Perceptions of Participating in Longitudinal Trauma Research among Women Exposed to Intimate Partner Abuse

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ABSTRACT: we examine motivations for, and costs/benefits of, participation in three interviews across a one-year period among women recently exposed to intimate partner abuse (IPA). Recruited from publicly accessible police reports, women were not informed that the study focused on IPA in recruiting materials or when they scheduled the first interview. Women's ratings on the Response to Research Participation Questionnaire (RRPQ) indicated a positive benefit-to-cost ratio across all three interviews. Negative responses to participation as well as severity of IPA and PTSD symptoms did *not* predict retention at the next interview. These data demonstrate that studies asking about IPA experiences, even when survivors do not know in advance that IPA will be the focus of study, can be implemented within a stable benefit-to-cost ratio over time.

KEY WORDS: trauma, intimate partner abuse, research ethics, responses to research participation

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While the extant literature has addressed many important questions about the costs and benefits of trauma research, several questions have yet to be addressed (see Newman & Kaloupek, 2009). For example, how is research participation perceived by individuals who do not self-select into the study on the basis of knowing the study focuses on trauma? Further, when participants are not told that research focuses on trauma at the time of recruitment, what factors influence their research experience, and how do their reactions to participation vary over time? The current study addresses these questions in a sample of women exposed to intimate partner abuse (IPA) who were not told about the study's IPA focus at the time of recruitment.

This study extends existing research in several ways. Recent empirical studies provide a wealth of data supporting the safety and acceptability of trauma-focused research for a broad range of participants, including clinical populations (Carlson et al., 2003; Griffin et al., 2003), medical populations (Newman, Walker, & Gefland, 1999), community samples (DePrince & Chu, 2008; DePrince & Freyd, 2004), college students (DePrince & Freyd, 2004), and children (Chu, DePrince, & Weinzierl, 2008). When trauma-exposed individuals are asked about their reactions to trauma-related research, they generally report personal benefits (e.g., Campbell & Adams, 2009) as well as favorable benefit-to-cost ratios (e.g., Carlson et al., 2003; DePrince & Chu, 2008; DePrince & Freyd, 2004; Newman et al., 1999; Ruzek & Zatzick, 2000). Thus, the extant literature suggests that trauma-related studies do not generally require extraordinary safety measures (Walker et al., 1997). However, as trauma measures are incorporated into research and practice more broadly, understanding the impact that participation has on people who did *not* self-select based on trauma is important. For example, medical providers may want to understand the potential impact of assessing for exposure to intimate partner abuse (IPA) as part of routine care appointments. In such cases, victims will not have self-selected into appointments knowing that they will be asked about IPA. Thus, knowing how research participation is perceived by women who do not know they will be asked about violence is directly relevant to assessing trauma in diverse research and practice settings.

Unfortunately, researchers and practitioners have little information to guide them with regard to asking about violence in settings where participants do not know in advance that violence will be a focus. Past research on participation costs and benefits has tended to involve studies where recruitment materials indicated the research focused on trauma in some way (e.g., DePrince & Chu, 2008; Ruzek & Zatzick, 2000; Kassam-Adams & Newman, 2005). When individuals are recruited to participate in research that advertises trauma as a focus, participant self-selection may skew the sample in favor of individuals who are more comfortable (and therefore less distressed) talking about their traumatic experiences. At least one prior study involved the random

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selection of female members of a large HMO who responded to mailed questionnaires that included measures of sexual, physical, and emotional victimization and neglect. Despite the fact that women in this sample did not self-select into a study on violence per se, participants generally reported the experience to be positive (Newman, Walker, & Gefland, 1999; Walker et al., 1997). The current study extends this research significantly by examining perceptions of research that involved in-depth interviews regarding IPA experiences.

The current study also extends empirical research on responses to trauma-focused research to longitudinal studies. Longitudinal research offers the unique opportunity to examine whether responses to research participation at one time point predict retention at the next time point. Cross-sectional studies document that the majority of participants report that, looking back, they would have participated in the research again if they had known in advance what the research experience would be like (Walker et al., 1997; Newman, Walker, & Gefland, 1999; Ruzek & Zatzick, 2000; DePrince & Chu, 2008). At least one previous study suggests that the positive benefit-to-cost ratios are maintained for short follow-up periods (e.g., Newman, Walker, & Gefland, 1999). However, few published studies (of which we are aware) examine responses to research participation in the course of a longitudinal study. The current study allows us to move beyond self-reports of *beliefs* about willingness to participate to look directly at whether or not participants actually return for later sessions.

