

**BELLINGHAM-WHATCOM COUNTY
COMMISSION AGAINST DOMESTIC VIOLENCE**

1407 Commercial Street
Bellingham, Washington 98225
360.671.5714 ext 235

**COMMUNITY SURVEY PROJECT:
Factors That Influence Disclosure of
Domestic Abuse to Providers**

Ad Hoc Survey Committee

Northwest Resource Associates
800.704.9273 www.nwresource.org

April 2002

COMMUNITY SURVEY PROJECT:
Factors That Influence Disclosure of Domestic Abuse to Providers

Table of Contents

Executive Summary		i
Introduction		1
Method		1
<i>Survey Development</i>		1
<i>Survey Procedures</i>		3
<i>The Women’s Survey</i>		3
Limitations		5
Results		6
<i>Demographic Data</i>		6
<i>Abuse Score/Abuse Group</i>		8
<i>Reasons Women are Discouraged from Disclosing Abuse</i>		9
<i>Reasons Women are Encouraged to Disclose Abuse</i>		12
<i>Frequency Providers in Whatcom County Ask about Abuse</i>		14
Discussion		14
<i>Recommendations for Providers</i>		17
Literature Review	Appendix	A
Women’s Survey	Appendix	B
Current Abuse Algorithm	Appendix	C
Comparison Current Abuse, Past Abuse, No Abuse Response	Addendum	1
Analysis by Level of Abuse	Addendum	2

Executive Summary

COMMUNITY SURVEY PROJECT:
Factors That Influence Disclosure of Domestic Abuse to Providers

The June 2000 Whatcom County Domestic Violence Comprehensive Plan identified a need to increase community knowledge about the fears, barriers, and experiences of victims in disclosing domestic violence to healthcare and social service providers. The *Ad Hoc* Survey Project Committee and project consultant, Northwest Resource Associates, began work in May 2001 to develop a strategy to survey women about these issues.

Design: Project design was guided by a literature review, a series of key informant interviews, and two victim focus groups. The Women's Survey included demographic information, an assessment of the participant's experience with domestic abuse, and two checklists for the respondent to identify those factors that would:

- 1) **discourage** her from disclosing abuse to a service provider, and
- 2) **encourage** her to disclose abuse to a service provider.

The survey also included questions about the participant's experience with being asked about abuse by a service provider.

The *Ad Hoc* Committee distributed the survey through the offices of healthcare providers and a limited number of social service providers in Whatcom County. Efforts were made to include sites that serve a variety of income and ethnic groups within the county. Results are based on the responses of women, age 18 and above, who voluntarily completed the survey at distribution sites that agreed to participate in the project. Respondents were not a random sample of women in Whatcom County.

Of primary interest were the responses of women who were currently experiencing domestic abuse. Participants were asked to rate how often they experienced certain behaviors from their intimate partner in the past three years. A scoring system was developed to ascertain which respondents had experienced a pattern of abuse. The scoring algorithm took into account patterns of emotional abuse, as well as physical violence. Respondents also were asked to indicate whether they had experienced domestic abuse prior to the past three years.

Limitation: The percentage of the sample identified as the Current Abuse group should not be considered a rate of domestic violence in Whatcom County. The survey was designed to learn about women's experience with disclosure, not to assess prevalence of domestic violence.

Results: A total of 1036 valid surveys were returned and included in the results. The assessment section yielded the following groups or respondents:

Current Abuse (past three years):	422 women, 40.7% of the sample
Past Abuse (prior to three years only):	133 women, 12.8% of the sample
No Abuse:	481 women, 46.4% of the sample

The results of what most discourages, and what most encourages, women to disclose abuse to a service provider is based on the responses of the 422 women who met criteria for the Current Abuse group.

Factors that influence disclosure.

Many of the factors that most often discourage a woman from talking to a provider are internal to her beliefs and feelings about her experience, some factors speak more directly to how the provider interacts with a victim, while still others suggest that there is much the community can do to increase information and education on what constitutes domestic abuse.

- Responses indicate that there is a strongly held desire for a woman to keep the experience of domestic abuse to herself.
 - Two out of three respondents reported they would not disclose abuse to a provider because they feel they can manage best by themselves.
 - One-third of the respondents report they would not disclose abuse because it is a private matter between husband and wife.
 - The surveyed women identified a constellation of items concerned with the consequences of a provider not keeping the disclosure confidential. Women would not disclose because they were concerned with retribution should their partner find out, that the police would be involved, and that disclosure might lead to the loss of their children. As one woman wrote, “I did not want a service provider to cause problems for myself and children when trying to help.”
 - More than 40% of the respondents would be encouraged to disclose by a provider reassuring them they could decide what happens next.
- Almost half the sample would not disclose abuse because they were unsure that what they experienced qualified as abuse.
- A number of feelings, beliefs, and individual circumstances impact a woman’s willingness to disclose domestic abuse.
 - Feelings of embarrassment and guilt for allowing the abuse to happen inhibit disclosure for almost half the respondents.
 - Nearly one-third report they would be discouraged from disclosing because they identify alcohol as the problem, identifying that “this only happens when [my partner] drinks too much.”

- Many women appear to make a connection between disclosure of abuse to a provider and having the resources to leave her abuser. Just over one-quarter of the respondents reported being discouraged from disclosure because they had no money or nowhere else to go.
- Half the respondents were encouraged to disclose because they were simply ready to tell someone, or were in crisis and didn't know what else to do.
- Respondents indicated that some provider behaviors can discourage and some can encourage disclosure.
 - Approximately half the respondents reported being encouraged to disclose abuse when the provider takes time to listen and asks questions in a caring manner.
 - More than one-third of the abuse victims indicated that just being asked about abuse or how an injury occurred would encourage them to disclose.
 - Approximately one-third of the respondents would be encouraged by a provider's apparent desire to know about the abuse and willingness to believe them.
 - Almost one-third reported they would not disclose for fear the provider would judge their partner. A relatively small percentage of women were concerned the provider would blame, or be disgusted with, them.
- Fewer than one in four (22.5%) respondents reported having ever been asked about domestic violence by a Whatcom County provider. However, of those who did talk to a provider, more than three-fourths (78.9%) reported they received a helpful response.

Recommendations for providers

The report makes a number of recommendations for providers based on the survey findings. These include:

- Routinely ask about domestic relationships and violence. Discuss domestic violence directly.
- If you suspect someone is a victim and they deny it, talk as if it were a possibility.
 - Define abuse to include emotional abuse.
 - Talk about common feelings of embarrassment, guilt, and shame.
 - Reassure the victim it is not her/his fault.
 - Say what you would do with the information, and reassure the victim that she/he would decide what to do next.
 - Reassure that domestic violence is complex, difficult to handle alone.
- Ask questions in a caring manner, and take time to listen.
- Learn domestic violence resources in the community and offer specific referrals.
- Beyond the requirements of mandatory reporting, give the victim control over what will happen next.
- Safety for victims is a first priority.

BELLINGHAM-WHATCOM COUNTY COMMISSION AGAINST DOMESTIC VIOLENCE

COMMUNITY SURVEY PROJECT: Factors That Influence Disclosure of Domestic Abuse to Providers

Introduction

The Whatcom County Domestic Violence Comprehensive Plan, completed by the Bellingham-Whatcom County Commission Against Domestic Violence in June 2000, identified the need for increased knowledge about experiences of victims and survivors of domestic violence, as they interface with Whatcom County community and health care providers. To find out more about how victims experience the prospect of disclosing domestic violence to providers, the commission decided to survey women in the county.

In April 2001 the commission contracted with Northwest Resource Associates of Seattle, Washington to act as a consultant in the research, development, implementation of this survey, and analysis of the information collected. NWRA met with the *Ad Hoc* Survey Project Committee over the course of several months to clarify the goals, establish the procedure, review the literature, and develop the survey.

Method

Survey Development

At the beginning the *Ad Hoc* Committee decided to limit the survey to women, age 18 years and older. The initial step in the development of the Women's Survey and procedures for implementation was a review of the professional literature. This was completed in June 2001 and can be found in Appendix A.

The next stage in the development of the survey was a series of key informant interviews with professionals working in the domestic violence (DV) field within Whatcom County, and a series of focus groups with victims of domestic violence.

The key informant interviews included: general issues of community response to domestic violence, questions about barriers to speaking out about this issue, and solicitation of issues to consider in the development and implementation of the survey. The findings from these interviews were used to ensure the survey addressed relevant issues within the community. Respondents felt that the community had made good progress; however, many issues remained to be addressed. Some expressed concern that it was difficult for women to seek services confidentially, and that in many ways a woman's autonomy to decide what course to take was not always honored. Many felt

the system did not consistently hold the offender accountable, and did not respect the safety issues involved in shelter and housing. Without accountability and safety, women would be reluctant to report abuse. Barriers to disclosure discussed by key informants were consistent with findings from the literature review.

Cultural barriers particular to Whatcom County were emphasized for Hispanic, Native American, and a local Russian community. As one respondent noted, "This community has gaps when it comes to providing culturally competent services." Another added, "Bellingham is a remote community. Providing culturally competent services for all of the diverse populations is probably not realistic and sending women out of the community for appropriate services is not possible."

The key informant interviews were followed by two focus groups of domestic violence victims. These were conducted to inform the survey process, as well as the nature of the survey, itself. In light of cultural issues raised in the key informant interviews and by committee members, efforts were made to include minority participants. Two Native American women and one African American woman participated.

Women in the groups reported it was critical for providers to ask about domestic violence. Furthermore, a provider's response to initial disclosure was very important to further disclosure. Information about DV and services was considered useful. Being judged or told what to do was not useful, according to group participants.

Participants suggested the survey be direct, personally introduced, and include resource information. Several participants were unenthusiastic about the presentation of a survey in a medical office waiting room and recommended women be allowed to take the survey with them and return it by mail. They were concerned with privacy and felt that many victims would decline to participate in this environment.

Development of the survey was guided by a review of the literature, key informant interviews, victim focus groups, and input from the *Ad Hoc* Survey Project Committee of the Bellingham-Whatcom County Commission Against Domestic Violence. The survey was comprised of several demographic items, an assessment section designed to identify which respondents had experienced domestic abuse within the past three years, and two checklists of feelings and experiences that would 1) discourage a woman from revealing abuse to a provider and 2) encourage her to disclose.

The survey was piloted with domestic violence professionals and focus group participants for feedback on readability, understandability, item inclusion, and tone. Minor changes were made to reflect the feedback. In light of cultural and language issues raised in the key informant interviews and by the *Ad Hoc* Committee, a Spanish version of the survey was added. The Spanish translation was reviewed for appropriateness by several Spanish speaking social service and DV providers.

Survey Procedures

The *Ad Hoc* Committee decided to distribute the survey through the offices of healthcare providers and a limited number of social service providers around Bellingham and Whatcom County. Efforts were made to include sites that serve a variety of income and ethnic groups within the county. The committee could think of no way to identify sites for Russian immigrants and a Russian translation of the survey was determined to be impractical.

