"IT'S ALL IN THE HOW": ADOLESCENT AND YOUNG ADULT WOMEN'S RECOMMENDATIONS FOR ESTABLISHING COMFORT WITHIN FAMILY PLANNING PROVIDERS' COMMUNICATION ABOUT AND ASSESSMENT FOR INTIMATE PARTNER VIOLENCE

by

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ABSTRACT

Context and Public Health Importance: Intimate partner violence (IPV) is a serious public health problem that disproportionately affects adolescent women seeking family planning services compared to general population estimates. Current clinical guidelines recommend routine assessment to identify and respond to IPV to prevent and attend to the negative health outcomes that are caused by violence victimization. There are gaps in the literature on how providers should communicate with their patients about sensitive issues like IPV and how to establish comfort for their patients. **Methods**: Clinic staff at 5 western Pennsylvania family planning clinics received communication skill-based and knowledge-based training as part of an exploratory study of IPV assessment. We audio recorded clinic encounters for participating providers and patients. We interviewed patient participants about their experiences with the providers' IPV assessment and they reflected on their audio-recorded clinic encounters. **Results**: The mean age for the 44 participants was 22.8 years old. Participants named "comfort" as a main component for discussing and disclosing IPV in the clinical setting. The sub-themes associated with how to create patient comfort include: Build the patient-provider relationship, Provider should communicate like a friend/be on the patient level, Patient needs to feel cared for by provider, and Appropriate timing and space. **Conclusion**: Methods for establishing patient comfort via communication should be incorporated into and examined within sensitive

healthcare areas such as IPV and can be extended to HIV, palliative, and oncological care to improve patient health outcomes. Further research on the subthemes of comfort and how they differ in patient populations and settings should be conducted.

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PREFACE

There are many people who have supported, encouraged, and guided me during the past four years of this master's program. My heartfelt thanks go to Dr. Jessica Burke, who always knew the right way in which to mentor, comfort, and challenge me. Thank you for providing a safe and supportive atmosphere for me through my career at GSPH. To Dr. Judy Chang, thank you for encouraging me to follow in your footsteps with qualitative research methodology and for pushing me to try harder and do better. I want to thank Dr. Mary Hawk for her graceful and detailed feedback throughout my writing of this thesis in addition to always cheering me on. To Dr. Elizabeth Miller, I send my deepest gratitude for constantly inspiring me to carry out the crucial community-based violence prevention work that we do, for her academic, professional, and personal mentorship, and for her unwavering support for me through this program. Thank you to my friends, family, and colleagues who have all had a huge part in my success through this program. I especially want to thank my husband, Zachary Zelazny. Without Zack's unconditional support and love, I absolutely would not have made it to this point. Thank you to my parents, Lewis and Janet Soltis for encouraging me to make big goals and never stop working toward them. Very special thanks to the staff at Looking for Group in the neighborhood of Brookline, who graciously gave me work space, coffee, food, and millions of high fives while I wrote this thesis. Finally, thank you to all of the young women who participated in the study that this thesis is based upon. It is an absolute honor to lift up your voices in this work. Thank you

for trusting me with some of the most private and sensitive stories of your lives. You are the reason I do this work. Thank you for your invaluable contributions to ending violence against women.

1.0   INTRODUCTION

Clinical communication – how health care providers inquire and counsel about health topics –

influences patient outcomes including medication adherence and treatment uptake. Clinical

communication impacts a wide array of healthcare areas and topics, with many models and

recommendations in the area of patient-centered communication.(Ali, Atkin, & Neal, 2006;

Beck, Daughtridge, & Sloane, 2002; Keller & Carroll, 1994; Lundeby, Gulbrandsen, & Finset,

2015; Makoul, 2001; Mauksch, Dugdale, Dodson, & Epstein, 2008; Mutha, Allen, & Welch,

2002; Ritholz, Beverly, Brooks, Abrahamson, & Weinger, 2014; Rocque & Leanza, 2015; Roter,

Frankel, Hall, & Sluyter, 2006; Teal & Street, 2009; Ventres & Frankel, 2015; Windover et al.,

2014) Relationship-building, empathic and supportive language, and appropriate nonverbal

communication between patients and providers play a critical role in patient health outcomes.

