Measuring Incidence and Factors Associated with Intimate Partner Violence on African American Women: A Cultural Competence Framework

DeShana Collett, University of Kentucky
Kelly D. Bradley, University of Kentucky

1 Please use as author of contact. dcollettpac@uky.edu
Intimate Partner Violence on African American Women

Measuring Incidence and Factors Associated with Intimate Partner Violence on African American Women: A Cultural Competence Framework

Abstract

Many health disparities have been noted in the African American community for decades. The incidence of domestic violence on African American women has been overlooked in the health education model. The number one killer of African-American women ages 15 to 34 is homicide at the hands of a current or former intimate partner (University, 2002). Establishing a core curriculum in cultural competency training is essential to the medical education curriculum. The medical community acknowledges the need for cultural competency training, yet has not established core curricular standards for implementation. Arguably, the importance of integrating cultural competencies in medical curricula and training, gives providers the necessary skills to institute interventions. Creating a valid instrument to evaluate student's perceptions of cultural competency training is an essential key in eliminating health inequalities, potentially even more so within the domestic violence framework.
Many health disparities have been noted in the African American community for decades. The incidence of intimate partner violence on African American women has been overlooked in the health education model for some time. The importance of integrating and evaluating effective cultural competency training, can sequentially decreasing health inequalities. Educating health practitioners and providing them with effective screening tools to institute interventions and resources of community based programs can sequentially decrease the threat to the existing structure of African American families. The literature review will address three main factors; socioeconomic, psychosocial, and social demographic.

It must first be explained, how African American women identify and define abuse and violence. The literature will look into why it is crucial to understand the history and cultural surrounding ideas of racism and sexism that has challenged African American women since slavery. The distrust and disappointment in the criminal justice system along with the lack of community education has continued to mask the reporting of violence and abuse. The purpose of this study is to construct a valid survey instrument that will provide evidence to necessitate establishing a cultural competency core medical education curriculum, with an overarching goal to determine whether will are educating Physician Assistants to be more aware of diverse cultural values and beliefs that will contribute to decreasing health disparities.

The focus will provide evidence of the need to establish a cultural competency core curriculum; argued to be an essential part of the medical education curriculum. Does current curriculum address the role of ethnicity in domestic violence education and prevention? The starting point is to explore the Physician Assistant Program’s current medical curricula content as it relates to the inclusion of African American Women in Intimate Partner Violence Education.
throughout the United States. Does the current curricular content address difference amongst racial diversity? How can faculty perceptions impact the prevention of domestic violence in African American women? Answers to these questions will give the educators an understanding on our current progress of educating culturally competent healthcare clinicians. This paper will evaluate faculties’ and students’ perceptions of exposure to Domestic Violence Education and Prevention pertaining to African American women and the related outcomes. Many questions still exist from the medical community. How are patients approached? What is referred and in what manner and/or process? Here, the overarching goal is to probe the idea of to what extent the medical profession is educating Physician Assistants to become more aware of the impact that diverse cultural values and beliefs has on decreasing health disparities.

Conceptual Framework

Cultural and linguistic competence is a set of congruent behaviors, attitudes, and policies coming together in a system, agency, or among professionals that enables effective work in cross-cultural situations. Culture refers to integrated patterns of human behavior, including language, thoughts, communications, actions, customs, beliefs, values, and institutions of racial, ethnic, religious, or social groups. Competence implies having the capacity to function effectively as an individual and an organization within the context of cultural beliefs, behaviors, and needs presented by consumers and their communities (Office of Minority HealthHealth, 2005) (Cross, Georgetown Univ. Child Development Center, & et al., 1989, p. 13).

Background

There has been extensive literature on domestic violence, and the need for adequate education among healthcare professionals to aid in knowledge of understanding the prevalence and prevention. Although their extensive literature on the importance of domestic violence
education, most of the education fail to address the roles of race and ethnicity. In this literature review, three main factors will be addressed; socioeconomic, psychosocial, and social demographic; that argue the necessity for developing culturally competent curriculum that addresses the cultural beliefs and values of African American women as it relates to intimate partner violence.

The National Violence against Women survey estimates approximately 1.5 million U.S. women are raped and or physically assaulted by an intimate partner annual (Tjaden, 2000; Wyatt, Axelrod, Chin, Carmona, & Loeb, 2000). The report makes important reference to the need for more research to establish explanations for variations in prevalence and prevention based on race and ethnicity.