A site coordinator was identified at each of twenty-seven sites that agreed to participate. Sites were encouraged to follow a similar procedure for introducing the survey. In light of focus group participants' concern for privacy, sites were encouraged to provide a private location for soliciting participation and completing the survey. Participation was completely voluntary. Women, ages 18 and over, were approached by clinic staff in a confidential manner and asked if they would be willing to complete a women's survey. The survey was enclosed in a plain manila envelope, along with a domestic violence resource information card. Participants were asked to place the envelope with the enclosed survey, completed or not, in a designated box, conveniently and discretely located on their way out of the clinic. The *Ad Hoc* Committee decided to not permit women to take the survey home for security reasons and because of the very small likelihood of return.

Data collection began in September 2001 and was completed by January 2002. Not all sites began at the same time, and surveys were completed for a maximum of six weeks at any given site. Surveys were collected weekly from sites by committee members and sent to NWRA in Seattle, where they were entered into a database. Surveys with limited information were excluded from the analysis.

The Women's Survey

The Women's Survey (Appendix B) included four sections. The first section consisted of demographic variables describing the respondents. The second section was a series of items used to assess whether a woman had been the victim of domestic abuse within the past three years.

Assessment of current abuse. Rather than depend on self-identification of abuse, all women surveyed were asked to respond to a list of behaviors and feelings they may have experienced with an intimate partner. This section consisted of a list of items adapted from two instruments found in the literature, the Conflict Tactics Scale—Revised (Straus, *et al*, 1996), and the Psychological Maltreatment of Women Inventory (Tolman, 1989.) Additional items addressing emotional abuse not covered in either instrument were also included. Women were asked to rate the frequency of each item on the following scale:

- 1 Never
- 2 Very rarely (1-3 times)
- 3 Sometimes (monthly)
- 4 Frequently (weekly)

To determine a subset of survey respondents who have experienced domestic violence within the past three years, an algorithm was developed to score participants' responses to the list of intimate partner behaviors. This algorithm was driven by a definition of domestic abuse identified in consultation with the *Ad Hoc* Committee, all of whom are local experts in domestic abuse. (See Appendix C for the algorithm.) Each intimate partner behavior and level of frequency was reviewed for its abuse potential and assigned a score of 0 – 9. Each of the behaviors and their frequency ratings were assigned values to connote how fully that behavior would contribute to a pattern of domestic abuse. A total score of five or more was chosen as the criteria for the Current Abuse group and scores were assigned with that criterion in mind. If a given behavior was considered to qualify a respondent for domestic abuse, even if it occurred once in the last three years, that behavior was assigned a minimum value of 5. For example, the item “My partner pushed, shoved, grabbed, slapped, or choked me” marked “Very rarely” was assigned 5 points. The most violent behaviors rated as occurring the most frequently were assigned the highest values. For example, the item above was assigned 9 points if it was marked as occurring “Frequently.”

The commission was also interested in the responses of women who reported domestic abuse prior to the past three years and an item asking this question was included in the survey. Respondents' abuse scores were calculated and respondents were assigned to either a Current Abuse, Past Abuse, or No Abuse group. If a woman met criteria for the Current Abuse group and also reported previous abuse, she was retained in the Current Abuse category.

Factors that Discourage Disclosure. The third section consisted of a checklist of factors that might discourage a woman from revealing abuse to a provider. All participants were asked to review the list and check those items that had discouraged them, or would discourage them, from disclosing abuse to a provider, regardless of whether or not they thought they had been the victims of abuse. Space was provided for additional responses. If a woman checked at least one item in this section, she was considered to have completed the section. If all the items in this section of the survey were left unchecked, the section was considered invalid and unchecked items were not included in calculation of percentages.

Factors that Encourage Disclosure. In the fourth section, the respondent was asked to review a list of reasons a woman might be encouraged to disclose abuse to a provider, and to check those that would most encourage them to reveal domestic violence. All women were asked to complete this section regardless of whether or not they thought they had been the victims of abuse. Again, space was provided for a woman to write in an individual response. As above, if a woman checked at least one item she was

considered to have completed the section, and unchecked items were counted toward calculation of percentages.

Unique responses were reviewed. When a woman wrote in a reason that was very close to an item listed, the researchers verified to see if it was checked. If not, it was entered as checked.

Three final questions reviewed the respondents' experience of being asked about domestic violence by a provider. Respondents reported whether they had ever been asked about violence by a provider in Whatcom County, if the provider had responded in a helpful way, and if not, to describe her experience. Most of the quotes used to illustrate findings came from this last section.

Limitations

Results of the survey are limited by a number of factors inherent in its design. It is important to be mindful of these limitations when interpreting results. The survey represents the experiences, thoughts, and feelings of the adult women who responded. This was not a random sample of women in Whatcom County. Women's participation was solicited only at sites that agreed to be a part of the process, and only those women who agreed to participate, completed the survey. Both elements may influence the sample. The survey does not include the voices of other possible victims of domestic violence, such as those who cannot read English or Spanish, children, the elderly, males, or teens, who may have experienced violence in dating relationships.

The vast majority of sites were in the community of Bellingham. The extent to which rural inhabitants use services in the city, and consequently are represented in the sample, is unknown. While efforts were made to include sites that would generate a response from Native American, Hispanic, African-American, and Asian women, as well as White-Caucasian women, the survey process did not ensure a sample that was perfectly representative of Whatcom County census data.

The original objective was to survey victims of domestic abuse to better understand what discourages and what encourages disclosure of the abuse to a provider. Primary results are based on the responses of women who experienced domestic abuse within the past three years. The selection process for this Current Abuse group was developed to be inclusive of patterns of emotional abuse and control, as well as physical violence. Some may argue with this inclusive definition. The definition was chosen to highlight that domestic abuse is more than physical violence.

For all of the reasons above, one should be extremely cautious about identifying the percentage of surveyed women who met the Current Abuse criteria, as a rate of domestic violence prevalence in Whatcom County. The survey was not designed to assess prevalence, and comparison with prevalence data in the literature is problematic, based on definitions and sampling.

The lists of items that would discourage and/or encourage disclosure have limitations as well. Attempts were made to comprehensively review the literature for barriers to disclosure and factors that encourage disclosure of abuse, considered by others. Moreover, items were added from ideas generated in the key informant interviews, focus groups, and from *Ad Hoc* Committee members. However, one must consider that other possibilities exist, that were not included on the lists. While space was provided for individual responses to be added, in a survey like this one there is a bias for the respondent to be limited to the list presented.

Throughout this report women who have experienced abuse are termed “victims.” This in no way is meant to imply a static label. The term victim simply means that the individual has experienced domestic abuse in the past three years.

Results

A total of 1081 surveys from women age eighteen or over, with sufficiently completed responses, were collected and entered into a database. A number of surveys did not include responses to the assessment of abuse items, or included too few responses to be reliably classified. Consequently, these surveys were excluded from the analysis. If a respondent completed at least half of the assessment items, or if a respondent completed enough items to meet the criteria for current abuse, the survey was included. The resulting sample includes 1036 surveys.

Demographic Data

Important characteristics of the sample are reported in Tables 1-6. The ages of respondents are reported in Table 1. Compared to 2000 Census figures, the sample consisted of more women in their 20’s and 40’s than are represented in the population. On the other hand, older women were under-represented in the sample.

Table 1. Age

Age group	#	Valid %	2000 Census
18-19	40	04.2	03.9
20-29	260	27.2	20.9
30-39	187	19.6	18.2
40-49	231	24.2	20.7
50-59	169	17.7	15.1
60-69	55	05.8	08.8
70+	14	01.5	12.4
Missing information	80		
Total	1036	100%	100%

Respondents’ marital status is reported in Table 2. Half of the sample was currently married. Another quarter identified themselves as single. The rest of the sample was divided between “divorced” and “domestic partner.”

Table 2. Marital Status

Marital Status	#	Valid %
Married	515	50.9
Divorced	140	13.8
Single	260	25.7
Domestic Partner	95	09.4
Widow	2	00.2
Missing information	24	
Total	1036	100%

Data on the racial makeup of the sample are reported in Table 3. The sample was fairly representative of the racial balance from the Whatcom County 2000 Census. The sample had a relatively high percentage of Native Americans and was under representative of the Asian/Pacific Islander population in Whatcom County.

Table 3. Race

Race	#	Valid %	2000 Census
White/Caucasian	810	85.6	88.4
Black/ Af Am	5	00.5	0.7
Asian/Pac Isl	10	01.1	02.9
Other/mixed	53	05.6	05.2
Native American	68	07.2	02.8
Missing information	90		
Total	1036	100%	100%

The percentage of respondents identifying themselves as Hispanic, is reported in Table 4. The percentage of Hispanic respondents was consistent with the 2000 Census figures if one assumes that those women who did not answer this item are Non-Hispanic. A Spanish version of the survey was available. Fourteen women completed the Spanish version.

Table 4. Ethnicity

Ethnicity	#	Valid %	Total %	2000 Census
Hispanic/Latina	53	18.5	05.1	05.2
Non-Hispanic	233	81.5	22.5	94.8
Missing information	750		72.4	
Total	1036	100%	100%	100%

The sexual preference of survey respondents is reported in Table 6.

Table 6. Sexual Preference

Sexual Preference	#	Valid %
Heterosexual	823	94.7
Gay/Lesbian	28	03.2
Bi-sexual	18	02.1
Missing information	167	
Total	1036	100

Respondents were asked how long they had been a resident of Whatcom County. Results are reported in Table 7. The majority of participants did not answer this item, and no firm conclusions can be drawn about length of residency.

Table 7. Residency

Number years Whatcom County Residency	#	Valid %
<= 3 Years	60	20.3
4 – 9 Years	65	22.0
10 – 19 Years	66	22.4
20 – 29 Years	56	19.0
>= 30 Years	48	16.3
Missing information	741	
Total	1036	100%

Abuse Score/Abuse Group

Abuse scores were calculated based on the algorithmic conversions (Appendix C) of responses to the assessment items from the survey. Four hundred twenty-two of the respondents (40.7%) met the criteria for abuse within the past three years. Survey responses from this Current Abuse group form the core sample for understanding what discourages women from reporting or encourages women to report domestic abuse to a provider.

Comparison of the prevalence of abuse in this sample to other rates in the reviewed literature is not appropriate. Firstly, this survey was not designed to assess prevalence of domestic abuse in Whatcom County. Secondly, it would be fair to say that the criteria for abuse in this study have been set at a sensitive level. Other rates of domestic violence prevalence in the literature reviewed for this study (National Institute of Justice and Centers for Disease Control and Prevention, 1998) (Dearwater, Coben, Campbell, Nah, Glass, McLoughlin, and Bekemeier, 1998) are based on physical abuse only, and do not include emotional abuse.

Some of the respondents, who did not meet criteria for having experienced domestic abuse during the last three years, reported that they had previously been the victims of abusive behaviors from an intimate partner. This group is labeled the Past Abuse group and is based on self-identification. How the sample was categorized is reported in Table 8.

