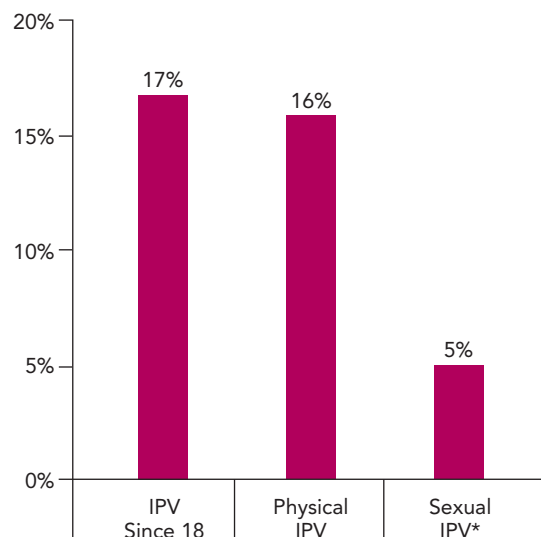


Nearly Four Million California Adults Are Victims of Intimate Partner Violence

Elaine Zahnd, David Grant, May Aydin, Y. Jenny Chia and D. Imelda Padilla-Frausto

Nearly 1 in 6 adults in California, about 3.7 million persons, report experiencing physical intimate partner violence (IPV) as adults.¹ Over one million Californians were forced to have sex (5%) by an intimate partner during adulthood.² Overall, 17.2% of adults—nearly four million Californians—report being a victim of physical and/or sexual IPV as an adult (Exhibit 1). These acts of violence are not merely a criminal justice problem, but a public health problem with deep and lingering social, psychological and health-related costs. Beyond the immediate trauma facing adult victims, IPV incidents may have a prolonged impact on the emotional and mental health of the victims, affect their ability to complete school or maintain employment, and result in adverse health behaviors to cope with the trauma, such as engaging in risky alcohol, tobacco or other drug use. Violence that occurs between intimates or family members is especially damaging when it takes place in the presence of children; previous studies have shown that witnessing violence can lead to intergenerational cycles of violence.³

Exhibit 1
Percent of Adult Victims of Physical or Sexual Intimate Partner Violence Since Age 18, Ages 18-65, California 2007



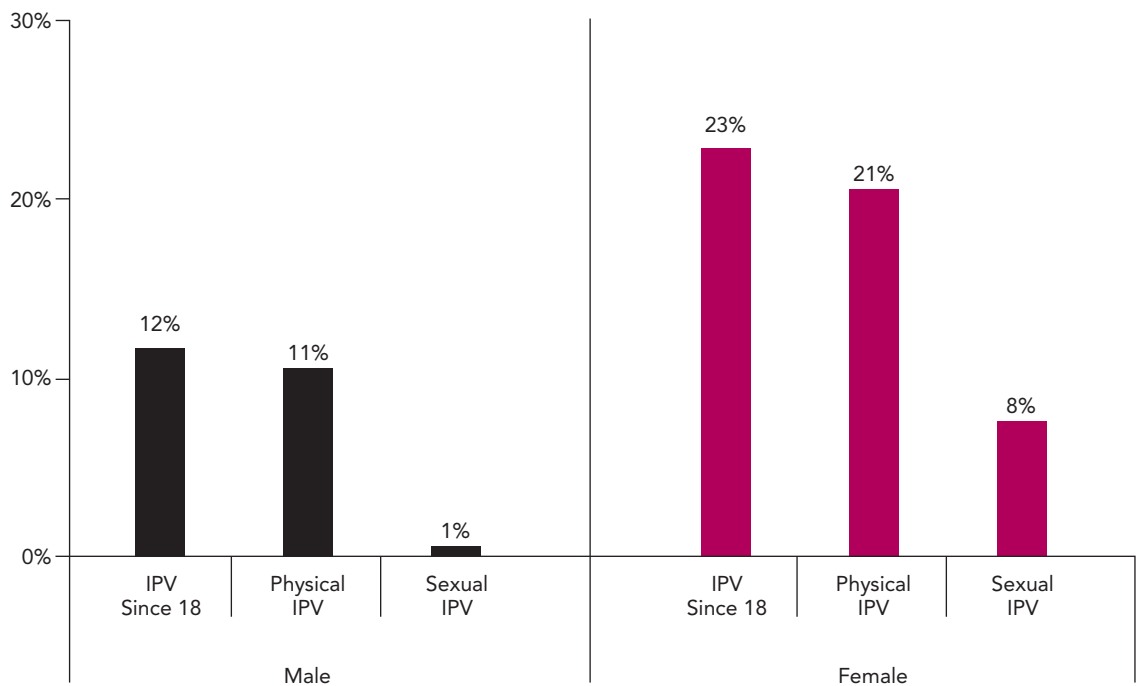
*IPV questions are asked separately allowing for overlap among respondents, thus when rates are combined, they don't add up to 23%.