Gaps remain in the literature regarding how clinical communication models and

recommendations might be applied to create patient comfort and how the delivery may vary by

patient population and setting. Despite the recognized impact of clinical communication on

patient care, research on specific techniques to ensure patient comfort and maximally convey

clinical information is limited. Furthermore, the developmental needs of adolescent and young

adults may influence patient preferences around clinical communication, especially sensitive

topics such as intimate partner violence. (Ambresin, Bennett, Patton, Sanci, & Sawyer; Ford,

Millstein, Halpern-Felsher, Irwin, & Jr, 1997; Lehrer, Lehrer, Lehrer, & Oyarzun, 2007)

Intimate partner violence (IPV) is a serious public health problem that disproportionately affects adolescent and young adult women who seek care at family planning clinics.(Keeling & Birch, 2004; Miller, Decker, McCauley, et al., 2010; Miller, Decker, Raj, et al., 2010; Miller et al., 2016; Rickert, Wiemann, Harrykissoon, Berenson, & Kolb, 2002; Tancredi et al., 2015) Little is known about adolescent and young adult women's preferences toward healthcare providers' communication methods about sensitive topics such as IPV. The purpose of our study is to explore the overarching themes about IPV assessment that 44 female adolescent and young adult family planning patients expressed to us in semi-structured interviews based on their reviews of audio recordings of their own clinic encounters. Our findings will inform future interventions and research addressing IPV assessment in family planning clinics and, additionally, enhance existing clinical guidelines and recommendations in other sensitive healthcare topics such as palliative, HIV, and oncological care.

This thesis will firstly examine the literature on IPV as a public health problem and how it affects adolescent and young adult women, IPV assessment in family planning settings, patient-centered clinical communication models and recommendations, and concerns specifically related to adolescents' and young adults' experiences in healthcare. Then it will describe an exploratory mixed methods study investigating provider communication in family planning clinic settings about intimate partner violence in adolescent and young adult women and present the qualitative findings from the study. Finally, this thesis will discuss the results of the study, clinical and research implications, limitations, and then provide a conclusion. Following this introduction, there will be a single, stand-alone article which will be submitted to the *Journal of Communication in Healthcare*.

2.0   BACKGROUND

Addressing female adolescent and young adult preferences in intimate partner violence (IPV) assessment requires examining a variety of topics in the literature including prevalence of IPV among female adolescent and young adult family planning patients, women's preferences in IPV assessment in medical settings, patient-centered clinical communication models and recommendations, the role of comfort in current communication models and recommendations, and adolescent and young adult-specific concerns about privacy and confidentiality in the healthcare setting.

IPV is described as physical, sexual, or psychological harm by a current or former partner or spouse,(Breiding, Basile, Smith, Black, & Mahendra, 2015) and it disproportionately affects younger women and their reproductive health. Young women utilizing family planning clinics report much higher rates of IPV (34-53%) compared to general population prevalence estimates.(Keeling & Birch, 2004; Miller, Decker, McCauley, et al., 2010; Miller, Decker, Raj, et al., 2010; Miller et al., 2016; Rickert et al., 2002; Tancredi et al., 2015) This is likely related to the negative reproductive health repercussions and risks from such violence exposure including unintended pregnancy, sexually transmitted infection (STI), condom non-use,(Sales, Salazar, & al., 2008; Silverman, 2005; Wingood & DiClemente, 1997) inconsistent condom use,(Coker, Derrick, Lumpkin, Aldrich, & Oldendick, 2000; Davila & Brackley, 1999; Decker, Silverman, & Raj, 2005; Eisenstat & Bancroft, 1999; Gazmararian et al., 2000; J. Hathaway,

Mucci, Silverman, & al., 2000; Raj, Silverman, & Amaro, 2000; Shrier, Pierce, Emans, & DuRant, 1998) and fear of condom negotiation.(Sales et al., 2008; Wingood & DiClemente, 1997) Clinical guidelines recommend that providers, especially in family planning settings, routinely assess for IPV in their patients, given documented associations among IPV and negative outcomes.(American College of Obstetricians Gynecologists, 2013, 2016; Chang, 2014; Colarossi, Breitbart, & Betancourt, 2010; Decker et al., 2012; Ghandour, Campbell, & Lloyd, 2015; Klevens, Sadowski, Kee, Trick, & Garcia, 2012; Latta, Elwy, Ngo, & Kelly, 2016; Lee, James, & Sawires, 1999; Miller, McCaw, Humphreys, & Mitchell, 2015)

Several studies have found that many women experiencing current IPV will deny abuse when asked.(Gerbert et al., 1996; McCauley, Yurk, Jenckes, & Ford, 1998; M. Rodriguez, Quiroga, & Bauer, 1996) Existing literature on disclosure indicates that only 5% to 15% of women have disclosed abuse to their providers.(Higgins, Manhire, & Marshall, 2015) Studies exploring clients' perceived barriers to disclosure of partner abuse reveal that common reasons for denying the abuse are fear of escalating violence(Caralis & Musialowski, 1997; Gerbert et al., 1996; McCauley et al., 1998; M. Rodriguez et al., 1996), feelings of shame and embarrassment,(Caralis & Musialowski, 1997; Gerbert et al., 1996; L. A. McNutt, Carlson, Gagen, & Winterbauer, 1999; M. Rodriguez et al., 1996) fear of losing their children, concern about loss of confidentiality,(McCauley et al., 1998; M. Rodriguez et al., 1996) and fear of police involvement.(M. Rodriguez et al., 1996) Despite the many reasons for a victim of violence to not discuss IPV with a provider, studies have shown that women (regardless of victimization experience) want to be asked about IPV (Caralis & Musialowski, 1997; Friedman, Samet, Roberts, Hudlin, & Hans, 1992; L.-A. McNutt et al., 2009; L. M. Rodriguez, Overup, & Neighbors, 2013) and that the providers' assessment approach is of great importance.(Gielen et

al., 2000; Hamberger, Rhodes, & Brown, 2014; J. E. Hathaway, Willis, & Zimmer, 2002; Spangaro, Zwi, & Poulos, 2011)

