

Trauma, Violence, & Abuse

<http://tva.sagepub.com/>

Health Disparities and Violence Against Women: Why and How Cultural and Societal Influences Matter

Tricia B. Bent-Goodley
Trauma Violence Abuse 2007 8: 90
DOI: 10.1177/1524838007301160

The online version of this article can be found at:
<http://tva.sagepub.com/content/8/2/90>

Published by:



<http://www.sagepublications.com>

Additional services and information for *Trauma, Violence, & Abuse* can be found at:

Email Alerts: <http://tva.sagepub.com/cgi/alerts>

Subscriptions: <http://tva.sagepub.com/subscriptions>

Reprints: <http://www.sagepub.com/journalsReprints.nav>

Permissions: <http://www.sagepub.com/journalsPermissions.nav>

Citations: <http://tva.sagepub.com/content/8/2/90.refs.html>

>> [Version of Record](#) - Jun 1, 2007

[What is This?](#)

HEALTH DISPARITIES AND VIOLENCE AGAINST WOMEN

Why and How Cultural and Societal Influences Matter

TRICIA B. BENT-GOODLEY

Howard University School of Social Work

This article encourages readers to consider the cultural and societal influences that impact health and health disparities among women survivors of intimate partner violence (IPV). Health consequences caused by IPV are widely documented and broadly discussed. Connections between health disparities and IPV are also discussed as related to women of color. Cultural factors and societal influences are identified to provide the reader with greater awareness of how these issues intersect with and impact IPV. Finally, the implications for scientific research and practice are discussed to include considerations for stronger assessment tools, greater collaboration and community participation, determination of best practices, requirement of cultural competence, mandated accountability, encouragement of mentorship, increased funding for research, increased advocacy, and increased culturally competent media and health promotion campaigns.

Key words: *culture; women of color; intimate partner violence; domestic violence; health; health disparities*

THE RELEVANCE of culture when responding to intimate partner violence (IPV) continues to be discussed. Some contend that violence is there regardless of culture and to distinguish cultural matters might allude to the notion that survivors contribute to the violence, that perpetrators are somehow less accountable for committing acts of violence, or that culture is at the root of abusive behaviors. This dilemma is particularly troublesome as there are still limited evidence-based interventions in this area, regardless of culture. The challenge of adding this seemingly evasive component to an already complex issue can be staggering. As we continue

to develop evidence-based interventions that are responsive to the grassroots initiatives at the forefront of this issue, we are called to respond to cultural influences. The purpose of this article is to encourage practitioners and scholars to consider the cultural and societal influences that impact health and health disparities among women survivors of IPV.

IPV AND HEALTH DISPARITIES IN CONTEXT

The connection between health and IPV has been discussed. It is still important to highlight the importance of the connection between

KEY POINTS OF THE RESEARCH REVIEW

Barriers: Individual Domain

- Help-seeking behaviors: Women of color often turn to informal service providers to receive services before reaching out to formal providers.
- Stigmatization: Women of color may feel shame and embarrassment with regards to experiencing IPV because of the lack of information of the prevalence of IPV in their respective communities.
- Family secrecy: Women of color are encouraged to keep the business of the family within the family.

Barriers: Institutional Domain

- Lack of physician training on IPV: There is a need for increased training on IPV for physicians and health care professionals, particularly with a focus on addressing the impact of stereotyping on quality of care.
- Screening tools are inadequate: Screening tools do not provide an assessment that considers cultural and societal influences.
- Stereotyping and labeling: Women of color experience several stereotypes and labels that discourage them from receiving assistance to deal with IPV.
- Lack of cultural competence: Ignoring the challenges faced by different groups denies and invalidates their experiences.
- Language barriers: It is not just the words that get lost in the translation but also the context for the words and meaning behind the language.

Barriers: Systemic Domain

- Discriminatory treatment: Disparate treatment leads to a suspicion that the system is out to get them as opposed to being interested in helping them.
- Poverty: The high prevalence of poverty in communities of color has a significant impact on the ways in which IPV is experienced.
- Immigration status: So many women are placed at a greater risk for violence because of immigration status, whether they are documented or undocumented.

IPV, health, and health disparities. IPV is defined as “a pattern of assaultive and coercive behaviors including physical, sexual, and psychological attacks, as well as economic coercion that adults or adolescents use against their intimate partners” (Schechter & Ganley, 1995, p. 10). It is estimated that 5 million women

experience IPV each year (National Center for Injury Prevention and Control, 2003). IPV is listed as 1 of the 10 leading health objectives of Healthy People 2010 (U.S. Department of Health and Human Services, 2007). It costs health systems more than \$44 million annually to address IPV (NCIPC, 2003). IPV is the leading cause of injuries to women between the ages of 15 and 44 and is more common than muggings, auto accidents, and cancer deaths combined. Women experiencing IPV are twice as likely to be in poor health as those who are not experiencing IPV. IPV results in 21,000 hospitalizations, 28,700 emergency department visits, and 39,900 visits to physicians annually (NCIPC, 2003). Thirty-seven percent of women reporting to emergency rooms are there because of IPV. IPV is connected to higher levels of hypertension, diabetes, pain syndromes, miscarriage, abortion, insomnia, fatigue, urinary tract infections, irritable bowel syndrome, arthritis, chronic disability, migraines, stomach ulcers, HIV/AIDS, and sexually transmitted diseases (D. W. Campbell et al., 2002; J. C. Campbell, 2002; Constantino, Kim, & Crane, 2005; Fisher & Shelton, 2006; Lee, Thompson, & Mechanic, 2002; Lichtenstein, 2006; Plichta, 2004; Sutherland, Bybee, & Sullivan, 2002; Wingood & DiClemente, 1997; Wyatt, Axelrod, Chin, Carmona, & Loeb, 2000). Perhaps the most illustrative form of the severity of physical violence is when women lose their lives to IPV. In the past 6 years, 1,200 to 1,324 women have been killed because of IPV (Fisher & Shelton, 2006). To put this number in context, 30% of women killed—compared to 3% of men killed—were murdered as a result of IPV. The health and IPV connection is not limited to the national landscape. In a study on the global health of women (World Health Organization [WHO], 2005), up to one half of women suffered physical injuries as a result of domestic violence, and at least 20% of those that acknowledged abuse in the study stated that they never reported it to anyone or any agency. The high degree of gender-based violence (GBV) has prompted lawmakers in this country to propose legislation focusing on addressing GBV in the world arena.

Compounded with these physical health issues are the mental health issues that often occur simultaneously with physical pain. Increased feelings of fearfulness, depression, anxiety, posttraumatic stress disorder (PTSD), suicidal ideation, loss of self-efficacy, and substance abuse are all mental health issues that compound and correspond to the pervasiveness and insidiousness of the physical health issues (Bogat et al., 2005; J. C. Campbell, 2002; Jordan, Nietzel, Walker, & Logan, 2004; Plichta, 2004; Walton-Moss, Manganello, Frye, & Campbell, 2005).