Current Study

The current study examines women's perceptions of the factors that motivated their research participation as well as costs and benefits of participating in longitudinal IPA research. The study is unique in several ways. First, we recruited a sample of women who did not self-select into the study based on the study focus because the focus was not advertised at the time of recruitment. Extending previous research, we hypothesized that participants would rate the benefits of research participation as greater than the costs despite not being told about the IPA focus at the time of recruitment. Second, the longitudinal design allowed us to examine changes in perceptions of research participation over time and relations between previous perceptions of research participation and retention at the next interview. We predicted that a positive cost-benefit ratio would be consistent across all three time points. Third, because women *were not* explicitly told about the study's extensive IPA focus at the time of recruitment, but *were* aware of the research focus when they chose to return for follow-up interviews, we had a unique opportunity to test behaviors over time (rather than beliefs about participating, as tested in cross-sectional research).

Method

Participants

Two hundred and thirty-six adult female participants were enrolled into a three-session study in a large urban area in the Rocky Mountain region between December 2007 and July 2008, as part of a larger study (for details on the larger study, see DePrince et al., in press; DePrince et al., 2012). Potential participants were identified through publicly accessible police incident reports following IPA. Incident reports were obtained for cases that involved perpetration of domestic violence by a male against a female partner. Cases that involved cross arrests for bidirectional violence, male victims of violence, juveniles, or same-sex couples were excluded from the study. The median time elapsed between the arrest incident and recruitment into the study was 26 days.

Procedure

Potential participants were contacted using address and phone information obtained from publicly accessible police incident reports. They were recruited first by a lead letter, which introduced the study and informed women that they could initiate contact on their own, or wait to receive contact from study personnel by phone. At the time of initial phone contact with study staff, women were told that they had been identified through public records to participate in the "Women's Health Study." Specifically, when contacted by phone, they were informed that "[The University] is conducting a study related to women's health. You have been selected to participate in this study. If you agree to participate, the information you provide during three interview sessions will be used to try to improve health-related services for women." Women were also informed that they would be asked to answer questions regarding physical health and emotions as well as stressful life events, such as exposure to crimes and violence. Due to safety concerns, women were *not* explicitly told that the study focused extensively on IPA or that their names were identified through police reports until the informed consent process at the first interview.

At the first interview (T1), women were informed during the consent process that they had been recruited

through publicly accessible police incident reports, and that one purpose of the study was to understand what helps women who have experienced IPA. Because they could not be informed of the focus on IPA prior to the first study visit, great care was taken to ensure that women were given the opportunity to decline to participate in the study, while still receiving full compensation. Only one woman declined to participate after being informed of the purpose of the study (a second woman initially declined to participate, but later contacted the lab and asked to be included in the study).

