Published in final edited form as:
J Interpers Violence. 2014 September ; 29(14): 2670–2694. doi:10.1177/0886260513517299.

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

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Abstract

BACKGROUND—Women in rural communities who are exposed to intimate partner violence (IPV) have fewer resources when seeking help due to limited health services, poverty and social isolation. Rural primary care physicians may be key sources of care for IPV victims.

OBJECTIVES—To assess the opinions and practices of primary care physicians caring for rural women with regard to IPV identification, the scope and severity of IPV as a health problem, how PCPs respond to IPV in their practices, and barriers to optimized IPV care in their communities.

METHODS—Semi-structured interviews were conducted with 19 internists, family practitioners, and obstetrician-gynecologists in rural central Pennsylvania. Interview transcripts were analyzed for major themes.

RESULTS—Most physicians did not practice routine screening for IPV due to competing time demands, lack of training, limited access to referral services as well as low confidence in their effectiveness, and concern that inquiry would harm the patient-doctor relationship. IPV was considered when patients presented with symptoms of mood, anxiety or somatic disorders. Responses to IPV included validation, danger assessment, safety planning, referral, and follow-up planning. Perceived barriers to rural women seeking help for IPV included traditional gender roles, lower education, economic dependence on the partner, low self-esteem, and patient reluctance to discuss IPV. To overcome barriers, physicians created a “safe sanctuary” to discuss IPV and suggested improved public health education and referral services.

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Preliminary results from this work were presented at the National Institutes of Health, Office of Research on Women’s Health, Building Interdisciplinary Research Careers in Women’s Health (BIRCWH) Annual Meeting, Bethesda, MD, on February 16, 2011.

CONCLUSIONS—Interventions to improve IPV-related care in rural communities should address barriers at multiple levels, including both physicians' and patients' comfort with discussing IPV. Provider training, community education, and improved access to referral services are key areas in which IPV-related care should be improved in rural communities. Our data support routine screening to better identify IPV and a more pro-active stance towards screening and counseling.

Keywords (MeSH Headings)

Domestic Violence; Spouse Abuse; Battered Women; Rural Health Services; Rural Population; Primary Health Care; Qualitative Research

Background

Intimate partner violence (IPV) – defined as physical violence, sexual violence, the threats of these behaviors, and emotional abuse between current or former spouses and dating partners (Centers for Disease Control and Prevention, 2012) -- poses a major public health risk. In the United States, IPV affects more than 1 in 3 women in the course of their lives and 18% of women each year (Black et al., 2011). IPV is associated with numerous adverse health conditions including adverse health behaviors (e.g., drug abuse, promiscuity), chronic somatic complaints (e.g., headaches, sleep disturbances), mental health problems, and physical injury and death (Bonomi et al., 2009; Breiding, Black, & Ryan, 2008b; Coker et al., 2002). The prevalence of IPV among American women, in combination with the adverse health sequelae that arise from IPV victimization, led the Institute of Medicine (IOM) to identify IPV as a significant threat to the health of U.S. women and an ongoing research priority for women's health (IOM, 2010). The IOM also recommended routine screening and counseling for IPV as a critical clinical preventive service for women (IOM, 2011).

Identifying IPV in healthcare settings has the potential to improve outcomes for women exposed to IPV (Trabold, 2007). In January 2013, the United States Preventive Services Task Force (USPSTF) recommended that screening for IPV be adopted as a routine preventive healthcare service for reproductive aged women (Moyer, 2013). A logical place for the IOM and USPSTF's recommended routine screening and counseling to occur is in the primary care setting. The prevalence of IPV in primary care settings exceeds the prevalence of IPV in community-based samples (Richardson et al., 2002); as many as 20% of all adult women accessing primary care services screen positive for recent IPV (Campbell et al., 2002; Campbell & Lewandowski, 1997). This, along with the demonstrated burden of disease among IPV survivors (Breiding, Black, & Ryan, 2008a), suggest that greater priority should be placed on identifying and treating IPV in primary care.

Despite the importance of routine identification and treatment of IPV in primary care settings, there are several barriers to providing optimal care for victims, especially those living in rural areas. Rural women experience at least as much (Breiding, Ziembroski, & Black, 2009) if not higher (Peek-Asa et al., 2011) rates of IPV when compared to non-rural women, as well as more frequent and severe abuse (Peek-Asa et al., 2011). In rural communities, health services and other resources are limited; and poverty, physical isolation, (Averill, Padilla, & Clements, 2007; Peek-Asa et al., 2011) social isolation, (Bosch & Schumm, 2004) community norms of self-reliance, and fear of disclosure in close-knit communities (Logan, Evans, Stevenson, & Jordan, 2005) compromise the ability of rural women exposed to IPV to access services (Eastman & Bunch, 2007; Logan et al., 2005). Self-selection may also result in increased rates of IPV in rural communities, as individuals desiring to hide abuse may seek residence in rural communities, where geographic and social isolation make abuse easier to conceal (Lanier & Maume, 2009; Murty et al., 2003). Because rural women have additional barriers to accessing services for IPV (Peek-Asa et al., 2011), and may be particularly vulnerable to adverse health consequences resulting from IPV, health care settings have been identified as key locations for domestic violence identification and intervention in rural communities (Van Hightower & Gorton, 1998).

