Oral Health Care Providers' Knowledge and Attitudes About Intimate Partner Violence

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Abstract

Introduction: Given its high prevalence, intimate partner violence (IPV) is an important public health issue. Oral health care providers (OHCPs) often encounter victims of intimate partner abuse in dental settings, but there is a lack of existing literature regarding OHCPs' attitudes toward and knowledge of IPV.

Purpose: This study assessed OHCPs' knowledge and perception of preparedness in assessment and management for IPV.

Methods: Using a validated survey tool called PREMIS, this study assessed a convenience sample of OHCPs' knowledge and attitudes about the identification, assessment, and management of IPV.

Results: The survey results obtained from 117 OHCPs indicated 92% had had some form of IPV education, but 45% felt they did not have sufficient training to assist individuals who were victims of IPV. Other areas in which the respondents felt ill-prepared included identifying victims of IPV (61.5%) and appropriate referrals to social services (64%). Only 7 to 9% screen new patients or those with abuse indicators on the history or exam.

Conclusion: This study explored OHCPs' attitudes and knowledge of IPV and provided insight into IPV screening practices and management in dental care settings. Because injuries to the head, neck, and face are very common in IPV, OHCPs have the opportunity to play a key role in managing "the silent epidemic" of domestic violence by routinely including screening of new and returning patients and having a referral resources available.

Keywords: continuing education, risk assessment, special needs patients, women's health issues

This study supports the NDHRA priority area, **Clinical Dental Hygiene Care:** Investigate the links between oral and systemic health.

Introduction

Intimate Partner Violence (IPV) has long been a part of human history, but it was not until the 1960s that there was recognition in the United States of its prevalence, impact, and outcomes.[1,2] IPV is defined by the World Health Organization (WHO) as physical, sexual, or psychological harm by an intimate partner.[3]

A WHO systematic review examined data from 79 countries and found the global lifetime prevalence of IPV among women who had ever had an intimate partner was 30%.[4] In the United States, the Centers for Disease Control and Prevention's (CDC) National Intimate Partner and Sexual Violence Survey (NISVS) found approximately 31% of women experience a lifetime prevalence of physical violence by an intimate partner, and more than 20 people per minute become victims of IPV.[5] Women are not the only victims of IPV: the lifetime occurrence for men is 27.5%.[5] Based on the global and national prevalence, IPV is undeniably a serious and pervasive public health issue for both men and women.[4,5]

Health Effects of IPV

The health effects of IPV include sexually transmitted disease, HIV infection, miscarriage, low birthweight and premature babies, mental illness, substance use, nonfatal physical injuries, and fatal injuries (homicide).[6] In terms of mental illness, depression, generalized anxiety disorders, and posttraumatic stress disorder (PTSD) are significant comorbidities that may affect 50% of women who experience IPV.[4,7–10] Evidence is more limited about the association of IPV and eating disorders, but it appears 60% of women and 34% of men with eating disorders have a history of experiencing IPV.[11]

Nonfatal physical injuries associated with IPV include injury to the head, neck, and face.[12,13] One of the most common IPV injuries is to the head and neck region and ranges from 50 to 77% with most

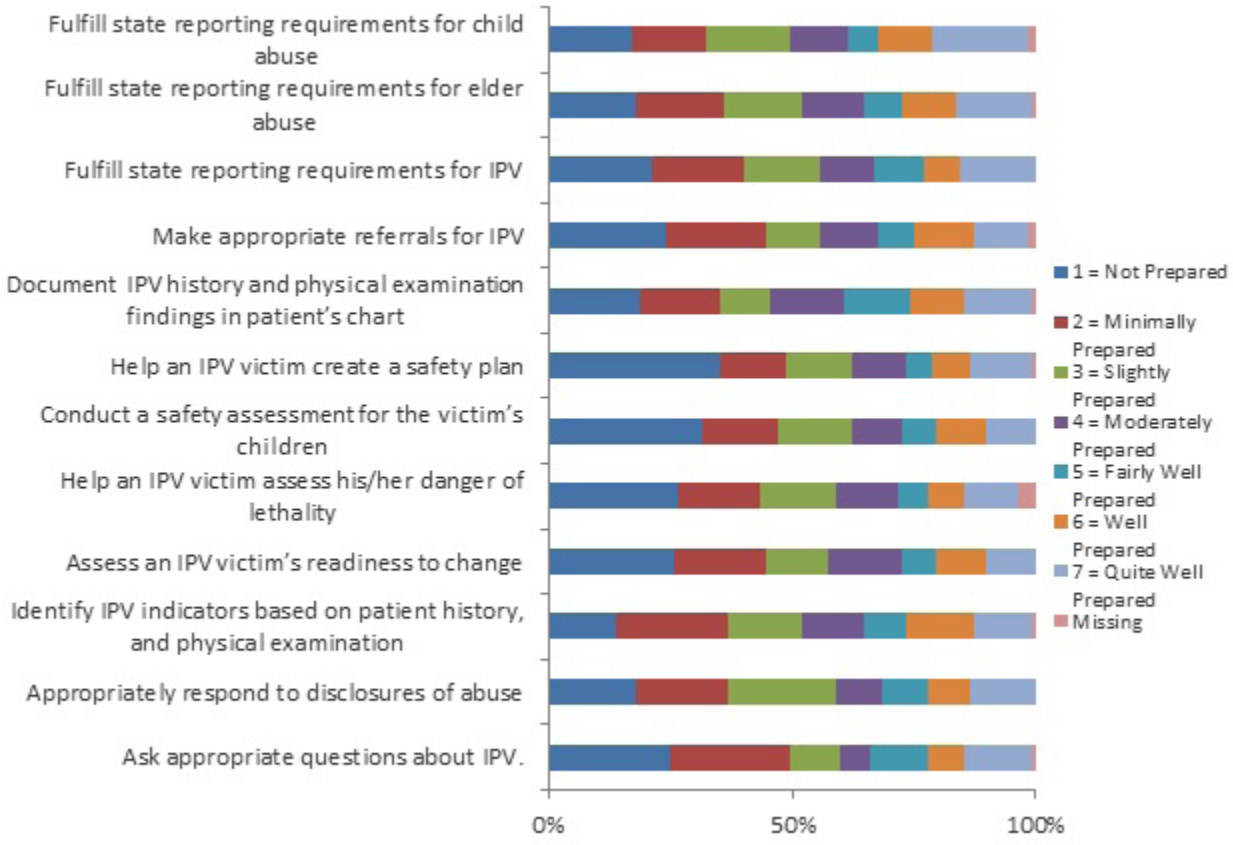
Table I: Demographics of Study Participants & Previous IPV Training

