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According to clinical observations and research findings in other fields, cultural issues may explain the poor outcomes associated with African American men in conventional batterer counseling. Practitioner-researchers recommend culturally focused batterer counseling as an appropriate response to these issues. Culturally focused counseling includes a curriculum that identifies specific cultural topics, counselors that respond to emergent cultural issues, and racially homogeneous groups that encourage disclosure. The outcome research on culturally sensitive counseling and racially homogeneous counseling in general is, however, very limited and offers only tentative support for culturally focused batterer counseling. Only some very preliminary research has been conducted on culturally focused batterer counseling. Clinical trial evaluations that control for cultural identification are therefore needed to substantiate the effectiveness of culturally focused batterer counseling. Other components, such as specialized case management and community linkages and development, might be necessary to achieve a substantial improvement in counseling outcomes.

Key words: batterer counseling, cultural diversity, domestic violence, African American men

IN MANY MAJOR URBAN AREAS, African American men compose at least half of the men arrested for domestic violence and referred to batterer educational or counseling programs (Gondolf, 1999a). The dropout and reassault rates of these men tend to be higher than those for White men in the same programs. African American researchers and practitioners working on domestic violence have argued that the conventional approach to working with these men needs to be revised to improve outcomes (e.g., Blake & Darling, 1994; Hampton, Carrillo, & Kim, 1998; Oliver, 1994; Williams, 1994, 1998). Their recommendation echoes that in related fields (e.g., alcohol treatment, psychotherapy, and social work): culturally focused counseling should supplement conventional counseling developed primarily for White middle-class cli-
Culturally focused counseling refers to specialized counseling for racially homogeneous groups that explicitly identifies and addresses cultural issues that may reinforce violence or present barriers to stopping violence. The approach also promotes the positive aspects of culture that can strengthen a man’s effort to be nonviolent. A set curriculum progressively leads men to and through cultural issues, and counselors are trained to acknowledge and elaborate cultural issues that emerge during group discussion. The counselors are to hear out the men’s viewpoint and understand the different styles of interaction and expression.

Culturally focused counseling differs in extent and intensity from what is commonly referred to as culturally sensitive or culturally competent counseling, although all three terms are sometimes used interchangeably (Williams, 1999). Culturally sensitive counseling implies using counselors trained in cultural issues and increasing awareness of how the issues may affect certain behaviors, including group attendance, participation, and personal change. The counselor is not necessarily of the same race, and the group participants may be racially mixed, but the counselor strives to recognize and respond to cultural issues when they emerge. In contrast, cultural issues are an explicit part of the curriculum in culturally focused counseling.
Cultural competence generally refers to demonstrated skill and experience with participants of different racial background and structural supports that ensure cultural information is available. A racially diverse staff, advisory committees, board members, program location, promotion materials, and program curriculum are some of the ways cultural information is ensured. Cultural competence is distinguished by organizational or structural components that help a program be more responsive to cultural differences. These components are also likely to make the program receptive and equipped for culturally sensitive counseling.

A recent survey of batterer programs indicates that very few of these programs specifically address cultural issues through any of these forms (Williams & Becker, 1994). Most of the programs asserted that they were open to working with African American men. Approximately half of the programs ($n = 142$) actually had some activity addressing cultural issues, such as outreach to minority communities, but only one fourth of the programs had cultural components in their curriculum. There appears to be a perception among most batterer programs that they are at least culturally sensitive even though they are doing little in their counseling approach to ensure this.

Unfortunately, very little research examines the outcomes of culturally oriented counseling in general, and the research that is available offers some contradictory results. It seems particularly important to evaluate culturally focused counseling in the domestic violence field because of its attachment to the criminal justice system. According to a Gallup Poll, more than half of adult African Americans have negative reactions to the criminal justice system, which might further affect their response to court-referred batterer counseling (Stone, 1999). These are reactions that do not necessarily apply to the mental health or alcohol treatment programs where most of the previous research has been conducted.

If culturally focused counseling does appear to reduce dropout and reassault among African American men, then more should be done to implement the clinical recommendations for such counseling that have thus far been largely neglected. If the culturally focused counseling does not have a significant effect, conventional counseling may be sufficient, or other means of cultural support might be considered. We also may find that culturally focused counseling is more effective with a subgroup of African American men who hold more culturally specific attitudes—that is, who identify most with African American culture. This finding would suggest some criteria for assigning and admitting men to culturally focused counseling.

We review the clinical recommendations for counseling African Americans, outcome research of culturally oriented counseling, and preliminary findings regarding batterer counseling with African Americans. Culturally focused counseling appears to warrant more consideration. It might be more widely implemented to develop and refine its curriculum and training. Currently, there are only a few articles describing such counseling and only a couple of manuals for culturally focused counseling in circulation (Williams, 1994, 1998, 1999; Williams & Donnelly, 1997; Wilson, Donnelly, Mederos, Nyquist, & Williams, 2000).

**CULTURALLY FOCUSED VERSUS CONVENTIONAL COUNSELING**

**Conventional Batterer Counseling**

“Conventional batterer counseling” follows the parameters common to most state guidelines for batterer programs (Austin & Dankwort, 1999) and the gender-based cognitive-behavioral treatment outlined in published manuals (e.g., Pence & Paymar, 1993; Stordeur & Stille, 1989). The main curriculum topics include the nature and impact of abuse, the conse-
quences and costs of abuse, taking responsibility for one’s abuse, ways to avoid abusive behavior, and beliefs and attitudes that sustain abusive behavior. The counseling sessions generally begin with a check-in period in which the participants report any particular accomplishments or problems from the previous week. A topic about domestic violence is presented followed by exercises, role plays, or demonstrations. Responses and discussions are integrated into the session or solicited in a period near the end of the session.

Trained counselors lead a racially mixed group of approximately 15 men in what might be considered a color-blind approach (Williams, 1998). Color-blind means that the counselors have not received any cultural-sensitivity training, do not pursue cultural issues in the group, and do not introduce any culturally relevant topics. The objective is to stay focused on the behavior of concern and not let tangents or rationalizations divert the group from this objective. Men who batter tend to use rationalizations in general to justify and perpetuate their abuse. The discussion of cultural issues can open the door to more of this in the form of “prejudice, the police, or my neighborhood made me do it.”

The conventional curriculum, moreover, focuses on attitudes and behaviors that supposedly represent commonalities of woman battering. These commonalities theoretically underlie the violent behavior of men regardless of race and ethnicity. One of the fundamental commonalities is to avoid personal responsibility for one’s behavior. Responding to cultural issues can easily become a way to diffuse this responsibility.

The effectiveness of conventional batterer counseling is, however, in question. Several reviews of quasi-experimental program evaluations suggest a weak effect (e.g., R. Davis & Taylor, 1999; Babcock, Green, & Robie, in press). Men who complete batterer programs do not have substantially lower reassault rates than men who drop out. Two recent experimental evaluations compared those assigned to batterer programs with men assigned to control groups without counseling (R. Davis, Taylor, & Maxwell, 1998; Feder & Forde, 2000). They found little or no program effect. These evaluations, however, encountered implementation and follow-up problems that may have compromised their results (Gondolf, 2000a). One of the evaluations examined a program in New York City, and the other studied one in South Florida. Both evaluations appeared to have had problems with the intervention system as a whole (e.g. the court response to noncompliance, probation supervision of men, referrals to drug and alcohol treatment) and low completion rates (less than 50%), which may have affected the results. Replication at other sites with better developed and operated programs is needed to confirm the initial findings.

Our multisite evaluation of batterer intervention systems did show a program effect that lends support to well-established batterer programs. This evaluation compared the outcomes of four different batterer programs across the country (n = 840). Approximately one third of the men who enrolled in the programs reassaulted their partners during a 15-month follow-up, according to reports from 70% of the men’s initial and new female partners (Gondolf, 1997b). The rate of reassault increased only slightly, to 41%, by the 30-month follow-up (2½ years after program intake). The men who completed at least 2 months of program sessions were significantly less likely to reassault than were men who dropped out within 2 months and had access to their female partners (67% vs. 40%, for 27% difference). This difference remained significant when controlling for demographics, previous violence and criminality, alcohol abuse, and psychological problems (Gondolf, 2000b). Moreover, instrumental-variable structural equations were used to control for the batterer characteristics, the association of these characteristics to program dropout and completion, and the program context (e.g., availability of victim services, probability of arrest for reassault, local unemployment rates). This more complex analysis identified a moderate program effect (.44 to .65) (Gondolf & Jones, in press).

Culturally Focused Counseling

As mentioned at the outset, culturally focused counseling comprises the conventional
batterer counseling and several components to accommodate the cultural issues of African American men (Williams, 1999; Williams & Donnelly, 1997). Culturally focused counseling goes beyond cultural sensitivity or cultural competency in placing violence against women within a cultural context and in explicitly integrating cultural issues into the curriculum. The components include (a) only men who identify themselves as African American in the group, (b) an African American counselor trained to identify and elaborate cultural issues suggested in the participants’ comments, and (c) specific cultural topics that are introduced for discussion as part of the curriculum (Williams, 1994, 1999; Williams & Donnelly, 1997).

Some of the distinguishing curriculum topics are African American men’s perceptions of the police, relationships with women, sense of African American manhood, past and recent experiences of violence, reactions to discrimination and prejudice, and support in the African American community. These topics address the major cultural issues facing African American men, according to clinicians and researchers (see counseling issues below). The curriculum also varies from conventional batterer counseling in that it is more structured with concrete examples, vignettes, and directive questions. This structure is to help engage men of less education, more resistance, and less counseling experience. It also ensures that the cultural issues will be systematically introduced and not neglected or overlooked as taboo.

The focus on cultural issues is not to fixate on negative cultural stereotypes or social pathology (Goldstein, 1990). These are, of course, a distortion of the dynamic and multifaceted aspects of any culture and need to be checked with cultural strengths as well as barriers. The so-called “strength perspective” in social work practice (e.g., Cowger, 1994; Saleeby, 1992) has been integrated into culturally focused counseling as a result (Williams & Oliver, in press). Specifically, culturally focused counseling is to encourage men to access the sense of brotherhood, communal spirit, initiative insight, poetic expression, spirituality, and ritual of the African American culture, as well as expose detrimental aspects it may hold.

The support for culturally focused counseling comes primarily from the cultural issues identified by clinicians and counselors in related fields, with some tentative reinforcement from outcome studies of culturally oriented counseling. There is only preliminary evidence in the batterer counseling research that culturally focused counseling is effective in reducing dropout and reassault beyond the current levels achieved in conventional counseling.

**Counseling Issues**

Clinical explanations from social work and psychotherapy suggest that cultural differences contribute to African American men dropping out of batterer counseling or reassaulting if they do complete it (e.g., Blake & Darling, 1994; Franklin, 1999; Logan, 1990; Lum, 1986; Rasheed & Rasheed, 1999; D.W. Sue & D. Sue, 1999; Thorn & Sarata, 1998). Three main types of issues are noted. The first type is subcultural or community-based issues. Many African American men draw on a more personalistic culture that values personal reputation and familiarity over ascribed position or authority (Gondolf, 1980; Williams, 1998). They are more likely to rely on kinship and friendship networks to talk about their problems. Consequently, they tend to be reluctant to disclose information to a group of strangers in group counseling or to test the sincerity and understanding of the group leader. Counselors may, therefore, see them as unresponsive to treatment and “unserviceable” (Logan, 1990). They are also likely to have different learning styles as well as communications patterns. Many of the batterer programs use highly cognitive—and even cerebral—approaches that slight the action and emotive orientation of many African American men referred to such programs.
The second type of issue is interracial differences and cultural clash. Some African American men are simply confused by the demands to change certain attitudes and behaviors that they see as normative and even essential to survival in their neighborhoods (Blake & Darling, 1994; Franklin, 1999; Oliver, 1994). This is especially the case with some of the antiviolence positions promoted in conventional batterer program curriculums. Furthermore, many Black men have historically been faced with a different model of male-female relationships than have middle-class White professionals (Asante, 1981; Bell, Bouie, & Baldwin, 1990). They have experienced a greater fluidity of roles and responsibilities in contrast with the gender assumptions asserted in some batterer programs. There is, moreover, the daily impact of prejudice, racism, and oppression that contributes to feelings of powerlessness, hopelessness, and rage. Not only do counselors often overlook or discount these feelings, but also they tend to criticize or condemn African American men who acknowledge these feelings (Franklin, 1999; Oliver, 1994; Williams, 1993, 1994).

The third type of issue is a reaction to racial discrimination or insensitivity (Hu, Snowden, Jerrell, & Nguyen, 1991; Logan, 1990; Rasheed & Rasheed, 1999). Some men see the Whites as unfamiliar and unsympathetic to their social reality and experiences. As a result, many African American men expect to be misunderstood or “screwed over” (Gary, 1985). White counselors are often trained with a middle-class perspective that views individual and intrapsychic factors as fundamental to behavior and neglects the social and cultural circumstances affecting many African American men (Brodsky, 1982; Oliver, 1994; Richardson & Molinaro, 1996). In many cases, there are few resources and services within African American neighborhoods, and the ones that do exist are primarily used to correct or punish Black men or deal with perceived deficits in the African American community (Logan, 1990).

The literature on counseling African American men uniformly prescribes greater social and cultural consideration to mitigate these issues and improve counseling participation and outcomes. The means to accomplish this prescription vary in terms and design but are similar in substance. One means is to learn to conduct a cultural assessment of program participants, as part of their individual assessment or program intake (Dana, 1998; Logan, 1990). This sort of assessment addresses the availability and access to needed resources and services, the assimilation of positive community norms and expectations, and emotional reactions to prejudice and racism. A second means is developing greater cultural competence among group counselors (Lum, 1986; Ponterotto, 1995; Richardson & Molinaro, 1996). Counselors need to be better educated about cultural differences, skills for identifying cultural issues, and collaboration with staff, community leaders, and program participants from diverse cultural backgrounds. A third means is a different dynamic and focus in group counseling (Robinson & Howard-Hamilton, 1994). The counselor establishes personal familiarity and shared meanings, probes cultural issues and digressions, and identifies community-based responses and solutions (Rasheed & Rasheed, 1999).

These sorts of recommendations might be best integrated and implemented through culturally focused batterer counseling with all African American men in the group (Williams, 1994, 1999). This approach and format is more likely to initiate cultural disclosure through its dynamics, curriculum, and group environment. Although racially homogeneous groups with only African Americans may improve rapport and disclosure in themselves, a trained sensitivity to cultural issues and a curriculum that explicitly identifies these issues are needed to ensure that culture is addressed.

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Outcome Research in Other Fields

A comprehensive review of the racial and ethnic outcome research concludes that culturally sensitive counseling produces more positive changes than does counseling that does not explicitly consider cultural factors (S. Sue, Chun, & Gee, 1995; S. Sue, Zane, & Young, 1994). (The term culturally sensitive refers here to a variety of means to identify and address distinguishing cultural attitudes and behaviors.) However, the limited research on this topic presents a less than clear and decisive picture. The few outcome treatment studies on conventional counseling groups provide only slight evidence that African American men necessarily have poorer outcomes in such groups. A few past evaluations showed that African American men tend to be equivalent to White men in terms of dropout and symptom improvement, and a few more current evaluations suggested they may do slightly worse (S. Sue et al., 1994). For instance, a major evaluation of a variety of drug treatments did find that African American outpatients were more likely to drop out and relapse (Brown, Joe, & Thompson, 1985), and a study of more than 1,000 mental health patients found that African Americans had the lowest improvement scores on the Global Assessment Scale among Asian Americans, Mexican Americans, and Whites (S. Sue, Fujino, Hu, Takeuchi, & Zane, 1991). Research on alcohol and drug use has detected different usage patterns among African American men as compared with Whites (Caetano, Clark, Tam, 1998; Harper, 1980). According to the researchers, this difference in itself implies the need for specialized treatment, as do the differences in communication and learning styles (Wade, 1994).

The limited research on African-American-only counseling groups and racially matched counselor-and-client treatment has produced inconclusive results (S. Sue et al., 1994). A few studies indicate similar mental health and alcohol use outcomes after conventional counseling in African-American-only groups or counselor-client matched treatment (Jones, 1982; Rosenheck, Fontana, & Cottrell, 1995). In the mental health treatment study, African Americans matched with African American counsel-
ors were less likely to drop out compared with those with a counselor of another race, but they were no more likely to improve (S. Sue et al., 1991). It may be that the cultural sensitivity of the counselor and the cultural focus of the curriculum mediate these results. If counseling clients perceive the counselor to be culturally aware and addressing cultural issues, they are more likely to judge the counseling positively, according to a study of African American college students (Parham & Helms, 1981, Pomailes & Williams, 1989). African American students with mistrust or suspicion of other races, moreover, are less likely to seek or accept counseling help (Nickerson, Helms, & Terrell, 1994). In addition, African Americans living in a predominately African American neighborhood are more likely to attend mutual help groups than are African Americans who live in predominately White areas (Humphreys & Woods, 1993). These sorts of findings imply that local African-American-only counseling groups are more likely to draw and retain African Americans better than are racially mixed groups, but racial matching by itself does not necessarily improve outcomes.

