Is Spanish Language a Barrier to Domestic Violence Assessment?

Aminah Jatoi, M.D.¹ and Carmen Radecki Breitkopf, Ph.D.²

Abstract

Background: Domestic violence is the leading cause of injury to premenopausal women and fatal in over 1000 women annually, but few healthcare providers ask about it, citing numerous barriers, including language. This study tested the hypothesis that language does, in fact, pose a barrier to screening and that Spanish-speaking women report lower lifetime screening rates.

Methods: This study was part of an ongoing, multiclinic site, cervical cancer prevention trial in which patients completed a baseline survey, available in both Spanish and English, with the question: "Has a doctor or other healthcare provider ever asked you about domestic violence?" as well as other questions.

Results: Of 2591 women, 1017 (39%) chose to complete the survey in Spanish and 1574 (61%) in English. Within the entire group, 1137 (44%) reported having been asked about domestic violence. Among those completing the Spanish survey, this rate was 47% (lifetime assessment), and among English-language respondents, it was surprisingly lower at 42% ($p=0.011$). In multivariate analyses, however, this language effect was reduced to nonsignificance. Instead, age (particularly the 28–34-year quartile), having been pregnant, clinic site, and type of medical visit (postpartum) were positively associated with lifetime assessment.

Conclusions: This study found a Spanish language preference is not a barrier to domestic violence assessment.

Introduction

AT LEAST 1 IN 4 WOMEN in the United States reports having suffered or having been threatened with physical domestic violence during her lifetime.¹ Such abuse, as incurred by a spouse, former spouse, fiancée, boyfriend/girlfriend, or a cohabitant, is thought to be markedly underreported. Nonetheless, domestic violence remains the leading cause of injury to premenopausal women and results in the death of over 1000 women per year.² Furthermore, domestic violence appears to have long-term consequences: victims manifest higher rates of sexually transmitted diseases (STDs), sexual dysfunction, chronic pain symptoms, heart disease, cervical cancer, fatigue, and arthritis over time compared to the general population.^{1,3–8}

Despite the magnitude and widespread ramifications of domestic violence, few healthcare providers ask about it. Surveying 582 physicians, Rodriguez et al.⁹ reported most physicians admit to not asking. Although 79% of physicians do ask when a woman has sustained an injury, this percentage plummets to 6% among internists and 17% among gynecologists during routine health maintenance examinations. Why

do healthcare providers shun this topic? Physicians cite numerous barriers, including patients' fear of retaliation by the partner, patients' unwillingness to disclose, patients' fear of police involvement, lack of physician training and time constraints, sparse resources to deal with reported domestic violence, and lack of privacy during the evaluation.⁹ Notably, 56% of physicians also describe feeling ill at ease in broaching this subject with a patient from a different culture and 39% cite an inability to speak the patient's language as factors that preclude a discussion of domestic violence.

This latter observation is an important one. Although numerous studies suggest that domestic violence occurs regardless of the victim's ethnicity and that ethnicity does not protect any group, language appears to have a strong influence on patients' disclosure of sensitive information to healthcare providers. Julliard et al.¹⁰ conducted a qualitative study among 28 Latina women, 23 of whom described how language barriers had a negative effect on disclosure in general. Their study described how healthcare providers sometimes appeared frustrated with a patient's accent. The involvement of translators led to concerns about confidentiality, particularly if a family member was helping with the

¹Department of Oncology, and ²Division of Health Care Policy & Research, Department of Health Sciences Research, Mayo Clinic, Rochester, Minnesota.

translation. Referring to the latter, one patient stated, "That situation is really embarrassing."

Despite such challenges, assessing domestic violence remains important, as indicated by the endorsement of such practices by several major healthcare organizations, including the American Medical Association, the American Academy of Family Physicians, and the American College of Obstetricians and Gynecologists.^{11–13} Thus, the current study was undertaken to test the hypothesis that language poses a barrier to healthcare providers' asking about domestic violence and that Spanish-speaking patients report lower rates of assessment for domestic violence. This study sought also to assess other factors that might be associated with domestic violence assessment.