		Previous IPV Training			
	Total Survey Population (n=117)	Attended a lecture or talk (n=68)	Attended skill's based training or workshop (n=17)	Dental/ Nursing/ Other - Classroom training (n=17)	Dental/ Nursing/ Other - School training (n=6)
Gender					
Female, n (%)	93 (79%)	50 (74%)	13 (76%)	16 (94%)	5 (83%)
Male, n (%)	23 (20%)	17 (25%)	4 (24%)	1 (6%)	1 (17%)
Transgender, n (%)	1 (1%)	1 (1%)	0 (0%)	0 (0%)	0 (0%)
Age in years					
18-24, n (%)	5 (4%)	2 (3%)	1 (6%)	1 (6%)	0 (0%)
25-34, n (%)	23 (20%)	15 (22%)	3 (18%)	4 (24%)	2 (33%)
35-44, n (%)	25 (21%)	13 (19%)	4 (24%)	3 (18%)	2 (33%)
45-54, n (%)	33 (28%)	17 (25%)	4 (24%)	6 (35%)	2 (33%)
55-64, n (%)	25 (21%)	18 (26%)	4 (24%)	1 (6%)	0 (0%)
65-74, n (%)	5 (4%)	2 (3%)	1 (6%)	2 (12%)	0 (0%)
≥75, n (%)	1 (1%)	1 (1%)	0 (0%)	0 (0%)	0 (0%)
Education					
Associate degree, n (%)	40 (34%)	22 (32%)	6 (35%)	7 (41%)	2 (33%)
Bachelor degree, n (%)	42 (36%)	23 (34%)	6 (35%)	6 (35%)	4 (67%)
Graduate degree, n (%)	35 (30%)	23 (34%)	5 (29%)	4 (24%)	0 (0%)
Primary Field of Dental Practice					
General, n (%)	81 (69%)	46 (68%)	11 (65%)	10 (59%)	5 (83%)
Public Health, n (%)	16 (14%)	10 (15%)	5 (29%)	3 (18%)	1 (17%)
Pediatric, n (%)	4 (3%)	1 (1%)	0 (0%)	1 (6%)	0 (0%)
Orthodontist, n (%)	3 (3%)	3 (4%)	0 (0%)	0 (0%)	0 (0%)
Periodontist, n (%)	2 (2%)	1 (1%)	0 (0%)	1 (6%)	0 (0%)
Missing, n (%)	11 (9%)	7 (10%)	1 (6%)	2 (12%)	0 (0%)
Employment Status					
Employed - full time, n (%)	86 (74%)	50 (74%)	13 (76%)	11 (65%)	4 (67%)
Employed - part time, n (%)	29 (25%)	17 (25%)	4 (24%)	5 (29%)	2 (33%)
Not employed - looking for work, n (%)	2 (2%)	1 (1%)	0 (0%)	1 (6%)	0 (0%)
Census Region					
Northeast, n (%)	56 (48%)	30 (44%)	6 (35%)	9 (53%)	3 (50%)
South, n (%)	27 (23%)	17 (25%)	6 (35%)	5 (29%)	2 (33%)
Midwest, n (%)	8 (7%)	5 (7%)	0 (0%)	1 (6%)	1 (17%)
West, n (%)	26 (22%)	16 (24%)	5 (29%)	2 (12%)	0 (0%)
Years practicing dental hygiene or dentistry, mean (SD)	19 (11.68)	19.73 (11.83)	18.28 (9.61)	16.53 (12.33)	14.69 (5.89)
Total hours of previous IPV training, mean (SD)	6.66 (12.32)	6.45 (8.39)	11.13 (11.92)	10.07 (15.44)	12.17 (18.69)

injuries being in the upper third of the maxillofacial region.[12,13] Soft tissue injuries such as abrasions, lacerations, and bruising are seen in approximately 88% of reported cases related to IPV.[13] Recognition of nonfatal injuries as an aid in identifying IPV victims is essential to prevent homelessness and possible fatal injury (homicide).[13–15]

Research has shown many women leave their homes due to violence, and therefore IPV becomes a contributing factor to the beginning of homelessness among women.[14] Women who experienced IPV in the last year had almost 4 times the odds of housing instability as those who did not experience IPV.[15] However, for women who stay in an abusive relationship,

Figure 1. Perceived Preparation (How prepared are you to perform the following?)



there is a risk of escalation of the violence resulting in fatal injury.[12] Homicide by an intimate partner is a significant issue and impacts women 6 times more often than men, with a global prevalence of 38% for all women who have experienced IPV.[4,6]

IPV remains a major public health problem that has a significant social impact at the individual, family, and community level, and health care providers are central to screening and identifying individuals experiencing intimate partner violence.[4,16] The American Medical Association and American Dental Association encourage health care providers to recognize, treat, and respond to IPV.[17–18] Additionally, the American Dental Hygienists' Association (ADHA) Standards for Clinical Dental Hygiene Practice include risk assessment for domestic violence.[19]