Table 8. Abuse Category

Abuse Grouping	#	%
No Abuse	481	46.4
Current Abuse	422	40.7
Past Abuse	133	12.8
Total	1036	100%

Results of the responses for the entire sample and a discussion of the differences in responses between groups are presented in Addendum 1. Respondents in the Current Abuse group were categorized into levels of severity based on their abuse scores. An analysis of responses by women at different levels of severity can be found in Addendum 2.

A number of demographic variables appear related to the abuse group. Age is related to abuse category. Young women in their teens, 20s and 30s have a higher likelihood of being in the Current Abuse category as compared to older women in the survey. Forty-two and a half percent (42.5%) of teens, 44.2% of twenty-year-olds, and 51.3% of thirty-year-olds are in the Current Abuse group, as compared to 17.4% of women over sixty ($X=40.4$, $p<.001$.) Women who are in their 40s and 50s are more likely to be in the Past Abuse category, 16.9% and 14.8% respectively.

Single and Divorced women are more likely to be in the Current Abuse group (46.9% and 60.0% respectively) than are Married women (31.7%.) ($X=68.4$, $p<.001$.)

Of participants identifying ethnicity (Hispanic vs Non-Hispanic), no significant differences in abuse groups were found. No significant differences were found for sexual preference or for length of residency in Whatcom County.

Reasons women are discouraged from disclosing abuse to a provider

A total of 664 women completed this section of the survey. Of the women completing this section, 364 met criteria for the Current Abuse group.

The reasons survey participants in the Current Abuse group gave for not talking to a service provider about domestic violence are reported in Table 9. The most frequently checked reasons are listed first.

Many of the most frequently identified barriers to disclosing abuse appear to involve attitudes that victims hold about themselves and their abuse. In fact, four of the top five

barriers to disclosure center on a woman's feelings, attitudes, and understanding of domestic violence.

Table 9. Percentage Identifying Item as Reason **Discouraged** to Disclose

%	<i>Reason to not disclose abuse to provider</i>
66.8	I thought I could manage by myself
52.2	I was too embarrassed
46.2	I wasn't sure what I experienced was abuse
41.2	I felt too guilty for allowing it to happen
39.0	I was afraid it would get back to my partner and he/she would be angry again
30.2	My partner drinks, and this only happens when he/she drinks too much
30.2	I do not have any money to get away
29.9	I was afraid they would think less of my partner
29.4	It is a private matter between husband and wife
29.4	I was afraid it would get back to my partner and he/she would be more violent
28.6	I did not go to see the provider for that problem
27.2	I was afraid the provider would call the police
25.0	I do not have anywhere else to go and have to live with my partner
23.1	I was afraid someone would take my children away from me
22.9	I was afraid someone would try to make me leave my partner
17.0	I did not think the provider would understand
16.8	I was afraid the provider would blame me
15.1	I thought this was just the way it is between partners and I needed to accept it
12.6	I thought the provider did not really want to know
12.4	I was afraid the provider would refer me to a psychiatrist
11.5	I was afraid the provider would be disgusted with me
11.0	I thought the provider would not believe me
10.4	I did not think the provider would know what to do
07.4	I thought the provider was too busy
04.7	I am from a different race, culture, or country and did not think my beliefs and values would be understood
04.4	I live way out in the county and help is not available
02.2	I am in this country undocumented and do not want anyone to investigate
01.6	I do not speak English well enough to explain
N=364	Current Abuse Group

More than two-thirds of the women who have experienced domestic abuse in the past three years do not disclose this to a provider because they believe they can manage best by themselves. This is by far the most common reason a woman is discouraged from disclosing domestic violence.

The second most frequently checked barrier to disclosure is the woman's feeling of embarrassment. More than half the respondents who met the criteria for abuse in the last three years report their own feelings of humiliation prevent them from telling a provider. In a similar vein, more than forty percent say they would not tell a provider because they themselves feel guilty for allowing the abuse to occur (the fourth most frequently checked item.) Embarrassment and guilt felt by the victim were highly correlated with one another (Pearson $r=.48$, $p=.01$) in this group of respondents.

The third most frequently checked item discouraging a woman from disclosing is not being sure what she experienced was abuse. This result suggests considerable reluctance by respondents to discuss domestic violence with a provider because they are unsure what actually constitutes abusive behavior on the part of their domestic partner. As one woman wrote on her survey, “ He didn’t hurt me physically—it was mostly emotional. I thought abuse was only broken bones.” Another woman wrote, “He was out of the house 9 months before I became knowledgeable of the mental and verbal abuse happening to me!” If a woman were to tell a provider she felt victimized, she may well be concerned that the provider would not agree with her definition and dismiss the concern. One woman’s experience illustrates, “A psychologist I’d agreed to talk with about how to deal with unwanted sexual demands seemed to disbelieve that could possibly be a problem.”

The fifth most commonly checked barrier to disclosure touches on an issue that relates to provider responses. Forty percent of respondents are reluctant to disclose abuse because they are afraid it will get back to their partner and they will have to face the partner’s anger again. Almost thirty percent are concerned about further violence if their disclosure gets back to their partner. These items were closely correlated with one another (Pearson $r = .65$, $p > .01$.) Concerns of what the provider will do with the information are seen in several other items on the survey, as well.

Five items that were endorsed more than twenty percent of the time involve concerns about who will find out about the abuse, and what they will try to do about it. In addition to many women reporting reluctance to talk for fear of their partners finding out, women noted fear that the provider would involve the police (checked in 27.2% of the surveys), fear that it would lead to having their children taken away (23.1% of surveys), and fear that someone would try to make them leave their partner (22.9% of surveys.) Also, a number of the individual, write-in barriers were about the negative consequences of telling. Many women in the survey seem afraid of losing more control of their lives if they were to reveal abuse. This fear inhibits them from telling professionals. As one woman put it, “I did not want a service provider to cause problems for myself and children when trying to help.”

Women are not only concerned with what will happen to the information they disclose, but also raise questions generally about privacy. Almost one-third of the respondents considers the nature of their domestic relationship to be a private matter and would not disclose it to a professional. We can speculate that this concern for privacy may be related to the strong feelings of embarrassment and guilt that violence is occurring in their most intimate relationship. We know from the focus group members that a non-judgmental response from providers is extremely important to victims and a number of respondents reported reluctance to disclose abuse for fear of judgment. Nearly thirty percent (29.4%) of respondents were afraid their provider would think less of the partner. Some (16.8%) of the respondents were reluctant to disclose abuse for fear of being blamed. Some (11.5%) feared their provider would be disgusted with them. Still others feared being referred to a psychiatrist (12.4%.)

A number of items checked by approximately thirty percent of the sample center on additional beliefs of the victim. Many women are discouraged from talking because they appear to identify alcohol as the problem, rather than the abuse (30.2%.) Next, a fair percentage of the respondents seem to perceive a connection between disclosure and a lack of resources to leave an abusive partner. Thirty percent checked that they did not have enough money to get away, and twenty-five percent checked that they had nowhere else to go as reasons not to disclose abuse. Six women wrote in a response that indicated she did not tell a provider because she did not know what her options were. Perhaps they perceive that disclosure will lead to separation. By not disclosing for these reasons, a woman misses the opportunity to learn of options and community supports that the provider might suggest.

Reasons women are encouraged to disclose abuse to a provider

A total of 674 women completed this section of the survey. Three hundred fourteen (314) of these women met criteria for the Current Abuse group.

The list of reasons a woman was encouraged, or would be encouraged, to tell a provider about abuse is reported in Table 10. Items are reported in the order of greatest frequency.

Table 10. Percentage Identifying Item as Reason **Encouraged** to Disclose

%	<i>Reason encouraged to disclose abuse to provider</i>
58.0	The provider took time to listen
53.5	I was simply ready to tell someone
51.6	I was concerned for the safety of my children
50.6	The provider was a woman
50.0	I was in crisis and didn't know what else to do
46.5	The provider asked me questions in a caring manner
45.2	The provider reassured me it was not my fault
42.4	The provider reassured me that I could decide what I wanted to do next
38.9	Someone close to me convinced me I should tell a professional
37.9	Office staff was friendly and personable
37.7	The provider seemed like he/she knew what to do about it
37.3	The provider asked me what I needed
36.3	The provider asked about how an injury occurred
34.7	The provider asked about abuse by a partner
32.5	I felt the provider would believe me
31.5	I thought I <u>should</u> tell a professional
28.1	The provider seemed like he/she really wanted to know
19.5	Information available in the office led me to think it safe
19.4	<ul style="list-style-type: none"> • domestic violence resource information
10.8	<ul style="list-style-type: none"> • brochures/cards
10.5	<ul style="list-style-type: none"> • posters/pictures
N=314 Current Abuse Group	

The most frequently checked item was “The provider took time to listen.” Fifty-eight percent of the respondents checked this item. How the provider listens and interacts with the victim is important to many of the women completing the survey, as well. Almost half (46.5%) noted they were, or would be, encouraged to disclose abuse because the provider asked questions in a caring manner. Disclosure of abuse is not a single act, but the unfolding of a story that is revealed gradually depending on the response of the listener (Gerbert, *et al*, 1999.)

Being asked about how an injury occurred (36.3%) and about abuse by a partner (34.7%) were important to about one third of the participants; however, it is taking the time to listen and the manner of questioning that seems important to more women.

Moreover, there are a number of things that professionals can do or say when discussing domestic violence to encourage a woman to disclose. Forty-five percent of the women who responded were encouraged by a provider reassuring them the violence was not their fault. Forty-two percent appreciated the provider reassuring them that they could decide what to do next. Thirty-eight percent of the respondents were reassured that their provider seemed to know what to do about the problem. A similar percentage of women (37.9%) were encouraged to disclose abuse because they felt that the medical office staff was friendly and personable. In other words, even the general atmosphere of a professional office can encourage a woman to reveal domestic violence. Nearly one-third of respondents (32.5%) were encouraged by the intangible sense that the provider would believe them and the feeling the provider really wanted to know (28.1%.) These beliefs or feelings are likely reinforced by many of the caring responses mentioned above. Finally, the most common individual, write-in response was that the provider assured them of confidentiality.

Providing information on domestic violence in the office waiting room encouraged some women to disclose their abuse, but only a relatively small percentage of women thought this was important to them. Resource information on domestic violence was twice as likely to encourage a woman to disclose abuse to a provider, as were general posters or brochures.

In addition to provider behaviors, many of the items that encourage a woman to disclose violence have more to do with the attitudes, beliefs, and circumstances of the woman than actions by a provider. The second most frequently checked item on this list was that the woman was simply ready to tell someone (53.5% of surveys.) A similar item, “I was in crisis and didn’t know what else to do” was also checked by fifty percent of the respondents. Half the respondents report that their own internal process is very important in their decision to disclose the abuse. Nearly forty percent (38.9%) of the respondents indicated that they had been influenced to tell a professional by someone close to them.

Finally, the sex of the provider appears to have an impact on a woman disclosing abuse. Half (50.6%) of the respondents checked that the provider being female was a factor encouraging them to disclose.

