



Underestimation of Potentially Traumatic Events Resulting From Underreporting of Physical and Sexual Violence Among People Entering Care for HIV in Cameroon

Lindsey M. Filiatreau^{1,2},

Peter Vanes Ebasone³,

Anastase Dzudie³,

Rogers Ajeh³,

Brian W. Pence²,

Milton Wainberg^{4,5},

Marcel Yotebieng⁶,

Denis Nash⁷,

Kathryn Anastos^{6,8},

Angela M. Parcesepe^{9,10}

¹Department of Psychiatry, School of Medicine, Washington University in St. Louis

²Department of Epidemiology, Gillings School of Global Public Health, University of North Carolina at Chapel Hill

³Clinical Research Education Networking and Consultancy, Yaoundé, Cameroon

⁴Department of Psychiatry, Columbia University

⁵New York State Psychiatric Institute

⁶Department of Medicine, Albert Einstein College of Medicine

⁷Institute of Implementation Science in Population Health, Graduate School of Public Health and Health Policy, City University of New York

⁸Department of Epidemiology and Population Health, Albert Einstein College of Medicine

⁹Department of Maternal and Child Health, Gillings School of Global Public Health, University of North Carolina at Chapel Hill

¹⁰Carolina Population Center, University of North Carolina at Chapel Hill

Correspondence concerning this article should be addressed to Lindsey M. Filiatreau, Department of Psychiatry, Washington University in St. Louis, 606 S. Euclid Avenue, St. Louis, MO 63110, United States. flindsey@wustl.edu. Lindsey M. Filiatreau contributed to conceptualization, data curation, formal analysis, methodology, and writing—original draft. Peter Vanes Ebasone contributed to project administration and writing—review and editing. Anastase Dzudie contributed to project administration, supervision, and writing—review and editing. Rogers Ajeh contributed to writing—review and editing. Brian W. Pence contributed to writing—review and editing. Milton Wainberg contributed to writing—review and editing. Marcel Yotebieng contributed to writing—review and editing. Denis Nash contributed to conceptualization and writing—review and editing. Kathryn Anastos contributed to writing—review and editing. Angela M. Parcesepe contributed to conceptualization, funding, methodology, and writing—revision and editing.

Abstract

Objective: Measures ascertaining exposure to potentially traumatic events (PTEs) frequently ask respondents about experienced physical and sexual violence. However, little is known about the performance of physical and sexual violence questions on PTE assessments and its effect on PTE classification overall. We estimated underreporting of physical and sexual violence on a PTE assessment among individuals entering HIV care in Cameroon.

Method: We compared reports of physical and sexual violence captured via a behaviorally specific measure of intimate partner violence (IPV; Demographic and Health Survey [DHS] domestic violence module = referent) to those captured via two single-item questions that assessed exposure to physical and sexual PTEs during one's adult life to determine the degree of underreporting on the single-item PTE assessment questions. We explored correlates of underreporting on the PTE assessment using Pearson's chi-squared tests.

Results: Overall, 99 (23%) and 113 (27%) of 426 total participants reported instances of sexual and physical violence in their most recent partnership on the behaviorally specific DHS IPV module, respectively. Of those reporting sexual and physical IPV on the DHS module, just 6% ($n = 6$) and 52% ($n = 59$) reported sexual and physical violence as an adult on the single-item PTE assessment questions, respectively. Underreporting of physical violence on the PTE assessment was associated with lower educational attainment ($p < .05$) and reporting being punched ($p < .01$) or having one's hair pulled or arm twisted ($p < .05$) by one's most recent partner.

Conclusions: PTE assessment tools should assess exposure to behaviorally specific acts of violence to ensure appropriate referral to services among survivors of IPV.

Keywords

intimate partner violence; trauma; underreporting; survey methods

Intimate partner violence (IPV) remains a critical public health concern. Globally, it is estimated that 35% of women have experienced physical or sexual IPV or nonpartner sexual violence within their lifetime (World Health Organization, 2013). Among people with HIV (PWH), particularly those in resource-constrained settings, these estimates can reach even higher magnitudes (LeGrand et al., 2015). Physical and sexual IPV is associated with a broad range of poor physical and mental health outcomes, including chronic pain, increased risk of sexually transmitted infections, depression, anxiety, sleep disorders, and posttraumatic stress disorder, among others (Dillon et al., 2013). Among PWH, physical and sexual IPV have also been shown to contribute to poor HIV care outcomes such as delayed linkage to care, antiretroviral treatment nonadherence, and viral nonsuppression (Schafer et al., 2012).

