Domestic Violence and Migrant Farmworker Women

1996 Final Report

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Abstract

The purpose of this report is to keep the participants and funders up-to-date on all the events occurring in the field. The principal goal of the PBRN is to have the MCN Domestic Violence Assessment Form implemented into the routine evaluation process. As an added bonus, vital research is accomplished. Through this research over the past two years, it has been found that 20% of farmworker women are in abusive relationships and intimate partners are the primary perpetrators. These data reflect national averages for domestic violence. Clinicians and researchers voiced concerns that women were underreporting the abuse. Many women denied being abused but admitted to being afraid of their partners. According to the clinicians participating in the study, most of the women they saw only spoke Spanish and were undocumented. The unique problems faced by the migrant farmworker woman must be addressed with unique solutions. Continued research is critical to further understanding and, thus, improve the treatment and interventions needed for these women and their children.

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Introduction

In 1994, the Practice-Based Research Network was created to meet a significant need in underserved and vulnerable populations. Rural health care providers consistently identified domestic violence as a health concern. Clinicians revealed they were facing this issue in their practices but did not know how to deal with the problem.

For the past two years, the PBRN has focused on documenting the incidence of domestic violence in farmworker families. Eight migrant health centers, with the permission of their Medical Directors, participated in the program during 1996. The centers were located in Michigan, New York, Colorado, Wisconsin, Pennsylvania, Iowa, Washington, and North Carolina. Nurses, nurse practitioners, and social workers were principally responsible for data collection.

While domestic violence research has been conducted for over 20 years, no studies have focused primarily on this population. Consequently, the PBRN began documenting the problem by surveying migrant farmworker women. To this end, the MCN adapted the Domestic Violence Assessment Form, created by Dr. Judith McFarlane, to meet the needs of migrant farmworker women. It was pilot tested in 1994 with promising results.

Goals for the PBRN

The vision of the PBRN is to integrate the different health care centers, migrant agencies, domestic violence shelters and services, legal service providers, and migrant clinicians to provide a comprehensive network of professionals working together. Through this grid of research and support, migrant farmworker families living with domestic violence will be better served. By routinely using the MCN Domestic Violence Assessment Form, clinicians will be able to diagnose and refer battered women and battering men to culturally and linguistically appropriate services. Only comprehensive services can provide the continuity that is essential for success in stopping the cycle of violence in these relationships.

It is the hope of the PBRN that migrant farmworker women will continue to organize in their own camps and communities to offer support and information to battered women. The success of the Lideres Campesinas Project in California is an example of the collective strength of farmworker women. They demonstrated that they have the power to support and assist each

in their communities and service providers. Through their ongoing development as leaders in this movement they will advocate for farmworker families' needs and serve as role models to the women they serve.

In the future, it is critical we strengthen the continued support and dialogue to ensure the participants do not become estranged from the PBRN. Through meetings or conference calls the PBRN support staff and participants can confront the problems that arise in the field together. These trouble-shooting meetings will foster a stronger bond and encourage objective exchanges between the PBRN and health care providers.

Methods

Sample

Five-hundred and twenty-four adult migrant farmworker women at seven health care centers across the country were surveyed. The type of service for which the women were seeking varied for each health center. Convenience sampling was conducted as the safety of the woman was of primary concern. Only women who might be surveyed alone could participate in the study.

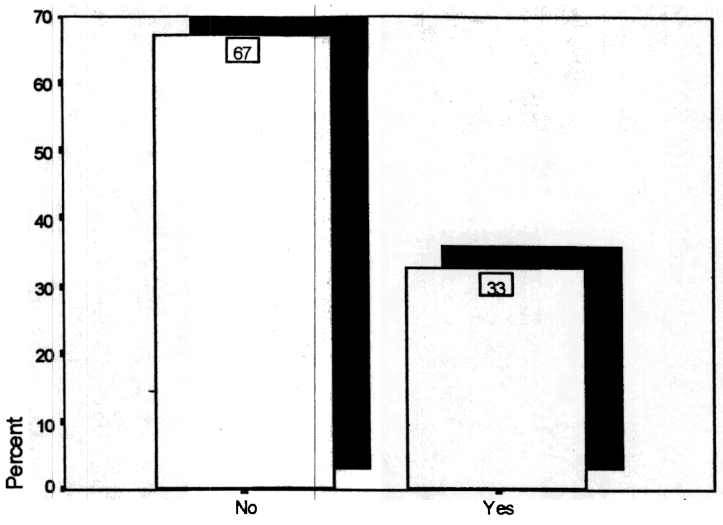
Design

In private, the clinician obtained informed consent and then surveyed the woman using the MCN Domestic Violence Assessment Form. The literature asserts that face-to-face interviews are more effective than self-reports for assessing domestic violence. Thus, clinicians read the form to the patient instead of having them fill it out alone. If the woman was identified as being abused, she was given referral information to services in the participating health center's area. (A copy of the form is included in Attachment A.)

