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Trends in Contacts Made by Immigrants to the National Domestic Violence Hotline, Before and During the COVID-19 Pandemic

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Abstract

Objectives: Immigrants in the United States are more likely than nonimmigrants to experience risk factors for intimate partner violence (IPV) and problems in getting support. The COVID-19 pandemic and recent incidents of xenophobia and anti-immigrant sentiment may have exacerbated exposure to IPV risk factors. We examined immigrant experiences of IPV before and during the COVID-19 pandemic.

Methods: This study identified changes in characteristics of abuse, services used, referrals, and barriers to services among those who contacted the National Domestic Violence Hotline (NDVH) and identified as immigrants, reported immigration status as a concern, needed immigration support, and/or identified immigration status as a barrier to accessing services (N = 49 817). We used joinpoint regressions to examine whether the rate of change differed significantly from 2016-2019 (before the pandemic) to 2019-2021 (during the pandemic).

Results: The number of immigrant contacts to NDVH peaked in 2017 (n = 9333) and declined 25% to 6946 in 2021. During 2016-2019, the percentage of contacts reporting the following increased significantly: technology-facilitated violence (+12.7 percentage points), economic/financial abuse (+10.8 percentage points), and involvement of firearms (+4.8 percentage

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points); during 2019-2021, these trends reversed. The percentage of contacts reporting separation or divorce was relatively flat until 2019 and then increased from 14.6% in 2019 to 19.9% in 2021 (+5.2 percentage points). Housing instability increased during 2017-2020 (+9.3 percentage points), but requests for shelters decreased (−4.5 percentage points). Immigration status and personal finances were commonly reported barriers to services; both decreased during 2016-2019 but then increased during 2019-2021.

Conclusions: This study can inform prevention and response strategies relevant for immigrants experiencing or reporting IPV.

Keywords

intimate partner violence; immigration; domestic violence hotline; COVID-19

Intimate partner violence (IPV) is a pressing health and safety concern in the United States. In 2016, more than 40% of women and 25% of men in the United States reported experiencing contact sexual violence, physical violence, and/or stalking by an intimate partner and reported an IPV-related impact during their lifetime.[1] IPV is also a critical concern for immigrants in the United States. As of 2019, an estimated 44.9 million immigrants in the United States constituted various nationalities, cultural backgrounds, and legal statuses.[2] Some US-based studies reported higher rates of IPV among non–US-born survey respondents (ie, immigrants) than among US-born survey respondents (ie, nonimmigrants),[3,4] while other studies, including 2 studies that used nationally representative data, found that non–US-born participants were less likely than US-born participants to experience IPV victimization.[5,6] These discrepancies suggest that additional research is needed on IPV among immigrants.

IPV is a driver of both forced and voluntary migration,[7–9] with additional risk for IPV, sexual assault, and trafficking along the immigration journey.[7] Once immigrants are in the United States, some risk factors for IPV remain, such as isolation from friends and family, low educational attainment, and economic instability.[10,11] The economic, social, and legal status of many immigrants in the United States can contribute to disproportionate risk for IPV.[12,13] For example, many immigrant populations work in low-paying, arduous jobs and are at high risk of wage theft,[14] exacerbating economic issues that may put them at risk for IPV.[12] In addition, compared with US citizens, some immigrant populations have fewer opportunities for workplace protections and tax credits that alleviate poverty.[15] Structural factors, such as residential segregation and inequitable funding of school systems,[16] may act as barriers to educational achievement for some immigrant populations. Immigrants also face unique risk factors such as xenophobia,[17] immigrant-related discrimination,[18,19] and cultural norms and attitudes that contribute to unhealthy relationship dynamics.[20,21] Xenophobia and anti-immigrant sentiment can increase social isolation, which is already a challenge for immigrants who are far from family and friends.[17] Furthermore, for some immigrants, fear of deportation and insecurity about their immigration status can be used as a controlling mechanism for victims of IPV (eg, partner threatening to call immigration or jeopardize visa status).[12,22] The financial, social, and legal experiences of immigrants can vary substantially among racial and ethnic groups.[2,23–25] Cultural backgrounds also differ across immigrant communities, and some immigrants may experience cultural normalization

of abuse, patriarchal cultural norms, and inequitable gender attitudes, each of which is a known risk factor for IPV.[20,21,26]

