Healthcare Screening for Intimate Partner Violence: Examining Patient Experiences, Disclosure, and Identity-Based Disparities

by

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Abstract

Intimate partner violence (IPV) is highly prevalent among emerging adults, yet relatively little is known about factors associated with IPV screening and disclosure within healthcare settings, particularly among gender-diverse populations (Leemis et al., 2022, Morris et al., 2025). The present study examined the frequency and predictors of IPV screening and disclosure among emerging adult women and gender-diverse individuals in the United States. Participants (N = 264) completed measures assessing IPV experiences, healthcare satisfaction, IPV screening and disclosure experiences, and demographic characteristics. Additionally, several novel measures assessing emotional responses to screening, barriers and facilitators to disclosure, provider responses, and supportive provider interventions were developed and psychometrically evaluated using exploratory factor analysis (EFA).

Results indicated that 72% of participants screened positive for either current IPV or IPV occurring since age 16. Despite the high prevalence of IPV, only 28% of participants reported being asked about IPV during their most recent healthcare visit. Among participants who reported IPV victimization and were screened, approximately one-third disclosed their experiences to their healthcare provider. Contrary to hypotheses, gender identity, race, and disability status were not significantly associated with screening or disclosure. Insurance status was the only significant predictor of screening, with insured participants reporting higher rates of IPV inquiry than uninsured participants. Healthcare satisfaction was not significantly associated with IPV history, screening occurrence, or disclosure status; however, correlational analyses demonstrated associations between healthcare satisfaction and greater emotional validation,

fewer perceived disclosure barriers, more positive provider responses, and greater supportive provider intervention. The newly developed measures demonstrated acceptable to excellent internal consistency and generally supported coherent factor structures reflecting emotional responses to screening, relational barriers and facilitators to disclosure, and provider engagement following disclosure.

Collectively, findings suggest that IPV remains highly prevalent among emerging adults while screening opportunities remain limited. Results further indicate that disclosure may be influenced less by demographic characteristics and more by relational aspects of healthcare interactions, including trust, emotional safety, validation, and provider responsiveness. Implications for clinical practice, future research, and IPV screening implementation are discussed.

Keywords: intimate partner violence, IPV screening, IPV disclosure, emerging adults, healthcare satisfaction, healthcare screening

Chapter 1: Introduction

Intimate partner violence (IPV) has long been considered a public health crisis within the literature, and it is known to involve behavior that causes physical, sexual, or psychological harm within an intimate relationship, which can be perpetrated by either current or former partners (American College of Obstetricians and Gynecologists [ACOG], n.d.; World Health Organization [WHO], n.d.). The notion of IPV encompasses actions of physical aggression (hurting a partner using physical force), sexual coercion/assault (forcing a partner to take part in sex/sexual acts when they do not or cannot consent), psychological abuse (use of verbal/nonverbal communication with the intent to harm a partner mentally/emotionally or to exert control over a partner), and controlling behavior (systematic pattern of dominance used to restrict a victim's autonomy/freedom/agency; ACOG, n.d.; Centers for Disease Control and Prevention [CDC], 2026; WHO, n.d.). Exposure to IPV affects nearly half of all women in the U.S. across their lifespan and is associated with a range of adverse outcomes, such as mental and neurological disorders, poor general health and daily functioning, cognitive impairment, and attachment problems (ACOG, n.d.; Leemis et al., 2022; Reisenhofer et al., 2019; WHO, n.d.). Beyond the immediate and acute effects of victimization, those who experience IPV often face lingering deleterious effects, such as subsequent violence victimization and even death, as it has been shown that up to 90% of women who experience IPV and leave their perpetrator face continued harassment, stalking, or abuse by their former partners (ACOG, n.d.; Leemis et al., 2022; Reisenhofer et al., 2019; Spearman et al., 2022; WHO, n.d.).

Prevalence of IPV

Within the United States, one in five women aged 16-64 reported experiencing some form of IPV in the past 5 years (Ranji et al., 2025). Overall, findings indicate that women are at greater risk for IPV victimization than men, regardless of relationship status (Harland et al., 2021; WHO, n.d.). Moreover, IPV can persist or even worsen after separation, emphasizing that the end of a relationship does not necessarily mark the end of victimization (Harland et al., 2021; WHO, n.d.). Within victimized groups, 70% reported that their first victimization by an intimate partner occurred before the age of 25 (Leemis et al., 2022).

Roughly half of all women who experienced IPV sustained a physical injury as a result (Ranji et al., 2025). Despite these harms, only 35% of women affected by IPV reported accessing healthcare for related needs, with barriers such as privacy concerns, fear, and intimidation contributing to more than 1 in 10 women being unable to access needed healthcare services (Ranji et al., 2025). Emerging data indicate that women, especially those who are low-income, LGBTQ+, disabled, or from racially minoritized groups, are at significantly elevated risk of experiencing IPV (Leemis et al., 2022; Ranji et al., 2025). For example, disabled women faced elevated risk, with 27% reporting IPV in the past five years (Leemis et al., 2022; Ranji et al., 2025). Low-income women were also particularly vulnerable, with 27% experiencing IPV compared to 14% among higher-income women (Leemis et al., 2022; Ranji et al., 2025).

Previous research has shown that ethnic minority groups are also at a higher risk of victimization (Leemis et al., 2022). Among women, reports of experiencing intimate partner violence (IPV) at some point within their lifespan were highest among multiracial, American Indian or Alaska Native, and Black women (Leemis et al., 2022). White and Hispanic women reported moderate rates of lifetime IPV, whereas Asian/Pacific Islander women reported the

lowest rates among all racial/ethnic groups. (Leemis et al., 2022). Within the past year, IPV was most commonly reported by non-Hispanic multiracial and Black women, with fewer reports among Hispanic and White women (Leemis et al., 2022). For those who belong to multiple minoritized groups, these disadvantages appear to be compounded and further impact clinical outcomes (Leemis et al., 2022; Morris et al., 2025).

Those who ascribe to nonconforming gender and sexuality groups are also posited to be at a higher risk of experiencing IPV at some point throughout their lives (Ranji et al., 2025; WHO, n.d.). Among LGBT+ women, 32% reported IPV experiences, which is twice the rate of non-LGBT+ women (16%). Additionally, LGBTQ individuals visiting emergency departments report higher rates of IPV across all subtypes compared to heterosexual individuals, with homosexual individuals showing significantly higher odds of physical or sexual IPV (Harland et al., 2021). Among transgender groups, rates are largely disproportionate to cisgender comparisons, as physical IPV victimization emerges as more prevalent than sexual IPV--yet transgender individuals are more than twice as likely to experience both physical and sexual IPV (Peitzmeier et al., 2020).

Guidelines Regarding Screening for IPV in Healthcare Settings

Within populations that experience heightened levels of IPV, healthcare settings offer a critical opportunity for early identification and intervention. Recognizing that IPV is a significant public health issue, the American Medical Association (AMA) recommends that IPV be routinely inquired about and screened (Kelly et al., 2025). The AMA establishes that physicians should be educated regarding the effectiveness of early detection, intervention, and the benefits and harms of screening (Kelly et al., 2025). The 2018 U.S. Preventive Services Task Force (USPSTF) guideline recommends that clinicians screen all women of childbearing age for IPV

and provide appropriate services for those who screen positive (Phares et al., 2019). The American College of Obstetricians and Gynecologists (ACOG) and the U.S. Department of Health and Human Services (USDHHS) recommend that physicians screen all patients for IPV periodically, regardless of age (ACOG, n.d.). However, Morris and colleagues (2025) found that of the 71% of individuals who reported experiencing IPV, only 35% had been asked about IPV during healthcare encounters in the previous year. Furthermore, a study of police-identified women victims of IPV found that screening occurred in only 30% of doctor visits, and fewer than 25% of identified victims received referrals for IPV services (Phares et al., 2019). Ideally, all individuals receiving medical care would be adequately screened for IPV, given the widespread prevalence among all groups (Leemis et al., 2022; Ranji et al., 2025). However, beyond recommendations, there is currently no standardized assessment, protocol, or mandate for screening (Rabin et al., 2009).

Multiple organizations, including the AMA, ACOG, the USDHHS, and the U.S. Preventive Services Task Force (USPSTF), recommend routine screening for all women of reproductive age and suggest that particular attention should be given to IPV screening during annual visits and throughout pregnancy (when screening opportunities may be more readily available; ACOG, 2012; Phares et al., 2019; Silverstein et al., 2025). Screening for IPV has the potential to yield two important outcomes: disclosure of victimization experiences (in which patients reveal experiences of IPV and can be connected with appropriate support and intervention) and opportunities for universal education, through which patients gain greater awareness of IPV and its warning signs (ACOG, 2012). Several validated tools exist for measuring IPV and victimization to aid in the enactment of this initiative, such as the Hurt, Insult, Threaten, and Scream measure (HITS; Sherin et al, 1998), the Extended-HITS (E-HITS;

Chan et al., 2010), Woman Abuse Screening Tool (WAST; Brown et al., 1996), the Partner Violence Screen (PVS; Feldhaus et al., 1997), the Abuse Assessment Screen (AAS; Soeken et al., 1998; Rabin et al., 2009), and the Revised Conflict Tactics Scale (CTS-2; Straus et al., 1996). The CTS-2 has become established as the "gold standard" within research in measuring prevalence, severity, and chronicity of IPV (Iverson et al., 2015; Straus et al., 1996). The CTS-2 is a 39-item written questionnaire that requires a lengthy and comprehensive diagnostic interview, which is unsuitable for most fast-paced healthcare and frontline clinical settings (Iverson et al., 2015; Straus et al., 1996). Although the current screener tools generally showed acceptable reliability and validity, their respective sensitivities and specificities varied widely, particularly across genders and settings (Rabin et al., 2009). Across these measures, many tools assessed physical violence and threats, but fewer asked about emotional or sexual abuse, and single-item screens perform inconsistently (Portnoy et al., 2020; Rabin et al., 2009). Subsequently, attention is needed in developing a validated, brief screening tool that is suitable within healthcare settings (Iverson et al., 2015; Rabin et al., 2009). Despite the promise of the current measures, all IPV screening tools need further validation as most tools remain untested for test-retest reliability, and few have been studied in diverse populations and settings (Rabin et al., 2009). Self-administered or computerized screeners may yield higher disclosure rates and patient satisfaction than face-to-face interviews; however, variability in definitions of IPV, lack of a universal gold standard for comparison/clinical use, and inconsistent sensitivity and specificity limit firm conclusions about their effectiveness, and screening implementation remains inconsistent (Hussain et al., 2015; Rabin et al., 2009). Thus, there is a clear need for prioritization, standardization, and guidelines regarding screening and identification of IPV (ACOG, n.d.; Kelly et al., 2025; Morris et al., 2025; Phares et al., 2019).

Research on Screening for IPV in Healthcare Settings

Given the unique role that healthcare settings can play, disclosure of IPV in medical settings is deeply influenced by interpersonal and structural factors (Portnoy et al., 2020). Patients and providers alike agree that strong rapport and a trusting patient-provider relationship facilitate a safe and willing disclosure (Portnoy et al., 2020). Individuals often assess their relationship with the provider before deciding to reveal their personal experiences, as a lack of trust, insufficient rapport, or a perception that the provider lacks empathy or IPV knowledge can deter disclosure (Heron & Eisma, 2021; Spangaro et al., 2011). However, logistic barriers including anticipatory stigma, racial disparities, lack of private space or sufficient time for sensitive interventions, time constraints, fear of retaliation by the abuser, concerns about law enforcement or legal involvement, and the presence of a partner during screening all work to influence an individual's decision to disclose (Phares et al., 2019). LGBTQ+ individuals may fear being outed or invalidated, while individuals with disabilities may fear increased surveillance or loss of autonomy (Morris et al., 2025; Peitzmeier et al., 2020). Thus, by proxy of ensuring informed and sensitive screening, victims are likely to become more inclined to disclose when healthcare providers demonstrate empathy, confidentiality, and knowledge of IPV complexities (Feder et al., 2006; Heron & Eisma, 2021). Trust, privacy, and nonjudgmental attitudes are central to fostering disclosure, while fear of judgment, loss of autonomy, and safety concerns remain common barriers (Heron & Eisma, 2021; Portnoy et al., 2020; Spangaro et al., 2011).

In marginalized populations, particularly LGBTQ+ and transgender individuals, barriers are compounded by provider bias, lack of inclusive resources, and fear of outing or invalidation (Morris et al., 2025; Peitzmeier et al., 2020; Santos et al., 2025). Those ascribing to

nonconforming groups or minority populations tend to be hesitant to disclose IPV experiences (Morris et al., 2025). Barriers like limited access to gender-inclusive shelters, fear of being outed, and history of legal systems not recognizing LGBTQ relationships hinder effective support (Harland et al., 2021). Specifically, patients were increasingly reticent if they had never shared their LGBTQ identity with their provider or believed the provider would lack resources to support LGBTQ survivors of color (Morris et al., 2025). Without attention to patients lived experiences, concerns, and contextual vulnerabilities, well-intentioned efforts may fall short (Miller et al., 2021; Morris et al., 2025). Collectively, these findings illustrate that even when screening occurs, disclosure is not guaranteed (Heron & Eisma, 2021; Niolon et al., 2017; Portnoy et al., 2020; Sprague et al., 2013).

Barriers

Screening for IPV requires careful consideration, as clinicians must balance brevity with comprehensiveness, recognizing that emotional and sexual abuse often predict more severe outcomes (Rabin et al., 2009; WHO, n.d.). Several barriers exist that contribute to missed or inadequate screenings (Phares et al., 2019). Providers face barriers such as time constraints, lack of training, and personal discomfort (Melhado et al., 2024; Sprague et al., 2012; Sprague et al., 2013). Phares et al. (2019) found that the most common barriers to effective screening were lack of training, provider attitudes and perceptions regarding IPV, lack of awareness, forgetfulness, and personal factors such as discomfort. Additionally, it was identified that in many cases, there was a lack of private space and sufficient time to address these sensitive topics or interventions. System-level gaps in training and infrastructure, along with limited follow-up pathways, further hinder effective responses (Miller et al., 2021).

Providers also share concerns over the consequences of positive screening, with a lack of evidence-based treatments, unclear clinic policies, limited support, and lack of resources (Portnoy et al., 2020). Of this shared sentiment across patients and providers, both groups also agree that there should be standardized universal screenings in order to reduce stigma, address IPV victimization, and address IPV use/perpetration to gain a more comprehensive understanding of the issue (Portnoy et al., 2020). To greater reduce burden of screening disclosure, it is recommended that physicians should also utilize nonjudgmental acknowledgment of their patients' sexual behavior and gender identities to give the best care to the patient and their specific healthcare needs and offer individuals resources (Kelly et al., 2025).

Overall, mental health settings have shown to be better suited for these types of conversations; however, primary care is positioned to become more strategically employed (Portnoy et al., 2020). Primary care settings offer several distinct advantages due to their accessibility and practicality, as well as their role as the first point of entry and initial contact within the healthcare system for many individuals experiencing victimization (Portnoy et al., 2020). While screening alone is not sufficient, its strategic implementation can enable early identification, safety planning, and access to support (Niolon et al., 2017; Silverstein et al., 2025). However, gaps remain in practice (Reisenhofer et al., 2019; Sprague et al., 2012). Few providers receive sufficient IPV education, and there is limited research on best practices for LGBTQ+ and intersectional populations (Morris et al., 2025; Sprague et al., 2013). Additional work is needed to strengthen provider training, integrate screening into routine workflows, and expand trauma-informed, culturally responsive interventions, particularly for those most at risk (Heron & Eisma, 2021; Sprague et al., 2012; Sprague et al., 2013).

