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# Rural Primary Health Care Providers' Response to Intimate Partner Violence and Survivors' Perceptions of Helpfulness

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Rural Primary Health Care Providers' Response to Intimate Partner Violence and Survivors'  
Perceptions of Helpfulness  
by  
Annah K. Bender

A dissertation presented to the  
Graduate School of Arts & Sciences  
of Washington University in  
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of Doctor of Philosophy

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Annah K. Bender

*Washington University in St. Louis*

*May 2015*

Dedicated to my sons.

## ABSTRACT OF THE DISSERTATION

Rural Primary Health Care Providers' Response to Intimate Partner Violence and Survivors'  
Perceptions of Helpfulness

by

Annah K. Bender

Doctor of Philosophy in Social Work

Washington University in St. Louis, 2015

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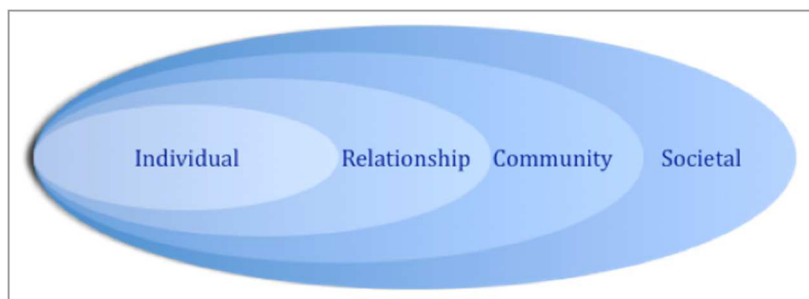
Intimate partner violence (IPV) affects the health and mental health of many women in the United States, with some estimates projecting that one in three women will experience physical, sexual, and/or psychological abuse from a current or former partner during their lifetimes (National Intimate Partner and Sexual Violence Survey [NISVS], 2011). The problems many survivors of IPV face as they attempt to secure help and establish a life free from violence are numerous and include housing, legal, employment, medical, and other domains. Such problems are frequently compounded for survivors residing in rural areas of the U.S., where access to social services, including domestic violence shelters, is notably scarce (Iyengar & Sabik, 2009). Although many rural areas are also medically under-served, rural health care providers represent one of the front lines of helping professionals with whom abused women have semi-regular contact. Rural health care providers may thus play an important role in the identification of IPV and the assistance or referral of survivors to additional helping services. However, the ways that rural health care providers identify and respond to IPV in their resource-poor communities is not known. This dissertation research was undertaken to address a gap in the social work and public health literature regarding the management of IPV by primary health care providers, specifically

rural primary health care providers, in addition to collecting information on the perceptions of helpfulness by survivors who received care from a rural provider. A mixed-methods study was conducted across rural Missouri and included surveys and interviews of rural providers and interviews with rural survivors of IPV. Overall, data indicated that rural providers are aware of IPV and view it as a problem in their communities, yet have low levels of knowledge regarding its dynamics and correlates with other problems, such as substance misuse. The lack of social, mental, and behavioral health services in many rural parts of the state also made it difficult for providers to respond effectively to the presenting concerns of their patients experiencing IPV. The majority of survivors interviewed stated they had never been asked about IPV by a primary health care provider and did not characterize their overall experience in the health care setting as helpful or effective in resolving issues related to their abuse. These and additional research findings indicate an urgent need for social workers to take an active role in health care, and that this role that may be especially meaningful for rural survivors of IPV.

# **Chapter 1: Introduction: Intimate Partner Violence and Women’s Health**

One of the major threats to women’s health in the United States is physical, sexual, and psychological violence by an intimate partner. Intimate partner violence, or IPV, is frequently devastating for the individuals and their families whom it affects. Rural women may be particularly susceptible to the consequences of IPV due to socioeconomic, health, and cultural distinctions from urban areas (Lanier & Maume, 2009). Yet relatively little research has focused on the nature, extent of, and response to, IPV in rural communities as compared to metropolitan areas. The rural cultural and social milieu may shape the dynamics and aftermath of IPV in ways that are different from what urban women experience (Van Hightower & Gorton, 2002), yet the rural context is rarely taken into account in studies of IPV or policy decisions affecting survivors and their advocates. From a social work and public health perspective, this lack of attention to environment is troublesome. *Place* is an integral part of social ecology, which considers individuals and relationships within the context of their communities (see Figure 1.1).

**Figure 1.1 Social Ecological Model.**



*Centers for Disease Control and Prevention, 2009*

Rural communities grapple with constraints on the amount and type of public services they are able to provide their citizens, a reality that will only grow more challenging as rural populations continue to decline in number, age, and become more entrenched in poverty as a whole (Blakely & Locke, 2005; Economic Research Service, 2012). These limitations extend to the provision of care for survivors of IPV. The shortage of domestic violence shelters, family planning clinics, and mental/behavioral health programs offering treatment for families affected by IPV in rural areas has been noted (Annan, 2008; Iyengar & Sabik, 2009; Peek-Asa, Wallis, Harland, Beyer, Dickey & Saftlas [Peek-Asa et al.], 2011). Furthermore, Few (2005) found that even when specialized services for survivors do exist, such as shelters, rural women are less likely than their urban counterparts to utilize these services or to find them helpful. Stigma and concerns about confidentiality play powerful roles in determining whether rural women seek help for IPV (Annan, 2008) as well as issues attendant with IPV, such as mental health problems and substance abuse (Gehlert, Kovac, Song & Hartlage, 2006). Limited options for helping resources in a small community may make survivors' help-seeking for IPV services more due to concerns about the confidentiality of such services and whether they might be noticed by an acquaintance (Annan, 2008). The scarcity of accessible help in rural areas points to the need for a fresh approach to identifying and responding to survivors in ways that consider the practical and cultural forces that influence survivors' decisions to seek assistance.

A growing body of research has begun to examine the efficacy of health care settings as sites for the early identification of and treatment for IPV. For instance, the American College of Obstetricians and Gynecologists (ACOG) now recommends that health clinics serving women implement universal IPV screening practices (2012). Recognizing that most women have contact with a health care provider with some regularity, and that women in abusive relationships utilize

health care services more often and for longer than non-abused women (Thompson, 2007), health care settings become a logical point of intervention for survivors. For rural women who do not have a domestic violence program in their community, the doctor's office may be one of the few safe places she can discuss the abuse she is experiencing. The focus of this dissertation research, undertaken across rural Missouri, was to explore and describe health care providers' and survivors' perspectives on IPV with the aim of improving health care delivery in rural communities.

This chapter will broadly describe IPV and the major health domains affected by it, followed by a review of IPV prevalence and dynamics in rural areas. The chapter will close with a brief discussion of the broader health disparities and health care access problems broadly typical of rural areas and those specific to Missouri. Chapter Two will describe practical challenges rural health care providers face during clinic encounters with survivors of IPV, followed by the study's research aims, questions, and constructs to be explored. Chapters Three through Five will describe the methods, data analysis, and results from each part of this mixed-methods study. A summary of key findings from the entire study will be presented in Chapter Six. This dissertation will conclude with a discussion of the study's implications for social work and possibilities for future research and practice.

## **1.1 Prevalence of Intimate Partner Violence**

The National Intimate Partner and Sexual Violence Survey (NISVS) estimates that one in seven women have experienced intimate partner violence (IPV) during their lifetime (2011). Some groups of women, such as women with disabilities or mental illness (Brownridge, 2006), impoverished women (Cunradi, Caetano & Schafer, 2002), and women of color, particularly



Native American<sup>1</sup> and African American women (46% and 43.7%, respectively) (NISVS, 2011) report IPV at rates surpassing the national average. Young women are particularly at risk, with 69% of IPV survivors first experiencing abuse before the age of 25 (NISVS, 2011). Most women report being victimized by a male partner (NISVS, 2011; Catalano et al., 2009; Tjaden & Thoennes, 2000a, 2000b), a feature that has remained relatively constant over time and across studies.<sup>2</sup>

### **1.1.1 Intimate Partner Violence and Health Outcomes**

Women affected by IPV often suffer from poor health and are at risk for injuries, mental health problems, and other life disruptions that carry long-lasting health consequences.<sup>3</sup> The damage caused by IPV ranges from the very minor (scratches, bruises) to life-threatening and death. The cumulative stress of coping with abuse and the numerous health problems that frequently occur in tandem with IPV also drastically lower quality of life. This co-occurrence of IPV and health problems means that an essential part of addressing IPV involves treating the health disorders, diseases, or complaints that afflict many survivors. The major domains of health outcomes affected by or associated with IPV are reviewed below.

#### **Injury**

Women who have been abused may not present with signs of obvious physical trauma, even in emergency room departments (Campbell, 2002). However, IPV is one of the most

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<sup>1</sup> The NISVS report urges readers to interpret their findings regarding violence rates against Native American women with caution, as these estimates were drawn from a low number of participants relative to other racial/ethnic groups (NISVS, 2011).

<sup>2</sup> A notable exception is Straus and colleagues' National Family Violence Surveys (1990-1995), which found that women were just as likely as men to engage in relationship violence. However, the methodological tactics used in this research, specifically the use of the Conflict Tactics Scale to accurately measure IPV, have been questioned by a number of scholars (DeKeseredy & Schwartz, 1998). Johnson (2006) provides a comprehensive overview of the theoretical differences between family violence and intimate terrorism, or IPV, and describes a nuanced view of "common couple violence" that seems to describe the majority of IPV cases but which has yet to be tested.

<sup>3</sup> Throughout this dissertation the term "health" will be used in the broadest sense, meaning physical and sexual health, mental health, and emotional well-being.

common causes of injury among women: a review of studies conducted in emergency room and acute care settings found that 11-30% of all injuries were a result of IPV (Rand, 1997). Injuries are most likely to result from attempted strangulation or blows to the head, face, neck, windpipe, breasts, or abdomen (Grisso, Schwarz, Hirschinger, Sammel, Brensinger, Santanna, Lowe, Anderson, Shaw, Bethel & Teeple, 1999; Rand, 1997). Traumatic brain injury is also common among survivors of IPV, with these symptoms appearing to have a dose-response relationship to the frequency and severity of blows to the head (Jackson, Philip, Nuttall & Diller, 2002). Children are often injured incidentally during IPV incidents: one study of 553 mothers at a pediatric practice found that children exposed to violence were 57 times more likely to have been injured than others (Parkinson, Adams & Emerling, 2001).

### **Fatality**

Almost three women are killed by their intimate partners every day (Rennison & Welchans, 2003). Firearms are used in over half of these murders (Center for Gun Policy & Research, 2003), with handguns the weapon of choice (Sorensen, 2006). The Bureau of Justice reports that over 70% of homicide victims were murdered by an intimate partner in 2007. The presence of a gun in the home increases the risk of injury and murder by an intimate partner fivefold (Campbell et al., 2003), and women are 3.6 more times as likely to be treated for a gunshot wound sustained by an intimate partner than they are to be assaulted by a stranger (Wiebe, 2003).

Murder is not the only lethal consequence of IPV. Suicide, one of the leading causes of death nationwide, has been linked to IPV in several regional studies (Campbell, 2002; Golding, 1999; Pico-Alfonso, Garcia-Linares, Celda-Navarro, Blasco-Ros, Echeburua & Martinez [Pico-Alfonso et al] 2006). In New Mexico, Olson and colleagues (1999) found that IPV was

documented in over 5% of female suicides, and in an additional 22% of cases, an argument with or separation from an intimate partner had directly preceded the suicide. Suicide among women who have experienced IPV, while less studied than the association between IPV and mental health disorders, is significantly higher among this population than women with no history of abuse (Campbell, 2002), a linkage that also holds true globally (World Health Organization, 2011).

### **Additional Health Problems**

Traumatogenic theories posit that the fear and stress associated with serious IPV damage the immune system over time and leaves victims more susceptible to diseases, infections, and other health disorders (Carlson, 2005; Najavits, 2002). For women with a violent partner, these stressors often manifest themselves in recurring health problems and central nervous system complaints (Campbell, 2002). Chronic pain, fatigue, hypertension, and gastrointestinal disorders are significantly higher among survivors of IPV than women with no history of abuse (Campbell, 2002). Obesity, a significant correlate of health problems among U.S. women, is tightly linked with depression and indirectly linked with IPV (Huang, Yang & Omaye, 2011). A study of 157 women residing in domestic violence shelters also found high levels of disruptive sleep, poor sleep quality, and frequent nightmares (Woods, Kozachik & Hall, 2010).

Sexual function and reproductive health, to say nothing of sexual pleasure, is frequently compromised in abusive relationships. The odds of having a gynecological problem among women who have experienced IPV are three times higher than those of the general population (Campbell, 2002). Rates of sexually transmitted infections including HIV, urinary tract infections, vaginal bleeding or infection, pain during intercourse, fibroids, decreased sexual desire, and chronic pelvic pain are higher among women with a history of IPV (Campbell, 2002).

These problems drastically lower quality of life for women and are costly to treat. The American College of Obstetricians and Gynecologists has identified vaginal, anal, and oral trauma from forced or coerced sex, including shame and its resultant stress on the body's immune system, as possible mechanisms for the higher rates of disease transmission and infection among survivors of IPV (ACOG, 2012). Evidence from national surveys of health behaviors is mounting that women in violent relationships are often subjected to or forced to engage in riskier sexual behaviors than other women. Violent partners may not be monogamous, may coerce or force women into risky sexual activities or refuse to practice safer sex methods (Coker, 2007). Women involved in abusive relationships frequently report sexual assault and rape by their partners (Bonomi, Anderson, Rivara & Thompson, 2007; Coker, 2007).

Abuse significantly decreases a woman's agency and sense of safety in negotiating safer sex practices with their partners (Purdie, Abbey & Jacques-Taqui, 2010), in turn raising the risk of contracting a sexually transmitted infection (ACOG, 2012; Coker, 2007). Reproductive coercion, which may lead to unexpected pregnancy, is another result of women's lack of agency in abusive relationships. Women in abusive relationships constitute a large percentage of those seeking abortions; a systematic review by Coker (2007) found that 17 of 24 studies on unwanted pregnancy and IPV found a link between abortions, including repeated abortions, and IPV. This association seems to hold true worldwide, according to the WHO Multi-Country Study on Women's Health (Sarkar, 2008). High risk pregnancies may be more common among IPV survivors, likely resulting from their already-compromised health status and including lack of emotional and financial support from their partner (Miller, Decker, McCauley, Tancredi, Levenson, Waldeman, Schoenwald & Silverman, 2010). Due to the increased stress associated with pregnancy, expectant mothers are at increased risk of abuse (Saftlas, Wallis, Shochet,

Harland, Dickey & Peek-Asa, 2010), as well as abuse that intentionally or unintentionally leads to miscarriage (ACOG, 2012).

### **Depression and Post-traumatic Stress Disorder**

Depression and Post-Traumatic Stress Disorder (PTSD) have both been associated with experiencing IPV (Campbell, 2002; Jewkes, 2002; Golding, 1999; Woods, 2005). Both of these disorders have largely been studied as mental health sequelae triggered by IPV victimization, although there is some evidence that women with major depressive disorders could be more susceptible to abuse (Friedman & Loue, 2007) or find their depressive symptoms exacerbated by it (Campbell, 2002). Depression magnifies the life stressors that often accompany IPV, such as childhood abuse, having many children (Jewkes, 2002), unstable residency or many moves (Li, Kirby, Sigler, Hwang, LaGory & Goldenberg, 2010), forced sex with an intimate partner (Coker, 2007), and other negative life events such as poverty and substance abuse (Carbone-Lopez, Kruttschnitt & MacMillan, 2006; Cunradi, Caetano & Schafer, 2002). Women in abusive relationships report higher frequency and severity of depressive symptoms and suicidal thoughts than do non-abused women (Pico-Alfonso et al., 2006). Golding (1999) found that the weighted mean average of depression among survivors of IPV was close to 50 percent.

Studies have found that all types of IPV, including physical, sexual, and psychological, are also important predictors of PTSD (Wineman, Woods & Zupinac, 2004; Woods, 2005). The psychological component of IPV can be particularly damaging; Pico-Alfonso (2004) found that PTSD was most strongly predicted by women who experienced severe psychological abuse. Anticipating and enduring violent attacks, coercion and control, threats, humiliation, and forced sex can activate a response to these stressors not unlike what survivors of war experience, with the exception that IPV is rarely a discrete event but an ongoing life reality (Hermann, 1992;

Najavits, 2002). Reported rates of PTSD range from 24 to 84 percent of IPV survivors (Golding, 1999; Coker, Weston, Creson, Justice, & Blakeney, 2005).

### **Substance Abuse**

Intimate partner violence is linked with substance abuse among many women, who may use substances as a coping strategy or whose addiction places them at risk of victimization (Campbell, 2002). Sustained, heavy substance use is tied to numerous health consequences, including risk of infectious diseases (Singer & Clair, 2003); highly correlated with mental illness, PTSD and increased suicidality (Mueser, Meyer, Penn, Clancy, Clancy & Salyers, 2006); and is tightly bound together with psychosocial factors such as child maltreatment, loss of children to the authorities, homelessness, incarceration, and early death (Drake, Wallach, Alverson & Mueser, 2002). Women involved in violent relationships and heavy substance use thus represent some of the most vulnerable members of society.

## **1.2 Intimate Partner Violence in Rural Areas: Prevalence and Dynamics**

The current systems and infrastructures for addressing IPV have been fitted to a metropolitan context (Van Hightower & Gorton, 1998). The main national surveys focused on IPV, the National Violence Against Women Survey (NVAWS) and the National Intimate and Sexual Violence Survey (NISVS), lack geocoded or regional information (Shuman, McCauley, Waltermauerer, Roche, Hollis, Gibbons, Dever, Jones & McNutt [Shuman et al.], 2008). Studies on IPV dynamics, risk factors, or interventions tend to be centered in urban areas when geographic variables are used at all. For these reasons and certainly others, prevalence of IPV in urban areas has historically been higher, or urban residence considered a risk factor for IPV (Bassuk, Dawson & Huntington, 2006). However, when rurality is specifically examined in studies, the available literature points to rates of IPV in rural areas that rival and sometimes

surpass those of metropolitan centers (Peek-Asa, Wallis, Harland, Beyer, Dickey & Saftlas [Peek-Asa et al.], 2011). Moreover, evidence from epidemiologic surveys as well as qualitative studies indicates that the severity of IPV experienced by rural women is greater (Annan, 2008; Peek-Asa et al., 2011). Lethality of IPV in rural areas where households are more likely to have guns (Shuman et al., 2008) or when the distance to health services for survivors prohibits or delays help-seeking (Peek-Asa et al., 2011; Van Hightower & Gorton, 1998) may have especially grave implications for women in rural communities.

### **1.2.1 Prevalence of Intimate Partner Violence in Rural Areas**

The Behavior Risk Factors Surveillance System (BRFSS), includes a module for IPV that was administered to respondents in 16 states in 2005 by the Centers for Disease Control and Prevention (CDC). Of the 25,000 rural respondents, 26.7% of women had experienced lifetime IPV victimization and 1.4% had been victimized by an intimate partner within the 12 months prior to the survey (Breiding, Ziembroski & Black, 2009). (These results were comparable to rates of IPV victimization in metropolitan areas.) The range of lifetime IPV victimization for rural women stretched from 20.9% in Nebraska to 40% in Nevada, and in Hawaii and Oregon, rural women experienced significantly higher rates of IPV than urban women in the same state (Ibid). The paucity of research on IPV specific to the rural context, particularly large-scale and population-based studies, has been noted (Breiding, Ziembroski & Black, 2009; Lanier & Maume, 2009; Van Hightower & Gorton, 1998; 2002). Smaller scale studies, state administrative data, and rural ethnographies currently provide the bulk of information on what researchers know about the dynamics of IPV outside of metropolitan areas.

Similar to the national level, information on violence against women within states is generally caught by administrative data from two camps: law enforcement statistics and state

coalitions against domestic and sexual violence. The former provides actual numbers of reported assaults, attempted and completed rape, and—via the state’s judicial and corrections systems—the number of perpetrators convicted of a crime (e.g. rape, aggravated assault) and the number of domestic violence orders of protection issued by courts within that state. Information is collected and stratified by county, so it is possible to compare rates between urban and rural counties using such data. However, the types of information vary from state to state, as do legal definitions of intimate and sexual violence. It is also generally acknowledged that criminal reports are not an ideal method of collecting and contextualizing data on IPV (Lanier & Maume, 2009). Intimate partner violence is frequently carried out in private, and under-reporting to the authorities is an unfortunate phenomenon (Tjaden & Thoennes, 2006) so statistics of violence against women provided by criminal justice systems likely underestimate the number of victims. For states with a mostly rural population, reporting to law enforcement may be further hampered by sheer lack of police officers (Websdale, 2002).

State coalitions and departments of health provide supplementary prevalence figures of IPV within that state by collecting administrative data from counties or domestic violence programs and shelters. For instance, the Missouri Coalition Against Domestic and Sexual Violence (MCADSV) reported that its member programs provided 43,370 IPV victims with shelter and/or services for IPV (e.g. case management, referrals, hospital and court advocacy) in 2011 (MCADSV, 2012). According to the same report, nearly 19,000 individuals seeking shelter were turned away due to overcrowding (MCADSV, 2012). Of course, these numbers represent indicated populations—that is, women who sought assistance for IPV or sexual assault from a shelter or MCADSV-affiliated agency—and do not necessarily mean that these women reported



their assault to authorities. Thus the number of women who experienced violence but did not seek help from a formal social services provider were not captured by these numbers.

The surveys mentioned above did not take into account the rural-urban continuum, did not include geographic variables, and did not examine differences by rural or metropolitan-area residency. Therefore, researchers studying rural IPV must depend on administrative data and other sources, such as reports from state coalitions or service providers, to extrapolate variance in prevalence rates between rural and urban areas. Unless these sources provide geographic information, it is very difficult to obtain reliable statistics on the prevalence of IPV in rural areas.

### **1.2.2 Rural Abuse Dynamics**

Most of the contextual information pointing to IPV severity in rural areas comes from a small body of ethnographies and qualitative research studies. Websdale (1995; 1998) in a widely cited work on IPV in rural eastern Kentucky, interviewed social workers at domestic violence shelters, law enforcement officers, community members, and survivors of IPV themselves to paint a picture of widespread violence against women and a near refusal on the part of the community to see IPV as a problem worth addressing. Certain unique dynamics of rural IPV that emerged from Websdale's ethnography have been supported by later qualitative work. The absence of helpful services, coupled with a lackluster state response (via the law enforcement and social services arm of the Kentucky government) characterized rural women's experience (Websdale, 1995)—literal geographic isolation (i.e. physical distance from neighbors, emergency responders, and other resources) that he found overlapped with the isolating tactics used by many abusive partners. Gun violence against women in this area was common; all the participants interviewed for Websdale's ethnography had been injured or threatened with a firearm (1995). These factors deepened the severity of the violence that the women experienced.

Undercurrents of the same run through Gagne's 1992 work with rural survivors in Appalachia, a project that took a very long time because the captive populations upon which many researchers depend to conduct IPV studies (i.e. formal domestic violence programs) simply did not exist in these isolated communities. There, the law enforcement understanding of and response to IPV was characterized by a hands-off approach—a feeling that quarrels between husband and wife were best left alone—or plagued by slow response times, due in part to the vast distances officers had to cover (Gagne, 1992). Reports of the hands-off mentality by law enforcement or first responders is scattered throughout studies of rural IPV. Finally, the extent of communal vigilance may be limited; a study participant quoted by Websdale (1995) summarized rural sentiment in this way: “Women couldn't leave the farms because they had no transportation of their own...Even if she did have transportation, a woman would not ask anyone for help, because the prevailing attitude held that she had made her bed and must lie in it” (p. 312).

The risk of severe violence is heightened in rural, remote areas. In a small rural community in Iowa, Murty and colleagues (Murty, Peek-Asa, Zwerling, Stromquist, Burmeister & Merchant [Murty et al.], 2003) found that 2.4% of its female residents had experienced severe physical IPV within the past year. (Severe physical violence as defined by the authors included choking, assault with a weapon, and rape.) The severity of this violence was compounded by the great distance to necessary medical, legal, and social services. As Peek-Asa and colleagues (2011) found in another study, over 25% of women in small rural towns and isolated areas lived more than 40 miles away from the nearest service provider, including health and social services. Moreover, rural women—because of the distance to help—may delay their escape from a violent relationship until their physical and emotional trauma becomes so severe that health problems begin to impede their activities of daily living. For example, a study of five domestic violence

shelters in rural Alabama uncovered high rates of sexually transmitted infections among 203 chronically physically and sexually abused women, with 33% of women acquiring an STI during their abusive relationship and 9.2% acquiring multiple STIs (Wingood, DiClemente & Raj, 2000).

While the lack or scarcity of necessary health and social services is exceedingly problematic for rural women, sociocultural factors can be equally as important for women's help seeking and safety when involved with an abusive partner. Comparing rural and urban battered women, again in Kentucky, researchers found that rural women were significantly, and dangerously, more likely than urban women to lack social support (a key protective factor across studies on IPV [Bogat, Levendosky & von Eye, 2005]), have a lower education, live in poverty, experience more physical abuse within the previous year, have experienced childhood physical and sexual abuse, be in poorer physical and mental health, and to be chronic, early victims of IPV (Logan, Walker, Cole, Ratliff & Leukefeld [Logan et al.], 2003).

Locke and Winship (2005), in a review of literature specific to rural areas, concluded that there was insufficient evidence to support a unique theory accounting for rurality in social work research. Thus there is not a cogent theory that would support disparate causes for battering in rural as opposed to urban areas. Risk factors for IPV are likely similar across these populations regardless of rural or urban setting, but the rural environment may shape the experience and aftermath of IPV in ways that differ from metropolitan locales. The historical and sociological factors as presented below may help explain the differential impact of rurality on IPV survivors.

### **Rural Culture**

The cultural makeup of rural areas is rich and varied; there is not one telltale or overriding cultural factor specific to rural areas that can explain IPV dynamics, prevalence, and

severity. Lohmann and Lohmann (2005) argue compellingly against what they see as the tendency of social scientists to view rural areas as whitewashed and homogeneous or rural inhabitants as passive and placid consumers of mainstream urban culture. “When you see one rural community, you’ve seen one rural community,” (Swanson & Brown, 2003, p. 397). Still, sociologists speculate that rural life is often characterized by greater adherence to traditional gender roles, conservative social and political values, and religion (Few, 2005; Lewis, 2003; Websdale, 1998). Ethnographies of life in rural areas tend toward familiar tropes: pastoral idyll masking poverty, or a powerful collective conscience that mistrusts outsiders, resents government intrusion, and carries an abiding distaste for bureaucracy (Few, 2005). Formal and informal social control mechanisms take on new meaning in a small or close-knit community. Where people tend to know or be related to each other, the social climate may be more personable and warm, but gossip and shame might also be more damaging (Lewis, 2003), especially for women who transgress cultural norms or mores typical of traditional gender roles.

Rural communities tend to be close-knit, with important social ties among nearby friends and family, and oftentimes, a collective sense of community among longtime residents (Ames, Brosi & Damiano-Teixeira, 2006), that can also be mistrustful or wary of outsiders (Websdale, 1998). This characteristic closeness can be a protective factor, in that it may suggest high levels of social support for IPV survivors<sup>4</sup>—one of the few consistent buffers for IPV found across many research studies (Bogat, Levendosky & von Eye, 2005). However, it also translates into a greater likelihood that someone in the process of responding to or providing care for the survivor will know the survivor herself, her abusive partner, or her family members, which all but erases

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<sup>4</sup> However, this social network may be small (Bushy, 1993), further underlining rural women’s vulnerability in the event that her limited social connections are not supportive or caring.

confidentiality (Annan, 2008), compromising a survivor's privacy and thus, her safety. Although rural service providers and first responders are probably not predisposed to breaches of confidentiality, the closer social networks of rural communities make it likely that someone—a physician, a dispatcher, a member of the ambulance crew, a police officer, court personnel, hospital staff, welfare caseworker, shelter staff—will know of the assault (Shuman et al., 2008). Survivors of IPV are undoubtedly aware of these close community ties and networks, and this knowledge makes it difficult for women to engage the authorities or other formal help systems (e.g. health care, social services, mental health counseling, faith-based services) (Few, 2005; Van Hightower & Gorton, 1998; Websdale, 1998) or to share their experiences with others informally (Annan, 2008).

A culture of gun ownership as personal liberty—stronger support for the right to bear arms, for example—is commonplace in many rural areas of the U.S. (Shuman, McCauley, Waltermaurer, Roche, Hollis, Gibbons, Dever, Jones & McNutt, 2008). There are more guns per capita in rural areas than in urban areas, likely due to a greater percentage of hunters and gamesmen. Gun ownership carries with it potentially grave consequences for women in violent relationships, as it exponentially increases severity and lethality of abuse. A gun in the home is linked to a five-fold increase in risk of homicide (Annan, 2008). The mere presence of a firearm may also be a powerful coercive tactic; simply reminding a woman that the gun is there and can be used against her was an extremely effective manipulative technique often employed by abusive men in Websdale's ethnography of rural eastern Kentucky (1998).

### **Isolation**

Rural life carries with it pleasures and challenges distinct from metropolitan or city living. In many ways, characteristics of rurality such as seclusion, privacy, or distance from the

nearest neighbor are desirable features of life in the country. Unfortunately, the same positive qualities that may distinguish rural from urban residence—more land, fewer and simpler amenities, a closer social circle, perhaps a slower pace of life (Lewis, 2003; Lohmann & Lohmann, 2005)—may also intensify the experience of IPV. A current running through the majority of studies that have concentrated on rural IPV, or compared IPV in rural and urban areas, is isolation, a geographic and sociocultural marker explaining the seemingly greater severity of rural IPV. Bouffard and Muftic (2006) describe the role of isolation in terms of the culture of violence in rural areas, highlighting the ties between concentrated poverty and population density. When economic hardship is the norm, and the community is spatially isolated or distant from others, the connections to other institutions, resources, people, and even ideas are limited. Isolation in and of itself does not cause violence, but it certainly colors the experience of it; furthermore, a number of practical considerations for survivors, first responders, social services, and health care workers, stem from the sheer distance between people.

Isolation has also been described in the violence against women literature as a tactic frequently employed by abusers to keep their partners dependent on them and to lessen opportunities for the survivor to tell someone else about the abuse (Follingstad, Rutledge, Berg, Hause & Polek, 1990). It is likely that each of these concepts of isolation—the physical or geographic distance from others, isolation as a lack of exposure to other experiences and ideas as described by Bouffard and Muftic (2006), and isolation as part of the dynamics of IPV—are all bound together in the rural experience of IPV. For the purposes of this dissertation, the term will be used throughout in its most literal sense, that is, geographic distance or physical isolation from people and services.

## Poverty

Economic hardships are common in rural settings. Rural household incomes tend to be low (Stommes & Brown, 2002); some 17% of people living outside metropolitan areas lived below the poverty line in 2010 (Census Bureau, 2011). It is difficult to discuss job opportunities without also mentioning education, which is strongly associated with job attainment and income level. Education level, including high school as well as two- and four-year college degrees, is persistently lower in rural areas than urban (Stelmach, 2011). Data from the 2011 American Community Survey (ACS) reveal that the percentage of persons over age 25 without a high school diploma ranges from 28-53% in rural areas. Low levels of education often translate into fewer or lower-paying jobs. Limited job opportunities in rural areas necessitate longer commutes for work (Blakely & Locke, 2005), and there is a greater tendency for such work to be seasonal, service, or laborer jobs, especially in agricultural communities. Long commutes to work may present a problem for women in abusive relationships; Websdale (1995) found that the necessity of a having access to a vehicle for work often meant that women either did not work or were left at home while their abuser, who was usually the breadwinner, took the family's only car to work. Multiple jobs are also common in rural areas, in order to piece together an income to keep a family afloat (Ames, Brosi & Damiano-Teixeira, 2006). Poverty or limited economic opportunities, coupled with transportation and other infrastructural barriers, may mean that women are less likely to report an assault to authorities because they are worried about paying a hospital bill or missing time from work for court appearances; however, to date there are no studies of rural IPV survivors that have specifically examined this relationship (Annan, 2008).

The detrimental effects of poverty are particularly troubling in light of recent population trends in rural areas. Rural inhabitants tend to be older, and as people age, their need for medical

care increases. Access to health care and a timely medical personnel response is thus very important for the elderly, and it has already been established that infrastructure barriers (related to existence of and distance to services, as well as the transportation problem) present rural communities with great challenges (Locke & Winship, 2005). Steadily draining rural populations in many parts of the country, particularly the Great Plains states, pose additional problems for already-low tax bases to fund public services. The most recent census saw a growth in “frontier counties”, a Census Bureau designation for classifying population density of less than six persons per square mile (National Rural Health Association, 2011), as well as those labeled persistently poor (Locke & Winship, 2005). These shifts in and of themselves do not cause IPV, but they form part of the rural landscape that directly impact women’s ability to access services for IPV and indirectly impact gender relations in rural areas (e.g. no tax base for a police department to respond to domestic disturbances).

### **1.2.3 Rural Women’s Health**

In addition to the poorer overall health status of women experiencing IPV, rural women tend to have poorer health and difficulties accessing the same level of care for their health than do urban women. Rural residents generally “smoke more, exercise less, have less nutritional diets” and are more likely to be obese than urban or suburban dwellers (Hartley, 2004, p. 1676). Cardiovascular disease, diabetes, tobacco use, mortality, and infant mortality are greater in rural areas (Hartley, 2004), problems compounded by the sparse primary and preventive care available and/or utilized by rural residents (ACOG, 2009; Vondracek, Coward, Davis, Gold, Smicklas-Wright & Thorndyke [Vondracek et al.], 2006). Despite these startling figures, very few studies of IPV effects on health have considered rural residency a risk factor, or included this important environmental information in their analyses (Annan, 2008). Very generally, however, rural



women suffer from poorer health compounded by the lack of access to basic health services. Some of the major health disparities between rural and urban women's health are noted below.

Rural women experience higher rates of injury and vehicle-related deaths, suicide, obesity, tobacco use, and limitation of other activities caused by chronic health conditions (National Center for Health Statistics, 2007). The incidence of cervical cancer is higher among rural women than urban women (Bernard, Coughlin, Thompson & Richardson, 2007). In some regions of the country, rates of heart disease and substance abuse (especially heavy alcohol consumption) are higher among rural women than urban women (Chandra, Martinez, Mosher, Abma & Jones, 2005). Proportionally fewer rural women receive recommended preventive services such as mammogram, Pap test, and cervical cancer screenings; however, only mammograms remain significant when socioeconomic status is controlled for (ACOG, 2009). Rural women receive fewer family planning services, inadequate or late pre-natal care, and less all-around maternity care, evidenced by higher teen pregnancy rates, higher infant mortality rates, and lower infant birth weights (ACOG, 2009).

In general, rural residents are more likely to be poor, uninsured, and to rely on Medicaid or Medicare for their insurance (National Center for Health Statistics, 2007). They must also travel farther for health care and have greater difficulty accessing a range of additional health services, including basic dental and mental health services (Colwill & Cultice, 2003). Obstetric care and family planning services (especially access to abortion services and emergency contraception) are especially limited in rural areas (ACOG, 2009).

### **1.3 Study Setting: Rural Missouri**

Located in the southern Midwest region of the United States, Missouri's rural population copes with the socioeconomic and health disparities roughly typical of rural areas as a whole.

Although nearly 90% of Missouri land is located within rural counties, only 37% of Missouri's population can be classified as rural (Census Bureau, 2013). The rural poverty rate is 18.8% compared to 14% urban (Rural Assistance Center, 2013). For children under the age of 18, the rural-urban divide is even starker, with 25.3% of rural children living at or below the poverty rate (Missouri Department of Health & Senior Services [MODHSS], 2011). Rural Missourians are significantly less likely than their urban peers to have health insurance, obtain a college degree, and earn less income for similar work (MODHSS, 2011).

Health resources such as hospitals, full-time physicians, and dentists are relatively scarce in rural Missouri. A mere 18% of the state's primary care physicians practice in rural areas (Kaiser, 2010; MODHSS, 2011), with 29 counties qualifying as a Health Professional Shortage Area (meaning a ratio of one physician to 3,500 persons) (MODHSS, 2011). Life expectancy at birth is lower in rural areas than urban, and the mortality rate from all causes of death in Missouri's rural counties, at 905 deaths per 100,000 residents, exceeds that of urban counties, at 840 deaths per 100,000 residents (Kaiser, 2010; MODHSS, 2011).

The backdrop of economic and health disparities in rural Missouri colors the experience of IPV. Over 36% of women in Missouri have experienced physical, sexual, and/or stalking violence by an intimate partner, slightly above the national average of 35.6% (NISVS, 2011). The need for services is urgent, as demonstrated by call volume to Missouri's crisis hotline, ranked 15<sup>th</sup> busiest in the nation: on any given day in 2011, over 500 individuals placed a hotline call, and 68% of them reported IPV victimization (Missouri Coalition Against Domestic & Sexual Violence [MCADSV], 2012a). Overcrowded shelters throughout the state were forced to turn away 19,000 women and children in that same year (MCADSV, 2012b).

## 1.4 Chapter Summary

The detrimental impact of IPV on women's health, as well as its tremendous health care costs, points to the need for integrative approaches to addressing the problem. Social workers have an ethical mandate to provide effective, culturally competent care to their clients and to engage in fruitful interdisciplinary collaboration when possible. By virtue of their education, social workers are well positioned to understand the social determinants of health and the multiple interlocking systems of oppression that influence people's lives, including IPV. Bywaters (2009) has called for greater social work research involvement in health-related disciplines overall, noting the linkages between health disparities, disease, and larger social problems related to racial, gender, and economic inequalities. Rural areas in particular grapple with many disparities in health and access to health care, pointing to an urgent need for social work involvement overall. The rural health care system's response to IPV is therefore an issue of concern to social workers with implications that reach health care providers, social workers, and survivors of IPV.

# **Chapter 2: Theory, Research Aims, and Study Description**

Consensus is growing within public health, and among health care providers in particular, that assessing and responding to IPV should be an essential element of women's primary health care. Despite recommendations to implement routine IPV screening and treatment in primary health care settings, it appears that such practices take place sporadically if at all (Coker, Smith, Whitaker, Le, Crawford & Flerx [Coker et al.], 2012). Yet health care providers have the potential to be an important resource for the prevention and treatment of IPV. Their potential may be amplified in rural areas, where community-based resources and traditional social services for survivors are scarce, and barriers specific to the rural setting prevent many survivors from accessing helpful services. This chapter will discuss conceptual issues and practical considerations related to addressing IPV within the health care setting, as well as the influence of the rural environment on health care providers' response to IPV and survivors' decisions to seek help from an outside source such as a health care provider. The chapter will close with a description of the study's purpose, research aims and questions arising from the issues discussed, the constructs explored in this research, and the research design.

## **2.1 Health Care Settings and Intimate Partner Violence**

According to Campbell (1998), health care professionals in all settings and practice areas have an important role to play in creating an "empowerment zone" for women (p. 3). This empowerment zone has been conceptualized as trauma-informed clinical practice that works from an understanding of the prevalence, risk factors, and dynamics of IPV, "including the notion that IPV can be thought of as chronic traumatization" (Ford-Gilboe, Varcoe, Wuest &

Merritt-Gray [Ford-Gilboe et al.], 2010, p. 115). Examples of such practice might include universal assessment for abuse during clinic visits, advocacy and counseling offered on-site following any disclosures of abuse, awareness of community resources for survivors, recognition of risk factors for IPV and its associated health outcomes, and a caring, empowering clinic atmosphere that aims to minimize the potential for re-traumatizing patients who may be experiencing abuse. Despite a substantial body of theory and research on which to base trauma-informed clinical care, comprehensive approaches for addressing IPV and its numerous health consequences have yet to be widely integrated into health care systems (Ford-Gilboe et al., 2010; Ulrich & Stockdale, 2002). Responding to IPV following disclosure in a health care setting is left to the discretion of the individual physician, and only a handful of studies have proposed or tested interventions at primary health clinics (Coker et al., 2012; Wathen & McMillan, 2003). In fact, Wathen and McMillan (2003) found that most studies claiming to test a clinic-based intervention for IPV merely examined whether physicians screened for IPV and did not report on specific treatment protocols for responding to IPV in the event of a positive screen.

### **2.1.1 Barriers to Health Care Providers' Screening for Intimate Partner Violence**

The rural setting presents several unique challenges to integrating IPV-informed practices into health care clinics. First, there is a dearth of research on IPV specific to the rural context in general, and large-scale and population-based studies focusing on rural women are nearly absent from the health and social sciences literature (Breiding, Ziembroski & Black, 2009; Lanier & Maume, 2009). There is also a lack of services for women, such as domestic violence programs (Peek-Asa et al., 2011) and primary health care providers (American College of Obstetricians & Gynecologists, 2009; Ulrich & Stockdale, 2002). As noted in the previous chapter, rural residency is associated with greater disparities in women's health, including higher rates of

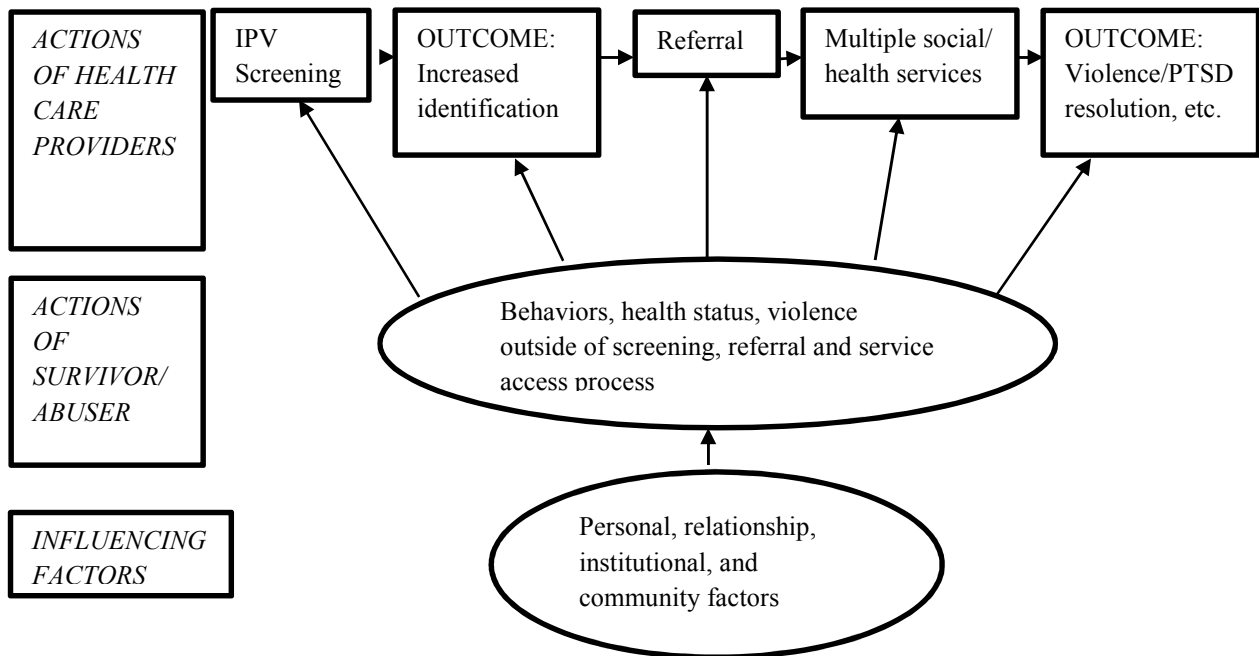
suicide, heart disease, and cervical cancer, and rural women are proportionally less likely than urban women to receive preventive and specialized health care (ACOG, 2009). Health services may be spread out over a large catchment area, translating to lengthy travel times for clinic visits—and necessitating the use of a vehicle, as reliable public transportation is nonexistent in many rural regions (Stommes & Brown, 2002). Distance also lengthens an emergency medical unit's response time when acute care is required following an IPV-related injury. Additionally, rural women often perceive a lack of confidentiality surrounding health care delivery (Annan, 2008; Ulrich & Stockdale, 2002). Closer social networks and small communities make it likely that health care providers or their ancillary staff will know the survivor or her batterer personally. Websdale (1998) found that rural women felt particularly vulnerable at hospital emergency rooms, where they feared a lack of anonymity among staff or other patients would mean the perpetrator would discover that she had disclosed the abuse to others, thus inviting retaliation. Finally, there may be a tendency on the part of rural health care providers to overlook signs of abuse, or refrain from asking about abuse (Ulrich & Stockdale, 2002). Websdale (1998) found that physicians in rural Kentucky appeared to be unfamiliar with the dynamics of IPV. In another statewide study all 240 clinicians surveyed were more comfortable discussing smoking and alcohol use than IPV (Sugg et al., 1999). Many physicians cite a lack of effective interventions for IPV once the abuse was identified by the provider, forestalling preemptive screening for IPV (Waalén et al., 2000).

### **Conceptual Issues Related To Addressing IPV in Health Care**

Previous studies have suggested that the implementation of routine screening procedures and protocols for response should be evaluated according to how well these actions reduce IPV (Wathen & MacMillan, 2003). However, the complex nature of IPV and the multiple steps

between screening and resolution of abuse mean that a change or reduction in IPV may not be the most appropriate outcome for screening (O’Campo, Kirst, Tsamis, Chambers & Ahmad [O’Campo et al.], 2011). Figure 2.1.1 demonstrates the complexity of the screening, referral, and problem resolution process, wherein a host of ecological factors (personal, relationship, community, and institutional) as well as the unique relationship of the survivor to her perpetrator, ultimately influence what actions health care providers take. These factors may influence not only the decision to screen for IPV but firstly, how a health care provider responds once IPV has been disclosed or diagnosed, and secondly, the overall purpose or aim of this response (e.g. to end the abusive relationship, to address a specific patient concern, to address mental health problems, or something else).

