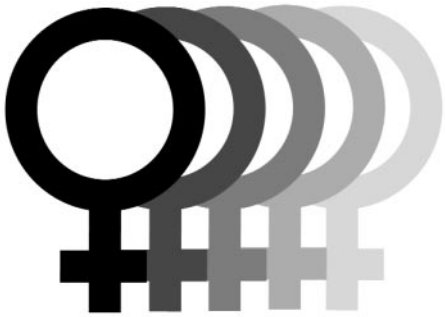
Intimate Partner Violence and Women of Color: A Call for Innovations



Roberta K. Lee, DrPH, RN, Vetta L. Sanders Thompson, PhD, and Mindy B. Mechanic, PhD

In this commentary, we focus on violence against women of color. Although African American women experience higher rates of intimate partner homicide than White women, the cumulative rates for nonfatal intimate partner violence are similar and do not vary between urban and rural locations (though access to services may vary by location).

Much of the research about intimate partner violence is based on women with low socioeconomic status and on interventions that were developed by and for White women. Current primary prevention strategies focus on violence that is perpetrated by strangers rather than their primary perpetrators—intimate partners.

We recommend the development and rigorous evaluation of prevention strategies that incorporate the views of women of color and attention to primary prevention. (*Am J Public Health.* 2002; 92:530–534)

THE DELETERIOUS IMPACT OF intimate partner violence (IPV) has been documented along a number of health-related dimensions, including acute injuries, somatic health complaints, diminished psychological functioning, and decrements in other social role domains, including occupational, interpersonal, and parental functioning.

Before 1980, there were only a few national studies of IPV in the United States.[1–3] These studies used survey methods that were criticized as biased because of the approaches used to recruit and interview participants. During the 1980s, a national strategic plan for health promotion was released and since 1990, reducing rates of IPV has been an objective. During the 1980s, the number of journal articles about IPV increased, although many studies used small convenience samples of women who either were residents of women's shelters or attended public prenatal clinics. Those studies primarily focused on women in poverty. Recently, after efforts to broaden case finding, studies have been conducted in emergency departments and in the practices of primary care providers; victims of IPV were found in these settings.

Increased attention to IPV during the 1990s resulted in the publication of an integrative review of IPV,[4] passage of the Violence Against Women Act in 1994, and establishment of a National Advisory Council on Violence Against Women. Currently, we observe unprecedented levels of collaboration and cooperation between federal, state, and local agencies that provide services or funds for research and services to victims of IPV and their families. One of the Healthy People 2010 objectives is to reduce the rate of physical assault by current or former intimate partners.[5]

Coercive control underlies the multidimensional expressions of IPV, which can include physical violence and injuries in the form of homicide; emotional, verbal, or psychological abuse; sexual coercion; rape; and stalking.[6] Many studies have focused on a single expression of violence, such as physical assault, without examining the interrelationships among various expressions of coercive control.

This commentary provides a review of the epidemiology of IPV, including current prevention efforts. We focus especially on the scope and magnitude of this problem among women of color and their responses to current prevention initiatives. We then suggest areas for further research as well as implications for public health and social policy to reduce the high toll of IPV.

INTIMATE PARTNER VIOLENCE MORTALITY

In the United States, the source for information about IPV mortality is the Federal Bureau of Investigation's Uniform Crime Reporting[7] and Supplemental Homicide Report programs.[8] The Uniform Crime Reporting program is estimated to capture information for more than 95% of homicides, and the identity of the perpetrator is known for most IPV cases.[9] When a woman is murdered, the perpetrator is 5 times more likely to be a spouse or intimate partner than to be a stranger.[10] While IPV homicide rates have declined during the past 20 years, the rate for African American women is more than double that observed for White women.[11]

NONFATAL INTIMATE PARTNER VIOLENCE

In 1995, using state-of-the-art technology and procedures to protect confidentiality, the US Institute of Justice and the Centers for Disease Control and Prevention collaborated to conduct the National Violence Against Women Survey[12] of the incidence and prevalence of nonfatal violence against women. Because of the design of this survey, these findings are the best current source of information about IPV. Key findings are summarized in Table 1.