Frequency with which providers in Whatcom County ask about abuse

Less than one in four (22.5%, N=815) of all respondents report having ever been asked about domestic violence by a Whatcom County provider. The percentage of Native American respondents who report being asked is significantly higher (45.0%, $X=19.1, p<.001$). Analysis of the sites from which respondents came, indicates this is likely the result of sites serving Native Americans being more likely to ask. No other ethnic differences were found.

Women were asked about the response they received when they did talk to a provider about domestic violence. A large majority, 78.9% (N=317) report that the provider responded in a helpful manner.

Of the 20% getting an unsatisfactory response, participants were asked to comment. The most common response was for a woman to say she had never told any professional. While the survey did not ask women directly if they had ever disclosed domestic abuse, this suggests that a fair number of respondents have not. Several respondents simply commented that they had never been asked about domestic violence.

When explaining unhelpful responses by providers, several women reported the problem was passivity. For example, women cited an uncaring manner, lack of belief, and being told she should try to get help. One woman reported her doctor offered an anti-depressant to help her cope. In other words, a number of providers were either non-supportive or ineffectual in their response. Other respondents cited more active problems. One respondent felt the provider wanted to enforce his/her beliefs on her, and another felt the provider made her feel even more embarrassed and ashamed. One woman wrote, "A counselor for marital disputes concluded I contributed to and justifiably received anger from him. She told me I couldn't live with him 'if I hated him,' which I never indicated in any way I did!"

Discussion

Respondents who have experienced abuse in their domestic relationships during the past three years identified some of the factors that influence their willingness to disclose the abuse to a provider. What women identify as the barriers to disclosure, and what factors encourage them to disclose, raise a number of issues. Many of these issues shed light on how to enhance the communication between victims and service providers as they address the problem of domestic violence. Some of the factors that most often discourage a woman from talking to a provider are internal to her beliefs and feelings about her experience, while other factors speak more directly to how the provider interacts with a victim. Still other factors suggest that there is much the community can do to increase information and education on what constitutes domestic abuse.

The number one reason cited by women for not talking to a service provider about violence they experienced is the belief that they thought they could manage by themselves. There is a strongly held desire to keep this experience to themselves. Two-thirds of the women responding felt they would cope with the abuse best on their own. This is consistent with findings from the National Crime Victimization Survey (Backman and Saltzman, 1994.) Nearly a third of respondents in this survey feel that abuse is a private matter in the relationship between intimate partners and this would discourage them from revealing it. They seem to consider it to be no one else's business.

One element in the desire to keep the abuse private may be found in a group of items that women frequently noted as important barriers. These items involve confidentiality and what the provider will do with information the woman reveals. A fair percentage of the respondents indicated they would be afraid their disclosure would get back to their partner and that the partner would again be angry or violent. Nearly one-third of the women feared that the police would be called, and still others were afraid it would lead to having their children taken away. Women seem to be inhibited by what they fear are the consequences of others finding out about the violence. Consequently, they believe it is safest to manage by themselves. We know from experience that many victims have been threatened by their abuser with more violence if they were to tell anyone. On the list of things that encourage a woman to talk, having a provider reassure her that she could decide what to do about the situation would encourage more than 40% of the women to reveal the abuse. Women want to retain control over their lives. Abuse and violence to a victim is about being controlled. If a provider takes away control by unnecessarily calling the police, attempting to confront the abuser, or in some other manner forcing actions without safety considerations for the woman, the provider can unwittingly become a part of the cycle.

Agencies and providers have different policies and practices around confidentiality and mandatory reporting of domestic violence. Professional organizations may have their own ethical guidelines. This study indicates that victims of domestic violence are very concerned about what will happen to information once they disclose their victimization. In fact, this concern keeps many victims from disclosing. In light of this finding, providers should make a point to inform victims about confidentiality practices and include the victim as much as possible in any steps that might involve mandatory reporting.

Two of the five most frequently endorsed barriers to disclosure involve very powerful feelings of victimization and provide another incentive for keeping the violence private. Women do not tell because they are embarrassed by their experience and feel guilty for allowing it to happen. They are ashamed by what is happening to them and do not want anyone else to know. Perpetrators often use these feelings to keep the subject taboo outside the family, maintain control, and perpetuate the cycle of violence.

Embarrassment and shame appear to become increasingly powerful as the abuse intensifies. The most severely abused women in this sample endorsed these items at

the highest rate (Addendum 2.) While relatively few of the sample endorsed items about fear, blame or disgust by a provider, many women blame themselves for the abuse. Harsh judgment by a provider is unlikely to facilitate anything positive. On the other hand, half of the sample endorsed a provider asking questions in a caring manner and being reassured the violence was not their fault as important behaviors that would encourage them to reveal their plight. Victims benefit from having their shameful feelings acknowledged and are reassured that the true responsibility for the violence is the perpetrator's. Victims have complex, confusing, and often ambivalent feelings. They respond best to sensitive understanding. One respondent summed it up nicely, "It's easy to accept horrible things when you think you are loved by him. I wouldn't tell someone who didn't seem sincerely nurturing."

A victim's feeling of guilt for allowing the abuse to happen is only one barrier to disclosure where the responsibility for the violence is misplaced. Nearly one-third of the sample indicated they would not talk to a provider about violence because it only happened when their partner drank alcohol. Many women in the study seem to believe that alcohol mitigates responsibility for the violence. It is a belief that inhibits disclosure and interferes with understanding the dynamics of abuse.

A woman's beliefs, understanding, and circumstances influence her readiness to discuss the abuse in her life. Many women in this study were not sure if what they experienced was abuse. Nearly half of the women identified as abused endorsed this item. One might argue that the threshold for abuse was set low and women experiencing lower levels of abuse might be less clear; however, nearly two-thirds (60.2%) of the most severely abused women endorsed this item. This is an important barrier to disclosure not reported elsewhere, most likely because no other study has addressed this question.

Some have argued that identifying oneself as a victim is a dynamic process of stages (Mills, 1985.) The second most commonly endorsed item encouraging disclosure was, "I was simply ready to tell someone." Closely following was, "I was in a crisis and didn't know what else to do." In short, a woman must first identify herself as a victim. Still, she may not be ready to talk.

On the other hand, there appears to be an interplay between providers' recognition of violence and abuse, and a woman's self-identification as a victim (Gerber, *et al*,1999.) In other words, how providers talk about domestic violence is very important to a woman recognizing that she is a victim and revealing her experience. Women in this survey identified a number of things a provider can do to facilitate her disclosure. Providers can take time to listen, ask questions in a caring manner, reassure the woman it is not her fault, give her the control to decide what to do next, and ask her what she needs. Of course, all of these things are predicated on discussing domestic violence in the first place, and this survey seems to indicate providers cannot assume a woman will initiate the subject.

Women in this survey, like women in other studies reviewed (Friedman, *et al*, 1992; Hamberger, *et al*, 1992; and Hamberger, *et al*, 1998) report that their healthcare providers have not frequently asked them about domestic violence. Fewer than one in four respondents have been asked about abuse by a Whatcom County provider. If providers are not asking, and women are reluctant to disclose for many of the reasons above, domestic violence remains hidden and likely continues.

Recommendations for providers

The findings of this survey indicate that the most powerful barriers to disclosing domestic violence are beliefs and feelings that victims hold about themselves and their abuse. Many victims do not identify themselves as victims. They feel responsible for the violence, or they minimize the pattern of control. They believe they can manage it by themselves and fear consequences of disclosure. They disclose when the timing is right for them, and when they feel heard and supported. Coming to the realization that they are victims is an unfolding process that can be facilitated with good information and sensitive understanding by professionals.

Results of this survey suggest a number of things that a provider can do to reduce the barriers to disclosure and provide support to a victim of domestic violence. Providers may want to develop policies and practices in response to domestic violence that include the following suggestions.

- Routinely ask about domestic relationships and violence. Discuss domestic violence directly. A few examples of ways to initiate the topic are:

“I don’t know if this is happening in your life, but many people I see are dealing with abusive relationships. Some are too afraid or uncomfortable to bring it up themselves, so I have started to ask about it routinely.”

“Because so many people we see are involved with a partner who hits them, threatens them, continually puts them down, or tries to control them, I now ask everyone about abuse in relationships.”

“Do you ever feel afraid of your partner? Ever feel you are in danger?”

“Are you in a relationship with someone who physically hurts or threatens you?”

- If you suspect someone is a victim and they deny it, talk as if it were still a possibility:
 - Talk about the common feelings of embarrassment, guilt, and shame.
 - Offer a definition of abuse that includes emotional abuse.
 - Reassure the individual that it is not her/his fault, and you are not there to judge or blame anyone.

- Tell them what you will do with the information if they were to disclose domestic violence.
 - Reassure the individual that he/she will decide what to do next.
 - Indicate you have resources for them if anything changes.
 - Let them know that domestic violence is a complex problem. Suggest that it is difficult to handle alone. Let them know there are specialized resources, support and information in the community to help.
- If a victim begins to reveal abuse, listen. It is likely just the tip of the iceberg. Consider the time spent listening as prevention work.
 - Acknowledge embarrassment, guilt, and fears. Identifying common feelings that a woman may hesitate to express indicates you know and understand domestic violence. Let them know they are not alone.
 - Ask questions in a caring manner.
 - Avoid judgment or simple conclusions. There are many reasons a victim remains in an abusive situation and many reasons a victim leaves. Recognize the limits of the victim's resources. Dealing with the effects of domestic violence is complex and resolution may be a long process.
 - Explain your policies on confidentiality and mandatory reporting. Give the victim control over what will happen next. When reporting of violence is mandatory, it is valuable to include the victim in the process.
 - Learn about domestic violence and the services in your community.
 - Offer specific domestic violence resources appropriate to the victim.
 - Keep domestic violence resource cards and information in areas where victims can access them confidentially.
 - Safety for victims should always be a first priority.

Appendix A

2001 Community Survey Project Literature Review

INTRODUCTION

The Whatcom County Domestic Violence Comprehensive Plan, completed by the Bellingham-Whatcom County Commission Against Domestic Violence in June 2000, identified the need for increased knowledge about experiences of victims and survivors of domestic violence as they interface with Whatcom County community and health care providers. To that end, a series of key informant interviews, focus groups, and a community survey of women's experience with service providers was planned. The first step in that process was a review of the literature on similar projects and pertinent issues.

PROBLEM

Information about how victims/survivors of domestic violence experience the support of the service system comes primarily from providers themselves. The Commission wants to hear directly from victims about their experiences, fears, and barriers to disclosure. Most specifically, they are interested in the perspective of victims, as they interface with service providers. The long range goal is to build and improve practices, responses, services, and professional training.

This literature review was conducted to inform the project of barriers to disclosure and service that have previously been reported by others. Furthermore, the literature was surveyed to investigate models of similar studies that can inform the development of this project.

REVIEW PROCESS

This review began with a search of internet resource sites for domestic violence services. References to studies and projects similar to the current endeavor, barriers to services, and issues of diversity were read. Additional references were gleaned from these reports. Studies related to barriers to disclosure and surveying victims of domestic violence were the highest priority. The internet search was supplemented by a review of PsychINFO citations back to 1998. Additional citations were suggested by Christina Byrne, Ph.D., Western Washington University, psychology department faculty and *Ad Hoc* Survey Project Committee member.

