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Adolescent and young adult women's recommendations for establishing comfort with family planning providers' communication about and assessment for intimate partner violence

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Abstract

Background: Intimate partner violence (IPV) is a serious public health problem that disproportionately affects adolescent women seeking family planning services. Current clinical guidelines recommend routine IPV assessment yet provide limited guidance on how to establish patient comfort in addressing this sensitive issue. Few studies exist describing the perspectives of

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adolescent female patients who have experienced IPV and their suggestions on how providers should communicate about IPV.

Methods: This study is a subset of a larger IPV intervention trial in family planning clinics. For this study, we chose a qualitative approach using individual interviews to explore patient perspectives in an open, in-depth manner without limiting potential responses with predetermined answers or investigator-imposed assumptions. We audio recorded clinic encounters for participating providers and patients and interviewed patient participants, asking them to listen to and reflect on how their provider talked about IPV in their audiorecorded clinic encounters.

Results: The mean age for the 44 participants was 22.8 years old. Participants named ‘comfort’ as a main component for discussing and disclosing IPV in the clinical setting. The sub-themes associated with how to create patient comfort include: Build the patient-provider relationship, Provider should communicate like a friend/be on the patient’s level, Patient needs to feel cared for by provider, and Appropriate timing and space.

Conclusion: Methods for establishing patient comfort via communication should be incorporated into and examined within sensitive healthcare areas such as IPV and can be extended to HIV, palliative, and oncological care to improve patient health outcomes.

Background

IPV is described as physical, sexual, or psychological harm by a current or former partner or spouse [1], and it disproportionately affects younger women and their reproductive health. A recent Institute of Medicine report on the health status of young adults notes that individuals throughout their twenties face particular social and health challenges including exposure to violence [2]. Adolescents (ages 15-19) and young adult women (ages 20-29) experience the highest prevalence of IPV compared with women of older ages, and more than half of women who have experienced IPV in their lifetime describe that their first IPV victimization occurred when they were 24 years or younger [3]. This age group also constitutes the majority of users of family planning clinics that provide reproductive and sexual health services [4]. Young women utilizing family planning clinics report much higher prevalence of IPV (34-53%) compared with other clinical populations [5-10]. Reproductive coercion (RC) is a type of IPV which refers to a male pressuring his female partner to become pregnant against her will via verbal pressure and threats to become pregnant, preventing her from using birth control, tampering with birth control/condoms, and controlling pregnancy outcomes [11]. Both IPV and RC are likely related to the negative reproductive health repercussions and risks including unintended pregnancy, sexually transmitted infection (STI), non- [12-14] and inconsistent condom use [15-22], and fear of condom negotiation [12, 14]. Clinical guidelines recommend that providers, especially in family planning settings, routinely assess for IPV in their patients, given documented associations between IPV and negative reproductive health outcomes [23-32].

Several studies have found that many women experiencing IPV will deny abuse when asked [33-35]. Studies exploring client-level barriers to disclosure of partner abuse reveal that common reasons for denying the abuse are fear of escalating violence [33-36], feelings of shame and embarrassment [33, 34, 36, 37], fear of losing their children, concern about loss

of confidentiality [33, 35], and fear of police involvement [33]. Despite the many reasons for nondisclosure, studies have shown that women (regardless of victimization experience) want to be asked about IPV [36, 38-40]. In addition, disclosure is more likely if the topic is initiated by the provider rather than the patient [41] and providers' assessment approaches are of great importance [42-45].

In the literature that describes clinical communication models and provides recommendations for improving patient satisfaction and patient-centered care, overarching themes that emerge include conversational and empathic interactions between the patient and provider in combination with friendly and supportive provider approaches. In addition to its application in general practice settings, the importance of patient-centered communication has been described in a range of nuanced healthcare areas such as HIV, palliative, and oncological care [46-51].

Many models describe connectedness between the patient and provider as the foundation of successful communication within a clinical context. Some models name "establishing rapport" as the first step in effective clinical communication and characterize connectedness as "patient engagement" or knowing patients "on a personal level" [52-54]. Other literature stresses that establishing connectedness should be viewed as "relationship establishment" or "relationship building" [55, 56], suggesting that providers place high value on developing personal relationships with their patients since all patient-provider communication stems from this crucial foundation, which can also impact the quality of health outcomes.