The overarching themes of conversational and empathic interactions in combination with friendly and supportive approaches are present in much of the literature on existing clinical communication models and recommendations that focus on patient satisfaction and patient-centered or relationship-centered approaches. In addition to its application in general practice settings, patient-centered communication work has focused on a range of nuanced healthcare areas such as HIV, palliative, oncological care.(Archiopoli et al., 2016; Bishop et al., 2016; Epstein et al., 1998; Epstein & Street, 2011; Pollak et al., 2007; Vergo et al., 2016)

Many clinical communication models describe connectedness between patient and provider as an essential value that should develop at the foundation of successful clinical communication. "Clinical communication model" refers to a theoretical framework which can be applied to describe the dialogue between patient and provider and serves as a tool to determine and measure elements that contribute to patient goals and outcomes.(Hantho, Jensen, & Malterud, 2002) Some models name "establish rapport" as the first step in effective clinical communication, characterizing connectedness as "patient engagement" or knowing patients "on a personal level."(Lundeby et al., 2015; Mauksch et al., 2008; Mutha et al., 2002) Other literature stresses that establishing connectedness should be viewed as "relationship establishment" or "relationship building," (Keller & Carroll, 1994; Windover et al., 2014) prescribing that providers place high value in a more personal relationship with their patients as all communication and the quality of health outcomes stems from this crucial foundation. The concept of the patient-provider relationship suggests that there is a deeper connection between the parties compared to having "rapport." Ventres et al contend that the most successful patient-

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provider communication grows from a complex model of "shared presence," involving "emotional connectedness," a continuous feedback loop between patient and provider to nurture the relationship, and a balance of power between patient and provider.(Ventres & Frankel, 2015) In addition to patient-provider connectedness, models identify other central clinical communication qualities as using empathic language, having open-ended conversations, and clear agenda-setting for clinical encounters. (Keller & Carroll, 1994; Lundeby et al., 2015; Mauksch et al., 2008; Mutha et al., 2002; Ventres & Frankel, 2015; Windover et al., 2014)

Many clinical communication studies and literature syntheses offer recommendations for provider verbal and non-verbal behaviors to improve patient-provider communication. "Recommendations" are based in systematic review of literature, research, and evaluation of associated health outcomes, which are intended to inform the optimization of patient care.(American Academy of Family Physicians, 2016) Several authors advocate for acute attention and use of empathetic language in response to patients' emotional presentations in clinical encounters in order to enhance communication and contribute to favorable health outcomes.(Beck et al., 2002; Makoul, 2001; Roter et al., 2006) There is also an emphasis on providers' ability to be sociable and friendly, while posturing themselves in a professional yet comfortable manner in their nonverbal communication.(Ali et al., 2006; Beck et al., 2002) Ritholz et al advise that providers establish trust with patients via use of non-judgmental language and by being open and honest with patients in order to communicate most effectively.(Ritholz et al., 2014) Some authors place emphasis on provider cultural awareness and competency above all other communication recommendations as an avenue to build trust and rapport.(Ali et al., 2006; Rocque & Leanza, 2015; Teal & Street, 2009)

Few known clinical communication models and recommendations include instructions for creating a comfortable emotional, social, or physical environment for patients. There is little literature addressing how providers can establish patient comfort. Smith's Patient-Centered Interviewing guidelines recommend that providers "ensure comfort and put the patient at ease" in the first step in which the provider welcomes the patient, taking the form of asking the patient if they feel comfortable in the exam room (i.e. "Is that a comfortable chair for you?").(Fortin, Dwamena, Frankel, & Smith, 2012) Moving away from the concept of physical comfort, Roter et al mention in their work that when providers use "comforting words," patients feel that they have a positive relationship with their providers, but there is no elaboration of how to use the recommended "comforting" language.(Roter et al., 2006) Other studies posit that patient comfort is derived from seeing a familiar provider and being acquainted with all practice staff, which aids in more transparency on the patient's behalf, especially when discussing sensitive topics like sexual health.(Boekeloo, Schamus, Cheng, & Simmens, 1996; Clark, Brey, Banter, & Khubchandani, 2012; Kapphahn, Wilson, & Klein, 1999)