An additional line of research has suggested that the less than emphatic findings supporting culturally focused counseling are due in part to the cultural diversity within the African American community. The few studies that considered cultural attitudes found that the conventional counseling outcomes worsen with fewer African American men in a group and higher racially specific attitudes (Aponte & Barnes, 1995). Cultural attitudes of African Americans are also associated with the client’s response to aspects of counseling. African American students with a greater sense of racial identity are also more likely to prefer racially matched counselors (Parham & Helms, 1981; Ponterotto, Anderson, & Grieger, 1986), and racial acculturation appears

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to contribute to dropout and relapse in conventional drug treatment (Pena & Bland, 2000). As suggested in the clinical literature, it is not only race that needs to be identified but also the cultural attitudes that accompany one’s racial and ethnic background (Dana, 1998; Logan, 1990).

**BATTERER COUNSELING OUTCOMES**

Our multisite evaluation of batterer intervention systems offers information that appears to support the need for a specialized response to African American men arrested for domestic violence (Gondolf, 1997b, 1999b, 2000b). This evaluation of racially mixed conventional batterer counseling was conducted by the first author of this review article. The multisite study was a longitudinal follow-up (every 3 months initially for 15 months and extended to 48 months) of men who were referred to batterers programs by the court because of an assault against their female partners \((n = 840)\). Pittsburgh was one of the four geographically distributed sites in the multisite evaluation, and its outcomes were based on unusually high response rates and verification procedures. Nearly one half of the Pittsburgh subsample \((n = 210)\) was African American men (the percentages were lower at other sites that also included a substantial portion of Latino men). The African American men, as compared with the White men in Pittsburgh, were more likely to drop out of what was a 12-week batterer program at the time. They were also more likely to be rearrested according to police records.

More specifically, only one half \((52\%)\) of the African American men completed the program in 1995, as compared with 82% of the White men \((n = 210)\). The current difference in completion rates is more than 40%. The African American men were more than twice as likely to be rearrested for domestic violence \((DV)\) than were the White men \((13\% \text{ vs. } 5\%)\) and were substantially more likely to be rearrested for any crime \((45\% \text{ vs. } 28\%)\) and for any assault \((29\% \text{ vs. } 17\%)\). The reassault rates reported by the women did not significantly differ and were in fact slightly lower for the African American men \((32\% \text{ vs. } 39\%, n = 180)\). Interestingly, the reassault rates are significantly higher for African American men in Colorado, 46% for African Americans and 27% for Whites; less in Dallas, 28% for African American men and 45% for Whites; and equivalent in Houston, both approximately 35%). The relationships for dropout and rearrest in Pittsburgh persist when controlling for the possible differences in partner contact, marital status, and prior arrests.

The second author of this review article conducted the only outcome study of culturally focused batterer counseling to date (Williams, 1995). It must be considered preliminary because of its small sample size \((n = 41)\) and limited outcome measures, but its findings do point toward some utility in culturally focused counseling for batterers. In the early 1990s, African American men in Minneapolis-St. Paul attended either a conventional batterer counseling or a culturally focused group of exclusively African Americans. The men were retrospectively interviewed in depth, either by phone or in person at the program site, about their experience in batterer counseling. Although the African American men in both groups identified some common lessons, the men in the culturally focused counseling were more likely to learn that they were not unique, isolated, or alone with their problems. They also felt more comfortable talking to other men in the group and were more likely to develop friendships that carried outside of the group. They were more positive about the counselor, as well, even though the counselor confronted and challenged the men at times. In sum, the culturally focused counseling appeared to achieve more trust, support, and openness. As a result, the African American men in that group seemed to learn more about themselves. These findings support the observations of clinicians in related fields and suggest that African American men are at least more comfortable and more engaged in culturally focused counseling. The outcomes in terms of program dropout and reassault, however, need to be documented.

An evaluation of a culturally sensitive curriculum for racially mixed groups is to begin this spring. The 26-week curriculum has been developed and implemented as part of a U.S. Department of Justice demonstration grant in Connecticut. It was designed to accommodate
men who have multiple domestic violence arrests. Furthermore, it will be accompanied by enhanced monitoring of the men and services for the victims. This evaluation is, therefore, of an intervention system for a special category of offenders and does not include a controlled comparison of culturally focused counseling in African-American-only groups (E. Lyon, personal communication, January 5, 2000).

What may ultimately be needed is a series of clinical trials of culturally focused batterer counseling for African American men. In an experimental program evaluation, African American men would need to be randomly assigned to culturally focused counseling, conventional counseling in a group of only African Americans, and conventional counseling in a racially mixed group. The African-American-only conventional counseling would be necessary to help isolate the effect of culturally focused counseling beyond the racial composition of the group. Attendance records, victim reports, and arrest records might then be compared across the three counseling options. The counseling approaches would need to be explicitly articulated in manuals and monitored regularly to ensure that no “leakage” occurred across the options, especially between the culturally focused counseling and the African-American-only conventional counseling. The latter could easily evolve into an approximation of the culturally focused counseling.

In addition, the cultural attitudes of the men might be tested with instruments such as the African American Acculturation Scale (Landrine & Klonoff, 1994, 1995) and the Racial Identity Attitude Scale (Helms & Parham, 1990, 1996; Parham & Helms, 1981). These attitudes are likely to modify the outcomes, according to the previous research. African American men with higher culturally specific attitudes are more likely to have better outcomes in culturally focused counseling than in racially mixed conventional counseling. Men with lower culturally specific attitudes, conversely, are likely to do best in the racially mixed conventional counseling as opposed to the African-American-only counseling groups.

Conducting a clinical trial of this scope is, however, more easily described than done. Recent experimental program evaluations have encountered major difficulties in implementing random assignment of the men and follow-up interviews with their female victims (Gondolf, 2000b).

ADDITIONAL CONSIDERATIONS

There are admittedly several additional considerations in addressing the needs of African American men arrested for domestic violence. For one, we cannot assume that all or most African American men have the same cultural experience or identification. Their response to similar cultural experiences may also vary. Men from different socioeconomic classes or different geographic regions are especially likely to differ culturally. The curriculum in culturally focused counseling does attempt to assert commonalities between African American men who are referred to batterer counseling programs and raises these for consideration. It is safe to assume that most African American men are aware of the cultural issues presented in the curriculum, if not directly affected by them. These men can help others in a counseling group who are affected by the issues. The overwhelming recommendation within the fields of clinical psychology and counseling is that cultural issues be recognized, discussed, and addressed in treatment and counseling.

Second, the substantial portion of African American men being sent to batterer programs may reflect prejudice and discrimination in the criminal justice system and one of the consequences of so heavily relying on criminal justice remedies for domestic violence (Richie, 2000). In many urban areas, policing is more aggressive in predominately African American neighborhoods, and services to deal...
with family problems are much less available. As a result, family problems that might be resolved by voluntary counseling or other supports are more likely to be addressed by the police (Hutchison, Hirschel, & Pesackis, 1994). The courts also may be more likely to send African American men to counseling or jail rather than order a fine or release. The apparent inequity of counseling referral, no doubt, adds to the resistance to batterer counseling. The criminalization of family problems may itself need to be addressed in order to improve counseling outcomes.

The apparent inequity of counseling referral, no doubt, adds to the resistance to batterer counseling. The criminalization of family problems may itself need to be addressed in order to improve counseling outcomes.

Third, a fully competent cultural response ultimately extends well beyond group format and approach, as the second author acknowledges in his work (Garfield, 1998; Williams, 1993). Linkages with the community, additional referrals and resources, specialized case management, and collaboration in social change efforts have also been recommended (Lum, 1986). We would expect these components to help reinforce what is being learned in group counseling sessions through the tone of the group and the experiences after the group. An initial focus on the group format may be warranted because it is the most immediate, fundamental, and malleable component of broader social intervention.

The concerns about counseling African American men appear to apply to other racial and ethnic categories of men, such as Latinos, Asians, and Native Americans (e.g., Carrillo & Tello, 1998). These men might also benefit from culturally focused counseling that identifies and addresses cultural issues. Obviously, there are differences in communication styles, relationship patterns, family structures, police contact, and employment opportunities across racial and ethnic groups. Is it practical, however, to have separate culturally focused counseling groups for each racial or ethnic category? A few programs, such as Emerge in Boston, do manage to have separate racial and ethnic groups for the men who want them. Others may approximate the effect of such groups with culturally diverse staff and staff otherwise trained in cultural sensitivity. Some previous research suggests that the counselor’s cultural sensitivity has some impact (e.g., Parham & Helms, 1981; Pomales & Williams, 1989) and that inclusiveness can be achieved in racially mixed groups (L. Davis, 1984). In both cases, the principles of culturally focused counseling are at least partially adapted and employed.

CONCLUSION

Our review of the clinical observations and research findings of culturally oriented counseling suggests that culturally focused counseling seems an appropriate response to the cultural issues associated with diminished outcomes. The outcome research substantiating this recommendation is very limited, and the sparse research offers only tentative support for culturally focused counseling. There is only some very preliminary research on culturally focused counseling for African American men arrested for domestic violence. Although this is encouraging, much more extensive and rigorous evaluation is in order. Ideally, clinical trials, comparing culturally focused batterer counseling with conventional batterer counseling, might be developed to test the effectiveness of this recommendation. Other components, such as specialized case management and community linkages and development, need to be implemented and tested. Ultimately, a broader system or community approach might be necessary to achieve a substantial impact. These broader approaches are, however, much more difficult to assess and evaluate (Gondolf, 1997a).

In the meantime, culturally focused counseling appears to be sufficiently endorsed to warrant implementation and development in more batterer programs nationwide. Culturally focused, or any culturally oriented counseling, is not being used in any systematic or extensive way across batterer programs. This counseling might be implemented, furthermore, with more community involvement, linkage, and outreach to enhance the counseling outcome and to develop new models of intervention. It may be that innovations such as neighborhood-based
groups, local mentors, and church-affiliated organizations may be more appropriate and effective in the African American community. More attention to culturally focused counseling seems at least a logical first step toward addressing the cultural issues at hand.

**IMPLICATIONS FOR PRACTICE, POLICY, AND RESEARCH**

- Clinical trials comparing culturally focused batterer counseling to conventional counseling are ultimately needed to test the effectiveness of one approach versus another.
- Cultural attitudes need to be assessed with existing validated scales because they may have a modifying influence on African Americans’ response to batterer counseling.
- The criminalization of family problems and aggressive policing in the African American neighborhoods have disproportionately affected African American men and may ultimately need to be addressed to improve counseling outcomes.
- Linkages with the community, specialized case management, and collaboration in social change efforts are also needed to broaden the scope and impact of the counseling.
- Culturally sensitive approaches with racially mixed groups may be a substitute where resources or racial diversity preclude culturally focused counseling with African-American-only groups.

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SUGGESTED FUTURE READING


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INTIMATE PARTNER VIOLENCE AGAINST CHINESE WOMEN
The Past, Present, and Future

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Chinese people make up one fifth of the world’s total population, yet little is known regarding the prevalence, risk factors, and health outcomes of intimate partner violence (IPV) among this population. There is a lack of public awareness as well as research about IPV in Chinese populations. Studies of IPV prevalence in the Chinese-American population are also limited. Thus, studies of IPV in Chinese populations are needed to increase the Chinese public’s recognition of this social problem and its impact on women’s rights and health. In order to help identify areas of needed focus for future research, this review centers on the strengths and weaknesses of existing literature on IPV in China and compares the findings with other populations. Also, knowledge about Chinese women’s position in society and family, risk factors for IPV, social barriers preventing victims from receiving help, and mental and physical outcomes of IPV are reviewed.

Key words: intimate partner violence, Chinese, Chinese American, prevalence, risk factors, barriers, health outcomes

INTIMATE PARTNER VIOLENCE (IPV) is very prevalent in the United States. The most recent published national random survey estimates that 4.4 million adult women are abused by a spouse or partner in this country each year (Plichta, 1996). Health care costs associated with IPV are in the billions of dollars (Chalk & King, 1998). It disrupts not only a woman’s physical health but also her mental health by increasing the risk of depression, high anxiety, low self-esteem, learned helplessness, post-traumatic stress disorder (PTSD), and substance abuse (J. C. Campbell & Lewandowski, 1997). U.S. physicians, public health experts, politicians, and community leaders recognize IPV as a serious health and social problem, and this is gradually becoming part of American public awareness. (Abbott, Johnson, Koziol-McLain, & Lowenstein, 1995). Actually, IPV is a worldwide social problem (Heise, Ellsberg, & Gottemoeller, 2000).

The People’s Republic of China, with a current population estimated at 1.26 billion people, contains 21% of the world’s people (China Pop-
Intimate partner violence (IPV) exists among the Chinese population, yet little is known about the extent or nature of IPV in this population either in China or in the United States.

People in China tend to overlook and ignore IPV because violence against a woman by her husband is considered to be one of the few categories of life protected as inviolably private.

In traditional Chinese families, the family structure is hierarchical and the husband assumes the highest authority.

Even though the literature has cited five societal rationales for IPV among Chinese women, no research studies have been conducted to test those premises.

Available data on the prevalence of IPV against Chinese women in Mainland China are mainly from physical abuse among divorce cases.

National data in the United States do not include Chinese Americans as a separate group. So far, there are only two studies that examined the prevalence of IPV among Chinese Americans.

It is difficult to compare IPV prevalence cross-culturally because of differences in sampling, design, IPV definitions, and measurement.

Battered Chinese victims are facing unique barriers to obtaining help.

Even though Western societies have reported adverse health outcomes associated with IPV for many years, no study has examined health ramifications of IPV among Chinese women.

IPV is a new area of investigation in China with very few studies conducted thus far. In 1995, the U.S. State Department speculated that at least one fifth of Chinese wives had been abused by their husbands (U.S. State Department, 1995) without giving a source for this estimate. No national survey study had been conducted in China or among Chinese American populations in the United States at that time.

It is impossible to state with accuracy the prevalence rate of IPV among women of Chinese descent from the Asian American proportions in studies in the United States or Canada because official statistics in both countries do not include Chinese or Asian American as a separate category (Bachman & Saltzman, 1995; Greenfeld et al., 1998; Lee & Au, 1998; Rennison & Welchans, 2000; Tjaden & Thoennes, 1999). We do know that in the United States, 4% of the population is Asian and Pacific Islander, and this group is among the fastest growing population group with a growth rate of 4.5% each year (Humes & McKinnon, 2000). We also know that in the past 5 years, Asians have been overrepresented in domestic violence deaths in Massachusetts. In 1994 through 1996, more than 10% of domestic fatality victims in Massachusetts were Asian although Asians constitute only 2.4% of the state’s population (C. I. Tan, 1997). The percentage of Chinese among Asians killed is not clear.

To synthesize what is known about IPV in Chinese populations and point out needed research directions, we have synthesized and reviewed a broad range of related literature. The review starts with the known literature on the prevalence rate of IPV in China. Because studies from China were extremely limited, we also explored what is known about the prevalence of IPV among Asian Americans, and the prevalence of IPV in Southeast Asian countries, which have a cultural background similar to China’s. In addition, we examined the social-historical-cultural factors of IPV in China. To point out the need for research regarding health outcomes of IPV in China, we briefly reviewed the research in the United States regarding physical and mental health outcomes of IPV. In each section, limitations of the existing studies and future research recommendations are delineated.

KEY POINTS OF THE RESEARCH REVIEW

- Intimate partner violence (IPV) exists among the Chinese population, yet little is known about the extent or nature of IPV in this population either in China or in the United States.
- People in China tend to overlook and ignore IPV because violence against a woman by her husband is considered to be one of the few categories of life protected as inviolably private.
- In traditional Chinese families, the family structure is hierarchical and the husband assumes the highest authority.
- Even though the literature has cited five societal rationales for IPV among Chinese women, no research studies have been conducted to test those premises.
- Available data on the prevalence of IPV against Chinese women in Mainland China are mainly from physical abuse among divorce cases.
- National data in the United States do not include Chinese Americans as a separate group. So far, there are only two studies that examined the prevalence of IPV among Chinese Americans.
- It is difficult to compare IPV prevalence cross-culturally because of differences in sampling, design, IPV definitions, and measurement.
- Battered Chinese victims are facing unique barriers to obtaining help.
- Even though Western societies have reported adverse health outcomes associated with IPV for many years, no study has examined health ramifications of IPV among Chinese women.

**REVIEW OF LITERATURE**

**Violence Against Women in China**

A popular Chinese custom requires that women submit to humiliation for the sake of an
important mission that they feel obligated to fulfill for the families and children. “Don’t wash your dirty linen in public” is one interpretation of an influential ancient Chinese text. It is a tradition for Chinese women to suffer, and the public rarely pays attention to issues of IPV.