Prior research has also offered recommendations for provider verbal and non-verbal behaviors to improve patient-provider communication. Several studies advocate for attention to and use of empathetic language in response to patients' emotional presentations in clinical encounters to enhance communication and contribute to favorable health outcomes [57-59]. There is also an emphasis on the provider's ability to be sociable and friendly, while posturing themselves in a professional yet comfortable manner in their nonverbal communication [58, 60]. Other studies underscore the need for providers to be culturally aware and competent above all other communication recommendations as an avenue to build trust and rapport with patients [60-62].

Few known clinical communication models and recommendations include instructions for creating a comfortable emotional, social, or physical environment for patients. Smith's Patient-Centered Interviewing guidelines recommend that providers first "ensure comfort and put the patient at ease" by welcoming the patient and asking the patient if they feel comfortable in the exam room (i.e. "Is that a comfortable chair for you?") [63]. Expanding beyond physical comfort, Roter et. al. mention in their work that when providers use "comforting words," patients feel that they have a positive relationship with their providers, but there is no elaboration of how to use the recommended "comforting" language [57]. Other studies posit that patient comfort is derived from seeing a familiar provider and being acquainted with all practice staff, which is particularly important when discussing sensitive topics like sexual health [64-66]. Little is also known about how patients define comfort and what type of comfort they prioritize when discussing sensitive discussions. The literature does provide insight into what patients want providers to say and do when assessing for IPV,

but lacks a comprehensive description of specific aspects of the interaction they feel will increase their comfort talking about IPV [67]. The extant literature also fails to address how providers can establish comfort when assessing for IPV among female adolescent and young adult patients specifically.

The purpose of this study was to fill gaps in the literature by learning more about adolescent and young adult women's preferences in IPV assessment delivery in family planning clinics, through patients' examinations of their providers' communication used in their own clinical encounters.

Methods

This current study is the qualitative interview component of a larger, multi-phase, parent study which was an intervention trial in twenty-four family planning clinics in Western Pennsylvania [5, 6].

Description of Parent Study:

The parent study (Addressing Reproductive Coercion in Health Settings; ARCHES) was a clustered, randomized, controlled trial during which intervention clinic staff were trained to implement a universal education and brief counseling intervention regarding IPV and RC. The intervention was designed to promote patient and provider discussion about IPV and RC using semi-scripted assessment tools, harm reduction counseling, and warm referrals to local victim advocacy resources [5, 6].

In the final years of the parent study, we provided IPV/RC training for all ARCHES control sites. During this time, we randomized five of the control sites to receive either the usual didactic ARCHES training or to receive a skills-based, communication training workshop focusing on communication strategies to address IPV/RC. The ARCHES training consisted of a similar length workshop with lecture and group discussions that provided information regarding a) the prevalence and health consequences of IPV and RC, b) the effectiveness of assessing and educating women about IPV and RC, c) review of the use of the safety card and scripted assessment questions, c) discussion of harm reduction strategies including safety planning and longer-acting reversible contraceptives that the partner cannot interfere with, and d) local resources for victims of IPV and services provided. The communication training consisted of a four-hour long workshop that focused on IPV communication skills-building using simulated clients. This training program is modeled after effective programs designed to teach medical professionals specific communication skills and focused on use of specific patient-centered communication strategies such as OARS (Open-ended questions, Affirmation, Reflections and Summarization)[68], Ask-Tell-Ask (e.g. asks client what she understands about IPV or RC, requests permission to provide information, then asks client to confirm what she understood) [69], and dealing with emotion using NURSE (Name the client's emotion, Understand and validate their emotion, Respect their strengths, Support without conditions, and Explore the context for their emotions)[51, 70, 71]. All five clinics were given printed resources including an educational safety card (Appendix).

We then assessed the impact of these different training approaches on patient-provider communication in all sites which included patient surveys, audio-recordings of patient-provider conversations during reproductive health visits, and patient and provider semi-structured interviews. This present study focuses on data collected from semi-structured qualitative interviews with patient study participants on provider-patient communication regarding IPV. The intent of this analysis was to describe the variety of cross-cutting or divergent themes regarding women's IPV communication recommendations and preferences from patients who experienced past or current IPV recruited from all of the sites regardless of site training designation.

