Intimate Partner Violence and Women’s Health: Problems and Prospects

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Objectives

• To learn about the epidemiology of intimate partner violence (IPV): its prevalence and its health effects on women

• To discuss the identification of IPV

• To review the evidence re effectiveness of interventions to prevent IPV
Epidemiology

Prevalence and health effects
Middle Ages

“When you see your wife commit an offense, don’t rush at her with insults and violent blows... Scold her sharply, bully and terrify her. And if this still doesn’t work... take up a stick and beat her soundly”
Definition and prevalence

• IPV includes physical, sexual, emotional, verbal and financial abuse
• Annual prevalence between 2 and 12%
• Lifetime prevalence 25 to 30%
• Canadian population-based 5-year rates of 8% for physical and sexual abuse

(Tjaden & Thoennes, 2000; Statistics Canada, 2000)
Experienced IPV in last year

13.9% in Acute
9.5% in Primary
8.0% in Specialty

(MacMillan et al., 2006)
IPV during pregnancy

• Most stable estimates are 4% to 8%
• Most studies find no significant difference in rates during the pre-, peri- and post-natal periods  OR
• Trend towards a decrease in abuse once a woman is pregnant
• Abuse during an earlier period is by far the strongest predictor of abuse during a later period
Health effects of IPV
Physical health

• Increased risk of injury and death
  Eisenstat and Bancroft (1999)

• More frequent use of health care services including physician, emergency room visits, hospitalizations
  (Ulrich et al., 2003; Coker, Remsburg, & McKeown, 1998; Kernic, Wolf, & Holt, 2000; Day, 1995; Centers for Disease Control and Prevention, 2003; Koss et al., 1991; Wisner et al., 1999; Coker et al., 2004).

• Annual estimated health costs of IPV against women in Canada is $1.5 billion
  (Statistics Canada, 2006)
Mental health

- Increased rates of mood and eating disorders
- Severe violence produced increased rates of mood, eating, substance dependence and antisocial personality disorders, as well as nonaffective psychosis (Danielson et al., 1998)
- Depression, suicidality, PTSD, and alcohol and drug abuse/dependence (Golding, 1999)
- Significantly higher rates of depression, anxiety, somatization, substance abuse/dependence and dissociation, compared to those without abuse (Roberts et al., 1998)
Abuse during pregnancy

Can result in

• pre-term birth
• injury
• low birth weight  (Campbell et al., 1999)

Indirect harm

• psychological distress
• woman’s reluctance or inability to obtain prenatal care  (Newberger et al., 1992; Cokkinides et al., 1999).
Persistence of effects

• exposure to abuse had an ongoing effect on physical and emotional health, even if recent abuse declined
  
  (Sutherland et al., 1998)

• when violence decreases or is eliminated, physical and mental health improves

  (Bybee et al., 2002; Sutherland et al., 1998)
Identification of IPV

Case finding versus screening
Case Finding

• Asking women presenting with specific signs, symptoms or risk indicators of abuse
  - injuries consistent with abuse
  - depression, somatic complaints, etc.
• Also called the “diagnostic method”
• Part of good clinical care
Universal Screening

“standardized assessment of patients, regardless of their reasons for seeking medical attention”

(Cole, JAMA 2000, 284; p. 551)

- Many tools are available for various settings, and for pregnant women
- Usually measure self-reported abuse
- Many perform reasonably well in identifying women who have been abused
Key Differences

• Universal screening
  - All women
  - Asymptomatic for abuse
  - No clinical “trigger” to ask

• Case finding
  - Women with clinical signs and symptoms
  - Clinical “trigger” for further asking and diagnostic assessment
Case finding: risk indicators

Aim of the study

• To develop evidence-based, clinically relevant questions to assess the relationship between specific risk indicators and exposure to IPV
• To examine this relationship with women presenting in the two emergency departments (EDs) N=768

(Wathen et al., Open Medicine, 2007)
Odds ratios for risk indicators

Regression with all indicators entered at once
IPV by number of indicators

<table>
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<tr>
<th>Indicators</th>
<th>Percent Positive</th>
<th>N</th>
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<tbody>
<tr>
<td>0</td>
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<tr>
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</tr>
<tr>
<td>2</td>
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<td>4, 5, 6</td>
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</table>
Prevention of IPV
Framework

Adult women

Identification of women experiencing abuse (who disclose)

Health outcomes: Repeat violence Physical health Mental health

Universal screening or Case-finding

Intermediate outcomes: Social support Safety behaviors Use of resources Others

Harms of screening or Harms of intervening

Intervention
Systematic reviews of interventions

- No studies of primary care counseling met review inclusion criteria
- Only 1 study evaluated shelter stay: judged “poor” quality
- Personal/Vocational counseling studies “poor”
- Prenatal counseling studies rated “poor”
- Batterer intervention programs have no to a small effect in reducing violence (0 to 7%)
- Good quality study of couple intervention showed no effect
  (Wathen & MacMillan, 2003; Babcock et al., 2004; Feder & Wilson, 2005)
Post-Shelter Advocacy RCT

Post-shelter women receiving counseling reported:

- Less physical re-abuse (76% vs. 89%) at 2 yr follow-up; no difference at 3 yr
- Improved quality of life
- Increased use of social support
- Increased effectiveness in obtaining resources

(Sullivan & Bybee, 1999; Bybee & Sullivan, 2005)
Insufficient evidence for

- Woman abuse shelters as a means of decreasing the incidence of violence
  (Wathen & MacMillan, 2003)

- Personal and vocational counseling, and prenatal counseling
  (McFarlane et al., 2006; Tiwari et al., 2005)

- Educational, community and policy-oriented interventions, although recent study suggests that permanent civil protection orders may be effective
  (Holt et al., 2002)
Guidelines vs evidence

• Non-evidence based guidelines generally favor screening, based on the prevalence and consequences of abuse.

