric emergency treatment had a history of IPV.

In 2002, a quality management study was conducted exploring the incidence of IPV among the population of adult patients at the institution that was the site for this study, including among the patients presenting to the emergency department. Information from that study indicated the following (n= 60 female respondents): the mean age was 37 ; 51% indicated this as their first visit to the ER; 32% reported a college education or higher; 42% were Caucasian; and 68% reported no insurance coverage, or insurance through public assistance. In this same study respondents reported the diagnoses: 86% reported depression; 10% PTSD; 49% anxiety; 31% problems with alcohol or drugs; 3% schizophrenia; and 19% bipolar disorder. Seventy-three percent of the respondents reported visiting the emergency department for evaluation/assessment, 34% reported needing medications, 32% were requesting therapy and 14% chose the nonspecific category of "other reasons" for their visit. Most importantly, among female respondents, 53% reported some type of abuse by a partner as an adult, 53% reported some type of sexual abuse in childhood and 47% reported physical abuse in childhood.

Aside from recent increases in patient volumes in the ER given the closure of the other large psychiatric provider in the urban setting of the study several years ago, there have been no significant changes in the operational or institutional structure of this program in the past three years that would have changed the essential population of women visiting the ER for services or their likelihood of reporting IPV on the questionnaire used for the study. Portions of the referenced questionnaire and the study design that were used successfully in the ER study of 2002 were replicated as closely as possible in this study to encourage participation and reporting of IPV. Therefore we project a similar proportion of women having experienced IPV to be part of the available pool of voluntary subjects in this study proposal.

Chapter One discussed the increased incidence of IPV among younger adult age groups, in women with psychiatric disorders and histories of childhood abuse, and among lower socioeconomic groups and unmarried or divorced women. In addition, in the previously referenced quality management study of 2002, information was obtained regarding the demographic profile and abuse history of the study participants considered relevant to the phenomenon as noted in the literature. Therefore, in this study, we also determined the demographic and abuse profiles of the participating adult female respondents and whether relationships exist between these factors, the perception of providers and the outcome of disclosure.

4.6 SUBJECTS

The sample for this study was adult women presenting for emergency psychiatric care in an urban, psychiatric emergency room. The selection of participants was completed in a non-random fashion. The opportunity to participate was offered to all female adult patients ages 19-60 presenting to the psychiatric ER with one exception.: patients with an impaired capacity due to mental retardation, or acute, severe psychiatric disorder or medical condition that would prohibit the comprehension and completion of a self-administered questionnaire were excluded from the study. Examples of such conditions included but were not limited to florid psychosis, dementia, or altered levels of consciousness due to organic causes, medical conditions or intoxication. The determination of exclusion from the study was based on the results of the mental status examination, which assesses the patient's cognitive integrity including orientation, judgment, insight and intellectual functioning. If the results of the mental status examination indicated that a patient was cognitively impaired to the extent that she could not be expected to comprehend or complete the questionnaire, the ER charge nurse communicated this to the PSC who then excluded the patient from participation. This mirrors the existing ER process currently used with regard to the patient satisfaction questionnaire.

4.7 SAMPLE AND SAMPLE SIZE ESTIMATES

Participants in the study came from a convenience sample of adult women, ages 19 and above, presenting to the psychiatric emergency department. Based on the past year's records from this emergency room, the volume of potential subjects for the study was 600 per month. It was estimated that approximately 25% of this number would be excluded based on identified exclusionary criteria, thus dropping the potential number of subjects per month to 400. The female participation rate from three years ago for a similar survey was 61/72 (84%). Adjusting the potential volume by a more conservative participation rate of 60% left an estimate of 240 potential participants per month. Several concerns arose related to the design in terms of the potential quality of the data and limitations affecting the validity of the design. The most pressing concern related to the issue of disclosure. Based on the previous study in the emergency department three years ago, many of the respondents had reported IPV (over 50%). However, based on the data extracted from medical record reviews, very few women (16%) disclosed their exposure to IPV during the psychiatric examination. According to national estimates, this number is below the reported prevalence estimates of IPV, with lower range estimates starting around 22% (see Chapter 1). Therefore, initial sample size estimates were based on smaller estimates of the proportion disclosing, using logistic regression as the data analysis method. The estimate of potential participants per month was reduced by half to estimate the number of subjects who had experienced IPV who could be available during a given month to participate, or 120. This was reduced yet again given estimates of low rates of disclosure of 10% or less. Preliminary sample size calculations based on logistic regression were conducted with PASS (Power Analysis and Sample Size) statistical software using a range of the possible disclosure rate, specifically 3%, 5% and 10%. A Type I error rate of 0.05 was used for all these calculations, and only sample sizes resulting in power close to or greater than .80 were considered. For the low possible proportion of 3% disclosing, for a power above .80, samples sizes required ranged from 300-600. Given the lack of a clear estimate for disclosure, there were two options: 1) Conduct a pilot administration of the questionnaire (with a preliminary goal of 50 questionnaires) to determine the rates of disclosure (along with testing other elements of the questionnaire and administration process) and re-estimate the required sample size for the larger study. If there was no disclosure reported from the pilot administration, this would have been taken into account as well and the study design modified, or 2) proceed with the study until a sample of 200 or more questionnaires was obtained and determine if significant results existed and if so, stop data collection at that point. If significant results did not exist at this point, the available information would be analyzed to determine how many additional subjects would be needed to reach an acceptable level of power. Based on the PASS calculations, for a disclosure rate of 5%, 400 subjects were required to obtain an effect size of an odds ratio of 2 and power of 77%. This is the number the author used as the working sample size target and estimated approximately four months of data collection to obtain this sample.

In the end, the disclosure rate well exceeded original estimates. Initial analysis was performed on data from 46 questionnaires and at that time, disclosure was approximately 60%. Therefore, using this new estimate of proportion of respondents disclosing IPV, the sample size requirements were recalculated, projecting a new disclosure rate of 60%. This final sample size estimate required 100 subjects to disclose to obtain statistical power of 80% to detect an odds ratio of 2 from the logistic regression analyses. Therefore, the final sample size of 216 completed questionnaires was adequate to perform the desired statistical analysis with acceptable power.

4.8 RESEARCH INSTRUMENT

The instrument used in this study is a self-report questionnaire with three separate sections (demographic, clinical/abuse history and disclosure, and clinician ratings) that total 55 questions in all. A copy of the final questionnaire used is available for review in Appendix A.

The first part of the questionnaire contains a series of items related to demographic information along with patient perception of chief complaint and reason for visit to the emergency department. These questions were used as a part of a survey conducted at the institution that was the site for the current study approximately three years ago. The questions soliciting abuse history were adapted from three existing, validated IPV assessment scales, the Women's Experiences with Battering Scale (Smith, Earp, & DeVellis, 1995), the Abuse Assessment Screen (Soeken, McFarlane, Parker, & Lominack, 1998), and the Conflict Tactics Scale (Straus, 1979).

In a qualitative study by Battaglia et al.(2003), four key provider behaviors were shown to contribute to a perception of providers as patient-centered by women who have experienced

IPV: a caring interpersonal style, getting to know the patient, communicating well, and a sense of trust. IPV survivors have identified these patient-centered behaviors as associated with the IPV survivor's ability or willingness to disclose abuse to the provider. This author contacted Dr. Battaglia at Tufts University in Boston, initially for permission to use her published work and conceptual framework as the basis for this study. During the course of our written and telephone correspondence, Dr. Battaglia supported the proposed study as a logical extension of her initial study and agreed to allow the use of her study findings.

A review of the literature was conducted to identify existing scales that measure a patient's perception of the clinical provider on the behaviors identified through Battaglia's work. No scales were identified that used a psychiatric population or setting. However, a scale was identified, the Primary Care Assessment Survey or PCAS (Safran et al., 1998) that measures primary care providers on several domains of patient satisfaction, including the target domains of interpersonal treatment, trust, communication and knowledge of the patient as a person. This scale was modified for use in assessing the respondent's perception of the clinician for this study. The PCAS was designed for use in establishing performance for a variety of primary care settings ranging from an individual provider's practice to a large health care delivery system. Therefore its use in this setting is consistent with the original design. The scale was originally designed to assess patient perception of the relationship with the provider across a series of sessions, not necessarily in one session, as it was used in this study, which was a potential issue with regard to the scale's performance in this setting.

The data for the analysis of the scale's performance came from a two-year study of Massachusetts state employees' (n=>6000) ratings of their primary care providers within specific health care insurance programs. Permission to use the scale was obtained from the study's author, Dana Safran, MD (see Appendix B).

The PCAS total scale consists of seven domains (See Table 4.1) related to the perception of care given by a provider as measured by eleven smaller scales for a total of 51 items. The seven domains together constitute a comprehensive assessment of performance indicators related to primary care delivery: access, continuity, comprehensiveness, and integration of care, and the quality of the clinical interaction, interpersonal treatment and sense of trust between the patient and provider. These seven domains are assessed through eleven discrete subscales which either assess an entire domain or part of a domain: for this study, only four of the seven domains were of interest, and of the six scales used to assess these domains, four were incorporated into the study questionnaire (Table 4.1). These four domains were interpersonal treatment and clinical interaction as perceived by the patient; the degree of comprehensiveness of the clinician in gaining knowledge about the patient; and the sense of trust in the provider. The other scales related more specifically to primary care issues or issues associated with an assessment of care over longer periods of time and are not considered relevant to this study. Since these subscales have been shown to be independently valid, using them apart from the rest of the PCAS questionnaire should not affect their validity, scoring or other related factors (Safran et al., 1998).

Table 4.1 Selected PCAS Scales and Measurement Properties

PCAS Domains	PCAS Scales	Selected Scales for use in Study
Access to Care	Organizational Access Financial Access	
Continuity of Care	Longitudinal Visit-based	
Comprehensiveness of Care	Contextual Knowledge of Patient Preventive Counseling	Contextual Knowledge of Patient
Integration	Integration	
Clinical Interaction	Clinician-Patient Communication Thoroughness of Physical Examination	Clinician-Patient Interaction
Interpersonal Treatment	Interpersonal Treatment	Interpersonal Treatment
Trust	Trust	Trust

Safran et al. (1998) report an average completion time of seven minutes for the entire scale, which is rated on a 5th grade reading level per the Flesch-Kincaid reading ease index. The majority of options for each question are in Likert format with five or six options. The questions are generally positively stated, however a small number are negatively stated. For scoring purposes, the negative items are first reversed, then points are assigned for each question. Possible scores for the entire scale range from 0-100, with 0 indicating no positive indication of the target attribute and 100 indicating the highest possible value of the attribute.

The psychometric properties of the total scale were tested by the authors (Safran et al., 1998). The t analysis of the five Likert scaling assumptions that are required so that the responses can be summed demonstrated good performance across all the scales.

The second set of tests regarding the scale related to the overall performance of the PCAS on measures of data completeness, score distribution characteristics and inter-scale correlations. The data produced by the PCAS were considered complete: there were no scales with more than 4.2% of the data missing and all scales had 98.35 or higher rate of computable scores available. Score distribution characteristics showed variation in responses with regard to range of scores across the options, and low numbers of scores at the scale's floor and ceiling. Finally, the individual scale's intra-scale reliability correlations were compared to correlations with other scales and found to exceed these correlations which is desirable and indicative of the individual scale's uniqueness in measuring target concepts and ability to stand alone as a measurement, separate from the rest of the scales. This last point is crucial to the study proposed as four of the PCAS scales will be separated out from the others and used in the study questionnaire.

4.9 QUESTIONNAIRE

The following information is a description of text from the questionnaire. An introductory statement for the study questionnaire begins with a paragraph informing the patient that: the questionnaire is part of a study to learn about people's experiences with violence, that their participation may help to improve care, that they do not have to complete the questionnaire if they do not want to, and that it should take less than seven minutes to complete. We tested and confirmed this average time of completion during the pilot administration of the questionnaire.

The introductory statement to the questionnaire also assures the patient that their health care at the ER will not be affected if they do not complete the questionnaire and that the information is anonymous and confidential. They are then informed that they may share the information on the questionnaire with the doctor or clinician they have seen in the ER after completion of the questionnaire in the event that there are issues, concerns or emotional upset brought on by the nature of the questions asked, but that the staff will not share the information with anyone. It assures the patient that the testing room is locked and that responses will be placed in a locked receptacle with no identifying information on it, for safety and confidentiality.

It establishes that there is no payment associated with participation, and that there are no risks or benefits to filling out the form. Finally, it gives the telephone contact number of the author conducting the study, who can be reached anonymously and confidentially, if there are any questions or concerns. It also reminds patients that if they have completed the form in the previous six months, they should not fill it out again.

The demographic section of the study instrument, a self-administered questionnaire, utilizes most of the same question content and structure (a few questions have been deleted or added using a similar format) used in the study completed at the ER approximately three years ago. This questionnaire was considered successful in capturing the target information; of the 72 women asked to participate, 61 (84%) participated and 11(16%) refused. However these groups did not vary by demographic representation so there were no discernible biases in the response rate apparent between participants and those refusing to participate. This portion of the study questionnaire rated on a 5th grade reading level per the Flesch-Kincaid reading ease index.

The questionnaire begins with a brief demographic section, asking for age, race/ethnicity, educational attainment (ranging from not graduated from high school to graduate or professional school), insurance status, and marital status. Patients are asked to give information regarding the reason for the visit that day, choosing from the following options: evaluation, medication, counseling or therapy, or other services and asked to specify. The next question asks them to choose from several options what they are seeking help for, in terms of a psychiatric problem: depression, PTSD, anxiety, alcohol/drugs, schizophrenia, bipolar disorder or other, and asked to specify. The third question asks about length of treatment at the institution where the ER was located.

The next section assesses the patient's abuse history and is prefaced with a paragraph that alerts patients to the following content and highlights participation as a chance to help improve the care that other patients receive, and thanks her for her participation.

The first set of questions has three yes/no items geared towards assessing for childhood abuse: " Before you were age 18, did any of the following things ever happen to you: Did a parent or another adult hurt or punish you in a way that left a bruise, cut, scratches or made you bleed? Did anyone who was five or more years older than you do something sexual with you or to you? Did anyone who was less than five years older than you do something sexual to you that was against your will."

This section is followed by three questions regarding relationships with her partner:

"I try not to "rock the boat" because I am afraid of what my partner might do"; "I feel owned and controlled by my partner"; and " My partner can scare me without laying a hand on me"; four response options rank levels of agreement. This set of questions is captures the psychological aspects of IPV.

Next she is asked a series of yes/no questions aimed at determining exposure to physical and sexual forms of IPV: "As an adult, has a romantic partner, spouse or ex-partner ever hit, slapped, kicked or otherwise physically hurt you? Has this happened in the last 12 months? As an adult, has a romantic partner or ex-partner ever forced you to have an unwanted sexual act? Has this happened in the last 12 months?"

The last set of questions explores if the patient was asked by clinical staff during her evaluation that day about any abuse she experienced as an adult. If she answered yes to any of the above, she is asked whether being questioned about abuse was helpful or not, and whether she was able to share that she had experienced abuse with the doctor or mental health professional during the evaluation. This latter question is added to the pre-existing questionnaire, and responses to this question will determine reported disclosure of abuse by the patient.

The next and final section is a series of 22 questions from the PCAS, assessing four major domains related to patient perception of care given by the provider.

The response choices are six Likert scale options ranging from very poor to excellent. Several minor changes have been made to make the wording more appropriate for the setting and certain items have been removed when not relevant to the targeted setting. These modifications include removing the word "regular" from the phrase," regular doctor", since this will not apply to the emergency psychiatric setting. In addition, "doctor" will be replaced with the phrase "doctor or other mental health professional", consistent with the rest of the questionnaire. A brief paragraph will be added before this set of questions instructing the patient on how to answer each question with respect to the primary clinical provider, which may vary by discipline to discipline from case to case. In addition, the word "today" has been added to the questionnaire at key points to orient the patient to the target time frame.

The following five questions encompass the Communication domain of the PCAS, and specifically ask the patient to rate:

1) The thoroughness of the doctor's or other mental health professional's (MHP) questions about symptoms and how she is feeling;
2) The attention that the doctor or MHP gives to what she has to say;
3) The doctor's or MHP's explanations of health problems or treatments that are needed;
4) The doctor's or MHP's instructions about symptoms to report and when to seek further care; and
5) The doctor's or MHP's advice and help in making decisions about care.