With the support of the Blue Shield Foundation of California, the 2007 California Health Interview Survey (CHIS 2007) included an adult IPV module. CHIS is a large, general population telephone survey of households in California conducted every other year since 2001 that covers a wide range of health and health-related topics (see Data Source). To assess intimate partner violence, CHIS asked adults ages 18-65 a series of questions to identify persons who have experienced intimate partner violence at any time since turning age 18, the nature of violent incidents they have experienced, and whether or not they were victimized in the past year. Additional questions reveal the relationship of the perpetrator to the victim and whether or not the perpetrator was using alcohol or drugs when the violence occurred.

The Blue Shield Foundation of California funded the research and development of this policy brief.

Exhibit 2

Percent of Adult Victims of Physical or Sexual Intimate Partner Violence Since Age 18 by Gender, Ages 18-65, California 2007



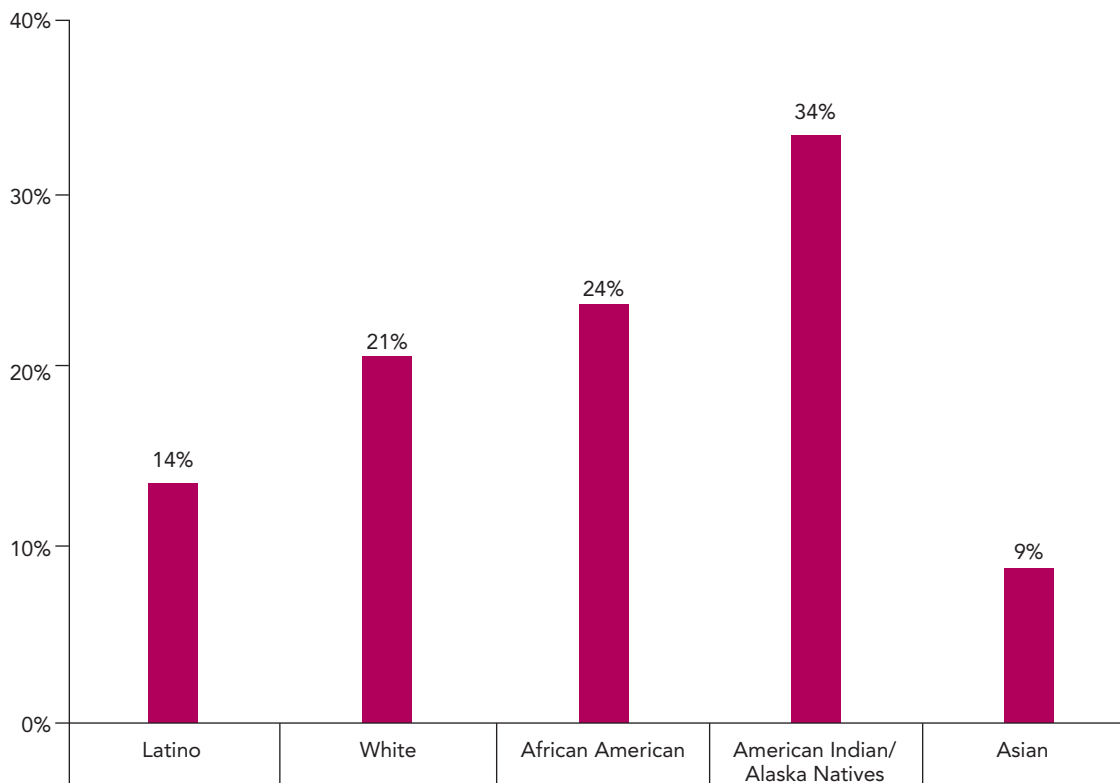
This policy brief presents data from CHIS 2007 about IPV in California. We uncover the patterns of IPV among California's diverse population, such as whether IPV differs due to gender, race/ethnicity, income, education and family status. Since alcohol use has been shown to be linked to violence, we also explore the role of alcohol and other drugs, including perpetrator drinking and drug use, and victim binge drinking.⁴ Prevalence estimates for men, by place of birth for Asians and Latinos, and among bisexual, gay, and lesbian Californians are also topics highlighted in the brief.

Women and American Indians/Alaska Natives More Likely Victims of Intimate Partner Violence

While all demographic groups experience intimate partner violence during adulthood, prevalence rates of IPV are higher among some groups than others. Based on the CHIS 2007 IPV module, women (21.1%) are twice as likely to be victims of physical violence as men (11%), and eight times (8%) as likely to report being the victim of sexual violence compared to men (1%).⁵ The prevalence of physical and sexual violent victimization among Californians reflects stark gender disparities (Exhibit 2).