Facilitators

While literature on IPV screening often highlights its unique emotional, legal, and relational complexities, physicians routinely navigate similarly sensitive and emotionally charged conversations in other areas of care (Choi & Lin, 2024). Many of the barriers reported in IPV screening, such as provider discomfort, uncertainty about timing, and fear of harming the patient relationship, closely mirror those encountered in discussions about organ donation, hospice care, withdrawal of life-sustaining treatment, and adolescent sexual health (Alexander et al., 2014; Pengel et al., 2025). Across these domains, research consistently shows that when providers engage patients in early, open, and compassionate conversations, outcomes improve in terms of disclosure and in ensuring that care aligns with patient values (Alexander et al., 2014; Choi & Lin, 2024; Keating et al., 2010). For example, Pengel et al. (2025) found that clinicians initiating conversations about organ donation often faced emotional distress and hesitancy around timing, fearing damage to trust. However, when equipped with training and structured communication tools, providers reported greater confidence and more value-aligned family decisions. Similarly, Wright et al. (2008) showed that patients who had the opportunity to discuss end-of-life preferences with their provider were more likely to receive care consistent with those preferences and experienced better psychological adjustment, highlighting how initiating difficult conversations fosters patient agency. Among adolescents, research has shown that youth are more likely to disclose and feel supported when physicians proactively address topics such as puberty and sexual health, helping normalize the discussion and avoid harmful assumptions (Alexander et al., 2014). In ICU settings, Keating et al. (2010) observed that delays in conversations about the withdrawal of life-sustaining treatment often stemmed from provider discomfort or assumptions about patient readiness, barriers that are also well-documented in the IPV literature (Keating et al., 2010; Melhado et al., 2024; Sprague et al., 2012; Sprague et al.,

2013). These delays restricted patients' ability to make informed, values-consistent decisions (Keating et al., 2010). Likewise, Rhodes et al. (2006) found that when electronic prompts reminded providers to ask about IPV, disclosure rates increased and follow-up support improved. This suggests that system-level interventions and informed training can reduce provider hesitancy and improve care (Hussain et al., 2015; Rabin et al., 2009; Rhodes et al., 2006). Together, these findings demonstrate that the challenges of IPV screening are not unique, and looking towards lessons learned from other emotionally complex medical conversations can inform IPV screening practices and offer a path forward (Alexander et al., 2014; Pengel et al., 2025). Across clinical contexts, the timing, tone, and presence of provider-initiated dialogue consistently contribute to patient empowerment, emotional safety, and better outcomes (Alexander et al., 2014; Choi & Lin, 2024; Keating et al., 2010; Pengel et al., 2025). Applying these strategies to IPV holds promise for enhancing trust, reducing missed opportunities, and ultimately improving care for survivors (Alexander et al., 2014; Choi & Lin, 2024; Keating et al., 2010; Pengel et al., 2025).

Present Study

The present study aimed to examine the frequency and predictors of IPV screening at the patient level and disclosure among emerging adult women, including cisgender women, transgender women, transgender men, and nonbinary/gender-nonconforming individuals in the United States. Given limited research on IPV screening experiences among LGBTQ+ and racially/ethnically diverse populations, this study explored disparities in being asked about IPV and in disclosing IPV experiences in healthcare settings. Based on previous literature, it was hypothesized that certain groups, such as people of color and LGBTQ+/nonconforming participants, may be less likely to report being asked about IPV in healthcare settings, and that

participants identifying as transgender women/men or nonbinary/gender-nonconforming may report distinct barriers to disclosure. Additionally, those who have higher rates of satisfaction with their health care interaction may have a greater likelihood of disclosing IPV if asked. However, these hypotheses are largely exploratory given the gaps in prior literature, yet aim to inform future, more targeted research on reducing disparities in IPV screening and response in clinical practice.

Chapter 2: Methods

Determining Sample

Participants were recruited online and eligible for inclusion in the study if they were 18 to 29 years of age, resided in the United States, were in a relationship in the past 12 months, were fluent in English, and had attended an in-person healthcare appointment in the past 12 months. Participants were also included if they identified as cisgender female, transgender (including transgender woman or transgender male), or as nonbinary/gender-nonconforming individuals (including intersex). Exclusion criteria included individuals outside the specified age range (18-29), identifying exclusively as cisgender men, not being in a relationship in the past 12 months, or not attending an in-person healthcare appointment.

A total of 647 individuals signed up to participate in this study via the Prolific platform. Of these, 380 did not meet the inclusion criteria and thus were screened out. Three participants were rejected for insufficient completion of the survey. The final sample consisted of 264 participants who met all inclusion criteria and completed the full survey.

Participants

Participants were 264 adults aged between 18 and 29 residing in the United States with fluency in the English language. The mean age of participants was 25.64 (range 19-29; *SD* = 2.6). Respondents who identified as women comprised 87.9% of the sample (*n* = 232), the majority of whom were cisgender women (87.5%, *n* = 231). Transgender participants accounted for 3.8% of the sample, including 2.7% transgender men (*n* = 7) and 1.1% transgender women (*n* = 3). Gender-diverse participants comprised 8.3% of the sample, including 6.8% who identified

as nonbinary (*n* = 18) and 1.5% who preferred to self-label (*n* = 4). Most participants were assigned female at birth (96.2%, *n* = 254), whereas 3% were assigned male at birth (*n* = 8) and 0.8% were assigned intersex at birth (*n* = 2).

Most participants identified as White (59.5%, *n* = 157), followed by Black/African American (12.9%, *n* = 34), Hispanic/Latinx (9.8%, *n* = 26), Asian/Pacific Islander (9.1%, *n* =24), Middle Eastern and North African (2.7%, *n* = 7), and Native American (2.3%, *n* = 6). Most (85.2%, *n* = 225) had at least some college education or more. Slightly less than three quarters (73.1%, *n* = 193) of the participants' parents had at least some college education. See Table 1 for detailed descriptors of participant and parent education.

In the past 12 months, 86% (*n* = 227) of participants reported having an in-person appointment with their primary care physician, 53.4% reported having visited the OB/GYN (*n* = 141), and 17.4% (*n* = 46) reported that they had attended another related in-person appointment. Status of health insurance was diverse, with private insurance through their employer (36%, *n* = 95) most commonly reported, followed by Medicaid (30.3%, *n* =80), insurance through a parent or spouse (26.5%, *n* = 70), no insurance (6.8%, *n* =18), private insurance purchased individually (6.4%, *n* = 17), and other insurance (2.6%, *n* = 7). When asked if they had a chronic health condition or disability, 40.4% of participants (*n* = 107) identified as having a disability or chronic illness, whereas 59.6% of participants did not (*n* = 157). The majority of participants worked outside of the home (70.1%, *n* = 185) or were students (11.4%, *n* = 30). Most were in an exclusive romantic relationship (83.7%; *n* = 221). Refer to Table 1 for further details on employment status and relationship status.

Procedure

IRB approval was obtained, and subsequent recruitment was conducted via Prolific, an online research recruitment platform that supports demographic prescreening. Convenience sampling was used to maximize participant screening from November 2025 through early December 2025. Prolific screening filters were used to target individuals who were U.S. residents, fluent in English, aged 18 to 29, reported a healthcare provider consultation within the past year, and of any gender (in order to maximize the initial sample, all genders were included due to language of the screener question in Prolific that constricted the target sample). Eligible participants were redirected from Prolific to an external Qualtrics survey.

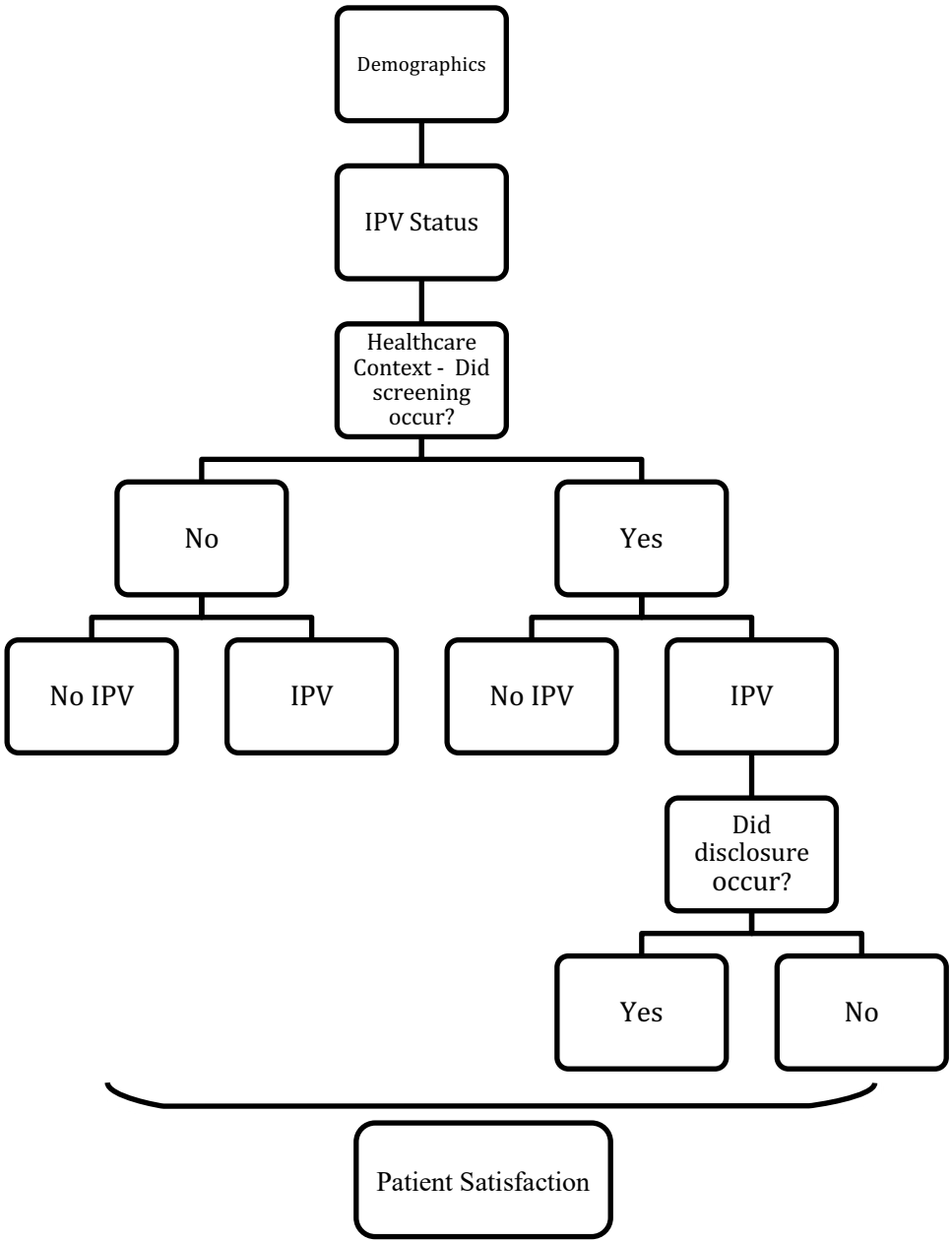
Upon entering the Qualtrics platform participants were first presented with an electronic informed consent form describing the purpose of the study, procedures, risks, benefits, confidentiality protections, and voluntary nature of participation. Participants were asked to indicate whether they agreed to participate by responding *yes* or *no* to the statement asking them to confirm their consent. Only individuals who indicated consent were allowed to proceed to the survey. Screening followed to assess gender, sex assigned at birth, age, relationship status, and recent healthcare visit. Those who initiated participation but were screened out of the survey due to ineligibility were compensated $0.25 for their time. Participants were instructed to complete the survey in a private location and avoid including personally identifying information in open-ended responses. The survey consisted primarily of closed-ended items; however, participants were also given the opportunity to describe their experiences via open-ended questions.

Figure 1 provides a graphic depicting the general survey flow. Eligible participants completed questions on demographics, IPV history/status, and most recent in-person healthcare experience (including whether they were screened for IPV). Participants were restricted to

respond regarding their most recent in person healthcare appointment to improve the interpretability of IPV screening experiences, as telehealth encounters may differ substantially in privacy and safety considerations. Participants were then asked to indicate who asked them about IPV during their healthcare appointment.

Figure 1

Survey Flow



Note. General outline for organization purposes. Further details are in Figure 2.

Based on participants' responses regarding IPV history and whether they had been asked about IPV, survey branching directed participants to question sets corresponding to their reported experiences. Branching was first determined by IPV screening status, then further branched based on whether or not the person had past experience with IPV as assessed by the E-HITS (see Figure 1 and Figure 2 for further information). Following branching, all participants completed questions assessing satisfaction with their healthcare provider at their most recent visit. They also had the opportunity to provide additional comments regarding their experiences through open-ended questions included at the end of each survey section.

There were two questions integrated into the survey assessing attention of respondents to ensure data integrity, and those who gave more than one incorrect response were excluded from data analysis (e.g., *please select agree for this question to show that you're paying attention*). Participants who met the criteria, consented, and returned a completion code were compensated $4.00 for survey completion. On average, survey completion took respondents just over 4 minutes (M = 261.42 seconds, SD = 413.82 seconds). All participants were provided with resource information at the conclusion of the survey. All responses were collected anonymously and stored securely in compliance with data protection regulations.

Due to a technical error, the ethnicity question was not included in the initial survey. Because the study was done on the Prolific platform, it was possible to send a targeted message to all participants who had completed the full survey inviting them to complete a one question follow up survey regarding their ethnic identity for which they were compensated $0.15. The final sample for the ethnicity variable comprised of 215 of the initial participants who responded to the follow up survey.

Measures

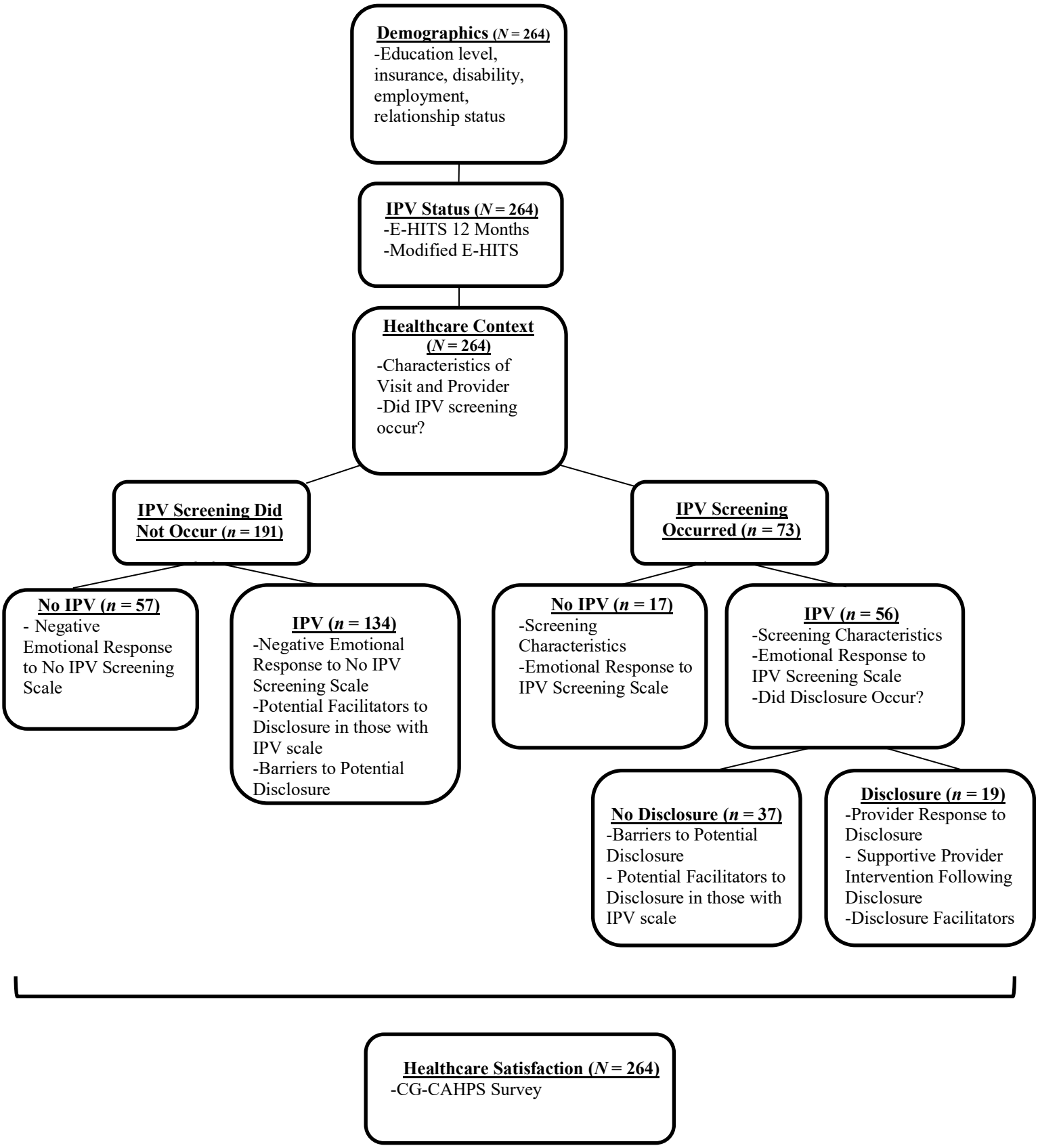
Screening

Following consent, participants completed eligibility screening questions assessing gender identity, sex assigned at birth, age, relationship history, and recent healthcare utilization. For example, participants were asked, *what is your current gender identity, what sex were you assigned at birth*, and *how old are you* (range = 16 to 29). They were then prompted to respond regarding their relationship status, *in the past 12 months, have you been in a romantic/sexual relationship*, and healthcare appointment status*, in the past 12 months, have you had an in-person appointment with the following (not including telehealth/virtual appointments*; see Appendix A for details).