Similar to IPV, experiences of trauma are more common among PWH compared to the general population. Trauma is associated with a range of adverse physical and mental health outcomes, including sexually transmitted infections, unhealthy drinking, depression, attempted suicide, and suboptimal HIV care outcomes (Felitti et al., 1998; Mugavero et al., 2006; O'Donnell et al., 2017; Pence, 2009; Pence, Mugavero, et al., 2012; Pence, Shirey, et al., 2012; Subica et al., 2012). For example, in a population of 926 individuals in Tanzania,

for each additional potentially traumatic event (PTE) reported by study participants, there was a 0.5-unit increase on the Patient Health Questionnaire-9 depressive symptoms scale and a 0.7-unit decrease on the SF-8 health-related physical functioning scale (Pence, Shirey, et al., 2012).

Given the potentially traumatizing effects of physical and sexual violence, questions ascertaining exposure to such violence are often incorporated into traumatic event assessment tools (Blake et al., 1995; Kubany et al., 2000). However, because PTE assessments aim to capture exposure to an array of PTEs, questions regarding physical and sexual violence are often limited in scope and number. In some cases, these tools have employed a single-question threshold approach (Carr et al., 2018; Nijenhuis et al., 2002), asking respondents one question each about exposure to physical or sexual assault or abuse, broadly (Kishor & Johnson, 2004).

Within the IPV literature, it is largely accepted that tools utilizing act- or behavior-specific questions (e.g., “How many times did your partner push or shove you in the past year?”) capture more experiences of IPV than single-item measures (e.g., “Have you ever been physically abused?”). Single-item measures may fail to capture experiences of physical and sexual violence if the survivor does not associate the behavior they experienced with the terms “abuse” or “assault” (Follingstad & Rogers, 2013; Smith et al., 1999; Waltermaurer, 2005). This can lead to measurement error, bias effect estimates (Bross, 1954; Jurek et al., 2008; Keys & Kihlberg, 1963; Rothman, 2012; Stefanski, 1985), and perhaps most importantly, yield a missed opportunity to refer IPV survivors to needed health services.

Despite IPV being one of the most common forms of PTEs experienced by women globally, little is known about the overall performance of physical and sexual violence questions on PTE assessment tools. In this analysis, we compared responses from a behaviorally specific IPV measure to those on a PTE assessment that utilizes two broad, single-item physical and sexual trauma exposure questions to determine the performance of the two single-item PTE questions. We explored the impact of physical and sexual violence underreporting on the ascertainment of PTE exposure overall and differential underreporting of exposure to physical and sexual PTEs with respect to sociodemographic factors and the types of reported IPV (e.g., slapping, pushing) to elucidate which groups of individuals are most likely to underreport physical and sexual PTEs.

Method

Study Area and Population

We used baseline data from a cross-sectional survey previously described that aimed to quantify the relationship between symptoms of mental health disorders and HIV treatment outcomes among people entering HIV care in three public sector health facilities in Cameroon between June 2019 and March 2020 (Parcesepe et al., 2021). To be eligible for participation in the parent study, individuals had to be 21 years of age or older, be newly entering HIV care at a study site, and provide written informed consent.

Data Collection

Research assistants fluent in French and English administered a structured quantitative interview to eligible and consenting individuals in the participant's language of choice (French or English). Interviews were conducted in a private setting within the health care facility and captured data on participants' sociodemographic and economic backgrounds, mental health, experiences with IPV, and history of PTEs. Ethical approval for this study was obtained from the University of North Carolina's institutional review board and the National Ethical Committee of Research for Human Health at Yaoundé, Cameroon.

Measures of Interest

Potentially Traumatic Events—We assessed exposure to 12 context-specific PTEs using a “PTE assessment,” including experiences of physical and sexual violence during adulthood (online supplemental materials Table S1). The single-item physical and sexual violence PTE questions asked participants if they had experienced “physical assault or abuse in your adult life from a spouse or partner” and “sexual assault or rape in your adult life,” respectively.

