Preventing Intimate Partner Violence and Sexual Violence in Racial/Ethnic Minority Communities

CDC's Demonstration Projects

Preventing Intimate Partner Violence and Sexual Violence in Racial/Ethnic Minority Communities:

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Dedication

This publication is dedicated to the memory of Dr. Linda E. Saltzman, who passed away unexpectedly in March 2005. Dr. Saltzman began her distinguished career at CDC in 1984. She was a longtime champion of violence prevention, especially violence against women. During her career at CDC, she conducted groundbreaking work in the areas of public health surveillance, definitions and measurement, and etiology of intimate partner violence and sexual violence. Her groundbreaking work has helped define the field and has also led to numerous advancements in violence prevention. Her passing is a great loss to the violence against women prevention community.

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Introduction to Preventing Intimate Partner Violence and Sexual Violence in Racial and Ethnic Minority Populations

Daniel J. Whitaker, PhD

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Intimate partner violence (IPV) is a substantial public health problem that has broad impact on our nation's health. IPV has been defined to include physical violence, sexual violence, threats of physical or sexual violence, and psychological or emotional violence in the presence of prior physical or sexual violence. Population studies indicate that almost 25% of women have experienced violence at the hands of a partner sometime during their lifetime and that 1.5 million women and 800,000 men have been physically assaulted or raped by an intimate partner in the previous year (1). The physical and mental health consequences of IPV are well documented. In addition to the immediate injuries from abuse (e.g., broken bones and cuts), several other more chronic physical and psychological effects have been described (2,3). The financial burden of partner violence against women is also substantial. Combined costs for medical, mental health, and productivity have been conservatively estimated at 5.8 billion dollars per year, a figure that does not account for associated legal, law enforcement, and other medical costs (4).

The burden of IPV on racial and ethnic minorities is not well documented. Some population-based studies have demonstrated few differences in the prevalence of IPV among these persons (5), yet other studies find substantially greater violence among racial and ethnic minorities. For example, the IPV prevalence rate for whites, African Americans, and Hispanics has been demonstrated to be 11%, 25%, and 25%, respectively (6). Likewise, results from the 1985 National Family Violence Survey show higher rates of partner violence among African Americans and Hispanics as compared with rates among whites, although those differences can be largely attributed to economic differences between

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racial/ethnic groups (7). Although more data on the racial disparities of IPV are clearly needed, the effects and impact of partner violence likely are greater for persons in racial and ethnic minority groups given the significant economic and health disparities suffered by those groups (8).

Relatively few rigorous empirical studies of IPV prevention strategies have been conducted, and fewer still have focused on specific minority populations. Recent reviews of interventions for IPV perpetrators and victims have found a few efficacious strategies (9,10), but none that have been developed for and tested among a particular racial/ethnic minority population. Regarding early prevention, a recent review of dating violence prevention programs identified only one evaluated intervention that focused on preventing partner violence targeted to a specific minority group; however, even this intervention was not rigorously evaluated (11). Other reviews of partner violence programs for adolescents (12,13) make no mention of programs for specific ethnic minority populations.

Recognizing the need for IPV/SV prevention and intervention programs that address specific racial/ethnic minority populations (14), the Centers for Disease Control and Prevention (CDC) issued a request for applications (RFA) in 2000 for demonstration projects that would develop, implement, and evaluate culturally competent IPV/SV prevention strategies targeted for specific racial/ethnic minority groups. The RFA specified several types of activities that could serve as focus of a proposal (e.g., victim services, school-based interventions, perpetrator interventions, and system-level interventions). Ten projects were funded for five years for the period October 2000 through September 2005.

This monograph describes the work of eight of the 10 funded projects: University of Arizona (Peterson et al., this volume); Johns Hopkins University (Yonas et al., this volume); Latino Community Development Agency (LCDA; Barney et al., this volume); Massachusetts Department of Public Health (MDPH; Pratt et al., this volume); National Asians Women's Health Organization (NAWHO; Ingram et al., this volume); RAND Corporation (Jaycox et al., this volume); and St. Luke's–Roosevelt Medical Center (Ferrante et al., this volume). Two of the 10 projects (Turning Point for Families [TPFF] and Boston Public Health Commission [BPHC]) elected not to contribute to this monograph.

The primary goal in assembling this monograph was to discuss approaches, challenges, and solutions faced in developing, implementing, and evaluating culturally competent IPV/SV intervention for racial/ethnic minority populations. The papers in this volume are primarily descriptive reports that focus on implementation challenges and lessons learned. Such descriptive work can be critical in advancing the development of culturally competent approaches, but papers such as these are often not published because of a lack of hard, empirical data. The lessons learned may never make it to press and thus may not be shared broadly with the prevention community. Implementation lessons are a critical precursor to rigorous research; evaluations cannot be rigorous if intervention implementation is suspect. Thus, the goal of publishing this monograph is to share the work of the funded projects, specifically with regard to the approaches taken, and the successes, challenges, and lessons learned during implementation.

Diversity of Intervention Settings, Targets, and Approaches

The collection of projects described in this volume in many ways reflects the current state of the IPV/SV intervention field. Reviews of IPV/SV interventions note a range of intervention strategies, targets, and settings for IPV/SV prevention, and the projects represented in this monograph mirrored this diversity. Table 1 shows the diversity in populations, prevention approaches, interventions, and evaluation goals. Of the 10 projects, seven focused on African-American or Latino populations, and overall, six unique racial/ethnic groups were targeted as part of this effort. About the same number of projects focused on primary prevention and secondary/tertiary prevention. Most projects targeted either victims alone or victims and perpetrators, with only one project focusing exclusively on perpetrators. With regard to evaluation designs, about half the projects used rigorous research designs (i.e., experimental or quasi-experimental) to address questions of intervention effectiveness, and half focused designs on program development and improvement. Intervention settings included schools (three projects), college campuses (one project), community-based settings (five projects), and health care clinics (three projects), with two projects working in multiple settings.

Traditionally, primary prevention efforts have been carried out in schools targeting middle- or high-school students (11), and secondary/tertiary prevention efforts have been conducted in community- or clinic-based settings, which allow access to known perpetrators or victims. There has been a call for broad expansion of primary prevention efforts regarding partner violence (15), especially for expansion to settings in which primary prevention efforts can be carried out (11). Two of the CDC-funded projects attempted to achieve such an expansion by implementing primary prevention in a community-based setting. The University of Arizona combined a school-based curriculum with community-based positive youth development activities to implement a comprehensive dating violence prevention program. BPHC developed a curriculum to be added to their community-based Father Friendly program, which offers a variety of services (e.g., parenting, substance abuse, and employment) for men. Though neither the University of Arizona nor BPHC were able to carry out a rigorous evaluation, these program development efforts have helped pave the way for primary prevention programs that could be rigorously evaluated.

Intervention Approaches for Culturally Competent Programs

CDC's RFA called for the development and evaluation of culturally competent interventions for specific racial/ethnic minority populations. Definitions and measures for cultural competence have varied, but the RFA defined culturally competent programs as "programs and services provided in a style and format respectful of cultural norms, values, and traditions that are endorsed by cultural leaders and accepted by the target population." The RFA did not provide guidance about how cultural competence should be operationalized or incorporated into prevention/intervention activities or about how it should be measured in terms of intervention development and evaluation outcome. As a result, the way in which projects attended to issues of cultural competence varied considerably.

A variety of approaches can be used to achieve cultural competence. Three different elements

of culturally competent violence prevention interventions have been described (16): culturally responsive materials reflect participants cultural strengths and support bicultural success; culturally effective providers refer to the knowledge, attitudes, and skills providers have to function; and cultural engagement refers to interventions that allow participants to build cultural knowledge and pride and a positive sense of self and bicultural competence. A slightly different framework is offered by Resnicow and colleagues (17) who discuss surface structure and deep structure in culturally sensitive interventions. In this framework, surface structure refers to matching the observable characteristics of intervention materials and messages to the target population (e.g., using people, places, and products that the target population prefers). It also refers to channels and settings that are appropriate for the target population. In contrast, deep structure conveys salience of an intervention to the target population by considering how cultural, social, environmental, and historical factors may influence behavior for a particular racial and ethnic group. Interventions that address deep structure may be based on core values of a specific racial/ethnic group or may address stressors and coping styles unique to that specific population.

In reviewing the strategies described in this volume for developing culturally competent interventions, each of these approaches to cultural competency are reflected. Virtually all projects focused on creating culturally responsive materials and/or training practitioners to provide IPV services in a culturally competent manner (16). Many projects also attempted to address some of the core cultural issues faced by specific racial/ethnic minority groups, thus incorporating the concept of deep structure.

Curriculum and Material Development

Virtually all projects developed materials or an intervention curriculum to be used specifically with the targeted racial/ethnic minority group. Six projects (NAWHO, TPFF, BPHC, USC, Arizona, and Johns Hopkins) developed or tailored a formal curriculum for delivery to a specific group, and one (RAND) evaluated an ongoing program that used a formal curriculum. Some curricula were designed directly around cultural concepts or included sections that addressed cultural issues. Examples of such projects include Turning Point for Families and NAWHO. TPFF developed an intervention for male perpetrators of IPV based on Native Hawaiians' cultural traditions. Men who participated in the Ke Ala Lokahi (Pathway to Harmony) program engaged in culturally rooted activities (e.g., learning native Hawaiian chants, learning about their personal genealogy, and visiting culturally significant sites) to demonstrate Native Hawaiian principles. The goal was to promote engagement in Native Hawaiian culture, which is inconsistent with intimate partner violence. NAWHO developed an intervention for college-aged females that incorporated Asian stereotypes and beliefs into that intervention; part of the curriculum involved engaging participants to reflect on and challenge their culturally based attitudes and beliefs about IPV/SV. All projects primarily relied on direction and feedback from members of the community to guide curriculum and material development. In addition, several projects relied heavily on culturally competent program developers or expert panels/steering committees to ensure culturally relevant materials (e.g., NAWHO, MDPH, LCDA, and RAND) and used pilot testing (e.g., focus groups) and qualitative studies to determine the cultural relevance of the curriculum.

Other projects attempted to develop, embed, and deliver IPV/SV prevention messages or programs within existing culturally based activities of the targeted racial/ethnic minority group, thereby addressing the concept of deep structure (17). For example, Johns Hopkins developed a four-session curriculum to be delivered in middle schools in inner-city Baltimore to an African-American population and packaged that curriculum with a set of activities culturally relevant to the targeted population (e.g., theater and other types of art). Similarly, the University of Arizona, which aimed to prevent IPV among Latinos and Native Americans, tailored the Safe Dates curriculum (18) for use in the target population by engaging in an iterative process (described in the volume in the report by Peterson et al.). This process was paired with positive youth development activities developed by members of the Latino and Native American communities. Other projects developed IPV/SV prevention curricula to be implemented by providers already serving the targeted population. Boston Public Health Commission developed a 16- to 20-session domestic violence prevention intervention as part of their Father Friendly Program, which provides an array of services to male racial and ethnic minorities in Boston.

Structured curricula were an important part of IPV/SV prevention efforts. Although several projects were unable to rigorously evaluate their curricula in this funding cycle, formal evaluations are a logical next step. If evaluations are pursued, it is critical that rigorous methods be employed (i.e., experimental and quasi-experimental designs), because prevention efforts for IPV/SV have been heavily criticized for being non-rigorous (9,10). Perhaps equally important as strong research designs is the use of clear training manuals with criterion-based training processes in place to ensure that interventions are carried out as designed. Criterion-based training and fidelity monitoring contribute not only to increased internal validity of a research trial (i.e., knowing exactly what the intervention consisted of), but are crucial to the dissemination of effective programs.

Provider Training

The second major approach used to promote culturally competent IPV/SV services was the training of providers. This approach typically focused on either a) training IPV providers to be more culturally competent in providing services to a diverse audience or b) training providers with access to or expertise with a particular racial/ethnic minority population to be more aware of and able to address IPV issues. MDPH employed the former approach by forming provider networks, each anchored by a bilingual, bicultural network coordinator, to promote greater collaboration across agencies. A key component of this approach was raising the level of cultural competence of program staff through training and in-service education. By increasing collaboration across agencies, MDPH hoped to tap the cultural expertise of a few staff members and share their knowledge with others, an important approach for programs with limited numbers of culturally competent staff.

Examples of projects that trained providers who had existing expertise or "competence" with a specified racial/ethnic minority group include LCDA, BPHC, St. Luke's-Roosevelt, and the University of South Carolina. LCDA and BPHC each added partner violence programs to organizations that provided an array of services to the targeted population. In LCDA's case, a

preventive case-management program for IPV victims was added to the array of services (e.g., health care and substance abuse programs) already provided to Latinos. In the BPHC project, culturally specific curricula for IPV prevention were developed for African-American and Latino men to be offered as part of the Father Friendly program, which offers a range of services to low income males of ethnic and racial minority groups (e.g., medical services, substance abuse counseling, and parenting services). In two clinic-based efforts, St. Luke's and University of South Carolina trained medical providers to screen and better work with IPV victims. St. Luke's-Roosevelt aimed to train providers who served human immunodeficiency virus (HIV)-positive persons to better identify and refer HIV-positive patients who are also victims of IPV. Similarly, the University of South Carolina trained medical providers (e.g., nurses and physicians) to screen female victims of IPV and to refer women screening positive for IPV to participate in an intervention.

These efforts illustrate that training is needed on various levels for different types of providers to fully address the problem of IPV. Providers who are experts in IPV services may need training to better serve diverse populations. Providers who have access or expertise with a particular population may need training on the provision of IPV services. In other words, the creation of culturally competent IPV services likely can be achieved in two ways: by training IPV service providers to be more culturally competent and by training practitioners with cultural expertise to be more IPV competent.

Challenges in Developing, Implementing, and Evaluating Culturally Competent Programs

Several challenges related to issues of culturally competent IPV/SV interventions were apparent across the 10 projects, some of which are specific to IPV/SV interventions and some of which are not (19). One such challenge is measurement of cultural competence. Though the projects focused a great deal of thought and effort on developing culturally competent interventions, relatively little effort was directed at empirically validating the cultural competence of the intervention (i.e., answering the question, "How do we know our intervention is culturally competent?"). Several projects relied on the development process rather than on empirical tests to make this determination. Although guidance is limited regarding how to validate cultural competence, several possible methods could have been employed (20). As noted, the most common validation method used involved relying on the expertise of program developers from the targeted racial/ethnic group and on qualitative feedback from intervention participants who were members of the targeted racial/ethnic group. A second option for validating cultural competence is building specific criteria into provider training that would indicate whether providers are capable of implementing services in a culturally competent manner. With this option, providers would have to demonstrate certain knowledge and skills to be determined "culturally competent." A final strategy would be to empirically test the impact of a culturally competent program by examining outcomes for the intended populations. In an ideal research initiative, all three methods would be employed: feedback from consumers to develop criteria for

culturally competent services, implementation of behaviorally specific criteria during staff training to indicate cultural competence, and rigorous empirical testing of the program for the targeted population. Although ideal, this is often not practical; the projects described here were typically able to use only one or two of these strategies.

A second challenge not discussed in detail in this volume but worthy of mention is associated with the tendency for culturally competent programs to be construed or developed for broad racial/ethnic groups (e.g., Asians, Latinos, and African Americans). However, considerable within-group variance typically exists within each broad category of race/ethnicity (19). For example, a program that is meant to be culturally competent for a Latino population may be relevant for specific subgroups of Latinos but not others. Several projects represented in this monograph faced this challenge. For example, although MDPH attempted to work with service providers to better serve specific groups of racial/ethnic minority populations in discrete geographic locations in Massachusetts (e.g., Latinos in Chelsea and African Americans in Boston), the project was faced with addressing differences within the broad categories of Latinos and African Americans in each location.

A third challenge in implementing culturally competent programs for IPV and SV prevention is that typical community-based practices for IPV/SV are sometimes directly at odds with the norms and beliefs of a specific population. This phenomenon was most apparent in projects that conducted prevention initiatives through existing victim services, in which one of the intervention goals was to separate the perpetrator from the victim. Certain victim services (e.g., shelters) allow no contact between the victims of abuse and the perpetrator for safety purposes. However, debate exists regarding whether this is an appropriate or feasible strategy for certain racial/ethnic groups that value keeping families intact, such as Latino populations. As discussed by Barney and colleagues in this volume, the Latino culture also embraces the concept of machismo (i.e., the belief that men are responsible for decisions and keeping the house in order), which conflicts with the philosophy of many IPV services that patriarchal norms such as machismo are a key contributor to IPV and must be rebuked. In fact, many states have mandated content for court-referred batterers that are based upon these assumptions (21).

Finally, several projects noted that some of the existing services for IPV/SV were not congruent or considerate of the social-ecological realities of the targeted populations. Issues such as immigration status, mistrust of law enforcement agencies, poverty, and discrimination were barriers to effective service provision for Latinos in Oklahoma City (Barney et al., this volume) and Latinos and African Americans in Massachusetts (Pratt et al., this volume). Extensive discussion has taken place in the literature regarding the way in which immigration status poses barriers to effective IPV/SV services (22).

Table 1. Characteristics of the ten funded programs

Grantee and location of intervention	Populations of focus	Prevention approach and setting	Victims or perpetrators targeted
University of Arizona (several locations in Arizona)	Native American and Hispanic middle school students	Primary; school and community	Both
Boston Public Health Commission* (Boston, MA)	Latino and African-American adult men	Primary and secondary; community	Perpetrators
Johns Hopkins University (Baltimore, MD)	African-American middle school students	Primary; school	Both
Latino Community Development Agency (Oklahoma City, OK)	Adult Latino women	Secondary and tertiary; community	Both
Massachusetts Dept. of Public Health (Boston, Chelsea, Lowell, Berkshire county, MA)	Latinos, African Americans, Cambodians	Secondary; community	Both
National Asians Women's Health Organization (various campuses throughout California)	Asian American college-aged women	Primary; college campuses	Victims
RAND (Los Angeles, CA)	Latino 9th graders	Primary; school	Both
University of South Carolina (Pee Dee region of South Carolina)	African-American adult women in rural setting	Secondary and tertiary; health care clinics	Victims
Turning Point for Families* (Hilo, Hawaii)	Native Hawaiian men and women (ages?)	Secondary; community	Both
St. Luke's–Roosevelt (New York, NY)	Adults with human immunodeficiency virus (HIV); largely African American	Secondary and tertiary; clinics and community	Victims

* Boston Public Health Commission and Turning Point for Families did not contribute to this volume.

Evaluation design	Intervention summary
Nonexperimental program development	Combined Safe Dates curriculum with positive youth development activities to form culturally competent programs to prevent dating violence.
Nonexperimental program development	Developed partner violence prevention curriculum for African American and Latino men involved in the Father Friendly program.
Experimental research	Conducted a multicomponent intervention in Baltimore city schools that included a curriculum, theater production, and Web-design group.
Nonexperimental program development	Developed preventive case management services, batterers intervention program for Latinos.
Nonexperimental research	Focused on creation of culturally competent "networks" of service providers across local agencies in four distinct communities.
Nonexperimental program development	Developed a four-session intervention to address IPV and SV victimization among Asians. Developed on seven campuses.
Experimental research	Evaluated Break the Cycle, a three-session in-school intervention focused on the legal aspects of partner violence among teens.
Quasi-experimental research	Implemented universal screening in primary care clinics in rural South Carolina, and evaluated the impact of two clinic-based interventions.
Quasi-experimental program evaluation	Developed program for perpetrators and victims of partner violence based on principles of Native Hawaiian culture.
Quasi-experimental research	Provided training for physicians working with HIV-infected individuals to assess for partner violence and make necessary referrals testing two models of referral.

The Primacy of Community in Partner Violence and Sexual Violence Work

Community plays a central role in research and programs to prevent violence against women, and the RFA for the current projects required a partnership between communities and researchers. The goal of this partnership was to promote both implementation and sustainability while using rigorous evaluation methods (i.e., to maximize internal and external validity). Most IPV/SV prevention strategies are community-based practices rather than researcher-initiated efforts (10), which presents several advantages and disadvantages. The advantages rest primarily in the inherent external validity of much of the IPV/SV work that is conducted and evaluated (i.e., there is no question about whether evaluated interventions *can* be conducted in the community because they *are* conducted in the community). With few exceptions, little question remains about whether the intervention strategies described in this volume are externally valid because they were done in real-world settings. The disadvantages lay primarily in the difficulties associated with conducting controlled, rigorous research. Only about half of the programs were able to carry out any sort of rigorous evaluation (Table 1), and many of those projects faced difficulties in making those evaluations. Several projects collected data primarily as part of a program evaluation aimed at shaping and improving the program. Such data collection is valuable, but it does not address the question of program effectiveness. The lack of empirically sound studies for many community-based IPV/SV services is an unfortunate fact of the current IPV/SV prevention/intervention literature (9,10).

Academic-community partnerships were key in forming culturally competent IPV/SV services. In many projects, community-based service providers and members of the targeted community played key roles in determining intervention directions, activities, strategies, and formats. The current projects may not qualify as "participatory action research" in the strictest sense of the term, in which the community sets the goals, direction, and methods of a research project (23,24). However, these projects relied on critical input from community members. In many projects, community-based agencies took the lead in developing all or parts of the primary intervention (e.g., LCDA, BPHC, and TPFF) or developed a plan to implement an intervention conceived by the research team(e.g., Arizona and MDPH). For instance, LCDA worked with evaluators from the University of Oklahoma to develop a preventive case-management program for IPV victims. The team worked together to conduct pilot studies to better understand the needs of IPV victims and the norms about IPV in Latino communities. TPFF worked with scientists from the University of Hawaii and CDC to develop a Ke Ala Lokahi, a culturally based batterer's intervention program. The University of Arizona teamed with community-based partners (extension service agents) to develop culturally appropriate, positive youth development activities that met a number of conceptual criteria. MDPH implemented a structural model for promoting greater collaboration and cultural competence, but allowed community partners to determine the specific activities that would be undertaken as part of the intervention program.

Conclusion

IPV and SV are pervasive public health problems that likely disproportionately affect racial and ethnic minorities. Addressing these problems will require community-based research and sustained programmatic efforts. Although much work remains in the development of culturally competent IPV/SV interventions, the projects described in this volume represent a set of unique efforts from which lessons can be learned about future IPV/SV work in racial and ethnic minority communities.

References

1. Tjaden P, Thoennes N. Prevalence, incidence, and consequences of violence against women: findings from the National Violence Against Women Survey. Washington (DC): Department of Justice (US); 1998.

2. Campbell J. Health consequences of intimate partner violence. Lancet 2002;359:1331–6.

3. Plichta S. Intimate partner violence and physical health consequences. J Interpers Violence 2004;19:1296–323.

4. National Center for Injury Prevention and Control. Cost of intimate partner violence against women in the United States. Atlanta (GA): Centers for Disease Control and Prevention; 2003.

5. 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): Department of Justice, National Institute of Justice; 2000. NCJ Publication No.: 183781.

6. Caetano R, Field CA, Ramisetty-Mikler S, McGrath C. The 5-year course of intimate partner violence among white, black, and Hispanic couples in the United States, J Interpers Violence 2005;20:1039–57.

7. Straus MA, Gelles RJ. How violent are American families? Estimates from the National Family Violence Resurvey and other studies. In: Straus MA, Gelles RJ, editors. Physical violence in American families: risk factors and adaptations to violence in 8,145 families. New Brunswick (NJ): Transaction Publishers; 1995. p. 95–112.

8. Institute of Medicine. Unequal treatment: confronting racial and ethnic disparities in health care. Washington (DC): National Academies Press; 2003.

9. Wathen CN, MacMillan HL. Interventions for violence against women: scientific review. JAMA 2003;289:589–600.

10. Whitaker DJ, Baker C, Arias I. Interventions to prevent intimate partner violence. In: Doll L, Bonzo S, Mercy J, Sleet D,editors. Handbook of injury and violence prevention. New York (NY): Kluwer; 2007. p. 203-21.

11. Whitaker DJ, Morrison S, Lindquist C, Hawkins SR, O'Neil JA, Nesius AM, et al. A critical review of interventions for the primary prevention of perpetration of partner violence. Aggression and Violent Behavior 2006;11:151–66.

12. Avery-Leaf S, Cascardi M. Dating violence education: prevention and early intervention strategies. In: Schewe PA, editor. Preventing violence in relationships: interventions across the life span. Washington (DC): American Psychological Association; 2002. p. 79–105.

13. Hickman LJ, Jaycox LH, Aranoff J. Dating violence among adolescents: prevalence, gender distribution, and prevention program effectiveness. Trauma Violence Abuse 2004;5:123–42.

14. National Research Council. Understanding violence against women: Washington (DC): National Academies Press; 1996.

15. Coker AL. Primary prevention of intimate partner violence for women's health: a response to Plichta. J Interpers Violence 2004;19(11):1324–34.

16. Hudley C, Taylor A. What is cultural competence and how can it be incorporated into preventive interventions? In: Guerra N, Smith EP, editors. Preventing youth violence in a multicultural society. Washington (DC): American Psychological Association; 2005. p. 249–69.

17. Resnicow K, Baranowski T, Ahluwalia JS, Braithwaite RL. Cultural sensitivity in public health: defined and demystified. Ethnic Disparities 1999;9:10–21.

18. Foshee VA, Linder GF, Bauman KE, Langwick SA, Arriaga XB, Heath JL, et al. The Safe Dates Project: theoretical basis, evaluation, design, and selected baseline findings. Am J Prev Med 1996;12(Suppl 5):29–47.

19. Dumas JE, Rollock D, Prinz RJ, Hops H, Blechman E. Cultural sensitivity: problems and solutions in applied and preventive intervention. Appl Prev Psychol 1999;8:175–96.

20. Like RC, Steiner P, Rubel AJ. Recommended core curriculum guidelines on culturally sensitive and competent healthcare. Fam Med 1996;28:291–7.

21. Austin JB, Dankwort J. Standards for batterer programs: a review and analysis. J Interpers Violence 1999;14(2):152–68.

22. Raj A, Silverman J. Violence against immigrant women: the roles of culture, context, and legal immigrant status on intimate partner violence. Violence Against Women 2002;8:367–98

23. Cornwall A, Jewkes R. What is participatory research? Soc Sci Med 1995;41:1667–76.

24. Leung MW, Yen IH, Minkler M. Community-based participatory research: a promising approach for increasing epidemiology's relevance in the 21st century. Int J Epidemiol 2004;33:499–506.

The Collaborative for Abuse Prevention in Racial and Ethnic (CARE) Minority Communities Project: The Development of Locally Based Strategies for Addressing Intimate Partner Violence

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Introduction

The Collaborative for Abuse Prevention in Racial and Ethnic (CARE) Minority Communities Project was initiated by the Massachusetts Department of Public Health (MDPH) in 2000 to enhance the delivery of intimate partner violence (IPV) services for racial and ethnic minority communities. This paper describes the CARE Project, including the design, challenges, and strategies used to address IPV among specified racial, ethnic, and immigrant groups. Lessons learned are discussed to inform the development and implementation of similar endeavors. Specifically, the paper presents the experience of four collaborative networks of local providers that serve and conduct outreach and education for Latinos, African Americans, and Cambodians. Immigrant and refugee groups were included within these populations.

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The public health impact of IPV is well documented; however, research about IPV disparities in race, ethnicity, country of origin, and immigration status is less conclusive. Some studies indicate that compared with white nonimmigrant women, the risk for IPV appears to be elevated among some immigrant and racial/ethnic minority women(1–8) whereas other studies report similar rates of IPV by race/ethnicity(9,10) and immigration status (8,11). Recent studies suggest that African-American women(12,13) and some groups of immigrant women(2,3,14–16) are overrepresented among victims of severe IPV and IPV-related homicides. However, because these studies are based on a limited number of immigrant groups, findings cannot be generalized to other immigrant groups.

Although questions about whether disparities in rates of IPV among racial/ethnic minorities and immigrants exist, studies indicate differences in IPV service utilization among these populations (17–19). For example, immigrant women who experience IPV report lower levels of help-seeking behaviors for IPV compared with other U.S. women (15,20). Also, research suggests that African-American women are more likely to report IPV to police but less likely to access community-based IPV services compared with women of other racial/ethnic groups (21–23). A study of Cambodians in Massachusetts found that, along with Vietnamese, Cambodians are more likely than other South East Asian groups to believe that battered women have few alternatives to living with violence(24).

Studies that examine disparities in service utilization identify that victims and perpetrators of IPV from minority and immigrant communities face many barriers that can alienate and prevent them from seeking services, receiving services, and reporting victimization. These include: a) linguistic barriers, b) religious/cultural barriers, c) social isolation, d) lack of awareness of IPV-related services or legal sanctions, e) perceived and actual cultural incompetence of and discrimination by service providers, f) fear or mistrust of social and criminal justice services, and g) fear of deportation(3,8,14,15,17,20,23, 25-27). Therefore, outreach, education, and services that are culturally tailored to address these specific barriers within communities are essential.

A report by the Massachusetts Governor's Commission on Domestic Violence (1998)(28) demonstrated locally the need for accessible domestic violence services for immigrants and refugees. The report described a) a lack of cultural sensitivity among mainstream social service agencies, b) language and cultural barriers that isolate refugee and immigrant communities from support services, and c) an increased strain on the few existing culturally competent and accessible resources. In 2000, with funding from the Centers for Disease Control and Prevention's National Center for Injury Prevention and Control, MDPH attempted to address these issues by initiating the CARE Project. The goal of the project was to work with existing IPV providers to develop new strategies to increase collaboration and cultural competence among providers, improve quality of services, and ultimately increase service utilization for specific racial/ethnic minority and immigrant communities.

Design of the CARE Project

Because existing strategies for providing IPV services to racial/ethnic minority and immigrant

communities have not been tested, one main tenet of the CARE Project was to establish a minimal structure for collaborative networks of service providers. One premise of the project was to encourage local providers to develop their own innovative strategies for addressing IPV within their communities. MDPH was responsible for evaluating the project and for overseeing the project's fiscal components. MDPH also had oversight for project implementation and responsibility for maintaining ongoing communication with the networks, holding information-sharing meetings across networks, providing training on cultural competence and collaboration to network staff, addressing issues and barriers to implementation, assisting with and reviewing work plans, and providing general support to each network's coordinator.

Each network was required to identify a lead agency that would hire and supervise a bilingual and bicultural network coordinator, presumably from the targeted community. Lead agencies were also responsible for subcontracting with the other programs to fund network activities. The participating programs included a rape crisis center, a domestic violence prevention and victim services/battered-women's program, a children-exposed-to-domestic violence program, a batterer intervention (BI) program, and a Refugee and Immigrant Safety and Empowerment (RISE) program (Figure 1). RISE programs provided IPV education, outreach, and direct service, including advocacy, to particular ethnic and racial communities. CARE networks always involved existing providers so those funds could be used to augment services, as opposed to creating new ones. The money awarded by MDPH to networks was primarily used to fund participation in the evaluation process; to fund development and implementation of outreach and education activities; to hire a part-time bilingual/bicultural network coordinator; and to fund activities associated with the development of cultural competence and collaboration (i.e., participation in training, conferences, and other staff development activities).

Funding was awarded to networks serving Latinos in the City of Chelsea (near Boston) and in Berkshire County (a rural county in western Massachusetts), African Americans in specific neighborhoods in Boston, and Cambodians in the City of Lowell (in northeastern Massachusetts). The Chelsea and Berkshire networks chose to target all Latinos in their communities. The City of Chelsea has a population of 35,080, 48% of which is Hispanic; most of the Hispanics living in Chelsea are originally from Central America (35%) and Puerto Rico (32%)(29). Berkshire County has a population of 134,953, of which 2% is Hispanic; however this percentage likely represents a substantial undercount resulting from the unwillingness of Latino immigrants to participate in the U.S. Census (based on interviews with members of the Berkshire network). Most Hispanics in Berkshire County are Puerto Rican (32%), Mexican (15%), or South American (12%)(29). The Boston Network limited its target population to African Americans living in the Boston neighborhoods of Roxbury, Dorchester, and Mattapan. The populations of these neighborhoods are 56,658, 92,115 and 37,607, respectively; African Americans in these neighborhoods account for 63%, 36%, and 77% of the population, respectively (29). The Lowell Network chose to focus on Cambodians in the City of Lowell. Lowell has a population of 105,167, of which 9% are Cambodian (29).

Figure 1. CARE Project Participants and Activities

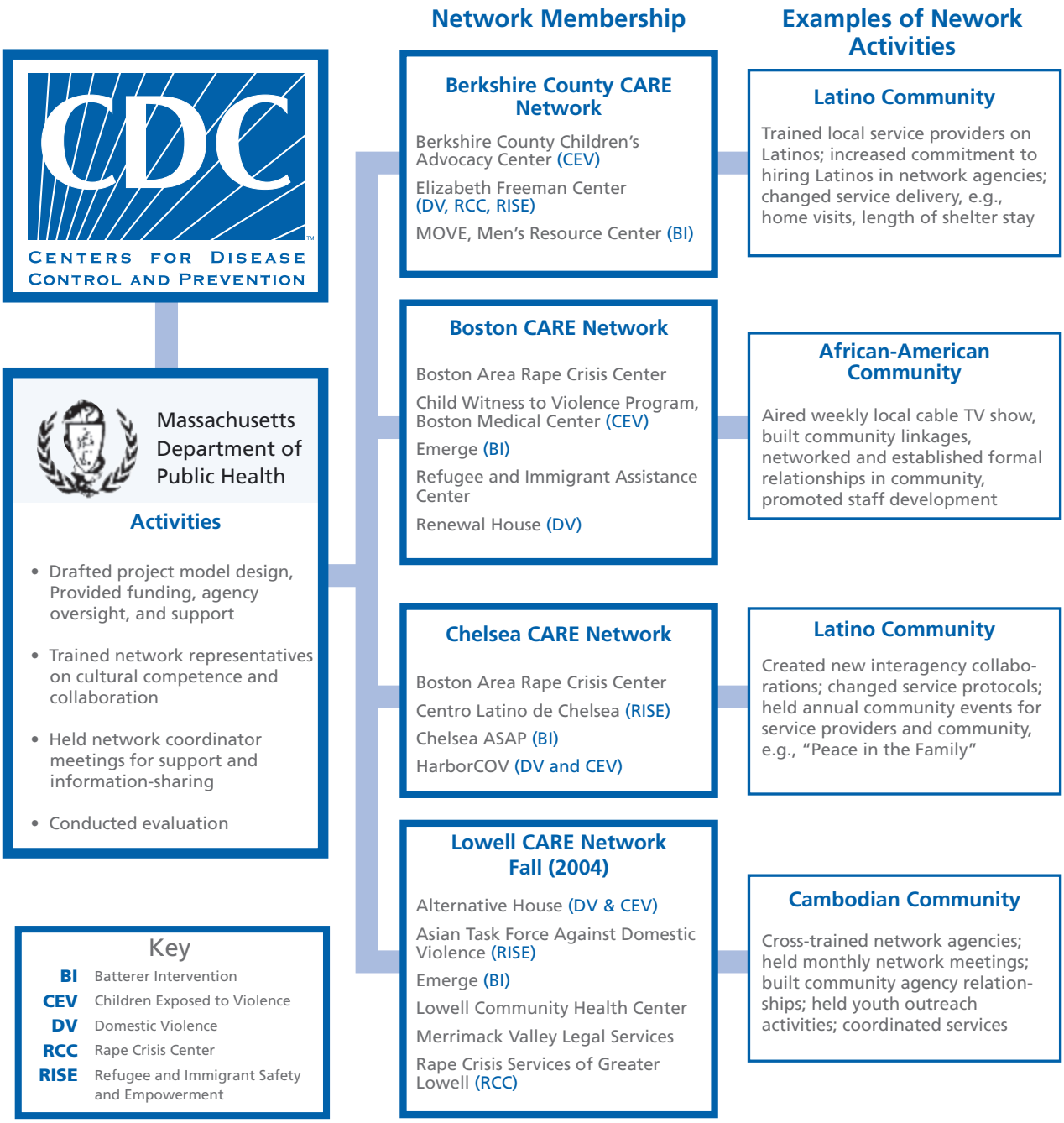

Table 1. Activities to promote collaboration and cultural competence

Collaboration	Cultural competence
• Hire a bicultural/bilingual network coordinator • Conduct monthly network meetings • Establish memoranda of agreement among network agencies • Develop network mission, goals, and annual work plans • Cross-train network members on agency philosophies and services • Develop guidelines for and conduct joint outreach efforts • Develop cross-agency referral protocols • Communicate information from the network back to individual agencies	• Hire a bicultural/bilingual network coordinator • Assess needs of the network's specified community • Receive education and training on the network's target community • Cross-train network members • Obtain feedback from the community on an ongoing basis • Establish relationships with community leaders, local providers, and other stakeholders • Develop and distribute culturally sensitive outreach and educational materials • Improve and implement culturally informed service provision and cross-referral protocols • Communicate information from the network back to individual agencies

Table 2. Description of purpose and content of methods

Method	Purpose	Content
Monthly reports monthly network reports provided by each network coordinator	To document monthly activities of each network	• Network membership • Attendance at meetings and training sessions • Outreach and education activities • Relationships made outside of network • Product development and dissemination
Project director interviews: annual interview of project director	To document progress and challenges to implementation of the networks and the project strategies	• Network goals • Network membership • Communication issues with network • Network successes and barriers • Relationship with and involvement of CDC • MDPH staffing and project changes • Project director's activities
Network coordinator interviews: semiannual interviews with each of the four network coordinators	To document progress in the implementation of the networks	• Network goals, mission, priorities, and work plan • Network membership • Network activities • Work environment • Conflict resolution • Member participation • Involvement with community • Knowledge of community • Network challenges and accomplishments
Network focus groups focus groups with three of the networks	To document network progress, challenges, and lessons learned	• Member participation • Member experience • Implementation issues for collaboration and cultural competence • Lessons learned and recommendations • Impact of networks • Institutionalization of project • Impact of budget cuts
Observations • Network meetings observed quarterly • Sample of network events • All lead agency and provider meetings	To document collaboration, monitor implementation, and describe barriers and successes	Observations of network meetings, network events, and lead agency and provider meetings

Table 3. Sample activities conducted by the networks *

Type of activity	Activities	
Outreach	• Brochures • Newsletters • Sponsorship of local events • Organization of events offering other needed services for the community (i.e., legal and immigration advice)	• Public service announcements • Participation at local health fairs • Map designating location of local service providers • Cultural celebrations • Development and distribution of resources (pamphlets, books, websites, toll-free numbers, etc.)
Community education	• Cable television shows • Radio shows • Presentations	• Training sessions • Workshops • Campaigns • Events
Provider education	• Community breakfasts for providers	• Training sessions • Conferences
Relationship development	• Community-based agencies • Public agencies • Health care agencies and providers	• Coalitions • Task forces • Faith-based organizations • Leaders in community • Members of community
Other activities	• Internship opportunities • Grant writing	• Incorporating cultural décor in agencies and workspaces

* Not all networks conducted each activity.