**Figure 2.1.1 Complexity of the Screening, Referral, and Problem Resolution Process**



*O’Campo et al. (2011). “Complexity of the Screening, Referral, and Problem Resolution Process.”*

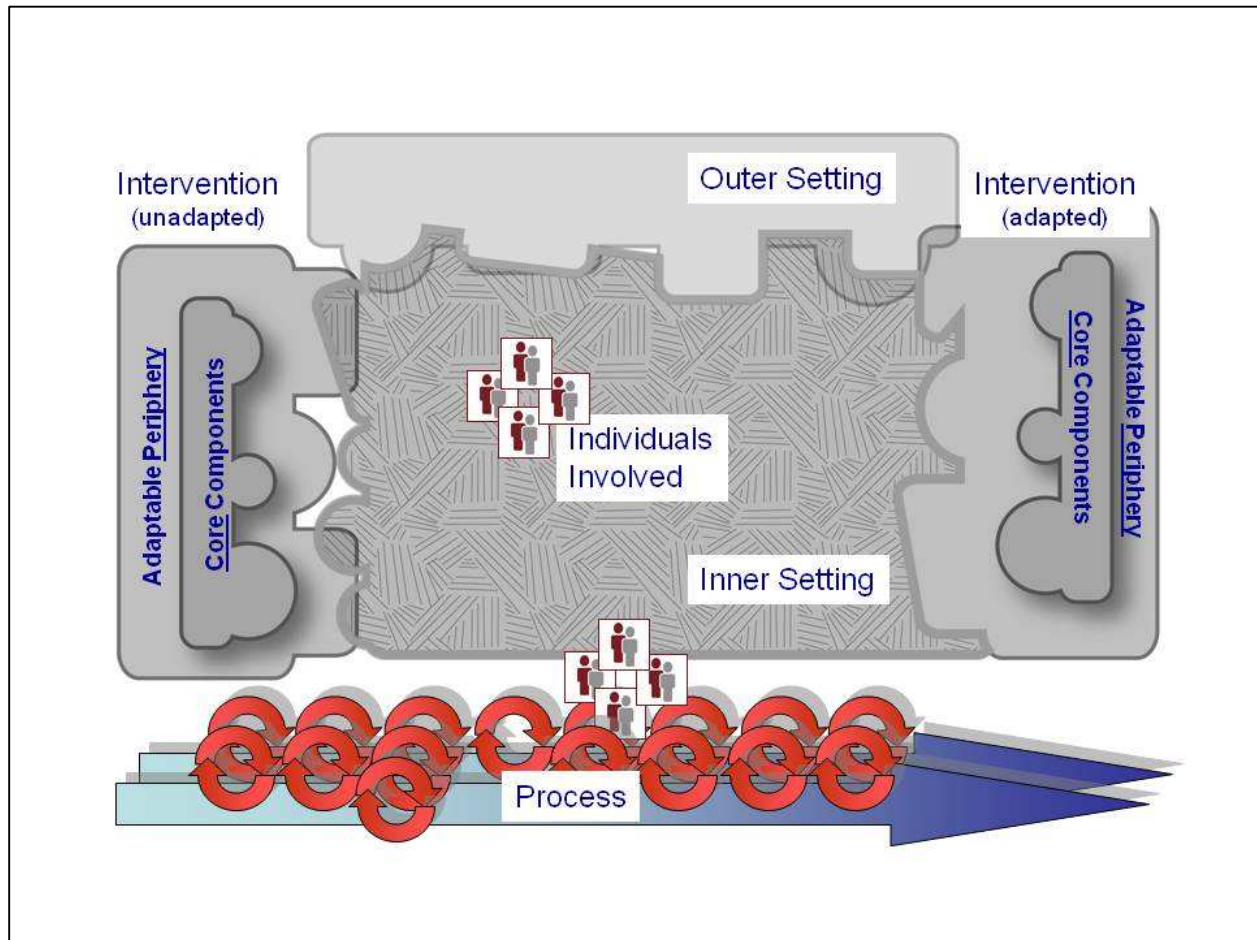
As the awareness of IPV, and health care providers’ role in detecting it, has increased, screening for abuse during routine and emergency patient exams has become more commonplace

yet not universal. Screening for IPV is a relatively new practice in the health care field, and as with many new practices it has met barriers to successful and complete implementation in many settings (MacMillan, Wathen, Jamieson, Boyle, McNutt, Worster, Lent, Webb & McMaster, 2009). One useful model that may aid understanding of the processes associated with integrating IPV screening and response practices into health care settings is the Consolidated Framework for Implementation Research (CFIR), developed by Damschroder and colleagues (2009). The CFIR is composed of five major domains including intervention characteristics, outer setting, inner setting, characteristics of the individuals involved in the implementation, and the process of implementation. Because interventions are often “complex, multifaceted, and have many interacting components” (Damschroder et al., 2009, suppl. p. 3), the CFIR is depicted by an irregular shape reminiscent of a cell (the inner and outer setting, the organization, and the individuals involved in carrying out the intervention) and external organism (the intervention, its core components, and the process of implementation). Each of these constructs involves a synthesis of existing theories from implementation science in the health care field, implicitly suggesting that researchers select which constructs are most helpful in their particular study setting. As such the CFIR is considered a meta-theoretical model and does not specify hypotheses or interrelationships between constructs; rather, it provides a framework for “what works where and why” (Damschroder et al., 2009, suppl. p. 2). Figure 2.1.2 provides a visual of the CFIR process of implementation: the un-adapted intervention moving through the process of modifications that are required to fit the intervention to a particular organization or setting. Spirals at the bottom of the figure represent the ongoing and iterative process of implementation science. For the purposes of this study, the “outer setting” is defined as the state of Missouri, and



the inner setting is the clinic itself. Providers' practices regarding IPV as well as the rural community context in which they work are thus filtered through these settings.

**Figure 2.1.2. Consolidated Framework for Implementation Research (CFIR)**



*Damschroder et al., 2009, suppl. p. 2. "Consolidated Framework for Implementation Research."*

Building from O'Campo and colleagues' (2011) portrayal of the complexities of the screening process and the basic CFIR model, conceptual issues related to addressing IPV in the health care settings may be loosely gathered into three areas: individual characteristics of the provider, specific community and organizational factors, and the broader setting in which the provider-patient encounter occurs. Figure 2.3.1.1 depicts the study's constructs regarding health care providers' practices concerning IPV juxtaposed onto these CFIR domains.

## Practical Issues Related To Addressing IPV in Health Care Settings

A number of studies using both survey and interview methods have revealed common barriers to addressing IPV in the primary health care setting. Often these problems stem from an overall reluctance to broach the subject with patients (Sugg et al., 1999). The reasons for this discomfort are frequently related to the provider's lack of education or expertise in the area of IPV. In a statewide survey of family medicine practitioners, Lapidus and colleagues (2002) found that prior training in IPV was the strongest predictor of routine IPV screening. Attitudes about IPV may also inhibit or facilitate screening for IPV—some providers may feel as though it is not their responsibility to ask about a social problem such as IPV, or may hold a bias against victims, especially when women repeatedly return to their abuser (Warshaw, 1993; Thurston, Cory & Scott, 1998). Other studies have found no link between providers' attitudes and their uptake of screening for IPV (Coker et al., 2012). Fear of offending the patient with questions about IPV is another reason physicians might forgo routine assessment (Lapidus, Cooke, Gelven, Sherman, Duncan & Banco, 2002; McNutt, Carlson, Persaud & Postmus, 2002; Sugg, Thompson, Thompson, Maiuro & Rivara, 1999). Yet several studies have since revealed that a majority of women, abused and non-abused alike, favor routine IPV screening by their primary care providers (Arias, Lynberg, Simon, Kresnow & Shelley, 2004; Coker et al., 2012; Nelson, Bougatsos & Blazina, 2012).<sup>5</sup>

The larger barrier facing primary care providers who assess for IPV is what practical steps should be taken to address the issue following disclosure of abuse. Between 60-90% of physicians cite “lack of effective/appropriate resources” for women experiencing IPV as the

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<sup>5</sup> Barriers citing discomfort or fear of offending the patient are smokescreens according to Flicraft, whose 1993 article reminded her public health audience that physicians discuss many potentially discomfiting health- and behavior-related issues with their patients, such as weight management, alcohol and drug use, and sexually transmitted infections.

primary reason why they do not routinely assess for it (Coker et al., 2012; Waalen et al., 2000). Few in-clinic interventions have been developed and evaluated, and while it is likely that most clinics have some protocol in place to handle situations when IPV is disclosed, these practices have not been made available in the professional literature (Coker et al., 2012). Indeed, few evidence-based interventions for IPV survivors exist at all (Wathen & McMillan, 2003), so providers may be justifiably reluctant to refer a patient to a community based resource that has no proof of effectiveness.

The scarcity of community-based resources for IPV survivors in rural areas compounds this problem. One study found that urban physicians were nearly twice as likely as their rural counterparts to routinely assess for IPV in their practice (Lapidus et al., 2002). This disparity may arise from the simple fact that urban communities have more comprehensive support systems in place for women experiencing abuse. However, rural women themselves are reticent to access many existing social services for IPV, such as domestic violence shelters. Macy and colleagues (2009) have estimated that merely 10-15% of ever-abused women seek shelter, and rural women consistently perceive shelters to be less helpful at meeting their needs than do urban women (Few, 2005; Shannon, Logan, Cole & Medley [Shannon et al.], 2006). Rural domestic violence providers in eastern Kentucky estimated that the majority of abused rural women would not seek services due to ingrained social and cultural norms that stigmatized survivors (Websdale, 1995). Often survivors perceive a lack of fit between shelter policy and survivor needs (Shannon et al., 2006). For instance, shelters willing to accommodate LGBT individuals, women with older teenage sons, women with disabilities, women with severe mental illness, women with substance abuse problems, and non-English-speaking women are still uncommon in

many cities, and may be all but nonexistent in rural regions. All of these issues complicate the provider's response to IPV.

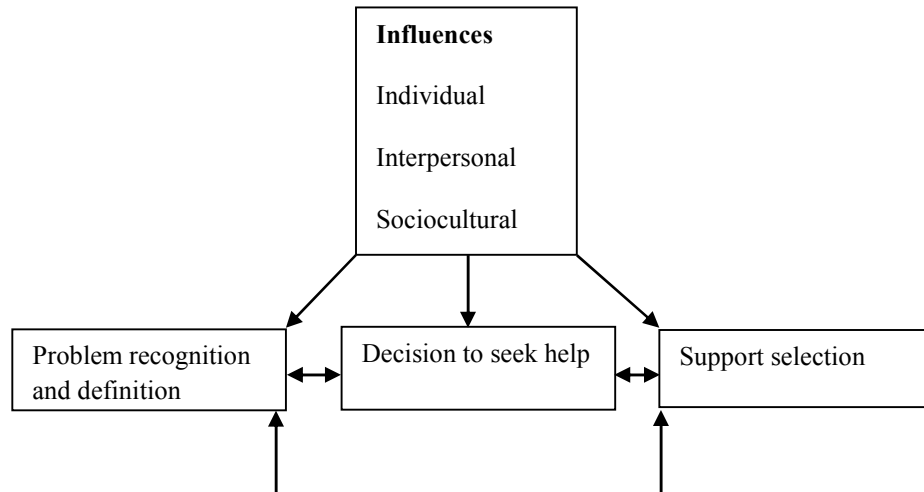
## **2.2 Help-seeking by Rural Survivors**

Chief among the observations from rural surveys and ethnographies on IPV is the potentially greater severity of IPV, caused or exacerbated by a shortage of services (Iyengar & Sabik, 2009), isolation from medical and social supports (Peek-Asa et al., 2011), and a cultural milieu of law enforcement and community members that often do not understand how to respond to IPV (Lehrner & Allen, 2009; Van Hightower & Gorton, 1998; 2002). In light of these findings, the help-seeking behaviors of rural women are all the more important to understand so that an appropriate response can be formed. There is some reason to suggest that rural women, due to a variety of the social and cultural factors previously discussed, delay help-seeking (Nurius, Macy, Nwabuzor & Holt, 2010), find available social services less helpful than urban women (Krishnan, Hilbert & Vanleeuwen, 2001), or never seek help at all because they are unaware such help exists (Annan, 2008; Websdale, 1995).

The decision of whether to seek help for a problem such as IPV, and from whom, is a complex one for many rural survivors (Krishnan, Hilbert & VanLeeuwen, 2001). Socio-ecological factors such as the acceptability of violence within relationships, predominant cultural norms or religious values, and the scarcity of resources for survivors in rural areas also determine whether women decide to utilize formal systems of care (Logan, Walker, Cole, Ratliff & Leukefeld, 2003). While barriers to help, or disparities in access to help, have been widely noted in the literature on rural IPV (Annan, 2008), the processes by which rural women conceptualize their abuse experience, sum the resilience to seek help, and decide which, if any, actions to take to resolve their situation, are unknown. Liang and colleagues have theorized that help-seeking

for a survivor is a cognitive process that involves three decision-making steps: defining the problem, deciding to seek help, and selecting a source of support (Liang, Goodman, Tummala-Narra & Weintraub [Liang et al.], 2005). Sources of support may be formal or informal, concrete or emotional (Liang et al., 2005), as exemplified in Figure 2.2.

**Figure 2.2 Conceptual Model of Help-seeking**



*Liang et al. (2005). "Figure 1. A model of help-seeking and change."*

The role of external actors, including health care providers, in influencing each of the decision-making steps described above may be meaningful for survivors (Liang et al., 2005; Shannon et al., 2006). The identification of IPV by rural health care providers becomes especially significant considering the noted absence of, or barriers to, the types of formal and informal support mechanisms typically utilized by survivors in other contexts. Most rural women do not seek shelter following abuse (Shannon et al., 2006)—but many rural women do have contact with a physician at some point in their lives, especially if they have children (American College of Obstetricians & Gynecologists, 2009). While health services are also scarcer in rural areas than urban settings (Kaiser, 2013), social services for IPV survivors such as domestic

violence programs tend to be scarcer still (Peek-Asa et al., 2011). Rural health care providers may be an important point of contact for IPV survivors insofar as identifying the occurrence of abuse. Providers may be able to respond to abuse disclosure with a safety plan or assist the survivor in locating or accessing additional helping resources.

When surveyed, the majority of women have supported routine screening for IPV at their health care provider's office (Ford-Gilboe et al., 2010; Gielen et al., 2000). However, these studies have not used rural samples, have not included survivors who have disclosed their abuse in a health care setting in their surveys, and have not examined whether the clinic's IPV treatment protocol was perceived as helpful or efficacious by the survivors. Rural health providers and their patients who are survivors of IPV therefore have much to tell researchers as well as health and social service practitioners about perceptions, practices, and the utility of these practices in effectively responding to the needs of rural women.

### **2.3 Major Study Constructs and Conceptual Model**

The issues described above and in the previous chapter point to several domains that form the core of this dissertation research, and can be summarized as follows: 1) an overall lack of information regarding the perspectives and practices of rural health care providers with regard to IPV, 2) a lack of information on the prevention and treatment protocols for IPV currently in use by rural health care providers, and 3) whether rural women receiving services at these health care sites find such treatment helpful in overcoming abuse. Each of these areas represents a substantial gap in knowledge that affects research and practice on IPV. The purpose of this dissertation research is to begin filling these knowledge gaps in order to overcome the current discrepancy between policy recommendations and practice reality. An understanding of the issues listed above will provide a foundation for the development of future strategies for

addressing IPV in health care settings. The implementation of IPV-informed practices in health care settings may be especially significant for rural women, who face unique health disparities and numerous practical and social barriers to accessing traditional services for survivors. Although this study does not directly compare rural areas with urban, the paucity of literature specific to rural IPV and rural health care in general indicate the need to explore these issues in a rural setting.

Therefore the main objective of this study is to understand how the perspectives (personal, organizational, and community factors) and practices (behaviors and practice issues) of primary care providers toward IPV affect survivors' experiences during and after the provider-patient encounter in rural health clinics. A secondary objective of the study is to describe the influence of the rural setting on provider practices and survivor experiences following disclosure of abuse in a rural health clinic.

Research Aim 1. To examine what practices concerning intimate partner violence screening and response, if any, are used by primary health care providers at health clinics in rural Missouri.

Research Question 1. How do rural primary health care providers respond to IPV identification and/or disclosure?

Research Aim 2. To understand the personal, organizational, and community factors that influence the perspectives of primary care providers toward screening and responding to IPV at health clinics in rural Missouri.

Research Question 2. What personal, organizational, and community factors influence the way rural health care providers screen and respond to IPV?

Research Aim 3. To understand the experiences of survivors of IPV concerning providers' responses, quality of care received, and self-reported outcomes following disclosure of IPV at health clinics in rural Missouri.

Research Question 3. How do survivors of IPV perceive the response by rural primary health care providers to detection of abuse?

Research Aim 4. To understand the overall impact of the rural setting on providers' perspectives and practices, and survivors' experiences, regarding IPV disclosure at health clinics in rural Missouri.

Research Question 4. How do characteristics of the rural setting influence health care providers' practices and survivors' experiences with health care providers at health clinics in rural Missouri?

### **2.3.1 Conceptual Framework and Definition of Major Constructs**

Figure 2.3.1 provides a visual depiction of the major constructs under examination in this study, as well as the possible relationships between these constructs. Note that arrows do not indicate hypotheses in this exploratory study, but instead indicate conceptual linkages between the constructs described in this section.

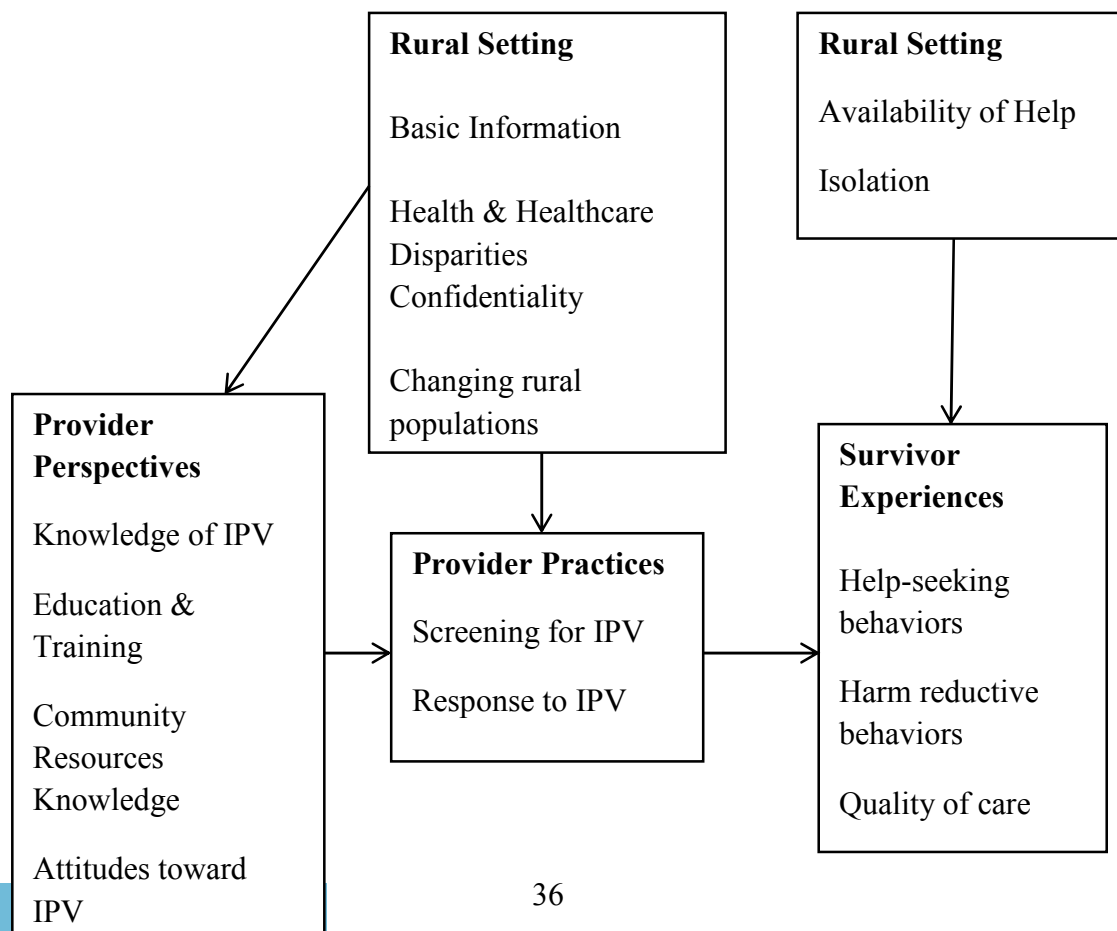
Provider Practices. Provider practices include the specific actions taken by a health care provider to determine whether a patient is experiencing IPV and how the provider responds if such a determination is made. Such practices may include whether or not a health care provider chooses to screen a patient for IPV and under what circumstances the screening would be done.

*Screening for IPV:* This construct is defined as the presence or absence of screening practices, and the circumstances in which health care providers screen their female



patients for IPV. Universal screening as recommended by the U.S. Preventive Services Task Force and described by Liebschutz and Rothman (2012) is defined as direct questions about intimate partner victimization asked of all female patients over the age of 12 during each visit. Selective screening as defined by Garcia-Moreno (2002) are direct questions about intimate partner victimization during circumstances in which the health care provider has reason to suspect IPV, including screening when the presenting health complaint is an injury (bruise, laceration) or an ongoing problem frequently associated with IPV (depression, chronic pelvic pain). Other health care providers may screen only during certain occasions, such as during new patient intakes or among certain groups of women only.

**Figure 2.3.1 Constructs and Relationships to Explore**



*Response to IPV:* The health care provider’s response to IPV is conceptualized as the actions following a patient’s disclosure of abuse—whether or not the disclosure was elicited by the provider or voluntarily supplied. The evidence base recommending specific actions or interventions on the part of the health care provider is very slim (Coker et al., 2012; Wathen & MacMillan, 2003). Health care providers’ responses have previously included referrals to community resources, patient counseling, and reporting of abuse to the authorities. “Response to IPV” thus includes the actions taken by the provider following determination of abuse and the frequency with which a provider undertakes certain actions following the identification or disclosure of abuse.

Provider Perspectives. Provider perspectives include the individual physician’s overall knowledge of IPV and its implications for women’s health, the amount and type of training about IPV they have received, their familiarity with community resources available to survivors of IPV, attitudes and opinions about IPV and IPV survivors, and organizational and community factors that may influence the provider’s decision to screen and their response.

*Knowledge:* General knowledge about IPV includes familiarity with common risk factors for victimization, reasons why women may choose to remain in abusive relationships, and a grasp of batterer behavior. Health care providers may also possess more specific knowledge about IPV, such as health-related implications and injury patterns common among women experiencing IPV.

*Education and Training:* Several studies have shown that health care providers with previous education or specific training about IPV dynamics led to an increase in routine screening (Coker et al., 2012; Garcia-Moreno, 2002; Gutmanis et al., 2007). Other studies

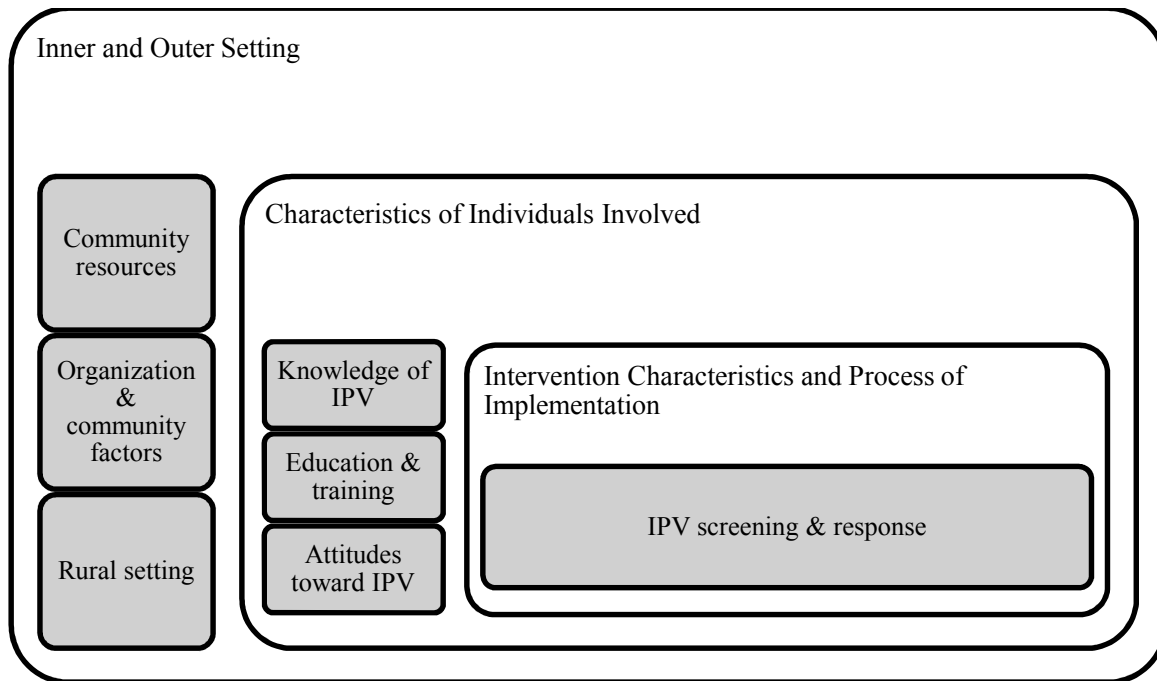
have found that, in addition to education, discipline determines whether a provider addresses IPV (e.g. nurses were more likely to routinely assess and refer patients than physicians) (Gutmanis et al., 2007; Klevens et al., 2012). Provider demographic information on education and the number of hours of training specific to IPV they have received constitutes their education and training.

*Community Resources Knowledge:* Several studies have shown that a major frustration of health care providers is the lack of effective interventions where survivors of IPV can be referred following the clinic visit (Waelen et al., 2000; Wathen & MacMillan, 2003). In addition, one statewide study on the East Coast found that rural physicians were less likely than their urban counterparts to screen for IPV, citing the lack of available resources in the area for follow-up care (Lapidus et al., 2002). Knowledge of community resources—what is available in the area and what would be accessible to the survivor—may predict whether a health care provider initiates conversations about IPV with patients.

*Attitudes toward IPV:* Theoretical work on addressing IPV in the health care system has focused on the attitudes and beliefs of health care providers as a potential barrier or facilitator toward addressing IPV (Warshaw, 1993; Thurston, Cory & Scott, 1998). The health sciences literature has not consistently illustrated whether these theories hold true (Coker et al., 2012), especially for rural health care providers. Personal comfort level discussing IPV with patients, attitudes about women and survivors of IPV, and opinions on providers' responsibility for responding to IPV (Warshaw, 1993) may all be important factors in a provider's decisions to screen and respond to IPV.

*Organizational and Community Factors:* Structural factors unique to the workplace, community, or state where the provider is employed may affect their screening and response to IPV (Thurston, Cory & Scott, 1998). The clinic staff size and the number of patients seen each week may affect the amount of time a provider has with each patient, thus influencing their decision whether to initiate a conversation about abuse. Existing protocols for managing IPV, such as workplace guidelines, adequate community referrals on hand, and state requirements about mandated reporting of abuse (including IPV, elder abuse, and child abuse) are other factors that may determine whether or not a provider screens for IPV.

**Figure 2.3.1.1 Provider Perspectives Constructs Juxtaposed onto CFIR**



Survivor Experiences. A survivor’s experiences are encapsulated within the unique story, personal circumstances, and rural milieu in which she lives. The decision to disclose her abuse to a primary care provider, whether the disclosure was voluntary or elicited by the provider, and how the provider responded to her are important aspects of this experience. These factors may

determine whether a survivor decides to seek help elsewhere and may influence her decision to engage in self-protective behaviors, such as safety planning. Few studies have examined the survivor's perception of treatment received by primary health care providers (an exception being McNutt and colleagues' 2000 survey of African-American survivors at an urban hospital center).

*Help-seeking Behaviors:* The decision to seek help for IPV is fraught with difficulty for many survivors (Few, 2005) and may be complicated by matters of race, class, age, sexual orientation, language, insurance status, and many other factors (see Figure 2-2). This construct aims to gather the reasons survivors have for speaking with their health care provider about IPV, whether the conversation was initiated by the survivor or the provider, and other factors seen as relevant to the disclosure of abuse as listed by the survivor.

*Harm Reductive Behaviors:* Harm reductive behaviors are here conceptualized as the survivor's utilization of any community resources or referrals offered by the primary care provider following her disclosure of abuse (e.g. counseling, police report, shelter), but also include any actions taken by the survivor independently as a means of increasing her safety. Such actions will likely be unique for each survivor and may reflect the community resources available to her as well as personal support networks. Any effort toward safety planning as defined by the survivor, utilization of formal or informal helping resources and ending the abusive relationship will be included as evidence of a survivor's harm reductive behaviors. Behaviors influenced by the interaction with the health care provider will be especially relevant for the purposes of this study and will be explored in depth as they arise from interviews with survivors.

*Quality of Care:* This construct focuses on the survivor's perception of the health care provider's response to her disclosure of abuse. The survivor's perceptions about the helpfulness of the encounter and any actions taken by the provider, as well as her feelings about the conversation with the provider, will be explored. Additionally, the helpfulness and appropriateness of resources offered, as well as any follow-up contact the survivor had with the health care provider, may provide important information on the quality of care (and variability of care) a survivor received. While several studies have asked whether survivors find screening by a health care provider helpful, none have explored the survivor's perception of the quality of care received during the encounter.

Rural Setting. The rural setting includes the physical and social dynamics of each community, dynamics that may be shifting but are characteristic of rural areas as a whole. Physical factors include geographic distance between people, the size of the population and area, and the existence and adequacy of basic public resources: hospitals, schools, law enforcement, social services. Social dynamics are social, cultural, and economic factors that overlap and interact with each other. These include social norms around IPV, the demographics of the population, and economic opportunities in the area. The cultural background and historical legacy of a certain community (e.g. agricultural versus industrial) also influence norms and the social dynamic.

The rural setting encompasses the constructs of provider perspectives, provider practices, and survivor experiences. Embedded within are factors characteristic of the rural setting that may exert an influence on each of the above listed constructs. Several characteristics that have been used to describe the rural influence on IPV in previous scholarly work are isolation, less diversity of values, greater adherence to conservative social and political values (Bouffard & Muftic,

2002; Websdale, 1995), high levels of gun ownership (Shuman et al., 2006; Websdale, 1995), more support for traditional gender roles, poverty, and the lack of resources for survivors due to sparse populations (Annan, 2008; Peek-Asa et al., 2011; Van Hightower & Gorton, 2002).

*Providers and the Rural Setting.* Rural health care providers are scarce in Missouri, with 29 counties qualifying as Health Professional Shortage Areas (MODHSS, 2011). Although little information is available regarding the distinct challenges responding to IPV poses for rural health care providers, several factors may influence a provider's decision to screen and how to respond to IPV. These challenges were described above and are here grouped together to form the following study constructs:

*Basic information:* There is a general scarcity of information on IPV specific to the rural context, including national and state prevalence estimates (Breiding, Ziembroski & Black, 2009). The potential for greater severity of IPV in rural areas has been suggested by a number of researchers who have found many aspects of rural culture and rural infrastructure to increase risk factors for IPV (Shuman et al., 2006; Van Hightower & Gorton, 2002; Websdale, 1995). Finally, the lack of effective interventions for IPV, within and outside of health care settings, has been noted (Wathen & MacMillan, 2003) and potentially contributes to some health care providers' reticence to screen for IPV (Coker et al., 2012).

*Health and health care disparities:* Hartley (2004) summarized certain behavioral factors that are more prevalent in rural areas as contributing to the poorer overall health of many rural residents as opposed to urban: dietary, lack of exercise, and tobacco use. Rural women in particular are also more susceptible to certain cancers, including cervical cancer, and are more prone to obesity (Kaiser, 2013) and possibly depression and

substance abuse (National Rural Health Association, 2013) than their urban peers. The lack of basic preventive resources to address health issues is notable in many rural communities, and Missouri is no exception. Rural counties often face shortages of health care providers (Kaiser, 2010) and fewer health and social services for women experiencing IPV (Iyengar & Sabik, 2009; Peek-Asa et al., 2011). Large catchment areas may lengthen an emergency medical unit's response and place a greater burden on health care providers' time and resources. These accessibility issues complicate matters for women's health, with rural women less likely to obtain preventive, specialty, behavioral, and dental health services than their urban peers (ACOG, 2009). Rural women are also likelier to lack health insurance than urban women (Vondracek et al., 2006). Rural health care providers must therefore cope with the strains of caring for a population with high levels of health risks and needs, and doing it with fewer resources.

*Confidentiality:* Small populations by design often mean that people know or recognize each other with greater frequency than large urban populations. It is likely that many rural health care providers or their staff will personally know either the survivor or the identified abuser (Annan, 2008). Unsurprisingly, many rural women perceive a lack of confidentiality surrounding health services, including emergency and primary care, thus delaying or forestalling their help-seeking process (Annan, 2008; Shannon et al., 2006). Although this concern has been frequently mentioned in the health sciences literature regarding rural help-seeking and rural health care delivery, no studies to date have examined health care providers' perspectives on confidentiality challenges in rural practice.



*Changing rural populations:* Shifting demographics in rural areas, such as declining and aging populations, and an influx of Latinos to rural communities, (Lohmann & Lohmann, 2005) may also play a role in determining what services, if any, are appropriate for survivors. Health care providers' awareness of these larger social influences on their own practice and patient population may influence their response to IPV.

*Rural culture:* Rural culture as described by Bouffard and Muftic (2002) and Lanier and Maume (2009) is peppered with risk factors known to increase the severity of IPV, such as high levels of gun ownership, widespread poverty, and infrastructure deficiencies. Despite this problematic laundry list, it is likely that rural areas also possess unique strengths and protective factors that shape the community response to IPV. These attributes have not been described in the health and social sciences literature on rural culture, rural IPV, or rural health care. It is possible, even likely, that the rural setting positively impacts the health care provider's response to IPV in ways that have yet to be recorded.

*Survivors and the Rural Setting.* Several of the rural setting constructs listed above (e.g. gun ownership, substance abuse, few community resources) are relevant for survivors of IPV. Two additional factors that are especially salient for survivors in rural areas and the purposes of this study are the *availability of help* and *isolation*.

*Availability of Help:* Rural women are less likely than urban women to seek help from traditional social services for IPV and find them less helpful overall than their urban peers (Few, 2005; Shuman et al., 2006; Websdale, 1995; 1998). The lack of resources for IPV in rural areas may be one reason why rural women do not seek formal help as often as do urban women. The availability of help in rural areas will be defined as the existence

of such formal help in the county where the clinic is located, such as domestic violence shelters, mental or behavioral health centers, home visiting services, victim advocacy, and other agencies known to the survivor (e.g. faith-based or private organizations).

*Isolation:* The existing studies on rural IPV all point to physical isolation—that is, distance and the resultant transportation barriers—from the survivor to community resources, including emergency medical care (Peek-Asa et al., 2011), as a major barrier to help experienced by rural women. This construct will be measured by distance from the survivor’s home to formal helping resources, including the health clinic at which she disclosed the abuse, the nearest critical access hospital, police station, fire department, shelter, town center, courthouse, neighbor, workplace and/or school. The survivor’s ownership or access to a reliable vehicle will also be addressed.

### **Relationships between Constructs**

Provider Perspectives/Provider Practices. Providers’ education, training, knowledge, and personal attitudes about IPV may influence their assessment and treatment practices. Increased awareness of the health consequences and risk factors of IPV may lead providers to screen their patients more thoroughly for signs of abuse or to routinely initiate conversation about abuse. Providers with education about IPV may also be more comfortable asking their patients about abuse and discussing the patient’s options following abuse disclosure. Providers’ personal opinions about IPV may also be a factor in their screening and response practices, and could influence their attitudes about IPV in positive (empathy, respectfulness) or negative (victim-blaming, pathologizing) ways. Organizational and community factors, such as the existence of and availability of help—and the provider’s knowledge of community resources—may also influence their decision to screen for IPV.

Provider Practices/Survivor Experiences. Assessment of IPV in the clinic setting, as well as responsiveness to the survivor's unique situation, may be associated with better patient experiences. These experiences, or outcomes, may be related to the quality of care survivors felt they received or specific actions taken by the patients following their clinic visit, such as ending the abusive relationship.

Provider Practices/Rural Setting. As described above, certain characteristics common to rural life have particular saliency for health care and health care providers. Practice in rural areas has often translated to fewer resources for patients and disparities in access to preventive medicine (American College of Obstetricians & Gynecologists, 2009). Rural culture, changes in rural populations, and basic information about rural IPV influence the interaction between the provider, the survivor, and the specific actions a provider takes upon determination of abuse (Flitcraft, 1993). Meanwhile, the closer-knit social climate of many rural areas functions as a deterrent to help-seeking by many survivors (Annan, 2008) and rural health care providers may also perceive challenges to confidentiality of health services and referrals for patients disclosing abuse.

Survivor Experiences/Rural Setting. While distance to services is certainly an impediment to receiving timely and effective care, many data on rural areas suggests that many services for survivors of IPV—such as domestic violence shelters—simply do not exist. In the event that such services do exist, and the survivor is willing and able to access the services, many shelters are unable to accommodate them. Therefore, availability of help indicates that 1) there is an appropriate service in the area to which a provider may refer the patient experiencing abuse and 2) the help is available to her, i.e. she is not turned away from services for any reason.

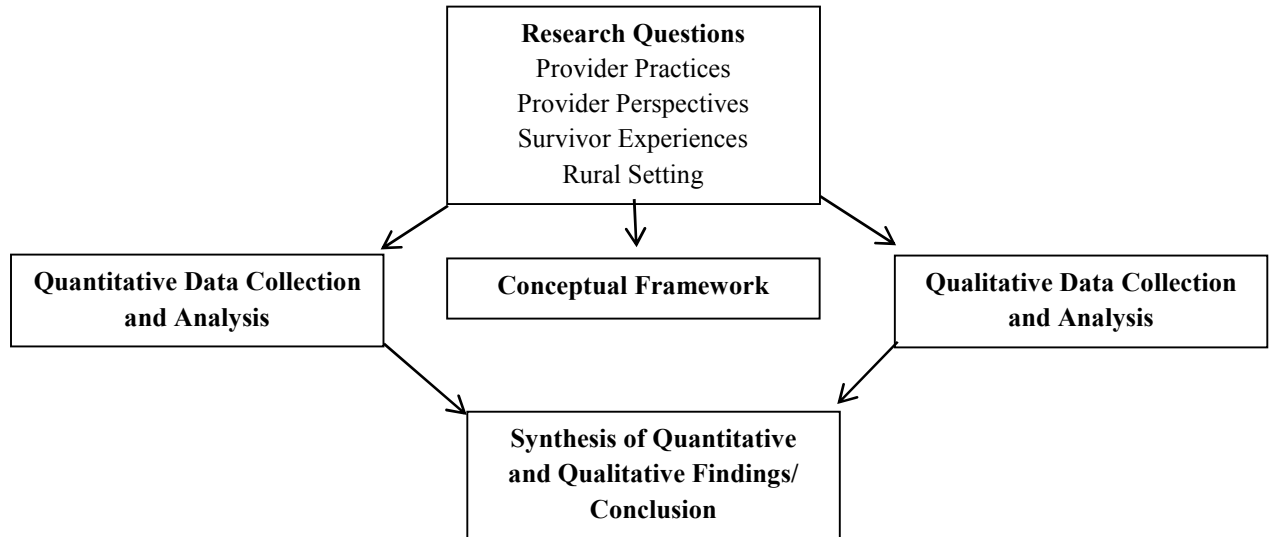
Availability of help impacts the type of assistance or community referrals providers are able to offer, and also determines whether survivors are able to receive help if they choose to seek it.

The geographic distance between people in rural areas affects the ability of survivors to access timely, appropriate help when most needed. The disclosure of abuse to a primary care provider may grow out of the sheer isolating effects of a sparsely populated rural area, wherein health care providers may be some of the only helping professionals with whom the survivor has semi-regular contact and knowledge. Isolation may encourage disclosure to a provider simply because there are few other helpful services available to the survivor.

### **2.3.2 Research Design**

This study's research aims as described above necessitated collecting data from two separate populations within the same sampling frame, calling for a flexible research design with mixed methods of data collection. In convergent parallel design, quantitative and qualitative data collection are conducted separately yet concurrently and merged at the point of interpretation (Creswell & Plano Clark, 2011; see Figure 2-6). Information pertaining to the practices and perspectives of primary care providers was collected in two ways: 1) a survey mailed to rural primary health care clinics in the state of Missouri, and 2) semi-structured interviews with health care providers at selected rural health clinics in the state. Information on survivors' experiences was gathered from semi-structured interviews with women who had been treated by a rural primary health care provider in selected regions throughout the state.

**Figure 2.3.2 Convergent Parallel Research Design**



*Sampling Frame.* The sampling frame consisted of primary health clinics in Missouri that met the definition of rural health clinic status according to provisions in the federal Rural Health Clinics Act of 1977 (P.L. 95-210) or Federally Qualified Health Clinic (FQHC) located in a rural area. By definition, a rural health clinic is located in a rural, medically under-served area that has a separate reimbursement structure from the standard medical office under the Medicaid and Medicare programs (Health Resources & Services Administration, 2006). At the time of the creation of a rural health clinic, the clinic must be located in an area that meets the U.S. Census Bureau definition of non-urban, must meet strict definitions of health care professional shortage and/or medically under-served, and must employ a nurse practitioner, physician assistant, or certified nurse-midwife at least 50% of the time during the clinic's regular operating hours (Department of Health & Human Services, 2013). An FQHC is a community health center providing care in a medically under-served area or population as specified in Section 330 of the Public Health Service Act. Federally Qualified Health Centers represent a critical component of the health care safety net, as their mandate enables them to provide comprehensive primary,

behavioral, and dental care to all individuals regardless of their ability to pay. While FQHCs typically have a broader service mandate than rural health clinics, they were included in this study of primary health care providers because they accept uninsured patients, and as has been discussed, many rural women lack insurance.

A list of all clinics with rural health clinic status from the Missouri Association of Rural Health Clinics and a list of all Federally Qualified Health Centers from the Missouri Primary Care Association were obtained by email request to the administrative assistant at each organization. Each listing contained the facility name, administrator, county, and contact information for the clinic. The list of FQHCs also contained a column denoting whether the clinic was located in an urban or rural area. Only those denoted “rural” were selected for this research (n= 61). Combined with 377 rural health clinics offering primary care, the total number of clinics eligible for this study came to 438. Private, for-profit, clinics providing only specialty services (e.g. dental care), county health departments, and other medical settings not meeting the criteria for rural health providers were excluded.

The two populations drawn from this sampling frame were thus primary health care providers at rural health clinics and rural FQHCs providing primary health care (hereafter both referred to under the umbrella term “rural health clinic”) and female survivors of IPV who had received health care services at a rural health clinic in the state of Missouri within the year prior to the study.

Due to the distinct parts of this study, the methods, data analysis, and results specific to each piece will be described in three separate chapters that are to follow. The quantitative aspect of this study is presented in Chapter Three, which represents health care providers’ practices and

perspectives. Chapters Four and Five form the qualitative part of the work, generated from interviews with health care providers and survivors of IPV.

# **Chapter 3: Rural Health Care Providers’ Perspectives and Practices: Quantitative Results**

## **3.1 Survey of Rural Health Care Providers**

Rural health care providers employed in primary practice at rural health clinics or rural Federally Qualified Health Centers (FQHCs) in the state of Missouri were invited to participate in a survey regarding their screening and response to IPV, as well as their perspectives on the overall experience of practicing medicine in a rural community while addressing IPV. The survey used for this project measured the “practices and perspectives” constructs as defined in the previous chapter by attempting to quantify providers’ general knowledge, attitudes, and practice issues surrounding IPV. Health care providers were eligible to participate in the survey if they were a physician or nurse employed at least part-time at a Missouri rural health clinic or rural FQHC.

### **3.1.1 Survey Instrument**

The survey adapted a validated measure, the Physician Readiness to Manage Intimate Partner Violence Survey (PREMIS) (Short, Alpert, Harris & Surprenant [Short et al.], 2006) to collect information on providers’ practices and perspectives of IPV. The PREMIS was developed by public health researchers who utilized expert consensus and previous surveys of physicians to facilitate understanding about IPV knowledge and practices. It has demonstrated reliability and good internal consistency, with a Cronbach’s alpha of  $\geq 0.65$  for ten scales measuring knowledge, attitudes, screening, response to IPV, and frequency of certain practices (Gregory, Ramsay, Agnew-Davies, Baird et al., 2010; Short et al., 2006). Attached to the PREMIS was a



scaled measure of providers' perceptions of the rural setting and its influence on their practices regarding IPV and women's health issues. The rural setting addendum included Likert-scaled questions asking providers to agree or disagree with statements tapping into the constructs defined in the previous chapter: basic information related to rural IPV, health and health care disparities, confidentiality, changing rural populations, and rural culture. The rural setting addendum was created by this student under the supervision of her committee chair and piloted with a professor and two students preparing for rural health care practice at the Sinclair School of Nursing, University of Missouri, one resident physician at the University of Missouri Medical Center, and one nurse employed at a regional hospital in a rural county south of St. Louis (n= 5). The feedback from each of these individuals indicated that the rural setting addendum's questions were appropriate and clearly worded. Therefore a comprehensive tool emerged from the adapted PREMIS and the rural setting addendum here introduced as the *Survey of Rural Health Care Providers* (reproduced in Appendix I). The final instrument contained 90 questions and took approximately 20 minutes to complete during a second round of piloting with one physician and two nursing students at the University of Missouri (n= 3).

