



Tri-County CHAIN

Report 2006_1

Prevalence of Interpersonal Violence within the Tri-County CHAIN Cohort

Barbara Bennet

Columbia University
Mailman School of Public Health
In collaboration with Medical and Health
Research Association of New York,
the NYC Department of Health,
the Westchester Department of Health,
and the NYC Health & Human Services
HIV Planning Council

Originally submitted Jan. 2, 2006
HRSA Grant #H89 HA 0015-15
© 2005 Trustees of Columbia University

C.H.A.I.N. Report

Acknowledgments

A Technical Review Team (TRT) provides oversight for the CHAIN Project in New York City and in the Tri-County area of Putnam, Rockland, and Westchester counties. In addition to Peter Messeri, PhD, Angela Aidala, PhD, and David Abramson, PhD, of Columbia University’s Mailman School of Public Health, TRT members include Mary Ann Chiasson, DrPH, MHRA (chair); Robert Cordero, NYCDOHMH Office of AIDS Policy, JoAnn Hilger, NYCDOHMH; Julie Lehane, PhD, Westchester County DOH; Jennifer Nelson, MHRA, and Ken Butler, PWA Advisory Board. Additionally, the Tri-County CHAIN project regularly consults with Tom Petro, Julie Lehane, Basil Reyes, and Renee Recchia of the Westchester Department of Health.

We are particularly grateful to all the participants in the Tri-County CHAIN Project, who share their time and their experiences with us. We take their trust in us seriously, and hope that our project serves to amplify the voice of the HIV-positive community in Putnam, Rockland, and Westchester counties.

Tri-County CHAIN Project

Peter Messeri, PhD	Principal Investigator
David Abramson, PhD MPH	Study Director
Barbara Bennet	Field Director
Tasha Stehling , MPH	Data Manager
Lauren Jewell	Office Manager & Research Assistant
Evelyn Choudory & Dave Hunter	Data Editors
Narine Malcolm	Administrator

Interviewers: Sofia Luyando, Rose Rivera, Elizabeth Romero

This research was made possible by grant number H89 HA 0015-15 from the US Health Resources and Services Administration (HRSA) HIV/AIDS Bureau. The CHAIN study is supported by the HIV Health and Human Services Planning Council of New York under a Title I grant of the Ryan White Comprehensive AIDS Resource Emergency Act of 1990 through the New York City Department of Health. It is conducted under the auspices of the Medical and Health Research Association of New York City, Inc, and in Tri-County under the Westchester Department of Health. Its contents are solely the responsibility of the researchers and do not necessarily represent the official views of the U.S. Health Resources and Services Administration; the City of New York; Putnam, Rockland, or Westchester counties; or the Medical and Health Research Association of New York.

The association between HIV risk behaviors and the experience of interpersonal violence, IPV, has been well documented in the last 15 years of the AIDS epidemic¹. According to recent CDC literature, women who experience both sexual and physical violence are significantly more likely to have sexually transmitted diseases³. Additionally, there exists an abundance of literature to support the concept that physical or sexual assault increases an individual's risk for HIV infection^(4,6). The presence of IPV is often coupled with negative health consequences such as poor mental health, lower self-efficacy, substance abuse, and increased risk of STDs². The effects of these and other unfavorable health outcomes associated with violence are often intensified for people living with HIV. This paper intends to assess and describe the prevalence of particular types of interpersonal violence and their associations with negative health outcomes as measured in the Tri-County CHAIN cohort.

Methods

During 2001-2002 the Tri-County CHAIN Project recruited and interviewed a randomized sample of 398 HIV+ individuals living in Westchester, Putnam and/or Rockland Counties and engaged in the care system. Individuals were recruited from 32 sites of services among 28 medical or social service agencies in the three counties. The sample is considered representative of the estimated 1,600 HIV+ individuals engaged in the Tri-County care system. Semi-structured face to face interviews were conducted at 12 month intervals with project participants by trained research staff. The data outlined in this paper represent the second set or first follow up interviews, designated as Wave 2. At the start of Wave 2 follow-up, 52 of the original 398 had died, moved, or were otherwise ineligible. Of the remaining 346 eligible participants 315 or 91% completed interviews the first follow up year.