Dramatic economic and social changes in China since the late 1970s have drawn the attention of social scientists interested in assessing the impact of these changes on various aspects of social stratification, including women’s status (Hannum & Xie, 1998). However, opposing violence against women did not even come to Chinese societal consciousness until after the Third World Women’s Conference in 1985 (Sun, 1997). In the Platform of Action of the Fourth World Women’s Conference in Beijing in 1996, prohibitions of violence against women (VAW) were for the first time concretely explicated in a worldwide forum, and women from all over the world were asked to take steps to help achieve those goals. In response, a few studies in China focused on VAW, especially on the problem of maltreating wives. In 1993, a group of women’s studies scholars at the Chinese Women’s College conducted face-to-face interviews with 30 female victims of violence in Pinggu, a county in the Beijing suburbs (Sun, 1997). The investigators did not release the results to Western society.

Sun (1995) reported the results of two large studies conducted in China that suggested the magnitude of the problem of IPV. The first study was a survey on marriage quality in Beijing in which 21% of the 2,118 respondents indicated that they had been beaten by their husbands. The other investigation, conducted in Shanghai in 1992, revealed that in 61.5% of 3,899 reported abuse cases, the violence perpetrator and victim were a couple.

In 1999, the Women’s Studies and Information Center in Beijing surveyed 4,000 women in four cities in China, with 1,000 participants from each city. It was an 18-month project designed to investigate the Chinese population’s attitude toward IPV and the causes, prevalence, and prevention of IPV in China. The four cities were chosen to represent (a) the capital, (b) the southeast coastal areas that are under reform and becoming more open to the outside world, (c) the areas with a high density of ethnic minorities, and (d) the northern poor rural areas. The investigators found that compared to other areas in China, violent acts happened more frequently in the economically advanced regions. In the areas with a high density of ethnic minorities, the investigators found a high incidence of severe violence cases, one in which a man locked his wife in iron underpants that he had made. Again, the results were not released to Western society (Sun, 2000).

Thus, at least to Western society, violence against women in China remains an unknown phenomenon. In this review, we examine sources published in Chinese and previously unknown to Western society.

Chinese Women’s Position In Society and Family

In traditional Chinese families, the family structure is hierarchical, and the husband assumes the highest authority (M. Ho, 1987). Chinese women’s social and family status can be clearly seen in the traditional Chinese aphorisms, such as “The wife I’ve taken, the horse I’ve bought: I can ride them both, and I can whip them both”; “Three days without beating your wife, and your home will fall apart”; and “Beating is love, and scolding is intimacy.” These three rules of obedience are widely accepted codes of behavior for moral, good women: (a) Before marriage, a woman follows and obeys her father; (b) after marriage, she follows and obeys her husband; and (c) after the death of her husband, she follows and obeys her son.
Cultural notions of male privilege and authority also exist in Confucius’s teachings. This ideology stresses the maintenance of hierarchical relationships, and men are viewed as the authority figures, whereas women are socialized to defer to the male head of the family (C. Ho, 1990). In Chinese families, husbands usually have the final authority on a variety of family issues, such as financial decisions, although they may give the illusion of power to their spouse (Yick & Agbayani-Siewert, 1997). Despite the fact that China is a country with little notion of individual privacy, violence against a woman by her husband is stubbornly considered to be one of the few categories of life protected as inviolably private. Therefore, people in China tend to overlook and ignore IPV.

Societal Rationales for IPV Among Chinese

The literature identified five common reasons given for IPV by Chinese people. First, the most common motivation for wife beating is attributed to traditional male chauvinism and sexism (Gallin, 1992; Xie, 1992). Commonly, violence is used to make one’s wife obey, with even extremely injurious violence used regarding a trivial matter. In addition, as less traditional economic and gender role norms accompany increasing Westernization, men may try to reassert their traditional prerogatives with violence (Gallin, 1992). Second, a woman may be beaten for giving birth to a girl or not producing children (Xu, Zhu, & J. C. Campbell, 2000). For many years, traditional Chinese culture regarded the failure of a woman to produce sons instead of daughters or failure to produce children to be her fault or indeed a crime. This failure serves as ground for the husband’s right to divorce her or take a concubine for passing on one’s family name (Gallin, 1992). This problem became more severe in China after the institution of the one child per family policy in 1979. Third, a man who has a lover may hope to use abuse or violence to force his wife to divorce him (Voice of America [VOA], 1998). Fourth, if a husband has some vice—for example, an addiction to gambling or alcohol (Xie, 1992; VOA, 1998)—a wife’s appeals to him to cease drunkenness or gambling losses are reasons to beat and abuse her. Last, there are reasons related to sex (Xie, 1992; Xu et al., 2000). Some husbands liked to watch pornographic videotapes after which they would force their wives to imitate what they had seen.

Even though the literature has cited and addressed these reasons, no research studies have been conducted to test these premises as risk factors, for example, which aspect of male chauvinism is the strongest risk factor. Or, as identified in other studies of risk factors for IPV (Levinson, 1989; Straus, 1973), is it underlying motives of asserting power and control, or is it financial inequality that is most salient?

Chinese Literature on Prevalence of IPV in China

The literature in China has seldom included incidence or prevalence data on IPV. Data stemming from divorce cases have provided the preponderance of available data (Table 1). According to a secondary source (Xie, 1992), in 1983, 70% of 760 divorce cases going through the Wuchang District Court in Wuhan were filed by women, of whom nearly 43% requested divorce because they had been abused or because of their husbands’ chauvinism. In the same city, in 1986, 33% of the 1,005 women who came to a Women’s Federation of Wuhan reception center to ask for help or protection reported IPV by their husbands. In the large Chinese city of Tianjin, among 100 randomly selected divorce cases from the years 1984 and 1986, 41 (41%) and 51 (51%) of the proceedings, respectively, were instituted by women who had been beaten by their husbands (Xie, 1992). In 1991, a female attorney actually interviewed 106 divorced women (Pi, 1991). She reported that 46% of the women asked for divorce because they could no longer stand the beatings they had endured from their husbands, and 70% reported being beaten by their husbands at some time during their marriage.

In August 1997, a staff member from Qindao Women’s Federation (QDWF) presented data related to IPV at a meeting sponsored by the Chinese government in Beijing. Among the
<table>
<thead>
<tr>
<th>City &amp; Year (Citation)</th>
<th>Sample</th>
<th>Study Design</th>
<th>Definition of Domestic Violence</th>
<th>Results</th>
<th>Limitation of the Study</th>
</tr>
</thead>
<tbody>
<tr>
<td>Wuhan, 1983 (Xie, 1992)</td>
<td>760 divorce cases</td>
<td>Record review</td>
<td>Abused by husband or husband's male chauvinism</td>
<td>30% due to domestic violence</td>
<td>Primary source (Chinese newspaper) cannot be accessed</td>
</tr>
<tr>
<td>Tainjin, 1983 (Xie, 1992)</td>
<td>100 random selected divorce cases</td>
<td>Record review</td>
<td>Wife beating (operationalization not clear)</td>
<td>41% had been beaten</td>
<td>Primary source (Chinese newspaper) cannot be accessed</td>
</tr>
<tr>
<td>Tianjin, 1984 (Xie, 1992)</td>
<td>100 random selected divorce cases</td>
<td>Record review</td>
<td>Wife beating (operationalization not clear)</td>
<td>51% had been beaten</td>
<td>Primary source (Chinese newspaper) cannot be accessed</td>
</tr>
<tr>
<td>Wuhan, 1986 (Xie, 1992)</td>
<td>1,005 women came to Wuhan Women's Federation</td>
<td>Descriptive</td>
<td>Abused without further definition (operationalization not clear)</td>
<td>33% had been abused</td>
<td>Primary source (Chinese newspaper) cannot be accessed</td>
</tr>
<tr>
<td>City unknown, 1991 (Pi, 1991)</td>
<td>106 divorced women</td>
<td>Interview</td>
<td>Wife beating (operationalization not clear)</td>
<td>46% asked for divorce due to beating, 70% had been beaten at least once by ex-husband</td>
<td>Best designed of all divorced studies but used convenience sample</td>
</tr>
<tr>
<td>Qindao, 1996 (C. Y. Tan, 1997)</td>
<td>205 divorced cases</td>
<td>Record review</td>
<td>No definition</td>
<td>25.3% (52 cases) caused by domestic violence</td>
<td>Primary source not known</td>
</tr>
<tr>
<td>Qindao, 1991-1997 (C. Y. Tan, 1997)</td>
<td>2,348 women came to Qindao Women's Federation</td>
<td>Descriptive</td>
<td>Wife beating (operationalization not clear)</td>
<td>15.2% (358 cases) had been beaten</td>
<td>Did not specify prior year or lifetime abuse</td>
</tr>
<tr>
<td>China, 1997 (Voice of America, 1998)</td>
<td>Divorced cases (data source unknown)</td>
<td>Unknown</td>
<td>Wife beating (operationalization not clear)</td>
<td>70%-80% of divorced cases due to beating</td>
<td>Data source unknown</td>
</tr>
<tr>
<td>Beijing, 1993 (Sun, 1995)</td>
<td>30 women, victims of violence</td>
<td>Qualitative face-to-face interview</td>
<td>Unknown</td>
<td>Unknown</td>
<td>Primary source not known</td>
</tr>
<tr>
<td>Beijing, 1995 (Sun, 1995)</td>
<td>2,118 women</td>
<td>Survey</td>
<td>Beating</td>
<td>21.3% had been beaten by husband (lifetime)</td>
<td>Primary source not known</td>
</tr>
<tr>
<td>Beijing, Wenzhou, Hinghan League, Qianxi, 1997-1998 (Sun, 2000)</td>
<td>4,000 women with 1,000 in each city</td>
<td>Random house survey</td>
<td>Defined as physical, mental, and sexual abuse</td>
<td>Wenzhou city has highest violence rate; Hinghan league has a high incidence of severe violence cases</td>
<td>Lack of conceptual definition and instrument weakness</td>
</tr>
<tr>
<td>Location, Year</td>
<td>Sample Description</td>
<td>Methodology</td>
<td>Spouse Aggression Definition</td>
<td>Prior Year Observations</td>
<td>Notes</td>
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<td>Hong Kong, 1992 (Tang, 1994)</td>
<td>246 female &amp; 136 male undergraduates</td>
<td>Survey (Conflict Tactics Scale [CTS] questionnaire), students filled out about their parents</td>
<td>Spouse aggression defined to include physical, psychological, and sexual abuse of spouse, operationally defined</td>
<td>Prior year: 14% of parents engaged in physical violence; 2%-5% of parents used weapons against each other; 75% of parents engaged in verbal aggression</td>
<td>Biased sample and results may underrepresent actual prevalence</td>
</tr>
<tr>
<td>Hong Kong, 1996 (Tang, 1999)</td>
<td>1,132 women above age 18</td>
<td>Telephone survey (CTS questionnaire)</td>
<td>Verbal and physical abuse, conceptually and operationally defined</td>
<td>Prior year: 67% of women had at least 1 incident of verbal abuse; 10% experienced at least 1 incident of physical abuse</td>
<td>Lack of evidence of cultural appropriation and equivalence of the instrument</td>
</tr>
<tr>
<td>Hong Kong, 1998 (Leung, Leung, Lam, &amp; Ho, 1999)</td>
<td>631 pregnant women</td>
<td>Abused Assessment Screen</td>
<td>Abuse defined as either emotional, physical, and/or sexual abuse</td>
<td>Lifetime: 17.9% were abused, 4.3% were abused while pregnant; year prior: 15.7% were abused, 9.4% were sexually abused</td>
<td>Lack of conceptual definition of abuse; instrument weakness; results may underrepresent the actual prevalence</td>
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<tr>
<td>Fuzhou, 1998 (Xu, Zhu, &amp; Campbell, 2000)</td>
<td>30 female in an OB-GYN outpatient clinic</td>
<td>Clinical assessment</td>
<td>Defined as physical, emotional, and sexual abuse</td>
<td>Lifetime: 3% physical abuse, 10% forced sex, 7% verbal abuse</td>
<td>Convenience sample (skewed population) and instrument limitation</td>
</tr>
</tbody>
</table>
Despite the fact that the above statistics provide a general sense that IPV is relatively high among divorced families in China, the results cannot be generalized to the Chinese population as a whole. Because people care less about losing face when getting a divorce, one cannot draw conclusions about the rising rate in IPV based on divorced cases alone. The divorce rate has increased tremendously in China during the past 20 years. According to VOA (1998), divorce cases increased from 300,000 (0.3%) in 1980 to 1,113,000 (1.1%) in 1996.

The above studies have other limitations. First, the data source for the VOA report is unclear. Second, in four of the above studies, the primary source (Chinese newspapers) cannot be accessed; therefore, secondary data sources were used. Third, none of the studies had operational definitions of domestic violence or wife beating. Finally, it is not clear whether the abuse happened during the year before the divorce or throughout the marriage. Pi’s (1991) study was the best designed of all the divorce studies; however, the use of a convenience sample may limit this study’s generalizability.

Three peer-reviewed Hong Kong prevalence studies have been published (Leung, Leung, Lam, & Ho, 1999; Tang, 1994, 1999). The earlier study by Tang (1994) used the parental form of the Conflict Tactics Scale (CTS) on undergraduate students (N = 482) to determine the prevalence of violence among undergraduate students’ parents. The results showed 14% of the parents used physical violence against each other, and 75% used verbal aggression during the prior year. The more recent random community survey of women older than 18 years old by Tang (1999), utilized the couple form of CTS; 67% of the women surveyed (N = 1,132) reported at least one incident of verbal aggression, and 10% experienced at least one incident of physical aggression by their husband/partner during the prior year. Both studies, like those in the United States, reported a higher prevalence of verbal aggression compared to physical aggression. Leung et al. (1999) used the Abused Assessment Screen (AAS) to identify the prevalence of abuse among a convenience sample of pregnant women (N = 631) in an OB clinic in Hong Kong. Of the women, 18% reported a history of abuse, 5% reported IPV while pregnant, 16% reported abuse in the year prior, and 9% reported sexual abuse in the year prior.

The above Hong Kong studies’ results are different from a preliminary clinical-based assessment study in Mainland China (Xu et al., 2000). Xu et al. found only 3% of a sample of 30 women reporting physical violence, 10% reporting forced sex, and 7% reporting verbal abuse by their husbands. This study was limited by its small convenience sample, but it was a direct inquiry (using a modified AAS) rather than an indirect assessment as in the first Tang (1994) study of students reporting about their parents. Tang’s (1999) recent study had a larger sample size; however, Tang did not present support for the cultural equivalence of the CTS. The original CTS also had limitations in terms of failing to consider the contexts (e.g., self-defense) and consequences of IPV (DeKeseredy, 2000). In addition, the sample consisted of only married women who were randomly drawn from another survey sample.

Leung et al.’s (1999) study is the first known IPV study in a health care setting in China. However, the authors did not define abuse consistently in their study. They defined abuse in the lifetime as emotional and/or physical ever and/or sexual abuse in the year prior and abuse in the year prior as physical and/or sexual abuse in the year prior. Similar to Tang (1999)
was the lack of assessment of instrument cultural appropriateness.

**Prevalence of Intimate Partner Violence in Southeast Asian Countries**

China is the origin of Asian culture. Because no national population-based study of prevalence of intimate partner violence in China is available, the few studies available on other Asian countries with similar cultural backgrounds are appropriate to examine (see Table 2). Among the five studies available, two (the Japanese and Malaysian studies) were national surveys. Yoshihama and Sorenson (1994) conducted a nationwide mail survey in Japan. Among 796 women surveyed, 58.7% reported having been physically abused, 65.7% reported having been emotionally abused, and 59.4% reported having been sexually abused by their spouse in their lifetime. The Malaysian study used a random sample of 1,221. Of this group, 39% of respondents knew a woman who had been abused by her husband in the prior year, and 15% of adults (22% Malays) considered wife beating appropriate (Abdullah, Raj-Hashim, & Schmitt, 1995). Among the other three studies, two used written instruments for data collection. McKelvey and Webb’s (1995) Vietnamese Amerasian study used self-administered questionnaires to assess history of physical and sexual abuse. The results showed that 18% of the women and 22% of the men reported some physical and/or sexual abuse in their lives. Paltiel’s (1987) Bangladesh study of national household mortality found that 49% of deaths were caused by severe beating, usually by husbands (see Table 2).