The development of the CARE Project was informed by literature in the areas of collaboration(30–38) and cultural competence (39–43), by lessons learned from the implementation of the RISE programs (i.e., the importance of providing services with emphasis on the family and addressing multiple issues), and by the findings and recommendations from the previously mentioned Governor's Commission report. An emphasis on collaboration was included into the project's design on the basis of empirical evidence demonstrating that collaboration among agencies produces greater effects than individual agencies acting alone (35–38). An emphasis on cultural competence was included to ensure that outreach, education, and services would be appropriate and accessible to the target populations. Cultural competence included the need to a) dispel racial and ethnic stereotypes among service providers, b) address the significance of race/ethnicity of the client, and c) remain sensitive to clients' needs(42). To promote collaboration and cultural competence, MDPH provided support for and required participating networks to engage in specific training and activities. (See Table 1.)

Evaluation Description

The evaluation describes the implementation of the project at the network level and provides anecdotal evidence as to the affect of the CARE project at the network, agency, and community levels. Primarily qualitative methods were utilized to obtain the data. Data were collected through monthly reports, interviews, focus groups, and observations at meetings, training sessions, and network events. Most data collection methods were first implemented in Year 3 of the project and included a) monthly reports prepared by network coordinators, b) semiannual interviews with network coordinators, c) annual interviews with the MDPH project director, and d) observations. In Year 4 of the project, focus groups involving all but one network were conducted (the City of Lowell network had already disbanded; see discussion on Lowell in the following section). A brief description of the purpose and content of each method is included in Table 2. Initial questions for interviews and focus groups and the focus for observations were informed by the above-mentioned review of the literature on cultural competence and collaboration. Additional questions were incorporated to explore themes that emerged after preliminary analyses. A content analysis of the qualitative data was conducted to identify coherent themes, patterns, and examples. Transcripts of interviews, focus group discussions, and observational notes were coded and sorted using Ethnograph version 5.0 (44). Network members reviewed evaluation findings to ensure accuracy.

Strategies Developed by Each Network

Although the structure of the networks was similar (i.e., types of agencies included, presence of a network coordinator, lead agency, and available funding), each network developed unique strategies for addressing the issues in their respective communities. The networks implemented a variety of activities such as outreach, provider and community education, and relationship development (Table 3). (For a more detailed description of specific outreach and education activities in the two Latino communities, see Whitaker et al.(45).)

Berkshire

The main objectives of the Berkshire network were to a) educate the service-provider community in the Berkshires about Latinos, thereby developing capacity to serve this population, and b) foster trust in their agencies by the Latino community through outreach, education, and service-delivery strategies that would meet the needs of the Latino community.

Information from focus groups and interviews with network members suggested that culturally appropriate services were minimal despite the growing number of Latinos in the county. Members reported that most providers were white, few were bilingual, and that most lacked knowledge about Latino cultures and immigration. The Berkshire network invited local and national cultural competence experts to train service providers throughout the county about the needs of the Latino community and how best to meet those needs.

The Berkshire network also provided language classes to member agencies to enable staff to hold a basic conversation in Spanish. Because these classes alone were recognized as being insufficient in ensuring culturally competent services, the Berkshire network emphasized the need to hire bilingual and bicultural staff. As a result, network members reported an increased commitment of participating CARE agencies to hire bilingual and Latino employees. For example, the Berkshire network coordinator related that many of the network member agencies' staff postings began including the phrase "bilingual preferred." Despite this effort, however, agencies had difficulty recruiting bilingual and bicultural candidates, primarily because the service provider community was populated with so few bilingual and bicultural job candidates.

The second network objective involved a need to build trust with Latinos in Berkshire County. As is true with many communities, the issue of IPV is difficult to discuss in the Berkshire Latino community. As one member stated, "I have to be careful about talking about domestic violence and sexual violence. It is a taboo subject. You have to proceed cautiously."

Building trust was also important "to create a safe place for people to be able to come and talk about their issues." Network members also discussed how incidents of discrimination within their community affected trust in community services; network members provided examples from the media and relayed stories told by their clients. As the network coordinator noted, "I am talking about discrimination in everyday life from opening a bank account to getting attention from a doctor…. how do you expect a person who is the victim of domestic violence to come and talk about what is going on if she does not feel safe about who she is?"

To foster trust in the community and address these issues, the domestic violence program allowed staff to work outside the traditional service provision framework. Staff members were given the flexibility to focus on other client issues to build trust and meet needs. For example, network members reported that often women would initially contact agencies for help with non-IPV related issues, but that this often fostered trust and led to later disclosures of IPV. The following story, related by Berkshire's network coordinator serves as an example: "A couple of clients that have come…three times to fill out

forms…to help them to register their children for school, and then all of the sudden they sit right there and you see the tears coming down and they start telling you [about domestic violence], because they know that I do domestic violence." She stated, "It might take me 10 minutes to fill out a form and explain to someone how to register a child for school, but the trust that you build with that individual is what allows this woman to come back and say there is [an IPV] issue." The network also held events on non-IPV issues that were important to the community (e.g., immigration and parenting); at these events, network members also made CARE materials available and answered questions about the project.

Boston

The main objectives of the Boston network were to a) build community awareness, b) educate the community about IPV and available community resources, and c) increase dialogue about IPV in the community. Network members related that IPV is often not discussed in the African-American community, not only because of the intimacy of the violence but also because of the denial within the population that IPV occurs and the need to protect their community from negative stereotypes attributed to racism.

One of the major barriers the Boston network faced in trying to meet these objectives was that the network member agencies did not have a strong presence in the community. Although the member agencies were often the main IPV providers in Boston, none of the agencies' main offices were located in the target neighborhoods. Therefore, it was difficult for the network to gain trust. Another barrier raised by network members was that "African-American people do not trust services that are white-run and white-dominated, especially in Boston." To address these barriers, the network focused on strengthening their relationships with leaders, agencies, and community members in the three neighborhoods.

In addition to a lack of presence in the community, members did not feel they represented the community. Most network members did not identify as African American, and thus members raised the issue of whether the network had the expertise to work with this population. To increase their knowledge, members used network meetings to exchange information they learned from working in the community or from other forums and to discuss how to incorporate this information into their work.

One such finding was that traditional strategies for providing IPV outreach and education may not be appropriate in the African-American community. The Boston network coordinator expressed the following sentiments about traditional strategies: "I think the framework for dealing with domestic violence and sexual assault is still very mainstream and middle of the road, with the perspective that a woman's primary concern is about her being abused or raped by a stranger or her husband…women of color have to contend with many other factors in addition to dealing with the abuse issues." According to network members, factors that tend to intersect with IPV among African-American communities in Boston include: high rates of poverty, youth violence, incarceration and reentry issues, lack of political power, less opportunity for education, and high rates of unemployment and underemployment. In addition, the Boston

CARE neighborhoods have only limited affordable housing. For the Boston network, moving away from the traditional IPV service model also meant moving away from a criminal justice approach. According to the network coordinator, "[the criminal justice approach] does not resonate with people of African descent because of our history. Talking about the criminal justice system and all the legal resources is not reassuring to us because it has not always been a safe place for us."

The network employed alternative strategies that incorporated a more holistic and Afrocentric perspective into their outreach and education efforts. Outreach and education activities included an emphasis on self-healing, spirituality, and the health of the community. Participants included both traditional and non-traditional service providers (e.g., artists, holistic healers, and health care providers) who were interested in integrating all aspects of well-being, including social, mental, physical, emotional, spiritual, and environmental health.

The primary method the network used to address its objectives was a local-access television program. The network coordinator conducted the program; a new show was produced weekly and aired five times per week. The show was moved to prime time, with a total estimated audience of 30,000 in the targeted neighborhoods. According to network members, the program created a consistent presence for their work in the community and served as a forum to discuss emerging issues. Guests were often trustworthy sources from the community. Staff from the different network member agencies were also guests on the show, thus increasing awareness of the agencies and their services. In addition to discussing IPV, guests talked about other issues of concern to the community. The network coordinator described the show as "a mode of engagement, where people can get information and also hear different stories so it reinforces this idea that people are not alone."

Chelsea

Because of the size of the Latino population in Chelsea, the main objectives of the Chelsea Network were to a) increase the service providers' capacity to serve Latinos, b) foster trust in its agencies by the Latino communities through outreach and education, and c) increase community awareness of its agencies and services. To meet the first objective, the network cosponsored trainings and events for service providers, business members, and community leaders to raise awareness of the cultural differences within Chelsea's Latino community and the need for appropriate services. According to the network coordinator, "people [are] from different cultures, countries, political and religious backgrounds… staff providing the service have to have some knowledge of the diversity within the Latino population in Chelsea."

To address the second objective, the network approached outreach and education indirectly and promoted the safety and confidentiality procedures within their agencies, with the objective of increasing trust and reducing the unwillingness by Latinos to discuss the issue of IPV. A primary contributor to the lack of trust has been immigration status. According to the Chelsea network coordinator, Latinos "are afraid that immigration is going to get batterers or they will get into legal entanglements if they seek services… new immigrants are afraid to

talk about this because some may view this as a private issue." In addition, members reported that Latinos may not define IPV-associated behavior as being abusive. The network coordinator noted, "You cannot just call [IPV] what it is. You have to kind of cover it up with something else, such as healthy families." The themes for many of their community events and activities organized by the Chelsea network concerned healthy families, healthy relationships, and peace in the family. Through these events and activities, the Latino community was provided with information about IPV and related services, often via take-home resource materials. These materials contained agency contact information that enabled recipients to inquire about services at a later time, in a more confidential setting. Incorporating the theme of family into the activities and events also acknowledged the strong role that family plays within the Latino culture.

To meet the third objective—increasing community awareness of CARE agencies—the network collaborated with Chelsea's domestic violence task force on events and activities; three of the network agencies were already members of the task force. The network's role was to develop materials, recruit speakers, and conduct outreach with the Latino community at local events. The Chelsea network coordinator viewed the network as "an extension of the task force." This collaboration also reduced the chances of duplicating services between the two entities through coordination and increased their resources through combined funding and efforts.

Lowell

Development and implementation in the City of Lowell presented many challenges. In the second year of the CARE project, the Lowell network disbanded. The lead agency in Lowell reported that project demands outweighed available resources, CARE members failed to participate in activities, and documentation required for evaluating the project was burdensome. According to other network members and the MDPH project director, multiple factors affected the Lowell network's ability to thrive, including network tension with the local task force, high rates of member turnover, and poor collaboration efforts.

Prior to the implementation of the Lowell network, the City had an existing task force in place to focus on preventing domestic violence in the Southeast Asian community. A disparity in resources began to emerge between the task force and the CARE network, a disparity that was exacerbated by a) the discontinuation of staff support for the task force by the network's lead agency and b) the lack of inclusion of task force members in the CARE network's decision-making process. These factors resulted in resentment and dissention, which led the task force to disband.

An additional challenge to the Lowell network's progress was a perceived lack of leadership from the network lead agency. One of the many network coordinators in the position reported that she did not receive any direction from the lead agency or guidance from MDPH as to what was expected from the network. According to the MDPH project director and this network coordinator, the lead agency was not providing sufficient support for the network coordinators and was not communicating effectively with other network member agencies.

Turnover was also a problem. The network coordinator position turned over seven times in the course of two years; the programs that originally agreed to represent the child witness to violence and BI programs changed; and a substantial amount of change in staff representation occurred within different network agencies. This instability affected the ability of the network to build collaborative relationships and develop a strategy for addressing IPV in the Lowell Cambodian community.

After this original lead agency withdrew from the project, other agencies unsuccessfully attempted to develop a competitive new proposal for funding. Aware of a need for assistance, MDPH hired a consultant to work with the former network agencies to build their capacity to work effectively as a network. The result was a unified and strong proposal and a new contract for a restructured Lowell network for the final years of the CARE Project.

Effects of Network Strategies

Although a rigorous outcome evaluation was not conducted, anecdotal evidence suggests that positive changes were observed at the agency, network, and community levels in three of the four target communities. Specific changes that network members have attributed to the project include a) changes in network member agencies' capacity and commitment to serve the target population, b) strengthening of interagency relationships, c) improved ability to reach the target community, d) increased service utilization by the target community, and e) enhanced capacity of other service providers to serve the target community. Although each network reported observing these changes, the extent and specific examples of changes were unique to each network.

Network members indicated that their agency's capacity for and commitment to serving the target population had improved through hiring and supporting bilingual and bicultural staff, changes in service practice, and changing attitudes and knowledge of agency staff regarding the target population. Examples of changes in service practice from the Berkshire network were a) increasing the acceptable length of stay for refugee and immigrant women in the local domestic violence shelter and b) conducting home visits. According to the Berkshire network coordinator, home visits are now becoming routine procedure for all clients. Changes in attitudes and knowledge of staff were demonstrated by the Berkshire network through an increasing willingness among staff members to work with entire families as opposed to individuals.

Capacity was also seen as having increased through the development of relationships with community stakeholders, which facilitated each networks' ability to reach the target community. Participation in the CARE project increased the recognition of some network agencies' capacity and expertise in serving the target community. These agencies came to be viewed as cultural experts by other service providers and were asked to provide training and consult on cases involving members of the target community. The network's credibility also was increased through its collaborative design. As one member of the Boston network stated, "I think it makes it easier to go into [a] roundtable and be able to talk about sexual violence and domestic violence than be a lone voice from one agency."

The network strategies were also associated with strengthening relationships between network member agencies. Members reported a better understanding of each other's agencies and an increase in interagency referrals. As one member from Chelsea said, "Before [the CARE project's implementation], if you don't really know someone at a different agency, you're not as likely to call…and refer someone over [to that local agency]." For the Chelsea network, the novel interagency collaboration has led to staff from the BI program offering to accompany referrals by literally walking them over to the domestic violence program.

Although member agencies expressed frustration at being unable to quantitatively determine whether the target community was effectively reached with their outreach and education activities, many provided examples of anecdotal feedback, including having people call into radio and television shows, receiving positive comments at local network events, and experiencing increased event participation by the target community. Members also reported an increase in the number of IPV-related calls to some agencies by the target population, and ultimately an increase in service utilization at some agencies.

Networks employed strategies that affected others in the community by changing their knowledge, attitudes, and perceived capacity. For example, the Berkshire network coordinator related the following story about a local school district as an example of their success: "Two years ago, we had doors slammed in our faces…[school districts were] saying they don't have a need. Eventually they called us and asked us to talk about CARE, when years ago their response was, 'we don't need you' or 'what are you doing bringing these people [Latinos] into our community.'"

Implementation Challenges

As is often the case in community-based projects, several implementation challenges emerged. The most substantial challenge was a state fiscal crisis, which resulted in the realignment of funding and changes in the level of funding available for both RISE and rape crisis center programs. These changes resulted in fewer resources, specifically less staff available to provide services. With fewer resources, some of the CARE Project funding had to be redirected from outreach and education initiatives to the direct provision of services. Despite reduced support, the RISE programs (or their parent agencies) in each of the CARE sites continued to participate in the networks, although for some it was on a more limited basis. The continued participation of RISE programs indicated their commitment to provide culturally appropriate services and their perception of the value of the collaborative CARE project.

Another major implementation challenge was a lack of adherence to the proposed project activities. A contributing factor was the delay in articulating the activities until Year 2 of project implementation. This delay primarily resulted from the absence of an initial time frame to allow for the development and buy-in of the project activities prior to the dissemination of network funding and implementation. The following aspects of the project activities could not be included in the implementation: a) conducting an initial community needs assessment, b) obtaining ongoing community feedback, c) developing

cross-agency referral protocols, and, in some cases, d) creating a system to communicate information from the networks back to the network agencies.

Lessons Learned

Although many of the lessons learned from the CARE Project are based on limited perspectives, a discussion of some of these lessons may benefit organizations developing other projects using a similar approach. These lessons include issues about the structure of the CARE Project, community capacity, existing task forces, community trust, staff development, and time required to develop effective collaborations.

Project Structure

Although a main tenet of the CARE Project was to allow the individual networks to develop their own strategies, MDPH required a service-based foundation and specified, at a minimum, the agencies that were to be included in the network. Involving the community prior to the development of this structure would have been ideal, but early involvement was not possible because of time constraints related to the CDC funding announcement and the perceived need to clearly articulate a structure for the proposal and begin implementation as soon as funding was received. The experience of the networks raised questions about the appropriateness of the assigned structure.

Members of the Boston network indicated that a community-based foundation was more appropriate for their community, and therefore, this network focused less on promoting services and more on promoting community awareness of and dialogue about IPV. As a consequence, the activities of the network were not always well coordinated with those of the member agencies. As one member stated, "in some ways there is a disconnect between what is happening at our agencies and this project."

Staff at some networks also questioned the requirement that each network include specific types of IPV service agencies. Some networks had member agencies with philosophies that were in contrast to the strategy and philosophy of the network, an issue that primarily pertained to the BI programs. As part of the BI programs' methods for holding batterers accountable, clients were required to pay a fee and attend a 40-week program. Such requirements were seen as a barrier to increasing access to services.

Another concern raised was whether the agencies' required to participate were the most appropriate, especially those agencies that lacked a strong presence in the community or expertise working with the targeted communities. For example, members of the Lowell network realized after working with a consultant that none of the agencies in Lowell that provided IPV services had a strong enough management capacity and infrastructure to serve as the lead agency. Instead, another agency that did not have IPV expertise but had experience working with Cambodians (the target population) was recruited.

MDPH concluded that the structure of the CARE Project was too rigid for some networks, hindering at times the ability of networks to create unique strategies to respond to their communities. On the other hand, some networks felt MDPH had not provided sufficient direction. By engaging community and agency input earlier in the project development process, community

needs might have been identified, alleviating the project's structural issues.

Task Forces and Community Capacity

The experiences in Lowell and Chelsea demonstrated that the role of an existing task force should be considered when developing a network. In Chelsea, the task force became an active partner and was involved in decision-making even before applying for the CARE network funding. The task force and network developed distinct yet complimentary roles that seemed to promote both entities. Any effort to integrate existing task force and network activities should foster the network's ability to develop a unique strategy. Network strategies should not be limited by being linked too closely to the strategies employed by an existing task force. By contrast, failing to engage an existing task force, which occurred in Lowell, could have a disastrous effect on a community and result in a decreased capacity to address IPV.

Building Community Trust

For each of the networks, building trust in the community was essential to carrying out project objectives. Strategies to promote trust included addressing non-IPV issues (in both outreach/education and direct service) and engaging community leaders. The latter strategy was particularly important in Boston, where agencies did not have a strong presence in the communities. Implementation of these strategies often required working outside of traditional IPV models and partners, particularly the criminal justice system, which is often not trusted by these communities.

Staff Development

Supporting staff development was identified as being fundamental to developing institutional capacity. In the Berkshire network, the network coordinator was given increasing responsibilities and support to expand her knowledge and skills. Her contributions and role in the agency helped lead to changes in agency policies and priorities. In networks where such support was not as prominent, less institutional capacity building was observed.

Building Effective Collaborations

The challenges faced in the formation of CARE networks were similar to those described in the formation of other collaborations (46). For all of the networks, building an effective collaboration required time. Network coordinators often reported minimal investment from other members at the start of project implementation, primarily because the network was viewed as being an additional responsibility unrelated to current duties. Only through the passage of time and the development of relationships could network agencies gain the understanding and trust essential to effective collaboration.

Limitations

Our goal in describing how these networks were implemented is to help inform other communities considering undertaking such a project. The ability to generalize these strategies to other communities may be limited. In addition, findings are based on limited and unbalanced perspectives and may be biased by the desire among members to provide positive rather

than negative accounts and information about their networks. Data were primarily obtained from network members, with most information provided by the network coordinator. Also, staff turnover in the networks meant that some members were new at the time of the focus groups and therefore were unable to participate fully. Finally, data collection was not initiated until Year 3 of the project.

Conclusion

The goal of the CARE Project was to increase access to culturally competent services and to develop appropriate outreach activities in specific racially and ethnically diverse communities. Preliminary reports on progress toward this goal are encouraging. Three of the networks developed and implemented strategies despite experiencing severe fiscal constraints, demonstrating that the network structure is useful for integrating limited resources and filling gaps in services. The project fostered the development of innovative interventions affecting the content and delivery of IPV services for racial and ethnic minorities by allowing networks leeway to develop strategies to address locally identified barriers to seeking and obtaining services. Such innovation is especially beneficial in interventions targeted to racially and ethnically diverse communities, where traditional, existing strategies may actually discourage women from seeking help. The network approach employed through the CARE project increases collaboration among IPV organizations and may result in better access to services for clients through increased interagency referrals. Although sustainability has not been investigated, the project will likely result in positive long-term effects, including an increase in agency commitment and capacity to work with the target population.

The CARE Project experience also highlights the need for researchers undertaking similar demonstration projects to build in time for community participation in project development as a step in project design, implementation, and evaluation. Allowing flexibility to incorporate implementation feedback and adjust the project accordingly is imperative to maximizing effectiveness. Often, new projects must be adapted during implementation and consequently are not suitable for rigorous outcome and impact evaluations. Once a project is solidified, more rigorous research is necessary to determine effectiveness and impact.

In the case of the CARE Project, further research should be conducted to determine the intermediate outcomes verifying whether network development has led to increased agency capacity and service utilization by the targeted communities. Research should also be conducted to assess the ability of the project to influence rates of IPV in target communities through effective prevention education strategies; such studies should take into account the variables outside of the intervention that can affect outcome and impact. Process and outcome evaluations, integrated with feedback and adjustments to project design and implementation, can help projects focus on the strategies that are the most effective.

References

1. Orloff LE. With no place to turn: improving advocacy for battered immigrant women. Fam Law Q 1995;29:313.

2. Rodriguez R. Evaluation of the MCN domestic violence assessment form and pilot prevalence study. Clinical Supplement of the Migrant Clinicians Network 1995;1–2.

3. Dutton M, Orloff LE, Hass GA. Characteristics of help-seeking behaviors, resources, and service needs of battered immigrant Latinas: legal and policy implications. Georgetown Journal on Poverty Law and Policy 2000;7:245–305.

4. Song YI. Battered women in Korean immigrant families: the silent scream. New York (NY): Garland; 1996.

5. Gondolf E, Fisher E, McFerron JR. Racial differences among shelter residents: a comparison of Anglo, Black and Hispanic battered women. J Fam Violence 1988;3:39–51.

6. Ho CK. An analysis of domestic violence in Asian American communities. In: Huisman KA. Violence Against Women 2. New York (NY): Harrington Park; 1996. p. 260–83.

7. Kantor GK, Jasinski J, Aldorondo E. Sociocultural status and incidence of marital violence in Hispanic families. Violence Vict 1994;9:207–22.

8. Sorenson SB, Telles CA. Self reports of spousal violence in Mexican American and in a non-Hispanic white population. Violence Vict 1991;6:3–16.

9. 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): Department of Justice, National Institute of Justice; 2000. NCJ Publication No.: 183781.

10. Tjaden P, Thoennes N. Prevalence and consequences of male-to-female and female-to-male intimate partner violence as measured by the National Violence Against Women Survey. Violence Against Women 2000;6:142–61.

11. Orloff L, Little R. Overview of domestic violence and battered immigrant issues, Chapter 1. In: Orloff L, Little R, editors. Somewhere to turn: making domestic violence services accessible to battered immigrant women: a 'how to' manual for battered women's advocates and service providers. Washington (DC): Ayuda Inc.; 1999. Available from: URL: www.vawnet.org/DomesticViolence/ServicesAndProgramDev/ServiceProvAndProg/BIW99-c1.php.

12. Centers for Disease Control. Surveillance for homicide by intimate partners – United States 1981-1998. MMWR 2001;50(SS03)1-16.

13. Puzone CA, Saltzman L, Kresnow M, Thompson M, Mercy J. National trends in intimate partner homicide: United States, 1976–1995. Violence Against Women 2000;6:409–26.

14. Frye V, Wilt S, Schomberg D. Female homicide in New York City: 1990–1997. New York (NY): New York City Department of Health, Office of Health Promotion and Disease Prevention, Domestic Violence Research and Surveillance Unit; 2000.

15. Raj A, Silverman JG. Violence against Immigrant women: the roles of immigrant culture, context, and legal status. Violence Against Women 2002a;8:367-98.

16. Schafer J, Caetano R, Clark CL. Rates of intimate partner violence in the United States. Am J Public Health 1998;88:1702–4.

17. 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.

18. 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.

19. McFarlane J, Wiist W, Soiken K. Use of counseling by abused pregnant Hispanic women. J Womens Health Gend Based Med 1999;8:541–6.

20. Yoshioka M, Gilbert L, El-Bassel N, Baig-Amin M. Social support and disclosure of abuse: comparing South Asian, African American, and Hispanic battered women. J Fam Violence 2003;18:171–80.

21. Rennison CM.Violent victimization and race, 1993–98. Bureau of Justice Statistics special report. Washington (DC): Department of Justice (US); 2001. NCJ Publication No.: NCJ176354.

22. Rennison CM, Welchans S. Intimate partner violence special report. Washington (DC): Department of Justice (US); 2000. NCJ Publication No.: 178247.

23. National Violence Against Women Prevention Research Center. Fostering collaborations to prevent violence against women: integrating findings from practitioner and researcher focus groups. Charleston (SC): National Violence Against Women Prevention Research Center; 2001. Available from: URL: www.vawprevention.org/research/focusgrprpt.shtml.

24. Yoshioka M, Dang Q. Asian family violence report: a study of Chinese, Cambodian, Korean, South Asian, and Vietnamese communities in Massachusetts. Boston (MA): Asian Task Force Against Domestic Violence; 2000.

25. Almeida RV, Dolan-Delvecchio K. Addressing culture in batterer's intervention: the Asian Indian community as an illustrative example. Violence Against Women 1999;5:654–83.

26. Raj A, Silverman JG. Intimate partner violence against South Asian women residing in greater Boston. J Am Med Womens Assoc 2002b;57:111–4.

27. Sorenson SB. Violence against women: examining ethnic differences and commonalities. Eval Rev 1996;20:123–45.

28. Governor's Commission on Domestic Violence Subcommittee on Immigrants and Refugees. Statewide hearings on domestic violence: findings and recommendations. Boston (MA): Governor's Office, Office of the Governor's Commission on Domestic Violence; 1998.

29. Census Bureau (US). American FactFinder: Census 2000 [cited 2003 April 5]. Available from: URL: http://factfinder.census.gov.

30. Butterfoss F, Goodman R, Wandersman A. Community coalitions for prevention and health promotion: factors predicting satisfaction, participation, and planning. Health Educ Q 1996;23:65–79.

31. Kegler MC, Steckler A, Malek SH, McLeroy K. A multiple case study of implementation in 10 local Project ASSIST coalitions in North Carolina. Health Educ Res 1998;13:225–38.

32. Kegler MC, Steckler A, McLeroy K, Malek SH. Factors that contribute to effective community health promotion coalitions: a study of 10 Project ASSIST coalitions in North Carolina. Health Educ Behav 1998;25:338-53.

33. Fawcett SB, Lewis RK, Paine-Andrews A, Francisco VT, Richter KP, Williams EL, Copple B. Evaluating community coalitions for prevention of substance abuse: the case of Project Freedom. Health Educ Behav 1997;24:812–28.

34. Paine-Andrews A, Harris KJ, Fisher JL. Effects of a replication of a multi-component model for preventing adolescent pregnancy in three Kansas communities. Fam Plann Perspect 1999;31:182–9.

35. Sabol B. Innovations in collaboration for the public's health through the Turning Point Initiative: the W.K. Kellogg Foundation perspective. J Public Health Manag Pract 2002;8:6–12.

36. Hassmiller S. Turning point: the Robert Wood Johnson Foundation's effort to revitalize public health at the state level. J Public Health Manag Pract 2002;8:1–5.

37. Wilson JL. Leadership development: working together to enhance collaboration. J Public Health Manag Pract 2002;8:21–6.

38. Cavanaugh N, Cheney KS. Community collaboration—a weaving. J Public Health Manag Pract 2002;8:13–20.

39. Cross T, Bazron B, Dennis KW, Isaacs MR. Towards a culturally competent system of care, Volume I. Washington (DC): CASSP Technical Assistance Center at Georgetown University Child Development Center; 1989.

40. Mason JL. Cultural Competence Self-Assessment Questionnaire: a manual for users. Portland (OR): Portland State University, Research and Training Center on Family Support and Children's Mental Health, Regional Research Institute for Human Services; 1995.

41. Vann A. Developing culturally-relevant responses to domestic abuse: Asha Family Services Inc. Harrisburg (PA): National Resource Center on Domestic Violence; 2003.

42. Bell CC, Mattis J. The importance of cultural competence in ministering to African American victims of domestic violence. Violence Against Women 2000;6:515–32.

43. Orloff L, Little R, McKnight M. Outreach and community collaboration, Chapter 6. In: Orloff L, Little R, editors. Somewhere to turn: making domestic violence services accessible to battered immigrant women: a 'how to' manual for battered women's advocates and service providers. Washington (DC): Ayuda Inc.; 1999. Available from: URL: www.vawnet.org/DomesticViolence/ServicesAndProgramDev/ServiceProvAndProg/BIW99-c6.php

44. Seidel J. Ethnograph v5.0. Qualis research: a user's guide. Thousand Oaks (CA): Scolari Sage Publications Software; 1998.

45. Whitaker DJ, Baker CK, Pratt C, Reed E, Suri S, Pavlos C, Nagy BJ, Silverman J. A network model for providing culturally competent services for intimate partner violence and sexual violence. Violence Against Women 2007;13:190-209.

46. Himmelman AT. Collaboration and the three T's: time, trust, and turf constraints. Health Syst Lead 1996;3:13–6.

Components of Culturally Responsive Intimate Partner Violence Intervention Services in an Hispanic Community

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The Growing Hispanic Population in the United States

Hispanics, a diverse group of persons with various cultural and national origins, are the fastest growing ethnic group in the United States (1). In 2002, Hispanics accounted for 13.2% (n=37.4 million) of the total U.S. population (2). Within the Hispanic population, 34.4% are younger than 18 years of age, compared with only 23% for other populations (2). Hispanics have an average family size of four persons, compared with 2.7 for persons of other races and ethnicities living in the United States. Because Hispanics tend to be young, have large families, and experience social discrimination, poverty remains a serious concern for them, with 27% living below the U.S. poverty line (1). In the past, most Hispanic immigrants to the United States migrated either to large metropolitan areas (e.g., Los Angeles and New York) or traveled throughout the country in search of employment as migrant farm workers. Currently, however, Hispanics are beginning to heavily populate states, cities, and communities that historically have had no experience dealing with a rapidly increasing population or with issues

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specific to this ethnic group. With this shift in demography, social service providers in these rural and traditionally non-Hispanic areas are now confronted with the need to expand their services to accommodate the increasing Hispanic population in their communities.

The recent increase in the Hispanic population in nontraditional areas provides substantial challenges for social service providers. These service providers are confronted with Spanish language barriers and difficulties in recruiting professional bilingual staff. Bilingual staff recruitment becomes increasingly difficult as multiple service providers (e.g., police, emergency shelters, court advocates, child/family social service agencies, and immigration services) compete to recruit personnel from an already limited pool of qualified job candidates. Another challenge is the provision of social services to a culturally diverse group with social service intervention models that have been typically developed for a predominately non-Hispanic, white U.S.-based population. Additionally, traditional collaboration between local social service providers has not included Hispanic service organizations, which are better equipped to address unique cultural issues and barriers to services experienced by the Hispanic population (3).

IPV in the Hispanic Community

One social service concern of particular relevance within the Hispanic community is the need for culturally responsive services to prevent the substantial public health problem of intimate partner violence (IPV). IPV includes physical, emotional, and sexual abuse. For all races, the U.S. Department of Justice found that 4.3 million women are violently victimized in the United States every year (4). Clinical data indicate that 22%–37% of emergency-room visits made by women are for injuries sustained from domestic violence, and 75% of these women are likely to be re-victimized (5). Among Hispanic women living in the United States, IPV is a significant social and health issue, with 54.9% reporting violent victimization in 1998 (6). The Family Violence Survey found that Hispanics experienced higher levels of partner abuse than did whites (23% vs. 15%) (7). Additionally, the National Crime Victimization Survey (NCVS), which was conducted at the same time, found that blacks and Hispanics across all age groups were at higher risk for violence than whites of comparable ages, with blacks experiencing slightly more violence (all types) than Hispanics (4). NCVS estimates typically underestimate the problem because of the nature of the survey which places acts in the context of a crime. The NCVS also found that for 18- to 21-year-olds, Hispanics experienced more serious victimization than whites, but less violence than blacks. A U.S. household population survey (Ninth National Alcohol Survey) demonstrated that the overall rates of male-to-female partner violence (i.e., violence perpetrated by males against female victims) were highest among black couples, followed by Hispanic couples; white couples reported the least amount of partner violence (8). The survey revealed Hispanic male-to-female violence risk factors as being a) lower household income, b) male unemployment, c) having a female household member classified as an infrequent drinker, and d) male impulsivity. Protective factors for male-to-female violence were a) being married, b) being retired from employment (for females), and c) having a male household member classified as a less-frequent drinker. The risk factors for female-to-male partner violence (i.e., perpetration of violence by females against male

victims) were identified as being higher levels of both impulsivity and education among male partners. Hispanic couples were almost three times more likely to engage in male-to-female partner violence and two times more likely to engage in female-to-male partner violence than white couples, even after controlling for socio-demographic characteristics, alcohol consumption, alcohol-related problems, and psychosocial variables (9). Alcohol use often plays a role in elevating the risk of IPV for Hispanics, although the precise role is not well understood (10).

Despite these data, some studies have found no significant difference in the rates for domestic violence among Hispanics and whites (11). More recent estimates from the NCVS indicated that for men and women, the rate of IPV for Hispanic and non-Hispanics did not differ significantly by race or ethnicity (12,13). In addition, the National Violence Against Women Survey (NVAWS) found Hispanic and non-Hispanic women and men almost equally likely to report a physical assault or stalking victimization. However, Hispanic women were significantly more likely than non-Hispanic women to report they were raped by a former or current intimate partner (14)—violence that might be particularly likely to occur among Hispanic women age 55 or older (15).

Cultural norms sanctioning male violence against their wives are not uniquely Hispanic and are found among other ethnic groups (16). The origination of such behavior may arise from the cultural norms of a person's country of origin. For example, studies of IPV in which IPV perceptions of Mexican women living in either Mexico or the United States were compared found women living in Mexico were more tolerant of abuse by their husbands than were Mexican-American women (17-19). Less-acculturated men residing in the United States may also be more accepting of abusive actions (20), often because they have witnessed such violence within their own birth families (21).

Machismo can be identified as the foundation of the nature and personality of the Hispanic male (22,23). As a complicated and global concept, machismo may consist of values and behaviors related to masculinity, bravery, and invulnerability. Unfortunately, machismo is most often known as exaggerated hyper-masculinity expressed in terms of physical and sexual aggressiveness (24). Negative aspects of machismo can result in heavy drinking, the pursuit of high-risk sexual activity, domestic violence, and HIV/AIDS (1). Machismo appears mostly within the context of family and interpersonal relationships (25). In general, machismo is perceived as rigid and pathological and usually reinforces negative cultural stereotypes of Hispanics (26). However, positive characteristics are also associated with the concept of machismo, including having "male honor," demanding respect from others, sticking to personal beliefs, and understanding that a man's most important responsibility is to his family (25). Although only 10% of Latino males participating in one study could be characterized as having traditional machismo values (27), the concept of machismo may provide perpetrators of IPV with a justification for aggressive behavior.

Numerous IPV-related social service issues for Hispanic men and women exist, including limited access to services because of acculturation and language. In one study, Hispanic immigrant women (N=309) (28) indicated the need for many IPV-associated services, including provision of information on personal rights, legal services, and domestic violence; b) assistance with court appearances (e.g., legal and advocacy services); c)

English lessons; d) personal safety protection; e) transportation; f) education about how to become independent; g) a place to stay; and h) someone to confide in. The effects of domestic violence identified in this study included disruptions in employment and isolation from family and non-family social networks. In addition, unique challenges in coping with domestic violence were identified, including stressors related to immigration, acculturation, language, legal issues, and economic pressures. The social service needs of immigrant Hispanic women were also explained in another study and were found to include emergency shelter, health care, housing, child care, economic assistance, and counseling (29). Less is known about the needs for Hispanic men. Because Hispanic men and women tend to highly value their families (a concept known as familismo), a comprehensive family approach to IPV intervention would likely be effective (30). Social service and public health programs also may be more effective when familismo is incorporated into intervention efforts (31-33).

Mental health services also should be considered in comprehensive IPV interventions, because the difficulties and stressors experienced by men and women involved in IPV may lead to depression. Studies comparing blacks, whites, and Hispanics have concluded that abused women belonging to these minority groups, particularly Hispanic women, may experience more depression than abused white women (34,35).

Although more information is needed to guide social service providers in meeting the comprehensive needs of Hispanics affected by IPV, several key characteristics of successful social services have been identified. A combined community response that incorporates a planned integration of approaches may be more effective than a single approach to prevention (36). In addition, interventions must be linguistically and culturally congruent with the population served (28). Where resources permit, cultural- and language-specific IPV service programs targeting specific populations should be implemented. IPV-related programs can be more easily incorporated into a community and culturally based service network, and therefore can be more effective in reaching persons most in need of services. Finally, IPV programs serving diverse populations also must develop alliances with culturally specific service organizations. Community agencies also must collaborate and cross-train in their efforts to develop culturally appropriate outreach initiatives (37).

IPV among Hispanics Living in the Oklahoma City Area

The U.S. Census Bureau (2000) reports that during the 1990s, the State of Oklahoma experienced a 100% increase in its Hispanic population. Most of the increase occurred in Oklahoma and Tulsa counties (2), with 57,336 Hispanics residing in Oklahoma County (8.7% of the total state population). However, it is possible that this percentage could be even higher; Hispanics may be underrepresented in census data because of documented immigrant status and language barriers.

Because of this population increase and on the basis of IPV incidence within the Hispanic community, a study was conducted to identify challenges associated with the provision of IPV services by non-Hispanic providers in the Oklahoma City area (38). Study results revealed the need for several actions and resources, including a) interpreters or bilingual services, b)

cultural diversity training, c) Spanish language literature on IPV, d) an intervention for male batterers, e) advocacy or case management for IPV victims, and f) emergency shelters for non-English speaking women. Provision of social services for Hispanics in the Oklahoma City area may be further complicated because the local population is not cognizant of the growing Hispanic population.

To address these needs, the Latino Community Development Agency (LCDA) has developed an IPV intervention and prevention program that addresses the IPV social service and education needs of the Hispanic community residing in the Oklahoma City area. Additionally, through its education component, LCDA provides training and information to non-Hispanic service providers on cultural sensitivity, cultural issues affecting access to services, and the social needs of the Hispanic community. This LCDA project, Proyecto Cambio, employed a four-pronged approach to addressing IPV consisting of a) a community coalition called the Community-based Linkage Council, b) preventive case management for women, c) a small-group intervention for men perpetrators, and d) community outreach and education.

The primary objective of our federal demonstration project was to identify the cultural factors associated with IPV interventions that must be considered by non-Hispanic social service providers serving Hispanic populations. Specifically, we elucidated these factors for the Hispanic community living and seeking IPV-associated social services in the Oklahoma City area. LCDA's Proyecto Cambio staff and clients and the community-based Hispanic community coalition served at all times to guide this research, develop research questions, review findings, and incorporate the results of an extensive data collection and analysis process into client and community-level services.