We observe little difference between White and African American women in lifetime incidence of IPV. There are substantial differences in patterns of IPV for other racial/ethnic

TABLE 1—Lifetime Victimization of Women (%), by Type of Victimization and Race

Type of Victimization	Total (n = 7850)	White (n = 6452)	African American (n = 780)	Asian/Pacific Islander (n = 133)	American Indian (n = 88)	Mixed Race (n = 397)
Rape	18.2	17.7	18.8	6.8	34.1	24.4
Physical assault	51.8	51.3	52.1	49.6	61.4	57.7
Stalking	8.2	8.2	6.5	4.5	17.0	10.6

Source. Adapted from Tjaden and Thoennes.[12]

groups; however, the sample sizes for these groups are relatively small. These recent estimates are different from those obtained by the National Crime Victimization Surveys and Uniform Crime Reporting, which consistently show that African American women are at much higher risk than are White women.[13] According to the National Crime Victimization Surveys, only about half of IPV is reported to police, and African American women are more likely to report IPV than are White women. A recent monograph appraises the strengths and limitations of the National Crime Victimization Surveys and Uniform Crime Reporting data.[4]

Because the National Violence Against Women Survey is based on a probability sample of US telephones, we consider it the best available source of information about IPV. It thus appears that the prevalence of IPV is similar between African American and White women and between urban and rural women. Although data are limited, analysis of IPV in the American Indian community consistently suggests higher rates than those found in other communities. The National Violence Against Women Survey data on rape in Asian/Pacific Islander communities is also consistent in that rates are lower than those found among other ethnic groups; however, rates of physical assault are higher than those reported in general crime statistics.

STALKING AS A RISK FACTOR FOR SEVERE AND LETHAL VIOLENCE

Stalking and morbid jealousy were identified as risk factors for severe and lethal violence in several studies.[14–18] Recent studies have found that severe stalking was associated with more frequent and more severe forms of concurrent partner physical violence, emotional abuse, and physical injuries. Stalking and emotional abuse were both significant predictors of lethal harm. Former partners were more likely than current partners to perpetrate stalking. Women who asked their partners to leave were at high risk of physical violence when their partners refused to leave or threatened to kill them if they left, or if the women themselves left and refused to return. In the National Violence Against Women Survey, White and non-White women experience similar rates of stalking. Among non-White women, American Indians/Alaska Natives report significantly more stalking, although this is based on small numbers, and further research is needed.[19]

These compelling data underscore stalking as a critical component of intimate partner abuse that may have implications for battered women's risk of concurrent, future, and lethal violence. The implications of these findings for screening are obvious: stalking should be included in risk assessments routinely conducted on battered women.

HEALTH CONSEQUENCES OF INTIMATE PARTNER VIOLENCE

Many studies of IPV document a variety of chronic somatic and physical health complaints and disproportionate use of primary health care services.[20–25] The health care costs alone associated with IPV are estimated to be $67 billion (1993 dollars) per year.[26] Diminished physical health, poor health care behaviors, and increased use of harmful tension reduction behaviors have been unequivocally demonstrated as consequences of IPV. Several studies of violence-related acute injuries among women presenting to hospital emergency departments and clinics have been published.[27–31] In case–control studies of IPV resulting in injury (with half of these cases being African Americans), increased risk of injury was associated with partners who were alcohol or drug users, were unemployed, had less than a high school education, had prior arrests, or were former or estranged partners. When the violence was perpetrated by a former partner, the risk of injury increased 3.5-fold; when the woman was living with the former partner, the risk was 8.9 times greater.