Health Care Providers Knowledge, Attitudes, and Management of IPV

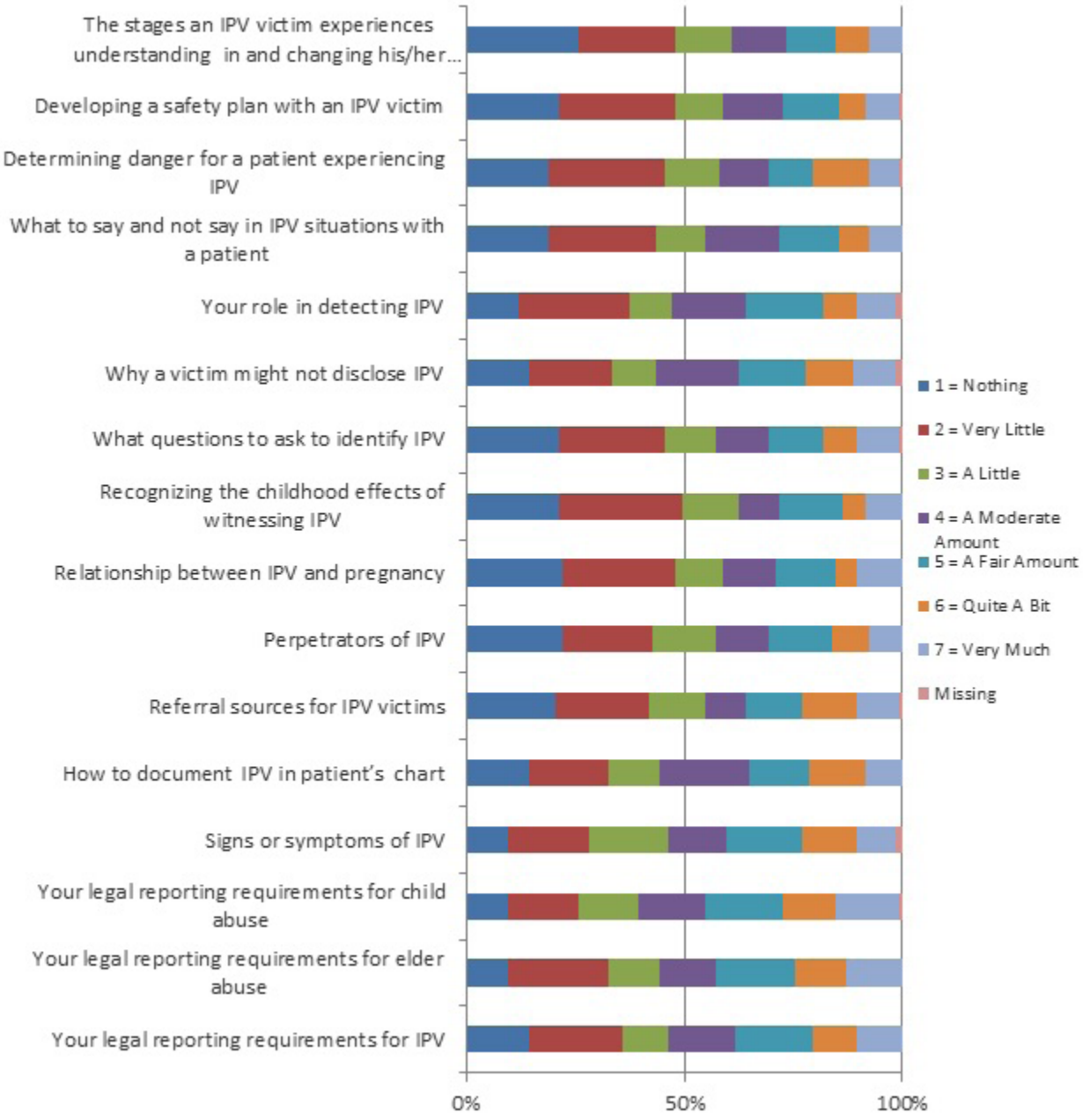
In many cases, health care providers do not recognize IPV.[20–23] Routine assessment for IPV by medical and dental professionals remains low,[20–23] yet the health care system is a necessary part of identification and management of IPV victims.[16]

OHCPs have a unique opportunity to identify and refer victims of IPV to support services because of the high prevalence of injury to the head, neck, and face.[12,13,24] Despite the important role OHCPs play in helping IPV victims, 50 to 87% never screen for IPV.[23,25,26] In the presence of head, neck, or facial injuries, 19 to 35% report not screening, and less than 50% refer patients to social services when IPV is suspected.[23,25] The percentage of providers screening and referring for services is remarkably a low number considering the national and global IPV prevalence rate.[4,5] However, 69% of IPV victims who saw an OHCP with signs of abuse reported that they would have liked the dental provider to ask about the injuries.[27] It is time for dental providers to get past their embarrassment and discomfort about addressing IPV head on.

The barriers OHCPs face in screening IPV victims have been identified as lack of training, concern about offending patient, embarrassment about bringing up the topic, patient accompanied by partner or children, and concern about legal issues.[23–26] Encouragingly, however, a recent survey found providers who received domestic violence education were more likely to have screened their patients ($p \leq 0.0001$) and more likely to take action when IPV was suspected ($p = 0.0006$).[23]

IPV research with OHCPs has consisted primarily of survey research with convenience sample sizes rang-

Figure 2. Perceived Knowledge (How much do you feel you know about the following?)



ing from 359 to 536 (response rates 68.5 to 90%), and one study using a random sample (n=321) with a 56% response rate.[25] Mascarenhas et al. conducted survey research that included dental hygienists.[23] A major limitation to the survey research in OHCPs to date is use of instruments for which internal validity and reliability were not clearly described and no Cronbach α or internal consistency was reported.[23,25,26]

Dental hygienists, who typically spend the most one-on-one time with a patient, are in an ideal position to address this issue and ensure victims of IPV get the help and support they need. This study seeks to explore dental hygienists' knowledge, attitudes, and readiness to manage IPV utilizing a survey instrument with good internal validity, reliability, and stable psychometric properties.[28] The findings will assist in planning future education related to IPV.

