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Intimate partner violence screening in the dental setting

Results of a nationally representative survey

Carrigan L. Parish, DMD; Margaret R. Pereyra, DrPH; Stephen N. Abel, DDS, MSD; Karolynn Siegel, PhD; Harold A. Pollack, PhD; Lisa R. Metsch, PhD

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.

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Intimate partner violence (IPV) has been identified by the Centers for Disease Control and Prevention (CDC) as a serious and preventable public health issue, affecting millions of people in the United States.[1] According to the CDC's National Intimate Partner and Sexual Violence Survey 2010 Summary Report, approximately 10 million men and women in the United States are subject to physical abuse by an intimate partner each year (1 in 3 women and 1 in 4 men report being subject to some form of physical violence by an intimate partner in their lifetimes).[2] Data from the National Crime Victimization Survey published in 2014 documented that more than one-fifth of all violent crimes were due to violence committed by family or intimate partners.[3] Furthermore, although almost one-half of such episodes inflicted injury, only 34% of people injured by an intimate partner sought medical attention. Research suggests that medical health care professionals who frequently encounter patients experiencing IPV, including emergency department physicians, obstetricians, and primary care physicians, do not routinely screen for such incidents, even when treating an afflicted patient's injuries.[4-8] Compared with other risk assessments, namely those for alcohol, tobacco, and drug use, screening for IPV has been found to be the least common and most difficult practice among primary and prenatal care providers because of discomfort, lack of resources, and, among male providers, a perceived sex preference that patients are more comfortable discussing IPV with female providers.[9,10]

The dental setting has been recognized as an important venue for identifying people who are survivors of IPV,[11] given that the most common locations of injury are the face and head.[12]

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.[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.[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.[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.[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.[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;
- whether 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;
- their perceived clinical knowledge about IPV.

METHODS

The methods of this study were described previously.[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.[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

ADA: American Dental Association.
CDC: Centers for Disease Control and Prevention.
HIV: Human immunodeficiency virus.
IPV: intimate partner violence.