The term interpersonal violence refers to the occurrence of physical or sexual assault perpetrated by one or more individuals on another. IPV includes physical and sexual encounters in addition to childhood as well as adult violent experiences. The World Health Organization defines interpersonal violence as violence between family members, intimate partners and violence between acquaintances and strangers that is not intended to further the aims of any formally defined group or cause. It is the use of force or power threatened or actual that has a high likelihood of resulting in death, injury, physical or psychological harm or deprivation⁴.

In the Tri-County CHAIN Wave 2 follow up interview supplementary questions regarding the experience of trauma were included in the instrument. These items were extracted from a portion of the Client Diagnostic Questionnaire, or CDQ, which was developed by researchers at Columbia University and is available through HRSA web site⁷. The CDQ is a mental health diagnostic tool designed specifically for use in HIV/AIDS service settings. It is a structured questionnaire that can be administered by professionals and non-professionals alike, and it is primarily used to diagnose and evaluate mental health needs for persons living with HIV/AIDS or who are at high risk of infection. The CDQ screens for depression, anxiety disorder including PTSD, and psychosis, as well as alcohol and/or drug use and dependence. It

provides a baseline assessment of mental health functioning and it can indicate the need for additional services, further assessment or referral for treatment by a clinician.

For this paper the measure of IPV was divided into five categories, adult physical assault by a non partner, adult physical assault by a partner, adult sexual assault, childhood physical assault, and childhood sexual assault. These categories correspond to five questions extracted from the Client Diagnostic Questionnaire which, measure the life time prevalence of each item.

Findings from the Tri-County CHAIN cohort provide a brief summary of of the prevalence of IPV among HIV+ adults living in Westchester, Rockland and Putnam Counties. . For analyses purposes the cohort was split into subgroups, which provided a clearer picture of characteristics associated with the reporting of IPV. The sub groups enlisted were gender, race ethnicity, HIV risk category, and geographical location. The presence or absence of each type IPV was compared within each sub group. Analyses were further divided to examine particular adverse health effects such as low mental health scores, poor adherence to medication regimes, expressed need for psychological services, and history of problem drug use were examined in relation to the presence of IPV. Working definitions for these categories are outlined below for the reader's convenience.

Subgroup Analyses and Definitions

Area of residence was divided into three locales. Rockland was considered as its own entity. Suburban Westchester and Putnam County were grouped into one category for analyses purposes. Urban Westchester was the third category and it was defined as the area south I287 in Westchester County.

Risk category was separated into four groups, MSM, PDU, MSM&PDU, and Other. MSM consisted of men who reported having sex with men. PDU, or problem drug user, included respondents who reported ever using drugs 3 or more times per week for one month or more. MSM&PDU consisted of respondents who fell into both of the previous categories. Other was comprised primarily of the heterosexual risk group.

Mental health was assessed by the Mental Health Component Summary Scale, or MCS, of the SF36. This is a nationally recognized scale consisting of a standardized set of questions that correlates with stages of disease. Scoring below 37 on the MCS is indicative of poor mental health. The cohort was divided into those scoring above 37 and those scoring 37 or less on the scale.

Adherence to medications was measured by three items. Respondents were categorized as non adherent if in the previous two days were off schedule or missed any of their HIV pills, or if within the last six months they sometimes skip a medication dose or they forgot to take their pills.

Expressed need for psychological services was assessed by three variables. Scored above

37.0 on mental health score AND (1) reported a need for help with emotional or psychological problems OR (2) felt counseling regarding sexuality and sexual issues was considerably or extremely important OR (3) strongly disagreed that “most of the time I am in firm control of my feelings and behavior.”