Health Disparities and IPV

These issues are compounded when race, ethnicity, and culture are taken into consideration (Banks-Wallace et al., 2002; Davis, 2003; Solis, 2003-2004). Crenshaw (1991) asserted that it is the intersectionality of abuse that women of color experience by virtue of their gender and race or ethnicity that warrants greater attention. That is, one cannot fully understand IPV and health disparities without examining the way in which they intersect with race and ethnicity, gender, socioeconomic status, and other considerations of social construction. An examination of one issue without consideration of the patterns of oppression renders an incomplete analysis.

Although some debate whether health disparities are dissipating and health care is becoming more equitable, inequity in the health care arena continues to be real (Cornelius & Ortiz, 2004; The Henry J. Kaiser Family Foundation [hereafter, "Kaiser"], 2003; Snowden, 2004). Women of color, particularly those of African ancestry, continue to experience higher infant mortality rates, cardiovascular disease, diabetes, hypertension, HIV infection, STDs, cancer, obesity, lupus, and poor dental care (Kaiser, 2003; Keppel, Percy, & Wagener, 2002; Thomas, 2006). Health disparities have been linked to the type and quality of care that women of color receive (Clark, 2003). Women of color tend to receive substandard care, lower quality of care, less follow-up, and fewer referrals, and they are less likely to possess health coverage compared to Caucasian

women (Kaiser, 2003). These issues are present regardless of socioeconomic status but are, of course, more pronounced among lower-income communities.

These disparities in health are compounded when we consider IPV. Already at greater risk, women of color who are experiencing IPV may not be able to obtain the necessary medical care for fear of revealing the violence (Lee et al., 2002). The perpetrator may discourage or prevent the survivor from obtaining medical treatment. Or the women may lack the necessary control of their finances to put money toward medical services. The stress of the violence and impending abuse may exacerbate health issues. One clear example of the connection between health disparities and IPV can be illustrated through the high rate of HIV/AIDS among African American women and Latinas. In 2002, HIV was the number one cause of death for African American women aged 25 to 34 (Kaiser, 2006a). African American women accounted for 67% of new AIDS cases in 2005, and Latinas accounted for 16% of new AIDS cases. The most common reason for infection is because of heterosexual transmission for both groups of women. Women experiencing IPV are less likely to negotiate using condoms for fear of greater abuse, placing them in a position of enhanced risk for contracting the virus (Wyatt et al., 2002). They are also less likely to adhere to antiretroviral medication regimes (Mugavero et al., 2006). Coupled with the rate of HIV infection, IPV exacerbates the disparities within the HIV infection rates. The connection between health disparities and IPV has received little attention in the research but is clearly problematic within oppressed populations.

Cultural and Societal Influences Matter

It seems that there is no sense of outrage about discriminatory treatment and lack of culturally competent care. Cultural competence has been defined as "an ongoing process in which one continuously strives to achieve the ability to work effectively within the cultural context of the individual or community" (J. C. Campbell & Campbell, 1996, p. 457). What is less emphasized is that culture shapes experiences, creates

perceptions, and impacts how we think, feel, absorb, refine, justify, and solidify information. It determines how we view ourselves and those around us and fundamentally determines who we are and where we see ourselves (Bent-Goodley, 2005a; Kanuha, 1994; Myers, 1995). Although women of color may share some experiences, ultimately the way culture is experienced is unique to the individual (Gutierrez & Lewis, 1999; Hill, 1997; Sokoloff, 2005; Solomon, 1976). Having a clear understanding of the individual's experiences and unique circumstances is needed to fully engage in assessment and planning. No one can or should diminish this experience. It is not simply about identifying a cultural practice, but it is also important to understand how culture—as experienced by the person—influences all that they do, think, and understand (Lee et al., 2002). One can hire a person of the same culture to provide a service or ask a research question, but if the program is not culturally relevant or the intervention not developed within a cultural framework, then the outcome is still uncertain.

Culture Is Not a Predictor of IPV

In examining the role that culture plays in IPV, it is important to acknowledge that having a particular cultural orientation is not a predictor that IPV will occur. However, understanding the cultural orientation provides an attuned sense of direction, an expanded awareness of potential factors, and a keen lucidity of latent barriers and strengths that can be used to address the challenges of IPV. For example, it has been stated that IPV is more prevalent in the African American community (Rennison & Welchans, 2000). Yet when socioeconomic status is controlled for, the differences of prevalence are contradicted and African Americans are no more likely to experience IPV than other groups (Hampton, Carrillo, & Kim, 1998; Lockhart, 1985; Rennison & Welchans, 2000). This examination points to the need, for example, to discern cultural influences from class considerations associated with living in poor and economically challenged communities (Fernandez-Esquer & McCloskey, 1999; Michalski, 2004).

Diversity Still Remains Within Racial and Ethnic Groups

There is diversity within racial and ethnic groups, so culture is experienced in different ways (Bent-Goodley & Williams, 2005; Boyd-Franklin, 2003; Dasgupta, 2000; Krane, Oxman-Martinez, & Ducey, 2000; Lee, 2000; Sullivan, Bhuyan, Senturia, Shiu-Thornton, & Ciske, 2005; Wyatt, 1994). No racial or ethnic group is monolithic. For example, although Latinos have experienced barriers to accessing health care services, there are differences between ethnic groups within the Latino community. Mexican Americans are less likely to have insurance and more likely to have language barriers compared with Cuban Americans and Puerto Ricans (Cornelius & Ortiz, 2004). This discrepancy is largely explained because of employment status and occupation. "The industries in which Mexican Americans are employed tend to be seasonal, rely on day labor, and pay cash to avoid giving benefits, paying taxes, or checking immigration documentation" (Cornelius & Ortiz, 2004, p. 158). The implications for IPV are similar. There are differential impacts of IPV among Latinas (Aldarondo, Kantor, & Jasinski, 2002), with studies finding a higher prevalence of IPV among Mexican American women (Firestone, Lambert, & Vega, 1999; Lown & Vega, 2001). Lacking access to health care limits a Mexican American woman who is experiencing IPV from obtaining preventive health services and limits her options when choosing a provider who makes her feel comfortable. When she does reach out for help, she is likely to experience language barriers among providers and a lack of understanding of the unique experiences she brings as a Mexican American woman. Consequently, it is vital to acknowledge the importance of ethnicity within the racial and ethnic experience to provide a more substantive and targeted service.

Cultural Strengths

Finally, culture should not be viewed simply as a barrier. Having a sense of the cultural strengths within groups allows for opportunities

to engage women experiencing IPV (Bent-Goodley, 2005b; Kanuha, 1994; Lown & Vega, 2001; Sokoloff & Dupont, 2005; Yoshioka, DiNoia, & Ullah, 2001). Another core cultural value shared by women of color is the emphasis and value placed on spirituality (Bent-Goodley & Fowler, 2006; El-Khoury et al., 2004; Fernandez-Esquer & McCloskey, 1999; Lown & Vega, 2001; Wahab & Olsen, 2004). As a strength, women of color have used their spirituality as a form of resistance ethics (T. C. West, 1999), a coping mechanism, and a method of retaining hope so that they can survive. It is true that these same core cultural strengths can be used in a negative manner and have been used to manipulate and maintain women in abusive relationships and submissive roles. As the importance of cultural and societal influences is considered, it is equally important to acquire greater understanding of those cultural strengths that can be more effectively and efficiently used to help women empower themselves and find solutions to end the violence in their lives.