Figure 2 provides a detailed outline of the measures and the sample size that correspond to each survey branch. The measures described in Figure 2 are described in greater detail below.

Figure 2

Descriptive Survey Flow



Demographics

Demographic questions assessed participant education level, parental education level, and insurance status (*what is your current form of health insurance?*). Participants were asked to provide disability status (*do you identify as having a disability or chronic health condition?*), employment status, and relationship status (*What is your current marital/relationship status*; See Appendix B for detailed information).

IPV Status

Participants were then asked about experiences of intimate partner violence (IPV) using the Extended-Hurt, Insulted, Threaten, Scream (E-HITS; Chan et al., 2010; Iverson et al., 2015). This measure began with a brief description indicating that IPV refers to situations in which an intimate partner may have acted in ways that were controlling, hurtful, or violent. The E-HITS is a 5-item measure that assesses IPV victimization in the *past 12 months*, including psychological (e.g., threaten you with harm), physical (e.g., physically hurt you), verbal (e.g., insult you or talk down to you), and sexual (e.g., force you to have sexual activities) forms of victimization (Chan et al., 2010). Items were rated on a 5-point Likert-style scale (frequency response options ranging from 1-*never* to 5-*frequently*). The five items were then totaled and, using the recommended cutoff score of ≥7, classified as experiencing IPV if they received a score of 7 or more (Chan et al., 2010). Total scores could range from 5 to 25, where higher scores indicated greater victimization (Chan et al., 2010).

The optimal cutoff score of 7 for the E-HITS provides the best balance of sensitivity (.75) and specificity (.82; Chan et al., 2010; Iverson et al., 2015). Previous psychometric data found no significant statistical difference between the E-HITS and the 'gold standard' (Revised Conflict Tactics Scale [CTS-2]) in detecting IPV in terms of specificity and sensitivity (Chan et al., 2010;

Iverson et al., 2015). The E-HITS has further demonstrated good psychometric properties in Chinese populations, with internal consistency reported as 0.90 and test-retest reliability at 0.71 (Chan et al., 2010) and moderate internal consistency of 0.76 in Hispanic populations (Chen et al., 2005). In the present study, Cronbach's alpha was considered good at .83.

A separate modified version of the E-HITS assessed IPV experiences *since the age of 16*. This scale contained the same 5-items as on the original E-HITS, measured using the same 5-point Likert-style scale (frequency response options ranging from 1-*never* to 5-*frequently*) but modification of instructions to inquire about victimization *since the age of 16* (*since the age of 16, have any of your previous or current partners done any of the following*; see Appendix C). Scores could range from 5 to 25, with higher scores indicating greater levels of IPV, and scores of ≥7 used to screen positive for having at least some experience with IPV since the age of 16. In the present study, Cronbach's alpha was considered good at .88.

Healthcare Context

Participants were then asked to think about their most recent in-person visit with a physician within the past year. They reported whether the appointment was with their usual physician, the primary purpose of the visit (e.g., *annual physical/routine check-up*), and the provider's gender. Participants were subsequently asked whether IPV screening occurred during that appointment. See Appendix D.

Response to IPV Screening (or Lack of)

As indicated above, all participants were asked if the healthcare provider conducted IPV/relationship safety screening. Two survey pathways led to different measures depending on whether they reported that they had been asked or not.

Emotional Response to IPV Screening. All participants who were asked about their experience with IPV or relationship safety at their most recent healthcare appointment, regardless of IPV status, were asked about their emotional reaction to having this be a part of their appointment. A 7-item measure was developed to assess the emotional range of reaction that may occur. This measure asked *to what extent did being asked about your experiences with IPV at your most recent physician visit make you feel each of the following*, with response options rated on a Likert-style scale (1-*not at all* to 5-*very much*). Although all participants who received this measure were asked about relationship safety, due to differing IPV status certain groups received different lead ins to the measure. Please see Appendix E for differences in instructions. Psychometric properties of this scale will be examined in the results below.

Negative Emotional Response to No IPV Screening. Similarly, all participants regardless of IPV status who were *not* asked about IPV or relationship safety at their most recent healthcare appointment were asked how they felt that they were not asked about this topic. A 5-item measure was developed to assess the emotional range of reaction that may occur in those who were *not* asked about their IPV experience at their healthcare appointment (*to what extent did you feel each of the following about not being asked about IPV or relationship safety during this most recent physician's visit?*). Response options were rated on a Likert-style scale from 1-*not at all* to 5-*very much*. Although all participants who received this measure were *not* asked about relationship safety, due to differing IPV status certain groups received different lead ins to the measure. Please see Appendix F for differences in instructions. Psychometric properties of this scale will be examined in the results below.

Responses Among Individuals Not Asked or Not Disclosing IPV

To examine experiences surrounding missed screening and non-disclosure, participants completed measures assessing emotional responses and factors influencing potential disclosure decisions.

Potential Facilitators of Disclosure in those with IPV. A 7-item measure was developed to assess potential facilitators of disclosure in those with experience of IPV who either did not disclose when asked or were not given the opportunity to disclose (were not asked). This measure asked *to what extent would each of these have made you feel safe or comfortable enough to disclose your IPV experience?* with response options rated on a Likert style scale from 1-*not at all* to 5-*very much* (e.g., *direct and respectful questions from the provider).* Instructions varied depending on experience, such that individuals who were asked but did not disclose considered factors that would have made them feel comfortable while individuals who were not asked considered potential circumstances that could foster their disclosure. For detailed information, see Appendix G. Psychometric properties will be examined in the results below.

Barriers to Potential Disclosure. Those with prior IPV experience who were not asked and those with IPV experience who were asked and chose not to disclose were given a 7-item measure to assess what factors hinder disclosure of IPV experiences. Instructions varied, with those who chose not to disclose asked to rate factors that worked towards dissuading their disclosure, while those who were not asked considered potential factors that would hinder their disclosure (e.g., *provider seemed too busy*). Response options were on a Likert-style scale (1-*not at all* to 5-*very much)*. See Appendix H for detailed information. Psychometric properties will be examined in the results below.

Understanding the Experience of Disclosure

Disclosure Facilitators. Those who were asked about their IPV experience and chose to disclose were given a 6-item measure that was developed to assess factors that led to disclosure. Response options were on a Likert-style scale (1-*not at all* to 5-*very much)*. Individuals in this category were asked *what factors led you to disclose your experience of IPV with your healthcare provider during this appointment?* (e.g., *the provider asked me directly about IPV*; see Appendix K for detailed information). Response options were on a Likert-style scale ranging from 1-*not at all* to 5-*very much*. Psychometric properties will be examined in the results below.

Provider Response to Disclosure. A 4-item measure was constructed to measure the healthcare providers' response to patient disclosure of IPV status. Respondents were asked *to what extent did your healthcare provider respond in the following ways when you shared your experiences of IPV* (s*upportive, empathetic/understanding, uncaring/dismissive, cold/detached;* see Appendix I for detailed information). Response options were on a Likert-style scale (1-*not at all* to 5-*very much)*. Psychometric properties will be examined in the results below.

Supportive Provider Intervention Following Disclosure. A 6-item measure was developed for those who disclosed their status of IPV when asked at their appointment were asked to rate the level of engagement in constructive activities their healthcare provider took part in. Individuals in this group were asked *to what extent did your healthcare provider engage of each of the following after your disclosure* (e.g., *ask you more about the situation*; see Appendix J for detailed information). Psychometric properties will be examined in the results below.

Healthcare Satisfaction

Satisfaction with the healthcare visit was measured utilizing modified questions from the Consumer Assessment of Healthcare Providers and Systems Clinician & Group Survey (CG-CAHPS) designed to measure patient experience with ambulatory care (Agency for Healthcare

Research and Quality [AHRQ], 2023). Multiple versions of the CG-CAHPS survey have been developed for multiple modes of use (e.g., mail, phone, or mixed-mode) and are available in several languages (AHRQ, 2023). The survey assesses several domains of patient experience, including provider communication, access to care, and care coordination (AHRQ, 2023). The specific items utilized in the modified measure focused on provider communication/respect (see Appendix L for details). These items have demonstrated good reliability in the literature with a Cronbach's alpha reliability of 0.89 for the communication composite (Dyer et al., 2012). In the present study, the items were modified to be on a 5-point Likert-style scale (1 - *No, not at all* to 5 - *Yes, definitely*). The overall satisfaction scale was modified from being on a 1-10 Likert-style scale to a 1-5 Likert-style scale (1 - *Worst visit possible* to 5 - *Best visit possible*). In the present study, Cronbach's alpha was considered good at .88. Further psychometric properties will be examined below.

Additional Details Collected to Aid in Survey Flow

Not Asked with IPV. Those that indicated that they had a history of IPV and were not asked about their experience with IPV at their most recent appointment were asked to select when their IPV experience occurred (e.g., *before age 18*, *age 18-24*, *age 25-59*). They were then asked to indicate whether they would have discussed their experience with a provider if they had been asked at their appointment (*if your provider had asked about IPV and/or relationship safety at this most recent appointment, would you have discussed your experience with IPV?*). Respondents were given the opportunity to provide information about how they felt about their provider not asking about relationship safety via an open-ended question and given the *Negative Emotional Response to No IPV Screening* scale, the *Potential Disclosure Facilitators* scale, and the *Barriers to Potential Disclosure* scale. Participants were then given an additional opportunity

to leave any additional comments about their experience via an open-ended question after completion of these measures. Further details are provided in measures; psychometric properties will be examined in the results below.

Asked About IPV. Participants who reported being asked about IPV were given additional questions about who conducted the screening (e.g., primary provider or other clinical staff), how the screening occurred (e.g., verbally, paper form, or electronic form), and their feelings about being asked. Those that indicated that they had a history of IPV and were screened for their experience with IPV were asked to select when their IPV experience occurred (e.g., *before age 18, age 18-24, age 25-59*). Participants then indicated how they felt about being asked about their IPV experience at the appointment through an open-ended question (*how did you feel about being asked about IPV at your most recent physician's appointment?*) and the *Emotional Response to IPV Screening* scale. Further details are provided in measures; psychometric properties will be examined in the results below.

Asked without IPV. Those who did not indicate IPV experience but were asked at their appointment about IPV were asked to provide additional information on the experience. They were first asked to indicate who asked them about their experiences and how they were asked (as detailed above). They were then given the option to leave comments about how they felt about being asked about IPV at their appointment via an open-ended question (as detailed above) and given the *Emotional Response to IPV Screening* scale. Further details are provided in measures; psychometric properties will be examined in the results below.

Chapter 3: Results

Prior to analysis, data from the initial and follow up surveys were merged by matching Prolific ID's and inputting ethnicity variables obtained through the follow up survey.

Scale Development

A number of scales were created for the present study. The psychometric properties of each of these will be considered before examining the results. Specifically, exploratory factor analysis (EFA) with varimax rotation was used to consider the factor structure of the scales while reliability analysis was used to assess internal consistency reliability. The goal was to ensure scales or subscales had a solid factor structure, were internally consistent, and assessed meaningful constructs of interest.

Screening Occurrence

Emotional Response to IPV Screening. Those who were asked about IPV (regardless of IPV experience) were asked to rate their perceptions of being asked about relationship safety with a 7-item scale that contained both positive and negative feelings about the experience. An initial EFA with varimax rotation was conducted on the 7-item scale suggested a two-factor structure. The resulting solution indicated potential multidimensionality with positive feelings loading on one factor and negative feelings loading on the second factor.

To evaluate this possibility, separate EFAs were conducted by item valence. The positively worded items demonstrated a clear one-factor structure accounting for 65.67% of the variance (eigenvalue = 1.97) and strong factor loadings (ranging from .64 to .90). The resulting subscale showed acceptable internal consistency (Cronbach's $\alpha = .72$). This subscale represented

emotionally validating and supportive screening experiences and from here on out will be referred to as the "IPV Screening was Validating" subscale.

The negatively worded items initially produced a two-factor structure; however, examination of factor loadings and inter-item correlations indicated that one item (*unsafe*) performed poorly and was not conceptually aligned with the remaining items. After removal of this item, the negatively worded items demonstrated a unidimensional structure with strong factor loadings (ranging from .69 to .93) and accounted for 72.39% of the variance (eigenvalue = 2.18). It demonstrated good internal consistency (Cronbach's $\alpha = .80$). This subscale will be named and referred to as the "IPV Screening Was Distressing," which captured adverse emotional reactions to screening experiences. See Table 2 for details.

Negative Emotional Response to No IPV Screening. Those who were not asked about IPV (regardless of IPV status) were asked to rate their feelings surrounding not being asked about relationship safety with a 5-item scale that assessed a range of positive, neutral, and negative feelings about the experience. An initial EFA with varimax rotation was conducted, resulting in a two-factor solution. Two items (*neutral* and *relieved*) were removed due to low-inter item correlations. With the removal of these items, the remaining three items revealed a single factor structure accounting for 70.28% of the variance (eigenvalue = 2.11). Each of the items loaded strongly onto the factor, ranging from .79 to .88. The scale displayed acceptable reliability (Cronbach's $\alpha = .77$). The resulting 3-item "Negative Emotional Response to No IPV Screening" scale seems to measure negative emotionality, given that the two items removed were the only neutral/positive leaning items. It is likely that this measure captured emotional reactions characterized by unmet expectations for provider inquiry and feelings of interpersonal disconnection within the healthcare encounter. See Table 3 for details.

Facilitators

Potential Facilitators of Disclosure in those with IPV. Those with IPV experience who either were not asked by their healthcare provider or did not disclose their experience when asked were given the chance to rate what factors may have increased the likelihood of disclosure. An initial EFA was conducted on the 7 items and revealed a single factor structure, signifying that all of the items relate to the same underlying construct regarding facilitators to disclosure in those who had the potential for disclosure. The final "Potential Facilitators of Disclosure in those with IPV" scale represented perceived relational and environmental conditions that support comfort and willingness to disclose IPV experiences to healthcare providers. All items loaded strongly onto this factor, ranging from .76 to .88. This component explained 68.9% of the total variance (eigenvalue = 4.82), with high inter-item reliability (Cronbach's $\alpha = .92$). See Table 4 for further information.