Percent of Adult Victims of Physical or Sexual Intimate Partner Violence Since Age 18 by Race/Ethnicity, Ages 18-65, California 2007

Exhibit 3



Note: The estimate for Native Hawaiian/Pacific Islanders is too unreliable to report.

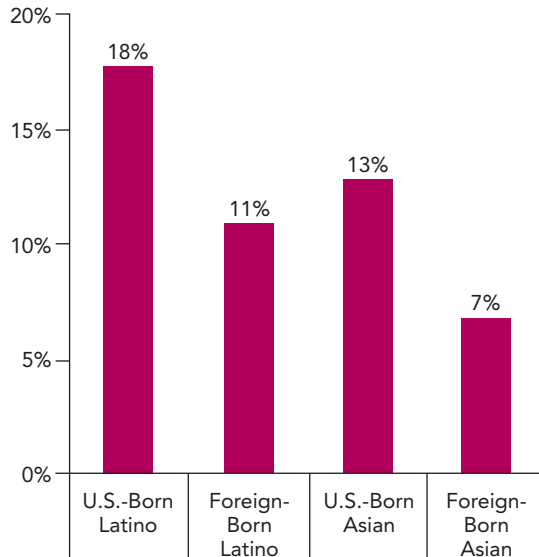
There are also considerable racial/ethnic disparities in intimate partner violence rates in California. The proportion of American Indian/Alaska Natives reporting IPV since age 18 (33.9%) is higher than African Americans (24.4%), Whites (20.6%), Latinos (13.7%) and Asians (8.5%). Compared to all other groups except Asians, Latinos are significantly less likely to be victims of IPV. The IPV prevalence rate among Asians is the lowest among major racial/ethnic groups in California (Exhibit 3). The estimate for the prevalence of adult IPV among Native Hawaiians/Pacific Islanders is unreliable due to small sample size, and therefore is not reported.

Foreign-Born Latinos and Asians Less Likely Victims of Intimate Partner Violence Compared to U.S.-Born Latinos and Asians

Since large proportions of Asian (73.5%) and Latino adults (56.3%) in California are born outside of the U.S., rates of IPV may differ considerably by place of birth, as well as by other proxy indicators of *acculturation* such as language spoken at home, ability to speak English and years in the U.S.⁶ Exhibit 4 illustrates IPV rates during adulthood for U.S.-born and foreign-born Latinos and Asians. The results indicate that while IPV rates for U.S.-born Latinos (17.9%) and

Exhibit 4

Percent of Latino and Asian Adult Victims of Physical or Sexual Intimate Partner Violence Since Age 18 by Place of Birth, Ages 18-65, California 2007



Asians (13.4%) are slightly lower than they are for other racial/ethnic groups, they are much higher than the comparable rates for foreign-born Latinos (10.5%) and foreign-born Asians (7.1%). As with other health behaviors that have been described as the *Latino Paradox*, the more *American* a group becomes, the less healthy, or in this case, the more exposed to violence the group becomes.

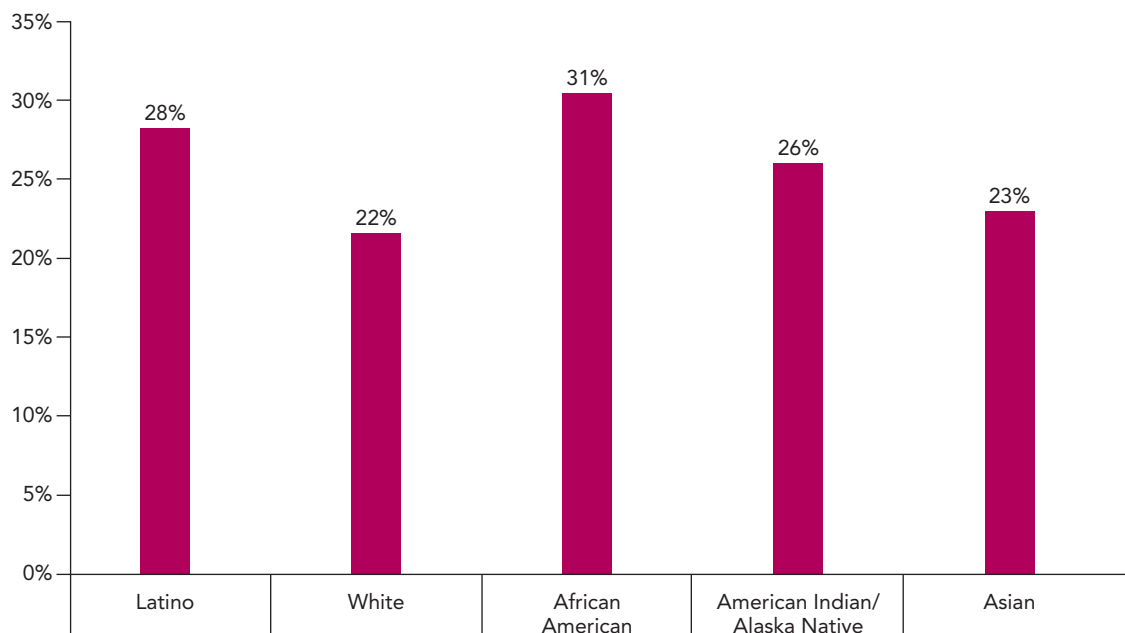
Recent Intimate Partner Violence Incidents More Likely Among African Americans and Latinos