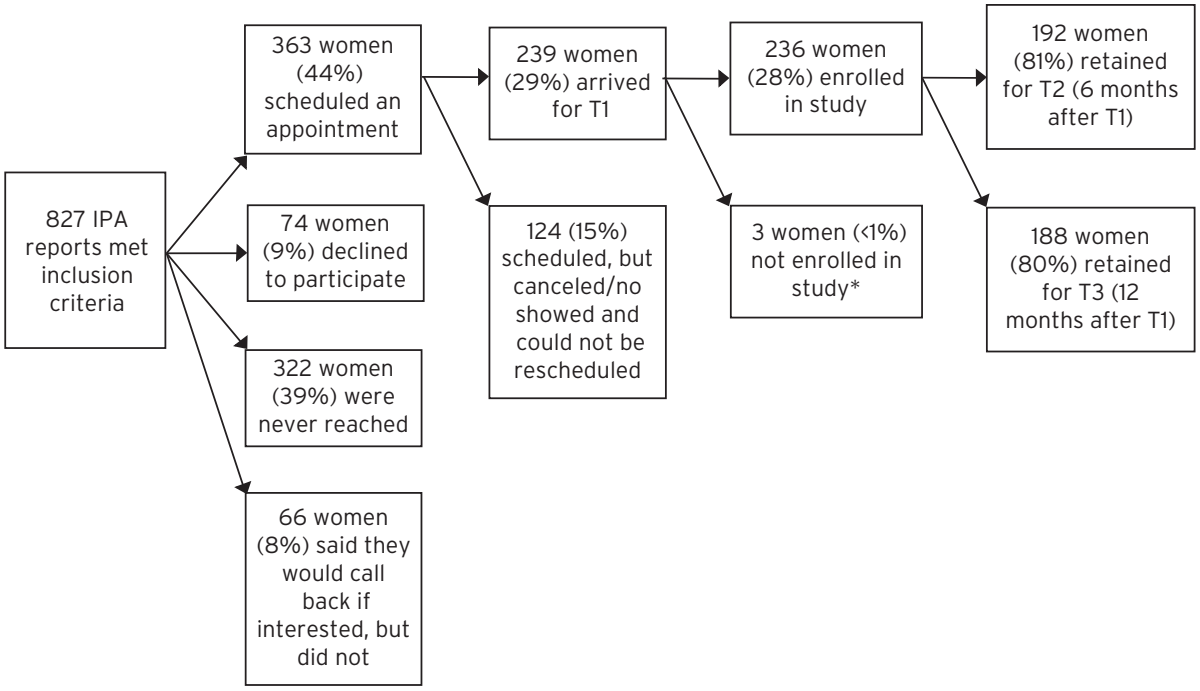
In order to ensure that participants who consented did not feel compelled to continue participation in the event should they became distressed or uncomfortable, participants were told that they could skip any question that they did not want to answer, and that they could stop the study at any point without affecting their compensation. Although formal consent was obtained only at the first visit, to assess participants' understanding of consent information, including the voluntary nature of participation, we reviewed the consent form and then administered a verbal "consent quiz" before each of the three interviews. The consent quiz included questions such as "Do you have to answer every question?"; "If you become upset by something you read or are asked to answer or write about, what can you do?"; and Do you have to have a 'good reason' to stop the interview?" If potential participants answered any of the questions incorrectly, the correct information was provided by the interviewer, who then repeated the question. Women were required to answer all consent quiz questions correctly within two tries in order to be considered as giving informed consent to participate in the study. Of the 239 women who scheduled and attended a first session, one declined to participate during the informed consent process and one was not enrolled because she appeared to be under the influence of alcohol. One woman did not pass the consent quiz; she was compensated for her time, but not enrolled in the study. Thus, 236 women who passed the consent quiz were enrolled into the study. For a visual representation of the study recruitment process, see Figure 1.

Interviews were conducted by female graduate students or the second author, all of whom underwent extensive training prior to data collection regarding ethical and clinical issues involved in conducting research on IPA, as well as extensive training on the study protocol. During the initial three-hour assessment, an interview was conducted that included questions about participants' experiences, thoughts, and feelings regarding the IPA incident reported to law enforcement (including PTSD symptoms) as well as factors that were helpful and unhelpful in dealing with the incident. Women were asked about their physical and emotional health as well as their trauma histories, including IPA with current and past romantic partners. Participants were invited to return for follow-up assessments six months (T2) and one year (T3) after the initial assessment; the content of these follow-up assessments closely paralleled the content of the first interview. Compensation for the first visit was $50, and was increased to $55 for the second visit and $60 for the third. Efforts were made to address transportation access as well as other potential barriers to research participation. For example, participants were offered childcare during the study visits as well as taxi fare to and from the study facility.

Measures

Demographic information was obtained regarding ethnicity, age, education, and occupation.