Methods

Our research represents an exploratory study aimed at identifying the key components of cultural competence needed by non-Hispanic providers to increase the effectiveness of IPV-associated social services designed to serve Hispanics. To identify these key components, three sources of information were used. First, professional Hispanic staff at LCDA were interviewed to obtain insight into cultural issues related to service delivery. Discussions were held with six expert LCDA staff members who routinely provide interventions, including the project director and case managers. In these discussions, the perspectives of these professionals were elicited regarding female victims of IPV who were accessing legal and social services. Second, we conducted 10 focus groups, each with an average of eight participants, for a total sample size of 77. Participants were recruited by LCDA staff and consisted of male and female Hispanic adults. Most were of Mexican heritage, and many of the women had been victims of IPV. The content of the focus groups centered on an IPV case vignette, wherein participants discussed what they believed to be the cultural issues related to the abuse situation. Finally, we conducted key informant interviews with 20 Hispanic men and women (13 victims and seven perpetrators). The key informant interviews helped define common perceptions about interpersonal issues among Hispanic adults involved in IPV. All data were collected for the purpose of informing Hispanic IPV program development and formative evaluation.

Results and Discussion

A trustworthiness committee, consisting of the authors of this paper, was established to identify the themes of the study data. The data, assessed with an inductive data-driven approach, revealed that for Hispanics living in the Oklahoma City area, four core factors affect the receipt of IPV-associated social services, including a) a monolingual dependence on Spanish, b) specific Hispanic cultural values, c) immigration status, and d) stressors experienced uniquely by Hispanic individuals and families. Each core factors (discussed in detail in the following paragraphs) should be included in any culturally responsive IPV intervention model for Hispanic populations.

Spanish Monolingual Emphasis

A significant barrier to services among Hispanics living in the Oklahoma City area was the inability to communicate effectively in English. Most service providers in the Oklahoma City area do not have bilingual staff members or interpreters. Providers participating in the study reported that many Hispanic women do not stay in emergency shelters because shelter staff are not bilingual and counseling is not available in Spanish. This language barrier has posed multiple challenges for Hispanics seeking services or requiring legal assistance, as well as for those retaining services, as demonstrated by the following statements made by Hispanics serving as key informants and focus-group members.

I was sent to [an] agency where they told me that I needed to be able to write English and to speak English . . . they told me that the class was not for me, and that it would be better to find a place where I could communicate . . . (male perpetrator referred by the courts for counseling)

I had no place to go, no job, no house, and I still didn't speak English. I had no one who could help me. (adult woman)

How am I going to file a report if I don't speak English? (female victim)

I don't speak English and the day that I had to go to court, I couldn't defend myself. (female victim)

If I had found someone that spoke Spanish, and that I would have been able to say, look this is happening and she had told me that there is this help, there's this program, I would not have allowed my kids to suffer . . . even they are now paying the consequence of my ignorance. (female victim)

We can not defend ourselves because we don't speak English. (female victim)

Specific Hispanic Cultural Values

Information collected from key informant interviews, community focus groups, and interviews with LCDA staff identified specific cultural values that participants believed were related to or should be considered when addressing IPV in the Hispanic community residing in the Oklahoma City area. These cultural values included a) the male gender role of machismo, b) family preservation, and c) an emphasis on obtaining help from the church.

The dominant gender-related issue identified in interviews and focus groups was the theme of machismo as a leading cultural value that impacts family relationships. The definition of machismo varied among participants, with most agreeing that the concept referred to male responsibility as the head of household. As head of household, the male is responsible for the financial well-being of the family, makes all family decisions, and keeps his house in order. The following statements emphasize the role of machismo in the family.

The man wears the pants in the family. (male perpetrator)

The way they have raised men is that . . . we have to serve them, they are the boss. (young woman)

The second identified cultural value emphasized the importance of family by encouraging women victims to "stay with the husband at all costs." This value was reiterated repeatedly in key informant interviews, focus group discussions, and discussions with LCDA staff. Participants noted that this familial value had been taught to them since childhood. Many participants disclosed that they had witnessed domestic violence as children. Many stated that their mothers would never consider leaving their fathers because of a belief that she was "married for life," and regardless of the violence, must do everything possible to keep the family together. LCDA staff reported that women victims often expressed feeling pressured by extended family members to stay with their husbands for the benefit of the children and to avoid the social stigma associated with divorce. Additionally, according to LCDA, IPV victims perceive that any attempt to access social services may create the appearance that they are breaking away from the family. The following statements reflect this thinking.

A wife's place is with her husband and she has to stay there, because they say the woman must be submissive. (adult female)

Because of family structure, because of family pressure, because her parents obligate her—that's why she stays in the home. (adult male responding to the question as to why a woman would possibly stay in an abusive situation)

A wife's place is with her husband. She must endure. (adult female)

Another underlying value was that of family noninterference. Participants in interviews and focus groups discussed at length the potential reasons why family members would not become involved in a son's or daughter's IPV issues. The general consensus was that, in some cases, the parents would remain uninformed about the violence, but in most other instances, the family would not interfere despite having this knowledge. The following statements illustrate this concept.

Well, I guess the brothers don't get involved. Whether they think it is right or wrong, they don't get involved. (young female)

But in the same family there are people that believe that the husband is the one who is right and not her. There are families that do not support women because that is the tradition; that is the way their mothers were treated, and they believe that is the way she should be treated. (young female)

'I want to tell you one thing, if tomorrow or the

day after tomorrow the old man hits you or abuses you, I don't want you to come here, so that's why you are seeing well who you are marrying. That's why people are afraid of going to their parents. (young female referring to her father's statement made prior to her marriage to an older man)

. . . even when you are older you make mistakes, so then they tell you so much not to do it that when you get abused, you don't go and look for the family because they already told you. (young female)

Data from participants and LCDA staff indicated that an individual's religious beliefs may influence a woman to stay with her abusive husband. In addition, church leaders may either insist that an abused women stay with her husband or may offer assistance to enable her to escape the violence (39). Many participants noted that women suffering from abuse should seek guidance and information from their church. However, participants believed that the church would focus on the need to keep the family together. The following are statements made by Hispanic study participants that support this value.

I always looked for help at church, always my mother taught us to think about the image of our Father, God, then I look for refuge and help in the priests. (adult female)

. . . well, I don't think that they [victims] would come to a place like this [social service agency] but they would go to church, people go to church. (young female)

To church, I've only ever followed the advice I get from church, because there you will find advice for the husband, the wife, the child, and everyone, it's all there. (elderly female)

One of the reasons that causes domestic violence is that the people in these last days become less religious. Sometimes we take it as an unimportant thing but He, when people have fear of God, He helps them in order to present a dignified behavior. I believe that in the search of God's way can help any family to improve the situation inside the home. (adult male)

Immigration Status

A substantial percentage of the population served by LCDA are confronted with issues directly or indirectly related to U.S. Immigration and Naturalization laws and policies. LCDA Staff reported that IPV victims who did not have legal status perceived themselves as ineligible for public services available to the general U.S. population, were unaware of their legal rights in the United States despite their undocumented status, and lacked awareness of social support services within the community. As a result, these immigrants fear deportation if they report perpetrator threats, contact police to report incidents, or attempt to access any public service. A repeated concern for victims of IPV was fear of losing custody of their children as a result of police intervention and deportation of the victim. The beliefs and attitudes regarding these fears are reflected in the following statements made by Hispanics participating in the study.

Here in the United States, the [perpetrator] tell you that you can't do anything because you don't have legal documents. If he hits you, the police will send you back to Mexico. (adult woman)

You look for help that is given to abused women that are legal residents, this program [Legal Aid] is given, but to people like me without papers, it is not. (adult woman)

Well, I'm illegal. And I would say that having papers would take a great weight off my shoulders. And I say that if I need to ask for aid, I would have a problem with immigration. (female victim)

. . . I have heard husbands who, if they have their paper and have processed them and his wife has not processed hers . . . I have heard them say, if you do not do this, don't do this, and I will call immigration so that they put you out. (adult male)

Stressors for Hispanic Individuals and Families

Review of the data collected from interviews, focus groups, and LDCA staff indicated that Hispanic victims of IPV encountered multiple stressors, including a) oppression and discrimination in employment and service access, b) acculturation, and c) family issues. Both female victims and male perpetrators stated that oppression and discrimination are substantial concerns for female victims and male perpetrators. These issues affected them within the family, at work, when accessing social services, and in their social activities. The overt acts of oppression and discrimination directly demeaned individuals, denied them equal status, and affected their perceptions of self-worth. A consequence of oppression and discrimination was frustration and anger by the Hispanic individuals affected by these overt actions. These sentiments are illustrated in the following statements.

If you go to a restaurant, they seat the white family before the Mexican. (young female)

I look American but I have an accent and I've gone places where as soon as they hear me speak they completely change because they hear my accent. (adult female)

I've seen case of police and the ones from immigration, they think, let's stop this one, his hair is black, he's Hispanic. (adult male)

From my own experience, I'll tell you something happens when the policeman see that you don't speak English. He doesn't believe you; he won't do anything for you. (adult female)

. . . because you don't speak English, they discount you and even if you speak English, if you come from another country, they discount you. (adult female referring to social worker)

Stressors resulting from acculturation primarily involved the male perception that after immigrating to the United States, women who were once subservient to men adopted a more liberated attitude of equality. Another major stress factor for men was that they were unaware of U.S. laws that protect women and children from abuse. The following statements illustrate the acculturation stressors identified by Hispanics participating in this study.

Abusers come to LCDA believing they have the right to abuse the wife and children and don't believe otherwise even when told by a judge. It is difficult for them to accept the judge's decision. (LCDA staff)

It's good that a woman wants to contribute financially so the family is better off, but that brings all sorts of problems that are 80% domestic. All because she has money, she becomes more liberated, more independent, contributes more than her husband does, and even yells at him or kicks him out. Women's liberation is the root of domestic problems. (adult male)

When I came to this country, one begins to act like a 'macho man,' one begins to feel bravery

and many times, as in my case, one is not used to having money or seeing money and things become easier, and it is the cause for many problems, indeed violence toward women, to our children . . . (adult male)

. . . the people come from Mexico, in Mexico I say that to have a wife in Mexico is different from here because there is not so[much] freedom as here, the women arrive here, they arrive limited, they don't arrive with freedom but in 2 or 3 months they get the freedom they want because here is a free country, a country that they do whatever they want, they start to do what they want, then they get a car, not, then, if they go there, if they go there is because they are free, if the husband hits them, if the husband hits them or even touches them, as here there is authority, there is police, they call the police and who's going to leave, the husband, here the woman feels…protected because there is so much authority. (adult male)

The third stressor identified was related to family issues. Most Hispanic study participants agreed that family is important in Hispanic self-identity. Participants and LCDA staff also indicated that family issues and attitudes can often contribute to stress (e.g., a mother who encourages her daughter to remain with her abusing husband). Other potential areas of stress were related to differing individual immigration status among family members. For example, a family could consist of a father who has acquired citizenship, a mother who does not have citizenship, and their U.S.-born children who have U.S. citizenship. Participants in this study noted that varying immigration status has a direct impact on women victims of IPV, because women who are not citizens often fear being deported, being refused services, and losing their children. Another concern expressed by women victim and focus group participants was the concern of the impact on children asked to translate for the mother during a domestic violence situation. Study participants made the following comment regarding use of children as translators.

. . . the policeman came, as I was talking to my daughter, she was translating [to the police officer]. (female victim)

Conclusions

Cultural issues, including limited English proficiency, immigration status, and acculturation stressors among Hispanics experiencing IPV, must be considered when evaluating existing and developing new IPV services for persons in the Hispanic community. Services and interventions must be linguistically and culturally congruent with the population being served (28). Language barriers to community services can be reduced by the recruitment of professional bilingual staff who are culturally competent. Obtaining bilingual staff may require community service providers to collaborate with Hispanic agencies capable of providing cultural sensitivity training, assisting with service awareness activities in the Hispanic community, providing interpreting services, and giving referrals to agencies known to have Spanish-speaking professional staff (37,40). Such collaboration can result in a community and culturally based service network of providers that can effectively reach those in need of services. Additionally, to increase the success of IPV-associated services, historical mistrust of public institutions must be overcome. Hispanics should be given information in Spanish, and they should be provided services in an environment that is supportive to all clients, regardless of their ethnicity. Information is most effectively

communicated when language and cultural barriers are removed and when actions promoting discrimination are eliminated (3). Despite the availability of culturally sensitive services, some members of the Hispanic community will continue to refuse services because they fear compromised confidentiality and fear advice reflective of traditional Hispanic attitudes and practices (e.g., remaining with an abuser) (41).

Cultural values for Hispanics may vary based on the country of origin, religious beliefs, social class, education, and other personal factors, including family upbringing. Thus, community service agencies (e.g., social services, police, hotlines, and medical clinics) must provide staff with cultural competence training tailored to the specific minority populations served by their agencies. Additionally, the social service community must be knowledgeable about the specific cultural values that affect response to services (e.g., the role of gender, help-seeking behaviors, and family). These agencies should not stereotype Hispanics from different countries and cultures as having identical needs (3,42).

Immigration issues pose multiple social and legal concerns for recently immigrated Hispanics. Data collected from interviews and focus groups indicate that culturally relevant information about the individual rights of immigrant women and children is not readily accessible to victims of IPV. Providers must take a comprehensive approach to addressing issues of immigration by collaborating with faith-based and other organizations that serve primarily Hispanic populations. To effectively protect and serve the Hispanic immigrant population, the approach must include the provision of service, education, and referrals (43). In addition, community service providers must be aware of the rights of immigrant victims and children, as well as their potential needs; such awareness will enable providers to adequately assist clients with immigration concerns. Service providers who are not prepared to assist clients with immigration-related issues should, at minimum, be capable of referring clients to more knowledgeable sources of information.

Family is the primary unit within Hispanic culture (1), and it serves as a source of both support and stress for women affected by IPV. This strong emphasis on family can create problems within systems of services that operate on the assumption that the individual is the primary unit. Additionally, awareness of the role of extended family in client care is critical to the success of the services or intervention. For instance, one issue repeatedly raised by LCDA staff and participants was the involvement of children as interpreters. Because of the emotional and volatile conditions associated with IPV, social service agencies should avoid asking children to serve as interpreters; agencies must instead develop a plan for having interpreters available when working with monolingual clients and their families.

As a result of the data collection and evaluation activities associated with this study, the decision was made to modify existing IPV interventions dealing with the importance of family. Initially, the project proposed services only to victims of IPV; however, as a result of feedback and recommendations from Linkage Council members, LCDA staff, victims, and focus groups (e.g., the necessity to ensure that the intervention was provided in Spanish and be made available to voluntary and court-mandated participants), Proyecto Cambio established intervention groups for male perpetrators of violence. Recruitment of Hispanic males from the community to work

with the perpetrators was also emphasized. The incorporation of the men's intervention was and continues to be supported by the agency, courts, and community service providers.

Intimate partner violence is a substantial public health problem that can only be prevented if the values, beliefs, and practices of all populations are addressed. Because the Hispanic population is rapidly increasing, persons serving Hispanic clients must address the unique needs of those clients in a culturally competent manner. To increase effectiveness of any public health program serving a specific population, members of that population must be fully included in the planning and implementation of such prevention or intervention programs. Addressing and preventing any public health problem requires the involvement and commitment of the entire community.

References

1. Galanti GA. The Hispanic family and male–female relationships: an overview. J Transcult Nurs 2003;14:180–5.

2. Census Bureau (US). The Hispanic population in the United States, March 2002. Washington (DC): Department of Commerce (US), Economics and Statistics Administration; 2003.

3. Maciak BJ, Guzman R. Establishing La Vida: a community-based partnership to prevent intimate violence against Latina women. Health Educ Behav 1999;26:821–41.

4. Perkins C. Age patterns of victims of serious violent crime. Washington (DC): Department of Justice (US), Office of Justice Programs, National Institute of Justice; 1997.

5. Warshaw C. Domestic violence: challenges to medical practice. In: Dan AJ, editor. Reframing women's health: multidisciplinary research and practice. Thousand Oaks, (CA): Sage Publications; 1994. p. 201–15.

6. National Woman's Law Center–University of Pennsylvania School of Medicine, Lewin Group. Making the grade on women's health: a national and state-by-state report card. Washington (DC): National Women's Law Center; 2000.

7. Strauss MA, Smith C. Violence in Hispanic families in the United States: incidence rates and structural interpretations. In: Straus MA, Gelles RJ, editors. Physical violence in American families: risk factors and adaptations to violence in 8,145 families. New Brunswick (NJ): Transaction Publishers; 1990. p. 341–67.

8. Caetano P, Cunradi CB, Clark C, Schafer J. Intimate partner violence and drinking patterns among white, black and Hispanic couples in the U.S. J Subst Abuse 2000;11:123–38.

9. Field CA, Caetano P. Longitudinal model predicting partner violence among white, black, and Hispanic couples in the United States. Alcoholism: Clinical and Experimental Research 2003;27:1451–8.

10. Field CA, Caetano P. Ethnic difference in intimate partner violence in the U.S. general population. Trauma Violence Abuse 2004;5:1303–17.

11. Sorensen SB, Telles CA. Self reports of spousal violence in a Mexican-American and non-Hispanic white population. Violence Vict 1991;6:3–15.

12. Rennison CM. Hispanic victims of violent crime, 1993–2000. Washington (DC): Department of Justice (US), Office of Justice Programs, National Institute of Justice; 2002.

13. Rennison CM, Welchans S. Intimate partner violence. Washington (DC): Department of Justice (US), Office of Justice Programs, National Institute of Justice; 2000.

14. Tjaden P, Thoennes N. Extent, nature, and consequences of intimate partner violence: findings from the National Violence against Women Survey. Washington (DC): Department of Justice (US), Office of Justice Programs, National Institute of Justice; 2000.

15. Grossman SF, Lundy M. Use of domestic violence services across race and ethnic women aged 55 and older. Violence Against Women 2003;9:1442–52.

16. Jasinski JL. Physical violence among Anglo, African American, and Hispanic couples: ethnic differences in persistence and cessation. Violence Vict 2001;16:479–90.

17. Diaz-Olavarrieta C, Ellertson C, Paz F, Ponce de Leon S, Alarcon-Segovia D. Prevalence of battering among 1780 outpatients at an internal medicine institution in Mexico. Soc SciMed 2002;55:1589–1602.

18. Olavarrieta CD, Sotelo J. Domestic violence in Mexico. JAMA 1996;275:1937–9.

19. Peek-Asa C, Garcia L, McArthur D, Castro R. Severity of intimate partner abuse indicators as perceived by women in Mexico and the United States. Women Health 2002;35;165–80.

20. Weis L, Centrie C, Valentin-Juarbe J, Fine M. Puerto Rican men and the struggle for place in the United States. Men and Masculinities 2002;4:286–302.

21. Champion JD. Life histories of rural Mexican American adolescents experiencing abuse. West J Nurs Res 1999;21:699–717.

22. Beattie PM. Beyond machismos: Recent examinations of masculinities in Latin America. Men and Masculinities 2002;4:303–8.

23. Patron MG. La psicologia del mexicano (The psychology of the Mexican male). Revista Mexicana de Psicologia 1969;3:350–4.

24. Mosher DL. Macho men, machismo, and sexuality. Annu Rev Sex Res 1991; 2;199–247.

25. Neff JA. A confirmatory factor analysis of a measure of "machismo" among Anglo, African American, and Mexican American male drinkers. Hisp J Behav Sci 2001;23:171–88.

26. Mirande A, Enriques E. La Chicana: The Mexican American woman. Chicago (IL): University of Chicago Press; 1979.

27. Torres JB, Solberg VSH, Carlstrom AH. The myth of sameness among Latino men and their machismo. Am J Orthopsychiatry 2002;72:163–81.

28. Murdaugh C, Hunt S, Sowell R, Santana I. Domestic violence in Hispanics in the Southeastern United States: a survey and needs analysis. J Fam Violence 2004;19:107–15.

29. Yoshioka MR, Gilbert L, El-Bassel N, Baig-Amin M. Social support and disclosure of abuse: comparing South Asian, African American, and Hispanic battered women. J Fam Violence 2003;18:171–80.

30. Perilla JL, Perez F. A program for immigrant Latino men who batter within the context of a comprehensive family intervention. In: Aldarondo E, Mederos F, editors. Program for men who batter: intervention and prevention strategies in a diverse society. New York (NY): Civic Research Institute; 2002. p. 11–31.

31. Aguirre-Molina M, Molina C, Zambrana RE, editors. Health issues in the Latino community. San Francisco (CA): Jossey-Bass; 2001.

32. de la Torre A, Estrada AL. Mexican Americans and Health. Tucson (AZ): University of Arizona Press; 2001.

33. Molina CW, Aguirre-Molina M, editors. Latino health in the US: a growing challenge. Washington (DC): American Public Health Association; 1994.

34. Caetano P, Cunradi CB. Intimate partner violence and depression among whites, blacks and Hispanics. Educational Psychology in Practice 2003;13:661–5.

35. Krishnan SP, Hilbert JC, VanLeeuwen D. Domestic violence and help-seeking behaviors among rural women: results from a shelter-based study. Fam Community Health 2001;24:28–38.

36. Begun AL. Intimate partner violence: an HBSE perspective. Journal of Social Work Education 1999;35:239–52.

37. Raj A, Silverman J. Violence against immigrant women: the role of culture, context, and legal immigrant status on intimate partner violence. Violence Against Women 2002;8:367–98.

38. Barney DD, Duran BES, Tobar C, Barajas-Mazaheri R. Qualitative study of Latina cultural values and beliefs about intimate partner violence. Presented at the Safety in Numbers Conference, Atlanta, GA; 2003.

39. Nason-Clark N. When terror strikes at home: the interface between religion and domestic violence. Journal for the Scientific Study of Religion 2004; 43:303-10.

40. Barcelona de Mendoza V. Culturally appropriate care for pregnant Latina women who are victims of domestic violence. J Obstet Gynecol Neonatal Nurs 2001;30:579–88.

41. Burman E, Smailes SL, Chantler K. 'Culture' as a barrier to service provision and delivery: domestic violence services for minoritized women. Critical Social Policy 2004;24:332–57

42. Aldarondo E, Kaufman Kantor G, Janiski JL. A risk marker analysis of wife assault in Latino families. Violence Against Women 2002;8:429–54.

43. Campbell JC, Campbell DW. Cultural competence in the care of abused women. J Nurse Midwifery 1996;41:457–62.

Lessons Learned From Training HIV/AIDS Clinicians to Screen for Intimate Partner Violence and Sexual Violence

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Introduction

Intimate partner and sexual violence (IPV/SV) is reaching epidemic proportions. The prevalence of IPV/SV differs by gender, ethnicity, and sexual orientation. A national survey conducted in 2000 reported that an estimated 1.3 million women and 835,000 men are physically assaulted by an intimate partner annually; 22% and 7% of women and men, respectively, reported having experienced a prior physical assault by an intimate partner (1). Ethnic minorities report higher rates of IPV/SV and are at a greater risk for IPV/SV than whites (2,3). For instance, blacks and Hispanics are at a threefold higher risk for male-to-female partner violence (i.e., violence perpetrated by a male partner) and are two times more likely to experience female-to-male partner violence (i.e., violence perpetrated by a female partner) than whites (2). Estimates of IPV/SV among men who have sex with men (MSM) are reported to be higher than heterosexual men, but comparable to heterosexual women (4). Among MSM, battering victimization has been correlated with behaviors that put MSM at high risk for human immunodeficiency virus

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(HIV) and other sexually transmitted diseases (STDs)(5). These differences in the prevalence of victimization present public health administrators with the responsibility of focusing on the specific needs of groups at increased risk for IPV/SV when developing prevention and intervention programs.

The prevalence of IPV/SV among HIV-infected adults is of growing concern. A national study of HIV-positive adults receiving medical care revealed that 21% of women, 12% of MSM, and 8% of heterosexual men reported having been physically harmed since being diagnosed with HIV (6). The relationship between HIV status and violence is of particular concern in New York State. In June 2000, New York State instituted a law for HIV case reporting and partner notification requiring that physicians and other health care providers report the names of identified sexual or needle-sharing partners of HIV-infected persons to the New York State Department of Health. HIV-infected patients are also required to disclose their sexual and needle-sharing partners to providers who will discuss options for notifying their partners. Although victims of domestic violence are exempted from these requirements, errors can occur in the notification process, resulting in the unintentional disclosure of an IPV/SV victim's HIV status to a batterer. This unintentional notification can result in additional violence against the patient—violence that can be expressed physically, sexually, or emotionally. Though a recent research study with women suggests that disclosure of HIV-positive status has not led to more or less abuse than that experienced by HIV-negative women (7), additional studies are needed to determine whether disclosure of a positive HIV status leads to an increase in violence.

For both providers of HIV/acquired immunodeficiency syndrome (AIDS) care and the patient, the intersection of IPV/SV and HIV/AIDS presents several critical challenges. For providers, IPV/SV in patients can present barriers to screening and require providers to gain an understanding of the often complex effects of IPV/SV on patients' lives. Providers must understand the best approach to broach the topic with the patient, conduct screening, and make referrals for needed services once a patient is identified as experiencing IPV/SV. Patients also face barriers to disclosing information to providers and are challenged to manage both their victimization and medical treatment. Although patients often would like health care providers to ask about IPV/SV issues and offer assistance in managing it (8), providers rarely do. The reported association between IPV/SV and HIV(9) suggests a need to incorporate violence prevention, identification, and intervention services in clinical settings where HIV/AIDS patients receive most of their primary health care.

In response to these challenges, a demonstration project[1] was begun at the Center for Comprehensive Care (CCC). CCC is an HIV/AIDS primary care setting in New York City that was established to a) educate and train primary care providers about how to screen for IPV/SV and b) provide primary care providers with a mechanism for referring patients who screen positive for IPV/SV to needed services. In addition, this demonstration project helped to test the effectiveness of an IPV/SV intervention. This report addresses the lessons learned in attempting to educate and train multidisciplinary staff about IPV/SV.

The Clinical Setting

CCC is part of the St-Luke's–Roosevelt Hospital Center (SLRHC) and provides care to an HIV/AIDS patient population that both research and experience suggest is at high risk for IPV/SV.[2] The CCC patient population is comprised predominately of ethnic minorities (about 82%), and almost all (>95%) receive some form of public assistance. In the year this project was being planned and initiated (July 1999–June 2000), CCC served 1,696 men and 916 women age 18 or older. Among the men, 43% were African American, 35% were Hispanic, 21% were Caucasian/other, and fewer than 1% were Asian. Of the women, 55% were African American, 35% were Hispanic, and 10% were Caucasian/other.[3]

At CCC, an interdisciplinary team consisting of medical, mental health, and social work staff, under the direction of Associate Medical Directors, develops a coordinated treatment plan for HIV/AIDS patients that addresses medical, psychosocial, and other clinical and support needs (e.g., substance abuse treatment and housing). Primary care providers at CCC are responsible for patients' outpatient and inpatient medical care. Case managers coordinate referrals to outside services and conduct follow-up activities.

The CCC endeavors to provide most patient services directly on site. This on-site provision of services has facilitated the receipt and navigation of needed health and social services for chronically ill patients. CCC's effort to address IPV/SV among their patient population was twofold: a) to formally acknowledge a suspected problem (through anecdotes and clinical experience) that affected the lives of many patients and b) to elucidate the best methods of integrating the provision of IPV/SV services into an existing comprehensive care package.

The Training Curriculum

Medical professional organizations (e.g., the American Medical Association and the American College of Obstetrics and Gynecology) recommend that clinicians be responsible for screening patients who may be at risk for future violence or are experiencing violence in their lives (10). However, because of the sensitive nature of IPV/SV issues, health care providers need to be educated about these issues before engaging in discussion with patients and conducting other screening activities. In recognition of this need and the lack of evidence-based interventions (11), a training program was provided to CCC's health care providers to better prepare them for screening patients and offering services to victims of abuse.

CCC's training curriculum was developed in collaboration with clinicians, social workers, psychologists, domestic violence (DV) experts, DV counselors, HIV professionals, and representatives of the gay and lesbian community. Although recent literature and existing trainings were reviewed (12–14), these subject-matter experts did not borrow specific components from existing training protocols (e.g., the Family Violence Fund) because the components did not target the population of HIV-positive patients with a history of substance abuse and psychiatric disorders. Instead, the training curriculum was developed to be more responsive to CCC's unique patient population and was designed to address a wide array of phenomena related to the experience of IPV/SV. The known epidemiology of IPV/SV was used to guide the design of the curriculum to best address the needs of CCC's urban, predominately minority, patient population. Although the curriculum development was guided by the epidemiologic reality that IPV/SV disproportionately affects women, the curriculum

Table 1. Topics incorporated into the intimate partner violence (IPV)/sexual violence (SV) training curriculum

Training content areas
1. Definitions of IPV/SV
2. Dynamics of IPV/SV
3. Epidemiology of IPV/SV
4. Interpersonal dynamics of IPV/SV
5. Male victims of IPV/SV
6. Legal aspects of screening for IPV/SV
7. Provider-related barriers to screening and referral
8. Long- and short-term effects of rape/sexual assault
9. Childhood sexual abuse
10. Treatment and psychosocial needs of individuals who experience IPV/SV
11. Legal and advocacy issues
12. Community resources
13. Validity and reliability of screening instruments
14. Cultural and gender differences among ethnic groups that shape the context, experience, and response to IPV/SV

does not exclusively focus on this type of violence; the curriculum also addresses the needs of other types of victimized patients, including heterosexual and homosexual men.

The intent of the training was to increase knowledge and understanding of the dynamics of IPV/SV and HIV/AIDS, promote awareness, and change attitudes and beliefs about IPV/SV. Health care providers at CCC participated in two half-day training sessions facilitated by social workers and clinical psychologists. New practice behaviors were introduced at these sessions, including identifying victimized patients and

making referrals for IPV/SV services[4], while offering staff an opportunity to voice their concerns about dealing with issues associated with the identification of patients experiencing IPV/SV.

The training curriculum was a pragmatic mix of theory, literature review, and clinical experience combining didactic and experiential training methods to communicate information and develop provider skills.[5] The content of the didactic component, including definitions of IPV/SV, the epidemiology of IPV/SV, and the validity and reliability of screening instruments, was borrowed from current national and regional epidemiologic data (7).[6] (See Table 1.)

The experiential training component was primarily a theater-based training (TBT) approach. Based on the principles of social learning theory (15), TBT presented participants with realistic patient cases and model practice behaviors to observe and experience. The purpose of the TBT was to provide information (16), excite discussion (17), and stimulate thought (18) about IPV/SV in an HIV setting. The NiteStar Program[7] created and delivered educational information in a theater production format[8] during the training. The NiteStar Program is affiliated with SLRHC and is an educational organization comprised of professional actors. Victimization experiences, modeled from CCC patient cases, were dramatized by the actors, who assumed the roles of characters designed to a) reflect the diversity of the patient population at the CCC; b) demonstrate the relationship between IPV/SV and its correlates (e.g., HIV, homophobia, racism, and substance abuse); c) show the psychological consequences of persons who experienced child and adult abuse; and d) illustrate the critical aspects of IPV/SV that health care providers are likely to encounter in an urban HIV/AIDS primary care clinic.

These characters appeared in different venues throughout the training session. First, the characters were introduced to trainees, and a dramatic scenario was performed to portray patients' personal background and interaction with family, significant others, and abusers.[9] The screening process was then demonstrated by these characters, who posed as patients being screened by a social worker. This exercise enabled the trainees to observe how IPV/SV screening can be implemented under different circumstances. An experiential exercise provided a "hands-on" approach to screening for IPV/SV, where the audience engaged in role-playing with an actor posing as a patient during a medical visit. This approach enabled trainees to confront barriers to screening and other patient-associated challenges (e.g., patient resistance). A social worker or training subgroup member was paired with each group to facilitate, assist, and support the participants as they engaged in role-playing activities.

Two additional experiential exercises were designed as part of the training module. The first exercise, facilitated by a social worker and victimization expert, exposed common myths and attitudes held about IPV/SV by the general population. Trainees were asked to identify personal attitudes that may interfere with their ability to effectively and sensitively screen for IPV/SV. The second exercise, facilitated by two clinical psychologists, was a listening exercise designed to share feelings associated with disclosing a victimization experience and to learn about the messages that body language conveys when listening to such a disclosure.[10]

Although themes of cultural competency were embedded throughout the training, a separate, specialized training session was offered to the primary care providers and social workers at CCC. This three-hour training, facilitated by an experienced clinical psychologist and social worker, was delivered approximately two weeks after the second training session. Although providers already had the necessary skills to work with a diverse patient population, the purpose of this formal training was to further educate staff, in the context of HIV/AIDS, about the cultural differences that exist among victims of abuse. The theoretical orientation used to guide the development of this training was the racial identity theory; general principles of cultural awareness also were integrated (19,20).

Methods

Self-administered surveys were used to assess staff satisfaction with the training and the way in which training influenced clinical knowledge, attitudes, and behaviors. In addition, informal group meetings were held to elicit a richer sense of what the clinicians thought about the training and the introduction of the IPV/SV screening. All surveys and group conversations were approved by the Institutional Review Boards (IRB) at both Centers for Disease Control and Prevention (CDC) and St. Luke's–Roosevelt Hospital Center (SLRHC).

Participants

All CCC staff with or without direct patient-care responsibilities, including physicians, physician assistants, nurses, nurse practitioners, dentists, clinical psychologists, social workers, and administrative staff, were required to attend the full training (N=54). Support staff members (e.g., secretaries) (N=13) were required to attend a separate, abbreviated training. To guarantee staff anonymity and increase survey response rates, demographics for training attendees were not collected.

Measurement

Knowledge, Attitudes, and Behaviors Survey

A previously published survey was used (21), with slight modification, to assess HIV/AIDS primary care providers' knowledge, attitudes, and behaviors toward victims of IPV/SV prior to and after the training.[11] The original 71-item survey by Sugg and Inui (1992) assessed only attitudes and practice behaviors; perceived prevalence of IPV/SV was the only set of questions that tapped provider knowledge in the original 71-item survey. Therefore, CCC's IPV/SV experts developed 20 additional true/false questions designed to tap clinicians' knowledge regarding IPV/SV and related risk factors. The knowledge items were derived by subject-matter experts and from two widely cited surveys (the National Crime Victimization Survey [NCVS](22) and the National Violence Against Women Survey [NVAWS]) (1). The final 91-item, self-administered survey was piloted with professional, nonmedical staff to determine survey completion time and address ambiguous questions or concerns. The final instrument is only considered to have face validity.[12]

Satisfaction with Training Survey

A brief satisfaction survey was developed to provide feedback and to document trainees' overall satisfaction with the training. The 31-

item satisfaction survey, which was created by the evaluation team, was based on the content and format of the training survey. A five-point Likert-type scale ranging from "strongly agree" (score of 1) to "strongly disagree" (score of 5) assessed satisfaction with general aspects of the training, including the actors' performance, trainer presentation, and quality of the training materials. A Yes/No question asked about recommending the training to a coworker, and an open-ended question provided participants with the opportunity to list additional comments.

Data Collection Procedures

Knowledge, Attitudes, and Behaviors Survey

The knowledge, attitudes, and behaviors survey was administered during staff meetings two weeks prior to the IPV/SV training. Follow-up surveys were administered one month and six months after the training to staff via interoffice mail. To increase response rates, multiple attempts to collect baseline data were undertaken via e-mail and interoffice mail.[13]

Satisfaction with Training Survey

Satisfaction surveys were administered in person by the evaluation team at the end of each two-day training session. The collection of data, however, differed in the two training sessions in an effort to improve response rates. Staff from the first training were asked to complete the surveys and return them via interoffice mail. For the second training group, staff were asked to complete and return the surveys before they departed the training room, thus improving response rates from 19% to 75%.

Qualitative Data Collection

Qualitative data from staff were informally collected by CCC project staff during administrative and clinical meetings. The training and practical applications (e.g., screening and referral mechanisms) were the topics that resulted in major changes to the project. The feedback regarding the content and format of the training was provided by training-session attendees and primary-care providers (PCPs) who were involved with conducting screening and making referrals. They identified problematic aspects of screening and referral procedures that they felt should be modified.

Data Analysis

All data analysis was conducted using either SAS or SPSS on a PC in a Windows NT environment.[14] For all analyses, data are reported only for PCPs who would be expected to screen patients for IPV/SV. Of CCC staff who completed the baseline survey, 38% (N=16) were classified as PCPs (Table 2). A PCP was defined as a staff member who a) possessed a medical, physician assistant, or nursing degree and b) provided direct patient care at least 50% of the time. For all post-training analyses, data from PCPs were used only if the survey indicated that these trainees had both attended a training session and completed a baseline survey.[15] Because of the small sample size, no statistical tests are presented, and only means and percentages are reported.[16]

Table 2. Demographics for staff respondents to the pretest and posttests

	Pretest (N=45)	Posttest 1 (N=18)	Posttest 2 (N=55)
Job function			
Administrative	12% (5)	28% (5)	32% (17)
Medical	30% (13)	39% (7)	20% (11)
Mental health	14% (6)	17% (3)	13% (7)
Nursing	12% (5)	11% (2)	9% (5)
Social work	14% (6)	(0)	7% (4)
Other	19% (8)	6% (1)	19% (10)
Total	100% (43)	100% (18)	100% (54)
Provide direct patient care			
Yes	82% (36)	83% (15)	62% (34)
No	18% (8)	17% (3)	38% (21)
Total	100% (44)	100% (18)	100% (55)
Primary care physician			
PCP	38% (16)	44% (8)	23% (12)
Non-PCP	62% (26)	56% (10)	77% (40)
Total	100% (42)	100% (18)	100% (52)

Results: Quantitative Data

Training Attendance

Of the 54 clinical and administrative staff CCC required to attend the full two-day training, 52 attended (96%). Of the 13 support staff required to attend the abbreviated training, all 13 attended (100%).

Response Rates

The response rates for the knowledge, attitudes, and behaviors survey were 69% for the baseline, 28% for the one-month survey, and 85% for the six-month survey.[17] Rates for the six-month survey were higher because of enhanced data-collection efforts (e.g., making frequent contacts and attending staff meetings).[18] Although respondent characteristics were recorded (e.g., job function, academic degree) participant anonymity was maintained at all times (Table 2). The overall response rate for the satisfaction survey was 75% (n=39), though the response rates varied by training site (58% at Site 1 and 89% at Site 2). (See Table 2.)

