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Personal Awareness of Domestic Violence: Implications for Health Care Providers

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NOTE: At the time of publication, author Susan Sorenson was affiliated with UCLA School of Public Health. Currently December 2006, she is a faculty member of the School of Social Policy and Practice at the University of Pennsylvania.

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Personal Awareness of Domestic Violence: Implications for Health Care Providers

Abstract

To estimate how many Californians know a victim of domestic violence, to examine their knowledge of certain characteristics of the violence, and to estimate and examine such knowledge among specific demographic groups. A total of 3713 California adults (similar numbers of whites, blacks, Hispanics, Korean Americans, Vietnamese Americans, and other Asian Americans) completed a random-digit-dial interview. Respondents were asked whether a friend, relative, or coworker had been threatened or harmed by an intimate partner. Weights were applied to the cross-sectional sample to obtain estimates for the general population. Descriptive statistics and multivariate regressions were used with the full sample.

Comments

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Objectives

To estimate how many Californians know a victim of domestic violence, to examine their knowledge of certain characteristics of the violence, and to estimate and examine such knowledge among specific demographic groups.

Method

A total of 3713 California adults (similar numbers of whites, blacks, Hispanics, Korean Americans, Vietnamese Americans, and other Asian Americans) completed a random-digit-dial interview. Respondents were asked whether a friend, relative, or coworker had been threatened or harmed by an intimate partner. Weights were applied to the cross-sectional sample to obtain estimates for the general population. Descriptive statistics and multivariate regressions were used with the full sample.

Results

Nearly half (45.5%) of the adult general population of California knows a victim of domestic violence (DV); 40.5% know a woman and 5.0% know a man. More than one-third of the population (35.7%) knew the victim while the abuse was happening. Although 86.5% of those who reported knowing a DV victim indicated that the victim incurred physical harm, only 18.3% of the injured victims were reported to have sought medical care. Gender was the most consistent respondent predictor: Men were less likely to know someone who was a victim of DV and to have specific information about the violence. Ethnic differences were fewer, but distinctions among groups were documented.

Conclusions

Knowing a victim of DV is common among California adults. Implications for medical practice are discussed in terms of the ethnicity, gender, and work force status of the population served and geographic location of the medical practice. (*JAMWA*. 2003;58:4-9)

Personal Awareness of Domestic Violence: Implications for Health Care Providers

Susan B. Sorenson, PhD; Catherine A. Taylor, MSW, MPH

Victimization from and perpetration of violence are not rare in intimate relationships. Nearly 1.3 million women and 825 000 men are physically assaulted by intimate partners each year in the United States.¹ What proportion of these individuals disclose the violence to friends, family, and others is not documented. If neither victims nor perpetrators talk about violence in intimate relationships, the problem may be perceived to be smaller than it is and to be something that should remain a private family matter.

Screening for domestic violence (DV) in health care settings challenges such silence.² Once DV is identified, optimal care for a woman in an abusive relationship depends, in part, on the physician's working knowledge of community resources that can provide safety, advocacy, and support.³⁻⁵ The victim's social network may be one such resource.

The purpose of the present study was to estimate and examine personal awareness of DV in the general public and among specific demographic groups. Such information is important for at least 3 reasons. First, as with other conditions,^{6,7} personal knowledge may shape attitudes toward and perceptions of DV. Second, such information may serve as a general indication of victims' willingness to disclose the violence, a useful piece of information for health care providers and others seeking to intervene in DV. And, third, social networks of victims of DV might prove useful in efforts to prevent and intervene in DV. A sense of the size and demographics of this group

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may be helpful in planning interventions; the latter is the primary focus of this paper.

Methods

Sample

The study sample consisted of a series of stratified samples of random-digit-dial telephone numbers, including a cross-sectional sample of Californians and 5 specialized samples designed to yield large numbers of specific ethnic groups. To reduce potential bias of attracting respondents who were more interested in DV than others, we used the next-birthday method of selecting the adult in the household who would be asked to participate in the survey. The samples were drawn and data were collected by the University of Chicago's National Opinion Research Center (NORC).