### **3.1.2 Survey Administration and Data Collection**

Using the list of rural health clinics obtained from the Missouri Association of Rural Health Clinics and the Missouri Department of Health and Senior Services, this student generated a list of mailing labels to create 417 packets for each clinic location. Each packet included a copy of the survey, a self-addressed, stamped envelope, and a cover letter addressed to the clinic administrator (a physician or nurse) that briefly described the overall study and provided instructions for completing and returning the survey by hand or electronically (on the

website [www.surveypplanet.com](http://www.surveypplanet.com))<sup>6</sup>. The introductory paragraph on the survey itself offered an incentive to generate prompt response: a \$20 gift card to Amazon for the first 50 respondents who completed the survey and provided their email addresses.

In addition to the mailed packets, this student emailed the same cover letter, instructions, and link to the electronic version of the survey to the Missouri Rural Health Association, the Missouri Primary Care Association, the Missouri Department of Health and Senior Services (Offices on Women’s Health and Rural Health), the Missouri Association of Rural Health Clinics, the Missouri League for Nursing, Southeast Health, SEMO Health Network, Great Mines Health Center, Katy Trail Community Health, Ozarks Community Health Center, Tri-Lakes Health Center, Missouri Highlands Health Center, the Northeast Missouri Rural Health Network, and the Northeast Missouri Health Council. The email described the study inclusion criteria and asked that these agencies forward the survey to applicable parties known in their respective organizations. Reminder emails with the survey link were sent to each of these organizations twice, at three weeks and two months after the initial mailing to further encourage survey response. The survey was made available electronically from January-August 2014.

Surveys returned by mail (hard copies) were kept in a locked file cabinet in this student’s home office. Surveys returned electronically were stored in this student’s password-protected Survey Planet account. At the close of the study, all surveys were entered into a Statistical”

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<sup>6</sup> The original plan for survey administration was to email each clinic administrator a link to an electronic version of the survey, but the Missouri Association of Rural Health Clinics would not provide email contact information for any of their clinics. Similarly, the Missouri Primary Care Association did not have email contact information for FQHC sites. Of the 155 FQHC sites in the state, 25 maintained unique websites but only three of these were “rural” clinics. No websites were listed for any of the rural health clinics in the spreadsheet provided by the Missouri Association of Rural Health Clinics. Without the means to contact each clinic administrator electronically, surveys were instead mailed to each site.

Package for the Social Sciences (SPSS version 22) file. Data from all surveys was then managed and analyzed using SPSS.

### **3.1.3 Data Analysis**

Data were entered into SPSS by this student as they were returned. At the completion of the study and close of the survey, data entry was finalized and cross-checked twice by this student. Potentially identifying information such as clinic names and email addresses which were voluntarily supplied on some of the surveys by participants were not entered into SPSS.

Univariate analyses to examine each variable's normality, distribution, and other descriptive properties were performed. Results indicated that the majority of variables fell within an acceptable range of the measures of normality, and data for each variable were largely intact. Few variables contained missing values and there were no systematic patterns to missing values. Because the variables selected for analysis all contained either no missing values or missing values totaling four or less, listwise deletion was used to correct for missing values. Univariates were run a second time with no major concerns about the integrity of the data.

The guide from the PREMIS included syntax for the summing and scoring of scales measuring knowledge, attitudes, and behaviors (i.e. screening and response actions). Variables to be included in each overall score of perspectives and practices--knowledge, attitudes, and practice issues--were recoded and summed to create scores for each category. Non-scored items such as demographic information, education and training, and perceptions of community resources for health- and IPV-related matters were gathered into groups tapping into the constructs of "perspectives and practices" as conceptualized in the previous chapter. Frequencies and descriptive statistics of these groups are provided in the following section.

Bivariate analyses were performed to examine associations between provider practices (screening and response items), demographic characteristics (gender, discipline, year of graduation, and clinic type), and perspectives (knowledge, attitudes, and certain organizational and community factors). Pearson's correlation was used to test whether an association existed between "screening" and "response" to IPV and the independent variables "knowledge" and "attitudes". The relationships between "screening" and "response" and organizational factors including "IPV Protocol", "IPV Policies", "Referrals on Site", "Community Resources Knowledge", "Training", "Number of Patients", "Number of Physicians" and "Number of Nurses" was assessed with non-parametric tests including Spearman's and the independent samples t-test. Pearson's correlation was also used to examine associations between "specific screening" and the organizational factors listed previously.

Based on the results of the bivariate analyses, binary logistic regression was performed to further examine the strength and direction of the associations between providers' perspectives and their practices. The following section of this chapter provides a full description of each variable included in these analyses; Table 3.1 lists each variable alongside the statistical tests that were performed with them.

**Table 3.1 Data Analysis**

<b>Dependent Variables</b>	<b>Independent Variables</b>	<b>Analyses Performed</b>
<i>Practices</i>  Screening Specific Screening Response	<i>Perspectives- Individual</i>  Knowledge Attitudes Training Gender Degree/Discipline Year of Graduation	<i>Independent Samples T-Tests</i>  Screening-→ IPV Protocol, IPV Policies, Referrals On Site, Community Resources Knowledge, Gender, Clinic Type  Response-→ IPV Protocol, IPV Policies, Referrals On Site, Community Resources Knowledge, Gender, Clinic Type
	<i>Perspectives- Organizational and Community</i>  IPV Protocol IPV Policies Referrals On Site Community Resources Knowledge Number of Patients Number of Physicians Number of Nurses Clinic Type	<i>Pearson's Correlation</i>  Screening-→ Knowledge, Attitudes  Specific Screening -→ Knowledge, Attitudes, IPV Protocol, IPV Policies, Referrals On Site, Community Resources Knowledge, Training, Number of Patients, Number of Physicians, Number of Nurses, Gender, Discipline, Year of Graduation, Clinic Type  Response -→ Knowledge, Attitudes
		<i>Spearman's Correlation</i>  Screening-→ Training, Discipline, Year of Graduation  Response -→ Training, Discipline, Year of Graduation  <i>Cross-tabulation</i>  Gender * Discipline Gender* Clinic Type  <i>Logistic Regression</i>  Screening-→ Knowledge, Attitudes  Response -→ Knowledge, Attitudes

### 3.1.4 Description of Variables

#### Dependent Variables

Screening: Providers were asked to identify situations in which they currently screen for IPV from a list of common patient presentations (i.e. “I currently screen all new female patients”, “I screen patients during specific times in their pregnancy”). Their answers were grouped to form a composite weighted variable, “Screening”, with values from zero to four indicating whether the provider screened for IPV selectively (among certain patient categories only, such as teenagers or drug-abusing women), occasionally (periodically screening patients during specific points in their pregnancy or screening those with abuse indicators in their chart) or universally/quasi-universally (all new patients). A score of zero indicated that the provider did not screen for IPV at all.

Specific Screening: Providers responded to questions that asked them to indicate whether they screened for IPV when a patient presented with one or more of the following common health indicators of IPV: injuries, chronic pelvic pain, irritable bowel syndrome, headaches, depression/anxiety, hypertension, and eating disorders. Questions were asked with a Likert-scale format in which an answer of “one” to any of the above questions was “never” and “five” equaled “always”. A high mean score (i.e. four or above) meant that providers recognized these health concerns as potentially indicative of IPV and screened accordingly.

Response: Steps taken by the provider upon identifying IPV were summed and scored to create a total score of appropriate actions in response to IPV. Appropriate actions included providing information about IPV, counseling the patient about her options for seeking help or taking other actions to end the relationship, conducting a safety assessment with the patient, conducting a safety assessment with the patient’s children (if applicable), helping the patient

create a personal safety plan, and referring the patient to outside resources in the community. Providers indicated which actions they had taken upon identifying IPV within the previous six months from each of these categories.

### **Independent Variables**

Knowledge: Provider knowledge of IPV dynamics was measured with a scale on the PREMIS entitled “Knowledge”. This scale included questions that asked providers about risk factors for intimate partner victimization and perpetration, reasons why survivors might remain in an abusive relationship, health and mental health indicators of IPV, and appropriate ways of asking patients about the possibility of IPV. Questions were constructed using item response, multiple choice, and true/false formats. A total knowledge score was created by summing all correct answers possible from the scale, with 36.00 as a perfect score. (Raw knowledge scores from each part of the “Knowledge” subscale are provided in Tables 3.2.4 and 3.2.5.)

Community Resources Knowledge: Providers were asked whether they felt they had adequate knowledge of the available resources for survivors of IPV in their community by indicating “yes” or “no”.

Training: Previous training on IPV was grouped into categories by the estimated number of total hours of training received. Training on IPV was defined as “previous training about IPV issues” that included reading institutional protocol about IPV, watching a video, attending a lecture, attending a skills-based workshop, classroom training, clinical training, residency or post-graduate training, or another type of certificate or continuing education program. Four categories of training by number of hours were created from the responses to this question: Group One had received zero to five hours of training on IPV, Group Two six to ten hours, Group Three 11 to 15, and Group Four 16 or more total hours of IPV training.

Attitudes: Attitudes about IPV as defined by this survey were attitudes toward patients experiencing IPV and ways to manage IPV in a health care setting. The *Attitudes* scale included questions about providers' perceptions of their own preparation and skills to manage IPV, their awareness of legal reporting requirements concerning IPV and other forms of abuse (child, elder), assessments of their own clinic's protocols (or lack of) for addressing IPV, their usual screening practices, their opinions of IPV and history of substance abuse, and their general attitudes toward women who are victimized by IPV. Providers were asked questions from each of the above mentioned categories following a Likert scale format, with one as "strongly disagree" and seven as "strongly agree". Attitudes toward IPV were then grouped into the following categories: *Preparation, Legal, Workplace, Screening, Substance Abuse, and Understanding*. Mean scores across each category were calculated to arrive at a score with values ranging from one to seven.

Number of Patients: Providers estimated the number of patients they saw every week by indicating one of four categories: fewer than 20, 20-39, 40-59, or 60 or more patients.

Number of Physicians: This variable indicated the number of physicians (including the survey respondent, if applicable) who were also employed either full- or part-time at the same clinic. Providers responded by checking boxes with numbers between zero to five, six to ten, 11 to 15, and 16 or higher.

Number of Nurses: Similar to the "Number of Physicians" variable described in the previous paragraph, this variable indicated the number of nurses (including the survey respondent, if applicable) employed at least part-time by the clinic where the respondent worked. Providers checked boxes with numbers between zero to five, six to ten, 11 to 15, and 16 or higher.



IPV Protocol: Providers were asked to indicate whether or not their clinic had a specific written protocol in place to address the identification and disclosure of IPV by answering “yes” or “no”. Providers who were unsure of their clinic’s protocols were not included in the calculation of this variable and were coded as system-missing.

Policies: The values of this variable indicated whether providers were familiar with their clinic’s policies on addressing IPV (1= “yes”, 0= “no”). Nine providers indicated that their clinic had no policy in place to manage IPV so their response was “not applicable”, and they were not included in their calculation of this variable (n= 9).

Referrals on Site: Providers were asked whether they felt they had adequate referral resources and materials to provide to their patients who were experiencing IPV by indicating “yes” or “no”. Providers who marked “not applicable” were coded as system-missing (n= 9).

Year of Graduation: Providers’ year of graduation from their medical or nursing program was grouped into one of the following four categories: “2000-present”, “1990-1999”, “1980-1989”, and “Before 1980”.

Discipline: Providers indicated their degree and discipline according to one of the four options: medical doctor (M.D.), doctor of osteopathy (D.O.), nurse practitioner (M.S.N.), or registered nurse/bachelor-level nursing degree (B.S.N.). (Inclusion criteria for this study stipulated that provider respondents held one of the above degrees.)

Clinic Type: Providers indicated whether they were employed at a Rural Health Clinic or Federally Qualified Health Center.

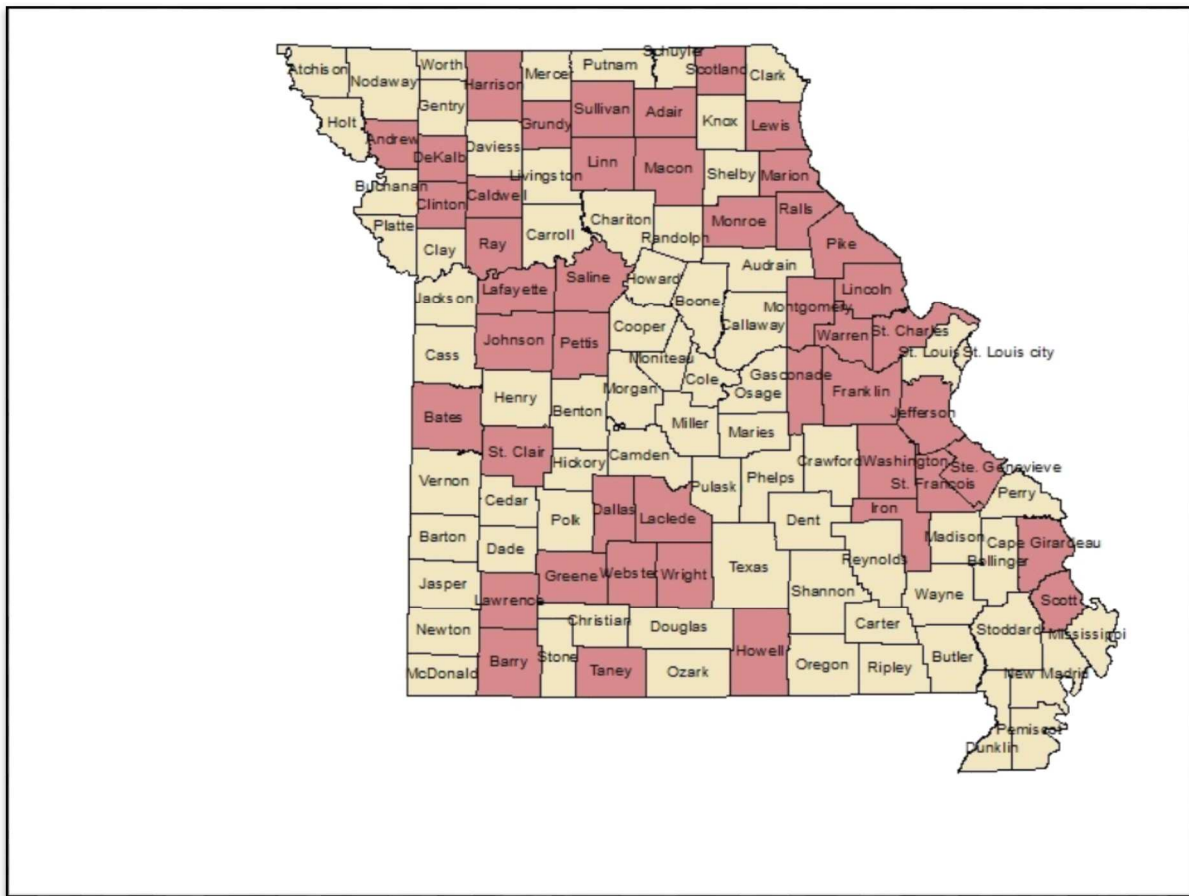
### 3.2 Results

Of the mailed surveys, 21 were returned as having bad addresses. This brought the total sample to 392. Forty-one surveys were returned by mail, and 93 were completed electronically, for a total count of 134 (34.2% response rate).

#### 3.2.1 Demographics of Survey Respondents

Rural health care providers in Missouri were well represented by this study, with surveys returned from multiple regions of the state. Figure 3.2.1 shows the number of surveys returned by county. Thirty-four respondents did not provide their county of practice and are thus not included on this map.

**Figure 3.2.1 Survey Respondents by County**



**Table 3.2.1 Demographic Characteristics of Survey Respondents**

<b>Respondent Demographics</b> <i>N= 134</i>	<b><i>n</i></b>	<b><i>% of Total</i></b>
<b>Sex</b>		
Male	63	47.4
Female	71	50.6
<b>Discipline</b>		
Nursing (MSN)	67	50.4
D.O.	42	31.6
M.D.	19	14.3
Nursing (BSN)	4	3.0
<b>Specialization</b>		
Family Practice	76	57.1
Obstetrics	27	20.3
Pediatrics	20	15.0
Other	10	7.6
<b>Year of Graduation</b>		
2000-present	105	84.0
1990-1999	13	10.4
1980-1989	5	4.0
Before 1980	2	1.6
<b>Clinic Type</b>		
RHC	61	48.4
FQHC	65	51.6
<b><i>Mean</i></b>		
<b>Age</b>	38.67	
<b>Years in Practice</b>	12.19	

Providers were asked about certain demographic indicators that may have been relevant to consider regarding their overall perspectives toward IPV. This demographic information is provided in Table 3.2.1. The sample was divided fairly evenly among men (n= 63) and women (n= 71), as well as respondents from RHCs (n= 61) and FQHCs (n= 65). Half the sample were nurse practitioners (n= 67) followed by D.O.s (32%, n= 42). The majority of respondents (58%)

specialized in family practice, and had been employed in their current field for an average of 12 years.

### 3.2.2 Provider Practices: Screening and Response to IPV

#### Screening

Nearly ninety-three percent of providers indicated that they had screened for IPV at least once in the past six months. Approximately one-third estimated they had identified between six to ten new cases of IPV within that time frame (30.6%, n= 41), and another third had made

between 11-20 new diagnoses of IPV (29.9%, n= 40). A mere 14 respondents claimed they had not seen a case of IPV within the prior six months.

Screening instances were divided into categories based off providers' responses to the situations in which they asked their patients about IPV. Nine providers (6.8% of respondents) stated they did not screen for IPV at all. "Selective" screeners (2.3%, n= 3) were those providers who indicated that they screened for IPV only among certain patient categories, such as teens or drug-abusing women. Most providers practiced "occasional" or "universal" screening. "Occasional" screeners (41.7%, n= 55) asked about IPV when they believed there were indicators of abuse based on the patient's presentation or history and during specific points of a patient's pregnancy. Nearly half of providers (49.2%, n= 65) screened universally or quasi-universally, asking all their new patients or all their patients periodically about the possibility of IPV.

Providers were then asked more specifically about instances in which they had screened for IPV based on presenting factors or other health indicators common among survivors of IPV during the previous six months. Sixty percent stated they had always or nearly always asked about IPV when the patient presented with an injury (n= 69), approximately 66% asked when the patient presented with chronic pelvic pain (n= 77), 56% asked when the patient complained of frequent headaches (n= 66), and approximately 54% asked when the patient had irritable bowel syndrome or hypertension (n= 65). Providers seemed more attuned to the possibility of IPV, and screened accordingly, when the patient presented with depression or anxiety (67.7%, n= 79). The mean score across all items pertaining to these specific screening instances within the prior six months was 3.69, with a minimum score of 1.00 and a maximum score of 5.00. Roughly, this score translates to the majority of providers asking about IPV "sometimes" when presented with

one or more of the above listed health concerns. (A score of 4.00 or above would indicate that providers nearly always or always screened for IPV when their patients presented with injuries, chronic pelvic pain, irritable bowel syndrome, headaches, depression/anxiety, hypertension, or an eating disorder.)

## **Response**

Upon identifying IPV, providers were asked which of several actions they had taken in response to patients within the previous six months: providing information about IPV, counseling the patient about her options, conducting a safety assessment, conducting a safety assessment of the patient's children (if applicable), helping the patient create a personal safety plan, or providing referrals to outside sources of support in the community. Of these possible courses of action, the majority of providers had engaged in "patient counseling" (38.8%, n= 52), meaning that they engaged the patient in a conversation about her options regarding seeking further sources of help, and either remaining in or ending the relationship. Only 19% (n= 26) had conducted a formal safety assessment with the patient and merely three percent (n= 4) had helped the patient create a personalized safety plan. Slightly less than ten percent (9.2%, n= 12) had provided information about IPV in general, and five percent (n= 7) had referred the patient to outside community resources. Twenty-one providers surveyed had taken no action at all upon identifying IPV in the previous six months.

**Table 3.2.2 Provider Screening Practices**

<b>Respondent Screening Practices</b> <i>N= 134</i>	<b>% of total</b>	<b><i>n</i></b>
No Screening	6.8	9
Selective Screening	2.3	3
<i>Teenagers</i>		
<i>Patients with abuse indicators</i>		
<i>Patients with drug/alcohol abuse history</i>		
Occasional Screening	41.7	55
<i>Pregnant patients</i>		
<i>Annual exam</i>		
Universal Screening	49.2	65
<i>All new patients</i>		
<i>All patients periodically</i>		

Providers were asked to gauge on a Likert scale of one to five (one meaning “never” and five meaning “always”) how often they had taken specific actions in response to identifying IPV within the previous six months. Specific actions included documenting a patient’s statements about IPV in their chart (46% of providers “always” or “nearly always” had done this in the prior six months), using a body-map to document a patient’s injuries, if applicable (54% had done this), or taking photographs of the patient’s injuries to include in their chart (49%). Slightly more than half of providers (54%, n= 72) stated they had contacted an IPV service provider. Yet less than half of providers—48%--had contacted the appropriate authorities when legally mandated to do so after identifying IPV in the past six months. (Health care providers in the state of Missouri are required to contact Children’s Division or file a report with the Elder Abuse Hotline [both administered by the state’s Division of Health and Senior Services] in cases of IPV involving individuals under the age of 18 or over the age of 65.)

Regarding the provision of patient education or resource materials about IPV, 39% of provider respondents stated they nearly always provided their patients experiencing IPV with

educational or resource materials about abusive relationships. Twenty-two percent (n= 30) provided such materials only when the patient determined it was safe to do so, while 14% (n= 19) gave materials only upon the patient's request. A small number of respondents indicated they did not provide resource materials because there were not adequate services for IPV in their community.

Providers were asked more pointedly what types of referrals to outside resources they had provided their patients experiencing IPV during the previous six months. While approximately five percent of providers indicated that their response to IPV identification had been solely to give referrals to patients, this question asked providers to specify what referrals they had provided during any encounter with a patient during which IPV was discussed. Providers thus could have given these specific referrals to resources as part of an overall response to IPV that primarily included, for example, counseling a patient about her options. Specific referrals included those to individual therapy (32.1%, or 42 of provider respondents indicated they had given this type of referral), couples' therapy (16.8%, n= 22), victim witness advocate, Children's Division (child protective services) (both 22.1%, n= 29), batterer's treatment program (14.5%, n= 19), on-site social worker or advocate (9.2%, n= 12), a religious leader or organization, domestic violence support group (both 9.9%, n= 13), domestic violence program or shelter (19.8%, n= 26), substance abuse counseling (10.7%, n= 14), national domestic violence hotline (12.2%, n= 16), local domestic violence hotline (8.4%, n= 11), an LGBT support group (4.6%, n= 6), law enforcement (11.5%, n= 15), and housing, educational, or job assistance (1.5%, n= 2).

### **Provider Perspectives**

Providers' perspectives on IPV were measured by questions asking about their organizational environment and rural community setting in which they practiced. Personal

characteristics, such as overall knowledge of IPV and attitudes toward IPV survivors, IPV screening, and clinic protocols for addressing IPV were assessed with scales on the PREMIS.

**Organizational Factors.** Rural health care providers tended to work in clinics with low numbers of staff with a comparatively high volume of patients. Many respondents (39%, n= 52) estimated that they saw between 20-39 patients per week, and 29% (n= 39) treated between 40-59 patients per week. At the same time, nearly 40% (n= 53) of providers worked in clinics with three or less physicians in practice, and half the clinics (52%, n= 71) also employed five or less nurses.<sup>7</sup>

The majority of providers stated they felt familiar with their clinic or organization's policies regarding the screening and management of IPV (81%, n= 108), and reported that their workplaces had clear protocols for identifying and addressing IPV. Yet less than half of providers—43%--stated these protocols were “widely used”, with another 22% indicating that the clinic's IPV protocols were used “to some extent”. Despite the majority of providers indicating that they felt reasonably comfortable addressing IPV and understood their responsibilities as a mandated reporter, nearly two-thirds of respondents (58%, n= 77) believed, erroneously, that they were legally required to report cases of IPV involving non-vulnerable adults. The majority of providers (60%, n= 80) felt they were equipped with adequate referral resources for their patients experiencing IPV at their clinic. However, less than half (46%, n= 62) indicated that their clinic had resource referral lists or other materials about IPV that were well displayed and frequently accessed by patients.

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<sup>7</sup> This survey did not differentiate between full- or part-time providers, which means that some clinics may have employed physicians or nurses on a part-time basis that would have been included in the total number of staff.



**Community Factors.** Despite the rurality of the communities where clinics were located, nearly 70% (n= 91) of providers surveyed stated that there were adequate community resources overall for women experiencing IPV. When asked about specific services, however, providers appraised their communities as slightly less resourced. The rural setting addendum of the survey asked providers about the availability and accessibility of nearby (that is, within the same community or county) services specific to IPV or women’s health. Providers were also asked whether they felt comfortable referring patients to those services that did exist. Rural communities in Missouri are frequently classified as medically under-served or, in at least 19 instances throughout the state, qualify as a Health Professional Shortage Area (a federal designation). The majority of providers (approximately 60%) stated there were “adequate” health services, defined as primary, dental, and emergency care in their community. However, more than two-thirds (66%) of respondents stated that mental and behavioral health services did not exist in their communities. Regarding IPV-specific services, such as domestic violence programs, just 19% (n= 25) felt there were adequate sources of support for IPV survivors nearby. However, approximately 40% of providers agreed that there were adequate forms of support available to primarily Spanish-speaking IPV survivors and IPV survivors in same-sex relationships. Respondents were divided almost evenly among those who felt comfortable referring their patients with IPV to those services that did exist (52.4%, n= 67), and those who remained neutral about the nearby services and overall community response to IPV (48%, n= 43). Of all community resources specific to IPV, providers seemed to be most comfortable with their local law enforcement, with 56% (n= 71) agreeing that the criminal justice response to IPV in their community was adequate.

Providers were then asked to give their perceptions of the effectiveness of existing community resources for patients experiencing IPV to resolve specific issues likely resulting from abuse, such as obtaining restraining orders and finding affordable housing. A full list of their responses is provided in Table 3.2.3. Roughly one-third of providers agreed that the services available in their community were effective at helping IPV survivors receive individual counseling (33%, n= 44), couples counseling (32%, n= 42), children's counseling (38%, n= 50), and thereby resolve issues related to PTSD, depression, and/or anxiety stemming from IPV (35%, n= 47). Short- and long-term help for women experiencing IPV was generally lacking in these communities, according to providers. Approximately half of providers agreed that community resources were effective at assisting women with securing orders of protection from their abusers (49%, n= 65), a third (29%, n= 39) agreed that the local criminal justice system effectively got violent abusers put in jail, and only 26% (n= 35) felt that overall services in their community effectively helped survivors leave their abuser for good. Forty-four percent (n= 58) of providers stated that there were temporary housing options available to survivors, such as shelters or motels, but fewer (36%, n= 47) agreed that existing services assisted women with securing permanent housing.

**Table 3.2.3 Effectiveness of Community Resources for IPV Survivors**

<b>There are available and adequate:</b>	<b>% of total</b>	<b><i>n</i></b>
Health (primary, dental, reproductive) services	41.3	54
Mental health services	34.4	45
IPV-specific support services	19.0	25
Services for Spanish-speaking IPV survivors	41.1	53
Services for LGBT IPV survivors	39.5	51
Law enforcement response to IPV	55.5	71
<b>Services effectively help IPV survivors with:</b>	<b>% of total</b>	<b><i>n</i></b>
Obtaining individual counseling	33.1	44
Obtaining couples' counseling	31.6	42
Obtaining a restraining order	48.9	65
Leaving the abuser/perpetrator for good	26.3	35
Finding a new, permanent place to live	35.3	47
Finding a temporary place to live (i.e. shelter or transitional housing)	43.6	58
Obtaining counseling or behavioral services for their children	37.6	50
Increasing their self-esteem and self-efficacy	31.6	42
Overcoming or resolving issues of PTSD, depression, and/or anxiety related to the abuse	35.3	47
Getting violent abusers/perpetrators put in jail or off the street	29.3	39
Obtaining counseling for the abuser/perpetrator	10.5	14
Helping victims connect or reconnect with their faith/religious values	11.3	15

The overall inadequacy of community-based resources specific to IPV and women's health was juxtaposed with providers' perception that IPV was a pressing issue for these communities (54% of providers surveyed felt that IPV was a "major problem" in the area where they worked). Providers were mostly family practitioners or generalists, uniquely positioning them to treat all members of a family and thus know of present or past abuse. Indeed, half of providers (50%, *n*= 64) stated they had treated both survivor and abuser in their practice. As the majority of patients came from the same county or community where the clinic was located, there was a tendency for providers to have a social relationship with their patients that extended

beyond the clinic. Half of provider respondents (49%, n=63) reported that they were personally acquainted with their patients.

**Individual Factors.** Providers rated their perceived knowledge of IPV and their overall ability to adequately identify and manage IPV on a Likert scale ranging from one (“not at all prepared”) to seven (“quite well prepared”). The majority of respondents (81%) indicated that they felt “moderately prepared/fairly well prepared” to identify and manage IPV, while 48% gauged their level of general knowledge of IPV signs and symptoms as “a moderate amount/a fair amount” overall. The survey then asked providers questions to assess their actual knowledge of IPV and attitudes toward a variety of factors related to IPV using two scales: *Knowledge* and *Attitudes*.

Knowledge: Providers responded to 38 items that asked about IPV risk factors, health indicators, appropriate ways of identifying IPV, stages of change, and abuse dynamics. The highest score possible after taking into account certain reversely coded items was 36.00. A complete list of the questions from this scale listed alongside the frequency of correct responses is provided in Tables 3.2.4 and 3.2.5 (true/false subscale). Providers’ *Knowledge* scores demonstrated wide variability across the sample of respondents, ranging from a low score of 5.00 to a high of 35.00. The average score was 18.89 and the most frequently occurring score, achieved by 17 respondents, was 14.00. Translating these scores to a 100-point graded scale, providers would have averaged a 52% on a test of IPV knowledge, and the mode would have scored just 39%.

The largest frequency of correct responses to a *Knowledge* question asked providers to identify one general truth about batterers from a list of four choices that included “they have trouble controlling their anger”, “they are violent because they drink or use drugs”, “they pick

fights with anyone”, and the most appropriate response, “they use violence as a means of controlling their partner”, which 80% of respondents answered correctly. Seventy-six percent of providers also indicated, again correctly, that there were general behavioral patterns in couples that could indicate IPV, and 83% of providers agreed that financial dependence on the abusive partner was a major reason that survivors might not leave a violent relationship. Providers were less able to match the stages of changes with a history of IPV, and the sample was fairly evenly split between the correct responses to true/false questions about IPV, such as “Victims of IPV are able to make appropriate choices about how to handle their situation” (50% of respondents indicated this was a true statement; the rest indicated this was false or that they did not know the answer). Asking about IPV was another area that demonstrated wide variability. Only one-fifth of respondents thought that asking a patient, “Has your partner ever hit or hurt you?” was an appropriate way to ask about IPV, yet over two-thirds (63.9%) said that asking, “Are you afraid of your partner?” was an appropriate way of initiating conversation about IPV. Warning signs of IPV was another area in which responses were mixed. Only one-third of respondents thought that depression could be a warning sign of IPV, yet 65% and 67% agreed—correctly--that chronic unexplained pain and anxiety, respectively, might indicate abuse. Another one-third did not recognize that substance abuse, a significant correlate of violence, should raise a red flag for IPV.

Attitudes: The *Attitudes* scale on the PREMIS attempted to measure, via Likert scale (with one being “strongly disagree” and seven being “strongly agree), providers’ opinions toward IPV and IPV management on several domains, including their understanding of survivors’ perspectives, how they felt about their workplace policies toward IPV identification

and management, and whether or not they felt adequately prepared to identify IPV and provide appropriate referrals to patients. The *Attitudes* scale was divided into eight subscales, each with its own mean score from the sum of responses; however, only six of these subscales were used in this analysis, as the PREMIS codebook indicated that two subscales attempting to tap into constructs measuring “Victim Autonomy” and “Staff Constraints” were not valid. Items from each of those subscales were not included in this data analysis. The six subscales included are categorized as “Staff Preparation”, “Legal Requirements”, “Workplace”, “Screening”, “Alcohol and Drugs”, and “Victim Understanding.” After taking into account certain reversely coded items, each mean score from the above listed categories indicates placement on a scale of one to seven, with seven as the “appropriate” attitude. Questions from the complete *Attitudes* scale alongside the mean score for each subscale are provided in Table 3.2.6.

**Table 3.2.4 Providers' Knowledge of Intimate Partner Violence**

Question/Item	%	n
<i>Questions are "check all that apply" unless otherwise indicated. Correct answers are marked in red. % and N indicate frequency of correct response.</i>		
The strongest single risk factor for becoming a victim of IPV is: <i>(check one)</i>		
Partner abuses alcohol/drugs	53.7	72
Gender—female	23.9	32
Family history of abuse	14.9	20
Don't know	7.4	10
Which one of the following is generally true about batterers? <i>(check one)</i>		
They have trouble controlling their anger	16.2	21
They use violence as a means of controlling their partners	80.0	104
They are violent because they drink/use drugs	3.1	4
They pick fights with anyone	0.8	1
Warning signs that a patient may have been abused by her partner are:		
Chronic unexplained pain	65.2	86
Anxiety	67.4	89
Substance abuse	60.6	80
Frequent injuries	56.8	75
Depression	31.8	42
Reasons a survivor may not be able to leave a violent relationship:		
Fear of retribution	58.3	77
Financial dependence on the partner	83.3	110
Religious beliefs	63.6	84
Children's needs	62.1	82
Love for one's partner	37.1	49
Isolation	33.3	44
Appropriate ways to ask about IPV:		
"Are you a victim of IPV?"	34.8	46
"Has your partner ever hurt or threatened you?"	73.5	97
"Have you ever been afraid of your partner?"	37.1	51
"Has your partner ever hit or hurt you?"	21.2	28
Which of the following is/are generally true?		
There are common, non-injury presentation of abused patients.	43.9	58
There are behavioral patterns in couples that may indicate IPV.	75.8	100
Specific areas of the body are most often targeted in IPV cases.	65.2	86
There are common injury patterns associated with IPV.	37.9	50
Injuries in different stages of recovery may indicate abuse.	31.8	42

**Table 3.2.5 Providers' Knowledge of Intimate Partner Violence (True/False Subscale)**

Question/Item <i>Frequency and N of all responses are indicated with the correct answer frequencies in red.</i>	TRUE		FALSE	
	%	n	%	n
Alcohol consumption is the greatest single predictor of the likelihood of IPV.	61.8	81	38.2	53
There are no good reasons for not leaving an abusive relationship.	41.7	57	58.3	77
Reasons for concern about IPV should not be included in a patient's chart if she does not disclose the violence.	55.5	74	45.5	60
When asking patients about IPV, physicians should use words like "abused" or "battered."	39.4	54	60.6	80
Being supportive of a patient's choice to remain in an abusive relationship would condone the abuse.	51.5	70	48.5	64
Victims of IPV are able to make appropriate choices about how to handle their situation.	50.4	68	48.6	67
Healthcare providers should not pressure patients to acknowledge they are living in an abusive relationship.	65.9	87	34.1	47
Victims of IPV are at greater risk of injury when they leave the relationship.	55.6	74	44.4	60
Strangulation injuries are rare in cases of IPV.	48.9	66	51.1	68
Allowing partners or friends to be present during a patient's history and physical exam ensures safety for an IPV victim.	42.1	57	57.9	77
Even if the child is not in immediate danger, physicians in all states are mandated to report an instance of a child witnessing IPV to Child Protective Services.	77.4	104	22.6	30

Providers' attitudes toward IPV and a range of issues related to addressing IPV again demonstrated wide variability across the sample. Half of providers (50.6%) felt they did not have sufficient training to address IPV. Another half disagreed that people who abused alcohol or drugs were likely to have a history of IPV, and only 41% believed that alcohol abuse was a leading cause of IPV. Victim understanding was another area in which providers' responses were mixed. Almost 63% of providers did not feel that survivors of IPV had the right to make their



own decisions about whether or not hospital staff should intervene in the situation. Half of respondents acknowledged that survivors might have valid reasons for remaining in an abusive relationship. A significant minority (34%) of providers indicated that women who remained in abusive relationships after repeated episodes of violence should accept responsibility for the violence.

Screening and responding to IPV seemed like a fraught issue for many providers. Over half stated that they did not feel as though there was adequate private space in their clinic to discuss abuse with patients. Less than half (44%) of providers felt they could make appropriate referrals to services within their community for patients experiencing IPV, and less than one-third (29%) felt that their workplace encouraged them to respond to IPV. A third of providers remained neutral regarding the statement, “Health care providers have a responsibility to ask all patients about IPV.”

**Table 3.2.6 Providers' Attitudes toward Intimate Partner Violence**

<b>Attitude/Opinion</b>	<b>Mean<sup>1</sup></b>
<i>Providers' Preparation to Address IPV</i>	4.8
"I do not have sufficient training to assist individuals in addressing situations of IPV." "I do not have the necessary skills to discuss abuse with an IPV victim who is female/male/from a different cultural or ethnic background."	
<i>Providers' Legal Reporting Requirements</i>	3.6
"I am aware of legal requirements in this state regarding reporting of suspected cases of IPV/child abuse/elder abuse." "I comply with the Joint Commission standards that require assessment for IPV."	
<i>Providers' Workplace Issues</i>	3.4
"My workplace encourages me to respond to IPV." "I can make appropriate referrals to services within the community for IPV victims." "My practice setting allows me adequate time to respond to victims of IPV." "I have contacted services within the community to establish referrals for IPV victims." "There is adequate private space for me to provide care for victims of IPV." "I am able to gather the necessary information to identify IPV as the underlying cause of patient injuries (e.g. bruises, fractures, etc.)."	
<i>Providers' Screening Practices</i>	3.3
"I ask all new patients about abuse." "I feel comfortable discussing IPV with patients." "I am able to gather the necessary information to identify IPV as the underlying cause of patient illnesses (e.g. depression, migraines)."	
<i>Providers' Knowledge of IPV and Alcohol/Drugs</i>	3.9
"Patients who abuse alcohol or other drugs are likely to have a history of IPV." "Alcohol abuse is a leading cause of IPV." "Use of alcohol or other drugs is related to IPV victimization."	
<i>Providers' Understanding of IPV Victimization</i>	4.7
"If an IPV victim does not acknowledge the abuse, there is very little I can do to help." "If victims of abuse remain in the relationship after repeated episodes of violence, they must accept responsibility for that violence." "If a patient refuses to discuss the abuse, staff can only treat the patient's injuries." "Healthcare providers have a responsibility to ask all patients about IPV." "Screening for IPV is likely to offend those who are screened."	

<sup>1</sup>Scored as 1 = strongly disagree to 7 = strongly agree.

### **3.2.3 Providers' Perspectives and Practices: Bivariate and Multivariate Analyses**

Providers' perspectives toward IPV, including organizational, community, and personal factors—knowledge, attitudes, and demographic characteristics—may have influenced their screening and response practices to IPV. To further examine these constructs of interest and how they may have related to each other, bivariate and multivariate analyses were performed with key

variables tapping into these constructs. These variables along with the associated statistical tests that were performed between each are presented in Table 3.2.1 for quick reference.

Screening. *Screening*, a categorical variable with four levels (no screening, selective screening, occasional screening, and universal screening), was not significantly associated with providers' *Knowledge* or *Attitude* scores using Pearson's chi-square. However, *Screening* was associated with the number of hours of previous training about IPV that providers had received. Providers with 16 or more hours of training on IPV were the most likely to screen across all categories, and providers with 6-10 hours of training were more likely than those with 0-5 hours to screen across all categories:  $\chi^2 (6, 134) = 23.29, p < .01$ , suggesting that more previous training on IPV is associated with screening in general. *Screening* was also significantly associated with certain organizational and community factors, including the provider working in a clinic that had instituted clear protocols for addressing IPV ( $\chi^2 [3, 134] = 23.19, p < .01$ ), knowledge of the clinic's policies ( $\chi^2 [3, 134] = 24.73, p < .01$ ), perceived knowledge of community resources ( $\chi^2 [3, 134] = 25.14, p < .01$ ), and having adequate referrals to provide to the patient disclosing IPV at the clinic site ( $\chi^2 [9, 134] = 12.35, p < .01$ ). Additional organizational factors, such as the number of patients providers saw each week and the total number of providers at the clinic—including physicians and nurses--were not significantly associated with *Screening*.

Certain types of screening were also associated with demographic indicators, such as the provider's year of graduation: more recent graduates (all those earning their medical or nursing degree after 2000) were significantly more likely to screen across all categories. However, this finding was not strictly interpretable because the majority of the providers who responded to this survey fell into the most recent graduate category (2000-present). Males were significantly more

likely to screen across all categories than females ( $\chi^2 [3, 134] = 10.24, p = .02$ ). The provider's degree was also significantly associated with higher levels of screening across all categories. Providers with an M.S.N. (nurse practitioner) or D.O. (Doctor of Osteopathy) degree were most likely to screen in all categories and did not differ significantly from each other. However, since the majority of provider respondents to this survey held either of those degrees, this finding may not be practically significant.

Binary logistic regression was used to examine whether *Knowledge* and *Attitude* scores predicted screening versus no screening. The categorical screening variable was dummy coded into two variables: "no screening/occasional screening" and "no screening/universal screening". (Note: no analyses were performed with "no screening/selective screening" because the category "selective screening" had too few observations to include in a regression model.) The first model, which tested knowledge and attitude scores by "no screening/occasional screening", had a poor overall fit and the estimates were not included in further analysis. The second model examined scores by "no screening/universal screening" responses, which again did not contain statistically significant coefficients. Therefore, providers' perspectives toward IPV, including their knowledge and attitudes, were not significantly associated with certain types of screening practices according to data from this survey.

Specific Screening. *Specific screening*, a continuous variable with values ranging from one to five, represented a mean score attached to a provider's responses regarding whether or not they screen when presented with certain health concerns indicative of IPV. Unlike the categorical *Screening* variable, *Specific screening* was weakly associated with *Knowledge* and *Attitude* scores. *Knowledge* scores were inversely correlated with specific screening scores:  $r = -.55, p < .01$ , meaning that higher *Knowledge* scores translated to lower *Specific screening* scores. Two of

the scores from the *Attitude* scale, “Staff Preparation” and “*Victim Understanding*” ( $r = -.52, p < .01$  and  $r = -.57, p < .01$ , respectively) were also inversely correlated with *Specific screening*: as these scores increased, *Specific screening* scores decreased.

*Specific screening* was also associated with organizational factors, including a clear clinic protocol for addressing IPV ( $t [117] = 5.09, p < .01$ ), a provider’s perceived knowledge of community resources ( $t [107] = -7.08, p < .01$ ), and having adequate referrals to resources within the community on hand ( $t [107] = -8.07, p < .01$ )<sup>8</sup>. Providers who “responded” yes to all these questions had higher scores on the *Specific screening* measure. *Clinic type* was significantly associated with higher scores on the specific screening measure. Rural health clinics had lower mean scores than FQHCs (3.27 versus 4.26), and this difference was statistically significant:  $t (118) = -6.50, p < .01$ . The number of patients seen per week, number of physicians and nurses employed by the clinic were not significantly associated with *Specific screening*.

Certain provider demographics were associated with specific screening scores, including *Gender* and *Degree* (D.O. versus M.S.N.). Males had higher screening scores than did females (4.13 versus 3.28, respectively), a statistically significant difference ( $t [125] = -5.32, p < .01$ ). Providers with a D.O. degree also had higher mean scores than nurse practitioners (4.20 versus 3.31) ( $t [103] = 5.09, p < .01$ ). The number of hours of previous training about IPV was not associated with *Specific screening* scores.

Again, while a provider’s knowledge and attitudes did not necessarily predict specific screening practices within the previous six months, certain organizational and personal demographic characteristics were indicative of higher *Specific screening* scores. These factors

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<sup>8</sup> Mean scores for *Specific Screening* based on clinic’s *IPV Protocol*, “yes”: 4.02 vs. “no” 2.68; *Community Resources Knowledge*, “yes”: 3.94 vs. “no”: 2.39, and *Referrals on Site*, “yes”: 3.88 vs. “no” 2.88.

included the clinic's IPV protocol, working at an FQHC, a provider's knowledge of community resources and having those resource referrals at their clinic site, being male, and practicing as a D.O.

Response. The categorical *Response* variable included six levels: “no action”, “provided information”, “patient counseling”, “safety assessment”, “safety assessment with children”, “safety planning”, and “referrals”. Providers indicated which of the above actions they had taken most often when addressing IPV within the previous six months. Several personal, organizational, and community factors were indicative of a provider's response to IPV. Higher *Knowledge* scores were associated with a provider's taking action of some kind to address IPV, including “providing information” ( $t [31] = 9.83, p < .01$ ) and “patient counseling about options” ( $t [71] = 7.06, p < .01$ ) when compared with “no action”<sup>9</sup>. Demographic indicators such as *Degree* and *Year of Graduation* were not meaningfully associated with a provider's response to IPV, but *Gender* was, with females most likely to fall into the “no action” category ( $\chi^2 [6, 134] = 25.63, p < .01$ ). As with *Screening*, a general trend of providers' taking action to address IPV (versus no action at all) was associated with having received 16 or more hours of training:  $\chi^2 (12, 134) = 50.93, p < .01$ . Of the providers who did not take any action to address IPV, the majority (15 of 20) had received five or less total hours of IPV training.