CULTURAL AND SOCIETAL INFLUENCES: BARRIERS TO CARE

It is critical to examine cultural and societal influences within individual, institutional, and systemic domains (Moracco, Runyan, & Dulli, 2003; Pyles & Kim, 2006). The individual domain denotes the internal barriers as experienced by women, impacting their decision making and experience with IPV. The institutional domain examines the barriers on the organizational level that impact how women experience services. The systemic level examines those systemic barriers that occur on the larger societal level that impact the functioning and experiences of survivors. The individual domain includes help-seeking behaviors, the stigma associated with IPV, and the need to maintain family secrecy. The institutional domain includes poor training on IPV, inadequate screening tools, stereotyping and labeling, lack of cultural competence, and language barriers. The systemic domain includes discriminatory treatment across systems, the high levels of poverty in communities of color, and issues surrounding immigration.

The Individual Domain: Barriers to Care

Help-Seeking Behaviors

Women of color often turn to informal service providers to receive services before reaching out to formal service providers (Bent-Goodley, 2004a; Bent-Goodley, 2006; El-Khoury et al., 2004; Sokoloff, 2005; C. M. West, Kantor, & Jaskinski, 1998; T. C. West, 1999). Turning to friends and faith-based communities first (Bent-Goodley & Fowler, 2006; El-Khoury et al., 2004), women of color are less likely to reach out to mental health, criminal justice, or health professionals as their first alternative. Typically women of color reach outside of their network to receive supports when the violence has severely escalated, when they are afraid of hurting their partner or themselves, or when they are trying to stop an abusive incident from occurring (Lipsky, Caetano, Field, & Larkin, 2006; Yoshioka et al., 2001). They are often not looking to have their partner prosecuted nor are they necessarily looking for counseling services, but instead they are seeking more of an immediate resolution to the situation at hand. It is important for health professionals and researchers to understand this trajectory, as it may be challenging for the woman to reveal what she is experiencing to someone she does not know and may not trust because of his or her association with a system that could report the violence.

The Stigma Associated With IPV

The stigma associated with having experienced abuse is profound. Women of color may be particularly stigmatized because they may have received messages that domestic violence does not take place in their respective racial or ethnic community (Plough, 2000). This message is reinforced when public health messages and institutions only feature Caucasian women. Not seeing themselves in the message and hearing that IPV is not common to the experiences of women of color fosters a perception that it is either the woman's fault or that something is wrong with the woman. As a result, the stigma associated with IPV is heightened. It is important for health professionals

and researchers to understand the power of stigmatization, as the feeling of shame may pose an obstacle for the woman to discuss the violence she is experiencing.

Maintaining Family Secrecy

Keeping family business in the family is a message commonly received by women of color (Abraham, 2000; Boyd-Franklin, 2003; Kanuha, 1994). The idea of “not airing your dirty laundry” has been passed down from generation to generation as a means of securing the family’s image and stability. It is not looked on kindly when someone betrays the trust of the family by revealing problems within it. It is assumed that the parties involved can resolve the problems on their own without the intervention of other people, including extended family members. Particularly when a woman marries, it is reinforced that she has to find ways of addressing marital problems and issues within her smaller family system. Sometimes family members will even send the woman back home to resolve the problem, regardless of the fact that she is experiencing abuse. In addition to these issues, sharing family issues is taboo and can be viewed as a form of betrayal of the larger family (Abraham, 2000; Lee, 2000). Thus, there can be great shame in telling others about IPV. It is important for health professionals and researchers to understand the depth of this obligation to the family, as it may hinder women of color from being willing to share information, even when they individually acknowledge the danger and risk they are experiencing.

Organizational Domain: Barriers to Care

Limited Training in IPV

Health professionals have received limited training in IPV. Although not specific to culture, it is important to acknowledge that the systematic training of health professionals regarding IPV is already lacking (Moracco, Runyan, & Dulli, 2003; Rhodes & Levinson, 2003; Stayton & Duncan, 2005; Virginia Department of Health, 2006). The desire to

respond to IPV among medical staff has even been seen in a negative light among health professionals (Moracco et al., 2003). Physicians have been found to have serious stereotypical notions of IPV survivors and women of color (Plough, 2000). In a study of barriers impacting physicians’ ability to identify and address IPV, the clear biases against women of color and survivors of IPV is evident.

Despite claims that services are not impacted because of prejudicial attitudes, women of color have been able to identify negative experiences with hospital staff and formal systems of care that leave an imprint in their mind when confronted with formal service systems again (D. W. Campbell et al., 2002; Haywood, 2000; McNutt, van Ryn, Clark, & Fraiser, 2000; Plichta, 2004; Rodriguez, Bauer, Flores-Ortiz, & Szkupinski-Quiroga, 1998). Accordingly, in addition to training in IPV, it is important to train health care professionals in cultural competence and to find creative ways to address and eliminate the prejudice that exists among physicians with a very vulnerable population of women.

Screening Tools and IPV

If we can agree that culture does matter and that a one-size-fits-all approach in IPV research and service provision does not best serve women, then new considerations and approaches truly rooted in abolishing these inequities and finding solutions that work are warranted. Our sense of science and rigor does not adequately capture the essence of culture. Current measures do not assess the impact of race, ethnicity, gender, sexual orientation, religion, age, and culture on IPV outcomes. Our screening tools and research designs are often not designed with a full understanding of the complexity of these issues for the people we are serving (A. L. Coker, Pope, Smith, Sanderson, & Hussey, 2001; Wyatt, 1994). A cultural experience that might lie dormant, but comes back to create serious issues for the individual, has to be considered despite its fluid nature. The field must also consider certain methods that best answer desired questions. There may be times when randomized controlled trials are not the best

design to answer questions. In the quest to thrust evidence-based practice into the forefront, we must ask: Are there negative implications related to culture that have yet to be fully considered? This is a vital question to critically discuss as we move forward.

Stereotyping and Labeling

Women of color experience several stereotypes and labels that discourage them from receiving assistance to deal with IPV (Bent-Goodley & Williams, 2005; Richie, 1996; Sullivan et al., 2005; C. M. West, 2002; T. C. West, 1999). African American women are often stereotyped as being strong or big enough to respond to violence. This stereotype has led to African American women being denied shelter services. Latinas have actually been denied services because they did not speak English and providers felt that they might feel isolated in an all-English speaking shelter (Crenshaw, 1991). Another cultural stereotype is that lesbian women have been perceived as being less likely to experience IPV because they have a same-sex partner (Bent-Goodley & Williams, 2005; McClennen, 2005). Some providers have questioned the urgency or validity of the threat because it is coming from another woman. The power of these stereotypes is critical to understand. The outcome of having experienced these types of stereotypical encounters may create a sense that the formal provider system is either not interested or is incapable of responding to their unique circumstances. In addition, these negative events may be shared with other women in the community. Once shared, other women may internalize what they experienced and perceive the formal service systems as being unresponsive and disinterested in helping them as well. Thus, in addition to the individual woman feeling isolated from formal providers, it can manifest into additional women being less likely to seek needed services.

