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Ramani N. Garimella

Stacey B. Plichta
Old Dominion University

Clare Houseman
Old Dominion University

Laurel Garzon
Old Dominion University

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How Physicians Feel about Assisting Female Victims of Intimate-partner Violence

Ramani N. Garimella, MD, PhD, Stacey B. Plichta, ScD, Clare Houseman, PhD, and Laurel Garzon, DNSc

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Abstract

Purpose. To assess the feelings of physicians about assisting female victims of intimate-partner violence (IPV), and to examine factors related to positive and negative feelings about assisting victims of IPV.

Method. In 1998, a total site sample of 150 physicians practicing in a large general hospital in the area of Virginia Beach, Virginia, was surveyed by questionnaire via the mail. Four specialties were represented: emergency medicine, family practice, obstetrics–gynecology, and psychiatry. The questionnaire asked about medical training and training in assisting victims of IPV. The physicians' feelings about working with victims of IPV were measured on a nine-item, five-point semantic differential scale.

Results. A total of 76 physicians responded to the questionnaire (response rate = 51%). Only a minority (11%) had overall positive feeling scores about assisting victims of IPV. While most physicians reported that it was "significant work," the great majority also felt that it was difficult, low-paying, and stressful. Training in assisting victims of IPV, in medical school or afterwards, did not appear to influence feelings about assisting victims of IPV. However, physicians who were white and who were married (the majority of the respondents) were significantly more likely than the other respondents to feel negatively about providing services to victims of IPV.

Conclusion. Graduate medical education and training programs need to address the association of negative feelings with helping women harmed by IPV, because these feelings may interfere with the appropriate screening, referral, and treatment of these victims.

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Despite strong recommendations by numerous health and governmental organizations to screen women for intimate-partner violence (IPV) in the health care setting, the great majority of physicians do not do so.[1] Health care professionals are frequently the first or only professionals from whom IPV victims seek help,[2] but the vast majority do not identify themselves as IPV victims to their health care providers. Without active screening, less than 10% of IPV victims are likely to be identified as such in the health care setting.[3,4] There has been much speculation as to why health care providers do not screen for IPV. A recent review of studies about provider-initiated screening indicated that barriers to screening (as perceived by providers) include a lack of effective interventions for IPV, fear of offending patients, and a lack of education for providers.[1] Studies also indicate that physicians' negative attitudes about victims of IPV may also play a role.[5–7] However, almost no research has been conducted to examine how physicians feel about the work of assisting victims of IPV, regardless of how they may feel about available resources or about the victims themselves.

Our study sought to measure physicians' feelings about assisting IPV victims. (Our study questionnaire used the term "spousal abuse" and focused on female victims of spousal abuse.) In particular, we examined the extent to which physicians find this work exciting, easy, significant, calm, high-paying, good, safe, pleasant, and satisfying (as opposed to boring, difficult, insignificant, angry, low-paying, bad, dangerous, unpleasant, and unsatisfying). We also examined the relationships of these feelings to the physicians' sociodemographic, training, and practice characteristics, IPV knowledge, and beliefs about the victims.

Dr. Garimella is assistant professor, Department of Health Science, San Jose State University, California. Dr. Plichta, Dr. Houseman, and Dr. Garzon are associate professors, College of Health Sciences, Old Dominion University, Norfolk, Virginia.

Correspondence and requests for reprints should be addressed to Dr. Plichta, School of Community Health and Physical Therapy, College of Health Sciences, Room 105, Spong Hall, Old Dominion University, Norfolk, VA 23529; telephone: (757) 683-4989; fax: (757) 683-4410; e-mail: ⟨splichta@odu.edu⟩.

Method

In 1998, we mailed a questionnaire to 150 physicians who practiced emergency medicine, family medicine, obstetrics–gynecology, and psychiatry, and who were associated with an urban general hospital in the area of Virginia Beach, Virginia. This hospital is one of two in an ethnically diverse city of approximately 425,000 people. The questionnaire contained a scaled measure of physicians' feelings about working with female victims of IPV constructed from a nine-item semantic differential scale. Specific scale items were based on findings from previously published qualitative research.[7–9] We developed these items, which were examined by an expert panel and pretested during the pilot phase of our study. Our scale had good internal consistency (Cronbach's alpha of .7353). In general, this type of scale has been shown to be a valid and reliable way to measure feelings and beliefs.[10]

The nine differential dimensions included: low-paying/high-paying, stressful/pleasant, difficult/easy, boring/exciting, risky/safe, angry/calm, bad/good, unsatisfying/satisfying, and insignificant/significant. For each of these dimensions, we asked the participants to rate, on a scale of 1 to 5, how they found working with IPV victims. For example, on the item risky/safe, physicians rated how safe they felt working with IPV victims (this item was based, in part, on reports of some physicians' being threatened by the IPV perpetrators). The score on each individual item was added up and divided by nine to get the mean score for "feelings." Note that higher scores indicated more positive feelings; physicians with scores of 3.5 or higher were defined as holding positive feelings about assisting IPV victims. Other variables in the questionnaire were sociodemographic measures, practice and training characteristics, knowledge about IPV, beliefs about victims of IPV, and personally knowing a victim of IPV.