Organizational factors again appeared most significant in terms of predicting a provider's response across the majority of categories, including a clinic having protocols in place to manage IPV ( $\chi^2 [6, 134] = 32.41, p < .01$ ), which was associated with providers engaging in “patient counseling about options” and “conducting safety assessments”. Knowledge of their clinic's

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<sup>9</sup> Mean *Knowledge* scores by *Response*: “No action”: 11.75 vs. “Provided information”: 26.09. Mean *Knowledge* scores by *Response*: “No action”: 16.44 vs. “Patient counseling”: 26.09.

policies regarding IPV ( $\chi^2 [6, 134] = 22.34, p < .01$ ) and community resources knowledge ( $\chi^2 [6, 134] = 27.18, p < .01$ ) were also associated with patient counseling and safety assessments. Having adequate referrals on hand to provide IPV survivors was associated with “patient counseling”:  $\chi^2 (6, 134) = 36.19, p < .01$ .

The other organizational factor that was significantly associated with provider response to IPV was the number of nurses employed by the clinic; providers employed at clinics with five or fewer nurses were those almost exclusively comprising the “no action” category (20 out of 21). This finding was significant ( $\chi^2 [18, 134] = 75.17, p < .01$ ). Number of physicians employed at the clinic did not appear to predict a response regardless of category, and number of patients treated per week was significantly associated with “patient counseling” and “safety assessments” ( $\chi^2 [24, 134] = 72.54, p < .01$ ), although this finding is not practically significant since the cell sizes for most of the patients-per-week categories were too small to be calculated into the total. Clinic type was also associated with “no action”: of the 19 providers falling into this category, 17 were employed at RHCs ( $\chi^2 [6, 134] = 29.44, p < .01$ ).

The likelihood of taking action to address IPV based on *Knowledge* and *Attitudes* of the provider was assessed with binary logistic regression. The seven-category variable *Response* was dummy coded into dichotomous variables, where “no action” equaled zero and one of the six additional responses (“provided information”, “safety planning” etc.) were coded as one. Three of these dummy variables could not be entered into a regression model due to few observations. The first model, which examined *Knowledge* and *Attitude* scores by no “action/provided information”, was a poor overall fit and the results were not significant. The second and third models assessed *Knowledge* and *Attitude* scores by no action/patient counseling and no action/safety assessment. Overall *Knowledge* and two *Attitude* subscales, “Staff Preparation” and

“Screening”, were significant in both of these models (see Table 3.2.7 below). In the first model, the likelihood of a provider responding to IPV with “patient counseling” decreased by 85% with every one-point increase on the “Staff Preparation” subscale, yet increased by nearly 52% for every one-point increase on the “Screening” subscale. A one-point increase on the *Knowledge* score was associated with a 25% decrease in the likelihood of a provider engaging in patient counseling upon identification of IPV. Therefore, providers with higher scores testing their IPV knowledge and more agreeable attitudes regarding health care staff’s preparation for addressing IPV were less likely to have responded to the identification of IPV by counseling their patient about her options within the previous six months.

All three of the above mentioned predictor variables (*Knowledge*, “Staff Preparation” *Attitudes* and “Screening” *Attitudes*) were also significantly associated with the likelihood of a provider responding to IPV by conducting safety assessments with their patients. The likelihood of conducting safety assessments decreased by 85% for every one-point increase on the “Staff Preparation” subscale, and a one-point *Knowledge* score increase was associated with a 20% decrease in the likelihood of conducting a safety assessment. This finding suggests that as providers’ *Knowledge* and agreeable attitudes toward health care staff’s preparation to address IPV increased, they were less likely to have responded to IPV by conducting a safety assessment with their patient. However, with every one-point increase on the “Screening” attitudes subscale, the likelihood of conducting a safety assessment increased by 32%. Therefore, providers with attitudes favoring health care providers’ screening for IPV predicted a greater likelihood of having performed a safety assessment within the previous six months.



**Table 3.2.7 Logistic Regression Analysis of Provider Response**

**Patient Counseling Response<sup>2</sup>**

Independent Variables	b	SE	P value	Odds	CI
Attitudes: Preparation	-1.88	.799	.019	.153	.032-.732
Attitudes: Screening	1.519	.647	.019	4.566	1.29-16.22
Knowledge	-2.99	.088	.001	.742	.624-.882

*Model  $\chi^2 = 6.943$ ,  $df = 7$ ,  $p = .543$*

*N = 134*

**Safety Assessment Response<sup>3</sup>**

Independent Variables	b	SE	P value	Odds	CI
Attitudes: Preparation	-1.940	.921	.035	.144	.024-.875
Attitudes: Screening	1.317	.640	.040	3.733	1.064-13.094
Knowledge	-.224	.101	.027	.799	.655-.975

*Model  $\chi^2 = 12.953$ ,  $df = 7$ ,  $p = .073$*

*N = 134*

\*Model fit was assessed with the Hosmer-Lemeshow Goodness-of-fit test.

<sup>1</sup> The dependent variable in this analysis is “screening” coded that 0 = no screening and 1 = universal screening.

<sup>2</sup> The dependent variable in this analysis is “response” coded that 0 = no action and 1 = patient counseling.

<sup>3</sup> The dependent variable in this analysis is “response” coded that 0 = no action and 1 = safety assessment.

### **3.3 Discussion of Survey Findings**

The results of the Survey of Rural Health Care Providers indicate that the majority of rural physicians and nurses in Missouri are aware of IPV and take steps to identify and address it with their patients. Despite varying degrees of knowledge and previous training about IPV, providers frequently encounter the issue in their practice and many respond to the situation immediately, often by providing information, counseling the patient about her options, and conducting safety assessments. Additionally, rural health care providers must respond to IPV given an overall dearth of available resources and services specific to IPV in the rural communities in which they practice. However, findings from the survey point to a number of

discrepancies, such as those between providers' perceived knowledge about IPV and their actual *Knowledge* scores, which bear closer examination. Key findings from this survey will be discussed in the sections below.

### **3.3.1 Individual Factors**

#### **Knowledge**

Perhaps the most surprising finding from this study was the gap between providers' perceived knowledge about IPV and their knowledge as measured by the PREMIS, coupled with findings indicating that higher knowledge scores were not significantly associated with most screening and response practices. Indeed, somewhat counter-intuitively, higher levels of knowledge predicted *lower* uptake of certain screening and response practices, such as patient counseling and safety assessments.

Because providers' overall knowledge about IPV appears to be quite low, it is difficult to meaningfully interpret some bivariate and multivariate results. It may be that an underlying reason behind the wide variability of responses to IPV is partially due to providers' general lack of knowledge about partner violence risks, dynamics, and health indicators. This may help explain why knowledge scores were not significantly associated with most screening and response practices—or when they were associated with such practices, it was to suggest that higher levels of knowledge were inversely correlated with certain common practices. Providers in this sample who possessed higher levels of knowledge about IPV may have been responding in ways that were not asked about in this survey, for example, which could have contributed to this inverse correlation. The incongruence of other findings may simply point to organizational factors, specific clinic protocols, or an existing provider-patient relationship that influenced providers' decision to screen for IPV that were not captured by this survey. For instance, less

than one-third of providers recognized depression as a risk factor for IPV, yet two-thirds stated they have screened for IPV based on a patient's having depression within the previous six months. It is thus unclear why the majority of providers would have asked a depressed patient about IPV since their *Knowledge* scores seemed to indicate that they did not realize these two problems are frequently associated with one another. A final caveat regarding the discrepancy between provider knowledge and practice may simply point to the fact that the survey asked about two different forms of knowledge—theoretical and applied. By virtue of their profession, health care providers apply their knowledge of health conditions, signs, and symptoms to diagnosis and treatment. This represents a set of skills that is probably different from academic knowledge of IPV dynamics which the *Knowledge* scale favored.

Yet providers' knowledge about IPV is significant because, given the lack of universal screening guidelines and procedures for health care settings in general, it may indicate an awareness of a major public health concern that could otherwise go unrecognized. It is therefore important that providers have sufficient knowledge about IPV risk factors and health correlates that prompt them to ask patients about the possibility of IPV, but also that such knowledge extends to the way they respond and treat the patient. Providers' relatively low levels of such indicators may translate to missed opportunities or inappropriate responses to the situation. A provider who does not know that depression may be a warning sign of IPV may thus never ask their depressed patient about this possibility, or a provider may give a patient in a violent relationship a referral for a couples' counseling program that could place the patient at risk of more severe violence.

Higher levels of knowledge about IPV may also translate to higher levels of knowledge about the existence and accessibility of community-based resources for IPV<sup>10</sup>. Data from this survey did not show an association between providers' overall *Knowledge* scores and their perceived knowledge of community resources per se, but some links could be drawn between these types of knowledge based on providers' appraisal of their community's overall response to IPV. The majority of providers indicated that health and mental health services were lacking, that shelters and housing options for survivors were scarce, and that the community's approach to IPV in general was not terribly effective at getting violent abusers off the street or helping survivors re-establish their lives by getting away from the abuser for good. Most providers were neutral about the effectiveness of their community's law enforcement and social services approach in responding to IPV, which could mean they had no experience with such services. Without knowledge of IPV dynamics, it is difficult to imagine that providers' actions in addressing IPV would be as adequate, appropriate, or ultimately helpful to the patient as they might otherwise.

### **Attitudes**

Attitudes toward IPV were largely not predictive of screening or responses taken to address the issue with patients. Feelings of preparation and perceived knowledge about IPV and legal reporting requirements were incongruent with providers' generally low levels of IPV knowledge. While overall there were no red flags indicating that providers held victim-blaming or pathologizing views toward women in abusive relationships, the largely neutral mean scores

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<sup>10</sup> A possible caveat regarding providers' knowledge of community resources and one which this survey did not address is whether the provider is a resident of the town in which the clinic is located. Providers who commuted to their clinic location from a metropolitan area or another community—or who were practicing in a medically underserved area on a J-1 visa to fulfill an immigration requirement—may not have familiarity with community resources simply because they are not from that community.

for each *Attitude* subscale do not imply a particularly understanding or empathic view toward such patients. Providers seemed to feel that their hands were tied unless the patient specifically asked for or wanted their help, largely agreeing with such statements as “If the victim does not acknowledge the abuse, there is very little I can do” and remaining neutral on the point that “Health care providers have a responsibility to ask all patients about IPV.” Again, attitudes supporting preparation for and responsibility for addressing IPV with patients, as with higher levels of IPV knowledge generally, may lead providers to respond to the issue in a way that is seen as more appropriate or effective by their patients experiencing IPV. While attitudes toward IPV were either not associated with or only weakly associated with screening practices, providers who hold a dim view of IPV may not approach the issue with appropriate amounts of sensitivity, thus discouraging patients from disclosing and perhaps ultimately failing to catch the problem.

### **Demographic Characteristics**

Although knowledge and attitudes as measured by the PREMIS did not exert a substantial influence on screening and response to IPV overall, a variety of other individual factors were significantly associated with certain provider practices. *Gender* and *Discipline* were characteristics that predicted screening for IPV, with males and D.O.s most likely to report screening and specific screening practices. As the majority of survey respondents held either a D.O. or M.S.N. degree, a comparison between the screening practices of these two disciplines was more meaningful than a comparison among all provider categories (M.D. and B.S.N. having too few respondents in each group to include in statistical analyses). Providers holding a D.O. were significantly more likely to screen across all screening categories, as well as engage in specific screening when presented with health concerns often indicative of IPV, than their nurse

practitioner counterparts. This finding may suggest that individuals receiving a D.O. degree receive more training about IPV, or at least preparation for IPV screening as part of a patient's routine exam, than do nurse practitioners. Males were also more likely to screen across all categories and engaged in specific screening more frequently than females. This finding is notable because male providers were more likely to hold a D.O. degree, while females tended to have their Master's degree in nursing (see cross-tabulations between sex and discipline in Table 3.3.1). Only seven females held a D.O. and 10 males were nurse practitioners. Providers holding a D.O. degree were more likely than nurse practitioners to screen, and males made up the majority of those holding a D.O.; therefore, men were more likely to screen for IPV than women.

**Table 3.3.1. Sex \* Discipline (D.O. vs. M.S.N.)**

		Discipline		Total
		<i>D.O.</i>	<i>M.S.N.</i>	
Sex	<i>Male</i>	35	10	45
	<i>Female</i>	7	57	64
Total		42	67	109

Training about IPV was indirectly linked with frequency of screening in a previous study (Gutmanis, Beynon, Tutty, Wathen & MacMillan, 2007), chiefly by helping the provider feel more prepared to address IPV. Indeed, more prior training on the issue was significantly associated with universal and specific screening practices according to this survey, suggesting an upward trend where training predicted awareness of the issue and prompted providers to screen for IPV. Yet the gap between provider's knowledge about IPV and their screening and response practices is all the more puzzling given the amount of previous training about IPV providers state they have had. The majority of providers had 16 or more hours of training on IPV, so their low overall *Knowledge* scores spark the question of what training about IPV has entailed for many of

these providers. Additionally, providers demonstrated gaps in basic knowledge of their own legal requirements, such as the state’s mandated reporter statutes. (Nearly two-thirds of providers believed they were required to contact the authorities even when IPV was disclosed by an adult, non-vulnerable woman between the ages of 18 and 65.) These survey findings indicate that more hours of training about IPV may technically increase screening practices, but the quality and content of IPV training probably matters more in terms of increasing multifaceted knowledge about the issues pertinent to effectively managing IPV.

### **3.3.2 Organizational and Community Factors**

#### **Organizational Factors**

Chief among the observations gleaned from this study were the indications that providers’ frequency of IPV screening (93% of survey respondents stated they had identified at least one new case of IPV within the previous six months) was more closely associated with organizational factors than with knowledge and attitudes about IPV. Clinic protocols describing how to manage IPV and providers’ familiarity with these workplace policies clearly predicted screening and response across most categories (when compared to “no screening” and “no action”). Having resource referrals on site to provide to patients also helped bolster frequency of screening. However, a large majority of providers indicated that their clinic had protocols for managing IPV—nearly 82% of respondents—and 81% stated they were familiar with these clinic protocols. Approximately 71% then indicated their clinic kept referrals for community services on hand to provide to patients experiencing IPV. Providers may have over-estimated their own policies or familiarity with such policies, especially since far fewer respondents agreed that their workplace specifically encouraged them to screen and respond for IPV according to the *Attitudes* scale. This survey did not define specifically what “IPV protocols” and “IPV policies” might

entail, so such terms could have been interpreted in different ways by different providers. From a data analysis standpoint, the skewed distribution of these data may have resulted in statistically significant associations with screening that are not practically meaningful. Therefore, these data should be interpreted cautiously.

The clinic size and weekly patient volume were other organizational factors that may have been too skewed statistically to make a strong claim for association between these workplace characteristics and frequency of screening and response practices. The majority of providers were employed at clinics with fewer than five full- or part-time physicians and nurses on site (70% and 53%, respectively). Providers who hailed from clinics with five or fewer nurses were those most likely to fall into the “no screening” and “no action” category, although the numbers in these cell sizes were very small compared to the rest of the sample. Fewer staff may indicate that providers have less time to spend with their patients and thus less time for effectively managing IPV, but since most of the clinics involved in this study generally employed small numbers of providers, a sample with wider variability is needed to confirm this claim.

*Clinic type* (RHC versus FQHC) was also not a meaningful predictor of provider screening and response, although providers from RHCs had lower mean scores on the *Specific Screening* measure and were more likely to fall into the “no action” group when compared with the other categories of actions on the *Response* measure. Reasons for this discrepancy are not well understood. The size of the clinic may have factored into the difference in scores and actions, yet according to survey respondents, RHCs were not significantly different from FQHCs in terms of staff employed at the clinic or patient load (although the majority of the clinics employing 16 or more physicians were FQHCs, this was too small a percentage of the overall



total to be meaningfully included in cross-tabulations). Clinic type was not associated with other factors that may have predicted specific screening, such as training, knowledge, or attitudes. It may be that FQHCs, by virtue of their patient population or reimbursement structure, have tighter guidelines about IPV screening and response for their staff or (as they are part of a larger health care organization) more oversight regarding these practices. Similarly, RHCs with their specific geographic mandates regarding operation in a designated medically under-served area may simply be located in more remote parts of the state where there are fewer community resources and thus less information for the provider to give their patients upon the identification of IPV. There may also be more variability among RHCs with regards to clinic oversight and nearby hospital affiliation due to their looser organizational structure, translating to more clinic autonomy with regards to the implementation of certain protocols that could involve the management of IPV.

Despite these caveats, findings from this study suggest that increased knowledge and supportive attitudes alone are insufficient measures to change or implement providers' screening practices. Clinics' operating protocols and workplace expectations seem to drive providers' awareness of the necessity of screening. It was these organizational factors which played the largest role in determining whether a provider screened for IPV, and likely factored into the types of screening that providers conducted. For example, those who screened during specific points in a patient's pregnancy may have done so because their clinic protocols mandated this practice. When clinics had clear protocols and policies regarding the screening and response to IPV, providers screened on a near-universal basis. It makes sense that organizations concerned about the issue of IPV would have instituted guidelines about it and maintained information for patients experiencing it. Screening was therefore associated tightly with providers being familiar

with their clinic's protocols and feeling they had adequate community resource referrals to give patients on site at the clinic.

### **Community Factors**

The majority of providers (81%) rated themselves as familiar with community resources for IPV survivors, and 71% claimed their clinic had adequate referral resources on hand for patients experiencing IPV. Yet when asked more specifically about community resources for patients, such as their effectiveness in responding to certain aspects of IPV, providers seemed more critical. Providers tended to find the availability of services with short-term outcomes for survivors, such as obtaining a restraining order, adequate. However, services that would have indicated a community's long-term responsiveness to victimization, such as "leaving the abuser for good" (26% of providers thought that adequate services existed for this outcome) or other IPV-specific support services, like a domestic violence shelter (only 19% of providers found these services adequate), were not seen as helpful or were nonexistent in that community. Furthermore, puzzling findings, such as the fact that a greater percentage of providers (approximately 40%) judged their community as having adequate support services for Spanish-speaking and LGBT survivors—more than compared to general IPV services, such as a domestic violence program (the aforementioned 19%). This finding was unexpected for rural Missouri and may warrant a close re-examination. It is likely, however, that because the survey questionnaire did not specifically define what "supportive services" for Spanish speakers and LGBT individuals meant, providers could have interpreted the question in multiple ways.

The paltry number of community resources for survivors in rural areas was not a surprising finding given the rural areas where providers were employed. However, the discrepancy between the 71% of providers who first claimed there were adequate resources

compared with the far fewer respondents who judged specific resources as adequate in the *Rural Setting Survey Addendum* is noteworthy. As has been discussed from other, seemingly incongruent survey findings, providers' perceptions of what was available and helpful in terms of community resources did not match their later responses to more concrete questions regarding type and accessibility of these resources. Providers may have had little experience with such resources or were unaware of their existence. They may have known that some general service for IPV was available—i.e., a hotline number to call—and judged this an adequate referral resource until asked about more specific services that would be likely to help survivors, such as a victim witness advocate. Again, such a discrepancy is troubling because it may indicate that providers make inappropriate suggestions or referrals when counseling patients about their options for addressing IPV. Fully one-third of providers suggested there were adequate services to provide both couples' counseling and children's counseling for families experiencing IPV. It is not known whether providers feel couples' counseling is an appropriate referral for IPV survivors, and it is unclear whether providers conflate such counseling services with, for example, the state's Children's Division, which can mandate families to certain forms of treatment based on allegations of child abuse and neglect—not IPV, necessarily. Community factors are thus important to consider with regards to the appropriateness and effectiveness of the provider's response to IPV, and specific questions about the types of resources available reveal that many rural health care providers have little to offer their patients and, furthermore, know little about the offerings that are available.

### **The Rural Setting**

The general dearth and lack of variety of effective services for IPV survivors may, according to providers surveyed, have to do with the rural community setting where clinics were

located. While this survey did not explicitly compare urban with rural settings, some inferences about the unique dynamics of rural practice can be drawn. For instance, nearly half of providers—49%—stated they were personally acquainted with many of their patients outside of the clinic. The majority of providers also acknowledged they individually treated partners of a couple involved in an abusive relationship. These social dynamics *are* likely something that is unique about rural practice. A personal or social relationship with a patient could either facilitate or serve as a barrier to IPV disclosure and management. Personal relationships with patients could compromise or at least make keeping confidentiality of the patient encounter more challenging for rural providers. Indeed, rural survivors have named breaches of confidentiality or fears about being exposed as a victim as reasons why they do not seek help from their health care provider (Annan, 2008).

A personal relationship with a patient may also color the provider's approach to IPV, as it may be difficult to remain neutral about a patient's choices if that patient happens to be a social acquaintance. Alternately, a personal relationship with a patient may mean that the provider is more aware of the situation and better positioned to respond with an effective tactic or resource based on this personal familiarity. Regardless, the small communities where providers practice and thus the likelihood that they are personally acquainted with at least some of their patients is an important facet of rural health care delivery that may be influencing screening and response practices.

### **3.4 Chapter Summary**

Rural health care providers across the state of Missouri participated in a survey designed to measure their overall knowledge and attitudes regarding IPV and gather important and heretofore unknown information on practice behaviors and the community factors that

influenced their response to IPV. Overall findings indicate that providers are aware of IPV as a health problem, view it as an issue of concern to their communities, and frequently encounter the issue in their practice. Providers also rated their community's response to IPV, especially the resources available for patients experiencing IPV, as inadequate: many services to help survivors are simply unavailable in the rural communities where these providers are employed. Therefore, rural providers in Missouri often identify IPV, yet according to the survey, have very little to offer the patient in terms of additional help.

Survey findings are less clear with regard to providers' perspectives and associations between individual characteristics such as knowledge and training on their practice behaviors in response to IPV. Discrepancies between disparate parts of the survey, such as perceived knowledge and actual knowledge, or perceived availability of community resources and actual availability, characterize these data. Such discrepancies may be related to the survey's item construction, which asked similar questions in multiple ways in order to confirm and re-confirm certain responses. It is likely in this scenario that providers have a modicum of understanding about IPV, believing that since they are generally aware of it that they are capable of managing it appropriately. However, when asked more specifically about IPV dynamics, coupled with the steps providers take to respond to IPV, these perceptions tend to break down. Providers may not know all they do not know about IPV issues.

In an effort to better understand some of the contextualizing factors surrounding rural health care delivery with regards to IPV screening and response, semi-structured interviews with a subsample of rural health care providers were undertaken as part of this research. The following chapter will discuss the methods and findings from this qualitative component of the Survey of Rural Health Care Providers.

# **Chapter 4: Rural Health Care Providers’ Response to Intimate Partner Violence: Qualitative Findings**

This chapter focuses on the qualitative experiences of rural health care providers when confronted with issues of IPV in the primary care setting. The beginning section will describe methods of recruitment, data collection, and data analysis. An overview of the providers’ relevant demographic and background information is provided, followed by interview content that addressed the providers’ screening and response practices to IPV. As will be discussed, providers’ response to IPV was not a uniform approach, and was heavily influenced by the rural community in which these clinics were located.

## **4.1 Interviews with Rural Health Care Providers**

The purpose of interviews with health care providers was to deepen the level of understanding about the strengths and challenges of addressing IPV in rural primary care practice. This student developed a list of 18 questions for rural health care providers under the supervision of her committee chair (this interview protocol is located in Appendix 2; selected questions are listed in Figure 4-1). The questions were piloted with a professor of nursing at the University of Missouri and a nurse employed at a regional hospital in a rural county south of St. Louis. Based on their feedback it was determined that the questions were appropriate, clearly worded, and would take approximately 30 minutes to complete in a face-to-face interview. Health care providers were eligible to participate in the interviews if they were employed at least part-time at a rural health clinic. The target goal for provider interviews was 15, and a \$20 Amazon gift card was offered as an incentive to participate.

## Figure 4.1 Selected Interview Questions

What, if any, challenges or barriers do women face when fleeing an abusive relationship in this community/area?

What, if any, services for victims of IPV are there in this community/area? What are your perceptions of the effectiveness of these services in addressing victims' needs and reducing IPV?

What are the challenges of identifying IPV in your practice? What are the challenges of responding to IPV in your practice?

How do you manage or ensure patient confidentiality when IPV is disclosed? What challenges, if any, does confidentiality present in a small community like this?

In your experience, in what ways, if any, does the overall health status of women experiencing abuse differ from non-abused women?

### 4.1.1 Recruitment

Provider participants were recruited using a combination of methods as outlined below. Note that each of the recruitment tools described here are reproduced in full and combined in Appendix 4. This student:

1. Created a website describing the study, inclusion criteria, and soliciting provider participation. (The link to access the study is here: [www.sites.google.com/site/moruralwomenshealth](http://www.sites.google.com/site/moruralwomenshealth).)
2. Enclosed a special cover letter describing the interviews and soliciting participation from health care providers in 75 randomly selected packets of the 438 total survey mailings.
3. Posted advertisements in the Missouri Department of Health and Senior Services' "Friday Fun Facts" newsletter describing the study and soliciting participation.

4. Emailed a flyer advertising the study and soliciting interviews to the Missouri Rural Health Association, the Missouri Department of Health and Senior Services (Offices on Women's Health and Rural Health), the Missouri Primary Care Association, the Missouri League for Nursing, Southeast Health, Northeast Missouri Rural Health Network, the Missouri Foundation for Health, the Bootheel Network for Health Improvement, Northeast Missouri Health Council, Pershing Health System, Katy Trail Community Health, Applegate Medical Group, Meadville Medical Clinic, and Community Health Associates.
5. Posted an advertisement on Craigslist in all the available Missouri locations excluding the metropolitan areas of St. Louis and Kansas City.
6. Publicized the study through social media accounts: Facebook, Twitter, and Google Sites.
7. Used her own social network and personal acquaintances familiar with the health care field and rural communities to generate awareness of the study by word of mouth.

Participants contacted this student by phone or email to arrange interviews. Potential participants were asked the following screening questions: 1) "Are you employed at least part-time at a rural primary health clinic or rural Federally Qualified Health Center providing primary care?" 2) "What is your profession/level of education [e.g. physician, nurse, nurse practitioner]?" Prior to beginning each interview, providers either read or were read an informed consent document. This document was signed by the provider when in person; verbal consent was given for phone interviews. Providers were given the option of having the interview audio recorded, to which they provided consent or assent in each case. Following the interview, each participant received an electronic gift card valued at \$20 to Amazon. Although it was possible, based on the



study's inclusion criteria and recruitment strategies, for providers to respond to both the survey and a call for interviews, none of the providers interviewed (n= 7) had participated in the survey.

Interviews were recorded using the Audio Memos application for iPhone and transferred to a removable file storage device immediately after the interview. Audio recordings were stored on the flash drive and in the program NVIVO (version 10, QSR International), which was used for qualitative data management and analysis. This student also took field notes during and after each interview, transferring them to a document within NVIVO following each encounter.

#### **4.1.2 Data Analysis**

Following transfer of recorded interviews and field notes to NVIVO 10, this student followed the same protocol for each interview: first, a coding scheme based on the study's construct was developed (see Figure 4-2). Second, the recording was transcribed directly in NVIVO. The same interview was played a second time, with the student typing a summary document of the encounter, specifically focusing on themes that touched on the study's proposed constructs. Each transcription was read carefully alongside the coding scheme to identify words, phrases, quotes, and other thematic content that related to the study's constructs, and highlighted or "coded" under the appropriate construct. During the second read-through of the transcription, any themes relevant to the provider's experience but outside of the existing coding structure were identified. This additional information was added to the summary documents matching each participant's interview transcription. The summary documents were then used as a quick reference guide during the final write-up of the interviews. This form of content analysis was thus a mixed approach to qualitative analysis, as suggested by Berg and Lune (2012), a directed method that involved deductive and inductive derivations from the raw data.

## 4.2 Interviews

### 4.2.1 Background

Seven providers agreed to participate in interviews. Three of these interviews were conducted in person at the provider's own clinic office; four others were conducted over the phone. Interviews lasted for an average of 39 minutes. Participants were mostly female and nurses (n= 6, 86%), and one male physician. All participants were Caucasian, and all except one were employed full-time at a rural health clinic (one nurse was employed part-time at a rural

**Figure 4.2 Coding Scheme for Providers' Interviews**

<i>Theme</i>	<i>Construct</i>
Prevalence and severity level of IPV in community	Rural culture, changing rural populations, protective factors
Perception of challenges faced by rural victims	Risk and protective factors, rural culture
Knowledge and perception of services for victims	Rural culture, risk and protective factors, health and health care
Challenges of identifying and responding to IPV	Rural culture, changing rural populations, health and health care
Confidentiality	Confidentiality
Perceptions of U.S. Preventive Task Force recommendations	Health and health care, rural culture
Opinions on mandated reporting of IPV	Health and health care, rural culture
Disclosure of IPV when partner present	Confidentiality, rural culture
Disclosure of IPV when victim/partner is personal acquaintance	Confidentiality, rural culture
Health status of abused vs. non-abused women	Risk and protective factors, health and health care
Reasons for becoming rural practitioner	Rural culture
Perceptions of rural challenges and strengths	Rural culture
Recommendations for ways to address IPV	Health and health care
Majority patient demographics & shifts over time	Changing rural populations
Risk factors specific to rural	Rural culture, health and health care, changing rural populations
Protective factors specific to rural	Rural culture, health and health care, changing rural populations

FQHC). All clinics were classified as primary care although each offered comprehensive care for women, such as gynecologic and family planning services. Clinics were located in seven counties in eastern, central, and southern regions of the state. Three of the participants (43%) were clinic directors as well as practicing nurses. The average length of time a provider had been in practice was 17.9 years, with the longest practice experience 37 years and the shortest four years.

#### **4.2.2 Providers' Practices and Perspectives**

##### **Screening**

Three providers stated that they screened their female patients for IPV at least once a year, during annual exams. A fourth provider stated that her clinic was mandated to screen for IPV during annual exams for patients receiving Medicare only. Of the three providers who practiced universal screening for IPV, one was required by her clinic's funding structure (Title 10) to screen all patients at every exam, regardless of their presenting issue. The other two providers who screened universally did so because they personally felt the issue was important to address with their patients. "I was a victim of domestic violence in my previous marriage, so I think that makes me more aware of it," explained Tracy<sup>11</sup>, a nurse practitioner and clinic director.

One provider practiced selective screening, asking questions about family violence and home safety issues during a health history appointment with new patients, usually during the first or second encounter with that patient. "I try to," said Robert. "I'm not 100 percent, but there are times. I usually try to ask that question—'are they in any danger?', 'how is your relationship?'"

The remaining three providers, including the nurse-clinic director at whose clinic all Medicare patients were screened yearly, indicated that their clinic's practice was to occasionally

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<sup>11</sup> All names have been changed to protect the participants' confidentiality.

screen—that is, ask questions when they suspected abuse, as when they discovered bruises during patient exams. When asked what other signs or symptoms might prompt providers to ask about IPV, all seven providers mentioned what Margie called a “red flag”: a partner that seemed disinclined to remain in the waiting room when providers brought the woman back into an examination room. “Any signs of an overly dominant, protective partner that wants to be in the room at the same time, and seems to be not one to ever leave,” Alice described. In these cases, providers would devise ways to get the woman alone in order to ask about what was going on. Some strategies that had been used involved asking the woman for a urine or lab specimen, and then intercepting her on her way to these separate rooms. Others found that simply telling the male partner politely but firmly that they needed to examine the woman alone was sufficient. However, providers did admit, ruefully, that it was ultimately up to the patient as to whether she would allow the partner in the room: “I’ll look right at her and say, ‘Do you want him to come back there with you?’ and if she says ‘yes’, then we have to let him back there,” said Margie.

One of the major barriers to identifying IPV was not whether the provider screened for abuse, but according to providers, hinged on whether the woman would disclose the truth once asked. All of the providers interviewed listed examples of times they had suspected abuse and asked specific questions about it, but the patient denied everything. The major reason providers suspected women would not disclose was due to stigma and perceived lack of anonymity in their close-knit communities. “Everybody knows everybody,” said Krista, echoing a common refrain. Alice stated, “They’re probably more hesitant to mention it in a rural area where everyone knows one another.” Tracy agreed: “It’s looked down upon in the community, so a lot of times it takes a lot in order for those patients to expand on what’s going on inside the home.” Providers speculated that some patients might be afraid that any information they provided about IPV

might be placed in their chart, which could potentially be viewed by an acquaintance of theirs who worked at the clinic.

Although universal screening for IPV is recommended by the U.S. Preventative Services Task Force, half the clinics where providers in this study were employed did not follow these recommendations. Alice, a nurse practitioner at an FQHC, stated that it would be challenging to ask each patient about IPV if the question did not seem appropriate for the visit. “Maybe they’ll think it’s pretty strange if they’re coming in for a cold and you’re asking them about domestic violence,” she said. Sharon agreed. “The patients who are coming in every three months for diabetes, and if we were to ask them every time about abuse even after they’ve repeatedly told us no, that just doesn’t make a whole lot of sense.”

Most providers felt comfortable with the way their clinic handled screening for IPV. “I think we’re doing all we can,” said Margie, who was employed by a clinic that was mandated through a state regulatory body to screen universally. Alice, who was employed in a clinic that screened selectively, suggested that her clinic might place flyers with the national domestic violence hotline or other materials in the women’s restroom: “Then the women could access that information privately, and if they thought the clinic was concerned about it they might be more willing to open up.” Opinions diverged on the use of automatic screening prompts in electronic medical records. Sharon thought it would help remind providers to screen, but Alice and Debbie, who had past or part-time experience in emergency rooms where IPV screening was required, felt differently: “You’d think they’d use their heads a bit more, but sometimes the [emergency room] staff who ask the questions do it in front of the abuser,” said Alice.

The organizational structure of the clinics (all of which were non-profit providers), combined with the lighter patient load than most urban clinics, meant that providers usually felt

they had more time to spend with their patients than they would in a larger clinic. This extra time was seen as particularly relevant for abuse disclosure by Debbie, who said, “Doctors who only have ten minutes to spend with their patients—they can’t ask about intimate partner violence. Even if they did, nobody would open up to them about a personal matter like that in ten minutes.”

Facilitating abuse disclosure generally took time—building rapport over several encounters with patients, or in some cases, treating the entire family over a period of time to get a sense of what was going on in the home. “The more you build a relationship with the patient, the more they’re coming into the office to see you, the more trust you build, the more likely they are to share things with you, than they are if they don’t know you,” said Krista. Alice elaborated:

“You may not ask the question the first time you see the woman, but as you get to seeing her over time and she gets to trust you, you’re both more *comfortable* with asking and trying to get at that information, and they’re more comfortable giving it to you. That long term relationship builds in a family practice more than it does in, say, an emergency room or a hospital.”

## **Response**

Referrals to community-based agencies were the most common provider response to IPV. Therefore, *community resources knowledge* was tightly bound with a provider’s response to IPV. However, all of the providers except one acknowledged that resources were fairly scarce in their community. Only two providers practiced in counties that had a domestic violence shelter. Others stated they knew of shelters within a range of ten to forty miles from their clinic’s location, but most had little experience referring patients to those places. After domestic violence shelters, providers most often mentioned faith-based services—three counties had an “alliance of

churches” network that were known to provide support to families in need. This support was thought to be food, help with utility bills, or possibly temporary motel placements for women fleeing abusive relationships. Sharon mentioned that the Division of Family Services might be willing to help some women with children, although she cautioned that the office was far away from her clinic and “I don’t know how friendly they are.” One provider knew of an agency that provided counseling to survivors of IPV in her community, and Robert mentioned that his town’s local food pantry did a good job of outreach to families in need.

Referrals to community resources were not always viewed as the best response to abuse disclosure, particularly because, as Krista pointed out,

“Information is not widely distributed. It’s hard to find out about it, and I think a lot of times what will happen is there will be one person to contact at some church somewhere, but that person will leave or move, so then we don’t have anybody, and people don’t realize that the person who helped with those services is now gone.”

Providers thought that the isolation of many rural women made accessing distant resources, such as shelters, very difficult. “Lack of transportation,” answered Tracy, when asked what barriers women might face toward getting to a shelter. “Even though it’s only twelve miles away, a lot of the families only have one vehicle, and the man usually has possession of that,” Debbie offered by way of explaining why none of her patients have gone to the domestic violence shelter in the county where she practices. One provider, although acknowledging the helpfulness of some community resources, personally doubted whether such services could really effect change for women in abusive relationships:

“All the programs and all the government things, that just doesn’t work. I’ve seen the way the government works and it’s not very effective and it’s not very compassionate and

it's not very efficient. That only comes when you have people that are loving and concerned about other people. And that doesn't come from legislation, that comes from God.”

Many providers found themselves working around the lack of adequate resources—which Krista expanded from shelter and material needs to include mental health counseling—by individually assessing each patient's personal resources and support systems. “When that comes up, I take a step back and really offer women options,” said Debbie. She mentioned conducting danger assessments—particularly when there were children in the home—and helping women create safety plans that might include how they could “squirrel away some money” and what documents to gather. Sharon engaged in similar practices, asking, “Does she have anybody she can stay with for now? What about her church family, can they help? Does she want to get a restraining order?” She added, “I can't imagine, if a patient came in here and was being abused and really had nowhere to go, that our staff wouldn't throw some money in the pot to get her a motel room for the night.”

None of the providers interviewed had experience with law enforcement approaches to IPV in their community. Margie thought that “they do a pretty good job, I hear they do a good job with that.” Police reports and restraining orders were viewed as one of several possible options that providers might offer to women disclosing abuse in their clinics. When services were available and accessed, most providers seemed to think that nearby community resources—particularly the alliance of churches and food pantries—were helpful. Providers did not seem to have very much firsthand experience with or knowledge of the available community resources, generally referring to a sheet or list of numbers that their office maintained for such instances. The exceptions were Tracy, Margie, and Debbie—all three of whom screened their patients



regularly for IPV and whom, unsurprisingly, characterized the prevalence of IPV in their communities as “high”. “Probably every day I run across an issue of either domestic abuse or child abuse,” said Debbie. These providers also had the most experience reporting families to the Division of Family Services for cases of child abuse and neglect, which frequently involved IPV in the same household. “And we are finding that even when we contact social services, they are not following up on our reports. And we have actually lost some patients because of this,” said Tracy. Margie and Debbie cited similar instances. “Oftentimes what happens is, I’ll call ‘em, and it will usually be because of a sexual thing, and they’ll say, ‘Well, what’s the name of the perpetrator? And I don’t know all of that information—that’s their job to find that out, I’m just doing my job and making the report!’” said Margie. The failure of such services to intervene even in cases of child abuse frustrated these providers, who felt it was the role of Family Services to assist vulnerable women and children. Sharon believed Family Services should help families where both IPV and child abuse were present, since they “almost always happen together”; however, “They’ve [Division of Family Services] closed down several offices, and even if you could get all the way to the one in Benton county [some 80 miles distant] I’m not sure now—I’m just not sure you could walk in there and say, ‘I need help, I’m being abused’, what they would do.”

Some providers felt that, as health care professionals, they were in a position to address IPV issues in the community on a broader scale. Margie stated that she would like her clinic to take an active role in educating her community, specifically high school students, about healthy relationships and healthy sexuality. She believed that community education, begun at a young age, would raise awareness about relationship violence and IPV. Taking action in this way, she

felt, was a way of preventing and responding to IPV; however, efforts to bring such programming into schools in the area were thwarted by the school board:

“We could get in there and talk to them about all these issues, you know, partner violence, it’s a biggie, but they won’t let us in. You know, they think they’ve addressed this in health class. So that’s a little challenge right now, too, is just getting the word out to where we need to be...I think some of this nonsense starts very young.”

Krista and Alice believed that an effective health care response to IPV was to offer mental health resources at their clinic site. Alice’s clinic, an FQHC, employed a part-time psychologist to whom she would refer any patient disclosing IPV for assistance with resource referrals and case management as well as counseling, if desired. “The good thing about that is, it’s a family practice clinic, so if you’re going in to see her [the psychologist] no one would know, you all just go into the same building and down the same hallway as you would to meet with the nurse practitioner.” Alice thought this might help remove some of the stigma associated with seeing a mental health professional. Krista, as clinic director, had recently received a grant to establish a telehealth psychiatry service at her clinic, which she thought would greatly benefit not only her patients experiencing IPV but the large portion of her patient caseload with untreated diagnoses of depression and anxiety.

### **Knowledge and Attitudes**

The providers in this portion of the study appeared to have a high level of awareness of IPV and knowledge of its basic dynamics. Each was able to understand why women might not wish to disclose abuse, the barriers they might commonly face when attempting to leave an abusive relationship—as well as reasons why they might remain with or return to an abusive partner. “I’m not sure I understand all of the psychology behind that, but yeah, you’d have to get

to a point where you'd say, 'I've had enough, I'm ready to totally disrupt my life and cut off all my support from this person.' And I think that's really tough for people, from the point of view of their own fear and maybe their psychological status," said Robert.

The majority of the providers interviewed described low socioeconomic status and low levels of education as major risk factors for IPV in their respective communities, exacerbated by "isolation", "no transportation", and "no access to food or alternative shelter". "Some women are afraid to report because the abuser's related to the sheriff or prosecutor," explained Alice. She went on, "It's easy to isolate someone in a rural area. And especially if they aren't coming in [to the clinic]—I think a lot of times, it's happening far more than we know about in rural areas, just because of the isolation." Sharon said, "Financial for most women. And I do think a lot of women—you just don't have it in your head to be mean, to fight back or to not take it and leave."

All providers except one stated that women who were abused exhibited more signs of depression and anxiety than non-abused women when describing the overall health status and health risks of IPV. "Any kind of depression symptoms, anxiety, stress—even high blood pressure, that's a sign to me, something's going on—'What are you stressed about?' and you can get at it [abuse disclosure] that way," said Sharon. "Those are the people you gotta watch for," Robert explained. "More psychological markers, like more depression, more anxiety, it's more of what used to be called the psychosomatic illnesses—headaches, stomach problems, bowel problems—might have something to do with that." "Those women tend to be the ones with depression, anxiety, problems with chronic pain, things like that," Alice agreed.

### **Education and Training**

Knowledge about IPV was, in most cases, gained through practice experience rather than formal education. All but one of the providers had attended nursing or medical school more than

ten years earlier, and IPV was not discussed in depth—or at all—during their programs. One nurse, who received her degree four years earlier, learned about IPV in the classroom. Another nurse was required by her clinic’s requirements to participate in yearly trainings about family violence, IPV, sexual abuse, and human trafficking—but she stated this was rare among the health care providers she knew, as her clinic was only one of 19 in the state who were mandated to receive this type of ongoing professional development. “We are doing more about it now, bringing it more into the classroom, and I think we do a good job of getting that information across to our nursing students. So it’s getting better,” said Alice, who taught a class at a nursing program through the University of Missouri. The same *organizational and community factors*, such as insurance mandates or specific clinic practices, that drove provider screening practices also tended to heighten provider awareness and vigilance around the issue of IPV.

### **4.2.3 The Rural Setting**

#### **Basic Information**

Providers were unaware of literature or protocols that specifically addressed IPV in rural settings. “I don’t know that it’s that different from anywhere else, but there are certainly different barriers for women in rural areas,” said Alice. The dearth of information was interpreted by several providers as a lack of up-to-date information on the social and community services available for survivors in their county. Krista mentioned that a recent community needs assessment undertaken by public health workers from the Missouri Department of Health and Senior Services had identified several domains of need in her county. Lack of mental health services, low levels of education, and a high percentage of the population—including children—without health insurance were some of the identified issues that Krista believed could affect rates of IPV, and which her clinic was attempting to address through expanded services. However,

IPV was not specifically identified and none of the providers interviewed could recall special trainings or information from the state as well as the broader medical literature regarding recommendations for rural health care providers addressing IPV.

### **Health and Health Care Disparities**

While the overall health status of abused women was seen as generally worse than that of non-abused women by most providers, health differences between urban and rural abused women were less obvious. Few providers had worked in an urban setting, which made drawing comparisons difficult. However, Sharon noted that, “They probably smoke a little more out here, there’s problems with obesity, with diabetes, with a lot of chronic health conditions.” Margie, a nurse who had trained and worked in a metropolitan area, said that in her experience, rural women “seem to wait to come in way later than they do [in the city]. We’ll have ‘em coming in and saying, ‘Oh, I’ve had this lump here on my breast for a couple of years,’ or whatever—well, why didn’t you come into the doctor before now? ‘Oh, I don’t know.’” Krista saw this as typical of areas where the level of formal education was low. “Here, the average reading level is below a fifth grade reading level,” she said. “Just getting women into the doctor, getting them to understand their disease processes and how to prevent sickness, how to take care of themselves—it’s ultimately an education issue.”

Four providers mentioned that substance abuse was a particular problem for their community, speculating that alcohol and drugs (whether used by the abusive partner or both partners) drove many of the health issues as well as IPV prevalence in the area. “There’s plenty of places to cook meth around here,” Robert said ruefully. Sharon mentioned methamphetamine and alcohol as major contributors to poor health in the region of the state where she practiced.

“That causes so much of it. And the financial stress—say she’s saving money, and he takes it and

drinks it all up. Well, that causes a huge fight right there,” she suggested. Krista thought that the overall lack of mental and behavioral health services exacerbated the issue of substance abuse in her county. When asked why specific kinds of substance abuse appeared to be greater problems for rural areas than urban, Sharon listed off several factors: “Less law enforcement. More remote areas, more places to cook the drugs. Less education. Less employment opportunities.” Krista agreed, “I think all of this [i.e. substance abuse] and the depression and anxiety that we’re seeing, the chronic pain—those issues are all really cropping up when our industries leave, when people don’t have jobs or lose their jobs, when they lose their unemployment benefits. It’s been very hard for many of the people here.”