One fourth of California adults who have experienced IPV since turning 18 report being the victim of a recent violent incident, defined as physical or sexual IPV that occurred in the past 12 months.⁷ The approximately 958,000 recent California IPV victims (4.1%), are nearly evenly split between men (50.4%) and women (49.6%) reporting an incident in the past 12 months. However, sharp gender differences emerge for recent sexual IPV (14% male vs. 86% female).

While the prevalence of recent IPV varies by race/ethnicity, the pattern does not mirror the racial/ethnic pattern portrayed among the larger California population who have experienced one or more incidents of IPV since turning age 18. For past 12 month IPV, the proportion of African Americans reporting recent IPV prevalence is highest (30.6%), followed by Latinos (28.3%), American Indian/Alaska Natives (26.1%), Asians (23.4%), and Whites (21.5%).⁸ The only significant differences in rates are between Latino and African-American adults compared to White adults (Exhibit 5).

Percent of Adult Victims of Recent Physical or Sexual Intimate Partner Violence Among Adults Who Experienced IPV Since Age 18, by Race/Ethnicity, Ages 18-65, California 2007

Exhibit 5



Note: Recent physical or sexual IPV is IPV that occurred in the past 12 months, and is asked only of respondents who experienced any IPV since age 18.

The Importance of Marital Status, Sexual Orientation and Family Type

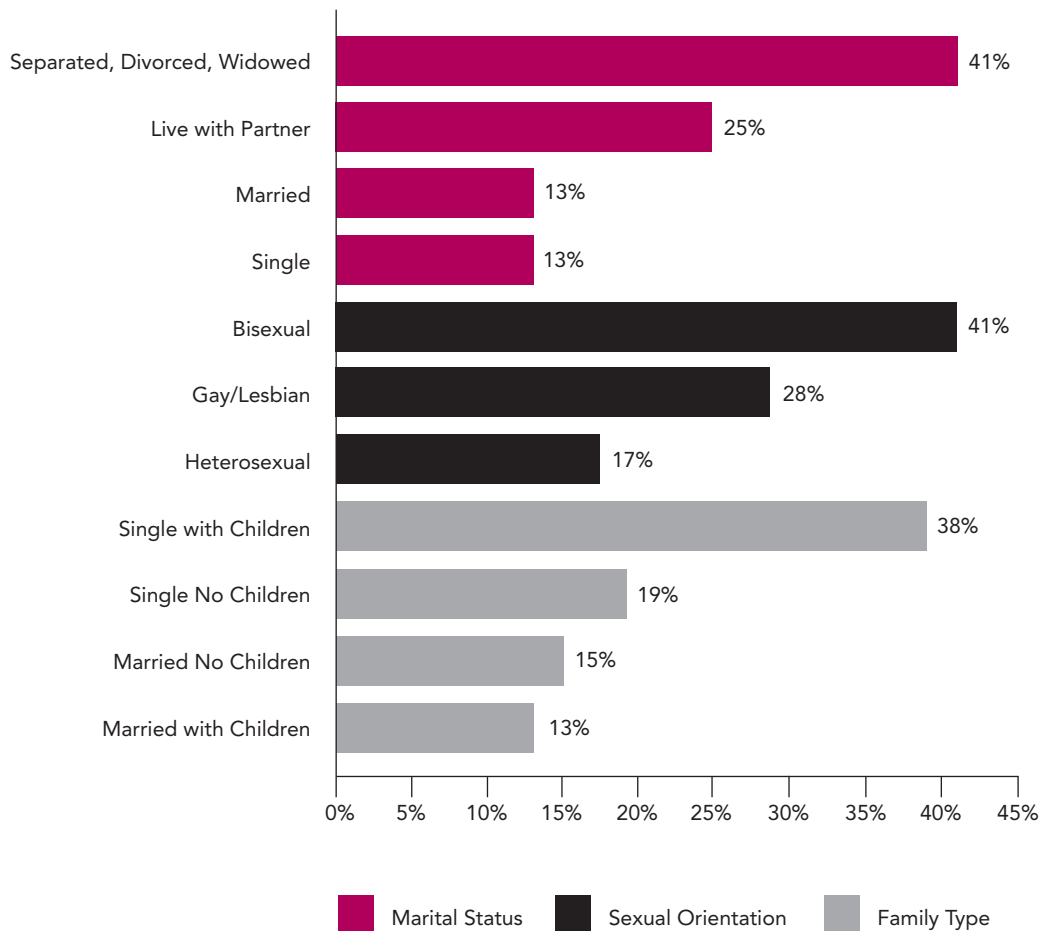
Unlike other forms of more public violence, IPV is typically a private affair that occurs behind closed doors. As such, the context of family life shapes a variety of risk factors associated with IPV. Among Californians, separated, divorced or widowed adults have higher rates of IPV since turning age 18 (41%) than adults living with a partner (24.6%), married (13.3%), or single (13.2%). IPV rates during adulthood also vary by family type with single parents with children having the highest IPV prevalence (38.3%). Single adults without children (18.8%), married adults without children (14.8%), and married adults with children (12.7%) are half as likely to report IPV. Each of these four family types differs significantly from the others (Exhibit 6).