Table 3. Select knowledge questions: baseline and change percentages for primary care providers (PCPs) who attended the intimate partner violence (IPV)/sexual violence (SV) training

	Percentage answered correctly	Increase or decrease in percentage correct from pretest to posttest*	
Knowledge questions most often answered incorrectly†	Pretest§ (n=16)	1-Month posttest (n=4)	6-Month posttest (n=6)
Black and Latina women are more likely to report intimate partner violence to authorities, than are white women. *(T)*	0%	0%	+17%
Intimate partner violence against men has decreased over time, while it has remained the same or increased against women. *(T)*	8%	0%	0%
Both sexual assault and domestic violence are mandated reported crimes in New York State (NYS). *(F)*	39%	+25%	-17%
Drinking causes battering. *(F)*	50%	+50%	+34%
The vast majority of all intimate partner crimes are committed against women. *(T)*	67%	+8%	-13%
Domestic Violence is a crime in NYS. *(T)*	69%	+17%	-17%
The prevalence of same sex battering is comparable to heterosexual battering. *(T)*	69%	-8%	+16%
According to NYS statute and Department of Health (DOH) regulations, a medical provider is mandated to address partner notification with all newly identified patients with human immunodeficiency virus (HIV). *(T)*	77%	0%	-16%

Note: Letters in *(italics)* represent the correct answer. The knowledge items were derived by subject-matter experts and from two widely cited surveys, the National Crime Victimization Survey (NCVS)(25) and the National Violence Against Women Survey (NVAWS)(1).

*** Change percentages are assessed only for those PCPs who had baseline scores and had attended the training.**

† 25% or more respondents responded to these eight questions incorrectly.

§ Baseline scores are only for the PCPs (N=16) who completed the pretest survey.

Knowledge of IPV/SV

Baseline data revealed that PCPs were knowledgeable about IPV/SV prior to training. Because of this preexisting knowledge, we restricted our analysis to those questions most likely to show change over time. Specifically, we created a cut-point to identify ceiling effects. If 75% or more respondents answered a question correctly, knowledge change on those topics was not considered likely; therefore data from these questions were not analyzed. The eight questions that were answered incorrectly by 25% or more of the participants at baseline were used as the basis for analyzing whether training altered knowledge (Table 3).[19] Overall, among staff who answered items correctly at baseline and one month post training, more staff provided incorrect answers to these items six months after the training. At baseline, PCPs were least knowledgeable about the following facts: a) white women are less likely to report IPV than black or Hispanic women and b) rates of IPV against men have decreased over time, whereas they have remained constant or have increased against women. When surveyed six months after the training, PCPs' knowledge improved for the following three facts: a) white women are less likely to report IPV than other ethnic groups (17% increase), b) drinking doesn't cause battering (34% increase), and c) the prevalence of same-sex battering is comparable to heterosexual battering (16% increase).

Attitudes Toward IPV/SV Results

At baseline, most PCPs were not fearful of offending patients when asking about abuse (≥73%), and few PCPs (≤7%) reported tendencies to blame the victim. Also, a substantial percentage of PCPs were confident in asking patients about sensitive issues during a medical visit (≥62%). When surveyed six months after training, CCC staff felt more comfortable asking about sexual orientation (17% increase) and emotional and physical abuse (33% increase for both types of abuse) as part of the medical history than before receipt of the training.[20] (See Table 4.)

IPV/SV Practice Behaviors Results

At baseline, few PCPs (15%) reported having ever identified an abused person by one month after the training, however, all PCPs had identified at least one victim of abuse. At baseline, PCPs were more likely to ask about the possibility of IPV/SV when seeing a patient for injuries (55%) or depression/anxiety (42%) than for headaches (8%), chronic pelvic pain (0%), or irritable bowel syndrome (0%). Frequency in asking about abuse either decreased or did not change post training, with the exception that more PCPs asked about IPV/SV when patient injuries were observed, as revealed by the one-month (25%) and six-month (10%) follow-up surveys (Table 5).

Satisfaction with Training

Survey Results

To protect respondent anonymity, the satisfaction survey did not capture information on the respondent's professional discipline or other demographics. Overall, more than 80% of the staff were satisfied or very satisfied with most aspects of the training curriculum. Data from CCC staff who were dissatisfied were evaluated to more easily determine areas in which training could be improved. Because the actual training

Table 4. A comparison of intimate partner violence (IPV)/sexual violence (SV) associated attitudes held by primary care providers (PCPs)

	Percentage affirmed	Increase or decrease in percentage correct from pretest to posttest*	
Domain	Pretest† (n=16)	1-Month Posttest (n=4)	6-Month Posttest (n=6)
Fear of offending			
Not an invasion of privacy	93%	0%	0%
Not concerned with offending	73%	0%	+16%
IPV/SV questions don't demean patient	100%	0%	0%
IPV/SV questions don't anger patient	80%	+25%	+16%
Blaming the abused person			
Done something to bring violence	0%	0%	0%
Personality caused abuse	7%	0%	0%
Passive-dependent personality caused abuse	7%	-25%	0%
Getting something out of relationship	7%	0%	0%
Confidence in asking			
Smoking	92%	0%	0%
Alcohol	92%	0%	0%
Possession or use of firearms	54%	0%	-17%
Sexual orientation	77%	0%	+17%
Emotional abuse	62%	+25%	+33%
Physical abuse	62%	+25%	+33%

***Change percentages are assessed only for those PCPs who had baseline scores and had attended the training.**
†Baseline scores are only for the PCPs (n=16) who completed the pretest survey.

Table 5. A comparison of behavioral data for primary care providers (PCPs)

	Percentage answering yes	Increase or decrease in percentage correct from pretest to posttest*	
Domain	Pretest† (n=16)	1-Month posttest (n=4)	6-Month posttest (n=6)
Self-reported practice behaviors			
Never identified an abused person	15%	0%	0%
Never identified a batterer	62%	+50%	-17%
In past year, had not identified an abused person	39%	-25%	0%
In past year, had not identified a batterer	69%	-8%	-34%
Frequency of asking about IPV/SV			
Injuries	55%	+25%	+10%
Depression or anxiety	42%	-33%	-3%
Chronic pelvic pain	0%	0%	0%
Headache	8%	0%	0%
Irritable bowel syndrome	0%	0%	0%

***Change percentages are assessed only for those PCPs who had baseline scores and had attended the training.**
†Baseline scores are only for the PCPs (n=16) who completed the pretest survey.

differed by site, the satisfaction data for the two sites were evaluated separately. Overall, staff were most dissatisfied with the way in which the training addressed IPV/SV among people in same-sex relationships and of different ethnicities. In addition, staff felt that barriers to screening for IPV/SV presented in the training were not consistent with their fears of asking patients about abuse.

Qualitative Data

At the conclusion of the training sessions, several clinical staff members raised concerns about the appropriateness and efficacy of the training. These comments, though not systematically recorded, were consistent with conversations held in informal group settings involving clinical staff and the clinical and administrative leaders of the demonstration program. These qualitative data not only helped deepen understanding of the training, but also supplemented and extended the quantitative data in many ways.

Suggestions for Changes to Training

Clinicians, including PCPs, indicated that the information presented during the training did not follow the evidence-based, didactic approach to which they were accustomed. Some felt that exercises used during the training (e.g., role-playing, talking about emotions regarding IPV/SV, and talking about dealing with stigmatized persons) disregarded the extensive skills and expertise of clinicians. Although the project team intended for the TBT to be interesting and provide insight into the experience of working with patients with IPV/SV histories, clinicians felt somewhat offended watching IPV/SV-related issues portrayed by actors. Many PCPs in the audience had been working with sensitive issues related to HIV for more than 15 years and had developed expertise in dealing with challenging personal issues faced by their patients. Rather than being "shown" how to do their jobs in the training sessions, PCPs expressed a desire to be credited for what they already knew.

These clinicians also suggested that the format used to teach about IPV/SV, including the TBT component, was not consistent with what they felt was an effective way for them to learn (i.e., via case-based teaching by clinical staff). Medical providers have the experience of being trained in a didactic fashion, in which evidence-based scientific information is presented within a short time frame for them to hear, digest, and commit to memory. The group-oriented, personal, and relational approach employed in this training was not a comfortable teaching method for some PCPs and did not enable them to gain the knowledge they felt they needed to perform the task of IPV/SV screening. Revisions to the training program were made between the first and second sessions based on feedback obtained from clinicians involved in the first training session. For instance, in response to PCPs' desire for more science-based information, additional speakers were asked to prepare and present scientific information. Specifically, the senior project scientist and co-investigator presented data on screening and referral of CCC patients to services because PCPs had indicated the desire to learn about what happens to their patients after they are referred. PCPs were reassured that the services to which they would be referring patients are actually accessed by patients and provide appropriate clinical support.

Suggested Program Modifications to Screening

During subsequent meetings that occurred post training, senior PCPs reported concerns and discomfort over raising the sensitive issues of IPV/SV during the initial examination. PCPs indicated that they routinely establish a relationship with patients and gradually gain their trust during the first encounter and subsequent patient visits. They suggested that IPV/SV issues not be raised during an initial visit for certain patients and in certain circumstances until rapport is built and a trusting relationship is developed. PCPs provided examples of patients who reported no abuse during the first two visits, but in subsequent interactions became more responsive and revealed that abuse had actually occurred. In response to these PCPs' concerns about screening during initial medical visits with new patients, the project team determined that the PCP had six months from the initial visit to screen new patients; a period that would enable the PCP to build rapport with the patient. Although mandated to screen during annual visits, PCPs are not restricted to screening for IPV/SV during initial and annual visits, but are encouraged to ask questions when deemed necessary. This flexible screening approach was initiated about four months after the training.

Suggested Program Modifications to the Referral Mechanism

The training program initially instructed PCPs to send patients suspected of experiencing IPV/SV upon screening (i.e., those who answered yes to any screening question) to a three-hour psychosocial assessment with a clinical psychologist. The assessment would serve as a component of an IPV/SV research effort. However, after the training had taken place (but before the program was fully implemented), PCPs expressed discomfort referring patients for a long, structured interview. Additionally, PCPs felt that referring patients to a study put them in an uncomfortable position. Not only did they feel that they could not answer patient questions about the study, but that such a referral put providers in the role of study recruiter or evaluator. In response to these concerns, program protocol was adjusted; instead of a three-hour assessment, patients screening positive would be asked to attend a 40-minute visit with a clinical psychologist representing this research project. At that time, the patient would be informed about participating in the research study and invited to complete a full baseline assessment during a scheduled three-hour appointment.

Challenges and Obstacles

The qualitative data gathered were instrumental in identifying the limitations of implementing a new standard of care as well as a research study in a busy, urban HIV-care center. The training, screening, and referral components of this project were modified to meet the pragmatic demands of a busy clinic practice and the need to work with PCPs to ensure that the provision of quality medical treatment would not be compromised.

The quantitative data are limited, both by the skewed responses and small sample size. However, the anecdotal information and group conversations suggested that a disparity existed between trainers (who had been oriented using the empowerment approach) and the PCPs (who had been oriented using biomedical and evidence-

based approaches). The empowerment model was developed by community-based organizations that placed IPV/SV in gender, social, and political contexts, whereas the biomedical model emphasizes the physician's primacy in the diagnosis and treatment of biological impairment and pathology within the patient, and the evidence-based orientation emphasizes providing critical research that demonstrates the efficacy of screening (i.e., effectiveness of the intervention being recommended) and referral and treatment for IPV/SV. The empowerment approach of social workers, although effectively used in small grassroots advocacy organizations, departs from the approaches traditionally used by PCPs in a hospital-based setting. Elements of these models are valuable; however, in developing a training program for professionals performing the clinical tasks of the project, the cultural differences between the training developers and target audience (i.e., PCPs) could have been bridged in a way that PCPs would perceive as making better use of their time and expertise.

The discomfort with the theater-based approach among experienced clinicians was evident in several ways. The two most prominent reasons were a lack of evidence for screening utility and efficacy presented in the training and that most of the presentations were conducted by social workers. Providers particularly appreciated a lecture given by an emergency department physician who shared information about methods of handling trauma cases in a hospital setting and the various symptoms which can mask victimization. This lecture, however, accounted for a small percentage of the overall training content. Again, a more varied approach integrating the models, as well as a diverse sample of multidisciplinary providers, may have proved more efficacious.

Another bias in the training was a possible gender discrepancy between the trainers (all of whom were women) and the clinicians (many of whom were men). The experience of IPV/SV may have been perceived by some providers as a "women's issue," especially because many training examples depicted women as victims and men as perpetrators of IPV/SV. The underlying gender dynamic might be overcome by including men as trainers (23).

Despite more than 80% satisfaction with the training, senior PCPs reported largely negative responses initiating an intense critique of the training. However, results from informal focus groups indicate a generally positive reaction to the training by staff working in other disciplines (i.e., those who do not have direct patient-care responsibility). One of the training areas that staff were most dissatisfied with was the role-playing between actors and staff. Staff felt that the model role-playing exercises were not helpful in depicting the screening process for IPV/SV. Although specific details were not obtained about which elements of these exercises were disliked, it is likely that despite efforts to make the characters real, the role-playing scenarios did not capture the uniqueness and complexity of the patient-provider relationship.

PCPs expressed practical concerns pertaining to actual screening practices and comfort with the referral mechanism based on their experiences in the initial project rollout. Screening for IPV/SV during the initial visit was a contentious issue. Although no data are available to indicate the benefits or harms of delaying screening, PCPs expressed the need to develop rapport with these new patients before broaching the topic of IPV/SV. As a result, the screening protocol was adjusted to enable PCPs to screen patients

Table 6. Results from the survey that assessed satisfaction with intimate partner violence (IPV)/sexual violence (SV) training for both training sites*

Survey questions†	Percentage dissatisfied	
	Site 1 (n=15)	Site 2* (n=24)
Overall, the IPV/SV training addressed IPV/SV among people in same-sex relationships	33%	8%
Overall, the IPV/SV training addressed IPV/SV among people of different ethnic identities	27%	4%
Barriers to IPV/SV screening are consistent with my fears of asking my patients about IPV/SV	20%	10%
Paired exercise where I described an experience with victimization	13%	7%
The model role-plays depicted the screening process for IPV/SV helpfully	13%	17%
Trainers openness to opinions	7%	0%
Discussion after the actors performances	7%	9%
Opportunities to ask questions	7%	0%
Meeting my professional needs	7%	4%
The NiteStar scenarios illustrated the effect of IPV/SV on patients with HIV	7%	0%
The NiteStar actors accurately depicted the patients at CCC	7%	4%
CVTC speakers communicated what I need to know about communicating with patients who have experienced IPV/SV	7%	13%
Overall, the IPV/SV training addressed the relationship between IPV/SV and HIV	7%	4%
The connection between IPV/SV and HIV care was made clear	7%	0%
The training met my expectations	7%	4%
Information provided	0%	4%
Clarity of materials	0%	4%
Expertise of trainers	0%	4%
Actors performance	0%	0%
Take-a-Stand exercise	0%	9%
Relevance of topics to my work	0%	0%
Length of training	0%	29%

Table Continued

Table 6. Continued

Survey questions†	Percentage dissatisfied	
	Site 1 (n=15)	Site 2* (n=24)
Overall, how satisfied or dissatisfied were you with this IPV/SV training	0%	10%
I felt comfortable participating in the discussions of IPV/SV	0%	4%
I am more knowledgeable about IPV/SV because of the training or than I was before the training	0%	13%
I feel more capable of screening for IPV/SV because of the training or than I was before the training	0%	13%
The training reflected the agenda	0%	4%

*These data are presented by ranking the first training session and comparing the percentages from the second session. The percentages are combined for "disagree" and "strongly disagree" responses and are interpreted as dissatisfaction with the statement pertaining to the training.
†Ranked in descending order of percentage of respondents who were dissatisfied

up to six months after the initial visit. Despite this potential delay in screening, CCC patients continue to receive a host of comprehensive services (e.g., mental health care and case management), and patients in crisis are offered immediate services. Identifying victims of abuse helps protect patients and provide them with the necessary support systems. Providers recognize that screening patients is important and that each medical visit is an opportunity to help reduce risk.

Referring patients to a research study placed PCPs in a new role dealing with unfamiliar territory. Although referring a patient to an on-site service or established agency was business as usual for providers, acting as a liaison between medical practice and research was a role that providers were not comfortable assuming. Initially, the protocol required PCPs to refer patients who screen positive for IPV/SV to a clinical psychologist who would conduct an in-depth psychosocial assessment. However, patients became confused as to whom they were being referred and what it meant to be a research participant, and providers were uncomfortable making such a referral and were unable to answer the questions patients asked about the research study. Consequently, the referral mechanism was modified. Instead of sending patients for a three-hour assessment, the PCP would refer patients to the same psychologist for only 40 minutes. At that time, the clinical psychologist would explain the nature of the study and invite patients back for a three-hour appointment to complete the assessment. This compromise appeased the providers and enabled patients to be appropriately informed about their involvement in the research project.

Lessons Learned

Initially, the evaluation component of the training effort was focused on assessing staff satisfaction levels about the training and the knowledge they gained. However, participants' reactions to the training raised a much broader issue: what must be further elucidated about how PCPs learn to ensure that they are effectively engaged?

Some of the lessons learned from the training effort are clear; others are more subtle. The more straightforward elements of the lessons are that a) training must build upon ways participants from different disciplines are accustomed to learning, b) representatives of the target audience should be involved in the development of the training materials, and c) physician educators should be part of the didactic component of training and deliver information to other physicians. Involving a broader range of PCPs during the developmental phase of the training might have thwarted concerns raised by participating PCPs; a careful balance must be maintained to ensure that PCPs' expertise and understanding of the issues surrounding stigmatized patients is acknowledged and that patronizing these professionals when delivering educational materials is avoided.

The more subtle lessons learned involves the composition of the training group. It is not surprising that a group of professionals with a long-standing history of researching and working with victims of IPV/SV felt they knew which materials would be most helpful in training HIV-primary care staff. However, the way in which the materials were presented coupled with characteristics of the presenters were problematic. In retrospect, having someone on the training team who had experience in creating educational sessions (in particular, training PCPs) might have been advantageous; learning the nuances of a new medical procedure differs greatly from understanding the complexities of IPV/SV dynamics. In addition, medical professionals have different learning needs and their expectations for and experiences with pedagogical programs differ across disciplines. All of these lessons learned should be considered when planning future training sessions.

Future Directions

Training health care providers to identify and screen for IPV/SV is necessary to combat the challenges faced in certain medical settings (e.g., the lack of reporting and screening in obstetrics/gynecology offices and emergency departments) (10,24). An effective training curriculum encompasses not only the content (e.g., current and scientific data), but also the contextual framework in which the information is presented. Addressing the educational desires and expectations of the audience is as important as providing the epidemiologic and clinical data to support the need for new practices. Developing a curriculum for PCPs is a complex undertaking, because PCPs (especially physicians) are accustomed to scientific data and proven medical techniques. However, a training program geared to convey the importance of IPV/SV screening, referral, and treatment can be tailored for these professionals. Much information is available supporting the need for IPV/SV-related clinical practices and services, and better preparing health care providers through the delivery of evidence-based training will result in lasting and meaningful changes in standard health care practices.

References

1. Tjaden P, Thoennes N. Extent, nature, and consequences of intimate partner violence: findings from the national violence against women survey. Washington (DC): Department of Justice (US), National Institute of Justice, Centers for Disease Control and Prevention; 2000.

2. Field CA, Caetano R. Longitudinal model predicting partner violence among white, black, and Hispanic couples in the United States. Alcohol Clin Exp Research 2003;27:1451–8.

3. Field CA, Caetano R. Ethnic differences in intimate partner violence in the U.S. general population: the role of alcohol use and socioeconomic status. Trauma Violence Abuse 2004;5:303–17.

4. Greenwood GL, Relf MV, Huang B, Pollack LM, Canchola JA, Catania JA. Battering victimization among a probability-based sample of men who have sex with men. Am J Public Health 2002;92:1964–9.

5. Relf MV, Huang B, Campbell J, Catania J. Gay identity, interpersonal violence, and HIV risk behaviors: an empirical test of theoretical relationships among a probability-based sample of urban men who have sex with men. J Assoc Nurses AIDS Care 2004;15:14–26.

6. Zierler S, Cunningham WE, Andersen R,Shapiro MF, Bozezette SA, Nakazono T. Violence victimization after HIV infection in a US probability sample of adult patients in primary care. Am J Public Health 2000;90:208–15.

7. Koenig LJ, Whitaker DJ, Royce RA, Wilson TE, Callahan MR, Fernandez MI. Violence during pregnancy among women with or at risk for HIV infection. Am J Public Health 2002;92:367–70.

8. Rodriguez M, Quiroga S, Bauer H. Breaking the silence: battered women's perspectives on medical care. Arch Fam Med 1996;5:153–8.

9. Cohen M, Deamant C, Barkan S,Richardson J, Young M, Holman S. Domestic violence and childhood sexual abuse in HIV-infected women and women at risk for HIV. Am J Public Health 2000;90:560–5.

10. Elliot L, Nerney M, Jones T, Friedmann PD. Barriers to screening for domestic violence. J Gen Intern Med 2002;17:112–6.

11. Wathen CN, MacMillan HL. Interventions for violence against women: scientific review. JAMA 2003;289:589–600.

12. Flitcraft A. Clinical violence intervention: lessons from battered women. Healthcare Poor Underserved 1995;6:187–97.

13. Hamberger L. Violence issues for health care educators and providers. New York (NY): Haworth Press; 1997.

14. Short L, Johnson D. Recommended components of health care provider training programs on intimate partner violence. Am J Prev Med;1998:14:283–8.

15. Bandura A. Self-efficacy: towards a unifying theory of behavioral change. Psychol Rev 1977;84:191–215.

16. Dalrymple L, du Toit M. The evaluation of a drama approach to AIDS education. Educational Psychology 1993;13:147–54.

17. Bosompra K. The potential of drama and songs as channels for AIDS education in Africa: a report on focus group findings from Ghana. Int Q Community Health Educ 1992;12:317–42.

18. Harding C, Safer L, Kavanaugh J, Bania R, Carty H, Lisnov L. Using live theatre combined with role play and discussions to learn what at-risk adolescents think about substance abuse, its consequences and prevention. Adolescence 1996;31:783–96.

19. Ho DYF. Internalized culture, culturocentrism, and transcendence. Couns Psychol 1995;23:4–24.

20. Markus HR, Kitayama S. The cultural construction of self and emotion: implications for social behavior. In: Kitayama S, Markus HR, editors. Emotion and culture: empirical studies of mutual influence. Washington (DC): American Psychological Association 1994;1–19.

21. Sugg NK, Inui T. Primary care physicians' response to domestic violence: opening Pandora's box. JAMA 1992;267:65–8.

22. Bachman R, Saltzman LE. Violence against women: a national crime victimization survey report. Washington (DC): Bureau of Justice Statistics, Office of Justice Programs, Department of Justice (US); 1994. NCJ Publication No.: 154348.

23. Sugg NK, Thompson RS, Thompson DC, Maiuro R, Rivara FP. Domestic violence and primary care: attitudes, practices, and beliefs. Arch Fam Med 1999;8:301–6.

24. Heinzer MMV, Krimm JR. Barriers to screening for domestic violence in an emergency department. Holistic Nurs Pract 2002;16:24–33.

Endnotes

[1] This demonstration project was funded through Centers for Disease Control and Prevention.

[2] In a study of predominantly African-American and Latina low-income women in care at the OB/GYN Clinic of SLRHC, the rates of interpersonal violence and trauma were significantly greater than estimates for the national population. Almost 40% of women in the study reported having experienced intimate partner violence (IPV). The women in the same study also were found to have higher rates (47%) of childhood sexual or physical abuse when compared to national rates (7%)(10).

[3] Demographic information on patients is derived from the administrative clinical medical record system. The administrative data do not contain information on socioeconomic status, education, or sexual orientation.

[4] The training, including components of the theater-based training (TBT) such as vignettes and "backstories," was videotaped and made available as a pedagogical tool to educate new providers and staff.

[5] The Family Violence Fund training was reviewed during development, no component was directly taken from this curriculum.

[6] A comprehensive training manual was also provided to all attendees.

[7] NiteStar is a theater-based performance group experienced in providing educational information through skits and role-playing. The NiteStar performances were supplemented to give staff an opportunity to direct patient-related questions to the actors who remained in character.

[8] The theater-based approach has been applied in various academic settings to understand the doctor–patient relationship, present students with client case studies, and teach clinical applications (20).

[9] A "backstory" for each character was created which became the basis of the character monologues and scenarios—the central pedagogic tools of the TBT. The "backstory" is a complex and realistic narrative of the antecedents of victimization and outcomes of a violent or abusive personal history.

[10] This exercise was eliminated from the second training session due to time constraints experienced during the first training session.

[11] The scale developed by Sugg and Inui (1992) has been revised from the time we decided to use it in this study (21).

[12] The instrument is available upon request to the authors.

[13] Baseline and post-training surveys were sent to all staff because the research team had promised anonymity to participants. Consequently, we could not identify individual respondents. There was, however, a unique identifier, created by the respondent following instructions by the research team, enabling us to link the post-training data with the pre-training data.

[14] These abbreviations stand for the Statistical Analysis System (SAS), Statistical Package for the Social Sciences (SPSS), personal computer (PC), and Windows network technology (NT).

[15] Not all respondents who completed the baseline survey took posttest surveys; and not all respondents who completed a posttest survey had a baseline survey. This left us with two analytical approaches—to treat the data as independent or paired samples. Because more than 50% of the respondents had paired data, paired analyses were used even though this reduced the sample size. An independent analysis treating the baseline and posttests as independent cross-sectional surveys yielded no difference from the paired analysis.

[16] Due to small sample size and skewed distributions, nonparametric paired sample analyses were used when comparing the baseline and follow-up surveys, but the data are not included in this report.

[17] Because all staff were sent surveys to complete, the response rate figures also include a few surveys from the 13 support staff.

[18] Data were collected at staff meetings and reminders were sent via e-mail messages.

[19] Training effectiveness was assessed using McNemar's test to compare the pretest to posttests. Although modest improvement in knowledge was observed, the eight knowledge items identified at baseline resulted in no significant changes either one or six months after training. As an additional check, the Mann-Whitney test for independent samples revealed that primary care providers (PCPs) did not significantly differ in baseline knowledge at one month after training.

[20] Non-Bonferroni corrected Wilcoxon tests indicate that no statistically significant changes in attitudes occurred by one month after the training; though by six months after the training, PCPs were more confident asking their patients about emotional and physical abuse as part of their medical history. A Bonferroni correction suggests these differences could have occurred by chance.

Design and Implementation of the Domestic Violence Services in Rural Clinics Intervention

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The findings and conclusions in this report are those of the authors and do not necessarily represent the views of the Centers for Disease Control and Prevention

Introduction

Since the 1980s, health professionals have increasingly been interested in understanding the health consequences of intimate partner violence (IPV)(1-3). In addition, health care communities are recognizing the need to identify ways to respond more effectively to the needs of abused women. Numerous studies have indicated that 10%-55% of women obtaining care in general practice settings have experienced some form of IPV either in a current relationship or during their lifetime (4-8). In addition to the physical injuries, disability, and death that can be associated with IPV, both women who have been victimized by an intimate partner and children raised in violent households are more likely to experience a wide array of chronic physical and mental health conditions, including frequent headaches, gastrointestinal problems, depression, anxiety, sleep problems, and post traumatic stress disorder (PTSD)(9-15).

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Healthy People 2010 (16) is a prevention agenda for the nation designed to identify the most significant preventable threats to health in the United States. Developed by the Office of Disease Prevention and Health Promotion of the U.S. Department of Health and Human Services, Healthy People 2010 has identified ten Leading Health Indicators (LHIs) that measure the health and well-being of the nation for the decade. These indicators include physical activity, overweight and obesity, tobacco use, substance abuse, responsible sexual behavior, mental health, injury and violence, environmental quality, immunization, and access to health care. Intimate partner violence (IPV) has been associated with eight of ten of the LHIs identified in Healthy People 2010. IPV is a leading determinant of health that must be addressed to advance the national prevention agenda for the 21st century.

Interventions to prevent IPV and its negative consequences would confer substantial public health benefit, including the prevention of future injuries and illness. In an effort to realize this health benefit, some health care providers around the country have implemented procedures to screen patients for abuse, and many organizations support routine screening for IPV (17-24). However, the value of screening has recently been questioned because of insufficient evidence regarding the benefit-to-harm ratio of screening tests (25).

Existing literature suggests that assessing IPV may be beneficial rather than harmful. Two prospective intervention trials involving prenatal clinics reported no evidence that assessment and intervention had detrimental effects; rather, both found that assessment and referral alone were as effective in reducing new episodes of physical assault over time as assessment and intervention (26,27). Another study found that an intervention consisting of six telephone calls to women screening positive for IPV in which safety behaviors were discussed over an eight-week period increased women's safety behaviors at three, six, 12, and 18 months compared with women receiving the IPV care routinely provided by the local district attorney's office (28). The utility of this intervention within the context of a clinical assessment is unknown because the trial was not clinic based; however, the results suggest that safety-behavior training may be effective. Finally, additional evidence has been demonstrated in a large trial in which violence was assessed in women attending public health clinics using a two-question, two-minute questionnaire. Those identified as abused were then assigned to one of two interventions: case management by a nurse to help the woman individually problem solve issues related to IPV or provision of an information card; both interventions resulted in a decrease in physical assaults and depressive symptoms in women over eighteen months. No harmful effects of the assessment or intervention were noted (29). All of these studies have been criticized because they have not included control groups; therefore, additional randomized clinical trials using clinic-based assessments and interventions and control groups are needed to determine the potential positive or negative impact on IPV.

Further investigation is needed to determine what type(s) of IPV should be assessed (e.g. physical, sexual, psychological violence), which assessment tools should be used, and what time frame an assessment should cover (e.g. current violence, recent, or lifetime). Each type of partner violence is associated with negative consequences; both physical and psychological abuse have been shown to result in the same negative outcomes (1,5). For successful IPV assessment, the proportion of women that report physical assault, battering, and psychological abuse (the most common forms of partner abuse) must be elucidated, as well as the

potential for overlap between these constructs. In an effort to make evaluations as brief as possible, several rapid assessment tools have been developed and validated against existing instruments (7,30-35). In reviewing the range of instruments, practitioners need to consider the intent of screening. If the focus of interventions is to reduce immediate harm, the time frame for screening should be current abuse, whereas instruments to address long-term health consequences should assess lifetime exposure. Additional research in this area will facilitate the development of a brief but comprehensive assessment tool that captures all types of abuse.

Research supports the notion that women are willing to talk with health care providers about IPV and realize the potential benefits of doing so (36). Specifically, 83% of both abused and non-abused women have reported that it would be easier for abused women to obtain help if health care providers routinely conducted violence assessments (36). Despite women's willingness to disclose abuse when asked, several studies have identified missed opportunities for potentially life saving interventions. Research indicates that two thirds of women who are victims of homicide by an intimate partner sought medical care in the year prior to their murder (37), and that 50% of homicide victims were not identified or appropriately referred as IPV victims during visits to emergency departments prior to their murders (38). Additionally, in one study (39), only 17% of women who reported partner violence in personal interviews with researchers had any indication of violence noted in their medical record. One potential reason that clinicians do not assess IPV is the lack of effective, clinic-based services for women who are IPV positive. Assessing IPV and corresponding interventions in health care settings might help prevent these missed opportunities.

Assessment and referral for IPV may be particularly challenging in rural settings because of increased isolation and limited access to resources. However, the incidence and prevalence of IPV among women living in different residential settings (i.e., rural, urban, and suburban) has not been clearly elucidated. Evidence from some studies indicates that the impact of partner violence might be greater in rural areas (13,40,41). In one study conducted in 2001, homicide rates among intimate partners were found to be higher in southern states (42), which are typically rural, although this rate might also be reflective of the study population's race; a greater proportion of the southern population is African American, a population along with other minority groups that has higher homicide rates than those observed in white populations (42). An analysis using FBI domestic state homicide rates for 1998-2000, however, found that rural residence was significantly associated with female domestic homicide after adjusting for the percentage of minority populations in each state ($p=0.01$; $R2$ value=24.1%). Using data obtained from the National Family Survey data (43), which employed a conflict tactic scale to determine levels of abuse for 1,310 women, researchers determined the 12-month estimate for severe physical violence to be 3.87% (44); in addition, these data revealed rates of physical violence to be highest among women living in rural, non-farm residences. In contrast, other researchers (13) have reported that the 12-month prevalence of severe physical partner violence among women who sought care in emergency departments or clinics in the Midwest during a two-week interval in 2002 was highest among urban women (10.2%; N=646), followed by rural women (3.8%; N=215) and suburban women (1.0%; N=406). Another study conducted in 2001 examined violence prevalence among 1,682 women who were seeking services in either a Women, Infant, Children site or a clinic in rural

west-central Minnesota (41); the 12-month prevalence of physical violence in this population was 6.5%. Although it is not known whether partner violence rates are higher in rural compared with urban settings, women living in rural areas likely face more challenges in receiving intervention for IPV than their urban counterparts.

Conceptual Model for Study

The research discussed in this report was guided by a conceptual model that proposes the intervening mechanisms through which IPV impacts health. The set of potential causal relationships that link IPV interventions to improvements in women's health also are identified in this model (Figure 1). Prior research has indicated that physical assault, psychological abuse, and battering negatively impact both physical and psychological health (45,46). The health outcomes assessed in our study (as indicated in the conceptual model) include a) health-related quality of life (47-50), b) mental health (9,35), c) depression (47,51), d) anxiety (47,51), e) PTSD (49,51,52), and f) number of health care visits (13,35,53). The model also proposes that the relationship between health-status outcomes and abuse is mediated by several factors including higher stress (50,53), lower perceived social support (53,54) lower perceived control (53,55), and greater use of certain negative coping behaviors (e.g., alcohol use (50,56)) and suicidal ideation (47,57). Additionally, the model suggests that the relationship between IPV and health is mediated by several behavioral factors, including help-seeking (58), safety planning (26), and self-care (13,55). These factors may also have a negative effect on abused women's health independent of her exposure to abuse. We proposed that the interventions would result in improvements in the intermediate endpoints (e.g., social support, perceived control, and perceived stress) which, in turn, would lead to improvements in behavioral outcomes (i.e., help seeking, safety planning, and self-care). In addition, we proposed that these changes would improve women's health status independent of changes in the level of IPV.

The health care intervention discussed in this report focused on victims of IPV rather than perpetrators; therefore, no changes in perpetrator behavior were expected to occur. In accordance, a reduction in the level of violence was not assessed as an outcome. Rather, we proposed the use of intermediate variables in the conceptual model as outcomes for our study (i.e., social support, perceived control, and perceived stress). We hypothesized that these interventions would address and create change in areas of women's lives that are within their spheres of control, ultimately increasing safety and improving health among female victims of IPV.

Research Questions

This study was designed to achieve several objectives. One objective was to enable the frequency of both current and recent (i.e., within the past five years) IPV (including physical, sexual, and battering) to be determined among women receiving primary care services in a low income, ethnically diverse, rural health care clinic setting. Few IPV assessment and intervention studies have been conducted in an ethnically diverse, rural setting. As recommended by the Centers for Disease Control and Prevention, we defined IPV to include physical violence, sexual violence, the threat of physical or sexual violence, and psychological/emotional abuse (59); in this report, the term "abuse" was used to describe experiencing any of these forms of IPV. We differed from CDC's recommendation in one aspect, because in

our definition of IPV, we included psychological battering for women not currently experiencing physical or sexual violence.

The second research aim involved evaluating the efficacy of two clinic-based interventions; these interventions were evaluated alone and in combination with one another. One intervention involved the presence of an on-site domestic violence specialist who immediately provided services for women positively screened for IPV. The second intervention was comprised of a seven-session "empowerment-focused patient education intervention," which was implemented by trained on-site counselors. This intervention focused on empowering women to make informed decisions about their relationships and their health. A cost-outcome analysis was also conducted group comparing women receiving interventions relative to those in the control group.

The study also aimed to examine the pathways by which changes in intermediate endpoints (i.e., help seeking, safety planning, and self-care) impact short-term outcomes (e.g., chronic perceived stress, social support, and self-care) and long-term physical and mental health outcomes. Understanding the mechanisms by which IPV impacts health, which is the primary outcome for this intervention, should lead to further refinements of the interventions and implementation strategies that will maximize their efficiency.

Although the interventions were developed to reflect the same conceptual model, the pathway for improving women's health may have differed. The on-site IPV services intervention was designed to directly affect help-seeking behaviors by improving linkages between abused women and IPV service providers. Because women received these messages during their first encounter with service providers, this intervention may also have increased safety planning and self-care. Women who seek help from services or follow a safety plan may feel more in control of their lives, perceive less stress, and in turn, have reduced anxiety or depression levels and increased quality of life scores (i.e., improved health outcomes).

In contrast to the on-site IPV services intervention, the empowerment intervention sought to impact self-care, social support, perceived stress, and perceived control. Women who recognize a link between IPV and health may focus on garnering support and resources from friends, agencies, and health care providers to help them cope with and address their abuse.

Methods

Setting and Population

Study participants were women who sought care at participating rural health care clinics in South Carolina's Pee Dee Region. The Pee Dee Region is comprised of the following counties: Chesterfield, Darlington, Dillon, Florence, Marion, Marlboro, and Williamsburg. The region is primarily rural and has high rates of poverty, infant mortality, poor educational achievement, and IPV (60). All participating clinics served women of low socioeconomic status, a population known to be at increased risk of domestic violence.

For our study, women 18 years of age or older who sought care at the clinics from April 2002 through August 2005 were offered IPV assessment each year as part of the clinic's standard assessment procedure. Approximately 55% of participants were African American, and the remaining 45% were white, non-Hispanic women. IPV assessment was limited to females because rates of victimization from partner violence are approximately threefold higher in women than men in South Carolina (61). Furthermore, assessment

of men for IPV would have required additional resources that were not available for this project; because no community-based services were available for men experiencing IPV, it would have been unethical to assess for a problem for which no help was available.

IPV Assessment Procedures

Trained clinic nursing staff identified eligible women, described the study, and explained the consent forms. Women who consented to the IPV assessment (Table 1) were given the option to have their assessment placed in their medical chart. Women were also offered a copy of the consent form and assessment; however, nursing staff recommended that a woman take the consent form only if she was sure it was safe to do so. Although we did not assess sexual or physical assault by someone other than an intimate partner in this study, reports of this type of violence to clinic and project staff resulted in a referral to the Pee Dee Coalition Against Domestic and Sexual Assault (PDC), which provides services and refers women to other medical or legal services as needed. All aspects of the study, including the consenting process, were explained and the IPV assessment administered in a private examination room before the clinical exam was conducted. Only the nursing staff member and the patient were allowed in the room. If a partner refused to leave the examining room when asked, the nursing staff member did not offer the assessment; instead, a notation was made that the IPV intervention should be offered during the next visit. Clinic nursing staff administered the questionnaire to eligible and consenting women, recorded the women's responses, and scored forms once assessments were complete.

IPV Assessment

During the IPV assessment, nurses first asked women to think about their current male partner, if relevant, or their most recent male partner. Partner was defined as "someone you have been married to, dated, or had a sexual relationship with." Women were then asked a series of questions assessing battering and physical/sexual assault (Table 1). Finally, women were asked about emotional abuse and physical abuse by any partner in the past 5 years. (See Table 1.)