Disclosure Facilitators. Those who were directly asked about their experience of IPV and did disclose their status were asked to rate what factors led them to disclose. An initial EFA with varimax rotation was run on the 9-item scale and revealed a two-factor structure. After the initial EFA, three items (*my health concerns were connected to IPV*, *I believed the provider could help my situation,* and *I wanted access to resources or support services*) were cut due to weak inter-item correlations and poor factor loadings. After the removal of these items, a single component structure emerged accounting for 60.72% of the variance and an eigenvalue of 3.64. The final 6-item scale titled "Disclosure Facilitators" demonstrated good internal consistency (Cronbach's $\alpha = .84$) with all items loading strongly onto the factor (ranging from .56 to .93). This scale captures perceptions of relational trust, emotional safety, and supportive healthcare

dynamics that facilitated participants' willingness to disclose IPV experiences. For details, see Table 5.

Barriers to Potential Disclosure

Individuals that were either asked about their experience with IPV and chose not to disclose or who had experience with IPV and were not asked at their appointment were given the opportunity to rate what factors hinder disclosure of their experiences of IPV. An EFA with varimax rotation was run on the initial 7-item scale and resulted in a two-factor scale. As a result, one item (*it was not applicable to my situation*) was deleted due to poor factor loading and inter-item correlations. Another EFA was conducted on the final 6-item scale titled "Barriers to Potential Disclosure" and accounted for 56.76% of the variance with a single factor structure, with loadings ranging from .38 to .87 (eigenvalue = 3.41). The internal consistency for the final scale was good (Cronbach's $\alpha = .84$). The final measure captures interpersonal mistrust, perceived lack of emotional safety and provider availability, and fears regarding potential consequences of IPV disclosure. See table 6 for further details.

Healthcare Response

Provider Response to Disclosure. Those who disclosed their experiences of IPV with their healthcare provider were asked to rate their providers' response to their disclosure. Two negatively valanced items were reverse coded before running the initial EFA so that higher scores consistently reflected a more supportive and validating provider response. An EFA was run on the 4-item scale and results indicated a single-component solution accounting for 69.67% of the variance with an eigenvalue of 2.79. All items loaded strongly onto the component (ranging from .65 to .93). This scale seems to capture perceived provider responsiveness and interpersonal engagement following IPV disclosure, ranging from supportive and empathic

responses to emotionally detached and invalidating reactions. The internal consistency of the final "Provider Response to Disclosure" scale was good (Cronbach's α = .82). See Table 7 for details.

Supportive Provider Intervention Following Disclosure. Those who disclosed their experiences of IPV with their healthcare provider were asked to rate their providers' engagement in various behaviors after the disclosure. An EFA on the 6-item "Supportive Provider Intervention Following Disclosure" measure was run and revealed a single-component solution. This solution accounted for 77.49% of the variance, with an eigenvalue of 4.65. The scale demonstrated excellent internal consistency (Cronbach's α = .94). All items loaded strongly onto the component (ranging from .78 to .93). This scale assesses the provider's supportive engagement following IPV disclosure, including follow-up discussion, sustained interpersonal support, and facilitation of access to additional resources and services. See Table 8 for further details.

Satisfaction. Satisfaction with the healthcare visit was measured utilizing modified questions from the Consumer Assessment of Healthcare Providers and Systems Clinician & Group Survey (CG-CAHPS) designed to measure patient experience with ambulatory care (AHRQ, 2023). An EFA was run on the Modified CG-CAHPS items. Results indicated a single-component solution with an eigenvalue of 3.42, accounting for 68.16% of the total variance. All items loaded strongly onto the component, with factor loadings ranging from .78 to .87, indicating that the items represent a single underlying satisfaction construct. In the current study, the measure demonstrated good internal consistency (Cronbach's α = .88). See Table 9 for detailed information regarding the EFA.

Having established the psychometric properties of the scales and subscales developed for the current study, the paper will now turn to an examination of the results.

IPV Experience

Skewness and kurtosis were examined on the E-HITS and adapted E-HITS lifetime screener with no notable abnormalities. Of the total sample, 190 participants (72%) screened positive for a history of IPV (either current or since the age of 16), while 74 participants (28%) screened negative (reported no IPV across lifespan or past 12 months using the cutoff score of ≥7). Of participants who screened positive for IPV, 99 (52.1%) reported IPV at both points (within the past 12 months and since the age of 16), whereas 2 (1.1%) reported IPV only within the past 12 months, and 89 (46.8%) reported IPV only since the age of 16.

Within the full sample, 162 participants (61.6%) scored below the E-HITS cutoff of 7 and were therefore categorized as not endorsing IPV within the past year. Scores of 7 or greater were considered indicative of IPV, with 89 participants (33.7%) scoring between 7 and 14, suggesting relatively mild or infrequent IPV experiences within the past 12 months. In contrast, 12 participants (4.6%) scored 15 or greater, indicating more severe and/or frequent IPV experiences during the past year. The mean score obtained on the 12-month screener was 7.01 (*SD* = 3.06). See Table 10 for further information.

For lifetime IPV (since the age of 16), within the full sample, 76 participants (28.8%) scored below the cutoff and were categorized as not endorsing IPV since age 16. Scores at or above 7 indicated IPV experiences, with 141 participants (53.4%) scoring between 7 and 14, reflecting relatively milder/less frequent IPV experiences across the lifespan. However, 47 participants (17.7%) scored 15 or greater, suggesting more severe and/or frequent IPV experiences since the age of 16. A substantial proportion of participants reported more chronic or

severe IPV experiences across the lifetime compared to the past 12 months, with the mean score obtained on the lifetime/since the age of 16 screener being 9.8 (*SD* = 4.51), nearly 3 points higher on average than the current IPV average score. Additionally, 71.2% of participants on the lifetime screening scored at or above the IPV cutoff, compared to 38.6% who screened at or above the IPV cutoff within the past 12 months. See Table 11 for further information.

Those who screened negative for current IPV and positive for past IPV (*n* = 89) were asked to indicate when their IPV experience occurred. Most individuals indicated that their experience occurred from ages 18-24 (*n* = 55; 62.5%), followed by before the age of 18 (*n* = 29; 33%) and ages 25-29 (*n* = 4; 4.5%). Among those reporting IPV before age 18, the majority scored between 7-10 on the E-HITS (*n* = 17; 58.6%), followed by scores between 11-14 (*n* = 8; 27.6%). Smaller proportions reported scores between 15-18 (*n* = 1; 3.4%) and 19-22 (*n* = 3; 10.3%). Among participants reporting IPV between ages 18-24, most scored between 7-10 (*n* = 34; 61.8%), followed by 11-14 (*n* = 8; 14.5%) and 15-18 (*n* = 9; 16.4%). Smaller proportions reported scores between 19-22 (*n* = 3; 5.5%) and 23-25 (*n* = 1, 1.8%) in this age group. Overall, approximately one-quarter of participants reporting IPV between ages 18-24 scored 15 or greater, suggesting more severe and/or frequent IPV experiences within this age range. Among participants reporting IPV between ages 25-29, scores were primarily between 7-10 (*n* = 2; 50%) and 11-14 (*n* = 2; 50%), with no participants reporting scores above 14.

When examining current age in relation to reported lifetime IPV experiences, older participants generally demonstrated greater IPV severity. Participants aged 19-21, on average, reported lower lifetime E-HITS scores, with relatively few endorsing scores above 14. In contrast, descriptive patterns show participants aged 25-27 and 28-29 showed greater representation in higher lifetime IPV severity categories (particularly scores between 15-18).

Notably, participants aged 28-29 had the highest proportion of elevated lifetime IPV scores, with nearly one-quarter (23.2%) reporting scores of 15 or greater.

When examining current age in relation to reported IPV experiences within the past 12 months, participants demonstrated relatively similar patterns of current IPV severity across age groups. Across all age categories, most participants reported E-HITS scores below the cutoff or within the lower severity categories (7-10 and 11-14). Relatively few participants in any age group endorsed scores above 14. Participants aged 28-29 showed the greatest representation in the 15-18 severity category (4.9%), and descriptive differences across age groups show that IPV severity fell at or just above the cutoff for most when looking at past year victimization, with older age groups indicating more severe levels of IPV.

Characteristics of Most Recent In-Person Healthcare Appointment

All participants who completed the survey reported an in-person doctor's appointment within the last twelve months ($N = 264$). The majority (86%; $n = 227$) reported seeing their primary care physician, followed by OB/GYN (53.4%; $n = 141$) and other (17.4%; $n = 46$). Most participants reported their recent appointment was for their annual physical/routine checkup (42.8%; $n = 113$). Other reasons that were less endorsed included birth control/reproductive health (16.3%; $n = 43$), illness (11.7%; $n = 31$), lab work (11%; $n = 29$), medication refill (9.1%; $n = 24$), and other (9.1%; $n = 24$). Most participants reported *not* being asked about relationship safety/IPV at their appointment ($n = 191$; 72.3%), and 73 reported they were asked (27.7%). These IPV screening categories were used for survey branching and will be considered in all analyses.

IPV Screening Did Not Occur at Healthcare Appointment

As noted above, 191 participants (72.3%) were not asked about relationship safety/IPV at their healthcare appointment. Of these individuals, 134 participants screened positive for IPV experience (70.2%). Of the 134 participants who had a history of victimization and were not screened for IPV, nearly 23% reported that they would have discussed their experiences if they had been asked by their provider (22.9%; *n* = 30).

IPV Screening Occurred at Healthcare Appointment

As described above, 73 participants reported being asked about experiences of IPV or relationship safety at their most recent appointment (27.7% of the full sample). Most (*n* = 39; 53.4%) were asked by their primary provider (e.g., physician, physician's assistant, nurse practitioner), 32 (43.8%) were asked by a nurse or other clinical staff member, and 2 (2.7%) were asked by another person. The most common way individuals were asked was verbally, in person (61.6%, *n* = 45). Paper forms (13.7%, *n* = 10), electronic forms (i.e., via tablet, computer; 11%, *n* = 8), and inquiring both verbally and on a form (13.7%, *n* = 10), were less common.

IPV Disclosure

Of the 73 participants who were asked about IPV or relationship safety at their most recent doctor's appointment, 76.7% (*n* = 56) reported IPV victimization in the E-HITS and modified E-HITS screener. More specifically, 55.4% (*n* = 31) screened positive for IPV in the past year, and 44.6% (*n* = 25) screened positive for a history of IPV since the age of 16. Of those who were asked, nearly 40% of those with victimization status disclosed with their provider (*n* = 19). Importantly, 37 (66.1%) of individuals who were asked about IPV and had prior victimization chose not to disclose to their provider when screened.

Participants who had not experienced recent IPV may have been less likely to perceive their experiences as immediately relevant to the healthcare encounter, thus, additional analyses were conducted to examine whether disclosure differed between participants reporting recent IPV experiences and those reporting only lifetime IPV experiences. A chi-square test of independence was conducted to examine whether IPV disclosure differed between participants reporting recent IPV (indication of IPV within the past 12 months) and those reporting only lifetime IPV experiences (only indication of IPV since age 16 and not in the past 12 months). Results indicated no significant association between IPV timing and disclosure status, $\chi^2(1, N = 56) = 0.09$, $p = .77$. Disclosure rates were similar across groups, with 32.3% of participants reporting IPV at both time points disclosing IPV experiences compared to 36% of participants reporting only lifetime IPV experiences.

Statistical Analyses

Relationship Between Emotional Response to IPV Screening Subscales

A Pearson correlation was conducted to examine the relationship between the IPV Screening Was Validating and IPV Screening Was Distressing subscales of the Emotional Response to IPV Screening scale. Results indicated a small negative association, $r(71) = -.24$, $p = .045$, such that participants who reported greater feelings of validation when screened for IPV tended to report lower levels of distress. The small magnitude of the correlation suggests that validation and distress represent related but distinct dimensions of emotional responses to IPV screening.

Healthcare Satisfaction

Screening Occurrence. To examine associations among healthcare satisfaction and emotional responses to IPV screening experiences, a series of Pearson correlations were

conducted. In those who were not screened, healthcare satisfaction/Modified CG-CAHPS scale had a significant moderate correlation with the Negative Emotional Response to No IPV Screening scale, $r(185) = -.32$, $p < .001$, indicating that patients who reacted negatively when screening did not occur tended to be less satisfied with their care. In those who were screened, healthcare satisfaction showed a significant strong correlation with the IPV Screening was Validating subscale of the Emotional Response to IPV Screening measure, $r(71) = .53$, $p < .001$, in that those participants with higher healthcare satisfaction reported greater feelings of validation and support when screened for IPV. Healthcare satisfaction was unrelated to the IPV Screening Was Distressing subscale, $r(71) = -.19$, $p = .12$.

Factors of Potential Disclosure. Further correlations examined the association among healthcare satisfaction and those with IPV experience who did not share their experience with a healthcare provider (either were not asked or were screened and chose not to disclose) via the perceived Barriers to Potential Disclosure scale and the Potential Facilitators of Disclosure in those with IPV scale. Results indicated that healthcare satisfaction showed a small negative correlation with the Barriers to Potential Disclosure measure, $r(166) = -.24$, $p = .002$, suggesting that participants who reported greater satisfaction with their healthcare experiences endorsed fewer concerns related to potential consequences of disclosure. No significant association was found between healthcare satisfaction and the Potential Facilitators of Disclosure in Those with IPV scale, $r(166) = -.06$, $p = .45$. Similarly, the measure of Barriers to Potential Disclosure was not significantly associated with the Potential Facilitators of Disclosure in Those with IPV scale, $r(166) = .12$, $p = .11$.

Disclosure & Provider Engagement. Correlational analyses were then conducted to examine relationships among healthcare satisfaction and disclosure experiences among the 19

participants who disclosed (participants' perceptions of factors related to IPV disclosure and provider responses following disclosure). Results showed that healthcare satisfaction/Modified CG-CAHPS measure was strongly positively associated with the Disclosure Facilitators scale, $r(17) = .70$, $p < .001$, the Provider Response to Disclosure scale, $r(17) = .58$, $p = .009$, and the Supportive Provider Intervention Following Disclosure measure, $r(17) = .48$, $p = .039$. The Disclosure Facilitators scale was also strongly positively associated with Provider Response to Disclosure, $r(17) = .70$, $p < .001$, but was not significantly associated with Supportive Provider Intervention Following Disclosure, $r(17) = .39$, $p = .103$. Finally, Provider Response to Disclosure was strongly positively associated with Supportive Provider Intervention Following Disclosure, $r(17) = .55$, $p = .015$. Overall, results suggested that more positive healthcare experiences were associated with greater perceived support for disclosure and more favorable evaluations of provider responses. Participants who reported greater overall satisfaction with their healthcare experiences were also more likely to report factors that facilitate disclosure, perceive their provider's response more positively, and report receiving supportive provider interventions, yet factors that facilitate disclosure may be conceptually distinct from the actions providers take after disclosure occurs.

Reaction to Screening Occurrence and Related Factors

Screening Reactions and Disclosure. Another series of correlations were conducted to examine the association between the measures that focused on screening reactions and subsequent actions within the healthcare encounter taken among the 19 participants who disclosed their IPV experience to their healthcare provider (including both subscales of the Emotional Response to IPV Screening measure, the Disclosure Facilitators scale, the Provider Response to Disclosure scale, and the Supportive Provider Intervention Following Disclosure

measure). No significant associations were observed between Disclosure Facilitators and the IPV Screening was Validating subscale, $r(17) = .45$, $p = .056$, Provider Response to Disclosure and the IPV Screening was Validating subscale, $r(17) = .44$, $p = .063$, or Supportive Provider Intervention Following Disclosure and the IPV Screening was Validating subscale, $r(17) = .39$, $p = .099$. Finally, the IPV Screening Was Distressing subscale was not significantly associated with Disclosure Facilitators, $r(17) = -.26$, $p = .289$, Provider Response, $r(17) = .06$, $p = .818$, or Supportive Provider Intervention, $r(17) = .11$, $p = .663$.