Materials and Methods

Overview

The current study is part of a larger, ongoing clinical trial (NCT00575510) that focuses on cervical cancer prevention. This larger prospective study has been approved by both the University of Texas Medical Branch (UTMB) and Texas Department of State Health Services Institutional Review Boards.

Eligibility

Women who had sought care in one of four UTMB regional clinics in southeastern Texas were screened for study eligibility and, if enrolled, were reimbursed \$5. Patient criteria that precluded participation are as follows: (1) outside of a 18–55-year age range, (2) unable to understand either English or Spanish, (3) pregnant, (4) currently undergoing treatment for cervical cancer, and (5) unwilling or unable to provide written informed consent.

Data for the present study were obtained from patients who completed a baseline survey in which the domestic violence assessment questions were included. Trained research personnel recorded the underlying reason for each clinic appointment, which was obtained from each provider's patient list.

Survey data

A paper-and-pencil survey was administered to all study patients in the language of their choice, either English or Spanish. Patients completed the survey independently or with the help of the research assistant immediately before their appointment. The 10-page survey collected patient demographics and captured a variety of psychological constructs, health attitudes, and behaviors using standard question wording and validated instruments where available. We also examined responses to the question: "In general, what language(s) do you read and speak?" This is from the language-based acculturation scale by Marin et al.¹⁴ in which women were given the following options: only Spanish, Spanish better than English, both equally, English better than Spanish, and only English.

For our primary outcome, women were asked: "Has a doctor or other healthcare provider ever asked you about domestic violence?" They were given a yes/no response option.¹⁵ This question was derived from a similar instrument from Klap et al.¹⁵ and from similarly formatted questions

from the Behavioral Risk Factor Surveillance System (BRFSS).¹⁶ The study team formulated the specific question used in this study based on advice from content experts and prior experience with the clinic population. We also included a brief, standard measure of social desirability, the Socially Desirable Response Set (SDRS-5), to enable the assessment of its relationship to self-reported assessment and to adjust for the possible confounding effect of social desirability on other survey items.¹³ This scale is the summed response of 5 items scored 0 or 1, with higher scores reflecting more socially desirable response tendencies.

Analyses

All statistical analyses were performed with SPSS version 16.0 (Chicago, IL). Most data are presented descriptively. Results of bivariate analyses are provided. A multivariate logistic regression model was constructed to examine the relationship between patients' recollection of having been asked about domestic violence and the primary variable of dominant language (Spanish or English) as well as a variety of other patient-related and appointment-related variables that have been associated or have been assumed to be associated with domestic violence, including patient age, number of prior pregnancies, and marital status.¹ Odds ratios (ORs) and 95% confidence intervals (CIs) are reported as appropriate. The criterion for multivariate model inclusion is 0.05 and for exclusion is 0.10. A *p* value of <0.05 is considered statistically significant.

Results

Demographics

A total of 2591 women are included, with characteristics as shown in Table 1. In general, 67% of the sample achieved a high school-level education (diploma or general equivalency diploma [GED]), >80% reported a household income of ≤\$24,999 per year, and about half reported their income was insufficient to pay their bills.

Of women who participated in this study, 54 (2% of 2645 women surveyed) did not answer the question on domestic violence assessment. There were no statistically significant differences in specific characteristics between these women and the larger group. Of note, during the survey distribution period, 583 other women were approached for study participation but declined it. Compared to those who participated, those who declined did not differ statistically with regard to race/ethnicity (*p*=0.26). A greater proportion of those who declined were in the oldest age range of 41–55 years and spoke English (*p*<0.01 for both).