Prior work evaluating clinicians' perspectives on caring for women who have experienced IPV (Waalen, Goodwin, Spitz, Petersen, & Saltzman, 2000) has pointed to numerous barriers to optimal care, including lack of provider education regarding IPV, lack of time and competing clinical demands, and lack of effective interventions (Colarossi, Breitbart, & Betancourt, 2010; Waalen et al., 2000). However, only one prior study has examined the perspectives of rural primary care providers (PCPs) caring for women who have experienced IPV. In 1997, researchers from the Centers for Disease Control and Prevention (CDC) surveyed 127 providers (physicians, nurses, physicians assistants, and nurse practitioners) in 13 primary care clinics in rural West Virginia regarding their perceived barriers to identifying IPV in the healthcare setting (CDC, 1998). In that study, most providers did not screen for IPV and many were not sure how to screen. The specific barriers to screening in rural communities, as well as treatment issues in the rural context, were left largely unexplained. Thus, prior work examining the PCP's perspective on IPV care has not specifically or adequately evaluated the rural context, which is a necessary ecological perspective in evaluating care of women exposed to IPV (Eastman & Bunch, 2007).

To help fill this knowledge gap, a study was designed to elicit the opinions and practices of PCPs caring for rural women with regard to: (1) IPV screening, (2) the scope and severity of IPV as a health problem, (3) responding to identified IPV, and (4) barriers to optimized IPV care in rural communities. This is the first study to elaborate in depth the opinions of rural PCPs caring for women who have experienced IPV. Qualitative methods were utilized to evaluate the perspectives of PCPs regarding approaches to IPV in rural Central Pennsylvania communities. Qualitative methods are uniquely appropriate for exploring understudied areas; they can be used to elaborate complex phenomena, generate hypotheses, and give voice to multiple stakeholders (Sofaer, 1999).

Methods

Study Design and Sample

This study was approved by the Institutional Review Board at the investigators' home institution. Semi-structured interviews with rural PCPs explored providers' attitudes and practices with regard to IPV for women in their practices. Semi-structured interviewing has a fluid and flexible structure, in which the interviewer follows a guide or series of prompts, but promotes a bidirectional discussion between the interviewer and respondent, allowing the respondent to ask questions of the interviewers, and the interviewers to follow new themes that come up over the course of the discussion as well as ask clarifying questions (Mason, 2004). This is an ideal method to explore perceptions when asking questions about complex and sensitive issues (Barriball & While, 1994), thus an optimal choice for the exploration of PCPs experiences regarding IPV-related healthcare.

Interviews were conducted either in-person at the PCP's office or by telephone, based on the participant preference and scheduling feasibility. Interviews lasted approximately one hour. Ten of the interviews were conducted in-person and nine were conducted by telephone. At least two investigators were present at each interview, with one investigator serving as the interviewer and one investigator serving as a note-taker. All interviews were audio-recorded and professionally transcribed.

Purposive sampling was used to recruit primary care physicians (PCPs) practicing in Central Pennsylvania. Purposive sampling, rather than representative sampling, is used in qualitative research to identify a sample with particular attributes of interest to the investigators (Barbour, 2001; Guest, Bunce, & Johnson, 2006). Using the American Medical Association's Physician Masterfile, PCPs actively practicing in rural communities were identified. PCPs were defined as physicians with primary specialties in family practice, general practice, internal medicine, or obstetrics-gynecology. Physicians were included if they were without further sub-specialization and identified themselves as PCPs. Obstetrician-gynecologists were included because women of reproductive age often obtain primary care services from their obstetrician-gynecologist (Weisman, 1998). Only physicians in non-Federal office-based patient care practices were included; Veterans Affairs practices were excluded.

The sample was limited to physicians whose practices were geographically located within a largely rural, 28-county region of Central Pennsylvania in which the investigators' prior work had identified deficits in primary, preventive, and mental health services for women (Hillemeier, Weisman, Chase, Dyer, & Shaffer, 2008; McCall-Hosenfeld & Weisman, 2011). Eligibility was further determined by identifying rural locations using Rural Urban Commuting Area (RUCA) codes, the U.S. Department of Agriculture's Census tract-based, zip code classification scheme based on population density, urbanization, and daily commuting practices (Rural Health Research Center). RUCA codes are scaled 1 to 10, with 1 representing the most metropolitan/urban zip codes and 10 representing the most rural. Due to relatively few physicians in the most rural zip codes (RUCA codes 7–10), practices located immediately adjacent to these zip codes were also eligible for inclusion, as women would likely travel to adjacent zip codes for their health care needs. All physicians practicing in zip codes geographically adjacent to the rural zip codes were categorized as RUCA codes 4–6, which are considered "micropolitan" or "large rural" areas.