Screening Reactions and No Disclosure. Correlation analyses were also conducted to examine associations between participants' emotional reactions to IPV screening and perceived barriers to disclosing IPV experiences in those who either were not asked or were screened and chose not to disclose. Results indicated a significant positive association between the IPV Screening Was Distressing subscale and the Barriers to Potential Disclosure measure, $r(35) = .62$, $p < .001$. Participants who reported greater feelings of disappointment, anger, and lack of support surrounding IPV screening also reported greater perceived barriers to disclosure.

Reaction to No Screening Occurrence and Related Factors

The association between the Negative Emotional Responses to No IPV Screening scale, the Barriers to Potential Disclosure scale, and the Potential Facilitators of Disclosure in Those with IPV measure was also explored via Pearson correlation analyses. Results indicated a weak significant positive correlation between the Negative Emotional Response to No IPV Screening scale and the Potential Facilitators of Disclosure in Those with IPV scale, $r(129) = .24$, $p = .007$, such that participants who reported stronger negative emotional responses when IPV screening did not occur also reported greater endorsement of factors that could facilitate disclosure in healthcare settings. No significant associations were found between Negative Emotional

Response to No IPV Screening measure and the Barriers to Potential Disclosure scale, $r(129) = .11$, $p = .22$, or between the Barriers to Potential Disclosure scale and the Potential Facilitators of Disclosure in Those with IPV scale, $r(166) = .12$, $p = .11$, such that reactions about not being screened are likely driven by a desire for supportive screening practices than by fears or obstacles to disclosure and suggesting that facilitators and barriers may represent distinct constructs rather than opposite ends of the same continuum.

IPV Screening Predictors

In order to examine what demographic factors were related to IPV screening a series of Chi-square of analyses were conducted. The first analysis considered the relationship between gender identity (cis-gender woman versus other) and IPV screening. Results indicated no significant association, $\chi^2(1, N = 264) = 0.13$, $p = .72$. Cisgender women (27.3%) and gender-diverse participants (30.3%) reported similar rates of being asked about IPV.

The second analysis considered the relationship between race and IPV screening. Results indicated no significant association between race and likelihood of being screened for IPV, $\chi^2(1, N = 264) = 1.34$, $p = .25$. However, participants identifying as Non-White or Multiracial were screened at a slightly higher rate (30.6%) compared to participants identifying as White (24.2%)

A third analysis considered insurance status and IPV screening. Results indicated a significant association between insurance coverage and IPV screening, $\chi^2(1, N = 264) = 4.91$, $p = .03$. Participants with insurance were screened for IPV at a higher rate (32%) compared to participants without insurance (19.1%).

A final chi-square analysis considered the relationship between disability status and IPV screening. Results indicated no significant association between disability/chronic health condition status and IPV screening, $\chi^2(1, N = 264) = 0.03$, $p = .87$. Participants identifying as

having a disability or chronic health condition were screened for IPV at a similar rate (27.1%) as participants who did not identify as disabled (28%).

Disclosure Predictors

Further analyses indicated there was no significant association between gender identity and IPV disclosure among participants who were screened, $\chi^2(1, N = 56) = 1.38, p = .24$. Cisgender women disclosed IPV at a somewhat higher rate (36.7%) compared to participants identifying as another gender identity (14.3%).

The next set of analyses were conducted to examine whether demographic characteristics were associated with IPV disclosure among participants who were asked about IPV. Results indicated no significant association between race and disclosure, $\chi^2(1, N = 56) = 1.99, p = .16$, with participants identifying as Non-White or Multiracial disclosing IPV at a higher rate (41.9%) compared to participants identifying as White (24.0%).

Analyses then examined whether insurance status was associated with IPV disclosure during a healthcare visit among participants who were asked about IPV. Results indicated no significant association between insurance status and disclosure, $\chi^2(1, N = 56) = 0.003, p = .95$. Participants with insurance disclosed IPV at similar rates (34.1%) as participants without insurance (33.3%).

The final chi-square analysis in this category examined whether identifying as having a disability or chronic health condition was associated with IPV disclosure during a healthcare visit among participants who were asked about IPV. Results indicated no significant association between disability/chronic health condition status and disclosure, $\chi^2(1, N = 56) = 1.07, p = .3$. However, participants identifying as having a disability or chronic health condition disclosed

IPV at a somewhat lower rate (26.1%) compared to those who did not identify as disabled (39.4%).

In order to examine whether Emotional Response to IPV Screening related to disclosure, a series of independent samples of *t*-tests were conducted. The first *t*-test was conducted to examine whether scores on the IPV Screening Was Validating subscale differed as a function of disclosure status among participants with IPV experience who were screened for IPV. Participants who disclosed IPV ($M = 3.47$, $SD = 0.99$, $n = 19$) reported somewhat higher levels of emotional validation than participants who did not disclose ($M = 3.01$, $SD = 0.99$, $n = 37$); however, this difference did not reach statistical significance, $t(54) = 1.65$, $p = .105$, $d = 0.47$.

The second *t*-test examined whether scores on the IPV Screening Was Distressing subscale differed as a function of disclosure when screened. Participants who disclosed IPV ($M = 2.11$, $SD = 1.10$, $n = 19$) reported somewhat higher levels of distress than participants who did not disclose ($M = 1.61$, $SD = 0.96$, $n = 37$); however, this difference was not statistically significant, $t(54) = 1.73$, $p = .09$, $d = 0.49$.

Satisfaction Predictors

A 2 × 2 analysis of variance (ANOVA) was conducted to examine healthcare satisfaction as a function of IPV history and whether participants were asked about IPV during their most recent healthcare visit. Results revealed no significant main effect of IPV history, $F(1, 258) = 0.02$, $p = .89$, $\eta^2p < .001$. Participants with a history of IPV reported similar levels of healthcare satisfaction ($M = 4.22$, $SD = 0.73$) compared to participants without a history of IPV ($M = 4.23$, $SD = 0.71$). There was also no significant main effect of being asked about IPV, $F(1, 258) = 0.56$, $p = .46$, $\eta^2p = .002$. Participants who were asked about IPV reported comparable healthcare satisfaction ($M = 4.31$, $SD = 0.7$) to those who were not asked ($M = 4.19$, $SD = 0.73$). Finally, the

interaction between IPV history and being asked about IPV was also not significant, $F(1, 258) = 0.52$, $p = .46$, $\eta^2p = .002$. However, the pattern of means was in the expected direct with healthcare satisfaction being highest among participants with a history of IPV who were asked about IPV ($M = 4.34$, $SD = 0.73$) and lowest among participants with a history of IPV who were not asked ($M = 4.16$, $SD = 0.72$). Among participants without IPV, healthcare satisfaction was nearly identical regardless of screening status (asked: $M = 4.24$, $SD = 0.61$; not asked: $M = 4.23$, $SD = 0.74$).

An independent samples *t*-test was conducted to examine differences in healthcare satisfaction between participants with a history of IPV who disclosed IPV experiences and those who did not disclose IPV experiences when asked by a healthcare provider. Participants who disclosed IPV reported slightly higher healthcare satisfaction scores ($M = 4.49$, $SD = 0.63$) compared to participants who did not disclose IPV ($M = 4.25$, $SD = 0.77$); however, this difference was not statistically significant, $t(54) = 1.17$, $p = .25$, $d = 0.33$.

Chapter 4: Discussion

Intimate partner violence has been established as public health crisis, with exposure affecting nearly half of all women in the U.S. across their lifespan (Leemis et al., 2022; WHO, n.d.). Previous studies have shown that within the United States, one in five women aged 16-64 report experiencing some form of recent IPV (i.e., within the past 5 years; Ranji et al., 2025). Women, as compared to men, tend to have greater IPV risk, with emerging data indicating that women who are low-income, LGBTQ+, disabled, or from racially minoritized groups, are at a significantly elevated risk of experiencing IPV (Leemis et al., 2022; Ranji et al., 2025). Beyond the immediate and acute effects of victimization, those who experience IPV are often subjected to further effects, such as mental and neurological disorders, poor general health and daily functioning, cognitive impairment, attachment problems, subsequent violence victimization, and even death (ACOG, n.d.; Leemis et al., 2022; Reisenhofer et al., 2019; WHO, n.d.). Despite these harms, only 35% of women affected by IPV report accessing healthcare for related needs, with barriers such as privacy concerns, fear, and intimidation contributing to more than 1 in 10 women being unable to access needed healthcare services (Ranji et al., 2025).

The present study examined patterns of IPV screening and disclosure among emerging adult women and gender-diverse individuals in healthcare settings. Given the limited research examining IPV screening experiences among LGBTQ+ and racially diverse emerging adults, the study sought to explore potential disparities in screening and disclosure while also examining the role of healthcare satisfaction and interpersonal factors associated with disclosure. In addition, the study developed and evaluated several novel measures assessing emotional responses to

screening, barriers and facilitators to disclosure, provider responses to disclosure, and supportive provider interventions. Several notable findings emerged regarding the prevalence of IPV experiences, rates of screening and disclosure, factors associated with screening, and the relationship between healthcare satisfaction and IPV-related healthcare interactions. Collectively, the findings suggest that IPV is highly prevalent among emerging adults, yet opportunities for identification through healthcare screening remain limited. Furthermore, the results indicate that disclosure may be influenced less by demographic characteristics and more by relational aspects of the healthcare encounter, including trust, emotional safety, validation, and provider responsiveness, reinforcing past findings that posit disclosure in medical settings as deeply influenced by interpersonal and structural factors (Portnoy et al., 2020).

Scale Development and Implications for Understanding Healthcare Experiences

The development and preliminary validation of several measures designed to assess emotional reactions to IPV screening, reactions to the absence of screening, barriers and facilitators to disclosure, provider responses following disclosure, and supportive provider interventions was a contribution of the present study. Overall, the exploratory factor analyses supported clear and interpretable factor structures, and all final scales demonstrated acceptable to excellent internal consistency reliability. These findings provide preliminary evidence that the constructs assessed in the present study represent meaningful and measurable dimensions of patients' experiences with IPV-related healthcare interactions.

One notable finding was the multidimensional nature of the Emotional Response to IPV Screening scale. Rather than representing opposite ends of a single continuum, positive and negative reactions to screening emerged as distinct but related dimensions. Specifically, the IPV Screening was Validating subscale captured feelings of support, validation, and understanding

following screening, whereas the IPV Screening Was Distressing subscale reflected emotional discomfort, embarrassment, anger, and other adverse responses. The relatively weak association between these subscales further suggests that positive and negative reactions may coexist within the same screening experience. This finding demonstrates the complexity of patient responses to IPV inquiry and suggests that screening experiences cannot simply be characterized as either positive or negative (Portnoy et al., 2020). Instead, individuals may simultaneously appreciate being asked about relationship safety while also experiencing discomfort discussing a sensitive topic (Morris et al., 2025; Peitzmeier et al., 2020; Portnoy et al., 2020; Santos et al., 2025).

Similarly, participants' reactions to not being screened were characterized by a distinct emotional response pattern centered on unmet expectations and feelings of interpersonal disconnection. The emergence of a single factor reflecting disappointment, lack of support, and related negative emotions suggests that some patients may interpret the absence of screening as a missed opportunity for provider concern or support (Alexander et al., 2014; Choi & Lin, 2024; Keating et al., 2010; Pengel et al., 2025). This interpretation is further supported by the finding that participants who reported stronger negative reactions to not being screened also endorsed more factors that would facilitate disclosure, suggesting that dissatisfaction with the absence of screening may reflect a desire for supportive provider inquiry rather than avoidance of disclosure (Keating et al., 2010; Melhado et al., 2024; Sprague et al., 2012; Sprague et al., 2013).

The disclosure-related scales revealed a particularly consistent pattern. Both facilitator measures and the barriers measure were largely organized around interpersonal and relational themes. Facilitators of disclosure reflected emotional safety, trust, empathy, privacy, direct provider inquiry, and supportive healthcare dynamics. In contrast, barriers reflected interpersonal mistrust, perceived lack of provider availability, concerns regarding emotional safety, and fears

about the consequences of disclosure. Notably, these constructs did not emerge as opposite ends of a single dimension. Instead, facilitators and barriers appeared to represent distinct psychological processes. The absence of significant correlations between the facilitator and barrier measures provides further support for this interpretation. Consequently, increasing disclosure may require more than simply reducing barriers; providers may also need to actively cultivate factors that promote trust, safety, and willingness to disclose (Feder et al., 2006; Heron & Eisma, 2021; Portnoy et al., 2020).

The provider response measures demonstrated a similarly coherent structure. Both the Provider Response to Disclosure scale and the Supportive Provider Intervention Following Disclosure scale yielded strong single-factor solutions and excellent internal consistency. Together, these scales suggest that patients distinguish between providers' interpersonal responses to disclosure and the concrete actions providers take following disclosure. Although related, these dimensions appear to represent separate components of effective IPV-related care. Patients may evaluate providers not only on whether they offer resources and referrals, but also on whether they communicate empathy, validation, and genuine concern during disclosure conversations (Feder et al., 2006; Heron & Eisma, 2021; Portnoy et al., 2020).

Collectively, the scale development findings point toward a broader conceptual conclusion: IPV screening and disclosure appear to be fundamentally relational processes (Portnoy et al., 2020). Across nearly all measures developed in the present study, themes of emotional safety, trust, validation, empathy, provider responsiveness, and interpersonal connection emerged repeatedly. Whether participants were discussing reactions to screening, reactions to not being screened, barriers to disclosure, facilitators of disclosure, or provider responses following disclosure, interpersonal dynamics consistently appeared to play a central

role (Feder et al., 2006; Heron & Eisma, 2021). This convergence across multiple independently developed scales suggests that relational factors may represent one of the most important mechanisms influencing how individuals experience IPV-related healthcare interactions (Feder et al., 2006; Heron & Eisma, 2021; Portnoy et al., 2020).

Although the psychometric findings were encouraging, the scales should be considered preliminary and warrant further refinement and validation. Several scales required item removal to achieve clear factor structures, suggesting that some items may not have adequately captured their intended constructs. Future research should replicate these factor structures in larger and more diverse samples, evaluate test-retest reliability, and examine convergent and discriminant validity with established measures of healthcare experiences, patient-provider relationships, and trauma-related disclosure (Heron & Eisma, 2021; Sprague et al., 2012; Sprague et al., 2013). Additional items may also strengthen certain scales by expanding coverage of important domains such as cultural responsiveness, identity-related concerns, perceived stigma, and readiness to disclose (Morris et al., 2025; Sprague et al., 2013). Nonetheless, the present findings provide an important foundation for future research by offering a set of theoretically meaningful measures that capture multiple dimensions of IPV screening and disclosure experiences within healthcare settings.

Incidence and Prevalence of IPV

Of importance and consistent with previous findings (Leemis et al., 2022; WHO, n.d.), the present study found a particularly high prevalence of IPV reported within the sample. More than 70% of participants screened positive for a history of IPV, including current IPV or lifetime IPV occurring since the age of 16. Some participants indicated only experiencing IPV since the age of 16 and not within the past 12 months and were later given an opportunity to select when

their experience occurred. Notably, many participants reported IPV experiences that occurred prior to the past 12 months, whereas relatively few reported past-year victimization in the absence of a prior history of IPV. Although prior studies using the E-HITS have primarily focused on past-year IPV and reported prevalence rates ranging from approximately 25% to 49% (Iverson et al., 2015; Portnoy et al., 2023), the present findings suggest that limiting screening efforts to recent victimization may overlook a substantial number of individuals with clinically relevant histories of IPV. Future studies may look further into screening characteristics, such as whether healthcare providers are asking about specific current experience or overall history, as this seems to have implications for disclosure experiences. For example, one woman, aged 28, with IPV experience who was screened at her most recent primary care visit and chose not to disclose stated "they didn't ask if I ever experienced it, just if I was currently experiencing it," indicating that there may be further analysis warranted on the impact of inquiring about the timing of the victimization experience.