Of women injured by IPV, fewer than half sought care for the injury. African American[32] and American Indian[33,34] women have been reported to experience more severe injuries and to more often have weapons used against them[35]; African American and Hispanic women reportedly experience greater mental health consequences.[36,37]

Hispanic women seek medical services but not at the time of the assault,[38] or they present with general complaints; few voluntarily disclose the abuse or recall being asked about it by providers. Reportedly, Hispanic, Asian, and American Indian women prefer medical and other service providers to ask directly about IPV.[39,40] Because of the opportunity for case finding and referrals, efforts have been made to improve detection in emergency and health services.[41]

Few studies examine IPV in rural communities.[42] Although higher rates for women of color have been reported, the samples were very small. Further research comparing rural communities and rural communities of color is needed.

INTIMATE PARTNER VIOLENCE AND PREGNANCY

The literature on IPV during pregnancy[43–48] is voluminous and allows comparisons among many racial/ethnic groups of women. Recent integrative reviews[49,50] have found that these studies generally produce mixed results, with most reporting lower rates of IPV during pregnancy among Hispanics.[51,52] In another study, Cuban and Central American women reported lower rates of IPV during pregnancy, while Puerto Rican and African American women reported higher rates.[53] The literature on abuse during pregnancy has not sufficiently addressed Asian or American Indian women.

CULTURAL CONTEXT AND PERCEPTIONS

The experience of IPV is shaped by the social and cultural context of a woman's life.[54,55] This context is a powerful lens through which the experience of IPV is viewed and interpreted. It also shapes perceptions of the viability of various options for responding to IPV. The most consistent finding according to current data is that context varies by race/ethnicity.[56]

Contextual factors include potential for retaliation by the abuser, available economic resources, potential for child abuse, personal emotional strengths, and perception of available social support. Racial/ethnic communities have different cultural norms regarding intimate partner roles, the acceptability of IPV, the importance of the family as an intact unit, and the appropriateness of seeking community services. Decisions about how, whether, and in what manner to respond to IPV are strongly influenced by beliefs and expectations about the impact of those choices on the woman, her children, and her extended community. While our information about IPV in communities of color or rural areas is limited, even fewer studies evaluate the service needs and preferences of communities of color.[57,58]

PREVENTION, INTERVENTION, AND IPV SERVICES

In the United States, there is an enormous array of IPV services.[59,60] These include shelters for women and their children, legal measures such as orders of protection and court interventions, establishment of specialized family violence police teams using IPV policing strategies,[61,62] advocacy services, psychological and social service counseling, and others.[63,64] Evaluations of these services and their effectiveness are emerging in the literature.[65–67] Findings suggest that different types of IPV require different types of services; short-term counseling services are often desired and seem to provide at least some benefit, and postshelter services may provide some benefits and assist women who do not wish to return to abusive relationships. Longer follow-up and a greater variety of programs and program components must be evaluated.

There are few rigorous intervention studies that include women of color.[68–70] Most existing IPV studies are largely qualitative and involve small convenience samples. Knowledge of cultural, social, and economic influences on help-seeking patterns suggests that when negative outcomes are expected to result from accessing traditional sources of help—such as contacting the police or going to a battered woman's shelter—or from the loss of social support (or from blame) related to leaving the abusive partner, women's choices about intervention are affected. In addition, cultural and social context may influence the timing, sequencing, and presentation of services offered in communities of color.

Ethnic differences in the source of aid that is sought have been noted.[71–73] Perhaps because of language barriers, Hispanic women are more isolated than African American and European American women in terms of seeking help. Hispanic women reportedly are least likely to contact a friend or a social service agency in response to IPV. Contrary to what has been noted with IPV, African American women are less likely than their White counterparts to report instances of rape to anyone. White women are more likely than ethnic minority women to call a psychotherapist or lawyer. Several studies note cultural issues that are associated with Asian women's degree of willingness to leave abusive relationships; cultural prescriptions for what makes a "good wife" and rigid gender roles that contribute to male dominance are noted.[74–77] Among Asian women, the support of elders may be important in assisting a woman to leave or to cope with a violent relationship.