It is difficult to make meaningful cross-cultural comparisons of these five studies because of differences in their study designs, definitions of IPV, and measures. The Japanese study had the best study design among the five studies, and operationally defined IPV based on actions involved in physical, emotional, and sexual abuse. However, the authors did not clearly state how they obtained the original survey sample, and the representativeness of the sample of the total population of women in Japan. Even though the Malaysian study used a national random sample survey, it only obtained indirect prevalence by asking whether respondents knew a woman who had been abused. The previously described Hong Kong study (Tang, 1999) used a sample of married women only, randomly drawing the sample from another survey sample. The Vietnamese study was a child abuse assessment instead of a spouse abuse assessment and used a sample from the Philippines instead of Vietnam. The Bangladesh study only reported the percentage within household deaths that were caused by severe wife beating. IPV-related homicides are usually expressed in terms of incidence or percentage of the total homicide rather than household death, precluding comparisons with other studies.

The five studies in Table 2 illustrate the impossibility of making cross-national comparisons of IPV without uniform definitions and time periods of measurement. Issues associated with IPV definition and measurement start with the scope of behaviors included in the definition. Narrow definitions can appear to trivialize abused women’s subjective experiences, restrain them from seeking social support, and exacerbate the problem of underreporting (DeKeseredy, 2000). Broad definitions with too many behaviors under IPV may result in people labeling each other’s behaviors as abusive or violent when the individual, couple, or culture does not consider the actions that serious (DeKeseredy, 2000; Duffy & Momirov, 1997). The second issue associated with an IPV definition has to do with research framework and design. As Gordon (2000) and Weis (1989) pointed out, different definitions of IPV implicate differences for describing the nature of IPV, data collection, and interpretation. Therefore, the researchers “should be explicit about their operational definitions and describe characteristics of their samples so that sample characteristics can be compared across studies” (Gordon,
<table>
<thead>
<tr>
<th>Country (Citation)</th>
<th>Sample</th>
<th>Study Design</th>
<th>Definition of Domestic Violence</th>
<th>Results</th>
<th>Limitation of the Study</th>
</tr>
</thead>
<tbody>
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<td>Hong Kong, 1994 (Tang)</td>
<td>246 female &amp; 136 male undergraduate students ages 17-30 yrs. (M = 18.9)</td>
<td>Survey (Conflict Tactics Scale questionnaire), students filled out about their parents</td>
<td>Spouse aggression includes physical, psychological, and sexual abuse of spouse, operationally defined</td>
<td>Prior year: 14% of parents engaged in physical violence; 2%-5% of parents used weapons against each other; 75% of parents engaged in verbal aggression</td>
<td>Indirect assessment may overrepresent actual prevalence</td>
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<td>1,132 women above age 18</td>
<td>Telephone survey (CTS questionnaire)</td>
<td>Verbal and physical abuse, conceptually and operationally defined</td>
<td>Prior year: verbal aggression experienced by 67% of women; physical aggression experienced by 10% of women</td>
<td>Lack of evidence of cultural appropriateness and equivalence of the instrument</td>
</tr>
<tr>
<td>Japan, 1994 (Yoshihama &amp; Sorenson)</td>
<td>796 women who completed the survey ages 20-80 yrs. (M = 43.5)</td>
<td>Nationwide mail survey; descriptive statistics analysis</td>
<td>Defined by actions of physical, emotional, and sexual abuse by spouse.</td>
<td>Lifetime: physical abuse, 58.7%; emotional abuse, 65.7%; sexual abuse, 59.4%</td>
<td>Not clear how original survey sample was obtained or representativeness of total population</td>
</tr>
<tr>
<td>Malaysia (Abdullah, Raj-Hashim, &amp; Schmitt, 1995)</td>
<td>Random sample of 713 women and 508 men</td>
<td>National survey in 1990</td>
<td>“Physically beaten” in the year before without further operational definition</td>
<td>Year prior: 39% of respondents knew a woman who had been physically beaten; 15% of adults (22% Malays) said wife beating appropriate</td>
<td>Indirect prevalence assessment</td>
</tr>
<tr>
<td>Bangladesh, 1987 (Paltiel)</td>
<td>National household death</td>
<td>Record review</td>
<td>Wife beating without operational definition</td>
<td>49% of household deaths caused by beating, usually by husbands (years covered unclear)</td>
<td>Does not allow comparisons (homicide usually expressed as incidence)</td>
</tr>
<tr>
<td>Vietnamese Amerasians (McKelvey &amp; Webb, 1995)</td>
<td>34 female and 68 male Vietnamese Amerasians in Philippines, ages 18-28 yrs. (M = 20.5)</td>
<td>Self-Administered Abuse Questionnaire, HSCL-25, Vietnamese Depression Scale, Youth Self-Report</td>
<td>History of physical and sexual abuse, operationally defined by actions</td>
<td>In childhood: physical and/or sexual assault reported by 22% of men, 18% of women</td>
<td>Child abuse assessment instead of spouse abuse assessment</td>
</tr>
</tbody>
</table>
2000, p. 750). Only definitional consistency, standard measures, and similar samples can result in comparison cross-culturally. The Centers for Disease Control (CDC)(2000) has developed uniform definitions that researchers can either adopt or use to state how their definitions are different.

Violence Against Women in Chinese American and Asian American Populations

According to Schmidley and Robinson (1998), based on the 1997 population survey, 24% of the U.S. Asian population is Chinese. In addition to the approximately 700,000 Chinese immigrants admitted to the United States in the past 7 years, there are approximately 2,000,000 ethnic Chinese residing in the United States today. The majority of them are first-generation immigrants who came to this country in the past two decades, mainly from China, Taiwan, Hong Kong, and Southeast Asian countries (U.S. Bureau of Census, 1997; U.S. Department of Commerce, 1993). Because of cultural and language barriers, most of these new Americans maintain their native tongues and read only Chinese newspapers (Du, 2001). Therefore, they are isolated and, consequently, perhaps even more vulnerable to violence.

Qualitative studies, case studies, and data from various social service agencies document the existence of IPV problems among Chinese immigrants to the United States. However, national studies have not examined the rates of IPV in Asian American communities separately. Even though several studies in the United States during the past decade have suggested that Asian families are affected by IPV (Furiya, 1993; C. Ho, 1990; Song, 1992), to date, only three studies (Yick, 1999; Yoshihama, 1999; Yoshioka & DiNoia, 2000) have examined the prevalence of IPV specifically among women of Asian descent in the United States. In Yoshihama’s random population-based Japanese American study, 80% of the respondents interviewed (N = 211) reported experiencing physically, mentally, or sexually aggressive acts from a male partner during their lifetime. When measuring the woman’s perceptions that the partner’s acts were abusive or that the relationship was abusive, the lifetime prevalence was 61%. The investigators did not clearly define the three different kinds of abuse and reported the frequency of each abusive item (action) rather than the prevalence rate of each type of abuse. The method for determining the lifetime prevalence of abuse was not clearly described in the research report.

Two recently reported studies were conducted with Chinese Americans in Los Angeles county (Yick, 1999) and an urban area of the northeastern United States. (Yoshioka & DiNoia, 2000). Yick (1999) conducted telephone interviews with a convenience sample of 262 Chinese American adults (133 men and 129 women) in Los Angeles county, using the CTS. She found that 81% had experienced verbal aggression, 7% minor physical violence, and 2% severe physical violence in the year prior. Lifetime occurrences of each of these types of violence were 85%, 18%, and 8%, respectively. The major limitations of the study are (a) the sample is not a representative sample even for Los Angeles county, (b) the investigator did not differentiate prevalence rates for men and women, and (c) the investigator did not report the cultural validity of the CTS among Chinese Americans. Yoshioka and DiNoia’s (2000) study compared attitudes toward marital violence among Chinese and Cambodian adults in an urban area of the Northeast, using a convenience sample of 229 (158 Chinese and 71 Cambodians). Of the sample, 36% of Chinese men (n = 33) and 16% of Chinese women (n = 111) witnessed their mother being hit by a partner. The validity of the study is questionable because it used an indirect method of inquiry about abuse.

Even though Asian women are underrepresented or absent from American prevalence studies on IPV, several researchers and practitioners who work with battered Asian women have estimated that wife battering occurs as frequently in the Asian population as it does in the general population.
have estimated that wife battering occurs as frequently in the Asian population as it does in the general population (Eng, 1990; Ikeda-Vogel, Lee, & Lee, 1993; Rimonte, 1989). Some scholars assert that Asian women who are battered are less likely than women from other racial and ethnic groups to report abuse, and those who do usually wait till the battering has reached a crisis level of severity (Bhaumik, 1988; Rimonte, 1989).

In terms of the saliency of IPV for persons of Asian descent, the EDK and Associates’ (D. W. Campbell, Masaki, & Torres, 1997) national survey found that Asian Americans were the least likely of the major American ethnic groups to be “very worried” (20% of women and 26% of men) about the growth of family violence and the most likely of any ethnic group to be “not worried” (30% of women and 28% of men). The EDK study was among the first to include Asian Americans in a breakdown of responses by ethnicity. Further research is important to gain more comparison data about Asian Americans’ perceptions about family violence and provide insight into the responses by Asian Americans in the study, particularly when they differ from the responses of all other ethnic groups.

Comparison of Prevalence of IPV Across Cultures

In the United States, prevalence studies also started with divorce cases. Among the first researchers reporting violence in divorce cases, Levinger (1966), O’Brien (1971), and Fields (1977) reported a wide range of prevalence among women seeking divorce: 37%, 17%, and 50%, respectively. Parker and Schumacher (1977), in the first published nursing research on IPV, further quantified the assaults in a sample of wives seeking divorce. They noted that 40% reported being assaulted three or more times, whereas 66% reported being assaulted at least once. It seems that the prevalence of violence in the divorce cases in the United States (at least in the 1960s and 1970s) is approximately the same as the prevalence from Pi’s study (1991) of divorced women in China. However, these U.S. studies did not specify the time frames in which the abuse occurred—prior year or lifetime. Therefore, it is difficult to make exact comparisons.

A population based prevalence study conducted by the Commonwealth Fund survey found more than 8% of U.S. women (n = 2,525) reported suffering physical abuse from their partner in the prior year and 35% in their lifetime (Plichta, 1996). These results are comparable with other national representative studies and statewide surveys that found a past year physical abuse prevalence of 5% to 20% and lifetime prevalence of 18% to 33% (CDC, 1998, 2000; Coker, Derrick, Lumpkin, Aldrich, & Oldendick, 2000; Klein, J. C. Campbell, Soler, & Chez, 1997; Schafer, Caetano, & Cook, 1998; Schulman, 1979; Straus & Gelles, 1986; Teske & Parker, 1983). Recent primary care investigations (Coker, Smith, Bethea, King, & McKeown, 2000; Coker, Smith, McKeown, & King, 2000; Jones et al., 1999; McCauley et al., 1995; Tollestrup et al., 1999) showed that 6% to 23% of women (n = 1,152, n = 1,401, n = 1,952, n = 1,138, and n = 2,415, respectively) had been physically abused in the year prior and 21% to 38% in their lifetime. Studies (Dearwater et al., 1998; Feldhaus et al., 1997; McLaughlin et al., 2000) conducted in the Emergency Department (ED) reported a higher lifetime prevalence of physical abuse (30%-47%). An ED study estimated that 22% to 35% of women (n = 648) seeking emergency treatment did so for symptoms related to abuse (Abbott, Johnson, Koziol-McLain, & Lowenstein, 1995). In other health care setting studies (N = 1,203 and N = 691), battered women account for 4% to 17% of women attending prenatal clinics (CDC, 1994; McFarlane, Parker, Soeken & Bullock, 1992; Parker, McFarlane, & Soeken, 1994).

In reviewing data from studies documenting IPV, it is almost impossible to directly compare the prevalence of violence among different cul-
tures because investigators are not consistent in the probes used to identify abuse or the operational definitions of their dependent variables (e.g., abuse or physical assault, lifetime vs. the last year). Even among those different health care setting studies in the United States, it is difficult to compare prevalence because of sample restrictions, definitions of IPV, and instruments for measurement. For example, Coker, Smith, McKeown et al. (2000) defined IPV as physical, sexual, battering, or perceived emotional abuse. They used the AAS and the Index of Spouse Abuse (ISA) in measuring IPV in the current/most current relationship, past relationship, and any relationship. However, most studies defined IPV as physical and/or sexual abuse only (Abbott et al., 1995; Dearwater et al., 1998; Jones et al., 1999).

Both poor ascertainment and women tending to underestimate and underreport the level of physical and psychological violence they experience in a relationship may deflate prevalence statistics (Frisbach & Herbert, 1997). Likely explanations for inaccurate estimates are that women in many cultures are (a) socialized to accept physical and emotional chastisement as part of husbands’ marital prerogative, thereby limiting the range of behavior they identify as abusive (Counts, 1990; Olavarrieta & Sotelo, 1996); (b) averse to reporting abuse out of shame or reluctance to incriminate family members or their culture (Heise, 1993; Rodriguez, Quiroga & Bauer, 1996); and/or (c) fearful of retaliation (Heise, 1993).

Risk Factors and Barriers to Obtaining Help for IPV Among Chinese

Risk factors. Studies have identified risk factors for IPV in the United States that are different from the rationales for abuse in China in the literature described previously. In the United States, researchers reported the following demographic risk factors: age less than 35 years (Martin, Kilgallen, Dee, Dawson, & Campbell, 1999; McCauley et al., 1995); single, separated, or divorced marital status (McCauley et al., 1995); partner with a low education level (Martin, Tsui, Maitra, & Marinshaw, 1999; Rath, Jaratt, & Leonardson, 1989); low socioeconomic or occupational status (Aldarondo & Sugarman, 1996; Hedin & Janson, 1999; Martin et al., 1999; Rath et al., 1989); couple living with husband’s parents (Martin et al., 1999); and multiple children (Martin et al., 1999). Adler (1996) reported that rural society and conditions could contribute to make it more difficult to escape from IPV. The private nature of modern society and social isolation of many nuclear families are also risk factors for IPV (Gelles & Straus, 1988; Martin et al., 1999). “As the nature of the family becomes more private, the family may become more insulated from social control and therefore at potentially greater risk for wife abuse” (Martin et al., 1999, p. 418).

Other studies found that the following psychosocial factors significantly correlated with abuse: (a) victim or partner’s having been abused as a child (de Vries, March, Vinen, Horner, & Roberts, 1996; Oriel & Fleming, 1998; Roberts, Lawrence, Williams, & Raphael, 1998; Roberts, O’Toole, Lawrence, & Raphael, 1993); (b) partner’s witnessing violence in the family of origin (Aldarondo & Sugarman, 1996); (c) partner with depression (Oriel & Fleming, 1998); and (d) high-level marital conflicts (Aldarondo & Sugarman, 1996). Several studies found that the partner’s alcohol consumption (Hutchison, Magennis, Shepherd, & Brown, 1998; Keenan, el-Hadad, & Balian, 1998; Kyriacou, McCabe, Anglin, Lapesarde, & Winer, 1998; Leonard & Quigley, 1999; McCauley et al., 1995; Oriel & Fleming, 1998) or drug use (McCauley et al., 1995) were risk factors. In one of the few international risk factor analyses, Keenan et al. (1998) found that in low-income Lebanese families, unmet gender role expectations and conflict with husband’s relatives are risk factors for woman abuse.

There are only two Chinese population studies that identify risk factors for IPV. Leung et al.’s (1999) study of pregnant Chinese women in Hong Kong found that unplanned pregnancy was one of the main risk factors for abuse. Women with husbands/partners who were unemployed or manual workers and who were permanent local residents rather than new immigrants were at risk for IPV. However, in another Hong Kong study (Tang, 1999), the researcher found that couples’ education level,
Barriers to obtaining help. Battered Chinese families, in China and in the United States, face many unique barriers to obtaining help. First, violence in the Chinese home is viewed as a family matter. Asking for help outside the family and divorce are perceived as a loss of face for the family (Xu, 1998). For many Chinese families, fear of losing face and criticism, and the traditional imperative to keep things within the family have made it difficult to break the silence of violence in the home. Second, leaving one’s spouse can result in ostracism from the community and loss of community respect and connection to the only existing support systems within the woman’s own culture.

For many Chinese families, fear of losing face and criticism, and the traditional imperative to keep things within the family have made it difficult to break the silence of violence in the home. Second, leaving one’s spouse can result in ostracism from the community and loss of community respect and connection to the only existing support systems within the woman’s own culture. Many Chinese refugees and immigrants have been traumatized by war or politics in China (C. I. Tan, 1997). Conditioned to fear uniformed authorities, these women are even less likely to report accounts of IPV to the police. In addition, many Chinese immigrants (especially those who entered the United States illegally) have limited educational opportunities. They also have minimal or nonexistent English language skills and may be illiterate in their native language (Lee & Au, 1998). With such restricted skills and the desire to obtain legal status to stay in the United States via marriage, women feel particularly unable to leave their spouses and lead independent lives. Battered Chinese families are often isolated by language and cultural barriers and trapped in violent and potentially violent homes (C. I. Tan, 1997). Many are not even aware that domestic violence is a crime because of cultural norms related to women. In addition, Chinese American women may be afraid of seeking outside help, and most IPV resources are still inaccessible because of language and cultural barriers. As a result, Chinese immigrant families have been particularly vulnerable when violence erupts in the home.