The higher rates observed in both timepoints in the present study may reflect characteristics of the sample, which consisted exclusively of emerging adults, which has been noted within the literature as a developmental period consistently identified as carrying elevated risk for IPV victimization (Leemis et al., 2022). Taking a closer look at severity patterns within E-HITS scores further suggests that IPV experiences accumulate across development, as lifetime IPV scores were generally higher than past-year scores. Among participants reporting lifetime IPV, most indicated that victimization occurred between the ages of 18 and 24. Furthermore, older participants tended to report greater lifetime IPV severity, with participants aged 28-29 demonstrating the highest proportion of elevated lifetime IPV scores, illustrating the accumulation effect of victimization, with older women having more opportunity for IPV to

occur throughout different points in time. Subsequently, findings reinforce the notion that first experiences with IPV commonly occur in adolescence or early adulthood, positioning IPV victimization as often an ongoing or recurrent issue, rather than an isolated incident at one point in time (i.e., past 12 months; Leemis et al., 2022). Additionally, the inclusion of gender-diverse participants and intentional recruitment of individuals with IPV experiences may have contributed to the elevated prevalence observed, as the present study intentionally oversampled individuals with IPV experience to ensure adequate representation of victimized participants for subsequent analyses.

Screening Occurrence

Despite the high prevalence of IPV, screening rates remained relatively low despite all participants reporting attendance of an in-person healthcare appointment within the previous year. Only 27.7% of participants reported being asked about IPV at their most recent healthcare appointment, which is consistent with prior research demonstrating that IPV screening remains inconsistently implemented in healthcare contexts (Morris et al., 2025; Phares et al., 2019). One possible explanation is that screening rates were low across the sample as a whole, limiting opportunities for disparities to emerge and suggesting that despite recommendations for routine IPV screening, many emerging adults continue to encounter healthcare visits in which discussions of relationship safety do not occur (ACOG, 2012; Phares et al., 2019; Rabin et al., 2009; Silverstein et al., 2025). This finding is noteworthy given longstanding recommendations from the American College of Obstetricians and Gynecologists (ACOG), the American Medical Association (AMA), and the U.S. Preventive Services Task Force (USPSTF), all of which recommend routine or universal IPV screening among women of reproductive age and emphasize the importance of early identification and intervention for victims of IPV (ACOG,

2012; Rabin et al., 2009; Silverstein et al., 2025). The emergent discrepancy between the high prevalence of IPV and the low frequency of screening indicate substantial opportunities for identification that are likely to be missed within routine healthcare encounters without consistent screening (ACOG, 2012; Morris et al., 2025; Phares et al., 2019; Rabin et al., 2009; Silverstein et al., 2025).

Within the gap between IPV prevalence and screening occurrence, findings of the present study show the impact of these missed opportunities. Among participants who were not screened (72.3%), more than 70% of unscreened participants indicated a history of IPV victimization. Further, nearly one quarter of unscreened participants who had a history of IPV indicated that they would have shared their experience via disclosure if they had been asked. One participant who identified as a woman, aged 26, who had a history of IPV and was not screened at her most recent PCP visit stated “I wish healthcare providers would create more space for conversations about mental health and relationship safety. It helps patients feel supported”. The absence of recommended screening (ACOG, 2012; Rabin et al., 2009; Silverstein et al., 2025) demonstrates clear ramifications among those with IPV experiences, resulting in missed opportunities for further support and provider engagement regarding experiences that they may otherwise be willing to share within a healthcare context (Melhado et al., 2024; Miller et al., 2021; Sprague et al., 2012; Sprague et al., 2013). Moreover, participants who reported stronger negative emotional reactions to not being screened also endorsed more factors that could facilitate disclosure, suggesting that dissatisfaction with the absence of screening may reflect a desire for supportive inquiry rather than avoidance of screening or disclosure (Alexander et al., 2014; Choi & Lin, 2024; Keating et al., 2010). Despite the challenges of healthcare screening, findings provide further support that the timing, tone, and presence of provider-initiated dialogue consistently

contribute to patient empowerment, emotional safety, and better outcomes (Alexander et al., 2014; Choi & Lin, 2024; Feder et al., 2006; Heron & Eisma, 2021; Keating et al., 2010; Pengel et al., 2025). Further demonstrating this notion, one woman aged 27 who had a history of IPV and was not screened at her most recent PCP visit commented on previous screening experiences, stating "It's hard to even know you are being abused when you are so isolated. When you have these questionnaires, I never want to answer them honestly… you want to be seen as a patient… I broke down and was crying and told her I don't know how I'll continue and asked for mental health resources, [and] she just rushed me out of the room and said they would call me soon for appointment, I got a call 3 whole weeks later. What I needed was human connection".

Contrary to expectations, demographic characteristics including gender identity, race, and disability/chronic health condition status were not significantly associated with whether participants reported being screened for IPV (Leemis et al., 2022; Peitzmeier et al., 2020; Ranji et al., 2025). These findings differ from concerns raised in previous literature suggesting that marginalized populations, including LGBTQ+ individuals and people of color, may experience disparities in IPV-related healthcare interactions (Leemis et al., 2022; Peitzmeier et al., 2020; Ranji et al., 2025). Although some descriptive trends emerged, such as somewhat higher disclosure rates among non-White participants and somewhat lower disclosure rates among participants reporting disabilities or chronic health conditions, none of these differences reached statistical significance. One possible explanation is that screening practices were generally infrequent across the sample, limiting opportunities for group differences to emerge.

Although most demographic variables were unrelated to screening, insurance status emerged as a significant predictor. Participants with health insurance were more likely to report

being screened for IPV than uninsured participants. This finding may reflect broader healthcare access disparities, as individuals with insurance are more likely to engage in routine preventive care, establish ongoing relationships with healthcare providers, and receive services in settings where screening recommendations are more consistently implemented (Orguntuase et al., 2025). In contrast, uninsured individuals may be more likely to seek episodic or urgent care, settings in which providers frequently report barriers to IPV screening such as limited time, competing priorities, insufficient training, and lack of referral resources (Melhado et al., 2024; Phares et al., 2019; Sprague et al., 2012). Thus, insurance status may indirectly influence opportunities for screening through differences in healthcare utilization and continuity of care, wherein individuals with insurance may be more likely to engage in routine preventive healthcare and develop ongoing relationships with providers, increasing the likelihood that recommended screening practices are implemented (Melhado et al., 2024; Orguntuase et al., 2025; Phares et al., 2019; Ranji et al., 2025; Sprague et al., 2012). In contrast, uninsured individuals may have fewer healthcare encounters overall, reducing opportunities for IPV screening (Melhado et al., 2024; Phares et al., 2019; Ranji et al., 2025; Sprague et al., 2012).

Disclosure Experiences

Although screening creates an opportunity for disclosure, the present findings suggest that being asked about IPV does not necessarily result in victimization being discussed (Feder et al., 2006; Heron & Eisma, 2021; Niolon et al., 2017; Portnoy et al., 2020; Sprague et al., 2013). Among participants who were screened and reported a history of IPV, only approximately one-third disclosed their experiences to their healthcare provider, while nearly two-thirds chose not to disclose. This suggests that screening alone may be insufficient to facilitate disclosure and highlights the complexity of disclosure decision-making within healthcare settings (Heron &

Eisma, 2021; Niolon et al., 2017; Portnoy et al., 2020; Sprague et al., 2013). One woman, aged 25, who was screened at her most recent OB/GYN appointment and disclosed her history of IPV stated "[the doctor] was so supportive. We had a lengthy conversation. She advised me on the next steps that I could take towards handling the situation." Similarly, another woman, aged 22, who disclosed her experience of IPV following screening at her most recent OB/GYN stated: "The healthcare provider responded with empathy and calm professionalism. They listened without judgment, validated my feelings, and reassured me that I wasn't at fault. They also explained safety resources and asked what kind of support I felt comfortable receiving." Interestingly, disclosure rates did not differ between participants reporting recent IPV experiences and those reporting only lifetime IPV experiences, as those who reported IPV within the past 12 months disclosed at rates similar to those whose IPV experiences occurred earlier in life. This positions contextual evaluation of interpersonal and personal factors over factors of recency of victimization when it comes to disclosure decisions (Portnoy et al., 2020).

Similarly, demographic characteristics were not significantly associated with disclosure. Race, gender identity, disability status, and insurance coverage were unrelated to whether participants disclosed IPV when screened. Although descriptive differences emerged in several analyses, such as somewhat lower disclosure rates among participants with disabilities or chronic health conditions and somewhat higher disclosure rates among non-White participants, these differences were not statistically significant, although may hint that reluctance to disclose IPV is relatively widespread across demographic groups within this sample. Alternatively, given the relatively small number of participants who disclosed, it is also possible that the study lacked sufficient power to detect meaningful group differences.

When looking towards reactions to screening and their relation to disclosure, the pattern of findings suggests that emotional responses to IPV screening may be related to disclosure decisions. Participants who disclosed IPV reported both greater feelings of validation and greater emotional distress in response to screening than those who did not disclose. This pattern highlights the complexity of sharing this experience, suggesting that disclosure may be accompanied by both supportive and difficult emotional reactions (Portnoy et al., 2020). Future research with larger samples is needed to determine whether these trends reflect meaningful differences in how individuals experience and respond to IPV screening.

Healthcare Satisfaction and Related Factors

The correlational findings provide additional insight into factors that may be associated with disclosure experiences. Participants who reported greater healthcare satisfaction were more likely to endorse factors facilitating disclosure, report more positive provider responses following disclosure, and report greater supportive provider intervention following disclosure. Disclosure facilitators were also strongly associated with positive perceptions of provider responses. Feelings of trust, emotional safety, validation, and provider responsiveness emerged repeatedly across the disclosure-related measures, highlighting the importance of relational dynamics in creating an environment where patients feel comfortable discussing IPV experiences (Heron & Eisma, 2021; Portnoy et al., 2020; Spangaro et al., 2011). Findings suggest that disclosure may be influenced not only by individual readiness but also by the extent to which healthcare environments communicate safety, trustworthiness, and support (Heron & Eisma, 2021; Portnoy et al., 2020; Spangaro et al., 2011). It should be noted that the present findings are correlational and do not permit conclusions regarding causality. Although positive provider characteristics were associated with greater endorsement of disclosure-facilitating factors, it is

equally plausible that individuals who generally report more favorable healthcare experiences may be more likely to perceive these facilitating factors as present. As such, it remains unclear whether provider characteristics directly promote disclosure or reflect broader perceptions of the healthcare relationship.

The study also examined whether healthcare satisfaction differed as a function of IPV history and screening experiences. The relationship between healthcare satisfaction and IPV-related experiences revealed several noteworthy patterns. Overall healthcare satisfaction did not differ significantly based on IPV history, screening occurrence, or the interaction between these variables. Similarly, participants who disclosed IPV reported somewhat higher satisfaction than those who did not disclose, but this difference was not statistically significant. Thus, screening alone may not be sufficient to influence perceptions of healthcare quality, which remains consistent with prior literature indicating that positive healthcare experiences among IPV survivors are more strongly associated with provider characteristics such as empathy, validation, patient-centered communication, and supportive responses following disclosure of an experience with victimization rather than with screening itself (Feder et al., 2006; Heron & Eisma, 2021). Moreover, the correlational findings emulate that screening overall trends towards greater healthcare satisfaction, however the nature in which screening occurs is likely to hold more weight. Participants who reported greater healthcare satisfaction also reported stronger feelings of emotional validation when screened, more positive perceptions of provider responses following disclosure, and greater endorsement of supportive provider interventions. Conversely, lower satisfaction was associated with stronger negative reactions to not being screened and greater endorsement of barriers to disclosure. Collectively, these findings suggest that patients'

perceptions of healthcare quality are not dependent on screening alone but are also closely tied to the nuanced interpersonal qualities of healthcare interactions.

Strengths and Limitations

Several strengths of the present study should be noted. First, the study examined both screening and disclosure experiences within a single investigation, allowing for a more comprehensive understanding of IPV-related healthcare interactions. Second, the inclusion of both women and gender-diverse participants addressed populations that have often been underrepresented in prior IPV screening research. Third, the study developed and evaluated several novel measures assessing emotional responses to screening, barriers to disclosure, facilitators of disclosure, provider responses, and supportive provider interventions. The psychometric analyses indicated that these measures demonstrated acceptable to excellent reliability and generally clear factor structures.

Several limitations should also be considered. The study relied on self-report data, which may be influenced by recall bias and participants' subjective interpretations of healthcare encounters. The cross-sectional design prevents conclusions regarding causality or temporal relationships among screening experiences, disclosure decisions, and satisfaction with care. Additionally, although the overall sample size was adequate for many analyses, the number of participants who were screened and subsequently disclosed IPV was small, limiting statistical power for some subgroup analyses. Finally, the sample was recruited online and therefore may not be representative of all emerging adults or healthcare settings.

Directions for Future Research

There are many viable avenues for future research that emerge from the present findings. First, additional research is needed to examine whether specific provider behaviors,

communication styles, or screening approaches contribute to greater feelings of emotional safety, trust, and validation among patients. The present findings consistently highlighted the importance of relational factors across emotional responses to screening, disclosure facilitators, disclosure barriers, and perceptions of provider response. Future studies should therefore investigate which provider characteristics and communication practices are most effective in fostering supportive environments for IPV disclosure.

Second, longitudinal research is needed to better understand how healthcare experiences influence disclosure decisions over time. The current study provides a snapshot of participants' most recent healthcare encounters; however, disclosure may be influenced by cumulative experiences with healthcare providers across multiple visits (Melhado et al., 2024; Orguntuase et al., 2025; Phares et al., 2019; Ranji et al., 2025; Sprague et al., 2012). Future longitudinal studies could examine whether positive screening experiences increase the likelihood of future disclosure, help-seeking behaviors, or engagement with healthcare services among individuals experiencing IPV.

Third, the findings suggest that disclosure decision-making is a complex process that extends beyond the simple presence or absence of screening. Future research should further investigate how factors such as emotional readiness, perceived relevance of IPV to the healthcare visit, trust in providers, fears regarding disclosure consequences, and previous healthcare experiences interact to influence disclosure decisions.

Finally, the scales developed in the present study demonstrated promising psychometric properties and warrant further validation. Replication of the factor structures in larger and more diverse samples would strengthen confidence in these measures and help establish their utility for future research. Additional work examining convergent validity, discriminant validity, and

test-retest reliability would further contribute to the development of standardized measures assessing IPV screening experiences, disclosure processes, and provider responses.

Clinical Implications

The findings have several implications for clinical practice. The discrepancy between the high prevalence of IPV and the relatively low rate of screening suggests that many opportunities for identification and intervention may be missed within healthcare settings (ACOG, 2012; Morris et al., 2025; Phares et al., 2019; Rabin et al., 2009; Silverstein et al., 2025). Nearly one-quarter of unscreened participants with IPV histories in the present study indicated they would have disclosed if they had been screened, highlighting the potential value of routine inquiry. Even when disclosure does not occur immediately, asking about relationship safety may communicate support, increase awareness of available resources, and create future opportunities for disclosure and intervention (Alexander et al., 2014; Choi & Lin, 2024; Keating et al., 2010; Pengel et al., 2025). Increasing implementation of routine screening practices may therefore improve opportunities for recognizing and responding to IPV experiences (ACOG, 2012; Alexander et al., 2014; Choi & Lin, 2024; Keating et al., 2010; Morris et al., 2025; Pengel et al., 2025; Phares et al., 2019; Rabin et al., 2009; Silverstein et al., 2025).

The findings also suggest that screening should not be viewed solely as a procedural task (Feder et al., 2006; Heron & Eisma, 2021). Emotional validation, interpersonal trust, provider responsiveness, and supportive engagement were consistently associated with more favorable experiences. Consistent with previous findings, providers may therefore benefit from approaches that emphasize empathy, patient-centered communication, and emotional safety when discussing relationship health and IPV (Feder et al., 2006; Heron & Eisma, 2021; Portnoy et al., 2020). Additionally, findings of the present study show further implications for clinical practice in

regard to healthcare administration and implementation of consistent screening within healthcare settings (ACOG, n.d.; Kelly et al., 2025; Morris et al., 2025; Phares et al., 2019). Based on past research and current findings, healthcare organizations should prioritize the development of standardized protocols that support universal IPV screening across settings commonly accessed by emerging adults, including primary care and reproductive healthcare (ACOG, 2012; Phares et al., 2019; Portnoy et al., 2020; Silverstein et al., 2025). Embedding screening into routine care through standardized workflows, electronic health record prompts, and clear referral procedures may reduce variability in screening practices while increasing provider confidence and consistency (Alexander et al., 2014; Choi & Lin, 2024; Keating et al., 2010; Pengel et al., 2025).

