Diverse Faces of Domestic Violence

Abstract: Domestic violence is one of the most common causes of serious injury among women. Domestic violence victims endure physical and psychological sequelae that often go undetected by the health care professionals they encounter. There are many barriers women who are victims of domestic violence face. Women of color encounter additional barriers such as stereotypes that construct domestic violence as a "minority" issue. This article surveys the relevant literature to provide the reader with a review of the current state of knowledge for this special sub-population of domestic violence victims. Health care professionals need to be aware of the issues of this sub-population and be appropriately educated and trained to actively screen them. In addition, health care professionals need to be culturally sensitive to the needs of women of color who may experience domestic violence in order to appropriately screen and refer women for services that meet their needs.

Key Words: Domestic Violence, Health Care, Women of Color

Domestic violence is the most common cause of serious injury among women in the United States, accounting for more injuries than car accidents, muggings and rapes combined (Huth-Bocks, Levendosky, & Bogat, 2002). In the United States, approximately 1.5 million women are raped and/or physically assaulted by an intimate partner annually (Tjaden & Thoennes, 2002). While it is true that intimate partner assaults are also committed against men, women experience intimate partner violence at greater rates than men. For the purposes of this paper, we will focus on violence against women, exploring the impact domestic violence has on women from different racial and ethnic backgrounds.

METHODS

A systematic review of literature was conducted to identify research that addressed domestic violence’s impact on women of color, and physician screening for domestic violence. PubMed was used to search the terms domestic violence and women of color or African American or Latina or Hispanic and physician screening. This search was limited to articles in English that were published between 1990 and 2005. Each search was conducted separately producing a total of 887 articles, after combining each individual search the total was 208. The title and abstracts of each study were reviewed to identify articles that specifically addressed physician screening among women of color, as well as a discussion of the perceptions, stereotypes and treatment of women of color that have experienced domestic violence. A web search was also conducted, resulting in an additional two articles. Many articles did not directly address issues related to the topic of race/culture and domestic violence, specifically connected to physician screening. A total of 20 articles were reviewed in full.

WHAT IS THE IMPACT OF DOMESTIC VIOLENCE ON HEALTH?

A variety of health care professionals and medical specialists come into contact with women of color who are victims of domestic violence. These patients suffer physical and psychological sequelae of domestic violence but they often go undetected. Therefore, physicians (generalists and specialists) need to actively screen for domestic violence in a culturally appropriate manner. In an effort to better understand the impact of domestic violence, it must first be defined. The definitions of domestic violence vary. For this paper, domestic violence is defined as the physical, sexual or emotional abuse of an adult woman by a man with whom she has or has not had an intimate relationship, regardless of whether the couple is currently living together or not. This definition not only includes physical violence, but also emotional abuse such as isolation from family or other support systems, intimidation, threats of violence, threats to harm or take the children away, and economic abuse (Bacchus, Bewley, & Mezey, 2001).

Domestic violence manifests itself in many ways. The health consequences of domestic violence are extensive having both physical and psychological effects on victims. Domestic violence victims seek assistance for medical problems, injuries, obstetrical or gynecologic problems, and psychiatric symptoms (Gerlock, 1999). A study conducted by Carlson, McNutt, Choi, and Rose (2002), revealed that both depression and anxiety were highly associated with having experiences of domestic abuse. Research has also demonstrated a direct link between domestic violence and increased rates of depression, trauma symptoms, substance abuse, suicide attempts, anxiety, self-harm and sleep disturbances (Humphreys & Thiara, 2003; Barthauer, 1999). The psychological ramifications of domestic violence have
been found to lead to increased dependence on drugs and alcohol (United Nations Children’s Fund, 2000; Martin, Kilgallen, Dee, Dawson, & Campbell, 1998). Domestic violence not only impacts the women’s health, but it affects the economy as well. It is estimated that companies nationwide lose between 3-5 billion dollars a year from employee absenteeism and decreased productivity directly correlated to domestic violence (Leupold, 2003).

