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# Community Leaders' Perceptions of Violence Against Women as a Public Health Issue

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# COMMUNITY LEADERS' PERCEPTIONS OF VIOLENCE AGAINST WOMEN AS A PUBLIC HEALTH ISSUE

by

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# COMMUNITY LEADERS' PERCEPTIONS OF VIOLENCE AGAINST WOMEN AS A PUBLIC HEALTH ISSUE

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The purpose of this thesis was to identify correlates of support for the involvement of local public health departments in the prevention of violence against women. The research is a secondary analysis of data from community leaders in the 50 public health catchment areas throughout Michigan.

A total of 525 community leaders were identified by health officers and were mailed surveys that dealt with a wide range of health policy issues. Three hundred and fifty-one surveys were returned.

The analysis was designed to determine which factors would affect support for treating violence against women as a public health issue. A step-wise multiple regression produced a model that included two attitudinal factors, viewing interpersonal violence as a personal and private matter and believing that prevention programs work, and one demographic variable, gender. These three items explained 25% of the variance in the dependent variable. Women are more likely than men to be involved in the issues of violence against women and to support the involvement of public health in efforts to reduce violence against women in their communities. Also, participants in violence against women programs tend to oppose public health moving into this field. Public health will have to address the issue of resources, both financial and support for programs, before it can successfully intervene in the issue of violence against women.

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# CHAPTER I

## THE RESEARCH PROBLEM

The extensive media coverage of the trials of O. J. Simpson once again brought domestic violence to national attention. Pictures of a bruised and battered Nicole Brown Simpson flashed across the evening news for months. The media, reacting to this and other high profile domestic violence cases, responded with television dramas, books, and made-for-television movies focusing on the issue of domestic violence. Almost every day newspaper headlines contain stories of women being abused and even dying at the hands of a spouse or significant other. Awareness of such violence against women has taken place in a context of greater public awareness of all forms of violence: child abuse, elder abuse, spouse abuse, and youth violence.

Communities are being forced to address the issue of domestic violence by answering some difficult questions. How do we deal with the issue of domestic violence in our community? What agency should be the primary means of responding to this critical issue? How do we define domestic violence and violence against women? Is this an issue for the criminal justice system, the social services system, or the mental health community? Is this a problem that should be addressed by public health?

The purpose of this thesis is to explore factors that are related to support for the involvement of local public health departments in the prevention of violence against women. The research is based on a secondary analysis of data collected from

community leaders in the 50 public health catchment areas throughout the state of Michigan who deal with public health issues in their communities. The data were collected in 1996 to assess the need and the readiness of local public health departments to address the issue of violence against women as a public health issue. Data were also collected from public health officials and staff, and directors of domestic violence programs. The focus of this study will be the issue of violence against women and the perception of community leaders as to whether the public health department should be a lead agency in the development of policy relating to violence against women and in the implementation of programs for the prevention of violence against women.

## Violence and Related Concepts

The Centers for Disease Control define violence as harm to another person through force or threat of force.(Rosenberg, Mercy, & Smith, 1984). The economic and human costs of all types of violence have continued to increase in recent years. Data indicate after car accidents that the leading cause of death for young men between the ages of 18–25 is homicide, showing the tremendous human costs of violence (Gest, 1994). The National Institute for Justice estimates that domestic violence alone costs Americans $67 billion per year in business, criminal justice and medical costs (Dunham & Leetch, 1997), indicating the huge economic costs.

Domestic violence is a broad concept covering many forms of violence occurring in the home. Domestic violence includes the actual or threatened physical, sexual, psychological, or economic abuse of an individual by someone with whom he or she has or has had an intimate relationship (Fact Sheet, 1996). This includes both violence against men and women, as well as elder abuse and child abuse. Few men,

however, report being victims of violence. Moreover, if they do report such violence, men are less likely to incur injuries (Murphy & Rickler, 1997). Closely related, although narrower, concepts include spouse abuse and battering. It is difficult to estimate the exact extent of violence against women in the United States, but an estimated 3.9 million women who are married or living with someone as a couple were physically abused, and 20.7 million reported verbal or emotional abuse by their spouse or partner in 1995 (Fact Sheet, 1996).

## Violence Against Women as a Public Health Issue

In 1985, Surgeon General C. Everett Koop sponsored a workshop focusing on "Violence and Public Health." Often seen as the beginning of the movement to treat violence against women as a public health issue, this workshop first linked the governmental health agencies with violence prevention. Since that time, the Centers for Disease Control, with the inception of the Violence Epidemiology Branch, have begun to systematically research five areas of violence: suicide, homicide, domestic violence, child abuse, and rape or sexual abuse. They have promoted the view that violence against women is a public health issue. However, this is not without controversy in the area of public health, where many have seen it as a major extension of the traditional public health role. Agencies already addressing the issue of violence against women, such as domestic violence programs, may also see the entrance of public health as a possible competitor for funding and other necessary resources to address the issue in communities.

Again, focusing on the economic costs to health care of domestic violence, it is estimated that in a given year in the United States, medical expenses from domestic violence cost between $3 and $5 billion (Dunham & Leetch, 1997). One study

reported that 30% of women presenting with injuries in an Emergency Department were victims of battering (Fact Sheet, 1996).

With the entrance of public health into the area of prevention of violence against women, it is important for state and local public health departments to understand the local perceptions and sources of both support and opposition for treating violence against women as a public health issue. The 1996 survey on which this thesis is based was a pilot program to begin to understand the link between local public health and the issue of violence against women. The data were gathered from members of communities identified as community leaders in the area of public health issues. These included county commissioners who had served on committees that had influenced the policy and strategic planning of a local health department; members of medical, legal, mental health, and social services agencies; and other community leaders who had influenced public health within the community. In the cover letter sent with each survey to participants (see Appendix A), the definition of violence against women was clearly defined "broadly as the threatened or actual intentional use of physical, sexual and/or psychological/emotional force against a woman." This definition will also be adopted for use in this thesis.

## Organization of Thesis

The second chapter of the thesis will review the literature concerning the issues of violence against women and violence against women as a public health issue. The third chapter will describe the methods used in conducting this research. The research design will be presented, including the development and implementation of the instrument used to identify opinion leaders in the public health catchment areas and the development of the opinion leaders survey. It will also include a discussion of

how the data were collected and the key variables used in the analysis. The chapter will close with a description the techniques used to analyze the data. The fourth chapter will be a discussion of the research findings. Descriptive techniques will be used to explain the demographic characteristics of the participating community leaders and their roles as community leaders. A correlational analysis will identify relationships among key variables. Finally, a multivariate analysis will be presented using a scaled dependent variable. Support for treating of violence against women as a public health issue and various independent variables are included in a model examining factors that determine the extent to which community leaders will support the involvement of local public health departments in the prevention of violence against women. The fifth and final chapter will be a summary of the thesis and a discussion of the findings and the implications of these findings.

# CHAPTER II

# LITERATURE REVIEW

## Introduction

The literature dealing with violence against women is extensive and diverse. This thesis draws on three bodies of research literature addressing this issue. The largest body of work places violence against women and related concepts (such as battering, spouse abuse, and domestic violence) in an historical context. The focus will then shift to literature on the agencies that have traditionally addressed the issue of violence against women and the policies these agencies have used to deal with the issue. The final and most central literature focuses on violence against women as a public health issue and the proposal that public health address this issue.

## Historical Perspective

The history of domestic violence in the United States really begins with the issue of child abuse as a social problem in the late 1800s (Breines & Gordon, 1983). The dominant religious, political, and economic systems in the United States contributed to the belief that women and children were subservient to men. According to this perspective, women and children were considered property owned by the men to whom they were married or born. This view of women and children contributed to the notion that violence against women and children was acceptable and, therefore, behavior such as physical and emotional abuse within the family

should be tolerated by society. This perception toward children changed during the social reform movement, but similar change would take another 100 years for women (Breines & Gordon, 1983).

Women being controlled by the men with whom they were in a relationship dates back to early times, when, both politically and religiously, women were subject to control by men. The Bible contains many passages where women were expected to be subservient to the men to whom they were married. There are also passages that refer to the property of women automatically becoming property of their husbands. In the late 1400s, Friar Cherubino of Siena, in his "Rules of Marriage," stated:

> When you see your wife commit an offense . . . scold her sharply, bully and terrify her. . . . Then readily beat her, not in rage but out of charity and concern for her soul, so that the beating will rebound to your merit and her good. (Browne, 1987, pp. 164–165)

The English Common Law also viewed violence as an acceptable means to keep wives in their place. Blackstone, the English jurist, stated, "The civil law gave the husband the same, or a larger, authority over his wife allowing him for some misdemeanors, to beat his wife severely with scourges and cudgels" (Browne, 1987, p. 165) This Common Law view of women and their control was brought to the new nation.

There was an attempt by some of the colonies to ban wife beating. Unfortunately, very few men were ever reprimanded for disciplining their wives by beating as a result of these more stringent laws. This led to an effort to at least control the severity of the abuse that women had to endure. The "rule of thumb law" was enacted, which allowed men to beat their wives only with sticks the size of their thumb or smaller (Browne, 1987). Many states had laws that explicitly permitted wife beating. Mississippi was the first state to have a law permitting spouse abuse "to

exercise the right of moderate chastisement in cases of great emergency" (Browne, 1987, p. 166). The laws that allowed husbands to beat their wives were eventually rescinded, but a culture supporting this abuse continued. North Carolina, in 1874, passed a law prohibiting wife abuse, which began the efforts to rescind all laws permitting wife abuse. This law was challenged and the North Carolina Supreme Court, in ruling on the constitutionality of the law, stated, "If no permanent injury has been inflicted, nor malice, cruelty nor dangerous violence shown by the husband, it is better to draw the curtain, shut out the public gaze and leave the parties to forge and forgive" (Browne, 1987, p. 167). Although this seems to allow abuse to continue, the law went on to state that "public abuse" was not allowed. This seemingly nonsupportive anti-abuse decision from the North Carolina courts was often cited as the reason that violence against women, and particularly against wives, was allowed to continue. The privacy section, "draw the curtain," has been the basis of many of the attitudes that still prevail in America's perceptions of violence against women. The family is personal and private and, therefore, government has no business interfering. The sanctity and privacy of the family have been held in highest regard and have been protected from governmental interference (Kurz, 1993).

It is from this historical background that the battered women's movement began. In 1955, the "crisis" in the family was initially identified. Family violence, permissive parenting, and the women's movement were characterized as the cause of this "crisis" (Breines & Gordon, 1983). The first large-scale campaign against violence in the family and specifically against women began in the 1970s as part of the rekindling of the feminist movement. The actual movement began in England in 1971 with a small group of women who collected money in grocery stores and on street corners, and who worked through the local government to acquire a house.

These women recognized that women who were being beaten in their homes had no economic or political protection. They wanted to provide this protection by providing shelter for the women when they left their abusive partners. The government was not responding to the needs of these women. That small refurbished house became the first battered woman's shelter in England and in the world (Pizzey, 1977). Although given some voice, it would take another 10 to 15 years for the problem known as battering and spouse abuse to truly come to the attention of the public (Sewell, 1989). With the encouragement of the women's movement talking about private family issues, abused women began to speak out about the violence occurring in their homes. As Ann Jones (1996) states, "The ongoing struggle of the battered women's movement has been to name the hidden and private violence in women's lives, declare it public, and provide safe havens and support" (p. 8). This grassroots movement has created a thousand shelters throughout the United States, the first being the shelter that Women's Advocates formed in 1974 in Minneapolis, Minnesota. This shelter is still in existence today. Unfortunately, there are still more shelters for stray animals in the United States than there are for women and children in abusive relationships (Jones, 1996). Those involved in the movement to reduce and eliminate violence against women have worked to change the laws and the attitudes of people toward women who have been victims of violence.