The present findings also highlight the importance of comprehensive provider education in reducing barriers for patients and providers alike (Miller et al., 2021; Phares et al., 2019; Portnoy et al., 2020). Training should extend beyond instruction on administering screening tools and include education on the prevalence of IPV among emerging adults, the diverse ways IPV may present, the complex dynamics that contribute to victimization and disclosure decisions, and the long-term physical and psychological consequences of victimization (Niolon et al., 2017; Reisenhofer et al., 2019; Silverstein et al., 2025; Sprague et al., 2012). Providers should also receive training in informed response, incorporating patient-centered communication that emphasizes validating responses, empathetic listening, and appropriate follow-up care (Feder et al., 2006; Heron & Eisma, 2021). Improving provider knowledge and confidence may reduce barriers to screening while promoting more consistent, supportive, and effective responses to patients experiencing IPV (Alexander et al., 2014; Choi & Lin, 2024; Keating et al., 2010; Niolon et al., 2017; Pengel et al., 2025; Silverstein et al., 2025). Additionally, routine healthcare encounters provide an opportunity to educate all patients about IPV, including nonphysical forms

of victimization that may be less readily recognized (Alexander et al., 2014; Choi & Lin, 2024; Keating et al., 2010; Melhado et al., 2024; Pengel et al., 2025). Providing this information universally may help patients recognize unhealthy relationship behaviors, reduce self-blame, and encourage future help-seeking, regardless of whether they disclose during the initial screening (Melhado et al., 2024; Pengel et al., 2025). Universal screening throughout emerging adulthood, supported by provider and patient education, has the potential to improve early identification, facilitate access to appropriate resources, and strengthen the continuity of care for individuals affected by IPV (Keating et al., 2010; Niolon et al., 2017; Pengel et al., 2025; Phares et al., 2019; Portnoy et al., 2020).

Chapter 5: References

"About Intimate Partner Violence." (2026). *Centers for Disease Control and Prevention*. https://www.cdc.gov/intimate-partner-violence/about/index.html

Agency for Healthcare Research and Quality. (2020). CAHPS Clinician and Group Survey. *U.S. Department of Health and Human Services.* https://www.ahrq.gov/cahps/surveys-guidance/cg/about/survey-measures.html

Alexander, S. C., Fortenberry, J. D., Pollak, K. I., Bravender, T., Davis, J. K., Ostbye, T., Tulsky, J. A., Dolor, R. J., & Shields, C. G. (2014). Sexuality talk during adolescent health maintenance visits. *Journal of the American Medical Association Pediatrics*, *168*(2), 163–169. https://doi.org/10.1001/jamapediatrics.2013.4338

American College of Obstetricians and Gynecologists. (n.d.). *Intimate partner violence.* https://www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2012/02/intimate-partner-violence

Brown, J. B., Lent, B., Brett, P. J., Sas, G., & Pederson, L. L. (1996). Development of the Woman Abuse Screening Tool for use in family practice. *Family medicine, 28*(6), 422–428.

Chan, C. C., Chan, Y. C., Au, A., & Cheung, G. O. C. (2010). Reliability and validity of the "Extended - Hurt, Insult, Threaten, Scream" (E-hits) screening tool in detecting intimate partner violence in hospital emergency departments in Hong Kong. *Hong Kong Journal of Emergency Medicine, 17*(2), 109–117. https://doi.org/10.1177/102490791001700202

Chen, P. H., Rovi, S., Vega, M., Jacobs, A., & Johnson, M. S. (2005). Screening for domestic violence in a predominantly Hispanic clinical setting. *Family practice, 22*(6), 617–623. https://doi.org/10.1093/fampra/cmi075

Choi, H. R., & Lin, C. (2024). Navigating tensions when life-sustaining treatment is withdrawn: A thematic synthesis of nurses' and physicians' experiences. *Journal of Clinical Nursing*, *33*(6), 2337-2356. https://doi.org/10.1111/jocn.17059

Dyer, N., Sorra, J. S., Smith, S. A., Cleary, P., & Hays, R. (2012). Psychometric Properties of the Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Clinician and Group Adult Visit Survey. *Medical Care*, *50*, 28. https://doi.org/10.1097/MLR.0b013e31826cbc0d

Feder, G.S., Hutson, M., Ramsay, J., & Taket, A.R. (2006) Women Exposed to Intimate Partner Violence: Expectations and Experiences When They Encounter Health Care Professionals: A Meta-analysis of Qualitative Studies. *Arch Intern Med. 166(*1), 22–37.

Feldhaus, K. M., Koziol-McLain, J., Amsbury, H. L., Norton, I. M., Lowenstein, S. R., & Abbott, J. T. (1997). Accuracy of 3 brief screening questions for detecting partner violence. *Annals of Emergency Medicine, 29*(4), 470-475.

Harland, K. K., Peek-Asa, C., & Saftlas, A. F. (2021). Intimate Partner Violence and Controlling Behaviors Experienced by Emergency Department Patients: Differences by Sexual Orientation and Gender Identification. *Journal of Interpersonal Violence*. https://doi.org/10.1177/0886260518812070

Heron, R. L., & Eisma, M. C. (2021). Barriers and facilitators of disclosing domestic violence to the healthcare service: A systematic review of qualitative research. *Health & Social Care in the Community, 29*(3), 612–630. https://doi.org/10.1111/hsc.13282

Hussain, N., Sprague, S., Madden, K., Hussain, F. N., Pindiprolu, B., & Bhandari, M. (2015). A comparison of the types of screening tool administration methods used for the detection of intimate partner violence: a systematic review and meta-analysis. *Trauma, violence & abuse, 16*(1), 60–69. https://doi.org/10.1177/1524838013515759

Iverson, K. M., King, M. W., Gerber, M. R., Resick, P. A., Kimerling, R., Street, A. E., & Vogt, D. (2015). Accuracy of an intimate partner violence screening tool for female VHA patients: a replication and extension. *Journal of traumatic stress*, *28*(1), 79–82. https://doi.org/10.1002/jts.21985

Kelly, M., Cascella, M., Kapadia, S., Nguyen, N., Schnurer, C., Reinhardt, M., Mellinghoff, S., Rezabek, R., Shin, N., & Hanson, M. (2025). Expansion of standardized screening for intimate partner violence in acute care settings. *American Medical Association Women Physicians Section.*

Keating, N. L., Landrum, M. B., Baum, S. K., Virnig, B. A., Huskamp, H. A., Earle, C. C., & Kahn, K. L. (2010). Physician factors associated with discussions about end-of-life care. *Cancer*, *116*(4), 998. https://doi.org/10.1002/cncr.24761

Leemis, R. W., Friar, N., Khatiwada, S., Chen, M. S., Kresnow, M., Smith, S. G., Caslin, S., & Basile, K. C. (2022). The National Intimate Partner and Sexual Violence Survey: 2016/2017 Report on Intimate Partner Violence. *National Center for Injury Prevention and Control, Centers for Disease Control and Prevention*.

Melhado, C., Decker, H., Schwab, M., Kaki, D. A., Shao, S., Harrison, J. D., & Bongiovanni, T. (2024). Barriers and facilitators to screening for intimate partner violence at a level 1 trauma center. *Surgery, 176*(5), 1525-1531. https://doi.org/10.1016/j.surg.2024.07.033

Miller, C. J., Adjognon, O. L., Brady, J. E., Dichter, M. E., & Iverson, K. M. (2021). Screening for intimate partner violence in healthcare settings: An implementation-oriented systematic review. *Implementation Research and Practice*. https://doi.org/10.1177/26334895211039894

Morris, S. M., Gunter, K. E., Jia, J. L., & Baig, A. A. (2025). Factors influencing shared decision-making between healthcare providers and lesbian, gay, bisexual, transgender, and queer people of color about intimate partner violence. *Journal of Interpersonal Violence*, *40*(1-2), 489–509. https://doi.org/10.1177/08862605241248434

Niolon, P. H., Kearns, M., Dills, J., Rambo, K., Irving, S., Armstead, T. L., & Gilbert, L. (2017). Preventing intimate partner violence across the lifespan: A technical package of programs, policies, and practices. *Centers for Disease Control and Prevention.*

Oguntuase, F. O., Uzzi, C., Okahia, T. W., Adetifa, O., Eziechi, C. F., Okobi, O. E., Nwoagbe, O. F., & Dare, O. A. (2025). Relationship Between Health Insurance Status and Frequency of Routine Medical Checkups. *Cureus Journal of Medical Science, 17*(7). https://doi.org/10.7759/cureus.87847

Peitzmeier, S. M., Malik, M., Kattari, S. K., Marrow, E., Stephenson, R., Agénor, M., & Reisner, S. L. (2020). Intimate Partner Violence in Transgender Populations: Systematic Review and Meta-analysis of Prevalence and Correlates. *American journal of public health, 110*(9), 1-14. https://doi.org/10.2105/AJPH.2020.305774

Pengel, L., Mazarello-Paes, V., Paredes-Zapata, D., Oniscu, G., Gouveia Gaglianone, C., Zhu, L., Wang, Y., Dhanda, N., Tocher, J., & Aviles, L. (2025). The experiences of clinical staff approaching families for organ donation consent: A systematic review and thematic

synthesis of qualitative studies. *Transplantation Reviews*, *39*(3), 100935. https://doi.org/10.1016/j.trre.2025.100935

Phares, T. M., Sherin, K., Harrison, S. L., Mitchell, C., Freeman, R., & Lichtenberg, K. (2019). Intimate partner violence screening and intervention: The American College of Preventive Medicine position statement. *American Journal of Preventive Medicine, 57*(6), 862-872. https://doi.org/10.1016/j.amepre.2019.07.003

Portnoy, G. A., Colon, R., Gross, G. M., Adams, L. J., Bastian, L. A., & Iverson, K. M. (2020). Patient and provider barriers, facilitators, and implementation preferences of intimate partner violence perpetration screening. *BMC Health Services Research, 20*(1), 746-746. https://doi.org/10.1186/s12913-020-05595-7

Portnoy, G. A., Relyea, M. R., Presseau, C., Orazietti, S. A., Bruce, L. E., Brandt, C. A., & Martino, S. (2023). Screening for Intimate Partner Violence Experience and Use in the Veterans Health Administration. *JAMA Network Open*, *6*(10). https://doi.org/10.1001/jamanetworkopen.2023.37685

Rabin, R. F., Jennings, J. M., Campbell, J. C., & Bair-Merritt, M. H. (2009). Intimate Partner Violence Screening Tools. *American Journal of Preventive Medicine*, *36*(5), 439. https://doi.org/10.1016/j.amepre.2009.01.024

Ranji, U., Frederiksen, B., Diep, K., Gomez, I., & Salganicoff, A. (2025). Womens experiences with intimate partner violence. *Kaiser Family Foundation*.

Reisenhofer, S. A., Hegarty, K., Valpied, J., Watson, L. F., Davey, A., & Taft, A. (2019). Longitudinal Changes in Self-Efficacy, Mental Health, Abuse, and Stages of Change, for Women Fearful of a Partner: Findings From a Primary Care Trial (WEAVE). *Journal of Interpersonal Violence*. https://doi.org/10.1177/0886260516640781

Rhodes, K. V., Drum M., Anliker, E., Frankel, R. M., Howes, D. S., & Levinson, W. (2006). Lowering the threshold for discussions of domestic violence: A randomized controlled trial of computer screening. *Journal of the American Medical Association Internal Medicine*, *166*(10), 1107-1114.

Santos, G., McFarland, W., & Wilson, E. C. (2025). Prevalence and correlates of sexual intimate partner violence among trans women in the San Francisco Bay Area. *Frontiers in Global Women's Health*, *6*, 1524148. https://doi.org/10.3389/fgwh.2025.1524148

Sherin, K. M., Sinacore, J. M., Li, X. Q., Zitter, R. E., & Shakil, A. (1998). HITS: a short domestic violence screening tool for use in a family practice setting. *Family Medicine, 30*(7), 508–512.

Silverstein, M., Wong, J. B., Davis, E. M., Chelmow, D., Coker, T. R., Fernandez, A., Gibson, E., Jaén, C. R., Krousel-Wood, M., Lee, S., Nicholson, W. K., Rao, G., Ruiz, J. M., Stevermer, J., Tsevat, J., Underwood, S. M., & Wiehe, S. (2025). Screening for intimate partner violence and caregiver abuse of older or vulnerable adults: US preventive services task force recommendation statement. *JAMA*. https://doi.org/10.1001/jama.2025.9009

Soeken, K. L., McFarlane, J., Parker, B., & Lominack, M. C. (1998). The Abuse Assessment Screen: A clinical instrument to measure frequency, severity, and perpetrator of abuse against women. *Empowering survivors of abuse: Health care for battered women and their children*. 195-203.

Spangaro, J. M., Zwi, A. B., & Poulos, R. G. (2011). “Persist. persist.”: A qualitative study of women’s decisions to disclose and their perceptions of the impact of routine screening for intimate partner violence. *Psychology of Violence*, *1*(2), 150–162. https://doi.org/10.1037/a0023136

Spearman, K. J., Hardesty, J. L., & Campbell, J. (2022). Post-separation abuse: A concept analysis. *Journal of Advanced Nursing, 79*(4), 1225. https://doi.org/10.1111/jan.15310

Sprague, S., Kaloty, R., Madden, K., Dosanjh, S., Mathews, D. J., & Bhandari, M. (2013). Perceptions of intimate partner violence: a cross sectional survey of surgical residents and medical students. *Journal of injury & violence research, 5*(1), 1–10. https://doi.org/10.5249/jivr.v5i1.147

Sprague, S., Madden, K., Simunovic, N., Godin, K., Pham, N. K., Bhandari, M., & Goslings, J. C. (2012). Barriers to screening for intimate partner violence. *Women & Health, 52*(6). 587-605.

Straus, M. A., Hamby, S. L., Boney-McCoy, S., & Sugarman, D. B. (1996). The Revised Conflict Tactics Scales (CTS2): Development and preliminary psychometric data. *Journal of Family Issues, 17*(3), 283–316.

World Health Organization. (n.d.). *Violence info – intimate partner violence*. World Health Organization. https://apps.who.int/violence-info/intimate-partner-violence/

Wright, A. A., Zhang, B., Ray, A. Mack J. W, Trice, E., Balboni, T., Mitchell S. L., Jackson, V. A., Block, S. D., Maciejewski, P. K., & Prigerson, H. G. (2008). Associations between end-of-life discussions, patient mental health, medical care near death, and caregiver bereavement adjustment. *Journal of the American Medical Association*, *300*(14), 1665–1673.

Chapter 6: Tables

Table 1

Frequencies of Demographic Characteristics

	N	%
Highest level of Education (participant)		
Less than high school	3	1.1
High school diploma or GED	35	13.3
Some college or associate's degree	77	29.2
Bachelor's Degree	115	43.6
Graduate or professional degree	33	12.5
Highest level of education (parent/caregiver)		
Less than high school	10	3.8
High school diploma or GED	61	23.1
Some college or associate's degree	60	22.7
Bachelor's Degree	67	25.4
Graduate or professional degree	66	25
Employment Status		
Employed full-time (35+ hours/week)	128	48.5
Employed part-time (<35 hours/week)	57	21.6
Unemployed, looking for work	28	10.6
Unemployed, not looking for work	17	6.4
Student	30	11.4

Disabled	4	1.5
Relationship/Marital Status		
Single, not in a romantic/sexual relationship	43	16.3
In a dating relationship, not living together	74	28
Living with a partner, not married	80	30.3
Married	67	25.4

Note. n = 263 due to a missing case in participant highest level of education category.

