Author’s response to reviews

Title: A comparison of intimate partner and other sexual assault survivors’ use of different types of specialized hospital-based violence services

Authors:

Janice Du Mont (janice.dumont@wchospital.ca)
Maryam Wolde-Yohannes (maryam.woldejohannes@wchospital.ca)
Sheila Macdonald (sheila.macdonald@wchospital.ca)
Sarah Daisy Kosa (sarahdaisy.kosa@wchospital.ca)
Linda Turner (lindat12@gmail.com)

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Author’s response to reviews:

Response to Reviewers

RE: Ms. Ref. No.: WHI-D-15-00230

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To Dr. Akiko Kamimura, BMC Public Health Editor,

We thank you for your review of our article “A comparison of intimate partner and other sexual assault survivors’ use of different types of specialized hospital-based violence services”. We have carefully considered all the points that were raised by the reviewers, and have addressed each of them, making appropriate changes to the manuscript. We believe that in addressing the reviewers’ helpful comments, the manuscript is improved.
Title: A comparison of intimate partner and other sexual assault survivors’ use of different types of specialized hospital-based violence services

Abstract

Background: Little is known about the health service utilization of women sexually assaulted by their intimate partners, as compared with those sexually assaulted by other perpetrators. To address this gap, we examined the use of acute care services as well as a broad range of survivor and assault characteristics among women assaulted by current or former intimate partners, other known assailants, and strangers.

Method: Information was gathered from individuals presenting to 30 hospital-based sexual assault and domestic violence treatment centres using a standardized data collection form. We examined the data from 619 women 16 years of age or older who were sexually assaulted by one assailant.

Results: Women sexually assaulted by a current or former intimate partner were less likely than those assaulted by another known assailant or a stranger to have been administered emergency contraception (p<0.001) and sexually transmitted infection prophylaxis (p<0.001), and/or have been counselled for potential use of HIV post-exposure prophylaxis (p<0.001). However, these women were more likely than those in the other two groups to have had their injuries documented with photographs (p<0.001), have undergone a risk assessment (p=0.008), and/or engaged in safety planning (p<0.001).
Conclusions: Women sexually assaulted by current or former intimate partners utilized services offered by sexual assault and domestic violence treatment centres differently than those assaulted by other known assailants and strangers, which may reflect their different health, forensic, and social needs and the importance of offering care tailored to their particular circumstances.

Reviewer # 1 Comment # 2: This research fills an important gap in the literature by examining the differences in health services utilization by types of sexual violence.

Minor Issues:

Line 38 there is an extra space

Line 48 there is a missing parentheses

The sentence between Lines 51-58 is awkward/run-on as written.

Response: The punctuation errors have been fixed. Lines 51-58 have been revised as follows:

They were also more likely to have been physically coerced (80.7% vs 49.2% & 58%, respectively; p. < 0.001) and verbally threatened or manipulated (43.0% vs 25.7% & 21.0%; p. < 0.001). As well, they were more likely to have sustained physical injuries as a result of the assault (53.2% vs 32.3% & 33.3%, respectively; p <0.001).

Reviewer # 1 Comment # 3: This paper lacks a grounding theoretical framework. Although the others present prevailing public "myths" about IPV (and these are very important to address), a nod to a broader theoretical framework (health belief model, gender or feminist theory) would greatly enhance the generalizability of this work.
Response: The Introduction of this manuscript now includes a new opening paragraph framing and better contextualizing the problem of sexual assault from a feminist theoretical perspective of male control and gender inequality and the relationship of these concepts to rape discourse and mythology:

The high prevalence of sexual assault, documented worldwide, largely can be attributed to pervasive cultures of male dominance that cultivate stringent gender inequalities and contribute to a pernicious rape discourse fuelled by “rape myths”[1-2]. Disturbingly, the harmful victimization of sexual assault survivors is often discredited or trivialized by “rape myths” which include attitudes and generally false beliefs about who is a “legitimate” victim and skewed perceptions of what constitutes a “legitimate” rape [3-4]. These myths are also often drawn upon to justify the perpetration of sexual assault and defend the assailant’s actions [4]. Examples of rape myths include: women lie about rape, women who drink or wear sexy clothes deserve to be raped, and rape is a crime of passion. Identifying and unpacking such myths is crucial as, according to Suarez and Gadalla and other researchers of violence, “the concept of rape myths contribute in a significant way to the understanding of rape and its consequences to victims” [5], p. 2013.