Key Findings

Table 1 displays the number and proportion of respondents in our cohort who experienced some type of violence. The self reported prevalence of childhood violence was higher among the Tri-County CHAIN cohort compared to National averages. According to data released in 2005 by National Clearinghouse on Child Abuse and Neglect, almost 19% of the US population experienced physical abuse as a child, and 10% of the population experienced sexual abuse during childhood⁴ In the Tri-County CHAIN cohort the prevalence of childhood physical and sexual abuse were 31% and 27%, respectively.

The estimated proportion of adult women reporting a lifetime prevalence of IPV by a partner or spouse os between 25% - 30%. The corresponding proportion of women in our study who said they were assaulted by a partner or spouse was 38%. According to CDC data one in six women (17%) and one in thirty-three men (3%) reported experiencing an attempted or completed rape at some time in their lives³. The proportion of Tri-County CHAIN participants who reported an experience of sexual violence was greater than the national averages. Within our cohort, 27 % of female respondents and 6 % of male respondents indicated an experience of sexual violence at some point in the lives.

Childhood violence by sub group

Demographics

- Within demographic sub groups the experience of childhood IPV was statistically significant for gender and for race/ ethnicity. Women were more likely than men to report any episode of childhood sexual and/or physical assault. The remaining sub groups did not indicate a significant differential in the reporting of IPV. Race/ethnicity geography, and risk category were not associated with increased reporting of childhood assault.

Drug use history and mental health

- Poor mental health scores on the MCS were associated with both types of childhood assault indicating a need for mental health services. Over 40% of respondents with an MCS score below 37 reported experiencing either sexual or physical assault during childhood. Over 30% of respondents reporting a current or past drug use problem indicated they were sexually assaulted as a child. Sexual assault as a child was almost twice as likely to be reported by respondents with a current or past drug problem.

Medication adherence

- Respondents indicating non adherence to HIV medication directives differed significantly in their reporting of IPV as a child. Participants who reported they were not completely adherent to their HIV medication regimes were more likely to indicate an

experience of physical and/or sexual assault as a child. Over 35% of non adherent participants indicated some form of childhood IPV. When controlling for gender, this finding persisted. Regardless of gender, non adherent respondents reported being sexually assaulted more frequently than those who were adherent to medication regimes.

Adult violence by sub group

Demographics

- Comparing adult violence within sub populations demonstrated significant differences within gender and race/ethnicity in reporting physical and sexual assaults. As expected, women more than men had a higher prevalence of reported physical and/or sexual assaults. Within race ethnicity, Black and Hispanic participants were far more likely to report being assaulted as an adult by a partner or non partner as compared to White participants.

Drug use history and mental health

- Low scores on the MCS were associated with an increased reporting in assaults by a partner. Over 30% of respondents with scores below 37 indicated at least one episode of assault by an intimate partner. Although not statistically significant, a greater proportion of respondents with low MCS scores experienced sexual assault in their adult life. A slightly higher percentage of respondents reporting a past or current drug problem indicated they had been physically assaulted by a partner. Participants who expressed a need for psychological services were almost twice as likely to report experiencing assault by a non partner compared to respondents who did not express a need for services. Thirty percent of those expressing need were at some point in their lives assaulted by a non-partner.

HIV medication adherence

- Respondents who were not completely adherent to their HIV medications were significantly more likely to report physical assault by partner in their life time. Of those receiving medications and who were not completely adherent to them 32% had a lifetime prevalence of IPV compared to 19% of completely adherent respondents.

Conclusions

The HIV+ adult population are reports higher rates of violence compared to national averages. Paired with an increased prevalence of violence are negative health outcomes such as sub par mental health scores, past drug use problems, expressed need for psychological services and non adherence to medication treatments. A routine screening for current and/or past experiences of interpersonal violence is recommended for HIV service agencies. Regular screening for IPV may assist in reducing the detrimental health consequences with which violence is associated.