The loss of industry that Krista mentioned also underscored another factor affecting the overall health status of women in rural areas, namely the issue of health insurance. All of the providers noted the scarcity of jobs in their communities. Many of the available jobs were located a considerable distance away, or were positions typically given to men: agricultural and factory work. Women were frequently dependent on their male partner’s employer-sponsored health insurance, Medicaid, or Medicare. When three factories closed down in Krista’s county, “That just wiped out a lot. Most of the places people can find work, they’re seasonal jobs or small businesses that don’t offer insurance.” Debbie described a similar lack of opportunities in her community. “I just don’t know how they’re making it, some people. They’re good people. I believe they would work if there was any work to be had.” Lack of insurance and public insurance had prompted all of the providers to adapt their billing structure so that they could care for the largest swath of patients possible regardless of their ability to pay. Each of the clinics where the providers worked accepted Medicaid or Medicare as their primary patient insurance, two clinics provided care to patients on a sliding-scale or income-contingent plan, and three

other clinics participated in a variety of state-funded programs that allowed them to see patients for certain types of visits, such as cancer screenings, for free.

Lack of health insurance was seen as a barrier to all patients' ability to receive preventative care. "Those are the ones that just aren't coming in regularly," lamented Tracy. Debbie and Margie both described themselves and their clinic staff as having to become very knowledgeable about various prescription drug programs, managed care, and free or low-cost programs to help offset the price of medication or lab services that patients might require. "We can't just send 'em off with a prescription—we have to know, 'OK, they can't afford to fill that, they can go here, they can try to get several months' worth of samples from this place, and so on," said Margie. She continued, "It's just so hard for people. And this being Missouri, basically you've got to be living in a tent before they'll get you Medicaid."

### **Changing Rural Populations**

There were no discernible demographic shifts reported by providers with regards to their patient population during the time they had been employed in their current position, with the exception of Krista. She described the rapid closing of several factories in and close to her small town that were the major sources of employment and revenue for her community. Following the plants' closures some three years ago, she said that "many of our young families" had moved away, as well as the town's Latino population, which had been a significant minority presence until recently. "They all left to go where the jobs go," she explained.

Larger macroeconomic factors represented by the recession of recent years and subsequent loss of businesses trickled into the social service sector, as well. Sharon and Tracy, when describing their frustrations with the state Division of Family Services, noted that many offices had recently closed down and merged, so that one center was often now serving several

counties instead of one. Krista mentioned ongoing problems with non-working numbers or incomplete information for social service providers when she attempted to refer patients for help. During the interview itself, Sharon called her receptionist to confirm that a small, church-run homeless shelter in a neighboring town had just lost its funding and closed its doors. Providers could not say explicitly whether the loss of such services was directly related to increasing poverty in the region, but speculated that economic factors and draining populations played a role: “It’s been hard times around here, for a lot of folks,” Sharon said.

Patients tended to reflect the racial and ethnic demographic composition typical of rural Missouri. Providers reported that between 80 and 99 percent of their patients were Caucasian, with most receiving Medicaid or Medicare. As family practitioners, providers tended to see a wide range of ages, from pediatric patients to elderly individuals. One exception was Margie’s clinic, which provided free family planning services; she stated that she almost exclusively saw young women, from the age of 12 through the mid-twenties.

### **Rural Culture**

The major aspects of rural culture that were seen as affecting IPV had to do with the isolation and poverty typical of the area as a whole. Women were often financially dependent, or inter-dependent, on their partners; therefore, “they lack the financial means to get out,” (Tracy), “they don’t have access to money or alternative means” (Sharon), and “they feel stuck because of their finances, or the fact that they depend on their husband’s or partner’s income” (Alice). Poverty, or financial dependence, also tended to affect the woman’s sense of isolation due to transportation difficulties. “A lot of the families around here have no car or just one car,” said Debbie, “and that’s usually controlled by the male.” Robert and Sharon agreed. “Getting around, you have to have a vehicle—especially if you’re going to have a job—there’s absolutely no taxis,



no buses, no way I could think of that you'd get around unless you just walked," Sharon explained. Providers could not think of a way most women would be able to access community resources, such as domestic violence shelters (which were not located in the same county the majority of the time), unless they had a vehicle or access to one from a family member.

Stigma around IPV, particularly because "some abusers don't fit who you think abusers would be," according to Tracy—was prevalent in the rural communities where each provider worked. Although providers all maintained strict confidentiality guidelines associated with patient care, as required by law, most of them admitted that the perceived lack of anonymity in a rural area might prevent some women from disclosing abuse or seeking help. "Usually, even if they will tell you in that [clinic] setting, they don't want anyone else to know about it, they don't want to do anything about it," said Alice. "They could be related to somebody in town. A lot of rural women don't say anything because their abuser's related to so-and-so, or they know somebody who works at the clinic and they're afraid she'll be in their chart," Sharon said. Providers thought this might be more of an issue in emergency rooms, but found that women "not wanting everyone to know their business" was a common concern in family practice settings, too. Speaking more about the stigma associated with IPV, Tracy explained, "You know, their abuser might be someone in, like, government or law enforcement, or someone related to the clinic staff, even."

### **Strengths**

Although the challenges faced by rural women, and rural providers when responding to IPV, were numerous, providers were quick to point out that rural settings simultaneously possessed major strengths for survivors and providers. One of these strengths was the proximity of family, which was seen as a potential source of social and instrumental support. "Rural areas

tend to have strong families,” Sharon asserted. Robert agreed. “There’s a lot of family support, or the potential for it, with families living close together and people knowing each other so well.”

While providers acknowledged that families could be less than helpful during times of crisis, the proximity of many family members made it likely that somebody could help provide shelter or other forms of help, according to the providers. “You may know of the family, and know of ways to help the women that you might not know otherwise because of your relationship with the family,” said Alice. Robert announced,

“In my practice, I see grandmothers, grandfathers, aunts, cousins, sisters, brothers, mothers, fathers. Now, I guess in some ways that could stifle somebody’s ability to talk about abuse—you know, ‘you care for my sister and I don’t want you knowing what’s going on’—but I think in most cases it helps, it really helps, because you get a pretty good sense of what’s going on in that family.”

Family support was cited as one of the first questions asked of women during abuse disclosures and subsequent safety planning—Debbie and Sharon both stated that they ask their patients specifically whether there are any family members they could stay with as a first resort.

Other strengths of rural areas, as stated by rural primary care providers, was the individualized care and attention that providers paid to each of their patients. “You get to know your patients, you have a much more human relationship with people than just ‘you’re patient number 17 today.’ That’s what I like about it. It’s more old-fashioned kind of medicine,” Robert explained. Alice said, “Rural providers are usually there because they really want to be, because they care about rural areas and like rural areas.” Tracy described the culture of rural health care as being more hospitable and caring than urban clinics, which she described as “more impersonal.” Sharon said, laughingly,

“We’re true humanitarians here. I’ve worked in places in Springfield [a metropolitan area] where if somebody walked up to the desk and said ‘I need help’, they’d just ship ‘em off to the emergency room. Here, we’d take ‘em in the back and ask ‘em what’s going on and try to help them.”

Margie felt proud of the treatment her clinic offered:

“The ones we can get in here for care—we take good, thorough care of them. We have all these resources ready to go, we know who they can call and get prescriptions filled with their insurance, we spend time with them. And that’s something—I have private insurance, and that sure doesn’t happen when I go to *my* doctor!”

### 4.3 Chapter Summary

The health care providers who participated in these interviews provided contextual information on the difficulties of identifying and responding to IPV in rural communities. Although each of the providers was aware of IPV and took specific steps to identify and address it in their practice, their efforts were often frustrated by women not wishing to disclose abuse or by the overall lack of appropriate services and resources to provide the patient following disclosure. High levels of poverty, low levels of education, and, in some communities, unemployment and substance abuse, were all seen as contributing factors to IPV in the communities where these providers practiced medicine. Yet the strengths of rural communities—especially the assumption of family and social support—coupled with the providers’ creative responses to individual situations of IPV—were cited as protective factors for rural women experiencing abuse.

The next chapter will describe the perspectives of survivors of IPV who were patients at rural health clinics. A full summary and interpretation of the findings from the providers' survey, providers' interviews, and survivors' interviews is presented in Chapter Six.

# **Chapter 5: Survivors' Experiences and Perceptions of Helpfulness**

This chapter will describe the survivors of IPV who participated in this study, providing an overview of their histories and relevant health and demographic information as reported during semi-structured interviews. The beginning section will detail the methods used from recruitment to data analysis. Major study constructs—help-seeking, primary health care provider response to IPV, the rural setting—as illuminated through these interviews are then explored. The chapter will conclude with a discussion of two themes that arose during the course of the study which had particular salience for the women. These themes are loosely defined as *severity of abuse* and *role of drugs and alcohol*.

## **5.1 Survivor Interviews**

### **5.1.1 Rural Women's Health Study**

Interviews with survivors sought insights into the experience of disclosing abuse to a rural health care provider, perceptions of the strengths and challenges of overcoming IPV in a rural area, and overall help-seeking decisions and behaviors as situated in a rural context. A high priority was placed on the careful recruitment, interviewing, and compensation of survivor participants, many of whom would be asked to discuss painful memories or whose participation might uncomfortably identify them as a victim of IPV in their small community. (In order to generate awareness about the study without specifically identifying potential participants as IPV survivors, the title “Rural Women's Health Study” was used in all materials pertaining to the survivors' interviews.) The interview protocol for survivors was developed by this student under the supervision of her committee chair and incrementally refined over the course of several

months to best reflect the research aims and major constructs of interest. The final set of interview questions consisted of 18 items asking women to describe their experiences at a rural health clinic, their perceptions of the services available to them in a rural community, and their sense of the specific strengths and challenges associated with overcoming abuse in a rural community, a selection of which is reproduced in Figure 5.1.2. It was determined that the interview would take between one to two hours to complete. The complete interview protocol is reproduced in Appendix 3.

### Figure 5.1.1 Selected Interview Questions

What made you decide to talk with your doctor/nurse about the abuse you were experiencing?  
OR What prevented you from talking with the doctor/nurse about the abuse?

How did the doctor/nurse response when you told him or her about the abuse?

What community services, if any, have you used during your abusive relationship (i.e. domestic violence shelter/program, hotline, couples' counseling)? How did you find out about these services [IF USED]?

How easy or difficult is it for you to get to the places you need to go (school, work, babysitter, grocery, doctor's office, police station, etc.)? In what ways, if any, does this affect your sense of safety?

What are some of the challenges you've faced as both a rural resident and survivor of abuse?  
What are some of the positive aspects of living in a rural area and coping with abuse?

Women were eligible to participate in interviews if they were over the age of 18, a survivor of IPV, and a patient at a rural health clinic in Missouri currently or during the year prior to the study (January-December 2013). An incentive of \$50 cash plus a \$10 gas card to Casey's General Stores was offered upon completion of the interview. This student also offered to assist the participants in arranging for childcare during the interview by hiring a Research

Assistant to accompany her to the interview location. A total of 20 interviews with survivors was desired.

## **Recruitment**

This student performed an extensive literature search to locate best practices and methods for recruiting and interviewing women with a history of IPV and rural women in general. Many of the recruitment methods listed below were carried out on a trial-and-error basis, using Logan and colleagues' 2008 example as a rough guide. (Note that each of the recruitment tools described below is reproduced in full and compiled in Appendix 4.) The steps taken to ensure participation were as follows:

1. As described above, this student first created a study website describing the project, eligibility criteria, and soliciting participation from survivors. (The study's link is provided here: [www.sites/google.com/site/moruralwomenshealth](http://www.sites/google.com/site/moruralwomenshealth).)
2. An advertisement was posted on Craigslist in all available Missouri locations excluding the metropolitan areas of St. Louis and Kansas City.
3. This student sent a cover letter describing the study and attached flyers in English and Spanish soliciting survivor participation to the Missouri Coalition Against Domestic and Sexual Violence's list-serv and individually emailed the directors at each agency listed on the MCADSV member guide. (This list included domestic violence shelters, victim services organizations, legal services organizations, counseling centers, and rape crisis centers.) The email requested that the directors of these programs post the flyer in their waiting rooms or common areas.
4. This student selected three regions of the state for further targeted recruitment of survivors. The state was divided laterally into three sections: "north", including all

counties north of Interstate 70; “central”, including all counties along the Interstate 70 corridor; and “south”, including all counties south of the Interstate 70 corridor. The metropolitan counties of St. Louis (City), St. Louis, St. Charles, and Jackson were excluded. A circular route through each of these areas was mapped and English- and Spanish-language flyers were posted in gas stations (n= 12), post offices (n= 4), grocery stores (n= 4), one antique mall, and one Laundromat.

5. The study was publicized through this student’s personal social media accounts: Facebook, Twitter, and Google Sites.
6. This student used her social network, personal acquaintances, and former colleagues in the social work practice sector to generate awareness about the study and recruit participants by word of mouth.
7. Participants were asked to pass along information about the study to other women they knew who were eligible (snowball sampling).

Advertisements contained a brief description of the study’s purpose and eligibility criteria (excluding mention of past abuse for those flyers hung in public locations). Women were asked to call, email, or text the number provided on the flyer for additional information and to determine their eligibility for the study. When a potential participant contacted this student, she was oriented to the study’s aims and this student’s educational and professional background and the dissertation topic. Potential participants were then asked three screening questions to determine their eligibility for the study, which were: 1) “Are you over the age of 18?”, 2) “Have you been a victim of domestic violence, or intimate partner violence, as an adult [If yes, is the abusive relationship ended and how long has it been over]?” and 3) “Have you been treated at or gone to a rural health clinic/rural FQHC within the past year [If so, what was the name of the



clinic and where was the clinic located]?” Participants were also asked where they found out about the study and about their county of residence. If eligible, participants specified a public location within the nearest town or community and arranged a convenient date and time for the interview to take place. Upon arrival at the interview location and making introductions, participants were provided an informed consent document in which they also agreed or disagreed to have the interview audio recorded. This student then described the format of the interview, provided an estimate of how long it would take to complete the interview, and informed the participant she could speak for as little or as long after any of the questions as she desired. With this acknowledgment, recording (if allowed) would begin.

Interviews were recorded using the Audio Memos application for iPhone and transferred to a removable file storage device immediately after the interview. Audio recordings were stored on the flash drive and in the program NVIVO (version 10, QSR International), which this student used for qualitative data management and analysis. This student also took field notes during and after each interview, transferring them to a document within NVIVO following each encounter.

### **5.1.2 Background Information**

Twenty woman from across the state participated in semi-structured, face-to-face interviews for this research project. This student traveled an approximate total of 1,845 miles during the course of these field interviews, with the average distance to an interview location 123 miles. Women learned about the study through flyers posted at domestic violence shelters or programs (n= 8), from other participants (snowball sampling) (6), Craigslist (4), one from a victim prosecutor’s office, and one from a faith-based residential job training program where she was staying. Once their eligibility for the study was determined over the phone, women set up an interview at the location and time of their choosing. Most of the interviews took place in a public

location, such as a library (n= 9) or restaurant (6). Others took place at the shelter where the woman was staying (n= 2), at the woman's house (2), and at a park (1). Although childcare was offered during the interview, none of the women requested this service.

## **Demographics**

Demographic information collected prior to each interview included the participant's age, race, sexual orientation, marital status, number of children, and county of residence. Table 5-1 provides the raw numbers and percent of total or average of these characteristics. All women were English-speaking; 85% were white, although one woman identified as biracial, another as black, and a third as Latina. Nineteen of the women identified themselves as straight, with one woman identifying as a lesbian (although her abusive ex-husband was male). Most of the women had children, the average number of which was two. The most common marital status was "separated" or "divorced". Figure 5.1.2 provides a graphic depiction of where each woman lived (and where the interviews took place), with the county of the interview highlighted and the number corresponding to the number of interviews in that county. All of the women had been raised and spent the majority of their lives in a rural county, and although some women had moved throughout the course of their lives, each had experienced abuse while living in an area designated as rural.

Once situated at the interview site, participants were re-oriented to the study's aims and research objectives, and any questions they had about the study were answered at this time. Participants were then provided an informed consent form which they read carefully in every case and signed before recording of the interview began. All but one woman consented to voice recording for this project. After signing the consent document and indicating she was ready to

proceed, the recorder was turned on and the interview commenced. Interviews took as long as three hours and as little time as fourteen minutes, with an average length of 45 minutes.

**Table 5.1.2 Participant Demographics**

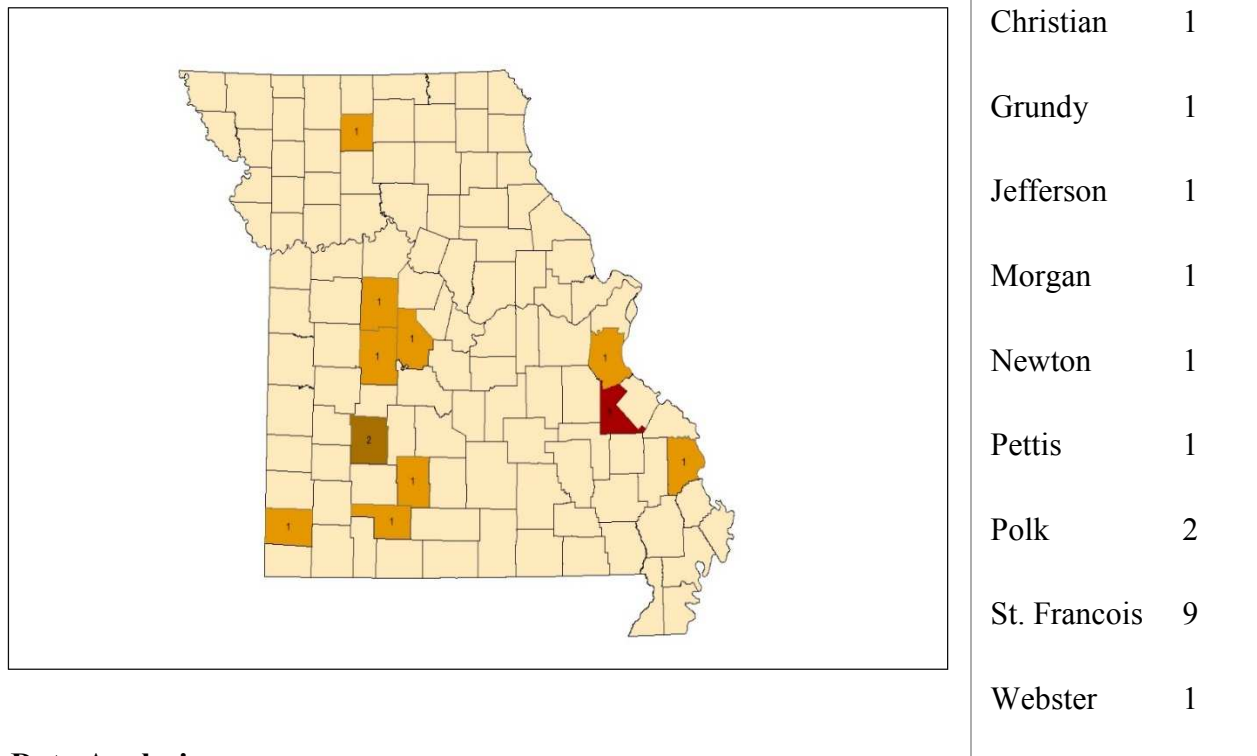
	Actual Number	Percent of Total	Average
<i>Race/Ethnicity</i>			
White	17	85	
Black	1	5	
Mixed race	1	5	
Latina	1	5	
<i>Sexual orientation</i>			
Straight	19	19	
Lesbian	1	5	
<i>Marital status</i>			
Single	4	20	
Married	3	15	
Divorced	6	30	
Separated	7	35	
<i>Region of state</i>			
North	1	5	
South	16	80	
Central	3	15	
<i>Age</i>			
18-25	2	10	42.4
26-35	2	10	
36-45	8	40	
46-55	7	35	
56-65	1	5	
<i>Number of children</i>			
0	3	15	1.9
1	2	10	
2	8	40	
3	6	30	
<3	1	5	

*\*The actual numbers for "Age" and "Number of children" represent the number of women who reported ages and number of children within the delineated categories.*

All participants were asked the same questions from the interview schedule located in Appendix 3, although due to each woman's unique experiences and interview style the order of the questions and some wording was altered from person to person. Interviews were completed

when the woman indicated that she had nothing left to say on the subject, at which time recording stopped. Each participant then received an envelope containing \$50 cash and a ten dollar gas card to help cover the costs of transportation to and from the interview location. The majority of participants (n= 13) indicated they would like to receive information about the study’s findings once complete and provided a safe means of contact for the future.

**Figure 5.1.2 Interviews by County**



**Data Analysis**

Following transfer of recorded interviews and field notes to NVIVO 10, this student followed the same protocol for each interview: first, a coding scheme based on the study’s construct was developed (see Figure 5.1.3). Second, the recording was transcribed directly in NVIVO. The same interview was played a second time, with the student typing a summary document of the encounter, specifically focusing on themes that touched on the study’s proposed

constructs. Each transcription was read carefully alongside the coding scheme to identify words, phrases, quotes, and other thematic content that related to the study’s constructs, and highlighted or “coded” under the appropriate construct. During the second read-through of the transcription, any themes relevant to the survivor’s experience but outside of the existing coding structure were identified. This additional information was added to the summary documents matching each participant’s interview transcription. The summary documents were then used as a quick reference guide during the final write-up of the interviews. This form of content analysis was thus a mixed approach to qualitative analysis, as suggested by Berg and Lune (2012), a directed method that involved deductive and inductive derivations from the raw data.

**Figure 5.1.3 Coding Scheme for Rural Women’s Health Study**

<i>Theme</i>	<i>Construct</i>
Disclosure of abuse: elicited by provider or voluntary disclosure	Help seeking
Factors influencing decision to seek help	Help seeking
Comfort during disclosure encounter	Help seeking, quality of care
Provider’s response and actions following disclosure of abuse	Quality of care
Contacting any referrals offered by provider	Help seeking
Utilization of any referrals offered by provider	Help seeking, harm reduction
Follow-up contact by provider	Quality of care
Previous initiation of conversation about abuse by others	Availability of help
Use of services for IPV (independent of provider referrals)	Help seeking, harm reduction, availability of help
Contact with law enforcement	Help seeking, harm reduction, availability of help
Disclosure of abuse to others	Help seeking, harm reduction
Factors influencing the decision to leave or end abusive relationship	Harm reduction, availability of help, isolation
Mode and reliability of transportation	Isolation
Accessibility of necessary services	Isolation
Rural experience	Rural culture
Challenges of rural IPV	Rural culture
Strengths of rural areas for IPV survivors	Rural culture
Awareness of resources for IPV survivors	Availability of help

## 5.2 Interview Findings

### 5.2.1 Overview of Abuse Histories

The majority of the women interviewed reported histories of very severe physical, sexual, and psychological abuse, often spanning multiple relationships or reaching back to childhood. All of the abusive intimate partners were male. Five of the twenty said that they had been left for dead by the abuser; in three of these cases, the state brought charges of attempted murder against the man. Several others cited incidences in which they said they truly believed they were going to die, prompting two of the women to take drastic escape actions such as jumping out of a moving vehicle. Most of the women referenced their abuser's gun collection and having been threatened with a gun; one woman had been shot at as she was fleeing the house. One had been beaten with the butt of a gun and had a damaged spinal cord as a result. Two had been stabbed and at least eight others described being beaten with a heavy, disabling object, such as a baseball bat. Three of these women reported having been beaten so severely by such an object that they required several facial reconstruction plastic surgeries. Four women described extreme abuse during pregnancy or immediately post-partum.

In addition to suffering from IPV, all of the women interviewed described lives that had been profoundly impacted by poverty. Only one woman had a full-time job, and two others worked part-time, all in low-wage, service sector positions. Seven of the women had no formal source of income at all, and the rest depended on a combination of public assistance, such as disability, food stamps, or their children's Social Security to survive. Sixteen depended on Medicaid as their primary insurance, and four had no health insurance at all.

Health and lifestyle factors characteristic of many low-income rural Americans were typical of participants. All but two of the women were smokers, and fifteen of the women

appeared to be overweight or obese. Long-term health conditions gone untreated and injuries from abuse combined to form a poor picture of overall health for most of the women. Chronic pain, sleep problems, digestive problems, headaches, arthritis, high-risk pregnancies, and histories of emergency surgeries were the norm rather than the exception. Only two of the women characterized their overall health as “good.” Oral health was another major health issue. Again, all but two of the women had some kind of oral health problem, including total or partial loss of teeth, decaying, rotted, or burned teeth. (In some cases, dental problems had been caused or exacerbated by substance abuse or during an abusive incident.) Only one of the women used dentures.

Nearly all of the women referenced feeling depressed. Five had been officially diagnosed with Post-Traumatic Stress Disorder, according to their accounts. Four others carried additional diagnoses, such as major depression, anxiety, and bipolar disorder. Four had been addicted to methamphetamine, and (including those four) twelve mentioned current or former alcohol abuse or periods of heavy drinking, combined with prescription pill abuse. The most common prescription drugs of choice were painkillers and cold medicine.

### **5.2.2 Interview Content: Key Themes and Findings<sup>12</sup>**

#### **Harm Reductive Behaviors**

Despite the many years of profound abuse that these women suffered, every interviewee was ultimately very pro-active in strategizing ways to reduce harm and promote their own and especially their children’s safety. Women developed unique approaches to minimizing the abuse they and their children experienced. Strategies were developed according to each participant’s abuser and the situation at hand; at times placating methods worked, other times resistance and

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<sup>12</sup> All names have been changed to protect confidentiality.

fighting back. Nine had sought orders of protection against their abuser. All of the women except one had eventually left her abuser, and had taken specific safety measures following the relationship's end that were ongoing for years in some cases. "That first year I moved five times and traded vehicles three times to hide from him," Stacy claimed. Cheree had also relocated: "I moved so many times to get away from him. One year my children went to six different schools." Kelly, describing how she had once survived a beating, simply stated, "Once I played dead."

The women who were mothers seemed to have summoned the courage to leave their abusers for good usually after threats to their children. One woman recalled that her abuser had begun to verbally threaten and berate her adolescent son, and she knew then it was "time to get out." Marie decided to leave when her young son refused to step foot in the house, afraid of his father; he had told his school counselor that he thought his mother was going to die. Millie sent her son to live with his grandparents until she "could get my life straightened out." After her children were removed from her custody by the state's Division of Family Services (DFS), Lauren was prompted to detox from methamphetamine and leave her abuser for good so she could work with DFS family support counselors to reunite her family. Lauren moved from her hometown to a county where she knew there was a domestic violence shelter, figuring she could stay there if her abuser happened to find her.

Other times the abuse became so severe that the women felt they had no choice but to leave. "Twenty-nine stitches down my chest to my stomach—yeah that's when I decided it was time," Stacy said ruefully. Shelly, who had been tied up and beaten with a bat, then pushed through a window, had no qualms about leaving the man with whom she was staying after this incident. Karen and Wanda were both beaten with baseball bats, disfiguring their appearances;



Karen's recovery necessitated six plastic surgeries to reconstruct her face. Both used their time in the hospital to imagine a life away from their abuser and to strategize about ways to leave. They eventually decided to work with county prosecutors to press charges against their abusers.

Two women who had been heavily involved with drugs during the time that the abuse was occurring decided to leave when it became clear that the abuser was not going to follow their example of staying clean. "I left because when I decided to get clean, he didn't," Lora explained. "He wasn't ever going to step up and take responsibility," Adrienne said of her abuser's failure to get help for his alcoholism after their daughter was born.

### **Help-seeking Behaviors and Results**

Just as women coped with abuse by using certain tactics to reduce harm for themselves and their children, each of the twenty women in this study demonstrated resourcefulness and persistence in seeking help to recover from violence. They sought out formal and informal sources of help, including health care providers, family, pastors, friends, police, and domestic violence shelters that in many cases were not even located within the same county. Help was not always forthcoming; Samantha remembers a physical therapist saying, "I don't want to know how that happened," when she arrived for an appointment to work on her knee, an injury sustained during a beating. "You have to twist arms to get help around here," agreed Millie. Thirteen of the women lived in a county with a domestic violence shelter, three having specifically relocated to that county to stay at the shelter.

**Law Enforcement.** Survivors did not view the rural law enforcement response to IPV as helpful, sensitive, or appropriate in most cases. "They'll separate you, and just tell you 'keep it down, work it out,'" said Sadie. Cheree, quoting a sheriff's deputy who had visited her home

during a domestic dispute, remembered hearing, “‘Somebody’s getting arrested if we have to come back out here.’”

All of the women had some experience with law enforcement responding to their home for domestic violence, whether called by themselves or others; in only one case did the participant state that the interaction with police had gone well. Shelly’s experience with police was fairly typical of most women: she had called police and even secured an order of protection against her abuser, but was arrested twice along with her abuser for disorderly conduct. Marie had also been arrested for fighting with her abuser; in self-defense, she hit him over the head with a bottle. Sadie and Cheree had both been told to “keep it down” by police officers.

Women stated that they found the police officers’ reactions (or lack thereof) aggravating, but were largely nonplussed: “See, out here, they’re all beating their wives too,” said Stacy. “It’s like a badge of honor around here.” Marie agreed. “It’s part of their culture. They see the woman as property and the man gets to keep her in line.” Yet the prospect of help kept most women trying to secure help from the authorities—by seeking orders of protection, by calling when there was a dispute in which they felt endangered, and (in four cases) ultimately pressing charges against their abusers. Of the nine women who sought orders of protection, the common sentiment was that “it wasn’t worth the paper it was printed on” (Judy). When asked why she sought one, she sighed and said, “Just in case—I wanted to do it right, to have all the written-down proof I could of what he was doing to me, in the very real likelihood that he ended up killing me.”

**Informal support.** Family members’ support ranged from critically helpful to almost nonexistent. Kelly’s parents helped her move out of her abuser’s house and into a new apartment; they cared for her children until she was able to get on her feet, and were currently providing her with transportation to and from all of her appointments. Cheree’s family, on the

other hand, told her she had “made her bed and had to lie in it.” The reaction of most family members upon learning of the abusive situation was more mixed. “Well, I sure wouldn’t put up with that!” exclaimed Judy’s sister-in-law after Judy disclosed her abuse. Participants were usually able to secure some material help from family members, such as lent money or help moving, but only two were able to stay with family for a time while attempting to leave the relationship. More commonly, family was sympathetic to a point but advised the participant to “just get out”, as in Adrienne’s case, or said, “I told you so,” as in Kendra’s case. Stacy remembered her stepfather telling her that he’d like to help her out, but he wasn’t big enough to take on her abuser in a physical fight.

Survivors’ friends were slightly more helpful, usually in the form of providing information about nearby shelters or resources that, often, they themselves had utilized. Shawna, Sadie, and Kendra all learned about shelters from their friends. Shawna, Lacey, and Karen had been able to live with friends for brief periods of time when fleeing their abusers. However, as Adrienne pointed out, friends were not always able to provide help because they often faced similar abusive situations. “Sure I told my friends, but heck, half of them were getting abused too,” Kelly said.

Two women had spoken to their pastors about the abuse. One pastor was kind and understanding, and offered a nonjudgmental listening ear and prayers that were meaningful to that participant. Samantha’s pastor, on the other hand, asked jokingly, “What do you do to these men?” after she talked to him about her multiple abusive relationships. Two other women had disclosed their abuse to counselors, with equally variant results: Judy’s therapist “validated my feelings and made me feel good but never said anything about getting out [of the relationship].” Marta’s therapist, upon learning of her history of abuse and rape, suggested a form of treatment

for her PTSD and at the time of the interview was trying to arrange for her to receive Eye Movement Desensitization and Reprocessing (EMDR) therapy from a psychologist trained in that practice.

### **Availability of Help**

**Shelters.** Fifteen of the women said that they had utilized a shelter at some point during their abusive relationship, and many did so on multiple occasions. About half the women that used shelters found them to be helpful—“these places saved my life,” said Lacey—with minor reservations and acknowledgments that certain aspects of the shelter experience could be improved. The other half found the shelter services lacking, particularly with regards to counseling, transportation, and helping women get on their feet. The length of time a woman could stay at a shelter seemed to heighten problems, with shorter stays (four to six weeks) leaving women feeling as though they did not have enough time to accomplish all the things they needed to do in order to establish a life free from abuse. “Every time I go to the bathroom in the morning, I wonder if I’ll be doing this behind a bush tomorrow,” said Cheree, concerned about homelessness after her shelter’s six-week maximum stay. Wanda said that advocates at her shelter were more concerned with her getting a job than they were with helping her heal. “They need to jump on the medical and the mental health stuff right away,” she stated forcefully. Having stayed at a shelter, Stacy thought that education was valued too highly over experience—sitting in groups, she said, “hearing this woman who has never walked in my shoes tell me what I ought to do and ought to feel” was grating and led to her leaving shelter early.

The women who reported that they found the shelter staff and services helpful described learning about resources and getting help with food and clothing as things that shelters did well, although as Kelly put it, “they should do community awareness and bake sales, something to get

nicer stuff and beautify the places a little bit.” Intensive case management had helped LaShonda, Lena, Marie, and Millie secure Social Security and disability income, find affordable housing, feed and clothe themselves and their children, obtain health insurance, and receive behavioral health services. Eight women spoke highly of the group at their shelter as an ongoing source of support and fellowship which all women—former residents as well as current residents of the shelter—were welcome to attend. The shelter’s in-kind support tended to depend on the level of awareness of its existence from the surrounding community. Two of the shelters seemed to generate particularly strong awareness in the town and received many ongoing donations of food, clothing, and toiletries. Other programs did not seem to possess this level of support.

Twelve of the fifteen women who had used a shelter during their abusive relationship stated their wishes for greater attention to health and mental health needs at the shelter. Only one of the women had been accompanied to a health care provider by a shelter advocate. Others were told their shelter did not provide transportation to and from doctor’s appointments, which in four cases prevented women from securing recommended follow-up care and treatment for their injuries. Additionally, none of the shelters offered therapy on-site, although “counseling” was typically listed as one of their services. Lena, Cheree, and Wanda, however, all described their shelters’ version of “counseling” to mean case management. “You don’t work on any of your issues. It’s not real therapy, even though they say they offer that,” said Cheree. Lena longed for individual therapy, stating that the support group her shelter offered in lieu of therapy made her uncomfortable.

**Other Social Services.** Besides shelter, approximately half the participants (n= 11) said that they had utilized mental and behavioral health services as an additional component to aiding their recovery from IPV. Two women had experienced psychiatric hospitalizations due to

suicidal ideation, with one woman staying eight days on the ward and another remaining hospitalized over one year. Three women were currently receiving treatment in conjunction with DFS as part of their family support case. Mental and behavioral health services included psychiatric medication management, case management, and in three cases, addiction recovery groups (AA or NA). Only one woman who stated she was currently receiving mental health services was actually seeing a licensed therapist for regular individual therapy sessions.

Mental and behavioral health services are rare in rural Missouri, and all of the women who were linked with such services happened to live in a county (either St. Francois, Pettis, or Polk) that hosts a federally qualified behavioral health services provider. In each of these cases, the actual services provider was based in a neighboring county where there was a large city; for example, BJC Behavioral Health serves women in St. Francois County but is based in St. Louis, a 90 minute drive away. At times, this meant that women had to travel out of their county for an initial consult or appointment with a specialist, if their case demanded it. Women who did not live in the counties listed above had no known access to a mental health services provider outside of the shelter where they stayed, if applicable.

In addition to mental and behavioral health services, five women had received help from a county Office of the Victim Prosecutor. In two of these cases, charges were brought by the state against the abuser for attempted murder. The only other formal helping service cited was one woman who was currently residing in an urban facility owned by a religious organization. The year-long program in which Adrienne was enrolled provided housing and job training for women with histories of IPV and substance abuse. Adrienne had relocated from a neighboring rural county to live in this facility.

## Isolation

**Distance to formal helping resources.** As described above, the majority of women lived in counties with a domestic violence shelter—although a significant number had changed their county of residence at one time or another in order to access the shelter’s services (n= 10). Other helping services, such as mental health or victim prosecutors, were only available in the three counties cited previously or the county’s seat. Response times by law enforcement and emergency personnel varied according to whether the woman lived in town or outside of it, and ranged from “pretty quick” (Sadie) to “sweet old time, 30, 40 minutes” (Marie). “It’s fifteen miles from here to where I live, so you’re looking at least a 20, 30 minute response time,” explained Stacy. “And someone can do a lot of damage in 20 minutes.” Two women mentioned that police response to domestic disturbance calls seemed to be slower than other calls. “They don’t take it as seriously as other stuff. They get sick of coming to the same place,” said Lauren.

**Transportation.** Transportation was a key factor in determining a woman’s safety and well-being. It affected her ability to leave her abuser and exerted a great impact on her quality of life and self-sufficiency after the relationship ended. Having access to a reliable vehicle meant women were able to get to appointments, job interviews, and the grocery store. Women who did not own a vehicle were completely dependent on others for transportation. In most cases, that other person had been their abuser. Once away from the abuser, women depended on family and friends for rides, borrowed vehicles, or walked to the places they needed to go. Sadie walked two hours along a rural highway to send out job applications in the town adjacent to where she was staying. Millie was also looking for a job but said she was afraid to walk at night, and the only types of jobs she was going to get with her criminal background were service jobs where one could not set her own schedule. Of the twenty women interviewed, six owned a vehicle, two had

reliable access to a shared vehicle, and the rest were desperate to purchase one. Two of the women who owned a vehicle stated they sometimes did not have enough money for gas.

Despite the universal lack of public transportation and taxis in the areas where these women lived, several women did have access to other means of transportation. Three shelters provided some form of transportation: three days per week during specific times, or a set number of rides that the shelter would allow. These rules seemed inflexible. Even with a Medicaid-funded transport service, Cheree had to tell the driver to pick her up at the closest landmark to the shelter because the shelter would not allow her to disclose its location. (The closest landmark happened to be a roadside café two miles up the road from the shelter.) Women with a certain type of Medicaid, such as Cheree and three others, were able to secure rides to and from primary and mental health appointments using this state-funded transport service. Lena received home visiting services from a case manager provided by her mental health treatment provider, paid for by her disability income.

For women with children, having a car seemed even more important, primarily in order to take the child to and from school. One woman lived too far away from town to be included on the school's bus route, and stated she did not know what she would do if she could not take her friend's vehicle to bring and pick up her daughter from school every day. Three women were completely dependent on their current partners for transportation, and a fourth secured rides for weekly errands, shopping, and church-going with a rotating cast of volunteers from her church. Transportation was not always cheap, even when provided by a loved one; most women who borrowed rides had to buy gas, cigarettes, or food for the vehicle lender before use was made available.



## Primary Health Care Settings: Experiences and Quality of Care

The majority of women (n= 11) reported that they had never been asked about or disclosed abuse to a primary health care provider. Six had been asked about abuse by their primary care provider, all within the past three years; in four of these cases, the abuse was no longer occurring. Three other women who had spoken to their primary care providers about abuse had voluntarily disclosed the information. Routine screening by health care providers seemed to be something that women were just beginning to notice as part of the provider-patient encounter; several women alleged that primary providers never used to ask about abuse, and that screening for IPV was a recent development in the primary care setting.

Survivors' perceptions of their providers' response to disclosures of abuse ranged from extremely helpful ("above and beyond" according to one interviewee) to lackluster or totally unhelpful. Samantha was never asked directly about IPV, but she was prompted to disclose during a regularly scheduled appointment that happened to follow an abuse episode. The nurse practitioner to whom she disclosed kept Samantha in the office while she spent most of the day calling various community agencies on Samantha's behalf. The nurse eventually found an open bed in a shelter in another county, where Samantha relocated immediately. Lynn said that she was asked about bruises on her ribs at an appointment three days after her daughter was born. The nurse examining her spoke to her about her options for leaving, and helped Lynn by supplying a portion of the money Lynn needed for a security deposit on a new apartment. LaShonda felt able to tell her physician about her history of abuse because "he was kind, and he was taking his time with me."

Shelly's voluntary disclosure of abuse, however, did not seem to have been met with the same level of empathy. She went to her primary care physician for a follow-up visit from the

emergency room due to bruised ribs, cuts, and other injuries she had sustained after being duct-taped and beaten, then pushed through a window. She described the source of her injuries to the doctor, but the doctor did not say anything about the abuse, and simply stated that she would call Shelly if she noticed a problem with her x-rays.

Adrienne and Lacey said that they were both asked about abuse during prenatal visits at their rural health care provider's clinic. Neither felt comfortable disclosing. Adrienne said, "It was like she was just asking from a checklist." Later on in her pregnancy, Lacey entered a shelter, and then told her health care provider about the true source of her bruises because, as she stated, "I had to give 'em my changed address, and they were gonna know as soon as they saw it that it was at the shelter." The provider simply stated she was glad Lacey was receiving the help she needed.

Three women stated that they currently see nurse practitioners with whom they would feel comfortable discussing their abuse histories (and one had volunteered the information to her current health care provider), but were not asked directly whether they were victims of violence. Millie felt that her nurse responded to her disclosure very empathically, and due to her other health needs scheduled regular appointments and follow-up dates to ensure she was staying safe. The remaining 11 women had never been asked during a primary care visit, while three had not seen a primary care provider at all during their abusive relationships because they lacked health insurance.

**Quality of care.** When asked why some health care providers do not ask about abuse, women speculated about a variety of reasons why this might be the case. "They want to get you in and get you out," said Kendra. "He just didn't want to get involved," Sadie said, talking about her physician. Lauren added, "A lot of them have a closed eye to abuse." Most of the women

were under the impression that providers had strict time constraints or were so used to hearing about IPV that they were not particularly welcoming of such confidences. Several women were also convinced their primary care provider must have suspected abuse, due to obvious bruising or abusers who insisted on accompanying them to their appointments. For instance, Judy described an appointment when her physician asked where she had gotten some bruises, and she lied, “I fell gardening.” The physician looked at her meaningfully and said, “Be careful gardening,” but offered nothing further to elicit disclosure. Even women who had disclosed to providers said that they were seldom asked directly about abuse and others, such as Lacey and Samantha, felt unable to disclose until after several encounters with the provider (always during some time when the abuser was not present at the appointment). Some thought that their discomfort talking about abuse with providers was because providers were “too busy, too rushed” (Judy). Others were more poignant with their reasoning, saying that health care providers see a lot of patients and become inured to people’s suffering over time. Cheree said there were usually two general reactions from health care providers toward IPV: “It’s like they’ve either seen so much of it that they’ve become sick of it, or else they want to swoop in and take over from you and save the day.” Cheree thought that the “save the day people”, as she characterized them, often did more harm than good, because they removed agency from the survivor. Marta and Wendy agreed. “They should talk to you before calling the police in, because what if you didn’t want to get the police involved because you were afraid, like I was?” Marta said. Eight of the women referenced feeling squeezed by most health care providers’ obvious lack of time for patients. “They want you in and out of there,” said Lauren, mentioning that the hustle-bustle and urgency clearly demonstrated by providers who must see many patients per day made her feel as though disclosure would simply annoy the nurse who clearly had little

time to talk at length with patients. “They don’t pry into your personal life,” Lena said, explaining that when one goes to see a doctor only matters pertaining to the presenting medical issue are discussed. Even if that medical issue is a result of abuse, she added, “they don’t think it’s their business, they are just gonna say ‘well you better leave him’. They don’t want to get involved in all that stuff.” “They don’t want to get involved” was a refrain echoed by three other women regarding health care providers’ failure to ask about IPV.

Having health insurance—specifically, Medicaid—was the major facilitator of timely and regular primary care appointments. “If you’re blessed with Medicaid, that does make it easier, because they will pick you up and take you to your doctor’s appointments,” stated Cheree. However, only women with dependent children were usually eligible for Medicaid, and if—like Shelly—the children had been removed from her custody by DFS, the Medicaid went too. Sadie, age 54, had not had health insurance since she gave birth to her sons, who were now in their late twenties; she estimated she had not been to a doctor in as many years, until her recent shelter stay.

Women had several ideas about how their primary health care experience might have been handled differently. They all agreed that it was the responsibility of the health care provider to ask about abuse. “It’s a good idea to always ask because many people won’t just come out and say it,” said Kendra. Lauren, Samantha, and Marta all had abusers who insisted on accompanying them to their appointments, and felt too afraid to disclose with their abuser there in the room. Therefore, Marta stated that it was imperative health care providers ask the man to leave the room before they ask any questions about IPV. In order to preserve a modicum of privacy, Lora suggested that health care providers give women a form to fill out with questions about safety listed on it; that way, she thought, women might feel less inhibited about raising the

subject with a healthcare provider. Women who had positive encounters with their providers, such as LaShonda, Millie, and Marie, emphasized that discussing abuse was possible only with a provider who was willing to spend time talking about it. A provider who listened and helped with specific information, rather than making general recommendations about leaving the abuser, was cited as facilitating disclosure. Many women felt rushed during their primary care visit and might have been more comfortable discussing their situation if they were not so aware of the doctor “tapping his foot, ready to get you out of there and onto the next one,” said LaShonda. Millie’s positive experience with her nurse practitioner came about through an hour-long interview about her health history, during which she felt able to frankly discuss her IPV and drug abuse with a non-judgmental, unhurried listener.