The *Response to Research Participation Questionnaire* (RRPQ; Newman & Kaloupek, 2001, 2004) is a 23-item self-report measure assessing participants' responses to research participation. The RRPQ consists of five well-established subscales (Newman et al., 2001; DePrince & Chu, 2008; Schwerdtfeger, 2009; Shorey, Cornelius, & Bell, 2011) that assess positive and negative aspects of participation. Three factors (Participation, Personal Benefits, and Global Evaluation) tap positive aspects of the research experience, including perceptions of personal benefits. Specifically, the Personal Benefits scale taps benefits to the individual, such as gaining insight or meaning (e.g., "I gained insight into my experiences through research participation"). The Global Evaluation scale taps beliefs about the importance of the research and the integrity of the research process (e.g., "I was treated with respect and dignity"). The Participation scale taps important global concepts, such as the participants' perceptions of the value of the trauma-related research and the participants' beliefs about empowerment to stop the research (e.g., "I felt I could stop participating at any time."). Two factors tap negative aspects of the research, including costs and unanticipated, negative emotional reactions. The Drawbacks scale taps regret and negative perceptions about the research procedures (e.g., "Participating in this study was inconvenient for me"). Two items on this scale were reverse scored. The Emotional Reactions scale taps unexpected and negative emotions during participation (e.g., "The research raised emotional issues for me that I had not expected"). The RRPQ was scored by computing averages for each of the five scales. Cronbach's alphas for four of these scales were acceptable: Personal Benefits =. 72; Emotional Reactions = .83; Perceived Drawbacks = .68; and Global Evaluation = .79. Cronbach's alpha for the Participation subscale (.49) was



*One woman declined participation once she learned that the study focused on IPA. Two women did not meet informed consent requirements, which required them to answer all consent quiz questions correctly to demonstrate understanding of consent material. All three women were componsated for their time, though they were not interviewed.

FIG. 1. Flow of Study Recruitment Protocol.

below the acceptable range; for this reason, the subscale was not included in analyses.

The RPPQ also includes a checklist of nine possible reasons for participation. This checklist includes items such as "I was curious," "To help others," "To help myself," and "For the money." Participants are asked to "please rank the top three reasons why you decided to participate." To evaluate the factors that motivated women to participate in the study for the initial assessment, when they did not yet know about its IPA focus, the checklist portion of the RRPQ was administered only at Time 1.

Participants reported on different aspects of the IPA that led to the report to law enforcement. The severity of the target IPA incident was assessed using the Revised Conflict Tactics Scale (CTS; Straus et al., 1996), which was administered by interview. We tallied the total number of psychologically (possible range: 0–15) and physically (possible range: 0–13) aggressive tactics used by the abuser in the target incident, as well as the number of injuries sustained by the victim (possible range: 0–17).

Past trauma history (not including the target IPA report to police) was assessed using the *Trauma History Questionnaire* (THQ; Green, 1996). The 24-item self-report assesses the occurrence of potentially traumatic events during both childhood and adulthood. Participants were asked to indicate lifetime occurrence using a yes/no format; for each event that is endorsed, frequency, age of onset, and relationship to perpetrator are assessed. Potentially traumatic experiences include events such as natural disasters, violent and nonviolent crime, serious illness, and loss of a romantic partner or child. The THQ has been used effectively in clinical as well as nonclinical samples. The THQ has been shown to have high test-retest reliability over a two- to three-month period. Correlations on items ranged from .54 to .92 (Green, 1996).

PTSD symptoms were assessed using the *Posttraumatic Diagnostic Scale* (PDS; Foa et al., 1997), a 28-item self-report instrument measuring severity of PTSD symptoms stemming from a single identified traumatic event. The PDS is keyed to DSM-IV criteria for PTSD and addresses symptoms occurring in the past month. It also assesses severity of PTSD symptoms, from 0 ("not at all or only one time") to 3 ("5 or more times a week / almost always"). Cronbach's alpha for the current sample was .82.

Results

Demographic data for the 236 women who participated at Time 1 demonstrate a diverse sample in terms of racial/ethnic background, marital status, and education

(see Table 1). Specifically, women's ages ranged from 18–63, with an average age of 33.4 (*SD* = 11.0). Women reported their racial/ethnic backgrounds to be 47% White/Caucasian, 30% Black or African-American, 2% Asian/Asian American, 1% Pacific Islander, 11% American Indian or Alaskan Native, 6% other, and 39% Hispanic or Latina. Across categories, 174 women (74%) identified as belonging to one or more racial and/or ethnic minority groups. Almost half the sample reported having ever been married (49%). Women described their current relationship status to be: 9% married, 8% living with someone, 18% divorced, 12% separated, 2% widowed, 40% single and never married, and 7% other. Women reported the following in terms of highest level of education: 3% 1st–8th grade; 27% some high school; 26% high school; 25% some college; 8% Associate's degree; 7% 4-year college degree; 2% postgraduate education; and 1% other (e.g., trade school).