We used the Women's Experience with Battering Scale (WEB) to assess battering. The WEB Scale has good construct validity, accurately discriminates battered from non-battered women, and shows strong internal consistency (35,62,63), (Cronbach's alpha = 0.96 in this intervention sample). The WEB Scale measures battering by operationalizing women's psychological vulnerability and their perceptions of a) susceptibility to physical and psychological danger and b) loss of power and control in a relationship with a male partner. We modified the WEB Scale for this study by simplifying the six-point Likert-scale response options to two dichotomous responses (agree or disagree) for 10 statements (Table 1). A validation analysis for this revision of the WEB indicated that this dichotomous response option ("agree with two or more of 10 statements") has a sensitivity of 79.8%, a specificity of 99.4%, and a positive predictive value of 96.6% when compared with the full scale of response options. While the WEB was designed to be self-administered, we chose to have the nurses read the assessment to each participant because of the low level at which some of the older and minority participants could read.

Table 1. Intimate partner violence (IPV) assessment items used in this domestic violence intervention project in rural clinics

The following questions (1–12) are asked about the woman's current or most recent partner. * (Note: Following 10 items are modified from the Women's Experience with Battering [WEB] Scale.)	**Agree**	**Disagree**
1. Your partner makes you feel unsafe even in your own home.	1	0
2. You feel ashamed of the things your partner does to you.	1	0
3. You try not to rock the boat because you are afraid of what your partner might do.	1	0
4. You feel like you are programmed to react a certain way to your partner.	1	0
5. You feel like your partner keeps you prisoner.	1	0
6. Your partner makes you feel like you have no control over your life, no power, no protection.	1	0
7. You hide the truth from others because you are afraid not to.	1	0
8. You feel owned and controlled by your partner.	1	0
9. Your partner can scare you without laying a hand on you.	1	0
10. Your partner has a look that goes straight through you and terrifies you.	1	0
Total Web Score (Add above scores. Circle score if 2 or more [positive].)		
	Yes	No
11. Is (was) this partner physically violent toward you? By violent I mean does (did) he punch, kick, hit, shove, slap, choke, or physically attack you in other ways that could result in an injury. It also means being made to do sexual acts when you don't want to.	1	0
12. Do (Did) you feel that violence or abuse is (was) a problem in your relationship with this partner? **	1	0
The following questions (13–14) are asked about any other partner in the past five years.		
13. Has any other partner, in the past five years, made you feel scared without laying a hand on you, ashamed of the things he does to you, made you feel like you have to react in a certain way to him?	1	0
14. Has any other partner, in the past five years, been physically violent toward you? By violent I mean did he punch, kick, hit, shove, slap, choke, or physically attack you in other ways that could result in an injury. It also means being made to do sexual acts when you don't want to.	1	0

* The following questions were used to identify a current or most recent partner. "Now I will ask you some questions about your [current] partner. A partner is someone you have been married to, dated, or had a sexual relationship with. Are you in a relationship now with a partner that has lasted at least three months?". If the response was yes, the woman answers questions 1–12 for the current partner. If the answer is no, the following question is asked: "Have you had a sexual relationship anytime during the past five years that has lasted for at least three months?" If the answer is yes, then the woman answers questions 1–12 for the most recent partner she had in the past five years. If the woman answers no to both questions, she is ineligible for the IPV assessment.

** This question was not used to assess IPV.

One question, which was obtained from CDC's Behavioral Risk Factor Surveillance System (BRFSS), was used to assess both physically and sexually violent acts by a current or most recent partner and for any partner in the past five years. The question was: "Has any partner been physically violent toward you? By violent, I mean did he punch, kick, hit, shove, slap, choke or physically attack you in other ways that could result in an injury. It also means being made to do sexual acts when you don't want to."

For purposes of the intervention, the results of each woman's IPV assessment were coded as either positive or negative for abuse. Women who screened positive for any form of IPV in either a current or past relationship (i.e., within the last 5 years) were referred for intervention. To examine the prevalence and overlap between physical abuse and battering, women who scored positive on the WEB but negative on the BRFSS question regarding physical assault were classified as having been psychologically battered. Women who either scored positive on the BRFSS question alone or scored positive on both assessments were classified as having been physically assaulted.

Referral for Intervention

Project staff trained all nursing staff in participating health care clinics prior to implementation of the IPV assessment. This training included general education on IPV, instruction on how to conduct and score the assessment tool, and instruction regarding how to make referrals for women who are IPV positive. Training employed skill-building, role-playing, and scripting techniques to facilitate the development of skills needed for conducting IPV assessment and ensuring supportive response to disclosure of abuse. These skills were targeted because although health care practitioners often have adequate knowledge about IPV, they often lack the skills to ask about IPV or to respond effectively to a positive finding (64).

Intervention Study Design

The current study employed a quasi-experimental design to evaluate the efficacy of the two interventions. The two different intervention strategies are being evaluated in a (2 X 2) factorial design resulting in four combinations of interventions: a) IPV assessment only with the "usual care" intervention, b) on-site IPV services intervention only, c) empowerment intervention only, and d) both on-site IPV services and empowerment interventions. Intervention assignment was done at the clinic level rather than the individual level. Participating clinics within the Pee Dee Region were allocated into the four treatment conditions based on their relative size and patient volume. Clinics added to the study after this initial random assignment were assigned to interventions on the basis of sample size considerations. Follow-up activities for the study are currently being conducted.

Description of the Interventions

Usual Care

In the "usual care" (or comparison) intervention, IPV assessment was conducted in the same manner that it was for the two study interventions. Women who reported current or recent IPV were given a referral card to the Pee Dee Coalition (PDC), the partner community-based service provider in the region. Specifically, women were given the business card of their health care provider, which listed the PDC hotline number on the reverse side.

On-site IPV Services Intervention

In clinics assigned to the on-site IPV services intervention, all women who were assessed as IPV positive were encouraged by the nurse to meet with an on-site IPV specialist immediately after their appointment. Women screening positive who had only limited time for their visits were encouraged to meet briefly with the IPV specialist to make an appointment for a subsequent visit. The IPV specialist was available during clinic hours to provide danger assessment, safety planning, education, support, and referral/facilitated linkage for women who reported current or recent past domestic violence. To protect confidentiality, abused women did not pass through any public areas (e.g., the waiting room) on the way to the IPV specialist's office. Furthermore, the nurse introduced the patient to the IPV specialist by first name only.

The on-site IPV specialist intervention was designed to be flexible depending on the amount of time that a woman had to spend with the IPV specialist and the results of the abuse/danger assessment. Regardless of the amount of time each woman could dedicate, she was encouraged to continue services at future clinic visits or as needed by appointment or walk-in. The IPV specialists reserved time each day to provide such ongoing services to returning clients; these visits took place during hours that the clinic was not seeing patients for routine care. The IPV specialist established rapport with each woman while assessing the nature of the IPV and affirming her need for support. Specialists then provided education about the dynamics of abuse, formulated a safety plan, and stressed the importance of ongoing support and services in the community through PDC. This extended session lasted up to 90 minutes if the woman was willing and her schedule permitted. Near the end of the session, the specialist attempted to make a direct, facilitated linkage to the ongoing, community-based services of PDC. This linkage effort was tailored to the needs of the individual woman. It consisted of contacting a group facilitator at PDC via telephone in the woman's presence (with permission) and making introductions. Each woman was also encouraged to attend a community support group conducted by the IPV specialists and was also informed of other community-based services provided by the Pee Dee Coalition, including emergency shelter services, Alternative to Violence services for the offender/partner, children's services for children exposed to IPV, and legal assistance. The IPV specialist also offered referrals to other community agencies in accordance with the woman's needs.

Empowerment-Focused Patient Education Intervention

Clinical counselors (i.e., licensed social workers or psychologists on staff at the clinics) conducted the empowerment intervention. Per the conceptual model described earlier in this report, this intervention was designed to improve abused women's health by enhancing their social support, coping mechanisms, perceived control, help-seeking behaviors, and self-care practices. This patient-education intervention was based on a patient-centered decision making model that empowers individuals to make decisions that bring about changes in their personal behavior and social environment. This approach has been used to develop other patient education interventions for chronic disease (65). It was chosen for this research effort because our empowerment intervention aimed to provide women with the skills they would need to make informed decisions about life circumstances that they can control. It was hypothesized that through the receipt of the empowerment intervention, battered women would become their own "daily caregivers" and develop their own "personal prevention plans" (66).

Table 2. The seven sessions of the empowerment-focused patient education intervention

	Topic	Purpose and activities
1	Assessing experience with abuse	• Increase her awareness of the dynamics of abuse relationship. • Reflect on her own experience to better understand how she is being abused. • Identify steps she can take to be safer.
2	Impact of abuse	• Increase her awareness of how women experience and are affected by abuse using the Assess Women's Experiences with Battered Framework: perceived threat, managing, altered identify, yearning, entrapment, and disempowerment. • Reflect on her own experience to better understand how she is affected. • Identify steps she can take to start to reduce the negative impact.
3	Selfcare and wellness	• Increase her awareness of the different aspects of health and wellness (i.e., spiritual, intellectual, emotional, social, and physical) and how they can be negatively affected by abuse. • Reflect on how the abuse she is experiencing may be affecting her health and wellness. • Identify steps she can take to improve her health and well-being.
4	Decision-making	• Increase her awareness of the decisions and choices she makes every day and the impact they have on her and her children. • Reflect on her own decisions and whether they are increasing her strength, security, and independence. • Identify her options and choices for decisions she is making/wants to make and how each might affect her strength, security, and independence.
5	Messages we receive	• Increase her awareness of the messages she is getting from others about what she should do. • Reflect on how these messages influence whether she makes choices that increase or decrease her strength, security, and independence. • Identify people she can listen to who can really help her make her best decisions.
6	Coping	• Increase her awareness of the many different ways that women can cope with the abuse they are experiencing. • Reflect on the ways she has coped in the past and how helpful these methods have been for her. • Identify new ways of coping that may be more helpful to her.
7	Social support	• Increase her awareness of the different types of social support and the role that support can play in her health and ability to make her best decisions. • Reflect on the types of social support she has and has not received. • Identify the types of support she needs and ways of receiving it.

This intervention was designed to be delivered in seven sessions. The goals were to help women assess and evaluate a) their personal experience with abuse; b) the impact of abuse; c) self-care and wellness behaviors and strategies; d) decision-making behavior; e) the messages they receive from others that affect decision-making; f) their coping strategies; and g) their social support. Within each session, women engaged in a) reflection of their personal situation; b) assessment of how the abuse is affecting them; c) assessment of their options; d) identification of choices they could make to improve their safety and self-care; and e) decision making and goal-setting.

Each session included a set of worksheets that the IPV victims and their counselors reviewed and completed together. All clinicians were trained by study staff to facilitate interactive and patient-directed sessions. The content for these interventions was derived from qualitative data obtained from a previous study of battered women.

Evaluation Plan

To evaluate the impact of the interventions on women's health, help-seeking behaviors, and subsequent abuse, all women who were assessed as IPV positive were invited into a cohort study designed to assess help-seeking behaviors, safety planning, self-care practices, and other variables conceptualized as mediators or moderators of the efficacy of the intervention (Figure 1). Because all women who were assessed as being IPV positive (including those in the comparison groups who were given referrals for care) were invited into the cohort study, exposure to comparison interventions will also eventually be assessed.

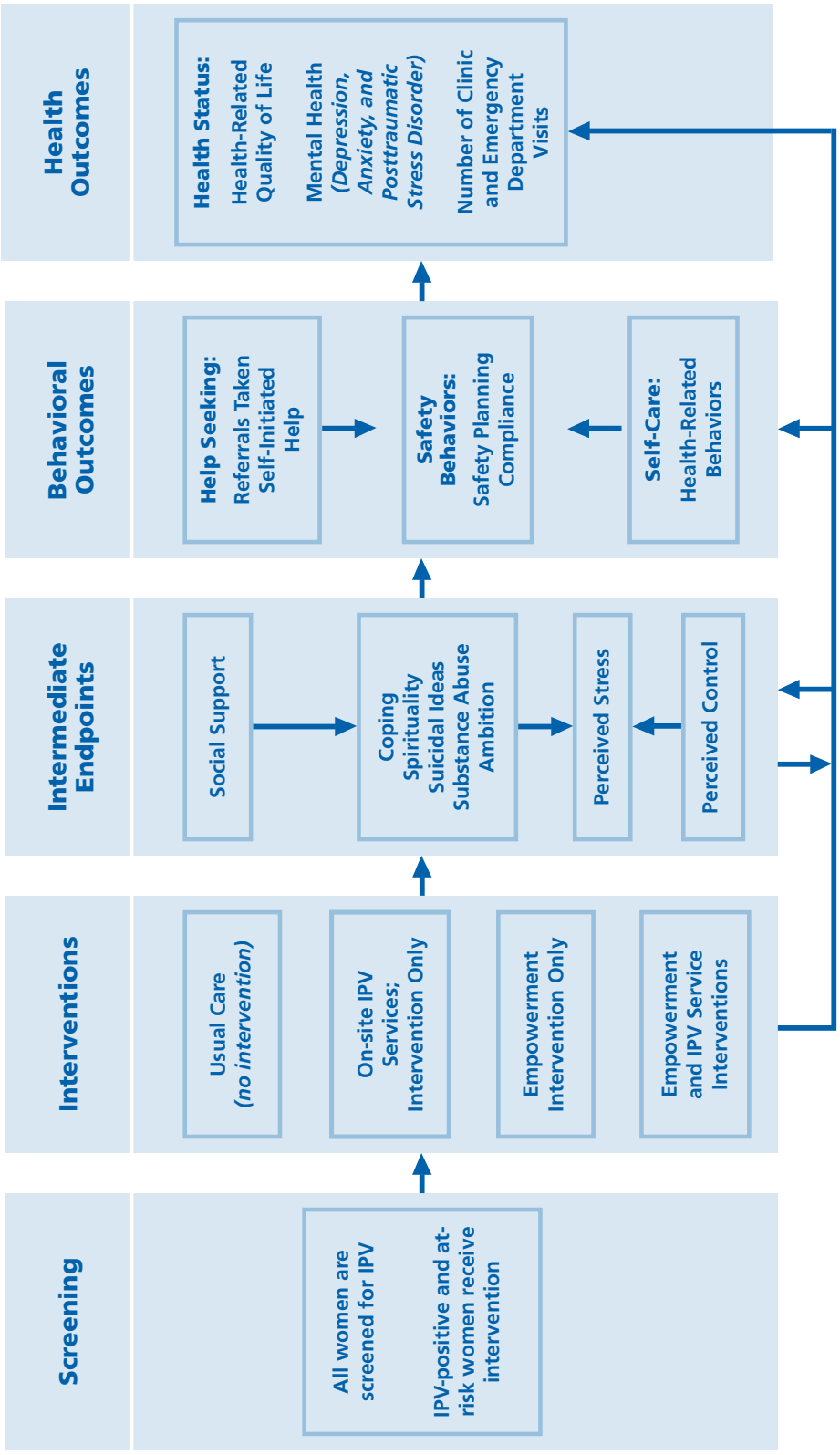
After assessment, all IPV-positive women were asked for permission to be contacted at a later time regarding participation in a follow-up study. Women were told that the follow-up study involved being interviewed, that they would be reimbursed for their time, and that they could decide later not to participate. Women were asked to provide phone numbers and contact information for a safe way to contact them. Within one week of IPV assessment, trained staff from the PDC contacted consenting women to invite them to participate in the follow-up study. This contact was made primarily by phone using one of the "safe" phone numbers provided at the time of the assessment. Informed consent was obtained via telephone from each woman after PDC staff explained the procedures, risks, and benefits to the follow up study. Consenting women were given the option of completing the interview by phone or in-person.

The follow-up cohort study is currently underway. It consists of four interviews every six months for a maximum of 24 months. Participants are compensated for their time in completing the interviews; a $20 money order is issued for the first interview (average time to complete is 45 minutes), and $10 for each additional interview (average time to complete is 20 minutes).

Summary of Planned Analysis

The first set of research questions concerning baseline IPV assessment rates by type and timing will be assessed using de-identified IPV assessment data. Estimates will be made regarding the number of women eligible for assessment, the number of women for whom assessment was attempted, and the proportion of women with positive assessment results. The second research question addresses the effectiveness of the two interventions, separately and in combination, relative to the "usual care" intervention (i.e., assessment and referral card only). The primary outcome will be the physical health of the woman; we also

Figure 1: Conceptual model of intimate partner violence (IPV) assesment and interventions: impact on intermediate, behavioral, and health outcomes



* Intermediate endpoints are assessed as outcomes for the purposes of this intervention

hypothesize several intermediate and behavioral endpoints (Figure 1), including the frequency and type of help seeking, safety planning, and continued violence. Intermediate or mediating factors include social support, coping, and perceived control. Data from the prospective cohort study of IPV-positive women will be used to evaluate the interventions using multivariate time-dependent linear and logistic regression. Because mediating factors are proposed in our conceptual model, we will also use structural equation modeling to test the conceptual model with baseline data and to evaluate the model with time-dependent intermediate, behavioral, and health-outcome data from the IPV cohort. Finally, the cost of the interventions will be estimated to understand the cost relative to improvement in health care outcomes.

Lessons Learned

Implementing IPV screening for women 18 years of age or older in rural primary-care clinics with no history of routine screening for IPV was challenging. Initially, project faculty met with clinic staff to introduce the project and to train nursing personnel to administer the screening. The project manager continued to meet with clinic staff on a regular basis to encourage comprehensive screening and referral according to the clinic's assigned treatment group. As anticipated, project staff encountered the barriers of time pressure and staff resistance to implementation. Making regular contact with clinic staff and encouraging feedback on screening coverage helped to achieve high screening rates (>75%). These efforts inspired clinic staff to out perform other participating clinics. Patient resistance to the screening was not encountered in any clinic. Although eligible patients in the participating clinics had to give written consent for an assessment that was explained as part of a research project, most (>75%) were willing to cooperate. Among women providing reasons for not participating, most reported that they did not have time to complete the screening. In future interventions, screening must be more time efficient and convenient for participants. Because this project was research and required consent this process increased the time required for screening.

Conclusion

This research will add to existing IPV knowledge by assessing the impact of novel interventions for abused women in their own health care clinics. To our knowledge, no studies have used prospective data from IPV-positive women to assess the impact of interventions on intermediate, behavioral, and health outcomes. This research is important, because it helps elucidate the mechanism by which the interventions may impact health outcomes. Finally, this study will add to the growing body of literature evaluating the efficacy of clinic-based IPV interventions.

References

1. Campbell JC. Health consequences of intimate partner violence. Lancet 2002;359:1331–6.

2. Plichta SB. Intimate partner violence and physical health consequences: policy and practice implications. J Interpers Violence 2004;19:1296–323.

3. Wathen CN, MacMillan HL, Canadian Task Force on Preventive Health Care. Prevention of violence against women: recommendation statement from the Canadian Task Force on Preventive Health Care. Can Med Assoc J 2003;169:582–4.

4. Bullock L, McFarlane J, Bateman LH, Miller V. The prevalence and characteristics of battered women in a primary care setting. Nurse Pract 1989;14:47,50,53–46.

5. 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;90:553–9.

6. Freund KM, Bak SM, Blackhall L. Identifying domestic violence in primary care practice. J Gen Intern Med 1996;11:44–6.

7. McFarlane J, Parker B, Soeken K, Bullock L. Assessing for abuse during pregnancy. Severity and frequency of injuries and associated entry into prenatal care [comments]. JAMA 1992;267:3176–8.

8. Rath GD, Jarratt LG, Leonardson G. Rates of domestic violence against adult women by men partners. J Am Board Fam Pract 1989;2:227–33.

9. Campbell J, Lewandowski LA. Mental and physical health effects of intimate partner violence on women and children. Psychiatr Clin North Am 1997;20:353–74.

10. Coker AL, Davis KE, Arias IA, Desai S, Sanderson M, Brandt HM, et al. Physical and mental health effects of intimate partner violence for men and women. Am J Prev Med 2002;23:260–8.

11. Coker AL, Smith PH, Bethea L, King MR, McKeown RE. Physical health consequences of physical and psychological intimate partner violence. Arch Fam Med 2000;9:451–7.

12. Graham-Bermann SA, Levendosky AA. Traumatic stress symptoms in children of battered women. J Interpers Violence 1998;13:111–28.

13. Kramer A, Lorenzon D, Mueller G. Prevalence of intimate partner violence and health implications for women using emergency department and primary care clinics. Women's Health Issues 2004;14:19–29.

14. Lehmann P. Posttraumatic stress disorder (PTSD) and child witnesses to mother-assault: a summary and review. Child Youth Serv Rev 2000;22: 275–306.

15. Sudermann M, Jaffe P. Children and youth who witness violence: new directions in intervention and prevention. In: Wolfe DA, McMahon RJ, editors. Child abuse: new directions in prevention and treatment across the lifespan. Thousand Oaks (CA): Sage Publications; 1997. p. 55–78.

16. Department of Health and Human Services (US). Healthy people 2010. 2nd ed. Washington (DC): Department of Health and Human Services (US); 2000.

17. American Medical Association. Diagnostic and treatment guidelines on domestic violence. Arch Fam Med 1992;1:39–47.

18. Anonymous. Position statement on physical violence against women. Am Nurse 1992;24:8.

19. United Nations. Declaration on the elimination of violence against women. New York (NY): Canada-USA Women's Health Forum; 1993. Available from: URL: www.hc-sc.gc.ca/canusa/papers/canada/english/violence.htm.

20. Anonymous. Violence as a nursing priority: policy implications. AAN Expert Panel on Violence. Nurs Outlook 1993;41(2):83–92.

21. American Academy of Family Practice. Family violence. Am Fam Physician 1994;50:1636–46.

22. Anonymous. Position statement on women and domestic violence among several approved by APA. Hosp Community Psychiatry 1994;45:185–6.

23. ACOG. ACOG issues technical bulletin on domestic violence. Am Fam Physician 1995;52:2387–8, 2391.

24. Emergency Nurses Association. Position statement: domestic violence. Park Ridge (IL): Emergency Nurses Association; 1996.

25. Nelson HD, McInerney Y, Klein J. Screening women and elderly adults for family and intimate partner violence: a review of the evidence for the U.S. Preventive Services Task Force. Ann Intern Med 2004;140:387–96.

26. McFarlane J, Soeken K, Wiist W. An evaluation of interventions to decrease intimate partner violence to pregnant women. Public Health Nurs 2000;17:443-51.

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

28. McFarlane J, Malecha, Gist J. Protection orders and intimate partner violence: an 18-month study of 150 black, Hispanic, and white women. Am J Public Health 2004;94:613–8.

29. McFarlane J, Malecha A, Gist J, Watson K, Batten E, Hall I, et al., Increasing the safety-promoting behaviors of abuse women. Am J Nursing 2004;104:40–50.

30. Brown JB, Lent B, Schmidt G, Sas G. Application of the Women Abuse Screening Tool (WAST) and WAST-Short in the family practice setting. J Fam Pract 2000;49:896–903.

31. Coker AL, Pope BO, Smith PH, Sanderson M, Hussey JR. Assessment of clinical partner violence screening tools. JAMA 2001;56:19–23.

32. Feldhaus KM, Koziol-McLain J, Amsbury HL, Norton IM, Lowenstein SR, Abbott JT. Accuracy of 3 brief screening questions for detecting partner violence in the emergency department [comments]. JAMA 1997;277:1357–61.

33. Pan HS, Ehrensaft MK, Heyman RE, O'Leary KD, Schwartz R. Evaluating domestic partner abuse in a family practice clinic. Fam Med 1997;29:492–5.

34. Sherin KM, Sinacore JM, Li XQ, Zitter RE, Shakil A. HITS: a short domestic violence screening tool for use in a family practice setting. Fam Med 1998;30:508–12.

35. Smith PH, Earp JA, DeVellis R. Development and validation of the Women's Experience with Battering (WEB) scale. Womens Health 1995;1:273–88.

36. Gielen AC, O'Campo PJ, Campbell JC, Scollenberger J, Woods AB, Jones AS, et al. Women's opinions about domestic violence screening and mandatory reporting. Women's opinions about domestic violence screening and mandatory reporting. Am J Prev Med 2000;19:279–85.

37. Sharps P, Koziol-McLain K, Campbell J, McFarlane J, Sachs C. Health care provider's missed opportunities for preventing femicide. Prev Med 2001;33:373–80.

38. Wadman MC, Muelleman RL. Domestic violence homicides: ED use before victimization. Am J Emerg Med 1999;17:689–91.

39. Coker AL, Bethea L, Smith PH, Fadden MK, Brandt HM. Missed opportunities: intimate partner violence in family practice settings. Prev Med 2002;34:445–54.

40. Logan TK, Shannon L, Walker R. Protective orders in rural and urban areas: a multiple perspective study. Violence Against Women 2005;11:876–911.

41. Kershner M, Long D, Anderson JE. Abuse against women in rural Minnesota. Public Health Nurs 2001;15:442–31.

42. Paulozzi LJ, Saltzman LE, Thompson MP, Holmgreen P. Surveillance for homicide among intimate partner—United States 1981–1998. MMWR 2001;50(SS-03):1–16.

43. Straus MA, Gelles RJ. How violent are American families? Estimates from the National Family Violence Resurvey and other studies. Newbury Park (NJ): Sage Publications; 1998.

44. Murthy SA, Peek-Asa C, Zwerling C, Stromquist AM, Burmeister LF, Merchant JA. Physical and emotional partner abuse reported by men and women in a rural community. Am J Public Health 2003;93:1073–5.

45. Coker AL, Watkins KW, Smith PH, Brandt HM. Social support reduces the impact of partner violence on health: application of structural equation models. Prev Med 2003;37:259–67.

46. Kaslow NJ, Thompson MP, Meadows LA, Chance S, Puett R, Hollins L, et al. Factors that mediate and moderate the link between partner abuse and suicidal behavior in African American women. J Consult Clin Psychol 1998;66:533–40.

47. Hathaway JE, Mucci LA, Silverman JG, Brooks DR, Mathews R, Pavlos CA. Health status and health care use of Massachusetts women reporting partner abuse. Am J Prev Med 2000;19:302–7.

48. McNutt LA, Carlson BE, Persaud M, Postmus J. Cumulative abuse experiences, physical health and health behaviors. Ann Epid 2002;12:123–30.

49. Pico-Alfonso MA. Psychological intimate partner violence: the major predictor of posttraumatic stress disorder in abused women. Neurosci Biobehav Rev 2005;29:181–93.

50. Tollestrup K, Sklar D, Frost FJ, Olson L, Weybright J, Sandvig J, et al. Health indicators and intimate partner violence among women who are members of a managed care organization. Prev Med 1999;29:431–40.

51. Coker AL, Smith PH, McKeown RE, Bethea L, Davis K. Social support protects against the negative effects of partner violence on mental health. J Womens Health Gend Based Med 2002;11:465–76.

52. Laffaye C, Kennedy C, Stein MB. Post-traumatic stress disorder and health-related quality of life in female victims of intimate partner violence. Violence Vict 2003;18:227–38.

53. Smith PH, Thornton G, DeVellis R, Earp J, Coker AL. A population-based study of the prevalence and distinctiveness of battering, physical assault, and sexual assault in intimate relationships. Violence Against Women 2002;8:1208–32.

54. Bender M, Cook S, Kaslow N. Social support as a mediator of revictimization of low-income African American women. Violence Vict 2003;18:419–31.

55. Nicolaidis C, Curry M, McFarland B, Gerrity M. Violence, mental health, and physical symptoms in an academic internal medicine practice. J Gen Intern Med 2004;19:819–27.

56. Weinsheimer RL, Schermer CR, Malcoe LH, Balduf LM, Bloomfield LA. Severe intimate partner violence and alcohol use among female trauma patients. J Trauma 2005;58:22–9.

57. Kaslow N, Thompson M, Meadows L, Chance S, Puett R, Hollins L, et al. Risk factors for suicide attempts among African American women. Depression and Anxiety 2000;12:13–20.

58. Kaukinen C. The help-seeking strategies of female violence-crime victims: the direct and conditional effects of race and the victim–offender relationship. J Interpers Violence 2004;19:967–90.

59. Saltzman LE, Fanslow JL, McMahon PM, Shelley GA. Intimate partner violence surveillance uniform definitions and recommended data elements— version 1.0. Atlanta (GA): Centers for Disease Control and Prevention; 1999.

60. Census Bureau (US). State and county quick facts: data derived from population estimates, 2000 Census of Population and Housing. Washington (DC): Census Bureau (US); 2000.

61. Centers for Disease Control and Prevention (CDC). Intimate partner violence among men and women— South Carolina,1998. MMWR 2000;49:691–4.

62. Smith PH, Smith JB, Earp JA. Beyond the measurement trap: a reconstructed conceptualization and measurement of woman battering. Psychol Women Q 1999;23:177–93.

63. Smith PH, Tessaro I, Earp JA. Women's experience with battering: a conceptualization from qualitative research. Womens Health Issues 1995;5:173–82.

64. Smith PH, Danis M, Helmick L. Changing the health care response to battered women: a health education approach. Fam Community Health 1998;20:1–18.

65. Feste C. A practical look at patient empowerment. Diabetes Care 1992;15:922–5.

66. Ruzek SB, Clarke AE, Olesen VL. Women's health: complexities and differences. Columbus (OH): Ohio State University Press; 1997.

The Break the Cycle Evaluation Project

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Introduction

Break the Cycle is a private, nonprofit organization that seeks to end domestic violence by working proactively with youth. Founded in 1996, it includes a preventive education and outreach program, a legal services program, and a peer leadership program. All three programs focus exclusively on youth aged 12–22 years. In 2000, Centers for Disease Control and Prevention (CDC) funded a five-year demonstration project to implement the program and study its impact on Latino youth in Los Angeles, California. The evaluation of the Break the Cycle program for Latino youth described in this paper had the following goals: a) to enhance programmatic cultural competence so Latino youth could be better served; b) to implement a process evaluation and a rigorous experimental outcome evaluation to provide data on program efficacy regarding knowledge, attitudes, help-seeking behaviors, and exposure to and perpetration of dating violence; and c) to provide a model for expansion of this program to other parts of the nation. Lessons learned from this evaluation are expected to inform other prevention efforts and to guide policy on the prevention of dating violence among youth.

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Dating Violence: A Public Health Issue

Violence against women is a substantial health problem for countries around the globe (1,2). The highest rates of many types of violence, including intimate partner violence (IPV) (3,4), occur among young women, with the highest rate of intimate victimization occurring among persons aged 16–24 years (2,4).

Recently, considerable attention has been given to the problem of violence in dating relationships among adolescents and young adults. Over a decade ago, 16%–26% of youth report having dated someone who became physically violent with them (5-7). Frequently, these abusive relationships persist despite this violent behavior, and additional violent encounters commonly occur (7).

More recent national studies on the prevalence of dating violence among teens have produced widely disparate estimates (8). For instance, the National Crime Victimization Survey shows prevalence of dating violence to be relatively low for boys and girls aged 12–15 years, but higher for those 16–19 years of age (4). This survey revealed that during 1993–1998, the average annual percentage of girls and boys aged 12–15 years who were victims of violence by an intimate partner was 0.3% and 0.1%, respectively. However, these percentages became more disparate with increasing age—among adolescents aged 16–19 years, 1.7% and 0.2% of girls and boys, respectively, reported violent physical or sexual victimization by an intimate partner. The Youth Risk Behavior Surveillance System demonstrated different findings. According to this survey, in 2001, 9.8% of girls and 9.1% of boys reported experiencing physical violence over the previous 12 months at the hands of a dating partner (9). Among those who had previously had sexual intercourse, this number increased to almost one in five teenage girls (10).

Although some researchers have reported that young women are more likely than men of the same age to report physical aggression in their relationships (6,11,12), homicide data show girls to be at much higher risk than boys for being victims of the most extreme form of partner violence. Specifically, about 10% of 12- to 15-year-old girls and 22% of 16- to 19-year-old girls murdered during 1993–1999 were killed by an intimate partner, whereas only about 1% of the perpetrators of homicides among males were intimate partners (13). The gender distribution of dating violence victimization and perpetration is complex, with studies showing widely varying estimates of prevalence (8).

Victims of dating violence are not only at increased risk for injury, but also are more likely to engage in substance abuse, have unhealthy weight control, experience poorer health, engage in risky sexual behavior, become pregnant, and engage in suicidal behavior (14,15). Thus, the need for prevention and early intervention programs is clear. Several such programs have been evaluated (8); the largest evaluation has focused on the Safe Dates program (16), which aims to prevent violence by changing dating violence norms, gender stereotyping, conflict management skills, and help-seeking behaviors. This evaluation demonstrated that the Safe

Dates program is associated with substantial primary and secondary effects. Safe Dates treatment group participants who reported no dating violence at baseline showed less initiation of psychological abuses, and those who were experiencing dating violence at baseline showed less psychological abuse and sexual violence perpetration (16). Moreover, a four-year follow-up showed sustained impact of the program, with reduced physical and sexual dating violence victimization and perpetration among program participants compared with controls (17). Despite the demonstrated success of the Safe Dates program, which involved a predominately white population, only a few dating violence prevention programs have been developed specifically for ethnic minorities (African Americans) (18,19), and none have focused on Latino youth.

The Social Learning Theory and Dating Violence

Several theories have been offered to explain relationship violence (e.g., dating violence), the predominant one being *social learning theory* (20,21). This theory focuses on observational learning as the key to acquiring adult interactional skills. In this model, witnessing or experiencing domestic violence as a child teaches children that this is an acceptable and even useful strategy for solving problems, expressing emotions, and interacting with intimate partners. The theory can also encompass the way that children learn from media and cultural factors such as the problematic portrayal of sexist and coercive relationships (22), peer norms about dating violence, and adolescent subculture (23).

Thus, in the social learning theory, youth views of intimate relationships and violence are formed on at least four levels: personal history of violence exposure, family norms, peer norms, and cultural norms. Moreover, recent immigrants have two potential sets of cultural norms: those from their countries of origin and those from the United States. Immigrant teenagers exposed to domestic violence before being involved in a dating violence intervention may believe that violence in intimate relationships is acceptable and normal; in addition, those immersed in family, peer, or cultural groups that explicitly or implicitly accept domestic violence will share those norms, regardless of whether they have been exposed to domestic violence themselves.

Break the Cycle Program

Break the Cycle is a Los Angeles-based national nonprofit organization that seeks to end domestic violence by working proactively with youth. It provides youth (i.e., those aged 12–22 years) with preventive education, peer leadership opportunities, free legal services, advocacy, and support. Break the Cycle was founded in 1996 in response to a critical, unmet need for domestic violence services focused exclusively on youth. Its preventive education programs and early-intervention legal services are designed to meet the unique needs of adolescents. Break the Cycle's goal is to alter learned behaviors associated with domestic violence. This prevention effort will reduce the number of youth victims or perpetrators of abuse by providing them with tools to create healthy futures. To date, staff attorneys in Break the Cycle's Los Angeles office have distributed vital domestic violence information to more than 40,000 youth and have provided free and confidential legal services to more than 2,000 victims of violence as they sought to put an end to their abusive relationships. In response to the growing national need for domestic violence services geared

Table 1. *Ending Violence* curriculum

Hour 1: Domestic Violence 101

Introduction

Overview of program, explanation of attorney-client confidentiality, and explanation of the prevalence and seriousness of dating and domestic violence

Video Presentation

Presentation of a video that introduces Break the Cycle and the issue of dating and domestic violence and its impact on youth

Forced Choice Scenerios

Interactive questions to stimulate disscussion among the students, while debunking myths that are pervasive among teens about dating and domestic violence.

Types of Abuse

Discussion of the different types of abuse (i.e., physical, sexual, verbal, and emotional)

Cycle of Violence

Explanation of the three-stage cycle often seen in abusive relationships

Warning Signs of Abuse

Disscusssion of common warning signs of a potentially abusive relationship.

Obstacles to Getting Help

Exercise to help students think of and understand why someone experiencing abuse might have trouble leaving the violent relationship (countering myths about why victims of abuse remain in relationships.

Hour 2: Domestic Violence Law

Lisa and Robert Story

Story about two teenagers in a dating relationship that becomes abusive

Legal Options: The Criminal & Civil Justice System

Expanation of the two legal systems available to protect victims of violence

The Game:

Crimes and Restraining Orders

A game that teaches about rights and responsibilities under the law surrounding domestic violence

Hour 3: The Legal Process, Safety Planning & Healthy Relationships

Obtaining a Restraining Order

Explanation of the process through which a person uses the civil legal system to obtain a restraining order

Mock Hearing for a Restraining Order

Role-play exercise in which students play the parts of Lisa and Robert (from the previous day's story), witnesses and court personell to explain and demystify the legal process for obtaining a restraining order.

Safety Planning

Group exercise to plan a strategy for ways a victim of abuse could increase his or her safety

Healthy Relationships

Exercise to discuss the characteristics of a healthy relationship

Conclusion/Wrap-up

Review of the program and reminder of Break the Cycle's services

toward youth, Break the Cycle expanded its work to other communities nationwide beginning in 2003.

Education and Outreach Program

Break the Cycle's curriculum, *Ending Violence: A Curriculum for Educating Teens on Domestic Violence and the Law*, teaches youth in middle schools, high schools, colleges, juvenile detention facilities, and community organizations about domestic violence, healthy relationships, and legal rights and responsibilities. *Ending Violence* is a three-day interactive program that uses visual aids, games, and role-playing activities to educate and engage students (Table 1). Instead of focusing on reactionary measures in response to individual incidents of violence, Break the Cycle's *Ending Violence* curriculum helps young people make lasting changes in their lives and their safety. *Ending Violence* teaches youth that domestic violence is not only wrong and hurtful but also illegal, that the choice to use violence carries serious consequences, and that the law can protect teenage victims as well as adults. Students learn that confidential help is available from Break the Cycle if they are experiencing abuse. Through its Education and Outreach Program, Break the Cycle also trains service providers to recognize signs of abuse and encourages young victims to seek help. All of these prevention efforts aim to end the cycle of violence at the community level and encourage young people to develop safe and healthy futures.

Legal Services Program

Just as Break the Cycle's Education and Outreach Program teaches youth about their legal rights, the organization's Legal Services Program encourages them to exercise those rights. Break the Cycle's Legal Services Program provides early intervention services in Spanish and English; services include free legal advice, counsel, and representation to persons aged 12–22 years who are experiencing abuse in their relationships or homes. The legal services are designed to empower clients by informing them of their options, helping them to decide what course of action is best for them, and then guiding and supporting them through that process. The goal is to make the clients' experience of freeing themselves from abuse an empowering one that restores their confidence.

Break the Cycle's staff attorneys assist clients in successfully filing temporary restraining orders and provide full representation to clients at hearings for permanent restraining orders and other domestic violence-related family law court proceedings. Through broader client advocacy services, Break the Cycle also provides post-hearing advocacy tailored to the individual needs of each client (e.g., speaking to a client's family, school, or employer about their responsibilities in enforcing a restraining order and helping a client connect with other agencies to obtain needed support services). Break the Cycle advocates for young clients in their transition from victim to survivor, thereby helping to secure lasting change and safe and healthy futures.