In terms of shelter services, a model program designed for women of Mexican descent[78] was bilingual and included counseling, transportation, legal services, and assistance with job training. African American women wanted appropriate food and grooming aids and reported a need for more material and financial support.[77] The ability to accommodate larger families, language barriers, and citizenship requirements have also been noted as issues among women of color.

In 1995, in response to an evaluation,[34] the Department of Justice began funding STOP Violence Against Women Grants in American Indian/Alaska Native communities.[79] These initiatives allow, among other things, a focus on traditional spirituality and culture as a part of the healing process and a way to reclaim one's identity and strength.

Perhaps because of the potential for serious physical harm and the limitations of our self-report measures, physical violence has received significantly more research attention than other forms of abuse. More inclusive measurement of multiple expressions of IPV is evident in recent IPV studies that find that emotional and sexual abuse can be as deleterious as physical injuries.[80–82] More thorough understanding of the nature and impact of IPV demands the inclusion of multiple dimensions of IPV and measures that account for cultural and ethnic variation in the experience, meaning, and impact of partner violence on women's lives.

It is clear that research on IPV among women of color is sparse. Evidence about the impact of programs in general—and on women of color in particular—is needed. There is a significant need to improve communication and collaboration between researchers, and community service providers, and governmental agencies.[83,84] We note the absence of a cost–benefit appraisal of one of the very common IPV

program strategies—orders of protection—and the relative absence of programs that focus on reducing IPV but potentially retaining the relationship.[85] We urgently need data on emerging issues such as effects on child witnesses and concurrent child abuse,[86,87] specific treatment and intervention needs not only for women but also for their abusers,[88,89] and culturally specific program evaluation. Finally, there is a significant need to focus on primary prevention.[90] ■

About the Authors

Roberta K. Lee is with the Barnes College of Nursing & Health Studies. Vetta L. Sanders Thompson and Mindy B. Mechanic are with the Department of Psychology, University of Missouri, St Louis.

Requests for reprints should be sent to Roberta K. Lee, DrPH, RN, Barnes College of Nursing, University of Missouri–St Louis, 8001 Natural Bridge Rd, St Louis, MO 63121 (e-mail: bobbie_lee@umsl.edu).

This commentary was accepted November 29, 2001.

References

1. Gelles RJ. Violence in the family: a review of research in the seventies. *J Marriage Fam.* 1980;42:873–885.

2. Strauss MA, Gelles RJ, Steinmetz SK. *Behind Closed Doors: Physical Violence in the American Family.* New York, NY: Doubleday/Anchor; 1980.

3. Strauss MA, Gelles RJ. Societal change and change in family violence from 1975–1985 as revealed by two national studies. *J Marriage Fam.* 1986; 48:465–479.

4. National Research Council. *Understanding Violence Against Women.* Washington, DC: National Academy Press; 1996.

5. *Healthy People 2010: Understanding and Improving Health.* 2nd ed. Washington, DC: US Dept of Health and Human Services; November 2000.

6. US Dept of Justice. Chapter 13: domestic violence. Available at: http://www.ojp.usdoj.gov/ovc/assist/nvaa/ch13dv.htm. Accessed July 30, 2001.

7. Greenfeld LA, Rand MR, Crafen D, et al. *Violence by Intimates: Analysis of Data on Crimes by Current or Former Spouses, Boyfriends, and Girlfriends.* Washington, DC: US Dept of Justice, Bureau of Justice Statistics; March 1998. Publication NCJ 167237.

8. US Dept of Justice. *Sourcebook of Criminal Justice Statistics, 1998.* Washington, DC: Bureau of Justice Statistics; 1999. Publication NCJ 176356.

9. Kellermann AL, Mercy JA. Men, women, and murder: gender-specific differences in rates of fatal violence and victimization. *J Trauma.* 1992;33:1–5.