It is also unclear how social environmental and demographic factors intersect with race and ethnicity to produce differences in intimate partner victimization rates among women of different racial and ethnic backgrounds. Thus, more research is needed to establish the degree of variance in the prevalence of intimate partner violence among women (and men) of diverse racial and ethnic groups and to determine how much of the variance may be explained by differences in such factors as cultural attitudes, community services, and income (Tjaden, 2000).

The National Black Women’s Health Project has identified women battering as the number one health issue for Black Women (Joseph, 1997, p. 163), with more than 53% of violent deaths occurring in the homes of female homicide victims (Bailey, et al., 1997). This establishes reason for inquiry.

Analyzing socioeconomic factors that affect the prevalence of intimate partner violence have proven to be significant in African American Women. In review of the literature,
employment status, work environment, education and social class, affected the rate of intimate partner violence (Tricia B. Bent-Goodley, 2001; Huang & Gunn, 2001; Wyatt, Axelrod, Chin, Carmona, et al., 2000), has also been cited as the most significant variable in determining the prevalence of Domestic Violence in African Americans (Tricia B. Bent-Goodley, 2001). Stress has contributed greatly to the prevalence and prevention. The occupation of abusers played an important role in relation to abuse. Blue collar workers were involved in partner abuse at higher rates than white collar workers (T. B. Bent-Goodley, 2007; Dennis, 1995; Huang & Gunn, 2001). While unemployment increases the likelihood of abuse rates, living below poverty level and a membership to a lower socioeconomic class, increased the likelihood of being a witness and a victim to violence. Along with poverty comes limited education, lower income and wealth, and lack of exposures to social norms (T. B. Bent-Goodley, 2007; Dennis, 1995). All these socioeconomic factors also contribute to perceptions of sex/gender roles portrayed in relationships of African American partners. History has placed Black men in a leadership role, awarding him traits of a repressor, authoritarian, dictating as head of the household, placing Black women in a constant oppressed state. Social policy has negatively impacted African American relationships mostly through the “Faustian Bargain”(Tricia B. Bent-Goodley, 2001, p. 319), which contributed to the traits previously mentioned. These roles have also been supported in the black communities and religious sector. Men has taken leadership roles within organizations, making women less visible (Gillum, 2008; Huang & Gunn, 2001).

Psychosocial factors that have contributed to the incidence of intimate partner violence include racial stereotypes, abuse behaviors, including physical and psychological. African American women have been viewed as, strong, independent, and the matriarch of the family, always putting her family before her own need (Tricia B. Bent-Goodley, 2001; Wyatt, 2000).
This has negatively impacted the prevalence and prevention of intimate partner violence, creating a circumstance in which, Black men feel the need to defend the notion that he is weak or overpowered by them strong matriarch. Many women internalize these stereotypes; feeling the need to maintain this image, thus exhibiting a respond to intimate partner violence that is contrary to social norms (Wycoff & Simpson, 2008). The social norms of appearing weak, vulnerable and submissive are replaced by anger, resistance, and violence (Wyatt, Axelrod, Chin, Vargas Carmona, & Burns Loeb, 2000). Because African American women assume the image of being strong and independent, she is often scrutinized by society. They are believed to be a survivor and not a victim, being able to cope with any situation. African American women are more likely to defend herself against violence; fighting back, using physical protective behaviors. Drug and substance abuse predictably increase the rates of violence, which is important to know since most victims will seek help through medical services than mental health services (Hampton, 2004; Oliver, 2000; Wycoff & Simpson, 2008).

The support network has a large impact on the rates of reporting incidences of violence and the rates at which they seek out help. The support network consists of the community, criminal justice system and social support. The Black community has historically supported silence among victims. It has been thought of as a “private” matter that should be kept private. You don’t let outsiders in. By claiming to be a victim, they label the Black man has a batter, making him “look bad” among his white counterparts. This cry for help again defies the image that has been created for Black women, making her like her white counterparts. This consequently, permits her to deny her race and be chastised for not being loyal to her race. The criminal justice system has been seen as racist and prejudice in the Black community, creating a relationship distrust and opposition. This is not without merit, “More than 50% of imprisoned
women have been subjected to domestic violence” (Tricia B. Bent-Goodley, 2001, p. 322). African American women tend to receive harsher sentences than white women and are more likely to use physical protective behaviors to defend themselves (Bailey, et al., 1997; Huang & Gunn, 2001; Wyatt, Axelrod, Chin, Vargas Carmona, et al., 2000). The criminal justice system has not been as responsive because Black women do not fit the stereotype of a victim. The consequences of seeking help have resulted in children being taken from an abuse situations and but in foster care, furthering the resistance to seek help. Studies have shown that African American women underutilize shelters due to lack of culturally competence and the fear of not being welcome (T. B. Bent-Goodley, 2007). Research has shown that women are less likely to be abused if she has a supportive social network. If the victims’ social network supports keeping her family and children together, she is more likely to seek out help.