Patient qualitative interviews—During study enrollment, research staff asked both patients and their providers for permission to record the clinical encounter to assess how reproductive health providers addressed sensitive topics with their patients. Broadening the focus of the study to overall patient-provider communication allowed us to reduce the likelihood of bias from study participation (e.g. the Hawthorne effect) without increasing risk to the patients. During the consent process, research staff stressed to both patient and provider participants that they could stop the recording for any reason at any time. Research staff stayed outside of the exam rooms as a safety precaution to ensure the audio recorders only captured discussions among enrolled patients and providers. Research staff were never in the exam rooms during the appointment nor were they present for any conversations between the patients and providers. After the clinical encounter, research staff explained the study to the participants, arranged for a time to interview the participant, offered a gift card as remuneration for their time, and provided IPV-related resource information.

All patient participants also completed a tablet-based exit survey at the end of their clinic visits, which was programmed to show a prompt at the end inviting women to talk to the research assistant (RA) for the second part (follow-up interviews) of this study. .. Based on the responses in the survey, if the woman reported ever experiencing IPV or RC, the computer program would take her to a prompt asking her whether she was interested in participating in a follow up interview to review that clinic visit. The prompt would be marked "A" on the ACASI screen so the RA could track distribution of interview participants. Similarly, women who responded "No" to ever experiencing IPV or RC on the baseline survey saw a different prompt marked "B" on the screen inviting her to participate in a follow up interview. Research staff were blinded to what the survey indicators represented.

One of the participating clinics received training, but the provider at the clinic declined the audio-recorded portion of the study. However, clinic administrators gave permission for enrollment of their patients in the study to allow them to complete the surveys as well as the follow-up interviews.

For the women who indicated willingness to participate in the interview portion of the study, we used a purposive sampling strategy to include diverse experiences and clinic encounters with different providers at each site. The RAs completed a tracking grid such that the interviews included encounters with different providers in the clinical site. About 70% of encounters were associated with prompt A (participant indicated they have experienced IPV

and/or RC) and 30% were associated with prompt B (participant did not indicate they had experienced IPV or RC). The tracking grids from each clinical site were reviewed by the research coordinator daily to help guide RAs at the sites on how to adjust recruitment for follow up interviews to achieve optimal distribution in each site. Selected patient participants who agreed to the recorded visits were invited to return within 4 weeks after the initial audio recording to participate in semi-structured interviews and review the audio recording to allow ample time to review the survey data, identify and contact eligible interview participants, and schedule interviews while also optimizing participants' recollection of their discussions with providers during the initial encounter. Participants who returned for interviews reviewed the consent process with a research assistant prior to starting the interview. Interview questions focused on patients' feelings toward their providers' overall communication style and IPV and RC assessment techniques, and perspectives on the best strategies for helping patients who are in unhealthy relationships (see Appendix for interview guide). During the interview, the portions of the patient's recorded visit when the provider mentioned anything about the patient's safety, relationship, potential concern for partner's controlling or coercive behaviors, or provided IPV/RC resources or safety card were played for each participant to give their reactions and feedback on the content and delivery of the assessment. . Patients from the clinic that opted out of the audio-recorded visits were asked the same general interview questions as the other participations but could not review and reflect on any audio-recordings of their visit; instead, they were asked to recall the visit from memory and describe what they remembered and how they felt. Each woman received a \$30 gift card for her participation in the interview.

Patient comfort as the focus for this paper emerged from observations during the interview that every participant described the concept of patient comfort in their response to our interview question "What are some things that you think the doctor or nurse could have done better when talking about healthy relationships and IPV?" As the ultimate objective of the larger project was to improve provider communication behaviors and processes regarding IPV/RC, we wished to better understand what the concept of comfort meant to our patient participants and their thoughts on the specific strategies and approaches providers could take to achieve patient comfort with talking about IPV/RC. Thus, our interviewers were trained to follow up with additional probing questions such as "How would he/she make you feel more comfortable talking about this?" and "What things can doctors and nurses do to make patients feel more comfort talking about unhealthy relationships?"