Results

Overall, 76 physicians returned usable questionnaires (response rate = 51%). Thirty percent of the respondents were specialists in emergency medicine, 24% in family practice, 33% in obstetrics–gynecology, and 13% in psychiatry. Respondents were predominately male (72%), over age 35 (mean age = 43.72, SD = 7.99), white (90%), and married (88%). The respondents were generally representative of medical professionals in the region.

The physicians in our study did not have substantial training in assisting victims of IPV. While a majority (79%) had received some training during medical school, most reported only "a little" training, and none reported "a great deal" of training. Only a minority (20%) had obtained some type of postgraduate training (e.g., continuing medical education) about IPV. While 65% did hold positive and supportive beliefs about IPV victims, only 27% had scores of 80% or higher on the measure of knowledge (mean score = 68.7%, SD = 10.0%).

Only 11% of the physicians had overall positive feelings about working with IPV victims (see Table 1). The mean summary score for working with victims was 2.96 (SD = .48, range 1.75–4.50). The majority of physicians viewed working with IPV victims as low-paying, stressful, difficult, boring, risky, and angry. A slight majority, 54%, found working with victims to be more good and satisfying than bad and unsatisfying. A majority, 85%, did feel that the work was significant.

In a series of cross-tabulations, we explored the relationships between having positive feelings about assisting victims of IPV and the sociodemographic characteristics of the respondents (see Table 2). White physicians had significantly more negative feelings about assisting victims of IPV than did nonwhite physicians, and married physicians had significantly more negative feelings about working with victims of IPV than did nonmarried, divorced, or separated physicians. Gender and age were not significantly related to whether physicians had positive feelings about working with victims of IPV.

We found no significant relationship between the physicians' practices or

Table 1

Overall Score and Individual-dimension Mean Scores for 76 Physicians and the Percentages of Physicians with Positive Feelings about Assisting Victims of Intimate-partner Violence, Virginia Beach, Virginia, 1998

Individual Dimension	Score* Mean (SD)	% with Positive Feelings
Overall score	2.96 (.48)	11
Low paying—high paying	2.3 (.81)	4
Stressful—pleasant	2.1 (.78)	8
Difficult—easy	2.2 (.97)	13
Boring—exciting	3.2 (.57)	22
Risky—safe	2.9 (.84)	22
Angry—calm	3.0 (.85)	30
Bad—good	3.6 (.96)	54
Unsatisfying—satisfying	3.3 (.94)	54
Insignificant—significant	4.1 (.81)	85

*On a scale of 1 to 5.

Table 2

Sociodemographic Characteristics of 76 Physicians and the Percentage with Each Characteristic Who Had Positive Feelings about Assisting Victims of Intimate-partner Violence, Virginia Beach, Virginia, 1998

Sociodemographic Characteristic	No.	% with Positive Feelings
Sex		
Female	21	5
Male	55	13
Age		
≤35 years	14	7
>35 years	62	12
Race*		
White	68	6
Other	8	50
Marital status*		
Married	67	8
Other	9	30

*Difference significant at $p \leq .05$ by the chi-square test.

training characteristics or knowledge of IPV and whether they had positive beliefs about assisting IPV victims (see Table 3). Note, however, that the differences for specialty seemed to vary in magnitude (with family practitioners and emergency room physicians having lower levels of positive feelings).

Discussion

In general, people do best at work they enjoy and find rewarding, and try to avoid or minimize work they do not enjoy. If, as our results indicate, physicians feel negatively about working with victims of IPV, they may seek to minimize the time they spend providing screening and services to this high risk-group. Physicians who do choose to provide services to women harmed by IPV may risk "burning out," because studies have indicated that perceiving work as stressful may lead to burnout.[11]

There are numerous opportunities throughout their training and career paths to help physicians feel more positive about assisting IPV victims. Attempts to create more positive feelings should start in medical school, continue in postgraduate training programs, and be incorporated into hospital and health center policies. These attempts should build on the positive feelings that our results show a majority of physicians already have (such as feeling that assisting victims of IPV is significant). However, it is important to note that most IPV training strategies (undergraduate and postgraduate) do not address, and thus are unlikely to influence, physicians' feelings about the work and the victims of IPV. This may be because the majority of IPV training

Table 3

The Practice and Training Characteristics of 76 Physicians and the Percentage with Each Characteristic Who Had Positive Feelings about Assisting Victims of Intimate-partner Violence, Virginia Beach, Virginia, 1998*

Practice and Training Characteristic	No.	% with Positive Feelings
Specialty		
Emergency physicians	23	4
Family practitioners	18	6
Obstetricians–gynecologists	25	17
Psychiatrists	10	22
Years of experience		
≤10 years	22	9
>10 years	54	12
Work site		
Urban	26	22
Other	50	4
Course content in IPV		
None	16	0
Any	60	12
Postgraduate training in IPV		
No	61	9
Yes	14	14
Personally knows an IPV victim		
No	45	12
Yes	30	10
Knowledge of IPV		
Scored less than 80%	55	10
Scored 80% or higher	20	12
Beliefs about victims		
Holds negative beliefs about victims	23	8
Holds positive beliefs about victims	53	13