Using these definitions, 85 physicians from the AMA Masterfile met the above inclusion criteria from rural zip codes, and 165 physicians met inclusion criteria from zip codes geographically adjacent to rural zip codes. The 250 eligible PCPs were notified by letter that the Rural Women's Health Care Project would be conducted in their area. Six PCPs responded to the initial invitation. Follow-up phone calls were made to eligible PCPs to recruit participants, with priority given to the PCPs located within rural zip codes (RUCA 7–10). Twenty-six PCPs received follow-up phone calls, of whom 13 participated. Not all PCPs were contacted in follow-up, as thematic saturation was reached at the completion of 19 interviews. Thematic saturation, also known as theoretical saturation, occurs when all themes have been fully elaborated and no new themes are emerging, and has become the gold standard by which purposive sample sizes are determined in qualitative research (Guest et al., 2006). Thematic saturation was determined based on the consensus of the investigators who were interviewing the participants and reviewing the transcripts.

Interview guide—The interview guide was pilot tested and sequentially revised with a convenience sample of six PCPs at the investigators' home institution until wording of the questions was optimized. All interviews began with ascertainment of years in practice, type of practice setting, and reasons for practicing in a rural location. The PCPs were specifically asked to focus their responses on their experiences providing primary care for adult women who lived in rural areas. The questions focused on four main topic areas: 1) cancer screening (Rosenwasser et al., 2013), 2) preventive reproductive health (Chuang et al., 2012), 3) intimate partner violence (IPV), and 4) mental health (Colon-Gonzolez et al., 2013). This manuscript presents the data from the section of the interview focused on IPV.

IPV questions included a definition to frame the discussion based on the CDC's definition of IPV as "four types of behavior: physical violence (e.g., hitting, kicking), sexual violence (e.g., forcing sexual acts), threats of physical or sexual violence (e.g., using words, weapons or gestures to communicate intent to harm), and emotional abuse (e.g., stalking, name-calling, intimidation, or forcing isolation). An intimate partner includes current and former spouses and dating partners" (CDC, 2006). The IPV questions that followed focused on: (1) IPV screening in the PCP's practice, (2) perceptions of IPV as a health problem, (3) current practices for responding to identified IPV, and (4) perceived barriers to care for women who have experienced IPV unique to rural communities. Specific prompts from the final version of this interview guide are shown in the Appendix.

Analysis—Frequencies for demographic data of the participating PCPs are presented. Two members of the research team (JSM-H, CSW) independently analyzed each transcript. A third member of the research team (ANP) reanalyzed the transcripts to ensure that no themes were overlooked in initial review. Directed content analysis was used to examine PCP approaches to IPV in rural communities. Content analysis is a qualitative analytic technique used to describe both explicit and inferred content in text data "through the systematic classification process of coding and identifying themes and patterns" (Hsieh & Shannon, 2005). A directed approach to content analysis allows investigators to pre-specify some of the codes to be examined, while still allowing for new inductive codes to arise from within the data (Hsieh & Shannon, 2005). This approach is particularly useful to "extend or refine existing theory" (Hsieh & Shannon, 2005), and thus an optimal strategy for examining a topic about which something is already known (e.g., PCP perspectives on IPV-related care) within a new context (e.g., the rural setting.) Pre-specified deductive codes included barriers to IPV screening based on primary care practice demands, lack of routine screening for IPV, and barriers specific to rural communities (Colarossi, et al., 2010; Logan et al., 2005; Logan, Stevenson, Evans, & Leukefeld, 2004).

An iterative process was used to organize the data. All authors agreed on the final list of major themes. Illustrative examples of the themes were selected using representative quotes from the participants. The NVivo8 software package for qualitative data (QSR International, Melbourne, Australia) was used to analyze the data and to group the responses into appropriate theme categories.

Results

Demographics—As shown in Table 1, the PCPs had been practicing between 1–38 years (median 21), 63% (n=12) were family practitioners, and 47% (n=9) were women. Practice settings ranged from solo practitioner to hospital owned, multi-specialty group practice. Participants practiced in 15 of the 28 counties within the target region, with 42% (n=8) practicing in the most rural areas and 58% (n=11) practicing adjacent to these rural areas. All PCPs provided adult primary care at least 50% of the work week, with most providing adult primary care more than 80% of the time. Forty-two percent (n=8) of the PCPs had been in the same practice for their entire career, and only 11% (n=2) had previously worked in urban locations. Fifty-seven percent (n=11) reported they practiced in a rural area because they grew up in a rural area, often the same community where they currently practiced. Sixteen percent (n=3) remained in rural practice locations after fulfilling a commitment to the National Health Service Corps, a loan repayment program, or a visa requirement.

Identified Themes—The major themes emerging from the interviews are shown in Table 2 and elaborated below. Frequencies are reported in the results that represent the number of PCPs in the sample that specifically stated each theme during the interviews. These frequencies are provided for reference only and are not intended to be interpreted as prevalence estimates, as the data in this study are qualitative.