Literature on communication has focused almost exclusively on adults, not adolescent and young adults. Developmentally, adolescent and young adults may have much greater concerns about privacy and confidentiality in the context of sensitive topics like reproductive health and IPV.(Ambresin et al.; Ford et al., 1997; Lehrer et al., 2007)

The literature provides insight into what patients want providers to say and do when assessing for IPV, but lacks descriptions of provider demeanor and how providers should act during this type of sensitive conversation. There is also a gap in the literature regarding comfort for female adolescent and young adult patients in IPV assessment and how providers can aid in establishing comfort for their patients during a clinic visit. Adolescent and young adult women

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experience the highest prevalence of IPV, underscoring the need to understand how to counsel about IPV for this age group.

Given the gaps in the literature, the purpose of this study was to learn more about adolescent and young adult women's preferences in IPV assessment delivery in family planning clinics through patients examining their providers' communication used in their own clinical encounters.

3.0 METHODS

This exploratory study on adolescent and young adult women's perspectives on provider communication style emerges from a larger study on training family providers to communicate about sensitive topics such as IPV and reproductive coercion (RC). Reproductive coercion is a type of IPV which refers to a male pressuring his female partner to become pregnant against her will via verbal pressure and threats to become pregnant, preventing her from using birth control, tampering with birth control/condoms, and controlling pregnancy outcomes.(Miller & Silverman, 2010 Sep) This communication study was developed from a large intervention trial in family planning clinics in western Pennsylvania, in which clinic staff were trained to implement a universal education and brief counseling intervention (Addressing Reproductive Coercion in Health Settings; ARCHES) designed to promote patient and provider discussion about IPV and RC using semi-scripted assessment tools, harm reduction counseling, and warm referral to local victim advocacy resources.(Miller et al., 2016; Tancredi et al., 2015)

3.1 DESCRIPTION OF PARENT STUDY

In this study, four western Pennsylvania family planning clinics were randomized to receive one of two three-hour trainings on IPV/RC assessment for all clinic staff, including nurses, medical assistants, and other support staff. The intervention arm providers participated an IPV/RC

communication skills building workshop using a simulated patient and patient-centered communication models such as "Ask-Tell-Ask"(Barnett, 2001) and NURSE (Name Understand Respect Support Explore).(Smith & Hoppe, 1991) The control clinic staff received didactic knowledge-based IPV/RC training. Both arms were taught how to deliver brief universal education and IPV/RC assessment using a brochure-based intervention.

During the study, clinicians at one of the intervention sites declined to participate in the study post-training. Another clinic was invited to participate in its place and all providers and clinic staff received training and participated in the study. Patients seeking services from the withdrawn clinic were invited to participate in the study without the participation of the clinicians. All five clinics participating in the current study had participated in the ARCHES study as waitlist control sites and, prior to this study, had not received any training around IPV/RC as part of a research study.

Patients ages 16 to 29 were invited to participate in the surveys. Baseline and exit surveys were administered to participants in a private space via laptop computer using ACASI (Audio Computer Assisted Self Interview).(Ghanem, Hutton, Zenilman, Zimba, & Erbelding, 2005) Research staff stayed in the private space with the patient in the event the patient had questions about the surveys or to direct the patient to clinic staff if they were to experience emotional distress as a result of reading and answering sensitive questions. After the baseline survey, the patient went in to their clinic visit, and then returned to the private space to complete an exit survey and receive their $30 WePay MasterCard compensation.

3.2   INTERVIEWS USED FOR THIS STUDY

For a subset of patient participants aged 18 years and older, research staff also asked permission to record their clinical visit and placed a digital audio recorder in the exam room during patient visits for patient and provider participants who gave permission to have their clinic encounter audio recorded. These recordings were obtained to assess how reproductive health providers addressed IPV and RC during the clinical visits. During the consent process, research staff stressed to both patient and provider participants that they could stop the recording for any reason at any time. Research staff stayed close to the exam rooms as a safety precaution to ensure the audio recorders were only capturing enrolled patient and provider participants' data. Patient visits at the withdrawn clinic were not recorded.

The exit survey was programmed to show a prompt at the conclusion of the survey inviting women 18 and older to talk to the research assistant (RA) about the second part (follow up interviews) of this study. Based on the responses in the survey, if the woman reported ever experiencing IPV or RC, the computer program would take her to a prompt asking her whether she was interested in participating in a follow up interview to review that clinic visit. The prompt would be marked "A" on the ACASI screen so the RA can track distribution of interview participants. Similarly, women who responded "No" to ever experiencing IPV or RC on the baseline survey saw a different prompt marked "B" on the screen inviting her to participate in a follow up interview. Research staff were blinded to what the survey indicators represented. Patient participants for this portion of the parent study were chosen using a purposeful sampling strategy to include diverse experiences and clinic encounters with different providers at each site (70% of patient participants with IPV/RC experiences, and 30% without). The RAs completed a tracking grid such that the interviews included encounters with different providers in the clinical

site and about 70% of encounters are associated with prompt A and 30% are associated with prompt B. The tracking grids from each clinical site were reviewed by the research coordinator daily to help guide RAs at the sites on how to adjust recruitment for follow up interviews to achieve optimal distribution in each site.