**Other Healthcare Settings.** Nineteen of the survivors said that they had sought emergency medical attention for injuries from the abuse they had experienced. Although most women were asked about the source of their injuries, some were asked directly about IPV—“Did that man out there do this to you?” a doctor asked Lauren, while others were simply asked, “What happened?”, as in Kendra’s case. Three women were not asked about IPV because “they already knew, the police had brought me in,” said Wanda. The atmosphere in the emergency room felt too hurried and chaotic for many women to feel comfortable disclosing the true source of their injuries; many, like Cheree and Lacey, lied about their injuries on multiple emergency room visits. Cheree stated that after a while she began giving fake names when she would go to the hospital so the staff could not look in her chart to see that she had been brought in before. Lacey did not want to disclose because she was afraid the hospital would call the police and have her abuser, who was the father of her children, put in jail. Marta lied about her injuries because her husband was in the waiting room and she was afraid the staff would go talk to him following

her allegations. “If you tell [that you’re a victim of abuse], a lot of times it’s infinitely worse,” explained Cheree. Women felt that by disclosing in an ER and putting the gears in motion for hospital and police involvement, they might end up homeless or have their children taken away; they might lose their job or simply have their business broadcast around the town. “There’s a lot of considerations that they [the hospital staff] don’t think of when they wanna swoop in and save the day,” said Cheree. Stacy agreed. “They don’t know what your life is like. They think you can just go to a shelter and everything will be fixed.”

Some women reported disclosing their experiences with IPV during the emergency room visit, with varying reactions. Sadie told her doctor that she had been strangled to the point of passing out, and the doctor simply asked her if she and her boyfriend had been drinking. The doctor did not tell her about the shelter in the county or offer any recommendations beyond intimating that her problems stemmed from alcohol. Other women, such as Kendra and Stacy, felt that their injuries were overlooked on purpose by hospital staff. Again, time and inconvenience were cited as reasons why nurses and doctors may not ask about injuries that, to these women, seemed obvious as signs of abuse. “They must see it all the time because they weren’t very personable,” Wanda recalled of her own experience. Stacy agreed: “They get sick of seeing the same thing over and over again.”

Some health care settings and staff seemed to have been more helpful than others. The surgeon who repaired Karen’s face after she was beaten with a bat spoke with her about leaving her abuser on several occasions, eventually persuading her to call the county prosecuting attorney and press charges against her abuser. Marie said that she was referred to a hospital social worker when she was admitted to the hospital for a rape kit, and the social worker put her in touch with a shelter in another county that had an open bed.

Yet most health care settings did not seem to invite women's confidence. Three women regularly saw specialists for physical therapy or hearing loss. One physical therapist told Samantha he "didn't want to know" how she had injured her knee. Lena's hearing specialists had never asked about the possibility of abuse because, "that's not their job and they don't want to hear about it." Cheree believed that a neurologist she was referred to "succumbed to the stereotype about tattoos and drugs," and refused to examine her at all because he was certain she was hoping to get narcotics or some other type of pain medication from the encounter.

"They ought to have a card with the shelter's information on it in every hospital and every first responder, police officer, paramedic should have that information and know to give it to women in those situations," Sadie announced, troubled that she was never told by a helping professional about the services available for survivors in her town. Lora and Lacey mentioned that asking women about abuse in emergency room situations, especially with so many people around, made it difficult and uncomfortable to disclose what was really going on. They stressed that when staff suspect abuse, they make efforts to ask in private or have the woman fill out a form with that information on it. "I've actually seen them make a man leave the triage area so they can talk to the woman alone," said Marta.

### **The Rural Setting**

**Challenges.** Overarching each woman's experiences with formal and informal helping resources—healthcare providers, shelters, law enforcement—was the rural setting in which she lived. Cultural and economic characteristics of rural communities shaped each woman's experience of IPV. "It's like it's an everyday thing around here, no big deal," Wanda said of the rural attitude toward IPV, an attitude she thought was shared by both men and women. "The

woman is still very much put down here,” Millie agreed, during a thoughtful discussion of the types of employment that were open to women in rural areas. She went on,

“Men are still the breadwinners, because a lot of the jobs here—they’re more physical or require strength, or it’s factory work, and men get all those jobs. And even in other places—I was a waitress at Culver’s for three years and watched male teenagers get promoted to management positions ahead of me.”

Marta said that until very recently, the husband’s permission was needed for any kind of procedure, deal, or decision involving the woman. The belief that health care providers or police would immediately take the man’s side prompted her to lie about her experiences with abuse in the emergency room. “It’s a good old boys’ club around here,” said Lindsey. “Cops, prosecutors, the male doctors—they all try to talk you out of the abuse, or they imply that you must have deserved it. Or that it’s your fault, you must want it because you ain’t leaving.”

The idea that gender roles are more trenchant in rural areas was largely borne out through interviews with these 20 women. Nearly all had been financially and materially dependent on their abusive partner. Many were looking for work and had been for a while, but only three currently held jobs. The idea of a male breadwinner and female homemaker seemed persistent, if not in these women’s own minds then in those of the wider community. Stacy felt that her community looked somewhat askance at adult women who were single:

“See, a lot of these women around here—they have their husbands help them with all that stuff [specifically referencing car troubles, farm work, appliance repair]. When you’re on your own you have to figure out how to fix the stuff or save up and keep it runnin’ until you can get a new one. You can’t just have your husband come fix it for you.”



A lack of economic opportunities and community infrastructure, including basic necessities such as grocery stores, was common in the rural communities where these women lived. “There’s no jobs, there’s no transportation, there’s no taxis, there’s no Wal-mart, there’s no sidewalks. There’s nothing,” said Marie. Stacy emphasized tearfully, “There are no jobs here. None. I seriously don’t know how some people are making it.”

Most of the women said that they felt intimidated by the more male-dominated establishments of law enforcement and medicine—calling it a “good old boys’ club” or, as in several cases, feeling comfortable disclosing abuse only to female nurse practitioners or social workers under the assumption that male professionals would not help.

Other challenges cited had mainly to do with law enforcement and shelter services—a lackluster response and not enough necessary services to meet the need in the area. Getting any type of help at all required persistence and an unusual amount of resourcefulness. Women heard about shelters and other services mainly through word of mouth—not from healthcare providers, law enforcement or other helping professionals. “I think they should have that information listed at the beginning of the phone book, with all the rest of the county services,” said Lindsey. “Every first responder should have that information,” agreed Sadie. Millie, Sadie, and Marta all mentioned the necessity of having police officers trained to respond to domestic violence and equipped with information about the shelter and other services for victims. Still, there was skepticism that more community awareness would lead to a faster and appropriate police response. “Whether or not it would do any good, I don’t know,” Millie said with a rueful laugh.

**Strengths.** Although the challenges of rural living and coping with IPV were many, none of the women reported the urge to move elsewhere. “It’s a great place to raise a family” was a refrain heard over and over again. Growing up in the country and going to smaller schools where

there was usually more attention paid to individual students precluded a lot of problems with education in urban areas, thought Marie and Stacy. “Instead of worrying about drugs and guns, my daughter’s worried about her spelling bee,” Stacy explained. “It’s safe and peaceful here, and in general the people are very friendly,” said Sadie. Living in the country helped Judy cope with her feelings of despair and isolation during her years of abuse. “Being in nature, being able to walk around the property, be healed by nature. That’s how I coped,” she said. All of the women had been raised in a rural area and intended to stay living in a small town or community, despite the other challenges. “Besides, where else would I go?” asked Millie.

Six women felt that their community rallied around IPV survivors by assisting with donations to the shelter and other resources that survivors and their children used. These women described feeling supported by their community to a certain extent, particularly within the service sectors they had accessed through their shelter—food pantries, school resources, or recovery groups. “The people around here are very generous to the shelter and to other charities,” Samantha reported. “There’s not a lot of individual awareness but people do go all out with donations to the shelter,” Millie agreed.

### **5.2.3 Other Key Findings**

#### **Formal Help Associated with Severity of Abuse**

All of the women spoke to the difficulties in accessing services for survivors of IPV. These difficulties stemmed from a lack of or scarce amount of service providers in their areas. In many cases barriers to accessing help were further compounded by little visibility or public awareness that such services were available. In one county where a shelter was available, several women who were lifelong residents of the county had never heard of it until well into or after their abusive relationships. Other services for families in need, such as job supports, court

advocates, affordable housing vouchers, and food pantries were often completely unknown to women until they had accessed the social services system through some other route (i.e. a shelter or DFS). “Women have no idea where to turn,” said LaShonda. Most of the women seemed to have a high opinion of the services available once they were realized. The women who appeared to have gotten the most help and seemed the most pleased with the services offered them were usually women whose point of access to the larger social services system was due to a behavioral health issue, a Children’s Division case, or a combination of the two. These women were eligible for more benefits because of their mental health diagnosis or issue with addiction. For instance, Millie described the services offered to her in one county as part of a behavioral health team that provided wraparound help, linking her with job skills training, transportation to and from her doctor’s appointments, getting her on the list for affordable housing, and providing her with case management and court advocacy.

In each of these cases, the women had been involved in seriously abusive relationships, but also had a number of additional debilitating problems: child abuse and neglect issues, hunger and homelessness or unstable housing, drug abuse, extreme poverty, coupled with poor overall health. It was as if the situation had to rise to the level of great extremity before the woman could get help, care, or access the social service system in general. It was not for lack of trying on the part of most women; throughout the years, they might have bumped up against a potential service access point, only to be denied services or the type of help they sought. In many of these women’s cases, the longer and more severe the abuse (and other life problems), the more likely they were to eventually get some kind of help that came only after some kind of life-threatening event spurred service providers into action. “It took this dramatic incident to even get noticed,” said Wanda of her near-death abuse experience.

## **The Role of Drugs and Alcohol**

Five of the women volunteered that they had been addicted to methamphetamine or other drugs, usually prescription medication. Others made references to heavy drinking by themselves and their partner during the worst of fights. Seven of the women who had been involved with drugs had partners who were dealing meth or otherwise heavily involved in drug use, and some women mentioned their abuser was addicted to meth or alcohol by way of explaining some of his actions. “Never had any trouble the first three and a half years of our relationship, til he went back to doing meth,” said Karen. Even those women who had not been addicted to meth indicated that the drug was a particular problem for the county or community where they lived. “Sedalia has a huge issue with meth,” Cheree asserted. Women from disparate parts of the state all seemed to think that methamphetamine use was a major issue affecting several community-wide issues, from the level of violence to the type of help offered to the reaction of healthcare and first responders to women experiencing IPV. In several cases, the perception by the healthcare provider that the woman was on drugs was enough to make the clinic or hospital encounter a very unpleasant one for the woman, and in a few cases resulted in participants not getting the help they believed they needed. Cheree went to her primary care doctor for her allergies and was denied the medication refill she wanted; the doctor told her she simply had a cold and seemed “like he thought I was there trying to get drugs.” She characterized the meth problem in town as a big one, so big that all of the clinics and hospitals had signs alerting patients that drug-seeking was not tolerated and physicians did not give out pain or allergy medication on demand. Health care providers’ vigilance about meth and prescription pill abuse was common throughout the state. After going to the hospital for burns on her face and neck when her clothes dryer exploded, Stacy was told she had a “sunburn” and denied medication

despite the great deal of pain she was experiencing. She believed her shoddy treatment was due to the ER doctor assuming she was lying about the dryer and looking for pain pills.

The perception by providers of certain women as drug seekers may have been based on appearance, according to Stacy and Cheree, or a heightened level of awareness and familiarity with what are real problems with meth and alcohol in rural areas and among IPV survivors. For women who were using drugs, the health care encounter was usually a negative one. Lauren said that the staff in the clinic which housed urgent, primary, and prenatal care “looked at me like I was stupid” and “was real snippy with me.” When asked why she thought this was the case, Lauren sighed and said, “Probably because I kept getting beat up by the same guy. And the drugs.” After learning she was pregnant, Lauren did not keep most of her prenatal appointments for the duration of her pregnancy because she knew as a Medicaid patient she would be required to submit to random drug tests. As it happened, Lauren’s son was born healthy; she relapsed soon after he was born, however, and her fears became a reality when he was removed from her custody.

Other health care providers tended to downplay the seriousness of the abusive situation if substances were involved, especially on the part of the woman. Sadie described having been nearly strangled to death by her abuser, who was an alcoholic; when she came to at the hospital and told the doctor what happened, he asked, “But hadn’t y’all been drinking?” She was released without anyone at the hospital talking to her about IPV or providing information about the nearby women’s shelter.

Sometimes the healthcare providers were cognizant of the abuser’s substance problem, as was the case with Samantha. Her abuser accompanied her to all of her doctor’s appointments, and would list off her ailments to the doctor or nurse during her exam, volunteering what

medication he thought she might need to fix whatever pain or ache she was having. The staff at the clinic caught on to him, and the medication that Samantha legitimately needed for chronic pain associated with longstanding injuries was suddenly withheld. Samantha thought that the doctors suspected (rightly so) that her abuser was taking her medication recreationally or selling it, and she mused that they might have suspected her, too, since she “always allowed him to come into the room with me. Maybe they figured I was in on it.”

Oddly enough, it was the women who had been addicted to meth who had eventually received the biggest cluster of services and community resources once they were caught up by the criminal justice system (incarcerated), the child welfare system (children removed from custody), or both. Once clean, these were the women who had the ability to access behavioral health services and the help with case management, transportation, affordable housing, and vocational rehabilitation that those services signified. Child welfare clients were helped by behavioral health and a family support team that included case management, legal services, counseling, and parenting skills classes. Perhaps these cases also represented the most seriously abusive cases, involving felony crimes as well as compromising children’s safety. It is worthwhile to note that the public awareness of meth addiction contributed to what women characterized as healthcare providers’ vigilance—due in some cases, unwarranted in others—surrounding the issue of IPV, and colored their responses to the women under their care.

### **5.3 Chapter Summary**

The 20 women who participated in these interviews revealed pertinent information about the way health care and other service providers both respond and do not respond to women in abusive relationships. Particularly valuable was the contextual information on the rural setting that the survivors were able to offer: the challenges of locating and accessing help, the

difficulties posed by an overall lack of available jobs and those posed by a lack of transportation. The following chapter will discuss the survivors' experiences in light of results from the health care providers' surveys and interviews.

# **Chapter 6: Conclusions: Rural Health Care Providers' Response to Intimate Partner Violence and Survivors' Perceptions of Helpfulness**

Rural health care providers across the state of Missouri affirm that they do take steps to identify IPV, especially among their first-time patients. Providers appear to have a high level of awareness of IPV, characterizing it as a widespread problem and one that family practitioners encounter frequently in their work. Survey respondents, as well as provider interviewees, appeared to be concerned about the impact of IPV on their patients and regarded it as a pressing issue for rural communities. Organizational policies regarding the identification of IPV seem to drive providers' screening practices, but the response to IPV is generally left up to the individual provider and patient's situation. Few community resources exist for survivors of IPV in rural areas, so providers may have very little with which to work—thus decreasing the likelihood that their response will be ultimately helpful for the survivor. Providers' own lack of knowledge and mixed attitudes about intimate partner victimization, however, likely also color the provider-patient experience and the management of IPV disclosure. This study uncovered multiple discrepancies between providers' perceptions of their overall skills and preparations to address IPV and survivors' perceptions of the quality of care they received from their providers.

## **6.1 Providers' Response to Intimate Partner Violence**

### **6.1.1 Knowledge, Screening, and Response**

A main objective of this study was to gather information on whether and how rural health care providers identify IPV and what steps they take upon its identification with their patients.



According to providers surveyed and interviewed for this study, rural health care providers across the state claim they regularly initiate conversations about IPV with patients. Yet this claim contrasts sharply with the accounts of survivors, all of whom had visited a rural health provider within the previous year (as a condition of their inclusion in this study): only three out of these 20 stated they had *ever* been asked about IPV by their primary care provider. Without interviewing providers and patients at the same clinic, one can only draw inferences between the claims of providers—93% of whom stated they have screened for IPV within the previous six months—and survivors, 85% of whom state that they have not been screened by a rural health care provider at all. Some of these factors may simply have been because providers, by their own estimation, do not necessarily screen for IPV with every patient at every visit; for instance, many screen only new patients or women at specific points during their pregnancy. “I try to—I’m not 100 percent,” Robert acknowledged.

It may also be that providers’ low level of knowledge about certain health concerns indicative of IPV, such as substance abuse (a history of which many survivors involved in this study had experienced), did not “raise a red flag”, as several provider interviewees characterized their decisions to ask about IPV. Providers and survivors alike may have been uncomfortable discussing the issue if they had not met each other previously—indeed, provider interviewees stated that building a relationship with a patient over time was necessary in some cases to facilitate conversation about IPV. Provider interviewees also stated that many suspected cases of IPV go unconfirmed even when they do screen for it, simply because patients will not disclose what is happening in the home. Indeed, when asked whether they would have been able to disclose their abuse if asked during the years it was happening, at least three survivors acknowledged that they would have been unlikely to do so. Even survivors who had shared their

experience with an empathic provider said that they had initially been afraid to do so, citing multiple reasons for such reticence: fear that the abusive partner would be told or would find out, fear that the provider would contact the authorities, fear that the provider would contact Children's Division and have the survivor's children removed from the home. Yet provider interviewees, when asked to describe why they thought women might not disclose abuse, did not mention any of these possibilities—once again pointing to an overall low understanding of basic IPV dynamics.

All of these factors point to a variety of possible explanations for the gap between providers' accounts of their screening practices and survivors' experiences of it. Further investigation of this issue based on survey results and interview accounts reveals additional discrepancies between the two study samples that contextualize the differences regarding participants' accounts of screening and response to IPV, described below.

### **Screening Questions**

Provider interviewees as well as survivors indicated that a disclosure of IPV is not guaranteed simply because the question is asked. The manner in which the question is asked matters, and according to survivors, can facilitate or inhibit disclosure. This survey did not ask providers how they asked about IPV other than one question from the *Knowledge* scale that required them to choose what they felt as the most appropriate screening question from a list. Provider interviewees who regularly screened for IPV stated that they tailored the question to each individual situation, generally initiating conversation about IPV by inquiring about feelings of safety in the home. Clinics with guidelines mandating the screening of certain patient categories, such as Medicare recipients, had screening prompts embedded within the electronic medical record. The clinic where Shannon was employed was one such site, and the IPV

screening questions (to be asked annually of all patients, male and female, receiving Medicare) were also structured as home safety questions: “Do you feel safe in your home?” with follow up questions for negative responses about ever having felt threatened or been victimized physically, sexually, or emotionally by a person in their home. (These questions were asked alongside others about basic adequacy of housing, such as heat, phone lines, number of occupants, and accessibility.)

When asked about how providers should ask about IPV, the majority of survey respondents indicated that it was ideal to refrain from using words like “abused” or “battered.” However, it is important that providers and patients both understand what it is they are asking about. Vague questions about home safety that are meant to encourage disclosure about IPV and fail to do so may mean that patients simply do not understand what is being asked of them. For instance, a systematic review of screening in health care settings revealed that the IPV assessment tools with acceptable psychometric properties—such as the Woman Abuse Screening Tool (WAST), the Abuse Assessment Screen (AAS), and the Hurt, Insults, and Threats Scale (HITS)—all explicitly use phrases such as “abuse”, “hurt”, or “hit” in their questionnaires (Rabin, Jennings, Campbell & Bair-Merritt, 2010). In light of this study’s findings with regards to survivors’ reticence to disclose, as well as scholarship on screening tools in health care settings that suggest more explicit wording about IPV is acceptable to patients, providers may reconsider the manner in which they pose questions about IPV to better facilitate a conversation about it.

### **Recent Uptake of Screening Practices**

Until 2013, the U.S. Preventive Services Task Force did not recommend for or against screening by health care providers, citing insufficient evidence that it was effective. However,

the USPSTF, along with the American Medical Association and ACOG, now recommend routine screening of all female patients of childbearing age even when no signs or symptoms of IPV are present, as well as referrals to appropriate helping resources following identification of IPV (Moyer, 2013). Although many health maintenance organizations (in addition to AMA and ACOG) have recommended or mandated IPV screening for nearly a decade (Moyer, 2013), the practice of screening in any formalized manner appears to be a relatively new development in the primary health care field. Providers were not asked during interviews how long they had practiced screening for IPV; however, interviewees from both study populations indicated that IPV screening was not commonplace until recently. “They never used to ask about that,” said one survivor, talking about primary and emergency care providers. Training or education about IPV that would theoretically raise a provider’s awareness of IPV and thus the need to screen for it was still emerging in medical and nursing programs. Provider interviewees acknowledged that their awareness of IPV had been developed from years of experience rather than classroom training, although two providers mentioned a growing trend toward including IPV training in medical and nursing programs.

### **6.1.2 Perspectives: Knowledge, Attitudes, and Community**

Key to eliciting a disclosure of abuse, according to interviews with survivors, is a provider’s comportment during the IPV screening phase of their patient encounter. A caring, empathic attitude behind the questions could facilitate disclosure and generally left the survivor feeling as though the encounter was helpful even if nothing specific about the situation had yet been resolved. Caring and empathy, however, were traits that seemed to be lacking from the accounts of many of the survivors interviewed for this study. Survey respondents, with their overall low knowledge and mixed attitudes about IPV, may have inadvertently contributed to this

overall perception of lack of empathy. They may have not asked the question because they were unaware of a “red flag” or health indicator of IPV, such as ongoing depression, with which their patient presented (pointing to lack of knowledge). Their own attitudes about longtime IPV survivors lacking the ability to make responsible choices about their situation (52%) may have influenced their questioning style. Few studies of providers’ attitudes toward IPV and IPV survivors have been published, and those in existence are inconclusive about the influence of attitudes on screening and response practices (e.g. Rodriguez, Bauer, McLoughlin & Grumback, 1999; Thurston, Cory & Scott, 1998). Findings from this study indicate, however, that attitudes about both IPV and substance abuse (especially when the two co-occur), likely affect the provider’s decision to screen, their manner when doing so, and the way they respond when or if abuse is disclosed.<sup>13</sup>

Whatever the reasons behind the incongruence between providers’ and survivors’ perceptions of IPV screening and response, it is clear that all parties involved may benefit from clear, concise guidelines on how to approach the issue, including the very words to use. Brief, validated instruments for assessing IPV, including those specifically developed for a health care setting as discussed previously, have been compiled by the CDC and may be a useful starting point for clinics to adopt, considering the lack of familiarity with IPV dynamics that many providers appear to have.

Organizational guidelines appeared to be the greatest driver of IPV awareness and screening. Yet clinic protocols for the management of IPV seemed to end once the question was

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<sup>13</sup> Primary care providers’ attitudes toward substance abuse have not been widely studied—an area for future research. One study found that 68% of primary care physicians claim they screen all new patients for illicit drug use, citing time constraints, attitudes about whether or not available treatment would be effective for the patient, and confidence in their ability to approach the issue of drug abuse as inhibiting or facilitating screening practices (Friedmann, McCullough & Saitz, 2005).

asked. Providers did not have a clear picture of what to do once IPV had been identified, an observation borne out in the surveys and interviews. Discussing the matter with the patients (i.e. “patient counseling about options”) and attempting to secure resource referrals on the patient’s behalf were common responses to the identification of IPV—“I just try to figure out what she wants to do,” said Margie. Providers framed their responses as unique to each patient’s situation—creative solutions to a thorny issue. The survivors who had been helped by providers following disclosure of IPV confirmed, via their accounts of the encounter, the varied approaches providers had taken with them. One survivor was given money from her provider’s own pocket. Another survivor waited in the clinic while her provider called domestic violence programs around the state and secured both temporary shelter and transportation on her behalf. Still another survivor stated she was “basically harassed” into contacting the police following her provider’s certainty that her life was in danger. Clearly, providers take action of some kind to assist their patients.

Yet again, the low levels of knowledge and mixed attitudes toward IPV, coupled with providers’ patchy knowledge about what few community resources are available to survivors, are troubling to consider in light of their “unique” responses to each situation. Inappropriate referrals based on the provider’s own lack of knowledge about IPV dynamics (i.e. couples’ counseling) or lack of awareness of what available community resources actually do (i.e. Children’s Division) may be all too common among providers with low levels of IPV knowledge or previous training. Inappropriate responses, such as persuading the survivor to take a certain course of action (Laurie’s experience of being “basically harassed”), are also not likely to be ultimately effective at helping survivors. In fact, the survey respondents were divided evenly regarding whether survivors of IPV were capable of making appropriate choices about how to handle their situation.

There were two glaring instances where providers' stated responses to IPV disclosure—in both the surveys and interviews—raised important questions about their ability to manage IPV. The first was the 58% of providers who apparently did not understand their state's legal requirements involving when to report cases of IPV to the authorities. This erroneous assumption was further convoluted by the fact that only 46% of providers stated they had exercised their mandated reporting requirements when they identified IPV in the previous six months. The gap between the two numbers suggests that even though two-thirds of providers thought they should report all cases of IPV to the authorities, less than half claim they did file such a report after identifying IPV. What authorities were contacted (i.e. Children's Division, the Elder Abuse Hotline, or local law enforcement) was not a question asked on the survey; neither were providers asked whether they had made the patient aware of their imminent call to the authorities before making the report. Regardless of how and whether the report was made, the fact remains that a majority of providers in the state of Missouri appear to be unaware of their mandated reporting requirements involving IPV among adult, non-vulnerable women. It is unclear whether such a pattern holds true nationwide, as no studies could be located that specifically ask about providers' knowledge of IPV, their professional obligations to report abuse, and how and whether they follow these requirements. This fundamental lack of knowledge is troublesome if it means that a significant number of providers automatically contact law enforcement or the state's child abuse investigators when IPV is identified. Misunderstanding their professional legal requirements may further indicate that many providers' management of IPV involves inappropriate responses to the situation.

Another discrepancy between the services that providers find effective versus what survivors experienced had to do with law enforcement. Of all the specific community resources

that were asked about on the survey, the best endorsement for effectiveness of response to IPV as judged by providers was their local law enforcement, with 56% of respondents perceiving their police or sheriff as helpful. Provider interviewees all characterized their local law enforcement in similarly positive lights, except for Margie, who acknowledged she did not have experience with the police but she had “heard that they do a good job with that.” Yet survivors did not share the same perception of their community’s criminal justice response to IPV. Many women interviewed for this study spoke at length about multiple negative encounters with police, including lackluster responses to their 911 calls, failures to enforce orders of protection, threats of arrest and arrest itself, verbal abuse, and failure to provide information about resources (i.e. nearby shelters or services) that could help the survivor. All 20 survivors in this study had some experience with law enforcement during their abusive relationships, similar to IPV survivors in general. It is important for helping professionals, such as providers, to be aware of the fraught relationships many survivors could have with the criminal justice system before making referrals to the police or contacting the police themselves. Providers must understand that their good opinion of the local criminal justice system may not necessarily be shared by their patients, particularly if their patients have a criminal record, prior arrests, or a substance abuse problem. This is not to suggest that providers should not contact the authorities when necessary, but rather implies another gap between providers’ knowledge of basic IPV dynamics and effective help in the community and survivors’ experiences.

## **6.2 Survivors’ Perceptions of Helpfulness**

Given the clear challenges of responding to IPV in a rural area, coupled with providers’ general lack of familiarity with the major systems impacting survivors (i.e. shelters, criminal justice, child welfare), it was not surprising that most survivors of IPV involved in this study did



not find their primary care provider to be particularly helpful in addressing IPV. Survivors who did perceive their provider as helpful (or those who imagined what could have made their experience more helpful) consistently named the provider's knowledge—of IPV in general and of community resources in particular—as a primary factor in responding to IPV. Knowledge was followed by “caring” or an empathic attitude that did not come across as judgmental or “snippy”, even when the survivor continued to remain in the abusive relationship. “Not feeling rushed” was mentioned by multiple survivor interviewees, who characterized the health care setting in general as one of “hustle and bustle”. Two survivors who had voluntarily disclosed their abuse to a provider had, in fact, felt comfortable doing so in part because their provider did not make them feel as though they were in a hurry. (Time constraints have been consistently cited by physicians as a barrier to initiating conversations about abuse [Chamberlain & Perham-Hester, 2002].)

The majority of survivors involved in this study, however, did not seem to have been ultimately helped by their provider, but were compelled by an outside force, such as Children's Division or law enforcement, to seek help from a formal social or state provider of services. Such help-seeking usually occurred after the abuse had become so severe, or was so longstanding, that the authorities' attention to their situation was drawn. Once put in place, women lost much of their autonomy in the situation, usually because certain requirements were imposed on them in order to serve a sentence or regain custody of their children. Health care providers across the state, in surveys and interviews—and according to survivors' accounts—are all too often unaware of this loss of control that many survivors experience, and are furthermore largely unaware of the dynamics of these systems on their patients' lives. A lack of knowledge about IPV, lack of understanding of what community resources for survivors actually do, and a lack of

understanding about the reticence many survivors could have in accessing services from their local law enforcement or Children's Division, may lead providers to assume that their patients are irresponsible or refusing offers for help. In fact, providers may be offering the wrong forms of help—or failing to understand survivors' reluctance in seeking certain types of help without further probing. An effective response to IPV, based on survivors' experiences, would include a provider who is not only knowledgeable about IPV but also knowledgeable about community resources and able to provide up-to-date resource referrals that are relevant to the survivor's own wishes and her particular situation.

To date, no studies could be identified that have specifically examined the effectiveness of provider referrals to law enforcement or Children's Division when the child is not the identified victim/patient. Likewise, collaborations spanning health care and criminal justice systems<sup>14</sup>, or health care and child welfare systems, either have not been studied or have not been studied when IPV is the issue of focus. Rural settings in particular may benefit from partnerships between these agencies, especially in areas where service providers specifically addressing violence against women are lacking and given the overlap between IPV, child abuse, and substance abuse generally (and specifically in the rural communities involved in this study). Each of these three intersecting issues are areas of equal concern for health care providers, child welfare practitioners, and law enforcement alike.

### **6.2.1 Attitudes and Substance Abuse**

Relatively little scholarship has focused on the attitudes or reactions of primary care providers with regards to substance abuse, particularly illicit drug use. Notable exceptions

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<sup>14</sup> Coordination between health care providers and social services, specifically mental and behavioral health services, regarding the response to substance abuse has been found beneficial from both provider and patient perspectives (Samet, Friedmann & Saitz, 2001).

include a national survey of physician screening for substance abuse (Friedmann, McCullough & Saitz, 2001) and one study that compiled predictors and consequences of physicians' attitudes toward the drug use of HIV-infected patients (Ding, Landon, Wilson, Wong, Shapiro & Cleary [Ding et al.], 2005). Similar to the barriers and facilitators providers cite when asked about their IPV screening and response practices, physicians who were unfamiliar with substance abuse dynamics, perceived a lack of time during the patient encounter, or did not feel that referring the patient to outside resources would be helpful, were less likely to ask about problematic substance use (Friedmann, McCullough & Saitz, 2001). Conversely, familiarity with illicit drug use etiology, patterns, and users predicted more positive attitudes toward substance-abusing patients by physicians (Ding et al., 2005). The caring attitude these providers demonstrated toward users of illicit drugs were associated with those providers being more knowledgeable about substance abuse and treating fewer patients per week (Ding et al., 2005).

The above cited factors predicting an empathic attitude toward the substance abuse of HIV-infected patients may well translate to the experiences of IPV survivors regarding providers' reactions to their suspected or confirmed substance misuse. "Caring" and "empathy" were cited as additional factors that providers used, or need to use, in order to facilitate disclosure and provide an effective response to IPV, according to survivors interviewed. Providers' mixed attitudes toward the nature of IPV and survivorship itself may have tainted their approach to the situation, as has been discussed above. Several survivors described encounters with a rural health care provider whose distaste for them and their situation was very clear, however. The 12 women in this study who had been involved with substance-abusing partners or abused drugs and alcohol themselves were the most likely to characterize their health care experiences in poor terms.

Providers appear to misunderstand some pertinent aspects of substance abuse and its association with IPV. Survey respondents and interviewees acknowledged that alcohol and drugs could be causes of violence or correlated with IPV, yet few providers agreed that they would view substance abuse as a risk factor or “red flag” that might prompt them to screen for IPV. Provider interviewees mentioned the problems of alcohol, painkiller, and methamphetamine abuse specifically in their communities, but were quite vague about how many patients with active use they had treated recently or whether the cases of IPV they had identified involved substance abuse. Due to the high profile of substance abuse, particularly methamphetamine use--but also heroin and prescription painkillers--in the state, it is likely that providers have a heightened awareness of the problem and are understandably vigilant about issues that might interfere with their practice, such as patients’ drug-seeking or overdoses. The overlapping dynamics of substance abuse and IPV appear to be not well understood, or not well treated, according to survivors.

Behavioral health resources in rural areas may be even fewer than those for IPV. Therefore, an effective response to a patient experiencing both IPV and substance abuse would be particularly challenging for a rural health care provider. Still, an empathic attitude that encourages discussion of all aspects of the patient’s history, even when the patient is a suspected or confirmed substance user, would likely lead providers to identify additional health concerns or problems related to IPV in addition to the substance abuse. By contrast, a judgmental attitude about substance abuse—or an automatic assumption that a patient is abusing drugs or seeking drugs based on their partner or physical presentation—may discourage survivors from continuing with necessary preventive care or seeking the more specialized behavioral health treatment they

may need. Each of these scenarios has poor overall outcomes for women's health and, by extension, the resolution of their abuse.

### **6.2.2 Emergency versus Primary Care Experiences**

Nineteen of the 20 women interviewed for this study had visited an emergency department at least once during the course of their abusive relationship, due to injuries sustained during a physical altercation with their partner. The majority of these 19 survivors had been screened for IPV in this emergency setting—or, due to the presenting circumstances, found that their abuse was already known by the hospital staff. Survivors listed many reasons why disclosing or discussing IPV in an emergency room was difficult. Many of these reasons hinged on the loss of control over the situation that many women felt, whether explicitly when they were brought in to the hospital by police or ambulance, or implicitly, when staff “tried to save the day” (according to Cheree) by pressuring women to go to a shelter. Training about IPV dynamics in emergency room settings seemed to lag behind the practices by primary care providers. Some survivor interviewees had been asked whether they were victims while their abusive partner was within earshot. “You’d think they’d use their heads a little bit more,” said one provider interviewee, referencing this tendency by hospital staff. The chaotic atmosphere of many acute care settings, as well as the perceived inurement to suffering and associated lack of empathy by hospital staff, prevented many women from disclosing their abuse or the extent of the abuse, even when directly asked, in these situations. Although this study was focused on the screening and response to IPV by primary care providers, the women in this study as well as women experiencing IPV in general tend to utilize emergency care frequently due to injuries from abuse (Campbell, 2002). It is possible that another reason women are reticent to disclose abuse to primary care providers stems from the legitimate fear that their disclosure will mean a loss of

autonomy, similar to what they may have experienced in an emergency room setting. Women with children in the home who are witness to the abuse, or who are being abused themselves, may be even more fearful to talk about their situation with any health care professional due to the fear (also legitimate) that a provider will contact Children’s Division.

### **6.3 The Rural Setting**

Strengths and challenges that rurality posed for survivors of IPV was one broad area where themes from participant interviews often converged. According to provider interviewees, rural health care delivery is characterized by more time to spend with patients due to a lower volume of patients, long-term relationships with patients, and other aspects of family practice that were seen as enjoyable: treating all members of the same family, for instance, or having a personal relationship with patients. “It’s old-fashioned medicine,” Robert said, pointing out that when medical students have visited his practice, “they are amazed at the things I do, the things I see, because there’s no specialists around that I can refer them [the patient] to, it’s all up to our clinic to take care of some of these things.”

#### **6.3.1 Community Resources, or the Lack Thereof**

However, numerous challenges associated with rural practice surfaced from the survey of and interviews with providers. Predictably, most of these challenges stemmed from a lack of resources—health, mental health, and IPV-specific—to help patients. Such a lack of resources frustrated the efforts of providers to effectively respond to IPV. On nearly every item, approximately two-thirds of survey respondents indicated that a given community resource either did not exist or was not effective at helping IPV survivors. “Please get us more services,” one interviewee responded, when asked whether she had further comments at the close of her interview. Providers and survivors alike discussed the lack of services for IPV, and a recurring

theme from interviews with both samples indicated troubling trends about the community resources that were available. Services that did exist, such as faith-based programs or domestic violence shelters, rarely seemed to make their existence known to the broader community. “You really have to dig for it,” Millie said. Tracy, a provider, confirmed this. “Oftentimes what we’re seeing is that you’ll call this number and the person who used to provide that service has moved or is no longer there.” The scarcity of community resources is thus one major challenge for rural providers and survivors, with a lack of awareness about existing resources forming yet another layer of this challenge.

### **Mental Health Services**

Mental and behavioral health is an area in which rural areas remain markedly underserved, to the detriment of women experiencing IPV, depression, trauma, substance abuse, or a combination of the above. A mere one-third of survey respondents claimed that services were available in their county or community to provide individual counseling for survivors of IPV. All the providers interviewed described the lack of mental health services as a problem for many of their patients, including those who were coping with abusive relationships. Few survivors had experience with mental health treatment until they were receiving other social services—such as Children’s Division case involvement that mandated family counseling, as in the cases of Lauren and Shawna. Even those survivors who were receiving some form of mental health services or who had received an official diagnosis at one time or another were not receiving ongoing counseling. Only one survivor interviewee was seeing a psychologist for individual therapy sessions. Others received mental health treatment in the form of shelter support groups, medication management by nurse practitioners or psychiatrists, and case management from behavioral health or shelter services. These services in and of themselves do not qualify as

“mental health treatment”, at least the kind of evidence-supported mental health treatment that is generally recommended for survivors of IPV to cope with and recover from abuse.

Providers and survivors alike discussed the need for mental health services in their respective communities during interviews. According to providers, depression and anxiety were some of the hallmark indicators of abuse, both current and former, among their patients. Several providers, such as Tracy, spoke about the general need for mental health treatment in light of environmental factors that may have caused or deepened life stressors for many people in her community, such as the loss of jobs and associated economic strain. All of the survivors interviewed for this study save one talked about the need for mental health treatment—meaning focused, individual therapy—as an integral part of the IPV recovery process that was largely absent in the social services to which they had access.

The dearth of mental and behavioral health treatment in rural areas is well known (National Alliance for the Mentally Ill, 2013). Some rural communities have responded to this services disparity by implementing telehealth psychiatry programs, in which a psychiatrist (often based in the closest metropolitan area), offers diagnostic, medication management, and staff consultation remotely on certain days of the week or month at a rural health clinic. One of the clinics where a provider interview took place had just received a year-long grant to implement such a program. Another provider mentioned that the stigma associated with mental health treatment remained so pervasive in her rural community that getting people to individual or family counseling would work only if the mental health services provider was located in the same building as the health clinic. In fact, this practice of co-locating services is a feature of many FQHCs, although ongoing counseling did not appear to be offered at any of the FQHC sites in this study. Some studies have examined the role of social workers or mental health



professionals in health clinics as a way of responding to abuse disclosures in the health care setting, notably Campbell and colleagues (2012) and Ulrich and Stockdale (2002). Both of these studies piloted a brief counseling or advocacy intervention by a mental health professional in a health clinic following the identification of IPV by a health care provider. Such coordination of care, as well as the sharing of space, may be practical and feasible for rural communities. Yet in the current state of affairs, survivors who desire longer-term counseling, or who have substance abuse problems that may be best addressed by the coordination of their health and mental health treatment, are largely unable to access these services in rural areas across Missouri.

### **6.3.2 Rural Abuse Dynamics**

#### **Severity of Abuse**

The inability of many rural survivors to access health or social services, including primary care, was complicated by certain factors that have already been described, such as the lack of mental health treatment or domestic violence programs. Lack of access to such supports is particularly troubling in light of the very severe abuse that the majority of women interviewed for this study experienced. In many cases, survivors endured years of grave, relentless physical violence that endangered their lives, not to mention damaged their quality of life. The severity of this abuse was cited as a cause and consequence affecting the overall health status of these survivor interviewees. Many interviewees enumerated health concerns stemming from old injuries, depression, PTSD, and anxiety. The majority of the women interviewed appeared to be in poor overall health due in part to socioeconomic and lifestyle factors that had likely exacerbated the violence, such as substance misuse.

## **Physical and Social Isolation**

While it is unlikely that the majority of IPV survivors in the U.S. experience such high levels of ongoing, extreme physical and sexual abuse, it appears that rural survivors may be at particular risk of such abuse and associated health problems due to several factors identified by both providers and survivors in this study. “It’s very easy to isolate someone in a rural area,” said one provider. Other providers agreed that isolation—distance from neighbors, from the nearest town, from many social services and resources in general—posed a particular threat for rural survivors. Scholars studying IPV have frequently referenced isolation as a tactic employed by many abusive partners (Follingstad, Rutledge, Berg, Hause & Polek, 1990), a coercive, emotionally and psychologically controlling behavior meant to reinforce total dependence on the abuser while keeping the abuse itself, or the extent of it, a secret from those outside the relationship. The simple fact of rural living, where people tend to live at greater distances from each other, could make, as Tracy speculated, physical and emotional isolation easier for abusive partners.

## **Poverty**

Socioeconomic factors likely played a role in the severity of abuse that the survivor interviewees experienced, as well. Providers and survivors discussed at length the poverty and lack of economic opportunities in the rural communities where they lived. Living at or below the poverty line has been associated with numerous health concerns and linked to IPV (World Health Organization, 2013). Poverty likely prevented many survivors from seeking the type of health care and social services that they desired to mitigate the effects of the abuse in a timely manner, thus contributing to further involvement in the abusive relationship and an accumulation of health problems. Providers likewise described the difficulties of encouraging many patients to

keep up with their routine primary care and health management (diabetes checkups, e.g.) that were associated with poverty: the lack or loss of health insurance associated with a job, the lack of a vehicle to drive to necessary appointments or pick up prescriptions, and the lack of understanding (according to two providers) of the importance of preventive care due to low levels of formal education in the community at large.

### **Gender roles**

An overarching theme that emerged from interviews with providers and survivors regarding the dynamics of IPV in rural areas were social mores surrounding gender in their communities. Rural areas have been characterized by some researchers as being generally more socially conservative; an adherence to traditional roles for men and women, such as male breadwinner and female caregiver, remain more common in rural communities, at least nominally so (Few, 2005; Lewis, 2003). While such norms are probably shifting, traditional gender roles shaped the dynamics of IPV in ways described both obliquely and explicitly by providers and survivors. Often the reference to gender roles was apparent through women's financial and material dependence on their male partner. Economic dependency on the male partner in any relationship was assumed by providers and was, indeed, the reality of the 20 survivors interviewed for this study. All of the survivor interviewees had relied on their partner, or partners, for the majority of their income, health insurance (if the partner was employed or received Social Security or veteran's benefits), housing, and transportation. Perhaps as a result of this economic imbalance, survivor interviewees had little or no experience working outside the home, hindering their ability to secure employment once out of the abusive relationship. This fact was also cited by providers as one of the reasons women remained in abusive relationships:

“no access to income or alternative shelter”, “complete dependence on the man”, “no money of their own or means to get anywhere”.

Access to a vehicle was the other major asset that male partners seemed to provide. Providers described how abusive men could easily isolate women simply because they controlled the transportation. Indeed, none of the survivor interviewees owned a vehicle during their relationships, and most did not currently drive. Providers also indicated that by default the vehicle title and other property ownership went to the male partner in any relationship, perhaps because men still tended to be the family breadwinners and to require a car for work.

There were several reasons cited by survivors by way of explaining the economic gulf between rural men and women. Two interviewees described the persistent gap as stemming from the legacy of farm and factory work in many of these communities, physical jobs for which women were simply not considered eligible. This made it difficult for women, particularly those with low levels of education, to access the types of relatively unskilled employment that could sustain a household. Even though employment opportunities in the agricultural sector or industries were disappearing rapidly, men still tended to make up the majority of the workforce—or, according to Millie, “got first dibs” on all the jobs that women might otherwise obtain, such as those in retail or restaurants. (Both Millie and another interviewee who were actively seeking employment felt they had been repeatedly passed over even for low-wage or seasonal work because managers preferred to hire young men.) Survivors also perceived that in general, their communities were run by a cadre of “good old boys”, prosecutors, sheriffs, and church leaders who were not knowledgeable or particularly sympathetic to situations involving family violence. “The woman is still very much put down here,” said one interviewee in summation. Women tended to believe that the law enforcement in their communities was

particularly hostile toward survivors of IPV, partially because these women were seen as transgressing social norms—those who fought back, drank or used drugs, or were not married, were “not ladylike enough” (according to Stacy) and “were just asking for it [because of their nontraditional lifestyle]” (according to Mary). Several women described the police or sheriff’s deputies in their town as “corrupt”; two gave anecdotal examples of law enforcement profiting from or being involved in local methamphetamine production and sales. Survivors’ opinions diverged on whether having more women on the police force would change such dynamics; some, like Lauren, believed that equal numbers of men and women in law enforcement, community administration, and health care was the best way to start addressing issues of concern to women, such as IPV. Others, like Stacy and Lesley, did not believe that female cops were any different and may even be worse in some cases—“because they have to try to be like the men” (Lesley).

### **Rural Substance Abuse**

The severity of abuse that many survivors experienced was complicated by their own or their partner’s substance abuse. Substance abuse also complicated the providers’ ability to identify and respond to IPV, and was cited by survivors as a reason why their primary care provider had not asked about IPV. The majority of provider and survivor interviewees characterized their communities as having a widespread problem with substance abuse—particularly methamphetamine—that escalated interpersonal violence and drove much of the crime in the area. Reasons why substance abuse was a particular problem for rural areas in Missouri, according to interviewees, stemmed from poverty and loss of work (“there’s not much else to do, so people turn to drink and drugs” according to one provider) and the remoteness of the communities themselves (“there’s lots of places to cook meth in a rural area”). Health care

providers, according to interviews with both providers and survivors, appeared to have a high level of awareness of community substance abuse and an associated vigilance about the issue that impacted survivors.