Two dominant perspectives for the continuing social problem that we identify as violence against women are the "learned helplessness" (Walker, 1979) and the "double jeopardy" (Dobash, & Dobash, 1979; Flitcraft, Stark, & Frazier, 1979) perspectives. The "learned helplessness" perspective suggests that women have learned through their abusive relationships that they have no control over the abuse and therefore no control over their fate. As the abuse continues, the woman becomes

exceedingly helpless to assist herself in leaving the relationship (Walker, 1979). The abuse that women endure in relationships is then compounded by the agents of social control who blame the victim for the abuse. This, of course, is the premise of the "double jeopardy" perspective (Dobash & Dobash, 1979; Flitcraft et al., 1979). It is from this history and these perspectives that we begin to view the public agencies that have traditionally addressed the issue of violence against women and the view of the entrance of public health as an agency to address this social problem.

## Agencies Addressing the Issue of Violence Against Women

There have traditionally been three agencies addressing the issue of violence against women: the criminal just system, mental health agencies, and the medical community. These agencies within communities have been charged by public opinion to address this social problem. This portion of the chapter will be a discussion of the literature dealing with the perceptions of these agencies and, in some cases, the effectiveness of these agencies in addressing the issue of violence against women.

### Criminal Justice

There are two agents, police departments and the court system, in the criminal justice system who address the issue of violence against women. The police are on the front line of this social problem and are usually the first agents to address the issue of violence against women. In recent years, the model of mandatory arrest laws has been the approach that police departments have been required to adopt. The proponents of the mandatory arrest laws point to the experiment conducted by the Minneapolis Police Department in 1981. At the time of the experiment, there were three practices in the police department: (1) arresting the offender, (2) ordering the

offender from the premises for 24 hours, and (3) trying to restore order. The conclusion of this study was that arresting the offender reduced the likelihood of new violence (Berk, 1993). Although police departments were not the agents who pressed for this change, it became the standard in law enforcement. Laws were changed throughout the country in communities large and small to empower police departments to arrest with or without the permission of the victim. Although replication of the Minneapolis study was done with conflicting results (Berk, 1993), the view that arrest is the criminal justice approach has become institutionalized into the public perception of how violence against women should be addressed. Many in society, including those in police departments, do not share the perspective that violence against women is a public and, therefore, a criminal justice issue. Many believe that violence is a private issue, and governmental agencies such as police departments should not intervene. The attitude often held by the public and police is that "both partners are at fault" and it is the responsibility of other agencies to assist couples in working out violence. The police are on the front line making the decisions to arrest or not, and their attitudes toward violence against women will affect choices that they make. These judgments by police officers sometimes circumvent the laws by not enforcing those laws in place to protect victims of violence (Buzawa, Buzawa, & Austin, 1995; Jones, 1994; Mignon & Holmes, 1995). The laws state that arrest is mandatory, but many times because of their attitudes toward violence against women, police officers choose to use less formal interventions, such as removing the abuser or the abused from the situation, talking, and other interventions that do not lead to arrest of the abuser. There is evidence that the attitudes of police officers may be influenced by the fact that many officers themselves are abusers (Mignon & Holmes, 1995). Training is another issue that is affecting how police officers handle domestic

violence interventions. If training for officers in domestic violence and how officers should intervene in these situations is given, police response appears to improve (Mignon & Holmes, 1995).

If the abuser is arrested by police officers, the victim of the abuse and the abuser then become a part of the court system. The courts can be a maze of conflicting messages to the point in which the victim becomes victimized again (Flitcraft et al., 1979). The decision to prosecute often is a decision that the victim must make. Prosecutors sometimes will encourage victims to either drop cases or reduce the charges, which is known as prosecutorial discretion. Unlike in other assault cases where courts and therefore the state decide whether the case will proceed, violence against women is not viewed as a priority conviction. This again victimizes the woman. Often fearing repercussions from the abuser, the victim will refuse to proceed with the charges. She fears that the abuse will increase if the abuser is eventually freed. If women do proceed with prosecution, these cases often have low priority and are often dismissed, again with the discretion of the prosecutor, without the victim's knowledge. Judges often victimize abused women. Abusers are given probation and suspended sentences because of the low priority of the cases. When women have defended themselves and their children, the evidence of prior abuse has not always allowed as evidence (Koss et al., 1994). Criminal justice approaches have had minimal success in reduction of violence against women.

Mental Health

The psychological impact on women who are battered is well documented. Women who have been battered are more likely to suffer from depression, eating

disorders, insomnia, and general health problems. They are also more likely attempt suicide (Stark & Flitcraft, 1988).

Mental health is the second agency that has been forced to address the issue of violence against women. Much of the early mental health literature, taking a Freudian perspective, tended to blame the victim. These perspectives used several stereotypes, including (a) victim masochism, (b) victim precipitation, and (c) victim fabrication (Koss et al., 1994). Victim masochism is the view that some women are seeking violent men and like the violence in the relationship. Those taking this position look at the women who have stayed in violent relationships for many years and suggest there can be only two explanations, the woman either likes being beaten or it is not as bad as she says. A second type of blame has been called victim precipitation. In this case, the woman asks for it or deserves the violence. This form of blaming the victim states that the woman in the violent relationship incites the violence either in a verbal or physical manner. Again, the presumption is that the victim must want to be in this type of relationship. The final approach has been called victim fabrication. In this case, the woman exaggerates the nature or the amount of violence that is occurring (Koss et al., 1994). In all of these situations, women cause the problem; therefore, if we fix women, the perception from these agencies is the problem will be fixed. This will include therapy and drugs to address the problems of women.

More recently the focus has been on the issue of learned helplessness and battered woman's syndrome. Lenore Walker (1989) developed this perspective to be used as a defense for women who, because of years of violence, defend themselves and their children, which leads to the death of the abuser. Proponents of battered

woman's syndrome argue that the psychological effect of years of beating cause women to fear for their lives.

> Terror of her abuser is a seed that is planted in the psyche of the battered woman by repeated subjection to psychologically sadistic manipulation and physical bullying; it grows and grows until she is incapable of believing in the effectiveness of taking positive action on her own behalf. . . (Walker, 1989, p. 64)

As Walker says, no longer can the battered woman take care of her own mental health. The woman is now totally under the control of her significant other. Unfortunately, in these kinds of cases, agencies often do not intervene until after there has been a death (Browne, 1987). Mental health agencies have not been able to address many of the issues that have affected women and the violence that they have endured. These agencies have had to take a reactive instead of a proactive approach.

Medical Agencies

It is estimated that 25% of women who are assaulted by their partners seek medical care at a medical emergency room for their injuries (Jones, 1994). It is believed that 100,000 days of hospitalization, 30,000 emergency room visits, and almost 40,000 private physician visits are annually caused by violence against women (Stark et al., 1981) It would make sense that physicians would identify the violence that is presented to them in the medical setting, but it is estimated that only 25% of the violence is actually identified by physicians treating victims of violence. Dr. Mark Rosenberg of the Centers for Disease Control observes, "It's striking that physicians almost never ask their patients about violence" ("Domestic Violence Intervention," 1990, p. 939). Fewer than 8% of these cases, in one study, were reported to a social worker and even fewer were reported to police, even though, if they had presented as victims of stranger assault, all would be considered assault and battery (Jones, 1994).

It is not clear why physicians resist recommending intervention for female patients who present with obvious violence injuries. Some studies indicate that physician attitudes towards race, age, and sex affect their medical treatment of these victims. They stitch the cuts and treat the bruises, prescribe tranquilizers, and send the victim back to a very dangerous situation. The impact on the victim is again one of trivialization of their situation and being labeled as "hysteric" or "hypochondriac" (Jones, 1994). The view of the family as private also may be impacting their belief that they best serve their patients by not getting involved.

The medical community has made some inroads into the issue of violence against women. Protocols for emergency rooms were developed but very few have been implemented. It has been recommended that physicians be given training while they are still in medical school on identifying and intervening in domestic violence. A *Boston Globe* investigation found that only 90 minutes of one class was dedicated to the identification and referral in domestic violence cases. It was also recommended that, like child abuse, physicians and medical personnel be required to report violence against women to the police. This recommendation was rejected by the American Medical Association as too intrusive into the private lives of their patients but it did establish guidelines for its members (Jones, 1994). The medical community has hesitated to become involved in the reduction and prevention of violence against women.

Public Health Agencies

C. Everett Koop, then Surgeon General, convened a conference dealing with the issues of violence, including violence against women. This conference took place in 1985 and marked the entrance of public health into an area that had not

traditionally been addressed by public health. In response to this new emphasis on violence as a public health issue, the Centers for Disease Control created the Center for Injury Prevention and Control in 1991 for research and demonstration projects on violence, including violence against women. (Dunham & Leetch, 1997; Stark & Flitcraft, 1988). In addition, Congress approved the Violence Against Women Act as Title IV of the Violent Crime Control and Law Enforcement Act of 1994. Among other things, this act provided $1.6 billion for prevention grants to reduce sexual assaults against women, a national domestic violence hotline, and new penalties under federal law for sex crimes. Through this act, various federal agencies have developed task forces to develop research, planning, and program initiatives (Stark & Flitcraft, 1988).

With public health now viewing violence as a public health issue, the perspective of public health design is brought to the discussion. The public health design approaches an injury or illness by first defining the problem as a health problem, providing a health-event surveillance of the illness or injury, and identifying the risk factors. Then, an epidemiologic analysis of the problem is conducted. Finally, an intervention is designed and evaluated. The focus of this process is the prevention of illness or injury (Rosenberg, Mercy, & Smith, 1984). This design, with an emphasis on prevention, has been very successful in eliminating many diseases such as smallpox from causing premature death. Some federal public health officials and others hold the belief that this design can be applied to the reduction and eventual elimination of violence and specifically the reduction and elimination of violence against women. This may seem naive, but public health believes that the application of this process has been successful in eliminating other social problems and, therefore, is applicable to violence against women.

This inclusion of violence against women as a public health issue is not without controversy, both within the public health community as well as from agencies that have typically addressed the issue of violence against women. The public health community (specifically local health departments) view this as requiring a stretching of scarce resources. With limited budgets and resources, some public health officials feel that their intervention into the issue of violence against women will detract from already needed services (Dunham & Leetch, 1997). Another area of discussion within public health is the involvement of physicians and other medical personnel in identifying and assisting female victims of violence. As shown in the medical literature, this community has hesitated or refused to become a part of the movement to reduce violence against women. This is not to say that the national medical and nursing associations have not recognized violence as a health issue. In 1992, the American Medical Association issued a statement encouraging its members to assist in the diagnosis and treatment of violence against women. Similarly, the American Nurses Association also encouraged its members to participate in recognizing and addressing the issues of violence against women (Dunham & Leetch, 1997). This hesitation and refusal is based on the belief that physicians and other health personnel have ethical responsibilities to protect their patients' privacy and the privacy of their family members. The other issue with physicians and medical personnel dealing with victims of abuse is that women who are abused generally present in the emergency room for treatment of their injuries. Physicians are then expected to diagnose one symptom without a relationship with past injuries or other symptoms. Physicians also report that they are unable and unaware of the proper protocols to assess female victims of violence and are not trained as to how to ask very difficult questions (Dunham & Leetch, 1997; Stark & Flitcraft, 1988).