Patient participants who had agreed to the recorded visits were invited to return within a few weeks of the recorded visit to participate in semi-structured interviews. If the participant was interested in doing the follow up interview, the RAs confirmed the participant's follow up contact information and scheduled the follow up interview. Patients from the withdrawn clinic were invited to participate in the interviews, but did not reflect on medical encounter audio recordings.

Participants completed interviews 4 to 8 weeks after the initial audio recording. Interview questions focused on patients' feelings toward their providers' overall communication, IPV and RC assessment technique, and what is most important for providers to do for patients who are in an unhealthy relationship (see Appendix A for interview guide). Sample audio clips were played for participants to facilitate patients' ability to give feedback on the content and delivery of the assessment. Women received a $30 gift card for their participation in the interview.

4.0   ANALYSIS

Audio-recorded interviews were transcribed verbatim, de-identified, quality checked by a third

party, and uploaded to the qualitative coding software program, Atlas.ti.(ATLAS.ti, 1997-2004)

Two independent coders reviewed five randomly selected patient interviews and an initial

codebook was composed, with additional codes created via consensus. Main themes identified

in the open coding process were refined using axial and selective coding.(Patton, 1990) For this

analysis, we reviewed codes specific to describing what patients want and need from clinicians

to feel emotionally comfortable in order to discuss IPV.

5.0   RESULTS

Forty four women participated in the interview phase of the study, eight interviewees from the

withdrawn clinic participated. Participants' mean age was 22.77 years (+/- .49) and most women

were Caucasian (82%) and had some college education or more (64%). 66% of the interviewees

were survivors of lifetime intimate partner violence victimization, which they indicated on their

computerized surveys. (See Table 1)

Table 1. Patient Participant Demographics

Characteristic	Total (n=44) % (n)
Race	
White	82 (36)
Black/African-American	9 (4)
Multiracial/other	9 (4)
Age	
18-21	41 (18)
22-25	36 (16)
26-29	23 (10)
Education	
Less than 12th grade	11 (5)
Finished high school	25 (11)
Some college	34 (15)
College degree or higher	30 (13)
Lifetime IPV	66 (29)

5.1   RELATIONSHIP BETWEEN CLINIC/CLINICIAN ELEMENTS AND

COMFORT

There were many overlapping themes describing what participants desire from their family

planning clinicians to feel emotionally comfortable, with comfort being described as a major

component for patients to disclose IPV to a provider in a clinic setting. The sub-themes

associated with comfort include: (a) Build the patient-provider relationship (b) Provider

communicate like a friend/be on the patient level (c) Patient needs to feel cared for by provider

(d) Appropriate timing and space.

5.1.1   Build the patient-provider relationship

Women offered that the feeling of comfort can be created via establishing a relationship that

extends beyond basic patient-provider rapport. The interviewees suggested that providers should

aim to understand their patients on a personal level, which goes deeper than being versed in their

patients' physical health. Women said that they have felt comfortable telling close friends or

family members about experiencing violence in their relationships because they had the context

to understand what the survivor was going through. Participants conveyed that they felt more

comfortable with providers who could talk about themselves (for example, their children or what

their plans were for the weekend) in addition to remembering details about the patient. Their

suggestions indicate that relationship building goes beyond knowing personal information about

a patient and that a reciprocal sharing of information between a patient and provider can create a

relationship that is more desirable to an adolescent and young adult patient. One woman

expressed that she wanted to have the feeling that the clinic providers were "here for (a patient)

and that (a patient) is not just a number," giving the advice that providers need to know their patients outside of a clinical context in order to help patients feel more comfortable opening up about their experience with violence.

In addition to helping women feel comfortable, building the patient-provider relationship can provide key insights into what is happening in patients' lives, further enhancing IPV assessment. By being in tune with their patients' personalities and behaviors, providers can build better relationships with patients and offer personalized and appropriate IPV assessment and care. One interviewee said:

> "Providers could take little notes or something on the patient to leave on their file. So if they ever come in and they're acting really not themselves that day, they could kinda learn those behaviors."