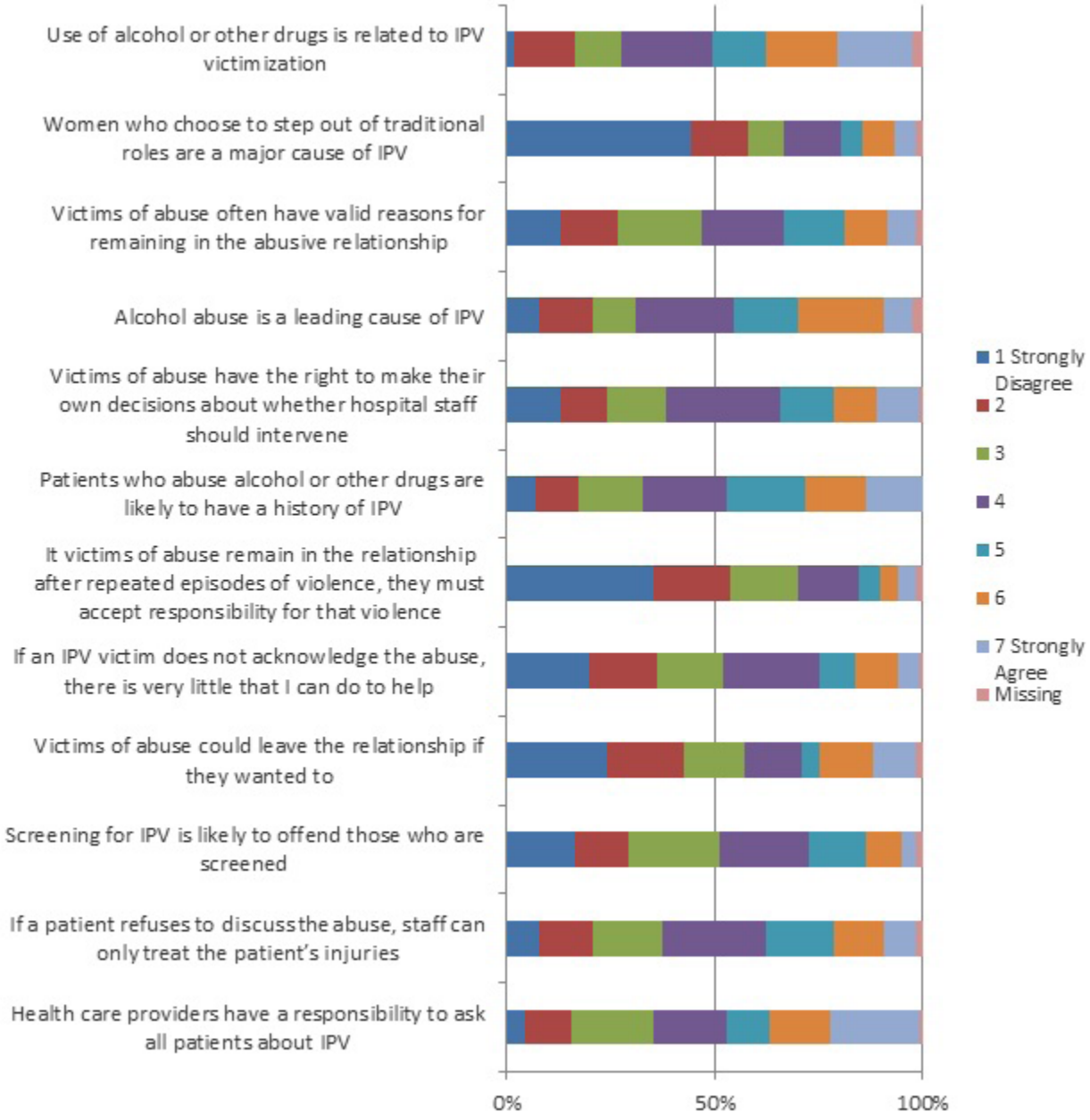
Methods and Materials

This cross-sectional, descriptive survey research was conducted using a web-based instrument with a convenience sample of dental hygienists. The study received approval from the university's institutional review board (IRB) (protocol #IRB060914H).

Description of Setting

Participants were recruited at the ADHA annual session in June 2014. The principal investigator used a table in the Exhibit Hall for the purposes of con-

Figure 3. Understanding Victims Experiencing Abuse



ducting this survey. The ADHA conference was selected to recruit a national sample of participants.

Research Participants

Inclusion criteria were currently practicing dental hygienists and dentists. Exclusion criteria consisted of individuals attending the conference who were not dental hygienists or dentists. Participants recruited were provided with a postcard with the URL for the web-based survey. All participants gave implied consent by completing the online survey.

Instrument

Permission was obtained, and the Physician Readiness to Manage Intimate Partner Violence (PREMIS) tool was modified to meet the purpose of this study. Modifications were limited to the respondent profiles to make them more applicable to dental providers. The survey questions consisted of 37 questions grouped into five major sections: (1) respondent profiles (11 items); (2) background (education or training) in IPV, perceived knowledge, and perceived preparation to manage IPV (4 items with multiple parts); (3) actual knowledge of IPV (8 items); (4) IPV opinions concerning attitudes and beliefs (1 item with multiple parts); and (5) practice issues dealing with behaviors and office practice policies (13 items).

Construct Validity. The original PREMIS instrument was developed in conjunction with expert reviewers.[28] Construct validity is based on the ability of a tool to measure what it claims to measure. The

Table II: Clinicians' Actual Knowledge

	% answering correctly
	(n=117)
Warning signs that a patient may have been abused by his/her partner:	
Chronic unexplained pain	67 (57%)
Anxiety	70 (60%)
Substance abuse	67 (57%)
Frequent injuries	95 (81%)
Depression	79 (68%)
An IPV victim may not be able to leave a violent relationship because:	
Fear of retribution	91 (78%)
Financial dependence on the perpetrator	97 (83%)
Religious beliefs	71 (61%)
Children's needs	85 (73%)
Love for one's partner	79 (68%)
Isolation	71 (61%)
Most appropriate ways to ask about IPV:	
"Are you a victim of intimate partner violence?" (is not appropriate)	23 (20%)
"Has your partner ever hurt or threatened you?" (is appropriate)	74 (63%)
"Have you ever been afraid of your partner?" (is appropriate)	79 (68%)
"Has your partner ever hit or hurt you?" (is appropriate)	53 (45%)
The following are generally true:	
There are common, non-injury presentations of abused patients	61 (52%)
There are behavioral patterns in couples that may indicate IPV	86 (74%)
Specific areas of the body are most often targeted in IPV cases	77 (66%)
There are common injury patterns associated with IPV	72 (62%)
Injuries in different stages of recovery may indicate abuse	74 (63%)

construct validity for PREMIS was based on the ability to measure attitudes, knowledge, and attitudes that contribute to health care providers responding effectively to victims of IPV. A final measure of construct validity for PREMIS was the extent to which knowledge, attitudes, and training predicted self-reported behaviors.[28]

Reliability. The PREMIS tool demonstrated good internal consistency among the items with a Cronbach's $\alpha > 0.963$.[28] The tool has good stability in psychometric properties and a good correlation with the measured office practices of IPV.[28] In addition, the correlation among the survey items relate to the OHCPs' opinions about the adequacy of previous training, attitudes and knowledge of IPV.[28] The survey instrument also helps determine awareness of IPV.[28]

Statistical Analysis

All data obtained was entered into Microsoft Excel spreadsheets and imported into STATA 11.2 software for statistical/data analysis. Descriptive statistics was used for the respondent profiles and survey questions.