Interview themes from both providers and survivors centered on the challenges of IPV when substances were involved, particularly alcohol and methamphetamine. Survivors who had undergone the most severe forms of abuse, including four women who had required multiple surgeries for life-threatening injuries, had all been partnered with men who abused alcohol or methamphetamine. The use of illicit substances prevented some women from seeing their primary care physician on a regular basis out of fear that the provider would suspect what was going on and contact the authorities or Children’s Division. In other cases, as with Samantha, the abuser’s taste for prescription painkillers drove him to accompany her to all doctor’s appointments, where he encouraged her to request certain types of medication and then used or sold it himself.

As was mentioned previously (c.f. “Substance Abuse” in Section 6.2), the provider’s attitude toward the survivor was perceived to be much less caring when substance abuse was a factor in their lives. The addiction seemed to be what providers saw first, and colored the provider-patient encounter. Two survivors gave examples of seeing a primary care provider who, after learning that their presenting injuries were due to abuse, immediately asked whether substances had played a role (“Hadn’t y’all been drinking?” one physician asked Sadie, regarding the bruises on her neck). Even those women who only used drugs as prescribed or needed them for a health condition, such as Cheree and Samantha, stated that health care providers did not believe them when they described their symptoms, perhaps suspecting them of drug-seeking. The stigma of substance abuse was such that Lauren delayed seeking health care—

for injuries, for pre-natal care—because she felt that the providers were unsympathetic, even hostile, toward her.

Provider interviewees did not believe they treated substance-abusing patients any differently than others, and, along with survey respondents, did not appear to endorse selective screening for IPV among populations of high risk, such as drug-using women. Attitudes about patients who misused alcohol and drugs was not significantly associated with screening (or not screening) and response to IPV according to the survey respondents. One provider interviewee stated that “as with abused women, those are the women who aren’t coming in as frequently” (meaning women with substance use or misuse problems). Another provider characterized alcohol and methamphetamine problems as more prevalent among males, with female partners seeming to bear the brunt of violence but not necessarily being involved in the substance use themselves. Still another provider speculated (confirmed by several survivor interviewees) that methamphetamine-addicted women would be afraid to visit a health care provider, much less disclose any abuse that was occurring, out of fear that the provider would call Children’s Division or report their activities to the police.

Substance abuse also limited women’s employment opportunities once they were sober and out of the relationship, further entrenching them in poverty. Although several women were able to access behavioral health treatment and case management services, often through Children’s Division, that assisted them with vocational rehabilitation, survivors with a history of substance abuse that had resulted in prior criminal convictions found it all but impossible to obtain employment. Jobs in the rural communities where survivors lived were scarce to begin with, and survivors’ perception was that few employers would hire someone with a criminal

background—or even someone who was known by word of mouth to have abused drugs in the past.

## **Family**

An important point of divergence between the themes from each sample of interviewees was the providers' assumption of the possibility of stronger family support in rural communities. According to the survivor interviewees, however, family support had largely been absent from their lives. Few survivors had been able to secure meaningful help from their families; only two women had ended up living with a family member after leaving her relationship. Although providers' inclination to ask about family support when counseling a patient about her options following an abuse disclosure is appropriate, the assumption that families or friends would be receptive to the survivor did not match the experiences of the survivor interviewees. Indeed, many survivors of IPV who have been involved in long-term or multiple abusive relationships have been coerced by their abuser to cut ties with all would-be social support networks (Follingstad et al., 1990); social isolation, even from family members who might live nearby, is likely easier for an abuser to accomplish in a rural area (Annan, 2008). Many survivors in general, and a notable minority of those involved in this study, tend to have social networks that are themselves peopled with others in abusive relationships. Survivors who have grown up in poverty may hail from families who lack the means to offer shelter, transportation, or other forms of help even when they are sympathetic to the survivor's plight. Although social support is an important protective factor in resiliency and recovery from IPV, providers must be aware that family and friendship dynamics can be complicated by poverty, a survivor's history of abuse and help-seeking, and the survivor's own history of abuse within her family of origin.



### 6.3.3 Rural Health Care Delivery

#### Health Insurance

One of the barriers to receiving any kind of health care, including mental health treatment, is the lack of health insurance. Provider interviewees affirmed that the majority of their patients received Medicaid or Medicare, and even then the cost of some needed prescriptions was out of reach. Survivors interviewed for this study had been uninsured most of their lives, or had received some form of public insurance (usually Medicaid or Social Security Disability Income) on behalf of their children. Although having visited a rural health clinic or rural FQHC was one of the inclusion criterion for this study, the majority of the women interviewed had not kept regular primary care appointments during their years of abuse and many had only recently re-established primary care as they sought to rebuild their lives in the wake of abuse. The chaos surrounding their relationships, in addition to substance abuse (in some circumstances) and the lack of health insurance all contributed to survivors' inability to access routine health care. Provider interviewees seemed to recognize this, suspecting that many women involved in abusive relationships were "those who we don't see as much, who aren't really coming in for their regular appointments," according to Tracy. Another provider stated that rural women in general were less likely than their urban counterparts to access routine preventive and primary care due to the health insurance barrier, echoing state and federal statistics on health disparities (National Rural Health Association, 2013).

Provider interviewees had not yet witnessed an appreciable increase in the number of their insured patients since the implementation of the Affordable Care Act (ACA) at the beginning of 2014. One interviewee's clinic, however, had recently implemented protocols, based on ACA rules, that mandated the screening of all patients receiving Medicare during every

office visit. As of the time of the interview, there were not enough data to judge whether these new screening practices had led to an increase in detected abuse cases among her patients. Three other providers referenced the ACA in hopeful terms, but indicated that so far, it did not appear that many of their patients had success obtaining affordable private insurance. In coming years the effect of the ACA on both the identification of IPV as well as the potential for previously uninsured survivors to access health insurance will be an important area of research on rural women's health.

### **Patient Confidentiality**

One aspect of rural health care delivery that may be especially important to consider, as it apparently influences the provider-patient encounter in rural areas, is the fact that many providers state they are personally acquainted with some of their patients outside of the clinic. Provider interviewees, who were also asked about their social relationships with patients, tended to downplay this aspect of their practice. “That’s more of a staff issue,” one provider said, indicating that her receptionist was more likely to know patients personally than she was. Margie also acknowledged that she regularly saw patients whom she knew from church or her daughter’s school. Other providers used the phrase “everybody knows everybody” multiple times when describing their community. However, provider interviewees did not seem to believe that this fact influenced or inhibited a patient’s disclosure of IPV. Providers undoubtedly practice high standards of protecting patient confidentiality, yet it is difficult to imagine, given the small populations of these towns and providers’ longstanding relationships with patients, that someone at the clinic site would not personally know the patient or her abuser.

Furthermore, if a provider knows a patient outside of the clinic—as a fellow churchgoer, for example—asking about IPV as a matter of course may feel awkward for both parties

involved, or may inhibit a disclosure that needs to be made simply because of the pre-existing social relationship. On the other hand, certain types of relationships may mean that a provider has more intimate knowledge of a patient's personal history than he or she might otherwise, thus facilitating disclosure and/or the provision of help. Yet providers who are not aware of this influence in their practice, or do not understand that a survivor might not want to discuss IPV since she knows the receptionist will see the details in her chart later, do not do themselves or their patients a service. Anonymity of patient disclosures may be all but impossible to ensure in a very rural setting regardless of the precautions taken, but best efforts must be made to address these concerns with patients. It may not be the provider whose confidence the patient is worried about sharing, for instance: it may be that the patient is concerned about another staff member overhearing or seeing in her chart the disclosure.

## **6.4 Chapter Summary**

### **6.4.1 Limitations**

#### **Surveys**

This study garnered a 34% response rate from survey respondents, which was lower than the desired minimum threshold of 50 percent. Reasons for this low response rate may have been due to the fact that many clinic sites employed only one health care provider meeting the inclusion criteria (physician, nurse practitioner, or nurse), whose time might have been too constrained to respond to this survey. Additionally, nearly 36% of the clinics were administered by a single entity, such as a health care system or conglomerate (n= 141). In certain cases, this could have meant that the same clinic director practiced at multiple sites, meaning that only one person would have received and/or responded to the survey for two or more clinics. Additional

time and funding may have enabled this student to expand recruitment efforts or keep the survey live for a longer period of time in order to boost the possibility of more respondents.

Other reasons for the low response rate may have been the length of the instrument itself—the 90-item questionnaire, which asked respondents some potentially difficult or thought-provoking questions about IPV using varied question construction, may have prevented many providers pressed for time from taking part in the study. Selection bias was probably a factor that affected the participation in this study by both respondents and interviewees. The title of the survey, “Physician Readiness to Manage Intimate Partner Violence” as well as the manner in which the research project was presented (i.e. “information on the ways rural health care providers identify and respond to domestic violence”) may have meant that providers with a particular interest in, or a higher-than-average level of awareness of IPV, chose to respond to the survey or call for interviews. The anonymous nature of the survey means that characteristics of respondents versus non-respondents could not be determined because of the lack of demographic information provided in the survey. Sampling bias was inherent due to the limited access granted to this student by the Missouri Association of Rural Health Clinics and the Missouri Department of Health and Senior Services, neither of which would provide direct contact information or other information about clinic size and attributes to this student. While there were no discernible patterns of survey response or non-response by county, there is no way to tell what personal or organizational factors differentiates respondents from non-respondents.

Reported practices may have differed from actual practices; respondents may have also looked up answers to the questions on the *Knowledge* subscales so as to return the “correct” response, rather than providing their instinctual response. Certain contextualizing information may have also been missing from the surveys simply because the questions were constructed in a

way that did not allow for a flexible answer. For instance, providers who stated they took “no action” following the identification of abuse may not have taken action because the patient disclosing abuse was no longer experiencing it; others may have taken “no action” because they did not know what to do or feel it was their responsibility to respond. The fact that none of the providers interviewed had taken the survey themselves thus limits the triangulation of findings that might better contextualize some of the information gained from the survey.

As it stands, the PREMIS is a useful tool for capturing foundational knowledge about IPV and identifying gaps between perceptions, knowledge, and reported behaviors. The *Attitudes* scale in particular illuminated possible areas of an empathic versus victim-blaming orientation on the part of the providers toward patients experiencing IPV. Therefore the survey is a helpful general tool for a quick scan of provider knowledge, attitudes, and practices; future research could deepen the level of questioning and analysis that may help explain some of the more counter-intuitive findings that the PREMIS generated.

Data analysis may have been limited by the number of responses. Much of the analysis of the surveys was descriptive or used non-parametric tests of association to examine variables. Certain statistical functions, such as chi-squares, could not be carried out or interpreted because of too few units in given variables. Indeed, the descriptive nature of this study itself means that drawing inferences from much of the quantitative results is not possible—or that the results themselves, such as those examining the associations between knowledge and screening practices, must be interpreted with care. A larger survey that included participants from metropolitan as well as rural areas, would likely have addressed some of these issues as well as provided the ability to compare between urban and rural practice.

## Qualitative Methods

A methodological limitation of this study was inherent to the manner in which providers and survivors were recruited and selected for interviews. These two populations were drawn from disparate areas of the state and different clinic settings, which may have heightened the applicability of study findings by capturing perspectives from multiple study sites and participants, yet made triangulating findings from the interviews difficult. Five of the seven providers interviewed did not practice in a county with an operating domestic violence shelter, for instance, whereas fifteen of the survivors either lived in or had relocated to a county with a shelter. These different service contexts undoubtedly influenced the type of help providers would have been able to offer, as well as the types of help survivors may have sought during their abusive relationships. A more appropriate method to address this limitation may have been to recruit providers and survivors from the same clinic for interviews. However, all but one of the clinic directors contacted directly for this study (n= 60) refused to allow study recruitment of patients at their clinic site. Providers' awareness that their patients may have participated in the study could have affected their responses to interview questions. To better address the disparities that could have arisen due to the different contexts from which these participants were drawn, recruiting providers and survivors from the same county (albeit not necessarily the same clinic) may have helped contextualize information while also remaining mindful of clinic directors' concern over recruitment of patients. As it happened, only one county in this study (Jefferson) contained both interviews from a provider and a survivor.

The survivors who participated in this study tended to have histories of very severe IPV. Their experiences may not reflect those of the majority of women who have experienced abuse. Furthermore, an important distinction with regards to help-seeking and health care experiences

may exist between women who leave versus women who choose to remain in abusive relationships. Each of the women interviewed for this study had ultimately left their abuser, a trait which may distinguish them from a potentially larger population of rural victims who do not leave. (Scholarship on IPV abounds with estimates that a large proportion of abused women cycle through violent relationships, return to abusers multiple times, or never seek formal services, such as shelter, at all [Macy et al., 2009]). Overall applicability of the study's qualitative findings was further limited by the socio-demographics of the survivors interviewed for this study; though these demographics tended to reflect the rural populace of the state in general (i.e., Caucasian, low income), findings from these interviews thus reflect a specific point of view and experience. A larger sample size and broader, community-wide recruitment efforts may have minimized these risks.

Interpretation of the study's qualitative findings may also be limited by the fact that this analysis was undertaken by one person—the researcher conducting the study—and was not transcribed, read, or coded by anyone else. Although this student was intentional about documenting the specific steps, methods, analytic approach, and interpretation of the qualitative findings, the final interpretation of the interview data remains solely that of the researcher.

#### **6.4.2 Conclusion**

Findings from this research confirm those from many other studies examining rural IPV. The challenges enumerated by providers and survivors during interviews tended to mirror not only each other but also echoed familiar themes from previous scholarly work: poverty, isolation, lack of transportation, and traditional gender role norms that shaped the experiences of abuse, often heightening the abuse severity, for rural women. Similarly, the dearth of health and social services in rural communities, as well as purported misinformation or lack of knowledge

about those services that did exist, was a common theme across surveys and interviews. Although providers did not report that the lack of resources prevented them from asking about IPV, the lack of resources coupled with their low knowledge of IPV dynamics in general (and thus, an awareness of what resources may or may not be appropriate) certainly appears to affect the helpfulness of their response. Furthermore, providers' lack of familiarity with community-based resources and social services in general even when they did appropriately conduct safety assessments or create safety plans, may have prevented some patients from seeking help.

Despite the many challenges that rurality posed for survivors, it is notable that none of the interviewees considered leaving the rural area for a metropolitan one that may have offered more resources, transportation options, or economic opportunities for women. Providers, who tended to hail from rural communities themselves, had also made the specific choice to practice in a rural community, where they likely earned less than their urban counterparts. Even when survivors had relocated from one county or small town to another, they preferred to remain in a rural setting. Ultimately, the strengths of rural areas—the closer social ties, the proximity (regardless of ability to help) of family, low overall rates of crime, and the promise, to which many interviewees ascribed, of providing a carefree childhood for their families—far outweighed the challenges of country living, even for women involved in or recovering from IPV.



# **Chapter 7: Implications and Future Directions for Social Work Research and Practice**

Broadly speaking, findings from this study indicate that increasing social work involvement in health care would exert a positive impact on providers as well as survivors of IPV. The lives of many individuals served by social workers have often been marked by socioeconomic, behavioral, and traumatic experiences that profoundly damage overall health and well-being. Social workers may take an active role in promoting the health of their clients by conducting routine health assessments, serving as advocates within and outside the health care system, and increasing advocacy and awareness regarding health insurance status and policies for their clients. Social work researchers likewise have opportunities for greater involvement in health and health care scholarship, rural IPV, and rural populations in general. This chapter will conclude the dissertation with a discussion of the implications for social work practice, policy, and research as indicated by this study.

## **7.1 Implications for Social Work Practice**

### **7.1.1 Social Services Presence in Rural Areas**

Increasing social work practitioner presence and social services in rural areas is an important piece in improving the health and well-being of rural residents overall. Specifically, however, findings from this study have implications for social service providers employed at domestic violence shelters or other programs addressing interpersonal violence, such as victim witness and Legal Aid advocates, and those who work within the state Children's Division. Just as many rural areas are under-served medically, so they are also frequently lacking specialized

support systems to address IPV. (A mere 19% of providers from the survey indicated that there was a domestic violence program in their community, and six out of seven providers interviewed worked in a county where there was no domestic violence program.) Even when services do exist, providers and survivors alike are frequently unaware that they are available. An important first step in addressing the barriers many rural survivors face with regards to help-seeking—and which providers face with regards to providing helpful community resource referrals—is for service providers addressing violence against women across the state to increase their community profile. Outreach efforts with the systems with which IPV survivors tend to interact regularly, such as health care (including primary and emergency care settings), law enforcement, and Children’s Division, may be areas that social service practitioners in domestic violence agencies focus their attention. It bears mentioning, in light of findings from this study that an important part of increasing awareness of existing resources for IPV survivors means that social workers ensure their contact information, menu of services, and information on the availability, accessibility, and location of those services is updated regularly and provided to the appropriate community agencies listed above. Social workers may also keep in mind that survivors may be contacting them from outside that community or county for assistance and strive to publicize their services as widely as possible. Although many domestic violence shelters prefer their physical location to remain anonymous, their policies around this issue must not interfere with help-seeking efforts by survivors and others on survivors’ behalf, such as health care providers. (Very little information about domestic violence shelters with “open” policies, that is, shelters who allow their address to be published, has been made available in the scholarly literature. However, such shelters do exist—the Safehouse Center<sup>15</sup> in Ann Arbor, Michigan, is one such

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<sup>15</sup> See [www.safehousecenter.org](http://www.safehousecenter.org).

example of a successful domestic violence and rape crisis program with a published address. Not coincidentally, this shelter is located in close proximity to a police station and offers yearly training to law enforcement officers on a specialized Domestic Violence Task Squad.)

### **7.1.2 Collaboration**

#### **Health care**

Service providers addressing violence against women in particular have a responsibility to develop partnerships with the rural health care providers in their own as well as surrounding communities (recognizing that survivors often re-locate from one town to another in order to access their services). Fostering ongoing relationships with local primary and emergency care personnel may facilitate referrals for services when providers identify IPV, and also helps ensure that helping professionals are aware of their presence. Although providers indicated that mental health services addressing IPV were scarce in rural areas across the state, social workers involved in private practice or mental health counseling outside of IPV should also make efforts to establish relationships with the rural health care providers in their catchment area.

The rural setting may foster on-site social work-health care integration driven by practical reasons of available space, budget, and distance to services. For instance, co-locating health and mental/behavioral health services within the same building may be more feasible for social workers in rural areas. One provider mentioned that offering mental health services in the same office as a primary care practice may reduce the stigma of seeking counseling, as no one else in the waiting room would know whether the patient was there to see a physician or a mental health services provider. Conserving space while expanding services' catchment areas may be especially practical for rural areas with large geographic distances between communities and low populations. Social workers may provide services during certain "clinic days" of the week or

month, which might help ensure that patients receive the benefits of social services while also establishing relationships with health care providers. One such study from rural Pennsylvania piloted a partnership between a primary health care provider and social worker who administered a brief advocacy intervention following the provider's identification of abuse (Ulrich & Stockdale, 2002). Preliminary results from this project indicated that providers' knowledge of IPV as well as their comfort initiating discussion of it with patients increased, and screening and referral to appropriate services in the area became commonplace.

Providers and survivors frequently characterized the substance abuse problems in their area as a major correlate of IPV as well as a side effect of poverty, lack of employment opportunities, and the isolation typical of many rural communities across Missouri. Social work integration into the health care system must also translate to greater involvement in behavioral health and attention to the problems of substance abuse, especially in rural areas where such problems may be widespread but treatment options limited or non-existent. In particular, social workers who educate and consult with helping professionals, such as health care providers, must incorporate information on the intersection of IPV and substance abuse into these trainings. Survivors interviewed for this study did not feel as though their provider responded helpfully during the health care visit when substance abuse was a real or suspected problem in their lives. Provider interviewees all acknowledged the problem of substance abuse but other than making general statements about the reasons for its prevalence, did not describe how it was addressed in their practice or in the community at large. Substance abuse thus appears to be an area about which providers are well aware and vigilant, particularly with regards to drug-seeking and prescription pill abuse, yet little is known about how to respond to it effectively, what mandated

reporting requirements are regarding the use of illicit substances when children are present<sup>16</sup>, and what treatment options are available for patients. Responding empathically to individuals with substance abuse histories or problems, particularly women who are concurrently experiencing IPV, is one area that social workers could immediately address with health care providers (and other helping professionals, such as police officers and first responders).

### **Law enforcement and Children's Division**

Social workers addressing violence against women must also seek to integrate their services more fully into those systems with which IPV survivors tend to interact—criminal justice and child welfare. Women experiencing IPV often encounter law enforcement as a result of the abuse, and IPV also frequently co-occurs with child abuse and neglect. Yet these systems are not well-equipped to address specific dynamics of IPV, especially when IPV is attendant with substance abuse, disability, or mental illness. As law enforcement and Children's Division serve as the major systems responding to IPV for rural survivors (given the lack of other social and helping services in many rural communities), rural domestic violence programs in particular must work with these organizations as advocates for their clients and to train and consult with officers<sup>17</sup> and Children's Division staff about IPV.

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<sup>16</sup> There is information available on mandated reporting requirements by state when illicit drugs are used in the presence of children via the Child Welfare Gateway website. To date, most of the scholarship around mandated reporting to child welfare or law enforcement of drug abuse by physicians has focused on pregnant women who are using illicit substances (Kelly, Zatzick & Anders, 2014).

<sup>17</sup> The Violence Against Women Act of 1994 led the International Association of the Chiefs of Police to take a victim-centered approach to IPV; their position statement includes training for officers about IPV, enforcement of protective orders, and collaborations with social services agencies to provide appropriate help to victims (International Association of the Chiefs of Police, 2006). The extent to which such policies are followed, particularly for rural areas or by state highway patrol or sheriff's departments, is not known; however, guidelines for IPV training of law enforcement exist and have been successfully implemented in parts of the U.S. (National Coalition Against Domestic Violence, 1997).

According to several interviews conducted with survivors in this study, the severity of abuse or substance abuse they experienced ultimately led to state-sponsored services intervening in their lives, usually with a helpful outcome. However, the impact of criminal justice involvement in a survivor's life limited her employment and housing prospects even after she left the abusive relationship and maintained her sobriety. Similarly, while Children's Division may have offered child welfare system-involved mothers certain social services on the condition of having child custody returned to her, these services were frequently inaccessible to survivors who lived in remote areas without a car and could not easily get to a family counselor or AA meeting in another town. Two survivors pointed out that their probation requirements and Children's Division service plans stipulated goals that were in direct opposition to each other (probation required one woman to seek employment, while her Children's Division plan mandated that she apply for Social Security Disability Income instead of working). There is a need for service providers addressing violence against women to serve as a bridge between these systems and advocate for their clients accordingly.

### **7.1.3 Training and Consultation**

One of the most important findings from this study was the revelation that providers across the state appear to have little knowledge in general about IPV, let alone specific community resource referrals for survivors. Social workers at domestic violence programs, regardless of where such programs are located, must thus increase their efforts to provide ongoing training and consultation within the health care system. It is especially important for rural primary and emergency care providers to receive good training and solid information about resources, as they are frequently the only helping professional with whom a survivor interacts on a regular basis.

Training tailored to a health care audience might specifically include education about the dynamics of IPV, focusing on social and health outcomes of abuse: discussing why women may remain in an abusive relationship, how abuse can cause depression, anxiety, and sleep problems, and what effects abuse has on the entire family system (particularly if the providers are also seeing pediatric patients). Health indicators of longtime abuse besides physical injuries should also be included in training, especially given rural areas' high prevalence of substance abuse. Data from the survey indicate that health care providers are unfamiliar with many of these signs.

Appropriate ways of framing questions about abuse and how to initiate conversations with patients about health concerns indicative of IPV could also be incorporated into health care training. Although providers claim they are asking about IPV, it is not known how they are framing their questions and whether such questions are being asked in an appropriate and sensitive manner. According to the survivors interviewed for this study, many providers in primary and emergency care settings are *not* asking about IPV in a caring or empathic manner. Training by social workers or domestic violence advocates could include guidelines for IPV screening, giving providers the exact phrase or phrases to use and coaching them on nonverbal cues: eye contact, active listening behaviors, and empathic facial expressions. These specific screening guidelines may facilitate disclosure among patients who would otherwise be reluctant to broach the topic themselves. Knowing the right ways to ask about IPV may also help providers feel more confident and comfortable in addressing the issue.

Additional training topics must include clear information about providers' role as mandated reporters in the state. Nearly two-thirds of survey respondents did not understand their mandated reporting requirements even though 80% affirmed they were clear on their legal obligations regarding the reporting of abuse. Reviewing these requirements, providing updated

contact information, and demonstrating the steps of calling the abuse hotlines to file a report should therefore be included in any training about IPV. This information would be useful not only for providers who identify IPV, but also those who suspect child or elder abuse.

Responding to IPV is an area in which providers have very little guidance, which is a problem in rural and urban areas alike. Rural health care providers are particularly bereft of guidance for their patients given the dearth of community resources and other helping professionals available. A critically important facet of training for health care providers in all sectors is thus a clear clinic protocol on how to manage IPV when it is identified. While certain providers, including some of those interviewed for this study, may feel that their case-by-case approach to addressing IPV is a strength, it is likely that many providers would feel more comfortable addressing the issue with some guidance. Training on responding to IPV may include brief safety assessments to understand immediate threats to the patient or her children, if applicable. A checklist of appropriate questions regarding the patient's specific situation, available sources of informal help, and desires for resolving (or not resolving) issues related to the abuse could be another way to help providers tailor an appropriate response to each individual and decide what referrals or further action might be appropriate.

Lastly, training must specifically list and define available community resources and potential courses of action that are up-to-date and appropriate for IPV survivors. Providers' knowledge of social services was particularly low, which means they are likely making referrals that are inappropriate or ultimately unhelpful to their patients experiencing IPV (when such referrals are offered). Providers may not be aware, as was one interviewee in this study, that the state's Children's Division does not provide shelter for IPV survivors. A brief overview of the systems with which survivors often interact, including Children's Division and law enforcement,



may help providers form a clearer picture of what could be helpful or not in specific instances and refer accordingly.

## **7.2 Implications for Social Work Policy**

Policy implications from this study point to social work advocacy around issues of health care access—Medicaid expansion, health insurance status, and the expansion of social services in rural areas generally.

### **7.2.1 Screening for IPV**

Organizational policies requiring providers to screen and respond to IPV—and to report it regularly—were the most important predictors of such practices according to this study. Advocating for the universal implementation of such organizational protocols in health care would likely translate to greater provider awareness of IPV and the incorporation of IPV screening into their routine practice. However, social workers—and social services across the state—must then be prepared to respond to the potential increase in survivors seeking help for IPV as providers become more comfortable identifying and referring patients. The need for more social services—mental health and behavioral health treatment, domestic violence and victim advocate programs, services for vulnerable families, vocational rehabilitation and job training opportunities—was a recurring theme among all of the interviewees who participated in this study. Truly meeting the needs of rural residents in particular, and those affected by IPV in general, requires targeted, concerted state- and federally-sponsored efforts for which social work practitioners and researchers must advocate.

### **7.2.2 Expanding Social Services**

In lieu of an immediate expansion of specialized social services for addressing both intimate partner and family violence as well as mental and behavioral health in every county,

steps could be taken by policymakers, existing programs addressing violence against women, and state agencies to create a stopgap for rural women. Some of these policies might include encouraging collaborations between health and social service systems, or creating avenues for social workers to practice part-time at health care sites. The state may also consider mandating training for first responders and law enforcement officers regarding IPV, an area that would have particular policy and practice involvement for social workers addressing violence against women.

### **Clinic-Based Practice Recommendations**

Rural health care delivery appears to be detrimentally impacted by the lack of community resources, specifically mental and behavioral health services, in many parts of the state. Mental health treatment in particular was cited by study participants as an important component of recovery from abuse. Rural health clinics may thus consider innovative means of addressing the mental health needs of their patients (and by proxy, those among their patients who are victims or survivors of IPV), such as the growing practice of telemedicine interventions. Telemedicine—specifically, telepsychiatry or tele-counseling—is an emergent practice in the health care field that remotely connects patients via internet video or conferencing to a mental health professional. Telepsychiatry often involves psychiatric assessment, diagnosis, and periodic medication management by a psychiatrist who may practice in a distal location, but the use of telemedicine technology has also been used to provide ongoing individual counseling (O'Reilly, Bishop, Maddox, Hutchinson, Fisman & Takhar [O'Reilly et al.], 2007). Randomized controlled trials have indicated that telepsychiatry is feasible to implement and a practical stopgap for rural communities lacking formal mental health services (Brown, 1998; O'Reilly et al., 2007).

Health care settings across the state of Missouri have already implemented or experimented with various telemedicine interventions. Indeed, one of the providers interviewed for this study mentioned that her clinic had just made arrangements for a psychiatrist to offer remote diagnostic and mental health treatment via telemedicine. These types of collaborations between the various health care sectors—specifically between primary care and mental health services providers—are possibilities rural health clinic administrators may consider given the lack of community resources to address the mental health needs not only of IPV survivors but of their patients in general.

Notwithstanding mental health services, community resources knowledge seemed to be particularly important in terms of the helpfulness of the provider's response to IPV. Yet the providers involved in this study appeared to lack community resources knowledge overall. An inner setting intervention that rural health clinics must consider when implementing IPV screening and response guidelines is community-specific resources and referrals to provide to patients when a disclosure of IPV is made. This particular intervention would be relatively simple to implement—a list of nearby services, hotline numbers, or agencies that provide shelter, food, legal, or other assistance for women experiencing abuse, updated regularly and prominently displayed in clinic exam rooms. For providers who do not live in the communities where they are employed, having a list of such resources with a description of the services provided and a contact person would seem particularly helpful in bolstering the effectiveness of their response to IPV.

Transportation is yet another challenge for rural women experiencing abuse, affecting their ability to accomplish tasks such as finding work and accessing health care, not to mention escape from a violent relationship. Rural health care delivery may benefit from the wider

implementation of services that already exist for Medicaid and certain Medicare recipients, such as offering transportation to and from health care appointments for individuals who do not own a vehicle. Offering a medical transport service on a wider scale may be especially significant in improving attendance at primary care appointments and facilitating women's access to health care in rural areas.

### **7.2.3 Health Insurance**

While an increase in health and social services is warranted in rural areas, health insurance status itself dictates whether survivors are ultimately able to access those services that do exist. The impact of the Affordable Care Act, particularly with regards to its IPV screening protocols for Medicare recipients, is an area of future scholarly inquiry that may examine whether identification of IPV by providers has increased, how having (or not having) marketplace health insurance affects the uptake of services that survivors can receive, and where improvements to these interlocking systems can be made. Although the provider and survivor interviewees in this study were not able to specifically describe the impact of the ACA on health care or help-seeking due to its novelty, the health care mandate may mean that survivors who would not have otherwise qualified for health insurance could now be accessing insurance and initiating health care visits. The impact of these new patients on the rural health care system, as well as the types of specialized health and social services to which their newfound insurance status may grant or prevent them from accessing, is an area with social policy and research implications.

Assisting rural residents with accessing health insurance should be of particular concern to social workers in all sectors. Beyond advocating for Medicaid expansion and other policies to increase health care access for all, social policymakers could offer training for social workers to

serve as patient navigators for the insurance marketplace. Facilitating the application and access process for ACA insurance may be one promising area for social work integration and collaboration in the health care system. Helping patients access insurance is a natural role for many social workers (indeed, advocating for health care access is a social worker's responsibility according to the Code of Ethics) and fits well within a health care delivery framework. Rural residents are more frequently uninsured than their urban counterparts (Kaiser, 2013), and according to the providers interviewed, less likely to understand how to access health insurance through the new marketplace system.

### **7.3 Implications for Social Work Research**

Findings from this study lend themselves quite readily to the development of screening guidelines that can assist health care providers with their identification and response to IPV. Such tools must be developed in concert with primary care providers themselves and piloted and evaluated by both providers and patients for feasibility and acceptability. Although provider interviewees in this study described their response to IPV as one tailored to each individual situation, providers need and deserve better guidance about responding and addressing the issue. Brief tools for providers to use that can be adapted with community-specific resource lists or information may help ensure that survivors, regardless of their decision following the abuse disclosure, receive help and a high quality of care from their health care provider. Tracking patient outcomes regarding the resolution of the abuse is then possible.

Improving providers' response to IPV hinges on organizational factors that require training about IPV and give staff clear protocols on how it is to be identified, how the questions should be framed, who should or should not be in the examination room while this interview is taking place, and what steps the provider can take upon determining that the patient is a victim.

Some instruments have already been tested for efficacy in a health care setting, such as brief safety assessments or patient counseling tip sheets (Campbell et al., 2012). Providers armed with such tools may feel better equipped not only to initiate conversation about IPV but also to respond effectively. One example of an intervention could be an electronic medical chart that prompts providers to screen, followed by specific guidelines or a checklist for further assessment, if necessary.

Few studies have examined the efficacy of clinic-based interventions to address abuse beyond brief screening and referrals to an on-site social worker or victim advocate (c.f. Campbell et al., 2012). As was briefly mentioned above, rural health and social services may find it practical to integrate their services or co-locate them under the same roof in order to better serve their communities. Exploring novel approaches to combining or adapting these services opens multiple avenues for research. Brief, evidence-based mental health treatment, a variety of support group formats (i.e. parenting, domestic violence, substance abuse), and/or behavioral health treatment in particular are services that may lend themselves readily to a clinic-based context. Given the dearth of these services, as well as services specific to IPV survivors, in many rural areas, developing or modifying such interventions and testing them in health clinics may have an impact on survivors' help-seeking and harm reduction.

Innovative frameworks for health care delivery exist and some have already shown promise for improving health outcomes in rural communities, such as Nurse-Family Partnerships. Likewise, the Assertive Community Treatment model, which brings health and social services to clients rather than requiring mentally ill individuals to make their way to outpatient appointments, may serve isolated, rural communities quite well. Adapting these models for a rural context or including social workers on community outreach or health

promotion teams that may already exist could reach survivors that otherwise may not be able to access services. Rural health clinics hosting interdisciplinary outreach teams such as Nurse-Family Partnerships or Assertive Community Treatment may also impact the lives of other rural residents who have difficulty accessing health care. Elderly individuals constitute a large and growing percentage of the rural citizenry; additionally, the lack of public transportation in rural areas may mean that people without access to a vehicle cannot keep their health care appointments. Exploring a “clinic without walls” approach to rural health care delivery may translate to better care and identification of health concerns overall for rural residents, as well as those who may be experiencing IPV.

### **7.3.1 Screening, Response, and the Consolidated Framework for Implementation Research**

The Consolidated Framework for Implementation Research (CFIR, refer to Figures 2.1.2 and 2.3.1.1) was introduced in Chapter 2 as a way of conceptualizing the personal, organizational, and community factors that may have influenced rural health care providers’ screening and response practices. Given this study’s findings, the CFIR is a useful tool for understanding the relative importance of these characteristics in determining not only whether a provider screens for IPV, but how effective their response to IPV is. Supporting providers in their uptake of screening and effective response practices to address IPV may be best accomplished through a multilevel intervention targeting the CFIR domains of outer (national and state) and inner (clinic) settings. These leverage points for changes that may be particularly meaningful for rural health care delivery are described below.

#### **Outer Setting**

**National.** The outer setting may be conceived of as the context in which health care is delivered, specifically the national and state regulatory and funding agencies overseeing clinics,

national medical and nursing organizations, and accrediting bodies for schools of medicine and nursing. Findings from this study point to implementation changes in the outer setting that could occur at the national or state level, separately or in tandem with each other. These potential leverage points were chosen because they exert an influence on the organizational policies that facilitate or inhibit providers' screening and management of IPV. The first of these leverage points takes place at the level of the federal government, which sets the policies that define rural health clinics and FQHCs and administers Medicaid and Medicare. Embedded within the Affordable Care Act are requirements for IPV screening among certain patient populations receiving government insurance subsidies through the health care marketplace. Each of these policy spheres could be leveraged to set guidelines that mandate screening for IPV in all clinics with rural health clinic or FQHC status, or generally for all providers treating patients receiving Medicaid, Medicare, and subsidized marketplace insurance. Indeed, the federal government already mandates IPV screening in rural health clinics and FQHCs who treat patients insured through Medicare; expanding these requirements to ensure rural health clinics and FQHCs are screening all patients regardless of insurance status may be a relatively simple step.

Non-federal, national bodies such as the American Medical Association, the American College of Obstetricians and Gynecologists, and the American Nursing Association have all instituted guidelines for health care providers regarding the identification of IPV. Their recommendations serve as guiding principles for evidence-informed practices in primary care. This study's findings indicate that these agencies, as well as other professional organizations associated with various health care disciplines, should expand their recommendations to include clear protocols on screening for IPV including exact phrases and words to use when asking about



abuse.<sup>18</sup> Providers would also benefit from guidelines clarifying appropriate ways to respond to disclosures of current and former abuse, including danger assessments, child abuse, and possibilities for additional measures to take that may include resources referrals or follow-up contact with the patient. Many screening and assessment tools for IPV exist and several have been tested for feasibility in health care settings already (Rabin, Jennings, Campbell & Bair-Merritt, 2009). Outlining a framework for “next steps” once IPV has been identified would provide much-needed guidance for physicians and nurses regarding effective ways to respond to abuse disclosures.

Schools of medicine and nursing are settings ripe for laying an educational foundation that could bolster awareness of and improve responsiveness to IPV. According to this survey’s results, providers with a D.O. degree were the most likely to screen for IPV (compared with medical doctors, nurse practitioners, and nurses). These findings may indicate that schools of osteopathy provide some form of training about IPV that could also be incorporated into curricula for M.D.s and nurses. National reviews of medical school education have revealed that training on IPV is inconsistent, leading to gaps in provider awareness and associated screening practices (Frank, Elon, Saltzman, Houry, McMahon & Doyle, 2006). In recent years, medical and nursing educators have called for integrated IPV training as a fundamental part of health care training across all disciplines (Tufts, Clements & Karlowicz, 2009). A rapprochement between schools of medicine and osteopathy with regards to IPV training, in classroom and clinical settings, would be especially significant in bolstering physician awareness, and likely screening, of IPV. Accrediting bodies governing nursing schools and programs may achieve even greater

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<sup>18</sup> Exact screening guidelines have been recommended in some instances; see ACOG (2009). However, most of the recommendations published by professional associations is somewhat vague, directing providers to ask questions about abuse among certain patient populations without guidance as to the initiation of the conversation itself or appropriate phrases/terms to use when discussing abuse.

results with regards to bolstering screening and improving response to IPV in health care settings, because nurses are very frequently responsible for initial patient contact and assessment in primary care settings (Ford-Gilboe et al., 2010). Indeed, many rural health clinics in Missouri are administered not by a physician but by a nurse practitioner and staffed by nurses or nurse assistants given the shortage of physicians in rural parts of the state (Kaiser, 2013; MODHSS, 2013). Training nursing students how to address IPV in classroom and applied settings may thus be an especially effective way to increase IPV screening in rural health clinics.

**State.** This study's findings point to a potential leverage point that the state could wield with regards to its oversight of all primary health care clinics receiving a portion of state funds (including rural health clinics and federally qualified health centers). Specific policies around IPV may thus include mandatory screening of all patients annually at these clinics, as well as yearly training for all physicians and nurses on IPV and their mandated reporting requirements (including a demonstration of how to file a report when abuse is identified).

Additionally, qualitative findings from this study suggest that providers' management of IPV might be further improved by state regulations that address substance abuse, including its co-occurrence with IPV and child abuse. Previous scholarship examining IPV management within the child welfare system has demonstrated that substance abuse masks the identification of IPV by child abuse investigators (Kohl, Edelson, English & Barth, 2005). Health care providers may experience a similar dissonance with regards to the management of IPV when substance abuse is also a factor in the patient's presentation. Given the frequent overlap of IPV with substance abuse, as well as the perceptions by providers and survivors alike of high levels of prescription drug-seeking, drug manufacturing, and illicit drug use in rural areas, providers would benefit from IPV training that includes an overview of substance abuse etiology,

dynamics, and professional obligations regarding the reporting of illicit drug activities to law enforcement or Children's Division.

Lastly, the state could potentially amplify opportunities for women experiencing IPV to be identified in health care settings simply by improving their access to health care. Expanding Medicaid and the state children's health insurance program while facilitating access to insurance through the ACA marketplace (particularly in rural communities where there are few health navigators to assist with this process) are immediate steps policymakers could take that would be significant for the health and health care of all Missourians.

### **Inner Setting**

The inner setting is comprised of the health care organization or clinic, affected by the rural community context in which that clinic is located. Many rural communities across the state are devoid of comprehensive health and social services, pointing to the need for rural health clinic administrators to consider the differential impact of rurality when implementing state-mandated screening and response guidelines. One aspect of the rural setting that providers believed inhibited many patients' ability to discuss IPV with them, even when asked directly about it, was the greater tendency for people in a small town or rural community to know each other. Indeed, providers from both the interviews and surveys indicated that they were often personally or socially acquainted with their patients, further limiting their ability to ensure complete, objective confidentiality. This barrier to screening and identifying IPV represents one aspect of the outer setting that is likely very different from that of an urban health care practice. Thus, confidentiality concerns in small towns may need to be addressed more directly to make women feel more comfortable disclosing their abuse to a health care provider. A leverage point to facilitate rather than inhibit the uptake of screening by providers and disclosure by survivors

might thus include extra precautionary measures taken in rural health clinics to maintain the privacy of patients. Often, according to interviews from providers and survivors alike, the concerns about information remaining private were not confined to the physician-patient encounter but extended to the clinic support staff, such as nurse assistants and receptionists, all of whom would have access to a patient’s chart. Thorough training about confidentiality and privacy issues, including training for support staff and potentially limiting access to certain parts of patients’ charts or medical histories, may provide additional safeguards for rural health clinics located in communities where “everybody knows everybody.”

Despite the resource deficiencies of many rural communities, there are strengths of rural health care system that could facilitate the uptake of universal screening and effective response practices to IPV. Rural health clinics tend to have lower patient volume per week than urban practice settings, which may translate to greater availability of time for the provider-patient encounter. Time was consistently noted during interviews as a facilitator or inhibitor of screening—when providers and patients alike both felt little pressure from time constraints, providers felt more comfortable initiating the conversation about abuse and survivors were more likely to disclose. Adequate time for each provider-patient encounter is also associated with the number of staff employed at the clinic. Survey findings exhibited a trend of increased screening with more staff, although this association was not statistically significant due to the fact that a large majority of clinics had five or less staff to begin with. The management of time and scheduling to allow for more flexibility during the provider-patient encounter is a task that may be addressed on a case-by-case basis due to clinic size, patient volume, and staffing. Increasing length of encounters, especially during initial visits with patients, is one area that would likely facilitate the uptake of universal screening practices.

## Characteristics of Individuals Involved

While structural factors such as policy or funding mandates would likely do the most to increase the frequency of screening for IPV at rural health clinics, personal attributes of the provider likely determine the effectiveness of the response to IPV. Providers that have an empathic attitude toward women experiencing IPV are probably the most likely to respond helpfully and effectively to that patient's needs. Findings from this study also indicate that empathic, non-judgmental attitudes on the part of the provider must also extend to those patients misusing or abusing substances; survivors who were suspected or actual drug users did not perceive their provider as helpful, even if the abuse was disclosed.

**Summary.** Figure 7.3.1 depicts this study's findings as interpreted through the CFIR framework. Those aspects that were found most pertinent to screening and responding to IPV are provided in this figure and each suggest possibilities for future research in this area. The implementation of universal screening and response guidelines as well as ongoing IPV training for providers is an immediate first step. Furthering scholarship and improving outcomes for rural survivors may follow from one of the possibilities mentioned previously, such as piloting brief clinic-based interventions or modifying rural health care delivery frameworks to include, for example, visiting or home-based services. The conclusion to be drawn from this study's findings is that changes to the outer setting is likely the most effective way to facilitate universal screening for IPV by providers, although individual characteristics such as knowledge and attitudes about IPV may make for the most effective response.