Physical and Sexual Violence—We used the Demographic and Health Survey (DHS) domestic violence module (i.e., DHS IPV module) to capture four distinct domains of IPV: controlling behavior and emotional, sexual, and physical IPV (online supplemental materials Table S2; U.S. Agency for International Development, 2006). This tool is a modified version of the Conflict Tactics Scale (Straus, 1979) and asks respondents if they have experienced 15 separate behaviorally specific events.

In this study, physical IPV was dichotomized to represent individuals who reported their current or most recent partner had or had not engaged in any of the following behaviors on the DHS IPV module: pushed you or threw something at you; slapped you; twisted your arm or pulled your hair; punched you with their fist or with something that could hurt you; kicked or dragged you; tried to strangle or burn you; or attacked or threatened you with a knife, gun, or other type of weapon. Sexual IPV was dichotomized to represent individuals who reported their current or most recent partner had or had not engaged in either of the following acts on the DHS IPV module: physically forced you to have sexual intercourse with them even when you did not want to or forced you to perform other sexual acts you did not want to perform. Individual types of violence (e.g., pushing, punching) were considered potential correlates of differential violence underreporting on the PTE assessment.

Correlates of Interest—We explored available sociodemographic correlates of interest, which included age, gender, relationship status, religion, and education to ascertain who was most likely to underreport experiences of violence. Participants' gender was ascertained by the research assistant conducting the interview, and age (< 40, 40+), relationship status (single/in a relationship), religion (Catholic/Protestant/Born Again/other), and education (none/primary/secondary or above) were captured through participant self-report.

Statistical Analyses

We estimated underreporting of violence on the two single-item physical and sexual PTE assessment questions among survivors of physical and sexual IPV using the results from

the DHS IPV module as the reference. We explored correlates of violence underreporting using Pearson's chi-squared tests. Mean number of PTEs in the total population and among survivors of physical and sexual IPV (DHS IPV module = reference) before and after recoding underreported physical and sexual PTEs were compared using Wilcoxon signed rank tests.

Results

A total of 426 participants were included in this analysis. Most participants were female (59%; $n = 250$), under the age of 40 (58%; $n = 249$), and in a relationship (58%; $n = 249$). Among participants, 99 (23%) and 113 (27%) individuals reported experiences of sexual and physical IPV in their most recent partnership on the DHS IPV module, respectively. Of those reporting sexual and physical IPV on the DHS IPV module, just 6% ($n = 6$) and 52% ($n = 59$) reported sexual and physical PTEs as an adult on the single-item PTE assessment questions (Tables 1 and 2). Mean number of experienced PTEs in the population overall was 3.57 ($SD = 2.13$) and 3.92 ($SD = 2.22$) before and after accounting for underreporting ($S = -3,937.5$; $p < .0001$). Mean number of PTEs among survivors of physical or sexual IPV was 4.05 ($SD = 2.11$) and 4.96 ($SD = 2.05$) before and after accounting for underreporting ($S = -3,937.5$; $p < .0001$).

Underreporting of physical PTEs among those reporting physical IPV on the DHS IPV module was associated with lower educational attainment ($p < .05$) and specifically reporting being punched ($p < .01$) or having one's hair pulled or arm twisted ($p < .05$) by their most recent partner (see Table 3). Underreporting occurred in 89% ($n = 8$), 53% ($n = 33$), and 43% ($n = 18$) of those completing no schooling, primary schooling, and secondary school or higher, respectively (see Table 3). Among those reporting being punched on the DHS IPV module, underreporting of physical violence on the PTE assessment tool was 70%, compared to 40% in those who did not (see Table 3). Among those reporting having their arm twisted or hair pulled, underreporting was 72%, compared to 46% in those who did not (see Table 3). Correlates of sexual PTE underreporting could not be assessed given small cell sizes.