Analysis

Audio-recorded patient interviews were transcribed verbatim, de-identified, quality checked by a third party, and uploaded to the qualitative coding software program, Atlas.ti version 9 [72]. While the concept of "patient comfort" is included in multiple models of patient experience and patient-provider communication[72-74], it's definition and characterization vary based on circumstance, topic, and setting; and the behaviors and processes used to achieve patient comfort are generally not described[75]. In light of this, we chose a more open coding style, an editing style as described by Crabtree and Miller[76], rather than use any existing framework or model as the initial template for our coding. Two trained, independent coders (AH and HL) reviewed five randomly selected patient interviews and

used to develop the initial codebook and as the process for our coding. This coding approach does not begin with a predefined set of codes. Instead, codes are generated as coders interact with the data—each coder independently assigning interpretive codes to each section of the transcript, meeting regularly to discuss their interpretations, and define the codebook in an iterative, “constant comparison” fashion [76]. While we intended that any interpretive differences that occurred would be reviewed with a third investigator (SZ) for arbitration, there were no interpretative differences. We noted no further refinement of codes needed at the fourth transcript and confirmed this with the fifth transcript. At this time, the final codebook was reviewed by the larger group and approved. This final codebook was then re-applied to all transcripts. The larger group then met to review the codes and generate topical categories. As we had noted during the conduct of the interview, patient comfort was a dominant subcategory in the larger category of “patient recommendations” for facilitating IPV/RC discussions. For this analysis, we focused on codes specific to describing what patients want and need from clinicians to feel comfortable to discuss IPV using axial coding [77]. This was then examined to identify and describe convergent and divergent themes across participants’ interviews both within and across the training group designation. As we noted no divergent themes, this paper focuses only on the convergent themes related to patient recommendations on establishing comfort to discuss IPV. Thus, results are presented without regard to training group distribution.

Due to logistical and financial constraints, we were not able to perform member checking to corroborate our findings. As an alternate approach to establishing a sense of “trustworthiness”, we presented the identified themes to IPV victims’ advocates, other IPV researchers, other public health researchers, and other adolescent/women’s health care providers. Our subthemes and illustrative quotations presented all resonated with and were corroborated by all audiences to which our findings were presented.

Results

Forty-four women participated in interviews, eight of whom were from the clinic that did not participate in the audio-recorded visits. Participants’ mean age was 22.77 years (+/- .49) and most women were Caucasian (82%) and had some college education or more (64%). Sixty-six percent of the participants had experienced IPV. (See Table 1)

Relationship between clinic/clinician elements and emotional comfort

Patients described many factors that they felt would increase their comfort in disclosing IPV to a provider. These factors were organized into four sub-themes: (a) Build the patient-provider relationship, (b) provider communicates like a friend/be on the patient’s level, (c) the patient needs to feel cared for by provider, and (d) appropriate timing and space.

(a) Build the patient-provider relationship—Participants expressed that providers can enhance comfort by establishing a more personal relationship with their patients. The patient participants suggested that providers should aim to understand their patients on a personal level, which goes deeper than being versed in their physical health. Women said that they have felt comfortable telling close friends or family members about experiencing IPV because they understood the context in which it was taking place. Participants conveyed

that they felt more comfortable with providers who could talk about themselves (e.g., their children or their weekend plans) in addition to remembering details about the patient. Patients' suggestions indicated that reciprocal sharing of information between a patient and provider can create a relationship that is more desirable to an adolescent and young adult patient. One woman expressed that she wanted to feel as if the clinic providers were "here for (a patient) and that (a patient) is not just a number," suggesting that providers need to know their patients outside of a clinical context to help them feel more comfortable opening up about their IPV experiences.

In addition to helping women feel comfortable, building the patient-provider relationship can provide key insights into what is happening in patients' lives, further enhancing opportunities for IPV assessment. One participant said: "Providers could take little notes or something on the patient to leave on their file. So if they ever come in and they're acting really not themselves that day, they could kinda learn those behaviors."

(b) The provider should communicate with their patients like a friend/be on the patient's level—Participants expressed a desire for providers to communicate with them like a friend would, being on the "same level," and not using "sugar-coated" language (i.e. a friend is "straightforward" with language). Participants articulated that feeling comfortable enough to offer sensitive personal information about their IPV experiences aligns with providers speaking to them in a casual, friendly, or conversational manner. Participants also expressed that providers should use layperson terms to "be on the same level" as their patients. One woman suggested that providers can do this by minimizing the use of medical jargon in the clinical encounter:

I know (IPV assessment at the clinic) could be hard because you're supposed to be in a professional setting but if you just kind of wipe away the certain words that you're supposed to use when it comes to a patient, the disconnecting words and be like 'I know it's scary... I do this for everyone but I have to make sure 'cause anyone could be hurting so I... got to talk,' but you have to be the friend. You can't be the doctor (because) I know some many people are afraid of medical professionals...