10. Bachman R, Saltzman LE. *Violence Against Women: Estimates From the Redesigned Survey.* Washington, DC: US Dept of Justice, Bureau of Justice Statistics; August 1995. Publication NCJ 154348.

11. Puzone CA, Saltzman LE, Kresnow M, Thompson MP, Mercy JA. National trends in intimate partner homicide: United States, 1976–1995 [published erratum appears in *Violence Against Women.* 2000;6:1179–1184]. *Violence Against Women.* 2000;6:409–426.

12. Tjaden P, Thoennes N. *Full Report of the Prevalence, Incidence and Consequences of Violence Against Women: Findings From the National Violence Against Women Survey.* Washington, DC: National Center of Justice; November 2000. Publication NCJ 183781.

13. Rennison DM, Welchans S. *Intimate Partner Violence.* Washington, DC: US Dept of Justice; May 2000. Publication NIJ 178247.

14. Tjaden P, Thoennes N. *Stalking in America: Findings From the National Violence Against Women Survey.* Washington, DC: US Dept of Justice; 1998. Publication NIJ 169592.

15. Block CR. *Chicago Women's Health Risk Study of Serious Injury or Death in Intimate Violence: A Collaborative Research Project* [revised report]. Chicago: Illinois Criminal Justice Authority; June 2, 2000.

16. Mechanic MB, Weaver TL, Resick PA. Intimate partner violence and stalking behavior: exploration of patterns and correlates in a sample of acutely battered women. *Violence Vict.* 2000; 15:55–72.

17. Mechanic MB, Uhlmansiek MH, Weaver TL, Resick PA. The impact of severe stalking experienced by acutely battered women: an examination of violence, psychological symptoms and strategic responding. *Violence Vict.* 2000;15:443–458.

18. McFarlane JM, Campbell JC, Wilt S, Sachs CJ, Ulrich Y, Xu X. Stalking and intimate partner femicide. *Homicide Stud.* 1999;3:300–316.

19. US Dept of Justice. *Third Annual Report to Congress Under the Violence Against Women Act.* Washington, DC: National Criminal Justice Reference Service; July 1998. Publication NCJ 172204.

20. Follingstad DR, Brennan AF, Hause ES, Polek DS, Rutledge LL. Factors moderating physical and psychological symptoms of battered women. *J Fam Violence.* 1991;6:81–95.

21. Golding JM. Sexual assault history and limitations in physical health functioning in two general population samples. *Res Nurs Health.* 1996;19:33–44.

22. Kimerling R, Calhoun KS. Somatic symptoms, social support and treatment seeking among sexual assault victims. *J Consult Clin Psychol.* 1994;62: 333–340.

23. Koss MP, Koss PG, Woodruff WJ. Deleterious effects of criminal victimization on women's health and medical utilization. *Arch Intern Med.* 1991;151: 342–347.

24. Resnick HS, Acierno R, Kilpatrick DG. Health impact of interpersonal violence, II: medical and mental health outcomes. *Behav Med.* 1979;23:65–78.

25. Walker E, Unutzer J, Rutter C, et al. Costs of health care use by women HMO members with a history of childhood abuse and neglect. *Arch Gen Psychiatry.* 1999;56:609–613.

26. Miller TR, Cohen MA, Wiersema B. *Victim Costs and Consequences: A New Look.* Washington, DC: National Institute of Justice; 1996.

27. Abbott J, Johnson R, Koziol-McClain J, Lowenstein SR. Domestic violence against women. Incidence and prevalence in an emergency department population. *JAMA.* 1995;273: 1763–1767.

28. Thompson RS, Rivara FP, Thompson DC, et al. Identification and management of domestic violence: a randomized trial. *Am J Prev Med.* 2000;19: 253–263.

29. Kyriacou DN, Anglin D, Taliaferro E, et al. Risk factors for injury to women from domestic violence. *N Engl J Med.* 1999;341:1892–1898.