Peer Leadership Program

Begun in 2003, Break the Cycle's Peer Leadership Programs (including the Barter, Student Liaison, and Youth Voices programs) empower young people to become the next generation of leaders in the movement to end domestic violence. The Barter Program gives legal

services clients the opportunity to volunteer with the organization. Through volunteering, they contribute to Break the Cycle's mission and help others escape abuse and create healthy futures. Break the Cycle's Student Liaison Program trains college students to raise awareness about dating and domestic violence on their campuses. Finally, Break the Cycle's Youth Voices Program mobilizes high school students to educate their peers about domestic violence by leading education workshops and speaking publicly about dating violence and Break the Cycle's programs.

Cultural Competency

As a first step in the programmatic implementation of this demonstration project, Break the Cycle and the RAND Corporation (a nonprofit research institute) convened a panel of expert advisors to help promote the cultural competency of the project, specifically its sensitivity and relevance to Latino culture. These advisors included a Department of Children and Family Services social worker; a clinical psychologist and professor specializing in mental health, culture, race and ethnicity; a physician specializing in obstetrics and gynecology; a professor of psychiatry and psychology; and an expert in youth corrections and probation from the California Youth Authority. The advisory panel also included two young Latina women who served as consumer experts; one was a former client of Break the Cycle's Legal Services Program, and the other was a volunteer for Break the Cycle whose teenage cousin was murdered by her abusive boyfriend. All expert advisors had personal and professional experience with the Latino community and were knowledgeable about the issues and challenges facing Latino youth. The advisors reviewed and provided feedback on Break the Cycle's *Ending Violence* curriculum about ways to make it more responsive to the needs and realities of Latino youth. On the basis of their feedback, Break the Cycle made some refinements to the language and approach in its curriculum. For example, the expert panel suggested more clear discussion of sanctions related to dating violence that might affect these urban teens and suggested that changes be made to the main scenario used in the program (e.g., the names of the main characters). Expert advisors also identified the need to strengthen the competence of Break the Cycle staff regarding youth culture in general. Feedback from the advisory panel was incorporated into the training of staff attorneys to make sure that they were cognizant of and sensitive to the issues raised by these experts.

How Break the Cycle Works

The Ending Violence curriculum helps youth reconsider family, peer, and cultural norms in several ways. First, youth are exposed to bilingual curriculum teachers who model an alternative view of domestic violence in which violence is unacceptable, though common, and one for which the teachers have obvious disdain. This exposure helps counteract other role models (e.g., familial, peer, and cultural) that implicitly endorse violence through acceptance. Second, participants are taught that the American legal system has codified specific acts that youth may view as normal as being illegal and punishable with fines, imprisonment, and other sanctions. Such education helps youth realize that violent behavior is not legal or formally accepted in American culture, despite it having been treated as legal in their countries of origin and despite popular American culture that condones domestic violence in many ways. Teaching participants about the

legal system definitions and sanctions provides them with more balanced views of cultural norms. Third, youth are taught about their own rights and responsibilities regarding violence exposure and perpetration. This knowledge also is imparted to participants to counteract the implicit acceptance and endorsement of violence that may be present in their culture and families. Fourth, by acting out a court procedure and coaching youth about ways to seek help, participants are given a new model for assertive help-seeking behavior that is expected to counteract the more common model of passivity. Finally, the group discussion about violence that occurs during the curriculum helps youth express their feelings about violence to one another, serving to counteract the implicit acceptance of violence among youth.

Design of the Evaluation

This evaluation aimed to evaluate Break the Cycle's *Ending Violence* curriculum for Latino youth in Los Angeles high schools. The curriculum was evaluated via an experimental design using random assignment of tracks within schools (i.e., groups of students following different year-round school calendars) to one of two groups: the intervention group and a wait-list control group. Both groups were followed for six months.

Break the Cycle's *Ending Violence* curriculum attempts primary prevention of domestic violence by changing knowledge about legal rights and responsibilities, attitudes, and behavioral intentions to lower the likelihood that young men and women will experience future violence in their homes or intimate relationships. In addition, *Ending Violence* encourages help-seeking behaviors among those already experiencing domestic violence through knowledge about community resources, referrals into its own legal services program, and increasing propensity to seek help. To evaluate the program's impact, we sought to measure these outcomes. We planned a controlled experimental design to enable comparison between outcomes observed among students who participated in the curriculum and those with similar demographics who did not. Because school administrators wanted to involve as many students as possible in *Ending Violence*, a wait-list control group was used in which students in the comparison group were offered the curriculum at the end of the school year, after the evaluation had concluded.

For the evaluation, high schools within the Los Angeles Unified School District whose student population consisted of 80% or more Hispanic students were identified. From the 15 schools that met this requirement, 11 were recruited on the basis of willingness to participate. The program was implemented and evaluation data were collected over three academic calendar years; the impact of the program was assessed on three cohorts of students. Six schools participated in the first cohort of the study, five participated in the second cohort, and six participated in the third cohort (including five schools that had participated in the first cohort and one that had participated in the second cohort).

The ethnic distribution of students in the 11 participating schools ranged from 81%–99% Hispanic, with no more than 9% of the population represented by any other ethnic group. All but one school operated on a year-round academic calendar, in which students are assigned to one of three school calendars (referred to as "tracks"); student population for these schools ranged from 2,900–4,900. The remaining school

operated on a traditional calendar and had approximately 2,800 students.

Originally, the design plan for the evaluation was to randomize schools as being either immediate recipients of the *Ending Violence* curriculum or serving as wait-list comparison schools. This plan called for pairing similar schools and then randomizing within each pair. However, in the process of gathering information to pair the schools for randomization (based on size of school, percentage of students with limited proficiency in English, stability, transience, attendance, suspensions/expulsions, and school achievement information), we discovered that tracks within these large schools were based on zip code, Advanced Placement status, and sports participation; this grouping resulted in a dramatic difference in the population characteristics of each track. Therefore, we revised our plan to allow randomization of tracks in year-round schools. This plan increased our power to detect changes while still controlling for clustering within tracks and schools. For schools that participated in the project twice, their intervention status for their second participation was assigned to the opposite of the one randomized during their first randomization to achieve balance across conditions.

After the initial phase of recruitment, three tracks withdrew from the study because of logistical problems; to preserve randomization within the study, the corresponding track within the randomization block also were excluded, leaving 40 tracks in 10 schools (55 classes in each condition) to participate in the outcome evaluation. Letters of introduction and parental permission forms in both English and Spanish were given to all students to take home to their parents. Because the violence prevention program met the school district's curriculum requirements for health instruction, the intervention component of this study did not require active parental consent (i.e., parents were notified of the program in the materials that were sent home with students and could call to request that their child not participate in the program). However, active parental consent was required for participation in the research study component (i.e., the surveys). In addition, student assent for participation in the study was also required. Parents returned consent forms for 78% of students, and among these, 93% of parents consented to the study. Among those present for survey administration, 98% of youth assented to complete each survey; however, absenteeism rates were high (nearly 10% each for the pre- and post-test surveys). The overall participation rate (after accounting for active and passive refusals, absenteeism, drop-out, and unusable data) was 67% of students enrolled in the class.

Program Challenges and Lessons Learned

From a program perspective, one valuable lesson learned was associated with cultural competency. When the project was undertaken, cultural competency was defined as involving sensitivity to and ability to identify with Latino youth, especially their Latino culture. Early study findings supported the idea that acculturation was related to attitudes and knowledge about dating violence (24), emphasizing the need for cultural sensitivity to engage students less skilled in English, including recent U.S. immigrants. However, as the project was implemented in broader communities of youth throughout Los Angeles County, it became apparent that the prevailing culture affecting the targeted program

population was *youth* culture; youth-based cultural competency was what was needed to ensure program success.

From its inception, Break the Cycle has involved youth in the design of its programs to ensure that services are responsive to the needs of the population served. In the earliest years of the organization, youth focus groups played an integral role in informing the design of programs and refining the content to reflect what worked with "real-world" youth. In addition, young Break the Cycle volunteers routinely review the curriculum to ensure its relevance to the quickly changing demographic that the program serves. Despite these efforts, however, only through this demonstration project was the profound importance of youth cultural competency identified and incorporated as an essential component of all program efforts. Fortunately, although advisory panel members were recruited specifically because of their competency of the Latino culture, much of the feedback received from them was equally tied to issues of youth cultural competency. For example, advisory panel members provided feedback that youth generally are reluctant to talk to their friends about difficult issues, and therefore, the program should place greater emphasis on participants' responsibility as friends to speak up when they are concerned about a friend's relationship. Information gathered in focus groups within the project also demonstrated that youth are even more reluctant to talk with authority figures, tending to rely more on informal sources of support (e.g., family and friends) (25). This type of information led to the creation of the Peer Leadership Program component of the *Ending Violence* curriculum. Additionally, feedback indicated that greater emphasis should be placed on communicating the deadly potential of domestic violence because many youth, regardless of ethnicity, do not recognize that the abusive behavior that they experience and accept as normal is not only unhealthy, but can escalate into serious, even deadly, danger. These examples illustrate that study feedback was more tied to youth culture in general than specifically to Latino culture.

The students' feedback received by our staff attorneys also proved to be similar regardless of a student's ethnicity or race. Thus, the need to maintain competence for youth-related issues as well as Latinos has become a top priority for the organization.

Evaluation Challenges and Lessons Learned

Various challenges were encountered when evaluating the *Ending Violence* curriculum. Many were posed by the logistics of working with large urban schools that face their own challenges on a daily basis. Others were associated with the sensitivity of the data collected, the need to maintain privacy, and the adherence to mandatory reporting laws on child abuse (26).

The first challenge encountered concerned privacy. To ensure privacy, we developed an alternate survey that contained nonsensitive questions about hobbies and activities. Those who chose not to participate in the research were provided the alternate survey, whereas participants were given an evaluation survey.

No students were aware of the type of survey being completed by their peers. Unfortunately, this effort to protect privacy added an extra layer of complexity to the classroom survey administration process and occasionally resulted in errors such as giving the wrong survey to a

Table 2: Number of Classrooms Participating in the Project

Cohort Participation		Intervention					Wait-List				
School	Year Included	Track					Track				
		A	B	C	Trad	**Total**	A	B	C	Trad	**Total**
School 1	1		3	2		**5**	2				**2**
School 2	1,3	2	2	**		**4**	3	3	*		**6**
School 3	1,3	3	3	3		**9**	1	2	2		**5**
School 4	1,3	3	3	3		**9**	3	2	2		**7**
School 5	1,3	2	2	*		**4**	3	3	**		**6**
School 6	1,3	2	2	2		**6**	3	3	3		**9**
School 7	2,3				4	**4**				4	**4**
School 8	2			4		**4**	3	3			**6**
School 9	2	3		4		**7**		3			**3**
School 10	2	**	**			**0**			*		**0**
School 11	2		3			**3**	3		4		**7**
TOTAL		**15**	**18**	**18**	**4**	**55**	**21**	**19**	**11**	**4**	**55**

* denotes randomization and subsequent withdrawal from study
** denotes removal of this track to balance design subsequent to with drawals

student. Over time, these errors were corrected through elaborate safeguards in the classroom such as adding an additional staff member to the survey administration team and color-coding the surveys (the two surveys appeared in three colors, so participation was still masked) to catch errors more easily. In retrospect, concerns about privacy and research participation might not have been important enough to warrant the possibility of data collection errors and the expensive procedures and safeguards that were ultimately included. Students are not used to that level of privacy in their normal school activities, and a simpler approach might have been acceptable to all parties.

Another challenge was associated with mandates requiring that any detected child abuse be reported to authorities. In California, the state in which the study took place, child abuse

is defined broadly and would include dating violence victimization. To protect the privacy of students and increase the validity of data, the survey section about personal dating violence experience was made anonymous; further, this information was removed from the section of the survey containing identifiers before it was handed in. Thus, students and parents could be guaranteed that their responses about dating violence victimization would be kept anonymous. Unfortunately, ensuring anonymity reduced the ability of the researchers evaluating the program to detect program-related changes; individual surveys could no longer be linked over time for this part of the survey, and outcomes could only be examined at the classroom level.

Multiple logistical challenges were encountered throughout the project, particularly the major challenge of retrieving consent forms because the active refusal rate was low. Coupled with absenteeism and drop-out, participation rates, especially at follow-up, suffered. Challenges also included teachers who withdrew from the project, last-minute schedule changes, fire alarms, student protests, and space constraints. These issues were compounded by communication problems with busy administrators and with teachers who had no access to telephones during the work day. Flexibility and adaptability were therefore key elements in the project. We built in make-up days for survey administration when possible, learned to inquire about certain persistent scheduling and space problems, and built in buffers to allow for last-minute rescheduling. In addition, the staggering of data collection over three years allowed us to attempt to balance the study design over time. For instance, in the first cohort, two tracks (both of which were Track C) withdrew from the study unexpectedly. Therefore, in the second and third cohorts, we sampled more classrooms from Track C to achieve balance.

We also encountered differing enrollment rates between the immediate intervention classrooms and the wait-list classrooms. Classrooms were assigned as being either participating or wait-list prior to the consent process, and teachers were not blinded to the condition. As a result, the enrollment rates between participating and wait-list classrooms differed by about 10%, likely because of varying levels of teacher motivation to retrieve the consent forms. Various ways to boost enrollment were considered, including providing classroom-level incentives and having research staff introduce the study and hand out the consent packets. These activities successfully increased enrollment rates for participating classes, but the enrollment gap between the two types of classrooms persisted. Keeping teachers blind to condition until after enrollment may have been helpful, but the tight school calendar and schedule made this logistically unfeasible.

Finally, we were concerned that students might not take the classroom-administered survey seriously and would provide false answers. To ensure candid and sincere student responses, survey administrators put a sticker on the surveys of students they suspected of "fooling around" based on their classroom behavior; the sticker enabled administrators to closely scrutinize flagged surveys. The data also was examined. Each student was given a "data flag" in the following circumstances: a) if students' answers were all in the extreme and socially undesirable end of the scales, b) if students responded in a way that seemed they did not notice a reverse-scored item, or c) if students indicated that their English reading or writing were poor. Flags for

each student were then counted, and surveys with more than one flag were further examined. Only about five students were given more than two flags, and in a few cases, the answers were implausible, even on demographic items; we therefore discarded the surveys obtained from these students as "bad data."

Findings

Our findings of the impact of the program are provided in detail elsewhere (27). In summary, the curriculum had a short- and long-term impact on student knowledge about attorneys, proclivity to seek help from them, and perceived helpfulness of these professionals. Several other short-term effects were observed, particularly regarding attitudes about female-on-male violence (i.e., violence in which the female is the perpetrator) and many other aspects of help-seeking behavior. No changes in attitudes were detected concerning male-on-female violence (i.e., violence in which the male is the perpetrator) or on dating violence exposure or perpetration. This was not unexpected, given that the intervention was a three-session educational intervention. Nonetheless, it points out the need for additional services and programs.

Much was learned from this evaluation in addition to elucidating the effectiveness of the *Ending Violence* curriculum. Regarding assessment tools for attitudes about violence, we found that the students in our study generally disagreed strongly with survey items about violence *before* the prevention program was implemented, making it difficult to detect changes. We hypothesize, however, that some teenagers have attitudes that if changed, might help to prevent dating violence, but that the tools we used were not precise enough to measure them. In addition, we detected differential item functioning by sex, indicating that males and females were interpreting survey questions differently. Such measurement issues must be resolved to enable the nuances in teen attitudes toward violence to be more thoroughly understood. We have undertaken some additional studies that employ qualitative or quantitative techniques to determine when youth are more or less accepting of violence (25). This information may lead to better assessment tools in the future.

Finally, the experimental design of this study allowed us to observe changes in attitudes and knowledge over time in the control group of students who took surveys but did not attend the curriculum. For instance, both the intervention and wait-list participants reported declines in their perceptions of others as being helpful if the participant were to become involved in a violent relationship at posttest compared with pretest, though the intervention group reported significantly less of a decline; the experience of taking the survey, waiting a few days, and taking it again appeared to result in a decrease in perceptions of others' helpfulness. Thus, although the experimental design was challenging to implement, it resulted in the collection of valuable information that would not otherwise have been detected.

Conclusions

The need for dating violence programs geared toward youth is evident. The development of school-based health promotion programs necessitates thinking carefully about how to implement programs addressing violence prevention. The community, ethnic group, family, and peers have an effect on an individual's

acceptance and perpetration of violence (28), and thus school programs cannot stand alone. To ensure a successful program, the effects of each of these influences on individual behavior must be carefully considered.

Break the Cycle, an expanding program with a legal focus, shows promise. One common impediment to successful school-based programs is the failure to create a program that is acceptable to youth (29). Youth culture has specific language, beliefs, and standards of behavior that should be incorporated into any program intending to promote healthy behaviors (e.g., nonviolence). The *Ending Violence* curriculum appropriately involved youth in matters that interested them and gave them information about the consequences of being violent. Students who received the *Ending Violence* curriculum had a better realization of how violent behavior could get them into legal trouble, improved attitudes about seeking help, and a perception of the legal system as being a more viable option for obtaining help. The adolescents who received the *Ending Violence* curriculum hopefully will make better decisions about the avoidance of violence in the years to come.

The *Ending Violence* curriculum serves as a key prevention tool for high-school students and compliments Break the Cycle's other programs for youth who are experiencing violence. Similar programs that are introduced into the normal school curriculum likely can play a key role in increasing awareness of dating violence among Latino youth. Augmenting the curriculum through additional school- or community-wide activities might expand the program's reach and impact on public health. In addition, to overcome some difficulties associated with implementing school-based programs, innovative methods of program delivery (CD-ROM, video tapes) should be investigated.

References

1. Krug EG, Dahlberg LL, Mercy JA, Zwi AB, Lozano R, editors. World report on violence and health. Geneva, Switzerland: World Health Organization; 2002.

2. Tjaden P, Thoennes N. Extent, nature, and consequences of intimate partner violence: findings from the National Violence Against Women Survey. Washington (DC): Department of Justice (US), Office of Justice Programs, National Institute of Justice; 2000. NCJ Publication No.: 181867.

3. Rennison CM. Intimate partner violence 1993–2001. Washington (DC): National Institute of Justice; 2003.

4. Rennison CM, Welchans S. Intimate partner violence. Washington (DC): Bureau of Justice Statistics, Department of Justice (US); 2000.

5. Aizenman M, Kelley G. The incidence of violence and acquaintance rape in dating relationships among college men and women. Journal of College Student Development 1988;29:305–11.

6. Arias I, Samios M, O'Leary KD. Prevalence and correlates of physical aggression during courtship. J Interpers Violence 1987;2:82–90.

7. Bergman L. Dating violence among high school students. Soc Work 1992;37:21–7.

8. Hickman LJ, Jaycox LH, Aronoff J. Dating violence among adolescents: prevalence, gender distribution, and prevention program effectiveness. Trauma Violence Abuse 2004;5:123–42.

9. Grunbaum JA, Kann L, Kinchen SA, Williams B, Ross JG, Lowry R, et al. Youth risk behavior surveillance—United States, 2001. In: CDC Surveillance Summaries. MMWR 2002;51(No. SS-4):1–21.

10. Silverman JG, Raj A, Clements K. Dating violence and associated sexual risk and pregnancy among adolescent girls in the United States. Pediatrics 2004;114:220–25.

11. Clark ML, Beckett J, Wells M, Dungee Anderson D. Courtship violence among African American college students. J Black Psychol 1994;20:264–81.

12. Foshee VA. Gender differences in adolescent dating abuse prevalence, types and injuries. Health Educ Res 1996;11:275–86.

13. Federal Bureau of Investigation. Supplementary homicide reports (1993–1997). Washington (DC): Department of Justice (US); 2002.

14. Silverman JG, Raj A, Mucci LA, Hathaway JE. Dating violence against adolescent girls and associated substance use, unhealthy weight control, sexual risk behavior, pregnancy, and suicidality. JAMA 2001;286:572–9.

15. Waigandt A, Wallace DL, Phelps L, Miller DA. The impact of sexual assault on physical health status. J Trauma Stress 1990;3:93–102.

16. Foshee VA, Bauman KE, Arriaga XB, Helms RW, Koch GG, Linder GF. An evaluation of Safe Dates, an adolescent dating violence prevention program. Am J Public Health 1998;88:45–50.

17. Foshee VA, Bauman KE, Ennett ST, Linder GF, Benefield T, Suchindran C. Assessing the long-term effects of the Safe Dates Program and a booster in preventing and reducing adolescent dating violence victimization and perpetration. Am J Public Health 2004;94:619–24.

18. Hammond WR, Yung BR. Preventing violence in at-risk African-American youth. J Health Care Poor Underserved 1991;2:359–73.

19. Weisz AN, Black BM. Evaluating a sexual assault and dating violence prevention program for urban youths. Soc Work Res 2001;25:89–102.

20. Bandura A. Aggression: a social learning analysis. Englewood Cliffs (NJ): Prentice-Hall; 1973.

21. Bandura A. Social learning theory. Englewood Cliffs (NJ): Prentice-Hall; 1977.

22. Wekerle C, Wolfe DA. Dating violence in mid-adolescence: theory, significance, and emerging prevention initiatives. Clin Psychol Rev 1999;19:435–56.

23. Garbarino J, Schellenback CJ, Sebes J. Troubled youth, troubled families. New York (NY): Adine de Gruyter; 1986.

24. Ulloa EC, Jaycox LH, Marshall GN, Collins RL. Acculturation, gender stereotypes, and attitudes about dating violence among Latino youth. Violence Vict 2004;19:273–87.

25. Ocampo BW, Shelley G, Jaycox LH. Latino teens talk about help-seeking and help-giving in relation to dating violence. Violence Against Women 2007;13(2):1-18.

26. Jaycox LH, McCaffrey DF, Ocampo BW, Shelley GA, Blake SM, Peterson DJ, Richmond LS, Kub JE. Challenges in the evaluation and implementation of school-based prevention and intervention programs on sensitive topics. AmJ Eval 2006; 27(3):320-36.

27. Jaycox LH, McCaffrey D, Eiseman E, Aronoff J, Shelley GA, Collins RL, Marshall GN. (2006). In press Impact of a school-based dating violence prevention program among Latino teens: a randomized controlled effectiveness trial. J Adolesc Health 2006; 39(5):694-704.

28. Smith P, Flay BR, Bell CC, Weissberg RP. The protective influence of parents and peers in violence avoidance among African-American youth. Matern Child Health J 2001;5:245–52.

29. Flay BR, Collins LM. Historical review of school-based randomized trials for evaluating problem behavior prevention programs. Ann Am Acad Pol Soc Sci 2005;599:115–46.

An Arts-based Initiative for the Prevention of Dating Violence Among African-American Adolescents: Theoretical Foundation, Program Components, and Lessons Learned

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Introduction

Violence has received increasing attention as a significant public health issue in our nation's communities. Of particular concern is the degree to which violence affects the lives of adolescents. Persons 12–24 years of age experienced violent victimizations at rates about twice that of other age groups (1). Those aged 18–21 were the most likely to experience a serious violent crime, especially African Americans in that age group (2). Dating violence, a form of intimate partner violence (IPV) is a serious problem among young people, especially young women ages 16–24 (3,4) and African Americans (5). In addition to experiencing violence in their communities and schools, adolescents may witness adult IPV in their homes or experience abuse by a parent, guardian, or the intimate partner of their parent or guardian. Dating violence victimization and perpetration is a recognized link between observed violence in the family and subsequent violence in adult intimate relationships (6). Research documents a number of factors that may increase the risk of dating violence victimization or perpetration: exposure to family violence including "marital violence" and maltreatment, parental use of discipline, expulsion or suspension from school, multiple dating partners, knowing others involved in dating violence, alcohol use, jealousy, access to weapons, prior injury from violence, and geographic location (7-13).

The prevalence of lifetime, past year, and current physical dating violence has varied significantly in recent investigations, with 9%–46% of adolescent males and females claiming to be a victim or perpetrator of physical dating violence (14). In some instances, adolescents admit to both victimization and perpetration (6,7,15). In African-American samples (12,16,17), 10%–25% of females reported experiencing violence in their relationships. One recent national survey of high-school students found that 1 in 11 said they had been purposely hit, slapped, or physically hurt by their boyfriend or girlfriend in the past year; 1 in 11 students reported being forced to have nonconsensual sexual intercourse (18). Though sometimes it is assumed that victim and perpetrator roles are gender-specific, a range of studies have demonstrated that both boys and girls are perpetrators and victims within adolescent dating (9). The wide variations in prevalence rates can be attributed to inconsistencies related to definitions of dating violence, measures of dating violence, age variations, differences in time frames assessed, and lack of longitudinal data (14).

Poor health outcomes associated with dating violence have been consistently reported and include conditions such as anxiety, depression, eating disorders, symptomotology, suicidal ideation (19), drug and alcohol use (20), and posttraumatic stress disorder (PTSD). Other studies show that youth who have experienced dating violence are at an increased risk for teenage pregnancy (16,21) and sexually transmitted infections (STI's). Considering the percentage of youth across the literature who report having experienced or perpetrated dating violence—the very serious health outcomes shown to be associated with this type of violence—dating violence among adolescents, especially within ethnic minority and economically disenfranchised populations, must be addressed as an important public health issue.

This article describes the development and implementation of a multifaceted, innovative

arts-based dating violence-prevention project ("Respect Me") for urban middle school youth. "Respect Me," an arts-based intervention with a theoretical basis in violence prevention strategies, is described below.

Prior Research: Dating Violence Prevention Strategies

Limited research exists on effective strategies to prevent violence, specifically dating violence, which includes forced sexual victimization and perpetration (6). In particular, only a few dating violence studies have focused on young or ethnic minority and impoverished adolescents (5,10,22,); most studies have focused on either college or high school European-American students.

Many adolescents (89%) begin intimate relationships by 16 years of age (24). For this reason, primary prevention efforts with younger adolescents would likely be most successful (7,24). The middle school years (6th–8th grade) may be the optimal time for primary violence prevention strategies because most youth violence emerges in the second decade of life (25). Therefore, violence research should focus on younger adolescents who may be at risk for becoming victims or perpetrators of violence. Hickman et. al. (2004) (9) report that partner violence prevention programs and services more often target adult victims and perpetrators than adolescents and teens. But programs developed for these populations tend to lack solid evaluation components.

Dusenbury and colleagues (1997) (26) identified nine critical elements of promising youth violence prevention programs which may also be applicable for dating violence prevention programs:

1. A comprehensive approach which includes families, peers, media, and community;
2. Early intervention, i.e., beginning programs in primary schools;
3. Developmentally tailored interventions;
4. Promotion of personal and social competencies;
5. Interactive techniques such as role playing, cooperative learning, and personal and social skills;
6. Ethnic and culturally sensitive materials;
7. Staff training to ensure proper implementation;
8. Activities that promote a positive school climate; and,
9. Activities that establish norms against violence, aggression, and bullying.

The same article stated that use of visual arts (theater, music, drawing, and dance) could be a valuable strategy for incorporating the above elements into school-based dating violence prevention programs for middle school youth.

School Based Interventions

Programs for prevention of dating violence are usually based in schools (27). Criticism of school-based violence prevention programs include:

- haphazard, one-time approaches that do not involve teachers, families, administrators, peers, the media, and community members;
- use of materials not developmentally or culturally appropriate; and
- use of instruments with uncertain validity and reliability (28,29).

Most dating violence prevention studies use White study samples and few studies try alternatives to classroom-based violence prevention such as an arts-based approach (27).

Two dating violence prevention programs demonstrate behavior change: the SafeDates Program (30) and the Youth Relationships Project (31). Foshee and colleagues (2000) developed the Safe Dates Program, an adolescent dating violence program (N=1603) among a predominately rural European-American (77%) sample. A key component of this intervention, a theater production, includes a student performance designed to change peer norms associated with dating violence by decreasing gender stereotyping, improving conflict management skills, and changing beliefs about help-seeking behaviors for victims and perpetrators of violence. At the study's one-year follow-up, intervention schools reported 25% less psychological abuse perpetration, 60% less sexual abuse perpetration, and 60% less physical abuse perpetration against current dating partners than comparison schools reported (30). Significant differences in dating violence norms, gender stereotyping, and awareness of services were also reported (30). At the four-year follow-up, researchers observed lower rates of physical violence, serious physical violence, and sexual violence among 8th-graders exposed to Safe Dates as compared to controls (32).

Wolfe and colleagues (31) created the Youth Relationships Project, which focuses on teenage children whose family history included violence (parents were involved in the child protective service system). Over a four-month period, eighteen two-hour sessions were conducted with the 14- to 16-year-olds. The intervention comprised classroom- and community-based activities including action planning, visitation of community agencies, fund-raising, and community awareness. An assessment demonstrated that girls and boys in the intervention group were 3.2 and 1.9 times less likely than girls and boys in the control group to have perpetrated physical partner violence.

Theoretical Basis of the Arts-Based Initiative to Prevent Dating Violence Among Urban African-American Adolescents

The literature suggests that dating violence is a complex multidimensional concept. Prevention may require interventions that address individual attitudes and behaviors and institutional/community values and norms. The arts-based initiative described here focuses on affecting attitudes and behaviors supporting violence while drawing upon the strengths of urban African-American communities. The theoretical bases of the intervention combine social learning theory with a culturally specific community organization and system change framework.

Social Learning Theory

In social learning theory, behavior is learned through others, within families or peer groups, or through modeling and vicarious processes (33). Peer groups, often formed in the school setting, are instrumental in young adolescents' behavioral development. According to youth violence literature, peer networks and friendships of aggressive children often comprise other aggressive children, and involvement with aggressive peers seems to increase the likelihood that an aggressive child will gravitate toward delinquent activity (34-36).

Social norms that support accepted and expected behaviors can either encourage or discourage violent behavior. Because learning from peers is an important piece in an adolescent's development, an intervention targeting attitudes and behaviors of groups of adolescents is an appropriate way to set positive social norms. The influence of peers, personal experiences, and familial modeling and reinforcing processes are particularly important for young adolescents. Peer groups are an influential source of social norms for adolescents; consequently, this intervention incorporates group activities and experiences that identify and address issues associated with adolescent relationships, experiences, and dating violence (37). The intervention also uses several different modalities for optimal learning and behavior change as identified in the National Academies' report, How People Learn (38).

Recent research also points to the importance of right-brain, creative, and affective learning in changing attitudes and in processing emotion-laden experiences such as violence (38). The arts basis of this intervention provides these essential right-brain learning activities.

Community Organization, System-Change Approach

Collaborative approaches to program development and implementation show promise in addressing various urban issues of public health (39) and in preventing repeat violence against women (28). The community organization approach is based on the principles of participation and ownership. Participation requires that the community (i.e., students, parents, faculty, health-clinic staff, and administrators) be involved in defining dating violence, in instituting steps to resolve the problem (theatre group, visual arts component, web construction, and support groups), and in establishing policies and procedures that influence school-wide culture around youth violence and sustain desired change. The impetus for involving the school staff (teachers and administrators) was, in part, to make them active participants in the project, thus creating a sense of investment and responsibility for lobbying for school policies and protocols that address violence-related issues. Ownership is defined as a sense of participant-based responsibility that sustains program change once it is achieved (40-42). Our intervention study provided this sense of ownership to the students by validating the importance of their thoughts and opinions about dating violence and by encouraging student ownership of intervention program components (for example, by asking them to set some goals and priorities for the activities). In keeping with the community organization framework, one approach shown to address and prevent violence more effectively than personnel training alone is system change (43). A system approach aims to change more than individual attitudes; it strives to change the entire climate of a school toward violence prevention.

Finally, and perhaps most importantly, the arts-based intervention builds on the cultural norms of this particular community. In addition to the arts being an area of great cultural relevance to African-American youth, the African-American culture has a long history of promoting youth expression through speech, multiple arts, and other media (44). This expressiveness often includes music, singing, dancing, and story telling. Gospel music as a popular culture medium with an African-American heritage has been recommended as an ideal method to address domestic violence prevention and intervention issues (45). Such music has been suggested as a useful tool to educate about risk factors, causes, and consequences of domestic violence and as a way to educate and inform potential victims of available intervention services (46). The gospel music genre presents characters, both positive and negative role models, and social situations that are immediately recognizable to African Americans (47). As such, the music can use behavioral modeling to influence audience members (46) and to stimulate peer communication about domestic violence in the African-American community (47).

Interventions aimed at promoting healthy relationships among African-American youth should consider the relationship context and cultural environment. The use of popular nonviolent Hip-Hop music (derived in part from Gospel), Afrocentric dance and drumming, and group discussions will provide opportunities for African-American youth to enhance their artistic expressiveness and creativity. Additionally, adolescents develop and form relationships by "trying on" different roles and by experimenting with various behaviors, and a comprehensive theater project can provide an environment for such growth (48). Drama is shown to be an effective component of adolescent dating violence prevention efforts (49). Therefore, an arts-based initiative is a culturally and developmentally relevant strategy to develop healthy male-female interpersonal relationships and thereby reduce dating violence. This approach shows promise in ameliorating the effects of violence (50,51).

Description of the Arts-Based Dating Violence Initiative, "Respect Me"

The Johns Hopkins University School of Nursing, in collaberation with the Historic East Baltimore Community Action Coalition (HEBCAC), NuWorld Art Ensemble Violence Prevention Theatre Project, George Washington University School of Public Health, and the House of Ruth(Battered Women's Shelter) developed and implemented a culturally competent dating violence prevention initiative in Baltimore, Maryland, called "Respect Me Dating Violence Prevention Project." The initiative promoted healthy relationships and prevented dating violence (physical, emotional, and sexual) among predominately African-American 7th-grade students in four of the city's middle schools.

Based on the National Academies' report How People Learn (38), the intervention uses several different modalities identified as optimal learning and behavioral-change approaches. The intervention has four key components:

1. Arts-based student activities (theater production and visual arts),
2. Dating violence-prevention curriculum,

3. Student support/discussion groups, and

4. Teacher/staff training focused on dating violence-prevention strategies.

The components are conceptualized as different ways to present information, allow processing, and promote positive social norms regarding dating violence among the students. Most 7th-graders participated in the program either by direct participation or by observing the final product (play, website, or mural) produced through the visual arts component. All students received the dating violence-prevention curriculum component.

Focus groups were held during the start-up phase of implementation to identify how youth and their teachers perceive dating violence and relationship issues (52). By gathering qualitative data, we gained a better understanding of the baseline quantitative attitudes and behaviors of the students, teachers, and staff at the beginning of each year (53). Consequently, the attitudes and behaviors seen by the end of the intervention could be better explained.

Each school developed its own recruitment methods for the intervention components. In some schools, the teachers and administrators recruited students who had the most to gain from the intervention; in other schools, the first students to volunteer formed the groups. Students participated in the activities during or after school. All components addressed the same central theme—dating violence prevention—but did so through various arts-based activities such as theater productions, visual arts projects, and Web design classes using computer art and graphics. The discussion groups were semi-structured sessions augmented by curriculum that addressed issues associated with dating violence. The Visual Arts and Web Design groups met once a week for 6 weeks, whereas the discussion groups and theater project were conducted over an eight- to ten-week period. Seventh-grade students received the dating violence prevention classroom-based curriculum over the course of four class periods. Teachers and staff participated in the training components during staff development periods. Again, because the program was based on a system-change approach, we presupposed many students would benefit from the program components indirectly, as social norms among students involved in the different components began to change. As is characteristic of a system-change model, not all students receive all components of the intervention; as such, the "dosage" of intervention differs among students. Subsequent evaluation will investigate whether the dosage was associated with significant differences in outcomes.

Theater Component

The theater component of the initiative was directed by WombWork Productions, Inc. (www.wombwork.com), a comprehensive and community-based performing arts production company founded in 1997 to preserve, restore, and empower families and communities by using a creative therapeutic approach to the arts. WombWork Productions incorporated indigenous, healing practices of music, dance, and theatrical expression in a culturally relevant process which addressed critical issues affecting youth such as dating violence. This comprehensive theater intervention was based on WombWork Productions' collaboration with the Historical East Baltimore Community Action Coalition (HEBCAC), which had produced a

series of domestic violence awareness productions for six consecutive summers.

The theater intervention was a unique, multifaceted program designed to reach African-American urban middle-school youth. Participants received professional performance training and factual information about dating violence. They wrote much of the narrative, creating an insightful, emotional production based on facts about dating violence coupled with their own life experiences. They told their stories to the group; in turn, the group, guided by the artistic directors of WombWork Productions. This creation and collaborative process afforded participants the opportunity to discover their talents and experience the world of performing arts, while exploring and role-playing creative ways to confront challenges such as dating and violence. Thus they processed their own experiences with victimization and witnessing violence, tried on victim roles to develop empathy, and practiced nonviolent conflict resolution while developing acting, singing, dancing, drumming, and other dramatic production skills. In addition, the program involved older members of a local theater group, the NuWorld Art Ensemble, to serve as role models and mentor the project participants in violence prevention strategies and the performing arts. The theater component culminated in an end-of-year production attended by the entire 7th-grade class. Through music and drama, all 7th-graders saw, heard, and experienced the violence prevention messages from their peers—not from their teachers.

Visual Arts Component

The visual arts component of the project was designed and conducted by the first author (MY) using the Visual Voices™ Inc. (www.visualvoices.org) process to cultivate social bridges and unify youth through art. The process incorporated facts and skills obtained from the House of Ruth's adolescent dating violence prevention curriculum. Students could engage in developmentally appropriate activities (painting, writing, drawing, and group discussion) within a creative, educational, and engaging setting (54). Three principle components involved painting, drawing and creative writing. During the six interactive group sessions, participants were encouraged to reflect on the dynamics of their relationships, both peer and romantic. Emphasis was placed upon strengthening individual communication, group dynamics, self-expression, and conflict-resolution skills through group exercises and discussions.

From the start, youth participating in this component become project co-leaders by helping to establish participant-ownership; by assisting and facilitating the creative activities sessions, group discussions, materials preparation; and by constructing and presenting the final exhibit to their peers, teachers, and school administers. The final, permanent exhibit—a collage of the participants' paintings, writings, and photographs —served as a "visual voice" from which everyone could learn and grow. It depicted the young participants' creative, reflective, and educational efforts, providing yet another venue for increasing the collective consciousness and understanding of dating violence.

Web Design Component

A website construction class was offered to interested students to further disseminate the anti-violence message. Creative design elements

included clip art, photographs, and links to dating violence prevention resources on the Web. Participants used their creative and artistic energies to identify dating violence-prevention messages that were meaningful to others of their age and background and to post for viewing by their peers. They also learned how to create a student-friendly website which became the default website on computers throughout the school. Flyers, newsletter blurbs, and other promotional materials encouraged students in the intervention schools to visit the website.

Discussion/Support Groups Component

Middle school students who had experienced, witnessed, or expressed an interest in learning more about interpersonal violence formed this component of the intervention. Participants were self-referrals or referred by faculty and staff. Separate groups of eight to 16 male and female students each are co-facilitated by a coed team comprised of an experienced domestic violence counselor and a graduate social work intern. The same students could participate in other components of the intervention if they so desired.

Group members discussed topics such as communication; gender socialization; sexual harassment and flirting; power, control, and equality in relationships; and sexual assault and supportive behaviors to use during a crisis. Designed to culminate in a social action project, group members used theater and visual arts to create a series of skits and posters based upon concepts learned through group interaction for presentation to the other 7th-graders. To date, the groups have showcased topics that define different types of abuse, identify resources to contact if you or a friend need help, discuss legal issues, and give examples of safety planning.