Results of the Survey

Data Analysis

***Question #1**: Does your partner use drugs or alcohol?*

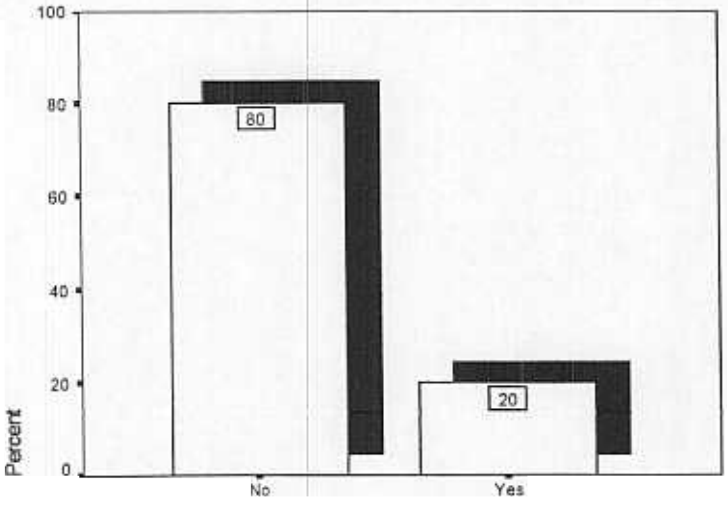


Spouse use drugs or alcohol?

Pilot testing in 1994 revealed that an introductory question unrelated to domestic violence is less intimidating to the patient. Other research has shown asking direct intimate questions about family dynamics is threatening and, generally, ill received. Hence, the clinician begins by asking a question about drug or alcohol use.

A common misconception among rustic populations is that beer does not contain alcohol. This would explain the relatively low 32.6% of women who responded yes to the alcohol/drug related question. Social desirability could be another factor that reduced reporting.

***Question** # 2: Within the past year, have you been hit, slapped, kicked, or otherwise physically hurt by someone?*



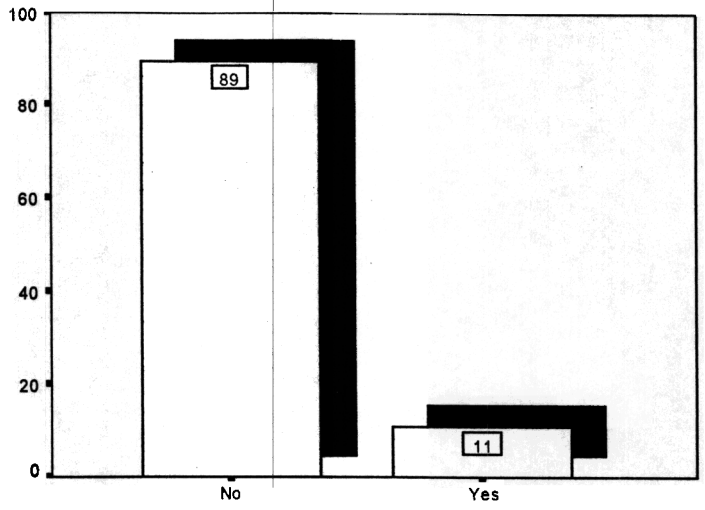
Physically abused in last year?

The second question lists the different types of physical abuse that have been identified in past research. It is crucial to define abuse for the women since most do not realize that slapping,