Interviews were completed with 3 713 California adults (age 18 to 92 years): 604 whites, 550 blacks, 666 Hispanics, 619 Korean Americans, 623 Vietnamese Americans, 617 other Asian Americans, and 34 persons of other ethnic backgrounds. The overall response rate, calculated using a method comparable to the standard response rate formula of the American Association of Public Opinion Research,⁸ was 51.5%. People who did not meet language eligibility criteria (ie, spoke English, Spanish, Korean, or Vietnamese, the languages in which the interviews were conducted) could not be screened out and thus remained part of the denominator in response rate calculations. If monolingual speakers of other languages could have been screened out, the response rate might have been higher. This issue is relevant when conducting community-based surveys in regions such as California, where a substantial portion of the population is foreign born and many do not speak English.

Questionnaire

This study of personal awareness of DV was part of a larger survey of social norms about DV. The questionnaire was developed in consultation with a panel of community-based experts in order to ensure its cultural competence. The panel comprised survivors of DV and DV service providers (typically the founder and former executive director of an agency who had many years of experience providing service to Hispanic, black, or Asian American battered women or batterers). The questionnaire was pilot tested with members

of each of the relevant ethnic groups and discussed in focus groups. The final English-language version of the questionnaire was translated into Spanish, Vietnamese, and Korean, then each was translated back into English. Minor adjustments were made to ensure equivalency of the forms.

Trained interviewers conducted the interviews from April 2000 to March 2001. The first section of the questionnaire described DV scenarios that included psychological, sexual, and physical abuse. After each scenario, respondents were asked a series of questions, including whether they thought that the behavior was right or wrong, whether it was illegal, and whether it should be illegal. The personal awareness section was next and asked all respondents whether a friend, relative, or coworker had been threatened or harmed by an intimate partner. Those who responded affirmatively were asked specific, nonidentifying questions about the DV; these questions are listed in the Appendix. The final section asked about demographic characteristics.

The study was reviewed and approved by the institutional review boards of both the University of California, Los Angeles and of NORC.

Analyses

The first set of analyses estimated the proportion of the general population that personally knew a victim of DV and knew about certain characteristics of the violence. Population weights were applied to

the cross-sectional sample to adjust for within-household selection, multiple residential telephone lines, nonresponse, and sex and ethnicity. The resulting findings, thus, can be viewed as a reasonable approximation of the experiences of the general population of California.

The second set of analyses addressed the second objective of the investigation, namely, to examine personal knowledge of a DV victim and characteristics of the violence among specific demographic groups. Analyses began with frequencies and χ^2 . Multivariate logistic regressions were used to examine the effect of one characteristic of the participants on their responses while taking into account their remaining characteristics. To limit error rates with the large sample, findings with a value of $p < .01$ only are discussed.

Results

Population Estimates

Almost half of California adults (45.5%) know someone

**The complex nature of
domestic violence
necessitates
multiple health care
prevention and intervention
strategies.**

Demographic Predictors of Knowing a Victim of Domestic Violence, adjusted odds ratios