Chinese women in China are facing an even more important barrier—lack of community support services. There are no women’s shelters in China. There are limited domestic violence hotlines. Women can report to the local Women’s Federation, a government agency that helps solve women’s problems. However, many women have a fear of authorities, and they are unlikely to report accounts of IPV to the government.

Mental health outcomes. Until recently, no study has looked at the mental health outcomes of IPV among Chinese women. Studies conducted in the United States showed that mental health consequences of abuse are significant and result in increased use of health care (Bland & Orn, 1986; J. C. Campbell, 1989a, 1989b; J. C. Campbell, Kub, & Rose, 1996; J. C. Campbell & Lewandowski, 1997; Frisch & MacKenzie, 1991; Gleason, 1993; Hamberger, Saunders, & Hovey, 1993; Jaffe, Wolfe, Wilson, & Zak, 1986; McCauley et al., 1996; Ratner, 1993; Torres, 1992; Trimpey, 1989). These studies found that depression, PTSD, low self-esteem, fear, and anxiety correlated strongly with severity and frequency of abuse. However, the relationship of IPV and mental health sequelae has seldom been investigated internationally (Heise, 1993).

Mental health studies conducted in the United States included samples only from White, African American, and Hispanic popula-
Because of the social factors and cultural differences, it is not clear that abused Chinese will have the same mental health outcomes. However, ethnographic data from China provide preliminary evidence that wife beating is widespread and is associated with depression and suicide (Gilmartin, 1990). Norton and Manson (1992), using a case study approach, also reported an association between major depression and IPV in a sample of Southeast Asian refugees. Thus, evidence supporting an association between adverse mental health and IPV in Chinese populations in the United States and in China is only preliminary.

Physical health outcomes. There is no research on the effect of IPV on physical health in Chinese populations. In the United States, researchers have found that battering is a significant risk factor for a variety of physical health problems treated in health care settings (J. C. Campbell & Lewandowski, 1997). Studies indicate that IPV results in different kinds of physical injuries: (a) muscular-skeletal injuries, such as pain, broken bones, facial trauma, and tendon or ligament injuries; (b) possible neurological problems, such as chronic headaches or undiagnosed hearing, vision, and concentration problems; (c) genitourinary health problems, such as chronic irritable bowel syndrome, dysmenorrhea, bladder infection, sexual dysfunction, pelvic pain, pelvic inflammatory disease, and sexually transmitted diseases (Bergman & Brisma, 1991; J. C. Campbell & Alford, 1989; Eby, Campbell, Sullivan, & Davidson, 1995; Grisso et al., 1991; Plichta, 1996; Straus & Gelles, 1990; Vavarro & Lasko, 1993; Zachariades, Koumoura, & Konsolaki-Agouridaki, 1990).

The societal changes in China have contributed to STDs becoming an urgent problem. Xu et al.'s (2000) preliminary study in China found that 10% of interviewed women had STDs. The potential for an epidemic of HIV/AIDS in China is enormous if the societal trends are not changed. Xu's (1998) interviews of Chinese women and a VOA (1998) report revealed that having lovers outside of home is currently in fashion in China, which will increase the spread of STD and HIV/AIDS. Research investigating the health consequences of IPV, including STDs and HIV, among Chinese women can be extremely important in the public health efforts needed to prevent an epidemic of HIV in China.

Summary of the Review

This review indicates how little is known in the knowledge of violence against Chinese women. First, the prevalence of violence among Chinese populations is not yet established. Obtained prevalence rates are from divorced and unrepresentative samples, using nonuniform definitions and indirect assessments. Second, there is a lack of culturally appropriate instruments for the assessment of IPV against Chinese women, which makes cross-cultural comparisons impossible. Third, even though the literature addressed the reasons for IPV against Chinese women, no research has tested those reasons as risk factors. Even though two studies from Hong Kong identified some of the sociodemographic risk factors of IPV, the evidence was inconsistent and did not assess factors specific to Chinese culture. Last, although research has been conducted for many years on the mental and physical health outcomes of IPV against women in Western cultures, leading to important changes in health and public policies, no study has focused on the health outcomes of violence against Chinese women.

CONCLUSION

Any kind of IPV is a violation of one's physical body, one's sense of self, and one's sense of trust. It disrupts a person's life and health with profound consequences. In China, unlike Western countries, people do not recognize IPV as a social problem that warrants discussion by citizens and coverage by the news media. The society usually ignores it. In addition, no one in the health care system is advocating attention to the
The societal and health systems’ lack of responsiveness may be a major factor in China’s acceptance of this social ill. References to verbal and physical abuse of women are scattered throughout writings on Chinese culture. Most comments consist of a sentence or two noting that abuse does occur, but the texts rarely discuss specific incidents or related dynamics (Cohen, 1976; Gallin, 1992; Lang, 1946). In American society, IPV is not only considered a health problem and social ill, it is also a crime. The perpetrators can be prosecuted and incarcerated like other criminals. Studies of violence in the Chinese population are needed to increase Chinese society’s awareness of spousal assault to start concentrating on women’s rights and health issues.

An example of the type of research needed is the World Health Organization’s (WHO) multicountry study of domestic violence against women (WHO, 1998). In 1996, the Women’s Health Program (WHD) in the WHO held a consultation with researchers, health care providers, and women’s health advocates from several countries who were active in the field of violence against women. They explored the potential role of WHO in addressing the issue. One of the main recommendations was that WHO should support international research to explore the dimensions, health consequences, and risk factors of violence. In response to this recommendation, WHD/WHO developed methods for implementing a multicountry study on women’s health and domestic violence against women. The study is currently an ongoing project in seven countries. This example of a sample study not only provides conceptual and operational definition of domestic violence but also adapts multiple culturally validated instruments. Most important, because the study is using the same operational definition and questionnaire, it enables cross-cultural comparisons of IPV in terms of prevalence, risk factors, and health outcomes among different cultures.

IMPLICATIONS FOR PRACTICE, POLICY, AND RESEARCH

- To effect policy change in China in terms of IPV and women’s rights issues, the Chinese society and government’s awareness of IPV needs to be increased.
- Research about IPV is needed to increase Chinese society’s awareness of spousal assault.
- As well as research, public education through mass media and educational courses is essential to increase public awareness of IPV.
- Researchers need to investigate the unique culturally related issues (e.g., barriers, risk factors) of IPV among Chinese populations.
- Culturally valid instruments with the same operational definitions of IPV are needed to make cross-cultural comparisons of IPV.
- Health care providers need to take active action to conduct culturally appropriate assessments of IPV and assessment of mental and physical health ramifications.

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**SUGGESTED FUTURE READING**


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ERADICATING DOMESTIC VIOLENCE IN THE AFRICAN AMERICAN COMMUNITY
A Literature Review and Action Agenda

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Though all cultural, religious, sexual orientation, and socioeconomic groups experience domestic violence, people of color continue to be largely ignored in domestic violence literature. African Americans sustain serious and lethal injuries as a result of domestic violence. Domestic violence poses a grave threat to the preservation of African American families and communities. In an effort to create an agenda for further discussion, this article provides a critical analysis of the current literature on domestic violence in the African American community, identifies gaps in knowledge, and discusses an action agenda to help eradicate domestic violence.

Key words: African Americans, domestic violence, intimate partner abuse

ALTHOUGH THE VAST MAJORITY of African American intimate relationships do not experience violence (Karenga, 1993), the problem of domestic violence in the African American community is quite serious. “The National Black Women’s Health Project has identified woman battering as the number one health issue for Black women” (Joseph, 1997, p. 163). Though all cultural, religious, sexual orientation, and socioeconomic groups experience domestic violence (Gondolf, 1985), African Americans are more likely to sustain serious and lethal injuries as a result of domestic violence (Fagan, 1996; Gordon-Bradshaw, 1988; Hampton, Carrillo, & Kim, 1998; Hampton & Yung, 1996; Powers, 1988; Richie & Kanuha, 1993; Sullivan & Rumptz, 1994). “Overall, blacks were victimized by intimate partners at significantly higher rates than persons of any other race between 1993 and 1998” (Rennison & Welchans, 2000, p. 4). Domestic violence poses a grave threat to the preservation of African American families and communities.

The purpose of this article is to identify gaps of knowledge and propose an action agenda to eradicate domestic violence in the African American community. Domestic violence is defined as “a pattern of assaultive and coercive behaviors including physical, sexual, and psychological attacks, as well as economic coercion that adults or adolescents use against their intimate partners” (Schechter & Ganley, 1995, p. 10). Using an inductive approach, a content analysis was conducted to examine the following: (a) inconsistencies in the literature, (b) issues identified relative to race and gender, and (c) methodological concerns of previous research. Prior literature reviews on domestic violence in the African American community were selected for analysis. The cumulative findings of the content
analysis unveiled four critical themes: the historical context, socioeconomic status, external barriers, and internal barriers. I hope that this conceptual framework will serve as the basis for a collective action agenda that is focused on eradicating domestic violence, particularly in the African American community.

LITERATURE REVIEW

The first national study on domestic violence was conducted in 1975 with 7% of the participants identifying themselves as African American. The study was replicated 10 years later with 16% of participants identifying themselves as African American. The first study stated that African Americans were 400% more violent in the home than were White Americans. The second study found that African Americans were twice as likely to engage in intimate partner abuse than were White Americans (Straus & Gelles, 1986; Straus, Gelles, & Steinmetz, 1980). Changes in methodology, respondent’s willingness to disclose information, behavior, socioeconomic status, and faulty generalizations were offered as explanations for the disparity between the two studies (Hampton, Gelles, & Harrop, 1989; Lockhart, 1985). However, these two studies established an inconsistency that still remains, particularly because people of color continue to be largely ignored in the domestic violence literature (Almeida, Woods, Font, & Messineo, 1992; Asbury, 1993; Hampton, 1991; Hampton, Carrillo, & Kim, 1998; Hampton & Yung, 1996; Neff, Holamon, & Schluter, 1995). In a 1988 review of the domestic violence literature, Coley & Beckett (1988a) concluded that “race alone did not distinguish violent and nonviolent couples” (p. 266). Instead, they identified environmental stress and structural linkages to explain the rate of domestic violence in the African American community, as experienced through the following: family disruption, residential mobility, poverty, social dislocation, economic deprivation, unemployment, and population density (Hotaling & Sugarman, 1986; Sampson, 1987; Shepard & Pence, 1988). This review also found that with an increase in social supports, women were abused less often in African American versus White families (Brown, 1986; Cazenave & Straus, 1979) and that African American women were more likely to use medical services than mental health resources to address domestic violence (Gullattée, 1979). This critical analysis helps to substantiate the importance of socioeconomic factors relative to African Americans and domestic violence. The review also highlights the formal resources utilized by African Americans to address domestic violence.
In their review of the literature, Uzzell & Peebles-Wilkins (1989) also highlighted the effects of socioeconomic status. They underscored that African American women whose husbands were in blue-collar occupations reported higher rates of abuse and that if the man or woman was unemployed, domestic violence was more likely to occur. Limited network embeddedness and rigid sex-role perception were also identified as important factors for African Americans. This review illuminates the importance of employment status, occupation, network embeddedness, and sex-role perception.

C. M. West (1998) also substantiated the importance of socioeconomic status in her literature review of this topic. She further identified institutional barriers, such as “geographic distance from minority communities, prohibitive fee structures, and inflexible or inconvenient hours of operation” (p. 203) and the “internalization of stereotypes” (p. 204). Therapeutic and policy recommendations that center on enhancing cultural competence, addressing socioeconomic factors, and improving research were offered as solutions.

Asbury (1999) further acknowledged the importance of socioeconomic status in determining domestic violence in the African American community, particularly the crippling effects of poverty. In her literature review of domestic violence and people of color, she highlighted that African Americans are not a homogeneous group. Diversity within the African American community needs to be better addressed in the research. She also argued that too much attention is spent on comparing rates of occurrence across groups versus fully understanding the nuances and unique needs of each group. Acknowledging the importance of cultural competence when intervening with African Americans, she advocates a better understanding of the sociohistorical context and the use of an Afrocentric approach in responding to domestic violence in African American communities.

This literature review will further the previous analyses to explore additional issues and offer a different perspective related to gaps, inconsistencies, and opportunities for an action agenda.

**METHOD**

Literature reviews focused on African Americans and domestic violence were first identified with the specific purpose of highlighting core arguments. Each publication was read and re-read for critical content analysis. As the author reviewed each publication, identified patterns were noted from the material on a sketchpad. Gaps, inconsistencies, and reverberations became more apparent, leading to the list of four categories: the historical context, socioeconomic status, external barriers, and internal barriers. Data were then coded according to these categories. Gaps were noted for each theme identified. Using a holistic approach, this content analysis focuses on the identified themes as a systemic whole rather than focusing on one particular publication. It is within the context of the cumulative findings that we are able to acquire a comprehensive analysis, create a conceptual framework, and determine an action agenda.

**RESULTS**

**The Historical Context**

Domestic violence in the African American community has been explained as a maladaptive behavior to societal oppression, racism, and discrimination (Oliver, 1999; Williams, 1993, 1999). It has been argued that domestic violence did not exist in African culture and that it followed the enslavement of Africans in America (Dennis, Key, Kirk, & Smith, 1995; Myers, 1993; Olufummi, 1996). Although there is diversity within Africa, “differences in Africa [are] minor compared to the binding quality of their commonality” (Nobles, 1991, p. 47). Mbiti’s (1970) pivotal work provided clear examples of the similar cultural and philosophical premises.
across Africa, particularly within West Africa. To deal effectively with domestic violence in the African American community, the practitioner must be aware of the history of enslavement and its impact on contemporary relationships (Dennis et al., 1995; Oliver, 1999). T. C. West (1999) and Hobbs (1992) explored the intimate partner violence experienced by enslaved African women using narratives and personal testimonies. Hopelessness, powerlessness, fear of attachment, anger, and distrust are all residual derivatives of enslavement that have influenced relationships between African American women and men (Franklin, 2000). These feelings have created an emphasis on materialism, objectification, the need to control, and dependency (Karenga, 1993).

In addition to acknowledging the effects of enslavement on African American relationships, Franklin (2000) also focused on the effect of the societal emphasis on patriarchy in African American relationships. “The Faustian bargain struck by white and black men—designating the black man as head of household, allocating him higher wages, and giving him authority over black women in exchange for their labor in the fields—was the first signal after emancipation of the erosion of gender relations in the African American community” (pp. 52-53). She discussed the increase in domestic violence as a result of the Faustian bargain and shared that many African American women elected not to get married during this time because they did not want to be oppressed within their home. Her documentation provided an example of how social policy negatively impacted African American relationships and acknowledged that African American women were not silent about the abuse they were experiencing but did have limited resources and options in addressing the violence.

Davis (1998) examined the blues as an outlet for poor and working class African American women to express how they felt about the violence experienced in their intimate relationships. Focusing on the 1920s, she stated that the blues were used to “highlight the inhumanity and misogyny of male batterers” (Davis, 1998, p. 26). T. C. West (1999) provided personal testimonies of the intimate partner abuse suffered by African American women during this time. Once again, African American women found a way to express their feelings about the violence and abuse suffered by the hand of an intimate partner. Although the abuse was considered to be private, these women created public mechanisms to tell their stories.

T. C. West (1999) highlighted how sexism within African American organizations increased during the 1960s and the 1970s due to the stereotypical image of the African American woman as a matriarch. The matriarchal stereotype creates a myth that African American women are taking the power of African American men. Simultaneously, African American women were called to assume less visible leadership roles within African American organizations to promote male leadership (Pierce & Williams, 1996). This further set the stage for domestic violence within the African American community as a private matter linked to a public position.

It has been stated that domestic violence was not publicly discussed in the African American community until the 1980s (Hampton & Yung, 1996). Yet, the history demonstrates that African American women did publicly express disarray toward violence experienced at the hands of an intimate partner. Since the 1980s, there have been three typical responses to domestic violence in the African American community: (a) the noninterventionist model, (b) devaluation, and (c) justification (Hawkins, 1987; Williams-Campbell, Campbell, King, Parker, & Ryan, 1994). In the noninterventionist model, outsiders refuse to become involved in the relationship, allowing the violence to persist. Devaluation suggests that African American women have historically received less protection than White women because they have not been perceived as necessarily needing such protection (Allard, 1991; Kupenda, 1998). “This minimization of Black women’s concerns is manifested in social, legal, and cultural norms, as well as by the lack of response of societal institutions that are supposed to address all women’s expectations of safety and redress” (Johnson, 1998, p. 484). Justification takes the form of believing that African American women ought to be able to cope with ill treatment (Williams-
Campbell et al., 1994). These responses demonstrate a reaction to the stereotypes promulgated throughout history.