Table 2

Exploratory Factor Analysis on Emotional Response to IPV Screening Scale

Final EFA (rotated)	Component
Item	
IPV Screening Was Distressing Subscale	1
Uncomfortable	.91
Embarrassed	.93
Angry	.69
IPV Screening was Validating Subscale	
Supported	.90
Respected	.87
Relieved	.64

Note. Extraction method: principal components analysis. Rotation method: varimax rotation; n = 72.

Table 3

Exploratory Factor Analysis on Negative Emotional Response to No IPV Screening

Final EFA (rotated)	Component
Item	1
Disappointed	.88
Unsupported	.84
Angry	.79

Note. $n = 72$.

Table 4

Exploratory Factor Analysis on Potential Facilitators of Disclosure in those with IPV

Final EFA (rotated)	Component
Item	1
The provider asked me directly in a respectful way	.85
The provider showed empathy and support	.83
I felt safe and had privacy during the appointment	.88
I trusted the provider	.85
I believed the provider could help my situation	.81
The provider was the same gender as me	.82
Access to resources or referrals was offered	.76

Table 5

Exploratory Factor Analysis on Disclosure Facilitators

Final EFA (rotated)	Component
Item	1
The provider seemed supportive and empathetic	.93
I trusted the provider	.79
I felt safe during the visit	.86
I had privacy during the visit	.72
The provider asked me directly about IPV	.56
I felt ready to talk about it	.76

Note. $n = 19$.

Table 6

Exploratory Factor Analysis on Barriers to Potential Disclosure

Final EFA (rotated)	Component
Item	1
The provider seemed too busy	.83
I did not trust the provider	.87
I was afraid of the consequences of disclosing	.74
I felt unsafe	.83
It was not relevant to my appointment	.38
I did not think the provider could do much to help my situation	.76

Note. $n = 168$.

Table 7

Exploratory Factor Analysis on Provider Response to Disclosure

Final EFA (rotated)	Component
Item	1
Supportive	.85
Empathetic/Understanding	.93
Uncaring/dismissive	.88
Cold/detached	.65

Note. $n = 19$.

Table 8

Exploratory Factor Analysis on Supportive Provider Intervention Following Disclosure

Final EFA (rotated)	Component
Item	1
Ask you more about the situation	.78
Provide referrals to mental health care	.92
Provide referrals to community services focused on IPV	.93
Provide referrals to legal aid	.82
Provide referrals to safety planning	.91
Take the time to talk to you about the situation	.90

Note. $n = 19$.

Table 9

Exploratory Factor Analysis on Modified CG-CAHPS

Final EFA (rotated)	Component
Item	1
During your most recent visit, did this provider explain things in a way that was easy to understand?	.78
During your most recent visit, did this provider listen carefully to you?	.87
During your most recent visit, did this provider show respect for what you had to say?	.84
During your most recent visit, did this provider spend enough time with you?	.83
Using any number from 1 to 5, where 1 is the worst visit possible and 5 is the best visit possible, what number would you use to rate your most recent visit?	.81

Note. $n = 262$.

Table 10

E-HITS 12 Month Total Scores by Interval

E-HITS 12 months Total Score	*n*	%
5-6	162	61.6
7-10	67	25.5
11-14	22	8.4
15-18	10	3.8
19-22	2	.8
23-25	0	0

Table 11

Modified E-HITS Total Scores (since age 16) by Interval

E-HITS Since 16 Total Score	*n*	%
5-6	76	28.8
7-10	93	35.2
11-14	48	18.2
15-18	31	11.7
19-22	13	4.9
23-25	3	1.1

Appendix A: Screener

What is your current gender identity?

- ○ Man (1)
- ○ Woman (2)
- ○ Non-binary (3)
- ○ Transgender man (4)
- ○ Transgender woman (5)
- ○ Prefer to self-label: (6)

What sex were you assigned at birth?

- ○ Female (1)
- ○ Male (2)
- ○ Intersex (3)

How old are you?

▼ 16 ... 45

In the past 12 months, have you been in a romantic/sexual relationship?

- ○ Yes (1)
- ○ No (2)

In the past **12 months**, have you had an in-person appointment with the following (not including telehealth/virtual appointments). Please select all that apply.

- ☐ Primary care physician (1)
- ☐ OB/GYN (2)
- ☐ Other (please specify) (3)
- ☐ No, I have not attended an in-person appointment with a physician in the past 12 months (4)

Appendix B: Demographic Variables

Based on your responses, you are eligible to participate in this study. Please complete the rest of the survey in a private, quiet environment and refrain from including any personally identifying information in response to the open-ended questions. Your answers are confidential. We'll start with some basic questions about yourself.

What is your highest level of education?

- ○ Less than high school (1)
- ○ High school diploma or GED (2)
- ○ Some college or associate degree (3)
- ○ Bachelor's degree (4)
- ○ Graduate or professional degree (5)

What is the highest level of education completed by your parent(s) or primary caregiver(s)?

- ○ Less than high school (1)
- ○ High school diploma or GED (2)
- ○ Some college or associate degree (3)
- ○ Bachelor's degree (4)
- ○ Graduate or professional degree (5)

What is your current form of health insurance? (check all that apply)

- ☐ Medicaid (1)
- ☐ Private insurance through employer (2)
- ☐ Private insurance purchased individually (3)
- ☐ Insurance through parent/spouse (4)
- ☐ Other (please specify) (5)
- ☐ No insurance (6)

Do you identify as having a disability or chronic health condition?

- ○ Yes (1)
- ○ No (2)

Which of the following best describes your current employment status?

- ○ Employed full time (35+ hours/week) (1)
- ○ Employed part time ((2)
- ○ Unemployed looking for work (3)
- ○ Unemployed not looking for work (4)
- ○ Retired (5)
- ○ Student (6)
- ○ Disabled (7)

Which of the following best describes your current employment status?

- ○ Employed full time (35+ hours/week) (1)
- ○ Employed part time ((2)

- ○ Unemployed looking for work (3)
- ○ Unemployed not looking for work (4)
- ○ Retired (5)
- ○ Student (6)
- ○ Disabled (7)

What is your current marital/relationship status?

- ○ Single, not in a romantic/sexual relationship (1)
- ○ In a dating relationship (not living together) (2)
- ○ Living with a partner (not married) (3)
- ○ Married (4)
- ○ Separated (5)
- ○ Divorced (6)
- ○ Widowed (7)

Appendix C: IPV History

Next, you'll be asked about your experiences with interpersonal violence (IPV). This refers to situations where an intimate partner may have acted in ways that were controlling, hurtful, or violent. These questions are designed to help us better understand experiences that occur within intimate relationships. You will be asked to reflect on experiences in the past year and since the age of 16.

Over the last **12 months**, how often did your partner:

	Never (1)	Rarely (2)	Sometimes (3)	Often (4)	Frequently (5)
Physically hurt you (1)	○	○	○	○	○
Insult you or talk down to you (2)	○	○	○	○	○
Threaten you with harm (3)	○	○	○	○	○
Scream or curse at you (4)	○	○	○	○	○
Force you to have sexual activities (5)	○	○	○	○	○

Since the **age of 16**, have any of your previous or current partners done any of the following:

	Never (1)	Rarely (2)	Sometimes (3)	Often (4)	Frequently (5)
Physically hurt you (1)	○	○	○	○	○
Insult or talk down to you (2)	○	○	○	○	○
Threaten you with harm (3)	○	○	○	○	○
Scream or curse at you (4)	○	○	○	○	○
Force you to have sexual activities (5)	○	○	○	○	○

Appendix D: Healthcare Context

Previously, you indicated that you had an annual visit with your physician in the past year (when you were not acutely sick). Please think about the MOST RECENT VISIT with your physician as you answer the next questions.

Was your **most recent** physicians appointment with your usual physician, primary care provider, or OB/GYN?

- ○ Yes (1)
- ○ No (2)

What was the primary purpose of your **most recent** appointment?

- ○ Annual physical/routine check-up (1)
- ○ Birth control/reproductive health (2)
- ○ Lab work (3)
- ○ Medication refill (4)
- ○ Illness (e.g. cold/flu, infection) (5)
- ○ Other (please specify) (6)

What was the gender of this provider at your **most recent** appointment?

- ○ Woman (1)
- ○ Man (2)
- ○ Non-binary (3)
- ○ Not Sure (4)

These next questions ask about whether healthcare providers asked you about experiences of intimate partner violence (IPV). IPV can include physical, sexual, or emotional abuse by a current or former partner.

At this appointment, were you asked about experiences of IPV or relationship safety?

- ○ Yes (1)
- ○ No (2)

Who asked you about experiences of intimate partner violence (IPV) or relationship safety at your **most recent** physician's visit?

- ○ The primary provider (physician, physicians assistant, or nurse practitioner) (1)
- ○ A nurse or other clinical staff member (2)

- ○ Another person (please specify) (3)

How were you asked about IPV or relationship safety during this appointment?

- ○ Verbally, in person (1)
- ○ On a paper form (2)
- ○ On an electronic form or survey (e.g., tablet, computer) (3)
- ○ Both verbally and on a form (4)
- ○ Other (please specify) (5)

When did your experience with IPV occur?

- ○ Before age 18 (1)
- ○ Age 18-24 (2)
- ○ Age 25-29 (3)

If your provider had asked about IPV and/or relationship safety at this **most recent** appointment, would you have discussed your past experience with IPV?

- ○ Yes (1)
- ○ No (2)

When you were asked about IPV at your **most recent** physician visit, did you disclose any experiences to the healthcare provider?

- ○ Yes (1)
- ○ No (2)

Appendix E: Emotional Response to IPV Screening

To what extent did being asked about IPV and/or relationship safety at your **most recent** physician's visit make you feel each of the following:

	Not at all (1)	A little (2)	Somewhat (3)	Quite a bit (4)	Very much (5)
supported (1)	○	○	○	○	○
respected (2)	○	○	○	○	○
relieved (3)	○	○	○	○	○
uncomfortable (4)	○	○	○	○	○
embarrassed (5)	○	○	○	○	○
angry (6)	○	○	○	○	○
unsafe (7)	○	○	○	○	○

Alternate lead in: To what extent did being asked about your experiences with IPV at your most recent physician visit make you feel each of the following:

Appendix F: Negative Emotional Response to No IPV Screening

To what extent did you feel each of the following about not being asked about IPV or relationship safety during this most recent physician's visit?

	Not at all (1)	A little (2)	Somewhat (3)	Quite a bit (4)	Very much (5)
Relieved (1)	○	○	○	○	○
Unsupported (2)	○	○	○	○	○
Disappointed (3)	○	○	○	○	○
Angry (4)	○	○	○	○	○
Unsafe (5)	○	○	○	○	○
Neutral/Indifferent (6)	○	○	○	○	○

Alternate lead in: To what extent did NOT being asked about your experiences with IPV at your most recent physician visit make you feel each of the following:

Appendix G: Potential Disclosure Facilitators

To what extent would each of these have made you feel safe or comfortable enough to disclose your IPV experience at your **most recent** physician's visit, if you'd been asked?

	Not at all (1)	A little (2)	Somewhat (3)	Quite a bit (4)	Very much (5)
Direct and respectful questions from the provider (1)	○	○	○	○	○
Having privacy during the visit (2)	○	○	○	○	○
Provider gender matching my own (3)	○	○	○	○	○
Provider empathy and support (4)	○	○	○	○	○
Trust in the provider (5)	○	○	○	○	○
Belief the provider could help me (6)	○	○	○	○	○
Information about confidentiality and resources (7)	○	○	○	○	○
Other (please specify) (8)	○	○	○	○	○

Alternate lead in: To what extent do you believe that each of the following would have made it more likely that you would have disclosed your IPV experience at your most recent physician's visit?

Appendix H: Barriers to Potential Disclosure

To what extent would each of these have kept you from disclosing at your **most recent** physician's visit, even if you had been asked?

	Not at all (1)	A little (2)	Somewhat (3)	Quite a bit (6)	Very much (5)
Provider seemed too busy (1)	○	○	○	○	○
Lack of trust in the provider (2)	○	○	○	○	○
Fear of consequences of disclosing (3)	○	○	○	○	○
Feeling unsafe (others might overhear) (4)	○	○	○	○	○
Not relevant to the appointment (5)	○	○	○	○	○
Belief provider could not do much to help the situation (6)	○	○	○	○	○
It was not applicable to my situation (7)	○	○	○	○	○
Other (please specify) (8)	○	○	○	○	○

Alternate lead in: To what extent do you believe that each of the following would have made it more likely that you would have disclosed your IPV experience at your most recent physician's visit?

Appendix I: Provider Response

To what extent did your healthcare provider respond in the following ways when you shared your experiences of IPV:

	Not at all (1)	A little (2)	Somewhat (3)	Quite a bit (4)	Very much (5)
Supportive (1)	○	○	○	○	○
Empathetic/understanding (2)	○	○	○	○	○
Uncaring/dismissive (3)	○	○	○	○	○
Cold/detached (4)	○	○	○	○	○

Appendix J: Supportive Provider Intervention Following Disclosure

To what extent did your healthcare provider engage of each of the following after your disclosure:

	Not at all (1)	A little (2)	Somewhat (3)	Quite a bit (4)	Very much (5)
Ask you more about the situation (1)	○	○	○	○	○
Provide referrals to mental health care (2)	○	○	○	○	○
Provide referrals to community services focused on IPV (3)	○	○	○	○	○
Provide referrals to legal aid (4)	○	○	○	○	○
Provide referrals to safety planning (5)	○	○	○	○	○
Take the time to talk to you about the situation (6)	○	○	○	○	○
Other (please specify) (7)	○	○	○	○	○

Appendix K: Disclosure Facilitators

What factors led you to disclose your experience of IPV with your healthcare provider during this appointment?

	Not at all (1)	A little (2)	Somewhat (3)	Quite a bit (4)	Very much (5)
The provider asked me directly about IPV (1)	○	○	○	○	○
The provider seemed supportive and empathetic (2)	○	○	○	○	○
I trusted the provider (3)	○	○	○	○	○
I felt safe during the visit (4)	○	○	○	○	○
I had privacy during the visit (5)	○	○	○	○	○
I believed the provider could help my situation (6)	○	○	○	○	○
I wanted access to resources or support services (7)	○	○	○	○	○
My health concerns were	○	○	○	○	○

connected to IPV (8)					
I felt ready to talk about it (9)	○	○	○	○	○
Other (please specify) (10)	○	○	○	○	○

Appendix L: Healthcare Satisfaction/Modified CG-CAHPS

The final set of questions concern your satisfaction with your physician following the **most recent visit** that you were thinking about as you answered the survey questions. Please answer in the way that best reflects your own experience.

During your most recent visit, did this provider explain things in a way that was easy to understand?

- ○ No, not at all (1)
- ○ No, not really (2)
- ○ Somewhat (3)
- ○ Yes, mostly (4)
- ○ Yes, definitely (5)

During your most recent visit, did this provider listen carefully to you?

- ○ No, not at all (1)
- ○ No, not really (2)
- ○ Somewhat (3)
- ○ Yes, mostly (4)
- ○ Yes, definitely (5)

During your most recent visit, did this provider show respect for what you had to say?

- ○ No, not at all (1)
- ○ No, not really (2)
- ○ Somewhat (3)
- ○ Yes, mostly (4)
- ○ Yes, definitely (5)

During your most recent visit, did this provider spend enough time with you?

- ○ No, not at all (1)
- ○ No, not really (2)
- ○ Somewhat (3)
- ○ Yes, mostly (4)
- ○ Yes, definitely (5)

Using any number from 1 to 5, where 1 is the worst visit possible and 5 is the best visit possible, what number would you use to rate your most recent visit?

- ○ 1 (worst visit possible) (1)
- ○ 2 (2)
- ○ 3 (3)
- ○ 4 (4)
- ○ 5 (best visit possible) (5)