Lack of Cultural Competence

Lack of cultural competence can impact services in several manners (Brach & Fraser,

2000; Hampton & Yung, 1996; Huang & Gunn, 2001). Some service providers believe in using a culture-blind approach, believing that everyone should be treated exactly the same and receive the exact same service (Gondolf & Williams, 2001). Ignoring the challenges faced by different groups denies and invalidates their experiences. Two results of ignoring the different needs presented by different cultures are (a) higher levels of withdrawal from services and (b) less effective treatment experienced among vulnerable populations (Gondolf & Williams, 2001; Haywood, 2000; McNutt et al., 2000; T. C. West, 1999; Williams & Becker, 1994). An additional issue when there is a lack of cultural competence is the inability to connect with the client (Bent-Goodley, 2004a, 2005b; Moracco et al., 2003). The service provider may not understand how to develop a relationship with the client because of different cultural values. Other times, the client may feel uncomfortable sharing her personal business with someone from a different cultural background because she feels that the person may not understand her situation or because she does not want to educate the person about her culture to receive services (Boyd-Franklin, 2003). The lack of cultural competence goes beyond a practice approach and really speaks to providing services that are ethical, competent, and effective. When such a significant element of the client's or patient's experience is denied, everything within the helping transaction is problematic—from the assessment of the individual's situation to the selected method of response. This phenomena is also true for researchers. To study these issues without using a culturally competent approach does little to really add to the science and promote scholarship that can be applied across groups.

Language Barriers

Language barriers are important considerations for all women of color (Bent-Goodley, 2005b; Kanuha, 1994; Loke, 1997). Even when using the teleconference method or interpreters to translate what women are saying, language barriers place women at tremendous risk. Something could be lost in the translation

or not fully understood, increasing the potential for further violence. Some formal providers continue to use children as a means of interpreting what a mother is saying. The woman may not choose to say everything to the child, masking the violence or leaving out critical information because of her lack of willingness to share the information with a child. Despite our awareness of this major barrier, little has been done to ensure that language is no longer a barrier for women across diverse racial and ethnic groups.

It is not just the words that get lost in the translation but also the context for the words and the meaning behind the language that is important (Bent-Goodley, 2005b). Some women of color may become offended when referred to as a "battered woman" or "victim" (Bent-Goodley, 2001, 2004b). They may not define IPV the same way as the service provider (Bent-Goodley, 2001; Plichta, 2004; Sokoloff & Dupont, 2005; Sullivan et al., 2005). As a result, the woman may not even know that she is experiencing IPV. And the service provider might not fully understand the severity of the issue because she does not understand the context of the vernacular in the culture. Therefore, language barriers must be a focal point for health care providers and researchers to avoid the possible miscommunication, disruption, and diffusion in relationship building or confusion and frustration within the professional relationship.

Systemic Domain: Barriers to Care

Discriminatory Treatment

Different cultural groups have experienced discriminatory treatment when attempting to get help for IPV. For example, a 1978 law titled *Oliphant v. Suquamish Indian Tribe* (435 U.S. 191) is a legal statute that prohibits tribal courts from having criminal jurisdiction over American citizens. As a result of this statute, American men who perpetrate IPV against Native American women cannot be prosecuted by tribal courts (Bent-Goodley, 2004a). Little has been done to document the numbers of perpetrators who have been abusive toward Native American women without being held

responsible because of their citizenship. This is a policy issue that warrants greater attention and advocacy.

When compared to all other groups of women, African American women have greater dual arrests when IPV is involved (Dennis, Key, Kirk, & Smith, 1995; Kupenda, 1998; Melton, 1999; Mills, 1998). They are also more likely to be prosecuted as a result of IPV. This type of discriminatory treatment leads to African American women being unwilling to reach out to the criminal justice system, despite the need for assistance. This disparate treatment leads to a suspicion that the system is "out to get them" as opposed to being interested in helping them. African American women have also experienced a higher degree of child removals when IPV is involved in similar cases across ethnic groups (Bent-Goodley, 2004b; Bent-Goodley & Brade, in press). Many African American women often choose not to tell child welfare workers about IPV because they know that once the information is revealed, they are at greater risk of losing their children. These examples of discriminatory treatment are critical to help-seeking behaviors. These issues occur within a context of disproportionate numbers of people of color in the criminal justice system and children of color in the child welfare system. This context exacerbates the perception that these systems are less interested in helping people of color and poor women.

High Levels of Poverty

Women of color are more likely than Caucasian women to experience living in poverty (Kaiser, 2006a). The high levels of poverty within communities of color must be acknowledged and addressed. Although poverty is not a cause of violence, there are issues stemming from these factors that are relevant to how IPV is experienced (D. W. Campbell et al., 2002; Sutherland et al., 2002; Williams & Mickelson, 2004). For example, women who are poor are often more reliant on public service systems than women who have greater financial means (Kaiser, 2006a; Plichta, 2004). Public health systems often do not cater to the individual or have the

same time parameters to consider the needs of each patient. Women often experience longer waits for service, less cordial care, fragmented services, transportation constraints related to having to travel to multiple places for services, and less time to talk with the health provider (Schulz, Parker, Israel, & Fisher, 2001). In addition, resources in the community, housing and shelter space, may be limited or have long waiting lists, impacting the woman's ability to follow up with issues identified by health personnel (Plough, 2000). Taxed and overwhelmed, these systems may not be responsive in addressing the complex needs of women living in poverty. The outcome is that poor women have fewer options, have less access to care, and experience poorer services and more barriers to services than do women with economic resources.

Immigration Status

Immigration status is an additional reason why so many women of color are placed at a greater risk for violence (Bent-Goodley, 2004a; Dasgupta, 2000; Loke, 1997; Orloff, 1999; Raj & Silverman, 2002). Whether the woman is documented or undocumented, she may feel uncomfortable reaching out for services. If she comes from a country where formal systems (such as law enforcement) cannot be trusted, then she may choose not to reach out to formal providers as a means of protecting herself from further perceived tyranny. Services for immigrant women who are experiencing IPV are limited in many communities, and even when they are available, the waiting lists for receiving such supports are often prohibitive because they are so long (Raj & Silverman, 2003). Long waiting lists to address IPV can lead to greater risk for violence. The woman may also experience threats and mixed messages from her family of origin (Abraham, 2000; Bent-Goodley, 2004a). Violence against women may be accepted in her country of origin, so she may face further stigmatization from her family or from her husband's family for reaching out for assistance. Understanding how immigration status impacts the choices of women is important for health care professionals and researchers because immigration

status can serve as a barrier to receiving services and create feelings of distrust of formal provider systems.

IMPLICATIONS

There are a number of implications as we consider the next wave of research addressing IPV and how it intersects with culture. The first step is to accept that culture matters and that when we design programs and interventions to meet the needs of *everyone*, we do little for *anyone*. This problem requires conscious emphasis and resolution to increase what we know in this area and find solutions that are diverse in thinking and rooted in a curiosity that centers around finding resolutions that are meaningful to people, not just one group of people, but representative of the changing needs of a growing demographic.