Routine screening for IPV in clinical practice is not commonly performed

Thirty-two percent (n=6) of PCPs reported that they performed routine screening for IPV using either direct inquiry or patient-administered risk assessment tools. Among the providers who provided routine screening, *there was no standardized interval for screening.* PCPs who screened did so in different venues and with varying frequency – i.e., at annual evaluations (16%, n=3), at every visit (5%, n=1), or with new patient visits only (5%, n=1). A PCP explained that while he does not have a regular interval for screening, “I try [to screen] especially during well visits…to at least bring out the idea that they’re safe in their relationship…to see if there are any problems going on that could be addressed or prevented, hopefully.” PCPs who performed routine screening were in the minority – 53% (n=10) of the respondents volunteered that routine screening was either not feasible or not performed in their practices.

Some providers do not believe they should ask everyone about IPV—While 21% (n=4) of PCPs expressed regret that they did not routinely screen for IPV, 37% (n=7) did not think routine screening was appropriate. As one general practitioner explained, "I don't think it's appropriate unless there's something to suggest it might be happening….We have a lot of patients who come in and are happy, healthy, well-adjusted, and I'm not going to ask those if they're getting beat-on...." Eleven percent (n=2) of PCPs felt that screening for IPV could be harmful to the patient-provider relationship, as expressed by a general internist, "If you're going to ask every single female, 'Are you getting abused at home?' … they might get mad at you and walk out of here."

Lack of time and competing priorities (26%, n=5), inadequate training (21%, n=4), and discomfort with IPV (21%, n=4) prevents screening—The challenge of addressing IPV screening with limited time is illustrated by a family practitioner, "I admittedly do not screen for it the way I should…but I am so overwhelmed with everything else that needs to be screened for and discussed, that…I just can't sit down and get a detailed…IPV history, from everybody that comes in the door." Additional barriers to IPV screening included lack of training (21%, n=4), and discomfort about approaching the topic of IPV with patients (21%, n=4). This family practitioner reflected the concern that IPV-related care should be managed by a better trained service agency, "I'd feel comfortable talking to [patients] about it if I was properly trained – what I could ask, what I could do… you know, could I even do a rape kit? No; I send the patients to one of the centers."

PCPs (16%, n=3) were not convinced that screening for IPV would be helpful, due to a lack of effective resources for referral and follow-up—For example, a family practitioner stated,

> If you don't have the resources…if you don't feel like you can do anything effective to help a person, sometimes it makes you reluctant to screen for it. Sometimes you'd rather not know. I mean now all of a sudden they've got this woman who is being abused and you can't do anything and you don't have the resources to be able to offer her care…that may be a barrier.

An internist noted, "I don't think we have resources to act on….We still need as providers… to be convinced that those "resources" can make the difference in this woman's life and not just create…more burden on our health system."

Lack of consensus on the prevalence of IPV may contribute to practice variation in IPV management in rural primary care settings

While the PCPs were in agreement that IPV is "…a multi-million woman health problem," when asked about the prevalence of IPV in their communities, 53% (n=10) reported that their communities' prevalence rates were far below the anchoring statistics cited in the interview guide (25% lifetime exposure to IPV for community based samples (Breiding et al., 2008b) and 16% recent exposure to IPV in primary care settings (Coker, Smith, Bethea, King, & McKeown, 2000)). Twenty-one percent (n=4) of PCPs felt that they were likely underestimating the prevalence of IPV. An internist explained that PCPs may underestimate the prevalence of IPV in their communities or practices, stating, "I think physicians would be surprised by that statistic because you know, we are so bogged down to treating patient's symptoms…and [do] not really look at the comprehensive care." Another PCP agreed, "It probably seems a little bit higher than what we're seeing, because we're not doing the proper screening for it." An internist reflected her perception that savvy PCPs were more likely to identify IPV, and thus more likely to believe IPV to be of a higher prevalence among their patients.

> I think there are some physicians in the community who would be surprised by that number and then I think there are some of us who take care of a lot of adult women …that number would not surprise us at all.

Thus, *PCPs inaccurately estimated the prevalence of IPV in their clinical populations*.

Rural PCPs perceive emotional abuse as more prevalent than physical abuse—Seventy-four percent (n=14) of PCPs witnessed the sequelae of many types of IPV; while 32% (n=6) reported that emotional abuse is a more common occurrence, and can have a significant impact on the health of their patients. A family practitioner explained,

> Much more commonly [than physical abuse], I have emotional abuse, massive amounts, a huge, huge amount of that. And then maybe threats of violence, and then if there is violence, I think it's on more of lower level…I just don't commonly have broken bones, broken ribs, punching in the face.

When explaining that he sees IPV often in his practice, an internist stated, "If you take the type of abuse…emotional abuse is probably number one."

PCPs inquire about IPV when it is suspected, i.e., when "alarm" is raised

The kinds of symptoms that PCPs reported would prompt a diagnostic investigation for IPV included physical injuries (32%, n=6), somatic complaints (26%, n=5), and mental health problems (68%, n=13) such as anxiety or mood disorders. The common approach for identifying IPV was not routine screening, but rather being alert for warning signs -- "*I just keep my antennae out*."

