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Increasing Screening for Intimate Partner Violence and Reproductive Coercion: Understanding Provider Motivations

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Abstract

Current estimates indicate that as few as 2% of health providers may be universally screening patients or clients for intimate partner violence and reproductive coercion. Barriers to screening have been well-described in the literature; however, little attention has been paid to the factors that motivate providers to carry out screenings. This study explored data from a sample of providers who had received specific screening and intervention training to ascertain what factors motivated them to complete screenings in practice. Patient-related, provider-related, and work setting factors were identified. Findings may support improved provider training and, ultimately, screening rates.

Keywords

reproductive coercion, violence, screening

According to the National Intimate Partner and Sexual Violence Survey (NISVS) (Black et al., 2011), roughly 36% of women and 10% of men in the United States have experienced rape, physical violence, and/or stalking by an intimate partner. The population-level incidences of acute and historical intimate partner violence (IPV) and reproductive coercion among women of reproductive age are important factors in overall health, particularly when these are co-occurring (Park et al., 2016). Increasing

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the rates at which providers screen patients for IPV and reproductive coercion has significant implications for promoting the health of women and families. Unfortunately, both IPV and reproductive coercion are often overlooked in routine care, even in the context of reproductive and/or women's health. In an effort to better understand how to increase screening practices, we conducted a qualitative examination of providers regarding their motivations for engaging in screening. This fills an important gap in the literature which has thus far focused largely on the *barriers to* engaging in screening rather than the *motivations for* doing so.

Intimate Partner Violence and Reproductive Coercion

IPV is a pattern of behavior by a current or former intimate partner that may include some or all of physical, sexual, and emotionally abusive behaviors, as well as stalking (Centers for Disease Control and Prevention, 2014). These behaviors can occur on a continuum or in isolation, but are always intended to maintain control of the partner. In intimate relationships, reproductive and sexual decision-making may be a nexus of control and decision-making (Banister & Schreiber, 2001; Halpern-Felsher et al., 2004). This is a vulnerable site for abusive behaviors such as reproductive coercion, or when one partner seeks to limit or completely eliminate reproductive choice for the other by sabotaging or refusing to use birth control, pressuring for pregnancy initiation or termination, or other acts that reduce reproductive and sexual agency (Chamberlain & Levenson, 2010; Miller et al., 2010, 2011). Because pregnancy and control over fertility have significant ramifications for educational attainment, socioeconomic status, and mental and physical health, reproductive coercion is an important consideration among women of reproductive age (Cha et al., 2015; Cha & Masho, 2014; Desmarais et al., 2014; Kozhimannil et al., 2013; Roberts et al., 2014). Moreover, experiencing any form of IPV can have significant impact on myriad health outcomes, including experiencing post-traumatic symptoms, needing medical care (Black et al., 2011), chronic health problems (Humphreys et al., 2011), ongoing fear and/or stress (Burton, Halpern-Felsher, et al., 2013; Zerubavel, Messman-Moore, 2013), and depression and other mental health issues (Burton et al., 2016; Simmons et al., 2017). Given its prevalence and impact on health, identifying effective strategies for IPV and reproductive coercion prevention—including use of secondary preventions strategies like screening—is a public health priority.

Screening

In 2013, the United States Preventive Services Task Force (USPSTF) recommended that providers of health care to women of reproductive age screen for IPV and provide or refer affected clients to supportive services (Moyer, 2013). This recommendation was supported by copious amounts of research indicating that women of reproductive age have the highest risk of IPV, in addition to the potential for reproductive coercion (Mathew et al., 2013; Romans et al., 2007), and that screening is neither offensive nor upsetting to women in the clinical setting (Garabedian et al., 2011; Litherland, 2012;