**Socioeconomic Status**

Socioeconomic status is acknowledged as a key variable in determining domestic violence in the African American community and is believed to correspond to the higher levels of abuse more so than culture or any other variable (Barnes, 1999; Hampton & Gelles, 1994; Hotaling & Sugarman, 1986; Lockhart & White, 1989; Neff, Holamon, & Schluter, 1995; Uzzell & Peebles-Wilkins, 1989; C. M. West & Rose, 2000). Tjaden and Thoennes (2000) reported that differences in domestic violence among ethnic groups “diminish when other sociodemographic and relationship variables are controlled” (p. iv). Thus, African Americans are not inherently violent (Sampson, 1987). High rates of poverty (Asbury, 1999; Hacker, 1992), financial problems within relationships (Carlson, 1977; Kunjufu, 1993; Walker, 1979), high levels of unemployment (Sampson, 1987), scant affordable housing, and inadequate educational opportunities (Sullivan & Ruptz, 1994) affect how African Americans experience domestic violence. This section will focus on the four areas of socioeconomic status that are consistently highlighted in the literature: income, employment, network embeddedness, and cohabitation.

The rates of battering among those earning between $6,000 to $11,999 are higher for African Americans compared with White Americans (Cazenave & Straus, 1990). This has led to the perception that poverty and domestic violence in the African American community are inextricably linked (Asbury, 1999). Yet, a larger proportion of African American middle-class women has been found to experience domestic violence than do White middle-class women (Coley & Beckett, 1988b; Hampton, Carrillo, & Kim, 1998; Lockhart, 1991). Lockhart (1987) suggested that this rate may reflect the transition from lower to middle-class status, whereby middle-class African American families may be experiencing residue from former lifestyles. It has also been postulated that traditional values that encourage women to maintain relationships may be an additional explanation (C. C. Bell & Mattis, 2000). The two findings and stemming explanations provide a real gap in knowledge related to income and battering rates.

Employment has proven to be a factor in determining domestic violence in the African American community. Sampson (1987) found that having viable employment opportunities actually implied a decrease in violence for African American men. Employed African American women are more likely than employed White women to leave an abusive relationship (Miller, 1989; Sullivan & Ruptz, 1994). In addition to employment status and opportunities, the occupation of the individual has also been found to be significant in relation to battering rates. Cazenave & Straus (1979) found that those with blue-collar versus white-collar statuses were more likely to engage in partner abuse. Determining the nuances behind these findings is critical to fully understanding how employment and occupation impact domestic violence in African American relationships.

Network embeddedness is the number of children in the home, the number of years living in a neighborhood, and an adult presence in the home in addition to the couple (Cazenave & Straus, 1979). This variable has had varying findings. African American couples demonstrating greater network embeddedness have been found to experience less domestic violence (Cazenave & Straus, 1990; Lockhart, 1987; Williams-Campbell, 1993). However, Bent-Goodley (1998) found that network embeddedness was statistically nonsignificant. The inconsistency of findings in this area warrants the attention of researchers.

Abuse is more likely to occur in intimate relationships if the couple is cohabitating (Ellis, 1989; Stets, 1991; Stets & Straus, 1990; Yllo & Straus, 1981). With an increase in the number of adults who cohabitate, particularly African Americans (Bumpass & Sweet, 1989), this factor
warrants particular concern. The central reason that has been used to explain the greater rates of abuse among those who cohabitate without marriage is increased isolation. Again, this reason has not been systematically proven, nor has there been targeted research to test the significance of cohabitation as a variable.

**External Barriers**

This author defines external barriers as those impediments imposed from outside of a group hindering them from addressing issues of concern. African Americans continue to experience barriers in receiving domestic violence services due to systematic oppression and lack of cultural competence (Allard, 1991; Barbee, 1992; Briggs & Davis, 1994; Campbell, 1989; Joseph, 1997; T. C. West, 1999; White, 1986; Williams, 1994). The effects of external barriers can be devastating and are believed to contribute to partner violence in the African American community (Campbell, 1985; Stark, 1990). These external barriers can be organized into three categories: labeling, lack of cultural competence, and systematic inequity.

Labeling itself is a barrier to services. Being called a domestic violence victim or batterer can be perceived as negative and alienating for African American clients (T. C. West, 1999; Williams, 1992). Some African American women do not want to identify their experiences as domestic violence because they associate the term with White feminism and male bashing (Fine, 1989; Kanuha, 1994). T. C. West (1999) argued that one should identify women who experience abuse as survivor-victims to recognize the victimization and the strength of the woman. In labeling men as batterers, there is often the perception that they cannot change. Williams (1992) emphasized the importance of the practitioner believing that the abuser can change his behavior. If the practitioner begins the psychoeducational process believing that men who abuse cannot change their behavior and thinking, then the process is destined for failure from the onset.

Numerous studies show that African American women underutilize shelters due to lack of cultural competence (Coley & Beckett, 1988a; Gondolf, Fisher, & McFerron, 1991; Sorenson, 1996) and the fear of not being welcome (Asbury, 1987; Williams-Campbell, 1993). These fears are not totally ungrounded. Shelter workers have been found to operate on the perception that African American women do not need shelter assistance because they do not sound distressed enough (Allard, 1991; Kupenda, 1998). Racist stereotypes and the effects of negative labeling of African American women often fuel these perceptions (Greene, 1994; Hampton & Gelles, 1994; Hawkins, 1987; Hill-Collins, 1991; Joseph, 1997; Richie, 1983, 1985; Wyatt, 1997). “In many minds a picture has been painted of Black women as hardened, tough, back-talking, strong, permissive, and undeserving of protection, women for whom blows might not be considered cruelty” (Kupenda, 1998, p. 8). Being aware of these perceptions impacts African American women’s willingness to report and seek intervention when domestic violence is experienced.

The well-documented lack of cultural competence in batterer’s intervention services has been used to explain the low participation and completion rate of African American men in service intervention (Edleson & Syers, 1991; Tolman & Bennett, 1990; Williams, 1999). A survey of batterer’s groups across the country revealed that staff were not trained in cultural competence and that limited efforts were made to become more culturally responsive (Williams & Becker, 1994). This confirms why African American men may question the sincerity and effectiveness of the worker, which greatly inhibits service delivery. If the man does not believe that the worker understands the pervasive effects of institutional racism, then the worker will be met with distrust and resistance. Gary (1995), Oliver (1984, 1989, 1999), Staples (1982), and Williams (1990, 1998) stressed that African American men may express themselves violently as a reaction to their social realities and overwhelming community environments. This is not to remove accountability from the indi-
vidual; however, the societal context is crucial to understanding the full magnitude of this problem. One must be prepared to address these issues if the practitioner is going to be successful in educating and intervening. In addition, most shelters and batterer’s groups are located outside of the African American community (Asbury, 1987; Williams & Becker, 1994). This creates transportation issues and demonstrates insensitivity to a fear of safety and discomfort in going to ask White practitioners for help. Again, this is where understanding the history and current realities of racial oppression are critical to increasing cultural competence.

Although an outcome of domestic violence, one can see the systematic inequity of treatment for African Americans within the criminal justice system. To fully understand the inequity, one must first be aware of the statistics. African American women are being incarcerated at an increasingly higher rate. This rise has been explained by the war on drugs but has also been linked to domestic violence (Beck & Mumola, 1999; Fagan, 1996; Richie, 1996). More than 50% of women imprisoned have been subjected to domestic violence and were sexually abused as children (Beck & Mumola, 1999). Richie (1996) used gender entrapment theory to provide an explanation of African American women’s involvement in crime as a result of the intricate interactions between racism, sexism, classism, and identity development. Gender entrapment theory is defined as “the socially constructed process whereby African American women who are vulnerable to male violence in their intimate relationship are penalized for behaviors they engage in even when behaviors are logical extensions of their racialized identities, their culturally expected gender roles, and the violence in their intimate relationships” (Richie, 1996, p. 4). Richie demonstrated how the life experiences of African American girls can prepare them for further victimization as adults (Wyatt, Axelrod, Chin, Carmona, & Loeb, 2000). Examining how unresolved childhood issues, such as sexual abuse, can lead to substance abuse, low self-esteem, and mental illness as adults, she is able to connect these issues with domestic violence, future criminal activity, and the trauma of societal influences such as poverty and gender discrimination.

Although it has been said that African Americans are more likely than White Americans to report domestic violence (Hutchinson, Hirschel, & Desackis, 1994; Sorenson, Upchurch, & Shen, 1996; Staples, 1976), it has also been noted that this is often a reflection of limited formal and economic resources, an escalation of the violence, or neighbors reporting the abuse (Williams-Campbell, 1993). Yet African Americans who experience domestic violence have found less protection within the criminal justice system (Dennis et al., 1995; Kupenda, 1998), and some feel that they cannot depend on the criminal justice system to help them or to be fair (Peterson-Lewis, Turner, & Adams, 1988). These fears or suspicions are not without merit. Mann (1987) found that African American women receive harsher sentences than do White women for the same crime. This is particularly important when African American women are more likely than are White women to strike back or kill their husbands due to ongoing abuse (Kupenda, 1998; Plass, 1993; Rennison & Welchans, 2000). Furthermore, police are more likely to arrest when the respondents are both African Americans (Roberts, 1994). Being aware of these issues impacts an African American woman’s decision to engage the criminal justice system, even when her safety is in question.

Internal Barriers

The author defines internal barriers as those challenges that come from within a community preventing them from addressing issues of concern. Internal barriers have been categorized as help-seeking behavior among African American women, sexism, and racial loyalty. The reluctance of African Americans to seek formal help and discuss personal problems with strangers is an internal barrier (Boyd-Franklin, 1989; Taylor, Neighbors, & Broman, 1989; T. C. West, 1999). This reluctance is often a reflection of feeling left out of the formal system and a learned behavior of self-survival. The resistance to use formal service networks is revealed in the following statistics. Compared to White
women, African American women are 1\(\frac{1}{2}\) times less likely to call the police regarding abuse, four times less likely to go to a shelter, and two times less likely to obtain an order of protection (Joseph, 1997). It is clear that African American women are less likely to seek help in resolving domestic violence.

Sexism cannot be ignored as an internal barrier to addressing domestic violence in the African American community (Marsh, 1993). Sexism is defined as “a system of assumptions and acts, theories, and practices which imply and impose unequal, oppressive, and exploitative relationships based on gender” (Karenga, 1993, p. 216). The historical context provides a backdrop for understanding how divisive sexism has been in the African American community. Sexism often gets played out in sex-role perception. Sex-role perception promotes the idea that men and women have a different status in society based on gender. Stereotypes form the basis for sex-role perception. Although traditional sex-role socialization has been stated as less typical of African American families (Billingsley, 1992), sex-role perception does appear to influence the attitudes and beliefs of African Americans toward domestic violence (Bent-Goodley, 1998; C. M. West & Rose, 2000). Discussing the pervasiveness of sexism within the African American community can be viewed as divisive (Crenshaw, 1994; Kanuha, 1994). Yet sexism encourages self-imposed limitations and provides the fertile soil for violence.

Many African American women do not report abuse to maintain racial loyalty (Richie, 1996; T. C. West, 1999; White, 1994). “There are cultural cues that foster the notion that because of the racist oppression suffered by Black men, a sacrificial role is demanded of Black women” (T. C. West, 1999, p. 83). The perception that racism is more serious than sexism often develops, denying an equally important part of the African American woman’s identity (Wyatt, 1990). The African American woman may withstand abuse and make a conscious self-sacrifice for what she perceives as the greater good of the community but to her own physical, psychological, and spiritual detriment. Not reporting abuse to maintain racial loyalty puts African American women at greater risk. Crenshaw (1994) conceptualized the intersectionality of violence against women as the “various ways in which race and gender interact to shape the multiple dimensions of Black women’s experiences” (p. 94). She explores the crippling effects of race, class, and gender converging to fuel violence in the lives of African American women. The inequity within sexism, racism, and classism feeds into violence against women. One cannot be separated from the other if we are to truly understand the complexity of this issue.

AN ACTION AGENDA

The literature presents four themes relevant to domestic violence in the African American community: the historical context, socioeconomic status, external barriers, and internal barriers. Building on these themes, a conceptual framework was developed to reveal a four-point action agenda: (a) historical analysis of domestic violence among African Americans, (b) research to promote new knowledge and address inconsistencies, (c) policy advocacy focused around addressing external barriers, and (d) self-help initiatives to address the internal barriers. This action agenda is relevant and presents opportunities for policy advocates, direct service practitioners, administrators, researchers, and community organizers.

Historical Context

The history that reflects a group’s experiences can aid in more effective service delivery (DeVore & Schlesinger, 1996). There is still a knowledge gap related to the enslavement of Africans and the onset of domestic violence. The response of the community is unclear. The role of self-help organizations is unknown. It is also important to explore the connection between partner violence experienced during enslavement and the current experiences of African American women.
ment and the violence perpetrated in intimate relationships today. This information may help to determine the nuances that can potentially aid in deterring violence today.

Additional historical gaps to consider should focus on how social policies have impacted relationships between African American women and men. An in-depth identification and analysis of these policies would prove to be useful to understanding some of the dynamics. Continued testimonies, a review of case records, community and organization meetings, and an examination of literature and music would be helpful to document the depth and extent of partner violence from a historical perspective.

**Research and Knowledge Development**

Intervention research needs to focus on the development and validation of tools and methods that are most appropriate for this population. The effect of income on battering rates is an area that warrants greater empirical understanding through large and diverse samples of African Americans. In addition, any research considering income must also focus on wealth or assets. For example, some middle-class families may have a high income; however, if they lack assets and possess a negative net worth, then the issue may be wealth not income. Again, the effect of income on battering rates cannot be determined without incorporating this new perspective and asking those critical questions to a diverse sample of participants.

The research clearly demonstrates that employment is significant; however, it does not go to the next step in explaining how employment is a significant factor and under what circumstances. In addition, it is not clear if the greater rate of battering within blue-collar versus white-collar occupations is a result of limited education, lack of exposure, inadequate resources, or lower income.

Clarification is needed as to the significance of network embeddedness. If one expands the notion of network embeddedness to include social supports, then it can be a potentially important variable to reducing isolation. However, the variable itself needs greater definition and more testing to determine its real effect on battering rates.

With the variation among couples who cohabitate, key research questions should include the length of time in the relationship, social supports for the couple, the number of children, the preference to marry or not marry, and the level of commitment to the relationship. Further research needs to be conducted to better understand the domestic violence experiences related to dating violence among African American teenagers and college students, as well as how diverse Black Americans encounter and respond to domestic violence (Brice-Baker, 1994). Statistics suggest that African American men are also experiencing abuse in greater numbers than White men (Rennison & Welchans, 2000). Research needs to be conducted to document and better understand the scope of the problem.

**Policy Advocacy**

Combating the effects of external barriers requires practice and policy methods that advocate social and economic justice. Policy development on the macro-, mezzo-, and micro-levels is necessary. Policy analysis needs to take place to determine the effects of social policy and systematic inequity on African Americans, such that a holistic policy agenda can be developed. One must consider a range of social policy issues not confined to domestic violence due to the intricate connection between domestic violence and other policy issues, such as income and employment status. There should be a particular focus on the criminal justice system to provide equal treatment and to build trusting relationships within communities of color.
treatment across race, gender, and class. These macro-policies should also both promote an increase of funding and encourage research and program development within communities of color. This includes funding researchers from the indigenous population to serve as principal investigators assuming familiarity with the community and the ability to bridge the gap of trust. Financial and structural support should also be given to African American social workers to create organizations within the community that can emphasize prevention and intervene when abuse occurs.

Mezzo-level policies that mandate an adherence to cultural competence through program materials, staffing, training, and evaluation are critical. On a micro-level, consistent process and outcome evaluations should be incorporated into program implementation, such that best practices can be identified, areas warranting improvement can be discovered, and individuals can be held accountable.

Self-Help Initiatives

The need for African Americans to continue to work responsibly and aggressively toward eradicating domestic violence is crucial. Building on cultural strengths, self-help initiatives have a history of success in the African American community and can respond to the internal barriers identified (Carlton-LaNey, 1999; Fine, Schwebel, & James-Myers, 1987; Hill, 1997). Using an African-centered approach to addressing domestic violence encourages the empowerment of the community, family, and individual. African-centered social work has been defined as “a method of social work practice based on traditional African philosophical assumptions that are used to explain and to solve human and societal problems” (Schiele, 1997, p. 804). The need to incorporate this perspective to address domestic violence has been discussed in the literature (Akbar, 1981; Asbury, 1999; Y. R. Bell, Bowie, & Baldwin, 1990; Joseph, 1997; Myers, 1990; Saunders, 1995; Williams-Campbell, 1993). Principles, such as sharing, reciprocity, balance, unity, and spirituality, have serious implications in addressing domestic violence and are culturally relevant. Further work has been done to specify how to apply these principles in domestic violence services (Bent-Goodley, in press).