Psychological distress and somatic symptoms are the most common presenting complaints among women with IPV—A PCP explained, "We see anxiety and depression as a very understandable result of that. We see non-compliance. We see lots and lots and lots of overutilization of services for reasons you can't figure out why they're coming in." PCPs noted that they typically inquired about IPV as part of a diagnostic evaluation for symptoms that "raise alarm" for IPV. An internist explained, "…the cases like that where you know there is something underneath…if they are crying, distressed, or depressed, anxiety attacks, I always ask the question…'Any problem in the home front that you need to talk about?'"

IPV is suspected when partner control tactics are observed—Sixteen percent (n=3) of PCPs were alert to partner control tactics that prompted further investigation, as noted by an internist, "if the partner is always back with them for every visit and won't let them be alone in the visit, you sort of start to get a little suspicious." Another PCP explained the difficulty of establishing privacy with his patient in the presence of a controlling partner, "We see intimate partners that come with women for gynecologic exams and answer for

> them and won't leave the room and darned near follow them into the bathroom….so we try and ask [the IPV] question in private, if we can.**"**

Rural PCPs use several appropriate counseling and referral techniques when addressing IPV among their patients

Despite the fact that many 42% (n=8) of PCPs reported that they were unprepared to treat IPV beyond "the medical thing," i.e., the assessment and treatment of physical and emotional harm, all of the physicians approached counseling of their patients who disclosed IPV in concordance with the precepts of consensus guideline recommendations (Family Violence Prevention, 2004) regarding care of women exposed to IPV in healthcare settings.

Validation and providing information (53%, n=10) -- reassuring the patient that she is believed, not alone, and not to blame for abuse – are key features in IPV-related care provided by rural PCPs—An internist described her approach - "It's oftentimes educating her to the facts and reassuring her that it's not her fault, that she did not bring this upon herself, and also that this is wrong—that she does not deserve this." Another PCP agreed, "I'll remind them that what they say to me is confidential, that I won't disclose anything without their permission, and make some general statements like, 'nobody deserves to be hurt.'"

PCPs (32%, n=6) reported assessing for acute safety considerations and engaging in safety planning with their patients—A family practitioner showed his concern, noting, "I need to let them know that I am afraid for them and concerned and that they need to think about what's going on and try to make some plans to get themselves away from the situation safely." Another described how she would take immediate action, telling patients, "I'm gonna close the doors; you can sit at my desk, talk to this counselor and they set up a safety plan."

PCPs (100%, n=19) referred to local resources and worked to develop a follow-up plan for women—All respondents indicated that if IPV is identified, they would refer the patient to community services, and 11% (n=2) specifically reported follow-up planning. A family practitioner explained, "I…ask them about it, and try and offer them resources and basically let them know that – it's never okay to be abused and that there's an army of resources waiting stand by to help you out of this situation…" One PCP even offered her personal contact information, "I make sure she knows how to get a hold of me 24/7 and make sure that she knows how to be safe."

Rural communities present unique challenges for women to receive care for IPV on multiple levels – the PCP, their patients, and the community

Acceptance of traditional gender roles prevents women in rural communities from seeking help for IPV—Thirty-two percent (n=6) of PCPs perceived that cultural expectations common to rural communities tend to establish IPV as a normative behavior, and that beliefs of female subservience persisted. This prevented women from taking pro-active steps to seek help or to leave an abusive situation. A family practitioner observed, "This is a little bit of a male-dominated kind of society here, more so than probably some other places and I think a lot of women are afraid to come forward." Other PCPs agreed, one noting patients'

> …perception of it and whether or not they think it's a problem because some may feel like, 'okay this is the way it's gonna be, this is the way it is, and I just have to accept it'… they just figure, 'this is the way everybody is.

Fifty-three percent (n=10) of the PCPs noted that *lack of privacy in small rural communities is an important barrier to accessing care for IPV.* One PCP noted,

> In small communities where you have a community of 500 people—where the police officer is down the street; they obviously know who you are and your husband knows who they are, and I think they are sometimes afraid to report it. So I think the intimacy you would think would prevent it, but I think sometimes it tends to cover it up.

Stigma and low self-esteem prevent rural women from accessing care for IPV—Thirty-seven percent (n=7) of PCPs reported this barrier, with one reflecting, "I think it's embarrassment. They feel that something is wrong with them, that they are being abused… their self-image is low." Another male internist noted, "I think [what] the women probably need is some support and self-esteem so they realize that they can do it on their own."

Patients may not consider primary care as a place they can go for help with IPV—Eleven percent (n=2) of PCPs perceived that many of their patients would never consider coming to their doctor for IPV-related care. A family practitioner observed,

> They may not feel that their doctor is the place to go with something like that. Maybe they think they should go to law enforcement or something along those lines, but I think a doctor is somewhere that could provide a lot of help in that situation.