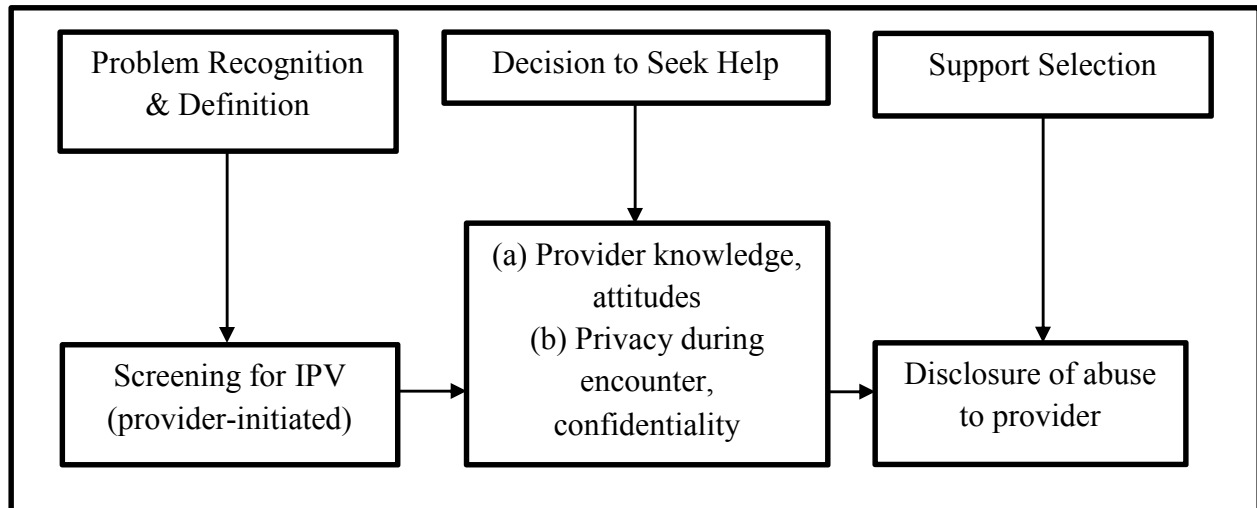
**Figure 7.3.1 CFIR as a Model for Increasing Screening and Response to IPV**

<b>Outer Setting</b>		
	<i>Leverage Point</i>	<i>Outcome</i>
<i>Nation</i>	→Federal Health Insurance Policies (e.g. Medicaid, Medicare, ACA guidelines)	→Mandate IPV Screening Among Patients Receiving Publicly Funded Insurance
	→Federal Policies Governing RHCs/FQHCs	→Set IPV Screening Mandates/Guidelines for Clinics Receiving Federal Funding
	→ IPV Education in Medical/Nursing Programs	→Increase Knowledge, Awareness of IPV and the Necessity of Screening
	→Publication of IPV Screening and Response Guidelines by Professional Associations	→Increase Knowledge, Increase Screening, Improve Effectiveness of Response to IPV
<i>Nation/ State</i>	→IPV Screening Guidelines for All Health Care Clinics Receiving State Funding/Subsidies	→ Set IPV Screening Mandates/Guidelines for Clinics Receiving State Funding and Increase Screening
	→ Ongoing IPV Training for All Health Care Providers	→ Increase Knowledge, Improve Response
<b>Inner Setting</b>		
	<i>Leverage Point</i>	<i>Outcome</i>
<i>Clinic</i>	→Additional Confidentiality Safeguards	→ Increase Screening, Facilitate Patient Help-seeking
	→Length of Provider-Patient Encounter	→Facilitate Screening and Disclosure
<b>Characteristics of Individuals Involved</b>		
	<i>Leverage Point</i>	<i>Outcome</i>
	→Improve Attitudes toward IPV	→Improve Response
	→Improve Attitudes toward Substance Abuse	→Increase Screening, Improve Response

### 7.3.2 Help-seeking by Rural Survivors

According to Liang and colleagues' conceptual model of help-seeking (refer to Figure 2.2) (2001), interpersonal as well as environmental factors play a large role in a survivor's decision to seek help and from whom during the course of an abusive relationship. Findings from this study suggest that for many rural survivors in Missouri, formal support services for IPV were non-existent or quite difficult to locate in the communities where they lived. Survivors felt that health care providers, as helping professionals, could provide appropriate sources of help by identifying signs of abuse and assisting them with locating additional, more specialized community resources or helping them achieve safety. However, based on the interviews with the women in this study, survivors were not likely to voluntarily disclose either their abuse history or current relationship violence to a primary care provider. This suggests that the onus is on providers to initiate the conversation about IPV, and to ask the appropriate questions in order to identify IPV if a patient's response is not forthcoming and the provider still suspects abuse is occurring. Each of the domains involved in the help-seeking process—problem recognition and definition, the decision to seek help, and support selection—may thus be affected by a health care provider's asking about IPV and the manner in which they ask the questions (see Figure 7.3.2). Providers who screen regularly, have appropriate resources or response protocols at the ready, ensure their patients' privacy, and project an air of warmth and empathy for all regardless of patient presentation (that may include substance abuse), thus exert an influence on the help-seeking process and the sources of formal support to which rural women may turn.

**Figure 7.3.2 Factors Impacting Survivors' Help-seeking from Health Care Providers**



### 7.3.3 Rural Intimate Partner Violence Research

Research on IPV in rural areas has tended to focus on women of child-bearing age who are either seeking health care, shelter services, or court orders of protection against their abuser (c.f. Logan et al., 2008). The differential experiences and impact of IPV on rural minority or elderly populations represents one area of scholarship about which very little is known. A final direction for research obliquely indicated by this study is broad-scale research on the experiences of rural women who do not fit the typical victim profile of the majority of existing studies. Women who are elderly, sexual and gender minorities, immigrant women, Native women, and women of color likely have experiences of IPV and help-seeking that are quite different from those of the mostly white, heterosexual women involved in this study. Additionally, women who have chosen to remain in an abusive relationship or who have not sought formal sources of help are under-represented in IPV scholarship because they are a more difficult population for researchers to access than those who are identified by health care providers or shelters (as was the case for most of the women interviewed for this study). Future research on IPV must endeavor to reach these women, who may have much to teach researchers and practitioners about



the pathways into and out of violent relationships, the life course of IPV, informal helping resources or coping strategies used by such women in order to survive, and why formal sources of help are not accessible or desirable to these women. Advancing scholarship on IPV means that attention is paid to the experiences, health, and help-seeking behaviors of all survivors.

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# Appendix 1

## Survey of Rural Health Care Providers

Your candid responses on the following survey will greatly assist us in our attempt to improve physicians' recognition and management of intimate partner violence-related<sup>19</sup> injuries and illnesses. Please record your first, instinctive answer, even if you don't think it is "politically correct." Don't try to think about what your answers "should" be. All responses will be coded by an identifying number only, kept confidential, and analyzed in group form so that no personal information is revealed. Some questions may seem similar to others. However, we ask that you answer all questions to help ensure the reliability of the assessment. The first 50 survey respondents will receive a \$20 Amazon.com gift card. Thank you for taking the time (estimated at 25 minutes) to complete this survey.

If you win the drawing for the Amazon gift card, you will need to provide your social security number (SSN) in order for us to give you the Amazon gift card. Your social security number is being obtained for payment purposes only, it will not be retained for research purposes. We will only need to obtain your SSN in the event that you win. The SSN will not be connected to any survey results, only your name, so that you can receive your Amazon gift card

Email address (optional)\*: \_\_\_\_\_

\*Providing your email address will allow us to contact you for your SSN and to send you the \$20 gift card in the event you win one of them.

Today's date: \_\_\_\_/ \_\_\_\_/ \_\_\_\_

### Section I: Respondent Profile

1. Your Age: \_\_\_\_\_

2. Gender:  Male  Female

3. County of Practice \_\_\_\_\_

4. Primary field of practice:

Internal Medicine     Emergency Medicine

Family Practice     Surgery

Pediatrics     Obstetrics/Gynecology

Psychiatry     Other (specify) \_\_\_\_\_

5. When did you graduate from medical/professional school? \_\_\_\_\_

6. What degree or certificate did you receive?  
\_\_\_\_\_

<sup>19</sup> Intimate partner violence (IPV) is also commonly referred to as domestic violence, partner violence, or family violence. It is typically violence between intimate partners including spouses or boy/girlfriends.

- MD  DO  
 Nurse Practitioner  Registered Nurse  
 Other: Specify: \_\_\_\_\_

7. Including your residency, how long have you been practicing in this field?

\_\_\_ Years \_\_\_ Months

8. Average number of patients you care for per week (*check one*):

- not seeing patients  
 less than 20  
 20-39  
 40-59  
 60 or more

9. Including yourself, how many physicians or physician assistants practice at your work site?

\_\_\_\_\_

And how many nurses or nurse practitioners?

\_\_\_\_\_

10. Including yourself, how many practitioners at your work site have participated in an IPV training course in the past 6 months:

\_\_\_\_\_

This represents:  All  Most  Some  A few  Don't know  
at my work site.

## Section II: Background

1. How much previous training about intimate partner violence (IPV/DV) issues have you had?  
(*Please check all that apply.*)

- None  
 Read my institution's protocol  
 Watched a video  
 Attended a lecture or talk  
 Attended a skills-based training or workshop  
 Medical/nursing/other school—classroom training  
 Medical/nursing/other school—clinical setting  
 Residency/fellowship/other post grad training  
 CME program  
 Other in-depth training (more than 4 hours)  
 Other (*specify*) \_\_\_\_\_

2. Estimated total number of hours of previous IPV training:

[15]

3. Please circle the number which best describes how prepared you feel to perform the following:

(1 = Not prepared; 2 = Minimally prepared; 3 = Slightly prepared; 4 = Moderately prepared; 5 = Fairly well prepared; 6 = Well prepared; 7 = Quite well prepared)

	<i>Not prepared</i>				<i>Quite well prepared</i>		
a. Ask appropriate questions about IPV	1	2	3	4	5	6	7
b. Appropriately respond to disclosures of abuse	1	2	3	4	5	6	7
c. Identify IPV indicators based on patient history, and physical examination	1	2	3	4	5	6	7
d. Assess an IPV victim's readiness to change	1	2	3	4	5	6	7
e. Help an IPV victim assess his/her danger of lethality	1	2	3	4	5	6	7
f. Conduct a safety assessment for the victim's children	1	2	3	4	5	6	7
g. Help an IPV victim create a safety plan	1	2	3	4	5	6	7
h. Document IPV history and physical examination findings in patient's chart	1	2	3	4	5	6	7
i. Make appropriate referrals for IPV	1	2	3	4	5	6	7
j. Fulfill state reporting requirements for:							
- IPV	1	2	3	4	5	6	7
- Elder abuse	1	2	3	4	5	6	7
- Child abuse	1	2	3	4	5	6	7

4. How much do you feel you now know about:

(1 = Nothing; 2 = Very Little; 3 = A little; 4 = A moderate amount; 5 = A fair amount; 6 = Quite a bit; 7 = Very Much)

	<i>Nothing</i>				<i>Very Much</i>		
a. Your legal reporting requirements for:							
- IPV	1	2	3	4	5	6	7
- Child abuse	1	2	3	4	5	6	7
- Elder abuse	1	2	3	4	5	6	7
b. Signs or symptoms of IPV	1	2	3	4	5	6	7
c. How to document IPV in patient's chart	1	2	3	4	5	6	7
d. Referral sources for IPV victims	1	2	3	4	5	6	7
e. Perpetrators of IPV	1	2	3	4	5	6	7
f. Relationship between IPV and pregnancy	1	2	3	4	5	6	7
g. Recognizing the childhood effects of witnessing IPV	1	2	3	4	5	6	7
h. What questions to ask to identify IPV	1	2	3	4	5	6	7
i. Why a victim might not disclose IPV	1	2	3	4	5	6	7
j. Your role in detecting IPV	1	2	3	4	5	6	7
k. What to say and not say in IPV situations							

with a patient	1	2	3	4	5	6	7
l. Determining danger for a patient experiencing IPV	1	2	3	4	5	6	7
m. Developing a safety plan with an IPV victim	1	2	3	4	5	6	7
n. The stages an IPV victim experiences in understanding and changing his/her situation	1	2	3	4	5	6	7

**Section III: IPV Knowledge.** Check one answer per item, unless noted otherwise.

1. What is the strongest *single* risk factor for becoming a victim of intimate partner violence?

- Age (<30yrs)
- Partner abuses alcohol/drugs
- Gender – female
- Family history of abuse
- Don't know

2. Which *one* of the following is generally true about batterers?

- They have trouble controlling their anger
- They use violence as a means of controlling their partners
- They are violent because they drink or use drugs
- They pick fights with anyone

3. Which of the following are warning signs that a patient may have been abused by his/her partner?

*(check all that apply)*

- Chronic unexplained pain
- Anxiety
- Substance abuse
- Frequent injuries
- Depression

4. Which of the following are reasons an IPV victim may not be able to leave a violent relationship?

*(check all that apply)*

- Fear of retribution
- Financial dependence on the perpetrator
- Religious beliefs
- Children's needs
- Love for one's partner
- Isolation

5. Which of the following are the most appropriate ways to ask about IPV?

*(check all that apply)*

- "Are you a victim of intimate partner violence?"



- "Has your partner ever hurt or threatened you?"
- "Have you ever been afraid of your partner?"
- "Has your partner ever hit or hurt you?"

6. Which of the following is/are generally true? (*check all that apply*)

- There are common, non-injury presentations of abused patients
- There are behavioral patterns in couples that may indicate IPV
- Specific areas of the body are most often targeted in IPV cases
- There are common injury patterns associated with IPV
- Injuries in different stages of recovery may indicate abuse

7. Please label the following descriptions of the behaviors and feelings of patients with a history of IPV with the appropriate stage of change.

(1 = Pre-contemplation 2 = Contemplation 3 = Preparation 4 = Action 5 = Maintenance 6 = Termination)

- Begins making plans for leaving the abusive partner
- Denies there's a problem
- Begins thinking the abuse is not their own fault
- Continues changing behaviors
- Obtains order(s) for protection

8. Circle **T** for "true", **F** for "false", or **DK** if you "don't know" the answer to the following:

- |  |   |   |    |
|--|---|---|----|
| a. Alcohol consumption is the greatest single predictor of the likelihood of IPV.  | T | F | DK |
| b. There are no good reasons for not leaving an abusive relationship   | T | F | DK |
| c. Reasons for concern about IPV should not be included in a patient's chart if s/he does not disclose the violence.   | T | F | DK |
| d. When asking patients about IPV, physicians should use the words "abused" or "battered."   | T | F | DK |
| e. Being supportive of a patient's choice to remain in a violent relationship would condone the abuse.   | T | F | DK |
| f. Victims of IPV are able to make appropriate choices about how to handle their situation.  | T | F | DK |
| g. Health care providers should not pressure patients to acknowledge that they are living in an abusive relationship.  | T | F | DK |
| h. Victims of IPV are at greater risk of injury when they leave the relationship.  | T | F | DK |
| i. Strangulation injuries are rare in cases of IPV.  | T | F | DK |
| j. Allowing partners or friends to be present during a patient's history and physical exam ensures safety for an IPV victim.   | T | F | DK |
| k. Even if the child is not in immediate danger, physicians in all states are mandated to report an instance of a child witnessing IPV to Child Protective Services. | T | F | DK |

## Section IV: Opinions

For each of the following statements, please indicate your response on the scale from "Strongly Disagree" (1) to "Strongly Agree" (7).

*Statements*

	<i>Strongly Disagree</i>	<i>Disagree</i>	<i>Agree</i>	<i>Strongly Agree</i>			
1. If an IPV victim does not acknowledge the abuse, there is very little that I can do to help.	1	2	3	4	5	6	7
2. I ask all new patients about abuse in their relationships.	1	2	3	4	5	6	7
3. My workplace encourages me to respond to IPV.	1	2	3	4	5	6	7
4. I can make appropriate referrals to services within the community for IPV victims.	1	2	3	4	5	6	7
5. I am capable of identifying IPV without asking my patient about it.	1	2	3	4	5	6	7
6. I do not have sufficient training to assist individuals in addressing situations of IPV.	1	2	3	4	5	6	7
7. Patients who abuse alcohol or other drugs are likely to have a history of IPV.	1	2	3	4	5	6	7
8. Victims of abuse have the right to make their own decisions about whether hospital staff should intervene.	1	2	3	4	5	6	7
9. I feel comfortable discussing IPV with my patients.	1	2	3	4	5	6	7
10. I don't have the necessary skills to discuss abuse with an IPV victim who is:							
a) Female	1	2	3	4	5	6	7
b) Male	1	2	3	4	5	6	7
c) from a different cultural/ethnic background	1	2	3	4	5	6	7
11. If victims of abuse remain in the relationship after repeated episodes of violence, they must accept responsibility for that violence.	1	2	3	4	5	6	7
12. I am aware of legal requirements in this state regarding reporting of suspected cases of:							
a) IPV	1	2	3	4	5	6	7
b) child abuse	1	2	3	4	5	6	7
c) elder abuse	1	2	3	4	5	6	7
13. Health care providers do not have the time to assist patients in addressing IPV.	1	2	3	4	5	6	7

14. I am able to gather the necessary information to identify IPV as the underlying cause of patient illnesses (e.g., depression, migraines).	1	2	3	4	5	6	7
15. If a patient refuses to discuss the abuse, staff can only treat the patient's injuries.	1	2	3	4	5	6	7
16. Victims of abuse could leave the relationship if they wanted to.	1	2	3	4	5	6	7
17. I comply with the Joint Commission standards that require assessment for IPV.	1	2	3	4	5	6	7
18. Health care providers have a responsibility to ask all patients about IPV.	1	2	3	4	5	6	7
19. My practice setting allows me adequate time to respond to victims of IPV.	1	2	3	4	5	6	7
20. I have contacted services within the community to establish referrals for IPV victims.	1	2	3	4	5	6	7
21. Alcohol abuse is a leading cause of IPV.	1	2	3	4	5	6	7
22. Victims of abuse often have valid reasons for remaining in the abusive relationship.	1	2	3	4	5	6	7
23. I am too busy to participate on a multidisciplinary team that manages IPV cases.	1	2	3	4	5	6	7
24. Screening for IPV is likely to offend those who are screened.	1	2	3	4	5	6	7
25. There is adequate private space for me to provide care for victims of IPV.	1	2	3	4	5	6	7
26. I am able to gather the necessary information to identify IPV as the underlying cause of patient injuries (e.g., bruises, fractures, etc.).	1	2	3	4	5	6	7
27. Women who choose to step out of traditional roles are a major cause of IPV.	1	2	3	4	5	6	7
28. Health care providers do not have the knowledge to assist patients in addressing IPV.	1	2	3	4	5	6	7
29. I can match therapeutic interventions to an IPV patient's readiness to change.	1	2	3	4	5	6	7
30. I understand why IPV victims do not always comply with staff recommendations.	1	2	3	4	5	6	7
31. Use of alcohol or other drugs is related to IPV victimization.	1	2	3	4	5	6	7
32. I can recognize victims of IPV by the way they behave.	1	2	3	4	5	6	7

## Section V: Practice Issues

1. How many *new diagnoses* (picked up an acute case, uncovered ongoing abuse, or had a patient disclose a past history) of intimate partner violence (IPV) would you estimate you have made in the last 6 months?

- None
- 1-5
- 6-10
- 11-20
- 21 or more
- N/A – not in clinical practice

2. Check the situations listed below in which you currently screen for IPV: *(check all that apply)*

- Not applicable – I am not in clinical practice
- I do not currently screen
- I screen all new patients
- I screen all new female patients
- I screen all patients with abuse indicators on history or exam
- I screen all female patients at the time of their annual exam
- I screen all pregnant patients at specific times of their pregnancy
- I screen all patients periodically
- I screen all female patients periodically
- I screen certain patient categories only (check below)
  - Teenagers
  - Young adult women (under 30 years old)
  - Elderly women (over 65 years old)
  - Single or divorced women
  - Married women
  - Women with alcohol or other substance abuse
  - Single mothers
  - Black or Hispanic women
  - Immigrant women
  - Lesbian women
  - Homosexual men
  - Depressed/suicidal women
  - Pregnant women
  - Mothers of all my pediatric patients (if applicable)
  - Mothers of pediatric patients who show signs of witnessing IPV
  - Mothers of children with confirmed or suspected child abuse, neglect
  - Other. Please specify: \_\_\_\_\_

3. How often in the past six months have you asked about the possibility of IPV when seeing patients with the following:

*Never    Seldom    Sometimes    Nearly always    Always    N/A*

a. Injuries	1	2	3	4	5	6
b. Chronic pelvic pain	1	2	3	4	5	6
c. Irritable bowel syndrome	1	2	3	4	5	6
d. Headaches	1	2	3	4	5	6
e. Depression/Anxiety	1	2	3	4	5	6
f. Hypertension	1	2	3	4	5	6
g. Eating disorders	1	2	3	4	5	6

4. In the past 6 months, which of the following actions have you taken when you identified IPV? (check all that apply)

- Have not identified IPV in past 6 months
- Provided information (phone numbers, pamphlets, other information) to patient
- Counseled patient about options she / he may have
- Conducted a safety assessment for the victim
- Conducted a safety assessment for victim's children
- Helped patient develop a personal safety plan
- Referred patient to:
  - Individual therapy  Child Protective Services
  - Couples therapy  Legal advocate/victim witness advocate
  - Child therapy/support group  Batterers' treatment program
  - On-site social worker/advocate  Religious leader/organization
  - Battered women's program/shelter  Battered women/s support group
  - Alcohol/substance abuse counseling  National DV/IPV Hotline
  - Local DV/IPV hotline  Lesbian/Gay/Transvestite/Bisexual support group
  - Police, sheriff, or other local law enforcement
  - Housing, educational, job or financial assistance
  - Other referral (*describe*): \_\_\_\_\_
  - Other action (*describe*): \_\_\_\_\_

5. Is there a protocol for dealing with adult IPV at your clinic/practice? (check one)

- Yes, and widely used
- Yes, and used to some extent
- Yes, but not used
- No
- Unsure
- Not applicable to my patient population
- I am not currently in a clinical practice

6. Are you familiar with your institution's policies regarding screening & management of IPV victims?

- Yes
- No
- N/A

7. Is a camera available at your work site for photographing IPV victims' injuries?

- Yes - - Type:  Polaroid or other instant camera,  Digital,  Other: \_\_\_\_\_

- No
- Unsure
- Not applicable to my patient population
- I am not currently in a clinical practice

8. Do you practice in a state where it is legally mandated to report IPV cases involving competent (nonvulnerable) adults?

- Yes
- No
- Unsure
- N/A (Not in practice)

9. For every IPV victim you have identified in the past 6 months, how often have you:

	<i>Never</i>	<i>Seldom</i>	<i>Some- times</i>	<i>Almost always</i>	<i>Always</i>	<i>N/A</i>
a. Documented patient's statements re. IPV in chart	1	2	3	4	5	6
b. Used a body-map to document patient injuries	1	2	3	4	5	6
c. Photographed victim's injuries to include in chart	1	2	3	4	5	6
d. Notified appropriate authorities when mandated	1	2	3	4	5	6
e. Conducted a safety assessment for victim	1	2	3	4	5	6
f. Conducted a safety assessment for victim's children	1	2	3	4	5	6
g. Helped an IPV victim develop a safety plan	1	2	3	4	5	6
h. Contacted an IPV service provider	1	2	3	4	5	6
i. Offered validating or supportive statements	1	2	3	4	5	6
j. Provided basic information about IPV	1	2	3	4	5	6
k. Provided referral and/or resource information	1	2	3	4	5	6

10. Are IPV patient education or resource materials (posters, brochures, etc.) available at your practice site? (*check one*)

- Yes, well displayed, and accessed by patients
- Yes, well displayed, but not accessed by patients
- Yes, but not well displayed
- No
- Unsure
- Not applicable to my patient population
- Am not currently in a clinical practice

11. Do you provide abused patients with IPV patient education or resource materials? (*check one*)

- Yes, almost always
- Yes, when it is safe for the patient
- Yes, but only upon patient request
- No, due to inadequate referral resources in the community

- No, because I do not feel these materials are useful in general
- No, other reason (*specify*) \_\_\_\_\_
- Not applicable to my patient population
- I am not currently in a clinical practice

12. Do you feel you have adequate adult IPV referral resources for patients **at your work site** (including mental health referral)?

- Yes
- No
- Unsure
- I am not currently in a clinical practice
- Not applicable to my patient population

13. Do you feel you have adequate knowledge of referral resources for patients **in the community** (including shelters or support groups) for adult IPV victims?

- Yes
- No
- Unsure
- I am not currently in a clinical practice
- Not applicable to my patient population

**Section VI. Rural Practice Setting.**

	<i>Strongly disagree</i>	<i>Disagree</i>	<i>Neither agree nor disagree</i>	<i>Agree</i>	<i>Strongly agree</i>
1. There is information about addressing IPV for rural medical practitioners in the health sciences literature.	1	2	3	4	5
2. There are adequate mental healthservices for women in this county/community.	1	2	3	4	5
3. There are adequate services to meet the needs of IPV victims in this county/community.	1	2	3	4	5
4. There are adequate health services, including primary, dental, and obstetric/gynecologic care for womenin this county/ community.	1	2	3	4	5
5. Women in rural areas have more difficulty accessing the same level of					

health services as women in urban areas.	1	2	3	4	5
6. In my experience, IPV is a prevalent issue in this county/community.	1	2	3	4	5
7. I consider IPV to be a major challenge for rural health care providers.	1	2	3	4	5
8. My patients generally come from the same county/community as this clinic.	1	2	3	4	5
9. I feel comfortable referring patients experiencing IPV victims to the services available in this county/community.	1	2	3	4	5
10. I have provided health care services to a patient who has perpetrated IPV.	1	2	3	4	5
11. I am personally acquainted with or see several of my patients socially.	1	2	3	4	5
12. There are adequate resources for victims of IPV who speak Spanish in this county/community.	1	2	3	4	5
13. There are adequate resources for victims of IPV in same-sex relationships in this county/community.	1	2	3	4	5
14. It is likely that one of my clinic staff will know a patient personally.	1	2	3	4	5
15. Law enforcement in this county/community respond promptly to allegations of IPV.	1	2	3	4	5
16. Victims of IPV in this county/community usually turn to their pastor or other faith-based community resource for support.	1	2	3	4	5
17. My personal faith, spiritual and/or					



religious values play a role in my response  
(e.g. types of referrals/recommendations)  
to a patient experiencing IPV.    1                      2                      3                      4                      5

18. In the past six months, I have seen and/or treated female patients at my clinic for the following health concerns: *(Check all that apply)*

- Obesity                       Heart disease                       Sexually transmitted infections
- Suicidal ideation                       Depression/anxiety
- Dental problems                       Breast cancer
- Cervical cancer                       Tobacco use
- Drug abuse                       Alcohol abuse

19. Services for victims of IPV in this county/community are effective in helping victims: *(Check all that apply)*

- Obtain individual counseling
- Obtain couples' counseling
- Obtain a restraining order
- Leave the abuser/perpetrator for good
- Find a new, permanent place to live
- Find a temporary place to live (shelter or transitional housing)
- Obtain counseling or behavioral
- Increase their self-esteem and self-efficacy services for their children
- Overcome or resolve issues of PTSD, depression, and/or anxiety related to the abuse
- Get violent abusers/perpetrators put in jail or off the street
- Obtain counseling for the abuser
- Help victims connect or reconnect with their faith/religious values
- Other (please fill in): \_\_\_\_\_

20. On average, how far do the majority of your patients travel to receive care at your clinic?

- 1-5 miles
- 6-10 miles
- 11-15 miles
- 16-20 miles
- 21-25 miles
- Greater than 26 miles
- Don't know

21. Approximately how many miles is your clinic located from the nearest:

- |  | Distance (in miles): |
|--|----------------------|
| <input type="checkbox"/> Critical access hospital                  | _____                |
| <input type="checkbox"/> Surgical hospital                         | _____                |
| <input type="checkbox"/> Substance abuse treatment facility        | _____                |
| <input type="checkbox"/> Substance abuse detox facility            | _____                |
| <input type="checkbox"/> Psychiatric inpatient facility            | _____                |
| <input type="checkbox"/> Community mental health center            | _____                |
| <input type="checkbox"/> Church- or faith-based counseling service | _____                |

- Food pantry
- Police station
- Women's health center

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Please use the space below to provide any additional information that was not captured by the survey and that you believe will be helpful.

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*Thank you for completing this survey!*

## **Appendix 2.**

### **Interview Protocol for Provider Participants**

1. Based on your experience at this clinic, how prevalent is intimate partner violence (IPV) in this community or area? What do you think contributes to the (high or low) prevalence?
2. What, if any, challenges or barriers do women face when fleeing an abusive relationship in this community/area?
3. What, if any, services for victims of IPV are there in this community/area? What are your perceptions of the effectiveness of these services in addressing victims' needs and reducing IPV?
4. What are the challenges of identifying IPV in your practice? What are the challenges of responding to IPV in your practice?
5. How do you manage or ensure patient confidentiality when IPV is disclosed? What challenges, if any, does confidentiality present in a small community like this?
6. The U.S. Preventative Services Task Force recommends that all female patients age 12 and above be asked directly whether they are experiencing IPV during every visit to the doctor. What do you think of these recommendations? If your clinic does not follow this protocol, what would it take to incorporate these recommendations into your practice? How realistic are these expectations for health professionals?
7. Some states require health professionals to report all instances of IPV to the authorities, regardless of the victim's consent. What do you think of this policy? Are there any circumstances under which you would support mandated reporting of IPV, similar to mandated reporting of child or elder abuse?
8. How have you managed disclosure of IPV when the abusive partner is present at the clinic?
9. How have you managed disclosure of IPV when one or both of the partners is a personal acquaintance of yours or one of your staff members?
10. In your experience, in what ways, if any, does the overall health status of women experiencing abuse differ from non-abused women?
11. What made you interested in rural practice?
12. What is it like trying to effectively respond to IPV as a health professional in a rural community/area like this? What barriers/challenges does a rural area present? What strengths does a rural area present?
13. What changes, if any, would you like to see or recommend that your clinic would make regarding the way IPV is handled? What would it take to implement these changes, if any?

14. What are the majority patient demographics at your clinic and have they changed at all since you've practiced here?

15. What do you think are some of the risk factors for IPV specific to rural areas?

16. What do you think are some of the protective factors for IPV specific to rural areas?

17. What else would you like me to know about practicing medicine in a rural community/responding to IPV in a rural community?

## **Appendix 3.**

### **Interview Protocol for Survivor Participants**

Demographic information to be collected: Age, race/ethnicity, sexual orientation, marital status, number of children, county of residence.

1. Have you ever sought medical attention or had to go to the doctor because of injuries from the abuse you experienced?
  - a. If yes,
    - i. Did any medical provider ever directly ask you if your injuries were a result of your partner hurting you?
    - ii. If they did not ask, did you disclose to them the source of your injuries?
    - iii. What made it possible for you to disclose/What prevented you from being able or willing to disclose?
  - b. If no,
    - i. Has there ever been a time when you told a doctor or nurse at this health clinic about the abuse you were experiencing?
  - c. What made you decide to talk with your doctor/nurse about the abuse you were experiencing? OR What prevented you from talking with the doctor/nurse about the abuse?
2. Has there been any time when you came to the clinic for any other type of health concern that a health care provider asked you if you were a victim of abuse?
  - a. If yes,
    - i. What was that experience like for you?
  - b. If no,
    - i. Has there ever been a time when you told a doctor or nurse at this health clinic about the abuse you were experiencing?
  - c. What made you decide to talk with your doctor/nurse about the abuse you were experiencing? OR What prevented you from talking with the doctor/nurse about the abuse?

**If she indicates that she ever talked with a health care provider, whether initiated by them or her ask questions 3-9, otherwise skip to 10:**

3. How did it feel to talk about your abuse with the doctor/nurse?
4. How did the doctor/nurse respond when you told him or her about the abuse?
5. What if any recommendations or advice did he/she offer?
6. What community referrals, if any, did the doctor/nurse give you for victims of abuse?
  - a. Which of these referrals, if any, did you contact?

- b. Which of these referrals, if any, did you use?
  - c. [IF USED REFERRALS] What was your experience using these services like?
  - d. [IF USED REFERRALS] In what way if any were these referrals helpful?
  - e. [IF DID NOT USE REFERRALS] What made you decide not to contact or use the referrals provided?
7. What follow-up contact, if any, did you have with the doctor/nurse or clinic after the visit in which you disclosed your abuse?
    - a. [IF FOLLOW-UP] Who contacted you and what happened as a result?
  8. Who else, if anyone, has ever asked you about the abuse? How was that experience for you?
  9. Who else—if anyone—have you told about the abuse? This could be a friend, family member, neighbor, pastor, counselor, or any other individual who you told about your situation.
    - a. [IF CONTACT] What was that like for you? How did he/she/they respond when you told him/her/them about the abuse?
  10. What community services, if any, have you used during your abusive relationship (i.e. domestic violence shelter/program, hotline, couples' counseling)?
    - a. [IF SERVICES USED] How did you find out about these services? In what way if any were they helpful to you?
  11. What contact, if any, have you had with law enforcement regarding the abuse you have experienced?
    - a. [IF CONTACT] What was that like for you?
  12. [IF ENDED ABUSIVE RELATIONSHIP] What led to your decision to leave the abusive relationship? In what way, if any, was this decision informed by your doctor/nurse?
  13. How do you get around (i.e. car, bus, walking, shared vehicle)? How reliable is this mode of transportation?
  14. How easy or difficult is it for you to get to the places you need to go (school, work, babysitter, grocery, doctor's office, police station, etc.)? In what ways, if any, does this affect your sense of safety?
  15. What are some of the challenges you've faced as both a rural resident and survivor of abuse?

16. What are some of the positive aspects of living in a rural area and trying to cope with an abusive relationship?
17. What is your sense of the services available to women in this town/community/county who are experiencing abuse? Are there sufficient resources? Do people seem generally aware of them? How helpful are they?
18. What else would you like me to know about your experience? What else is important for me to know about domestic violence in rural areas like this?

# Appendix 4.

## Recruitment Materials

### *1. Survey of Rural Health Care Providers Cover Letter*



GEORGE WARREN BROWN SCHOOL OF SOCIAL WORK

DATE

RURAL HEALTH CLINIC

ADDRESS HERE

C/O DIRECTOR NAME HERE

My name is Annah Bender and I am a PhD candidate in Social Work at Washington University in St. Louis. As part of my doctoral dissertation I am collecting information on rural communities' response to intimate partner violence. **I am particularly interested in the ways primary health care providers identify and respond to intimate partner violence among their patients.** As you are well aware, rural communities face unique challenges to providing quality health care to patients. One of these challenges is the response to common threats to overall health and well-being, including family violence. **The purpose of this study is to establish what providers at rural health clinics in Missouri do when patients are experiencing intimate partner violence.** Recognizing the fact that many communities in rural Missouri do not have a domestic violence shelter or many options for treatment, I hope to glean information from primary care providers who I believe may be some of the “front line” providers of care to victims of intimate partner violence—yet are often not recognized as such.

It is my hope that the findings from this study will assist rural health centers in comparing and contrasting treatment protocols across sites and regions, and may assist in developing a standard treatment protocol for addressing and responding to intimate partner violence. **What rural communities sometimes lack in resources and funding, they more than make up for in innovation, creativity, and collaborative spirit.**

**This survey should be completed by members of your staff who are in clinical practice (see patients) and who have either a medical (M.D., D.O., P.A.) or nursing (B.S.N., M.S.N.) degree.** You may click on the following link to complete the survey electronically: [www.surveymonkey.com/r/ruralwomenshealth](http://www.surveymonkey.com/r/ruralwomenshealth). Participation in this survey is completely voluntary and will be anonymous. The first 50 individuals to complete and return the survey will receive a \$20 Amazon gift card.

I realize that your clinical staff are extremely busy, and I am grateful for your time. With that acknowledgment, the survey design is easy to follow and should take no longer than 30 minutes to complete. If you have any questions or need clarification on survey items, please do not



hesitate to contact me at (xxx) xxx-xxxx or emailaddress@wustl.edu.

Once again, I sincerely thank you for your participation in this study. Your answers will help fill a gap in knowledge from which others will certainly benefit.

My best,

Annah K. Bender, MSW, PhD Candidate  
Washington University in St. Louis  
George Warren Brown School of Social Work  
1 Brookings Drive, Campus Box 1196  
St. Louis, MO. 63130  
T: (xxx) xxx-xxxx  
E: emailaddress@wustl.edu

## 2. Cover Letter Soliciting Provider Interview Participants



Washington University in St. Louis

GEORGE WARREN BROWN SCHOOL OF SOCIAL WORK

DATE

RURAL HEALTH CLINIC

ADDRESS HERE

C/O DIRECTOR NAME HERE

My name is Annah Bender and I am a PhD candidate in Social Work at Washington University in St. Louis. As part of my doctoral dissertation I am collecting information on rural communities' response to intimate partner violence. **I am particularly interested in the ways primary health care providers identify and respond to intimate partner violence among their patients.** As you are well aware, rural communities face unique challenges to providing quality health care to patients. One of these challenges is the response to common threats to overall health and well-being, including family violence. **The purpose of this study is to establish what providers at rural health clinics in Missouri do when patients are experiencing intimate partner violence.** Recognizing the fact that many communities in rural Missouri do not have a domestic violence shelter or many options for treatment, I hope to glean information from primary care providers who I believe may be some of the “front line” providers of care to victims of intimate partner violence—yet are often not recognized as such.

I am contacting you to ask for your assistance in this research. I would like your permission to:

- 1) post recruitment materials at your clinic soliciting study participation (interviews) from female patients at your clinic**
- 2) interview any willing physicians and nurses employed at your clinic about their thoughts on screening for intimate partner violence among their patients and their perspectives on practicing medicine in a rural community.**

It is my hope that the findings from this study will assist rural health centers in comparing and contrasting treatment protocols across sites and regions, and may assist in developing a standard treatment protocol for addressing and responding to intimate partner violence. **What rural communities sometimes lack in resources and funding, they more than make up for in innovation, creativity, and collaborative spirit.**

I appreciate your careful consideration of this request. Please do not hesitate to contact me if you have questions about this research study and to discuss your potential involvement. I look forward to hearing from you and hopefully working together in the future.

My best,

Annah K. Bender, MSW, PhD Candidate

[35]

Washington University in St. Louis  
George Warren Brown School of Social Work  
1 Brookings Drive, Campus Box 1196  
St. Louis, MO. 63130  
T: (xxx) xxx-xxxx  
E: emailaddress@wustl.edu

### 3. Craigslist Advertisement for Survivor Participants



TITLE OF AD: Researcher Seeking Participants for Study of Rural Women's Health

Earn \$50 for one hour of your time!

Researcher from Washington University in St. Louis recruiting female patients over the age of 18 for a study of rural women's health and wellness.

Complete an interview about your health and experiences living in a rural community and you will receive:

- \$50 cash

- A \$10 gas card to help cover costs of transportation to the interview location

- Childcare during the interview if needed

For your convenience:

- Schedule the interview at a time that works best for you (evenings and weekends are OK)

- Interview will take place at this clinic unless you prefer to meet at another public location

Questions? To see if you are eligible to participate, call or email:

Annah Bender

(xxx) xxx-xxxx

[emailaddress@wustl.edu](mailto:emailaddress@wustl.edu)

4. Recruitment Flyer for Survivor Participants

Seeking female patients for participation in a research study of rural women's health!

Researcher from Washington University recruiting female patients over the age of 18 at this clinic for a study of rural women's health and wellness.

Complete an interview about your health and experiences living in a rural community and you will receive:

- \$50 cash
- A \$10 gas card to help cover costs of transportation to the interview location
- Childcare during the interview if needed

**Contact Annah Bender at  
314-740-8382 or akbender@wustl.edu  
to see if you are eligible.**

Visit:  
<https://sites.google.com/site/MOruralwomenshealth>

Rural Womens Health  
(314) 740-8382

Rural Womens Health  
(314) 740-8382

RURAL WOMEN'S HEALTH STUDY

Rural Womens Health  
(314) 740-8382

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Visit:  
<https://sites.google.com/site/MOruralwomenshealth>

Rural Womens Health  
(314) 740-8382

## Annah K. Bender, MSW, PhD

Brown School of Social Work  
Washington University in St. Louis  
1 Brookings Drive, CB 1196  
St. Louis, MO 63130

Brown Hall 11  
(314) 935-8751-office  
(314) 698-8398-cell  
akbender@wustl.edu

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### Education

PhD, Washington University, St. Louis, MO. 2015  
Dissertation Title: "Rural Primary Care Provider's Response to Intimate Partner Violence and Survivors' Perceptions of Helpfulness"  
Chair: Dr. Tonya E. Edmond

MSW, University of Michigan, Ann Arbor, MI. 2008  
Concentration: Interpersonal Practice and Mental Health

BA, Missouri State University, Springfield, MO. 2004  
Major: English

### Grants and Fellowships

Agency for Healthcare Research & Quality (NIH) 2014-2015  
• Dissertation grant of \$40,000 to support research and data collection

Center for Violence & Injury Prevention PhD Scholar 2013-2014  
• Fellowship providing living stipend and training funds

Brown School Dissertation Award 2014  
• Departmental award of \$3000 to aid with costs related to dissertation data collection

Inter-Exchange Foundation "Christianson Grant" 2009  
• Award of \$3000 to support an international social service project

### Academic Awards and Scholarships

University of Michigan School of Social Work Merit Scholarship 2007-2008  
University of Michigan School of Social Work Opportunity Grant 2007-2008  
National Honors Society member 2007-2008  
Missouri State University Dean's List 2002-2003

### Research Experience

Research Assistant, Washington University, St. Louis, MO. 2015-present  
• Analysis of qualitative data from a research study regarding the search for affordable housing and experiences of racial and housing discrimination by Section 8 renters in St. Louis, MO.  
○ PI: Dr. Molly Metzger, Washington University

Research Assistant, Washington University, St. Louis, MO. 2013  
• Analysis of qualitative data from a research study involving the trauma experiences of justice-involved women in St. Louis.

- Co-PIs: Drs. Carrie Pettus-Davis and Tonya Edmond, Washington University

PhD Scholar, Center for Violence and Injury Prevention, St. Louis, MO. 2013-2014

- Collaborated with a community-based service provider, The Women’s Safe House, to assist with research, development, and evaluation efforts to quantify program effectiveness.
  - Supervisors: Dr. Melissa Jonson-Reid, Washington University; Denise Burns, Residential Director, The Women’s Safe House

Research Assistant, Heartland Center, Saint Louis University, St. Louis, MO. 2012

- Researched primary prevention practices for sexual violence among vulnerable populations and developed findings into training modules for service providers addressing sexual violence.
  - PI: Dr. Kate Wright, Saint Louis University

Research Assistant, Center for Social Development, Washington University, St. Louis, MO. 2011-2012

- Analyzed qualitative data from a large project examining outcomes of volunteer teachers in rural Costa Rica.
  - PI: Dr. Amanda Moore McBride, Washington University

## Publications and Presentations

**Bender, A.** (in press). Ethics, Methods, and Measures in Rural Intimate Partner Violence Research: The Current State of Knowledge. *Violence Against Women*.

**Bender, A.** & Chalise, N. (revise and resubmit). Differentiating Perceptions of Intimate Partner Violence in Nepal. *International Social Work*.

**Bender, A.** (2013, October). *Intimate Partner Violence and Culture*. Invited presentation at the Saint Louis University School of Medicine, St. Louis, MO.

**Bender, A.** & Chalise, N. (2013, January). *Differentiating Perceptions of Intimate Partner Violence in Nepal*. Presentation at the annual conference of the Society for Social Work & Research, San Diego, CA.

**Bender, A.** & Chalise, N. (2012, March). *Women’s Empowerment and Justification of Domestic Violence*. Invited presentation at the symposium of the International Students’ Association at Washington University, St. Louis, MO.

## Teaching Experience

Instructor, Washington University Fall 2015

- “Social, Political, and Economic Environment”

Teaching Assistant, Washington University Fall 2014

- “Introduction to Advanced Research” (doctoral course)

Teaching Assistant, Washington University Fall 2014

- “Social Work Practice with Individuals, Families and Groups”

Teaching Assistant, Washington University Spring 2013

- “Intervention Approaches with Women”

Co-Instructor Spring 2012

- “Promoting Recovery for Persons with Mental Illness”

Teaching Assistant, Washington University Summer 2011

- “Substance and Alcohol Abuse”

Teaching Assistant, Washington University Spring 2011

- “Social and Economic Development”

**Course Development** 2011-2012

- “Promoting Recovery for Persons with Mental Illness” (MSW-level)

**Academic Service- Departmental**

Academic Advisor 2015-present

- Concentration advisor to MSW students specializing in mental health.

Member, PhD Student Pro-Seminar Committee 2011-2012

- Member of a committee that organized monthly professional development seminars and events with invited guest lecturers for doctoral students.

Peer Reviewer, Social and Economic Development Writing Group 2011-2013

- Member and peer reviewer for a doctoral student writing group.

**Academic Service- Extramural**

Reviewer, *Violence Against Women* 2015

- Invited manuscript reviewer for peer-reviewed journal

**Professional Experience- Master’s Level**

Coordinator, El Nahual Community Education Center, Quetzaltenango, Guatemala 2009-2010

- Supervising community outreach programs at El Nahual, program evaluation, coordinating and supervising volunteers, and leading international fundraising efforts.

Client Services Manager, Community Support & Treatment Services, Ann Arbor, MI. 2009

- Clinical supervisor for four group homes serving individuals with co-occurring mental illness and substance use disorders. Resources coordinator at a housing complex for individuals with disabilities and mental illness.

Client Services Manager (Intern), Community Support & Treatment Services, Ann Arbor, MI. 2008

- Case manager on a team using the Assertive Community Treatment model to provide wraparound services for individuals with severe mental illness living in the community.

**Professional Experience- Bachelor’s Level**

Senior Case Manager, Brooklyn Child Advocacy Center, Brooklyn, NY. 2007

- Provided crisis counseling and case management for families experiencing child abuse.



Senior Client Advocate, Lang House (Safe Horizon), New York, NY. 2006-2007

- Provided advocacy, case management, and brief counseling for women in a transitional shelter for intimate partner violence. Facilitated weekly support groups and assisted clients with finding housing, employment, legal and community resources.

Women's Advocate, Harmony House, Springfield, MO. 2001-2005

- Answered crisis hotline for women experiencing intimate partner violence, processed shelter intake assessments, provided direct services as frontline staff at a 24-hour residential facility.

### **Community Service and Volunteer Activities**

Associate Board Member, NARAL Pro-Choice Missouri, St. Louis, MO. 2011-present

- Associate Board member for reproductive rights advocacy organization in Missouri.

Emergency Responder, Interfaith Coalition for Immigrant Rights, Ann Arbor, MI. 2008-2009

- Resources coordinator for families undergoing immigration raids and deportations.

Support Group Facilitator, Carrot Way Community Center, Ann Arbor, MI. 2009

- Co-facilitator of an art therapy group for low-income women experiencing intimate partner violence.

### **Professional Memberships**

Missouri Coalition Against Domestic and Sexual Violence	2011-present
National Association of Social Workers	2012-present
Rural Social Workers' Caucus	2013-present
Society for Social Work and Research	2011-present
Academy of Violence and Abuse Scholars	2014-present
Council on Social Work Education	2014-present