CHIS is one of few large public health surveillance tools that includes questions about sexual orientation, permitting separate estimates for IPV by sexual orientation—and the findings are alarming. Bisexual (40.6%), gay, lesbian or homosexual adults (27.9%) are almost twice as likely to experience IPV as heterosexual adults (16.7%; Exhibit 6). The high rates of IPV among sexual minorities that are identified by CHIS 2007 data warrant further attention and exploration so that preventative measures may be undertaken.

Recent IPV and Family Status. Estimates of past 12 month (recent) IPV also vary by family status in California, although estimates differ from patterns shown since age 18 (Note: Data showing rates of recent IPV by family status

Exhibit 6

Percent of Adult Victims of Physical or Sexual IPV Since Age 18 by Marital Status, Sexual Orientation and Family Type, Ages 18-65, California 2007



are not graphed). For marital status, single Californians have the highest recent IPV rate (44.9%), significantly higher than all other groups; this pattern does not reflect the pattern for IPV rates by marital status since age 18. Among married Californians, the prevalence of recent IPV (17.3%) is lower than among Californians who are single (44.9%) or living with a partner (26.4%), but not than separated/divorced/widowed Californians (18%). In direct contrast to IPV rates since age 18, recent IPV rates are higher among adults living with a partner

than separated/divorced/widowed individuals. Another difference is that rates for recent IPV do not differ by sexual orientation. For family type, single adults without children (29.3%) and with children (27.9%) both have higher rates than those married with or without children (20.5% vs. 15.6%, respectively). Being married without children also results in lower rates than being married with children; this pattern is in direct contrast to the one shown for IPV rates since age 18.

Severity of Intimate Partner Violence, Coping with Recent IPV, and the Role of Alcohol and Other Drugs

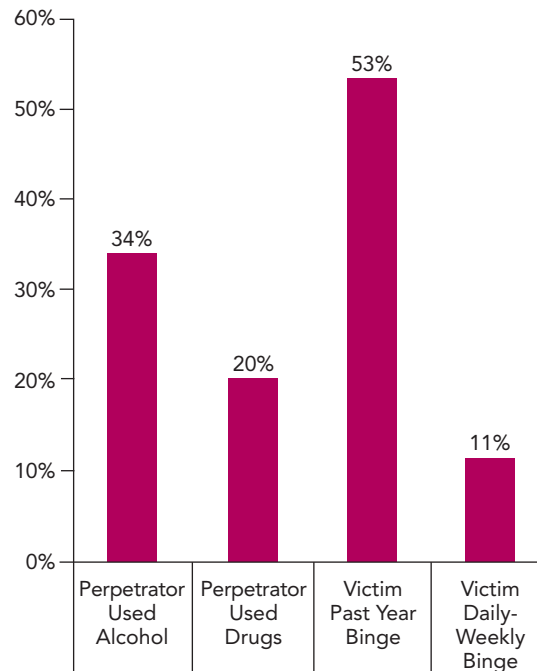
Recent or past 12 month IPV is measured through a series of questions that also include separate measures to assess *moderate* and *severe* physical violence. The two IPV levels are somewhat similar to the differences between simple and aggravated assault, where aggravated assault can cause grave bodily harm and may include the use of a weapon.⁹ The rates for moderate and severe IPV are not mutually exclusive since they were measured independently to determine each type. An adult could experience moderate but not severe IPV, could be subject to both, or could experience severe but not moderate IPV (of note, the latter situation would be rare).