In addition to these long-standing risk factors, immigrants have been disproportionately affected by the COVID-19 pandemic.[10] Such large-scale crises can increase the risk of IPV for affected communities.[27] One study found that the pandemic increased and compounded existing vulnerabilities to IPV, such as employment insecurity, lack of access to critical safety net services, lack of access to technology, and/or isolation.[27] Furthermore, the pandemic affected immigration processes and services, potentially creating additional destabilization and uncertainty in the lives of immigrants.[27] To date, much of this research has been qualitative; additional research with larger sample sizes would contribute to understanding of immigrants' IPV experiences and needs as affected by the pandemic.[27–29]

Anti-immigrant sentiment, restrictions on immigration, and criminalization of immigrants can affect immigrants' vulnerability to IPV and their ability to access services.[30,31] These risk factors can hinder formal and informal help seeking.[24,32,33] Economic marginalization and labor exploitation can also prevent a survivor from achieving sufficient economic independence to leave an abusive relationship.[30,34] Uncertainty about legal rights, fear of deportation, or misinformation from the abusive partner about their rights in the United States may prevent people from seeking help or reporting violence to the police.[26,35] Community sentiment and policies about immigration can also affect rates of IPV and access to services.[36] For example, research using 2003-2017 data from the Federal Bureau of Investigation's Uniform Crime Reports found that living in a community with "sanctuary" policies (ie, policies that regulate cooperation between local authorities and federal immigration authorities) was associated with lower rates of intimate partner homicide among Latina victims in the United States.[37]

Although social services are available in the United States to address IPV and other services are specific to immigration-related issues, these services and organizations are often separate from each other and, as a result, not prepared to address the intersections of IPV and immigration.[38] IPV prevention services range from emergency hotlines, shelter, and housing to counseling, advocacy, and legal services, including help with immigration issues.[39] Hotlines are the most common initial access point to IPV services for survivors[40] and are effective at providing immediate help and resource referral to long-term support.[41] However, immigrant survivors must first know that IPV services are available in the United States.[32,42] Language and cultural differences are frequently cited as barriers to services,[12,20,43,44] with access issues more pronounced in rural areas.[20] Concerns about confidentiality may also prevent immigrants from accessing traditional IPV services.[45] Xenophobia, discrimination, residential segregation, and economic marginalization can also prevent or impede access to care for IPV survivors.

Improving IPV prevention and response for immigrants requires a better understanding of their experiences.[46] Much research on the topic to date has relied on qualitative data or on experiences from previous studies of immigrants in the United States or from communities affected by other health, natural, and political disasters. Our study used a large, unpublished quantitative dataset from the National Domestic Violence Hotline (the Hotline)

to characterize trends in abuse type, services used, referrals, and barriers to services from 2016 through 2021.

Methods

Participants and Procedures

The Hotline is a 24-hour national service that provides contacts with telephone, online chat, and text-based intervention, prevention, and resource assistance as well as emotional support, relationship education, and information. The Hotline was established as a part of the Violence Against Women Act (VAWA) in 1996.[47] The Hotline began collecting contact and interaction data in 2002; more detailed characteristics were recorded starting in 2016. Data are self-reported during the contact and entered by the Hotline worker during and after the interaction. The Hotline and the Centers for Disease Control and Prevention (CDC) formalized a 5-year partnership in 2020 to explore trends in call patterns over time and to guide prevention and response efforts. Data from the Hotline are anonymous and are used for public health surveillance purposes; as such, institutional review board assessment was not necessary per CDC's Human Research Protection Office.

The sample included survivors who self-identified as immigrants or those who called on behalf of immigrant survivors, identified immigration as a concern, requested immigration support, or identified immigration status as a barrier to accessing services (further described as "immigrants"; eTable 1 in Supplemental Material). These categories were not mutually exclusive.