The nature of the demographic data obtained from police reports did not allow us to compare our sample to the larger group of women who were eligible for the study but did not choose to participate. However, spatial location data suggest that the sample was representative of the neighborhood distribution of reported IPA incidents within the city (DePrince et al., in press; DePrince et al., 201Despite the challenges to retaining women exposed to IPA in longitudinal studies (DePrince et al., in press), 81% (N=192) of the initial 236 women returned for a six-month follow-up assessment, and 80% (N=189) returned for a one-year follow-up assessment. Women who did not complete the second assessment were still contacted to complete the third assessment. The number of women who completed at least one follow-up assessment visit represented 87% (N=206) of the original study sample.

At the conclusion of the first visit, participants were asked to rank their top three reasons for participating in this study from a list of nine possible reasons. Of the items on that list, women reported participating for the following reasons: *I was curious*, 66.9%; *To help others*, 61.9%; *To help myself*, 55.1%; *For the money*, 47%; *Thought it might improve my access to health care*, 18.6%; and *Felt I had to*, 11.9% (participants could check more than one reason, thus the total percentage sums to greater than 100). In examining the RRPQ item-level responses of women who endorsed *Felt I had to* as a reason for participating, an independent samples t-test showed that participants who endorsed this item were no less likely to also report that "I felt I could stop participating at any time" and "participating was a choice I freely made."

In addition to calculating means for the four RRPQ subscales,[1] we created four benefit-to-cost ratio variables with which to analyze the benefits relative to the costs of participation (DePrince & Chu, 2008). To do so, we calculated four difference scores by subtracting negative RRPQ subscale scores from positive RRPQ subscales scores: Emotion Reactions subtracted from Personal Benefits, Drawbacks subtracted from Personal Benefits, Emotional Reactions subtracted from Global Evaluation, and Drawbacks subtracted from Global Evaluation. Because difference scores were calculated by subtracting negative subscale scores from positive subscale scores, larger and more positive difference scores indicated more positive cost/benefits ratios, while smaller and more negative scores indicated more negative cost/benefit ratios. Descriptive statistics for RRPQ (including the five scales as well as difference scores reflecting benefit-to-cost ratios) and PTSD measures are described in Table 2.

To assess the perceived costs and benefits of participating in this research, we first used one-sample t-tests that compared each subscale mean score to 3, the neutral

TABLE 1: Sample Characteristics.

		Range	Mean (SD)
Age		18–63	33.4 (11.0)
		%	N
Years of Education	1st–8th grades	3	9
	Some high school	27	63
	High school graduate	26	61
	Some college	25	59
	Associate's degree	8	18
	4-year college degree	7	16
	Postgraduate	2	5
	Other (trade school, specialized training)	1	3
Race and Ethnicity	White/Caucasian	47	111
	Black or African-American	30	71
	Asian	2	5
	Pacific Islander	1	3
	American Indian or Alaskan native	11	26
	Other	6	14
	Hispanic or Latina origin	39	92
Marital Status	Have ever been married	49	116
	Married	9	21
	Living with someone	8	19
	Divorced	18	43
	Separated	12	29
	Widowed	2	5
	Single and Never Married	40	95
	Other	7	16

Note: Participants endorsed multiple racial and ethnic categories where applicable. Percentages do not total 100% due to rounding.

TABLE 2. Descriptive Statistics for Study Measures.