One of the most pernicious myths about sexual assault is that it is an act committed by a stranger.

Reviewer # 1 Comment # 4: A major limitation would be analytic robustness. Additional statistical analyses are recommended. Cross-tabulation and chi-squared tests are useful for descriptive statistics. However, as presented, these results are not adjusted for potential confounding factors. Did the authors attempt to use regression techniques (such as logistic regression) to assess outcomes while controlling for covariates? The authors have access to a basic set of controls (marital status, age, employment, social support etc). Given that the sample size is around 500-600 (depending on variables used), the authors should use regression techniques to assess the probability or likelihood of receiving forms of treatment based on assailant type (i.e., dependent variables in Table 4) while controlling for available covariates. This would enhance the quality of this study.

Response: While a multivariate analysis of factors that might be associated with service utilization overall could constitute an interesting study, the purpose of the present study was to explore the use of different and specific types of services (and other important characteristics) by
assailant-survivor relationship type. The analyses in this study meet our research objectives and, given the dearth of research examining this issue, provide increased understanding of the important role of relationship type in sexual research and practice. Moreover, even if we had been interested in any service use as an outcome, almost 100% of clients in our study had used at least one service, precluding a multivariate analysis.

However, we have added to the Conclusions of the manuscript that future research examining factors associated with service utilization in the sexual assault context should control for the important variable of survivor-assailant relationship type:

In any future research examining factors associated with use of services by survivors of sexual assault, the nature of the relationship between the assailant and the survivor is clearly an important factor to consider.

Reviewer #2 Comment #1: Editing

Extra spacing on Page 5 line 38-39. "by…Sexual"

Extra space on Page 7 line 21-22 "client..was"

Response: These edits have been made in the manuscript.

Reviewer #2 Comment #2: What percentage of woman who are assaulted (by any type of assailant) go to the hospital at all to be seen by SANE nurses? Are the woman in this study a representative sample of woman sexual assaulted. Please provide citation.

Response: To the best of our knowledge, there are no data available directly measuring what proportion of women who are sexually assaulted in Canada seek care at hospital-based sexual assault centres. However, there is research that has shown that sexual assault survivors rarely
report their assaults to formal support providers of any kind. Therefore, we have added the following to the discussion:

Additionally, the study findings may be limited in their generalizability as all data were collected from an acute hospital-based sample which may not be representative of the general population of sexual assault victims given survivors rarely disclose to formal support providers [6].

Reviewer # 2 Comment # 3: How are assailants distinguished? In the Logan 2007 they are distinguished by intimate partner, acquaintance, acquaintance just met, or stranger. Then in Stermac et al study assailants are distinguished by current/previous boyfriends and then acquaintance known for less/more than 24 hrs. Is there some form of standardization in the categories of assailants and how do these categories fit within this manuscript?

Response: As indicated in the Introduction to the manuscript there is little research focused on sexual assault by different assailant types particularly with regard to service use. Those studies that do exist have conceptualized the categorizations of survivor-assailant relationship sometimes differently, usually with regard to the known assailant category that does not include current or former intimate partners. We have added the following to the Introduction to directly address this:

Although comparisons across studies must be made cautiously as the categories used and definitions for known assailants have varied, in one such study of 331 women …

With regard to how we “distinguished” our assailants, we have added the following to the Method to clarify:

For the bivariate analyses, we collapsed assailant type into three categories allowing for comparisons among our categories of interest: current or former intimate partner, other known assailant [parent/guardian/other relative, acquaintance, friend, co-worker, authority figure, sex trade customer], and stranger.
Reviewer # 2 Comment # 4: As a follow up to #1, does current or former husband/boyfriend (wife/girlfriend) have any effect on the results presented in the manuscript? Was that accounted for? As in would a utilization of hospital-based violence services be different between current and former partners instead of lumping them together.

Response: We examined sexual assault by a current or former intimate partner together so that our research findings could be compared easily to other studies. We have clarified this throughout the manuscript, as it has been customary to collapse these two groups in research. Throughout the Introduction of the manuscript, we have noted where studies have examined current and former intimate partners together and also have provided a definition of what normally constitutes, from a research standpoint, the grouping of “intimate partner”:

One of the most pernicious myths about sexual assault is that it is an act committed by a stranger. However, more than two decades of research has shown that most sexual assaults are committed by known assailants—a substantial proportion of which are committed by intimate partners [6-7], a grouping which in research typically has included current or former spouses (married, common-law, or co-habiting), boyfriends, girlfriends, and/or other dating partners [6, 8-12].