The last question in this communication domain referred to the patient's perception of whether her questions regarding her illness and treatment have been answered and offered five Likert type options from none to many regarding whether she still has unanswered questions at the time of her discharge. However, it was decided to drop this question from the communication grouping as additional modifications to the wording were required which may have substantially changed the original meaning. This set of questions related to communication style is supported in the literature as consistent with patient-centered provider behaviors (Battaglia et al., 2003; Gerbert et al., 1999; Rodriguez et al., 1998; Thom & Stanford Trust Study, 2001).

The next section relates to the domain of interpersonal treatment and has five questions. The responses are six Likert scale options ranging from very poor to excellent. They ask the patient to think about and rate the personal aspects of the care she received from her doctor or MHP that day:

1) The amount of time the doctor or MHP spent with them;
2) The doctor's or MHP's patience with questions or worries;
3) The doctor's or MHP's friendliness and warmth;
4) The doctor's or MHP's caring and concern; and
5) The doctor's or MHP's respect.

The stated behaviors map directly to provider behaviors associated with a patient-centered approach (Battaglia et al., 2003; Gerbert et al., 1999; McCauley et al., 1998; Thom & Campbell, 1997; Thom & Stanford Trust Study, 2001).

The next section is the trust domain and it has seven Likert scale questions with five options ranging from strongly agree to strongly disagree. This is followed by one additional question which is a semantic differential scale with 10 numbered options, with an adjective pair that asks patients to rate how much trust they put in the doctor or MHP, from “not at all” at the zero option to “completely” at the number 10 option. The first seven questions ask the patient to think about how much they trust the doctor or MHP:

1) She can tell the doctor or MHP anything, even things that she might not tell anyone else;
2) The doctor or MHP sometimes pretends to know things when he or she isn’t really sure;
3) She completely trusts the doctor’s or MHP’s judgments about her medical or psychiatric care;
4) The doctor or MHP cares more about holding down costs than about doing what is needed for her health;
5) The doctor or MHP would tell her the truth about her health, even if there was bad news;
6) The doctor or MHP cares as much as she does about her health; and
7) If a mistake were made in her treatment, the doctor or MHP would try to hide it from her.

The last question is on scale of 1-10: all things considered, how much does she trust the doctor or MHP? Trust has been shown to be an important concept in the development of patient-centered patient-provider relationships (Thom & Campbell, 1997; Thom & Stanford Trust Study, 2001).

The final questions encompass the contextual knowledge of the patient domain of the PCAS, and consist of four questions with the Likert format of six options ranging from very poor to excellent. Several modifications were made, including the addition of the word “psychiatric” to the phrase “medical history”. Given the setting, the last question in the group on the PCAS, which refers to whether the patient believes that if she were unconscious or in a coma that her doctor would know what she would want done for her, was eliminated. The remaining questions ask the patient to rate:

1) The doctor’s or MHP’s knowledge of her entire medical and psychiatric history;
2) The doctor’s or MHP’s knowledge of her responsibilities at work or home;
3) The doctor’s or MHP’s knowledge of what worries her most about her health; and
4) The doctor’s or MHP’s knowledge of her as a person (her values and beliefs).

The provider’s attempts to gain in-depth knowledge of the patient as a person is a central concept in patient-centered provider approaches (Battaglia et al., 2003; Keating et al., 2002; Thom & Campbell, 1997).

The questionnaire ends with a note thanking the respondent, followed by instructions to put the questionnaire in the designated box, and informs her that they are welcome to take a card from the table with information and phone numbers if she wants to discuss the issues further or to tell the PSC in attendance if she wants to talk to a clinician about any issues before she leaves. This opportunity is provided in the event that answering questions about traumatic life events brings about any additional discomfort, concern or emotional upset that the patient like to discuss further with a clinical staff member, at that time or later by telephone with the proctoring psychologist assisting with the questionnaire administration.

4.10 DATA COLLECTION: PROTOCOLS FOR ADMINISTRATION OF QUESTIONNAIRE

Prior to discharge from the ER, adult female patients identified by the ER charge nurse as appropriate for the study were asked to take part in completing several voluntary patient satisfaction questionnaires by the PSC. The protocols for identification of appropriate candidates and for the administration of the questionnaire are available for review in Appendix C. This is currently a standard process in the ER as in many other medical settings. If the patient agreed, she was taken to the testing room in the ER and given a packet of questionnaires, including the standard patient satisfaction questionnaire and the study questionnaire. If the patient required assistance in completing the questionnaire because of limitations such as reading difficulties, the PSC could offer to read the questions aloud to the participant and mark her answers confidentially. The ER charge nurse was responsible for documenting on the study log the gender of the PSC and the treatment team members. At no time were the PSC's name or the names of the treatment team members documented.

The PSC remained with the patient in the testing room and assisted by answering questions about the process but were instructed to not discuss the questionnaire or its contents with the patients during it's completion. A large visibly secured box with a slot in the top was located in it. No one except the patient and PSC were allowed in the testing room in the event the participant was an unidentified victim of IPV and the perpetrator was in attendance during the ER visit. No one but the PSC was allowed to be with the patient while she was answering the questionnaire nor was anyone else able to view the questionnaire's contents or the participant's answers. In the event a family member, friend, partner or anyone else accompanying the patient would insist on coming into the testing room, the PSC's were trained to abandon the administration of the questionnaire and proceed with the regular patient satisfaction survey process. The patient would then be considered ineligible for the study. The door and box containing completed questionnaires was locked in the event the perpetrator attempted to gain access to the room.

The PSC then directed the patient to the clinical staff for discharge. Several of the above steps should be noted as necessary given the concern for the safety of women who are at risk for IPV. Strict confidentiality and safety measures were universally implemented in the event that a woman presenting to the emergency department with an abusive partner was not placed in jeopardy in the event she decided to complete the questionnaire.

The patient completing the questionnaire was apprised of these measures on the questionnaire. All participants received the same protocol outlined above so that there was no difference discernible to a perpetrator that would make him suspect that his partner had divulged active abuse to the ER staff or would do so if participating in the questionnaire process. In addition, these measures, along with the anonymity of the questionnaire, reassured participants of the confidentiality of their responses. The box containing the completed questionnaires was emptied routinely by the ER Clinical Administrator and completed questionnaires stored in a locked file in a locked office in the facility. This data storage plan complied with institutional policy on storage of patient data as cited in the institution’s policy regarding the data security.

4.11 TRAINING

A mandatory training was conducted for ER charge nurses and PSC's on the protocol to be used in approaching potential participants and monitoring during completion of the questionnaire. Only those ER charge nurses and PSCs who completed this training were permitted to determine eligibility or offer the questionnaire to potential participants. The training consisted of two hours of didactic instruction on IPV and safety issues in the emergency department, as well as protocol completion and competency assessment through use of scenario completion. A staff psychologist with expertise in IPV completed the staff training and ongoing monitoring of data collection. In addition, this psychologist provided 24/7 on call back up for any clinical emergency that might arise during the data collection process that required clinical expertise in IPV safety management, referral issues or other clinical matters.

Following the didactic portion of the training, the trainer provided ten mixed case scenarios (some appropriate for the study, some inappropriate) to the ER charge nurses and had them demonstrate their competency in applying the inclusion and exclusionary criteria. ER charge nurses had to pass their competency or undergo re-training until they were proficient; all charge nurses passed this competency test. In addition, the ER charge nurses were trained in completion of the study log that tracked patient identification for the study, eligibility, willingness to participate and gender of the treatment teams and PSC.

The PSC competency determination consisted of the trainer demonstrating the implementation process twice during the pilot administration phase and then required the PSC to complete a return demonstration of the implementation with the trainer present on two cases. The trainer completed a competency assessment on the PSC during this return demonstration and if the staff member completed the implementation without variance, they could begin offering the survey to possible participants. If a PSC could not pass the competency assessment, the trainer was to repeat the training portion or at their discretion excuse the PSC from assisting in the study. All PSC's passed their competency training with the initial training.

This trainer then met with each ER charge nurse and PSC periodically throughout the data collection portion of the study to offer assistance and to review procedural compliance. As previously noted, the trainer was available by pager 24/7 during this phase of the study to staff in the program including the PSC's if any issues or concerns arise with the implementation of the protocol or to assist in the event a clinical emergency arose with a patient related to IPV.

Several issues of compliance with administration arose during the course of the collection. During the first few months of data collection, the volume of completed questionnaires being completed was below that expected. The psychologist monitoring data collection reviewed the study logs and found gaps of time ranging from hours to several days in length where the logs were incomplete. For these periods, the logs were only partially filled out and sections regarding patient eligibility/ineligibility, willingness to participate or refusal, and gender of treatment team and PSC were often left blank. Several factors emerged as the proctoring psychologist reviewed the logs and the missing data with the staff. Staff reported it was often difficult to attend to the study during high volume periods when the ER charge nurse and PSC's were busy with patient care. The psychologist intervened several times during the course of data collection with the trained staff and reinforced the protocols; however there continued to issues with full compliance. In addition, unbeknownst to the study author and the study proctor, the program administration attempted to improve completion by staff by using a contest as an incentive until the practice was discontinued.

These problems with staff failure to adhere to the study protocols may have been averted if the pilot administration phase of testing the questionnaire had included periods of monitoring the use of the protocol during different periods of ER operation and for extended periods. In addition, conducting focus groups with staff trained in the protocol, prior to implementation, for revisions that would have made implementation to facilitate compliance should have been completed, giving an opportunity to revise the protocol based on staff input. The data resulting from the study log related to eligibility was incomplete and is described in the data analysis section. In addition, the data from the study log related to capturing the gender of the treatment team and the PSC administering the questionnaire were available on only a few cases, therefore analysis of the role of gender of provider was not conducted. In the event the study was repeated, alternate methods should be explored such as tracking provider gender immediately on the questionnaire packet.

4.12 PILOT ADMINISTRATION

A pilot administration of the questionnaire and protocol for implementation was conducted during the training of the PSC staff to detect flaws and/or gaps in the questionnaire and protocol for implementation. The study proctor was on site to monitor the process. Six patients completing the questionnaire during this pilot denied having difficulty with answering the questions and completed the questionnaires in less than seven minutes. In addition, the questionnaire was given to two support staff working with the author. They both completed the questionnaire in less than seven minutes and reported no difficulties understanding the questions or following the form. However, monitoring compliance with the study process during the pilot administration was limited to observing PSC's administer the questionnaire and patients completing the questionnaire. Monitoring compliance with determining patient eligibility and completion of the study log was not conducted during actual ER operational hours and over time, and as noted, the logs were incomplete. In the event the study were repeated, an extensive pilot administration phase is recommended, with observations by proctors occurring during off shifts and high volume periods in the ER to determine obstacles to compliance.

4.13 QUALITY APPROVAL PROCESS

This study was approved through the quality management committee for the institution in which the study took place. This committee is an arm of the Investigational Review Board (IRB) for this institution and performs the quality management approval process for studies that do not involve experimentation in treatment interventions, identification of subjects or other elements of research design typically requiring IRB authorization. The process involves the submission of a description of the intended study and application for approval to the quality management committee where it is reviewed and approved. A copy of this document is available in Appendix D.

4.14 DATA COLLECTION AND ENTRY

The data were collected from March 16th 2006 until August 31st, 2006. The data collected from the completed questionnaires were entered by the author into a database constructed for this study. This database was stored in the author's personal computer and shared only with the statistician providing assistance on the study. Both personal computers were equipped with safety systems preventing access to the data by unauthorized personnel. In addition, there was no identifying information contained on the questionnaires themselves, in order to protect the confidentiality of the respondents.

The responses from the questionnaire were only entered into the database when they were clearly and unambiguously marked. For items that contained more than one response where only one response was acceptable, no response data were entered for that item. Written responses were entered verbatim. The author entered the data and data verification was performed by validation of the entries.

4.15 PLAN FOR DATA ANALYSIS

Data collection for this study was halted at 218 completed questionnaires. This decision was based on the preliminary findings once approximately half the data showed a much higher rate of disclosure than originally anticipated.

The contribution to any predictive relationship between the respondent's demographic profile, psychiatric treatment history, or direct inquiry and the outcome of disclosure of IPV was explored. There was no directional working hypothesis for the demographic information in terms of impact on the outcome variable of disclosure. The interface between the demographic data, psychiatric treatment and abuse history, and the provider ratings of patient-centeredness was also explored to determine if there is any evidence of an interaction that affects the disclosure variable as well.

The statistical analysis package of SAS software, version 9, (2004) was used to analyze all data. For the three sets of information, descriptive statistics were produced, including frequencies and percentages, for the categorical variables of: 1) demographics, including marital status, race/ethnicity, insurance status, religious preference, educational attainment, and 2) clinical markers including chief complaint, reason for visit, length of treatment at WPIC, gender of PSC and treatment team members, assessment of abuse history, experience of assessment of abuse and actual abuse history, and disclosure of abuse history.

For these data, additional testing using chi-square contingency tables was performed to determine if there were significant differences between the proportions of these groups with regards to their IPV exposure. These analyses were then repeated for the groups who reported disclosing IPV and those who did not disclose.

Descriptive statistics were produced on the quantitative demographic variables of age and number of children to determine if there were significant differences in the means of the IPV and non-IPV reporting groups.: the number of children response was compared using a nonparametric Wilcoxson rank sum test, and t tests were used to analyze respondent age. This analysis was repeated for the IPV-disclosing and non-IPV disclosing groups as well.

Data from the four PCAS subscales were scored and detailed descriptive statistics of the score distribution were reported on each of the PCAS subscales, including means and standard deviations.

Inferential statistical procedures, namely logistic regression, were utilized in exploring for relationships between the independent variables of demographic information, clinical information and patient-centeredness ratings to the dependent variable of disclosure. Given the study design, logistic regression appeared to be the most appropriate statistical test to apply to the data set since the outcome variable of disclosure is dichotomous and independent variables are of a variety of data types. In addition, logistic regression appeared most appropriate for this study design because, due to the dearth of available literature on and previous study of the phenomenon of IPV disclosure in psychiatric settings, we cannot assume the normal distribution of any of the independent variables, nor the linearity of the relationships between the independent variables and the outcome variable. Logistic regression does not require these assumptions be met for the analysis of data.

Multiple logistic regression allowed for the development of a prediction model for the independent variables which emerged from the initial analysis as significantly related to disclosure, to determine their relative importance and contribution to the determination of the outcome variable and to allow for the exploration of interaction effects between them. A sample size of 100 disclosing subjects provided 80% power to detect an odds ratio of 2 for the logistic regression. Significance levels of $p< .05$ were used for all analysis.

Finally, analyses of all possible correlations were conducted and aside from expected high correlations between the PCAS ratings, no other strong correlations between the independent variables were detected. In addition, effect sizes analyses were conducted. One effect size, for the variable of interpersonal interactions, emerged as potentially clinically significant.

5.0 FINDINGS

5.1 STUDY PARTICIPATION

This study explored IPV in the psychiatric emergency setting among adult females. All women presenting for services were the target group for consideration of eligibility to participate in this study. Information provided by the registration department of the emergency setting of this study indicated 2864 services were provided to women ages 19 and older during the data collection period. This number does not reflect unique patients. According to the study log completed by the charge nurses, approximately 2064 female patients were evaluated for eligibility to participate in the study. As noted above, the log was not completed with total accuracy during the data collection time period in that not all potentially eligible female patients were considered for the study. Of the 2064 entries started, approximately 1259 contained incomplete information that could not be used to determine eligibility due to incomplete information. In addition, some log entries noted that the identified patient was too young to participate, or a male, both of which were automatic exclusionary criteria and indicated that an entry should not have been made.

Of the remaining 832 accurately completed log entries, 601 were documented as being ineligible. The exclusionary criteria listed for these 601 patients were as follows: 1) psychotic/agitated/combative 33.3% (n = 200); 2) receiving ambulatory detoxification services or other services not resulting in psychiatric evaluation 23.8% (n = 143); 3) substance intoxication or impaired secondary to intoxication 14.5% (n = 87); 4) needing acute medical treatment and transfer 11.6 % (n = 70); 5) having a diagnosis of mental retardation 8.3% (n = 56); and 6) having a diagnosis of dementia or presenting with an impaired mental status 7.5% (n = 45). Of the remaining 231 entries of eligible patients, 14.3% (n = 33) patients were documented as refusing to participate, for an overall participation rate for identified subjects of 85.7%. The remaining 198 log entries were completed with regard to documentation of patient eligibility, agreement to participate, and ER charge nurse initials. Given that 218 completed questionnaires were obtained, the log entries were missing for approximately 20 respondents. Two of the 218 completed questionnaires had respondent's age's reported as18, below the eligible age for participation, and therefore the data from these two questionnaires was excluded from the analysis.