Results

One hundred thirty-three participants met the study inclusion criteria and were given and submitted the survey. To account for large amounts of unanswered questions by participants, responses for participants who left one or more of the 5 major sections in the survey instrument entirely unanswered were excluded from the analysis. Following this exclusion for missing data, a total of 117 participants were included in the analysis. The participants were primarily 25 to 64 years of age, and predominately female (79%) with 20% male and 1% transgender (Table I). The most common specialties in the primary field of dental practice included general dentistry (69%), periodontal practice (2%), public health (14%), pediatric (3%), and orthodontics (3%). The respondents had a mean of 19 years in practice.

Table II (cont.): Clinicians' Actual Knowledge

Stages of Change:	
Begins making plans for leaving the abusive partner is "preparation"	58 (50%)
Denies there's a problem is "pre-contemplation"	86 (74%)
Begins thinking the abuse is not their own fault is "contemplation"	60 (51%)
Continues changing behaviors is "maintenance"	32 (27%)
Obtains order(s) for protection is "action"	70 (60%)
The following statements are false:	
Alcohol consumption is greatest single predictor of the likelihood of domestic violence	48 (41%)
Reasons for concern about domestic violence should not be included in a woman's medical record if he/she does not disclose the violence	71 (61%)
Being supportive of the person's choice to remain in a violent relationship would condone the abuse	49 (42%)
Strangulation injuries are rare in cases of domestic violence	70 (60%)
Allowing partners or friends to be present during the consultation of a person who had experienced domestic violence ensures their safety	69 (59%)
The following statements are true:	
There are good reasons for not leaving an abusive relationship	54 (46%)
Persons who have experienced domestic violence are able to make appropriate choices about how to handle their situation	14 (12%)
Clinicians should not pressure IPV patients to acknowledge that they are living in an abusive relationship	61 (52%)
Persons who have experienced domestic violence are at greater risk of injury when the leave the relationship	55 (47%)
Even if the child is not in immediate danger, clinicians have a duty of care to consider an instance of a child witnessing domestic violence in terms of child protection	85 (73%)

Previous Intimate Partner Violence Training

Of those participants who provided information on their previous IPV training, 58% attended some form of lecture or talk about IPV training, 14.5% attended a skill-based training or workshop, 14.5% attended other classroom training, 5% attended school-clinical setting training, and 8% received no previous training. The mean number of training hours was ≤6.66 hours (Table I).

Perceived Preparation for Managing Intimate Partner Violence

In the questions related to Perceived Preparation, 50 to 63% of participants felt slightly, minimally, or not prepared except in relation to documenting IPV history or physical examination findings in the patient chart (45%) (Figure 1). The items with the highest percentages of participants feeling slightly, minimally, or not prepared were creating a safety plan and conducting a safety assessment (62.4%). Fifty-nine percent felt slightly, minimally, or not prepared to respond to a disclosure of abuse. For the second question related to Perceived Knowledge 44 to 62% reporting knowing a little, very little, or nothing about each of the items with the exception of legal requirements for reporting child abuse (39%) (Figure 2). Approximately 14 to 27% of respondents reported knowing quite a bit or very much about the items. The items participants felt most knowledgeable about were the legal reporting requirements for IPV (20.5%), child (26.5%), and elder abuse (24.7%); how to document IPV in a patient's chart (21.4%); determining danger for a patient experiencing IPV (19.7%); why a victim might not disclose IPV (20.5%); and signs and symptoms of IPV (21.4%).

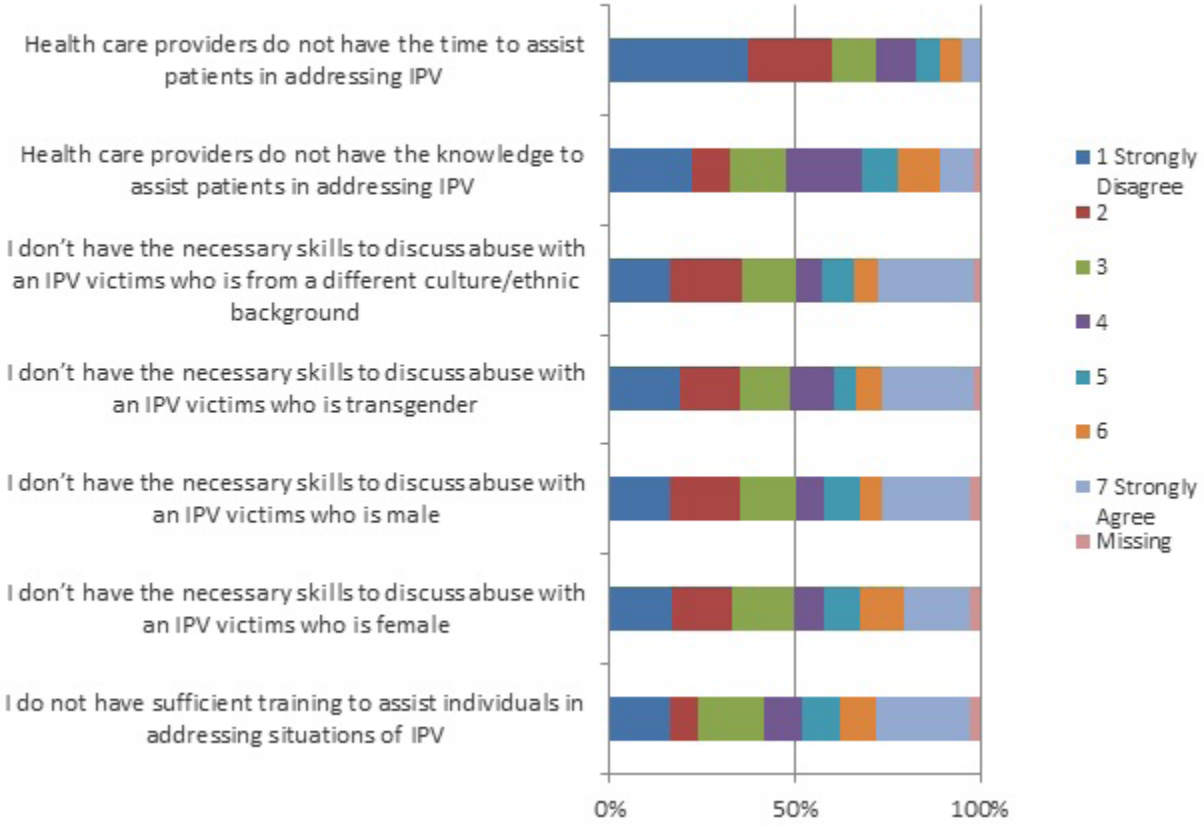
Actual Knowledge of Intimate Partner Violence