Reviewer # 2 Comment # 5: Was it known if any woman had any previous sexual assault training courses either provided during high school or college and could that have any effects on the categories?

Response: No, we do not know this. We have added to the Method section some clarification about what and why certain information was collected:

The data collection form was designed to collect information potentially desirable from a research standpoint (e.g., variables that have been associated sexual assault and service utilization in previous studies), while not placing too high a burden on the client during a crisis admission.
Reviewer # 2 Comment # 6: Did any of the participants of the study have any history previous sexual abuse? Was this the first experience of sexual abuse for participants and could previous abuse history affect health service seeking behavior? Why wasn't this included in analysis?

Response: These data are not available as, as noted above, as researchers we had to balance what would be potentially desirable from a research standpoint to collect with what might place too high a burden on the client during a crisis admission.

Reviewer #2 Comment # 7: The study states that woman assaulted by current/former partner less likely to receive prophalaxysis STI and HIV post exposure. The authors claim that forced vaginal/anal penetration increases risk for STI's. This would make sense for HIV but not necessarily for other STI's. If forced penetration is associated with other STI's please provide a citation.

Response: The text has been tweaked and a citation has been added to the manuscript:

This fact may be problematic given that women sexually assaulted by an intimate partner were also potentially at increased risk for some STIs given their higher rates of forced vaginal and anal penetration [28].

Reviewer # 2 Comment # 8: On page 12 line 7, authors state WHO "the importance of reducing ongoing risk within intimate relationship..." I am assuming authors are referencing to HIV risk. Please clarify possibly "reducing on going risk [of HIV] within.."

Response: The manuscript has been revised as suggested:
However, in this context, the World Health Organization states “the importance of reducing the ongoing [HIV] risk within the intimate relationship should be emphasized as part of the counselling process” [33], p.8.

Reviewer #2 Comment # 9: Woman assaulted by current/former are offered safety planning more than woman assaulted by strangers or acquaintances. Authors should explore why safety services aren't offered to woman assaulted by strangers and acquaintances.

Response: The following sentence has been added to the Discussion of the manuscript:

These findings are consistent with previous research that has found that sexual assaults committed by intimate partners, as compared to those committed by strangers and other known assailants, are often ongoing in nature and are associated with increased risk of the survivor experiencing physical assault, severe violence, disability, and death, as well as children potentially being in the home who may be exposed to the violence [25-27].

Reviewer # 2 Comment # 10: Author states that page 12 line 14. Woman sexual assaulted by an intimate partner less likely to have used medication to prevent pregnancy. Do the author's mean previous oral contraception use or emergency contraception? Please clarify. Also clarify who is administering the emergency oral contraception? Are women taking this themselves before showing up to the hospital or is the hospital administering the emergency contraception?

Response: We are referring to emergency contraception administered by the SANE at the hospital, which is noted as one service provided in the Method section of the manuscript:

All data were collected prospectively. From April 1, 2009, through June 30, 2011, clients were interviewed by attending SANEs as part of the delivery of clinical care. Each client was offered services as appropriate including health care (i.e., crisis counselling, medical care/treatment, sexually transmitted infection prophylaxis, HIV post exposure prophylaxis counselling, pregnancy prophylaxis),…
We have also clarified in the Discussion:

Women sexually assaulted by a current or former intimate partner were also less likely than those assaulted by another known assailant or stranger to have been administered emergency medication at a SA/DVTC to prevent an unintended/unwanted pregnancy. This finding is potentially concerning given that women sexually assaulted by an intimate partner were more likely than other sexually assaulted women to have been vaginally penetrated.

Reviewer # 2 Comment # 11: Authors claim that women who suffer and fear violence from partners don't use contraception without permission (reference 31). This citation is of worldwide data. Do these same conditions apply to the population within Toronto? Was there much variance among cultural/ethnic/demographic backgrounds of the manuscript study population?