Measure		Time 1 Mean (SD) N=222	Time 2 Mean (SD) N=187	Time 3 Mean (SD) N=178
RRPQ Scales, Positive:	Participation	4.56 (.49)	4.64 (.47)	4.62 (.60)
	Personal Benefits	3.94 (.71)	4.05 (.64)	4.25 (.69)
	Global Evaluation	4.72 (.44)	4.73 (.36)	4.76 (.48)
RRPQ Scales, Negative:	Emotional Reactions	2.80 (1.08)	2.50 (1.06)	2.65 (1.07)
	Perceived Drawbacks	1.55 (.51)	1.55 (.53)	1.50 (.54)
Benefit-to-cost ratios	Personal Benefit – Emotional Reaction	1.13 (1.08)	1.55 (.1.07)	1.60 (1.13)
	Personal Benefit – Drawbacks	2.39 (1.00)	2.50 (.97)	2.75 (1.09)
	Global Evaluation – Emotional Reaction	1.91 (1.14)	2.23 (1.16)	2.11 (1.18)
	Global Evaluation – Drawbacks	3.16 (.82)	3.17 (.80)	3.26 (.92)
PTSD		16.62 (12.13)	12.62(11.58)	13.03 (11.50)
			Range	
Target IPA Incident Severity	Psychological Aggression	4.53 (2.68)	0–14	
	Physical Aggression	3.01 (2.65)	0–11	
	Injuries	2.68 (2.52)	0–10	

Note: RRPQ scale scores are based on the following scoring: 1=strongly disagree, 3=neutral, 5= strongly agree. Benefit-to-cost ratios reflect difference scores based on RRPQ scale scores, because difference scores were calculated by subtracting negative subscale scores from positive subscale scores, in which larger and more positive difference scores indicated more positive cost/benefits ratios while smaller and more negative scores indicated more negative cost/benefit ratio.The RCMS-PTSD was used to measure PTSD symptom severity. The Revised Conflict Tactics Scale was used to measure target IPA incident severity.

point on the scale (1=strongly disagree; 5=strongly agree). For all three time points, scores on the three positive factors (Participation, Personal Benefits, and Global Evaluation) were significantly greater than 3 (neutral point), indicating agreement with statements indicative of positive gains and experiences in the study. Scores on the negative factors (Perceived Drawbacks and Emotional Reactions) were significantly less than 3, indicating disagreement with statements that tap unexpected or negative emotional reactions and inconveniences caused by the study. Thus, RRPQ responses from all three assessment visits indicated that participants consistently viewed the positive aspects of study participation as being greater than the negative aspects. In addition, the benefit-to-cost ratios that were calculated by subtracting negative subscale scores from positive subscale scores were consistently positive across all three time points.

Next, we examined whether responses to research participation predicted retention at the next interview while controlling for several factors that had the potential to influence retention, including PTSD symptoms severity, RRPQ subscales, and arrest incident severity (CTS physical aggression, psychological aggression, and injury severity) distinguished between participants who returned for at least one subsequent study visit and those who did not (see Table 3). Using logistic regression, the three CTS scores, four RRPQ subscale scores, and total PTSD scores were entered into the model predicting retention. The full model was not significant ($X^2(8) = 2.60$, $p = .95$). Two additional logistic regressions were conducted to assess for whether responses to participation at T1 were related to retention at T2, and whether responses at T2 were related to retention at T3, again controlling for several factors. In assessing whether CTS scores, RRPQ subscale scores, and total PTSD scores at T1 predicted for retention at T2, the full model results of a logistic regression were not significant ($X^2(8) = 5.29$, $p = .72$). In assessing whether these same factors at T2 predicted retention at T3, full model logistic regression results were again not significant ($X^2(8) = 10.86$, $p = .21$).

Discussion

Prior research indicates that trauma research participants generally rate the benefits of participation as outweighing the costs. However, individuals who self-select into studies—and therefore know in advance that the research focuses on violence (or other traumatic events)—may be better prepared to tolerate potential negative emotional reactions than individuals who do not select to participate in trauma-focused research. The current study gave us an opportunity to evaluate responses to research participation in the context of a research protocol where participants were not told that the interview would focus specifically on IPA (for safety reasons) when recruited for the first assessment, and therefore did not self-select into (or out of) the research

TABLE 3. Logistic Regression Analysis of Retention as a Function of RRPQ Subscale Scores, Arrest Incident Severity, and PTSD Symptom Severity.