Among Respondents Who Reported Knowing a DV Victim										
	Knows a Victim (n=3713)	Male Victim (n=1372)	Physical Harm (n=1345)	Sought Medical Care (n=1272)	Called Police (n=1321)	Left Rel'ship (n=1350)	Used Shelter* (n=1139)	Children at Home (n=1315)	Knew During Abuse (n=1361)	3 Closest Friends/Relatives (n=1385)
Gender										
Male (v female)	.66 [†]	4.13 [†]	.70 [†]	.97	.98	.81	.61	.75 [†]	.61 [§]	.69 [§]
Age										
40+ (v <40)	.84	1.14	.81	.53 [§]	1.11	1.05	4.07 [†]	1.45 [†]	.90	.76
Ethnicity										
Black (v white)	.93	1.22	.63	1.43	2.17 [†]	1.02	1.20	1.03	2.14 [§]	1.15
Hispanic	1.15	1.52	1.04	.87	1.20	.91	.96	1.42	1.04	1.06
Korean	.87	.61	.64	.90	.53 [‡]	.72	.19 [§]	1.12	1.26	1.31
Vietnamese	.47 [†]	1.94	.58	.85	.79	.68	.83	.89	.84	1.27
Other Asian	.62 [§]	1.32	1.27	1.01	.66	.63	.82	.80	.72	1.04
Nativity										
Non-US (v US)	.41 [†]	1.75 [‡]	.65	.97	1.20	.76	1.43	.93	.82	.72
Education										
<High school (v HS grad)	1.00	.81	.84	1.08	.77	1.15	1.40	.96	1.47	1.34
Some college	1.34 [§]	.80	.90	1.22	1.01	1.09	1.07	.90	.66	.98
College graduate	1.07	.75	1.17	1.24	.70 [‡]	1.39	1.12	.75	.85	.78
Employment										
Part (v full time)	1.19	.70	.75	.92	.89	1.17	.90	.62 [†]	1.27	.70
Unemployed	.83	.65	.98	.67	.86	1.38	1.19	.71	2.49	1.31
Retired	.49 [†]	1.82	.78	.82	.62	1.00	.60	.86	1.40	.89
In school	.72 [†]	.84	.98	.74	.47 [§]	1.28	2.02	.59 [†]	1.17	.63
Keeping house	.76	.67	.71	.44 [§]	1.05	.66	.52	1.05	.77	.65
Other	1.69 [‡]	1.76	1.53	1.12	1.04	.70	.83	1.53	2.22	2.97 [§]
Income										
\$20 000-39 999 (v <\$20k)	1.35 [§]	.98	1.10	.99	.79	.98	2.19 [‡]	1.17	1.43	1.46 [‡]
\$40 000-59 999	1.39 [‡]	.93	.70	.97	.82	1.35	1.76	.97	1.39	1.09
\$60 000+	1.50 [§]	.60	.70	1.18	.90	1.61 [‡]	1.29	.67	1.00	1.11
Relationship history										
Never married (v ever)	1.49 [†]	1.03	1.32	1.44	1.38	.78	.82	.85	.62	1.37
Ever divorced (v never)	2.26 [†]	1.26	1.33	1.31	1.29	1.33	.67	1.05	1.05	1.38

*Only those who knew a victim who was female were asked about their knowledge of her use of a battered women's shelter.

[†] p < .01

[‡] p < .001

[§] p < .05

Note. The multivariate logistic regressions also took into account the number of people supported on the reported income, household composition, and missing values of each of the variables. Two substantive variables – locale (eg, small town or farm) and current relationship status – that also were taken into account in the analyses were generally unrelated to the outcome variables. A table showing all 95% confidence intervals is available from the authors.

“such as a friend, relative, or coworker, who [has] been the victim of domestic violence, that is, someone who has been threatened or harmed by an intimate partner.” Two-fifths (40.5%) of California adults know a woman victim of DV, and 5.0% know a male victim. More than a third (35.7%) knew the victim while the abuse was happening, and for 19.2%, the victim was 1 of their 3 closest friends or relatives.

Nearly two-fifths (39.4%) of California's general population know a victim who experienced physical harm; but only 18.3% of respondents reported that medical care was sought for the injuries. More than one-fourth (29.2%) of California adults know of DV in which children were home during at least some episodes of the violence, and 26.1% of California's adults know of DV in which the police were called. One-third

(33.5%) of the general population of California know someone who was a victim of DV and left the relationship; 3.0% know a woman who used a battered women's shelter.

Study Sample

A substantial minority (37.5%) of the respondents said that they knew a victim of DV, and 84.2% of those knew the victim while the abuse was happening. In most cases the victim was female (88.2%), and in 65.8% of the cases children were home during at least some episodes of violence. Police were called to intervene in 58.0% of the cases. Most (83.9%) of the victims were physically hurt, but only 40.6% sought medical attention. Two-thirds of the victims (66.8%) left the relationship. Only 9.9% of the female victims used the services of a battered women's shelter. Nearly half (48.9%) of the respondents who knew a DV victim said that 1 of their 3 closest friends or relatives had been threatened or harmed by an intimate partner.

Bivariate analyses indicate that respondent sex, age, ethnicity, nativity, education, employment, income, marital status, relationship history, household composition, and area of residence were all statistically significantly associated with personal knowledge of a DV victim. (Tabled data are available from the authors.)