*None of the relationships was significant by chi-square test at $p \leq .05$.

programs are didactic in nature and do not attempt to engage the emotions of the physician. It may also be that the majority of programs do not address the negative aspects of working with victims of IPV, for instance, that it can be low-paying, stressful, and difficult. Strategies to change physicians' negative feelings need to be developed and tested. One recent study conducted in the primary care setting indicated that intensive training does show some promises of success.[12]

The two main limitations of our study are the small sample size and that we conducted it with physicians from only four specialties associated with a single hospital. A response rate of 51%, however, is not particularly low for the physician population, because physicians tend to be less responsive to survey materials than other health care providers. Another limitation is that we used a newly developed quantitative scale to measure physicians' feelings. The results of our study need to be confirmed with a larger, multisite study, and the reliability of the quantitative scale needs further testing. One strength of using our quantitative scale in larger studies would be that it would measure the feelings of a large number of physicians in a resource-efficient manner.

In conclusion, our study provides further evidence of what previous, more qualitative studies have indicated, that a major impediment to routine screening and referral may be physicians' negative feelings about the work of providing assistance to female victims of IPV. Research is needed to explore how physicians' feelings may influence behavior, to help physicians address their feelings about treating IPV victims, and to develop and test training strategies that might create more positive feelings as well as impart clinical knowledge.

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Books of Note

"BEYOND COMPLEMENTARY MEDICINE"

Over the last ten years complementary and alternative medicine (CAM) have rapidly become mainstream concepts in health care. This rise in use of unconventional medicine derives from globalization of medical information, increasing health education and involvement in decision making among the public, fear of side effects from drugs and surgery, and a rising interest in a holistic view of health. Since these forces behind the rise of CAM are long-term and substantial, it is likely that unconventional medicine will continue to grow.

How does medicine deal with concepts such as holism, spirit, consciousness, and vital energy in a world where disease has become scientific, physical, and reduced to its molecular and cellular foundations? A simplistic answer is to say that all medicine, conventional or unconventional, must be explored with universal standards of rigorous research. This requirement, however, results in the methods driving the mind rather than the mind using the method. Many CAM practices involve self-care approaches, healing rather than curing, produce only mild effects that are hard to measure, and venture into the subjective and spiritual side of disease. By explicitly addressing these more invisible aspects of complementary (and all) medicine, Mr. Cohen does what his title claims—he goes *Beyond Complementary Medicine* and in the process directly to the heart of our dilemma.[1]

The recently published three-armed, placebo-controlled trial of the herb St. John's wort is an example of our trying to fit a round peg (complex herbal mixtures with multiple, mildly active ingredients) into a square hole (the state-of-art drug study approach to determine "specific" efficacy).[2] When, as director of the Office of Alternative Medicine at the NIH, I initiated this study with the help of the NIMH and the FDA, we hoped that this would demonstrate our ability to test alternative medicines in a definitive way. The study took six years and six million dollars and ended up a "failed" study. Even the known active pharmaceutical arm (the positive-control group) did not do better than the placebo-control group. Using rigorous clinical trial methods to settle questions of the efficacy of alternative medicine treatments is much more difficult than we thought.

Indeed, executing the "definitive" clinical trial even with conventional medicine is becoming problematic. Witness the hugely expensive sets of studies on beta-carotene, hormone replacement therapy, arthroscopic surgery for arthritis, and bone marrow transplant—all thought to be proven therapies and all enthusiastically in use until large trials showed otherwise. Will we need a new "gold standard" for therapeutic acceptance that requires 10,000 subjects, all of whom are randomized? Can we afford such studies, and under what conditions is it worth such an investment? Certainly, treatments that are in wide public use and that pose significant risks must be studied for harm in large controlled trials. But what of low-risk practices, such as acupuncture, massage, homeopathy, mind–body methods, and spiritual healing. Certainly, false hopes, false responsibilities, and delay of effective treatments must be avoided, but do we need to know whether these practices have "specific" effects according to their latest pet theories?

Perhaps the criteria we use to accept these practices should be more pragmatic than scientific, more focused on their use in context rather than their alignment with theory or general application, and more appropriate to their risks than their efficacies. A serious effort on defining those standards of research and use of alternative medicine is needed.[3]

Mr. Cohen poses many of the hard questions that arise at the interfaces of different cultures, beliefs, and goals. Wisely, he rarely offers answers to these complex questions. Rather, he points out the consequences of applying legal and ethical principles to concepts and assumptions not usually discussed in conventional circles yet used and believed daily by the public. In doing so, he challenges us to take a self-critical look at our role in a global community, where science isn't king and the spirit emerges in relentless diversity. How we handle this diversity is the question of our time.

WAYNE B. JONAS, MD

Dr. Jonas is director of the Samueli Institute for Information Biology, Corona del Mar, California, and Alexandria, Virginia. He is former director of the Office of Alternative Medicine, National Institutes of Health.

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