Developing Stronger Tools to Assess the Impact of Culture

As we explore solutions for women experiencing IPV, it is important for us to develop tools that better assess the impact of culture (D. W. Campbell et al., 2002). Many surveys have participants check blocks to identify their racial background, but that does not necessarily identify the impact of culture for that person. As we evolve as scientists, it is critical that we develop tools and measures that ascertain the meaning of culture for the patient or participant.

Encouraging Greater Collaboration and Community Participation

Researchers and providers should be expected to engage in greater collaboration across disciplines and systems to best serve the needs of those experiencing and perpetrating IPV. The solution to IPV cannot be found with any one profession. Acknowledging the necessity of interdisciplinary collaboration is critical to finding solutions to address the complexity of IPV.

Participation from the community is key in finding enduring solutions to IPV that can be

sustained beyond a particular research study or program. Although coordinated community responses are promulgated, they are often a collaborative effort of formal service providers systems as opposed to community and grassroots organizations. It is critical to find ways to incorporate diverse professional perspectives and increased community participation to find viable solutions for IPV in diverse communities. Using these partnerships to discuss the implications of culture can create stronger, more effective interventions.

Engaging in More Intervention Research and Determining Best Practices

As we search for solutions, it is critical to not only further our understanding of these issues but also to engage in intervention research to determine best practices for working with diverse cultural groups. It is evident that there is no one approach that will work for everyone, so it is vital to engage in research that tests programs, services, and practices that can aid in resolving IPV within diverse frameworks. As opposed to focusing solely on evidence-based practices, it is important to also identify those best practices that are used within the indigenous systems of care and have been found to be helpful. It should not be assumed that communities do not know how to develop their own services. For example, Native American communities have developed a range of indigenous methods of addressing domestic violence, such as the Navajo Peacemaking Method, through tribal domestic violence laws (D. Coker, 1999; Valencia-Weber & Zuni, 1995; Wahab & Olson, 2004). Communities of color have a long history of mutual aid, established long before formal systems would provide them with services (Carlton-LaNey, 2001). Scientists may need to find ways to support indigenous responses.

Requiring Cultural Competence

Cultural competence should be required within the research enterprise and within systems of care, particularly those that receive public funding. Researchers or providers who

receive public funds should be able to provide evidence of culturally competent procedures and practices that demonstrate an understanding and respect for diverse populations. Clearly, cultural competence should be evident in practice, but it should also be evident within administrative structure, policy and procedure, staffing, board membership, evaluative measures and tools, and research design (Pyles & Kim, 2006). If we continue to encourage the use of cultural competence without having consequences for *not* using a culturally competent approach, then many providers and researchers will continue to dismiss using a culturally competent approach.

Mandating Accountability

Scientists should be held accountable for the research they conduct. Communities should not be left without sustainable efforts following the completion of research. Communities should be able to see the collective benefits of their participation beyond publications and the advancement of the knowledge base from which they receive no direct benefit. As part of the research enterprise, participants should be able to develop sustainable means of addressing IPV. Researchers should be held accountable for helping these systems to find appropriate long-term solutions for IPV within their diverse communities. Too many participants never even know the results of studies. It is imperative that there be some accountability to the community that goes beyond publications and scholarly presentations.

Encouraging Mentorship

To add to the scholarship of scholars of color, mentorship must be viewed as a means of advancing diverse ideas and varying thinking within science development. It is critical to support and guide scholars of color as to the funding and publication process. Mentorship is key, as it is difficult to understand the research and publication enterprises when unfamiliar or unaware of how they function. Having the support of experienced and seasoned scientists who are willing to create

opportunities and open doors for individuals capable of conducting research that adds to diversity and advancing the science is necessary if we are to truly strengthen the practice and science in this area.

Increasing Funded Research Examining This Intersection

Although the funding opportunities to conduct research on IPV are highly competitive, it is still important to strengthen and expand funded research that examines the intersection between IPV and culture. Without a funding imperative specific to the intersection, it may be difficult to obtain funding to conduct research that is specific to populations often understudied and misunderstood. A focus on the intersection will allow for developing and testing relevant measures, creating interventions that allow for the diversity within groups of color and determining approaches that are more effective across diverse cultures. It is likely that, by increasing our understanding of how culture intersects with IPV, we will also learn more about how to address IPV across all communities.

Increasing Advocacy to Address Systemic Discrimination

Advocacy is at the heart of eradicating IPV regardless of culture, yet there is a particular need for advocacy that addresses the systemic discrimination often experienced by people of color and other oppressed populations. Each opportunity, whether on an individual, familial, communal, or societal level, offers an opportunity to use advocacy as a way to identify discriminatory treatment and create responses that address these persistent forms of oppression. Strategies to aid survivors of IPV should also be examined to gauge how they might differentially impact people of color and other oppressed populations. It should be acknowledged that some policies perceived as supporting survivors of IPV could potentially have a differential impact among people of color. Once acknowledged, strategies can be developed to ensure that there is equity within

policies. Advocacy without consideration of the reality of persistent discrimination and oppression is irresponsible and fuels the oppression experienced by far too many women on the margins.

Increasing Culturally Competent Media and Health Promotion Campaigns

More attention needs to be given to creating more culturally competent media and health promotion campaigns. There are still many oppressed populations that do not believe that IPV occurs in their respective communities, or they do not know when they are in an abusive relationship. It is critical that media and health promotion campaigns continue to be developed specifically for these populations while ensuring that the methods and messages are culturally targeted to optimize the impact. In addition to developing targeted media and health promotion campaigns, it is important to target family members and friends who may have the ability to support or assist with stopping the violence.

CONCLUSION

The connection between health disparities and IPV is clearly documented. Despite the connection, little is being done to address the inherent inequity within treatment and research. Our commitment to finding solutions to stop violence should not be deflated by an inability to acknowledge that culture is relevant to how women experience IPV. Rekindling our sense of curiosity and affirming our commitment to saving lives, scientific inquiry and practice within IPV should be centered on finding enduring solutions to eradicate this devastating problem. It is only through our own integrity that we are able to recognize that culture is not an elusive concept. Taking into account that IPV affects and is affected by the whole person, not confined to gender and its social distinctions, we can find solutions that are holistic and capable of addressing the needs and circumstances of diverse groups of women and the communities to which they belong.

IMPLICATIONS FOR PRACTICE, POLICY, AND RESEARCH

Implications for the Future

- Develop stronger tools: We need to develop tools that better assess the impact of culture.
- Encourage greater collaboration and community participation: Researchers and providers should be expected to engage in greater collaboration across disciplines and systems to best serve the needs of those experiencing and perpetrating IPV.
- Engaging in more intervention research: We need to determine best practices for working with diverse cultural groups.
- Requiring cultural competence: Cultural competence should be required within the research enterprise and within practice systems.
- Mandating accountability: Communities should not be left without sustainable efforts following the completion of research.
- Encouraging mentorship: We must support and guide scholars of color as it relates to funding and the publication process.
- Increasing funded research on the intersection: It is important to have targeted funded research opportunities that examine the intersection between IPV and culture.
- Increasing advocacy to address systemic discrimination: Advocacy is at the heart of eradicating IPV regardless of culture.
- Increasing culturally competent media and health promotion campaigns: More attention needs to be given to creating more culturally competent media and health promotion campaigns for diverse communities.