The Actual Knowledge was scored based on correct responses. Fifty to 83% of respondents answered correctly for a majority of items (Table II). The items the respondents answered correctly least often included persons who have experienced domestic violence are able to make appropriate choices about how to handle their situation (12%) and the most appropriate way to ask about IPV: are you a victim of intimate partner violence? (20%).

Opinions

The opinion scale represented the OHCP's attitudes and beliefs about IPV.

Figure 4. Self-Preparation



Understanding Victims Experiencing Abuse. Results showed participants had a fairly good understanding of IPV victims with the exception of relationship of drug and alcohol abuse to IPV (30.8 to 32.5%) (Figure 3).

Self-Preparation. Fifty percent or more of respondents somewhat disagreed, disagreed, or strongly disagreed that health care providers didn't have the skills and knowledge to address IPV with all items except the last one (Figure 4). More than 45% somewhat agreed, agreed, or strongly agreed with the statement: I do not have sufficient training to assist individuals in addressing situations of IPV.

Self-Efficacy. Respondents were evenly divided in their response to the items related to self-efficacy (Figure 5). The items that respondents more strongly disagreed, disagreed, or somewhat disagreed with included the following: I am too busy to participate on a multidisciplinary team that manages IPV cases (70.9%); I ask all new patients about abuse in their relationships (76%); I am capable of identifying IPV without asking my patient about it (57.3%); and I can recognize victims of IPV by the way they behave (62.4%).

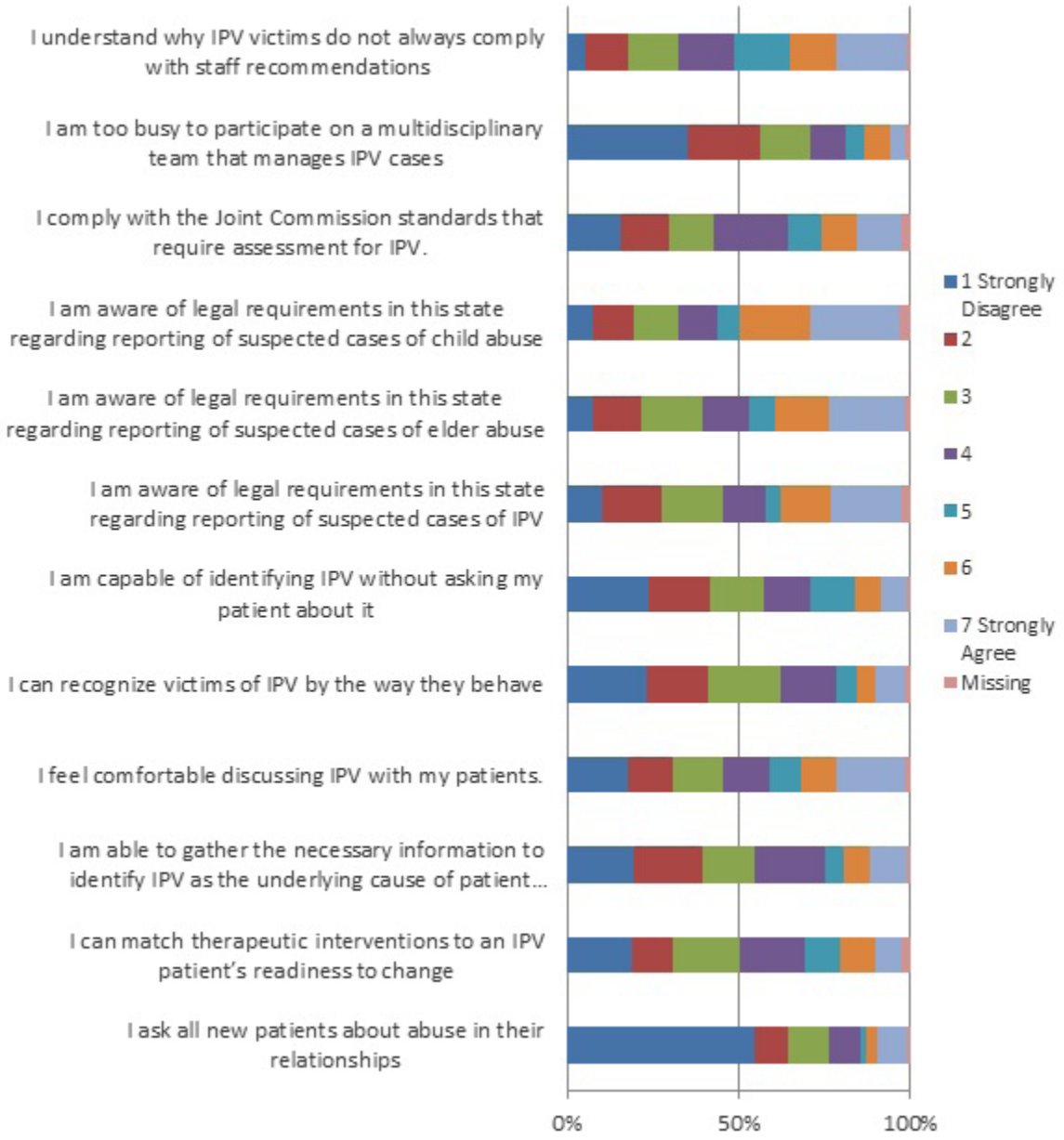
Workplace Issues. Approximately 50% of respondents strongly disagreed, disagreed, or somewhat disagreed with all but 2 items related to workplace issues (Figure 6). The responses were evenly divided between agreed and disagreed with the statement: my practice setting allows me adequate time to respond to victim of IPV. Fifty percent disagreed with the item: I can make appropriate referrals to services within the community for IPV victims, and another 64% disagreed with the statement: I have contacted services within the community to establish referrals for IPV victims.