Despite this, many physicians are still hesitant to delve into domestic violence issues as a routine part of their screening and assessments. Physicians have difficulty recognizing and making appropriate referrals for victims. A study of psychiatry residents found that even when domestic violence victims were identified, less than half were referred for domestic violence services (Barthauer, 1999). Health care providers’ reluctance to screen for domestic violence often stems from a belief that domestic violence is a private and personal issue. Beliefs like this result in a lack of training for health care professionals that would increase their knowledge and skills around detection of domestic violence. Despite health care providers’ current lack of knowledge, many report that they are open to receiving information and training on domestic violence (Cann, Wittnell, Shakespeare, Doll, & Thomas, 2001).

Physicians specializing in obstetrics and gynecology need to be particularly aware of domestic violence and its various presentations. Several studies have shown that pregnancy can act as a trigger for new incidences of domestic violence or an exacerbation of an existing problem (Huth-Bocks et al., 2002; Bacchus et al., 2001). Bacchus, Bewley, and Mezey (2001), indicate that violence against pregnant women is more common than gestational diabetes or preeclampsia, both of which are routinely screened for throughout a woman’s pregnancy. However, domestic violence is rarely, if ever, addressed in an ongoing manner during the pre- or post-natal period. In addition, Huth-Bocks and others (2002), noted that 95% of women who are battered during pregnancy were also battered three-months post-partum with 52% of these women requiring medical care for the injuries incurred from the abuse. Furthermore, victims of domestic violence are more likely to be polysubstance abusers and are less likely to quit using substances during their pregnancy (Martin et al., 1998). These issues place not only the woman, but also her unborn or newborn child at risk as well.

RACE/ETHNIC ISSUES IN DOMESTIC VIOLENCE

Historically, domestic violence has been portrayed and perceived by society as a “minority” issue. That is, domestic violence victims are routinely portrayed as poor women of color (Martinson, 2001; Weis, 2001; Bograd, 1999). Many African-American women are aware of these stereotypes, and this in turn impacts their willingness to report and disclose their own abusive or violent relationships. They perceive that reporting violence will be an opportunity for the public or authorities to use this information to reinforce negative stereotypes of the African-American community (Martinson, 2001).

The stereotypes that surround domestic violence as “minority” issues lose validity when compared with empirical data. The literature has shown that there is little difference among the lifetime incidence of domestic violence among African-American and White women (Lee, Sanders-Thompson, & Mechanic, 2002). Despite the similarities in the rates of domestic violence among these groups, there continues to be perceived social differences among the two groups that impact how each experiences domestic violence and the treatment and services available to them (Weis, 2001; Lee et al., 2002). The most influential factor on how a woman responds to and experiences domestic violence is the social and cultural context of her life (Lee et al., 2002). Locke and Richman (1999), recognize that although domestic violence does not discriminate who its victims will be, the social construction and practices surrounding the issue of domestic violence are discriminatory.

Discriminatory practices limit a woman’s comfort level in disclosing domestic violence and seeking out services to address it. The race of the victim influences who a therapist might define as a “real” or “appropriate” victim. The stereotypes that surround domestic violence often deny the legitimization of women of color as victims (Bograd, 1999). Often, violence against Black women is not considered as serious as the violence committed against White victims (Harrison & Esqueda, 2000). This creates a barrier in a woman’s willingness and ability to disclose issues of domestic violence to health care providers. In the African-American community, women are often reluctant to report abuse due to its stereotypical association to communities of color, mistrust of authorities and poor prior experiences or relationships with authorities and mistrust of the judicial system (Humphreys & Thiara, 2003). The social practices of racism create a reality that places women of color at a disadvantage. According to Sullivan & Rumpitz (1994), the African-American women surveyed in their study were more likely to be living below the poverty level, be the sole providers of their families, less likely to have access to a car and had more children living with them. As a consequence of these issues, services that are culturally competent would have to recognize that there is a higher incidence that services would be needed among this population and must be prepared to address them.

