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Intimate Partner Violence Screening and Pregnant Latinas

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Abstract

Little is known about factors associated with healthcare screening of Intimate Partner Violence (IPV) for Latinas during pregnancy. This study builds on current research examining IPV-associated outcomes among Latinas by analyzing 210 pregnant Latina responses to a patient survey. A multivariate logistic regression model examined factors associated with being screened for IPV. One-third of pregnant women reported being screened for IPV. Factors related to being screened for IPV are reported and did not match those associated with having experienced IPV. While most pregnant Latinas were not screened for IPV, having systematic processes in place for IPV screening and fostering good patient-provider communication may facilitate identification of IPV. Having a greater awareness of the risk factors associated with IPV may also provide cues for clinicians to better address the issue of IPV.

Keywords

Intimate Partner Violence; communication; health indicators; screening

Introduction

Women who experience intimate partner violence (IPV) are more likely to suffer from health problems than women without IPV (Coker et al., 2002). Each year, morbidity and mortality result from 5.3 million cases of intimate partner violence (IPV) in the US (Tjaden & Thoennes, 2000). The prevalence of IPV during pregnancy ranges from 6-21% (Gazmararian et al.; Anderson et al., 2002). Intimate partner violence is widespread cutting across all populations; however, it is more prevalent among minorities and women of lower socioeconomic status (Tjaden & Thoennes, 2000). While there is increased risk for IPV among women who are younger, are of low income, or those who experienced childhood trauma, all women carry some risk for IPV (Tjaden & Thoennes, 2000).

Pregnant women who experience IPV are at increased risk for several adverse health conditions. Depression and post-traumatic stress disorder (PTSD) are common conditions associated with IPV (Bonomi et al., 2006; Flynn et al., 2007; Lipsky et al., 2005). IPV among pregnant women is of great concern due to the deleterious impact on the pregnancy such as antepartum hemorrhage, intrauterine growth retardation, perinatal death, abortion/miscarriage,

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low birth weight, preterm labor, as well as risk for homicide (Jansenn et al., 2006; Glander et al., 1998; Hedin & Janson, 2000; Murphy et al., 2001; McFarlane et al., 2002; Anderson et al., 2002). Moreover, pregnant women exposed to IPV are more likely to obtain prenatal care later in their pregnancy, making it more difficult to address potential complications (Anderson et al., 2002; McFarlane et al., 1992).

The American College of Obstetrics and Gynecology (ACOG) recommends screening all women for IPV due to its high prevalence and associated adverse health consequences (ACOG, 2006.) In August of 2006, the Committee on Health Care for Underserved Women developed a statement endorsing screening of IPV as part of the comprehensive care that women receive when seeking pregnancy evaluation or prenatal care (ACOG, 2006). Even still, few clinicians routinely screen for IPV leading to low rates of detection (Kaur & Herber, 2005; McCaw et al., 2001; Glass et al., 2001) despite the availability of brief and valid IPV screening tools for Latinas and other women (Wrangle, 2008; Soeken, 1998). Moreover, not all professional organizations agree that screening should be conducted universally (U.S. Preventative Services Task Force, 1996).

Factors associated with screening are generally associated with a perceived risk for abuse (Witting et al., 2006). Without universal screening procedures in place, screening generally occurs for those who are suspected of being involved in abusive relationships (Horan et al., 1998). Health care providers also may not screen patients due to feeling uncomfortable discussing IPV with patients and feeling they do not have sufficient time or experience to address IPV issues (Taft et al., 2004; Waalen et al., 2000; Rodriguez, et al., 1998; Rodriguez et al., 2001). While the majority of women support the need for screening, they also face barriers in disclosing IPV to health care professionals (Bauer et al., 2000; Chang et al., 2003; Gerbert et al., 1999; Hamberger et al., 1998; Plichta, et al., 1996). Barriers may vary if the women are immigrants or Latinas (Sokoloff et al., 2005; Raj & Silverman, 2002), suggesting a need to better understand these subgroups to tailor programs appropriately. An earlier study of Asian and Latina immigrant women found that social isolation, language, family dedication, discrimination, shame, stigma and fear of deportation were some barriers to patient-provider communication and help seeking (Bauer et al., 2000).