All journal articles, reports, and abstracts were reviewed for relevance. Much of the literature concerns the prevalence of domestic violence, use of shelter services, and healthcare provider knowledge of abuse. Many more sources were consulted than appear as references in this document.

BARRIERS TO DISCLOSURE OF DOMESTIC VIOLENCE

The literature reviewed emphasized studies that sought the voices of domestic violence victims reporting their feelings and experiences. The literature reports a number of individual and psychological factors that impact disclosure of and seeking service for domestic violence. Some (Mills, 1985) have argued that identifying oneself as a victim is a dynamic process of stages. Re-evaluating a partner's behavior as abusive and identifying oneself as a victim are the last stages. Only when one self-identifies as a victim, can one consider disclosing the abuse to a service provider.

Data from the National Crime Victimization Survey (Backman and Saltzman, 1994) suggest that barriers to disclosure include the private nature of the event, a perceived stigma associated with victimization, and a belief that no purpose will be served by reporting.

In a study of focus group participants Rodriguez, Quiroga, and Bauer (1996) report barriers to disclosure include 1) fear of escalating violence or death caused by the perpetrator; 2) psychological vulnerability factors such as low self-esteem, shame, embarrassment, felt responsibility for the abuse, and guilt for staying in the relationship; 3) fulfillment of family responsibilities, such as protection of children and keeping the family together; 4) economic and accessibility barriers to healthcare services; 5) fear of police involvement and mandatory reporting.

In a number of studies of disclosure to medical practitioners, a common reason for not disclosing is the belief by victims that the doctors were too busy, did not understand domestic violence, or did not know what to do with the information (Rodriguez *et al*, 1996; Caralis and Musialowski, 1997). Hamberger, his associates (Hamberger, Saunders, and Hovey, 1992; Hamberger, Ambuel, Marbella, and Donze, 1998) and others (Friedman, Samet, Roberts, Hudlin, and Hans, 1992) have found victims report their physicians tend not to ask directly about abuse or how an injury occurred. Nor do they refer them effectively to community resources. A study of physicians, themselves, (Sugg and Inui, 1992) supports this experience of victims by reporting that physicians tend not to ask about violence to avoid opening a "Pandora's Box" of identification with victims, fear of offending, a sense of powerlessness, and the deterrence of time constraints to adequately respond to the problem.

There is good evidence that women respond more completely to being asked personally about abuse, in contrast to responding to a questionnaire from the healthcare provider. McFarlane, Christoffel, Bateman, Miller, and Bullock (1991) report a four-fold increase in incidence of physical abuse as reported in a nurse interview (29.3%), over the incidence reported in a questionnaire (7.3%).

Conversely to studies reporting the negatives of healthcare interactions, several studies of victims identify what they appreciate from their physicians that facilitate disclosure of domestic violence. These include direct asking about family violence (Friedman *et al*, 1992), compassionate emotional support, follow-up link to domestic violence resources

(Rodriguez *et al*, 1996), sensitive examination of injuries, and supportive literature in the office (Hamberger *et al*, 1998.)

Furthermore, there is some evidence that disclosure is not simply a matter of the specific conditions directly leading to the revelation of abuse. In an analysis of semi-structured interviews with victims, Gerbert, Abercrombie, Caspers, Love, and Bronstone (1999) propose a complicated interplay of identification of violence by health care providers and disclosure by victims. Indirect or tacit identification of the violence seems to provide a validation of experience that sets in motion the process of self-identification as a victim that may not materialize immediately. The authors suggest that providers assume the patient is battered, acknowledge that abuse is wrong, and offer support to the patient.

CULTURAL BARRIERS

The *Ad Hoc* Survey Committee to the Bellingham-Whatcom County Commission Against Domestic Violence identified several ethnic cultural groups as having significant presence in Whatcom County. The largest ethnic group in Whatcom County is the Latina population. The Native-American population, specifically members of the Lummi Nation, and Asian Americans persons were identified as comprising the second largest portion of the cultural diversity in the community. The committee also identified rural residents and a Russian immigrant population as other sizeable elements in the diversity of the community. African-American persons in Whatcom County are relatively few in number.

Several issues affecting ethnic populations and domestic violence are evident in the literature reviewed. Chief among these are isolation, the degree of acculturation, and the role that male domination plays in the culture of origin. All play a role in establishing barriers to disclosure of violence to healthcare and other providers.

Both geographic and social isolation play an important role in inhibiting disclosure and seeking services. Rural populations with limited transportation resources are extremely limited in their ability to access multiple services (Gagne, 1992; Gondolf, Fisher, and McFerron, 1988; West, Cantor, and Jasinski, 1998). Social isolation is experienced by immigrants as they struggle to live in a different culture (Tran and Des-Jardins, 2000; Jasinski, 1998). If an individual has undocumented status, this further exacerbates the social isolation and decreased likelihood of disclosing violence (Gondolf *et al* 1988; Van Hightower and Gorton, 1998).

Social isolation is related to the concept of acculturation, or the degree to which an immigrant has adopted the cultural norms of another culture. Limited facility with the English language, continued cultural constraints against self-disclosure, family traditions, and degree of acceptance of violence against women all impact Asian-American women's (Thomas, 2000) and Hispanic women's (Van Hightower *et al*, 1998; Torres, 1991; Gondolf *et al*, 1988) identification of violence as unacceptable in the first place. Subsequently, limited acculturation appears to inhibit disclosure and access to services (West, Kantor, and Jasinski, 1998). On the other hand, Jasinski (1998) argues

that acculturation for Latinos breaks down their own cultural values, such as familism, that inhibit domestic violence. Consequently, acculturation increases the likelihood of violence within the family and decreases the likelihood of seeking service. Furthermore, Latinos appear to be particularly impacted by poverty (Gondolf *et al*, 1988; Van Hightower *et al*, 1998), increasing the life stressors and decreasing access to service providers.

Male domination plays a strong role in Latino culture (Jasinski, 1998; Torres, 1991), especially when compounded by alcohol use (Van Hightower, Gorton, ,DeMoss, 2000; West *et al*, 1998.) Patriarchal structure and a culture of control through violence has been documented in rural populations. Social control of women impacts disclosure by a restriction of resources (transportation and financial), increased burden through forced parenthood, and fear of violent recrimination (Gagne, 1992.)

The only study of Russian culture reviewed suggests that an extremely high rate of domestic violence in Russia is influenced by a history of institutional oppression of women (Horne, 1999.) The impact of male domination in Native-American populations is less clear, as some tribes practice matrilineal descent, which mitigates the power of males (Hamby, 2000.)

SURVEY CONSTRUCTION AND FORMAT

None of the studies reviewed matched exactly the purpose of the current project. The closest match is the study by Hamberger and associates (1998), in which victims were surveyed for the desirability of physician behaviors relative to domestic violence. This study and several others included measures of abuse that ranged from two questions (Caralis and Musialowski, 1997) to several instruments assessing multiple dimensions of abuse (McFarlane, Parker, Soeken, and Bullock, 1992).

Several instruments show promise to inform this project about making a determination of domestic violence among respondents. The Abuse Assessment Screen (AAS) (Parker and McFarlane, 1991) is a five item screening device for medical use. Its language in a couple of the items has been adopted in other studies for determining whether a woman has been abused. The AAS is brief; however, it includes questions about pregnancy and all items refer to physical or sexual abuse. Consequently, the whole instrument would not be appropriate for the planned design of the current project.

The Psychological Maltreatment of Women Inventory (PMWI) (Tolman, 1989) was developed as an adjunct to measures of physical abuse. Fifty-eight (58) items ask about psychologically abusive behaviors. The PMWI's length and focus on psychological abuse limit its use as a complete measure in this project; however, certain items may be useful in assessing whether respondents meet criteria for being a victim.

The Revised Conflict Tactics Scale (CTS2) (Straus, Hamby, Boney-McCoy, and Sugarman, 1996) is a revision of the widely used Conflict Tactics Scale (CTS.) Doubling the number of items, the CTS2 was expanded to measure psychological and sexual abuse, in addition to physical attacks in an intimate relationship. CTS2 includes

a variety of conflict responses. Although it is heavily weighted for abusive responses, it includes functional behaviors to manage conflict as well. This feature makes it more attractive for a survey of all women in a healthcare setting. The CTS2 maintains high standards of reliability and validity; however, its 39 item length may be problematic for this project.

Hamberger, *et al* (1998) provides a listing of desirable and undesirable physician behaviors in his Physician Assessment and Treatment of Abuse Inventory (PATAI.) Although the current project will be querying victim's interaction with a variety of social service providers, the PATAI provides some useful guidelines for evaluating provider behaviors that facilitate or inhibit disclosure.

The National Center for Injury Prevention and Control of the Centers for Disease Control and Prevention (CDC) has published uniform definitions and recommended data elements (Saltzman, Fanslow, McMahon, and Shelley, 1999.) This document contains useful definitions of intimate partners and four categories of violence: Physical Violence, Sexual Violence, Threat of Physical or Sexual Violence, and Psychological/Emotional Abuse.

SURVEY PROCESS

A large number of studies were reviewed which used victims as the primary data source, either by survey or interview. A number of issues are relevant to this project and to the plan for obtaining survey information from women as they present themselves to healthcare facilities.

A number of studies relied on approaching female patients over the age of 18 in a healthcare facility. Screening for abuse occurred in some studies (McFarlane, Soeken, Reel, Parker, and Silva, 1997) and all clinic patients were invited to participate in others (McFarlane *et al*, 1992; Hamberger *et al*, 1992; Friedman *et al*, 1992; Caralis *et al*, 1997.) Most of the reports ensured safety by not using the terms "abuse" or "domestic violence" in recruitment, or by doing screening in a private room without the male partner present (McFarlane *et al*, 1997.)

Voluntary participation and confidentiality are important assurances in studies of victim opinions and experiences. Participation for most studies was clearly voluntary and many relied on signed consent to participate (Hamberger *et al*, 1998) or assurance that participation was anonymous and the information would not be placed in the medical record (Caralis *et al*, 1997; Hamberger *et al*, 1992.) Confidentiality is an assurance made in virtually all of the studies of a victim's perspective.

A majority of the studies made a point of making domestic violence services available to participants. Some provided information on domestic violence, law enforcement and legal resources, shelter services, or counseling (McFarlane *et al*, 1992; McFarlane *et al*, 1991; Wagner, Mongan, Hamrick, Hendrick, 1995.) Other studies made provisions for counseling to be available to participants in distress (Friedman *et al*, 1992; Hamberger

et al, 1992; Hamberger *et al*, 1998.) or in combination with information on domestic violence services (Caralis *et al*, 1997.)

The language of study participants was an issue in several of the studies. Some studies restricted participation to English speaking women (Friedman *et al*, 1992; Hamberger *et al* 1992; Caralis *et al*, 1997), while others made provisions for a Spanish, as well as English, version of their instruments (McFarlane *et al*, 1997; McFarlane *et al*, 1992; McFarlane *et al*, 1991.)