The issue of public health participating in the area of violence has also generated discussion within the traditional agencies that have addressed this violence. Specifically, the criminal justice agencies have questioned the "take over" of public health. James Mercy, a leading proponent of public health in the area of violence stated,

> A new vision for how Americans can work together to prevent the epidemic of violence now raging in our society has emerged from the public health community. . . . Fundamental to this vision is a shift in the way our society addresses violence, from a focus on reacting to violence after it occurs to a focus on changing the social, behavioral, and environmental factors that cause violence. (Moore, 1993, p. 35)

At the community level, some in criminal justice would welcome assistance from public health but do not welcome a takeover of a problem as large and complex as violence against women. The criminal justice approach argues that individual and moral accountability must be maintained and that prevention can be enhanced through punishment. This is in striking contrast to the public health view, which is one of rooting out causes and attempting to fix the social problems (Moore, 1993).

Through all of the controversy, many states have begun initiatives to approach violence against women as a public health issue. Wisconsin is one of several states beginning initiatives to address violence against women as a public health issue through training in medical schools. They have begun to educate medical personnel, especially physicians, on the treatment of violence against women. They have also begun programs linking shelters and hospital emergency rooms. Many community-based programs have been developed from this initiative (Dunham & Leetch, 1997).

One question that emerges from the literature is, Where is there local support for treating violence against women as a public health issue? This thesis will look at a data set of community leaders and the factors that affect their support for the

violence against women initiatives. Thus far, this has been a top down issue. The solutions have been recommended by the public health community in Washington but not by local public health officials. This has created a view of public health intruding into the issue rather that being a grassroots partner on violence against women. It is now time to understand whether the community will support this perspective and what factors may contribute to such support.

# CHAPTER III

# METHODS

This thesis is a secondary analysis of data from a statewide survey conducted for the Violence Against Women Project, sponsored by the Michigan Association of Local Public Health and the Michigan Department of Community Health, by Advanced Data Services of Kalamazoo. During 1996, surveys were conducted with health officers and executive staffs of local public health departments in Michigan, directors of women's shelters, and community leaders. These surveys assessed sources of support and opposition to treating violence against women as a public health issue. This thesis will focus on the community leader data.

## Research Design

A series of three focus group type discussions were conducted in the early spring of 1996 with representatives from local public health departments and the Michigan Department of Community Health. Nursing directors, health officers, and behavioral officers participated in discussions addressing the issue of violence against women as a public health issue, both statewide and within their catchment areas. Topics relating to violence against women discussed during the focus groups, as well as issues facing local health departments in addressing violence against women, assisted researchers with survey development. In addition, the process of how to identify community leaders in public health from the various target groups from each of the 50 catchment areas was discussed. Four survey instruments and an instrument

to be used by health officers to identify community leaders were developed from this process. Copies of all survey instruments can be found in Appendix B. These survey instruments were reviewed by the National Center for Injury Prevention and Control at the Centers for Disease Control. Pretesting of the instrument was done in several health departments outside of Michigan, so as not to contaminate potential respondents in the health departments in the state of Michigan. The research was conducted by Advanced Data Services, a research and marketing organization located in Kalamazoo, Michigan.

Key Informant Identification Survey

The instrument to identify community leaders was sent to health officers in all 50 catchment areas in the State of Michigan (the first survey in Appendix B). It was conducted during the spring of 1996. This initial survey requested that the health officers identify community leaders who have or have had an impact on public health issues in their local public health catchment area. The first wave of the instruments was sent with a self-addressed stamped envelope and a cover letter explaining the project. Follow-up phone calls were made to each nonresponding local health departments in the first wave. Follow-up continued until all catchment areas were represented with at least one community leader identified. This procedure, in effect, produced a modified snowball sample of community leaders in the 50 catchment areas. In snowball sampling, persons are identified to include in the sample and they in turn identify others who should be included in the sample, who in turn identify others. This process is continued until the sample is complete (Monette, Sullivan, & DeJong, 1998). The community leader sample in this research was created by contacting one informant, the public health officer, who then identified the

community leaders within his or her catchment area. Although this type of sampling does not produce a sample representative of the population in the catchment area, it is an effective means of identifying community leaders who have been involved with issues affecting public health in their communities. It is also possible, of course, that the choices made by the health officer may be biased because of cultural differences, personality, political issues, and professional status (Gregor & Galazka, 1990).

Survey Procedures

Health officers from the 50 catchment areas were identified using the directory from the Michigan Association of Local Public Health. Several of the health officers serviced multiple catchment areas. These individuals were asked to fill out the instrument for each of their catchment areas serviced so that all areas would be represented. The survey asked that health officers identify up to four county commissioners in the catchment area who serve "on the public health committee or similar body that has a direct influence on the policy and strategic planning for your health department" (see Appendix B). They were then asked to identify one individual in each of the following areas who have played "an important role in influencing public health policy, issues, or programs in your catchment area": medical (not the department's medical officer); legal (prosecutor, private attorney, or law enforcement); mental health (community mental health or in private practice); and social service community (a private practitioner or someone who works with a public or private local social service agency). Finally, they were asked to provide up to six additional names of local community leaders, not limited by the above role descriptions, but who had played some role in advancement of local public health policies or programs. When the lists were received, a database of community leaders'

names and addresses was created and the names were checked to make sure that they were not included on other lists (shelter directors or executive staff of public health departments in the catchment areas). They were also checked for duplication, as some catchment areas overlap counties and health departments. Five hundred and forty community leaders were identified by the health officers in the 50 catchment areas from the previous survey. Fifteen cases were identified as duplicates, leaving a total of 525.

### Violence Against Women Opinion Leaders Survey

A community leaders survey containing 29 items, many with multiple parts, including seven demographic items, was mailed to the 525 identified community leaders (the second survey in Appendix B). The survey dealt with (a) issues of importance of health problems in the community, (b) participation of the local health department in the area of violence against women, (c) perceived strengths and barriers for the local health department to participate in violence against women issues, and (d) the efficacy of prevention and problem-solving techniques employed by the local health department.

### Data Collection Procedures

The community leader survey was a mailed survey. The initial mailing was done in May of 1996. The packet contained a cover letter (see Appendix A), a self-addressed stamped return envelope, and the survey. Three weeks after the initial mailing, a reminder postcard was mailed to everyone who had received a questionnaire to improve survey response rates.

As shown Table 1, the response rates for all of the groups were at the 50% level or higher, which, according to Babbie (1990), is adequate for analysis. County commissioners had a low response rate of 49.7%. The groups with the highest response rates were mental health leaders and social services leaders. An overall response rate of 67% was achieved.

Table 1

Survey Response Rates

| Respondent Type | Number of Surveys Mailed | Number of Surveys Returned | Response Rates in Percentage |
|---|---|---|---|
| County Commissioners | 157 | 78 | 49.7 |
| Medical Community Leaders | 40 | 27 | 67.5 |
| Legal Community Leaders | 43 | 30 | 69.8 |
| Mental Health Community Leaders | 44 | 37 | 84.1 |
| Social Services Community Leaders | 40 | 33 | 82.5 |
| General Community Leaders | 201 | 146 | 72.6 |
| Total | 525 | 351 | 66.9 |

## Key Variables

### Dependent Variable

The dependent variable is defined as the degree of support for local public health departments treating violence against women as a public health issue. Ten

questions from the community leaders survey were identified as possible measures of this variable. The items were:

1. "Importance of violence against women as a public health problem."

2. "I would support the active participation of my local health department in implementing programs to address violence against women in our community."

3. "Preventing violence against women should be a goal of my local health department."

4. "What priority should your local health department place on efforts tc prevent violence against women?"

5. "Local public health agencies should assume a leadership role in preventing violence against women."

6. "Local health departments should have an active role in developing policies at the local level, which address the prevention of violence against women."

7. "Local health departments should have an active role in describing and tracking the number of incidents of violence against women in the communities in their jurisdiction."

8. "Local health departments should have an active role in collecting and reporting on data concerning the risk factors for violence against women."

9. "Local health departments should have an active role in developing and implementing programs to prevent violence against women."

10. "Local health departments should have an active role in gaining political recognition of violence as a public threat."

The responses for all of the items, with one exception, were "strongly agree," "agree," "disagree," and "strongly disagree." The fourth item, asking about priority, included the responses "high priority," "above average," "average," "below average,"

and "low priority." All scores for these items ranged from 1 through 4 with 1 being the lowest degree of support in all of the measures and 4 being the highest with one exception. The fourth item in the above list of items had scores ranging from 1 to 5, with 1 being highest. The values of this variable were reflected, reversing the scores, to permit it to be used in the summative scale.

A zero-order correlation matrix was created to determine the levels of correlation among the variables (Table 2). Nine of the 10 variables chosen were found to be moderately intercorrelated, with Pearson product–moment correlations in the range of .5 to .8. The item measuring perceived importance of violence against women as a public health issue, however, was only weakly correlated with the other variables; coefficients range from .2 to .3. The 9 variables that were moderately correlated were, therefore, combined into a summative scale of support. The scale was created by adding the scores obtained on each of the 9 variables. The potential values of this summative scale could thus range from 9 to 37. Table 3 shows that cases did, in fact, occur at each possible scale value. Cases were, however, concentrated in the upper half of the scale's range.

Independent Variables

Three types of independent variables were used in the analysis: demographic, attitudinal measures, and prior experience with violence against women. Demographic characteristics such as age, gender, and type of community role were used.

Attitudinal measures used from the questionnaire were:

1. "Violence in interpersonal relationships is private and personal and governmental agencies have no business getting involved."

Table 2

Zero-Order Correlation Matrix of Proposed Dependent Variables

| | Import | Implement | Goal | Prior | Leader | Develop | Describe | Collect | Role |
|---|---|---|---|---|---|---|---|---|---|
| 1 Import | | | | | | | | | |
| 2 Implement | .300** | | | | | | | | |
| 3 Goal | .279** | .803** | | | | | | | |
| 4 Prior | .298** | .595** | .612** | | | | | | |
| 5 Lead | .211** | .597** | .624** | .600** | | | | | |
| 6 Develop | .241** | .503** | .523** | .524** | .653** | | | | |
| 7 Describe | .218** | .524** | .549** | .500** | .615** | .592** | | | |
| 8 Collect | .228** | .482** | .502** | .509** | .630** | .577** | .822** | | |
| 9 Role | .222** | .632** | .654** | .595** | .710** | .603** | .649** | .687** | |
| 10 Political | .286** | .553** | .586** | .576** | .685** | .670** | .668** | .659** | .671** |

**$p \leq .000$

Table 3

Scale Frequencies

| Values | Frequency | Percent |
|---|---|---|
| 9 | 3 | .9% |
| 10 | 1 | .3% |
| 12 | 2 | .6% |
| 13 | 2 | .6% |
| 14 | 1 | .3% |
| 15 | 1 | .3% |
| 16 | 3 | .9% |
| 17 | 3 | .9% |
| 18 | 12 | 3.8% |
| 19 | 8 | 2.5% |
| 20 | 8 | 2.5% |
| 21 | 4 | 1.3% |
| 22 | 10 | 3.1% |
| 23 | 6 | 1.9% |
| 24 | 14 | 4.4% |
| 25 | 11 | 3.4% |
| 26 | 15 | 4.7% |
| 27 | 39 | 12.2% |
| 28 | 32 | 10.0% |
| 29 | 26 | 8.1% |
| 30 | 24 | 7.5% |
| 31 | 12 | 3.8% |
| 32 | 13 | 4.1% |
| 33 | 11 | 3.4% |
| 34 | 8 | 2.5% |
| 35 | 11 | 3.4% |
| 36 | 18 | 5.6% |
| 37 | 22 | 6.9% |
| Total | 320 | 100% |

2. "Viewing violence as a legitimate response to difficult interpersonal situations."