After reviewing the literature, it is an understatement to say we need to do more research on the cultural impact on intimate partner violence. This research will aid in developing more cultural competent curriculums for health care advocates and practitioners. Research has shown that our community advocates have been affected by negative labeling.

Upon further review of the literature, one quickly comes to an understanding that there is a need to do more research on the cultural impact on intimate partner violence. This research will aid in developing more cultural competent curriculums for health care advocates and practitioners. Research has shown that our community advocates have been affected by negative labeling. The perception that African American women are “hardened, tough, back talking, strong, permissive and undeserving of protection, women for whom blows might not be considered cruelty”(Kupenda, 1998, p. 9). Understanding the impact of the historical and
cultural context that contribute to the prevalence and prevention on intimate partner violence will allow health care advocates to be more sensitive to the difference in this ethnic group.

Although the research has been done to show why there is a need to classify domestic violence into subgroups of race, there has been little research done on effective education models that incorporate cultural competency education and its impact has on the prevalence and prevention of intimate partner violence.

Research Design

Focusing on the literature, a critique and synthesis of how cultural competencies have been operationalized and utilized, specific to the purpose of construction a final instrument, were given attention. An instrument was then constructed and validation process began. The process was embedded and ongoing.

Objectives of Survey Research

To explore the medical curricula as it relates to the inclusion of African American Women in Domestic Violence Education in Physician Assistant education curricula. A validation of literature specific to the curricular goals will be analyzed to establish a need for a more comprehensive core curriculum. In addition, results will be used to establish and construct items to execute a survey regarding the cultural competencies in Domestic Violence Education.

Response Frame

The population will consist of current faculty and second year physician assistant students in all 160 accredited Physician Assistant programs in the United States. A list will be obtained Physician Assistant Education Association for all faculties from each respective program. The list of students will be obtained from the programs registrar office for each respective program. The list will contain email address for all targeted population. The students will be in their last
year of their clinical curriculum. The target will include all faculties’ and students’ in Physician
Assistant Programs located in the United States. The sample design will consist of cluster sample
then a quota sample. First: all colleges of allied health; then all in PA programs; then all faculties
in those areas. The same approach will be taken for the 2nd year physician assistant who have
completed didactic course work. Looking at past studies there was a response rate of 70% to
90% respectively. The survey will be a self-administered and web based. A high number is
expected in response rates based on the large sample population, with expected response rate of
70-80%, and a targeted response rate of 80-90%. To insure that the expected response rates are
achievable, all of the non-responders will receive a follow up email reminder in 48 hours after
the initial request.

Method of Measurement

Faculties’ and students’ representative of the target population will be emailed self-
administered web based survey. The survey instrument will consist of 5 multiple choice items
related to curriculum content over the past 2 years. Questions will also include barriers relating
to topic areas of domestic violence education and domestic violence in African American
women. The curriculum content choices including 7 multiple choice items instruction on
intimate partner violence education, course delivery methods, and instruction hours. Two
categories are related to attitudes about the related topics of intimate partner violence education
and African American women. There are 4 demographics multiple choice items include.

Pretesting

A pilot test will be given to a small sample of second year physician assistant students
and medical faculty in a college of health sciences. This will address content validity. These
participants will not be included in the final survey. They are representative of what the sample
survey population will contain. This will constitute a peer review and invite faculty from the College of Education and the Center for Women’s Health at the University of Kentucky take the survey as expert reviewers. All the reviews will be asked to discuss the survey format and what they learned from the survey. This will help in evaluating what questions need further clarity or even help develop new questions. A pilot test to evaluate time frame issues will be conducted since responders are asked to relay on memory of when they received Domestic Violence Education. The survey may need to be adjusted due to faculty bias also, with anticipation that this assumed bias may be due to memory recall and not dishonesty or prestige bias.