Dating Violence Curriculum Component

The dating violence curriculum was presented to all 7th-grade students. It consisted of four sessions beginning and ending with the arts-based theater production and post-performance discussion to reinforce messages and lessons learned. The other two sessions (classroom presentations implemented in consecutive weeks) focused on attitudes, power and control, and elements of a healthy versus unhealthy relationship using role-play and discussion.

Teacher/Staff Training Component

Training was offered during regularly scheduled in-service days to faculty, staff, and nurses in the intervention schools. The training program increased awareness of dating violence issues and identified specific actions that teachers and staff could implement to recognize student behaviors that may be precursors to dating violence and sexual harassment and thereby intervene early. In addition, the curriculum was designed to increase sensitivity to youth experiences, encourage open dialogue among school personnel around these issues, disseminate information and make students aware of resources, and create policies to address dating violence.

Evaluation Design: Outcome and Process Evaluations

The evaluation used a comparative group pre-post quasi- experimental design with baseline and outcome evaluations (quantitative and qualitative data). Using a delayed wait-list intervention study design, two intervention schools were compared with two control schools in similar neighborhoods. Comparison data included a student survey, observation of the schools' climate (observational instrument), behavioral observation instrument data, and a teacher/school personnel survey. Data were collected pre- and post-intervention each year of the study

Process evaluations were conducted throughout the project, assessing data from focus groups, tracking school-based policies and procedures regarding violence, conducting an observational assessment of the school's climate regarding dating violence, studying field notes from the in-school intervention personnel, and reviewing minutes from periodic meetings with school administration and faculty.

Successes and Challenges

Implementing this arts-based project in four urban Baltimore middle schools has been rewarding and challenging. Administrators and teachers in the participating schools usually welcomed the research team and sought to improve the overall school climate and decrease violent behavior among their students. They were also anxious to learn how to respond to incidents of dating violence or sexual assault.

Initially, the evaluation design had two intervention and two comparison schools; by the final year, all schools had been converted to intervention schools. While the specific evaluation data is forthcoming, the middle schoolers anecdotally enjoyed participating in the arts-based intervention activities. At the intervention schools, parents were invited to see their child participate in the end-of-year theater production, which was a highlight both for students who participated in the theater component throughout the year and for their teachers, parents, and project staff.

Along with the rewards of implementing this intervention in the schools, there were also challenges in its implementation. Although the teachers were generally enthusiastic and supportive, they also were overloaded and disheartened due to a teacher shortage and system-wide budget crisis. The budget crisis left teachers concerned about job cuts, and the resulting tension lowered teacher morale and impinged on some teachers' ability to focus on additional responsibilities associated with the intervention (i.e., encouraging collection of parental/guardian consent forms for evaluation surveys). Throughout implementation of the intervention, the multiple challenges of budgetary crises, frequent testing, requirements of No Child Left Behind legislation, schools' failure to meet even minimal educational standards, and schools being designated as "persistently violent" because of frequent disciplinary crises frustrated the teachers and staff, making them less enthusiastic about participation in the program.

A significant challenge was getting students to return parental consent forms allowing them to participate in the pre- and post-surveys and program activities. The teachers suggested that we reward students for returning the consent forms. Despite the use of incentives and best efforts of

the project team and teachers, the response rate was low (less than 50%) during the first year. Part of the issue was that comparison schools were not as motivated to participate in the survey because they had not yet had the opportunity to be part of the intervention. The low participation rate for the student surveys in these schools was an issue throughout the evaluation.

Lessons learned from implementing this project centered on being more sensitive to conditions and events occurring in our schools. For example, budgetary cuts reduced the number of teachers and increasing class sizes allowed little time for projects beyond the required assignments. School administrators, on the other hand, expressed appreciation for the opportunity to participate in the "Respect Me" project; but, they also stated that teachers are overwhelmed with teaching, professional development activities, and other required work. Consequently, these administrators concur that teachers have little time to participate in outside community programs—no matter how worthy the project. Researchers must be prepared to shoulder the burden of work generated by the intervention and its evaluation activities. Even if school personnel want to assist with the implementation, in reality, they may not have the capacity. Careful and thoughtful design and recruitment of a qualified, capable, and enthusiastic research team is essential. We ensured that the research team was ethnically diverse, which proved advantageous in our schools. The team also used high school, undergraduate, and graduate students in nursing and public health to great advantage when implementing and evaluating the program. Being closer in age to the students than was the primary team, they brought youth (age much closer to the students than the primary team), enthusiasm, and creativity to the project. On the other hand, they also brought the challenge of scheduling conflicts and competing priorities.

Finally, one important lesson learned by this project is to acknowledge and address youth culture, especially that of African-American youth. Youth culture should be an essential component of all public health prevention programs designed to serve this particular population. In this project, African-American youth culture was considered in the context of the wider community (i.e., the school staff and school climate). School-based violence prevention interventions for youth should address youth culture, ethnic culture, and school culture in the planning and implementation phases.

Discussion and Conclusion

The literature review and theoretical perspectives demonstrated the need to develop innovative early-intervention programs in urban minority communities. Dating violence prevention programs have typically been oriented toward majority culture high school or college students and most often focus on activities for the victims only. This arts-based initiative is unique in several ways: a) it focuses on both individual and institutional change to affect dating violence, and b) it considers both boys and girls as potential perpetrators and victims of dating violence. In addition, the initiative is theoretically based, involves a collaboration of academic institutions and community agencies, and targets an underserved urban African-American adolescent population through multiple interactive, right-brain focused culturally and developmentally relevant activities.

The arts-based initiative strives to be an effective dating violence prevention effort by embracing and integrating nine critical elements (described earlier) for promising violence prevention strategies (26); further, the initiative addresses social norms, system change, cultural relevance, and community collaboration. The intervention expanded from a summer play with a limited audience to a multifaceted arts-based dating violence prevention program conducted at four middle schools in Baltimore. Each middle school group staged a beginning and end-of-the-school-year theater performance for the community. Additionally, the development, implementation, and evaluation of a culturally competent anti-violence curriculum improve the school-wide climate toward dating violence. Curriculum for staff, faculty, school nurses, and administrators was integrated into in-service education programs, and the student curriculum was incorporated into classroom activities, thus enhancing sustainability. The discussion group for middle school students who had experienced, witnessed, or wanted to learn more about dating violence was offered weekly through a partnership with the local domestic violence shelter and in collaboration with school counseling services. Experiential learning has been characterized as an ideal educational approach to use with students by providing opportunities to attain skills, feelings, and knowledge through participation rather than didactic, formal educational processes (38,55,56). Through its theater arts, visual arts, technology, and creative group discussion components, this project cultivates an experience-based learning environment in which young people can reflect upon, learn about, and develop skills associated with exposure to relevant life experiences, including experiences with romantic relationships, friendships, and violence. The complexities inherent in addressing dating violence and related issues within the urban school setting are substantial. Schools with serious financial constraints, which also serve economically disadvantaged students, are often the same schools that might benefit most from such intervention activities. Considering the associations that have been documented in the literature between dating violence and physical and mental health outcomes, it is most important that all adolescents be reached in some way, with this multimedia arts-based intervention model serving as one additional possible approach.

References

1. Department of Justice (US), Bureau of Justice Statistics. Criminal victimization 2002. Washington (DC): Department of Justice (US); 2003 Aug. NCJ No.: 199994.

2. Perkins CA. Age patterns of victims of serious violent crime. Washington (DC): Department of Justice; 1997.

3. Rennison CM, Welchans S. Intimate partner violence. Washington (DC): Department of Justice; 2000.

4. Rennison CM. Intimate partner violence 1993–2001. Washington (DC): Department of Justice; 2001.

5. Watson JM, Cascardi M, Avery-Leaf S, O'Leary KD. High school students' response to dating aggression. Violence Vict 2001;16(3):339–48.

6. Coker AL, McKeown RE, Sanderson M, Davis KE, Valois RF, Huebner S. Severe dating violence and quality of life among South Carolina high school students. Am J Prev Med 2000;19(4):220–7.

7. Avery-Leaf S, Cascardi M, O'Leary KD, Cano A. Efficacy of a dating violence prevention program on attitudes justifying aggression. J Adolesc Health 1997;21:11–7.

8. Dahlberg LL. Youth violence in the United States. Major trends, risk factors, and prevention approaches. Am J Prev Med 1998;14:259–72.

9. Hickman LJ, Jaycox L, Aronoff J. Dating violence among adolescents prevalence, gender distribution, and prevention program effectiveness. Trauma, Violence, & Abuse 2004;5(2):123–42.

10. Malik S, Sorenson SB, Aneshensel CS. Community dating violence among adolescents: perpetration and victimization. J Adolesc Health 1997;21(5):291–302.

11. McCloskey LA, Lichter EL. The contribution of marital violence to adolescent aggression across different relationships. J Interpers Violence 2003;18(4):390–412.

12. O'Keefe MK, Brockopp K, Chew E. Teen dating violence. Soc Work 1986 Nov–Dec:463–8.

13. Reuterman NA, Burcky WD. Dating violence in high school: a profile of the victims. Psychology 1989;26:1 –9.

14. Glass NE, Campbell JC, Kub J, Sharps PW, Fredland N, Yonas M. Adolescent dating violence: prevalence, risk factors, health outcomes and implications for clinical practice. J Obstet Gynecol Neonatal Nurs 2003;32(10):2–12.

15. Foshee V, Linder GF, Bauman KE, Langwick SA, Arriaga XB. The Safe Dates Project: theoretical basis, evaluation design, and selected baseline findings. Am Prev Med 1996;12:39–47.

16. Wingood GM, DiClemente RJ, McCree DH, Harrington K, Davies SL Dating violence and the sexual health of black adolescent females. Pediatrics 2001;107(5):E72.

17. Valois R, Oeltmann J, Waller J, Hussey J. Relationship between number of sexual intercourse partners and selected health risk behaviors among public high school adolescents. J Adolesc Health 1999;25(5):328–35.

18. Centers for Disease Control and Prevention (CDC). Youth risk behavior surveillance—United States, 1999. In: CDC Surveillance Summaries 2000 Jun 9. MMWR 2000;49(No. SS-5):8.

19. Singer MI, Anglin TM, Song LY, Lunghofer L. Adolescents' exposure to violence and associated symptoms of psychological trauma. JAMA 1995;273:477–82.

20. Plichta SB. Violence and abuse: implications for women's health. In: Falik MM, Collins KS, editors. Women's Health: The Commonwealth Survey. Baltimore, Maryland. Johns Hopkins University Press; 1996. p. 237–72.

21. Silverman JG, Raj A, Mucci LA, Hathaway JE. Dating violence against adolescent girls and associated substance use, unhealthy weight control, sexual risk behavior, pregnancy, and suicidality. JAMA 2001;86:572–9.

22. Harrykissoon SD, Rickert VI, Wiemann CM.Prevalence and patterns of intimate partner violence among adolescent mothers during the postpartum period. Archives of Pediatric and Adolescent Medicine 2002;56(4):325–30.

24. Wekerle C, and Wolfe DA. Dating violence in mid-adolescence: theory, significance, and emerging prevention initiative. Clin Psychol Rev 1999;19:435–56.

25. Patterson GR, Forgatch MS, Yoerger KL, Stoolmiller M. Variables that initiate and maintain an early-onset trajectory for juvenile offending. Developmental and Psychopathology 1998;10:531–47.

26. Dusenbury L, Falco M, Lake A, Brannigan R, Bosworth K. Nine critical elements of promising violence prevention programs. J Sch Health 1997;67(10):409–14.

27. Whitaker DJ, Morrison S, Lindquist CA, Hawkins SR, O'Neil JA, Nesius AM, et al. A critical review of interventions for the primary prevention of perpetration of partner violence. Aggression and Violent Behavior 2006;11:151-66.

28. Chalk R, King P. Violence in families: assessing prevention and treatment programs. In: Chalk R, King PA, editors. Health care interventions. Washington (DC): National Academy Press; 1998. p. 223–4.

29. Jaffe PG, Suderman M, Reitzel D, Kilip SM. An evaluation of a secondary school primary prevention program on violence in intimate relationships. Violence Vict1992;7(2):129–46.

30. Foshee VA, Bauman KE, Ximena, BA., Helms RW, Koch GG, Linder GF. The Safe Dates Project. The Prevention Researcher 2000;7(1):5–7.

31. Wolfe DA, Wekerle C, Scott K, Straatman A, Grasley C, Reitzel-Jaffe D. Dating violence prevention with at-risk youth: a controlled outcome evaluation. J Consult Clin Psychol 2003;71:279–91.

32. Foshee VA, Bauman KE, Ennett ST, Linder GF, Benefield T, Suchindran C. Assessing the long-term effects of the Safe Dates Program and a booster in preventing and reducing adolescent dating violence victimization and perpetration. Am J Public Health 2004;94(4):619–24.

33. Bandura A. Aggression: a social learning analysis. Englewood Cliffs (NJ): Prentice Hall; 1973.

34. Dishion T, Andrews D, Crosby L. Antisocial boys and their friends in early adolescence: relationship characteristics, quality, and interactional process. Child Dev 1995;66:139–51.

35. Jessor R, Donovan JE, Costa FM. Beyond adolescence: problem behavior and young adult development. New York (NY): Cambridge University Press; 1991.

36. Patterson GR, Capaldi DM, Bank L. An early starter model for predicting delinquency. In: Pepler DJ, Rubin K, editors. The development and treatment of childhood aggression. Hillsdale (NJ): Lawrence Earlbaum; 1991. p. 139–68.

37. Ho MK. Minority children and adolescents in therapy. London, England: Sage Publications; 1992.

38. Bransford J, Brown A, Cocking R, editors. How people learn: brain, mind, experience, and school. Washington (DC): National Research Council, National Academies of Science; 2002.

39. Wallack L, Wallerstein N. Health education and prevention: designing community initiatives. Int Q Community Health Educ 1986;7(4):87.

40. Green LW. The theory of participation: a qualitative analysis of its expression in national and international health politics. Advances in Health Education and Promotion,1986;1: 211–36.

41. Gondolf EW, Yllo K, Campbell JC. Collaboration between researchers and advocates. In: Kantor GK, Jasinski JL, editors. Out of the darkness: contemporary perspectives on family violence. Thousand Oaks (CA): Sage Publications; 1997. p. 255–67.

42. Campbell JC, Dienemann J, Kub J, Wurmser T, Loy E. Collaboration as a partnership. Violence Against Women 1999;5:1140–57.

43. Campbell, JC, Coben JB, McLoughlin E, Dearwater S, Nah G, Glass NE, Lee D, Durborow N. An evaluation of a system change training model to improve emergency department response to battered women. Acad Emerg Med 2001;8(2):131-38.

44. Schubiner H, Scott R, Tzelepis A. Exposure to violence among inner-city youth. Society for Adolescent Medicine 1993;5:214–9.

45. Oliver W. Preventing domestic violence in the African American community: the rationale for popular culture interventions. Violence Against Women 2000;6(5):533–49.

46. Maibach E, Holtgrave DR. Advances in public health communication. Annu Rev Public Health 1995;16:219–38.

47. Shefner-Rogers C, Rogers F. Evolution of the entertainment-education strategy. Paper presented at the Second Annual International Conference on Entertainment-Education and Social Change; Athens (OH); 1997.

48. Zaslow MJ, Takanishi R. Priorities for research on adolescent development. Am Psychol 1993;48:185–92.

49. Foshee VA, Bauman KE, Arriaga XB, Hems RW, Koch GG, Linder GF. An evaluation of Safe Dates, an adolescent dating violence prevention program. Am J Public Health 1998;88(1):45–50.

50. Bosworth K, Espelage D, DuBay T, Dahlberg L, Daytner G. Using multimedia to teach conflict resolution skills to young adolescents. Am JPrev Med 1996;Suppl 12(5):229–55.

51. Gibbs JT. Black American adolescents. In: Gibbs JT, Huang LN, editors. Children of color: psychological interventions with minority youth.: San Francisco (CA): Jossey-Bass; 1989.

52. Fredland N, Ricardo I, Campbell JC, Sharps P, Kub J, Yonas M. The meaning of dating violence in the lives of middle school adolescents: a report of focus group data. Journal of School Violence. In press.

53. Kub J, Fredland N, Soeken K, Smith D, Lary H, Roberts J, Walton-Moss B, Sharps P, Campbell JC. Risk Factors for violence in girl/boyfriend relationships in early adolescence. Violence Against Women. Forthcoming.

54. Araya T. Teen dating violence prevention initiative curriculum [adapted from Wolfe DA, Wekerle C, Gough R, Reitzel-Jaffe D, Grasley C, Pittman AL, et al. The youth relationships manual: a group approach with adolescents for the prevention of woman abuse and the promotion of healthy relationships. Thousand Oaks (CA): Sage; 1996]. Baltimore (MD): House of Ruth; 1997.

55. Brookfield DD. Adult learning, adult education and the community. Milton Keynes Open University Press. In "David A. Kolb on Experiential Learning" accessed online at http://www.infed.org/biblio/b-explrn.htm. 1983.

56. Houle C. Continuing learning in the professions. San Francisco (CA): Jossey-Bass; 1980.

Dating Violence Prevention Among American Indian and Hispanic Youth: Arizona's Promoting Healthy Relationships Project

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Overview

In April 2000, Centers for Disease Control and Prevention's National Center for Injury Prevention and Control (CDC's Injury Center) announced the availability of funds to support the development, implementation, and evaluation of culturally competent early intervention and prevention programs designed to promote healthy relationships and prevent sexual violence and intimate partner violence among school-aged youth. This announcement prompted the University of Arizona Cooperative Extension and the John and Doris Norton School of Family and Consumer Sciences to create a project to address Arizona's need for the development of an effective, culturally respectful approach for reducing the risks of dating violence and promoting healthy relationships among American Indian and Hispanic youth and those with mixed ethnicities. The Promoting Healthy Relationships Project was built on a foundation of existing partnerships between Arizona Cooperative Extension, the Norton School, two American Indian tribes, and other schools and community-based organizations. The project's primary goal

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was to develop, implement, and evaluate a dating violence prevention curriculum delivered in the context of a comprehensive, positive youth development program. This paper describes the rationale for this approach; the need for the project; the participating communities; and methods for the development, modification, implementation, and evaluation of program activities.

Need and Rationale

Although prevalence rates for dating violence among youth vary greatly by study (1), representative surveys indicate that about one in five female high school students is victimized through dating violence (2). A range of negative outcomes are associated with dating violence, including eating disorders (3,4), low self-esteem, emotional problems (3), and suicidal ideation (2,5). In addition, dating relationships between adolescents that involve psychological abuse have been shown to lead to more severe forms of perpetration of partner violence during adulthood (6,7). Partner violence is a substantial social and public health problem, with societal costs recently estimated at $5.8 billion per year (8).

Although only minimal data are available regarding violent behavior among specific racial and ethnic communities, results from the 2003 Youth Risk Behavior Survey show that youth who belong to ethnic or racial minority groups are more likely to report having experienced physical dating violence within the previous 12 months than are white youth (9). For example, about 7% of white participants reported being hit or slapped by a boyfriend or girlfriend compared with 15% of American Indian or Alaska Native youth, 14% of Black or African-American youth, 9% of Hispanic or Latino youth, and 17% of Native Hawaiian or other Pacific Islander youth. Despite this apparent disparity, few dating violence prevention programs have been developed or evaluated specifically for minority youth (10).

The broad goal of the Promoting Healthy Relationships Project was to implement a culturally competent dating violence prevention program in the context of a positive youth development program in four underserved communities in Arizona. Historically, dating violence prevention programs have consisted of universally offered curricula that are delivered in middle or high schools (10). However, because studies have shown that dating violence co-occurs with other behaviors (e.g., substance use [11,12], bullying [13], and street violence [14]), dating violence prevention materials created to change teens' knowledge, attitudes, and specific behavioral skills concerning dating violence and healthy relationships should be delivered in the context of activities that provide teens with more general skills and motivation to behave in pro-social ways; positive youth development programs offer the ideal setting for this (15). The goals of youth development programs are to provide youth with a sense of safety and structure, self-worth and contribution, independence and control over their lives, closeness and relationships with peers and adults, and competence (16). Positive youth development programs have been employed successfully to prevent many high-risk behaviors in which adolescents engage, including drug use, risky sexual behavior, and physical violence (15).

Project Setting

Arizona has a substantial population of Hispanics and American Indians; therefore, the

four sites that participated in the Promoting Healthy Relationships Project were selected on the basis of community need and ability to implement the project. Two of the selected sites were communities on American Indian reservations, and two sites were located within areas populated primarily by Hispanics. Few statistics have been documented for these communities; much of the information presented in this section was derived through conversations with key community stakeholders (e.g., police officers, health personnel, and school personnel).

Community A is an isolated, rural community of 5,200 located on an American Indian reservation. The entire reservation encompasses 1.7 million acres and has a population of approximately 13,000. More than three fourths of the youth in Community A qualify for the national school lunch program and are classified as being low income, and more than half of the population is dependent on some form of public assistance. Youth in this community have a substantial need for intervention because 15% of the elementary school population receives support services for either child abuse or neglect. In addition, of the 3,800 cases of domestic violence brought before the local tribal courts during a 1-year period, 1,500 cases involved youth. Alcohol and drug abuse are key factors involved in violent behavior within Community A; 50% of all child abuse cases are associated with substance use.

Community B is another isolated, rural community with a population of about 3,700. It is located within an American Indian reservation that comprises about 3,000 square miles of diverse lands and 10,000 to 12,000 residents. Resources are scarce; 60% of the households have income levels below the poverty line, no public transportation is available, and most families do not have telephones. The reservation has an unemployment rate of 25%, which is above the statewide average rate for Arizona (4%). The health department receives at least two calls per week about domestic violence incidents, which is notable given the size and nature of this community and because domestic violence is frequently underreported.

Community C is an agricultural community of 10,300 residents who are primarily Hispanic. The community has high levels of poverty, and a substantial percentage of its population is employed only seasonally. The community is experiencing a period of economic distress. The unemployment rate in Community C is 13%, which is higher than both state and national averages. In a 15-month period, the police department received 555 domestic violence calls. In roughly 12% of the cases, children were found at the scene of the offense when the police arrived.

Community D is located within a small city of about 60,000 people. The Promoting Healthy Relationships Project target community involves a specific neighborhood that is primarily Hispanic. Because of various cultural and economic factors, the neighborhood has been primarily inhabited by migrant workers and their families. The neighborhood includes about 5,000 residents, many of whom have low incomes; 66% of the neighborhood population has an annual household income less than $25,000. The neighborhood experiences a high incidence of crime, although it only encompasses a small percentage of the community's entire population.

Project Structure

The collaboration that served as the foundation for the Promoting Healthy Relationships Project was critical in bringing research findings to community program development and implementation. The project combined the resources and expertise of two divisions of the College of Agriculture and Life Sciences at the University of Arizona: the John and Doris Norton School of Family and Consumer Sciences and Cooperative Extension. The Norton School is home to both the Division of Family Studies and Human Development and the Division of Retailing and Consumer Sciences. Cooperative Extension is the outreach arm of the University of Arizona and serves as a statewide network of knowledgeable faculty and staff that provides lifelong educational programs based on research and community need for all Arizonans. Masters-level Cooperative Extension agents who serve as University faculty work off campus within each county. Extension agents provide the community linkages necessary for community-based implementation, and are thus the lynchpins that connect campus-based faculty to communities by facilitating the flow and exchange of information. Extension agents are skilled in community outreach, making research useful to the citizens, networking and collaboration, and planning and presenting education and prevention programs. They maintain a board of local citizens to ensure that they remain responsive to county needs. As a result, programs can be developed using the research base of the University to help solve local problems as community members define them.

For the Promoting Healthy Relationships Project, campus-based faculty members working in the Division of Family Studies and Human Development were responsible for the overall project and grants management, training, human subjects protection approvals, evaluation, and technical assistance. They also provided the broad program framework, along with empirically supported starting points for community programs. Extension agents were charged with hiring and supervising the instructional specialists and program assistants who implemented the program, maintaining relations with local stakeholders, and obtaining the appropriate support (e.g., Tribal Council resolutions, school board approvals, and neighborhood association support). Extension agents also managed their portion of the budgets for in-state travel, materials and supplies, and other operational costs.

Actual implementation was carried out by instructional specialists and their program assistants. To increase the likelihood that the program was culturally relevant, instructional specialists were purposefully screened, interviewed, and hired directly from each participating community to ensure a thorough knowledge of the community and its culture. Instructional specialists participated heavily in the curriculum development and modification; they were responsible for recruiting participants, implementing the dating violence prevention curriculum within the framework of a youth development program, collecting evaluation data and keeping records, and working with the county Extension agents to keep good working relationships within the communities. Instructional specialists also were charged with integrating culturally appropriate examples, language, references, and youth development activities throughout the project. As the primary source of local information about the project and the population, they also informed

Extension agents and campus-based faculty of community and cultural issues that influenced the implementation and success of the program.

Campus-based faculty, Extension agents, and instructional specialists formed a team for the development and implementation of the project. The team communicated frequently through e-mail, conference calls, and face-to-face visits to ensure that the relationships, training, and learning experiences between campus- and county-based project staff were bidirectional. For example, although the initial group and one-on-one community-level training focused on staff responsibilities for the project (e.g., recruiting, implementation, and evaluation), subsequent training and communication also involved instructional specialists who educated county Extension agents and campus-based faculty on issues of local importance.

Program Development

With the goal of implementing a dating violence prevention program in the context of a positive youth development program, campus-based faculty worked with Extension agents and instructional specialists to develop the local implementation of each program. The Safe Dates curriculum (17) was used in all communities as the starting point for the development of a culturally sensitive dating violence prevention curriculum. Safe Dates was originally designed to target both primary and secondary prevention of dating violence (18). The nine-lesson curriculum, which was explicitly developed from theoretical and empirical bases (17), includes lectures, role plays, group discussions, and other hands-on activities. The Safe Dates program covers the following topics: defining caring relationships, defining dating abuse, determining why people abuse, helping friends who have experienced dating violence, defining images of relationships, exploring communication skills, understanding feelings, managing anger, and understanding sexual assault.

The Safe Dates curriculum was originally implemented and evaluated in rural North Carolina and used in a predominantly white population (18-20). Because Safe Dates was not originally developed for American Indian and Hispanic populations, a key consideration in this project was ensuring that the curriculum and evaluation components used in the Safe Dates curriculum were culturally relevant. After piloting the curriculum as initially written in each community, it became clear that modifications were needed. Therefore, a major component of this project was modifying the curriculum for each participating community to ensure cultural relevance. This modification process will be described more fully later in this paper.

The dating violence prevention curriculum was offered in the context of a positive youth development program, because youth development strategies that are incorporated into effective prevention programs have been demonstrated to be successful in preventing negative health outcomes (21). A thorough review of the youth development literature revealed that youth development programs provide participants with many opportunities for positive emotional and physical growth by encouraging academic success, citizenship and contribution, close relationships with caring adults, communication skills, community connection, creativity, decision-making/reasoning skills, emotional health and well-being, facing challenges/taking initiative, family relationships, leadership, peer

relationships and friendship, physical health and well-being, respect for diversity, sense of autonomy and independence, social justice/ethics, spirituality/philosophy of life, taking an active role with adults, understanding and valuing self, vision for the future, and workforce preparation (http://www.bpy.n4h.org). All Extension agents, instructional specialists, and program assistants involved in developing the dating violence prevention curriculum received training on how to incorporate these 21 characteristics, or elements, of youth development programs into their programming.

The youth development program, created to serve as the context for offering dating violence curricula, was tailored for each community to ensure cultural relevance. Therefore, different activities were implemented at each site. Regardless of community type, however, each activity planned and conducted as part of this project included at least seven of the 21 characteristics identified as essential to positive youth development programs. The decision to include seven characteristics was arbitrary; however, requiring one third of the characteristics (7 of 21) to be reflected in each curriculum encouraged flexibility and cultural relevance while ensuring comprehensive programming. After community-specific activities were identified and proposed, program staff (i.e., instructional specialists, program assistants, and Extension agents) reviewed the list of 21 characteristics to determine which were addressed. If fewer than seven were incorporated, staff were required to find a different activity or to expand the current activity. Program staff reevaluated the activities once implemented to determine whether additional characteristics emerged over the course of the program.

Program Modification

Dating Violence Curriculum

The Safe Dates curriculum was implemented in each community as originally written. Following the initial implementation, however, the project team recognized that curriculum modifications would be necessary to promote cultural relevance. To date, the curriculum has been adapted multiple times in each community, with fewer changes required with each subsequent implementation.

Several data sources were used to determine the curriculum modifications needed to ensure cultural relevance (see Project Evaluation for a detailed description of these sources). Data were collected via surveys administered to each instructional specialist upon session completion. In this survey, instructional specialists were asked to document the number of activities initiated, their perception of the effectiveness of those activities, a description of issues that arose, ways they modified that day's activities, and whether those modifications were successful. Data also were obtained from the students participating in the program. Participants completed a brief feedback survey at the end of each session to rate what they learned, how well the session went, the leader's skills, and what they still wanted to learn. Additional feedback was gathered through the formation of participant focus groups. The focus groups, which were convened after full curriculum implementation, were used to determine perceptions regarding how well the program went and how it could be improved. Finally, the instructional specialists documented their observations of student behavior during the youth development activities with the goal of incorporating real-life examples into the

dating violence curriculum (e.g., gender-based stereotyping during a rock climbing activity).

Upon review of these data, project staff met to discuss potential revisions to curriculum-based activities and topics and to achieve consensus regarding these changes. Criteria used by project staff to determine whether modifications to the initial Safe Dates curriculum were needed included a) strong positive or negative reactions by youth, b) program staff judgment as trained educators in these populations, c) timing and pacing of delivery, and d) cultural relevance. In most cases, major changes to content of the curriculum were not needed. However, some of the details in the information presented affected how students received and accepted that information. For example, in one of the scenarios used in the original Safe Dates curriculum, a boy gives his girlfriend a CD for her birthday; the girlfriend breaks the CD in anger because she believes the gift is inadequate. After being given this scenario, students in one community laughed and stated that this behavior would never happen in their community because CDs are too expensive. On the basis of this reaction, this scenario was removed. More examples of curriculum modifications and the rationale for the changes are listed below:

- A session was added on positive relationships. Focus group and survey data showed that students wanted to learn more about healthy relationships, not just problematic ones. Some topics in this new session included positive and negative aspects of relationships, equality in relationships, and safe and healthy strategies for initiating a relationship.

- Names and scenarios were modified to be more reflective of names, activities, and beliefs in the participating communities. For example, one scenario involved going to a movie, but because no theater was located within the community, it was modified to describe attending a high school basketball game. Additionally, the session on images of relationships was modified to include culturally specific gender stereotypes. The students became more engaged in the discussions because these examples were culturally relevant.

- Scenarios were modified to include female perpetration of violence, which focus group participants reported to be as common as male perpetration. For example, one original scenario depicted a male student's jealousy over his girlfriend speaking to one of her male friends. Roles in this scenario were reversed to show a female student's jealousy.

- Some activities that involved reading a scenario and then responding to questions were redesigned as role-playing activities with accompanying discussion. Participants requested greater variety in the activities, and role-playing was an activity that would allow for more student interaction.

Youth Development Program

Youth development program activities were community-specific and designed by local program staff (i.e., instructional specialists, Extension agents, and program assistants), the youth, and in some cases, local community councils or organizations (e.g., Tribal Councils, Tribal Health Departments, and Boys and Girls Clubs). Activities were typically developed to focus on specific community holidays and cultural events (e.g., Red Ribbon Week, Veteran's Day, and the Fourth of July), as a response to specific

needs in the community (e.g., a diabetes walk and youth camp), or as a result of youth requests (e.g., open gym, horseback riding, rock climbing, and summer recreation programs). The content and specific activities, however, were less important than how those activities were conducted. Each youth development activity addressed at least 7 of the 21 characteristics shown to be essential to positive youth development programs; the delivery of the dating violence prevention curriculum and the interaction among participants during these classes were enhanced as program participants used these characteristics to develop meaningful relationships and skills.

The specific youth development activities were often implemented in collaboration with other community agencies, which facilitated the pooling of resources and staff time and allowed the Promoting Healthy Relationships Project to draw on the strengths of existing community organizations. For example, for some activities, the Promoting Healthy Relationships Project provided staff time and expertise while a collaborator provided snacks and supplies, which served as an effective method of gaining and maintaining youth participation.

Program Implementation

Four communities (designated as Communities A through D) participated in the Promoting Healthy Relationships Project. Each community received a unique program curriculum to ensure cultural relevance. In Community A, about 250 American Indian 9th graders in the public high school participated in the program for one semester. The 10-session dating violence prevention curriculum was implemented one day per week (for a total of 10 weeks) during the school day. To date, the curriculum has been implemented for six different sets of 9th-grade youth. The youth development program was conducted outside of the regular school day. This program allowed participants to rock climb, garden, take dance classes, and receive youth leadership training.

In Community B, about 200 American Indian 7th, 8th, and 9th graders in the junior high and high schools participated in the Promoting Healthy Relationships Project. The program lasted for 1 semester, with the dating violence prevention curriculum being offered one day per week (for a total of 11 weeks). To date, the 11-session program has been implemented three times with 9th graders, three times with 8th graders, and twice with 7th graders. The youth development program was held outside of the regular school day. This program enabled students to participate in community health fairs and walks, recreational sports, and summer camps.

In Community C, approximately 120 9th and 10th graders in the local high school were offered the program; these students were either Hispanic or of mixed ethnicity. The program was held over two semesters. During the first semester, eight sessions of a youth development program were offered once per week during the school day. The youth development program consisted of various team-building and trust-building exercises. In the following semester, the 10-session dating violence prevention curriculum was implemented with students who participated in the youth development program. Both programs were offered to two different groups of 9th and 10th graders.

In Community D, approximately 50 teen mothers attending a high-school-based Teenage

Parenting Program participated in the program. The program was offered one day per week for 10 weeks (i.e., 10 sessions). To date, the program has been implemented twice. The program has also been implemented in community-based settings involving about 20 youth. The youth development program in Community D was held during and outside of the school day. One of the main activities of the program was the creation of a video about youth dating violence. Youth took the lead in scripting, acting, filming, and editing this educational video for peers.

Project Evaluation

The broad goals of the project were to develop a culturally relevant dating violence prevention curriculum and to implement it in the context of a positive youth development approach. To achieve these goals, data collection focused on a) documenting reactions, participation, and perceived impact of the program activities to facilitate program improvement and b) documenting and describing the success (or lack thereof) in implementing the program activities to better understand what is needed to address dating violence in the participating communities. Because the focus of the Promoting Healthy Relationships Project was on program and curriculum development, pre and post data regarding program impact on knowledge, attitudes, and behaviors were collected exclusively from the intervention communities—nonintervention communities were not included in comparisons.

Data Collected

Because process evaluation data are needed for a full understanding of a program's impact, both process and outcome evaluation data were collected (22). To enhance program success, the following evaluation data were collected in conjunction with local project staff and youth.

Staff/Program Monitoring Log

Progress in the implementation process was documented through use of the Staff/Program Monitoring Log. For each activity, staff members recorded the program goals addressed; the date, time, location, and description of the activity; time spent on the activity; and the person who implemented it. These data were aggregated to determine the extent to which the implementation adhered to the goals, structure, and procedures of the program design.

Check-In Sheet

A Check-In Sheet was used at each activity to collect demographic data for identifying persons who received services. Through the use of the Staff/Program Monitoring Log and Check-In Sheets, a participant's exposure to each intervention could be documented.

Program Leader Survey

At the end of each session, the instructional specialist completed a Program Leader Survey to assess fidelity. Leaders recorded their thoughts about future training needs for specific content areas as well as their perceived effectiveness in carrying out the session. The survey presented

leaders with open-ended discussion topics related to the session (e.g., "What I liked most about this session was...," and "What I found most difficult about this session was…"). Valuable feedback was received through use of this survey; for example, in one community, the instructional specialist had difficulty completing the curriculum material during the allotted class period. This difficulty was effectively communicated through a Program Leader Survey, which allowed project staff to identify the activities that should be shortened or eliminated.

Student Process Evaluation Survey

Student program participants completed a brief survey following each program session. Participants rated their satisfaction with the session (e.g., what they learned, how the session went, and the leader's skills), identified which facts they would use and remember, and noted what they still wanted to learn. One main theme that consistently emerged from these surveys was the students' desire for more emphasis on positive relationships. This resulted in the addition of a lesson on healthy relationships to the dating violence prevention curriculum.

Youth Development Elements Worksheet

For every youth development activity, staff completed a Youth Development Elements Worksheet. This worksheet included a description of the activity, an explanation of how and why the activity was chosen, the date(s) and time(s) the activity was conducted, the total amount of time spent on the activity, the person(s) implementing the activity, and a youth development element checklist. Before and after implementation, program staff used this checklist to evaluate each activity for the inclusion of at least 7 of the 21 characteristics, or elements, associated with positive youth development programs.

Focus Groups and Key Informant Interviews

Upon completion of the dating violence prevention curriculum and youth development program, student focus groups were held and interviews with key informants (e.g., school personnel and community members) were conducted to gain knowledge regarding perceptions of the program and its impact on youth, parents, and the community. These qualitative methods provided insights into program impacts that were not captured by surveys. For example, one student focus group participant described sharing information from the program with his mother. He explained how his mother was in an emotionally abusive relationship and was being isolated from her family and friends. After several conversations with his mother about these issues, she ended the abusive relationship.

Teen Relationships Survey

A 135-item questionnaire measured variables related to topics in the dating violence prevention curriculum. The questionnaire measured experience as victim and perpetrator of dating violence, attitudes toward dating violence, alcohol and drug use related to dating violence, age at first dating violence episode, number of violent partners, help-seeking behaviors related to dating violence, peer violence, history of family violence, and conflict negotiation. This survey

assessed baseline rates of and attitudes toward dating violence among program and nonprogram participants prior to program implementation. This survey served as the pre-program assessment for participating youth. Following program implementation, participants were surveyed again as a post-program assessment tool.

Use of Evaluation Data

The evaluation data obtained through this project were used in several ways. Primarily, evaluation results were used to modify the program for optimal success in each community. The Program Leader Surveys and Student Process Evaluation Surveys were examined to determine ways in which the program could be adapted to better reach the students. For example, the Program Leader Surveys noted that a "fishbowl" activity in one session was unsuccessful, because students were uncomfortable being "put on the spot" in the fishbowl. As a result, this activity was modified to become a group discussion. Data from the youth focus groups and key informant interviews also provided guidance on other ways to modify the program. For example, in one community, both the Student Process Evaluation Surveys and the youth focus groups revealed that many students wanted to learn more about healthy relationships. In response to this need, a lesson on healthy relationships was added to the curriculum. Additionally, because the surveys revealed that students enjoyed participating in role-playing, some discussion-centered activities were rewritten as role-playing exercises.

Evaluation data from the Teen Relationships Surveys were used to inform stakeholders in each community. Results from these surveys were incorporated into community-specific newsletters, which were written in lay language and formatted to be visually appealing to the reader. Feedback from the instructional specialists and Extension agents was obtained before the newsletters were finalized, and the newsletters were then distributed to community stakeholders. Through the newsletter, parents, teachers, school administrators, community members, and students found out about the program and its progress. For example, in one community, the school principal held a meeting for all school personnel in which he presented the findings reported in their community newsletter and discussed next steps.