Low socioeconomic status and financial dependence on the abuser in rural communities prevents women from receiving care for IPV—Forty-seven percent (n=9) of the PCPs cited low socioeconomic status for women in rural communities as a key barrier to receiving care for IPV. Specifically, economic dependence on an abusive spouse implies dependence on the spouse for transportation and fear for the financial security of their children if women were to seek care for IPV. One internist explains his perception of the rural community he serves,

> [For] the woman, freedom is very much limited because there's a lot of financial dependency on the partner…in this rural area, [there are] more hidden problems than [a] big city [where] a woman is more free to be on her own and she can survive on her own; here – they cannot.

PCPs noted that economic insecurity in rural communities becomes further complicated by both social and geographic isolation, which is amplified by a lack of transportation. A patient may be

> basically isolated because her husband won't give her any money, she doesn't work outside the home, and he won't let her drive the car and will not give her access to the car… you're looking at farms that are 100, 200, 300 and more acres and they're quite widely dispersed outside of town.

PCPs believe that community-level interventions are needed to help rural women who have experienced IPV—Although 68% (n=13) of PCPs reported that they could play an important role in helping to overcome the barriers for IPV care, for example, by creating what one referred to as a "safe sanctuary" to discuss abuse and how to address it, 37% (n=7) acknowledged that the answers to improving care for rural women with IPV also lay outside of primary care, in the community. Forty-two percent (n=8) felt that public health education about recognizing IPV and seeking care for it would be helpful. Using the media, such as local newspapers and radio campaigns, was offered as a potential strategy for overcoming rural women's lack of awareness of IPV and the stigma associated with IPV, citing examples of prior media campaigns that had been successful in increasing awareness for other potentially stigmatizing health problems, such as stress incontinence. As noted by one PCP,

> I think if more information, education, and dollars - if available - would be put towards getting things out in rural areas that could help educate people and let them know that those types of things are available, and you don't have to feel that there is any stigma associated with that.

Lack of referral services to assist with the care of their patients who experienced IPV was an additional resource barrier for PCPs to address IPV with their patients—Thirty-seven percent (n=7) of PCPs perceived that even if women were educated, the stigma surrounding IPV were overcome, and financial barriers to health care were eliminated, the lack of accessible domestic violence treatment programs and mental health services would remain a barrier for their patients. Overcoming this barrier was cited as key to optimizing comprehensive care for rural women who experience IPV, as noted by a family practitioner,

> Being in a rural area, sometimes we don't have all those other things accessible, such as mental health and other…maybe, we don't even have a shelter right here in town that other, maybe larger communities have, so I think that is somewhat—[it] makes it difficult.

Interaction with the criminal justice system presents a challenge for rural PCPs who have identified women exposed to IPV—Thirty-seven percent (n=7) of the PCPs were concerned about possible legal ramifications and their responsibility under the law to report abuse, "…some women will tell you but they don't want anything done about it. For that, you have to respect their privacy." When to involve the criminal justice system, and when not to, was not entirely clear to the PCPs. This uncertainty caused concern among PCPs when asked how they responded to IPV in their patients, "Physical abuse—straightforward. Police [have] to be involved. I inform the police. Now if it's verbal abuse/ emotional abuse…then I don't know what to do with them, really."

Discussion

All of the rural PCPs interviewed in this study recognized that IPV poses a significant health risk for patients in their practices, and the majority agreed that emotional abuse was prominent in their community. Their perception that emotional abuse is more common than physical or sexual abuse is likely correct, as recent national surveys estimate the prevalence of a 12 month history of psychological aggression by an intimate partner to be about 13.9% among women, compared to 0.6% for rape and 4.0% for physical violence (Black et al., 2011), and a recent review notes that nonphysical abuse is more than four times more frequent than physical abuse by a current partner (Carney & Barner, 2012). The PCPs correctly indicated their understanding that emotional abuse is associated with significant adverse health complications (Yoshihama, Horrocks, & Kamano, 2009).

However, despite awareness of the scope of IPV, the PCPs identified numerous barriers to *routinely screening* for IPV and to *responding* appropriately to IPV among their patients. Barriers to screening were identified at multiple levels. Many of the physician-level barriers articulated echoed prior findings which have been described in non-rural settings, such as concerns about taking too much time from other clinical demands, inadequate training in IPV-related care, lack of clinician confidence in addressing IPV, and lack of professional supports to assist PCPs in managing patients identified by screening (Colarossi et al., 2010; Gerber, Leiter, Hermann, & Bor, 2005; Gutmanis, Beynon, Tutty, Wathen, & MacMillan, 2007; Jaffee, Epling, Grant, Ghandour, & Callendar, 2005; Trabold, 2007; Waalen et al., 2000). Patient-level barriers to identifying IPV in primary care - such as financial insecurity and physical isolation preventing disclosure – were noted to be especially important among rural women.

Even where IPV is identified and resources available, PCPs identified rural culture and low socioeconomic status as important barriers to IPV treatment. In noting that rural women may be less educated, more economically dependent upon their spouses, and more likely to normalize IPV, PCPs implied that rural women are less able to effectively respond to IPV. A more directive approach to counseling, however, might enable physicians to discuss cultural barriers with their patients and to help them problem-solve appropriate responses – including seeking appropriate social services – without undermining patient autonomy. Some patients prefer a more “doctor centered” and directive approach to counseling (de Haes, 2006), which enables them to understand how others perceive similar situations and how others might act differently to reduce exposure to IPV or its sequelae.