Whether patients are directly asked by a health care provider about being abused by a partner or ex-partner has a major impact on the identification of IPV (Rodriguez et al., 2001). Previous research has indicated characteristics of pregnant African American women reporting domestic violence to help facilitate identification (Datner et al., 2007) Yet, despite current research, much is still unknown about factors associated with IPV screening and disclosure in prenatal settings, particularly among Latina populations. This paper presents findings related to health care systems and communication between providers and patients associated with IPV status and screening for IPV from a study of 210 Latina women receiving care during pregnancy in two health care systems in a large metropolitan area. Specifically the goals of this paper are twofold; 1) to explore whether Latina pregnant women are screened for IPV in accordance with recommendations made by ACOG and the Committee on Health Care for Underserved Women and 2) to investigate whether characteristics of those screened for IPV are congruent with characteristics of those who actually have history of IPV.

Methods

Recruitment

This cross-sectional analysis uses baseline data from a longitudinal cohort study exploring the longitudinal effects of intimate partner violence on the mental health of pregnant Latinas. Eligibility criteria required participants to be self-identified Latinas aged 18 years or older and spoke English or Spanish, were at least 12 weeks pregnant, received care at one of the project

sites, intended to live in Los Angeles County for 12 months after the birth of their child, and planned to personally raise their child during their first year of life. The recruitment sites were two large, non-profit, health care organizations with an obstetric patient population that was over 80% Latina. The private medical center had a system to screen all patients for IPV during their pregnancy intake (with systematic screening) while the HMO had no such screening system (without systematic screening). All women who attended the obstetric/gynecologic clinics at these sites between January 2003 and January 2004 were approached and informed about the study during wait times for routine obstetrics appointments. If a respondent expressed interest, she was screened for eligibility in a private area. IPV+ and IPV- women were recruited simultaneously and after 118 IPV- women were recruited efforts were limited to recruiting IPV+ women. This was done in order to have approximately equal representation of pregnant women who reported previous exposure to IPV (IPV+) and who reported no previous exposure to IPV (IPV-). The study protocol was approved by the UCLA Institutional Review Board.

Interview Design

In-person interviews of the women were conducted individually, without the presence of any partners or companions, in a private area by bilingual and bicultural Latina interviewers. During the screening process participants were subsequently provided with local 24 hour crisis numbers, given information about the health risks associated with IPV, were encouraged to identify a supportive person with whom they could discuss any unpleasant reactions and were given appropriate referrals if they were identified as having had IPV experiences.

Measures

Survey—The questionnaire was developed and modified based on a literature review, consultation with IPV researchers and advocates, and data from focus groups conducted with pregnant Latinas. Questions were drawn from multiple surveys and assessment tools and integrated into one comprehensive interview document (Stewart et al., 2007). The questions had been used previously with Latino populations. Minor modifications were made following a pilot test with 30 Latinas.

Screening—The main outcome measure, whether or not the patient was screened for IPV, was assessed using one question asking whether or not the patient was directly asked by a health care provider during their current pregnancy about being emotionally, physically, or sexually abused by a partner or ex-partner.

Demographic variables—Demographic variables included age, employment, partner status (married/with partner or not), birthplace, years of formal education, recruitment site, language of interview and Poverty Index. Total family income was divided by the federal poverty guidelines for a specific number of persons in the household to create the Poverty Index (higher poverty index means lower income).

Covariate Variable—Patient health and behavior characteristics were included in the initial bivariate analyses. The recruitment site was also included as a covariate in order to account for variance due to whether the site had systematic screening in place. The results of these analyses were used as the basis for inclusion in the subsequent multivariate logistic regression. Self-assessed health status was queried and subsequently dichotomized into fair or poor versus excellent, very good, or good. Depression was measured with the Beck Depression Inventory Fast Screen (BDI-FS) for Medical Patients (Beck et al., 2000) with a cut off score of four or above indicating depression. A 97% clinical efficiency was found using this screening tool with a sensitivity rate of 97% and specificity rate of 99% (Steer et al., 1991). Patients were asked a single question about their anxiety level during the previous six months (Keskiner et

al., 1997). Contraception use at conception was assessed and used to determine whether or not the pregnancy was planned.

IPV status was assessed using questions adapted from the Abuse Assessment Screen (McFarlane et al., 1995), which address lifetime experiences of psychosocial, physical, or sexual abuse by a partner or ex-partner. As compared to other violence measures this screening method was found to hold a 97.5% reliability (Soeken, 1998). Questions regarding obstetric history included questions about having a prior premature delivery or a low birth weight baby, age at first childbirth, having the first prenatal visit at 12 weeks or earlier, having a personal doctor or nurse, and the number of unscheduled visits during the current pregnancy.

Additional questions regarding communication were evaluated as predictor variables including whether the provider used understandable explanations and whether the provider listened to the woman. These were originally coded in four response categories (always, usually, sometimes, never) but were dichotomized to reflect always versus the other three categories for these analyses.