Miller et al., 2011; Morse et al., 2012). Despite these recommendations, a recent systematic review of screening practices for IPV found that as few as 2% of providers may be routinely screening, and that among those reporting screening there were still inconsistencies in screening behaviors even within a single clinic setting (Alvarez et al., 2016). A number of factors likely contribute to these low rates, but some of the reported barriers—both procedural and individual—to performing screening for IPV and reproductive coercion include lack of time, lack of knowledge about IPV and reproductive coercion, discomfort with the topic, lack of a defined screening procedure, concerns about client reactions to screening, and lack of standard case definitions for IPV and reproductive coercion (Burton & Carlyle, 2015; Centers for Disease Control and Prevention, 2014; Glass et al., 2001; Ramachandran et al., 2013; Thurston et al., 2009). Clearly, screening is both an important and complex act in the health care setting. Increased exploration of what factors motivate provider screening for IPV and reproductive coercion is likely to lead to improvements in screening education and to improve overall rates of screening and identification of affected individuals.

Little has been written about what motivates the providers who do screen their clients for IPV and reproductive coercion to do so. Although none specific to screening for IPV and reproductive coercion, there is some extant literature on motivations for carrying out various types of screenings in clinical practice. For example, a study of screening for adolescent suicide and mental health issues found support for incentivizing providers, improving confidence, and valuing provider personal contact with affected individuals were all motivating factors (Diamond et al., 2012). Price et al. (2012) reported a study of perinatal depression screening following provider training on a structured screening procedure. In this sample, 71% reported that they routinely assessed for perinatal depression in their pregnant and postpartum patients. In addition, in the study's subsample of providers who had ever diagnosed and/or treated a case of perinatal depression (n = 859), 51.6% reported routinely providing some type of intervention—either treatment or referral—to those patients affected by perinatal depression. The investigators concluded that both a sense of the importance of perinatal depression risks to patient health and confidence in the ability to screen and intervene effectively predicted screening. Finally, Brennan and colleagues (2015) reported a mixed-methods study of medical residents' use of a self-audit process to examine their HIV screening practices and found that self-direction is also a powerful motivator for providers to improve screening practices. Understanding the circumstances under which providers perform screening can help improve the development of screening tools and protocols, and ultimately enhance health promotion among women and families.

Current Study

This article reports on motivations to screen identified in a naturalistic inquiry study. The purpose of the study was to gather feedback from reproductive health care and home visiting providers on their implementation experiences following training on Project Connect screening and intervention tools for IPV and reproductive coercion.

Developed by Futures Without Violence, Project Connect is an initiative to enhance public health responses to IPV and reproductive coercion through provider trainings on screening, intervention, and follow-up preplanning, as well as provision of specific tools. Training and intervention tools are specifically adaptable to the provision of culturally competent care, and are designed to reduce retraumatization in affected individuals (Burton, Carlyle, & Crawford, 2013; Duplessis & Futures Without Violence, 2013). The data were gathered as part of an overall evaluation and review of the program implementation with the trained providers. The study was organized around the essential research question, "How have trained providers incorporated screening into their work?"

Methods

Prior to initiating data collection, the study and all relevant materials were approved by the Virginia Commonwealth University Institutional Review Board. In 2010, Virginia Department of Health (VDH) was selected as one of 10 pilot sites for Project Connect, and within 2 years, over 1,100 Virginia-based reproductive health and home visiting providers had received training. These providers in turn saw more than 84,000 unduplicated clients in a single fiscal year (Burton, Carlyle, & Crawford, 2013). By specifically targeting VDH reproductive health clinics and partnering with the Virginia Home Visiting Consortium (VHVC), the Project Connect initiative achieved this dissemination in a relatively short time. The VHVC is a collaborative, state-wide organization of early childhood home visiting programs that serve families from pregnancy through a child's fifth year (Virginia Home Visiting Consortium, 2010).

Data collection procedures and analytic strategy. Data collection was completed via focus groups and utilized an original, semi-structured focus group interview guide developed by the investigators with input from VDH and Futures Without Violence staff. The investigators conducted all focus groups. Participants were recruited via the Project Connect trainings registration database, and invitations to participate were sent via an e-mail with a study information sheet attached. The purpose of the interview guide was to engage the participants in conversation, which was then allowed to flow with little direction from the investigators. The guide included clarifying questions about when the participants employed the Project Connect screening and intervention tools, and what effects the training and tools had on their work.