5.2 OVERVIEW OF ANALYSIS

The data analysis and results of this study are presented as follows: first, the total study sample was analyzed, providing a baseline for comparison on the metrics of the key study questions. Three main categories of information were produced including demographic characteristics, clinical markers, and ratings of providers on patient-centered behaviors. These data were then broken down into the first sub-group of respondents, those reporting exposure to IPV and those who did not. In an effort to reduce confusion, the reader should note the use of the phrase "reporting of abuse" as referring to respondents indicating an abuse history on the study instrument, as opposed to the phrase "disclosing abuse" which refers to the respondent sharing their experience of abuse directly with a clinician. The resulting data answers the first study question, namely what percentage of the total sample had experienced IPV in the past.

Differences between the two groups were also defined by demographic characteristics and clinical markers. The types of IPV abuse reported are outlined as well.

The resulting subgroup of IPV-exposed respondents is then broken down yet again into those who disclosed abuse to the clinical staff and those who did not, and data analysis/comparisons were repeated. These data partially address the second and third study questions aimed at defining the percentage of female abuse victims who disclosed their abuse during their examination, and identifying relationships between disclosure and demographic characteristics or clinical markers. Additional analyses were performed to determine the rate of screening for abuse and the results compared with the outcome of disclosure.

Finally, the ratings of respondents on four patient-centered provider behaviors were analyzed on the basis of disclosure to determine the presence of any relevant relationships. For data that emerged as significantly related to the outcome variable of disclosure, additional analyses using multiple logistic regression methods were performed.

5.3 DESCRIPTION OF THE SAMPLE

The analysis begins with descriptive statistics of the demographic characteristics of the total study sample (see Table 5.1). The median age for the respondents in the study was 34, eight years lower than the median age of 42 for adult females in the urban setting. The mean age for the total study sample was 35.6 years, SD = 11.44 (n = 214). The age range was 18-67 years. The racial/ethnic make up of the respondent group was predominantly Caucasian, approximately 71%, with African-Americans making up the next largest group at almost 26%, and the remaining 4% made up of other racial and ethnic groups. This racial/ethnic distribution is comparable to that of the general population of the urban setting of the study, where 67% of the population is reported as Caucasian, 27.12% are reported as African American, with all other racial and ethnic classifications combined accounting for less than 6%. The majority of participants reported being single (62.7%), followed by separated or divorced (21.5%), then married (12.4%). Few respondents were widowed (3.3%). As an estimate of socioeconomic status (SES), educational attainment was measured; less than 14% of the respondents reported having less than a high school degree. Over 50% of the respondents reported having some college experience at a minimum, which would indicate a higher socioeconomic status for a large portion of the respondent group. However, this result is an accurate representation of the urban setting's population based on the census in that 56% of adults over age 25 have at least some college experience or higher levels of education (Census, 2000).

Table 5.1 Demographic Characteristics of Total Sample: Frequencies and Percentages

	Total Sample (n = 218)	**n**	**Percent**
Marital Status	209		
Single		131	62.7
Married		26	12.4
Separated/Divorced		45	21.5
Widowed		7	3.3
Have Children	207	133	64
Education	211		
<High School		29	13.7
High School/GED		68	32.2
Some College/Tech		64	30.3
College/Graduate		50	23.7
Race/Ethnicity	206		
Caucasian		146	70.9
African-American		53	25.7
Latino-Hispanic		1	<1
Other		6	<3

5.4 RESEARCH QUESTION #1: PREVALENCE OF IPV AND DEMOGRAPHIC CHARACTERISTICS

Respondents were divided into those who reported IPV on the study questionnaire and those who did not. Table 5.2 contains a summary of the demographic characteristics of the respondent group divided into two subgroups; one reporting IPV and the other with no report of IPV. No significant differences emerged between these two groups with respect to the demographic characteristics of age, race/ethnicity, marital status, education, and number of children. The testing was conducted using the t-test to detect any significant differences between groups for the continuous variables of age. Number of children was compared with a nonparametric Wilcoxson rank sum test, and testing of Chi-square contingency tables was used for the remaining categorical variables. All findings were insignificant, using the p = .05 level for significance.

Of the 216 total completed questionnaires, for the 210 respondents who answered the set of questions related to IPV, almost 75% (n = 157) reported experiencing some type of IPV in the past. This surprisingly high percentage of reported IPV exceeds other findings from the literature estimating IPV in the national population (Tjaden & Thoennes, 2000) in an emergency room setting (Dearwater et al., 1998) however these published estimates were not specific to psychiatrically ill patients. In a rare study of IPV in psychiatric patients, Briere et al. (1997) found a history of IPV in 42% of female patients presenting to an emergency psychiatric clinic, nevertheless this prevalence is still much lower than this study’s findings.

Table 5.2 Comparison Of Demographic Characteristics Of IPV Group Vs. No IPV Group

	Reported IPV (n =157)	**No Report of IPV (n =53)**	**X^2or t**	**df**	**p value**
	Mean (SD)	***Mean (SD)***			
Age	35.4 (11.1)	36.6 (12.2)	t =0.65	205	.52
	n(%)	*n(%)*			
Race/Ethnicity			X^2= 1.01	4	.91
Caucasian	106 (74)	36 (26)			
African-American	39 (75)	13 (25)			
Latino/Hispanic	1 (100)	0 (0)			
Other	5 (83)	1 (17)			
Education			0.46	3	.93
<High School	23 (79)	6 (21)			
High School/GED	49 (74)	17 (26)			
Some College/Tech	48 (76)	15 (24)			
College /Graduate	35 (72)	13 (28)			
Marital status			5.72	3	.13
Single	100 (77)	29 (23)			
Married	16 (66)	8 (34)			
Divorced/Separate	35 (79)	9 (21)			
Widowed	3 (42)	4 (58)			
Have children	98 (76)	30 (24)	.61	1	.44

5.5 DESCRIPTION OF REPORTED ABUSE

The data presented in Table 5.3 shows the types of abuse by lifetime history and for the past year. Roughly one third of respondents reported some type of psychological abuse, while over

60% reported physical abuse in the past. Sexual abuse was reported by 40% of the respondents. Psychological abuse was captured in a separate set of questions differentiating it from physical and sexual abuse associated with IPV. In these three questions, Q8- Q10 on the questionnaire, respondents were asked to indicate their degree of agreement with these statements: " I try not to rock the boat because I am afraid of what my partner might do"; "I feel owned and controlled by my partner"; and "My partner can scare me without laying a hand on me". These questions are reflected in the table as avoiding conflict, feeling controlled by partner, and fear by proxy, respectively. The percentages of female abuse victims reporting psychological abuse ranged from approximately 27-34 % (n = 55, 62, 70).

Roughly 62% (n =129) of respondents reporting some type of hitting, slapping, kicking or other type of physical harm inflicted by a romantic partner, spouse or ex-partner at some point in adulthood and 24% (n = 43) reported this occurring in the last year.

Table 5.3 Types of Reported IPV Abuse

Abuse Type	Total n	Reporting "Yes" To Abuse n (%)
IPV-Psychological abuse: avoiding conflict	204	70 (34.3)
IPV-Psychological abuse: controlled by partner	203	62 (30.5)
IPV-Psychological abuse: fear by proxy	202	55 (27.23)
IPV-Physical Abuse-history	208	129 (62.02)
IPV-Physical Abuse-past year	180	43 (23.89)
IPV-Sexual Abuse- history	205	84 (40.98)
IPV-Sexual Abuse-past year	193	34 (17.62)

However, it should be noted that for the latter question related to recent abuse, there was an high number of responses missing, specifically 36 or 16.7%. It is unclear as to why this occurred. However, there are several possibilities. One is that the question itself was confusing to the respondents in structure or appearance. The question is slightly indented under the preceding question and may not have captured the respondent’s attention as a distinct question. The high rate of missing responses may also be related to the respondent having answered the question already in the affirmative or negative above, e.g. already having answered for an event occurring in the past year. Given the rate of missing responses, this question should be reformatted on the questionnaire for differentiation from the previous question in the event the questionnaire is administered again in the future. Finally, it is possible that the respondents who skipped this question were reluctant to endorse IPV occurring as recently as the past year.

The final set of questions related to abuse history were directed at past history of forced, unwanted sexual acts. Approximately 41% (n = 84) of respondents indicated experiencing IPV-related sexual abuse in the past and 18% (n = 34) in the past year. There was a similar pattern of missed responses for this second question regarding recent sexual abuse, as with the question related to recent physical abuse. In this case, 10.6% (n = 23) responses were missing for the total response set for this question. Again, similar explanations may exist for these missing responses, as for the missing responses to recent physical abuse, as these two questions were formatted alike and explore the similar concept of recent abuse as opposed to past abuse.

5.6 RESEARCH QUESTION #1: IPV GROUP COMPARISONS ON CLINICAL MARKERS

Differences between the IPV reporting and non-IPV reporting groups were detected on the measure of chief complaint by self-report, namely higher numbers of female abuse victims reported difficulties with depression, anxiety, PTSD and bipolar disorder than their non-victimized counterparts (Table 5.4). In the categories of chief complaint, depression was reported by 82% of the IPV group, PTSD by 24%, anxiety by 54%, and bipolar by 37% compared to 64%, 4%, 32%, and 19%, respectively, for the non-IPV group. Chi-square analysis was conducted for the four variables to determine with the following results: depression (X^2= 7.40, df =1, p = .007), PTSD (X^2= 10.58, df =1, p = .002), anxiety (X^2= 7.29, df =1, p = .007), and bipolar (X^2= 6.18, df = 1, p = .013). These results indicate that the female abuse victims were more likely to be experiencing problems with depression, PTSD, anxiety and bipolar disorder than other respondents. These findings are consistent with the literature that links IPV with anxiety and mood disorders (Astin et al., 1995; Bauer et al., 2000; Briere et al., 1997; Danielson et al., 1998; Krishnan et al., 2001; Porcerelli et al., 2003; Scholle et al., 1998). However these cited studies, with the exception of the study conducted by Briere et al., compared abuse victims with non-abused women seeking services in primarily traditional medical settings, not with other women requiring psychiatric attention. Given the results of this study, greater understanding is required of the prevalence of IPV among this population.

The history of child abuse among respondents was highly associated with a history of IPV. Significant differences were found for the analyses of the groups reporting IPV. Eighty-seven percent (n = 120) of respondents who reported child abuse also reported IPV (X^2= 23.6, df = 1, p = < .0001).

Table 5.4 Clinical Markers in IPV and non-IPV Reporting Groups

Category	**IPV N=157**	**Non IPV N=53**	**X^2or t**	**df**	**p**
	n(%)	***n(%)***			
Chief complaint					
Depression	129(82)	34(64)	7.40	1	.007
PTSD	37(24)	2(4)	10.58	1	.002
Anxiety	84(54)	17(32)	7.29	1	.007
Alcohol/Drugs	69(45)	23(43)	0.05	1	.83
Schizophrenia	15(10)	3(6)	0.87	1	.35
Bipolar	58(37)	10(19)	6.18	1	.013
Service Desired					
Evaluation	89(59)	27(51)	0.93	1	.34
Medication	58(38)	18(34)	0.33	1	.56
Counseling	74(48)	20(38)	1.79	1	.18
Treated past year	71(46)	19(37)	1.45	1	.23
Previous ED visits	56(44)	13(33)	1.59	1	.21

No statistically discernable differences were noted between the two groups by types of services being sought, previous mental health services at WPIC, or previous DEC visits in the past year, indicating that no apparent relationship exists between types of services being sought, or previous mental health services at WPIC.

5.7 RESEARCH QUESTION #2: DEMOGRAPHIC CHARACTERISTICS BY DISCLOSURE

The next set of analyses was conducted on those who disclosed IPV to the ER clinician and those who did not disclose, despite reporting IPV on the questionnaire. These data reflect that a substantial number, 41% (n = 53), of abuse victims did not disclose their history of abuse, by their own report, to the clinical staff working with them.

The demographic characteristics of the IPV disclosing and non-IPV disclosing groups were compared (see Table 5.5). Statistically significant findings emerged from the analysis of marital status between the IPV disclosing and non-disclosing groups (X^2= 9.07, df = 3, p = .028). The findings indicated that married victims were less likely to disclose abuse than their unmarried counterparts, and that divorced/separated respondents were more likely to have disclosed their experience of IPV than non-divorced/separated respondents. On review of the data, two areas of potential significance were noted between group means in the categories of married, 4% (n = 3) in the IPV disclosing group compared with 17% (n = 9) in the Non-IPV disclosing group; and divorced/separated, 30% (n = 22) in the IPV disclosing group and 19% (n = 10) in the Non-IPV disclosing group. This result indicates that there is some relationship between marital status and the disclosure of IPV among these respondents. These findings may be a function of patient concerns related to identifying their abusers. Obviously, married women who disclose abuse will be automatically identifying their abuser in most cases, while unmarried women could disclose abuse without necessarily indicating the identity of their abuser.

There were no statistically significant differences between the two groups on the measures of age, race, education, or having children, indicating that no apparent relationship exists between these variables and disclosure or nondisclosure of IPV.

Table 5.5 Demographic Characteristics of Abuse Victims by Disclosure

	Disclosed N=75	**Did Not Disclose N=53**	**X^2 or t**	**df**	**p**
	mean (SD)	*mean (SD)*			
Age	35.5 (10.8)	36.1 (11.3)	0.31	126	.76
	n (%)	*n (%)*			
Race/Ethnicity			4.62	4	.33
Caucasian	50 (59)	34 (41)			
African-American	15 (47)	17 (53)			
Latino/Hispanic	1 (100)	0 (0)			
Other	4 (80)	1 (20)			
Education			0.14	1	.99
<High School	12 (57)	9 (43)			
High School/GED	24 (57)	18 (43)			
Some College/Tech	24 (60)	16 (40)			
College/Graduate	14 (61)	9 (39)			
Marital status			9.07	3	.028
Single	45 (58)	33 (42)			
Married	3 (25)	9 (75)			
Divorced/Separate	22 (69)	10 (31)			
Widowed	3 (100)	0 (0)			
Have children	47 (59)	32 (41)	.41	1	.52

5.8 RESEARCH QUESTION #2: SCREENING AND DISCLOSURE

An additional factor that may affect disclosure is whether the clinicians specifically asked about IPV history during the interview. The disclosure rates obtained must be compared with the screening rate for IPV, given that roughly half of all respondents reported that no direct inquiries were made to them by a provider regarding abuse. In addition, respondents who were directly asked by clinicians about abuse were more likely to disclose than those who were not asked.

Respondents were asked to indicate whether any of the healthcare providers had asked them if they had ever experienced any of four different types of abuse (see Table 5.6): child abuse, IPV-psychological abuse, IPV-physical abuse and IPV-sexual abuse. Respondents indicated they were not asked about: child abuse in almost 47% (n = 97) of the cases; psychological abuse in 52.6% (n = 110) of the cases; physical abuse in 45.4% (n = 94) of the cases; and sexual abuse in 53.1% (n = 109) of the cases. Using a chi-square test, the number of respondents who disclosed IPV and were directly asked by a clinician about abuse was compared to the number of respondents who disclosed but were not asked about IPV. The results were significant, indicating that being asked by a clinician about abuse was strongly associated with disclosure (X^2=7.77, df =1, p = .005). The perception of helpfulness of being asked about abuse may play a role in disclosure as well. Significant differences were also found among groups by ratings of helpfulness when being asked about abuse by a clinician (X^2 = 11.20, df = 4, p = .02). In particular, respondents who experienced being asked by a clinician about abuse as very helpful, 82% (n = 23) also disclosed abuse.

Table 5.6 Screening for Abuse by Patient Report

Abuse type	**Total n**	**Asked**	**Not Asked**	**Not Sure**
		n (%)	***n (%)***	***n (%)***
Child abuse	208	99 (47.6)	97 (46.6)	12 (5.8)
IPV-psychological abuse	209	80 (38.3)	110 (52.6)	19 (9.1)
IPV- physical abuse	207	103 (49.8)	94 (45.4)	10 (4.8)
IPV- sexual abuse	207	84 (40.6)	109 (53.1)	13 (6.3)

However, these results may be due in part to a failure on the part of the questionnaire to reflect the actual practice of screening in the ER. Clinicians are trained to begin assessment about abuse with one general abuse screening question, and to follow up with additional questions into the nature of the abuse if the initial screening is positive. Therefore patients may have replied literally to the three questions on the instrument pertaining to direct inquiry about physical, sexual and psychological abuse, when indeed they may have been screened appropriately. These issues should be taken into consideration when reviewing the ER screening rates.

