Finding What Works to Reduce Violence Against Women

Aaron E. Carroll, MD, MS

A recent issue of JAMA highlights 2 studies that examined how physicians might treat or help prevent violence against women. If one only glanced at the results, they might seem like bad news. But a further reading should provide us with optimism about how we might address this difficult issue through the health care system.

One study was a research letter that looked at 3-year follow-up of a randomized trial of screening for partner violence (http://bit.ly/1J3XClj). The United States Preventive Services Task Force (USPSTF) recommends universal screening of women of reproductive age (http://bit.ly/1WEUIHy). Over 4 years, about 2700 women were randomly assigned to 1 of 3 groups. One group underwent computerized partner violence screening. Those with a negative test result received a list of general resources; those with a positive test result received a printout of partner violence–related resources combined with a list of general resources, and also watched a video that presented information about the hospital-based partner violence advocacy program. The second group received the same resource list without screening. The third group got neither screening nor the list of resources.

Three years later, the 3 groups did not differ, regardless of intervention, in their use of health care resources, including outpatient visits, emergency department visits, and hospitalizations.

A too-high number of women experienced partner violence in the year before enrollment (about 15%). The utilization of care even in this subgroup did not differ as well, whether it was 1 year or 3 years after the study was performed.

The second article described the results of another randomized trial that examined whether a motivational interviewing intervention provided in the emergency department might reduce intimate partner violence and heavy drinking (http://bit.ly/1WEUJHy). Over 4 years, women who were seen in the emergency department and found to be involved in intimate partner violence were randomly assigned to the intervention, an assessed control that received the same number of assessments as the intervention group, or a control that was assessed only once (at 3 months).

The intervention was impressive. It involved a 20- to 30-minute motivational interview, guided by a manual and administered by a master’s level therapist, with a telephone booster as follow-up. About 600 women were enrolled in the program and followed for a year.

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DR NADIMPALLI: Probably the most common surgery that we do is the C-section. If it was more accessible, it would save thousands of women’s lives a year. In conflict zones, in disasters, acute surgery is a huge need. We are able to set up a surgical unit very quickly, within days, and this includes not just the surgeons but the whole surgery team: anesthetists, scrub nurses, and surgical nurses. But it also includes precare at the emergency department level, postoperative care at the ward, rehabilitation care, and all the things we as doctors don’t really think about: sterilization, the laboratory component, the blood bank, hygiene, and security and safety. We try to find surgeons who are already on the ground, and try to work with them much like we did at the Nepal Orthopedic Hospital, to alleviate some of their burden, especially in the postoperative care.

JAMA: What are the priority initiatives that the MSF has planned in the next year?

DR NADIMPALLI: As a field worker, I’m very much focused on where I am. When I was in Liberia with Ebola, that was almost all I thought about, and now with Nepal, the post recovery is almost all I think about. It’s hard for me to speak for the organization, but on a personal level, it’s to finish what is needed here in Nepal. Another priority would be what’s happening still in West Africa with Ebola, where the health facilities need the ability to restart with a higher level of infection control. Also the Central African Republic, where a civil war that’s been ongoing for 10 years is probably hidden from the world’s view. On a personal level, you’re still connected to the places you’ve been, so for me those would be the places that I would push us to continue prioritizing.

JAMA: When you’re not in the field, how long before you feel the itch to go back?

DR NADIMPALLI: For myself, usually 2 to 4 weeks. I’m quite restless when I’m not in the field, and there’s just an energy that you get from the other people who work for MSF, but also from our patients and the kind of work we do. That kind of energy just propels you and you go until you’re completely tired, and when you’re tired you take some time off. For me, a couple weeks is enough to get a refresher, and I’m really happy to go back.
As with the previous study, the intervention had no significant effect. The number of days of heavy drinking and the number of incidents of intimate partner violence were unaffected by the program.

It would be easy to dismiss these findings as flawed in some way or to decide that they weren’t generalizable. But that would be to miss the point.

We have spent so much time trying to get issues like intimate partner violence to the forefront that it feels like doing anything is better than doing nothing. But that’s a mistaken belief. All of these interventions have a cost, in terms of both time and money. If they don’t work, then we are wasting limited resources if we continue to perform them.

The take-home message shouldn’t be that focusing on intimate partner violence is a mistake. It should be that we need to focus our efforts differently. Neither of these studies said that we shouldn’t figure out if women are being abused. They also didn’t say that it’s not worth our time in terms of interventions. What they did say is that merely screening is not enough. Merely talking to women isn’t enough. We need to do more.

Moreover, they showed these things in the form of randomized clinical trials. That’s the gold standard of interventional research. Too often we think that such research is too difficult to perform, or that it can’t be applied to interventions like these. Neither of those beliefs is true. We should give these results the recognition that they warrant. We should stop saying that the USPSTF recommendations are enough. We should stop thinking that motivational interviewing for women who are in danger is enough.

Doing so is wrong, especially when high-quality studies exist that show some things do work. Results of another recent randomized clinical trial showed that the Enhanced Assess, Acknowledge, Act Sexual Assault Resistance program, given to young women attending college in Canada, resulted in a significant drop in completed rape, from 9.8% in the control group to 5.2% in the intervention group, and a similar drop in attempted rape (http://bit.ly/1e8O6Q3). The program consisted of four 3-hour units that attempted to educate young women in assessing risk from acquaintances, overcoming barriers to acknowledging danger, and engaging in verbal and physical self-defense.

I agree with many others that it would be better if we could focus on the perpetrators of rape and partner violence rather than the women they target in our interventions to improve outcomes (http://onforb.es/1KSyIVD). But sometimes we have to work with the means available to us in the health care system. The system is more likely to see and hear from women who have been abused than those who abuse them. Physicians would like to see violence against women, in all forms, become less common, and it’s important to use the available tools.

Despite the disappointing findings in some studies, it’s rewarding to see so many examples of robust research design being used to test the effectiveness of programs to improve outcomes in this area. We may not always get the results we’d like, but discovering what doesn’t work is just as important as discovering what does. We should adjust our prior beliefs based on these studies and get back to work and try again.

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