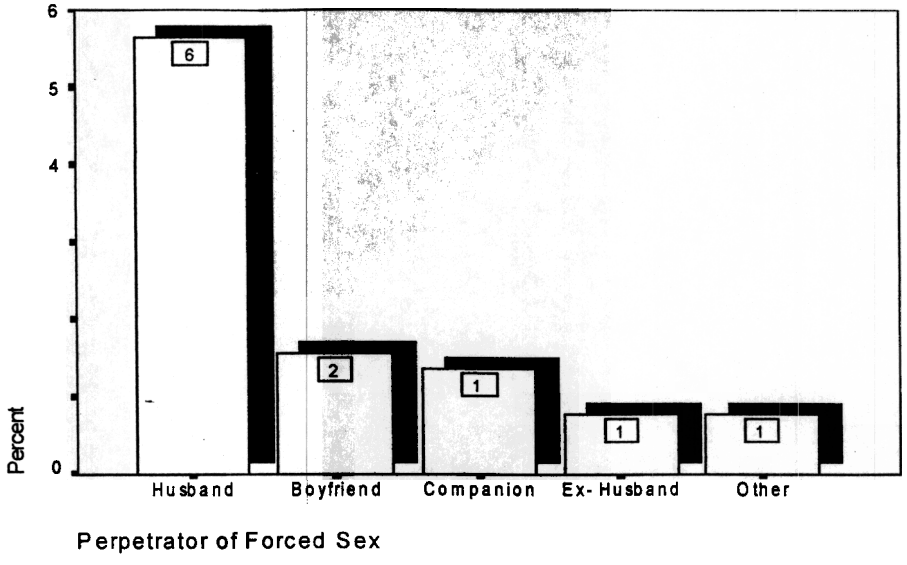
for instance, is considered abuse. The women were asked to identify who was abusing them. The following graph plots who the perpetrators were.

19.8% (N=520) reported physical abuse within the past year. Perpetrators of the abuse are primarily intimate partners, husbands and/or boyfriends. This is consistent with the national average of approximately 20% of women have been physically abused at least once by a male partner (Stark & Flitcraft, 1991). Types of abuse spanned the range from threats to use of weapons. The body maps provide a visual for the women. In this way, the women are given the option to relate information by pointing to the map or talking openly. On the graph below, the percentages and class of the perpetrators is given.

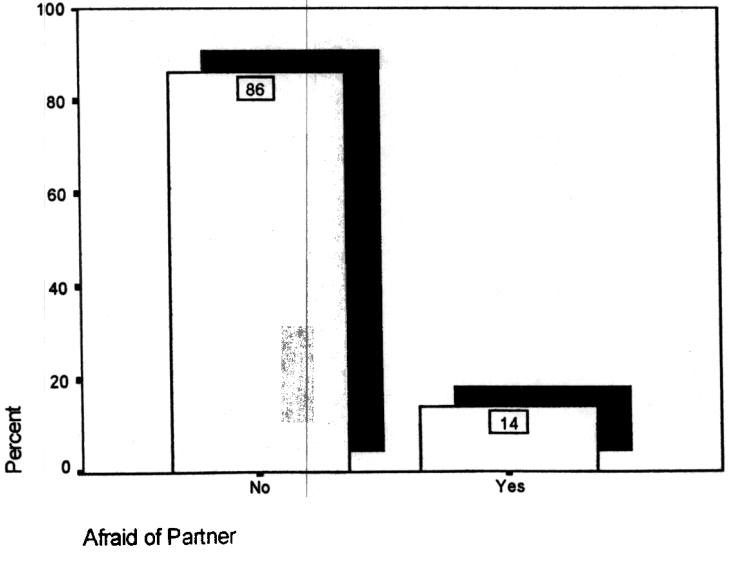
***Question # 3**: Within the last year has anyone forced you to have sexual activities?*



In question three, it is asked if they have been forced to have sexual activities instead of raped. Rape has connotations that vary among different populations. For example, many people do not identify forced sex as rape if the perpetrator is the husband. Approximately 11% of the women surveyed (10.6%) stated they had been forced into sexual activities within the past year. As you can see in the graph below, the primary perpetrator was the husband.



***Question # 4**: Are you afraid of your partner or anyone listed above?*



Fear is "alarm and agitation caused by the expectation or realization of danger" (Webster, 1984). If the woman answers yes to this question, she is admitting to a problem regardless of how she responded to the abuse questions. This question parallels an internal validity test.

Table I indicates the percentage of women reporting substance or alcohol abuse by their partner and physical abuse within the last year.

TABLE I

CORRELATIONS BETWEEN DRUG USE AND PHYSICAL ABUSE				
		Does your spouse use drugs or drink alcohol?		
		NO	YES	TOTAL
Physically abused within last year?	NO	61.5%	19.1%	80.7%
	YES	5.9%	13.5%	19.3%
	TOTAL (N=512)	67.4%	32.6%	100.0%

These data describe an association with partner's use of drugs or alcohol and the presence of domestic violence. As these data indicate, about 41% of the women in the survey who reported their partner's use of drugs or alcohol also reported physical abuse within the past year. It is important to remember that the literature has shown a coincidental relationship, not a causal relationship between substance use and domestic violence. As shown in the survey, only 5.9% of the women reported physical abuse *without* the use of drugs or alcohol by their partner.