Informed consent was completed prior to beginning participation, and focus groups were audio recorded with the permission of participants. Participants were asked to avoid use of proper names or other identifying details. Recordings were transcribed verbatim, and transcriptions were analyzed using an emergent thematic analysis strategy within a naturalistic inquiry framework (Lincoln & Guba, 1985). We selected this strategy because the study processes necessarily met several of the benchmarks for establishing trustworthiness and credibility of findings in naturalistic inquiry. These included prolonged engagement with the Project Connect program and with the investigators: one investigator is a member of the Project Connect Leadership Team and the

other is involved with IPV advocacy and training at state and local levels. Both investigators are also Project Connect trainers and health care system researchers, which allowed for persistent observation as well as triangulation, because we are not from the same discipline—both additional benchmarks for trustworthiness.

The focus groups were conducted in the practice setting and among colleagues to encourage description of the shared realities and social contexts in which the work occurred (McInnes et al., 2017). Finally, peer debriefing and member checks were fundamental to the study because we were university-based while the program was based at VDH and because the study participants had attended a variety of different Project Connect trainings with different training personnel. Member checking was invaluable in assuring that all participants addressed their Project Connect training, the tools, and their experiences with screening, as well as to glean additional knowledge of what participants thought could be improved. These are all elements of trustworthiness in naturalistic inquiry (Lincoln & Guba, 1985).

Thematic analysis. To allow the broadest exploration and interpretation of the providers' feedback, we inductively explored the data for contextually significant, tacit knowledge that indicated how and when the providers carried out screenings. We then applied a thematic analysis approach to parse the different kinds of information conveyed and to identify information that was "new, and advance(d) understanding, (was) useful in addressing real world problems, or . . . both" (Buetow, 2010). Thematic analysis requires pattern identification within data and allows the investigator(s) to consider the influence of the social context on individuals and their actions (Braun & Clarke, 2006). This was important in this study because of the multiple social contexts that had the potential to affect the screening encounter, including all possible relationships among patient, partner, provider, and care-provision setting.

We first identified each indicated motivation with an open, verbatim quote code referencing the motivating factor. Using the constant comparative method described by Lincoln and Guba (1985), we examined these codes to identify linkages and used these linkages to establish primary and then integrated code categories. Final thematic concepts were then established, based on whether the integrated category of motivator was a characteristic of patients, providers, or the environment. Analysis was carried out using version 7 of the ATLAS.ti software.

Results

Focus groups were held between February and May 2013. A total of 47 providers from family planning or women's health clinics and agencies providing family support through home visits throughout Virginia participated. Slightly more than half (53.2%; see Table 1) identified as Caucasian/White, 31.9% as African American/Black, and the remaining 15% as other ethnicities. Participants were between 29 and 66 years of age (M = 49.57, SD = 10.30). The majority of participants were full-time providers (97.9%) and ranged in position tenure from 6 months to 40 years (M = 9.01, SD = 8.83). Participants included nurses, medical assistants, and home visiting providers.

Table 1. Participant Demographics.

Participants (N = 47)	n	%
Ethnicity		
Caucasian/White	25	53.2
African American/Black	15	31.9
Asian American	1	2.1
Hispanic/Latino	3	6.4
Multiracial	1	2.1
Other	2	4.3
Highest education		
High school/GED	4	8.5
Associate's degree	9	19.1
Bachelor's degree	21	44.7
Graduate school	12	25.5
Employment status		
Full-time	46	97.9
Part-time	1	2.1

In this analysis, we identified and categorized 154 instances of participants describing motivations for screening. Motivating factors were consolidated into thematic conceptual groups based on where the factor originated: patient, provider, and work setting (see Table 2). We review each of these and its associated integrated categories.