5.8.1 Research Question #2: Associations between Type of Abuse and Disclosure

Rates of disclosure were examined based on the type of abuse reported. Disclosure of all three types of IPV abuse occurred roughly 2/3 of the time in cases where abuse had been reported on the questionnaire. In Table 5.7, the data from the inquiries related to the three different types of IPV (psychological, physical and sexual) used for the questionnaire are displayed along with information regarding disclosure to a clinician. Psychological abuse was reported by 39.6% (n = 76) of the 192 respondents who completed this inquiry, however only 63% (n = 48) of these respondents reported disclosing to a clinician. Physical abuse was reported by 60.6% (n = 111) of 183 respondents, however only 58.5% of those (n = 65) reported disclosing to a clinician. Sexual abuse was reported by 40.3% (n =75) of 186 respondents, and 65% (n = 49) reported disclosing to a clinician.

It should be noted that missing responses were noted for all three questions about abuse type: 26 missing psychological abuse responses, 35 missing physical abuse responses, and 32 missing sexual abuse responses.

Table 5.7 Reporting of Abuse Compared To Disclosure

Abuse Type	Total N Responses Inquiry Into Types of Abuse*	Reported Abuse N (%)	Disclosed Abuse to Clinician N (%) "Yes"
IPV-Psychological abuse	192	83 (43)	48 (57)
IPV-Physical Abuse	183	128 (70)	65 (50
IPV-Sexual Abuse	186	87 (47)	49 (56)

*****Missing responses noted: 26 responses missing for psychological abuse, 35 missing for physical abuse, and 32 missing for sexual abuse.

5.8.2 Research Questions #2: Associations between Disclosure and Clinical Markers

Clinical markers of chief complaint and treatment history were examined for the disclosing and nondisclosing groups, and differences were detected among the chief complaints (see Table5.8). There was statistical significance in the number of women who disclosed PTSD as compared to the non-disclosing group on the basis of chi-square testing ($X^2 = 6.56$, df =1, p = .010). This suggests that a relationship may exist between the experience of PTSD and the disclosure of IPV, in that having PTSD may increase the likelihood of disclosure to clinical staff. This was an unexpected finding. One plausible explanation is that women who report PTSD have likely been diagnosed formally, indicating they have also sought treatment. Treatment for PTSD often involves encouragement by the provider to openly discuss traumatic events that are associated with the patient's symptoms in the therapeutic setting. This group of respondents may be inherently more comfortable disclosing abuse than other respondents. No significant differences were found among the disclosing and nondisclosing groups by history of child abuse ($X^2 = 3.25$, df = 1, P = .07)

Table 5.8 Association between Chief Complaint, Service Expectation, and Treatment Experience and Disclosure

Category	Disclosed N=75	Did Not Disclose N=53	X^2 or t	df	p
	n (%)	n (%)			
Chief complaint					
Depression	65 (61)	42 (39)	1.25	1	.26
PTSD	26 (76)	8 (24)	6.56	1	.010
Anxiety	46 (66)	24 (34)	3.23	1	.072
Alcohol/Drugs	34 (60)	23 (40)	0.18	1	.67
Schizophrenia	9 (82)	2 (18)	2.98	1	.085
Bipolar	32 (60)	21 (40)	0.17	1	.68
Treated past year	38 (58)	27 (42)	0.04	1	.84
Previous ED visits	26 (56)	20 (44)	0.86	1	.35

There were no statistically significant differences detected for the remaining five chief complaint options of depression, bipolar disorder, substance abuse, schizophrenia or anxiety. No differences were noted between groups in the categories of services being sought, treatment in past year at the institution in which the study was conducted or previous ED visits, indicating a lack of relationship between these variables and disclosing abuse.

5.9 RESEARCH QUESTION #3: PROVIDER RATINGS BY IPV REPORT

Respondents were asked to rate their experience with healthcare providers in the ED during their evaluation using four measures of patient-centered behaviors categorized as knowledge of the patient, communication, interpersonal interactions and trust scales. There were no statistically discernible differences between the IPV reporting group and the comparison group in the ratings of providers on the four scales measuring patient-centered behaviors (see Table 5.9). The mean scores for each provider rating scale for the IPV reporting group were compared to the mean scores from the non-IPV group via the t-test and no significant differences were detected. This indicates no apparent relationship exists between the ratings of providers on patient-centered behaviors by respondents and the IPV history of these respondents. This finding is not totally unexpected, given that these data were obtained by patient report on the questionnaire, under strict anonymity and confidentiality, and the perception of the provider would not necessarily affect the respondent's willingness to report the IPV on the questionnaire. This comparison was useful as a baseline to determine if any significant differences in these mean ratings scores by IPV exposure existed prior to conducting the next relevant analysis on the set of provider ratings, that of disclosure.

The scores derived from the provider ratings are mean scores transformed from the raw scale scores into a score on a 0-100 continuum. However these scores cannot be interpreted as standardized test scores. Instead, these scores indicate where the score lies against the highest possible score for that item. The scores demonstrate variability for each category, with standard deviations on average for all scores of approximately 23 points, however the standard deviation for the trust responses was notably less than the others (SD =17.67). The scores for interpersonal interactions, trust and communication averaged slightly above or below 70%.

However, the knowledge rating mean was much lower, at approximately 55%. This would indicate from a broad interpretation that both groups of patients rated their perception of providers as being knowledgeable about them much less favorably than the other three measures. This is an unexpected finding, and raises questions about the importance of this particular metric among the four provider behaviors examined. Unfortunately, since this is the first time to this author's knowledge that the PCAS has been used in this particular setting and under the study's unique circumstances, no benchmarking is available to compare this study's scores with similar scores. However, in one study of the use of the PCAS (Safran et al., 2000), measuring patient satisfaction with five types of health plans, reported scores for the measures of interpersonal interaction, communication, and trust ranged generally in mid-seventies to low 80's, and for the knowledge scale the score averaged 56, findings somewhat similar to this study.

Table 5.9 Perception Of Provider Ratings By IPV Versus Non-IPV Respondents

Scales	Total Sample Mean Scores/(SD) N = 210	IPV Mean Scores/(SD) N = 157	Non-IPV Mean Scores/(SD) N = 53	X^2 or t	df	p
Communication	71.38 (23.08)	72.3 (22.9)	69.6 (23.4)	-0.72	203	.47
Interpersonal Interaction	72.22 (23.39)	73.3 (23.3)	69.8 (23.3)	-0.94	203	.35
Trust	69.02 (17.67)	69.6 (18.0)	67.9 (16.5)	-0.60	200	.55
Knowledge of Patient	55.42 (23.95)	55.9 (23.6)	55.0 (25.4)	-0.22	197	.83

5.9.1 Research Question #3: Association between Provider Rating and Disclosure

Among the four patient-centered provider rating scales of communication, trust, interpersonal interactions, and knowledge of patient, only knowledge of patient emerged as significantly related to the outcome of disclosure (see Table 5.10). There was a statistically significant difference between the disclosing and non-disclosing groups in the category of the knowledge of patient, with an overall mean score of 62 (standard deviation 23.6) for the IPV disclosing group as compared to an overall mean score of 51.8 (standard deviation 23.7) for the non-disclosing group (t = -2.37, df =121, p = .019). This result indicates a relationship between patient perception of the provider as knowing the respondent well as a person and an increase in the disclosure of IPV. This finding was unexpected given the original hypothesis that all patient-centered behaviors would contribute to disclosure. In addition, of note are the markedly lower overall scale scores on the measure of patient knowledge in the disclosing group, in comparison with the other scale scores, e.g., the means for the other scores among the disclosing group ranged between approximately 72 and 77 points, while the mean for the knowledge of patient score was 62.

As discussed earlier in this chapter, similar findings regarding the lower scale scores for knowledge rating were found when the PCAS was used in another study. However, why this particular measure is different from the other three measures of patient-centered behavior among female abuse victims and disclosure is unclear. One potential explanation lies in the social stigma associated with being a victim of IPV; this, combined with the stigma of needing emergency psychiatric treatment, creates a special challenge for providers trying to encourage disclosure. It is possible that the patient's perception of the provider as knowing them as a person, including knowing their values, beliefs, daily life struggles and responsibilities, has an equalizing effect between the patient and provider, and allows disclosure to occur despite possible stigmatization. One other explanation is that other patient-centered behaviors also play an important role in disclosure but that the study design and sampling lacked adequate power to detect these contributions. This is explored further in the discussion of the regression model.

Table 5.10 Association Between Perception of Provider as Patient-Centered and Disclosure

Scales	**Disclosure N=75**	**Not Disclosed N=53**	**X^2 or t**	**df**	**p**
	Mean (SD)	*Mean (SD)*			
Communication	73.9 (23.3)	72.8 (21.2)	-0.29	125	78
Interpersonal Interaction	77.1 (22.9)	70.6 (21.3)	-1.61	125	11
Trust	72.3 (17.4)	68.9 (17.6)	-1.07	123	29
Knowledge of Patient	62.0 (23.6)	51.8 (23.7)	-2.37	121	.019

As noted, there were no significant differences between the mean scores among the disclosing and non-disclosing groups in the ratings of the providers on the behavioral categories of trust (p = .29), communication (p = .78) or interpersonal interactions (p = .11), as determined by a t-test. This indicates that there is no apparent relationship between the perception of providers on these behavioral categories and the eventual disclosure of IPV.

5.10 REGRESSION ANALYSIS

Three distinct variables emerged from the data analysis related to the measure of disclosure. From the demographic and clinical data, chi-square testing revealed significant differences between groups in the categories of marital status ($p = 0.028$) and the chief complaint of PTSD ($p = 0.010$). From the provider rating data, provider knowledge ratings appeared significant in relation to the disclosure of abuse. A multiple logistic regression analysis was performed on 110 surveys with complete data using these three variables to determine the nature of their contribution to a predictive model for disclosure (see Table 5.11). The two variables from the marital status category that had the largest variation in proportions between the disclosing and non-disclosing groups were the married group and the divorced/separated groups. Both forms of this marital status variable were tested alongside with PTSD and the knowledge rating scale variable in alternate logistic models. A marital status of being divorced/separated in comparison to all other marital classes was found to be statistically insignificant at $p = 0.2720$. However, the classification of being unmarried, when included in the regression model, remained significantly associated with the increased likelihood of disclosure. These three predictor variables were statistically significant in the logistic model as follows: knowledge of patient (Wald $X^2= 9.6101$, df =1, $p = 0.0019$), PTSD (Wald $X^2= 5.0966$, df = 1, $p = 0.0240$), and unmarried status (Wald $X^2= 10.6146$, df = 1. $p = 0.0011$). These findings indicate that each of these variables has a unique and significant contribution to the larger model of disclosure, controlling for all other independent variables. Overall model fit was significant, likelihood ratio $X^2= 25.98$, df =3, $p = .0001$.

Table 5.11 Multiple Logistic Regression Model for Disclosure Predictors

Predictor	df	OR*	SE	Wald	p
Knowledge of Patient Rating**	1	1.031	0.00991	9.6101	0.0019
Unmarried	1	5.273	0.7365	5.0966	0.0240
PTSD	1	6.437	0.5716	10.6146	0.0011

*OR = Odds Ratio **Continuous Variable

The odds ratio estimate produced from this logistic regression for the independent variable of scores on the rating of providers on the knowledge scale, for the dependent variable of disclosure was 1.031. This statistic is based on the continuous variable of rating scale scores (as opposed to a dichotomous categorical variable) and therefore the resulting statistic from the logistic regression model is interpreted slightly differently. This finding indicates that for every point increase in the score for the knowledge rating scale, there is a 3.1% increase in the likelihood of disclosure of IPV by the respondent. In other words, the odds of a respondent with a score of 62% on the knowledge rating scale disclosing abuse are 31% higher than their counterpart scoring 52 on the knowledge rating scale.

For the independent, dichotomous variable of unmarried status, the resulting odds ratio from the analysis was 5.273, indicating that the odds of an unmarried respondent disclosing were more than five times greater than the odds of nondisclosure. For the independent variable of having PTSD, the resulting odds ratio was 6.437, indicating that the odds of a respondent with PTSD disclosing were more than 6 times greater than the odds of nondisclosure.

Additional analyses were conducted to identify any other potential factors relating to the outcome variable of disclosure. Correlation analyses were conducted to detect the presence of strong relationships existing between independent variables that may have confounded the findings related to the outcome measure. As anticipated, correlations were found between the four provider rating variables. However, no other strong correlations were detected among all other independent variables.

In addition, an effect size of .29 was obtained for the variable of interpersonal interaction that has potential clinical significance. The effect sizes for the three other provider ratings of interpersonal interactions, communication and trust were examined, since the original study hypothesis was interested in the role these four ratings measures had in the outcome of disclosure. The Cohen's d effect size was .05 for communication, .29 for interpersonal interactions, and .19 for trust. This is a standardized measure based on the differences for the means divided by the standard deviation for the variable in question. Findings for effect sizes below .3 are generally considered small. However, the effect size of .29 for interpersonal interactions may have clinical significance and warrants additional attention. This effect size translates into an almost seven point difference between the mean scores of patients who disclosed from those who did not on this provider rating (SD = 23.3). This indicates the study lacked adequate power to detect this smaller effect size. The other two effect sizes were small and had little clinical significance.

6.0 DISCUSSION

6.1 PURPOSE OF STUDY

The intent of this study was aimed at defining exposure to IPV among adult female patients in emergency psychiatric settings and the relationship between the dependent variable of disclosure of IPV in a psychiatric emergency setting to clinical staff and the independent variable of perception of the provider by respondents. Other potentially related independent variables, including demographic characteristics and clinical history, were also examined for any possible association with disclosure.

6.2 RESEARCH QUESTION #1: IPV PREVALENCE

The high rate of self-reported exposure to IPV by the study respondents confirms that women with psychiatric difficulties may be at increased risk for experiencing IPV. Indeed, the findings of 75% of the sample reporting IPV exceed national estimates of IPV prevalence (Tjaden & Thoennes, 2000). In a rare study based in the psychiatric emergency setting, Briere et al. (1997) found a history of IPV in 42% of the participants. This study's findings add to the understanding of the prevalence of IPV in female abuse victims with psychiatric emergencies. However, much more extensive research is required to further explore the prevalence and incidence of IPV in the population of women with acute presentations of psychiatric disorders.

6.3 RESEARCH QUESTION #1: IPV AND DEMOGRAPHIC CHARACTERISTICS

The study findings also provided new information related to the demographic make-up of the sample of adult, female abuse victims seeking services in a psychiatric emergency setting. There are many studies exploring the relationships between demographic characteristics and the prevalence of IPV in the general population (Bergman & Brismar, 1991; Coker et al., 2002; Coker et al., 2000; Rennison & Welchans, 2000; Sorenson et al., 1996); women who are younger, African-American, unmarried, and from lower socioeconomic groups have been found to be at greater risk of IPV. However, this study demonstrated that on measures of age, race, marital status, education (as an estimate of SES), and number of children, there was little variation between groups of abuse victims and non-abused women presenting for emergency psychiatric treatment.

6.4 RESEARCH QUESTION #1: IPV AND CHIEF COMPLAINT

The findings from this study confirm that female abuse victims experience higher rates of anxiety, depression, PTSD and bipolar disorders than their non-abused counterparts in the psychiatric emergency setting. The relationships between these mood and anxiety disorders and exposure to IPV is well established in the literature (Astin et al., 1995; Bauer et al., 2000; Briere et al., 1997; Danielson et al., 1998; Scholle et al., 1998) however additional research is needed to expand upon the understanding of these relationships as they interface in female abuse victims with acute psychiatric illness. One key area of interest would be determining if exacerbations of the symptoms often seen in these disorders, such as depressed mood, mood lability, heightened anxiety, avoidance or activation, are precipitated by an episode of IPV. Conversely, are women with these disorders more likely to be victimized secondary to an acute worsening of their symptoms? Although both scenarios are likely true to some degree, an understanding of whether and how IPV potentiates a psychiatric crisis in female abuse victims is crucial to effective diagnosis and treatment.