	Retention for all future visits				Retention from T1 to T2				Retention from T2 to T3			
Subscale	B	SE	e^b	Wald	B	SE	e^b	Wald	B	SE	e^b	Wald
CTS Psychological Aggression	-.07	.08	.92	.89	-.05	.07	.95	.47	-.04	.12	.95	.13
CTS Physical Aggression	.03	.12	1.03	.07	.08	.10	1.08	.63	-.27	.15	.75	3.39
CTS Injuries	.02	.12	1.02	.03	-.06	.10	.93	.37	.25	.18	1.28	1.94
PTSD Symptom Severity	-.01	.02	.98	.34	-.00	.01	.99	.01	.01	.03	1.02	.34
Global Evaluation	.26	.61	1.29	.17	.44	.49	1.56	.80	.16	1.06	1.17	.02
Personal Benefit	.01	.36	1.01	.00	.41	.30	1.51	1.78	-.06	.50	.94	.01
Drawbacks	.51	.56	1.67	.82	.91	.50	2.4	3.2	.35	.76	1.41	.20
Emotional Reaction	.11	.23	1.12	.23	-.11	.20	.89	.30	.66	.41	1.93	2.52

based study's direct IPA focus. Instead, participants learned of the IPA focus during the informed consent process at the first interview. Only one woman (less than 1%) declined to participate when learning about the study's focus during the informed consent process. Importantly, RRPQ responses from the T1 assessment indicated that participants viewed the positive aspects of study participation as being greater than the negative aspects, resulting in a positive cost/benefit ratio. Thus, these data demonstrate that research can be carried out in such a way that the benefits outweigh the costs for participants even when the topic of violence was not directly communicated to potential participants at the time they scheduled the first interview.

Though participants were not made aware that the study focused on IPA at the time that they made the decision to come in for the T1 assessment, they did know the focus of the study when making decisions to return for T2 (six months later) and T3 (one year later) assessments. Thus, a steep decline in retention could have indicated that though participants reported a positive benefit-to-cost ration immediately after the initial assessment, their views became more negative over time leading to attrition. Strikingly, most participants in this study returned for subsequent visits in spite of the high degree of transition (e.g., frequent changes in residence; see DePrince et al., in press, for discussion) faced by recent IPA victims that might negatively affect retention. Thus, retention rates suggest that participants did not radically change their views of the relative benefits and costs of participating in the first interview given the decisions to continue participation six months later.

In addition to establishing a stable cost/benefit ratio over the course of subsequent study visits, the current study also evaluated the possibility that this finding was due to self-selection for the second and third visits. We controlled for PTSD symptom severity as well as arrest incident characteristics when assessing retention. Discussing traumatic events that are more violent or severe, or participating in trauma research while experiencing severe PTSD symptoms, may be more difficult for participants, and these women would therefore be more likely to perceive participation negatively and to decline to return for future visits. However, PTSD symptoms as well as arrest incident severity were unrelated to either retention or perceptions of the research experience at T2 and T3 interviews.

A somewhat unexpected finding was that 12% of participants checked a box to indicate that they participated because they felt they had to. This result is consistent with other research: Ruzek and Zatzick (2000) note that 19% of respondents in a sample of acutely injured motor vehicle accident and assault survivors reported feeling that they were unable to decline enrollment in a trauma research protocol. Because participants completed the checklist privately at the first visit, the assessor was not able to ask follow-up questions or correct women's perceptions at that time. However, this issue was addressed at the start of each follow-up interview, where consent information was carefully re-reviewed, emphasizing the voluntary nature of participation. In addition, we administered a consent quiz to assure participants' understanding of the voluntary nature of the research. For example, participants were asked: "Do you have to answer every question?" and "Do you have to have a 'good reason' to stop the interview?"

In discussing their similar finding, Ruzek and Zatzick also noted that 95% of their sample reported a positive cost/benefit ratio, as well as agreement with the statement "Had I known in advance what participating would be like for me I still would have agreed." This trend is consistent with prior research indicating that a substantial majority of trauma-focused research studies positively endorse items indicating the perceived ability to refuse participation, to stop or skip questions, and to voice discomfort with the research protocol (Kassam-Adams & Newman, 2005; Ruzek & Zatzick, 2000). This trend was also evident in the current research study, in

which 92% of participants reported that they would participate in the study again. Additionally, further examination showed that women who endorsed "felt I had to" as a reason for participating were not more likely to disagree with the RRPQ items "I felt I could stop participating at any time" and "participating was a choice I freely made." This suggests that although women indicated participating because they felt they had to, on a practical level, they understood that participation in the study was voluntary, and were any not less likely to return for future visits.