Another participant spoke about how she felt more comfortable talking about an unhealthy relationship when the provider minimized any sense of a difference in power or authority

So... what would make me feel more comfortable (is) that I would have more of a mutual... 'let's talk about this kind of thing' instead of 'you [the provider] know more about all this than I do and what you [the provider] think matters more than what I think.'

Participants also expressed that they felt comfortable in a conversation when the other person was being "straightforward" with their questions and that this helped to put the provider on the same level as the patient. They advised that providers should not "sugar coat" their questions when asking their patients about IPV but instead should ask more directly.

(c) The patient needs to feel cared for by the provider—Participants conveyed a need to feel cared for by their providers to feel comfortable discussing IPV. Women explained that they want providers to show concern for their patients as “whole people” and to be able to broaden their focus beyond patients’ chief clinical complaints. Participants described the notion of feeling “cared for” by providers as a “genuine interest” in their well-being outside of providers “just doing their jobs”. One woman suggested that she would feel more comfortable discussing IPV with a provider if they were genuine and attentive in a caring way:

Honestly, I feel like the comfort of (providers being) themselves is a good thing because if you walk in (to a clinic) and you have really rude and inconsiderate physicians... you're not gonna want to tell them your problems, you're not gonna wanna say anything to them, you're just gonna want to keep it to yourself. But you come in here and someone's very understanding and... wanna know your problems and genuinely care about (you), I feel like it's a better thing... I'm not gonna wanna sit here and tell all my personal information to someone who's having like an 'I don't care' attitude... Someone that's (looking) at me in my eyes and telling me, 'oh I'm here for you, this is what I do, if you need anyone to talk to I'm here.' I would want to tell my story to them more than the other person.

(d) Appropriate timing/space—The themes of when and where to have a conversation about IPV arose for many women who expressed that comfort was a main factor in their willingness to discuss IPV with their providers. Women described comfortable space in the physical sense, in which the client was private, as well as in terms of where providers positioned themselves in the space during the assessment. Some participants specified that the desired distance between the patient and provider when discussing IPV should be 2 to 3 feet, and that both parties should be seated.

Participants also said that the timing of the IPV assessment is important. They explained that asking about IPV at the beginning of the visit, during a pelvic exam, and in the middle of a “list” of questions were not appropriate times for the assessment. Participants advised that providers should “ease into” the discussion by asking about IPV toward the middle of a visit and not rush through the questions on this topic. One participant provided this advice:

...People aren't so willing to right away give information up so maybe you might have to ask again in the middle of the... appointment or at the end maybe just drop some hints or something and get them comfortable with you talking to them... (if) you first walk in (and say) 'hey you have any problems at home?'... and then you're just done... Maybe they do (have problems at home) and then they just aren't comfortable with you yet 'cause you are (at the family planning clinic), I mean really who likes to come and have (pelvic) exams done...?'

Discussion

This study focused on adolescent and young adult perspectives on how providers can create comfort during clinical encounters and how they should ask about IPV. Findings highlight

the extent to which patients need and expect that providers try to get to know them on a more personal level before discussing sensitive topics such as IPV.

The key themes “build the patient-provider relationship,” “patient needs to feel cared for by provider,” and “appropriate timing and space” align with the existing literature on patient-centered care and clinical communication models and recommendations [37, 52, 58, 61, 63, 78]. Our results extend beyond naming emotional comfort as an important element within communication models and recommendations and offer insight into how adolescent and young adult women want providers to discuss sensitive topics like IPV with them. The literature on similarly sensitive topics of palliative, HIV, and oncological care stress that providers should use patient-centered communication strategies, to which comfort-enhancing communication could be added for improved health outcomes and greater medication adherence [46-51].

“It’s all in the how”: assessment delivery

Providers’ assessment of IPV is guided by screening tools, clinic policies, and protocols for responding to violence disclosure such as referral to resources or safety planning. Our findings show that adolescent and young adult women place importance on *how* their providers deliver IPV assessment in addition to the methods/tools that they use.