The next set of analyses used multivariate logistic regression to assess whether these patterns of association would hold when all respondent characteristics were taken into consideration simultaneously. As shown in the table, the odds of knowing a DV victim were lower for men (95% CI .56, .77), Vietnamese Americans (95% CI .33, .66), other Asian Americans (95% CI .46, .83), immigrants (95% CI .33, .51), and retired people (95% CI .36, .65). The odds were higher among those with some college education (95% CI 1.03, 1.67), with incomes more than \$20 000 (95% CI .67, .79), or who had been divorced (95% CI 1.76, 2.90).

Relatively few demographic characteristics were associated with responses to the remaining questions. (Recall that subsequent analyses were limited to respondents who reported that they knew a DV victim.) Gender was the only variable related to knowing a male victim of DV – odds were higher for men (95% CI 2.81, 6.05). No respondent characteristics were associated (at $p < .01$) with the odds of knowing a victim who incurred physical harm, who left the relationship, or who had children at home when the violence occurred. The odds of knowing whether the victim sought medical care were higher for respondents who were 40 years old or older (95% CI 1.14, 2.06) and lower for those who were keeping house (95% CI .24, .79). The odds of knowing whether police were called were higher among black

respondents (95% CI 1.47, 3.18) and lower among students (95% CI .28, .78). The odds of knowing whether a female victim went to a battered women's shelter were higher for respondents who were at least 40 years old (95% CI 2.40, 6.91) and lower for Korean Americans (95% CI .05, .64). The odds of knowing the victim while the abuse was happening were lower for men (95% CI .44, .85) and higher for black respondents (95% CI 1.23, 3.72). The odds of reporting that 1 of the respondent's 3 closest friends or relatives was a DV victim were lower for men (95% CI .54, .88) and higher for those whose employment status was "other" (95% CI 1.55, 5.70). The odds of knowing a DV victim or certain characteristics of the violence were unrelated to where the respondents lived (farm or small town, suburb, city).

Discussion

Estimates derived from this investigation indicate that more than 11 million Californians know a victim of DV, and more than 8 million Californians knew the victim while the abuse was happening. (Numbers calculated using US Census data.⁹) In addition, about 87% of those who knew a DV victim reported that the victim was physically harmed, yet only 18.3% reported that the injured victim sought medical care. Prior national research has estimated that about half of female victims of DV sustain injuries and that about 20% of those who are injured seek medical treatment.¹⁰

To our knowledge, no peer-reviewed research has addressed the extent to which Americans know victims of DV. The ability to examine demographic groups and make population-based estimates is a strength of the present research.

The limits of self-reported data, such as those used here, are well documented.¹¹ Another limitation of our study is the relatively low response rate, 51.5%. The general public is increasingly unwilling to participate in scientific surveys. Even widely used and well-regarded national telephone surveys have experienced a substantial drop in participation rates: Response rates in the national Behavior Risk Factor Surveillance System dropped from a median of 68.4% in 1995 to 55.2% in 1999; in 1999, 18 states had participation rates below 50%.¹² Our response rate is similar to or higher than those obtained in other recent statewide California surveys.^{13,14}

Implications

A number of respondent characteristics associated with knowing a DV victim have implications for health care practice, especially the patient's ethnicity, sex, work force

status, and place of residence. Although other demographics were also predictors of awareness, they will not be the focus of this discussion because they have less relevance to clinical practice. For example, although nativity is an important predictor of DV awareness, health care services tend not to be offered for immigrants in general but, rather, organized for immigrants of a certain ethnic group, nationality, or language.

Latinos did not differ statistically from whites in their general or specific personal knowledge of DV. Blacks were more likely than whites to report knowing a victim of DV while the abuse was happening and to know that police were called to intervene. In contrast, Vietnamese and “other Asian Americans” were less likely to know a DV victim, and the odds of knowing someone who went to a battered women’s shelter were much lower among Korean Americans. Substantial social stigma is attached to DV in South Asian communities, and it is rare for Asian Americans to admit such abuse, even to close friends.¹⁵ Therefore, a strategy more relevant to this population would focus on basic education to help reduce the stigma of DV. In addition, as with most clinical services, cultural and language barriers may hinder victim disclosure to professionals.¹⁶

Women were consistently more likely than men to report that they knew a victim of DV, that they were close to the person, and that they knew the victim during the abuse. Respondents were 8 times more likely to report knowing a female than a male victim of DV. These reports are consistent with the greater likelihood of physical harm among women victims of DV¹⁷ and with women’s greater likelihood to disclose personal information and to have other women as their confidantes.