Best Practices

The positive benefit-to-cost ratio even when women were naïve to the study's direct IPA focus has important implications for research and practice. In terms of other research protocols, these data provide important information for researchers who may seek to ask participants about violence exposure when violence is not advertised as a focus of the study. In terms of practice, the current study approximates situations where questions about trauma (especially violence) history may be asked even when trauma was not the presenting problem. For example, as medical practitioners are increasingly encouraged to assess trauma (particularly violence) exposure during routine health care appointments (e.g., Allen et al., 2007), the current study addresses the situation where someone comes to an appointment not expecting to be interviewed extensively about violence. Understandably, in the absence of empirical data about how patients might respond to being asked about violence when they are not otherwise expecting that to be part of the assessment, practitioners may be wary. For example, in a study of 12 community-wide health centers, Allen et al. (2007) reported that fewer than half of providers consistently screened their patients about IPA; they also found that 43% of health care providers did not disagree/strongly disagree that asking patients about domestic violence exposure would offend them. Thus, the current study has important public health implications insofar as we have demonstrated that women perceive benefits as outweighing costs of even in-depth discussion of violence exposure when they came to the appointment not expecting to be asked about violence. Allen et al. found that individual and organizational factors were related to screening practices. Providers who perceived that their organization was supportive of screening, who felt comfortable and competent to conduct screenings, and who more positively viewed the value and appropriateness of screening, were more likely to routinely screen their patients about IPA. Awareness of the importance and feasibility of asking patients about IPA increases the likelihood that women in violent relationships will be identified and supported in health care settings.

Research Agenda

The current study has potential ramifications for research that is conducted in a range of settings. There are many challenges to retaining women exposed to IPA in longitudinal studies (see DePrince et al., in press), such as limited access to transportation, childcare, and the frequency with which participants may change addresses and phone numbers. The degree to which this study's original sample was retained despite this and other obstacles to retention lends additional support to the strength of these findings, and challenges the notion that women exposed to IPA are less able or willing to engage with the research process and with community agencies.

In conclusion, the importance of ethical considerations in the conduction of trauma research has been well established. Newman and Kaloupek (2004) note that an important component of ethical practice in human subjects research is that of *autonomy*, which stipulates that researchers take into account the "wishes of those who are competent to make choices and protecting those with impaired abilities" (Newman & Kaloupek, 2009). In light of current research indicating that individuals exposed to trauma are no less competent to provide informed consent to research participation than other groups, while weighing the potential risks of negative emotional reactions, there is no empirical evidence to justify denying these individuals a voice in the scientific literature. These findings suggest that women can be successfully included in research that occurs in a variety of contexts.

Educational Implications

In the absence of empirical data, researchers and practitioners may worry about asking women about abuse exposure in contexts where women are not aware that such questions may be a focus. However, few empirical studies have addressed women's reactions to focusing on abuse in samples where the recruitment procedures did not explicitly state the abuse focus. In the current study, we looked at multiple indicators of discomfort, from attribution to self-reported ratings of positive and negative responses to participation. We believe that these findings are relevant to a range of stakeholders, from researchers and ethics committee

members to practitioners. In terms of the latter, practitioners who see clients for non-abuse reasons (e.g., routine health screenings) can use these data to educate colleagues that women with abuse histories can tolerate (and even find positive benefits in) reporting on their abuse histories, even when they did not know that abuse would be addressed during the appointment. Further, practitioners can educate their colleagues that women's responses to being asked to share extensive details about their recent experiences of abuse did not predict attrition at later time points. Thus, in the context of careful and compassionate interview protocols, it is possible to retain participants over time even when the initial focus on abuse was not anticipated. For effective dissemination, training should be provided to individuals who are involved with all aspects of the research process, including students, professionals, and IRB members.

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Note

1. A handful of outlying scores affected the distribution of the Global Evaluation subscale at T1 (n = 3) and T3 (n = 4). When these data were pulled back to 3 standard deviations of the mean, all study results were comparable to those obtained with the original data; therefore, we report original data here.

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