Measures

Reported contact characteristics included (eTable 1 in Supplemental Material):

1. IPV type (emotional/verbal abuse, physical abuse, economic/financial abuse, technology-facilitated violence, sexual abuse, strangulation, firearms, sexual coercion, and/or stalking);
2. reported survivor characteristics and service(s) requested (disability; same sex/lesbian, gay, bisexual, transgender, queer [LGBTQ]; family and children [children involved, separation/divorce, custody/visitation, pregnant, requested children's counseling]; immigration [immigration status concerns, requested assistance with VAWA legalities]; legal [requested legal advocacy, requested legal representation, police report, requested assistance with a protective/restraining order]; mental health and supports [requested individual professional counseling, requested IPV support groups, substance abuse by an abusive partner, substance abuse by survivor, suicidality of an abusive partner, suicidality of survivor]; rural; COVID-19; housing/economic [requested shelter, housing instability, requested emergency financial aid, requested transitional housing, homelessness, requested transportation]); and
3. barriers to services (immigration status, finance, language, no police report, culture, transportation, COVID-19, accessibility, gender, services do not exist).

Analyses

We conducted analyses in Stata version 14 (StataCorp LLC) and reported descriptive statistics by year. We used pairwise comparisons of means, using the Bonferroni method, to identify whether abuse types, services requested, referrals, or barriers changed between years. To examine how the COVID-19 pandemic may have affected abuse types, we conducted unadjusted Joinpoint regressions for services requested and barriers to services to test whether the rate of change differed significantly from 2016-2019 to 2019-2021, using the *mkspline* function. We calculated the percentage of callers reporting each variable by year and each regression line (ie, 2016-2019; 2019-2021). We also calculated the percentage of contacts reporting each variable by year, the change (Δ) in percentage, the beta coefficient (b) for unadjusted regression lines, and associated P values, with $P < .05$ considered significant.

Results

From 2016 through 2021, 2.4% (n = 49 749) of total contacts to the Hotline (N = 2 106 078) were identified as immigrants (Table 1). The sample of contacts included survivors who self-identified as immigrants or those who called on behalf of survivors who were immigrants (n = 41 966; 84.4%), identified immigration as a concern (n = 26 250; 52.8%), requested immigration support (n = 21 628; 43.5%), and/or identified immigration status as a barrier to accessing services (n = 11 904; 23.9%). The number of these contacts peaked at 9327 in 2017 and declined to 6941 in 2021 (a 25.6% decrease).

Types of Abuse

During the 6-year study period, the most common forms of abuse reported were emotional/verbal abuse (average, 92.9%), physical abuse (average, 62.0%), economic/financial abuse (average, 42.7%), technology-facilitated violence (average, 16.4%), and sexual abuse (average, 11.2%) (Table 1). Multiple forms of abuse increased significantly during 2016-2019 and then decreased significantly during 2019-2021 (Table 2). The percentage of contacts reporting technology-facilitated abuse increased from 8.5% in 2016 to 21.2% in 2019 (+12.7 percentage points; $b >= 0.04$; $P < .001$) and then decreased to 17.3% in 2021 (−3.9 percentage points; $b = −0.02$; $P < .001$) (Figure 1d). Physical abuse (eFigure 1b in Supplemental Material) and strangulation (eFigure 1f in Supplemental Material) followed similar patterns. Economic/financial abuse and sexual coercion increased significantly from 2016 to 2020 (economic/financial abuse: 35.7% in 2016 to 47.8% in 2020; +12.1 percentage points; $P < .001$; sexual coercion: 3.8% in 2016 to 8.2% in 2020; +4.3 percentage points; $P < .001$) and then decreased to 44.0% (−3.8 percentage points) and 5.6% (−2.6 percentage points) in 2021, respectively (Table 2). Stalking did not change during the full study period.