6.5 RESEARCH QUESTION #2: DEMOGRAPHIC FACTORS AND DISCLOSURE

The demographic data was then analyzed for the group of female abuse victims and categorized by those who disclosed and those who did not disclose IPV. No specific relationships were predicted for this analysis of demographic information as compared with IPV disclosure, as there are no other studies predicting the nature of these relationships. However, one variable, marital status, emerged unexpectedly from the demographic data as significantly related to disclosure. For all other variables, there were no relationships detected differentiating the two groups on these measures. The significance of the relationship detected between unmarried women and higher rates of disclosure among patients seeking psychiatric emergency treatment is a unique finding and warrants additional study as well. Speculation about the origin of this finding would include that marriage implies a stability and legal status to the women's relationship with a romantic partner that prevents their willingness to disclose abuse. In addition, for married women who disclose, the identification of their abuser is essentially automatic, while for unmarried women this is not the case, for instance an unmarried woman could disclose without the provider necessarily ever knowing the identify of the abuser. Fear of retaliation from the abuser is a strong deterrent to disclosure (Gerbert et al., 1996; McCauley et al., 1998; Rodriguez et al., 2001). Additional study is required to determine in depth the nature of this association between disclosure and being unmarried in female abuse victims.

6.5.1 Disclosure and PTSD

The relevance of the self-report of PTSD and an increase in disclosure of abuse is another unexpected finding from the study. As noted above, although IPV has been linked with PTSD (Astin et al., 1995), there are no other known findings from available research suggesting this relationship as significantly related to the disclosure of IPV. One potential relationship may be that patients who self-identify as having PTSD and subsequently disclose their abuse may have had more severe experiences with IPV than non-disclosing female abuse victims or experienced IPV for a longer period of time. In this scenario, the increased severity or duration of abuse then increases the likelihood of disclosure. A more likely explanation is that patients who self-reported PTSD may have also received treatment for the disorder, and as a result may have been encouraged by treating professionals to discuss the abuse openly in clinical sessions (e.g. disclose the abuse) as part of the treatment process. If this is the case, there may be important therapeutic interventions used in treating PTSD that can be applied in other settings that will facilitate disclosure by IPV victims, including the emergency psychiatric setting. Clearly, additional research is needed to clarify the nature of this relationship between PTSD and the disclosure of abuse.

6.6 RESEARCH QUESTION 3: DISCLOSURE AND PATIENT-CENTERED PROVIDER BEHAVIORS

The findings appear to partially support the conceptual framework for this study, that patient-centered provider behaviors play a role in assisting the female abuse victim to disclose their experience with IPV, in that the perception of a provider as knowledgeable about their patients was associated with the increased likelihood of disclosure. The knowledge scale assessed patient's perceptions of their provider's knowledge of the patient's medical and psychiatric history, their responsibilities at work and home, what worries them the most about their health, and knowledge of their values and beliefs.

Battaglia et al.'s (2003) work with IPV victims produced information on the provider behaviors that were reported as positively associated with the willingness to disclose abuse. Provider behaviors such as offering personal stories in order to show a common experience, along with other behaviors including persistent questioning about abuse, making oneself accessible to the patient, comprehensive history taking, and collaborative decision making were reported by the IPV victim as facilitative to disclosure. However, the exact nature of these relationships was unknown, e.g. the degree to which one degree of patient-centeredness is more important to the outcome of disclosure versus another is not clear from the literature. It was also unknown if the effect of patient-centeredness is a linear one or a function of the interaction with other variables.

The driver for these study findings may lie in the specialized nature of the study's sample of female abuse victims seeking emergency psychiatric treatment. For this unique population, the sense that a provider has developed an understanding of them that goes beyond simple medical information may be the key to encouraging them to disclose their abuse history. Issues such as the social stigma which still prevails in today's society of having a psychiatric illness, compounded with the stigma of IPV, presents a unique challenge to providers in screening successfully for IPV. Therefore, a patient's belief that a provider has knowledge of them as a person may mitigate the sense of stigma enough to allow for disclosure. Additional research is required to explore this relationship identified between disclosure and the respondent's perception of being known as a person by the provider, and how these factors affect disclosure in psychiatric settings.

In addition, the direction of the relationship is unknown. It may be that the perception is driven more by patient- related factors that affect their perception or it may be primarily determined by the conduct of the provider towards the patients. If the latter is true, what exact provider behaviors produce the perception of the provider as knowing the patient as a person? Can these behaviors be developed as a skill set in providers by virtue of training and supervision? These questions could be answered through a targeted qualitative study. Finally, more study is needed to determine if the findings from this study are truly unique to women with abuse histories and psychiatric difficulties or if the concepts are relevant to all abused women and can inform provider practices in all health care settings.

6.7 IMPLICATIONS FOR CLINICAL PRACTICE

The immediate implications apply to the emergency psychiatry clinical setting in that ED providers should be alert to the fact that adult female patients with acute psychiatric presentations may be at very high risk for past exposure to IPV. As a result, screening for IPV in these settings should be immediately revisited and prioritized. This is especially true for the clinical setting used in the study, given that the respondents reported that providers inquired directly regarding their exposure to abuse in only 50% of the cases studied. In addition, these findings support the continued need for safety measures in place for this setting to protect IPV victims from additional harm from their abusers, including environmental protections, procedural protections and training for all staff in the development of safety planning for identified victims. Finally, additional study is needed to confirm these findings in other emergency care settings where female abuse victims present for psychiatric treatment. If confirmed, similar measures mentioned to those above should be taken to ensure adequate screening and safety measures in these settings.

Additional implications for practice in the study setting also include sensitizing the providers in psychiatric ED settings to the importance of the adult female’s marital status and exploring issues of abuse accordingly. Given the possibility that married women may fear the automatic identification of the abuser as a result of disclosing abuse, this ED provider should go to extra lengths when screening married women to assure them of the confidentiality of any disclosures and to ensure that no actions to address abuse will be taken by the provider without their express permission. These cautionary measures may also apply to other ED settings and healthcare settings and should be studied through additional research.

6.8 LIMITATIONS

6.8.1 Study Design

This study used a descriptive approach to the exploration of relationships between the independent variables of demographics, clinical history and the patient perception of providers on the dependent variable of disclosure of IPV. The sample consisted of a convenience sample and although the group of respondents appears to be representative of the demographic make up of the urban setting, because randomization did not occur there may be unknown selection bias. Although the participation rate of 86% was high, no information is available regarding the patients who refused to participate to determine if they were similar to the participants with regard to the independent variables, thereby introducing additional potential for selection bias. In addition, no causal relationships can be inferred due to the non-experimental nature of the study.

6.8.2 Operationalization of Study

One of the main weaknesses of the study relates to the sporadic identification of potential subjects for the determination of eligibility and subsequent recruitment into the study. Staff reported difficulties completing identification of eligibility during high patient volume periods. As a result, only 29% of potentially eligible adult females presenting for DEC services during this time frame were considered for the study, presenting the potential for sample bias. In addition, of the 832 potential participants, 72% were excluded due to acute psychiatric or medical conditions or mental retardation. Therefore any conclusions from this study related to psychiatric emergency patients must be tempered with the understanding that these groups were not represented in the findings. For example, acutely psychotic and intoxicated patients were deemed ineligible for participation. Since these presentations are consistent with an exacerbation of schizophrenia or substance abuse disorders, patients with these psychiatric conditions may be underrepresented in the findings.

More importantly, the screening for IPV was conducted sporadically as well, in only approximately half of the cases studied, per patient report. Yet it was determined that screening, by direct clinician inquiry, was significantly related to increases in disclosure. On the other hand, issues with the screening questions may have been misleading to respondents, and actual screening rates underreported as a result, as discussed below. The inability to clearly determine the actual screening rates constitutes a serious potential confound to the study findings. These issues with selection bias and potential confounds to the findings related to the outcome measure of disclosure present concerns regarding the internal validity of the study.

However, despite the difficulties associated with conducting the study in this very acute setting with seriously ill psychiatric patients, it is also the “ in vivo” nature of the study that enables this study’s findings to translate directly into other clinical settings.

6.8.3 Instrument

Overall, since this study relied on the self-report by respondents for all of the questionnaire data, no confirmation of the accuracy of the data is possible and therefore the results are subject to over-or under-reporting. For instance, given the sensitive nature of the questions and despite assurances of confidentiality, underreporting may have occurred related to IPV exposure. On the other hand, reports of disclosure of IPV and provider ratings may have been subject to inflated ratings if patients were concerned about confidentiality and feared a negative reaction from caregivers if they indicated negative provider ratings or nondisclosure. The question related to disclosure produced a high number of missing and “not applicable” responses, even in cases where abuse was reported earlier in the questionnaire.

In addition, this question was tied with the inquiry into abuse which was identified in retrospect as inconsistent with clinician practice related to abuse inquiry, i.e. the formatted questions would not necessarily reflect the actual questions asked of the patient by the clinician during an evaluation. Three of four questions were used to assess whether a patient had been asked directly by a clinician about IPV abuse. However it is unlikely that a ER clinician would ask questions about abuse in this manner. It is much more likely that only one screening question regarding abuse would have been asked. Therefore, it is possible that the respondents were answering these questions literally and in the negative when indeed they may have been asked a general question regarding abuse, in which case the actual percentage of respondents who had been directly asked about abuse would be higher than the data reflect.

These issues suggest that this particular set of questions was confusing to some respondents and that instrument failure may have introduced an unknown amount of inaccurate data into the findings.

The scales selected for use in determining the patient's perception of the provider, the PCAS, was designed for use in primary care situations where patients may have had multiple and long-term visits with a physician. It is possible that these scales did not translate well into the emergency setting, and lacked the appropriate content required to detect important findings with regard to the perception of patient-centered provider behaviors.

6.9 IMPLICATIONS FOR FUTURE RESEARCH

This study identified several additional directions for follow-up research related to the factors facilitating the disclosure of IPV in an emergency psychiatric setting. The data obtained regarding the different types of IPV abuse reported should be mined further, to determine if disclosure and/or provider ratings are somehow affected by permutations of the type of abuse experienced, whether it be psychological, physical, sexual or various combinations of abuse experiences. Different abuse experiences may sensitize the patient differentially to the same abuse assessment experience and affect the outcome of disclosure, regardless of other factors, such as perception of the provider, remaining constant.

As previously noted, the nature of the relationship between PTSD and disclosure also requires further study: if the obtained results are a function of the disorder, what changes occur in women with PTSD that leads them to disclose more frequently than others? Is this an indication of severity of abuse, or is the finding secondary to receiving treatment for the disorder and encouragement to disclose abuse?

Smaller qualitative studies are indicated to expand upon the findings related to the patient-centered provider behavior concepts. These types of studies, conducted on women reporting IPV in the psychiatric setting and using an interview-based data collection methodology, could capture respondents’ verbatim impressions of the psychiatric evaluation experience and the nature of the patient-provider interaction. Detailed information regarding what behaviors were particularly helpful as well as unhelpful behaviors on the part of the clinical staff could be coded for recurring patterns and themes. This information could then be used to develop training curricula for the emergency psychiatric staff aimed at improving their patient-centered clinical skills. Changes in clinician practice style could then be protocolized, moving staff away from the current standards of rigid interpersonal boundaries, authoritarian or interrogatory clinical styles, and diagnostic focus to a relationship oriented, collaborative approach, should the need for such be confirmed by future research. Subsequent testing could then be conducted to determine if these changes improve the experience of the psychiatric evaluation for the female abuse victim and any impacts on disclosure. Videotaping of clinical sessions and subsequent critique, by other clinicians or patients, with regard to the provider’s grasp of patient-centered skills could also produce powerful training opportunities. If a constellation of particularly effective provider behaviors can be distilled from additional testing that is shown to improve the experience of psychiatric assessment as supportive and non-threatening to IPV victims, this new set of clinical skills should be curriculized for training with other health care providers working with this population.

This study highlighted an additional concern, that of assessing women who are so acutely psychiatrically ill that they are unable to take part in the typical psychiatric assessment process, including abuse screening. Many women in this study were excluded from participation due to extreme cognitive impairment, severe behavioral disturbances, acute intoxication, and other psychiatric presentations. Women who experience such debilitating symptoms during an exacerbation of their psychiatric illness, which could be prolonged and left untreated for long periods of time, may be at even greater risk for IPV and serious negative sequalae. In addition, attempts to assess IPV exposure in these patients will need to be repeated throughout the course of treatment, since at certain periods when the patient is acutely ill, assessment will be unreliable. Unfortunately, current models for assessment of abuse in healthcare often are conducted only at certain points in time, e.g. when entering into treatment, and are not repeated. Clearly, research is needed into what modifications to IPV assessment and safety planning are needed for this type of patient.

Finally, no information from the study was captured on the women that did disclose IPV to a provider, or the interventions that were offered as a result of their disclosure. Additional research in this setting of female abuse victims should explore the nature of the supportive interventions, safety planning, referral options and any other interventions provided to IPV victims that disclose and the patient experience of these interventions.

Perhaps a reconsideration of the focus on the outcome of disclosure as the key to intervening with IPV is required. Chang et al.(2005) found that in a qualitative study of women who had experienced IPV that interventions requiring abused women to disclose their abuse to healthcare providers in order to receive interventions or information were rated as less desirable. Instead, the participants recommended that providers: 1) offer multiple options for abused women to consider based on their “readiness” for change, and 2) offer this information in a secure, confidential setting. Cluss et al. (2006) propose a psychosocial readiness model for change for IPV victims. In this model, external factors, which can include interactions with family, friends, or even healthcare providers, can positively or negatively impact on the woman’s readiness to change. Instead of targeting the goal of disclosure of IPV, a provider in the psychiatric emergency setting could facilitate a woman’s movement along this continuum of change by virtue of a supportive, empowering patient-centered clinical approach. The provider’s focus on disclosure would be replaced with a repertoire of referral, educational, and support options for reference and use, in combination with a humanizing, collaborative approach to the abuse victim.

Given the high prevalence of IPV in women seeking psychiatric treatment, additional research into the forces putting these women at high risk and identifying how best to treat them, is urgently needed. Health care providers, IPV support groups and community programs, and government agencies dollars must direct their combined efforts towards addressing this under recognized public health concern through targeted research development.

APPENDIX A

QUESTIONNAIRE

Date _____/_____/2006

We are conducting a research study to learn about people's experiences with violence. We are asking people who are being seen for services in this program to fill out a questionnaire. It takes 7 minutes or less to complete. You do not have to fill it out if you do not want to. If you don't fill it out, your health care at XXX will not be affected. The information you give us will be anonymous. We will not ask you for your name. YOU MAY CHOOSE TO DISCUSS YOUR ANSWERS WITH YOUR DOCTOR OR CLINICIAN BUT WE WILL **NOT** GIVE THIS INFORMATION TO THEM OR ANYONE ELSE.

IF YOU FEEL UNSAFE AT ANY TIME WHILE YOU ARE COMPLETING THIS QUESTIONNAIRE, PLEASE TELL US. WE CAN HELP TO KEEP YOU SAFE. We will also protect your privacy by locking the door to this room. No one else can enter while you are completing the questionnaire. When you are done you will be able to put the completed questionnaire into a securely locked box. No one else can read your questionnaire or identify which questionnaire you filled out. There is no payment for filling out the questionnaire. There are no risks to filling it out and no direct benefits to you for doing so. Your opinions and experiences are extremely important and may help us to improve the quality of care provided here. XXXX, who can be reached at (412) 246-6818 if you have any questions, is conducting this study.

If you have filled out this form in the last six months, PLEASE DO NOT FILL IT OUT TODAY.

What is your age? _____

What is your race or ethnicity? ☐ Caucasian ☐ Latino/Hispanic ☐ African American ☐ Asian
☐ American Indian ☐ Pacific Islander ☐ Other

What is your marital status? ☐ Single ☐ Married ☐ Divorced/Separated ☐ Widowed ☐ Other

How many children do you have? ☐ None ☐ 1 ☐ 2 ☐ 3 ☐4 or more

1. What is the reason (or reasons) for your visit today? (Check all that apply)

   a) ☐ Evaluation
   b) ☐ Medications
   c) ☐ Counseling or Therapy
   d) ☐ Other: (Specify) ______________________________

2. I am here to get help for:

   a) ☐ Depression
   b) ☐ Post-traumatic Stress Disorder
   c) ☐ Anxiety
   d) ☐ Alcohol or Drugs
   e) ☐ Schizophrenic
   f) ☐ Bipolar Disorder
   g) ☐ Other: (Specify) ________________________________

3. How long have you been in treatment at XXX?

   a) ☐ Today is my first appointment.
   b) ☐ Less than three months.
   c) Three months to one year.
   d) One to two years.
   e) More than tow years.