We found that many women prefer that their providers speak to them with a direct tone and avoid using vague or sugar-coated/diffusive language. Many studies have focused on the need for providers to communicate in a relatable, casual, and friendly manner when working with patients [59, 63, 79, 80]. Miller et al. explain that adolescent and young adults’ perception of relatable language involves a balance between non-jargon use, non-slang use, and casual but still professional language [10]. The notion of communicating “like a friend” is a new characteristic that this study brings to the literature on communication styles, which implies an enhanced feeling beyond being “friendly” or “cordial.” From this finding, we can deduce that adolescent and young adults may be seeking a relationship with their provider that aligns more with a peer relationship, which may play a key factor in increasing patient comfort when discussing sensitive topics.

Additionally, our findings suggest that young women place emphasis on how providers can “set the stage” for IPV assessment and, possibly, other discussions of sensitive topics. We heard participants advising how providers can establish patient comfort. —They shared specific suggestions regarding the type of physical space in which to have these conversations, how the provider should be positioned relative to the patient, and when during the reproductive health visit the topic should be introduced

Unique method, unheard voices

We are aware of no other studies that investigate patient clinical communication preferences through patients’ reviews of recordings of their own clinic encounters. By audio recording the patient-provider interaction and revisiting the encounter during future visits, patients had the opportunity to provide direct criticism, praise, and specific suggestions for the encounter. This method is unique in comparison to other studies that have asked about patient preferences based on hypothetical situations or actual past experiences, which are subject to

recall bias. Also, while the interview questions did not directly ask about comfort, women independently emphasized the importance of patient comfort in the context of disclosing IPV to a clinician, which underscores the saliency of our findings particularly given the high prevalence of IPV in our sample.

The perspectives that we heard from these young women give us a richer and deeper understanding of how providers can better tailor their communication styles to fit the needs and wants of their patients. By hearing the voices of adolescent and young adult victims of IPV, we can more effectively contribute to clinical violence prevention efforts by refining clinic-based interventions.

Clinical implications

Based on the findings that providers should approach patient-centered care with personable and relatable communication, we note that it may not be sufficient to focus on knowledge or content acquisition of the topic of IPV/RC without training providers on skills and strategies for effective communication. When providers use patient-centered communication skills and as their levels of comfort discussing IPV improve, other patient experiences within the clinic may also develop, such as increased patient satisfaction, increased patient trust, and increased sense of partnership in making reproductive health decisions. Simultaneously, clinic-level factors that may increase the likelihood that providers will use these communication skills should be explored in future studies.

Women had suggestions for when and where providers should initiate discussions with them about IPV. Specifically, they suggested introducing sensitive topics such as IPV toward the middle of the clinical encounter, asking IPV-related questions when they ask questions about other sensitive topics, and easing into (as opposed to being in a string of questions about smoking and seat-belt use, for example). Women were also concerned about privacy and wanted discussion to occur in a private area. The use of the private area for IPV assessment is mirrored in the work Martin et al, where teens describe an ideal IPV resource center as being “confidential” and “safe” [81].

Our participants’ perspectives and advice on creating patient comfort in clinic-based IPV assessment can translate to other sensitive topics such as palliative and end of life care and often-stigmatized areas like HIV or other sexually transmitted infection treatment. We suggest that emphasizing emotional comfort patient comfort can be a beneficial addition to the existing patient-centered and open-ended communication methods that are already commonly applied in these areas [82-85].

Because our findings among young women in family planning clinics mirror many of the themes in other communication models and recommendations, this need not add to the burden of what providers must pursue to learn. Rather, our recommendation to providers is to take inventory of what they know about patient-centered care and learn how best to deliver that care for their younger patients.

Education implications

The women's identification of and recommendations for specific strategies and approaches for health care providers to use to ensure patient comfort when discussing IPV has significant implications for teaching communication skills and strategies to medical providers. Since the mid-1990s there has been an increased emphasis among medical schools and their accrediting bodies to ensure skills in patient-provider communication were being taught to physicians-in-training [86]. Since 2004, a standardized patient-based clinical skills assessment was added to the United States Medical Licensing Exam Step 2 that includes a focus on students' communication skills with patients in clinical encounters [87]. In 2008, the American Association of Medical Colleges published its Recommendations for Clinical Skills Curricula for Undergraduate Medical Education in which patient-provider communication skills is highlighted as a core area in which to establish and demonstrate competency [88]. While the majority of medical schools now describe patient-provider communication training in their curriculum, there is little standardization regarding what content, training approach, and specific skills should be consistently used to effectively teach these skills.