Patient Factors

This thematic concept described those factors that motivated a provider to initiate screening based on something about the patient. For example, the client's age—either currently or at the time of past abuses—was a motivating factor. In most cases, the client in question was an adolescent. As one of the participants stated,

> I'm much more mindful particularly of young women, not that I neglect anyone else but especially if I have a client who is 14, 15, 16, 17 asking about . . . are you being forced in this or feeling some pressure to have sex. And also . . . there was a part that says have you ever been kicked, slapped, punched, felt unsafe? and I really pay a lot of attention to that and more . . . than . . . I used to.

Similarly, whether children were involved influenced providers' screening processes. This included both instances when something had happened to a client's child or children and when the provider was obligated under mandatory reporting statutes to report that children had witnessed or been exposed to IPV in the home. One participant noted, "All clients love their children. Do anything for their children. So once the children's involved . . . they'll do whatever (needs to be done)." Another pointed out that sometimes supporting a client to seek help involved making sure that their children were

Table 2. Thematic Concepts and Exemplar Codes.

Thematic concept	Exemplar codes
Patient factors	"women who were young at the time" "what happened to the children" "That's because it was about the child" "(she) felt very bound to this man" "(her) having enough support" "there was bruises on her" "scratches all over and bleeding" "positive result of chlamydia (from abuser)" "you notice that people are not quite ready for you to leave" "you are able to pick up some of the language that they are giving"
Provider factors	"helping nurses to see . . . value" "feel more comfortable that I'm doing the right thing" "sometimes (providers) may not see why . . . to be involved" "Continuous training is helpful" "you cannot fix it so keep . . . telling her" "I have offered (the tools) when they're like . . . in a scary situation, do you want help" "a good ending here, we still see her back and things are much better"
Environmental factors	"the flyers that we have with the little tear off boxes, I replace constantly" "we put up some posters in the . . . rooms where the clients have their exams" "it's a part of the screening on their . . . chart . . . So if somebody goes back . . . they can see that documentation" "We were . . . fortunate that it became a priority where we're working"

also safe: "I'll ask her, well, if this occurs again what would you do with your children? Do you have any numbers you can call, or where you can (take) them? . . . That's how my safety planning goes."

Providers were also motivated by concerns that the client might lack confidence, self-efficacy, or awareness of resources that could help them exit or recover from an abusive relationship. In one case, one provider was concerned about a client who "was in a . . . upper middle class situation, but had never completed high school and . . . felt very bound to this (person) who was . . . (supporting) her." Another told the story of two clients:

> . . . we were working with them . . . every time we saw them in our practice, to get them to go back to school and that's what they both did . . . one of them got a college education.

Providers were also motivated to screen by noticing a range of symptoms or cues in the client encounter. For example, one provider observed an injury that suggested abuse when a client came in for a routine surveillance visit: "I was doing the TB clinic—she came in for, I don't know, TB X-ray and stuff. . . . There was bruises on

her . . .” Another provider described a case when a young client said that she and her partner were “play fighting”: “They don’t understand what’s appropriate and what’s not. They think that play fighting is ok . . . (they play fight) and she ended up with scratches all over and bleeding . . . that’s just not ok.” Other times, providers were prompted to screen because the client had a diagnosis or other health issue that could indicate an abusive relationship. One provider described

> one of the young women I saw . . . she came back with a positive result of chlamydia, you know she never thought that would happen to her so I asked her about coercion and so forth and as it turns out . . . she has a bad home situation and that’s her only opportunity for closeness and feeling like she belongs . . .

Some of the cues described by providers were behavioral, rather than clinical. One provider described this as “once that person comes into the room and you see them, you know, something (about) how they walk into the room, how they sit, how they ask the first question . . .” Another said that she was prompted to screen when:

> I have a client who constantly says, “I need to check with my husband, let me see what he thinks about this.” (And) she’s not willing to make decisions independent of him . . . or if she’s somebody who doesn’t have a lot of control over the financial resources in the family, if she gets phone calls or texts from her spouse during the . . . visit.

In addition to being motivated by factors related to the individual client, providers also described internal motivations for screening.