4. How many times have you received services in the past year in the Emergency Department at XXX? _______________

5. What is the highest level of schooling you have completed? (Check <u>one</u> box).

   a) ☐ Did not graduate high school
   b) ☐ Earned GED
   c) ☐ High school graduate
   d) ☐ Some college/technical school but did not graduate
   e) ☐ College degree
   f) ☐ Graduate or professional school

6. What is the name of your main health insurance plan? _________________________________

   a) ☐ Unknown
   b) ☐ I do not have health insurance.

Violence and abuse are important issues today. We want to get an idea about people's experiences so we can better meet our patients' needs. The following questions ask about your experience with different kinds of violence and abuse. Please answer the questions based on your experience here today in the XXX emergency department. Your help with this important survey is greatly appreciated.

7. Before you were age 18, did any of the following things ever happen to you: (Please check one).

   a) Did a parent or another adult hurt or punish you in a way that left a bruise, cut, scratches or make you bleed? ☐ Yes ☐ No
   b) Did anyone who was 5 or more years older than you do something sexual with you or to you? ☐ Yes ☐ No
   c) Did anyone who was less than 5 years older than you do something sexual to you that was against your will? ☐ Yes ☐ No

Think about your relationship with your current partner. How much do you agree with these statements?

8. I try not to "rock the boat" because I am afraid of what my partner might do . . .

   ☐ Agree Strongly; ☐ Agree a little; ☐ Disagree a little; ☐ Disagree Strongly; ☐ NA

9. I feel owned and controlled by my partner

   ☐ Agree Strongly; ☐ Agree a little; ☐ Disagree a little; ☐ Disagree Strongly; ☐ NA

10. My partner can scare me without laying a hand on me.

   ☐ Agree Strongly; ☐ Agree a little; ☐ Disagree a little; ☐ Disagree Strongly; ☐ NA

Think about current and past relationships with romantic partners as you answer the following two questions.

11. As an adult, has a romantic partner, spouse, or ex-partner ever hit, slapped, kicked or otherwise physically hurt you? ☐ Yes ☐ No ☐ NA
    a) Has this happened in the last 12 months? ☐ Yes ☐ No ☐ NA

12. As an adult, has a romantic partner or ex-partner ever forced you to have an unwanted sexual act? ☐ Yes ☐ No ☐ NA
    a) Has this happened in the last 12 months? ☐ Yes ☐ No ☐ NA

Now we will ask you about your experiences today in the Emergency Room.

13. Did any of the healthcare providers (doctors, nurses, clinicians, social workers) here today at XXX **ask you about** whether you were: (Please check one for each item).
   a) Physically or sexually abused as a child? ☐ Yes ☐ No ☐ Not Sure
   b) Physically abused by a partner as an adult? ☐ Yes ☐ No ☐ Not Sure
   c) Sexually abused by a partner as an adult ☐ Yes ☐ No ☐ Not Sure
   d) Emotionally controlled or made to be afraid by a partner as an adult?
   ☐ Yes ☐ No ☐ Not Sure

14. If you answered "Yes" to any of the questions in #13 above, how helpful was it for someone to ask you about this?

   ☐ Not at all helpful
   ☐ Somewhat helpful
   ☐ It didn't matter
   ☐ Pretty helpful
   ☐ Very helpful

15. Did you share information about the abuse you have experienced as an adult with a healthcare provider (doctor, nurses, clinicians, social workers) today, here in the Emergency Department? ☐ Yes ☐ No ☐ Not Applicable

Think about the healthcare provider that you talked with the most today. Then answer the questions below about that healthcare provider.

16. Thinking about how the healthcare provider communicated with you today, how would you rate the following: 1) Very Poor; 2) Poor; 3) Fair; 4) Good; 5) Very Good; 6) Excellent

	1	2	3	4	5	6
Thoroughness of the healthcare provider's questions about your symptoms and how you are feeling.						
Attention the healthcare provider paid to what you have to say.						
Healthcare provider's explanations of your health problems or treatments that you need.						
Healthcare provider's instructions about symptoms to report and when to seek further care.						
Healthcare provider's advice and help in making decisions about your care.						

17. Thinking about the personal aspects of the care you received from the healthcare provider caring for you today in the Emergency Department, how would you rate the following:

	1	2	3	4	5	6
Amount of time the healthcare provider spent with you.						
Healthcare provider's patience with your questions or worries.						
Healthcare provider's friendliness and warmth toward you.						

Healthcare provider’s caring and concerns for you.						
Healthcare provider’s respect for you.						

18. Thinking about how much you trust the healthcare provider, how strongly do you agree or disagree with the following statements: 1) Strongly Agree; 2) Agree; 3) Not Sure; 4) Disagree; 5) Strongly Disagree

I could tell the healthcare provider anything, even things I might not tell anyone else.	1	2	3	4	5
The healthcare provider sometimes pretended to know things when he/she was really not sure.					
I completely trust the healthcare provider’s judgments about my medical care.					
The healthcare provider cared more about holding down costs than about doing what is needed for my health.					
The healthcare provider would always tell me the truth about my health, even if there was bad news.					
The healthcare provider cared as much as I do about my health.					
If a mistake was made in my treatment, the healthcare provider would try to hide it from me.					

19. All things considered, how much do you trust the healthcare provider?

1 2 3 4 5 6 7 8 9 10
Not At All Completely

20. Thinking about how the healthcare provider knows you, how would you rate the following: 1) Very Poor; 2) Poor; 3) Fair; 4) Good; 5) Very Good; 6) Excellent

	1	2	3	4	5	6
The healthcare provider’s knowledge of your entire medical history.						
The healthcare provider’s knowledge of your responsibilities at work or home.						
The healthcare provider’s knowledge of what worries you most about your health.						
The healthcare provider’s knowledge of you as a person (your values and beliefs.						

THANK YOU FOR TAKING THE TIME TO ANSWER THESE QUESTIONS. Sometimes answering questions about violence and abuse can cause some people to think carefully about these issues in their lives. This may result in additional concerns or questions. If you would like to speak to one of our clinical staff about the questionnaire or your responses, please inform the staff sitting with you. They will arrange for you to speak privately with someone immediately. **IF YOU FEEL UNSAFE AT ANY TIME, PLEASE TELL US. WE CAN HELP TO KEEP YOU SAFE**.

APPENDIX B

PERMISSION TO USE PCAS

7

617-636-8351
Angie Mae Rodday

Tufts New England Medical Center
Institute for Clinical Research and Health Policy Studies
The Health Institute

PERMISSION TO USE THE PRIMARY CARE ASSESSMENT SURVEY (PCAS) FOR NONCOMMERICAL PURPOSES

Dear PCAS User:

The Primary Care Assessment Survey (PCAS) is provided to {Fill in "Name of Individual/Organization"} for use in {Fill in "Name of Protocol/Project"}.

As a registered User of PCAS, you will be provided the following services:

- Access to the Primary Care Assessment Survey (PCAS) for use in the above-named protocol(s);
- Permission to duplicate the Primary Care Assessment Survey (PCAS) for dissemination to project personnel and targeted survey respondents as needed for the above-named protocol/project(s);
- Scoring documentation and scoring algorithms for the Primary Care Assessment Survey (PCAS);
- Access to updated information about the Primary Care Assessment Survey (PCAS) as it becomes available.
- Where applicable, information enabling you to connect with other PCAS Users who have similar interests and uses of the measures.

The following restrictions apply to all Users of the Primary Care Assessment Survey (PCAS):

- Permission to use the Primary Care Assessment Survey is granted for the above-named protocol/project(s) only.
- By signing this agreement, you certify that the PCAS will not be used by you or your agents for any commercial purposes.
- You may not disclose the PCAS or PCAS scoring algorithms to any individual or organization not directly involved in above-named protocol/project(s):
- When reproducing the PCAS questionnaire for use in the above-named protocol/project(s), please include an identifier as follows:

> **The Primary Care Assessment Survey (PCAS), © 1995 D.G. Safran/The Health Institute, New England Medical Center Hospitals, Inc. All Rights Reserved.**

Tufts New England Medical Center
Institute for Clinical Research and Health Policy Studies
The Health Institute

If you embed items from the PCAS in a larger survey, please include the following statement on the questionnaire form, including at its end:

> **<u>Questionnaire includes items adapted from:</u> The Primary Care Assessment Survey (PCAS), © 1995 D.G. Safran/The Health Institute, New England Medical Center Hospitals, Inc.**

When reporting on results obtained with the PCAS or a subset of its items, please use the following citation in your biography:

> Safran DG, Kosinski M, Tarlov AR, Rogers WH, Taira DA, Lieberman N, Ware JE. The Primary Care Assessment Survey: Test of data quality and measurement performance. Medical Care 1998; 36(5): 711-723.

The PCAS questionnaire in its entirety may not be reproduced in reports or presentations of findings from the above-named protocol without prior written permission of the PCAS Administrator;
The PCAS scoring algorithms may not be reproduced or distributed at any time and for any purpose.

If you agree to the terms of this **User's Agreement**, please return a signed copy to my attention and a $20 materials fee. We will mail or email you a copy of the PCAS and supporting documentation.

If we may provide you with technical advice or consultation regarding your use of the PCAS, please feel free to be in contact with us. Good luck in your research and/or quality improvement endeavors!

Yours truly,

PCAS Administrator
Dana Gelb Safran, Sc.D.

Agreed to by:

Kimberly Owens

Date: 3/21/05

Kimberly R. Owens, MSN, BSN

Date: 3/21/05

APPENDIX C

RN AND PSC TRAINING PROTOCOL FOR QUESTIONNAIRE ADMINISTRATION

Patient Service Coordinators (PSC's) and ER Charge Nurses will participate in separate structured trainings conducted by XXXX PhD, which will consist of didactic sessions giving basic information regarding Intimate Partner Violence (IPV). In addition to a basic orientation to IPV, the content for the ER Charge Nurses will focus on applying the exclusionary criteria in determining which patients are appropriate to approach regarding participation in the study. For the PSC's, the particular focus will be on the process of approaching patients to participate and proctoring their completion of the questionnaire, as well as maintaining patient safety and the importance of confidentiality and anonymity.

*All ER Charge Nurses will participate in training. In the event a ER Charge nurse is not available, patients will not be able to be referred for participation in the study during this time period in the ER. Only Patient Service Coordinators (PSC) who have completed the training will be permitted to approach potential subjects regarding completing the questionnaire. In the event that no PSCs are available who have been trained in the study process, patients will not be able to be referred for participation during this time.

<u>ER Charge Nurse Training: Identifying Appropriate Study Candidates</u>

Following the didactic portion of the training, the ER Charge nurses will be trained in the process of identifying patients and determining the patient's appropriateness for participation in the study based on exclusionary criteria. The exclusionary criteria will be obtained in large partf from the completed psychiatric evaluation form (PEF) , specifically the physician's diagnostic fomulation and impression. Additional information will be obtained through clinical examination and patient history.

Exclusionary criteria:

- ○ Age 18 or under

- Patients carrying historical or new diagnosis of mental retardation as per patient records, caregiver report or PEF
- Acute medical condition requiring transfer to XXX for medical clearance as per medical transfer summary
- Substance intoxication as indicated by a breathalyzer reading over .08 for alcohol intoxication, or substance intoxication as per Psychiatric Evaluation Form (PEF) MD diagnostic formulation
- Active/severe psychosis as per PEF
- Unable to sign informed consent for treatment per MD evaluation per PEF
- Dementia based on Folstein Mini-Mental Status Exam (score under 25)
- Impaired Altered level of consciousness per MD exam per PEF

ER Charge nurses will be trained to determine the presence of any exclusionary criteria. They will be asked to keep a log of patients who were referred for participation and those who were not and the accompanying exclusionary criteria. No information identifying the patients' identities will be documented; this information will allow us to determine the numbers of patients that were excluded from participation.

To standardize the referral process and establish inter-rater reliability among Charge Nurses, ER Charge Nurses will be required to complete a training competency. Each Charge Nurse will be given ten patient scenarios/PEFs and asked to evaluate the patients for appropriateness for inclusion in the study.

PSC Training: Protocol Administration

Following this didactic portion of the training, the PSC's will be trained in the protocol for administering the questionnaire as follows.

1. After a review of the exclusionary criteria , the ER charge nurse will identify patients who are appropriate to be approached by the PSC for participation in the study.

2. Once the charge nurse has identified a patient as appropriate to approach and once their disposition has been agreed upon, the PSC will approach the patient regarding participation in the study. . This will occur in the main waiting areas of the ER. The PSC will use the following script:

“**Patient Name**: **We would like you to complete an anonymous questionnaire about your satisfaction with the services you received today in the ER; would you be willing to take a few minutes to complete this questionnaire?**”

If the patient accepts, the PSC will go with them to a specially designated interview room in the ER which can be locked so that no one else can enter the room. The PSC will instruct any family members, friends or other accompanying persons with the patient that the questionnaire must be administered in a special room in the ER and that only the patient can be present. The PSC will ensure the door is locked upon entry. In addition, there will be a special locked box with a hole in the top to insert completed questionnaires. No one will be able to extract a completed questionnaire once it is inserted except for the supervising psychologist or study author.

The patient will be asked to sit at the designated table. The PSC will obtain information from the ER charge nurse at the time the patient is identified as an appropriate study patient as to the genderof the treatment team members that worked with the patient . This information , as well as the PSCs gender will then be noted on the designated separate form provided for this purpose, and the form will then be enclosed / sealed in an envelope attached to the questionnaire packet.. The envelope will have instructions written, “ For staff use only, do not open“.

The PSC will sit in the room with the patient quietly during the completion of the questionnaire. The PSC’s will log each patient participating in the questionnaire into a log book noting the time and date. No identifying information regarding the patient will be documented. The PSC may not take telephone calls, leave the room, leave the patient unattended, or conduct program business during completion of the questionnaire.

The PSC will hand the patient the packet of information to be completed which will include the current ER patient satisfaction monitoring form (which is standard procedure in the ER) along with the study questionnaire. The PSC will be instructed to answer any questions from the participants from a menu of approved, scripted bolded responses as below:

1. If patient inquires as to the purpose of the questionnaire, the PSC will respond:

- **“Please read the introductory paragraph at the top of the questionnaire; if you still have questions after reading this, let me know”**

2. If the patient asks about anonymity of their responses, the PSC will affirm this by stating:

- “**All information on the questionnaire will remain anonymous unless you wish to speak to a ER staff member regarding the information “.**

3. If the patient asks about a particular question, the PSCs will be directed to tell the patient

- “**Simply answer to the best of your ability. If you are unable to understand the question, leave the question blank”,** PSCs will be instructed not to interpret questions for the patients.

4. If the patient decides not to complete a questionnaire that they started, the PSCs will instruct them to put them in the locked box regardless of completion.

5. If the patient reports willingness to participate but has difficulty reading due to a physical limitation or skill deficit, the PSC will be instructed to state:

- “**I can assist you by reading the questions and answers to you and marking your responses if you would. I will not share the information with anyone unless you ask me to do so.”**

6. If the patient asks to speak with a clinician or MD after completing the questionnaire, the PSC will instruct them to finish the questionnaire and insert it into the locked box and then accompany them to the waiting area where the PSC will immediately notify the charge nurse that a patient requires assistance. The ER charge nurse will assess the patient and arrange for the most appropriate clinical member to intervene.

7. In the event that the clinical staff require additional consultation regarding the patient (whether it be in regard to issues related to completing the questionnaire, concern about participation, emotional disturbance related to thinking about childhood or adult experiences with abuse, etc.) Dr. XXXX should be paged for additional consultation (412-958-3580).

8. Each weekday morning either Dr. XXX or XXX will empty the locked box containing questionnaires. The completed questionnaires will be taken to XXX (assistant to XXX XX) office XXX where they will be stored in a locked file behind a locked office door.

APPENDIX D

QUALITY IMPROVEMENT PROJECTS VS. RESEARCH STUDIES TEMPLATE FOR SUBMISSION OF STUDIES

Date of Submission: June 1, 2005

Title of Study: The Association between Provider's Patient-Centered Behaviors and the Disclosure of Intimate Partner violence (IPV) in Women presenting to Psychiatric Emergency Settings.

Sponsor: Kimberly Owens **Department:** Nursing Administration, WPIC

Co-Sponsors: Patricia Cluss, Ph.D.

Anticipated Start Date: July 1, 2005

Anticipated End Date: September 30, 2005

Estimated Duration of Entire Study: 3 months

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1. Goal (s) of study:

- Determine the proportion of women seeking treatment in the psychiatric emergency setting who have experienced Intimate Partner Violence (IPV) as well as the demographic and diagnostic composition of this group.
- Determine the disclosure rate, defined as the number of respondents disclosing IPV to a mental health professional (MHP) during the evaluation process.
- Compare the perceptions of the providers by the patients with IPV who disclosed during their evaluation with those who did not for differences in the areas of trust, interpersonal treatment, knowledge of the patient and communication.
- Compare the demographic and diagnostic information for relevant trends affecting the outcome variable of disclosure.