Retired people were less likely than full-time workers to know a victim of DV, to identify someone close to them as a victim, and to know of police being called to intervene. If, as some suggest, social norms regarding DV and its disclosure have shifted over time,¹⁸ this shift may not have included the elderly. That is, DV may still be regarded as a predominantly private matter among older age groups. (Note that 85% of the retired persons in the sample were age 60 or older.)

The odds of knowing a DV victim or certain characteristics of the violence were unrelated to place of residence (farm or small town, suburb, or city), suggesting that personal knowledge of DV does not differ by the geographic locale of the medical practice.

Intervention Strategies

An often overlooked resource in DV intervention and prevention efforts is the victim’s social support network of

friends, relatives, and coworkers. These individuals may be powerful allies in helping – or hindering – victims of DV. As shown in a clinical trial of advocacy services, those who worked with advocates experienced less violence over time, higher quality of life, and less difficulty connecting with community resources.^{19,20} Women who are victims of DV are more likely to use health care resources and are at increased risk of a multitude of poor physical and mental health outcomes,²¹⁻²³ yet only about one-third have disclosed the violence to their physicians.^{24,25} It is, therefore, critical for health care providers to routinely screen for DV among their patients and to intervene as appropriate for the patient population being served.

Presuming that an effective DV screening protocol is in place, health care providers should encourage victims to identify and use their own social networks for safety and emotional support. This can be especially important for victims who refuse or are not eligible for placement in battered women’s shelters. In one study, almost one-quarter of women who left abusive partners cited friends as being most helpful to them in ending their victimization.²⁶ Another study found that victim-partner contact increased with family encouragement to make the relationship work and that such contact decreased when coworkers encouraged women to leave the abusive relationship.²⁷ Engaging patients through an exploration of available social networks can be an effective and empowering intervention.

In addition to identifying specific victims and perpetrators,²⁸ practice-based health education efforts may be helpful. For example, health clinics might consider a campaign to encourage patients who know victims of DV to intervene on the victim’s behalf. Appropriate interventions could include talking to the victim to see what she or he might need and encouraging the victim to talk with his or her health care provider or other health care professionals or to seek help from the criminal justice system. Encouraging this sort of community involvement can help to break the silence and isolation of DV and encourage supportive, personal connections for the victim. Additional research on the social networks of DV victims and how their actions could support ending the violence would be useful as well.

The complex nature of DV necessitates multiple health care prevention and intervention strategies. One potential strategy, engaging the social networks of DV victims, may aid victims in a number of important ways. Health education efforts directed to those who know DV victims may also be a useful practice-based intervention. Such efforts can increase the level of support and options available to DV victims and, more broadly, increase community awareness, involvement,

and investment in reducing DV. Such efforts may eventually lead to changes in social norms within a community, namely, less tolerance for DV and less consideration of DV as a private, family matter.

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Appendix

Personal Awareness of Domestic Violence Survey

"Has someone you know, such as a friend, relative, or coworker, been the victim of domestic violence that is, someone who has been threatened or harmed by an intimate partner?"

If the respondent said "Yes," the interview continued with the following:

"If there is more than one, choose the person you know best. I am not going to ask you who this person is or how you know them."

"Is this person male or female?"

"Was [he/she] ever physically hurt as a result of the abuse?"

"Did [he/she] ever seek medical care because of the violence?"

"Were the police ever called as a result of the violence?"

"Did [he/she] ever leave the relationship?"

If the victim was female:

"Did she ever go to a battered women's shelter?"

"Were there ever children in the home when the violence occurred?"

"Did you know the victim while the abuse was happening?"

"Now think of your three closest friends or relatives. Have any of them been threatened or harmed by a partner?"