REFERENCES

- Abraham, M. (2000). *Speaking the unspeakable: Marital violence among South Asian immigrants in the United States*. New Brunswick, NJ: Rutgers University Press.
- Aldarondo, E., Kantor, G. K., & Jasinski, J.L. (2002). A risk marker analysis of wife assault in Latino families. *Violence Against Women, 8*, 429-454.
- Banks-Wallace, J., Enyart, J., Lewis, L., Lewis, S., Mitchell, S., Parks, L., et al. (2002). Development of scholars interested in community-based health promotion research. *Western Journal of Nursing Research, 24*, 326-345.
- Bent-Goodley, T. B. (2001). Eradicating domestic violence in the African American community: A literature review, analysis and action agenda. *Trauma, Violence, & Abuse, 2*, 316-330.
- Bent-Goodley, T. B. (2004a). Policy implications of domestic violence for people of color. In K. E. Davis & T. B. Bent-Goodley (Eds.), *The color of social policy* (pp. 65-80). Alexandria, VA: CSWE Press.
- Bent-Goodley, T. B. (2004b). Perceptions of domestic violence: A dialogue with African American women. *Health and Social Work, 29*, 307-316.
- Bent-Goodley, T. B. (2005a). Culture and domestic violence: Transforming knowledge development. *Journal of Interpersonal Violence, 20*, 195-203.
- Bent-Goodley, T. B. (2005b). An African centered approach to domestic violence. *Families in Society, 86*, 197-206.
- Bent-Goodley, T. B. (2006). Domestic violence and the Black church: Challenging abuse one soul at a time. In R. L. Hampton & T. P. Gullotta (Eds.), *Interpersonal violence in the African American community* (pp. 107-119). New York: Springer.
- Bent-Goodley, T. B., & Brade, K. (in press). Domestic violence and kinship care. *Journal of Health and Social Policy*.
- Bent-Goodley, T. B., & Fowler, D. (2006). Spiritual and religious abuse: Expanding what is known about domestic violence. *Affilia, 21*, 282-295.
- Bent-Goodley, T. B., & Williams, O. J. (2005). *Community insights on domestic violence among African Americans: Conversations about domestic violence and other issues affecting their community, Seattle, Washington*. St. Paul, MN: Institute on Domestic Violence in the African American Community.
- Bogat, G. A., Leahy, K., von Eye, A., Maxwell, C., Levendosky, A., & Davidson, W. S. (2005). The influence of community violence on the functioning of women experiencing domestic violence. *American Journal of Community Psychology, 36*, 123-132.
- Boyd-Franklin, N. (2003). *Black families in therapy: A multi-systems approach* (2nd ed.). New York: Guilford.
- Brach, C., & Fraser, I. (2000). Can cultural competency reduce racial and ethnic health disparities? A review and conceptual model. *Medical Care Research and Review, 57*, 181-217.
- Campbell, D. W., Sharps, P. W., Gary, F., Campbell, J. C., & Lopez, L. M. (2002). Intimate partner violence in African American women. *Issues in Nursing, 7*(1). Retrieved from http://www.nursingworld.org/ojin/topic17/tpc17_4.htm
- Campbell, J. C. (2002). Health consequences of intimate partner violence. *The Lancet, 359*, 1331-1336.
- Campbell, J. C., & Campbell, D. W. (1996). Cultural competence in the care of abused women. *Journal of Nurse-Midwifery, 41*, 457-462.
- Campbell, J., Jones, A. S., Dienemann, J., Kub, J., Schollenberger, J., O'Campo, P., et al. (2002). Intimate partner violence and physical health consequences. *Archives of Internal Medicine, 162*, 1157-1164.
- Carlton-LaNey, I. B. (Ed.). (2001). *African American leadership: An empowerment tradition in social welfare history*. Washington, DC: NASW Press.
- Clark, S. L. (2003). African American women and health disparities: Implications of race, class and gender. In T. B. Bent-Goodley (Ed.), *African American social workers and social policy* (pp. 123-136). New York: Haworth.
- Cohen, S., DeVos, E., & Newberger, E. (1997). Barriers to physician identification and treatment of family violence:

- Lessons from five communities. *Academic Medicine*, 72, 19-25.
- Coker, D. (1999). Enhancing autonomy for battered women: Lessons from Navajo Peacemaking. *UCLA Law Review*, 47, 1-111.
- Coker, A. L., Pope, B. W., Smith, P. H., Sanderson, M., & Hussey, J. R. (2001). Assessment of clinical partner violence screening tools. *Journal of the American Medical Women's Association (JAMWA)*, 56, 19-23.
- Constantino, R., Kim, Y., & Crane, P. (2005). Effects of a social support intervention on health outcomes in residents of a domestic violence shelter: A pilot study. *Issues in Mental Health Nursing*, 26, 575-590.
- Cornelius, L. J., & Ortiz, L. A. (2004). What will ensure Mexican Americans equal access to health care? In K. E. Davis & T. B. Bent-Goodley (Eds.), *The color of social policy* (pp. 155-168). Alexandria, VA: CSWE Press.
- Crenshaw, K. (1991). Mapping the margins: Intersectionality, identity politics, and violence against women of color. *Stanford Law Review*, 43, 1241-1299.
- Dasgupta, S. D. (2000). Charting the course: An overview of domestic violence in the South Asian community in the United States. *Journal of Social Distress and the Homeless*, 9, 173-195.
- Davis, K. E. (2003). The policy implications of the Surgeon General's Report on mental health, race, culture and ethnicity. In T. B. Bent-Goodley (Ed.), *African American social workers and social policy* (pp. 93-122). New York: Haworth.
- Dennis, R. E., Key, L. J., Kirk, A. L., & Smith, A. (1995). Addressing domestic violence in the African American community. *Journal of Health Care for the Poor and Underserved*, 6, 284-293.
- El-Khoury, M., Dutton, M. A., Goodman, L. A., Engel, L., Belamaric, R. J., & Murphy, M. (2004). Ethnic differences in battered women's formal help-seeking strategies: A focus on health, mental health and spirituality. *Cultural Diversity and Ethnic Minority Psychology*, 10, 383-393.
- Fernandez-Esquer, M. E., & McCloskey, L. A. (1999). Coping with partner abuse among Mexican American and Anglo women: Ethnic and socioeconomic influences. *Violence and Victims*, 14, 293-310.
- Firestone, J. M., Lambert, L. C., & Vega, W. A. (1999). Intimate violence among women of Mexican origin: Correlates of abuse. *Journal of Gender, Culture and Health*, 4, 119-134.
- Fisher, J. W., & Shelton, A. (2006). Survivors of domestic violence: Demographics and disparities in visitors to an interdisciplinary specialty clinic. *Family & Community Health*, 29, 118-130.
- Gondolf, E. W., & Williams, O. J. (2001). Culturally focused batterer counseling for African American men. *Trauma, Violence, & Abuse*, 2, 283-295.
- Gutierrez, L. M., & Lewis, E. (1999). *Empowering women of color*. New York: Columbia University Press.
- Hampton, R., Carrillo, R., & Kim, J. (1998). Violence in communities of color. In R. Carrillo & J. Tello (Eds.), *Family violence and men of color: Healing the wounded male spirit* (pp. 1-30). New York: Springer.
- Hampton, R., & Yung, B. R. (1996). Violence in communities of color: Where we were, where we are, and where we need to be. In R. L. Hampton, P. Jenkins, & T. Gullotta (Eds.), *Preventing violence in America* (pp. 53-86). Thousand Oaks, CA: Sage.
- Haywood, Y. (2000). Health systems response to victims of domestic violence. In *Forum Proceedings: Health and mental health consequences of domestic violence in the African American community* (pp. 59-72). Minneapolis, MN: Institute on Domestic Violence in the African American Community.
- Hill, R. B. (1997). *The strengths of African American families: Twenty-five years later*. Washington, DC: R & B Publishers.
- Huang, C., & Gunn, T. (2001). An examination of domestic violence in an African American community in North Carolina: Causes and consequences. *Journal of Black Studies*, 31, 790-811.
- Jordan, C. E., Nietzel, M. T., Walker, R., & Logan, T. K. (2004). *Intimate partner violence: A clinical training guide for mental health professionals*. New York: Springer.
- The Henry J. Kaiser Family Foundation (Kaiser). (2003). *Key facts: Race, ethnicity and medical care*. Washington, DC: Author.
- Kaiser. (2006a, November). *The HIV/AIDS epidemic in the United States*. Washington, DC: Author.
- Kaiser. (2006b, August). *Who are the uninsured? A consistent profile across national surveys*. Washington, DC: Author.
- Kanuha, V. (1994). Women of color in battering relationships. In L. Comas-Diaz & B. Greene (Eds.), *Women of color: Integrating ethnic and gender identities in psychotherapy* (pp. 428-454). New York: Guilford.
- Keppel, K. G., Pearcy, J. N., & Wagener, D. K. (2002, January). *Trends in racial and ethnic specific rates for the health status indicators: United States, 1990-98*. Washington, DC: National Center for Health Statistics.
- Krane, J., Oxman-Martinez, J., & Ducey, K. (2000). Violence against women and ethnoracial minority women: Examining assumptions about ethnicity and race. *Canadian Ethnic Studies*, 32, 1-19.
- Kupenda, A. M. (1998). Law, life, and literature: A critical reflection of life and literature to illuminate how laws of domestic violence, race, and class bind Black women based on Alice Walker's book *The Third Life of Grange Copeland*. *Howard University Law Journal*, 42, 1-26.
- Lee, M. Y. (2000). Understanding Chinese battered women in North America: A review of the literature and practice implications. *Journal of Multicultural Social Work*, 8, 215-241.
- Lee, R. K., Thompson, V. L., & Mechanic, M. B. (2002). Intimate partner violence and women of color: A call for innovations. *American Journal of Public Health*, 92, 530-534.
- Lichtenstein, B. (2006). Domestic violence in barriers to health care for HIV-positive women. *AIDS Patient Care and STDs*, 20, 122-132.
- Lipsky, S., Caetano, R., Field, C. A., & Larkin, G. L. (2006). The role of intimate partner violence, race, and ethnicity in help-seeking behaviors. *Ethnicity and Health*, 11, 81-100.

- Lockhart, L. L. (1985). Methodological issues in comparative racial analyses: The case of wife abuse. *Research and Abstracts, 13*, 35-41.
- Loke, T. (1997). Trapped in domestic violence: The impact of United States immigration laws on battered immigrant women. *Boston University Public Interest Law Journal, 6*, 589-628.
- Lown, E. A., & Vega, W. A. (2001). Prevalence and predictors of physical partner abuse among Mexican American women. *American Journal of Public Health, 91*, 441-445.
- McClennen, J. C. (2005). Domestic violence between same-gender partners: Recent findings and future research. *Journal of Interpersonal Violence, 20*, 149-154.
- McNutt, L. A., van Ryn, M., Clark, C., & Fraiser, I. (2000). Partner violence and medical encounters: African American women's perspectives. *American Journal of Preventive Medicine, 19*, 264-269.
- Melton, H. C. (1999). Police response to domestic violence. *Journal of Offender Rehabilitation, 29*(1-2), 1-21.
- Michalski, J. H. (2004). Making sociological sense out of trends in intimate partner violence. *Violence Against Women, 10*, 652-675.
- Mills, L. G. (1998). Mandatory arrest and prosecution policies for domestic violence: A critical literature review and the case for more research to test victim empowerment approaches. *Criminal Justice and Behavior, 25*, 306-318.
- Moracco, K. E., Runyan, C. W., & Dulli, L. (2003, May). *Violence against women: Synthesis of research for public health policymakers* (NCJ 201567). Washington, DC: National Institute of Justice.
- Mugavero, M., Ostermann, J., Whetten, K., Leserman, J., Swartz, M., Stangl, D., et al. (2006). Barriers to anti-retroviral adherence: The importance of depression, abuse, and other traumatic events. *AIDS Patient Care and STDs, 20*, 418-428.
- Myers, L. J. (1995). *Understanding of Afrocentric world view: Introduction to an optimal psychology*. Dubuque, IA: Kendall/Hunt.
- National Center for Injury Prevention and Control (NCIPC). (2003). *Costs of intimate partner violence against women in the United States*. Atlanta, GA: Centers for Disease Control and Prevention.
- Orloff, L. E. (1999). Access to public benefits for battered immigrant women and children. *Journal of Poverty Law and Policy Clearinghouse Review, 33*, 237-256.
- Plichta, S. B. (2004). Intimate partner violence and physical health consequences. *Journal of Interpersonal Violence, 19*, 1296-1323.
- Plough, A. L. (2000). Domestic violence in the African American community: A local public health perspective. In *Forum Proceedings: Health and mental health consequences of domestic violence in the African American community* (pp. 17-31). Minneapolis, MN: Institute on Domestic Violence in the African American Community.
- Pyles, L., & Kim, K. M. (2006). A multilevel approach to cultural competence: A study of the community response to underserved domestic violence victims. *Families In Society, 87*, 221-229.
- Raj, A., & Silverman, J. (2002). Violence against immigrant women: The roles of culture, context, and legal immigrant status on intimate partner violence. *Violence Against Women, 8*, 367-399.
- Raj, A., & Silverman, J. (2003). Immigrant South Asian women at greater risk for injury from intimate partner violence. *American Journal of Public Health, 93*, 435-438.
- Rennison, C. M., & Welchans, S. (2000, May). *Intimate partner violence*. Washington, DC: U.S. Department of Justice, Bureau of Justice Statistics.
- Rhodes, K. V., & Levinson, W. (2003). Interventions for intimate partner violence against women. *Journal of the American Medical Association, 289*, 601-605.
- Richie, B. E. (1996). *Compelled to crime: The gender entrapment of battered Black women*. New York: Routledge.
- Rodriguez, M. A., Bauer, H. M., Flores-Ortiz, Y., & Szkupinski-Quiroga, S. (1998). Factors affecting patient-physician communication for abused Latina and Asian immigrant women. *Journal of Family Practice, 47*, 309-311.
- Schechter, S., & Ganley, A. L. (1995). *Domestic violence: A national curriculum for family preservation practitioners*. San Francisco, CA: Family Violence Prevention Fund.
- Schulz, A., Parker, E., Israel, B., & Fisher, T. (2001). Social context, stressors, and disparities in women's health. *JAMWA, 56*, 143-149.
- Snowden, L. (2004). Mental health policy and people of color: The Surgeon General's supplement on culture, race, and ethnicity and beyond. In K. E. Davis & T. B. Bent-Goodley (Eds.), *The color of social policy* (pp. 117-130). Alexandria, VA: CSWE Press.
- Sokoloff, N. J. (Ed.). (2005). *Domestic violence at the margins: Readings on race, class, gender, and culture*. New Brunswick, NJ: Rutgers University Press.
- Sokoloff, N. J., & Dupont, I. (2005). Domestic violence at the intersections of race, class and gender: Challenges and contributions to understanding violence against marginalized women in diverse communities. *Violence Against Women, 11*, 38-64.
- Solis, H. L. (2003-2004). Health disparities: A growing challenge in the Latino community. *Harvard Journal of Hispanic Policy, 16*, 53-67.
- Solomon, B. (1976). *Black empowerment*. New York: Columbia University Press.
- Stayton, C. D., & Duncan, M. M. (2005). Mutable influences on intimate partner abuse screening in health care settings. *Trauma, Violence, & Abuse, 6*, 271-285.
- Sullivan, M., Bhuyan, R., Senturia, K., Shiu-Thornton, S., & Ciske, S. (2005). Participatory action research in practice: A case study in addressing domestic violence in nine cultural communities. *Journal of Interpersonal Violence, 20*, 977-995.
- Sutherland, C. A., Bybee, D. I., & Sullivan, C. M. (2002). Beyond bruises and broken bones: The joint effects of stress and injuries on battered women's health. *American Journal of Community Psychology, 30*, 609-635.
- Thomas, S. B. (2006). Historical and current policy efforts to eliminate racial and ethnic health disparities in the