3. "Prevention programs can be effective in reducing the incidence of violence against women."

Prior experience was measured using the following variables:

1. "On the following scale, how would you rate your personal familiarity with programs and efforts in your community to reduce violence against women?"

2. "How long have you been actively involved in helping to address the public health problems in your community?"

3. "Have you participated in any community-based efforts to address the issue of violence against women, either in a professional or personal capacity?"

## Analysis Techniques

Descriptive statistics including frequency and percentage distributions, means, and standard deviations are used to summarize the data from the community leaders and the roles they occupy in their communities. The principal data analytic techniques used to examine relationships among the variables are analysis of variance, Pearson product–moment correlation, and step-wise multiple regression.

# CHAPTER IV

# FINDINGS

## Demographic Characteristics of Participants

The survey participants were drawn from five types of community leaders: county commissioners, medical, legal, mental health, and social service. The final type was identified as general community leaders with no specific role. As stated previously, these groups were cross checked so that there was no duplication across the groups.

Table 4 shows the overall age breakdown of all of the respondents. The table indicates that over 48% of the respondents were 50 years or older. Fewer than 15% of the leaders were under 40 years of age.

Table 4

Age of Respondents

| Age | *f* | % |
|---|---|---|
| 20–29 | 6 | 1.8 |
| 30–39 | 40 | 11.7 |
| 40–49 | 131 | 38.4 |
| 50–59 | 98 | 28.7 |
| 60 or older | 66 | 19.4 |
| Total | 341 | 100 |

Table 5 provides the age breakdown of the different types of community leaders. As the table indicates, the most common age of all but one of the leader types was between 40 and 59 years of age. The types with the youngest participants were the mental health with 18.9% between the ages of 20 and 39 and the general community leaders with 19.3% of the participants between the ages of 20 and 39. The county commissioners were the oldest leader type with 70.2% being 50 years of age or older.

Gender was another demographic variable used in the analysis. Table 6 indicates the overall gender distribution of the community leaders. In the overall participant data, 46.9% of the respondents were male and 53.1% were female. As Table 7 indicates, several types were overrepresented by either males or females. Two groups, medical and social service community leaders, were fairly evenly divided between males and females. As might be expected, county commissioners and legal community leaders were overrepresented by men. Again, as might be expected, women are overrepresented among the mental health community leaders as well as the general community leaders. Chi-square (see Table 8) indicates that gender composition of the community leader types varied significantly from chance.

## Attitudinal Measures

Three questions were used to measure participants' attitudes toward violence against women. The first item, "Violence in interpersonal relationships is private and personal and governmental agencies have no business getting involved," looks at the underlying belief of the respondents that violence is a private issue. The second, "Viewing violence as a legitimate response to difficult interpersonal situations," measures the belief that violence is acceptable in responding to conflict in

Table 5

Age of Participants by Community Type

| Age of Participant | County Commissioners | | Medical | | Legal | | Mental Health | | Social Services | | Community Leaders | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | *f* | % | *f* | % | *f* | % | *f* | % | *f* | % | *f* | % |
| 20–29 | 1 | 1.4 | 0 | | 0 | | 1 | 2.7 | 0 | | 4 | 2.9 |
| 30–39 | 4 | 5.4 | 1 | 3.8 | 5 | 16.7 | 6 | 16.2 | 0 | | 23 | 16.4 |
| 40–49 | 17 | 23.0 | 12 | 46.2 | 1 | 63.3 | 1 | 40.5 | 16 | 51.6 | 52 | 37.1 |
| 50–59 | 22 | 29.7 | 7 | 26.9 | 5 | 16.7 | 1 | 32.4 | 12 | 38.7 | 38 | 27.1 |
| 60 or older | 30 | 40.5 | 6 | 23.1 | 1 | 3.3 | 3 | 8.1 | 3 | 9.7 | 23 | 16.4 |
| Total | 74 | 100 | 26 | 100 | 3 | 100 | 3 | 100 | 31 | 100 | 140 | 100 |

Table 6

Gender of Community Leader Types

| | *f* | % |
|---|---|---|
| Male | 160 | 46.9 |
| Female | 181 | 53.1 |
| Total | 341 | |

Table 7

Gender of Participants by Community Leader Type

| Community Type | Male | | Female | | Total |
|---|---|---|---|---|---|
| | *f* | % | *f* | % | *f* |
| County Commissioners | 46 | 62.2 | 28 | 37.8 | 74 |
| Medical | 12 | 46.2 | 14 | 53.8 | 26 |
| Legal | 21 | 70 | 9 | 30 | 30 |
| Mental Health | 14 | 37.8 | 23 | 62.2 | 37 |
| Social Services | 16 | 51.6 | 15 | 48.4 | 31 |
| Community Leaders | 50 | 35.7 | 90 | 64.3 | 140 |
| Total | 159 | 47 | 179 | 53 | 338 |

Table 8

Chi-square Community Leader Type by Gender

| | Value | *df* | Asymp. Sig. (2-sided) |
|---|---|---|---|
| Pearson Chi-square | 22.106 | 6 | .001 |
| Likelihood Ratio | 22.392 | 6 | .001 |

interpersonal relationships. The final item, "Prevention programs can be effective in reducing the incidence of violence against women," measures the respondent's belief in the effectiveness of prevention programs. Tables 9, 10, and 11 provide the community leaders' responses for each of these variables.

Table 9

Community Leaders' Perception of Violence as Private and Personal

| Type of Community Leader | Violence is private and personal. | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | Strongly Disagree | | Disagree | | Agree | | Strongly Agree | |
| | *f* | % | *f* | % | *f* | % | *f* | % |
| County Commissioners | 27 | 36.5 | 41 | 55.4 | 4 | 5.4 | 2 | 2.7 |
| Medical | 15 | 57.7 | 10 | 38.5 | 1 | 3.8 | 0 | |
| Legal | 21 | 70.0 | 8 | 26.7 | 0 | | 1 | 3.3 |
| Mental Health | 27 | 75.0 | 8 | 22.2 | 1 | 2.8 | 0 | |
| Social Services | 22 | 68.8 | 9 | 28.1 | 0 | | 1 | 3.1 |
| Community Leaders | 89 | 63.6 | 49 | 35.0 | 2 | 1.4 | 0 | |

As Table 9 shows, all of the community leader types overwhelmingly disagree or strongly disagree with the statement that violence is personal and private. The groups with the highest percentage of strongly disagree responses are the legal and

the mental health community leaders. The leader type with the lowest percentage of strongly disagree responses (36.5%) is the county commissioners.

Table 10 shows the responses for the question, "In your opinion would reducing the following risk factor have no or little effect, a moderate effect, or a major effect in preventing violence against women in your catchment area?" The legal community leaders, with 89.7 % responding that it would have a major effect, were the leader type most likely to feel that reducing the belief that violence is a legitimate response to conflict would have a major impact. In contrast, only 39.2% of county commissioners felt such a reduction would have a major impact.

Table 10

Community Leaders' Perception of Violence as a Legitimate Response to Conflict

| Type of Community Leader | Violence is a legitimate response to conflict. | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | No effect | | Little effect | | Moderate effect | | Major effect | |
| | *f* | % | *f* | % | *f* | % | *f* | % |
| County Commissioners | 1 | 1.4 | 17 | 23.0 | 27 | 36.5 | 29 | 39.2 |
| Medical | 0 | | 0 | | 7 | 29.2 | 17 | 70.8 |
| Legal | 0 | | 0 | | 3 | 10.3 | 26 | 89.7 |
| Mental Health | 0 | | 0 | | 9 | 25.7 | 26 | 74.3 |
| Social Services | 1 | 3.3 | 3 | 10.0 | 6 | 20.0 | 20 | 66.7 |
| Community Leaders | 10 | 7.2 | 8 | 5.8 | 35 | 25.2 | 86 | 61.9 |

Table 11 provides the responses to the question about perceived effectiveness of prevention programs. The medical community leaders, with only 12% strongly agreeing with the statement, were the leader type with the lowest level of strong agreement. On the other hand, 76% did agree that prevention programs can work. Social services were the community leader type with the highest response in the strongly agree category (50%).

Table 11

Community Leaders' Perception of Prevention Programs

| Type of Community Leader | Prevention programs can be effective. | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | Strongly Disagree | | Disagree | | Agree | | Strongly Agree | |
| | *f* | % | *f* | % | *f* | % | *f* | % |
| County Commissioners | 3 | 4.1 | 6 | 8.1 | 37 | 50.0 | 28 | 37.8 |
| Medical | 1 | 4.0 | 2 | 8.0 | 19 | 76.0 | 3 | 12.0 |
| Legal | 0 | | 1 | 3.3 | 16 | 53.3 | 13 | 43.3 |
| Mental Health | 1 | 2.8 | 2 | 5.6 | 16 | 44.4 | 17 | 47.2 |
| Social Services | 1 | 3.1 | 0 | | 15 | 46.9 | 16 | 50.0 |
| Community Leaders | 1 | .7 | 2 | 1.5 | 72 | 52.6 | 62 | 45.3 |

ANOVA reveals that there are significant differences among the leader types for the three items. Table 12 shows the ANOVA for the three variables. The *F* values for all three items were significant at the .05 level.

Table 12

ANOVA of Three Variables and Community Leader Type

| Variable | Sum of Squares | *df* | *F* | Sig |
|---|---|---|---|---|
| Violence in interpersonal relationships is private and personal and governmental agencies have no business getting involved. | | | | |
| Between Groups | 8.671 | 6 | 4.166 | .000 |
| Within Groups | 115.874 | 334 | | |
| Total | 124.545 | 340 | | |
| Viewing violence as a legitimate response to difficult interpersonal situations. | | | | |
| Between Groups | 11.825 | 6 | 3.198 | .005 |
| Within Groups | 198.418 | 322 | | |
| Total | 210.243 | 328 | | |
| Prevention programs can be effective in reducing the incidence of violence against women. | | | | |
| Between Groups | 6.443 | 6 | 2.587 | .018 |
| Within Groups | 136.993 | 330 | | |
| Total | 143.436 | 336 | | |

## Prior Experience Measures

Three items were used to measure the community leader types' familiarity and participation in programs that address violence against women and how active they reported they had been in local public health problems. The first question was, "How would you rate your personal familiarity with programs and efforts in your community to reduce violence against women?" The responses ranged from "No

Knowledge" to "Very Knowledgeable" on a 5-point Likert scale. The second item, "How long have you been actively involved in helping to address the public health problems in your community?" was scaled from "less than 2 years" to "21 years or more." The final item, with a response of "yes" or "no," was "Have you participated in any community-based efforts to address the issue of violence against women?" Table 13 shows the distribution of responses to the item on familiarity of violence against women programs and efforts to reduce violence against women.