**Organization of Data Management**

The data will be securely stored in the survey monkey data base under my account. No IP addresses will be kept for tracking purposes. All questions will be precoded and most given ordinal codes. Variables will be identified using univariate analysis. This will help clean up the data and look at what can be analyzed. Frequency tables, graphs and statistical measures will be used to help identify categories for further analyses. Statistical measurements will help measure central tendencies and distribution of variables. This will be done by looking at the curve that is produced with the data analysis.

**Data Analysis**

The questions to be answered: What is included in the Domestic Violence Education curricula content? How much instruction time is spent on Domestic Violence Education? What are the barriers to instituting Domestic Violence Education? Is diversity included in the Domestic Violence Education? The delivery methods used to teach competencies will analyze
the quality of Domestic Violence Education and also the barriers defined by the number of competencies.

The faculty and student responses will be analyzed, and then compared. This will look at what the faculty feel they teach and what the students’ believe they have learned. The univariate data go through descriptive analysis using frequency tables and percentage values for individual variables. The frequency tables will have columns with descriptive dichotomized independent variables of whether Domestic Violence Education curriculum content is included; yes, no, or prefer not to answer. The dependent variables placed in the rows with each topic covered in the Domestic Violence Education. The 4 point attitudinal scales will be collapsed into a dichotomized scale of Agree/Disagree. “Prefer Not to Answer” will be in a separate category. Open ended responses will be coded after the survey is closed. The number of courses will also be treated as an independent variable. Demographics will be used to describe the responding sample population. This will look at their perceptions and general barriers, and also offer comparison data.

The population means will be calculated for the data sets. Once this is done, bivariate relationships will be tested using Spearman rho statistical measurement. Cross tabulations will be used to analyze the comparison between faculty responses and student responses. In past studies of this kind, Chi square test was useful for statistical analysis of data. This will increase reliability and validity of the data. The Ha= there is an association between faculty and student responses related to the inclusion of cultural competency in Domestic Violence Education as it relates to African American Women. The Ho= There is no association between the faculty responses and the student responses related to the inclusion of cultural competency in Domestic Violence Education as it relates to African American Women. For the hypotheses of no
association, alpha is set at 0.05. If the findings are not statistically significant, then the study will need to be revised but all finding will need to be reported.

What follows is a sample of the validation process, which includes purpose and objectives, type of variable, and a coding schedule.

**Instrumentation:**


<table>
<thead>
<tr>
<th>Questions Groups</th>
<th>Purpose/Objective</th>
<th>Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q1. Please indicate the topic covered in the Domestic Violence Education (DVE) course content.</td>
<td>Evaluate what topics are included in the medical curricula to constitute DVE. Studies have shown that content of DVE varies among medical curricula. DVE is not mandatory in medical education.</td>
<td>1.1 DV- Domestic Violence defined 1.2 Vic-Issues with Victim 1.3 Perp-Perpetrator 1.4 G-Gender 1.5 MultIC- Multicultural Awareness 1.4 ComS- Communication Skills, 1.6 ClinA-Clinical Assessment, 1.7 ClinD-Clinical Documentation 1.8 LR-Legal Reporting Requirements, 1.9 Res- Resources Descriptive Yes=y No=n Prefer Not to Answer=NA</td>
</tr>
<tr>
<td>Q2. Please indicate your agreement regarding DVE.</td>
<td>Assess attitudes about DV. Students who receive DVE from positive supportive faculty are more likely to incorporate screening and prevention tools. Faculty will lead by example. If they have negative attitudes, then the student’s action will mirror those displayed</td>
<td>2.1 through 2.5 Attitudinal Scale Strongly Agree=1 Agree=2 Disagree=3 Strongly Disagree=4 Prefer Not to Answer=5</td>
</tr>
<tr>
<td>Q3. Please indicate your agreement regarding barriers</td>
<td>Explore some of the reasons why DVE may not be included</td>
<td>3.1-3.5 Attitudinal Scale</td>
</tr>
<tr>
<td>Question</td>
<td>Description</td>
<td>Data Type</td>
</tr>
<tr>
<td>----------</td>
<td>-------------</td>
<td>-----------</td>
</tr>
<tr>
<td>Q4.</td>
<td>Over the last 2 years, how many courses include instruction related to DVE?</td>
<td>Ordinal data</td>
</tr>
<tr>
<td>Q5.</td>
<td>Please indicate the type(s) of course delivery method(s) utilized for topics related to DVE. Mark all that apply.</td>
<td>Each item will be treated as a question. Yes, they use delivery method= 1 No, they do not use delivery method =2</td>
</tr>
<tr>
<td>Q6.</td>
<td>How many instruction hours are devoted to DV prevention? Please indicate number of hours in all that apply.</td>
<td>Ordinal data</td>
</tr>
<tr>
<td>Q7.</td>
<td>Please indicate your perceptions of cultural awareness inclusion into DVE curriculum.</td>
<td>Attitudinal scale Interval data</td>
</tr>
<tr>
<td>Q8.</td>
<td>What method was used to evaluate the level of cultural competency? Mark all that apply</td>
<td>10.1-10.9 is descriptive nominal data</td>
</tr>
</tbody>
</table>
Intimate Partner Violence on African American Women