Another barrier to screening was rural PCPs uncertainty regarding reporting requirements for identified IPV. This suggests that interventions to improve IPV-related care in rural communities will be most effective if they are multi-level interventions, addressing PCP practice structure and training, patient education, community supports, and interactions between the PCP and other agencies such as social services and the criminal justice system.

PCPs reported feeling unprepared to provide care for women patients identified as exposed to IPV. Interestingly, despite the common feeling of inadequacy in handling IPV, all of the PCPs reported providing at least some of the interventions that are recommended by national consensus guidelines for treatment of patients who have been identified in healthcare settings as having experienced IPV (Family Violence Prevention Fund, 2004). This suggests that PCPs may be underestimating their ability to provide appropriate care for women exposed to IPV, or that dissemination of current guidelines is insufficient.

Moreover, some PCPs in this study suspected the prevalence rates of IPV in their rural communities were lower than rates in other communities. Since published data indicate that rural women experience at least as much (Breiding et al., 2009) if not greater (Peek-Asa et al., 2011) risk of IPV when compared to non-rural women, provider education should address IPV prevalence in rural communities to improve screening practices.

Strategies that empower PCPs to approach IPV screening and counseling in their practices through provider training are important but not sufficient. Competing time demands and scarce resources in rural communities remain significant barriers to optimizing IPV-related care. Thus, programs to improve provider training and counseling must be accompanied by systemic changes that reduce relative time constraints and improve referral resources for rural women exposed to IPV. Physicians inevitably must prioritize preventive healthcare service delivery, and are likely to prioritize more highly preventive services for which there are clear guidelines (Pollak et al., 2008), or for which they can be compensated. Since this data was collected, two important guidelines recommending IPV screening have been published by the Institute of Medicine (IOM, 2011) and the United States Preventive Services Task Force (USPSTF) (Moyer, 2013). These clear guidelines in favor of IPV screening are likely to increase awareness of the importance of offering this service, and thus lead PCPs to prioritize it more highly relative to competing demands. IPV identification and treatment in primary care settings will also likely increase as a consequence of the Patient Protection and Affordable Care Act (ACA) of 2010, as screening and counseling for domestic violence has been added as a primary preventive service that all private health plans must cover (Futures Without Violence, 2012).

These conclusions must be considered in light of several limitations. First, the population served by the PCPs in this study is largely low-income white, and the results may not extrapolate to rural areas with larger proportions of racial and ethnic minorities. Second, there were few obstetrician-gynecologists practicing in our target rural region, so the perspectives of that specialty may not have been optimally explored. Third, data on the patients served by these PCPs was not collected and thus the prevalence of IPV exposure in the participant patient panels cannot be confirmed. Fourth, this data reflects practices and opinions of 19 PCPs in one rural area and may not be generalizable to other rural areas.

Nevertheless, this study represents a significant contribution to the literature. This is the first study addressing the opinions and practices of rural PCPs regarding IPV in-depth. Thematic saturation speaks to the robustness of the study’s findings. Subsequent examination of the data in strata -- by the type of interview (in person versus telephone) and gender of the respondent -- did not reveal any systematic differences warranting further investigation, although the small sample was not designed to detect these differences.

This research suggests a number of avenues for improving the care of IPV-exposed women who present for care in rural primary care practices. First, physicians should be encouraged to provide routine screening for IPV exposure. There are a number of tools available to integrate routine screening into practice (Basile, Hertz, & Back, 2007). Routine screening is now a recommended clinical preventive service for reproductive aged women (IOM, 2011; Moyer, 2013) and is likely to increase the identification of IPV-exposed women needing treatment (Freund, Bak, & Blackhall, 1996). As one family practitioner succinctly stated, “If you don’t ask, they’re not gonna tell us.”

Second, recognizing the issues of privacy and stigmatization in rural communities, PCPs could be trained in ways to assure women of confidentiality, to ensure privacy of medical encounters, and to determine privacy of medical billing and referrals. Training in more pro-active counseling techniques could help PCPs overcome the perception that little can be done to help less educated or economically dependent women who may not have the resources to seek appropriate services. Incorporating IPV care into continuing education for physicians could help overcome the perception held by some PCPs that they are not providing guideline-concordant IPV-related care. Further, empowering physicians to recognize that much of the care that they are already providing for their patients who disclose IPV is appropriate, and that there can be positive health-related benefit to assessing for IPV in the healthcare setting (McCloskey et al., 2006), may overcome some of the physician related barriers to IPV care. Community-based education to inform women that IPV is not their fault, is a risk to their health, and that their PCP may be able to help could remove prominent barriers to addressing IPV in rural communities.