In addition to the issues addressed above, Latina women may also experience language barriers, isolation, lack of access to even minimum wage jobs and uncertain legal statuses (Menjivar & Salcido, 2002). In many instances, the batterer serves as the primary interpreter for the woman. This represents a clinical dilemma and a conflict of interest in court. The literature has noted that health care service providers perceive immigrant women as “accepting” of domestic violence, claiming that they bring this belief and culture of acceptance with them. Immigrant women are also more likely to lack a social network, making it easier for the abuser to isolate and control them. Some immigrant women’s dilemma is compounded by the fact that they may only have citizenship through marriage, limiting their ability to leave the abuser for fear of losing citizenship (Menjivar & Salcido, 2002). Although African-American women do not fear loss of citizenship, they do fear a being ostracized within their community for reporting abuse, and may be viewed as contributing to the racial stereotypes and criminalization of the African-American male (Martinson, 2001). These barriers make it more difficult for these women to not only disclose the abuse, but also to access services that will support their decisions to leave their abusive situation.

Many women stay with their abuser for economic reasons. This may be especially pertinent to women from ethnic backgrounds and minorities. A study by Humphreys and Thiara (2003), notes that Black and minority ethnic women were significantly more likely to continue to suffer substantial problems both emotionally and materially more than six months after separation from their abuser. Furthermore,
many African-American women face the huge obstacle of poverty (Martinson, 2001). Economic instability is a key factor in the decision of whether or not a woman feels she is able to leave her abusive situation. The inability to create a stable home for herself and her children due to limited financial resources often results in a significant delay in leaving the abuser, not leaving the abusive situation at all, or, lastly, returning to the abuser for economic support.

African-American women and Latina women reportedly experience greater mental health consequences when they are victims of domestic violence (Lee et al., 2002). These women are not only dealing with the "typical" stress that accompanies domestic violence, but they also are dealing with the stigma associated with domestic violence, race, and the negative effects it has on the availability and access to culturally sensitive services. United States legislators have begun to acknowledge the fact that domestic violence is not solely a minority or marginalized population's problem (Martinson, 2001). However, in an attempt to challenge the stereotypes of domestic violence as a "minority" issue, the proposed legislation neglects to address concerns about services for poor women of color. In an effort to challenge the stereotypes of domestic violence victims as poor, minority, battered women, most of the legislation that addresses domestic violence issues, focus on white, middle-class women. The unintended effect of these efforts is less emphasis on and concern for poor women of color who remain at the margins, unseen and deemed undeserving of services (Bograd, 1999). In a study by Krishnan, Hilbert, VanLeeuwen and Kolia (1997), Latina subjects reported experiencing more types of violence (e.g., physical, emotional, etc.); however, they were less likely to report the violence to law enforcement officials or seek medical care. This finding indicates a need to make both traditional and non-traditional avenues available to these women in order to increase the likelihood of disclosure, ultimately resulting in referrals and treatment. Practices that do not recognize cultural differences in reporting and seeking out care place women of color at a greater disadvantage than white women in obtaining the services and resources necessary to leave and remain free of their abusive situations. Ultimately, resulting in inadequate services for the very population the legislation was intended to protect.

When women are able to leave their abusive situations, they report a lack of culturally appropriate services that meet their individual needs. It has been noted that services for battered women are often geared towards the needs of White, non-immigrant, English-speaking women (Garcia, Hurwitz, & Kraus, 2001). In addition, service providers often come from different class and racial backgrounds than their patients, and as a result may not understand the complex obstacles faced by women of color (Martinson, 2001). Research demonstrates women of differing race and ethnicities require different and culturally sensitive services and domestic violence services need to be developed accordingly (Lee et al., 2002). Although some research has been done in this area, there is limited information on the incidence and prevalence of domestic violence among minority populations (Krishnan et al., 1997), therefore it is pertinent that these issues be explored in order to develop culturally sensitive services that are effective. Possible culturally sensitive services include information provided in languages other than English, awareness and understanding of barriers facing women of color in addition to the experience of being a victim of domestic violence.