<table>
<thead>
<tr>
<th>Q9. Please indicate your perceptions of exposure to Domestic Violence Curriculum. The Curriculum:</th>
<th>Assess attitudes, knowledge and beliefs of the faculty and students’ concerning individual perceptions of curricular content</th>
<th>9.1-9.4</th>
<th>Attitudinal scale Interval data</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q10. Please indicate your level of awareness regarding African American Women and DVE with each item below: Domestic Violence (DV)</td>
<td>Assess attitudes, knowledge and beliefs of the faculty and students’. This will help address the need for increase faculty expertise and also what the students are learning from DVE concerning AAW</td>
<td>7.1-7.4</td>
<td>Attitudinal scale Interval data Accumulative Cultural Competency score to build on foundation</td>
</tr>
<tr>
<td>Q11. Please indicate your agreement regarding barriers to curriculum inclusion African American women in regards to DVE with each item below</td>
<td>Explore some of the reasons way DVE doesn’t include AAW or way it may be limited in the educational curriculum</td>
<td>11.1-11.5</td>
<td>Attitudinal Scale Interval data</td>
</tr>
<tr>
<td>Demographic Questions Q12-Q18</td>
<td>Faculty or Student. This will help to compare and contrast differences. Will help me understand attitudes and knowledge between the two groups. There have been studies that show some bias with answers. Ex. Faculties’ are aware that you are assessing their curriculum, so they try to pick the answers that they feel the researcher wants. These questions will look at the general barriers from the sample and how do they differ.</td>
<td>Q12- Branching question Q13-Q15- Faculty Q16-Q18-Students</td>
<td>Faculty=1 Student=2 Q13-Q15 is descriptive nominal data Q16-Q18 is descriptive nominal data</td>
</tr>
</tbody>
</table>

Discussion and Conclusion

The self administered web based survey is a good choice for this large population but does have related strengths and weakness. This format allows the researcher to gain insight on values and attitudes. The data is instant and cost efficient. The survey can be taken in private. This approach is selected because it allows the faculty and students to take the survey any place and at any time. The survey can be administered any place they can access a computer with
internet capabilities. This format does not address the limitations in relation to reading or vision difficulties, learning or physical disabilities. Allowing the survey to be taking at anytime may also alter the results you obtain. The month chosen in the semester the survey administered can affect attitudes therefore affecting your results. Were there any current news or media attention that may change respondents’ answers? Examples may be racial tension on campus or hate crimes in the news. The format does have limitation associated with technology failure and accessibility. Email accessibility and restrictions can be challenging. The respondent also cannot ask for clarity or explanations.

Other factors that may be acknowledged as confounding variables include reporting bias from all participants. Students may not be aware of the curricular content, therefore not appropriately identifying data. The course delivery could possibly affect response, whether it was delivered in one setting or multiple settings. This may affect memory bias. After reviewing the literature, it is an understatement to suggest that researchers need to do more studies on the cultural impact on domestic violence. This research will aid in developing more cultural competent curriculums for health care advocates and practitioners. Research has shown that our community advocates have been affected by social stereotypes, affecting the quality of health care delivered. Understanding the impact of the historical and cultural context that contribute to the prevalence and prevention on domestic partner violence will allow health care advocates to be more sensitive to the difference in this ethnic group. Although the research has been done to show why there is a need to classify domestic violence into subgroups of race, there has been little research done on effective education models that incorporate cultural competency education and its impact has on the prevalence and prevention of domestic violence. Future research on
evaluation of effective education models will help develop standards for creating a cultural competency core curriculum that can be adopted by all Physician Assistant programs.

References