Future research should address strategies to support PCPs’ care of rural women, including screening for IPV and providing care for women identified as IPV victims. Because lack of economic empowerment was perceived to be an important barrier to rural women’s seeking help for IPV-related issues, future research might address rural women’s expectations and preferences for help within their communities. In addition, research could identify how the rural PCP practice could link patients to social services that address economic empowerment for rural women, including supports for child care, transportation, and housing (Raheim & Bolden, 1995). Research that addresses the seamless integration of social service supports into rural primary care is needed (Keefe, Geron, & Enguidanos, 2009) and could help to change policy to support greater integration. With these interventions, the rural primary care clinic could be well positioned to fill a void for rural women needing care for IPV.

Acknowledgments

The Rural Women’s Healthcare Project was funded by the Pennsylvania State University CTSI, grant number UL1RR033184. Dr. McCall-Hosenfeld’s work on the project described was supported by Award Number K12HD055882 (Penn State BIRCWH Program) from the Eunice Kennedy Shriver National Institute of Child Health and Human Development. Dr. Chuang was supported by K23 HD051634 from the *Eunice Kennedy Shriver* National Institute of Child Health and Human Development. The content is solely the responsibility of the authors and does not necessarily represent the official views of the Eunice Kennedy Shriver National Institute of Child Health and Human Development or the National Institutes of Health or the Clinical and Translational Sciences Institute of the Pennsylvania State University. The authors wish to thank Sara A. Baker, MSW, and Lara Rosenwasser, BA for their assistance with the Rural Women’s Healthcare Project.

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Appendix. Interview Guide for IPV Topics

Have you ever had a woman in your practice who disclosed to you that she had experienced intimate partner violence? (If no) Have you ever had a woman in your practice who you suspected was actively experiencing intimate partner violence? Can you tell me more about this?

Do you think that there should be a role for primary care providers in addressing intimate partner violence?

Do you think intimate partner violence is a health problem?

The estimates of lifetime and ongoing intimate partner violence arevariable and differ by community and practice setting. One community-based study showed that approximately 25% of all American women have experienced physical or sexual intimate partner violence at some time in their lives(Breiding et al., 2008b). Do you think that doctors in your community would be surprised by this statistic, or do you think that this accurately reflects what happens in your community? Does it surprise you?

One study in a primary care setting found that 16% of women reported intimate partner violence in their current or most recent relationship (Coker et al., 2000). Do you think that other doctors in your community would be surprised by this statistic, or do you think that this accurately reflects what you see in your practice?

Do you think there are barriers for women in your community seeking care for intimate partner violence?

Can you think of any other ways in which living in a rural area impacts the ability of women to seek or obtain care for intimate partner violence?

Table 1

Primary Care Physician (PCP) Characteristics, N=19

PCP Characteristic	%	N
Female	47%	9
Specialty		
Family Medicine	63%	12
Internal Medicine	27%	5
Obstetrics-Gynecology	5%	1
General Practitioner	5%	1
Rural Location	42%	8
Years in practice – median (range)	21	1–38

Table 2

Intimate Partner Violence: Major Themes and Subthemes Identified from PCP Interviews

Theme	**Subthemes**
Routine screening for IPV in clinical practice is not commonly performed	• There was no standardized interval for screening. • Some providers do not believe they should ask everyone about IPV. • Lack of time and competing priorities, inadequate training, and discomfort with IPV prevents screening. • PCPs were not convinced that screening for IPV would be helpful, due to a lack of effective resources for referral and follow-up.
Lack of consensus on the prevalence of IPV may contribute to practice variation in IPV management in rural primary care settings.	• Rural PCPs inaccurately estimated the prevalence of IPV in their clinical populations. • Rural PCPs perceive emotional abuse as more prevalent than physical abuse.
PCPs inquire about IPV when it is suspected, i.e., when “alarm” is raised	• Psychological distress and somatic symptoms are the most common presenting complaints among women with IPV. • IPV is suspected when partner control tactics are observed.
Rural PCPs use several appropriate counseling and referral techniques when addressing IPV among their patients	• Validation and providing information - reassuring the patient that she is believed, not alone and not to blame for abuse – are key features in rural IPV-related care provided by rural PCPs. • PCPs reported assessing for acute safety considerations and engaging in safety planning with their patients. • PCPs referred to local resources and worked to develop a follow-up plan for women.
Rural populations present unique challenges for women to receive care for IPV on multiple levels – the PCP, patient, and the community	• Acceptance of traditional gender roles prevents women in rural communities from seeking help for IPV. • Lack of privacy in small rural communities is an important barrier to accessing care for IPV. • Stigma and low self-esteem prevent rural women from accessing care for IPV. • Patients may not consider primary care as a place they can go for help with IPV. • Low socioeconomic status and financial dependence on the abuser in rural communities prevent women from receiving care for IPV. • PCPs believe that community-level interventions are needed to help rural women who have experienced IPV. • Lack of referral services to assist with the care of their patients who experienced IPV was an additional resource barrier for PCPs to address IPV with their patients. • Interaction with the criminal justice system presents a challenge for rural PCPs who have identified women exposed to IPV.