Discussion

In this population of PWH in Cameroon, underreporting of physical and sexual violence on the single-item physical and sexual PTE assessment questions among those indicating experiences of physical and sexual IPV on the behaviorally specific DHS IPV module was high. This resulted in a lower mean number of PTEs than would be observed if patterns of reporting physical and sexual violence on the PTE assessment tool were similar to those on the behaviorally specific DHS IPV module. This may be due in part to differences in the construction of the physical and sexual violence questions in the PTE versus DHS tool. Results from studies assessing the performance of behavior-specific versus single-item threshold IPV screening tools suggest behavior-specific questions, such as those in the DHS IPV module, capture a greater number of experiences of violence among respondents. For example, in a study comparing results from a single-item abuse measure to those from the

Conflict Tactics Scale, 17% of participants reported experiences of violence on the Conflict Tactics Scale, while just 3% reported abuse on the single-item tool (Sagrestano et al., 2002).

Concerns around underreporting of physical and sexual trauma are particularly relevant to populations where physical and sexual IPV are common or where such violence may be normalized within relationships. Underreporting of sexual trauma was especially common in this population of PWH in Cameroon, with just 6% of participants who reported acts of sexual IPV in their most recent partnership (captured with the DHS IPV module) also reporting sexual abuse on the PTE assessment. In comparison, 52% of individuals who reported acts of physical IPV in their most recent partnership (captured with the DHS IPV tool) reported physical abuse on the PTE assessment. When physical or sexual violence is normalized, individuals may be less likely to label actions such as being punched by or forced to have intercourse with their partner as abusive or potentially traumatizing. Evidence from Cameroon and sub-Saharan Africa broadly suggests women may not feel comfortable refusing sex from an intimate partner (Seidu et al., 2021). As such, women may not label unwanted sex or physically violent acts perpetuated by a partner as abusive.

Our results also suggest individuals with lower levels of formal education may be less likely to identify specific acts of physical IPV as violence or abuse. Similarly, existing evidence from Cameroon has demonstrated that current students or those with less formal education feel less able to refuse sex (Hattori & Derose, 2008). This underlines the need for early sexual health education that promotes sexual self-efficacy and equitable sexual relationships.

This study was limited in that the PTE assessment and DHS IPV module were always asked in the same order, with the PTE assessment asked before DHS IPV module. It remains unclear if the ordering of the instruments influenced results. Further, though the PTE assessment questions are similar to those in validated measures, this specific tool has not been validated among PWH. Finally, though we aimed to explore correlates of sexual violence underreporting, small cell sizes limited our ability to do so.

In sum, a large proportion of survivors of physical and sexual IPV (DHS IPV module) did not report exposure to physical and sexual abuse when assessed via a PTE assessment. Compared to using single-item measures, PTE assessments that assess behaviorally specific acts of physical and sexual violence can reduce underreporting of traumatic experiences. In research, underreporting of violence on trauma screening tools can bias effect estimates and obscure meaningful relationships important to trauma and violence prevention and response efforts. Clinically, underreporting of violence is of concern as survivors of IPV may be missed by trauma screening tools, thereby prolonging linkage to critical mental and physical health care and IPV-related services that could improve the health, safety, and well-being of this population.

Supplementary Material

Refer to Web version on PubMed Central for supplementary material.

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Clinical Impact Statement

Behaviorally specific measures of physical and sexual violence capture more instances of violence compared to single-item measures asking about exposure to physical and sexual abuse or assault broadly. In this study of people entering HIV care, underreporting of physical and sexual violence on two single-item questions assessing exposure to physical and sexual potentially traumatic events was 48% and 94%, respectively. Trauma screening tools should use behaviorally specific questions similar to those in intimate partner violence (IPV) assessment tools to avoid missed opportunities to refer survivors of IPV to appropriate mental health, trauma, and IPV-related services.

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Reports of Sexual Trauma as an Adult on a PTE Assessment by Report of Sexual IPV on the DHS Domestic Violence Module

Table 1

Sexual trauma response	Total/N (%)	Reported sexual IPV/N (%)	Reported no sexual IPV/N (%)
Reported sexual PTE as adult	18 (4.2)	6 (6.1)	12 (3.7)
Reported no sexual PTE as adult	406 (95.8)	93 (93.9)	313 (96.3)
Total	424 (100.0)	99 (23.3)	325 (76.6)

Note. Missing: n = 2. PTE = potentially traumatic event; IPV = intimate partner violence.