In terms of language preference, 1017 (39%) chose to complete the survey in Spanish and 1574 (61%) in English. As expected, 99% of women who chose a Spanish survey indicated they generally read and speak only Spanish (67%), Spanish better than English (24%), or both equally (8%). Similarly, 98% of those who selected an English survey expressed English dominance or that they read and spoke only English (69%), English better than Spanish (15%), or both equally (14%). With respect to regional demographics, most patients were seen in clinic 1 (*n*=1355, 52%), with the rest in clinic 2 (*n*=692, 27%), clinic 3 (*n*=360, 14%), and clinic 4 (*n*=184, 7%). The underlying reason for patients' medical

TABLE 1. PATIENT-REPORTED DEMOGRAPHICS (*n*=2591)

Characteristic	n (%) ^a
Age, median in years (range)	28 (18–55) (mean ± SD) = 30 ± 9
Marital status	
Married	944 (36)
Single, never married	1055 (41)
Divorced	274 (11)
Widowed	20 (0.8)
Separated	253 (10)
Previous pregnancies	
0	347 (13)
1–3	1565 (60)
> 3	621 (24)
Education (last grade completed)	
8th grade or less	627 (24)
Some high school (did not graduate)	376 (15)
High school diploma or GED	733 (28)
Vocational training	141 (5)
Some college (no degree)	488 (19)
College degree (associate or bachelor)	174 (7)
Graduate/professional degree	30 (1)
Annual household income	
<\$5,000	562 (22)
\$5,000–\$9,999	298 (12)
\$10,000–\$14,999	484 (19)
\$15,000–\$24,999	463 (18)
\$25,000–\$34,999	262 (10)
≥\$35,999	148 (6)
Income sufficient to pay bills	
No	1285 (50)
Religious affiliation	
Catholic	1286 (50)
Baptist	365 (14)
Christian	518 (20)
No preference	233 (9)
Other	150 (6)
Ethnicity	
Hispanic/Latina	1614 (62)
White, non-Hispanic	599 (23)
Black, non-Hispanic	378 (15)
Survey language	
Spanish	1017 (39)
English	1574 (61)

^aNumbers in parentheses refer to the percentage of the entire group unless otherwise specified. Percentages that do not total 100 reflect missing data.

GED, general equivalency diploma; SD, standard deviation.

appointments on the day of study enrollment included family planning (*n*=1789, 69%), postpartum (*n*=416, 16%), and maintenance healthcare, for example, annual or well-woman visit (*n*=386, 15%).

Prevalence of domestic violence and associations

In response to the question: “Has a doctor or healthcare provider ever asked you about domestic violence?” 1137 patients (44%) reported that they had been asked previously. Among patients who completed the survey in Spanish, the rate of having been asked was 47%, whereas among those completing it in English, the rate was 42% (continuity corrected chi-square = 6.40, *p* < 0.011).

In other bivariate analyses (Table 2), patients’ report of previous domestic violence assessment was not associated with race/ethnicity, income, or level of education, but it was directly associated with being married, having a prior pregnancy (gravidity > 0), type of upcoming medical visit (with the highest rate of 63% reported before a postpartum visit), clinic site (with as many as 58% of patients at clinic 3 having reported previous assessment), and a young adult age range (notably ages 28–34). In contrast, SDRS-5 scores were not associated with self-reported assessment history, an observation that suggests women were not modifying their survey responses based on a tendency to create socially desirable answers. Of note, with respect to the SDRS-5, Cronbach’s alpha in the current sample was 0.72, and the intraclass correlation was 0.34, both of which are consistent with published values.¹⁷ The sample mean was 2.32 with a standard deviation (SD) of 1.7 and a range of 0–5.