Contact Details and Services Requested

The percentage of contacts mentioning separation/divorce increased from 14.6% in 2019 to 19.8% in 2021 (+5.2 percentage points; $b = 0.03$; $P < .001$) (Table 2, eFigure 2 in Supplemental Material). The percentage of contacts who mentioned a partner who used substances increased from 0% in 2016 to 9.9% in 2019 and then continued to increase, but at a gentler slope, to 12.1% in 2021 (+2.2 percentage points; $P < .001$) (Table 2, eFigure

2m in Supplemental Material). The percentage of contacts requesting individual professional counseling increased or decreased by 1 percentage point to 2 percentage points from year to year, except from 2019 to 2020, when requests for individual counseling increased significantly from 17.6% to 23.4% (+5.8 percentage points; $P < .001$) (Table 2, eFigure 2k in Supplemental Material).

The percentage of contacts reporting immigration status concerns increased from 46.8% in 2016 to 56.6% in 2019 (+9.8 percentage points; $b = 0.03$; $P < .001$). The percentage of contacts with a police report or questions about obtaining one increased from 9.7% in 2016 to 18.1% in 2019 (+8.4 percentage points; $b = 0.03$; $P < .001$) and then declined to 14.8% in 2021 (−3.3 percentage points; $b = −0.02$; $P < .001$) (Table 2, eFigure 2i in Supplemental Material). Service requests for legal advocacy also increased from 40.6% in 2019 to 51.6% in 2020 (+11 percentage points; $P < .001$) and then decreased to 49.0% in 2021 (−2.6 percentage points; $P = .02$).

While the percentage of contacts reporting housing instability increased from 6.8% in 2016 to 10.2% in 2019 (+3.4 percentage points; $b = 0.01$; $P < .001$) and then again to 14.5% in 2021 (+4.3 percentage points; $b = 0.03$; $P < .001$) (Table 2, eFigure 2q in Supplemental Material), we found significant decreases in requests for shelter, from 21.8% in 2016 to 17.3% in 2019 (−4.5 percentage points; $b = −0.02$; $P < .001$), which then remained steady. The percentage of contacts requesting emergency financial aid was steady from 2016 to 2019 and then increased from 3.3% in 2019 to 5.1% in 2021 ($P < .001$).

Barriers to Services

Barriers reported by contacts related to immigration status, finance, not having a police report, and culture decreased from 2016 to 2019 and then increased from 2019 to 2021 (Table 2; eFigure 3 in Supplemental Material). For example, barriers reported as a result of immigration status decreased from 28.8% in 2016 to 17.1% in 2019 (−11.7 percentage points; $b = −0.04$; $P < .001$) and then increased to 23.4% in 2021 (+6.3 percentage points; $b = 0.03$; $P < .001$) (Table 2, eFigure 3a in Supplemental Material). Similarly, barriers to services due to finances decreased from 15.9% in 2016 to 8.4% in 2019 (−7.5 percentage points; $b = −0.02$; $P < .001$) and then increased to 16.0% in 2021 (+7.6 percentage points; $b = 0.04$; $P < .001$) (Table 2, eFigure 3b in Supplemental Material).

Discussion

Contacting a hotline is often the first step to accessing support related to IPV experiences. Immigrant survivors of IPV face multiple barriers when accessing services, including lack of service knowledge, misinformation about supports, conflictual cultural norms, and safety concerns. Many of these barriers were likely exacerbated by the COVID-19 pandemic. This study used data from 2016-2021 from the Hotline, often a survivor's first outreach for formal support, to explore and understand experiences of IPV reported by immigrants and those who contact the Hotline on their behalf.

We found significant increases in the percentage of contacts reporting economic/financial abuse, technology-facilitated violence, firearms, and strangulation among immigrant

contacts from 2016 to 2019, followed by slighter declines during 2020-2021. An analysis of all Hotline contacts found similar results.[44] For example, technology-facilitated violence decreased among all Hotline contacts from 2019 (30% of calls) to 2021 (15% of calls).[48] IPV survivors in actively abusive environments may not be able to seek help while in the same space as the perpetrator (ie, during stay-at-home orders). Research suggests that abusive partners had more opportunities to exert control and IPV survivors may have sought less formal help during the initial period of the COVID-19 pandemic than before the pandemic.[49,50] In line with those studies, Hotline contacts related to immigration decreased significantly during the pandemic (ie, in 2020 and 2021). Qualitative research found that advocates and practitioners tried to use innovative strategies during the pandemic to address this dynamic. Examples included increasing immigrant survivors' comfort with virtual options, providing refurbished cell phones, providing for basic needs (eg, food) to reduce stress in the house, providing resources and information in public spaces (eg, grocery stores), and creating opportunities for survivors to leave the house (eg, picking up donated food supplies).[27]