TABLE II

PERCENTAGES OF WOMEN WHO ARE BEING ABUSED PHYSICALLY AND SEXUALLY				
		Within the last year, has anyone forced you to have sex?		
		NO	YES	TOTAL
Physically abused within last year?	NO	76.6%	3.7%	80.3%
	YES	12.7%	6.9%	19.7%
	TOTAL	89.4%	10.6%	100.0%

The table above shows the results of a crosstabs analysis of forced sexual activity and physical abuse. It shows a high percent of women who are being physically abused are also being abused sexually. Essentially a third of women reporting physical abuse also report sexual abuse.

In addition, this table shows 76.6% of women are not being abused. This means 23.6% are experiencing some form of abuse. This is higher than the national average.

TABLE III

PERCENTAGES OF WOMEN EXPERIENCING ABUSE WHILE PREGNANT				
		Are you pregnant?		
		NO	YES	TOTAL
Physically abused last year?	NO	32.1%	47.4%	79.8%
	YES	11.7%	8.5%	20.2%
	TOTAL	44.1%	55.9%	100.0%

Most of the women in the study were pregnant (55.9%). This table illustrates that 1 in 6 women in these clinics who are pregnant are also being abused. The dangers of physical abuse on a fetus can be severe and coupled with the poor nutrition and living conditions these women face, these unborn children are in jeopardy.

Discussion

Limitations of the Research

The primary limitation of the research is the inability to generalize the results from the sample to the general population. This is mainly due to the use of convenience sampling. The method of choice is random sampling but is difficult when the safety of the woman is a factor. This problem is exacerbated by the language barriers that exist in the health centers. Therefore, only women who could be interviewed alone could be included in the study. One obstacle to privacy is the need for translators. The English-speaking clinicians can not understand the Spanish-speaking patients and require a third party. If clinic staff is not available, family members, including the partner, or even children of the patient serve as translators. This impedes the clinicians task to assess/diagnose domestic violence, and consequently, jeopardizes the woman's chances of getting help. A strict methodology needs to be adopted for collecting data in future research. In particular, within each service area of the health centers there needs to be a consistent method of sampling. In this fashion, results could be compared for women using well-woman services, prenatal services, general medicine, etc.

A second limitation of the research is that the form only comes in two languages. It was translated into Spanish first since the majority of the population was Latino. However, as the

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A second limitation of the research is that the form only comes in two languages. It was translated into Spanish first since the majority of the population was Latino. However, as the PBRN has grown, the need for other languages has grown. Clinicians in the eastern migrant stream have reported language problems when trying to assess Haitian women for domestic violence. The assessment forms need to be accessible to a wide range of immigrants.

Another limitation of the research is the inability of the participants to speak with each other on a regular basis. Additional funding is needed to provide the PBRN participants with follow-up training. The participants can identify problems they encountered in the research process and share ideas for improvement.

Implications for Migrant Health Clinicians

It is well known that domestic violence is consistently underreported by most women in the U.S. With this in mind, clinicians must look at the 20% of women reporting physical abuse in this survey as just the "tip of the iceberg". The same is true for the 11% of women reporting forced sexual activity in this survey.

Clinicians reported the health effects that result from migrant women living in a violent relationship included: stress, pregnancy complication (premature labor), missed medical and dental appointments, alcohol use/abuse, depression, anxiety, and psychosomatic complaints.

This is an area that lends itself to further study by clinicians as the PBRN continues to identify its agenda for research.

As clinicians are assessing the reasons for missed appointments, "non-compliance" with treatment regimes, and the recurrence of infections or other conditions, domestic violence must be considered as a contributing factor. Health care providers must be trained to assess women's injuries and/or other related trauma as possibly related to domestic violence. Clinicians can develop partnerships with domestic violence service providers in their local communities to create networks of support for battered migrant farmworker women. This would forge a reciprocal relationship between domestic violence service providers and migrant health clinicians. Migrant health staff could depend on a reliable referral base and domestic violence providers would procure a stable support for documentation of injuries stemming from abuse. Other services, such as translation, could be traded between both service providers.

A principal goal of the PBRN is to have the MCN Domestic Violence Assessment Form institutionalized across the country. Every woman who goes to a migrant health center should be assessed for domestic violence. However, funding is needed to train clinicians in each migrant health center in order for this to occur. The literature, as well as the JCAHO, supports the practice of domestic violence assessment for all women using the health care system. Funding is also needed to develop protocols for assessment and evaluate their utility.