5.1.2 Provider should communicate like a friend/be on the patient level

Themes of wanting providers to communicate like a friend with participants, being on the "same level," and not using "sugar-coated" language (i.e. a friend is "straightforward" with language) were prominent among patients' descriptions of comfort in the context of IPV assessment. Participants articulated that feeling comfortable enough to offer sensitive personal information about their experiences with violence aligns with providers speaking to them in a casual, friendly, or conversational manner. Interviewees also expressed that providers should use layperson terms so as to "be on the same level" as their patients. One woman connected her desire for her provider to act like a friend toward her to the minimization of medical jargon in the clinical encounter:

"I know (IPV assessment at the clinic) could be hard because you're supposed to be in a professional setting but if you just kind of wipe away the certain words that you're supposed to use when it comes to a patient, the disconnecting words and be like 'I know it's scary… I do this for everyone but I have to make sure cause anyone could be hurting so I… got to talk,' but you have to be the friend. You can't be the doctor (because) I know some many people are afraid of medical professionals…"

Another participant spoke about the association between feeling comfortable talking about an unhealthy relationship and having a conversation with the provider in which the provider does not create a hierarchical barrier between her/himself and the patient. This woman also touches on the desire for providers to have a relationship with the patient.

"Just like more of a meeting, have more of a relationship with the person that you're talking (with) about (unhealthy relationships) instead of (providers asking) you the questions and if it's not asked then it's not talked about kind of thing. So… what would make me feel more comfortable (is) that I would have more of a mutual… 'let's talk about this kind of thing' instead of 'you know more about all this than I do and what you think matters more than what I think.'"

Some participants advised that providers should not "sugar coat" their questions when asking their patients about IPV. They expressed that they felt comfortable in a conversation when the other person was being "straight-forward" with their questions and that this helped to put the provider on the same level as the patient.

5.1.3 Patient needs to feel cared for by provider

Participants gave details on the need to feel cared for by their providers as it relates to feeling

comfortable when discussing IPV. Women explained that they want providers to show concern

for their patients as "whole people," and be able to broaden their focus beyond patients' clinical

chief complaints. Interviewees described the notion of feeling "cared for" by providers as a

"genuine interest" in their well-being outside of providers "just doing their jobs," and in the

realm of patients being cared for emotionally. This woman expressed that if providers can be

their genuine selves and give attention to patients in a caring way, that she would take comfort in

her interactions with the providers:

> "Honestly, I feel like the comfort of (providers being) themselves is a good thing because
>
> if you walk in (to a clinic) and you have really rude and inconsiderate physicians…
>
> you're not gonna want to tell them your problems, you're not gonna wanna say anything
>
> to them, you're just gonna want to keep it to yourself. But you come in here and
>
> someone's very understanding and… wanna know your problems and genuinely care
>
> about (you), I feel like it's a better thing… I'm not gonna wanna sit here and tell all my
>
> personal information to someone who's having like an 'I don't care' attitude… Someone
>
> that's (looking) at me in my eyes and telling me, 'oh I'm here for you, this is what I do, if
>
> you need anyone to talk to I'm here.' I would want to tell my story to them more than the
>
> other person."

5.1.4 Appropriate timing/space

The themes of when and where to have a conversation about IPV arose for many women who expressed that comfort was a main factor in discussions about IPV. Women described comfortable space as the physical clinic space being private as well as where the providers positioned themselves in the space when doing IPV assessment. Some participants specified that the desired distance between the patient and provider when discussing sensitive questions about their relationships should be 2 to 3 feet, and that both parties should be seated.

Participants told the interviewer that the time point within the visit for doing IPV assessment is important. They explained that asking about IPV at the beginning of the visit, during a pelvic exam, or in the middle of a "list" of questions were not appropriate times for the assessment. Women offered the suggestion of introducing sensitive topics such as IPV toward the middle of the clinical encounter, which should be framed around other sensitive questions and eased into (as opposed to being in a string of questions about smoking and seat-belt use, for example), and should be discussed in a private area. Participants advised that providers should "ease into" the discussion by asking toward the middle of a visit and not rush through the questions about patient relationships. One interviewee provided this advice directed to providers:

> "…People aren't so willing to right away give information up so maybe you might have to ask again in the middle of the… appointment or at the end maybe just drop some hints or something and get them comfortable with you talking to them… (if) you first walk in (and say) 'hey you have any problems at home?'… and then you're just done... Maybe they do (have problems at home) and then they just aren't comfortable with you yet

'cause you are (at the family planning clinic), I mean really who likes to come and have (pelvic) exams done…?"

5.2   OVERLAPPING THEMES

Multiple intersecting sub-themes were within each participant's description or mention of comfort. Many participants touched on each of the comfort sub-themes in one sentence or thought. Here is one example of how a participant touched on each theme while providing guidance on how providers can help their patients to feel more comfortable talking about IPV:

"Well, if (providers) notice that you're sitting there and you're down and that you can tell. They could go up to you and be like 'Oh, is everything ok. Do you wanna talk to us about anything?' Just go up to you and make a friendly conversation and see if you'd like to talk back here (in a private clinic room)."