• Evidence-based assessments find insufficient evidence to determine whether screening does more good than harm.

(e.g. USPSTF, CTFPHC; see also Ramsay et al., BMJ 2002; 325:314-327)
CTFPHC statement

• “There is insufficient evidence to recommend for or against routine universal screening for violence against either pregnant or nonpregnant women, however clinicians should be alert to signs and symptoms of potential abuse and may wish to ask about exposure to abuse during diagnostic evaluation of these patients”

(CMAJ 2003; 169: 583-4)
If, When and How to Ask the Question(s): Assessing Screening Approaches to Identify Woman Abuse in Health Care Settings

Supported by the Ontario Women’s Health Council, Ontario Ministry of Health and Long-Term Care
Objective

To answer the question:

*Does universal screening for VAW in health care settings do more good than harm?*

Tests the effectiveness of universal screening vs. no screening in:

- reducing violence and improving life quality
- balanced against potential harms
VAW Team

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VAW Research Program

Phase 1 Studies (complete)

“Testing Trial” of Screening Methods (complete)

Screening Effectiveness RCT (underway)

- Focus groups with abused and non-abused women
- Health care provider survey
- Population attitudes towards screening
- Meta-analysis of risk indicators
- Development & testing of risk indicator questions
Focus groups messages

- Women do not support targeted screening based on demographic risk factors, feeling it is akin to “profiling”
- Abused women fear disclosing IPV to a health or social service provider
- Little consensus among abused or non-abused women regarding which health care setting is the most appropriate place for asking about IPV
Methods of screening

Instruments and administration
The “Testing Trial”

In four types of health care settings:

1. The best of three screening methods
   - Paper-pencil (PP)
   - Face-face (FTF) with health care provider
   - Computerized (C)

2. The better of two screening tools
   - Partner Violence Screen (PVS)
   - Woman Abuse Screening Tool (WAST)
Settings

- Two emergency departments
- Two family practices
- Two women’s health clinics: colposcopy clinic and obs/gyne clinic
Criteria for choosing method

- Women’s responses to 3 evaluation items
- Disclosure rates
- Rates of missing data
Sample recruitment

- Appeared at site: 13767
  - Eligible: 2602
    - Completed screen: 2461
      - Refused: 141 (5%)
      - Ineligible: 11165
        - Not patient: 3646
        - Age: 3317
        - Missed: 1216
        - Prev app: 982
        - Other: 2004

- Computerized: 769
- Face-to-face: 853
- Paper-pencil: 839
Women's evaluation of methods

<table>
<thead>
<tr>
<th>Method</th>
<th>Computer</th>
<th>FTF</th>
<th>PP</th>
<th>% rating 5 (best)</th>
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<tbody>
<tr>
<td>Easy</td>
<td>87.5</td>
<td>77.1</td>
<td></td>
<td>94.6</td>
</tr>
<tr>
<td>Like it</td>
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<td>Private</td>
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Summary

• Disclosure rates not significantly higher for computerized screen
• Computerized screen had highest rates of missing data
• Women least preferred FTF screening

(MacMillan et al., JAMA 2006)
RCT Design

Follow up
Baseline*  3m**  6m  9m  12m  15m  18m

Universal screening
- Positive: 100% Positive
- Negative: 5% Negative

No Screening
- Positive: 100% Positive
- Negative: 5% Negative

*Baseline within 7 days of screen
**"mini" phone interview at 3, 9, 15 m
Settings & participants

- Acute care: 11 sites
- Primary care: 12 sites
- Obs-gyne clinics: 3 sites
- Women aged 18-64
- Presenting for their own appointment
- Not too ill to participate
- Able to read and write English
Outcomes

Primary

- Reduction in repeat violence
- Improvement in quality of life
- Potential harms of screening*

Secondary

- Health measures (physical and mental)
- Health service utilization
- Social support, use of information, specific strategies and safety behaviours
- Women’s perceptions re: screening & follow-up

* We have developed and tested an instrument to measure harm
Sample generation

Seen at site 121,892

- Ineligible 100,346 (82%)
- Refused eligibility 6527 (5%)
- Missed by recruiters 6643 (5%)

Eligible 8376

- Refused participation 1549 (18%)

Randomized 6827

Screening 3296

- Withdrew 224 (7%)
- Missed Exit Q 361 (11%)

- PosPos 347 (10%)
- Neg 2364 (90%)

No Screening 3531

- Withdrew 183 (5%)
- Missed Exit Q 420 (12%)

- PosPos 349 (10%)
- Neg 2579 (90%)
New prevention efforts
Nurse Family Partnership

• NFP is program of *nurse* home visiting for disadvantaged first-time mothers
• Visits start prenatally, go to child age 2
• Proven benefits in a range of maternal and child outcomes
• Child maltreatment is reduced *except* in families where there is IPV
• 5 year funding from CDC to develop and evaluate an IPV component for NFP
Conclusions

• IPV is common
• It has effects across multiple health domains
• There are indicators of its presence aside from injury
• We know little about how to prevent IPV or reduce its recurrence
• There is evidence from one specific advocacy program re improving quality of life
violence against women
Testing the effectiveness of screening

If, When and How to Ask the Questions: Assessing Screening Approaches to Identifying Woman Abuse in Health Care Settings.

This is an integrated, multi-disciplinary program of research which looks at the effectiveness of screening in reducing violence and improving the quality of life for women and their children.

It is funded by the Ontario Women’s Health Council, and began in March 2003.

The program is headquartered at the Offord Centre for Child Studies at McMaster University.