30. Coker AL, Smith PH, McKeown RE, King MJ. Frequency and correlates of intimate partner violence by type: physical, sexual, and psychological battering. *Am J Public Health.* 2000;90: 553–559.

31. Grisso JA, Schwartz DF, Hirschinger MA, et al. Violent injuries among women in an urban area. *N Engl J Med.* 1999;341:1899–1905.

32. Sullivan CM, Rumptz MH. Adjustment and needs of African American women who utilize a domestic violence shelter. *Violence Vict.* 1994;9:275–285.

33. Norton I, Manson S. A silent minority: battered American Indian women. *J Fam Violence.* 1995;10: 307–318.

34. Bachman R. *Death and Violence on the Reservation: Homicide, Family Violence, and Suicide in American Indian Populations.* New York, NY: Auburn House; 1992.

35. Gondolf EW, Fisher ER, McFerron R. Racial difference among shelter residents. *J Fam Violence.* 1988;3:39–51.

36. Lefley H, Scott C, Llabre M, Hicks D. Cultural beliefs about rape and victims' response in three ethnic groups. *Am J Orthopsychiatry.* 1993;63: 623–632.

37. Perilla JL, Bakeman R, Norris FH. Culture and domestic violence: the ecology of abused Latinas. *Violence Vict.* 1994;9:325–339.

38. Sorenson SB, Siegel JM. Gender, ethnicity, and sexual assault: findings from a Los Angeles study. *J Soc Issues.* 1992;48:93–104.

39. Rodriguez MA, Bauer HM, Flore-Ortiz Y, Szkupinski-Quiaga S. Factors affecting patient–physician communication for abused Latina and Asian immigrant women. *J Fam Pract.* 1998; 47:309–11.

40. Bohn DK. Nursing care of Native American battered women. *AWHONNS Clin Issues Perinat Womens Health Nurs.* 1993;4:424–436.

41. American Medical Association, Council on Scientific Affairs. Violence against women: relevance for medical practitioners. *JAMA.* 1992;267: 3184–3189.

42. Krishnan S, Hilbert J, VanLeeuwen D, Kolia R. Documenting domestic violence among ethnically diverse populations: results from a preliminary study. *Fam Community Health.* 1997;20: 32–48.

43. Helton AS, McFarlane J, Anderson ET. Battered and pregnant: a prevalence study. *Am J Public Health.* 1987;77: 1337–1339.

44. Berenson AB, Wiemann CM, Wilkinson GS, Jones WA, Anderson GO. Perinatal morbidity associated with violence experienced by pregnant women. *Am J Obstet Gynecol.* 1994;170: 1760–1769.

45. Campbell JC, Torres S, Ryan J, et al. Physical and nonphysical partner abuse and other risk factors for low birth weight among full term and preterm babies: a multiethnic case–control study. *Am J Epidemiol.* 1999;150: 714–726.

46. Campbell JC, Poland ML, Waller JB, Ager J. Correlates of battering during pregnancy. *Res Nurs Health.* 1992; 15:219–226.

47. Dietz PM, Rochat RW, Thompson

BL, Berg CJ, Griffin GW. Differences in the risk of homicide and other fatal injuries between postpartum women and other women of childbearing age: implications for prevention. *Am J Public Health.* 1998;88:641–643.

48. Gazmararian JA, Lazorick S, Spitz AM, Ballard TJ, Saltzman LE, Marks JS. Prevalence of violence against pregnant women. *JAMA.* 1996;275:1915–1920.

49. Campbell J, Parker B. Clinical nursing research on battered women and their children: a review. In: Hinshaw AS, Fleetham SL, Shaver JL, eds. *Handbook of Clinical Nursing Research.* Thousand Oaks, Calif: Sage Publications; 1999:535–559.