At the beginning of the quote, the participant implies that the provider knows the patient well enough to notice that the patient is not acting "like herself" and is "down." The gesture of checking in about "everything" was coded as the theme of "patient needs to feel cared for," as the question does not specifically ask about the patient's health and can extend to the patient's overall well-being. Finally, the participant recommends that providers talk to her in a friendly, casual way and in a private space.

6.0 DISCUSSION

This study focused on adolescent and young adult perspectives on how they would like providers to create comfort during the clinical encounter and how to ask about IPV. Findings highlight the extent to which patients expect that providers try to get to know them on a more personal level before discussing sensitive topics such as IPV.

The keys themes -- "build the patient-provider relationship," "patient needs to feel cared for by provider," and "appropriate timing and space" align with the existing literature in that the sub-themes are mirrored in patient-centered care and clinical communication models and recommendations. (Beck et al., 2002; Boquiren, Hack, Beaver, & Williamson, 2015; Fortin et al., 2012; L. A. McNutt et al., 1999; Mutha et al., 2002; Rocque & Leanza, 2015) Our results extend beyond naming comfort as an important element within communication models and recommendations and offer insight into how adolescent and young adult women want providers to discuss sensitive topics with them. The literature on similarly sensitive topics of palliative, HIV, and oncological care stress that providers should use patient-centered communication strategies, to which comfort-enhancing communication could be added for improved health outcomes and greater medication adherence. (Archiopoli et al., 2016; Bishop et al., 2016; Epstein et al., 1998; Epstein & Street, 2011; Pollak et al., 2007; Vergo et al., 2016)

6.1 "IT'S ALL IN THE HOW": ASSESSMENT DELIVERY

There are many mechanisms through which providers are guided on *what* to do to perform IPV assessment including screening tools, clinic policies, and protocols for responding to violence disclosure such as referral to resources or safety planning. Our findings show that adolescent and young adult women place importance on *how* their providers deliver IPV assessment in addition to the methods/tools that their providers use.

We found that many women prefer when their providers speak to them with a direct "tone" and avoid using vague or sugar-coated/diffusive language. Many articles focus on the need for providers to communicate in a relatable, casual, and friendly manner when working with patients.(Fortin et al., 2012; Makoul, 2001; Studer Group, 2005; Ventres & Frankel, 2015) Miller et al explain that adolescent and young adults' perception of relatable language involves a balance between non-jargon use, non-slang use, and casual but still professional language.(Miller, Decker, Raj, et al., 2010) The notion of communicating "like a friend" is a new characteristic that this study brings to the literature on communication styles, which implies an enhanced feeling beyond being "friendly" or "cordial." From this finding, we can deduce that adolescent and young adults may be seeking a relationship with their provider that aligns more with a peer relationship, which may play a key factor in increasing patient comfort when discussing sensitive topics.

In addition to provider use of tone to be on the patient level, we can see in our findings that young women place emphasis on how providers can "set the stage" for IPV assessment and, possibly, other discussions of delicate topics. Again, we heard participants advising on how providers can establish patient comfort in their recommendations for how providers should move through the clinic visit from engaging with the patient, to making the investment in knowing

their patient, and ensuring that IPV assessment occurs at a comfortable time and space for the patient.

6.2   UNIQUE METHOD, UNHEARD VOICES

There are no other known studies that investigate patient clinical communication preferences that have employed the use of reviewing one's own clinic encounter recording. Through the use of this unique study design of audio recording the patient-provider interaction and revisiting the encounter weeks in the future, patients were able to provide direct criticism, praise, and specific suggestions as opposed to other studies that may ask about preferences based on hypothetical situations or real past experiences which may not be recalled accurately by participants. Also, while the interview questions did not directly ask about comfort, women independently emphasized the importance of patient comfort in the context of disclosing IPV to a clinician, which underscores the saliency of our findings.

The perspectives that we heard from these young women give us a richer and deeper understanding of how providers can better tailor their communication styles to fit the needs and wants of their patients. Two thirds of interview participants are survivors of IPV. The perspectives we heard from these young women help elucidate how providers can better tailor their communication styles to fit the needs and expectations of their patients.

Through hearing the voices of adolescent and young adult violence survivors, we are able to more effectively contribute to clinical violence prevention efforts by refining clinic-based interventions.

6.3   CLINICAL IMPLICATIONS

Based on the findings that providers should approach patient-centered care with personable and relatable communication, we recommend that enhanced communication-skills training be embedded within more provider trainings as it may not be sufficient to focus on knowledge or content acquisition of the health topic alone. When providers use patient centered communication skills and as their level of comfort with discussing IPV improves, changes within the clinic may also ensue. Simultaneously, clinical level factors that increase the likelihood that providers will use these communication skills should be identified.