Table 13

Community Leader Type Familiarity With Programs and Efforts

| Type of Community Leader | No Knowledge | | 2 | | 3 | | 4 | | Very Knowledge-able | |
|---|---|---|---|---|---|---|---|---|---|---|
| | *f* | % | *f* | % | *f* | % | *f* | % | *f* | % |
| County Commissioners | 5 | 6.6 | 15 | 19.7 | 21 | 27.6 | 25 | 32.9 | 10 | 13.2 |
| Medical | 2 | 7.7 | 7 | 26.9 | 6 | 23.1 | 8 | 30.8 | 3 | 11.5 |
| Legal | 0 | | 0 | | 8 | 26.7 | 8 | 26.7 | 14 | 46.7 |
| Mental Health | 0 | | 2 | 5.6 | 6 | 16.7 | 15 | 41.7 | 13 | 36.1 |
| Social Services | 0 | | 1 | 3.1 | 4 | 12.5 | 16 | 50.0 | 11 | 33.0 |
| Community Leaders | 1 | 0.7 | 18 | 12.8 | 41 | 29.1 | 49 | 34.8 | 32 | 22.7 |

Social services community leaders ranked themselves (83.3%) the most familiar with programs and efforts to reduce violence against women. The least

knowledgeable were participants from the medical community leader types (42.3%) (see Table 13).

The second item asked the respondent to report on how long they have been involved with public health issues in their community. The distribution for the responses is shown in Table 14.

Table 14

Community Leader Type and Number of Years Active in Public Health

| Type of Community Leader | Less than 2 years | | 3–5 years | | 6–10 years | | 11–20 years | | 21 years or more | |
|---|---|---|---|---|---|---|---|---|---|---|
| | *f* | % | *f* | % | *f* | % | *f* | % | *f* | % |
| County Commissioners | 6 | 8.1 | 21 | 28.4 | 17 | 23.0 | 17 | 23.0 | 13 | 17.6 |
| Medical | 2 | 7.7 | 2 | 7.7 | 3 | 11.5 | 8 | 30.8 | 11 | 42.3 |
| Legal | 1 | 3.3 | 2 | 6.7 | 9 | 30.0 | 12 | 40.0 | 64 | 20.0 |
| Mental Health | 2 | 5.6 | 2 | 5.6 | 3 | 8.3 | 18 | 50.0 | 11 | 30.6 |
| Social Services | 0 | | 2 | 6.5 | 2 | 6.5 | 9 | 29.0 | 18 | 58.1 |
| Community Leaders | 12 | 8.5 | 18 | 12.8 | 31 | 22.0 | 44 | 31.2 | 36 | 25.5 |

As Table 14 shows, mental health (80.6 % 11 years or more) and social services (87.1% 11 years or more) community leader types have the most years active involvement in public health issues. Community leaders (56.7% 11 years or more) and county commissioners (40.6% 11 years or more) were the community leaders with the least amount of years active involvement in public health issues. To

determine if the level of personal familiarity with programs and efforts in their communities and the length of active involvement in public health issues varied by leader type, the means of the community leader types were compared using ANOVA. Table 15 shows the ANOVA distribution. There is a significant difference among the groups on the two items. Both are significant at the .05 level.

Table 15

ANOVA of Community Leader Types and Familiarity Items

| Variable | Sum of Squares | *F* | Sig |
|---|---|---|---|
| How would you rate your personal familiarity with programs and efforts in your community to reduce violence against women? | | | |
| Between Groups | 43.062 | 7.224 | .000 |
| Within Groups | 334.819 | | |
| Total | 377.881 | | |
| How long have you been actively involved in helping to address the public health problems in your community? | | | |
| Between Groups | 40.717 | 4.937 | .000 |
| Within Groups | 460.490 | | |
| Total | 501.208 | | |

The final item of the familiarity measures was the question that asked, "Have you participated in any community-based efforts to address the issue of violence against women either in a professional or personal capacity?" Table 16 shows the distribution of community leader types and whether they participated in these efforts. As the table indicates, each of the community leader types had some members involved in community efforts to address issues of violence against women. As might be expected, 100% of the legal and over 90% of the mental health and social service

Table 16

Participation in Community Efforts to Address Violence Against Women

| Community Leaders | Response | *f* | % |
|---|---|---|---|
| County Commissioners | Yes | 38 | 50.7 |
| | No | 37 | 49.3 |
| Medical | Yes | 13 | 50.0 |
| | No | 13 | 50.0 |
| Legal | Yes | 30 | 100 |
| | No | 0 | |
| Mental Health | Yes | 33 | 91.7 |
| | No | 3 | 8.3 |
| Social Services | Yes | 29 | 90.6 |
| | No | 3 | 9.4 |
| Community Leaders | Yes | 101 | 72.1 |
| | No | 39 | 27.9 |

leader types have participated in these efforts. The community leader types with the lowest percentages were county commissioners (50.7%) and medical (50%). To test for significant differences among the community leader types, a chi-square test was conducted. Table 17 shows the results of this test. Community leaders showed patterns of participation in community efforts to address violence against women that significantly varied from chance.

The independent variables were found to be weakly to moderately intercorrelated with the Pearson product–moment correlations in the range of –.014 to –.582 (see Table 18). Several items were significantly intercorrelated with other

Table 17

Chi-square of Participation Community Efforts to Address Violence Against Women

| | Value | *df* | Asymp. Sig. (2-sided) |
|---|---|---|---|
| Pearson chi-square | 48.650 | 6 | .000 |
| Likelihood ratio | 57.922 | 6 | .000 |

items. The item violence is legitimate response to conflict is negatively correlated (–.143) with viewing violence as a personal and private matter. It is significant at the .01 level. The belief in the effectiveness of prevention programs and viewing violence as a legitimate response to conflict were positively correlated (.190) and significant at the .01 level. Two items, belief that violence is a personal and private matter (–.208) and the belief that prevention programs are effective (.222), were significantly intercorrelated with personal familiarity with efforts in the community to reduce violence against women. The belief that violence is a personal and private matter is negatively correlated with the familiarity with efforts in the community to prevent violence at the .01 level. The familiarity item and the prevention program were significant at the .05 level. Gender was significantly intercorrelated with the belief that violence is personal and private (–.202), viewing violence as a legitimate response to conflict (.145), and personal familiarity with programs (.134). The personal and private item was negatively intercorrelated with gender. The personal and private item and personal familiarity with programs item were significant at the .05 level. Gender and viewing violence as a legitimate response were significant at the .01 level. Age was significant at the .01 level with three of the items: belief that

Table 18

Zero-Order Correlation Matrix of Independent Variables

| | Personal | Legitimate Response | Prevention Programs | Personal Familiarity | Gender | Age | Actively Involved | Partici-pation | Depend. Variable |
|---|---|---|---|---|---|---|---|---|---|
| Personal and Private | 1.00 | | | | | | | | |
| Legitimate Response | −.143** | 1.00 | | | | | | | |
| Prevention Programs | −.093 | .190** | 1.00 | | | | | | |
| Personal Familiarity | −.208** | .119* | .222* | 1.00 | | | | | |
| Gender | −.202* | .145** | .055 | .134* | 1.00 | | | | |
| Age | .165** | −.005 | −.081 | −.258** | −.175** | 1.00 | | | |
| Actively Involved | −.014 | .074 | .069 | .197** | −.050 | .323** | 1.00 | | |
| Participa-tion*** | .267** | −.157** | −.145** | −.582** | −.168** | .237** | −.179* | 1.00 | |
| Dependent Variable | −.386** | .180** | .290** | .100 | .213** | −.108 | .050 | −.191** | 1.00 |

*Significant at the .05 level.
**Significant at the .01 level.
***Participation 1 = yes; 0 = no.

violence is personal and private (.165), personal familiarity with efforts in the community to reduce violence against women (–.258) and gender (–.175). As age increases, the participant's knowledge of efforts in the community to reduce violence against women decreases, which would be expected because violence against women has only recently been recognized as a social problem. The older the participants, the more likely they are to be male. Respondents who indicated that they were involved in public health issues in their community were intercorrelated with personal familiarity with efforts in the community (.197) and age (.323). Participation in efforts to reduce violence against women is intercorrelated with all of the items. It was negatively intercorrelated with the belief that violence is a legitimate response to conflict, belief that prevention programs can reduce violence against women, personal familiarity with efforts to reduce violence against women, gender and active participation in public health issues. It was significant at that .01 level with: belief that violence is a personal and private matter item (.267), belief that violence is a legitimate response to conflict item (–.157), belief that prevention programs can be effective (–.145), personal familiarity with efforts in reducing violence against women in your community (–.582), gender (–.168) and age (.237). Active involvement in public health issues (–.179) was significant at the .01 level. (The variable role code was not included in the analysis as it was a nominal variable and is not appropriately used in the correlation analysis.

The relationships between the independent variables and the dependent variable were weak to moderate in the range from .05 to –.386. The attitudinal variables, viewing violence as personal and private, viewing violence as a legitimate response to conflict, and the view that prevention programs work, were all significantly correlated at the .01 level. Viewing violence as personal and private was

negatively correlated (–.386) with the perception that violence against women should be a public health issue. This indicates that those respondents who disagree with viewing violence as personal also feel that violence against women should be a public health issue. The other attitudinal variable that was correlated with the dependent variable was the view that prevention programs work (.290). Those who feel that programs work also tend to feel that violence against women should be a public health issue. The prior experience variables, personal familiarity, actively involved public health issues, and participation in programs, were weakly correlated with one, participation (–.191), significant at the .01 level. It appears that those who participate in programs that address the issue of violence against women do not necessarily support the view that violence should be addressed as a public health issue. The demographic variables in the equation, gender (.213) and age (–.108), only gender was significant at the .01 level. They do indicate that females and the younger community leader types are more likely to support violence against women as a public health issue.

To help determine how the independent demographic, attitudinal and prior experience variables explain violence against women as a public health issue, a multiple regression was conducted (Table 19). For the multiple regression, the stepwise model was used. This allowed both conservative criteria (pin at .05 and POUT at .10) and inserted the variables until the equation is satisfactory. All of the slopes were significant at the .05 level.

Inserting the variables in the stepwise manner, three of the nine original variables inserted met the criteria, two of the attitudinal and one demographic characteristic. Respondents who felt that violence was not personal and private and government should get involved also feel that violence is a public health issue and

therefore should be addressed the public health department. Also, not surprisingly, respondents who felt that prevention programs work felt that violence against women should be viewed as a public health issue. Women are more likely to believe that violence against women is about public health and should be addressed in that manner. Altogether, 25% of the variance in attitude toward violence against women as a public health issue is explained by these three variables.

Table 19

Regression Table for Variables in Equation

| Variable | $r$ | $r^2$ | Beta | $t$ | Sig |
|---|---|---|---|---|---|
| Violence is personal and private | .393 | .155 | –.347 | –7.320 | .000 |
| Prevention programs can be effective | .486 | .236 | .285 | 5.591 | .000 |
| Gender of respondent* | .499 | .249 | .116 | 2.227 | .000 |

$F = 32.198, p \leq .000$
Constant = 21.880
*Male = 1, Female = 2

# CHAPTER V

## SUMMARY AND DISCUSSION

The purpose of this thesis was to explore which factors, demography, attitude, or prior experience, would affect support for treating violence against women as a public health issue. The data were collected through a statewide mailed survey to six types of community leaders in all 50 public health catchment areas in Michigan. The response rates for the community leader types ranged from a low of about 50% for county commissioners to a high 84% for mental health community leaders. The overall response rates for the six types of community leaders was 66.9%. Such a rate is generally considered excellent for mailed surveys.