Research implications

Further research is needed to better understand the interactions between the different components of provider communication and how to successfully combine communication approaches to increase comfort among patients. While patient comfort is often included in various models of quality patient care and patient-provider communication, rarely are the processes, strategies, and approaches for achieving comfort detailed [75]. Other qualitative studies could focus specifically on describing patient comfort in various healthcare settings and patient populations and developing and testing provider training content. Notably, this study could not discern differences in communication preferences by gender as all of the patients and all of the health care providers were women.

Based on the young women's recommendations, tailored IPV assessment scripts (providing both the verbiage and tone for providers to use) could be developed and studied in family planning clinic settings to further understand patient preferences in provider communication.

As new strategies for communicating with young women about IPV are established, it will be important to evaluate the extent to which they improve violence-related knowledge for patients and providers (e.g., knowledge of IPV resources, use of safety and harm-reduction strategies, and reductions in violence victimization) and reproductive health outcomes. Also, a similar study with younger adolescent participants would be helpful in providing further guidance on IPV assessment to family planning providers. Future research should ensure inclusion of adolescent perspectives and voices and further delve into the types of relationships and interactions they desire from their health care providers.

Limitations

One limitation of this study lies within the sampling design. We endeavored to attain a participant sample of 70% IPV survivors (as indicated on the computerized survey), but interviewed 66%. Still, our sample size of 44 adolescent and young adult participants is

larger than all other known qualitative studies' samples on similar topics. We did not assess details of the women's histories of IPV in this study, as the focus was on communication preferences among survivors of IPV. The consistency of emergent themes related to provider-patient communication preferences is noteworthy given the heterogeneity of women's ages and experiences. Another limitation is that the interview guide did not specifically include questions about comfort, which should be explored further in future research. We did not have audio recordings of the clinical encounter for eight of the patients recruited from the clinic that declined participation in this audio-recording portion of the study, and thus had to rely on patients recalling the clinical encounter on the day they took the survey. Additionally, because we did not specifically ask about or define comfort in the interviews, the participants may have used the word "comfortable" to mean "confidentiality" and/or "safety," which other research with adolescent and young adults has shown [10, 89]. Finally, given that both providers and patients were participants in this study and that most of the providers understood that their communication would be recorded, there is the possibility that the study participation changed or affected their communication and interaction. However, we suspect that if there were any bias caused by study participation, it would bias health providers toward trying harder to use good communication and interaction behaviors. This may then have provided our patient participants with more positive experiences and allowed them the ability to identify what components were present that led to increased comfort talking about IPV and RC. Thus, the direction of this bias may have enriched our interview data with more examples and descriptions of positive provider behaviors.

Conclusion

In conclusion, we found that adolescent and young adult women place complex, interwoven, and unique meanings behind the idea of comfort within the realm of IPV screening in clinical settings. Additionally, we discovered that patient comfort is a main overriding element that lends to enhanced and improved clinic-based conversations about IPV, which can be generalizable to other areas of healthcare where sensitive topics are discussed between patients and providers. Future research should include further investigation on how to incorporate communication practices that promote comfort among adolescents around sensitive topics and the potential impact of improved communication on health outcomes

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Appendix – Patient Interview Guide

Patient participant interview guide

Introduction: This is the second part, the follow up part, where we are inviting women back to talk about their discussion with their health care provider. And what we are interested about in particular is how providers talk to patients about sensitive topics such as intimate partner violence or unhealthy relationships. There are different styles used by providers in talking about intimate partner violence, and even some differences of opinion as to whether this is an area that providers should ask about at all. We're interested in learning more about that patient-provider communication about intimate partner violence.

What did you think of the overall visit?

What did you think about the communication between you and your doctor/NP/NMW? What are some things that you liked about the interaction?

What are some things that you think the doctor could have done better?

Tell us a little bit about any non-verbal communication that you remember from that visit.

What did you think about how she brought up the subject of IPV or safety with you? Listen to the tape, focused on IPV:

What do you think your doctor/nurse/midwife/practitioner means when she asks this question? Tell me what she is asking about. What does this include? What does she mean by the phrase "... ..."?

At your visit, we asked about partner violence by the computer and in person with your provider. Tell me a little about how you felt about those two different styles of bringing up this topic. What are some of the differences? How do you feel with each style?

