Author's response to reviews

Title: Alcohol misuse, drinking contexts and intimate partner violence in St. Petersburg, Russia: Results from a cross-sectional study

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Author's response to reviews: see over
Dear Dr. Ajuwon and Mr. Dizon,

We would like to thank you for considering our manuscript. We also thank the two reviewers for their thoughtful comments and suggestions. We have adjusted the manuscript accordingly. In the following four pages, we reply to the specific comments of each reviewer.

Please address all correspondence concerning this revised manuscript to me at Yale University School of Public Health and feel free to correspond with me by e-mail: nadia.abdala@yale.edu.

Sincerely,

Nadia Abdala
Referee 2

Discretionary revision – indicate the limitations to the study.

RE: We have modified our study limitations as follows.

“The study has several limitations. First, the prevalence of IPV in the past three months might be underestimated because self-reported IPV measurements are likely to be affected by a social desirability bias. Self-administered questionnaires were used to collect information to minimize such bias. Second, the method used to identify significant drinking contexts may increase chances of detecting a significant association since a series of logistic regression models were conducted to examine the relationship between different drinking contexts and IPV. Third, the confidence interval for the association between drinking context and IPV is relatively wide, suggesting that future studies with larger sample sizes may be needed to better understand such correlations. Fourth, the results may not be generalized to the general population or other clinical settings. Fifth, this is a cross-sectional study and thus a causal relationship cannot be established.”

Referee 1

A. Abstract
Methods section:
– Add the place where participants were recruited from: …among 440 participants, recruited…
RE: We added the place from which participants were recruited in the Methods section of the Abstract.

B. Introduction
1. Second paragraph: It would be interesting to add information on the prevalence of IPV in Russia before your third paragraph showing the association between alcohol and IPV. What is the situation in Russia? Are there previous studies conducted in Russia?
RE: We added a paragraph introducing previous studies conducted in Russia and the prevalence of IPV in Russia.

C. Methods
1. Study participants and data collection
– Provide a short description of the study setting (STI clinic center in St. Petersburg): is it the only center in the city? Does this center receive a particular/specific population such as marginalized people?
RE: We provided a short description of the study setting as suggested.
– Provide information on the sample size: how did you come up with the need for 500 participants? The clinic provides services to ~3000-5000 patients annually but for the period June 2008-June 2009, you recruited ~500 participants! What were the selection criteria? Did you select all the adults (> 18 years) who visited the clinic during the study period? What is the proportion of participants when compared to the total number of patients who visited the clinic during the study period?

RE: We provided information on the sample size. The selection criteria were patients aged 18 years and older who reported genitourinary complaints or had a need for STI-related services (e.g., STI testing or concern about STIs). We did not select all adults who visited the clinic during the study period since an STI clinic in Russia usually also provides services to non-STI problems, such as skin diseases (about half of the cases). The clinic keeps approximate records of the numbers of patient visits made to the clinic and not of the number of patients visiting the clinic. Therefore the numbers of patients attending the clinic is an estimate determined by the clinic director. The number of 3,000 to 5,000 visits is an old estimation because the number of patient visits recorded by the clinic has recently decreased. An updated number may be 2,000 to 2,500 per year. In addition, the number of patient visits includes patients returning for consultation several times within a year (e.g., to pick up test results, follow-up visits or renewed infections).

Thus the number of 500 eligible patients between June 2008 and June 2009 is reasonable under the following circumstances: if patients who had genitourinary complaints or a need for STI-related services are counted and patients seeking care for skin disease are excluded (approximately half the cases), if patients below 18 years of age and those who may have visited the clinic on multiple occasions are excluded. Moreover, recruitment into our study was performed with the help of STD specialists. A loss of some potential participants was possible since some physicians enrolled more patients than others. We do not know whether these physicians actually had fewer patients or if they simply did not show enthusiasm about the study.

D. Results
1. Characteristics and behaviors
– Although this paper is on IPV, authors don’t seem to give importance to the magnitude of IPV in this paragraph: What is the prevalence of IPV in your population (in the text)? Was it similar according to gender? When do you consider that a participant is a victim of IPV? What is your case definition of IPV in the bivariate or multivariate analysis?