Among those CHIS respondents who had reported an IPV incident during the past 12 months, 92.8% were exposed to moderate violence, while 7.2% were not. Over half of those who experienced a recent incident reported it as severe violence (55.3%), while 44.7% did not. While women were more likely to report moderate violence (57.2%) than men (42.8%), the rates of severe IPV were nearly identical (i.e., women = 50.5%; men = 49.5%).¹⁰

Alcohol or other drugs may play a role in escalating IPV incidents as well as in coping with victimization.¹¹ More than one-third of IPV victims (34.1%) reported that their partner appeared to be drinking alcohol during the most recent violent incident. One in five IPV victims (19.5%) report that their partner was using drugs during the most recent incident (Exhibit 7). Women are significantly more likely than men to report that their partner was using alcohol (40.5%

Percent of Adult Victims of Recent Physical or Sexual Intimate Partner Violence Among Adults Who Experienced IPV Since Age 18, Who Report Perpetrator Alcohol or Drug Use and Victim Binge Drinking, Ages 18-65, California 2007

Exhibit 7



Notes: *Recent physical or sexual IPV* is IPV that occurred in the past 12 months, and is asked *only* of respondents who experienced any IPV since age 18.

vs. 27.9%), and that their partner was using drugs (25.4% vs. 13.6%). While alcohol or other drug use may not directly cause IPV, it may increase the risk of violence.¹²

The link between adult binge drinking and IPV was also examined, as previous research suggests that alcohol may be used by victims in an attempt to mask the emotional or physical pain associated with violence.¹³ Rates of binge drinking are higher among IPV victims of recent incidents over the past year (52.8%) compared to non-IPV victims (32.4%). Nearly one in ten IPV victims (11.2%) report daily to weekly binge drinking compared to 3% of non-victims of recent IPV (Exhibit 7).

Talking to someone about being a victim of IPV may have therapeutic value, yet there are barriers to disclosing victimization, including fear of retaliation, cultural barriers, emotional trauma or stress. When asked if they ever talked to anyone about what happened to them during the most recent incident, only 56.5% of victims report talking about the incident. Women are significantly more likely to have discussed the incident with someone (66.4%) compared to men (46.8%), yet over one-third of female victims and over half of male victims did not talk to anyone about what had happened to them.

Policy Implications

The results of this study point to several needed interventions directed at adults exposed to intimate partner violence. The strong connection between adult interpersonal violence and substance use suggests that there is an ongoing need for routine health screening of women and men for violent victimization as well as for substance use in order to be able to effectively refer to and provide needed support and services. Screening for IPV by physicians and other health professionals has grown over the years in California; however, IPV screening is still a rare occurrence for males as well as for young adults and adolescents, and is not uniformly done for women statewide.¹⁴ Screening for alcohol or drug problems is also not a uniform practice in California despite encouragement by the federal government and from medical associations.¹⁵ Yet screening can be an effective IPV and substance abuse prevention and intervention tool.

In addition to outreach by health providers, a second line of intervention and prevention is the provision of IPV services and shelters. Given the disparities in IPV experiences by gender and by race/ethnicity, special attention and outreach continues to be needed for women, American Indian/Alaska Native, Latino and African-American IPV victims, as well as for U.S.-born Latinos and Asians. The results comparing U.S.-born versus foreign-born Latinos and Asians indicate that for the U.S.-born groups being immersed in American culture from birth may negatively

impact their IPV exposure or vulnerability compared to their foreign-born counterparts. Additionally, the new findings about the bisexual, gay, and lesbian communities demonstrate a strong need for preventative and interventional outreach in these often ignored communities.

Domestic violence services and shelters continue to be underfunded and have suffered sharp cuts in recent years due to California's ongoing budget crisis. Financial support for community-based, safety-net providers that offer domestic violence shelter services is unstable during economic downtrends. Even with solid and continuing support for domestic violence shelters from a number of funders, such as the Blue Shield of California Foundation, the need for additional beds is often greater than the supply.¹⁶

Given the extent to which Californians are affected by IPV, coupled with a difficult economy that increases family stress, funding on the intervention as well as preventative fronts should be increased. Funding will enhance prevention efforts and outreach, encouraging providers and staff to intervene with IPV early to insure safe places for victims, as well as help encourage victim disclosure, substance use and other counseling, and healing. Together such efforts can help break the cycle of violence, assure that no victim is ever turned away, and help prevent violence between intimate partners for future generations.