All patient identification data collected and stored for this study needs to comply with UPMC Policy HS MR1000 regarding the privacy and security of clinical data.

2. Is there a commitment to implementing a corrective plan based on the outcomes of the study (check one)?

No ☐ Yes ☒

3. Is the study being funded by an external agency (check one)?

   No ☒ Yes ☐ If yes, specify agency:

4. If patient data is being collected, please indicate how data is going to be collected (check all that apply):

   ☐ Chart review through medical records (i.e., Access Anywhere ™ and records)

   ☐ Chart review through electronic medical records (i.e., Powerchart™, MARS Stentor™ -- State the name of the system you will be using for data retrieval:

   ☒ Patient interviews/observations: Self-administered anonymous questionnaires.

5. Provide a brief summary (One page) or abstract of your proposed study and attach it to this page.
   Summary attached.

6. If the study involves a therapeutic intervention, is the intervention to be delivered in a blinded fashion? N/A No ☐ Yes ☐

7. Does the study involve "withdrawing" or holding back any needed and generally accepted treatments for the patients' condition:

   No ☒ Yes ☐

8. Does the study involve prospective assignment of patients to different procedures or therapies based on predetermined plans such as randomization?

   No ☒ Yes ☐

9 Is the study evaluating a drug, biologic or device which is not currently FDA approved (i.e., off label use)?

   No ☒ Yes ☐

10. Are patients involved in the study exposed to additional risks or burdens (i.e., other than the completion of patient satisfaction surveys) beyond standard clinical practice?

No ☒ Yes ☐

A statement has been added to the introduction and end of the questionnaire which encourages patients to speak to clinical staff in the program if they have concerns about the issues being addressed in the questionnaire. In addition, a WPIC staff psychologist considered an expert in IPV will be on call 24/7 during the data collection period in the event that a patient or clinical staff require additional assistance related to the administration of the questionnaire and the issue of IPV.

11. What outcomes are being evaluated?

- The disclosure of IPV during the evaluation phase of the emergency psychiatric evaluation in the WPIC ED as reported on self-administered, anonymous questionnaire.
- The perceptions of provider's behaviors as patient-centered as rated by patients on the self-administered, anonymous questionnaire.

For completion by Total Quality Council (TQC) designee:

Date of Review: June 7, 2005 **Date Approved: June 9, 2005**

Approved as Quality Improvement Study – Yes

Agree: X

Disagree:

Date to be presented to Total Quality Council: June 2005

Prospective date for feedback to TQC on outcomes: Nov/Dec 2005

Comments:

Completed by: Dr. Juliet Jegasothy

The Association of Provider's Patient-Centered Behaviors on the Disclosure of IPV in Women Presenting to Psychiatric Emergency Settings

Purpose

Intimate Partner Violence (IPV) is considered one of the most pressing threats to women's health in the nation; however, most women avoid disclosing their experience of IPV to health care providers for many reasons, including factors inherent in the health care setting and the nature of the patient-provider relationship. However, although there is evidence that women with psychiatric disorders are at higher risk for IPV, research to date has ignored the exploration of the special needs of this population with regard to IPV assessment and intervention. This study seeks to inform the understanding of how women with psychiatric emergencies who are experiencing IPV perceive providers and the association of this perception with disclosure of the abuse.

Method

The study will focus on adult women ages 18+ presenting to the emergency department of WPIC for psychiatric evaluation. A self-administered, anonymous questionnaire will collect information regarding the demographic background, chief complaint and IPV history/disclosure of the respondents. In addition, the questionnaire will ask respondents to rate the provider on measures of patient-centeredness, specifically communication, trust, interpersonal style and knowledge of the patient.

Conclusion

The results of the study will assist in developing training methods and programmatic protocols for providers in the psychiatric emergency setting with regard to patient-provider relations and the assessment of IPV.

BIBLIOGRAPHY

Abbott, J., Johnson, R., Koziol- McLain, J., & Lowenstein, S. R. (1995). Domestic Violence Against Women: Incidence and Prevalence in an Emergency Department Population. *Journal of the American Medical Association*, *273*(22), 1763-1767.

Albright, C. L. (1997). Resources for faculty development in family violence. *Academic Medicine*, *72*(1 Suppl), S93-101.

Alpert, E. J., Sege, R. D., & Bradshaw, Y. S. (1997). Interpersonal violence and the education of physicians. *Academic Medicine*, *72*(1 Suppl), S41-50.

American Medical Association. (2003). *Family and Intimate Partner Violence*, from http://www.ama-assn.org/apps/pf_new/pf_online?f_n=resultLink&doc=policyfiles/HnE/

Anderson, L. A., & Dedrick, R. F. (1990). Development of the Trust in Physician scale: a measure to assess interpersonal trust in patient-physician relationships. *Psychological Reports*, *67*(3 Pt 2), 1091-1100.

Astin, M. C., Ogland-Hand, S. M., Coleman, E. M., & Foy, D. S. (1995). Posttraumatic stress disorder and childhood abuse in battered women: comparisons with maritally distressed women. *Journal of Consulting & Clinical Psychology*, *63*(2), 308-312.

Auerbach, S. M., Kiesler, D. J., Strentz, T., & Schmidt, J. A. (1994). Interpersonal impacts and adjustment to the stress of simulated captivity: An empirical test of the Stockholm syndrome. *Journal of Social and Clinical Psychology*, *13*(2), 207-221.

Battaglia, T. A., Finley, E., & Liebschutz, J. M. (2003). Survivors of intimate partner violence speak out: trust in the patient-provider relationship.[see comment]. *Journal of General Internal Medicine*, *18*(8), 617-623.

Bauer, H. M., Gibson, P., Hernandez, M., Kent, C., Klausner, J., & Bolan, G. (2002). Intimate partner violence and high-risk sexual behaviors among female patients with sexually transmitted diseases. *Sexually Transmitted Diseases, 29*(7), 411-416.

Bauer, H. M., Rodriguez, M. A., & Perez-Stable, E. J. (2000). Prevalence and determinants of intimate partner abuse among public hospital primary care patients. *Journal of General Internal Medicine, 15*(11), 811-817.

Belknap, R. A. (2003). Understanding abuse and violence against women: a two-day immersion course. *Nurse Educator, 28*(4), 170-174.

Bergman, B., & Brismar, B. (1991). A 5-Year Follow-up Study of 117 Battered Women. *American Journal of Public Health, 81*(11), 1486-1488.

Berry, L. L., Seiders, K., & Wilder, S. S. (2003). Innovations in access to care: a patient-centered approach. *Annals of Internal Medicine, 139*(7), 568-574.

Bowker, L. H., & Maurer, L. (1987). The medical treatment of battered wives. *Women & Health, 12*(1), 25-45.

Boyle, D., & Vivian, D. (1996). Generalized Versus Spouse-Specific Anger/Hostility and Men's Violence Against Intimates. *Violence & Victims, 11*(4), 293-315.

Brandt, E. N., Jr. (1997). Curricular principles for health professions education about family violence. *Academic Medicine, 72*(1 Suppl), S51-58.

Briere, J., Woo, R., McRae, B., Foltz, J., & Sitzman, R. (1997). Lifetime victimization history, demographics, and clinical status in female psychiatric emergency room patients. *Journal of Nervous & Mental Disease, 185*(2), 95-101.

Brookoff, D., O'Brien, K. K., Cook, C. S., Thompson, T. D., & Williams, C. (1997). Characteristics of Participants in Domestic Violence: Assessments at the Scene of the Domestic Assault. *Journal of the American Medical Association, 277*, 1369-1373.

Burge, S. K. (1989). Violence against women as a health care issue.[see comment]. *Family Medicine, 21*(5), 368-373.

Burgess, A. W. (2002). *Domestic Violence:How Many Steps Forward? How Many Steps Back?* from http://www,nursingworld.org/oijn/topic17/tpc17ntr.htm

Buss, D. M. (1989). Conflict Between the Sexes: Strategic Interference and the Evocation of Anger and Upset. *Journal of Personality & Social Psychology, 56*(5), 735-747.

Buzawa, E. S., Buzawa, Carl G. (2003). *Domestic Violence: The Criminal Justice Response*. Thousand Oaks: Sage Publications.

Bylund, C. L., & Makoul, G. (2002). Empathic communication and gender in the physician-patient encounter.[see comment]. *Patient Education & Counseling, 48*(3), 207-216.

Census, U. S. (2000). *Selected social characteristics in the United States, 2005*. Retrieved 11-18-06, from www.http:factfinder.census.gov

Chang, J. C., Cluss, P. A., Ranieri, L., Hawker, L., Buranosky, R., Dado, D., et al. (2005). Health care interventions for intimate partner violence: What women want. *Women's Health Issues, 15,* 21-30.

Cluss, P. A., Chang, J. C., Hawker, L., Scholle, S. H., Dado, D., Buranosky, R., Goldstrohm, S. (2006). The process of change for victims of intimate partner violence: support for a psychosocial readiness model. *Women's Health Issues, 16,* 262-274.

Cohen, R. A., Rosenbaum, A., Kane, R. L., Warnken, W. J., & Benjamin, S. (1999). Neuropsychological correlates of domestic Violence. *Violence & Victims, 14*(4), 397-411.

Coker, A. L., Davis, K., Arias, I., Desai, S., Sanderson, M., Brandt, H., et al. (2002). Phsyical 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., McKeown, R. E., & King, M. J. (2000). Frequency and correlates of intimate partner violence by type: physical, sexual, and psychological battering.[see comment]. *American Journal of Public Health, 90*(4), 553-559.

Crandall, M. L., Nathens, A. B., Kernic, M. A., Holt, V. L., & Rivara, F. P. (2004). Predicting future injury among women in abusive relationships. *Journal of Trauma-Injury Infection & Critical Care, 56*(4), 906-912; discussion 912.

Danielson, K. K., Moffitt, T. E., Caspi, A., & Silva, P. A. (1998). Comorbidity between abuse of an adult and DSM-III-R mental disorders: evidence from an epidemiological study. *American Journal of Psychiatry, 155*(1), 131-133.

Dannenberg, A. L., Baker, S. P., & Li, G. (1994). Intentional and unintentional injuries in women. An overview. *Annals of Epidemiology, 4*(2), 133-139.

Dannenberg, A. L., Carter, D. M., Lawson, H. W., Ashton, D. M., Dorfman, S. F., & Graham, E. H. (1995). Homicide and other injuries as causes of maternal death in New York City, 1987 through 1991. *American Journal of Obstetrics & Gynecology, 172*(5), 1557-1564.

Dearwater, S. R., Coben, J. H., Campbell, J. C., Nah, G., Glass, N., McLoughlin, E., et al. (1998). Prevalence of intimate partner abuse in women treated at community hospital emergency departments. *JAMA, 280*(5), 433-438.

Deinemann, J. P., Trautman, D. M, Shahan, J. B, Pinella, K., Krishnan, P. M., Whyne, D. M., et al. (1999). Developing a domestic violence program in an innercity academic health center emergency department: the first 3 years. *Journal of Emergency Nursing, 25*(2), 110-115.

Dickson, F., & Tutty, L. (1996). The Role of Public Health Nurses in Responding to Abused Women. *Public Health Nursing, 13*(4), 263-268.

Dickstein, L. J. (1997). Practical recommendations for supporting medical students and faculty in learning about family violence. *Academic Medicine, 72*(1 Suppl), S105-109.

Drossman, D. A., Leserman, J., Nachman, G., Li, Z. M., Gluck, H., Toomey, T. C., et al. (1990). Sexual and physical abuse in women with functional or organic gastrointestinal disorders. *Annals of Internal Medicine, 113*(11), 828-833.

Dutton, D. G. (2002). Personality dynamics of intimate abusiveness. *Journal of Psychiatric Practice, 8*(4), 216-228.

Elliott, L., Nerney, M., Jones, T., & Friedmann, P. D. (2002). Barriers to screening for domestic violence. *Journal of General Internal Medicine, 17*(2), 112-116.

Ellis, J. M. (1999). Barriers to effective screening for domestic violence by registered nurses in the emergency department. *Critical Care Nursing Quarterly, 22*(1), 27-41.

Evaluating Domestic Violence Programs. (2002). Retrieved 11/19/2006, from http://www.ahrq.gov/research/domesticviol/

Fantuzzo, J., Boruch, R., Beriama, A., Atkins, M., & Marcus, S. (1997). Domestic violence and children: prevalence and risk in five major U.S. cities.[see comment]. *Journal of the American Academy of Child & Adolescent Psychiatry, 36*(1), 116-122.

Friedman, L. S., Samet, J. H., Roberts, M. S., Hudlin, M., & Hans, P. (1992). Inquiry about victimization experiences. A survey of patient preferences and physician practices. *Archives of Internal Medicine, 152*(6), 1186-1190.

Gazmararian, J. A., Lazorick, S., Spitz, A. M., Ballard, T. J., Saltzman, L. E., & Marks, J. S. (1996). Prevalence of violence against pregnant women.[erratum appears in JAMA 1997 Apr 9;277(14):1125]. *JAMA, 275*(24), 1915-1920.

Gearon, J. S., Kaltman, S. I., Brown, C., & Bellack, A. S. (2003). Traumatic life events and PTSD among women with substance use disorders and schizophrenia. *Psychiatric Services, 54*(4), 523-528.

Gerbert, B., Caspers, N., Bronstone, A., Moe, J., & Abercrombie, P. (1999). A qualitative analysis of how physicians with expertise in domestic violence approach the identification of victims. *Annals of Internal Medicine, 131*(8), 578-584.

Gerbert, B., Johnston, K., Caspers, N., Bleecker, T., Woods, A., & Rosenbaum, A. (1996). Experiences of battered women in health care settings: a qualitative study. *Women & Health, 24*(3), 1-17.

Gondolf, E. W. (1990). *Psychiatric Response to Family Violence: Identifying and Confronting Neglected Danger*.Lexington: Lexington Books.

Gondolf, E. W. (1998). *Assessing Woman Battering in Mental Health Services*.Thousand Oaks: Sage Publications.

Goodman, L. A., Koss, M. P., Fitzgerald, L. F., Russo, N. F., & et al. (1993). Male violence against women: Current research and future directions. *American Psychologist, 48*(10), 1054-1058.

Gracia, E. (2004). Unreported cases of domestic violence against women: towards an epidemiology of social silence, tolerance and inhibition. *Journal of Epidemiology and Community Health, 58*(7), 536-537.

Graham, D. L. R., Rawlings, E. I., Ihms, K., Latimer, D., Foliano, J., Thompson, A., et al. (2001). A Scale for Identifying "Stockholm Syndrome" Reactions in Young Dating Women: Factor Structure, Reliability and Validity. In K. D. O'Leary & R. D. Maiuro (Eds.), *Psychological abuse in violent domestic relations*. New York: Springer Publishing Company.

Grych, J. H., Jouriles, E. N., Swank, P. R., McDonald, R., & Norwood, W. D. (2000). Patterns of adjustment among children of battered women. *Journal of Consulting & Clinical Psychology, 68*(1), 84-94.

Hamberger, L. K., Lohr, J. M., Bonge, D., & Tolin, D. F. (1996). A Large Sample Empirical Typology of Male Spouse Abusers and Its Relationship to Dimensions of Abuse. *Violence & Victims, 11*(4), 277-292.

Harris, R., Firestone, J. M., & Vega, W. A. (2005). The interaction of Country of Origin, Acculturation, and Gender Role Ideology on Wife Abuse. *Social Science Quarterly, 86*(2), 463-483.

Healthy People 2010: Objectives for Improving Health. Retrieved October 14, 2006, 2006, from http:www/healthypeople.gov/document/html/volume2/15/injury.htm#_Toc490549392

Heinzer, M. M. V., & Krimm, J. R. (2002). Barriers to screening for domestic violence in an emergency department. *Holistic Nursing Practice, 16*(3), 24-33.

Holtzworth-Munroe, A., & Saunders, D. G. (1996). Men who batter: recent history and research. *Violence & Victims, 11*(4), 273-276.

Institute of Medicine (2001). *Crossing the quality chasm: A new health system for the 21st century*. Washington, D.C.: National Academy of Sciences.

Jacobson, A., & Richardson, B. (1987). Assault experiences of 100 psychiatric inpatients: evidence of the need for routine inquiry. *American Journal of Psychiatry, 144*(7), 908-913.