Analyses

SAS version 9.1 was used for all analyses. Univariate descriptive statistics were generated to examine exposure to IPV and exposure to screening as well as for all potential independent variables. Bivariate analyses were then conducted to assess the relationship between characteristics associated with IPV and those characteristics associated with screening for IPV. Stratified analyses by recruitment site were explored to identify any significant differences. Multivariate logistic regression was used to identify characteristics associated with being screened for IPV. Characteristics that were significantly associated with IPV or being screened for IPV, as well as variables that are relevant based on the literature were entered in multivariate logistic regression models to examine their association with being screened for IPV. A p-value ≤ 0.05 was considered statistically significant to our analysis.

Results

Screening and Indicators Associated with Screening for IPV

Almost two-thirds (63.8%) of the Latina women participating in this study had never been screened for IPV. Significant characteristics associated with being screened for IPV are included in Table 1. Lower income women were more likely to be screened for IPV. The site with a systematic process in place for IPV screening was significantly associated with being more likely to screen patients for IPV than the site that does not have a system in place (82.9% of those screened were at the site with systematic screening in place). Having an unplanned pregnancy is significantly associated with being screened for IPV. Finally, having a health care provider who used understandable explanations and one who listened to the patient were both significantly associated with screening for abuse.

Table 2 presents the association between selected characteristics and IPV status. Marital status is significantly associated with IPV status with a greater likelihood of being IPV+ if single, divorced, or separated than if women were married or with a partner. Recruitment site was statistically significant with more IPV- women at the site that systematically screened and a greater proportion of IPV+ women at the site that did not screen systematically. Depression was associated with being IPV+ as was worrying excessively or being anxious in the past six months. IPV+ women reported significantly more unscheduled visits to healthcare providers than IPV-women. Women with higher rates of IPV were more likely to report health care providers who used understandable explanations.

Logistic Regression with variables associated with Screening

Variables associated with screening for IPV were further analyzed using multivariate logistic regression and are presented in Table 3. Having an unscheduled visit was associated with having decreased odds of being screened (OR: 0.56, 95% CI: 0.35, 0.89). Having an unplanned pregnancy was associated with almost two and a half times the odds of being screened for abuse (OR: 2.46, 95% CI: 1.14, 5.33). The communication variables are both indicative of screening. Having a health care provider who used understandable explanations was associated with having almost two and a half times the odds of being screened (OR: 2.43, 95% CI: 1.06, 5.56) and having a health care provider who listened to what the patient said was associated with having almost three times the odds of being screened for IPV (OR: 2.86, 95% CI: 1.08, 7.58). Finally, site of care is an important variable. Being a patient at a site that had a systematic intake screening for IPV was associated with 6.25 times the odds of being screened than for those at the site that did not have a systematic screening process (95% CI: 2.12, 18.48).

Discussion

Despite the ACOG's recommendation that all women be screened for IPV, consistent with previous research (Burge et al., 2005), two-thirds of the Latina women participating in this study had never been screened for IPV. There was discordance between characteristics of women who were screened for IPV and women who were IPV positive. In systems that depend on identifying cases based on risk factors this represents missed opportunities for screening and identification.

As expected, having a systematic approach in place to ask about IPV during pregnancy was the variable that was most associated with being screened for IPV. Having institutionalized systems in place significantly increases the likelihood that all patients are screened for IPV. This is consistent with other studies that focus on promising multi-faceted interventions that involve screening, staff training, telephone based counseling by a case manager (Krasnoff & Moscati, 2002) and providing contact information for self-referral to on-site services that may improve access to IPV care (Kaur & Herber, 2005; McCaw et al., 2001, Crandall et al., 2005; Hobson et al., 2005; Maiuro et al., 2000). This supports the need for systematic approaches to screening and responding to patients with a history of abuse.

Communication between the women and health care providers was also very important. If women perceived that health care providers listened to them and always gave understandable explanations, women were more likely to be screened for IPV. This reinforces the importance of creating an atmosphere of support, safety, respect and trust. Clinician behaviors that foster this trust and subsequent disclosure of IPV included good communication by clinicians (Battaglia et al., 2002). Patients report that being listened to and not being interrupted by the provider as extremely important in the patient-provider interaction (Hobson et al., 2005). While the literature details the importance of good patient-provider communication, few examine the relationship between this important facet of the relationship and the influence it has on screening for IPV (Maiuro et al., 2000). Other studies show that providers who had higher self-rated confidence in their ability to ask patients about IPV had a greater likelihood of screening for IPV (Jonassen & Mazor, 2003). Increased IPV training for health care professionals in this area could potentially increase the likelihood of more women being screened and help health care providers feel more confident performing this task. Some studies suggest that communication barriers may be related to the practice setting and gender of the health care provider (Jonassen & Mazor, 2003). Uniform, standardized procedures in place should help address variability in settings. A 2006 meta analysis showed that female patients desired certain communication patterns from their health care providers when responding to their abuse disclosure including nonjudgmental, nondirective, and tailored responses that demonstrated an understanding of the complex nature of IPV (Borowsky & Ireland, 2002). While this study

only examined responses after disclosure, it shows that the nature of the relationship and the communication patterns between patients and health care providers is important.