50. Campbell J, Parker B. Battered women and their children. In: McElmurry BJ, Parker RS, eds. *Annual Review of Women's Health.* New York, NY: National League for Nursing Publications; 1996:259–281.

51. McFarlane J, Parker B, Soeken K, Bullock L. Assessing for abuse during pregnancy: severity and frequency of injuries and associated entry into prenatal care. *JAMA.* 1992;267:3176–3178.

52. Torres S. Intervening with battered Hispanic pregnant women. In: Campbell JC, ed. *Empowering Survivors of Abuse: Health Care for Battered Women and Their Children.* Thousand Oaks, Calif: Sage; 1998:259–270.

53. Torres S, Campbell J, Campbell D, et al. Abuse during and before pregnancy: prevalence and correlates. *Violence Vict.* 2000;15:303–321.

54. Dutton MA. Battered women's strategic responses to violence: the role of context. In: Edleson JL, Eiskovits ZC, eds. *Future Interventions With Battered Women and Their Families.* Thousand Oaks, Calif: Sage; 1996:125–153.

55. Dutton MA. Understanding women's responses to domestic violence: a redefinition of battered woman syndrome. *Hosftra Law Rev.* 1993;21: 1191–1242.

56. Root MPP. Women of color and traumatic stress in "domestic captivity": gender and race as disempowering statuses. In: Marsella AJ, Friedman MJ, Gerrity ET, Scurfield RM, eds. *Ethnocultural Aspects of Posttraumatic Stress Disorder. Issues, Research, and Clinical Applications.* Washington, DC: American Psychological Association; 1996: 363–387.

57. Allen I. PTSD among African Americans. In: Marsella AJ, Friedman MJ, Gerrity ET, Scurfield RM, eds. *Ethnocultural Aspects of Posttraumatic Stress Disorder. Issues, Research, and Clinical Applications.* Washington, DC: American Psychological Association; 1996: 209–223.

58. Sorenson SB. Violence against women: examining ethnic differences and commonalities. *Eval Rev.* 1996;20: 123–145.

59. US Dept of Justice. Office of Justice programs. Available at: http://www.ojp.usdoj.gov/vawo/communities.htm. Accessed July 30, 2001.

60. US Dept of Justice. Violence Against Women Office Website. Available at: http://www.vaw.umn.edu/library.asp#A3. Accessed July 30, 2001.

61. Berk RA, Sherman LW. Police responses to family violence incidents: an analysis of an experimental design with incomplete randomization. *J Am Stat Assn.* 1988;83:70–76.

62. Fleury RE, Sullivan CM, Bybee DL, Davidson WS. "Why don't they just call the cops?" Reasons for differential police contact among women with abusive partners. *Violence Vict.* 1998;13: 333–346.

63. Saathoff AJ, Stoffel EA. Community-based domestic violence services. *Future Child.* 1999;9:97–110.

64. Bennett LW, Williams OJ. Intervention programs for men who batter. In: Renzetti CM, Edleson JL, eds. *Sourcebook on Violence Against Women.* Thousand Oaks, Calif: Sage; 2001:261–277.

65. Tutty L, Weaver G, Rother MA. Residents' views of the efficacy of shelter service for assaulted women. *Violence Against Women.* 1999;5:898–925.

66. Tutty L. Post shelter services: the efficacy of follow-up programs for abused women. *Res Soc Work Pract.* 1996;6:425–441.

67. Centers for Disease Control and Prevention. Use of medical care, police assistance, and restraining orders by women reporting intimate partner violence—Massachusetts, 1996–1997. *MMWR Morb Mortal Wkly Rep.* 2000; 49:485–488.

68. McFarlane J, Wiist W. Preventing abuse to pregnant women: implementation of a "mentor mother" advocacy model. *J Community Health Nurs.* 2001; 14:237–249.

69. Parker B, McFarlane J, Soeken K, Silva C, Reel S. Testing an intervention to prevent further abuse to pregnant women. *Res Nurs Health.* 1999;22: 59–66.