From a cultural perspective, it is critical that domestic violence be acknowledged as a community issue. Domestic violence is connected with other community ills. For example, African American children are more likely to be removed from their home due to domestic violence (Edelman, 1989; Kanuha, 1994). African American women are at a greater risk of becoming infected with HIV due to domestic violence (Kalichman, Williams, Cherry, Belcher, & Nachimson, 1998; Wingood & DiClemente, 1997; Wyatt et al., 2000). The rising number of African American women being incarcerated has strong linkages to domestic violence. This phenomenon poses a threat to the community as more children are placed in foster and kinship care as a result (Richie, 1996). African Americans are more likely than are White Americans to experience fatal wounds or serious medical injuries due to domestic violence (Plass, 1993). These issues go beyond the individual and the family and pose great threats to the survival of the community.

Self-help initiatives must also emphasize combating sexism. African Americans must be as vigilant to eliminate sexism as they are to eliminate racism. They must understand that as long as African American women are subjected to stereotyping and abuse, the family and community cannot progress. The need to build healthy relationships transcends domestic violence and speaks to the need for positive relationships based on mutual respect, understanding of differences, and support around commonalities. Helping African American women and men to redefine their relationships, publicly and privately, is a beginning step toward eradicating domestic violence. This can happen through organizational and faith-based efforts. Community and organizational education initiatives can help re-educate communities to find nonviolent ways of resolving issues (Klein, Campbell, Soler, & Ghez, 1997). Communities can also identify domestic violence, connect people to support systems, and help survivors feel normal in seeking assistance. African American communities are receptive to
engage in structured and safe dialogues about domestic violence (Bent-Goodley, 1998).

Faith-based communities have a particularly long history of providing social welfare services and addressing community ills within the African American experience (Billingsley, 1992; Martin & Martin, 1995). They are trusted allies who, in addition to their official positions, must practice and preach equality for women (Adams & Fortune, 1995; Poling, 1998; T. C. West, 1999). Faith-based communities are challenged to change, to fight violence in all of its forms, and to encourage members to get the help they need and deserve. This role is not alien to African American churches, who have addressed domestic violence in the past (Gordon, 1994).

Faith-based communities offer many possibilities for eliminating domestic violence.

**IMPLICATIONS FOR PRACTICE, POLICY, AND RESEARCH**

- **Research and knowledge development**: The development, strengthening, and validation of tools and methods that address gaps and inconsistencies in knowledge are necessary. Research must address emerging issues that approach African Americans as a diverse community.

- **Self-help initiatives**: An Afrocentric social work approach provides a culturally competent method of addressing domestic violence. Domestic violence must be approached as a community issue, in addition to being a family issue, as part of a culturally responsive approach. African American women and men should be encouraged to build healthy relationships and to establish community education initiatives.

- **Policy advocacy**: Advocacy is needed for targeted funding of domestic violence programs in African American communities, with researchers and practitioners from the indigenous populations being the primary investigators/administrators. Policies must be implemented and monitored on the mezzo- and macro-levels of the policy-making process. Policies must be approached from a broad and comprehensive perspective as opposed to the fragmentation of issues. There must be advocacy for fairness in the policy-making and implementation process within the criminal justice system.

- **Historical context**: More historical research is needed concerning the onset of domestic violence in the African American community. The impact of social policy on African American relationships needs to be more fully explored to better understand its true influence.

**REFERENCES**


**STUDY SUGGESTIONS**


Tricia B. Bent-Goodley, Ph.D., is an assistant professor at Howard University, School of Social Work. She was recently appointed by the CSWE National President to serve as a member of the CSWE Commission on Women. She is the chair of the NABSW National Academy for African-Centered Social Work, immediate past chair of the NABSW National Public Policy Institute, and an active member of numerous professional and community-based organizations. Noted for her expertise on domestic violence, Dr. Bent-Goodley also serves as an advisory board member to Our Pride and Joy, a magazine for African American parents. Dr. Bent-Goodley received her doctorate from Columbia University School of Social Work in social policy, planning, and analysis and her master’s degree in social work from the University of Pennsylvania. She is a certified New York State social worker and a licensed Washington, DC, clinical social worker. Dr. Bent-Goodley has coedited a forthcoming book with Dr. King Davis titled *The Color of Social Policy*, to be published by CSWE. She has also edited an additional forthcoming book, titled *African American Social Workers and Social Policy*, to be published by Haworth Press. She has also written in the areas of domestic violence, criminal justice, ethics, policy practice, faith-based organizing, child welfare, and African-centered social work. Dr. Bent-Goodley has also served as an administrator, supervisor, and direct service provider of a number of community-based family violence prevention and child welfare programs.
This article addresses the ethical issues and dilemmas that clinical practitioners face when providing services to sexually abused children and their families. The differences between the roles of forensic evaluator and treating therapist are highlighted, with a particular emphasis on the ethical dilemmas related to role boundaries, confidentiality, therapeutic alliance, and court testimony. The position adopted throughout the article is that therapists for sexually abused children should avoid becoming involved in legal/forensic matters because of the inherent conflict associated with these different roles. Recent guidelines promulgated by professional organizations that have a bearing on these issues are discussed. Concrete and practical strategies that clinicians can utilize when dealing with these issues are offered.

Key words: sexual abuse, children, adolescents, ethical, legal, role conflict

PRIOR TO THE EARLY 1980s, there were few clinical programs dedicated exclusively to abused children and their families or mental health practitioners who primarily provided services to this population. During the past 15 years, this situation has changed dramatically, as there has been a proliferation of clinical programs for abused children and practitioners who specialize in the field of child maltreatment. One has only to attend the numerous regional or national conferences on child maltreatment or read any of the many specialized journals dedicated to child abuse and trauma to appreciate how the field has rapidly expanded.

Unfortunately, in our quest to attend to the needs of maltreated children and their families, a number of ethical and legal controversies have arisen. In the forensic area, there have been concerns about the nature of the investigative interviewing process (Myers, 1992) and the suggestibility of children as witnesses (Ceci & Bruck, 1995). With respect to treating adult survivors of child sexual abuse, major questions have arisen about some of the methods that therapists use to elicit memories and whether these memories are true and accurate representations of what may have occurred in the past (Loftus, 1993).

Less attention has been paid in the literature to the ethical issues and dilemmas that practitioners confront when providing clinical services to abused children and their families when the victim is still a child. This article will primarily focus on one broad ethical issue: namely,
multiple professional roles with sexually abused children. In this context, the differences between the roles of forensic evaluator and treating therapist will be highlighted, with a particular emphasis on the ethical dilemmas related to role boundaries, confidentiality, therapeutic alliance, and court testimony associated with these differences. Recent guidelines promulgated by professional organizations that have a bearing on these issues will be discussed. Concrete and practical strategies that clinicians can utilize when dealing with these issues will also be offered.

This article will not address the unique ethical and legal challenges that professionals face during the investigative interview/forensic assessment process with children who may have been sexually abused. These issues that include interviewer biases, the nature of the interview questions, and the suggestibility of children have been reviewed extensively elsewhere (Ceci & Bruck, 1995; Lamb, Sternberg, & Esplin, 1998) and are beyond the scope of this article. The forensic evaluator role will only be addressed in relation to the ethical concerns about multiple professional roles with sexually abused children.

PROFESSIONAL ROLES AND BOUNDARIES

Role Definition

Children who allegedly have been sexually abused and their families may have contact with a variety of mental health practitioners who play different professional roles. The two most prominent roles are that of forensic evaluator/investigative interviewer and treating therapist. These are inherently different and potentially highly conflicting roles. The treating therapist works on behalf of the abused child and her family to provide help or assistance in the healing process. Typically, therapy is a very private experience in which the child and family share their thoughts and feelings about what has occurred. In this regard, understanding the abused child’s subjective perceptions of the alleged perpetrator and/or abusive events and attributions of responsibility related to the abuse are important in helping to determine appropriate goals for treatment. Goals may include helping the child and family to better understand the psychological impact of the abusive experience, assisting the child in obtaining symptomatic relief, and helping all family members to develop better coping strategies. Regardless of the specific treatment objectives, the treating therapist’s primary commitment is to the abused child and trying to enhance her psychological well-being.

In contrast, the forensic evaluator or investigative interviewer works on behalf of a third party to assist in the gathering of facts to resolve legal disputes. Third parties could be the court, police, district attorney’s office, or local child protective service system. The forensic evaluator may be asked to assist in determining an alleged victim’s credibility or contribute to placement decisions. The key issue here is that forensic evaluators and treating therapists have different clients and different commitments that

Unfortunately, in our quest to attend to the needs of maltreated children and their families, a number of ethical and legal controversies have arisen.
make these roles inherently conflicting. Accordingly, it would pose a significant ethical challenge for a treating therapist to take on a forensic role and avoid the conflicts that would be present.

The boundaries of these two conflicting roles can become blurred even when a clinician believes that he or she is solely in the role of a treating therapist for a patient. For example, although not having conducted a formal forensic assessment, many therapists for sexually abused children may still be asked by the local child protective service system to give a professional opinion about credibility issues or custody matters. Even if therapists only respond to such requests by giving their opinion in a brief letter or phone call, they have still put themselves in the middle of the legal process, although perhaps inadvertently. This can become a slippery slope. Providing even limited information about treatment or an opinion directly related to the legal issue at hand would likely be perceived by outside parties as a partial waiver of confidentiality. In this context, how would therapists deal with additional requests or demands for information? It would be hard for the therapist to argue that treatment is completely confidential because some information has already been released. Additionally, outside parties could certainly conclude that the therapist is receptive to communicating about treatment-related issues, as this has indeed occurred previously. This whole process can become very tricky for the therapist, who may find it difficult over time to keep from slipping into the position of releasing more and more information. At what point would the therapist’s obligations to the sexually abused child be compromised by complying with requests from outside parties? Such a slippery slope would pose serious ethical dilemmas even for the most conscientious therapist.

The next sections will review the specific nature of other dimensions along which forensic and treatment roles differ and how these differences result in ethical challenges for professionals who attempt to simultaneously play multiple roles in the same sexual abuse case.

Other Dimensions Along Which Forensic and Treatment Roles Differ

Confidentiality. Confidentiality is the hallmark of the therapeutic relationship. With limited exceptions such as reporting child abuse, suicidality, or protecting potential victims from patients who make violent threats (Tarasoff v. Regents of University of California, 1976), therapists operate under the principle of maintaining the privacy of any information shared with them by patients/clients. Indeed, protecting confidentiality is an ethical principle that is highlighted in the ethical codes of mental health practitioners. For example, the American Psychological Association (1992) has an entire section of its Code of Conduct for Psychologists that is exclusively devoted to issues of privacy and confidentiality. Additionally, the U.S. Supreme Court recently affirmed the principle of privileged communications between a psychotherapist and patient (Jaffee v. Redmond, 1996). Although this ruling specifically applies only to cases tried in federal court under the Federal Rules of Evidence for United States Courts (1975), it nonetheless established a broad standard recognizing the critical importance of protecting confidentiality in a therapeutic relationship.

In a forensic evaluation, there is typically no confidentiality between the professional and patient, as there is an expectation that the information gathered will be reported to the court, police, child protective service system, or other third party. Given the lack of confidentiality in a forensic evaluation, how can a clinician engage in this activity while simulta-
neously being the treating therapist in the same case? How can the issue of confidentiality be managed in an ethical manner when the expectations of these two roles are so different?

There are a number of ways that ethical issues related to confidentiality can arise when clinical services are provided to sexually abused children. For example, child protective service workers may request treatment information from the therapist to guide decision making about family reunification. Such information might include the victim’s feelings about the alleged perpetrator or the previous abuse. Although this kind of information may be important when caseworkers develop reunification plans, abused children share their feelings about these issues in confidence and believe that their privacy will be maintained. If they are informed that this information will now be provided to a child protective service worker, it is easy to understand how a sense of betrayal might result. This would be most unfortunate given that sexually abused children have typically been betrayed already through the abusive experience. Even though therapists may believe that they are ultimately helping maltreated children by giving certain information to caseworkers or other third parties, they cannot easily avoid the ethical problem of violating confidentiality when they do so.

To illustrate this problem, several years ago the first author had a 12-year-old female sexual abuse victim as a patient who discovered from her mother that her medical record was being subpoenaed by the alleged perpetrator’s defense attorney. Although the subpoena was eventually quashed and the record was never released, this child was very angry and felt extremely betrayed. Although she knew that the therapist was trying to protect the confidentiality of the record, her comment during one session was, “You said you’d never tell anyone what we talk about.”

Of course, as discussed earlier, there is never complete confidentiality, as there are clear circumstances when a therapist would be required to breach it, such as mandated reporting of new, previously undisclosed abuse episodes; if the child presents a danger to herself; or to protect potential victims if the child is making violent threats. These limits to confidentiality need to be discussed and clarified with the child and her parents at the beginning of treatment. Additionally, the limits to confidentiality will depend on the child’s age and other developmental factors such as mental ability. For example, a therapist may find it acceptable to inform the parents of a young abused child about specific things that are discussed during individual treatment sessions, whereas with an older teenager this would not occur without the patient’s permission.

The critical issue here is whether information about treatment should be released to outside parties, beyond the notable circumstances described above. In this regard, perhaps one solution would be for therapists to inform their sexual abuse victims at the outset of treatment that when necessary, information would be provided to third parties. However, it is the authors’ clinical experience that such a decision would result in children not being able to fully discuss their maltreatment experiences. Feelings about the abuse or the alleged perpetrator, such as shame for having enjoyed aspects of the abusive experience, may be impossible for most victims to discuss in treatment if they knew that this information might not be kept confidential.

Additionally, the concept of the slippery slope applies to the issue of confidentiality as it does to the blurring of role boundaries. Even if it were acceptable to a maltreated child and her parents to release some treatment information to a third party, it is very likely that the outside party would persist in trying to obtain as much information as possible. What would the limits of this process be? At what point would the ethical principle of confidentiality in treatment be shattered? Moreover, from a legal perspective, there may be no such thing as a partial waiver of confidentiality. Judges could rule that if part of a record is released, then confidentiality no longer exists. The entire record might therefore become accessible to outside parties.

In summary, although therapists may desire to be helpful to the child protective service system or court by providing treatment information about sexual abuse victims, by doing so they take on conflicting professional roles related to the issue of confidentiality. Preserving
Confidentiality while providing information to a third party is inherently an ethical dilemma and poses a serious challenge for clinicians who treat sexually abused children.

Neutrality. A therapy relationship is not neutral. Sexually abused children develop a positive therapeutic alliance with their therapist, who tries to create an atmosphere of psychological safety and trust. Within this context, victims are better able to talk about their very private feelings related to the abusive experience, and their feelings are validated by the therapist. Additionally, therapists offer emotional support and probably do not hesitate to acknowledge that the sexual abuse did occur. In short, sexually abused children believe that their therapist is on their side.

The positive feelings generated by the therapeutic relationship are not unidirectional, however. Therapists care about their patients/clients and what happens to them. With sexually abused children, therapists are typically invested in these children’s outcomes, particularly with regard to safety issues. As mentioned above, therapists will ordinarily tell sexually abused children that they believe that they were abused, especially in response to a direct question. This is true even though therapists have not conducted a formal forensic assessment. The therapeutic relationship is therefore not typically neutral. Sexually abused children believe that their therapists are on their side, and most therapists would readily admit that they are. There are positive feelings in both directions, and this is the significant foundation on which treatment progress occurs.

In contrast, the forensic evaluator who interviews sexually abused children must remain neutral. The goal is to conduct an impartial assessment to gather information as to the likelihood that the abuse did or did not occur. The evaluator assists outside parties to draw conclusions about the abuse. The commitment is not to the child who has allegedly been sexually abused and her recovery. In light of this role difference, it would clearly be very difficult, if not impossible, for therapists working with sexually abused children to offer unbiased opinions about whether abuse occurred in a specific case.

Competent forensic evaluators attempt to be impartial and unbiased, whereas therapists are typically allied with their patients. Thus, how could therapists provide opinions about the likelihood of abuse that would be deemed valid by the legal or child protective service systems?

Despite this issue, many therapists do not hesitate to inform child protective service workers, attorneys, and sometimes even judges that they believe that their child clients/patients have been abused and are willing to defend this position within the legal system. This is a dangerous step. Therapists will be challenged by attorneys, especially those representing alleged perpetrators, that they are not neutral, and indeed they are not. There is nothing wrong with therapists being allied with and supporting the sexually abused children that they treat, as long as this occurs in the therapist’s office and not in the courtroom.

Court Testimony

Forensic evaluators who assess sexually abused children expect that they will go to court to provide information about their findings and conclusions. Typically they would be qualified by the court as expert witnesses. In some family and/or juvenile courts, they would be permitted to give expert opinions as to the likelihood that the abuse occurred. In criminal proceedings this would not be allowed, but forensic evaluators might be requested by a prosecutor to present information to the court about a specific issue (e.g., the nature of the disclosure process) to rehabilitate a victim’s testimony (Myers et al., 1989).