Women who reported that they were using contraception during the period of conception were more likely to have experienced IPV. These findings are consistent with several other studies (Palitto et al., 2005; Palitto & O'Campo, 2004; Lau, 2005; Gazmararian et al., 2000; Saltzman et al., 2003; Goodwin et al., 2000). In those studies, if there was an unintended or unwanted pregnancy, women were four times more likely to experience violence. In an earlier study conducted in the US to explore the relationship between violence, sexual coercion, and pregnancy, some women felt they could not avoid intercourse with their abusers, despite fears of pregnancy (Goodwin et al., 2000).

Significant health and social consequences are related to IPV and include acute and long-term psychological, physical, social and economic effects, with the costs of IPV exceeding \$5.8 billion each year including \$4.1 billion in direct medical and mental health care services (Draucker, 2002; Max et al., 1999). Screening and intervention for IPV that occurs early and systematically may minimize the health and economic impact on women, providers and health care systems. Evidence of good communication between providers includes both listening to the patient and giving explanations that are understood by the patient. Providers who recognize specific factors associated with IPV may better identify IPV. Missed opportunities for IPV identification allow IPV to remain under-diagnosed, and under-managed and may further impact the health of vulnerable women. These findings emphasize the potential importance of system level policies in influencing provider behavior. It also highlights the possible importance of excellent communication in influencing screening practices.

Limitations

The data analyzed for this paper are from one point during pregnancy collected following the first trimester. It is possible that the women in this study had not yet been screened by the baseline assessment but that they were subsequently screened during a future visit. Nevertheless, all women were interviewed after their first trimester suggesting few were screened early in their pregnancy despite visits during this period. This investigation focused on Latina women living in a metropolitan area within the US and cannot be generalized to other cultural groups or rural areas.

Future Steps

Our study suggests that systems and health care providers play an important role in helping to facilitate screening for IPV. This screening process is most effective with providers who have good communication with their patients. Good communication includes both listening and using understandable language and explanations. Ensuring that this bidirectional communication strategy is achieved, it is essential to achieve effective screening for IPV. Once conditions for screening are in place, appropriate management steps must be taken such as assessing safety and ensuring that safety plans and resources are provided to women who screen positive for IPV.

Another step supported by this study is that health care settings implement systemic approaches to screening in order to increase the likelihood of screening women. By implementing policies at the system level health care providers may become more aware of the importance of systematic IPV screening. Health care providers' offices, hospitals, and health systems could all implement systematic screening processes to increase the likelihood of women being screened for IPV, especially during pregnancy when women come into contact with the health care system frequently. Systematically screening pregnant women will help address an all too common problem affecting both the mother and the fetus in an already vulnerable population.

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Abbreviations

IPV Intimate Partner Violence

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Table 1

Selected characteristics for all pregnant women, by whether or not they were screened for abuse (n=210).

	Screened -	Screened +
Characteristic	N=134	N=76
Directly Asked by Health Care Provider about Current/Past Abuse [n(%)]:		
<u>Patient Demographic Characteristics:</u>		
Language of Interview [n(%)]:		
Spanish	76 (56.7)	51 (67.1)
English	58 (43.3)	25 (32.9)
Marital Status [n(%)]:		
Single/Divorced/Separated	14 (10.5)	11 (14.5)
Married/with Partner	120 (89.6)	65 (85.5)
Poverty Index [mean(SD)]: **	1.50 (1.51)	0.97 (0.12)
Site [n(%)]:		
Setting with a Systematic Screening Process in Place	66 (49.3)	63 (82.9)
Setting without a Systematic Screening Process in Place	68 (50.8)	13 (17.1)
<u>Patient Health and Care Characteristics:</u>		
History of Intimate Partner Violence [n(%)]:		
Depression Scale [mean(SD)]:	61 (45.5)	31 (40.8)
Worried Excessively or Been Anxious in Past Six Months [n(%)]:	10.43	10.25
Unplanned Pregnancy [n(%)]:[†]	57 (42.5)	44 (57.9)
Had First Baby at 16 Years of Age or Younger [n(%)]: [‡]	9 (9.7)	11 (20.4)
Had Any Unscheduled Visits During Current Pregnancy [n(%)]:	53 (39.9)	25 (33.3)
Number of Unscheduled Visits During Current Pregnancy[mean(SD)]:	0.65 (0.94)	0.47 (0.79)
<u>Communication:</u>		
Health Care Provider Always Used Understandable Explanations [n(%)]:[†]	65 (48.5)	48 (63.2)
Health Care Provider Always Listened to What Patient Said [n (%)]: **	79 (59.4)	60 (79.0)