70. Sullivan CM, Campbell R, Angelique H, Eby KK, Davidson WS. An advocacy intervention program for women with abusive partners: six-month follow-up. *Am J Community Psychol.* 1994;22:101-22.

71. Bauer HM, Rodriguez MA, Quiroga SS, Flores-Ortiz YG. Barriers to health care for abused Latina and Asian immigrant women. *J Health Care Poor Underserved.* 2000;11:33–44.

72. West CM, Kantor GK, Jasinski JL. Sociodemographic predictors and cultural barriers to help-seeking behavior by Latina and Anglo American battered women. *Violence Vict.* 1998;13: 361–375.

73. McFarlane J, Wiist W, Soeken K. Use of counseling by abused pregnant Hispanic women. *J Womens Health Gend Based Med.* 1999;8:541–546.

74. Riomonte N. Domestic violence against Pacific Asians. In: Asian Women United of California, ed. *Making Waves.* Boston, Mass: Beacon; 1989:327–337.

75. Song YI. *Battered Korean Women in Urban America: The Relationship of Cultural Conflict to Wife Abuse* [dissertation]. Columbus: Dept of Psychology, Ohio State University; 1986.

76. Ho CK. An analysis of domestic violence in Asian American communities: a multicultural approach to counseling. In: Brown L, Root MPP, eds. *Diversity and Complexity in Feminist Therapy.* New York, NY: Haworth Press; 1990: 129–150.

77. Sullivan DM, Rumptz MH. Adjustment and needs of African American women who utilized a domestic violence shelter. *Viol Vict.* 1994;9: 275–86.

78. Valencia A, Van Hoorn J. La Isla Pacifica: a haven for battered Mexican American women. *Am Psychol.* 1999; 54:62–63.

79. Luna E. *Impact Evaluation of STOP Grant Programs for Reducing Violence Against Women Among Indian Tribes. National Institute of Justice Grant 96-WT-NX-0006 Final Report.* Washington, DC: National Institute of Justice; January 2001. Publication NCJ 186235.

80. Arias I, Pape KT. Psychological abuse: implications for adjustment and commitment to leave violent partners. *Violence Vict.* 1999;14:55–67.

81. Dutton MA, Goodman LA, Bennett L. Court-involved battered women's responses to violence: the role of psychological, physical, and sexual abuse. *Violence Vict.* 1999;14:89–104.

82. Belknap J, Fisher BS, Cullen FT. The development of a comprehensive measure of the sexual victimization of college women. *Violence Against Women.* 1999;5:185–214.

83. Kracke K. *The "Green Book" Demonstration.* Washington, DC: US Dept of Justice; May 2001. OJJDP Fact Sheet No. 21.

84. National Violence Against Women Prevention Research Center. Fostering collaborations to prevent violence against women: integrating findings from practitioner and researcher focus groups. Available at: http://www.vawprevention.org. Accessed July 30, 2001.

85. Dennis RE, Key LJ, Kirk AL, Smith A. Addressing domestic violence in the African American community. *J Health Care Poor Underserved.* 1995;6: 284–290.

86. Socolar RR. Domestic violence and children. *N C Med J.* 2000;61:279–283.

87. Ross S. Risk of physical abuse to children of spouse abusing parents. *Child Abuse Neglect.* 1996;20:589–598.

88. National Advisory Council on Violence Against Women and the Violence Against Women Office. Toolkit to end violence against women. Available at: http://toolkit.ncjrs.org. Accessed November 28, 2001.

89. Williams OJ, Becker RL. Focus groups of African-American men: perspectives on addressing domestic violence. Feb 10, 1999. Available at: http://www.vaw.umn.edu/FinalDocuments/2Oliver.htm. Accessed November 28, 2001.

90. Wolfe DA, Jaffe PG. Emerging strategies in the prevention of domestic violence. *Future Child.* 1999;9: 133–144.