Evaluation

During 1996, Dr. Rachel Rodriguez and Linda Hunt, devised a debriefing interview that examined positive and negative aspects of participation, improvement in the survey, and future research interests. In the original proposal, participants were going to conduct qualitative interviews with migrant farmworker women. However, through other funding mechanisms, these qualitative interviews had already been conducted. To avoid redundancy, Dr. Rodriguez suggested surveying the participants about their experiences with the process and their plans for the PBRN. Since the members participated on a voluntary basis, i.e. no funds from this project go to the health centers, it was considered important to discover how the participants managed. In addition, the de-briefing form served as an external validity study. We wanted to know if the participants were having similar problems or if the difficulties were region specific.

According to the clinicians, most of the women participating in the survey were from Mexico. Approximately one-half were undocumented and were either new arrivals or had been coming to the US on a regular basis. Most of the participants spoke Spanish only. The most frequent obstacle encountered by the clinicians when referring was the lack of culturally appropriate services, especially Spanish speaking staff at domestic violence service centers.

In most areas there were domestic violence services, shelters, or counseling programs that women could be referred to as needed. One clinic that participated in the PBRN had a social worker on site who provided domestic violence services full-time. In the eastern stream, clinicians stated the reluctance of migrant farmworker women to be referred to services. This is

consistent with data obtained by Dr. Rodriguez from qualitative research with migrant farmworker women (Suffering in Silence, MCN, 1995).

The clinicians' insight into the causes of domestic violence differed from their report of the women's perception of the causes. The clinicians stated that stressors, such as lack of basic necessities (food, shelter, money) and cultural acceptance of male violence were the primary causes of domestic violence. The clinicians reported that the women thought the abuse was primarily related to alcohol, drugs, and stress.

Clinicians were asked how practical and useful the MCN Domestic Violence Assessment form was for use in their practice. Overall, clinicians felt the form was easy to use because it gave accurate information and asked direct questions. They stated that by specifically defining the abuse, issues that may not usually be considered abuse by women could be identified. They also felt that the length contributed to the utility of the form. There was some concern from clinicians in the eastern stream that women may not be revealing the abuse, i.e. the problem of "social desirability" that is commonly seen in survey research. Clinicians did not report problems in obtaining a private environment in which to interview the women. Recommendations for improvement of the form included asking about the history of the abuse and emotional/mental abuse questions. The clinicians found no resistance from their staff in using the form. This is an improvement over last year when the survey was considered a "task". Through continuing education, the importance of integrating research and practice in a clinical setting has been emphasized.

The clinicians described their personal and professional commitment to working with battered migrant farmworker women. They also stated that they had support from administrative levels at their health centers to work on this issue and participate in the PBRN. When asked what they hoped to gain from participating in the project the responses ranged from individual professional growth, working on policy issues related to domestic violence, and conducting further research. Other areas of interest for members of the PRBN included: substance abuse, sexual abuse, teen pregnancy, mental health issues related to farmworkers, and issues related to access to prenatal care.

Conclusions

The creation of the PBRN has been successful in a number of ways. The Network has implemented the first incidence study of domestic violence in the migrant farmworker population. With these data, further research can now be conducted to build on this foundation. The PBRN has also successfully provided a forum for migrant health clinicians to promote their own professional growth and be an integral part of a research project.

The results of this incidence survey have been incorporated into a number of other domestic violence projects currently being conducted by MCN and Dr. Rachel Rodriguez. Replication of this survey and the development of the PBRN will soon be proposed for use by

the Centro de Atención a Víctimas de Delitos in Monterey, Mexico. Dr. Rodriguez will be working with the Center's Director in Spring, 1997 to develop programs for health care workers.

Acknowledgments

In appreciation of the continued support and dedication to domestic violence, we would like to thank the Agency for Health Care Policy Research (AHCPR), the Bureau of Primary Health Care (BPHC), and the Division of Migrant and Community Health, Office of Migrant Health. These agencies provide essential financial assistance that improves the quality of health care services migrant women receive.

In addition to the above agencies, we would like to thank Clinch Valley College, Keystone Health Center, Northwest Michigan Health Services, Inc., Rushville Health Center, Tri-County Community Health Center, and Yakima Valley Farm Worker for their commitment and insight into the problems migrant farmworker women face. Furthermore, we would like to thank the Administrators for recognizing the problem of Domestic Violence and committing to an intervention protocol.

The success of the Practice-Based Research Network is completely dependent upon the support of the devoted individuals in the field of migrant health and domestic violence. A few of these individuals are Laura Aponte, Charlotte Chase, Deanna Lehl, Willa Hayes, Candace Kugel, Patricia Rios, and Vicki Ybarra. These women have spent a great deal of their time and energy participating in the study and deserve many thanks.