Treating therapists are not typically qualified as expert witnesses, but may appear in court to testify as fact witnesses (Greenberg & Shuman, 1997; Strasburger, Gutheil, & Brodsky, 1997). They may provide descriptive information to
the court about mental status, diagnosis, course of treatment, prognosis, and so forth, but are not permitted to give an expert opinion about the ultimate legal matter before the court (i.e., whether their patient was abused). Unfortunately, when therapists testify in court, they may be asked by attorneys to give an expert opinion about whether the abuse occurred. Even the most ethically conscious therapists who are aware of the difference between an expert and fact witness may experience a great deal of pressure in this situation and have an exceedingly difficult time refraining from giving an expert opinion.

Implicit in the above discussion is our position that it is the ethical responsibility of the therapist to not respond to questions pertaining to the ultimate issue before the court. Not surprisingly, attorneys are not hesitant to pose questions to therapists about any aspects of a given case as long as they believe that the answers will benefit their client. Moreover, some judges may not understand the differences between forensic evaluator and therapist in abuse cases and would not necessarily prevent attorneys from asking questions related to the ultimate issue. Accordingly, it is up to the therapist to clarify his or her role and refrain from responding to these types of questions.

There is another ethical dilemma that therapists encounter when they testify in court. The sexually abused children that they treat and the children’s nonoffending parent(s) are typically present to hear this testimony. If therapists respect the expert witness–fact witness distinction and do not offer an opinion about whether the abuse occurred, what will be the impact on the victim and her parent? In the office, the therapist has supported the sexually abused child and validated her feelings, but in the courtroom, the therapist will not even say that the child has been abused. It is obvious that the sexually abused child and nonoffending parent might experience significant anger and betrayal in this scenario.

Another concern is how the treating therapist responds on the witness stand. Therapists, particularly those not accustomed to testifying in court, may become frustrated, angry, and/or anxious when testifying, and these qualities will be observed by the sexually abused child and nonoffending parent. This may generate awkward feelings for the victim, who has developed a perception of the therapist in the office as being confident, calm, and even tempered. Now that the sexually abused child has observed the therapist function less adequately in a different context, what impact will this have on the treatment process? Will the sexually abused child and nonoffending parent continue to have faith and confidence in the therapist as someone who can help them? Thus, the treatment process can easily be compromised when the victim has observed the therapist struggle in the stressful situation of being a witness in the courtroom.

In a similar fashion, although an abused child may feel supported if the therapist goes to court, more negative concerns such as worry about what the therapist will say or fear that the therapist may feel differently about her could be generated as a result of the court hearing. Also, it could be very upsetting and create feelings of betrayal in an abused child if she sees the therapist interact with the offender or offender’s attorney in the courtroom. Again, the feelings and perceptions that an abused child might have as a result of the therapist being in court could have an adverse impact on the therapeutic relationship.

Finally, what about the therapist’s reactions to going to court? In some circumstances, therapists may be required to testify but are very reluctant to do so, and this may generate anger and/or anxiety. Also, therapists may feel dissatisfied with the quality of their testimony or feel that they were not able to adequately articulate specific treatment issues. These types of reactions may affect a therapist’s feelings about working with an abused child and also have an adverse impact on the therapeutic process.
During the past several years, a number of professional organizations have published guidelines with regard to role conflicts in child abuse cases. These standards have generally taken the position that forensic evaluator and treating therapist are distinct and separate roles in child abuse cases and that it is a conflict for professionals to simultaneously take on both roles. These guidelines are summarized in Table 1.

The American Academy of Child and Adolescent Psychiatry (AACAP) was the first to take a position on this issue when it published “Guidelines for the Clinical Evaluation of Child and Adolescent Sexual Abuse” (1988). AACAP stated that the evaluator and therapist should be different professionals so that roles would be clear and confidentiality would be maintained in treatment. In 1997, AACAP published the “Practice Parameters for the Forensic Evaluation of Children and Adolescents Who May Have Been Physically or Sexually Abused.” Although this document primarily focused on the role of forensic evaluator in abuse cases, it clearly indicated that forensic evaluator and treating therapist are distinct roles and that the therapist should not be performing a forensic evaluation.

More recently, the American Psychological Association published the Guidelines for Psychological Evaluations in Child Protection Matters (1998). This document indicates that “psychologists generally do not conduct psychological evaluations in child protection matters in which they serve in a therapeutic role for the child or the immediate family” (p. 7). These guidelines suggest that it would also be inappropriate for evaluators to accept any parties involved in an ongoing evaluation as therapy clients/patients. Additionally, this document discourages a forensic evaluator from treating the child or other participants following the completion of an evaluation. The American Psychological Association’s position that psychologists should avoid multiple relationships in child protection matters is consistent with its earlier position that psychologists should avoid multiple roles in child custody evaluations in divorce proceedings (American Psychological Association, 1994).

The only child abuse–related organization that has published a document regarding the evaluation of children who may have been sexually abused has taken a less firm stand regarding the separation of forensic and treatment roles (American Professional Society on the Abuse of Children [APSAC], 1996). APSAC’s guidelines indicate that evaluations of children who may have been sexually abused may be conducted for clinical or forensic reasons and that forensic evaluations contribute to legal decisions. Furthermore, “Forensic evaluations generally require a different professional stance and contain additional components” (p. 1), including reviewing relevant documents and conducting interviews with other parties. Nonetheless, APSAC’s guidelines do not specifically discourage professionals from taking on forensic and treatment roles in the same case, although the statement that “the difference between the evaluation phase and a treatment phase should be clearly articulated if the same
professional is to be involved in both” (p. 1) seems to suggest the potential for role conflict.

**FACTORS THAT MAY AFFECT THE SEPARATION OF ROLES**

The position advocated in this article and generally supported by recent professional guidelines is that in child sexual abuse cases, the roles of forensic evaluator and treating therapist are distinctly different and should not be played simultaneously by the same professional. However, there are a number of factors that may make it difficult for the professional to refrain from taking on multiple roles in these cases.

One of these factors is that some legal and mental health professionals may have misunderstandings about the parameters of the forensic and treatment roles (Mannarino & Cohen, 1992). Many family attorneys who have significant experience in the child abuse area would hesitate to request that a mental health professional take on multiple roles in these cases, but other attorneys may not recognize that asking for an expert evaluation and treatment for the child from the same professional would be problematic. (A more pessimistic position would be that some attorneys recognize that multiple roles in child abuse cases would cause role conflict for the mental health professional but that they would not hesitate to ask for this if it would help their case.)

In the same vein, some mental health professionals may not fully consider the potential conflict involved in such scenarios as giving an expert opinion in court about the likelihood of abuse when one is the treating therapist or conducting treatment with a sexually abused child after having conducted a court-related evaluation. Fortunately, it appears that understanding the differences between forensic and treatment roles in child abuse cases among attorneys and mental health professionals has improved in recent years. This apparent change may reflect increased efforts to provide education about this issue (Mannarino, 1999, 2000).

A second factor may be pressure from the parents of a sexually abused child (Mannarino & Cohen, 1992). Even in the context of a forensic evaluation, a child who may have been abused can develop a strong relationship with the evaluator, particularly if the child has made abuse-related disclosures. The parents of this child may request that the evaluator provide treatment for the child after the evaluation has been completed. It is easy to understand why the parents in this situation would not want their child to have to see yet another professional for therapy and may exert a considerable amount of pressure on the professional to continue with the case.

As discussed earlier, on the other side of the spectrum would be a situation in which the parents of a sexually abused child request that the treating therapist write a letter to an attorney or judge about such issues as custody disputes or visitation. A caring and compassionate therapist may experience this kind of request as pressure to “do the right thing” and may have a difficult time staying within the parameters of the therapeutic role.

A third factor may be related to limited professional resources in the field of child sexual abuse in specific communities, particularly rural areas (Mannarino & Cohen, 1992). In these communities, mental health professionals may feel the need to take on forensic and therapeutic roles in these cases, as there may not be other professionals with the requisite expertise. It is a major challenge for professionals in these situations to try to do the right thing from an ethical perspective but also respond to the needs of the abused child and her family, the legal system, and the community.

**PRACTICAL SUGGESTIONS FOR CLINICIANS**

**Establishing Professional Boundaries**

Establishing appropriate role boundaries with sexually abused children and their families
is a challenging ethical issue for all practicing clinicians who provide services to this population. This can best be accomplished prior to any clinical contact with a family. For example, a parent may call with concerns that his or her child has been sexually abused and about possible associated behaviors/symptoms such as sexually inappropriate behaviors, separation anxiety, or sleep problems. This parent may want to know whether the child has been abused, how to deal with visitation and custody issues, and also how to deal with the presenting behavioral difficulties.

This initial phone call is the best time to clarify one’s professional role and also to help the parent to understand a variety of other relevant issues. In particular, the parent needs to be informed that the child protective service system will become involved in cases of intrafamilial abuse, mental health professionals have a mandated reporting requirement, and that child sexual abuse is a criminal offense. Providing education about these issues is important, as many parents are quite naïve about the legal process. Even when the authors have not been able to accept a specific case into their clinic, parents have frequently indicated that this type of education over the phone was enlightening and helped the parents with their decision making.

In addition to providing basic education about the legal process, clarifying one’s professional role at the initial phone call is essential. A treating clinician needs to help the parent to understand that determining whether a child has been abused and being the therapist are separate roles (e.g., forensic evaluators gather facts, deal with custody issues, and go to court, whereas therapists help children to deal with their feelings and symptoms associated with the sexual abuse). Addressing the issue of confidentiality is often beneficial in helping the parent to understand these role differences, in particular, that a sexually abused child needs to know that treatment will be confidential if she is going to talk about her private feelings related to the abuse. Most parents can understand that sharing this type of information with the child protective service system or the court is problematic if treatment is going to be successful.

In a parallel way, attorneys, child protective service (CPS) workers, or other referral parties also may not understand the differences between the roles of forensic evaluator and treating therapist. Clarification of one’s professional role with these individuals at the initial phone call is also a wise decision. Nonetheless, some parents, attorneys, and CPS workers may still resist this explanation of the separation of roles and pressure the professional to engage in multiple professional activities in the same case. There can be a variety of pressure tactics such as suggesting that the family does not have enough money to hire more than one professional, or the use of flattery (e.g., “We’ve heard you’re the best”) (Mannarino, 1997). These strategies may not be purposely manipulative and can be extremely difficult to resist, but the professional needs to remain firm in his or her resolve to keep these roles separate. Our clinical experience suggests that the professional may need to inform a parent or other referral party several times that playing multiple roles in child sexual abuse cases is inappropriate. If the treating clinician keeps the door open even a little bit that one is receptive to the idea of also becoming involved in the legal process, the clinician can be sure that he or she will be pressured again about this at a later date.

At the time of the initial clinical assessment of a sexually abused child, one’s professional role should again be clarified. Any misunderstandings from the intake phone call can be addressed. Despite these attempts at role clarification, we occasionally encounter parents in our clinic who pressure therapists to take on multiple roles. In these instances, we have requested that parents sign a document in which they indicate that they understand the scope of the therapeutic role and that the treating therapist will not...
become involved in the legal process (Mannarino, 1997). Parents have generally responded well to this document. Furthermore, parents have less frequently pressured therapists to take on multiple roles when this document has been signed. Even when a formal document has not been used, parents can be reminded of the original treatment contract if they begin to pressure therapists to cross professional boundaries later in the treatment process.

Maintaining Confidentiality

In the role of treating clinician, the mental health professional protects the confidentiality of the therapeutic process with some limited exceptions. Nonetheless, when providing services to sexually abused children, outside parties (e.g., CPS workers, attorneys, etc.) will typically request information from the treating professional. However, the parents of the abused child and the child herself (if she is of the age of consent) have the legal right to decide if they want any information to be released. If they are educated about the importance of confidentiality to the therapeutic process, the privacy of treatment can be maintained.

In our clinic, our clinicians have been served with numerous subpoenas to provide information to an outside party. In most instances, we call the party issuing the subpoena to clarify our professional role in a given case. When a CPS worker or attorney learns that a clinician will not give a professional opinion about whether the abuse occurred or about custody, placement issues, and so forth, subpoenas have typically been withdrawn. In those few cases where they have not, hospital attorneys have filed a petition to have the subpoena quashed. These petitions have always been successful. When a sexually abused child and her parents have wanted to maintain confidentiality, we have yet to encounter a legal situation in which our clinicians have been court ordered to release information.

Maintaining confidentiality can be an even greater challenge when a subpoena comes from defense counsel if criminal charges have been pressed against the alleged perpetrator. In these instances, it is possible that the alleged perpetrator’s attorney wants to examine the record to demonstrate that the alleged victim has serious emotional difficulties to lessen her credibility. Or the defense attorney may suggest that the therapist has somehow influenced the child to make a false allegation. Similar to subpoenas in civil cases, when we have received subpoenas from defense attorneys in a criminal proceeding, we have requested that hospital attorneys file a petition to have the subpoena quashed. Again, these petitions have always been successful and we have never been forced to testify in criminal court or release a record without a patient’s consent.

This strong position about maintaining confidentiality is supported by all of the therapists in our program. From the time of the intake phone call through the initial evaluation and during treatment, this position is conveyed to the sexually abused child and her family and to all outside parties. Because of the consistency of our position, other professionals, attorneys, and judges throughout our region are aware of how strong an emphasis we place on the privacy and confidentiality of treatment. Interestingly, in recent years, there have been fewer attempts by outside parties to obtain information about the abused children that we treat in our clinic. We believe that this decrease has been the direct result of the strength and consistency of our position that the confidentiality of the therapeutic relationship is critical to a victim’s recovery.

If the sexually abused child and nonoffending parent decide to release limited information (e.g., that the child is in treatment, number of treatment sessions, diagnosis, etc.) to an outside party, this can be a slippery slope. As was discussed earlier, from a legal perspective, there may be no such thing as a partial waiver of confidentiality. A judge could rule that if part of a record is released, then confidentiality no longer exists. The entire record might then become accessible to outside parties. Furthermore, when therapists provide even limited information to outside parties, it has been our clinical experience that these same parties push for more and more information, including statements from the therapist about visitation, the child’s feelings about the alleged perpetrator, and so forth. When the latter information is provided, the therapist has placed himself or herself, perhaps
unintentionally, into the middle of the legal process. Accordingly, if therapists are going to release limited information to outside parties, they need to be very careful not to say anything that may directly or indirectly pertain to the legal issues which are part of the case.

**Court Testimony**

Our advice to therapists treating sexually abused children is to stay out of court. As discussed earlier, there are a number of reasons for therapists not to testify in court, including blurring the boundaries of their professional role, potentially not legally supporting the abused child, and testifying poorly in front of the child and parent. Unfortunately, in some instances, therapists either voluntarily testify in court or are ordered to do so. When therapists do testify, they need to remember their role as the treatment provider and not give expert opinions on such matters as to whether the abuse occurred, custody or placement issues, and so forth. If they are asked specific questions about these issues, they need to clarify their role for the court and indicate that they cannot respond to these types of questions given their professional role in the case (Greenberg & Shuman, 1997). This is a difficult position for therapists to take, but they must do so to maintain the integrity of their professional role.

**CONCLUSION**

Therapists who provide services to sexually abused children and their families face many challenges. The treatment process can be extremely difficult with many obstacles to overcome. At times, it may seem convenient for the therapist to wear multiple hats in the same case not only to facilitate a better treatment outcome, but also to resolve legal issues. The main premise of this article has been that forensic and treatment roles in sexual abuse cases are separate and distinct. Accordingly, therapists must take the necessary steps to maintain the integrity of their professional role, including establishing role boundaries, protecting confidentiality, and avoiding legal testimony. Therapists will face many pressures to step outside of their treating role. We have postulated that when therapists do so they will compromise the essence of their true professional responsibility to help sexually abused children and their families recover from this traumatic life event.

**IMPLICATIONS FOR PRACTICE, POLICY, AND RESEARCH**

- Training opportunities to help clinicians become more familiar and increase their understanding of the ethical issues involved in providing services to sexually abused children and their families are limited at this time and need to be increased.
- Practice guidelines pertaining to the evaluation and treatment of sexually abused children that have been promulgated by professional organizations need to be more widely disseminated so that these can be incorporated into clinical practice.
- Research is needed to increase our understanding as to what factors professionals consider in their clinical decision making when faced with ethical choices in their work with sexually abused children.
- Given the complexity of the ethical dilemmas confronted by professionals who deliver services to sexually abused children and their families, funding at the state and national level needs to significantly increase to support education and training related to these issues.

**NOTE**

1. The pronoun she or its possessive form her will be used throughout the article for simplicity when reference is made to a sexually abused child.

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