Provider Factors

This thematic concept was derived from instances in which the motivating factors were unique to the individual provider. In contrast to patient factors, in which the motivation to screen was external and related to some characteristic of the client, these factors included characteristics of the providers themselves, their training, and professional identity. For example, some providers described the motivation to screen as coming from something they learned in the Project Connect training. One provider explained,

> What I hadn’t really thought about before were other family planning opportunities and asking them more about “How does your partner feel about your birth control?” and the idea of . . . sending (them) home to use condoms . . . you know, “What’s your partner going to think about this?” And then people who come in for Plan B and that sort of thing. I . . . never really saw this opportunity (to screen) before.

Another stated that the training made them

> more aware that it needs to be done, I mean I really do it! . . . we knew but it just brings it home [. . .] so you may be the only person that serves as a link.

Providers also described feeling empowered and supported to carry out screening as a motivating factor.

> I mean it's just the whole idea of like you go into the training not knowing what it's like or knowing really what it's all about but once you come out you're like now I know how to talk to this person about (IPV and RC) so you feel like very empowered and ready to do this.

Another said,

> If they answer yes, to know what to do, you know because the first time you see a yes, you're like ooookkaayyy [*sic*] . . . what do I do with this? So I think that's helped a lot, to know what to do and to get the updated referrals.

Interestingly, the providers also talked about how being included in the training had motivated their screenings. Some of the participants were in very rural areas and relatively isolated from their potentially supportive colleagues. One participant captured this in noting that what she liked about training was the opportunity to connect with other providers: ". . . it's nice to sit and talk about (screening)," adding that she felt she had become more effective and adaptable in her screenings as a result of hearing others' stories. Others indicated that they appreciated the ongoing trainings and the opportunities to talk to Project Connect staff about their experiences.

Another aspect of provider-specific factors included being motivated when they perceived screening to be consistent with their professional goals and values. Participants described how the act of screening and using the Project Connect tools fit with their sense of doing something positive in their work, including providing opportunities to show compassion, provide an immediate response, and facilitate success stories. For example, participants suggested that the Project Connect tools and protocols helped them feel that they were providing clients with good care, even if responses to screening were initially or consistently negative. As one provider said,

> . . . you know that first meeting they may not open up to you but the next one they might. I had a girl, this week, we talked about some things the last time she was in, and this time she told me, I just don't really want to discuss it today. She said if you don't mind I think we're just not going to do that today. And I told her, I said well I appreciate you telling me that, but just know that we're always here for you if you need anything. And I said so this is what we're going to do, we're going to set you a follow up because I need to check on you. And she said that's fine.

Here, the provider indicates that consistent screening and provision of resources represents showing care and concern for the client. Another provider noted, ". . . you cannot fix it, so keep . . . telling her," emphasizing the desire to support patients in abusive or coercive situations regardless of how they responded to screenings. Similarly, providers saw professional value in having tools and protocols to respond to clients in cases of IPV and reproductive coercion. One provider stated that these gave

her clarity about "what you can do and . . . that there is value in what you can do," while others reported feeling that it was an important part of their role as providers to have an immediate strategy to help clients.

Finally, providers described how screening and intervention actions led to a positive outcome, with that success motivating them to keep performing screening. As one provider said, "I've heard people say . . . 'Yeah she told me this and this and that and I did . . . and I am better now.'" Another described a successful outcome for a client as "a good ending here, we still see her back and things are much better."

Environmental Factors

The final thematic concept identified those factors in the practice environment that motivated or supported providers to screen for IPV and reproductive coercion. For example, participants indicated how the Project Connect protocols were motivators in themselves because they fit easily into the provider's interaction with the client. One participant noted that having the tool in the client's file or chart helped to "remind us that it needs to be done each time even though you're busy . . . and you've got fifty-eleven other things (to do)." Another noted that the tools were helpful for clients with undocumented immigration status: "Those little cards and numbers are really good cause then they could call a number and say, not having that face-to-face if they're afraid to do that." Similarly, providers were reminded of screening by things they could see around them. One participant described ". . . the flyers that we have with the little tear off boxes . . . People are constantly taking those little numbers off." She added that this reminded her to perform screening, but also helped her realize that more people might need help than were asking for it in appointments. Elsewhere, a participant noted that posters advising patients that help was available had been added to some of the examination rooms. This participant believed that in addition to providing information to clients, the posters reminded providers of the need to screen at each visit.