TABLE 2. BIVARIATE ASSOCIATIONS BETWEEN PRIOR ASSESSMENT FOR DOMESTIC VIOLENCE AND PATIENT AND APPOINTMENT CHARACTERISTICS

Characteristic		% Responding yes to ever screened	p ^a
Ethnicity	Hispanic/Latina	45	0.28
	White (non-Hispanic)	44	
	Black (non-Hispanic)	40	
Dominant language	English	42	0.011
	Spanish	47	
Age (years) ^b	18–23	37	<0.0001
	24–27	47	
	28–34	52	
	35–55	40	
	Unmarried ^c	42	
Marital status	Married	47	<0.01
Income range	<\$5,000	45	0.81
	\$5,000–\$9,999	43	
	\$10,000–\$14,999	46	
	\$15,000–\$24,999	45	
	\$25,000–\$34,999	44	
	≥\$35,999	50	
Gravidity	0	24	<0.0001
	1–3	48	
	> 3	46	
Education	<High school	44	0.77
	High school diploma or GED	45	
	>High school	43	
Clinic site	1	43	<0.0001
	2	40	
	3	58	
	4	38	
Type of medical visit	Health maintenance	36	<0.0001
	Family planning	41	
	Postpartum ^d	63	

^a*p* value resulting from chi-square statistic.

^bWhen examined as a continuous variable, the mean age of those ever assessed vs. never assessed was not statistically significant (*t* = 0.16, *p* = 0.87).

^cUnmarried combines the following categories: single, divorced, widowed, and separated.

^dPostpartum visit reflects the 6-week postpartum check.

A multivariate regression model showed that the association between language and assessment was reduced to non-significance. In contrast, age (28–34 years), having been pregnant, clinic site (clinic 3), and type of medical visit (postpartum) were positively associated with ever having been assessed (Table 3).

Discussion

This multiclinic study explored the hypothesis that Spanish-speaking women are less likely to have ever been queried about domestic violence. We initially observed the exact opposite in our bivariate analysis: Spanish-speaking women were more likely to report having been assessed for domestic violence compared to English language-dominant women, a finding that was reduced to nonsignificance in the multivariate model. In contrast, we did find that age (based on quartiles), being married, and having at least one pregnancy were directly associated with a greater likelihood of patient-reported lifetime assessment, whereas several other patient-related factors, such as race/ethnicity, mean age, and education level, were not. Taken together, our findings suggest that language is not a barrier but that healthcare providers' assessment for domestic violence remains infrequent.

Of importance, our findings also suggest that certain healthcare providers may be more committed than others to asking patients about domestic violence. For example, in our study, a higher lifetime assessment rate appears to have occurred among patients seen at clinic 3. Although women are not required to always attend the same clinic, many do. It is important to note that all clinics follow the same guidelines, and all are known for providing patient-centered care.¹⁸ Similarly, providers may be more conscientious in assessing women at postpartum visits or assessing women who have a

child, although this interpretation must be viewed with caution, as our assessment question pertained to ever and did not include assessment practices at the time of the current visit and not necessarily assessing at a women's health visit. Nonetheless, the foregoing observations suggest that medical specialty (for example, obstetrics) or certain practice patterns among specific groups of healthcare providers may translate into more pervasive assessment practices. In turn, these observations may also suggest that domestic violence assessment might be a mode of action that can be successfully inculcated into other healthcare providers' practice patterns over time; if some healthcare providers appear to assess the majority of their patients, perhaps others can as well.

How do our patient-reported assessment rates compare with those previously reported by others? Rates of screening for domestic violence remain highly variable, depending on the healthcare provider's medical specialty, the circumstances surrounding the healthcare encounter, the patient's age and socioeconomic status, and the patient's previous history of domestic violence.^{15,19,20} In general, however, patient-reported lifetime rates vary from 2% to 50%, with the latter having been derived from an addiction recovery unit and with most rates being on the lower end of this range. Thus, the rates observed in our study appear to be higher than what one might find in many other clinical settings.