Bolding in the Table indicates significance of variables

* Significant at the $p \leq 0.0001$ level** Significant at the $p \leq 0.01$ level[†] Significant at the $p \leq 0.05$ level[‡] Borderline significance at the $p < 0.07$ level

Table 2

Selected characteristics for all pregnant women, by intimate partner violence status (IPV) (n=210).

	IPV -	IPV +
Characteristic	N=118	N=92
<u>Patient Demographic Characteristics:</u>		
Language of Interview [n(%)]: [‡]		
Spanish	78 (66.1)	49 (53.3)
English	40 (33.9)	43 (46.7)
Marital Status [n(%)]: **		
Single/Divorced/Separated	8 (6.8)	17 (18.5)
Married/with Partner	110 (93.2)	75 (81.5)
Poverty Index [*] [mean(SD)]:	1.22 (1.31)	1.43 (1.46)
Site [n(%)]:		
Setting with a Systematic Screening Process in Place	90 (76.3)	39 (42.4)
Setting without a Systematic Screening Process in Place	28 (23.7)	53 (57.6)
<u>Patient Health and Care Characteristics:</u>		
Self-Assessed Health Status [n(%)]:		
Fair/Poor	26 (22.0)	22 (23.9)
Excellent/Very Good/Good	92 (78.0)	70 (76.1)
Depression Scale [mean(SD)]: **	9.54 (2.95)	11.43 (4.50)
Worried Excessively or Been Anxious in Past Six Months [n(%)]: *	41 (34.8)	60 (65.2)
Unplanned Pregnancy [n(%)]: [‡]	50 (42.4)	51 (55.4)
Had Premature or Low Birth Weight Baby [n(%)]:	16 (13.6)	14 (15.2)
Had First Baby at 16 Years of Age or Younger [n(%)]:	10 (13.2)	10 (14.1)
Had Prenatal Visit at 12 Weeks or Earlier [n(%)]:	112 (94.9)	86 (94.5)
Had Any Unscheduled Visits During Current Pregnancy [n(%)]: *	30 (25.6)	48 (52.8)
Number of Unscheduled Visits During Current Pregnancy [mean(SD)]: *	0.26 (0.44)	0.53 (0.05)
Has a Personal Doctor/Nurse [n(%)]:	61 (51.7)	53 (57.6)
<u>General Communication:</u>		
Health Care Provider Always Used Understandable Explanations [n(%)]: [‡]	56 (47.5)	57 (62.0)
Health Care Provider Always Listened to What Patient Said [n(%)]:	78 (66.7)	61 (66.3)
<u>IPV Related Communication</u>		
Directly Asked by Health Care Provider about Current/Past Abuse [n(%)]:	45 (38.1)	31 (33.7)

Bolding in the Table indicates significance of variables

* Significant at the $p \leq 0.0001$ level** Significant at the $p \leq 0.01$ level[‡] Significant at the $p \leq 0.05$ level[‡] Borderline significance at the $p < 0.07$ level

Table 3

Logistic regression modeling the odds of a pregnant woman being screened by a health care Provider for IPV (n=210)

Independent Variable	Odds Ratio	95% CI
Marital Status	1.36	(0.42, 4.34)
Poverty Index	0.89	(0.57, 1.38)
Depression Index	0.95	(0.84, 1.06)
Worried Excessively/Anxiety in Last 6 Months	1.46	(0.64, 3.36)
Unscheduled Visits to Health Care Provider[†]	0.56	(0.35, 0.89)
Setting with a Systematic Screening Process in Place[*]	6.25	(2.12, 18.48)
Unplanned Pregnancy[†]	2.46	(1.14, 5.33)
Health Care Provider Always Used Understandable Explanations[†]	2.43	(1.06, 5.56)
Health Care Provider Always Listened to What Patient Said[†]	2.86	(1.08, 7.58)

Bolding in the Table indicates significance of variables

* Significant at the $p \leq 0.001$ level

[†] Significant at the $p \leq 0.05$ level.