The dependent variable was created after examining 10 survey items as measures of support for violence against women as a public health issue. Following a zero-order correlational analysis, 9 items were selected to create a summative scale, support for treating violence against women as a public health issue. Scores on the summative scale ranged from a low of 9 to 37.

The demographic analysis of the types of community leaders showed both similarities among the groups as well as differences. The community leader types seemed to be fairly homogenous when looking at the overall data for both age and gender. Overall, 67% of the community leaders were between the ages of 40 and 59. However, there were significant differences among the community leader types with respect to age. The mental health and the general community leaders tended to be

younger (in the 20–39 range) and the county commissioners tended to be older (60 or older range).

When focusing on the overall data in the gender category, the leader types were nearly evenly distributed between men and women (46.9% and 53.1%), but when comparing the community leader types, chi-square showed that there were significant differences among the community leader types. Two types were disproportionately male, county commissioners and legal community leaders, which would be expected. Women are overrepresented in the mental health leader types and in the general community leaders. The results in the mental health area were not unexpected, but the general community leader type results were somewhat of a surprise. One explanation might be that when asked to identify community leaders in public health and violence against women, health officers did indeed identify women who were volunteers in those areas in the community rather than more general business or professional types who often serve as community leaders.

The attitudinal factor was measured using three survey items:

1. Violence in interpersonal relationship is private and personal, and governmental agencies have no business getting involved.

2. Reduction of viewing violence as a legitimate response to difficult interpersonal situations to assist in the reduction of violence against women.

3. Prevention programs can be effective in reducing the incidence of violence against women.

In general, community leaders overwhelmingly disagree or strongly disagree that violence is private and personal, but there are significant differences among types where this factor is concerned. The item was intercorrelated with the following items: viewing violence as a legitimate response to conflict, personal familiarity with efforts

to reduce violence against women, gender, age, and participation in programs. Someone who disagreed that violence is private also tends to not feel that violence is a legitimate response to interpersonal conflict. Those who have a high level of personal familiarity with efforts in the community and participation in community efforts also are more likely to disagree with the view that violence is personal and private. Age and gender also impact the view of violence as personal and private. Women are more likely to view violence as personal and private as are older respondents.

The question for the second item was asked differently from the others. The actual question asked was whether "reducing the risk of viewing violence as a legitimate response to difficult interpersonal situations would have no or little effect, moderate effect, or major effect in preventing violence against women in your catchment area?" Most of the legal community leaders (89.7%), not surprisingly, responded that they felt that this would have a major effect. In contrast, fewer than half of the county commissioners (39.2%) responded that they felt this would have a major effect. The types of community leaders were again significantly different in their perspectives on whether this would reduce violence against women. The belief that prevention programs can reduce violence against women, personal familiarity with efforts to reduce violence against women, gender, and participation in programs to reduce violence against women were intercorrelated with the item focusing on violence as a legitimate response. Those who participate in programs to reduce violence against women are less likely to believe that reducing the view that violence is legitimate will address the issue of violence against women in their community. Respondents who believe that prevention programs work and men are more likely to

believe that a reduction in viewing violence as a legitimate response to interpersonal conflict will have an effect.

Prevention programs and their perceived value in reducing violence against women was the final attitudinal measure. The medical community type had the lowest percentage of respondents strongly agreeing (12%) with the perception of the effectiveness of prevention programs. County commissioners were the second lowest with 37.8% of respondents strongly agreeing. Participation in efforts to reduce violence against women is negatively correlated with the belief that prevention programs work. Those who are in the field working with programs tend to feel that prevention programs in the community to reduce violence against women do not actually work.

Three items were used to measure the prior experience factor:

1. Rate your personal familiarity with programs and efforts in your community to reduce violence against women.

2. How long have you been actively involved in helping to address the public health problems in your community?

3. Have you participated in community-based efforts to address the issue of violence against women, either privately or professionally?

Not surprisingly, 83% of social service community leaders rated their personal familiarity with efforts to address violence against women programs and efforts in their community as knowledgeable or very knowledgeable. This result would be expected. Social service community leaders would interact with these programs in their professional capacity. Forty-two percent of the medical community reported that they felt they were very knowledgeable of programs to reduce violence against women. The literature indicates that the medical community has been hesitant to

become involved in the issue of violence against women; therefore, these results were relatively high. Again, the interactions and knowledge may come from their professional status. The items age, active involvement in public health issues, and participation in efforts to reduce violence against women were significantly intercorrelated with personal familiarity with efforts to reduce violence against women. This indicates that younger leaders, those actively involved in public health issues, and persons who tend to participate in programs are more familiar with the efforts in the community. Overwhelmingly, mental health and social service community leader types generally have more active involvement in public health issues. County commissioners generally had the fewest years of active involvement, which was surprising, as many county commissions have boards that address the issues and assist the public health department in making policy decisions in the public health area. Both of these items were found to be significantly different among the community leader types using ANOVA. The diversity of the community leaders would indicate these differences. Participation in efforts to address violence against women was the final item. Three community leader types, legal (100%), mental health (91.7%), and social services (90.6%), had high levels of participation in community-based efforts to reduce violence against women. The medical community leader type showed significant lower rates of participation (50%) in efforts to reduce violence against women. This again points to the limited support in the medical community for programs to address the issue of violence against women.

A zero-order Pearson product–moment correlation was computed for all the dependent and independent variables. Five of the nine independent variables were significantly intercorrelated with the dependent variable. Viewing interpersonal violence as personal and private matter and those who participation in programs to

reduce violence against women were negatively intercorrelated with the dependent variable, support for treating violence against women as a public health issue. It appears that respondents who participate in programs tend to believe that violence against women should not be a public health issue. One explanation for this finding might be that they fear competition for resources for already struggling programs. Women, those who believe prevention programs work, and those who feel that if we can reduce the perception that violence is an acceptable solution to interpersonal conflict also appear to support the view that violence against women should be addressed by public health.

The next step was to determine whether these factors, demographic characteristics, attitude, and experience, contributed to the support for violence against women as a public health issue. A multiple regression using the step-wise model was conducted. The model created by this process included two attitudinal factors, viewing interpersonal violence as a personal and private and the view that prevention programs work, and one demographic variable, gender. Altogether these three items explained 25% of the variance in the dependent variable. The first item, violence in interpersonal relationships is private and personal and governmental agencies have no business getting involved, was the best predictor of support for violence against women as a public health issue. This was not surprising, although the fact that it was the top predictor was not expected. The second item, prevention programs can be effective in reducing the incidence of violence against women, was more surprising. At the zero-order level, although weak, there had been a negative relationship between this variable and support for violence against women as a public health issue. However, when it entered the multiple-regression model, it had a positive slope. Apparently, when the personal and private attitudinal item is

controlled, the belief that prevention programs can be effective has a positive impact on the dependent variable. Of the demographic items, gender was the only item that entered the equation. The literature and this research supports that fact that women are more likely to be involved in the issues of violence against women and therefore would tend to support the introduction of public health to increase the efforts to reduce violence against women in their communities.

So what are the implications for support for public health and the issue of violence against women? As the media and literature indicate, violence against women is a serious social and health problem in communities throughout the United States. Many community groups and social agencies have made efforts to reduce violence with the hope of eliminating the incidence of violence against women. The issues that affect this violence are complex and varied. The most important questions are: What can public health bring to the violence against women issue? and What support will public health have if it enters into this complex social problem?

Public health has addressed many social and health problems using the public health protocol. This protocol includes the following tools: (a) epidemiology, (b) surveillance, and (c) risk factor definition (Rosenberg et al., 1984, pp. 125–126). Using these three tools has assisted public health in reducing some of the social and health problems that have impacted communities. They have been applied to such diverse problems as teenage pregnancy, bike helmet safety, infant immunization, and smoking, with mixed success.

When it was identified that children and adults involved in bike accidents were more likely to be seriously injured or killed when not wearing head protection, public health began an informational campaign to educate and encourage parents in the use of bike helmets. Through a massive educational blitz with the assistance of bike

helmet manufacturers, the bicycle industry, and public health, the campaign has been very successful. All one has to do is drive on any street where children are riding bikes and one realizes the impact that this particular public health campaign has had. As further evidence, many communities require you to wear helmets if riding on community bike trails. This campaign to protect children and adults has been very successful and has reduced injury and death for children and adults alike, therefore reducing the medical costs in the community.

Infant immunization is another area in which public health and the education protocols designed to raise awareness of the danger of not having infants immunized have been very successful by public health. By identifying children in the community who are not being immunized and then targeting the education protocols for this population, the proportion of children who have received their immunizations has improved. This again protects the children as well as the community from health and social problems that are associated with children not being immunized.

Public health has not always been successful in its campaigns to impact social and health problems. Teenage pregnancy is one area in which public health and the protocols have not been as effective.

If public health is to enter the violence against women issue, it will need to identify where the support for its entrance into this complex problem lies. The support for treating violence against women as a public health issue is found with community leaders who tend to feel that violence against women is not personal and private and therefore government does have an obligation to intervene. This will include community leaders who are younger and female. The county commissioner leader type, largely older males, are least supportive of treating violence against women as a public health issue. Public education programs may have some impact on

this group. Educational attempts to increase support for public health programs to reduce the incidence of violence against women at the local community level will, however, find more receptive audiences among those who support governmental intervention: legal community leaders and mental health, social service, and general community leader types.

The belief that prevention programs work to reduce the incidence of violence against women is also a predictor of support for treating violence against women as a public health issue. Attempts to increase support should be targeted toward prevention programs and those who support those programs. According to the findings, women tend to support the view that public health should be an agency assisting in the reduction of violence against women.

This is a very preliminary study of a large data set, but it does give some indication of where community support exists for public health entering the area of violence against women. The community leaders generally seem to view interpersonal violence as not personal, but to what level they want government to intervene and which governmental agency they want to intervene is still not clear. What is clear is that if public health is going to begin to address the issue of reduction of violence against women, it will have to enter with a limited support base in the community. According to this study, people with the highest level of participation in existing programs to address the issue of violence against women tend not to support public health entering the field. Therefore, public health will have to address the issue of resources, both financial and support for programs, at the community level. If local public health agencies are seen as competing for these resources, their presence may not be welcome.

# Appendix A

## Cover Letter

DATE

FIELD(Title ) FIELD(First name) FIELD(Last name)
FIELD(Title 2)
FIELD(Street address)
FIELD(City and state)

Dear FIELD(Title ) FIELD(Last name):

Earlier this fall, you received a survey from the Michigan Department of Community Health about the role of local public health in the prevention of violence against women. For the purpose of this survey, **violence against women is defined broadly as the threatened or actual intentional use of physical, sexual and/or psychological/emotional force against a woman.** If you completed the survey, we thank you. If, however, you have not yet returned your questionnaire, it is essential that we have the highest possible response rate for the data to be scientifically valid. Please complete the attached questionnaire and mail it to us in the enclosed self-addressed stamped envelope.

Advanced Data Services, Inc. is conducting this survey under contract from the Michigan Department of Community Health and will compile the results. Please be assured that your responses will be kept confidential. The code numbers on the questionnaires are needed to permit us to monitor returns and to follow-up to get the best possible response rate. No data will, however, be reported in a manner where the views of an individual could be identified.