Jacobson, N. S., & Gottman, J. M. (1998). *When men batter women*. New York: Simon and Schuster.

Jenkins, P. J., & Davidson, B. P. (2001). *Stopping domestic violence: How a community can prevent spousal abuse*. New York, New York: Kluwer Academic/Plenum Publishers.

Jones, A. (1998). *Violence Against women: Battered women*, from http://college. hmco/ history/ readerscomp/women/html/wm_038002_batteredwome.htm.

Jouriles, E. N., McDonald, R., Spiller, L., Norwood, W. D., Swank, P. R., Stephens, N., et al. (2001). Reducing conduct problems among children of battered women. *Journal of Consulting & Clinical Psychology, 69*(5), 774-785.

Kaplan, C. B., Siegel, B., Madill, J. M., & Epstein, R. M. (1997). Communication and the medical interview. Strategies for learning and teaching. *Journal of General Internal Medicine, 12 Suppl 2,* S49-55.

Keating, N. L., Green, D. C., Kao, A. C., Gazmararian, J. A., Wu, V. Y., & Cleary, P. D. (2002). How are patients' specific ambulatory care experiences related to trust, satisfaction, and considering changing physicians?[see comment]. *Journal of General Internal Medicine, 17*(1), 29-39.

Kernic, M. A., Wolf, M. E., & Holt, V. L. (2000). Rates and relative risk of hospital admission among women in violent intimate partner relationships. *American Journal of Public Health, 90*(9), 1416-1420.

Kilpatrick, D. G., Acierno, R., Resnick, H. S., Saunders, B. E., & Best, C. L. (1997). A 2-year longitudinal analysis of the relationships between violent assault and substance use in women. *Journal of Consulting & Clinical Psychology, 65*(5), 834-847.

Krishnan, S. P., Hilbert, J. C., & Pase, M. R. (2001). An Examination of Intimate Partner Violence in Rural Communities: Results from a Hospital Emergency Department Study from Southwest United States. *Family and Community Health, 24(1),* 1-14.

Krug, E. G. (2002). *World Report on Violence and Health; Intimate Partner Violence*, from http://www.who.int/violence_injury_prevention/violence/global_campaign/en/chap4.pdf.

Kurz, D. (1987). Emergency department responses to battered women: Resistance to medicalization. *Social Problems, 34*(1), 69-81.

Kyriacou, D. N., Anglin, D., Taliaferro, E., Stone, S., Tubb, T., Linden, J. A., et al. (1999). Risk factors for injury to women from domestic violence against women.[see comment]. *New England Journal of Medicine, 341*(25), 1892-1898.

Laine, C., & Davidoff, F. (1996). Patient-centered medicine. A professional evolution.[see comment]. *JAMA, 275*(2), 152-156.

Larkin, G. L., Hyman, K. B., Mathias, S. R., D'Amico, F., & MacLeod, B. A. (1999). Universal screening for intimate partner violence in the emergency department: importance of patient and provider factors. *Annals of Emergency Medicine, 33*(6), 669-675.

Larkin, G. L., Rolniak, S., Hyman, K. B., MacLeod, B. A., & Savage, R. (2000). Effect of an administrative intervention on rates of screening for domestic violence in an urban emergency department.[see comment]. *American Journal of Public Health, 90*(9), 1444-1448.

Liebschutz, J. M., Feinman, G., Sullivan, L., Stein, M., & Samet, J. (2000). Physical and sexual abuse in women infected with the human immunodeficiency virus: increased illness and health care utilization. *Archives of Internal Medicine, 160*(11), 1659-1664.

Loue, S. (2001). Intimate partner violence: Societal, medical, legal, and individual responses, (pp. 23). New York: Kluwer Academic/Plenum Publishers.

Lown, E. A., & Vega, W. A. (2001). Intimate partner violence and health: self-assessed health, chronic health, and somatic symptoms among Mexican American women. *Psychosomatic Medicine, 63*(3), 352-360.

Maheux, B., Haley, N., Rivard, M., & Gervais, A. (1999). Do physicians assess lifestyle health risks during general medical examinations? A survey of general practitioners and obstetrician-gynecologists in Quebec.[see comment]. *CMAJ Canadian Medical Association Journal, 160*(13), 1830-1834.

Marvel, M. K., Epstein, R. M., Flowers, K., & Beckman, H. B. (1999). Soliciting the patient's agenda: have we improved?[see comment]. *JAMA, 281*(3), 283-287.

Matevia, M. L., Goldman, W., McCullough, J., & Randall, P. K. (2002). Best practices: Detection of intimate partner violence among members of a managed behavioral health organization. *Psychiatric Services, 53,* 555-557.

McCauley, J., Jenckes, M. W., & McNutt, L. A. (2003). ASSERT: the effectiveness of a continuing medical education video on knowledge and attitudes about interpersonal violence. *Academic Medicine, 78*(5), 518-524.

McCauley, J., Kern, D. E., Kolodner, K., Dill, L., Schroeder, A. F., DeChant, H. K., et al. (1995). The "battering syndrome": Prevalence and clinical characteristics of domestic violence in primary care internal medicine practices.[see comment]. *Annals of Internal Medicine, 123*(10), 737-746.

McCauley, J., Yurk, R. A., Jenckes, M. W., & Ford, D. E. (1998). Inside "Pandora's box": Abused women's experiences with clinicians and health services. *Journal of General Internal Medicine, 13*(8), 549-555.

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*, 435-444.

Mead, N., & Bower, P. (2002). Patient-centred consultations and outcomes in primary care: a review of the literature.[see comment]. *Patient Education & Counseling, 48*(1), 51-61.

Murphy, C. C., Schei, B., Myhr, T. L., & Du Mont, J. (2001). Abuse: a risk factor for low birth weight? A systematic review and meta-analysis.[see comment]. *CMAJ Canadian Medical Association Journal, 164*(11), 1567-1572.

Novack, D. H., Suchman, A. L., Clark, W., Epstein, R. M., Najberg, E., & Kaplan, C. (1997). Calibrating the physician. Personal awareness and effective patient care. Working Group on Promoting Physician Personal Awareness, American Academy on Physician and Patient [see comment]. *JAMA, 278*(6), 502-509.

Olshansky, E. R. (2002). Emergency Department care of women who were abused was driven by the prevailing practice pattern of efficient patient processing. *Evidence-Based Nursing, 5(1)*, 29.

Olson, L., Anctil, C., Fullerton, L., Brillman, J., Arbuckle, J., & Sklar, D. (1996). Increasing emergency physician recognition of domestic violence. *Annals of Emergency Medicine, 27*(6), 741-746.

Peters, J., Shackelford, T. K., & Buss, D. M. (2002). Understanding domestic violence against women: using evolutionary psychology to extend the feminist functional analysis. *Violence & Victims, 17*(2), 255-264.

Plichta, S. B., Duncan, M. M., & Plichta, L. (1996). Spouse abuse, patient-physician communication, and patient satisfaction. *American Journal of Preventive Medicine, 12*(5), 297-303.

Porcerelli, J. H., Cogan, R., West, P. P., Rose, E. A., Lambrecht, D., Wilson, K. E., et al. (2003). Violent victimization of women and men: physical and psychiatric symptoms. *Journal of the American Board of Family Practice*, *16*(1), 32-39.

Quill, T. E., & Brody, H. (1996). Physician recommendations and patient autonomy: finding a balance between physician power and patient choice. *Annals of Internal Medicine, 125*(9), 763-769.

Rennison, C. M.. (2003). *Intimate Partner Violence, 1993-2001* (No. 197838).

Rennison, C. M., & Welchans, S. (2000). *Intimate Partner Violence*: U.S. Department of Justice, Office of Justice Programs, Bureau of Justice Statistics.

Resnick, H. S., Acierno, R., & Kilpatrick, D. G. (1997). Health impact of interpersonal violence. 2: Medical and mental health outcomes. *Behavioral Medicine, 23*(2), 65-78.

Robinson, G. E. (2003). Current Concepts in Domestic Violence. *Primary Psychiatry, 10*, 48-52.

Rodriguez, M. A., Bauer, H. M., Flores-Ortiz, Y., & Szkupinski-Quiroga, S. (1998). Factors affecting patient-physician communication for abused Latina and Asian immigrant women. *Journal of Family Practice, 47*(4), 309-311.

Rodriguez, M. A., Sheldon, W. R., Bauer, H. M., & Perez-Stable, E. J. (2001). The factors associated with disclosure of intimate partner abuse to clinicians. *Journal of Family Practice*, *50*(4), 338-344.

Rogers, C. (1961). *On Becoming A Person*.Boston: Houghton Mifflin Company.

Rosenberg, M. L., Fenley, M. A., Johnson, D., & Short, L. (1997). Bridging prevention and practice: public health and family violence. *Academic Medicine, 72* (1 Suppl), S13-18.

Roter, D. (2000). The enduring and evolving nature of the patient-physician relationship. *Patient Education & Counseling*, *39*(1), 5-15.

Rudolph, M. N., & Hughes, D. H. (2001). Emergency assessments of domestic violence, sexual dangerousness, and elder and child abuse. *Psychiatric Services, 52*(3), 281-282.

Sackett, L. A., & Saunders, D. G. (1999). The impact of different forms of psychological abuse on battered women. *Violence & Victims, 14*(1), 105-117.

Safran, D. G., Kosinski, M., Tarlov, A. R., Rogers, W. H., Taira, D. A., Lieberman, N., et al. (1998). The Primary Care Assessment Survey: Tests of Data Quality and Measurement Performance. *Medical Care, 36*(5), 728-729.

Safran, D. G., Rogers, W. H., Tarlov, A. R., Inui, T., Taira, D. A., Montgomery, J. E., et al. (2000). Organizational and Financial Characteristics of Health Plans: Are They Related to Primary Care Performance? *Archives of Internal Medicine, 160*, 69-76.

Safran, D. G., Taira, D. A., Rogers, W. H., Kosinski, M., Ware, J. E., & Tarlov, A. R. (1998). Linking primary care performance to outcomes of care.[see comment]. *Journal of Family Practice, 47*(3), 213-220.

Saltzman, L. E., Fanslow, J. L., McMahon, P. M., & Shelley, G. A. (1999). *Intimate Partner Violence Surveillance: Uniform definitions and recommended data elements. Atlanta: National Center for Injury Prevention and Control.*

SAS Institute.(2004). *SAS/STAT Software, Version 9*. Cary, N.C.

Scholle, S. H., Rost, K. M., & Golding, J. M. (1998). Physical abuse among depressed women. *Journal of General Internal Medicine, 13*(9), 607-613.

Short, L. M., Cotton, D., & Hodgson, C. S. (1997). Evaluation of the module on domestic violence at the UCLA School of Medicine. *Academic Medicine, 72*(1 Suppl), S75-92.

Smith, P. H., Earp, J. A., & DeVellis, R. (1995). Measuring battering: Development of the Women's Experience with Battering (WEB) scale. *Women's Health: Research on Gender, Behavior and Policy, 1*, 273-288.

Smith, R. C., Lyles, J. S., Mettler, J., Stoffelmayr, B. E., Van Egeren, L. F., Marshall, A. A., et al. (1998). The effectiveness of intensive training for residents in interviewing. A randomized, controlled study.[see comment]. *Annals of Internal Medicine, 128*(2), 118-126.

Soeken, K. L., McFarlane, J., Parker, B., & Lominack, M. C. (1998). The Abuse Assessment Screen: A clinical instrument to measure frequency, severity, and perpetrator of abuse against women. In J. C. Campbell (Ed.), *Empowering survivors of abuse: Health care for battered women and their children.* (pp. 195-203). Thousand Oaks, CA.: Sage Publications.

Sorenson, S. B., Upchurch, D. M., & Shen, H. (1996). Violence and injury in marital arguments: risk patterns and gender differences. *American Journal of Public Health, 86*(1), 35-40.

Straus, M. A. (1979). Measuring intrafamily conflict and violence: The conflict tactics (CT) scale. *Journal of Marriage and the Family, 41*, 75-88.

Street, R. L., Jr. (2002). Gender differences in health care provider-patient communication: are they due to style, stereotypes, or accommodation?[see comment]. *Patient Education & Counseling, 48*(3), 201-206.

Sugg, N. K., & Inui, T. (1992). Primary care physicians' response to domestic violence. Opening Pandora's box.[see comment]. *JAMA, 267*(23), 3157-3160.

Taft, A., Broom, D. H., & Legge, D. (2004). General practitioner management of intimate partner abuse and the whole family: qualitative study.[see comment]. *BMJ, 328*(7440), 618.

The American College of Obstetricians and Gynecologists. (2004). *Violence against women*, http://www.acog.org/from_home/departments/ category.cfm?recno=17&bulletin=585.

The Joint Commission for the Accreditation of Health Care Organizations. (2005). *Comprehensive Accreditation Manual for Hospitals: The Official Handbook*. Oakbrook Terrace: The Joint Commission for the Accreditation of Health Care Organizations.

The World Health Organization. (2004). *The World Health Organization (WHO) Multi-Country Study on Women's Health and Domestic Violence Against Women*, from http://www.who.int/gender/violence/multicountry/en/.

Thom, D. H., Bloch, D. A., & Segal, E. S. (1999). An intervention to increase patients' trust in their physicians. Stanford Trust Study Physician Group. *Academic Medicine, 74*(2), 195-198.

Thom, D. H., & Campbell, B. (1997). Patient-physician trust: an exploratory study. *Journal of Family Practice, 44*(2), 169-176.

Thom, D. H., & Stanford Trust Study. (2001). Physician behaviors that predict patient trust.[see comment]. *Journal of Family Practice, 50*(4), 323-328.

Thompson, M. P., Simon, T. R., Saltzman, L. E., & Mercy, J. A. (1999). Epidemiology of injuries among women after physical assaults: the role of self-protective behaviors. *American Journal of Epidemiology, 150*(3), 235-244.

Tilden, V. P., Schmidt, T. A., Limandri, B. J., Chiodo, G. T., Garland, M. J., & Loveless, P. A. (1994). Factors that influence clinicians' assessment and management of family violence. *American Journal of Public Health, 84*(4), 628-633.

Tjaden, P., & Thoennes, N. (2000). *Full report of the prevalence, incidence and consequences of violence against women: Findings from the National Violence Against Women Survey.*, from http://www.ncjrs.org/txtfiles1/nij/183781.txt.

Ulrich, Y. (2003). Medical care utilization patterns in women with diagnosed domestic violence. *American Journal of Preventive Medicine, 24*, 9-15.

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. *American Journal of Preventive Medicine, 19*(4), 230-237.

Wadman, M. C., & Muelleman, R. L. (1999). Domestic Violence Homicides: ED use before Victimization. *American Journal of Emergency Medicine, 17*(7), 689-691.

Walker, L. E. (1999). Psychology and domestic violence around the world. *American Psychologist, 54*(1), 21-29.

Warshaw, C. (1996). Domestic violence: Changing theory, changing practice. *Journal of the American Medical Women's Association, 51*(3), 87-91.

Warshaw, C. (1997). Intimate partner abuse: developing a framework for change in medical education. *Academic Medicine, 72*(1 Suppl), S26-37.

Warshaw, C., & Alpert, E. (1999). Integrating routine inquiry about domestic violence into daily practice. *Annals of Internal Medicine, 131*(8), 619-620.

Warshaw, C., Gugenheim, A. M., Moroney, G., & Barnes, H. (2003). Fragmented services, unmet needs: Building collaboration between the mental health and domestic violence communities. *Health Affairs, 22*(5), 230-234.

Waters, H., Hyder, A., Rajkotia Y, B., Rehwinkel, J., & Butchart, A. (2004). *The economic dimensions of interpersonal violence. Department of Injuries and Violence Prevention, World Health Organization*.Geneva.

Wisner, C. L., Gilmer, T. P., Saltzman, L. E., & Zink, T. M. (1999). Intimate partner violence against women: do victims cost health plans more? *Journal of Family Practice, 48*(6), 439-443.

Women's Advocates Inc. (2002). *Domestic violence fact sheet.* Retrieved 19 January, 2005, from http://www.wadvocates.org/factsheet.htm

Yam, M. (2000). Seen but not heard: battered women's perceptions of the ED experience. *Journal of Emergency Nursing, 26*(5), 464-470.

Zanarini, M. C., Frankenburg, F. R., Reich, D. B., Marino, M. F., Haynes, M. C., & Gunderson, J. G. (1999). Violence in the lives of adult borderline patients. *Journal of Nervous & Mental Disease, 187*(2), 65-71.