Our study has limitations. First, this study focused heavily on patients' recall of domestic violence assessment as opposed to written documentation or direct observation that a healthcare provider had in fact assessed for domestic violence. Although subtle, this distinction does have implications for healthcare providers' adherence to guidelines. A healthcare provider may in fact meticulously ask patients about domestic violence, but patients might not remember these queries. Indeed, by relying on patient recall, our study might

TABLE 3. MULTIVARIATE ASSOCIATIONS BETWEEN PRIOR ASSESSMENT FOR DOMESTIC VIOLENCE AND PATIENT AND APPOINTMENT CHARACTERISTICS

Outcome variable	Variable(s) in model		Wald	Odds ratio (95% confidence interval)	p
Answered yes to having been asked about domestic abuse	Dominant language	English ^a			
		Spanish	0.011	1.01 (0.82-1.25)	0.92
	Age (years)	18–23 ^a			
		24–27	2.29	1.22 (0.94-1.57)	0.13
		28–34	12.95	1.58 (1.23-2.03)	<0.0001
		35–55	0.857	1.13 (0.87-1.48)	0.36
	Marital status	Unmarried ^a			
		Married	0.045	1.02 (0.84-1.23)	0.83
	Gravidity	0 ^a			
		1–3	37.86	2.51 (1.87-3.37)	<0.0001
		>3	28.87	2.49 (1.78-3.47)	<0.0001
	Clinic site	1 ^a			
		2	2.49	1.19 (0.96-1.48)	0.11
		3	33.85	2.17 (1.67-2.82)	<0.0001
		4	0.619	1.15 (0.81-1.64)	0.43
Type of medical visit	Health maintenance ^a	Family planning	9.25	1.49 (1.15-1.93)	0.002
		Postpartum	41.88	3.00 (2.15-4.19)	<0.0001

The model chi-square was 180.47, *df* = 12, *p* < 0.0001, with 61.6% of cases correctly classified. This final model excluded one statistical outlier (residual = 2.53). Cox and Snell *R*² was 0.068, and Nagelkerke *R*² was 0.092, all suggesting good model fit.

^aReferent group in the analysis. Unmarried combines the following categories: single, divorced, widowed, and separated. Postpartum visit reflects a 6-week postpartum check.

be underestimating assessment rates. Second, our analyses used patients' choice of the Spanish or English questionnaire as an indicator of their dominant/preferred language when, in fact, further questioning revealed that a notable percentage of patients were proficient in both. Our conclusions might have been different—and potentially more indicative of a language effect in multivariate analyses—had we surveyed a group of strictly unilingual patients. Third, this study was undertaken within a group of clinics in southeastern Texas. The regional confinement of our study population raises some concerns about our ability to generalize findings widely. Fourth and finally, the terminology used in our screening questionnaire might potentially lead to patients' underestimating whether they had been ever assessed for domestic violence. The latter term might suggest only physical violence to some patients, not taking into account psychological aggression or even sexual violence from the patient's partner. Future studies on such patient-reported assessment rates might choose to use other, more encompassing terminology and behavior-specific measures.

Finally, one might, in fact, question if routinely asking women about domestic violence is of value. Although not all studies have been consistent,²¹ at least two recent randomized controlled trials—one that examined assessment followed by discussions and referrals at the discretion of the treating physician and another that identified abused patients and then intervened in an attempt to improve victims' depression—have not demonstrated that assessment or a subsequent intervention improves outcomes among abused patients.^{22,23} Such data have led some to conclude that if assessment does not yield tangible benefits, it should not be pursued.²⁴ Admittedly, assessing domestic violence is a controversial topic, but we contend that it remains important. The two trials alluded to^{22,23} are noteworthy in that they demonstrate that assessment, at the very least, is safe and yields no harm, such as partner retaliation. In view of the humanistic aspects of the healthcare provider-patient encounter, the importance of learning the multidimensional aspects of the patient's life and her healthcare concerns, and the higher rates of disease among domestic abuse victims, we believe that it behooves healthcare providers to ask about domestic violence, to continue to do so in a language that patients truly understand, and to work toward improving domestic violence assessment rates. Perhaps Bradley et al.²⁵ put it aptly when they described the role of domestic violence assessment "as a way of uncovering and reframing a hidden stigma."

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Disclosure Statement

The authors have no conflicts of interest to report.

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Address correspondence to:

Aminah Jatoi, M.D.

Mayo Clinic

200 First Street SW

Rochester, MN 55905

E-mail: jatoi.aminah@mayo.edu