If you have any questions about the survey, please call Advanced Data Services, Inc. (616-327-4300). Thank you for your participation in this Michigan Department of Community Health survey.

Sincerely,

James C. Petersen
President
Advanced Data Services, Inc.

# Appendix B

## Survey Instrument

# MALPH Project on the Role of Public Health in the Prevention of Violence Against Women

## Identification of Community Leaders on Public Health Issues

First, please provide the names, addresses, and phone numbers of County Commissioners in your catchment area who serve on the public health committee or similar body that has a direct influence on the policy and strategic planning for your health department.

**Name:** _____
**Address:** _____
_____
_____
**City:** _____ **Zip:** _____
**Telephone:** _____

**Name:** _____
**Address:** _____
_____
_____
**City:** _____ **Zip:** _____
**Telephone:** _____

**Name:** _____
**Address:** _____
_____
_____
**City:** _____ **Zip:** _____
**Telephone:** _____

**Name:** _____
**Address:** _____
_____
_____
**City:** _____ **Zip:** _____
**Telephone:** _____

Next, we would like you to identify one individual who fits each of the following four role descriptions. While we will be sending these people a questionnaire about the role of public health in the prevention of violence against women, the person may or may not have focused on injury issues. What is important is that the person have some visibility and have demonstrated leadership related to local public health issues. If no such person exists for a role description, please write "None" in the name field for that role description.

Please identify a leader in the **medical community** (not your department's medical officer) who plays an important role in influencing public health policies, issues, or programs in your catchment area. This individual should have a track record of working on community-level public health issues.

**Name:** _____

**Address:** _____

_____

_____

**City:**_____ **Zip:**_____

**Telephone:** _____

Please identify a member of the **legal community** (e.g., prosecutor, private attorney, or law enforcement officer) who has played an important role in influencing public health policy, issues, or programs in your catchment area.

**Name:** _____

**Address:** _____

_____

_____

**City:**_____ **Zip:**_____

**Telephone:** _____

Please identify a member of the **mental health community** (either in community mental health or in private practice) who has demonstrated active involvement in local public health policy, issues, or programs.

**Name:** _____

**Address:** _____

_____

_____

**City:**_____ **Zip:**_____

**Telephone:** _____

Please identify a member of the **social service community** (either a private practitioner or someone who works with a public or private local social service agency) who has demonstrated active involvement in local public health policy, issues. or programs.

**Name:** _____
**Address:** _____
_____
_____
**City:**_____ **Zip:**_____
**Telephone:** _____

Finally, please provide up to six additional names of local community leaders. not limited by the role descriptions above. These individuals should be people who have in the past or who currently play a significant role in influencing local public health policy, supporting health promotion programs, and helping set the local public health agenda. These individuals should not be current County Commissioners. They may have served on various advisory boards for local public health or may be identified due to their public or professional actions that have contributed to the advancement of local public health policies or programs.

**Name:** _____
**Address:** _____
_____
_____
**City:**_____ **Zip:**_____
**Telephone:** _____

**Name:** _____
**Address:** _____
_____
_____
**City:**_____ **Zip:**_____
**Telephone:** _____

**Name:** _____
**Address:** _____
_____
_____
**City:**_____ **Zip:**_____
**Telephone:** _____

**Name:** _____

**Address:** _____

_____

_____

**City:** _____ **Zip:** _____

**Telephone:** _____

**Name:** _____

**Address:** _____

_____

_____

**City:** _____ **Zip:** _____

**Telephone:** _____

**Name:** _____

**Address:** _____

_____

_____

**City:** _____ **Zip:** _____

**Telephone:** _____

Thank you for your cooperation in identifying local community leaders for the upcoming MALPH-sponsored survey on the role of public health in the prevention of violence against women. Please return your completed listing of names of community leaders in the enclosed postage-paid envelope to:

Advanced Data Services, Inc.
8135 Cox's Drive
Kalamazoo, MI 49002
616-327-4300

## Local Public Health Issue Survey
## (Key Informants)

1. Please rate the importance of each of the following public health problems in your community. (Circle the number that shows the importance of each problem.)

| | Not Important | | | | Highly Important |
|---|---|---|---|---|---|
| Infant mortality | 1 | 2 | 3 | 4 | 5 |
| Drug and alcohol abuse | 1 | 2 | 3 | 4 | 5 |
| Youth suicide | 1 | 2 | 3 | 4 | 5 |
| Homicide | 1 | 2 | 3 | 4 | 5 |
| Motor vehicle crashes | 1 | 2 | 3 | 4 | 5 |
| Sexually transmitted diseases | 1 | 2 | 3 | 4 | 5 |
| Violence against women | 1 | 2 | 3 | 4 | 5 |
| Unintentional Injury (e.g., burns, falls, sport injuries, etc.) | 1 | 2 | 3 | 4 | 5 |
| Childhood infectious diseases | 1 | 2 | 3 | 4 | 5 |
| Chronic diseases (e.g., cancer, heart, diabetes, etc.) | 1 | 2 | 3 | 4 | 5 |

2. To the best of your knowledge, how active would you say your local health department is in efforts to reduce violence against women in your community?

| 1 | 2 | 3 | 4 | 5 | 6 |
|---|---|---|---|---|---|
| Not Active | | | | Highly Active | Don't Know |

3. Do you agree or disagree with the following statement: "I would support the active participation of my local public health department in implementing programs to address violence against women in our community."

| 1 | 2 | 3 | 4 |
|---|---|---|---|
| Strongly Disagree | Disagree | Agree | Strongly Agree |

4. Do you agree or disagree with the following statement: "Preventing violence against women should be a goal of my local health department."

| 1 | 2 | 3 | 4 |
|---|---|---|---|
| Strongly Disagree | Disagree | Agree | Strongly Agree |

5. In your opinion, would you say the following would be a **large barrier, a barrier, or not a barrier** to implementing violence against women prevention programs at your health department?

| | Not A Barrier | A Barrier | A Large Barrier | Don't Know |
|---|---|---|---|---|
| Violence against women is not a major concern of this local health department's primary constituency | 1 | 2 | 3 | 4 |
| Lack of skill and expertise in this area | 1 | 2 | 3 | 4 |
| Turf battles with other agencies | 1 | 2 | 3 | 4 |
| Case-finding is too difficult because the target group conceals their status | 1 | 2 | 3 | 4 |
| Violates the confidentiality and privacy of families | 1 | 2 | 3 | 4 |
| Reluctance of physicians/nurses to ask about the cause and context of women's injuries | 1 | 2 | 3 | 4 |
| Lack of funds | 1 | 2 | 3 | 4 |
| Time spent on violence against women inhibits progress on other public health concerns | 1 | 2 | 3 | 4 |
| Reluctance of non-medical program staff (e.g., family planning) to ask women if they are in a violent relationship | 1 | 2 | 3 | 4 |

6. Thinking about all of the public health problems in your community, what priority should your local health department place on efforts to prevent violence against women?

| 1 | 2 | 3 | 4 | 5 |
|---|---|---|---|---|
| high priority | above average | average | below average | low priority |

**Please indicate your personal position with regard to the following questions by circling the appropriate number.**

7. Violence against women is primarily an issue for the criminal justice system.

| 1 | 2 | 3 | 4 |
|---|---|---|---|
| Strongly Disagree | Disagree | Agree | Strongly Agree |

8. Violence against women is primarily an issue for social service agencies.

| 1 | 2 | 3 | 4 |
|---|---|---|---|
| Strongly Disagree | Disagree | Agree | Strongly Agree |

9. Violence against women is primarily an issue which should be addressed by the educational system.

| 1 | 2 | 3 | 4 |
|---|---|---|---|
| Strongly Disagree | Disagree | Agree | Strongly Agree |

10. Violence in interpersonal relationships is private and personal, and governmental agencies have no business getting involved.

| 1 | 2 | 3 | 4 |
|---|---|---|---|
| Strongly Disagree | Disagree | Agree | Strongly Agree |

11. Local Public Health agencies should assume a leadership role in preventing violence against women.

| 1 | 2 | 3 | 4 |
|---|---|---|---|
| Strongly Disagree | Disagree | Agree | Strongly Agree |

12. Local health departments should have an active role in developing policies, at the local level, which address the prevention of violence against women.

| 1 | 2 | 3 | 4 |
|---|---|---|---|
| Strongly Disagree | Disagree | Agree | Strongly Agree |

13. Local health departments should have an active role in describing and tracking the number of incidents of violence against women in the communities in their jurisdiction.

| 1 | 2 | 3 | 4 |
|---|---|---|---|
| Strongly Disagree | Disagree | Agree | Strongly Agree |

14. Local health departments should have an active role in collecting and reporting on data concerning the risk factors for violence against women.

| 1 | 2 | 3 | 4 |
|---|---|---|---|
| Strongly Disagree | Disagree | Agree | Strongly Agree |

15. Local health departments should have an active role in developing and implementing programs to prevent violence against women.

| 1 | 2 | 3 | 4 |
|---|---|---|---|
| Strongly Disagree | Disagree | Agree | Strongly Agree |

16. Local health departments should have an active role in gaining political recognition of violence as a public health threat.

| 1 | 2 | 3 | 4 |
|---|---|---|---|
| Strongly Disagree | Disagree | Agree | Strongly Agree |

17. Many factors may increase the risk of violence within families. In your opinion, would **reducing** the following risk factors have **no or little effect, a moderate effect, or a major effect** in preventing violence against women in your community.

| | No Effect | Little Effect | Moderate Effect | Major Effect |
|---|---|---|---|---|
| Viewing violence as a legitimate response to difficult interpersonal situations | 1 | 2 | 3 | 4 |
| Early, teenage marriage | 1 | 2 | 3 | 4 |
| Unemployment of husbands | 1 | 2 | 3 | 4 |
| Housing instability/homelessness | 1 | 2 | 3 | 4 |
| Drug and alcohol abuse | 1 | 2 | 3 | 4 |
| Economic dependence of women on their husbands | 1 | 2 | 3 | 4 |
| Depression and anxiety | 1 | 2 | 3 | 4 |
| Children fathered out of wedlock | 1 | 2 | 3 | 4 |
| Low education | 1 | 2 | 3 | 4 |
| Child abuse | 1 | 2 | 3 | 4 |
| Witnessing family violence as a child | 1 | 2 | 3 | 4 |
| Poor economic opportunity | 1 | 2 | 3 | 4 |
| Community norms that condone fighting and violence | 1 | 2 | 3 | 4 |
| Divorce and separation | 1 | 2 | 3 | 4 |

18. In your opinion, would you say the following would be **an important benefit, a benefit, or not a benefit** of implementing prevention programs at your health department that address violence against women?

| | Not A Benefit | A Benefit | An Important Benefit | Don't Know |
|---|---|---|---|---|
| Expanding the scope of the health department's work | 1 | 2 | 3 | 4 |
| Getting to collaborate with non-traditional community partners | 1 | 2 | 3 | 4 |
| Building the capacity and skills of our staff | 1 | 2 | 3 | 4 |
| Increased opportunities for funding | 1 | 2 | 3 | 4 |
| Building greater recognition for our health department in the community | 1 | 2 | 3 | 4 |
| Help our health department achieve its goals | 1 | 2 | 3 | 4 |

19. In your opinion, would you say each of the following interventions would have **no or little effect, a moderate effect, or a major effect** in preventing violence against women?