The work setting also provided motivation. For example, consistency among providers generated a kind of group-oriented motivation that came from all providers in a practice doing the same screening in the same way. A family planning clinic nurse described that "I ask everybody this, we're not just asking you, we ask everyone these questions that way so they don't feel like 'oh my gosh, why is she asking me that.'" Another noted how consistency among providers helped to assure that vulnerable clients got needed support:

> . . . some people hold themselves like . . . we can't quite tell, like in the beginning . . . when we're first meeting them, is that just their personality? Or if something else is going on, if this person is just extremely quiet or . . . shy, or what is it? . . . Something is—we gotta get to the bottom of it. And they're not very open about telling us what's going on. . . . It's like, what's going on, why are we not getting through? So that's . . . one of our cues. . . . She may not open up to us (that first time) but at least she has the information.

In addition, there were instances where providers indicated that their workplace culture supported the practices of screening and intervening, which motivated them to complete it. One provider said, “We were . . . fortunate that (screening) became a priority where we’re working.” Another noted that in the “maternity clinic, there’s an actual (check) box for (screening) for every time they come back (so) you can see what it says,” which prompted the providers to screen to complete the chart. Both of these demonstrate how workplace structure and culture can motivate providers to screen for IPV and reproductive coercion.

Discussion

Efforts beyond addressing the most commonly identified barriers—often time and training—are necessary to support providers in screening patients for IPV and reproductive coercion. Developing understanding of what factors act as motivations or prompts for providers to provide screening and intervention is one possible means of improving rates of and practices for screening. In our study, providers described a variety of factors that motivated them to carry out screenings, ranging from concern for the age of the affected client to tools that fit well with their standard practices. Aspects of the patient, the provider, and the workplace were identified as motivating providers to carry out IPV and reproductive coercion screenings. This is consistent with other studies of perception and motivation that suggest multilevel constructs of motivation, created from both individual and contextual elements (Dever, 2016; Jung et al., 2016).

In some cases, the patient’s age and the presence of or risk to children in proximity to the relationship prompted providers to screen for IPV and reproductive coercion. This suggests that potential vulnerability was a possible motivation for screening and that providers were attentive to at-risk groups. In addition, the providers perceived vulnerability to IPV and reproductive coercion in clients who were disempowered in the context of a relationship. This also acted as a motivation for screening and intervention in that the providers recognized the potential for prevention of both IPV and/or reproductive coercion, as well as for long-term impact on the lives of their clients through empowerment and restoration of personal agency. The potential for such impact has been suggested in previous studies that document the increase in risk for further abuse after an initial abusive experience (Valentine et al., 2016), and in those that suggest long-term mental and physiological effects of IPV and/or reproductive coercion (Burton et al., 2016; Humphreys et al., 2012; Park et al., 2016).

For these providers, risk perception was an important influence and motivation. Interestingly, this is consistent with affective and experiential models of risk perception, which indicate that preventive action is often the result of both predisposition to believe in risk and/or prior experiences that appear to demonstrate the level of risk (Ferrer & Klein, 2015). Although some of the providers in this study had experienced poor patient outcomes from IPV and/or reproductive coercion, it may also be that they had stronger independent beliefs in the risks of IPV and reproductive coercion to their patients. Exploring perception and integration of risk in thinking about IPV and

reproductive coercion, rather than simply providing educational information about these risks, could enhance screening protocol uptake among providers.