Practice Issues

Clinical Management. A majority of respondents (89%) reported not identifying IPV in the last 6 months, but only 7% screen all new patients, and 9% screen patients when abuse indictors on history or exam are noted (Table III). When IPV had been identified, 14% reported referring the patient to a local domestic violence/IPV hotline, and 21% provided information to the patient.

General Practice Resources. Nineteen percent of practices reported having a protocol for dealing with adult IPV, 46% reported no protocol, and another 18% were unsure or felt it is not applicable to their patient population. See Table IV for the results of resources available for victims of IPV in practice settings.

Figure 5. Self-Efficacy



Discussion

In this study, 92% of participants reported attending some form of IPV education or training as compared to Love et al., who found over 70% of dentists had not received any education related to domestic violence.[25] In this study, the average IPV education or training was just over 6.5 hours for participants, which is twice as much as that reported by Ramsey et al. among primary health care providers in the UK.[29] Other literature has reported on whether health care providers have had training, but most did not gather information on the number of hours OHCPs had received regarding IPV education or training.[23,25,26,30]

IPV Knowledge. In this study, 50 to 83% of respondents had correct responses, and the survey identified areas for improvement to help identify individuals who are at risk or victims of IPV. This is lower than seen in studies with other health care providers, which is of concern given that 60 to 77% of IPV injuries are to the head and neck area and OHCPs acknowledge a role in reducing the prevalence of IPV.[23,25,26,31,32]

Preparation. The areas where OHCPs feel most prepared to manage IPV was documenting it in patient charts and requirements for legal reporting, which is consistent with research found in other health care professions.[23,25,30]

Table III: Practice Issues: Clinical Management

	(n=117)
How many new IPV diagnoses have you made in the last 6 months	
None	81 (69%)
1-5	21 (18%)
6-10	6 (5%)
11-20	5 (4%)
≥21	1 (1%)
Not in Clinical Practice	3 (3%)
What patient groups are screened for IPV?	
All new patients	8 (7%)
All new female patients	4 (3%)
All patients with abuse indicators on history or exam	11 (9%)
All female patients at the time of their annual exam	0 (0%)
All pregnant patients at specific times of their pregnancy	1 (1%)
All patients periodically	10 (9%)
Certain patient categories:	0 (0%)
Teenagers	0 (0%)
Young adult women (under 30 years old)	0 (0%)
Elderly women (over 65 years old)	2 (2%)
Single or divorced women	1 (1%)
Married women	0 (0%)
Women with alcohol or other substance abuse issues	1 (1%)
Single mothers	1 (1%)
Black or Hispanic Women	1 (1%)
Immigrant women	1 (1%)
Homosexual men	0 (0%)

Opinion, Attitudes, and Beliefs about IPV. Lack of training was reported as a barrier by 45% of respondents in this study, which is lower than seen in other studies. Love et al. reported 61% of dentists would like more IPV training, and similarly Mascarenhas et al. reported 82%, which may be related to the high percentage of respondents in this study who had previous IPV training or education.[23,25] Workplace issues noted in this study were consistent with other research and included: lack of time, lack of training to screen for or identify IPV, and ability to make appropriate referral to community services for IPV.[23,25,26,29,30]

Clinical Management. The literature on screening for IPV has shown 50 to 87% never screen for IPV, which is consistent with the findings in this study where 93% do not screen new patients.[23,25,26,29] In the presence of head, neck, or facial injuries, 19 to 40% report not screening in the literature, while this study found only 9% screened in the presence of abuse indicators. [23,25,26,30] IPV research has found less than 50% of health care providers and OHCPs refer patients to social services when IPV is suspected, and this study found 28% refer to IPV hotlines, battered women's shelters, and other local and national domestic violence resources.[23,25,30] The percentage of providers screening and referring for services is a low number considering the national prevalence of IPV.[4,5] However, 69% of victims of IPV reported that they would have liked the dental provider to ask about the visible injuries.[27]

Implications for Research and Practice

This study highlights the areas of inadequate OHCP knowledge and preparation for responding to the needs of women and men experiencing IPV. In particular, enhancing OHCPs knowledge of IPV along with protocols for screening and referral to domestic violence services could make a significant impact on this major public health issue.[23] Preliminary research was done by Hsieh et al. in 2006 using an interactive multimedia tutorial on domestic violence with a focus on Asking, Validating, Documenting, and Referring (AVDR), but little follow up or implementation of this model has occurred in the dental professions.[26,31]

Table III (cont.): Practice Issues: Clinical Management

Lesbian women	0 (0%)
Depressed/suicidal women	6 (5%)
Pregnancy women	0 (0%)
Mothers of all my pediatric patients	0 (0%)
Mothers of pediatric patients who show signs of witnessing IPV	0 (0%)
Mothers of children with confirmed or suspected child abuse	3 (3%)
Do not currently screen	49 (42%)
N/A	14 (12%)
When IPV has been identified, what actions have you taken over the past 6 months	
Provided information	24 (21%)
Counseled patient about options she/he may have	16 (14%)
Conducted a safety assessment for the patient	14 (12%)
Conducted a safety assessment for the victim's children	13 (11%)
Helped the patient develop a personal safety plan	6 (5%)
Referred the patient to individual therapy	11 (9%)
Referred the patient to alcohol/substance abuse counseling	6 (5%)
Referred the patient to local domestic violence/IPV hotline	16 (14%)
Referred the patient to Child Protective Services	9 (8%)
Referred the patient to national domestic violence / IPV hotlines	6 (5%)
Referred the patient to religious leaders/organizations	3 (3%)
Referred the patient to LGBT	4 (3%)
Referred the patient to battered women's program/shelter group	10 (9%)
Referred the patient to police, sheriff, or other local law enforcement	9 (8%)
Referred the patient to housing, education, job or financial assistance	5 (4%)
Have not identified IPV in past 6 months	88 (75%)