Our findings offer the suggestion of introducing sensitive topics such as IPV toward the middle of the clinical encounter, which should be framed around other sensitive questions and eased into (as opposed to being in a string of questions about smoking and seat-belt use, for example), and should be discussed in a private area. The use of the private area for IPV assessment in mirrored in the work Martin et al, where teens describe an ideal IPV resource center as being "comfortable," "confidential," and "safe."(Martin, Houston, Mmari, & Decker, 2012)

Our participants' perspectives and advice on creating patient comfort in clinic-based IPV assessment can translate to other sensitive topics such as palliative and end of life care and stigmatized areas like HIV or other sexually transmitted infection treatment. We suggest that the integration of patient comfort could be a beneficial addition to the existing patient-centered and open-ended communication methods that already commonly applied in these areas.(Callon et al., 2016; Korsvold et al., 2016; Remien et al., 2015; Rice, Dobry, Novakovic, & Appel, 2012) Because our findings among young women in family planning clinics mirror many of the themes

in other communication models and recommendations, this need not add to the burden of what providers must pursue to learn. Rather, our recommendation to providers is to take inventory of what they know about patient-centered care and learn how best to deliver that care for their younger patients.

6.4   RESEARCH IMPLICATIONS

It is crucial to note that the main subthemes in our findings are overlapping, meaning that in practice they may not stand alone, but rather, practitioners could draw upon many of the subthemes concurrently within a medical encounter to assist in establishing comfort for a young woman. Further research is needed to better understand the interactions between the different components of provider communication and how to successfully combine communication approaches to incite patient comfort. Other qualitative studies could specifically focus on describing patient comfort in various healthcare settings and patient populations and developing and testing provider training content.

Based on the young women's recommendations, tailored IPV assessment scripts (providing both the verbiage and tone for providers to use) could be developed and studied in family planning clinic settings to further understand patient preferences in provider communication.

Further studies are needed on the relationship between violence-related outcomes (such as knowledge of IPV resources, use of safety and harm-reduction strategies, and reductions in violence victimization) and improving "comfort" during clinical encounters.

6.5   LIMITATIONS

One limitation of this study lies within the sampling design. We endeavored to attain an interviewee sample population of 70% IPV survivors (as indicated on the computerized survey), but interviewed 66%. However, out sample size of 44 adolescent and young adult interviewees is larger than all other known qualitative studies' samples on similar topics. Another limitation is that the interview guide did not specifically include questions about comfort, which should be explored further in future research. We did not have audio recording for eight of the patients from the withdrawn clinic, and thusly had to rely on patients recalling the clinical encounter on the day they took the survey. Additionally, because we did not specifically ask about or define comfort in the interviews, the participants may have used the word "comfortable" to mean "confidentiality" and/or "safety," which other research with adolescent and young adults has shown.(Herrman, 2009; Miller, Decker, Raj, et al., 2010)

7.0   CONCLUSION

In conclusion, we found that adolescent and young adult women place complex, interwoven, and unique meaning behind the idea of comfort within the realm of IPV screening in clinical settings. Additionally, we discovered that patient comfort is a main overriding element that lends to enhanced and improved clinic-based conversations about IPV, which can be generalizable to other areas of healthcare where sensitive topics are discussed between patients and providers. Future research implications include more investigation on how to incorporate communication practices which promote comfort among adolescents around sensitive topics.

APPENDIX: PATIENT PARTICIPANT INTERVIEW GUIDE

Introduction: This is the second part, the follow up part, where we are inviting women back to talk about their discussion with their health care provider. And what we are interested about in particular is how providers talk to patients about sensitive topics such as intimate partner violence or unhealthy relationships. There are different styles used by providers in talking about intimate partner violence, and even some differences of opinion as to whether this is an area that providers should ask about at all. We're interested in learning more about that patient-provider communication about intimate partner violence.

What did you think of the overall visit?

What did you think about the communication between you and your doctor/NP/NMW?

What are some things that you liked about the interaction?

What are some things that you think the doctor could have done better?

Tell us a little bit about any non-verbal communication that you remember from that visit.

What did you think about how she brought up the subject of IPV or safety with you?

Listen to the tape, focused on IPV:

What do you think your doctor/nurse/midwife/practitioner means when she asks this question? Tell me what she is asking about. What does this include? What does she mean by the phrase "… …"?

At your visit, we asked about partner violence by the computer and in person with your provider. Tell me a little about how you felt about those two different styles of bringing up this topic. What are some of the differences? How do you feel with each style?

(when in the past) You had shared that this violence was something that happened in the past, what would be your suggestions for providers about what they could say or what would be helpful to women who have had this in their past? (consider having them listen again to the section) After listening to this part of the discussion again, any other suggestions you would have for providers on how to respond?

What could the provider have said or done differently what would have been helpful for you personally?

What about if it were something happening currently? How should they address that?

Anything else you wanted to comment on about your visit.

What do you think about your participation in this study? What do you think we could improve on?

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