Following from this, of interest in regard to the providers themselves was our finding that some of these were intrinsic to the providers as part of their professional values, rather than being strictly related to education or clinical processes. This valuation of the practice of screening by the providers resonates with literature on the phenomenon of moral distress, which has been described in health care providers as occurring when the provider feels that the appropriate course of action—usually the one they would most value—cannot be carried out due to the constraints of the practice setting (Peter & Liaschenko, 2013). Here, our providers saw value in screening practices in that the practice of screening was in accord with their values of compassion, being able to respond to patient needs, and successful outcomes. Consideration of and attention to the professional values of the providers who are expected to administer a given screening or intervention therefore may be vital to the development of a successful protocol.

Finally, participants described environmental factors that motivated them in screening and intervention implementation. Loscalzo et al. (2011) posited the need for institutions to develop a culture around screening such that providers are engaged at all levels of the process—from protocol development to evaluation. Noting that health and psychosocial care providers are often very focused and independent by both training and personality, they suggest that these qualities may render these providers very effective in their client encounters while simultaneously "protective of the status quo" (p. 457). This may be due to concerns about workload management, increased referral burden, or loss of independence, and lack of control over a client's experiences with outside resources. To minimize these issues, the process of integrating screenings into practice must involve the providers directly, as well as clarity about expectations and focus on broader clinical rather than individual outcomes. Normalization around difficult topics—such as IPV and reproductive coercion—may also help providers to integrate these into the flow of their practice and client interactions (Loscalzo et al., 2011).

Social cognitive theory (SCT) (Bandura, 1986) provides a theoretical lens for understanding our findings and translating them into practice. Self-efficacy, knowledge, outcome expectations, and perceived facilitators and impediments are key outcome determinants in SCT. As the initiating event for this project was training on a new screening and intervention protocol—an intended behavior change—application of this theory allows the thematic categories motivating change in the appropriate conceptual domain. Bandura (2004) argued that personal efficacy beliefs are the foundation of motivation insofar as they provide impetus to persist in the face of obstacles and facilitate continued belief in the ability to effect change. For example, knowing that many people do not disclose IPV or reproductive coercion at the first inquiry may help providers persist in the face of repeated negative responses, or it could also discourage screening if the provider anticipates that there will not be a disclosure. Outcome expectations can also guide behavior, regardless of whether the expectations are guided by previous experience or anticipated consequences (Bandura, 1986). If an

outcome is likely to take a long time to be achieved—for example, a client experiencing IPV or reproductive coercion disclosing and seeking help—self-regulatory and self-evaluative incentives are required to sustain motivation (Bandura, 1986). In addition, those providers who view screening and intervening with clients as integral to their professional identity may be more motivated to devote the time and energy to persist with screening. Similarly, internal standards and self-evaluative appraisals are important internal incentivizing functions and contribute to persistence in the face of obstacles. For some providers, social incentives provide important motivations. Providers may be motivated to continue screening despite perceived barriers because the effort itself is rewarding for them and supports their own efficacy (Bandura, 1986). Alternatively, positive social incentives such as praise, gratitude, or approval could motivate adherence to screening guidelines while more negative social incentives like disapproval for failing to follow procedure could have consequences such as job loss or reprimand (Bandura, 1986).

Limitations and Conclusions

Two limitations affect the generalizability of our findings. First, data collection was limited to a single state. Virginia is largely rural, and although we sought to include providers from a variety of demographic locations, we were limited by where training had been held and which providers had participated. Second, data collection occurred just after the USPSTF recommendation. It may be that subsequent to these recommendations, screening practices have changed or improved in many settings.

Identifying factors that motivate providers to effectively screen for IPV and reproductive coercion is crucial to reducing both the incidence of these adverse events and their health sequelae. Here, we sought input about such factors from providers trained in the Project Connect protocol. Using SCT to understand our findings provides guidance on mechanisms of change and facilitators of health-promoting behaviors—many of which are included in Project Connect trainings. Our findings thus make a unique contribution to the literature by specifying some intrinsic and extrinsic motivators in screening for IPV and reproductive coercion. By developing greater understanding of motivating factors in screening for IPV and reproductive coercion, it may be possible to circumvent usual barriers and improve case identification. Increased case finding and subsequent intervention offers significant potential for improving the health and well-being of women and families affected by or at risk for IPV and reproductive coercion.

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