Certain practical considerations were discussed in a report of a community satisfaction survey in Denver (Stark, 2000.) The return rate for this study was low. The author attributed this low rate to the length of the survey, a complicated survey format, and resistance to administer the survey by service providers. These findings reinforce the importance of keeping the survey brief and understandable. A number of studies and instruments reviewed reported that the readability of forms was kept to a sixth grade level. The Denver study author recommends, “mentoring” service providers throughout the survey process by meeting personally with agency staff and assisting with the implementation process.

SUMMARY NOTE

This literature review emphasized papers and studies that reported the victim’s perspective on disclosure of domestic violence, including factors that inhibit, as well as factors that facilitate, disclosure of abuse and subsequent seeking of services. Cultural diversity issues impacting disclosure and access to service were also reviewed. Finally, the literature was evaluated for instruments that may be useful and survey processes that can inform the current project.

This report should be considered as one stage in the ongoing process of developing the survey for the Whatcom County project. It should not be considered as a final product, but rather as the information reviewed to date in a dynamic process of project development. As other sources are brought to the attention of project staff, they may be incorporated into the final survey product.

REFERENCES

- Backman R., Saltzman L.E. (1994). Violence against women: A national crime victimization survey report. Bureau of Justice Statistics report. Wash DC: U.S. Department of Justice. (Publication no. NCJ-145325).
- Caralis P.V., Musialowski,R. (1997). Women's experiences with domestic violence and their attitudes and expectations regarding medical care of abuse victims. *Southern Medical Journal*, 90(11).
- Dearwater S.R., Coben J.H., Campbell J.C., Nah G., Glass N., McLoughlin E., and Bekemeier B. (1998). Prevalence of intimate partner abuse in women treated at community hospital emergency departments. *Journal of the American Medical Association*, 280: 433-438.
- Friedman L.S., Samet J.H., Roberts M.S., Hudlin M., Hans P. (1992), Inquiry about victimization experiences: survey of patient preferences. *Archive Internal Medicine*, 152: 1186-1190.
- Gagne P. (1992). Appalachian women: violence and social control. *Journal of Contemporary Ethnography*, 20(4): 387-415.
- Gerbert B., Abercrombie P., Caspers N., Love C., Bronstone A. (1999). How health care providers help battered women: the survivor's perspective. *Women & Health*, 29(3): 115-135.
- Gondolf E., Fisher E., McFerron R. (1988). Racial differences among shelter residents: a comparison of Anglo, Black, and Hispanic. *Journal of Family Violence*, 3(1): 39-51.
- Hamberger L.K., Ambuel B., Marbella A., Donze J. (1998). Physician interaction with battered women: the women's perspective. *Archives of Family Medicine*, 7: 575-582.
- Hamberger L.K., Saunders D.G., Hovey M. (1992). Prevalence of domestic violence in community practice and rate of physician inquiry. *Family Medicine*, 24: 382-387.
- Hamby S.L. (2000). The importance of community in a feminist analysis of domestic violence among American Indians. *American Journal of Community Psychology*, 28(5): 649-669.
- Horne S. (1999). Domestic violence in Russia. *American Psychologist*, 54(1): 55-61.
- Jasinski J. (1998). Role of acculturation in wife assault. *Hispanic Journal of Behavioral Sciences*, 20(2): 175-191.
- McFarlane J., Christoffel K., Bateman L., Miller V., Bullock L. (1991). Assessing for abuse: Self-report versus nurse interview. *Public Health Nursing*, 8(4): 245-250.

McFarlane J., Parker B., Soeken K., Bullock L. (1992). Assessing for abuse during pregnancy: severity and frequency of injuries and associated entry into prenatal care. *Journal of the American Medical Association*, 267(23): 3176-3178.

McFarlane J., Soeken K., Reel S., Parker B., Silva C. (1997). Resource use by abused women following an intervention program: associates severity of abuse and reports of abuse ending. *Public Health Nursing*, 14(4): 244-250.

Mills T. (1985). The assault on the self: stages in coping with battering husbands. *Qualitative Sociology*, 8(2): 103-123.

National Institute of Justice and Centers for Disease Control and Prevention. (1998). *Prevalence, Incidence, and Consequences of Violence Against Women: Findings from the National Violence Against Women Survey*. Washington, DC: National Institute of Justice and Centers for Disease Control and Prevention.

Parker B., McFarlane J. (1991). Nursing assessment of the battered pregnant woman. *The American Journal of Maternal Child Nursing*, 16(3): 161-164.

Rodriguez M.A., Bauer H.M., Flores-Ortiz Y., Szkupinski-Quiroga S. (1998). Factors affecting patient-physician communication for abused Latina and Asian immigrant women. *Journal of Family Practice*, 47(4): 309-311.

Saltzman L.E., Fanslow J.L., McMahon P.M., Shelley G.A. (1999). Intimate partner violence surveillance: uniform definitions and recommended data elements, Version 1.0. Atlanta, GA: National Center for Injury Prevention and Control, Centers for Disease Control and Prevention.

Rodriguez M.A., Quiroga S.S., Bauer H.M. (1996). Breaking the silence: battered women's perspectives on medical care. *Archives of Family Medicine*, 5: 153-158.

Stark E. (2000). Denver victim services 2000 needs assessment. *Office for Victims of Crime Bulletin*. October 2000.

Straus M.A., Hamby S.L., Boney-McCoy S., Sugarman D.B. (1996). The revised Conflict Tactics Scales (CTS2): development and preliminary psychometric data. *Journal of Family Issues*, 17(3): 283-316.

Sugg N.K., Inui T. (1992). Primary care physician's response to domestic violence: opening pandora's box. *Journal of the American Medical Association*, 267: 3157-3160.

Thomas E.K. (2000). Domestic violence in the African-American and Asian-American communities: comparative analysis of two racial/ethnic minority cultures and implications for mental health service provision for women of color. *Psychology: A Journal of Human Behavior*, 37(3-4): 32-43.

Tolman R.M. (1989). The development of a measure of psychological maltreatment of women by their male partners. *Violence and Victims*, 4(3): 159-177.

Torres S. (1991). A comparison of wife abuse between two cultures. Issues in mental health nursing. *Issues In Mental Health Nursing*, 12: 113-131.

Tran C.G., Des-Jardins K. (2000). Domestic violence in Vietnamese refugee and Korean immigrant communities. Chin J.L. (Ed.) *Relationship among Asian American women*. Washington DC: American Psychological Association. pp71-96.

Van Hightower N.R., Gorton J. (1998). Domestic violence among patients at two rural health care clinics. *Public Health Nursing*, 15(5): 355-362.

Van Hightower N.R., Gorton J., DeMoss C.L. (2000). Predictive models of domestic violence and fear of intimate partners among migrant and seasonal farm worker women. *Journal of Family Violence*, 15(2): 137-154.

Wagner P.J., Mongan P., Hamrick D., Hendrick L.K. (1995). Experience of abuse in primary care patients: racial and rural differences. *Archives of Family Medicine*, 4 (11): 956-962.

West C., Cantor G., Jasinski J. (1998). Sociodemographic predictors and cultural barriers to help-seeking behavior by Latina and Anglo battered women. *Violence and Victims*, 13(4): 1-15.

Appendix B

Women's Survey

Domestic violence is a serious problem in Whatcom County. We are interested in the thoughts and experiences of women regarding abuse by an intimate partner (current or former spouse, girlfriend, boyfriend or domestic partner). This survey is being conducted by the Bellingham-Whatcom County Commission Against Domestic Violence to learn about disclosure of abuse to a health care or service provider. ***Your participation is completely voluntary. If you proceed, your responses are anonymous. No one will be able to connect your answers to you.***

First, we would like some information about you. {OPTIONAL}

Marital status	Race	Ethnicity	Sexual Preference	Age ____ years
<input type="checkbox"/> Married	<input type="checkbox"/> White/Cauc	<input type="checkbox"/> Hispanic/Latina	<input type="checkbox"/> Heterosexual	
<input type="checkbox"/> Divorced	<input type="checkbox"/> Black/Af Am	<input type="checkbox"/> Non-Hispanic/Latina	<input type="checkbox"/> Gay/Lesbian	
<input type="checkbox"/> Single	<input type="checkbox"/> Asian/Pacific Is			
<input type="checkbox"/> Domestic Partner	<input type="checkbox"/> Other/Mixed			____ # years Whatcom County resident

Never
Very rarely (1-3 times)
Sometimes (monthly)
Frequently (weekly)

Please rate how frequently within the past three years you experienced these behaviors and feelings with an intimate partner (current or former spouse, girlfriend, boyfriend, or domestic partner).

Please circle a number for each item.

- 1 2 3 4..... During a conflict, my partner explained his/her side of a disagreement to me
- 1 2 3 4..... During a conflict, my partner showed respect for my feelings about an issue
- 1 2 3 4..... During a conflict, my partner agreed to a compromise
- 1 2 3 4..... My partner yelled, insulted, criticized or swore at me
- 1 2 3 4..... My partner stomped out of the room, house or yard during a disagreement
- 1 2 3 4..... I was frightened by my partner's temper
- 1 2 3 4..... I avoided seeing friends or family because of my partner
- 1 2 3 4..... My partner forced me to justify everything I did and everyone I saw
- 1 2 3 4..... My partner threatened to hit or throw something at me
- 1 2 3 4..... My partner destroyed things belonging to me
- 1 2 3 4..... My partner threatened to hurt himself or herself
- 1 2 3 4..... My partner threatened to, or took something away from me
(children, contact with family, transportation, telephone, or medical care)
- 1 2 3 4..... I was frightened by my partner's violence toward others
- 1 2 3 4..... My partner punched or hit me with something that could hurt
- 1 2 3 4..... My partner pushed, shoved, grabbed, slapped or choked me
- 1 2 3 4..... My partner insisted on, or forced sexual activity when, or in ways, I did not want
- 1 2 3 4..... My partner burned or scalded me on purpose
- 1 2 3 4..... My partner used a weapon on me

Have you experienced any of the abusive behaviors above from an intimate partner, *prior to three years ago*? ____Yes ____No

We want to know how comfortable women feel talking to service providers (social workers, counselors, medical professionals like a nurse, doctor, or physician assistant) about abuse they have experienced from an intimate partner. ***Even if you are not a victim, we want to hear from you.***

First, we want to know what discouraged or what would discourage you from talking to a service provider about domestic violence. Look at the list below and check every reason you *did not* or *would not* tell.