This study illustrates the legal, economic, housing, and counseling needs and requests of immigration-related contacts to the Hotline. From 2016 to 2021, the percentage of contacts who discussed legal matters (ie, domestic violence protective orders, police reports, requests for legal representation), custody, and visitation fluctuated but increased overall. The percentage of contacts mentioning separation or divorce increased from 2019 to 2021, and the percentage of requests for individual professional counseling increased from 2019 to 2020, mirroring other studies noting the increased relational stressors and mental health needs of immigrants and survivors during the pandemic.[22,25,50] While the percentage of contacts reporting housing instability increased from 2019 to 2021, the percentage of contacts requesting shelter during that same period decreased. Reports documenting all contacts to the Hotline also reported increases in housing instability and homelessness in 2019, 2020, and 2021.[48,51,52] These findings could be related to the COVID-19 pandemic leading to increased financial and housing insecurity while decreasing accessibility to shelters because of reduced shelter capacity or fears of infection.[53] Furthermore, housing programs may not reflect the length of time immigrants and refugees need to find stable housing.[38,45]

Approximately 9% of immigrant NDVH contacts in 2020 and 2021 reported being affected by COVID-19, including contacts' ability to receive services, a provider (eg, crisis center) being closed because of a positive COVID-19 test result, or a shelter-in-place order that restricted the contact's mobility. Research found that the immigrant population generally faced increased risk for IPV and barriers to services because of COVID-19.[54–56] Several economic relief strategies, such as paid sick leave, tax relief credits, and unemployment benefits, were put in place during the pandemic to support families and possibly mitigate the risk for IPV. However, many of these strategies were unavailable to certain groups of immigrants, including those without documentation status or working in the cash economy.[10,27,57]

Access to services is a proven prevention strategy to mitigate the effect of IPV among survivors.[58] For example, previous research found that accessing needed services, such as

case management, therapy, and community-focused social support, resulted in improved mental health and safety outcomes for IPV survivors.[59,60] The current study reported an increased percentage of contacts reporting immigration status as a barrier to IPV services from 2019 to 2021. Several studies suggest this increase could be related to increases in anti-immigrant sentiment across the nation and shifts in immigration policy during the data collection period; additional research is needed on this topic.[30,31] Previous research indicates a decrease in calls to law enforcement about IPV when immigration enforcement increases.[36] Furthermore, those without documentation are excluded from the Health Insurance Marketplace, and physicians can be an important gateway to help those affected by violence in the home.[31]

Limitations and Strengths

Our study had several limitations. First, the sample is not representative of all immigrants in the United States, only of contacts made to the Hotline. People who contact the Hotline may differ from those who do not contact the Hotline, either because they are not aware of the resource or because they cannot or do not want to use it. Substantial sex, gender, racial, economic, and cultural diversity in the immigrant community in the United States was not accounted for in this study. Second, data on immigration status, country of origin, or years in the United States were not collected. Third, because the Hotline is designed to provide resources and support to IPV survivors, a survivor may have contacted the Hotline more than once, but the focus of our study—understanding trends in IPV and barriers to accessing services among immigrants—and the large sample size should not be affected by multiple contacts. Fourth, data on all variables, including immigration, were collected passively so as not to negatively affect the interaction with the caller; consequently, for all variables, undercounting occurred relative to what would have been identified using an active data collection process. Nevertheless, data were sought consistently across years, so the trends examined in our study reflect real changes over time in the topics discussed by contacts.