Data Source

Data was analyzed from the 2007 California Health Interview Survey (CHIS 2007). CHIS is a population-based telephone survey of randomly-selected California households, the largest state survey in the nation. Because 2007 was the initial year in which adult IPV was included on the CHIS Adult Survey, CHIS 2007 provides the only current information on adult violent victimization of both men and women based on CHIS data. CHIS 2007 provides the most recent information available on adult alcohol use and adult emotional health for the state of California. Completed interviews were drawn from every county in the state, and conducted in English, Spanish, Chinese (Mandarin and Cantonese dialects), Vietnamese and Korean. Data was weighted to the California Department of Finance's 2007 Population Estimates and 2007 Population Projections.

CHIS 2007 completed interviews with 51,048 adults. For the adult survey, an adult was randomly selected from every household. For this policy brief, we analyzed data from 37,330 adults ages 18-65 years. All statements in this report that compare rates for one group with another group reflect statistically significant differences ($p < 0.05$) unless otherwise noted. CHIS is a collaboration of the UCLA Center for Health Policy Research, the California Department of Public Health, the Department of Health Care Services and the Public Health Institute. Funding for CHIS 2007 came from multiple sources: the California Department of Public Health, the Department of Health Care Services, The California Endowment, the National Cancer Institute, First 5 California, the Robert Wood Johnson Foundation, the California Department of Mental Health, the California Office of the Patient Advocate, Kaiser Permanente, Blue Shield of California Foundation, LA Care Health Plan, the San Diego County Human and Health Services Agency, and the Office of the California Attorney General. For more information on CHIS, please visit www.chis.ucla.edu

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Endnotes

- 1 Findings are based on data from the 2007 California Health Interview Survey (CHIS 2007). Intimate partner violent *physical* incidents are defined as “being hit, slapped, pushed, kicked, or physically hurt in any way by any current or former husband, wife, boyfriend, girlfriend, or someone that the adult lived with or dated.” The questions cover any physical IPV that occurred since the adult turned 18 years of age. The measure is adapted from the modified Conflict Tactic Scale (CTS) developed by Murray Strauss and colleagues. See Straus MA, Hamby SL, Boney-McCoy S and Sugarman DB. The Revised Conflict Tactics Scales (CTS2): Development and Preliminary Psychometric Data. *Journal of Family Issues*, 1996: 17(3): 283-316.
- 2 Intimate partner violent *sexual* incidents are defined as “being forced by a current or past intimate partner into unwanted sexual intercourse, oral or anal sex, or sex with an object by force or threats of harm since the adult was 18 years old.”
- 3 See McAlister Groves B. Children who see too much: Lessons from the child witness to violence project. Boston, Mass: Beacon Press: 2002; Avakame EF. Intergenerational transmission of violence, self-control, and conjugal violence: a comparative analysis of physical violence and psychological aggression. *Violence Victimization* 1998: 13:301-16; Taylor CA, Guterma NB, Lee SJ and Rathouz PJ. Intimate partner violence, maternal stress, nativity, and risk for maternal maltreatment of young children. *American Journal of Public Health* 2009: 99(1):175-183; Miller BA, Testa M and Panek D. Long-term effects of parent-to-child violence for women. *Journal of Interpersonal Violence* 1992 Sept; Vol. 7 (3):365-382.
- 4 See Thompson MP and Kingree JB. The roles of victim and perpetrator alcohol use in intimate partner violence outcomes. *Journal of Interpersonal Violence* 2006: 21(2):163-177. Lipsky S, Caetano R, Field CA, Larkin GL. Is there a relationship between victim and partner alcohol use during an intimate partner violence event? Findings from an urban emergency department study of abused women. *Journal of Studies in Alcohol* 2005: 66(3):407-412. Caetano R, Schafer J and Cunradi CB. Alcohol-related intimate partner violence among Whites, Blacks and Hispanics. *Alcohol Research and Health* 2001: 25(1):58-65. Zahnd E, Klein D and Needell B. Substance Use and Issues of Violence among Low-Income, Pregnant Women: The California Perinatal Needs Assessment. *Journal of Drug Issues* 1997: 27(3), 563-584.
- 5 Only 4.1% report being abused by more than one partner in the past 12 months (CHIS 2007). Slightly more perpetrators are current spouses, partners or boyfriends/girlfriends (56.6%) versus former spouses, partners or boyfriends/girlfriends (48.1%). A small number of perpetrators were listed as a date or *other*.

