Intimate partner violence screening in the dental setting
Results of a nationally representative survey

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ABSTRACT

Background. The dental setting is a potential venue for identifying patients experiencing intimate partner violence (IPV). The study objective was to assess dentists’ current practices and attitudes about IPV screening.

Methods. A nationally representative survey of US general dentists assessed dentists’ use of health history forms that queried about IPV and their acceptance of IPV screening as part of their professional roles. Parsimonious Poisson regression models were used in multivariable analysis to estimate risk ratios for the 2 dependent variables.

Results. Almost all dentists did not include a question to screen for IPV on their patient history forms. More than one-half of dentists also did not know of a referral place for patients experiencing IPV and did not believe that IPV screening should be part of their professional roles.

Conclusions. Uptake of IPV screening and favorable attitudes toward screening were low among dentists studied. However, prior IPV training and clinical knowledge plus awareness of IPV referral mechanisms were positively associated with greater screening uptake and attitudes.

Practical Implications. The inclusion of brief, focused IPV interventions in dental education and the establishment of collaborations between dentists and IPV agencies for referral mechanisms, in conjunction with an overall shift in dentists’ attitudes about their professional responsibilities, may facilitate IPV screening uptake in the dental setting.

Key Words. Intimate partner violence; oral health; screening.

This article has an accompanying online continuing education activity available at: http://jada.ada.org/ce/home.
Common specific orofacial signs of abuse that can be identified through a dental examination include bruising of the neck and palate, bite marks, tearing of the labial frenum or mucosal lining, lacerations, nonvital or discolored teeth, traumatic tooth or jaw fractures, pathologic process that is not consistent with the self-reported cause, and multiple injuries that are in different healing stages. \textsuperscript{13-15} Potential behavioral indicators of abuse that are relevant to the dental setting include dental neglect, failure to attend appointments for required treatments because of activity restrictions enforced by the perpetrator, unnecessary partner attendance at appointments, patient reluctance to speak in the presence of the partner, and anxious, fearful, or depressed behavior. \textsuperscript{13,14,16}

Research has found that dental professionals have sometimes failed to recognize signs of abuse or failed to report suspected cases out of concern for patient alienation and retaliation lawsuits from family members.\textsuperscript{15,17} The results of a 2009 survey of women residing in violence shelters in north Texas found that more than one-half had seen a dentist when physical signs of their abuse were visible, which consisted of high percentages of lip, facial, and neck injuries (29%, 25%, and 14%, respectively) and broken teeth (15%). Although just more than 13% of these women reported that a dental staff member actually inquired about their injuries, more than two-thirds indicated that they would have appreciated being asked.\textsuperscript{18} A national survey of dentists conducted in 1997 through 1998 found that most dentists did not screen returning or new patients (85% and 87%, respectively) for IPV, and almost one-fifth did not screen patients even in the presence of multiple visible injuries.\textsuperscript{19} Barriers to such screening included lack of training, concern about patient responses, lack of a referral mechanism, and attitudes that such screening was not of their professional concern.

To better understand how dentists perceive their roles in addressing the IPV epidemic, we conducted a nationally representative survey of dentists and asked

- if they were using a health history form that inquires about family violence or IPV;
- if they had a referral source to which they could refer patients experiencing abuse;
- if they agreed that screening for IPV should be part of their role as a health care professional;
- if they had any prior training about IPV;
- if they perceived clinical knowledge about IPV;

**METHODS**

The methods of this study were described previously.\textsuperscript{20,21} The institutional review boards of the University of Miami, Columbia University, and University of Chicago approved the study. We conducted a nationally representative survey of US dentists with the use of the American Dental Association (ADA) Survey Center sampling frame. A random sample was drawn, stratified by urbanicity and by practice type, specifically oversampling 80% of the 383 dentists who identified as being a public health dentist. This specific subset of the dental workforce was oversampled because public health and community-based dentists have been identified by the CDC and National Association of Community Health Centers as more amenable to nontraditional screenings than private practitioners.\textsuperscript{22,23} The survey was distributed and monitored for participation by the University of Chicago’s National Opinion Research Center, which used multiple forms of contact (for example, prenotification letters, multiple mailings of the instrument, and repeated email and fax and telephone reminders) to achieve a high response rate over the study period (November 2010 through November 2011). All elements of informed consent were described in the cover letter, and survey participation implied consent. Dentists were given the option of completing the survey electronically or on paper and received monetary remuneration in the initial mailing ($10) and on completion ($20 for initial responders, and bonus incentives of $50 to $100 over time to increase incentive for long-term nonresponders).

The survey instrument consisted of 38 questions that queried dentists about their attitudes, practices, and willingness to conduct specific kinds of medical preventive screenings, including IPV. Additional information was collected about dentists’ demographic, practice, and patient characteristics and about knowledge and education in the specified areas of preventive health care. For the present analysis, the 2 main outcomes of interest were

- whether dentists agreed that screening for family violence or IPV should be part of the dental professional role, using a 4-point Likert scale ranging from “strongly disagree” to “strongly agree” that was later dichotomized for analysis to “agree” or “disagree”;

**ABBREVIATION KEY**

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Definition</th>
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<tbody>
<tr>
<td>ADA</td>
<td>American Dental Association.</td>
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<td>CDC</td>
<td>Centers for Disease Control and Prevention.</td>
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<td>HIV</td>
<td>Human immunodeficiency virus.</td>
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<td>IPV</td>
<td>Intimate partner violence.</td>
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دریافت فوری متن کامل مقاله

امکان دانلود نسخه تمام متن مقالات انگلیسی
امکان دانلود نسخه ترجمه شده مقالات
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