This study also had several strengths. Hotline data offer important insights into the IPV experiences, service needs, and barriers to services among immigrant contacts to the Hotline. With such a large sample size, we were able to conduct an analysis of trends over time; furthermore, the Hotline's robust set of variables allowed for a nuanced understanding of this population of contacts.

Conclusions

Future studies can continue monitoring trends in immigrant contacts to the Hotline. Further research is needed to elucidate why immigrant survivors access Hotline services and the effect of services received to prevent or reduce IPV. Our study did not account for various racial identities, disability statuses, sexual orientations, and gender identities; future research can inform prevention and response strategies for these groups. Recommendations to health and social service providers serving immigrants who are experiencing IPV include offering similar core services that any population would receive, such as counseling, temporary shelter, and accessible legal service providers. However, providing these services in clients' first language and understanding their unique cultures could improve the quality and

usefulness of these services.[61] The Hotline currently offers assistance in English and Spanish with access to more than 170 languages through telephonic interpreter services. The Hotline also offers teletypewriters and video phone–only lines for callers who have hearing or speech impairments.[62]

Preventing IPV is critical. CDC has identified several prevention strategies based on the best available evidence, including teaching safe and healthy relationship skills, engaging influential adults and peers, disrupting the developmental pathways toward IPV, creating protective environments, and strengthening economic supports for families.[58] However, few IPV prevention strategies have been tailored to immigrant populations, and several policy-level strategies may not be accessible based on immigration status.[15,24,57] Addressing these gaps could reduce disparities in risk for IPV in immigrant communities in the United States.

Supplementary Material

Refer to Web version on PubMed Central for supplementary material.

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Table 1.

Percentage of intimate partner violence (IPV) types, services used, referrals, and barriers to services among immigrant contacts to the National Domestic Violence Hotline (n = 49 749), United States, 2016-2021

Characteristic	2016 (n = 8752)	2017 (n = 9327)	2018 (n = 8755)	2019 (n = 8042)	2020 (n = 7932)	2021 (n = 6941)
IPV type						
Emotional/verbal abuse	90.4	90.5	93.8	95.3	94.0	93.2
Physical abuse	57.7	61.1	63.1	65.1	64.3	60.7
Economic/financial abuse	35.7	40.1	42.4	46.4	47.8	44.0
Technology-facilitated violence	8.5	13.5	18.0	21.2	20.1	17.3
Sexual abuse	8.5	9.8	12.3	13.4	12.9	10.4
Strangulation	5.4	9.0	11.1	13.3	12.1	9.8
Firearms	3.1	5.1	6.6	8.0	7.6	7.4
Sexual coercion	3.8	4.4	5.9	7.3	8.2	5.6
Stalking	4.6	4.4	4.1	4.3	4.3	4.7
Disability	1.2	1.3	1.3	1.6	2.1	2.1
Same sex/LGBTQ	2.0	1.4	1.5	1.8	2.0	1.9
Family and children						
Children involved	50.5	51.8	50.6	49.5	49.6	47.5
Separation/divorce	13.6	13.5	13.4	14.6	17.0	19.8
Custody/visitation	11.7	11.5	12.4	13.7	15.0	14.5
Pregnant	2.6	3.0	3.0	2.6	2.3	2.3
Requested children's counseling	2.1	2.1	1.5	1.8	2.5	1.3
Immigration						
Immigration status concerns	46.8	48.9	52.5	56.6	55.7	57.8
Requested assistance with VAWA legalities	43.0	44.7	43.9	45.4	42.9	40.2
Legal						
Requested legal advocacy	40.6	44.0	47.0	47.3	51.6	49.0
Requested legal representation	17.3	15.9	15.6	17.0	18.5	19.1
Police report	9.7	13.9	15.4	18.1	17.1	14.8
Requested assistance with a protective/restraining order	9.6	9.4	8.1	9.1	12.6	12.4
Mental health and supports						