| | No Effect | Little Effect | Moderate Effect | Major Effect | Don't Know |
|---|---|---|---|---|---|
| Screening of injury and trauma patients by health care providers | 1 | 2 | 3 | 4 | 5 |
| Family support and preservation programs | 1 | 2 | 3 | 4 | 5 |
| Increasing the certainty of a jail sentence for batterers | 1 | 2 | 3 | 4 | 5 |
| Increasing the length of jail sentences for batterers | 1 | 2 | 3 | 4 | 5 |
| Treatment and rehabilitation programs for batterers | 1 | 2 | 3 | 4 | 5 |
| Building more womens' shelters | 1 | 2 | 3 | 4 | 5 |
| Home visits by public health nurses to "at risk" families | 1 | 2 | 3 | 4 | 5 |
| Educating policy makers about the extent and seriousness of spouse/partner violence | 1 | 2 | 3 | 4 | 5 |
| Training police to identify and refer violent families | 1 | 2 | 3 | 4 | 5 |
| Media and public information campaigns about spouse/partner violence | 1 | 2 | 3 | 4 | 5 |
| Reducing societal unemployment | 1 | 2 | 3 | 4 | 5 |
| Mediation between batterer and woman | 1 | 2 | 3 | 4 | 5 |
| Tracking women with recurring injuries to improve case identification at ERs, clinics, and physician practices | 1 | 2 | 3 | 4 | 5 |
| Publicizing the domestic violence hot line phone number | 1 | 2 | 3 | 4 | 5 |
| Programs in schools to discourage dating violence | 1 | 2 | 3 | 4 | 5 |
| Assisting battered women to make life plans during the transition from shelter to community | 1 | 2 | 3 | 4 | 5 |
| Screening for spouse/partner violence during routine checkups at primary medical care settings | 1 | 2 | 3 | 4 | 5 |
| Teaching families to resolve disputes non-violently | 1 | 2 | 3 | 4 | 5 |
| Training health care staff to identify and refer victims of violence | 1 | 2 | 3 | 4 | 5 |

20. For each of the following please **circle** the score which best describes how programs to prevent violence against women at your health department would be ...

| | | | | | | |
|---|---|---|---|---|---|---|
| Complex to implement | 1 | 2 | 3 | 4 | 5 | Simple to implement |
| Easy | 1 | 2 | 3 | 4 | 5 | Difficult |
| More effective than criminal justice approaches | 1 | 2 | 3 | 4 | 5 | Less effective than criminal justice approaches |
| Undesirable | 1 | 2 | 3 | 4 | 5 | Desirable |
| More effective than social services approaches | 1 | 2 | 3 | 4 | 5 | Less effective than social service approaches |
| Will produce positive reactions from the community | 1 | 2 | 3 | 4 | 5 | Will produce negative reactions from the community |
| Worthwhile | 1 | 2 | 3 | 4 | 5 | Worthless |
| Require major changes in this health department's operations & procedures | 1 | 2 | 3 | 4 | 5 | Require minor changes in this health department's operations & procedures |
| Full of potential to reduce levels of violence | 1 | 2 | 3 | 4 | 5 | Unlikely to reduce levels of violence |
| Of unknown effectiveness | 1 | 2 | 3 | 4 | 5 | Proven to work |
| New and innovative | 1 | 2 | 3 | 4 | 5 | More of the same |
| Create rivalry with other agencies | 1 | 2 | 3 | 4 | 5 | Create opportunities to form partnerships with other agencies |

21. Historically, public health has employed several approaches to health problem solution. If applied to the problem of violence against women, how valuable do you believe each of the following traditional approaches would be?

| | **Not Valuable** | **Somewhat Valuable** | **Extremely Valuable** | **Don't Know** |
|---|---|---|---|---|
| Historic, strong link with underserved, at risk populations | 1 | 2 | 3 | 4 |
| Basing prevention programs on the reduction of risk factors that are epidemiologically established | 1 | 2 | 3 | 4 |
| Orientation towards solving health problems for entire populations | 1 | 2 | 3 | 4 |
| Tradition of involving the community in needs assessment and problem solution | 1 | 2 | 3 | 4 |
| Integrating the efforts of diverse disciplines to work together to solve problems | 1 | 2 | 3 | 4 |
| Focus and expertise in primary prevention | 1 | 2 | 3 | 4 |

22. How much do you agree or disagree with the following statement: "Prevention programs can be effective in reducing the incidence of violence against women."

| 1 | 2 | 3 | 4 |
|---|---|---|---|
| Strongly Disagree | Disagree | Agree | Strongly Agree |

23. On the following scale, how would you rate your personal familiarity with programs and efforts in your community to reduce violence against women?

| 1 | 2 | 3 | 4 | 5 |
|---|---|---|---|---|
| No Knowledge | | | | Very Knowledgeable |

**Respondent Characteristics**

These last pieces of information are included only to help determine the representativeness of the sample. All responses will, of course, remain anonymous.

24. Sex of the respondent

___ Male
___ Female

25. Age of the Respondent

___ 20-29
___ 30-39
___ 40-49
___ 50-59
___ 60 or older

26. How long have you been actively involved in helping to address the public health problems in your community?

___ less than 2 years
___ 3 to 5 years
___ 6 to 10 years
___ 11 to 20 years
___ 21 years or more

27. Have you participated in any community based efforts to address the issue of violence against women, either in a professional or personal capacity?

___ Yes
___ No

28. How long have you been employed in your current profession?

___ less than 2 years
___ 3 to 5 years
___ 6 to 10 years
___ 11 to 20 years
___ 21 years or more

29. Which of the following best describes your current profession? (Check only one)

___ Medical
___ Nursing
___ Legal
___ Criminal Justice
___ Social Service
___ Not for profit community service
___ Education
___ Public Health
___ Mental Health
___ Counseling
___ Other (please specify) _____

Do you have any additional comments you would like to make about violence against women as a public health issue?

_____

_____

_____

_____

_____

Thank you your participation. Please return your completed questionnaire in the enclosed envelope to:

Advanced Data Services, Inc.
8135 Cox's Drive
Kalamazoo, MI 49002

# Appendix C

## Letter of Permission for Use of Data

JOHN ENGLER, Governor

JAMES K. HAVEMAN, JR., Director

COMMUNITY PUBLIC HEALTH AGENCY

3423 N. MARTIN L. KING JR. BVLD.
PO BOX 30195
LANSING, MI 48909

November 3, 1997

Deborah J. Bartz
7127 Winter Forest
Portage, MI 49024

Dear Ms. Bartz:

This letter is to inform you that you have been granted permission for the one-time use for your Master's Thesis the data from the 1996 MDCH/MALPH survey of Michigan's local public health capacity and role in addressing violence against women. It is our expectation that you will acknowledge the Department and the survey as the source of the data. Additionally, permission will be needed for any publications beyond your thesis which use these data.

Your analysis of patterns of community support for local public health programs designed to prevent violence against women will be of great interest to my office. I would appreciate a copy of your thesis once it is completed. Good luck with your writing. I know that it will be a relief when this step in your graduate school career is completed.

Sincerely,

Patricia K. Smith

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# BIBLIOGRAPHY


Babbie, E. (1990). *Survey research methods* (2nd ed.). Belmont, CA: Wadsworth.

Berk, R. A. (1993). What the scientific evidence shows: On the average, we can do no better than arrest. In R. Gelles & D. R. Loseke (Eds.), *Current controversies on family violence* (pp. 323–337). Newbury Park, CA: Sage.

Breines, W., & Gordon, L. (1983). The new scholarship on family violence. *Signs: Journal of Women in Culture and Society, 8*(3), 490–531.

Browne, A. (1987). *When battered women kill.* London: Collier Macmillan.

Buzawa, E., Buzawa, C. G., & Austin, T. L. (1995). Responding to crimes of violence against women: Gender differences versus organizational imperatives. *Crime & Delinquency, 41*(4), 443–466.

Dobash, R. E., & Dobash, R. P. (1979). *Violence against wives: A case against the patriarchy.* New York: Free Press.

Dobash, R. E., & Dobash, R. P. (1992). *Women, violence and social change.* London: Routledge.

Domestic violence intervention. (1990). *Journal of the American Medical Association, 264,* 939.

Dunham, N. C., & Leetch, L. J. (1997, January). An emerging public health perspective on domestic violence: Implications for Wisconsin physicians and health care organizations. *Wisconsin Medical Journal, 96*(1), 46–50.

Fact Sheet. (1996). *Health care response to domestic violence* [On-line]. Available: http://english.hss.cmu.edu/feminism [November 2, 1996].

Gest, T. (1994). Violent crime is a serious problem. In S. Barbour & K. L. Swisher (Eds.), *Violence: Opposing viewpoints* (pp. 17–22). San Diego: Greenhaven.

Gregor, S., & Galazka, S. S. (1990, March-April).The use of key informant networks in assessment of community health. *Family Medicine, 22*(2), 118–121.

Jones, A. (1994). *Next time, she'll be dead: Battering and how to stop it.* Boston: Beacon Press.

Koss, M. P., Goodman, L. A., Browne, A., Fitzgerald, L., Keita, G., & Russo, N. (1994). *No safe haven.* Washington DC: American Psychological Association.

Kurz, D. (1993). Social science perspectives on wife abuse: Current debates and future directions. In P. Bart & E. Moran (Eds.), *Violence against women: The bloody footprints* (pp. 252–269). Newbury Park, CA: Sage.

Mercy, J. A., Rosenberg, M. L., Powell, K., Broome, C., & Roper, W. (1993, Winter). Public health policy for preventing violence. *Health Affairs*, pp. 7–29.

Mignon, S. I., & Holmes, W. M. (1995). Police response to mandatory arrest laws. *Crime & Delinquency, 41*(4), 430–442.

Monette, D. R., Sullivan, T. J., & DeJong, C. R. (1998). *Applied social research: Tool for the human services.* Orlando: Harcourt.

Moore, M. H. (1993, Winter). Violence prevention: Criminal justice or public health? *Health Affairs*, pp. 124–127.

Murphy, J., & Rickler, M. (1997). *Domestic violence FAQ's men and women against domestic violence* [On-line]. Available: http://www.silcom.com/ [May 8, 1996].

Pizzey, E. (1977). *Scream quietly or the neighbors will hear you.* Short Hills: Ridley Enslow.

Rosenberg, M. L., Mercy, J. A., & Smith, J. C. (1984, Summer). Violence as a public health problem: A new role for CDC and a new alliance with educators. *Educational Horizons,* pp. 124–127.

Sewell, B. D. (1989). History of abuse: Societal, judicial and legislative responses to the problem of wife beating. *Suffolk University Law Review, 23,* 983–1017.

Stark, E., & Flitcraft, A. (1988). Women and children at risk: A feminist perspective on child abuse. *International Journal of Health Services, 18*(1), 97–118.

Stark, E., Flitcraft, A., & Frazier, W. (1979). Medicine and patriarchal violence: The social construction of a "private event." *International Journal of Health Services, 9*(3), 461–493.

Stark, E., Flitcraft, A., Zuckerman, D., Grey, A., Robinson, J., & Frazier, W. (1981). Wife abuse in the medical setting: An introduction for health personnel. *Domestic Violence Monograph Series, No. 7.* Washington, DC: Office of Domestic Violence.

Walker, L. (1979). *The battered woman.* New York: Harper & Row.

Walker, L. ( 1989). *Terrifying love.* New York: Harper & Row.