- ***If you have experienced domestic violence personally, please think about your experience in the most recent 3 years.***

I *did not* or *would not* tell a service provider about domestic violence because:

- | | |
|---|---|
| <ul style="list-style-type: none"><input type="checkbox"/> I wasn't sure what I experienced was abuse<input type="checkbox"/> I did not go to see the provider for that problem<input type="checkbox"/> I thought I could manage by myself<input type="checkbox"/> It is a private matter between husband and wife (partners)<input type="checkbox"/> I thought this was just the way it is between partners and I needed to accept it<input type="checkbox"/> My partner drinks, and this only happens when he/she drinks too much<input type="checkbox"/> I did not think the provider would understand<input type="checkbox"/> I did not think the provider would know what to do<input type="checkbox"/> I felt too guilty for allowing it to happen<input type="checkbox"/> I was afraid the provider would blame me<input type="checkbox"/> I was afraid it would get back to my partner and he/she would be angry again<input type="checkbox"/> I was afraid it would get back to my partner and he/she would be more violent<input type="checkbox"/> I was afraid the provider would call the police<input type="checkbox"/> I thought the provider was too busy<input type="checkbox"/> I thought the provider did not really want to know<input type="checkbox"/> I was afraid someone would take my children away from me | <ul style="list-style-type: none"><input type="checkbox"/> I was afraid someone would try to make me leave my partner<input type="checkbox"/> I do not speak English well enough to explain<input type="checkbox"/> I am from a different race, culture, or country and did not think my beliefs and values would be understood<input type="checkbox"/> I was afraid the provider would refer me to a psychiatrist<input type="checkbox"/> I was afraid the provider would be disgusted with me<input type="checkbox"/> I was too embarrassed<input type="checkbox"/> I thought the provider would not believe me<input type="checkbox"/> I live way out in the county and help is not available<input type="checkbox"/> I was afraid they would think less of my partner<input type="checkbox"/> I do not have anywhere else to go and have to live with my partner<input type="checkbox"/> I do not have any money to get away<input type="checkbox"/> I am in this country undocumented and do not want anyone to investigate
<input type="checkbox"/> Other _____

_____ |
|---|---|

➤ **Please turn over to page 3**

Next, we want to know what encouraged or would encourage you to talk to a service provider about domestic violence. Look at the list below and check every reason you did or would tell.

- ***Again, if you have experienced domestic violence personally, Please think about your experience in the most recent 3 years.***

I *did* or *would* tell a service provider about domestic violence because:

- | | |
|--|---|
| <input type="checkbox"/> The provider asked about how an injury occurred | <input type="checkbox"/> The provider asked about abuse by a partner |
| <input type="checkbox"/> I was in crisis and didn't know what else to do | <input type="checkbox"/> The provider took time to listen |
| <input type="checkbox"/> I was simply ready to tell someone | <input type="checkbox"/> The provider reassured me that I could decide what I wanted to do next |
| <input type="checkbox"/> I thought I <u>should</u> tell a professional | <input type="checkbox"/> The provider asked me what I needed |
| <input type="checkbox"/> The provider asked me questions in a caring manner | <input type="checkbox"/> The provider was a woman |
| <input type="checkbox"/> Someone close to me convinced me I should tell a professional | <input type="checkbox"/> Information available in the office led me to think it safe |
| <input type="checkbox"/> I was concerned for the safety of my children | <input type="checkbox"/> posters/pictures |
| <input type="checkbox"/> The provider seemed like he/she really wanted to know | <input type="checkbox"/> brochures/cards |
| <input type="checkbox"/> I felt the provider would believe me | <input type="checkbox"/> domestic violence resource information |
| <input type="checkbox"/> The provider seemed like he/she knew what to do about it | <input type="checkbox"/> Office staff was friendly and personable |
| <input type="checkbox"/> The provider reassured me it was not my fault | <input type="checkbox"/> Other _____ |
| | _____ |
| | _____ |

Has a service provider in Whatcom County ever asked you about domestic violence? _____ Yes _____ No

**When you did talk to a provider, did he/she respond in a helpful way?
_____ Yes _____ No**

If No, please explain briefly _____

Thank you for answering the questions on this survey!
**Please place the completed survey in the attached envelope,
seal and drop in the box provided.**

Appendix C

Algorithm Scores for Assessment Items

A total score of 5 or more is indicative of a pattern of abuse.

Never
Very rarely (1-3 times)
Sometimes (monthly)
Frequently (weekly)

Please rate how frequently within the past three years you experienced these behaviors and feelings with an intimate partner (current or former spouse, girlfriend, boyfriend, or domestic partner).

[The number represents the score assigned to each item for a given frequency of occurrence.]

- | | | | | | |
|---|---|---|---|-------|---|
| 0 | 0 | 0 | 0 | ..... | During a conflict, my partner explained his/her side of a disagreement to me |
| 0 | 0 | 0 | 0 | ..... | During a conflict, my partner showed respect for my feelings about an issue |
| 0 | 0 | 0 | 0 | ..... | During a conflict, my partner agreed to a compromise |
| 0 | 1 | 3 | 5 | ..... | My partner yelled, insulted, criticized or swore at me |
| 0 | 0 | 1 | 3 | ..... | My partner stomped out of the room, house or yard during a disagreement |
| 0 | 1 | 3 | 5 | ..... | I was frightened by my partner's temper |
| 0 | 1 | 3 | 5 | ..... | I avoided seeing friends or family because of my partner |
| 0 | 3 | 5 | 7 | ..... | My partner forced me to justify everything I did and everyone I saw |
| 0 | 3 | 5 | 7 | ..... | My partner threatened to hit or throw something at me |
| 0 | 3 | 5 | 7 | ..... | My partner destroyed things belonging to me |
| 0 | 2 | 3 | 5 | ..... | My partner threatened to hurt himself or herself |
| 0 | 4 | 6 | 8 | | My partner threatened to, or took something away from me
(children, contact with family, transportation, telephone, or medical care) |
| 0 | 4 | 6 | 8 | ..... | I was frightened by my partner's violence toward others |
| 0 | 5 | 7 | 9 | ..... | My partner punched or hit me with something that could hurt |
| 0 | 5 | 7 | 9 | ..... | My partner pushed, shoved, grabbed, slapped or choked me |
| 0 | 5 | 7 | 9 | ..... | My partner insisted on, or forced sexual activity when, or in ways, I did not want |
| 0 | 5 | 7 | 9 | ..... | My partner burned or scalded me on purpose |
| 0 | 5 | 7 | 9 | ..... | My partner used a weapon on me |

Developed by *Ad Hoc* Survey Committee, December 2001.

ADDENDUM 1--Comparison of Responses from Current Abuse, Past Abuse, & No Abuse Groups

The primary focus of the survey was women who are currently experiencing abuse; however, women with a history of domestic violence and women with no experience of abuse also responded to the lists of reasons they would be discouraged or encouraged to disclose. Their responses are interesting and can add to the picture of how women interface with providers regarding domestic violence.

Results of the frequency with which women who were in the Past Abuse group and No Abuse group checked reasons that would discourage them from reporting domestic violence to a provider are compared to the responses of women in the Current Abuse group in Table 1.1. Figures represent percentages of surveys with a given item checked. *p* indicates the level of statistical significance for differences between groups.

The order of frequency of items checked by the Past Abuse and No Abuse women follows roughly the order of frequency from the Current Abuse group. In other words, women with a history of abuse and no abuse have similar thoughts on what would discourage them from revealing violence, as do women who are currently experiencing abuse.

For the majority of items the Past Abuse group checked reasons at a rate that was more like the Current Abuse group than the No Abuse group. Generally, however, both Past and No Abuse women checked items less frequently than did Current Abuse women. They did not select barriers as frequently as the women who experienced abuse within the last three years, with minor exceptions.

In several instances, women in the No Abuse group seem to vastly underestimate the negative impact of a fear, belief, or attitude for a woman currently experiencing abuse. Nowhere is this more clear than with the item, "My partner drinks, and this only happens when he/she drinks too much." Women who have not experienced domestic violence checked this item only one-fourth as often as women experiencing abuse (7.9% versus 30.2%, respectively.)

Items involving guilt for allowing the abuse to occur, fear that the disclosure would get back to a partner, lack of money to get away, not having anywhere else to go, fear the provider would blame them, fear the provider would be disgusted, acceptance that abuse was the norm, and fear that they would not be believed were checked by non-abused women at a rate less than one half the rate of abused women. These items are perceived as barriers less frequently by women who have not experienced abuse. The reality of living in situations of domestic abuse may intensify these feelings and attitudes.

Table 1.1 Comparison of Reasons **Discouraged** to Disclose, Across Abuse Groups

Current Abuse% N=364	Past Abuse% N=98	No Abuse% N=202	Total Sample% N=664	p	Reason not to disclose abuse to provider
66.8	61.2	54.0	62.0	.011	I thought I could manage by myself
52.2	46.9	33.8	45.9	.001	I was too embarrassed
46.2	42.9	37.1	42.9	--	I wasn't sure what I experienced was abuse
41.2	32.7	20.8	33.7	.001	I felt too guilty for allowing it to happen
39.0	25.5	18.3	30.7	.001	I was afraid it would get back to my partner and he/she would be angry again
30.2	21.4	07.9	22.1	.001	My partner drinks, and this only happens when he/she drinks too much
30.2	18.4	12.9	23.2	.001	I do not have any money to get away
29.9	13.4	20.3	24.6	.001	I was afraid they would think less of my partner
29.4	20.4	18.8	24.8	.011	It is a private matter between husband and wife
29.4	12.2	12.9	21.8	.001	I was afraid it would get back to my partner and he/she would be violent
28.6	21.4	19.3	24.7	.036	I did not go to see the provider for that problem
27.2	14.3	14.4	21.4	.001	I was afraid the provider would call the police
25.0	09.2	12.4	18.8	.001	I do not have anywhere else to go and have to live with my partner
23.1	11.2	23.3	21.4	.029	I was afraid someone would take my children away from me
22.9	14.3	12.9	18.6	.007	I was afraid someone would try to make me leave my partner
17.0	09.2	12.4	14.5	--	I did not think the provider would understand
16.8	10.2	05.0	12.2	.001	I was afraid the provider would blame me
15.1	05.1	06.9	11.1	.001	I thought this was just the way it is between partners and I needed to accept it
12.6	03.1	08.4	09.9	.013	I thought the provider did not really want to know
12.4	06.1	06.5	09.7	.033	I was afraid the provider would refer me to a psychiatrist
11.5	08.2	02.5	08.3	.001	I was afraid the provider would be disgusted with me
11.0	07.1	04.5	08.4	.024	I thought the provider would not believe me
10.4	10.2	09.4	10.1	--	I did not think the provider would know what to do
07.4	04.1	07.4	06.9	--	I thought the provider was too busy
04.7	03.1	05.0	04.5	--	I am from a different race, culture, or country and did not think my beliefs and values would be understood
04.4	03.1	02.5	03.6	--	I live way out in the county and help is not available
02.2	01.0	05.9	03.2	.022	I am in this country undocumented and do not want anyone to investigate
01.6	01.0	05.0	02.6	.034	I do not speak English well enough to explain

A number of items were checked by women with a history of past abuse at a rate less than one-half the rate of the Current Abuse women. These are “I was afraid they would think less of my partner,” “I was afraid it would get back to my partner and he/she would be more violent,” “I do not have anywhere else to go and have to live with my partner,” and “I thought this was just the way it is between partners and I needed to accept it.” Possibly, these items lose their power to discourage a woman, at least in her memory of how it felt to be in an abusive relationship.

A comparison of responses across groups that identifies items that would encourage a woman to disclose domestic violence is reported in Table 1.2. *p* indicates the level of statistical significance for differences between groups.