(when in the past) You had shared that this violence was something that happened in the past, what would be your suggestions for providers about what they could say or what would be helpful to women who have had this in their past? (consider having them listen again to the section) After listening to this part of the discussion again, any other suggestions you would have for providers on how to respond?

What could the provider have said or done differently what would have been helpful for you personally?

What about if it were something happening currently? How should they address that? Anything else you wanted to comment on about your visit.

What do you think about your participation in this study? What do you think we could improve on?

Appendix – Safety Card

Who controls PREGNANCY decisions?

Ask yourself. Has my partner ever:

- ✓ Tried to pressure or make me get pregnant?
- ✓ Hurt or threatened me because I didn't agree to get pregnant?

If I've ever been pregnant:

- ✓ Has my partner told me he would hurt me if I didn't do what he wanted with the pregnancy (in either direction—continuing the pregnancy or abortion)?

If you answered YES to any of these questions, you are not alone and you deserve to make your own decisions without being afraid.

Getting Help

- ✓ If your partner checks your cell phone or texts, talk to your health care provider about using their phone to call domestic violence services—so your partner can't see it on your call log.
- ✓ If you have an STD and are afraid your partner will hurt you if you tell him, talk with your health care provider about how to be safer and how they might tell your partner about the infection without using your name.
- ✓ Studies show educating friends and family about abuse can help them take steps to be safer—giving them this card can make a difference in their lives.

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FUTURES WITHOUT VIOLENCE
Formerly Family Violence Prevention Fund
FuturesWithoutViolence.org

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WOMEN'S HEALTH CARE PHYSICIANS

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All these national hotlines can connect you to your local resources and provide support:

For help 24 hours a day, call:

National Domestic Violence Hotline
1-800-799-SAFE (1-800-799-7233)
TTY 1-800-787-3224
www.thehotline.org

National Dating Abuse Helpline
1-866-331-9474
www.loveisrespect.org

National Sexual Assault Hotline
1-800-656-HOPE (1-800-656-4673)
www.rainn.org

Did You Know Your Relationship Affects Your Health?

Are you in a HEALTHY relationship?

Ask yourself:

- ✓ Is my partner kind to me and respectful of my choices?
- ✓ Does my partner support my using birth control?
- ✓ Does my partner support my decisions about if or when I want to have more children?

If you answered YES to these questions, it is likely that you are in a healthy relationship. Studies show that this kind of relationship leads to better health, longer life, and helps your children.

Are you in an UNHEALTHY relationship?

Ask yourself:

- ✓ Does my partner mess with my birth control or try to get me pregnant when I don't want to be?
- ✓ Does my partner refuse to use condoms when I ask?
- ✓ Does my partner make me have sex when I don't want to?
- ✓ Does my partner tell me who I can talk to or where I can go?

If you answered YES to any of these questions, your health and safety may be in danger.

Is your BODY being affected?

Ask yourself:

- ✓ Am I afraid to ask my partner to use condoms?
- ✓ Am I afraid my partner would hurt me if I told him I had an STD and he needed to be treated too?
- ✓ Have I hidden birth control from my partner so he wouldn't get me pregnant?
- ✓ Has my partner made me afraid or physically hurt me?

If you answered YES to any of these questions, you may be at risk for STD/HIV, unwanted pregnancies and serious injury.

Taking Control:

Your partner may see pregnancy as a way to keep you in his life and stay connected to you through a child—even if that isn't what you want.

If your partner makes you have sex, messes or tampers with your birth control or refuses to use condoms:

- ✓ Talk to your health care provider about birth control you can control (like IUD, implant, or shot/injection).
- ✓ The IUD is a safe device that is put into the uterus and prevents pregnancy up to 10 years. The strings can be cut off so your partner can't feel them. The IUD can be removed at anytime when you want to become pregnant.
- ✓ Emergency contraception (some call it the morning after pill) can be taken up to five days after unprotected sex to prevent pregnancy. It can be taken out of its packaging and slipped into an envelope or empty pill bottle so your partner won't know.

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Table 1.

Patient Participant Demographics

Characteristic	Total (n=44) % (n)
Race	
White/Caucasian	82 (36)
Black/African-American	9 (4)
Multiracial/other	9 (4)
Age	
18-21	41 (18)
22-25	36 (16)
26-29	23 (10)
Education	
Less than 12 th grade	11 (5)
Finished high school	25 (11)
Some college	34 (15)
College degree or higher	30 (13)
Lifetime IPV	66 (29)