- 6 The percentage of U.S.-born Asians and U.S.-born Latinos in California is based on CHIS 2007 California Department of Finance racial/ethnic data. The Asian category of adults, aged 18 years and above, who were born in the U.S. includes Native Hawaiian/Pacific Islanders. Of note, U.S.-born citizens are twice as likely to report IPV since age 18 (20.7%) than non-citizens in California (10.7%).
- 7 The recent IPV questions are asked as part of a modified CTS series, specifically: "In the past 12 months did any intimate partner do any of the following: 1) Throw something at you that could hurt you? 2) Push, grab, shove or slap you? 3) Kick, bite you, or hit you with a fist? 4) Beat you up, choke you, or try to drown you? 5) Hit you with an object? 6) Threaten you with a gun, knife or other weapon? 7) Use a gun, knife or other weapon on you? 8) Force you to have unwanted sex, or or anal sex, or sex with an object by using force or threatening to hurt you?"
- 8 The rate for Native Hawaiian/Pacific Islanders is unreliable due to small sample sizes.
- 9 According to Murray A. Strauss's modified Conflict Tactic Scale (CTS) or CTS2: *Moderate IPV* includes questions that ask whether the intimate partner or perpetrator threw something that could hurt the victim; pushed, grabbed, shoved or slapped the victim; or kicked, bit or hit the victim with a fist. *Severe IPV* includes questions that ask whether the intimate partner beat, choked or attempted to drown them; hit them with an object; threatened them with a gun, knife or other weapon; or used a gun, knife or other weapon. See Straus MA, Hamby SL, Boney-McCoy S and Sugarman DB. The Revised Conflict Tactics Scales (CTS2): Development and Preliminary Psychometric Data. *Journal of Family Issues*, 1996: 17(3): 283-316.
- 10 Of note, a much larger number of California women than men experienced IPV since age 18, so more women were asked about past 12 month incidents compared to men.
- 11 See Field CA and Caetano R. Ethnic Differences in Intimate Partner Violence in the U.S. General Population: The Role of Alcohol Use and Socioeconomic Status. *Trauma, Violence and Abuse*, 2004: 5(4):303-317. Caetano R, Schafer J and Cunradi CB. Alcohol-related intimate partner violence among Whites, Blacks and Hispanics. *Alcohol Research and Health* 2001: 25(1):58-65.
- 12 See Thompson MP and Kingree JB. The roles of victim and perpetrator alcohol use in intimate partner violence outcomes. *Journal of Interpersonal Violence* 2006: 21(2):163-177.
- 13 See Lipsky S, Caetano R, Field CA, Larkin GL. Is there a relationship between victim and partner alcohol use during an intimate partner violence event? Findings from an urban emergency department study of abused women. *Journal of Studies in Alcohol* 2005: 66(3):407-412. Zahnd E, Klein D and Needell B. Substance Use and Issues of Violence among Low-Income, Pregnant Women: The California Perinatal Needs Assessment. *Journal of Drug Issues* 1997: 27(3), 563-584.
- 14 The American Academy of Pediatrics' official policy encourages pediatricians to screen and intervene for female victims of IPV, because they realize family/domestic IPV is harmful to families and to children, and that physicians need to do more screening and intervening. See http://www.aap.org/policy/re9748_.html. Of note, a large epidemiological study of adult Kaiser Health Plan members, the Adverse Childhood Experiences (ACE) study links current adult health to childhood adverse experiences that occurred decades earlier, and indicates that seven experiences of personal abuse when growing up (i.e., recurrent physical abuse, emotional abuse and sexual abuse), growing up with an alcoholic or drug user, or with someone who was incarcerated, mentally ill, depressed or suicidal, or with a mother who experienced IPV results in adverse physical and emotional health outcomes. See Felitti VJ, Anda RF, Nordenberg D, et al. Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults: The Adverse Childhood Experiences (ACE) study. *American Journal of Preventive Medicine* 1998 May; Vol. 14 (4):245-258.
- 15 SBIRT stands for Screening, Brief Intervention and Referral to Treatment, a practice advocated by the American Medical Association and by the federal U.S. Centers for Medicare and Medicaid Services (CMS). In 2006, CMS developed a protocol to reimburse Medicare/Medicaid providers who provide SBIRT services. Each State Department of Health Services determines whether or not to opt in to the federal program, the number of visits allowed, which providers are covered, and which federally-recommended alcohol and other drug screeners will be selected for reimbursement. In 2009, California passed AB 217, a bill that would provide federal pass-through funding for SBIRT programs provided by doctors and other health professionals statewide. The bill passed both legislative bodies in October 2009, but was vetoed by Governor Schwarzenegger.
- 16 According to a 2008 Blue Shield Against Violence Survey of California's domestic violence shelters, more than 72% of the local shelters turned people away due to a lack of beds. See Blue Shield of California Foundation, *What Matters Most*, 2008-2009 Foundation Report, November 2009, p. 4.



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