- United States: Future opportunities for public health education research. *Health Promotion Practice*, 7, 324-330.
- U.S. Department of Health and Human Services. (2007, March 13). *Healthy people 2010*. Retrieved from <http://www.healthypeople.gov/>
- Valencia-Weber, G., & Zuni, C. P. (1995). Domestic violence and tribal protection of indigenous women in the United States. *Saint John's Law Review*, 69. Retrieved from <http://www.vawnet.org/DomesticViolence/PublicPolicy/TribalProtection.pdf>
- Virginia Department of Health. (2006). *Intimate Partner Violence Health Care Provider Survey: Virginia 2006*. Richmond, VA: Author.
- Wahab, S., & Olson, L. (2004). Intimate partner violence and sexual assault in Native American communities. *Trauma, Violence, & Abuse*, 5, 353-366.
- Walton-Moss, B., Manganello, J., Frye, V., & Campbell, J. C. (2005). Risk factors for intimate partner violence and associated injury among urban women. *Journal of Community Health*, 30, 377-389.
- West, C. M. (Ed.). (2002). *Violence in the lives of Black women: Battered, black and blue*. New York: Haworth.
- West, C. M., Kantor, G. K., & Jaskinski, J. L. (1998). Sociodemographic predictors and cultural barriers to help-seeking behavior by Latina and Anglo American battered women. *Violence and Victims*, 13, 361-375.
- West, T. C. (1999). *Wounds of the spirit: Black women, violence, and resistance ethics*. New York: New York University Press.
- White, E. (1994). *Chain, chain, change: For Black women in abusive relationships*. Washington, DC: Seal Press.
- Williams, O. J., & Becker, R. L. (1994). Domestic partner abuse: The results of a national survey. *Violence and Victims*, 9, 287-296.
- Williams, S. L., & Mickelson, K. D. (2004). The nexus of domestic violence and poverty: Resilience in women's anxiety. *Violence Against Women*, 10, 283-293.
- Wingood, G., & DiClemente, R. (1997). The effects of an abusive primary partner on the condom use and sexual negotiation practices of African American women. *American Journal of Public Health*, 87, 1016-1018.
- World Health Organization (WHO). (2005). *WHO multi-country study on women's health and domestic violence against women: Initial results on prevalence, health consequences, and women's responses*. Geneva, Switzerland: Author.
- Wyatt, G. E. (1994). Sociocultural and epidemiological issues in the assessment of domestic violence. *Journal of Social Distress and the Homeless*, 3, 7-21.
- Wyatt, G. E., Axelrod, J., Chin, D., Carmona, J. V., & Loeb, T. B. (2000). Examining patterns of vulnerability to domestic violence among African American women. *Violence Against Women*, 6, 495-514.
- Wyatt, G. E., Myers, H. F., Williams, J. K., Kitchen, C. R., Loeb, T., Carmona, J. V., et al. (2002). Does a history of trauma contribute to HIV risk for women of color? Implications for prevention and policy. *American Journal of Public Health*, 92, 660-665.
- Yoshioka, M. R., DiNoia, J., & Ullah, K. (2001). Attitudes toward marital violence: An examination of four Asian communities. *Violence Against Women*, 7, 900-926.

SUGGESTED FUTURE READINGS

- Bent-Goodley, T. B. (2001). Eradicating domestic violence in the African American community: A literature review, analysis and action agenda. *Trauma, Violence, & Abuse*, 2, 316-330.
- Bent-Goodley, T. B. (2004a). Policy implications of domestic violence for people of color. In K. E. Davis & T. B. Bent-Goodley (Eds.), *The color of social policy* (pp. 65-80). Alexandria, VA: CSWE Press.
- Campbell, J. C. (2002). Health consequences of intimate partner violence. *The Lancet*, 359, 1331-1336.
- Richie, B. E. (1996). *Compelled to crime: The gender entrapment of battered Black women*. New York: Routledge.
- Sokoloff, N. J., & Dupont, I. (2005). Domestic violence at the intersections of race, class and gender: Challenges and contributions to understanding violence against marginalized women in diverse communities. *Violence Against Women*, 11, 38-64.
- West, T. C. (1999). *Wounds of the spirit: Black women, violence, and resistance ethics*. New York: New York University Press.

Tricia B. Bent-Goodley, PhD, MSW, is an associate professor at Howard University School of Social Work. She has published in a number of areas, including social policy, domestic violence, child welfare, social work entrepreneurship, and African American social welfare history. Her research has largely focused on the intersection of violence against women with cultural competence, child welfare, probation and parole, adolescent violence, health and mental health, and faith- and community-based interventions.