Strengths and Limitations

The strengths of this cross-sectional survey included the use of a validated questionnaire to explore the knowledge, attitudes, and practices of OHCPs in relationship to intimate partner violence with a national sample of OHCPs. However, a limitation of this study is the lack of correlation with actual IPV clinical practices since self-reporting may introduce bias. Another limitation was the use of a convenience sample, which limits generalizability even though the survey did include a national sample of OHCPs. A further limitation of the study was the length of the modified PREMIS tool that specified it would take about 15 minutes to complete; however, respondents reported that it actually took 30 minutes to complete the survey. This may have caused the missing or incomplete answering of items found within the survey.

Conclusion

This study explored OHCPs' attitudes and knowledge of IPV, and provided insight into IPV screening practices and management in dental care settings. A much higher percentage of participants in this study reported some education or training in IPV than in previous IPV literature; however, nearly half still felt they were inadequately prepared to assist victims of IPV.[25,30] Knowledge about identifying victims of IPV needs improvement as well as a defined office screening protocol for IPV. The other major barrier that must be addressed includes resource and referral information to provide to individuals who are identified as victims of IPV. OHCPs who do not let embarrassment or discomfort be a barrier in professionally addressing the issue have the opportunity to play a pivotal role in managing the "silent epidemic" of IPV.

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Figure 6. Workplace Issues

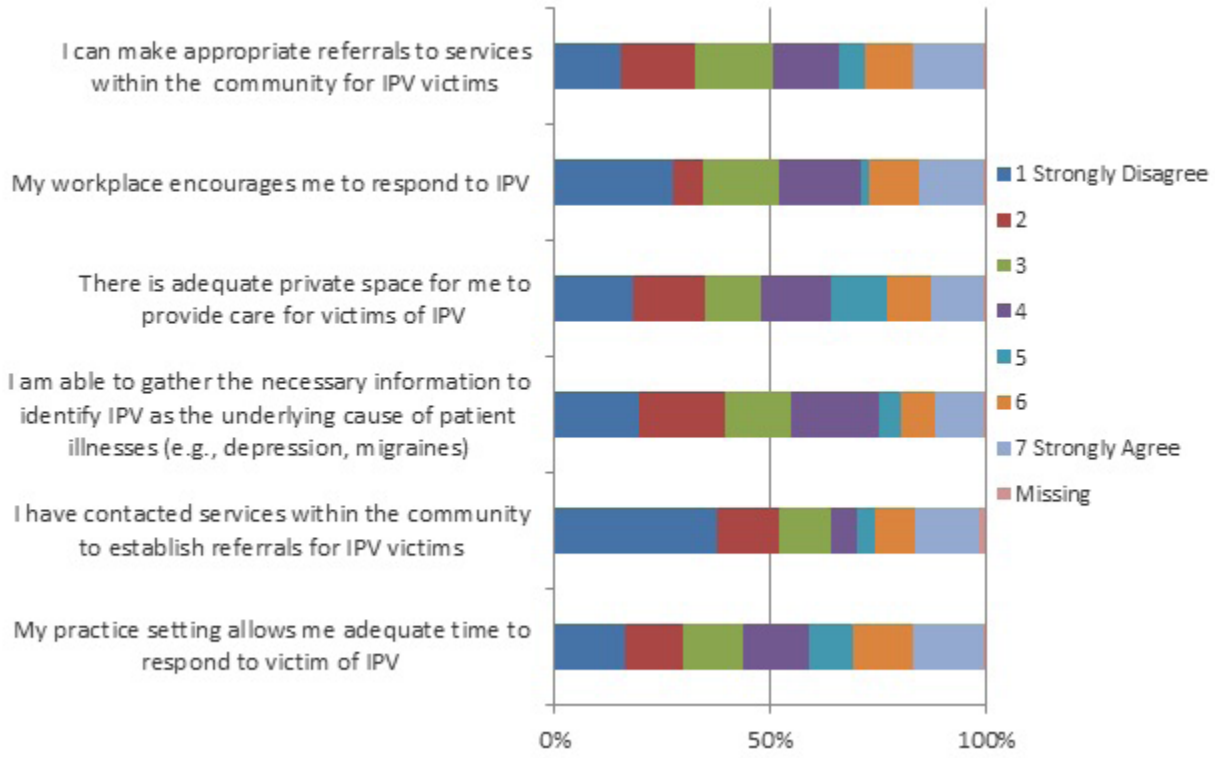

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Table IV: Practice Issues: General Practice Resources

	% answering correctly (n=117)
Is there a protocol for dealing with adult IPV at your Practice/Clinic?	
Yes, and widely used	22 (19%)
Yes, and used to some extent	14 (12%)
Yes, but not used	5 (4%)
No	54 (46%)
Unsure	14 (12%)
Not applicable to my patient population	3 (3%)
Not currently in practice	4 (3%)
Missing	1 (1%)
Is there a camera available at your work site photographing IPV victims' injuries?	
Yes	68 (58%)
No	27 (23%)
Unsure	16 (14%)
Not applicable to my patient population	1 (1%)
Not currently in practice	3 (3%)
Missing	2 (2%)
Do you provide abused patients with IPV patient education or resource materials?	
Yes, almost always	24 (21%)
Yes, when it is safe for the patient	17 (15%)
Yes, but only upon request	19 (16%)
No, due to inadequate referral resources in the community	17 (15%)
No, because, I do not feel these materials are useful	6 (5%)
Not applicable to my patient population	29 (25%)
Missing	5 (4%)
Do you have adequate adult IPV referral resources for patients at your work site?	
Yes	43 (37%)
No	52 (44%)
Unsure	15 (13%)
Not currently in practice	4 (3%)
Not applicable to my patient population	3 (3%)

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