Finally, evaluation data were used to identify areas for which additional training was needed. For example, the Youth Development Elements Worksheets revealed the youth development program elements that were most and least frequently addressed in youth development activities. Because youth benefit from exposure to a broad range of these elements, subsequent discussions and one-on-one training with program staff focused on how to incorporate additional elements into the program.

Lessons Learned

The primary goal of the Promoting Healthy Relationships Project was to develop, implement, and evaluate a dating violence prevention curriculum delivered in the context of a comprehensive, positive youth development program. This paper described the rationale for this approach; the need for the project; the participating communities; and methods for the development, modification, implementation, and evaluation of program activities. Through the process of working with these communities

and program evaluation findings, this project has resulted in a wealth of information about implementing and evaluating dating violence prevention programs for ethnic minority youth. The following lessons learned may be helpful to others working in similar settings.

- Take time to build and maintain relationships with various groups of stakeholders in each community (i.e., school personnel, community partners, Tribal Council members, students, and parents). Such relationships are necessary for gaining access to population segments as well as ensuring continued community support and program sustainability.

- Hire staff from each community when possible. Local staff are the primary source of information about each community and its population. They are accepted within their communities and have a commitment to projects that may have a positive impact.

- Consider and incorporate community beliefs throughout the project. For example, some communities may have a history of tolerance toward intimate partner violence. A community's history should be taken into account when designing, implementing, and evaluating violence prevention programs.

- Provide feedback to each community. In this project, community-specific newsletters were prepared to inform each community about the project and elicit feedback for additional program modifications. These newsletters are another way of maintaining community support.

In summary, the most important lesson learned that underlies every aspect of the project is the importance of knowing the targeted community. Listening to and learning from each other is the only way to create a project that is respectful of and useful to everyone involved.

Implications and Conclusions

Dating violence prevention has typically consisted of universally offered curricula delivered in middle schools and high schools (10). To date, research studies, programmatic efforts, and program evaluations addressing dating violence among American Indian and Hispanic youth have been limited. Arizona's Promoting Healthy Relationships Project is attempting to fill this gap. The four communities described in this paper engaged in culturally respectful programs designed to provide early intervention and prevention of intimate partner and sexual violence within the context of a comprehensive positive youth development program. Empirical evidence is increasingly suggesting that youth development is an effective prevention strategy, particularly when it is incorporated into effective prevention programs (21). Therefore, future program efforts should consider adopting a youth development approach.

Survey, focus group, and interview evaluation data indicate that the Promoting Healthy Relationships Project is being received favorably by participants and is having a positive impact on their knowledge of and attitudes toward dating violence. However, a need for additional research exists, and programmatic efforts are needed to help further elucidate the context of violence and co-occurring behaviors in culturally diverse communities. In addition, more rigorous evaluation designs could be used as a next step in testing the effectiveness of such programs. In

future efforts, a balance between scientific rigor and cultural appropriateness and respect must be maintained; although this balance can be difficult to achieve, it is the only way to ensure authentic and useful data, as well as a program that is truly beneficial to the community.

The objectives outlined in Healthy People 2010 (23) challenge individuals, communities, and professionals to take specific steps to ensure that good health and long life are enjoyed by all. As more is learned about how specific minority populations define and understand dating violence and as key community stakeholders are engaged to focus not only on violence prevention but on the promotion of healthy relationships, curricula, programs, and research can be developed and adapted to meet the needs of other minority populations.

References

1. Hickman LJ, Jaycox LJ, Aronoff J. Dating violence among adolescents: prevalence, gender distribution, and prevention program effectiveness. Trauma Violence Abuse 2004;5: 123–42.

2. Silverman JG, Raj A, Mucci LA, Hathaway JE. Dating violence against adolescent girls and associated substance use, unhealthy weight control, sexual risk behavior, pregnancy, and suicidality. JAMA 2001;286:572–9.

3. Ackard DM, Neumark-Sztainer D. Date violence and date rape among adolescents: associations with disordered eating behaviors and psychological health. Child Abuse Negl 2002;26:455–73.

4. Thompson KM, Wonderlich SA, Crosby RD, Mitchell JE. Sexual violence and weight control techniques among adolescent girls. Int J Eat Disord 2001;29: 166–76.

5. Coker AL, MeKeown RE, Sanderson M, Davis KE, Valois RF, Huebner ES. Severe dating violence and quality of life among South Carolina high school students. Am J Prev Med 2000;19:220–227.

6. Dutton DG, Starzomski A, Ryan L. Antecedents of abusive personality and abusive behavior in wife assaulters. J Fam Violence 1996;11:113–32.

7. Murphy CM, O'Leary KD. Psychological aggression predicts physical aggression in early marriage. J Consult Clin Psychol 1989;57:579–82.

8. Centers for Disease Control and Prevention (CDC). Costs of intimate partner violence against women in the United States. Atlanta (GA): Department of Health and Human Services (US), CDC; 2003.

9. Centers for Disease Control and Prevention (CDC). Results: Dating violence. In: Surveillance summaries, May 21, 2004. MMWR 2004;53(No. SS–2): 6.

10. Whitaker DJ, Morrison S, Lindquist CA, Hawkins SR, O'Neil JA, Nesius AM, et al. A critical review of interventions for the primary prevention of perpetration of partner violence. Aggression and Violent Behavior 2006;11:151-66.

11. Foo L, Margolin G. A multivariate investigation of dating aggression. J Fam Violence 1995;10:351–77.

12. O'Keefe M. Predictors of dating violence among high school students. J Interpers Violence 1997;12:546–68.

13. Connolly J, Pepler D, Craig W, Taradash A. Dating experiences of bullies in early adolescence. Child Maltreat 2000;5:299–310.

14. Gorman-Smith D, Tolan PH, Sheidow AJ, Henry DB. Partner violence and street violence: Do the same family factors relate? J Res Adolesc 2001;11:273–95.

15. Catalano RF, Berglund ML, Ryan JAM, Lonczak HS, Hawkins JD. Positive youth development in the United States: research findings on evaluations of the Positive Youth Development Programs—report to the U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation and National Institute for Child Health and Human Development. Seattle (WA): Social Development Research Group, University of Washington; 1998.

16. Kirby D, Coyle K. Youth development programs [review]. Child Youth Serv Rev 1997;19:437–54.

17. Foshee VA, Linder GF, Bauman KE, Langwick SA, Arriaga XB, Heath JL, et al. The Safe Dates Project: theoretical basis, evaluation design, and selected baseline findings. Am J Prev Med 1996;12:39–47.

18. Foshee VA, Bauman KE, Arriaga XB, Helms RW, Koch GG, Linder GF. An evaluation of Safe Dates, an adolescent dating violence prevention program. Am J Public Health 1998;88:45–50.

19. Foshee VA, Bauman KE, Ennett ST, Linder GF, Benefield T, Suchindran C. Assessing the long-term effects of the Safe Dates Program and a booster in preventing and reducing adolescent dating violence victimization and perpetration. Am J Public Health 2004;94:619–24.

20. Foshee VA, Bauman KE, Greene WF, Koch GG, Linder GF, MacDougall JE. The Safe Dates Program: 1-year follow-up results. Am J Public Health 2000;90:1619–22.

21. Klindera K, Pagliaro S. Youth development can strengthen prevention programs. Transitions 1999;10:1, 5–6, 13.

22. Rossi PH, Lipsey MW, Freeman HE. Evaluation: a systematic approach. 7th ed. Thousand Oaks (CA): Sage Publications; 2004.

23. Department of Health and Human Services (US). Healthy People 2010: understanding and improving health. 2nd ed. Washington (DC): Government Printing Office (US); 2000.

Culturally Competent Approach to Violence Prevention: The Asian-American Women's Discussion Group

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Introduction

Sexual violence (SV) and intimate partner violence (IPV) represent a significant public health problem that affects women and their families across the country and around the world (1). The 2000 National Violence against Women (NVAW) study report found that 52% of U.S. women had been victims of physical assault, and 18% had been raped in their lifetimes (2). Of women surveyed in the NVAW study, nearly 25% reported being raped or physically assaulted in their lifetime by an intimate partner (2). Experiencing SV or IPV can lead to serious and debilitating physical and psychological health effects, including disability, gynecological problems, depression, posttraumatic stress disorder, sexual dysfunction (3-8), and death; 1,320 women died at the hands of their intimate partners in 1998 alone (9). Other reports indicate that 22%–35% of emergency room visits by women are in response to partner violence (10-12), with 53% of IPV victims presenting to physicians repeatedly (i.e., six or more visits per year) (13,14).

Asian American Women and Sexual and Intimate Partner Violence

Asian Americans are one of the fastest growing communities in the country, with population numbers increasing fourfold since 1970 (15). More than 11 million Asian

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Americans and Pacific Islanders live in the United States (representing 5% of the total national population), with California, New York, Hawaii, Texas, New Jersey, Illinois, Washington, Florida, Virginia and Massachusetts as the states with highest populations (16). By 2050, the number of Asian Americans living in the United States is expected to more than triple to 33 million, representing 8% of the total population (17). In addition to exponential growth, the Asian American population is increasingly diverse, representing more than 50 ethnicities with varying levels of English proficiency, cultural integration, and economic status (18). Yet popular perceptions and stereotypes of Asian Americans as a uniform group and a "model minority" have masked the reality of Asian American economic and social hardships and the extent to which Asian American women have endured IPV and SV. These perceptions also have led Asian Americans themselves to believe that they are not an at-risk population (19,20). Despite these stereotypes, the NVAW study revealed that 50% of Asian American and Pacific Islander women had experienced physical assault by an intimate partner, and 7% reported being victims of rape in their lifetimes (21).

Other indicators suggest that the burden of SV and IPV against Asian American women is even greater than that demonstrated in the NVAW study. For instance, data from Massachusetts residents revealed that in 1997 Asian American women comprised 18% of the residents killed by an intimate partner as a result of violence in the home, although these women represented only 3% of the state's population (22). Although the SV and IPV experiences of Asian American women remain substantially understudied (23), the prevalence of these experiences is estimated to be similar to that among other women in the population (24)

Cultural factors, values, and traditions frequently influence Asian American women's experiences of SV and IPV. These factors must be understood before IPV and responses to SV among Asian American women can be clearly explained. Studies show that cultural norms involving family, marriage, and gender roles may contribute to the experience of IPV among Asian American women—particularly the way in which these norms contribute to views regarding responsibility for one's own actions (25). For example, the notion that one is responsible for one's actions and therefore must accept the responsibility for any outcomes is a central concept of many Asian cultures. Consequently, many Asian American women who have been sexually victimized may view themselves as being responsible for their victimization (26,27).

Because of cultural influences, Asian Americans are often considered less likely than other ethnic groups to perceive certain actions abusive (28). The way in which a woman defines her partner's actions is partly shaped by her sociocultural background. In Japan, for example, no specific laws define spousal violence as a crime; but in 1991, 18% of female victims of murder or attempted murder were attacked by their husbands, indicating that IPV is a serious problem (29). In addition, although women will not say they are being abused, 58% of the women surveyed in one study indicated actions that would be considered physical abuse (29). Of those who indicated behavior consistent with physical abuse, 85% reported being slapped or hit with a fist (29). The tendency to ignore the sociocultural context and women's subjective perceptions of abuse may result in an incorrect interpretation of the low rates of SV and IPV being reported among Asian Americans (30).

A second cultural factor is the influence of gender roles. Specifically, Asian culture defines a relationship hierarchy from eldest to youngest and from men to women (31). In the Asian society, everyone is expected to conform to their specified role. According to Ho (1990), the domestic violence problem is rooted in the oppression of women based on this relationship hierarchy (25). In addition, traditional attitudes toward marriage fostered by many Asian cultures limit rights and resources of women to cope with family violence (25).

The effort to understand the phenomenon of and responses to violence against women of Asian descent is further complicated by the great diversity within and between the various Asian American ethnic groups (32). In the United States, most Asian Americans' experiences are influenced by their or their parent's country of origin as well as their assimilation into American society. At the cultural level, the assumptions about what is considered an effective and appropriate response to violence may vary among the different ethnic groups. However, across the different Asian cultures, certain family structures, roles, and responsibilities have been identified as being core to all Asian ethnicities (33).

The perception that these core values characterize Asians can be used as a starting point to address basic issues of violence against women in Asian communities. Nevertheless, any program seeking to address Asian American women's response to violence must grapple with the issues generated by these different values and cultural norms. Cultural norms (e.g., norms relating to differential treatment based on gender) also place Asian American women at high risk for SV and IPV and contribute to their low rates of reporting SV and IPV. Though not necessarily the case in all Asian cultures, in many Asian cultures, women and girls may be highly devalued in the Asian family in relationship to males and therefore occupy a subordinate position (25,34).

Further exacerbating the affect of SV and IPV is that Asian American women often experience cultural and systematic barriers that prevent them from seeking assistance and services. Asian American women, 66% of whom are foreign-born (35), are often faced with language barriers and a lack of culturally competent services and facilities and are unlikely to seek or continue to use any type of care, much less services related to sensitive issues (e.g., SV and IPV) (36).

In addition, many female Asian American victims of IPV have expressed feeling unable to seek help because of the strong cultural emphasis on "saving face"; communicating about issues such as rape, violence, or sexual experiences is viewed as bringing shame upon the family and community (25,37). This perception may lead many Asian American women to accept negative IPV-related consequences and to persevere in the face of their abuse (25,34). For example, in general, female Asian American college students have a stigma against the discussion of sensitive topics (38). Results from a mental health study of female Asian American college students confirms that members of this group feel unable to discuss the powerful stressors in their lives, especially issues such as sexuality, mental health, or personal and bodily integrity (38). In fact, the women in this study reported reluctance to discuss their own problems with others and would dwell on problems without seeking outside help. Such beliefs and practices, as taught to them since childhood by family members and their communities, often hinder female Asian American college students from participating in

campus-based health interventions; this lack of help-seeking behavior too often can lead to poor outcomes, including drug and alcohol abuse and depression (4-9).

To address IPV and SV in Asian American communities, culturally appropriate interventions are needed to help women resolve conflicting cultural views in a manner that promotes an effective response to these types of violence. A culturally responsive educational curriculum is needed to address barriers and stigmas that have been preventing Asian American women from communicating their experiences and seeking help for SV and IPV.

Female Asian American College Students and Violence Prevention Interventions on College Campuses

More than other population groups in the United States, female college students of all ethnicities are at high risk for becoming victims of SV and IPV (39). The National College Women Sexual Victimization (NCWSV) study has estimated that over the course of an average college career, 25% of women students will be victims of attempted or completed rape (39). Similar studies have revealed that 8% of college women reported rape within the six to nine months preceding the studies (40), and about 33% of college women reported experiencing some form of aggression within their intimate relationships (39). In the NVAW study, almost 30% of female respondents indicated that they were raped for the first time during their college years (21).

As a result of the prevalence of IPV and SV on campuses, many colleges and universities have implemented programs to prevent or reduce sexual assault. Recent literature reviews indicate that most sexual assault prevention programs focus on changing attitudes about assault (41,42). Most of these programs include at least the following components: information about the prevalence of sexual assault among college students, dispelling rape myths, discussion of the influence of sex role socialization practices, and identification of risk-related dating behaviors (43). Sexual assault prevention programs have been credited with increasing knowledge about sexual assault, reducing rape myth acceptance, and modifying self-reported risk-related dating behaviors (43). However, drawing definitive conclusions on the effectiveness of these interventions is difficult because the studies conducted to date have had substantial methodological inadequacies (43).

In addition to basic violence-related issues, college-based IPV/SV interventions aimed at Asian American women must address additional, unique sociocultural factors; failure to do so would affect intervention participation levels and success. Currently, these programs are absent from almost all college campuses, which likely reflects the lack of communication about IPV and SV in Asian communities (36). Few violence prevention services and programs have been developed for Asian American women, and most of these are domestic violence shelters or hotlines operating on limited resources (36). Although critically important for women in crisis, such services are neither a long-term solution for preventing violence nor likely to be widely accessed by female Asian American college students. Furthermore, other forms of SV and IPV within this population (e.g., date rape and stalking) have

received even less attention than other areas of domestic violence. Though critically needed on college campuses due to the high prevalence of acquaintance violence, prevention services and intervention programs are conspicuously absent—especially ones that are culturally sensitive to the needs of Asian American women.

Breaking the Silence: The Intervention

To fill the critical gap in culturally sensitive SV and IPV prevention programs, the National Asian Women's Health Organization (NAWHO) has developed a curriculum-based intervention that draws on the organization's experience with health-equity issues for Asian Americans. NAWHO was founded in 1993 to achieve health equity for Asian women and their families. As the only national organization dedicated to the health of Asian American women, the organization's goals are to raise awareness about the health needs of Asian Americans through education; to support Asian women as decision-makers through leadership development and advocacy; and to strengthen systems serving Asian women and families through capacity building. By establishing programs focused primarily on the education and empowerment of Asian American women, NAWHO aims to better reach and involve individuals and families within the diverse Asian American community with its critical health promotion efforts.

Through its Asian American Women's Discussion Group Program, NAWHO is seeking to increase knowledge, expand access to services, and change attitudes about SV and IPV. To achieve these objectives, NAWHO designed a curriculum-based intervention (Breaking the Silence: Culturally Competent Approaches to Violence Prevention for Asian American Women) to prevent SV and IPV among young Asian American college women currently attending California university campuses. Although Asian American women often have difficulty sharing personal experiences, the program's initial focus group results indicated that college-aged Asian American women were willing to discuss these issues in a small group setting of women with similar cultural values, norms, and traditions.

Description of the Intervention

The Breaking the Silence intervention consists of a discussion group for female Asian American college students, known as the Asian American Women's Discussion Group. The intervention, which is intended for implementation on the campuses of California colleges and universities, consists of discussion groups based on a curriculum containing four modules. Each curriculum module is designed for implementation as a one- to two-hour block of facilitated discussion. Module 1 presents the various cultural influences that confront Asian American women and the involvement of these cultural factors in SV and IPV related experiences. Examples include gender inequities in American society, persisting stereotypes of Asian American women, and patriarchy in Asian cultures. Module 2 provides information on sexual violence statistics and definitions, combating common assumptions such as "rape myths," and integrating the specific barriers faced by Asian American women in preventing and addressing this form of violence. Module 3 focuses on IPV by defining it, citing its effects on women's health, articulating barriers to addressing and reporting IPV, and discussing barriers faced by Asian American women victims of IPV. Module 4 addresses effective strategies for SV and IPV prevention,

provides information on developing safety plans, and provides an overview of available campus and community resources for SV and IPV victims.

A combination of teaching methods is used to implement the discussion group curriculum, including multimedia presentations, role-playing, and both small- and large-group structured discussions. Peer facilitators working under the guidance of campus administrative facilitators are used as needed. As the only culturally sensitive violence prevention program for Asian American women on most California college campuses, the Asian American Women's Discussion Group seeks to attract self-identified Asian American women currently enrolled in an undergraduate or graduate field of study at each campus. To facilitate the development of the curriculum for the discussion group, NAWHO formed an advisory council (the Working Partners Council) comprised of local, regional, and national organizations that focus on SV and IPV, including organizations of higher education represented by the Community Health Studies Group at San Jose State University. Other Working Partners Council members include representatives from health departments from the following seven states: California, Georgia, Illinois, Massachusetts, New York, Texas, and Washington. Other organizations (e.g., Asian Human Resources and the Asian Pacific Medical Students Association) also participated in the Council.

The curriculum for the discussion group is based on NAWHO's current health promotion programs, which employ multiple intervention designs built upon theories on health behavior change, including the Health Belief Model (44) and Social Learning Theory (45). According to social learning theory, new health behaviors are successfully acquired and maintained through social processes conducted within a peer group, including observation of new skills and peer support of new skills associated with help-seeking by victims of violence. An intervention program designed under these theories provides its participants with a) information to increase awareness and knowledge about health risks, b) social and self-regulatory strategies to implement new skills, c) information about available community resources, and d) social support for necessary help-seeking behaviors.

Consistent with a Health Beliefs Model approach, NAWHO's curriculum sought to provide participants with information that would address the perceived severity and susceptibility of IPV and SV for Asian American women, as well as perceived barriers to actively confronting IPV and sexual assault on campus. This information was provided because it is expected to increase behavioral capability. For instance, by addressing issues of consent in relationships, young Asian American women may achieve heightened self-confidence in their ability to successfully handle situations in which consent is an issue.

By informing participants about services related to IPV/SV prevention located on campus, the curriculum helps to reduce economic barriers Asian American women might encounter if trying to access resources on their own. In addition, the effort required to locate such services without guidance provided during the discussion groups might discourage many participants from trying to find help.

Curriculum Development

The Asian American Women's Discussion Group curriculum was based on the findings of a random digit dial (RDD) survey previously conducted in California in April 2001, which served as a needs assessment for Asian American women 18–34 years of age (35). The RDD survey examined the level of awareness; prevalence; and access to SV-, IPV-, and stalking-related services in this population. Because accessing public-use household telephone listings for women who were both enrolled in college and of Asian ethnicity was a challenge, NAWHO's telephone interview included a broader sample pool of respondents to facilitate adequate numbers of complete interviews by the target group. To ensure adequate sampling, the survey was not conducted specifically on college campuses; instead, Asian-American women age 18–34 possessing the general characteristics of the target group served as the study sample. NAWHO purchased a public-use household telephone listing that was generated on the basis of three characteristics: a) geographic location (i.e., the San Francisco or Los Angeles metropolitan areas where the largest Asian-American communities in California currently reside), b) likelihood of a college-aged female residing in the household (i.e., women 18–34 years of age), and c) Asian surname of the head of household. NAWHO's rationale for limiting the survey population to age 18–34 years was based on trends in available fall enrollment data, which indicated that most female Asian American college students (85.5%) are in this age range (17).

The results of the RDD survey indicated that Asian American women lack knowledge of the behaviors that constitute sexual violence and rape. For instance, contrary to the facts, many women indicated that rape does not happen between two people in a relationship and do not feel that rape is likely to be committed by someone they know. Respondents also perceived emotional abuse as "not really abuse" and that such abuse is "more acceptable," suggesting that many Asian American women may lack knowledge about the behaviors that constitute abuse (35). Other research efforts have revealed that young Asian American women who have been victims of violent acts refrain from taking action or speaking out for several sociocultural reasons, including fear of bringing shame to their families (46) and feeling responsible for their victimization (26). Consequently, the survey results reflect the need for a culturally focused educational program to inform young Asian American women about SV and IPV and to address cultural differences in defining abuse.

To identify issues that would need to be covered in a curriculum for the Asian American Women's Discussion Groups, a needs assessment was conducted in collaboration with the NAWHO Working Partners Council and with campus administrators and social service providers on the advisory council campuses. This needs assessment was built on the foundation of topics that NAWHO had laid out based on the results of the RDD survey, including basic SV and IPV information, the prevention of violence, and ways to become advocates and exercise leadership on the area of violence against women. Although there were limitations in the design of the RDD with the inability to identify if the participants were or had attended college, given the limited information regarding Asian American women in general, and Asian American women college student in particular, it was determined the information could be used to design the curriculum and modified as necessary

to address significant difference that may occur due to the modification of the target population. Specifically, NAWHO developed a set of discussion questions covering six main topic areas: a) the prevalence of SV and IPV among Asian American women on campuses and surrounding communities, b) the existing campus policies that address SV and IPV, c) the extent of collaboration between community based organizations and college campuses concerning violence-related services, d) Asian American women's access to prevention programs and services, e) gaps in existing SV and IPV services, and f) new directions and strategies for addressing SV and IPV among college-aged Asian American women. These six areas became the basis of the earliest versions of the curriculum. As the curriculum was developed and reviewed, however, certain areas (e.g., gaps in services or campus policies) could be logically combined into a single module. This review of the curriculum resulted in condensing the six areas into four modules.[1]

I. Module 1 ("Violence against Women in the Asian Population") introduces the extent of violence against women in the United States and provides a health-based framework for examining how violence against women manifests in the Asian American culture and how it impacts health. The objective of this module is to stimulate participants to explore their own culture, particularly attitudes, beliefs, gender expectations, and stereotypes about Asian American men and women. Participants also explore how institutional and social factors influence violence-related responses at the individual, family, community, and societal levels.

II. Module 2 ("Sexual Violence") educates participants about the behaviors that constitute sexual violence and the dynamics operating in its perpetration and in sexual victimization. In this module, IPV/SV-associated health ramifications and barriers to addressing and reporting sexual violence for women are discussed. This module specifically addresses the nature of sexual victimization among Asian American women and discusses the barriers they face in addressing and reporting sexual violence and the mechanisms for overcoming those barriers.

III. Module 3 ("Intimate Partner Violence") builds on the previous modules and leads participants to explore in-depth the dynamics of violence between current or former intimate partners. The activities contained in the module stimulate participants to identify and recognize the characteristics of IPV, explore challenges and barriers to engaging in help-seeking activities or reporting IPV, identify ways to overcome barriers to seeking help and reporting IPV, and identify strategies to overcome these barriers for Asian women.

IV. Module 4 ("Prevention Strategies, Advocacy, and Resources") engages participants in identifying campus- and community-based strategies for reducing their own risk of violence and conducting activities that can nurture a community free of violence against women. The objective of this module is to promote a broad scope of community response to violence against Asian women.

Facilitator Orientation

The first step in testing the curriculum consisted of conducting the facilitators' orientation on April 1, 2004. NAWHO invited student services administrators from 36 California colleges and universities to attend this orientation, during which they were introduced

to the discussion group curriculum; the orientation served to train those administrators responsible for implementing the program on their campuses. The curriculum was presented and the meeting facilitated by staff from California Applied Research, the organization under contract with NAWHO to provide training and implementation services. About 35 participants from 16 different campuses attended the training. Facilitator training was designed to allow participant feedback regarding the curriculum and ensured that facilitators had the information necessary to conduct the discussion groups. As part of the curriculum development process, issues and ideas raised at the training session by the administrators were considered and then included in the development process, when appropriate, to improve the curriculum. To determine whether facilitators were minimally knowledgeable of the information and issues contained in the curriculum, a survey that assessed existing familiarity with the issues of SV and IPV was administered to all participants; feedback on the extent to which participants felt the training provided useful information about curriculum implementation also was solicited.

Through the survey and during meeting sessions, the trainees identified the issue of program participants having same-sex partners as being potentially problematic. Training session participants suggested that the curriculum include more gender-neutral language as an acknowledgement of participants with same-sex partners. The original curriculum, however, was based on formative research for male-to-female violence; it was not designed to address all needs of women facing abuse from a same-sex partner, but instead focused on male-to female violence. Despite the original intent of curriculum developers, this feedback from trainees resulted in the modification of the curriculum language to meet the needs of their audience. The issue of program recruitment was addressed by each individual campus. At the orientation, representatives from each campus were asked to provide a detailed description of their Asian American student population and information about the way in which the participant recruitment process and discussion group implementation would be carried out. Specific approaches to implementing the discussion groups were discussed. The participants were encouraged to conduct all four modules over the course of two training sessions, and they were apprised of the need to collect the process and impact data forms to help determine the effectiveness of the program. Because each campus environment differs and student activities may preclude the use of the recommended implementation approach, the campuses were given leeway to conduct the discussion groups in a fashion most appropriate for their circumstances. To ensure program evaluation and further curriculum development, the training participants were instructed to provide NAWHO with descriptions of modifications made in implementing the curriculum (i.e., why and how the modules were changed to meet specific needs).

The curriculum received broad and enthusiastic acceptance from the participants. Of those administrators attending the training, about 75% indicated they would be facilitating the training on their campuses, while 25% would identify a facilitator at a later date. Because of limited funding, NAWHO used a competitive funding mechanism to fund seven campuses in 2004 and 2005; administrators at these seven campuses agreed to implement the unaltered NAWHO curriculum. Each applicant for these funds was required to provide information

describing their plans for implementing the intervention. Other campuses, though not part of the formal evaluation, were encouraged to use and adapt the curriculum.

Implementation Procedures

Because the accessibility of the program's target population (i.e., female Asian American college students) varied depending on academic environment, the implementation process was intended to be flexible. Despite the recommendation that the facilitated discussion groups be conducted over either a two- or four-day period, participant campuses were instructed to use implementation schedules that accommodated its particular student population. Ideally, the program should be presented over two days; the first two modules (1 and 2) should be conducted on day one, and the last two modules (3 and 4) on day two. Another acceptable option is conducting one module per day for a period of four days. On each campus, the women's discussion groups were facilitated by student services administrators or peer facilitators who are self-selected members of student organizations or chosen by the campus student services administration with assistance from NAWHO.

Integrating Evaluation within the Curriculum Development Process

The evaluation consists of participant knowledge and attitude survey, a participant satisfaction questionnaire, and a facilitator questionnaire. The participant survey evaluates the impact of the intervention on participant knowledge and attitudes; it is completed twice—once before the implementation of the curriculum and again immediately following it. The questions in this survey assessed knowledge and attitudes and were developed to coincide with the content of the curriculum. The participant satisfaction questionnaires and the facilitator questionnaire are to be completed at the end of each module. In the participant satisfaction questionnaire, participants are required to rate various portions of the curriculum on its utility and their level of satisfaction. The facilitator completes the facilitator questionnaire at the end of each module; each facilitator identifies which aspects of the curriculum were covered during the module and notes any problem areas. The participant survey and the facilitator questionnaire serve as process measures to track implementation of and satisfaction with the curriculum.

The goal of these evaluation tools is to a) detect changes in knowledge and attitudes targeted in the curriculum and b) modify and refine the curriculum. NAWHO is in process of analyzing information gathered from six California college campuses and one nonprofit organization, which partnered with NAWHO (2004–2005) to implement the curriculum and administer the evaluation tools to their participants. Curriculum content may be modified based on observed changes in knowledge and attitudes (or lack of change), perceived utility of various portions of the curriculum, participant satisfaction, and specific problems with the facilitation of particular modules. After the curriculum development evaluation is complete, NAWHO will make the curriculum available to the public on its website (www.nawho.org) in late spring 2006.

Conclusion

The scope of any intervention developed to address IPV and SV in the Asian American college community is limited by the need to understand the diversity that exists within and between various Asian American ethnic groups. This diversity complicates the effort to understand the IPV/SV phenomenon and responses to violence against women of Asian descent (32).

NAWHO's Breaking the Silence is a program that seeks to address IPV/SV prevention strategies for young Asian American women by working with college-aged women who are not only at increased risk for these types of violence, but are in the best position to make a difference for themselves and for other Asian American women in the future. However, the impact of acculturation must be considered when examining IPV/SV among Asian Americans. The characteristics of second-generation Asian Americans may differ from those of third-generation Asian Americans in several areas, including native language fluency, beliefs, ways of coping, network of friends, and place of residence (25). These factors further complicate the process of developing an intervention with broad ethnic appeal. Despite potential acculturation-related challenges, Breaking the Silence attempts to address a small core of attitudes and beliefs that likely are common to most Asian groups and appropriate to various levels of acculturation into American society.

Only a small portion of the many people of Asian descent living in the United States attend colleges and universities; IPV and SV prevention must also address the broader Asian community. Such prevention programs and interventions must be carefully developed to operate within and to meet the needs of the targeted communities. Despite gains made in understanding and preventing SV and IPV among Asian Americans, additional research and interventions are needed.

References

1. World Health Organization. World report on violence and health: summary. Geneva, Switzerland: World Health Organization; 2002.

2. Tjaden P, Thoennes N. Extent nature and consequences of intimate partner violence: findings from the National Violence Against Women Survey. Washington (DC): National Institute of Justice, Centers for Disease Control and Prevention; 2000. NCJ Publication No.: 181867.

3. Campbell, J. Health consequences of intimate partner violence. Lancet 2002;359:1331–6.

4. DeLahunta EA, Baram DA. Sexual assault. Clin Obstet Gynecol 1997;40:648–80.

5. Koss MP, Heslet L. Somatic consequences of violence against women. Arch Fam Med 1992 Sep;1(1):53–9.

6. National Research Council. Causes and consequences of violence against women. In: Crowell NA, Burgess AW, editors. Understanding violence against women. Washington (DC): National Academy Press; 1996. p. 74–80.

7. Plichta SB. Intimate partner violence and physical health consequences: policy and practice implications. J Interpersonal Violence 2004;19(11):1296–1323.

8. Resnick HS, Acienrno R, Kilpatrick DG. Health impact of interpersonal violence 2: medical and mental health outcomes. Behav Med 1997;23:65–78.

9. Rennison CM, Welchans S. Intimate partner violence. Washington (DC): Department of Justice (US), Office of Justice Programs, Bureau of Justice Statistics Special Report; 2000. p. 1–11.

10. Abbott J, Johnson R, Koziol-McLain J, Lowenstein S. Domestic violence against women: incidence and prevalence in an emergency department population. J Am Med Assoc 1995;273:1763–7.

11. McLeer SV, Anwar R. A study of battered women presenting in an emergency department. Am J Public Health 1989;79:65–6.

12. Randall M, Haskall L. Sexual violence in women's lives. Violence Against Women 1995;1:6–31.

13. Stark E, Flitcraft A, Frazier W. Medicine and patriarchal violence: the social construct of a private event. International Journal of Health Services 1979;9:461–8.

14. Mouradian VE. Prevalence and incidence estimates for intimate partner violence. Wellesley (MA): National Violence Against Women Prevention Research Center, Wellesley Centers for Women, Wellesley College; 2006. Available at: URL: www.vawprevention.org/research/ipvestimates.shtml

15. Department of Commerce (US), Bureau of the Census. The Asian and Pacific Islander population in the United States [update]. Washington (DC): Department of Commerce (US); 1998.

16. Bureau of the Census (US). People: Race and Ethnicity [on-line]. 2004. [cited 2007 May 22] Available at: URL: factfinder.census.gov/jsp/saff/SAFFinfo.jsp?_pageID=tp9_race_ethnicity

17. Bureau of the Census (US). The Asian Population: 2000. Washington (DC): Bureau of the Census (US); 2002. Available at: URL: www.census.gov/prod/2002pubs/c2kbr01-16.pdf

18. Chen MS Jr. Cancer prevention and control among Asian and Pacific Islander Americans: findings and recommendations. Cancer 1998; 83: 1856-1864.

19. Agbayani-Siewert P. Assumptions of Asian similarity: the case of Filipino and Chinese American students. Social Work 2004;49:39–51.

20. Hayashi MC. Far from home: shattering the myth of the model minority. Irving (TX): Tapestry Press; 2003.

21. Tjaden P, Thoennes N. Extent nature and consequences of intimate partner violence: findings from the National Violence Against Women Survey. Washington (DC): National Institute of Justice, Centers for Disease Control and Prevention; 2000. NCJ Publication No.: 181867.

22. Foo LJ. Asian American women: issues, concerns, and responsive human and civil rights advocacy. New York, NY: The Ford Foundation; 2002. p.130. Available at: URL: www.aapip.org/about.php?section=book

23. Yoshihama M. Reinterpreting strength and safety in a socio-cultural context: dynamics of domestic violence and experiences of women of Japanese descent. Children and Youth Serv Rev 2000;22(3–4):207–9.

24. Huisman KA. Wife battering in Asian American communities: identifying the service needs of an overlooked segment of the U.S. population. Violence Against Women 1996;2:260–83.

25. Ho CK. An analysis of domestic violence in Asian American communities: a multicultural approach to counseling. Women Ther 1990;9:129–50.

26. Chen SA, True RH. Asian/Pacific Island Americans. In: Eron LD, Gentry JH, Schlegel P, editors. Reason to hope: a psychosocial perspective on violence and youth. Washington (DC): American Psychological Association 1994;145–62.

27. Hall GCN, Windover AK, Maramba GG. Sexual aggression among Asian Americans: risk and protective factors. Cult Divers Ment Health 1998;4:305–18.

28. Moon A, Williams O. Perceptions of elder abuse and help-seeking patterns among African-American, Caucasian American, and Korean-American elderly women. Gerontologist 1993;33:386–95.

29. Yoshihama M, Sorenson SB. Physical, sexual, and emotional abuse by male intimates: experiences of women in Japan. Violence Vict 1994;9:63–77.

30. Yoshihama M. Domestic violence against women of Japanese descent in Los Angeles: two methods of estimating prevalence. Violence Against Women 1999;5:869–97.

31. Hsu FLK. Americans and Chinese. New York (NY): Doubleday; 1970.

32. Mizokawa DT, Ryckman DB. Attributions of academic success and failure: a comparison of six Asian American ethnic groups. J Cross Cult Psychol 1990;21:434–51.

33. Sue DW, Sue D. Counseling the culturally different: theory and practice. 2nd ed. New York (NY): John Wiley & Sons; 1990.

34. Shum LM. Asian American women: cultural and mental health issues. Ann N Y Acad Sci 1996 Jun 18;789:181–90.

35. National Asian Women's Health Organization. Breaking the silence: a study of depression in Asian American women. San Francisco (CA): National Asian Women's Health Organization; 2001.

36. Eng P. Domestic violence in Asian/Pacific Island communities: a public health issue. In: Adams DL, editor. Health issues for women of color: a cultural diversity perspective. Thousand Oaks (CA): Sage Publications; 1995. p. 78–8.

37. Yick AG. Domestic violence in the Chinese American community: cultural taboos and barriers. Family Violence and Sexual Assault Bulletin 1999;15:16–23.

38. National Asian Women's Health Organization. Expanding options: a reproductive and sexual health survey of Asian American women. San Francisco (CA): National Asian Women's Health Organization; 1998.

39. Fisher BS, Cullen FT, Turner MG. The sexual victimization of college women. Washington (DC): National Institute of Justice, Centers for Disease Control and Prevention; 2000. p. 10.

40. Fisher BS, Sloan JJ, Cullen FT, Lu C. Crime in the ivory tower: the level and sources of student victimization. Criminology 1998;36:671–99.

41. Lonsway KA, Fitzgerald LF. Attitudinal antecedents of rape myth acceptance: a theoretical and empirical reexamination. J Pers Soc Psychol 1995;68:704–11.

42. Yeater EA, O'Donohue W. Sexual assault prevention programs: current issues, future directions, and the potential efficacy of interventions with women. Clin Psychol Rev 1999;19:739–71.

43. Breitenbecher KH. Sexual assault on college campuses: is an ounce of prevention enough? Appl Prev Psychol 2000;9:23–52.

44. Strecher VJ, Rosenstock IM. The Health Belief Model. In: Glanz K, Lewis FM, Rimer BK, editors. Health behavior and health education: theory, research and Practice. 2nd ed. San Francisco (CA): Jossey-Bass; 1997. p. 41–59.

45. Bandura A. Social foundations of thought and action: a social cognitive theory. Englewood Cliffs (NJ): Prentice Hall; 1986.

46. Yoshihama M, Parekh AL, Boyington D. Dating violence in Asian communities. In: Levy B, editor. Dating violence: young women at risk. Seattle (WA): Seal Press; 1991. p. 184–95.

Endnotes

[1] Once fully developed, the curriculum will be available from NAWHO at www.NAWHO.org

For more information:

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