Response: The population of Ontario from which the study is drawn is very ethnically diverse (http://www12.statcan.gc.ca/census-recensement/2006/dp-pd/tbt/Rp-eng.cfm?LANG=E&APATH=3&DETAIL=0&DIM=0&FL=A&FREE=0&GC=0&GID=0&GRK=0&GRP=1&PID=99017&PRID=0&PTYPE=88971,97154&S=0&SHOWALL=0&SUB=0&Temporal=2006&THEME=70&VID=0&VNAMEE=&VNAMEF=), as is the clientele of centres seen at Ontario’s SA/DVTCs (e.g., Loutfy et al., 2008). Although we could not find a relevant Canadian reference to reproductive control in this context, we have added a reference to an American study (Miller E, Decker MR, McCauley HL, Tancredi DJ, Levenson RR, Waldman J, Schoenwald P, Silverman JG. Pregnancy coercion, intimate partner violence and unintended pregnancy. Contraception. 2010 Apr 30;81(4):316-22.) and adjusted the text in the Discussion, as noted in part immediately above, as follows:

Women sexually assaulted by a current or former intimate partner were also less likely than those assaulted by another known assailant or stranger to have been administered emergency medication at a SA/DVTC to prevent an unintended/unwanted pregnancy. This finding is potentially concerning given that women sexually assaulted by an intimate partner were more likely than other sexually assaulted women to have been vaginally penetrated.

However, it is possible due to the fact that, as in earlier research [12,24,34-36], they tended to be older than the other survivors, and may have already been using a consistent method of birth control (information not documented in this study) [37], the use of emergency contraception was
less frequently indicated. It must be acknowledged at the same time though that some women assaulted by intimate partners may not be using any contraception due to fear of repercussions from their intimate partner: “Women who fear or suffer violence from their partners often find it difficult or impossible to discuss contraception with them; they may also fear or suffer abuse if they use contraceptive methods without … permission” [38], p. 8, [39]. Therefore, institutional policies should ensure that acute health services discuss and universally offer prophylactic treatment for pregnancy, to all survivors of sexual assault regardless of assailant type [33, 40].

Reviewer # 2 Comment # 12: Table 2- Please indicate how many people fell into the 3 categories at the top of the table (partner+ex- 117, other known assailant -?, Stranger- 111)

Response: The top of each relevant table has now been revised to include overall group counts.

Reviewer # 2 Comment #13: Why is social supports included in the Table 2 when it isn't mentioned in the methods, results, or discussion?

Response: As is customary, we report on and discuss only those variables that were statistically significant. However, the Method of the manuscript has been revised as follows to include a listing of examples of client, assailant, and assault characteristics collected; this list includes social supports:

The information about service use was collected using a 28-item standardized client intake form completed by the attending SANE who also gathered information about date and time of presentation, and client (e.g., age, marital status, employment status, disability status, living situation, social supports), assailant (e.g., relationship to survivor), and assault (e.g., type of sex acts, use of coercive tactics, weapon use, physical injuries) characteristics (see Tables for full listing of variables).
Reviewer #2 Comment #14: Disability is listed in Table 2 but should be mentioned in the methods section

Response: As noted immediately above, we have revised the Method section to include a listing of client, assailant, and assault characteristics collected, including disability status.

Reviewer #2 Comment #15: Table 2- Where are the remaining p values? They are listed (even when not significant) in tables 2 and 3

Response: Categories that are mutually exclusive have only one p-value listed, and categories that not mutually exclusive have multiple p-values listed. Those that are not mutually exclusive are identified clearly with an asterisk, and denoted at the bottom of the relevant tables.

Reviewer #2 Comment #16: Table 3- Please indicate how many people fell into the 3 categories at the top of the table (partner+ex- 117, other known assailant -?, Stranger- 111)

Response: As noted above, the tops of all relevant tables have been revised to include overall group counts.

Reviewer #2 Comment #17: Table 3- Weapons are listed here but not mentioned in the methods section

Response: As noted above, the Method has been revised to include a list of client, assailant, and assault characteristics collected, including weapon use.
Reviewer #3 Comment # 18: Table 4- Please indicate how many people fell into the 3 categories at the top of the table (partner+ex- 117, other known assailant -?, Stranger- 111)

Response: As noted above, the tops of all relevant tables have been revised to include overall group counts.

Sincerely,

Janice Du Mont
Scientist, Women’s College Research Institute, Women’s College Hospital
Associate Professor, Dalla Lana School of Public Health, University of Toronto
Janice.DuMont@wchospital.ca