Table 1. Prevalence of Interpersonal Violence by Sociodemographic Characteristics (row percentages)

	Total	Childhood physical assault		Childhood sexual assault		Adult physical assault - non partner		Adult physical assault by a partner		Adult sexual assault	
	n	n	%	n	%	n	%	n	%	n	%
Total Sample	315	98	31%	86	27%	58	18%	82	26%	45	14%
Gender											
Male	162	39	26%†	25	16%**	29	19%	20	14%***	9	6%***
Female	152	59	37%	61	38%	30	19%	62	38%	36	24%
Race/Ethnicity											
White, non-Hispanic	63	18	29%	16	26%	11	30%*	11	17%	7	11%
Black, non-Hispanic	157	45	29%	40	26%	57	53%	35	22%	20	12%
Hispanic/Latino	87	33	38%	26	30%	29	58%*	33	38%*	16	18%
Risk categories											
MSM	50	18	36%	12	24%	13	26%	9	18%	6	12%
PDU	136	44	32%	37	27%	23	17%	34	25%	16	12%
MSM & PDU	14	7	50%	6	43%	4	29%	3	21%	1	7%
Other	115	30	26%	32	28%	18	16%	36	31%	21	18%
Geographical Location											
Urban	177	59	33%	52	29%	33	19%	49	28%	28	15%
Suburban	128	34	27%	31	24%	21	16%	31	24%	15	12%
Rural	10	5	50%	3	30%	4	40%	2	20%	2	20%
MCS score											
<37	125	55	44%***	52	42%***	25	20%	45	36%***	24	19%
37 -41.9	35	9	26%	7	20%	7	20%	12	34%	4	11%
>42	154	34	31%	27	18%	26	17%	25	16%	16	10%

† p<=.10

* p<=.05

** p <=.01

*** p<=.001

Table 1 continued

	Total	Childhood physical assault		Childhood sexual assault		Adult physical assault - non partner		Adult physical assault by a partner		Adult sexual assault	
		n	%	n	%	n	%	n	%	n	%
Total Sample	315	98	31%	86	27%	58	18%	82	26%	45	14%
History of problem drug use											
<i>Never</i>	92	25	27%	16	17%*	15	16%	24	26%	10	11%
<i>Past</i>	178	54	30%	56	31%	35	20%	43	43%	29	16%
<i>Current</i>	44	19	43%	14	32%	8	18%	15	34%	5	11%
Adherence to medications n=249											
<i>Not completely adherent</i>	85	35	41%*	31	36%**	18	21%	27	32%*	14	16%
<i>Completely Adherent</i>	164	44	26%	33	26%	25	15%	31	19%	22	13%
Need for psychological services											
<i>No need</i>	251	76	30%	61	24%*	39	16%**	60	24%	33	13%
<i>Expressed need</i>	64	22	34%	25	39%	19	30%	22	34%	11	17%

References

1. Ompad, D.C., Ikeda, R.M., Shah, N., Fuller, C., Bailey, S., Morse, E., Kerndt, P., Maslow, C., Wu, Y., Vlahov, D., Garfein R., Strathdee, S.A., 2005 Childhood sexual abuse and age at initiation of Injection drug use. American Journal of Public Health April 2005 Vol 95 No 4, 703-709.
2. Plitcha, S.B., 2004. Intimate partner Violence and Physical Health Consequences. Journal of Interpersonal Violence 2004 Vol 19 No 11 1296-1323.
3. CDC National Center for Injury Prevention and Control, Sexual Violence Fact Sheet, 2005 <http://www.cdc.gov/ncipc/factsheets/svfacts.htm> (accessed 12/03/2005)
4. Krug, E.G., Dalhberg, L.L., Mercy, J.A., Zwi, A.B., Lozano, R., Editors World Report on Violence and Health Geneva World Health Organization 2002.
5. US Department of Health and Human Services National Clearing House on Child Abuse and Neglect Child Maltreatment 2003: Summary of Key Findings, 2005 <http://nccanch.acf.hhs.gov/pubs/factsheets/canstats.cfm> (accessed 12/03/2005)
6. Campbell, J.C., Health Consequences of Intimate Partner Violence Lancet 2002 Vol 359 1331-1336.
7. US Department of Health and Human Services Human Resources and Services Administration The Client Diagnostic Questionnaire <http://hab.hrsa.gov/tools/topics/cdq.htm> (accessed 12/21/2005)