Characteristic	2016 (n = 8752)	2017 (n = 9327)	2018 (n = 8755)	2019 (n = 8042)	2020 (n = 7932)	2021 (n = 6941)
Requested individual professional counseling	18.3	17.9	15.9	17.6	23.4	22.0
Requested IPV support groups	8.3	8.3	8.3	8.2	7.5	7.1
Substance abuse by an abusive partner	0	0	3.4	9.9	11.8	12.1
Suicidality of an abusive partner	1.4	1.9	2.2	2.7	2.7	2.7
Suicidality of survivor	0	0	0.8	2.3	2.2	2.0
Rural	1.8	1.9	2.1	2.1	1.1	1.1
COVID-19	0	0	0	0	9.4	8.8
Housing/economic						
Requested shelter	21.8	21.1	19.7	17.3	17.3	17.4
Housing instability	6.8	5.3	6.6	10.2	14.6	14.5
Requested emergency financial aid	2.9	3.0	3.4	3.3	4.9	5.1
Requested transitional housing	4.1	3.7	3.3	2.9	4.4	3.9
Homelessness	6.1	4.1	3.6	2.9	2.3	3.3
Requested transportation	3.3	3.4	3.1	2.2	2.5	2.4
Barriers to services						
Immigration status	28.8	28.7	21.2	17.1	23.3	23.4
Finance	15.9	13.4	10.2	8.4	14.8	16.0
Language	14.8	13.3	10.7	10.5	11.7	8.3
No police report	6.5	6.7	4.4	2.6	4.3	4.7
Culture	8.9	6.8	3.0	1.7	4.3	3.2
Transportation	5.5	5.0	4.1	3.2	2.9	2.8
COVID-19	0	0	0	0	8.2	7.4
Accessibility	4.6	2.6	1.4	0.8	1.4	1.5
Gender	2.3	1.8	1.4	1.8	2.4	2.0
Services do not exist	4.8	3.6	2.0	0.4	0.4	0.5

Abbreviations: LGBTQ, lesbian, gay, bisexual, transgender, queer; VAWA, Violence Against Women Act.

Table 2.

Change in characteristics of contacts made by immigrants to the National Domestic Violence Hotline, United States, 2016-2021[a]

Characteristic	2016-2017	2017-2018	2018-2019	2019-2020	2020-2021	2016-2019	2019-2021
Type of IPV							
Emotional/verbal	0.1	3.3[b]	1.5[c]	−1.3[d]	−0.8	5.0[b]	−2.1[b]
Physical	3.4[b]	2.0	2.0	−0.8	−3.6[b]	7.4[b]	−4.4[b]
Economic/financial	4.5[b]	2.2[d]	4.1[b]	1.4	−3.8[b]	10.7[b]	−2.4[b]
Technology-facilitated	5.0[b]	4.4[b]	3.2[b]	−1.1	−2.8[b]	12.7[b]	−3.9[b]
Sexual	1.4[d]	2.5[b]	1.0	−0.4	−2.6[b]	4.9[b]	−3.0[b]
Strangulation	3.5[b]	2.2[b]	2.2[b]	−1.2	−2.3[b]	7.9[b]	−3.5[b]
Firearms	1.9[b]	1.5[b]	1.4[c]	−0.4	−0.2	4.8[b]	−0.6[b]
Sexual coercion	0.6	1.5[b]	1.5[b]	0.8	−2.5[b]	3.5[b]	−1.7[b]
Stalking	−0.2	−0.3	0.2	0	0.4	−0.3	0.4
Disability	0.1	0	0.3	0.5	0	0.4	0.5
Same sex/LGBTQ	−0.6[d]	0.1	0.3	0.1	−0.1	−0.2	0.1
Family and children							
Children involved	1.3	−1.2	−1.2	0.2	−2.1	−1.0	−1.9
Separation/divorce	0	−0.1	1.2	2.4[b]	2.8[b]	1.1	5.2[b]
Custody/visitation	−0.1	0.8	1.3	1.3	−0.6	2.1[b]	0.8
Pregnant	0.4	0	−0.4	−0.3	−0.1	0.1	−0.4
Children's counseling requested	0	−0.6[d]	0.4	0.7[d]	−1.2[b]	−0.3	−0.5
Immigration							
Immigration status concerns	2.1	3.6[b]	4.2[b]	−0.9	2.1	9.8[b]	1.2
Requested assistance with VAWA legalities	1.7	−0.8	1.4	−2.5[d]	−2.6[d]	2.3[d]	−5.1[b]
Legal							
Requested legal advocacy	3.4[b]	3.0[b]	0.3	4.3[b]	−2.6[d]	6.8[b]	1.7
Requested legal representation	−1.3	−0.3	1.4	1.5	0.6	−0.3	2.1[b]
Police report	4.2[b]	1.5	2.7[b]	−0.9	−2.3[b]	8.4[b]	−3.2[b]