Table 1.2 Comparison of Reasons **Encouraged** to Disclose, Across Abuse Groups

Current Abuse% N=314	Past Abuse% N=97	No Abuse% N=263	Total Sample% N=674	<i>p</i>	<i>Reason encouraged to disclose abuse to provider</i>
58.6	59.8	63.1	60.5	--	The provider took time to listen
53.5	58.8	55.5	55.0	--	I was simply ready to tell someone
51.6	52.6	58.6	54.5	--	I was concerned for the safety of my children
50.6	51.0	41.8	47.3	--	The provider was a woman
50.0	54.6	58.2	53.9	--	I was in crisis and didn't know what else to do
46.5	49.5	62.7	53.3	.001	The provider asked me questions in a caring manner
45.2	35.4	46.4	44.3	--	The provider reassured me it was not my fault
42.4	50.5	43.1	43.8	--	The provider reassured me that I could decide what I wanted to do next
38.9	41.2	52.5	44.5	.004	Someone close to me convinced me I should tell a professional
37.9	35.1	40.3	38.4	--	Office staff was friendly and personable
37.7	46.4	48.7	43.2	.024	The provider seemed like he/she knew what to do about it
37.3	44.3	44.1	40.9	--	The provider asked me what I needed
36.3	40.2	51.0	42.6	.002	The provider asked about how an injury occurred
34.7	36.5	31.3	33.6	--	The provider asked about abuse by a partner
32.5	41.7	46.0	39.1	.004	I felt the provider would believe me
31.5	33.0	48.3	38.3	.001	I thought I <u>should</u> tell a professional
28.1	30.2	36.5	31.7	--	The provider seemed like he/she really wanted to know
19.5	30.9	27.8	24.4	.019	Information available in the office led me to think it safe
19.4	15.5	18.7	18.6	--	• domestic violence resource information
10.8	12.4	14.1	12.3	--	• brochures/cards
10.5	12.4	16.8	13.2	--	• posters/pictures

In a pattern that mirrors the items that discourage disclosure, items that encourage a woman to disclose abuse were checked less frequently by the Current Abuse group, than by women in the Past or No Abuse groups. In only a few items is this difference large, and it is the No Abuse women who checked them dramatically more often. Women who have not experienced abuse identified, “The provider asked me questions in a caring manner,” “Someone close to me convinced me I should tell a professional,” “The provider asked about how an injury occurred,” “I felt the provider would believe me,” and “I thought I should tell a professional” as things that would encourage disclosure much more frequently than did currently abused women.

Results of this section suggest that women who have not experienced abuse underestimate the power of many of the feelings abused women have about themselves and their situation that inhibit them from disclosing the abuse to a provider. While non-abused women understand the feelings and issues in roughly the order of importance to abused women, they do not completely understand the extent to which guilt, fear of

rejection, fear of retribution, economic realities, and the excuse of alcohol negatively impact the decision to discuss ongoing domestic violence with a third party.

From inside a violent relationship, many feelings, beliefs, and attitudes may look quite different. Things are not as clear as they might seem to a woman who has not experienced the pattern of violence and control. More importantly, it highlights the value of listening carefully and being sensitive to what abused women feel and think, regardless of how an outsider might perceive her options and think about what she should do.

ADDENDUM 2--Analysis of Responses by Level of Abuse

Assessment of abuse scores for the entire sample are reported in Table 2.1. Four hundred twenty-two (422) women surveyed met the criteria for the Current Abuse group based on the algorithm scores from the assessment items (Appendix C.)

The Current Abuse group was further divided into three groupings based on the distribution of scores. The Current Abuse1 group represents women whose scores met criteria and were in the lowest half of the total Current Abuse group. The Current Abuse3 group represents women in the upper third quartile of scores and signifies a more serious degree of abuse or violence experienced. The Current Abuse4 group represents women in the top fourth quartile of abuse scores and is comprised of women who report the most severe degree of domestic abuse and violence.

The level of abuse is a measurement of the frequency and severity of violence as defined in this study. Use of the terms, “more serious” and “severe” does not mean that one type of abuse is more serious or severe than another. The impact of a given behavior on a victim is unique to that individual.

Table 2.1 Assessment of Abuse Scores

Score	Category	#	%
0-4	No abuse	614	59.3
5-23	Current Abuse1	214	20.6
24-47	Current Abuse3	101	09.8
48-105	Current Abuse4	107	10.3
Total		1036	100%

Results of the frequency of endorsement of items that discourage disclosure are reported in Table 2.2. All items reported in this table were found to vary significantly across the level of abuse. The level of statistical significance (based on Chi-square analysis) is listed in the fourth column.

For the vast majority of the items (including all the most frequently checked items), how often the item was checked increased with the degree of abuse. In other words, women with higher abuse scores were more likely to identify the items as a barrier to disclosure. For many items this increase was quite dramatic among the most severely abused women (Abuse4.) The most frequently endorsed barriers to disclosure, including embarrassment, guilt, fear of reprisal if a partner found out, and other fears of consequences, doubled in frequency checked by Abuse4 women over the frequency of even the Abuse3 group. Internal feelings and control over consequences of disclosure are powerful deterrents for women who are experiencing the highest levels of violence and abuse.

The barrier “My partner drinks, and this only happens when he/she drinks too much” was checked more frequently as the level of abuse increased. The same applies to the practical considerations of lack of resources or alternatives. The barrier about violence being a private matter did not increase in frequency from the Abuse3 group to the Abuse4 group.

Table 2.2 **Discourage** Disclosure Items Significantly Different By Abuse Level

Abuse1 % N=168	Abuse3 % N=93	Abuse4 % N=103	p	Discourage disclosure item
42.9	43.0	75.7	.001	I was too embarrassed
26.8	38.7	67.0	.001	I felt too guilty for allowing it to happen
22.6	33.3	70.9	.001	I was afraid it would get back to my partner and he/she would be angry again
19.0	31.2	47.6	.001	My partner drinks, and this only happens when he/she drinks too much
13.1	21.5	47.6	.001	I do not have any money to get away
22.0	35.5	35.9	.017	It is a private matter between husband and wife (partners)
13.7	21.5	62.1	.001	I was afraid it would get back to my partner and he/she would be more violent
20.8	30.1	39.8	.003	I did not go to see the provider for that problem
20.2	21.5	43.7	.001	I was afraid the provider would call the police
13.1	21.5	47.6	.001	I do not have anywhere else to go & have to live with my partner
16.7	17.2	38.8	.001	I was afraid someone would take my children away from me
13.1	21.5	40.2	.001	I was afraid someone would try to make me leave my partner
10.1	10.8	34.0	.001	I did not think the provider would understand
08.3	11.8	35.0	.001	I was afraid the provider would blame me
06.5	15.1	29.1	.001	I thought this was just the way it is between partners and I needed to accept it
07.1	11.8	22.3	.001	I thought the provider did not really want to know
03.0	12.9	24.3	.001	I was afraid the provider would be disgusted with me
05.4	08.6	22.3	.001	I thought the provider would not believe me
06.5	05.4	21.4	.001	I did not think the provider would know what to do
06.5	03.2	12.6	.036	I thought the provider was too busy
01.8	05.4	08.7	.029	I am from a different race, culture, or county and did not think my belief and values would be understood
02.4	00.0	11.7	.001	I live way out in the county and help is not available

The finding in the main report that “I wasn’t sure what I experienced was abuse” was the third most frequently endorsed barrier to disclosure among the Current Abuse group. Interestingly, this item is absent from the list above; meaning, there was no significant difference between levels of severity on how frequently this item was checked. Women at the most severe level (Abuse4) indicate that being unsure of abuse is a barrier to disclosure as frequently as women with lower abuse scores (Abuse1 and Abuse3.) This suggests that a good percentage of the women surveyed are unsure of labeling what they experienced as abuse, even among those women who are experiencing the most frequent and violent forms of abuse.

Items from the list of reasons a woman would be encouraged to disclose abuse that varied significantly across levels of abuse are reported in Table 2.3.

The pattern of response across levels of abuse is different for many items that would encourage disclosure. For some, the percentage of women checking an item decreases as the severity of abuse increases. In other words, women who experienced more abuse are somewhat less likely to identify some items as encouraging them to disclose the abuse. That the woman was simply ready to tell someone, and provider behaviors of asking questions in a caring manner and appearing to know what to do about abuse had less of an impact on women who were in the Abuse3 and Abuse4 groups as compared to the Abuse1 group.

Table 2.3 Encourage Disclosure Items Significantly Different By Abuse Level

Abuse1 N=143	Abuse3 N=78	Abuse4 N=93	p	Encourage disclosure item
62.2	46.2	46.2	.018	I was simply ready to tell someone
55.9	37.2	57.0	.013	I was concerned for the safety of my children
58.0	34.6	38.7	.001	The provider asked me questions in a caring manner
46.2	28.2	58.1	.001	The provider reassured me it was not my fault
44.1	23.1	40.9	.007	Office staff was friendly and personable
45.1	30.8	32.3	.049	The provider seemed like he/she knew what to do about it
44.1	24.4	34.4	.013	The provider asked about how an injury occurred
32.9	26.9	44.1	.052	The provider asked about abuse by a partner
37.8	19.2	32.3	.018	I thought I <u>should</u> tell a professional
18.9	11.5	26.9	.040	Domestic violence resource information [in office]

A very interesting pattern is evident in seven of the items. Concern for safety of the children, provider assurance that abuse was not her fault, friendly and personable office staff, provider asking about an injury, provider asking about abuse by a partner, thinking she should tell a provider, and domestic violence resource information in the office were all less likely to be checked as encouraging disclosure by women in the Abuse 3 group than in either the lowest or highest abuse groups.

We might expect these items to lose their power to encourage disclosure as the level of abuse increased. This is the converse of the pattern of items that discourage disclosure. However, the women who have experienced the most severe abuse endorse a number of these items more frequently than do women in the middle group. These findings are difficult to interpret, and speculation does not enhance our understanding of how providers and the community can best support victims. The factors that encourage disclosure remain in relative order of importance to women.

ACKNOWLEDGEMENTS

Funding for the Survey Project was provided by:

Alcoa Intalco Works
BP Cherry Point Refinery
Pacific Northwest Bank
Phillips Petroleum
Skagit State Bank
St. Joseph Hospital
Whatcom Community Foundation

The Survey Project owes its success to the work of the following individuals and organizations:

- ◆ Ad Hoc Survey Project Committee Members:
Natalie Briggance
Christina Bryne
Natalia Calhoun
Caryl Dunavan
Florence DiJulio
Elaine Hanson
Diane Wood
Kathy Washatka
- ◆ The 30 health care and social service provider sites that distributed the survey, with special thanks to Dr. Bruce Jorgensen.
- ◆ Project Consultants: Northwest Resource Associates
- ◆ Project Staff: Sue Parrott, Linda Ward
- ◆ And, to the support provided by Bellingham-Whatcom County Commission Against Domestic Violence members.

The Bellingham-Whatcom County Commission Against Domestic Violence gratefully acknowledges these contributors.