Table 2
 Reports of Physical Trauma as an Adult on a PTE Assessment by Report of Physical IPV on the DHS Domestic Violence Module

Physical trauma response	Total/N (%)	Reported physical IPV/N (%)	Reported no physical IPV/N (%)
Reported physical PTE as adult	124 (29.2)	59 (52.2)	65 (20.8)
Reported no physical PTE as adult	301 (70.8)	54 (47.8)	247 (79.2)
Total	425 (100.0)	113 (26.6)	312 (73.4)

Note. Missing: n=1. PTE = potentially traumatic event; IPV = intimate partner violence.

Table 3
Underreporting of Physical Trauma on a PTE Assessment Among Those Reporting Physical IPV on the DHS Domestic Violence Module

Potential correlate	Total (n = 113)N (%)	Reported physical IPV and abuse on DHS IPV module and PTE assessment (n = 54)N (%)	Reported physical IPV (DHS IPV module) but no physical abuse (PTE assessment) (n = 59)N (%)	χ^2	p
Sociodemographics					
Gender					
Male	33 (29.2)	17 (51.5)	16 (48.5)	0.26	0.61
Female	80 (70.8)	37 (46.2)	43 (53.8)		
Age					
< 40	66 (58.4)	33 (50.0)	33 (50.0)	0.31	0.58
40+	47 (41.6)	21 (44.7)	26 (55.3)		
Relationship status					
Single	55 (48.7)	25 (45.4)	30 (54.5)	0.23	0.63
Partnered	58 (51.3)	29 (50.0)	29 (50.0)		
Education					
None	9 (8.0)	1 (11.1)	8 (88.9)	6.35	0.04
Primary	62 (54.9)	29 (46.8)	33 (53.2)		
Secondary	42 (37.2)	24 (57.1)	18 (42.9)		
Religion					
Catholic	43 (38.0)	17 (39.5)	26 (60.5)	5.16	0.16
Protestant	29 (25.7)	19 (65.5)	10 (34.5)		
Born Again	31 (27.4)	14 (45.2)	17 (54.8)		
Other	10 (8.9)	4 (40.0)	6 (60.0)		
Specific IPV acts reported					
Pushed/threw something					
No	63 (55.8)	33 (52.4)	30 (47.6)	1.20	0.27
Yes	50 (44.2)	21 (42.0)	29 (58.0)		
Slapped					
No	23 (20.5)	7 (30.4)	16 (69.6)	3.31	0.07
Yes	89 (79.5)	46 (51.7)	43 (48.3)		
Twisted arm/pulled hair					
No	87 (77.7)	47 (54.0)	40 (46.0)	5.27	0.02

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Potential correlate	Total ($n = 113$)/ N (%)	Reported physical IPV and abuse on DHS IPV module and PTE assessment ($n = 54$)/ N (%)	Reported physical IPV (DHS IPV module) but no physical abuse (PTE assessment) ($n = 59$)/ N (%)	χ^2	p
Yes	25 (22.3)	7 (28.0)	18 (72.0)		
Punched					
No	67 (59.3)	40 (59.7)	27 (40.3)	9.36	<0.01
Yes	46 (40.7)	14 (30.4)	32 (69.6)		
Kicked/dragged					
No	81 (71.7)	42 (51.8)	39 (48.2)	1.89	0.17
Yes	32 (28.3)	12 (37.5)	20 (62.5)		
Strangle/burn					
No	100 (89.3)	51 (51.0)	49 (49.0)	2.90	0.09
Yes	12 (10.7)	3 (25.0)	9 (75.0)		
Threatened with weapon					
No	87 (77.7)	44 (50.6)	43 (49.4)	0.87	0.35
Yes	25 (22.3)	10 (40.0)	15 (60.0)		
Used weapon					
No	99 (88.4)	51 (51.5)	48 (48.5)	3.72	0.05
Yes	13 (11.6)	3 (23.1)	10 (76.9)		

Note. Missing: slapped $n=1$; twisted arm/pulled hair $n = 1$; used weapon $n = 1$; threatened with weapon $n = 1$; strangle/burn $n = 1$. DHS = Demographic and Health Survey; IPV = intimate partner violence; PTE = potentially traumatic event.