IMPLICATIONS FOR THE PRACTITIONER

Due to the physical and psychological trauma incurred by domestic violence victims, physicians and other health care professionals are often the first persons to encounter domestic violence victims, particularly in the emergency room setting. The National Institute of Justice (Isaac & Enos, 2001), released a research brief detailing the importance of the health care provider's role in helping to identify and document domestic violence. Research demonstrates that women are more likely to disclose abuse when directly asked by a health care provider (Barthauer, 1999; Cann et al., 2001). Women themselves may feel uncomfortable bringing up the topic of domestic violence or may initially be reluctant to disclose their domestic violence situation. Health care providers who routinely screen for domestic violence provide vital opportunities for women to disclose abuse and receive services.

Once a woman has disclosed abuse, the next step is providing information and resources that will connect her to appropriate resources. Health care professionals would benefit from reaching out to community resources in order to facilitate a relationship that would allow for easy and quick referral for women who disclose domestic violence. Additionally, having information (handouts, pamphlets) available in emergency rooms, clinics and women's bathrooms provides women with multiple opportunities to access domestic violence services.

The services available to women of color who are screened and ultimately referred fail to meet the complex needs of this population (Martinson, 2001; Bograd, 1999; Lee et al., 2002; Menjivar et al., 2002). In an effort to meet these needs, Bograd (1999) suggests developing theories that move beyond simple descriptions of domestic violence, but take into account intersections of race and class, in order to provide access to appropriate services for women of color. Considering factors such as the stigma of domestic violence in communities of color, language barriers and economic issues will help to inform the training that should be provided to health care professionals. For example, a model program designed for women of Mexican descent provided bilingual services including counseling, transportation, legal services, and assistance with job training (Lee et al., 2002). Providing these culturally sensitive services supported the needs of these Latina women, making it less likely that they would return to their abuser. Just as Latina women have specific needs, African-American women have reported a need for appropriate food and grooming materials and a need for more material and financial support to meet these needs (Lee et al., 2002). Women of color have also requested shelters that accommodate larger families in order to obtain appropriate housing that is able to meet their individual and familial needs. Furthermore, providing culturally appropriate information and support may assist all women, regardless of their race/ethnicity to disclose domestic violence, ultimately seeking out and obtaining services that will assist them in leaving the abusive situation, being less likely to return to their abuser.

CONCLUSION

Domestic violence is a significant issue in clinical practice warranting the attention of health care providers. Domestic violence has detrimental effects on the women directly involved as well as society at large. Lack of training for health care providers has multiple effects on both the providers and the women that they treat. Women are less likely to report domestic violence due to barriers such as fear
and shame. Likewise, health care providers are reluctant to screen for domestic violence due to personal discomfort, lack of awareness, training and skills, therefore, the opportunity for women to disclose is often missed in the clinical setting. Minority and ethnically diverse women are even more reluctant to disclose domestic violence due to the societal stigma and stereotypes. The inability to access culturally sensitive services for these women allows the cycle of domestic violence to take its toll on their physical and psychological well-being. Furthermore, when women suffer the consequences of domestic violence they are more likely to be absent from work and less productive, impacting the entire economy as well. Many studies suggest a need for improved reporting, additional education and programs that are culturally appropriate (Donnelly, Cook, Ausdale, & Foley, 2005) in order to detect and treat women who are victims of domestic violence.

The literature addressing cultural, ethnic and racial differences is limited and further work is needed to understand how a woman’s race/ethnicity shapes her willingness to disclose domestic violence to her health care provider, as well as her ability to identify and access services that are culturally sensitive. Health care providers should receive training in order to increase their knowledge and skills in identification and referral of victims for culturally competent services. Health care providers should also be aware of the social practices that perpetuate racism (e.g., stereotypes of domestic violence as a minority issue), resulting in limited services and resources that support the needs of women of color, limiting their ability to leave their abusive situation and remain abuse free. Lastly, health care providers need to be knowledgeable of the cultural differences among women in their practice and use this information when broaching the topic of domestic violence with their patients on a routine basis.

REFERENCES


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