RE: We modified our presentation in the text to clearly state the prevalence of IPV. There was no gender difference in IPV prevalence (6.8% in men and 8.0% in women, p = 0.66). We added the information as a note in the table and to the text. In this study, we did not include IPV victimization in our analysis since we did not target the association between alcohol misuse and IPV victimization. We are interested in the association between alcohol use and IPV perpetration. Hence IPV in the paper refers to IPV perpetration (defined as ever having insulted, sworn at, threatened, pushed, grabbed, slapped, punched, beaten, choked, or physically forced a partner to engage in unwanted sexual behavior) within the past three months.
– Provide information on why you took 15,000 rubles as a limit.
RE: We tried to dichotomize the variable (monthly income), and the cut-off at 15,000 rubles is the most appropriate point for such an effect. In the questionnaire, the options for monthly income were no income, less than 3,000 rubles, 3,000-8,999 rubles, 9,000-14,999 rubles, 15,000-29,999 rubles, 30,000-44,999 rubles, etc. The most frequently reported (39%) monthly income range was 15,000-29,999 rubles.

– Give the equivalent in USD (in brackets).
RE: We added the equivalent in USD as suggested.

– Table 1 (bottom): The mean and median ages for participants were 28.4 and 25.0 years, respectively (???)
RE: Yes.

2. Alcohol misuses and IPV
– Other variables are analyzed in this section and not only “alcohol misuses”.
The title should change (Correlates??).
RE: Thanks for pointing it out. Since the focus of the section was the association between alcohol misuse and IPV, we modified the title to “Alcohol misuse and IPV (controlling for socio-demographics)”.

– Same comment for table 2.
RE: We added the words “controlling for socio-demographics” in the title of Table 2.

3. Drinking context and IPV
– Second paragraph: ….Accordingly, the adjusted odds ratios….
RE: For a clear presentation, we deleted this sentence and modified the description as follows: “We then examined the associations between drinking contexts and IPV among drinkers. In two separate models, we found that the preference for drinking liquor/sherry/vermouth (odds ratio [OR]: 4.19, 95% confidence intervals [CI]: 1.34-13.15) and drinking in the street or park (OR: 5.58, 95% CI: 1.80-17.30) were significantly associated with IPV.”

– Second paragraph: ….Age, gender, education and employment status were not independently significantly associated...... (Data not shown).
RE: Because Table 3 contains information from 34 models (17 for unadjusted OR and 17 for adjusted OR), it is difficult for us to show the specific magnitudes of those potential confounders (including significant and non-significant socio-demographics) in one table. Thus, we put that information as notes with the table and did not specifically show the ORs and their 95% CIs in the text.

E. Discussion
– 1st paragraph: “The present study provides new evidence....suggesting that violence against men should not be neglected.” What was the prevalence of IPV by gender? Is it similar to findings in other settings in Russia?
RE: After the inclusion of information regarding gender differences in IPV prevalence as suggested by the reviewer in the comment on Characteristics and behaviors, this sentence became evidence-based. There was no gender difference in IPV prevalence (6.8% in men and 8.0% in women, p = 0.66).

It is difficult for us to compare IPV prevalence to findings in other settings in Russia because of the limited IPV studies conducted in the country (we added related information to the introduction section as suggested by the reviewer), different definitions used for IPV and different periods for IPV (e.g., lifetime, one-year or three-months).

2nd Paragraph: “In this present study, we found that alcohol misuse was significantly associated with IPV in a typical city of Russia.” Are these findings from one clinic generalizable to the whole city? Authors should be cautious while making inferences because this center is an STI clinic, with specific clients...

RE: These findings are from one clinic. Hence they should not be generalized to the whole city or even beyond our setting. To clarify this, we modified the sentence: “In the present study, we found that alcohol misuse was significantly associated with IPV among patients attending an STI clinic center in St. Petersburg, Russia, which is consistent with results from previous studies conducted in Russia”.

In the last section, authors discuss limitations of this study conducted in a STI clinic. I wonder whether HIV/AIDS might have a role in the explanation of drinking habits and settings and the consequence with regards to IPV. It has been shown that HIV/AIDS is associated to IPV. Have you analyzed this aspect in your study?

RE: This is a very good point. We specifically examined the relationship between IPV and HIV/AIDS behaviors in another manuscript, which has been asked to “revise and resubmit” by the Journal of Traumatic Stress.

We examined whether HIV/AIDS related behaviors (e.g., injection drug use, inconsistent condom use, multiple partners and an STI history) might have a role in the explanation of drinking habits and settings and the consequence with regard to IPV. Although some factors were associated with IPV, none of them changed the association level between alcohol misuse/drinking settings and IPV. To avoid the overlapping between the two manuscripts, we did not include these factors in the present study since this paper is primarily interested in the association between alcohol use and IPV.

Drinking on the streets or at parks was not associated with particular HIV/AIDS behaviors such as drug abuse and a history of STI. Only three participants reported HIV-positive. Thus we cannot obtain a good estimate for the association between drinking settings and HIV infections.