Characteristic	2016-2017	2017-2018	2018-2019	2019-2020	2020-2021	2016-2019	2019-2021
Requested assistance with protective/restraining order	−0.2	−1.3[d]	1.1	3.4[b]	−0.1	−0.4	3.3[b]
Mental health and supports							
Requested individual professional counseling	−0.4	−2.0[c]	1.8[d]	5.8[b]	−1.4	−0.7	4.4[b]
Requested IPV support groups	0	0	−0.2	−0.6	−0.5	−0.1	−1.1
Substance abuse by an abusive partner	0	3.4[b]	6.5[b]	1.9[b]	0.3	10.0[b]	2.2[b]
Suicidality of abusive partner	0.5	0.3	0.5	0	0	1.3[b]	0
Suicidality of survivor	0	0.8[b]	1.6[b]	−0.1	−0.2	2.3[b]	−0.3
Rural	0.1	0.2	0	−1.0[b]	0	0.3	−1.0[b]
COVID-19	0	0	0	9.4[b]	−0.6	0	8.8[b]
Housing/economic							
Requested shelter	−0.7	−1.4	−2.4[b]	0	0.1	−4.5[b]	0.1
Housing instability	−1.5[c]	1.3[d]	3.6[b]	4.4[b]	−0.1	3.4[b]	4.3[b]
Requested emergency financial aid	0.1	0.4	−0.1	1.5[b]	0.3	0.4	1.8[b]
Requested transitional housing	−0.4	−0.4	−0.4	1.5[b]	−0.5	−1.2[b]	1.0[d]
Homelessness	−2.0[b]	−0.6	−0.7	−0.6	1.1[c]	−3.2[b]	0.4
Requested transportation	0.1	−0.3	−0.9[c]	0.3	−0.1	−1.1[b]	0.2
Barriers to services							
Immigration status	−0.1	−7.4[b]	−4.1[b]	6.2[b]	0.1	−11.7[b]	6.3[b]
Finance	−2.5[b]	−3.2[b]	−1.8[c]	6.4[b]	1.2	−7.5[b]	7.6[b]
Language	−1.5[d]	−2.7[b]	−0.1	1.2	−3.4[b]	−4.3[b]	−2.2[b]
No police report	0.2	−2.4[b]	−1.8[b]	1.8[b]	0.3	−3.9[b]	2.1[b]
Culture	−2.1[b]	−3.8[b]	−1.3[b]	2.5[b]	−1.0[d]	−7.2[b]	1.5[b]
Transportation	−0.5	−0.9[d]	−0.9	−0.3	−0.1	−2.3[b]	−0.4
COVID-19	0	0	0	8.2[b]	−0.8[c]	0	7.4[b]
Accessibility	−2.0[b]	−1.2[b]	−0.5	0.6	0.1	−3.8[b]	0.7[d]
Gender	−0.5	−0.4	0.4	0.6	−0.4	−0.5	0.2
Services do not exist	−1.3[b]	−1.6[b]	−1.6[b]	0	0.1	−4.5[b]	0.1

Abbreviations: LGBTQ, lesbian, gay, bisexual, transgender, queer; VAWA, Violence Against Women Act.

[a] All values are change in percentage points between years.

[b] Significant at $P \leq .001$; determined by Bonferroni method of comparison of means.

[c] Significant at $P \leq .01$; determined by Bonferroni method of comparison of means.

[d] Significant at $P \leq .05$; determined by Bonferroni method of comparison of means.