

**MCHB/DHSPS October, 2006 Webcast**  
**Domestic Violence Among Women of Color**

October 10, 2006

LISA KING: Hello, everyone. My name is Lisa King and I'm the women's health program director for the Maternal and Child Health Bureau in the health resources and services administration. And with me today I have Johannie Escarne within the Maternal and Child Health Bureau and we'd like to welcome you today to the "The Realities and Health Disparities of Domestic Violence for Women of Color" webcast. This webcast is brought to you in recognition of domestic violence awareness month and again we'd like to thank you for tuning in. Domestic violence is an important issue that touches the lives of many of us, either directly or indirectly. And it is certainly an issue that the Maternal and Child Health Bureau is concerned about as it relates to women, children and, of course, families. So we're fortunate today to have this distinguished array of experts in the field to talk about the issue and how it impacts women of color in particular.

So without further adieu I would like to introduce our speakers. First we have Dr. Jacquelyn Campbell. She's the Anna D. Wolf chair at the John Hopkins School of Nursing in Baltimore. Next we'll hear from Heidi Beth Burns who is a coordinator and sexual assault advocate and legal lay advocate of the tribe of Chippewa Indians in Bad River Band of Lake Superior in ODANAH, Wisconsin. We have Hannah Sin from Washington. Then we'll hear from Tricia Bent-Goodley an association professor at Howard University School of Social Work in Washington, D.C. and lastly we'll hear from Dr. Linda Laras an assistant director for the women and health center and assistant professor at the

University of Puerto Rico School of Medicine in San Juan, Puerto Rico. I do want to make one little comment to particularly give a special thanks to Dr. Bent-Goodley for filling in at the 11th hour for us because a previously scheduled speaker had a medical emergency and needed to cancel. Again, we really appreciate Dr. Bent-Goodley filling in for us and now I'll turn it over to Johannie Escarne.

JOHANNIE ESCARNE: Hello, everyone. Before we begin the webcast I would like to make a few technical comments. Slides will appear in the central window and should advance automatically. The slide changes are synchronized with the speakers' presentations. You don't need to do anything to advance the slides. You may need to adjust the timing of the slide changes to match the audio by using the slide delay control at the top of the messaging window.

Even though we're saving the question and answer session until the end of the presentation, we do encourage you to ask speakers questions at any time during the presentation. Simply type your question in the white message window on the right of the interface, select question for speaker from the dropdown menu and hit send. Please include your state or organization in your message so that we know where you're participating from. Also include which speaker the question is for. The questions will be relayed onto the speakers periodically throughout this broadcast. If we don't have the opportunity to respond to your question during the broadcast, we'll email you afterwards. Submit questions at any time during the broadcast. On the left is the video window. Use

the volume control slider which you can access by clicking the loudspeaker icon to adjust the sound.

Those of you who selected accessibility features when you registered will see text captioning underneath the video window. At the end of the broadcast the interface will close automatically and you'll have the opportunity to fill out an online evaluation. Please take a couple of minutes to do so. Your responses will help us to plan future webcasts in this series and improve your technical support. We'll now begin with our presentation, the first presenter is Jacquelyn Campbell.

JACQUELYN CAMPBELL: Good afternoon and I'm delighted to be part of this webcast. The perspective I'm going to take is some of the realities and health disparities of domestic violence for women of color.

And next slide. One of the basic questions here is, is there a higher prevalence of intimate partner violence among ethnic minority women. The evidence here is very mixed. In most studies when we control for income, most or any preliminary apparent differences in prevalence between majority and minority populations disappear. However, when we do find differences, we find that past year rates are where we tend to find differences rather than lifetime rates. In other words, for any woman, no matter what her ethnic or cultural background, her chances of being abused in some intimate partner relationship are approximately equal and we see somewhere between a 25% and 35% prevalence among women in the United States.

In some studies we do see a higher past year prevalence of intimate partner violence amongst poor women and women of color. And what we hypothesize is that it's the differences in resources that sometimes make it harder for women to address the problem by either leaving an abusive relationship or by resolving the abuse by other means. So in other words, if you are -- if you have a lower education rate or a lower economic resources, it is harder for you to escape the relationship or use other means to help the abuser become non-violent. And so we may see a higher past year prevalence among women of color who unfortunately in this country are less likely to have high levels of resources. However, there is unambiguous evidence that there is higher rates of intimate partner violence among Native American or first nations women and that's true of indigenous peoples all over the world. We have a speaker from that world but we're very clear that there is a lot of historical trauma issues involved with that difference. So some of the issues that we find in the literature in the research that complicate the picture that may explain some of the differences we see, women of color who are abused may fight back more often. Fight back literally and fight back in terms of resistance and my colleagues and I did a longitudinal study of women that were primarily African-American that we entitled voices of strength and resistance and it was a qualitative study over time and showed how many different strategies that these women used in order to resist the abuse and sometimes it was with physical violence and most often not but that was one of the strategies that was sometimes used.

Tricia is going to talk about the importance of community and church support for many women of color. We also find women talking about trying to protect males in a racist society. One of the things that they're conscious of is, for instance, amongst African-American women that so many of the men are already incarcerated and that oftentimes leads to reluctance to call the police. Women who are foreign born or whose families are foreign born not only fear more incarceration for men of color in our criminal justice system, unfortunately, but also that there are fears of their partners being deported. Although they want the violence to end, they may not want deportation to happen to him. No drop policies in the criminal justice system may mean for some men that a relatively minor domestic violence offense, which for white man would mean nothing basically, that the record would be erased might be the third strike for a man of color who has been involved in the criminal justice system and may end up being incarcerated for many years. There is also fears that they themselves will be arrested and this all too often happens for women of color when they do call the police. Some of the other issues that we find is that for women of color there is oftentimes a history of multiple trauma.

This is on the next slide. We find from the Commonwealth Fund Survey published in 2001 asked lifetime prevalence in terms of violence. A total of over 40% of the women in this survey reported some form of violence. That in and of itself is important to realize. And that many women are reporting both child abuse, physical and sexual as well as non-intimate partner physical assault, sexual assault and rape and intimate partner violence and all of these were significantly higher among ethnic minority women except intimate partner violence. It was higher in the past year. The definition that I have used for IVP

which is repeated physical or sexual assault within a context of coercive control and I think it's important for us to think about that as a pattern of behavior. It happens over time. It is not a one-time push or shove and that it's not only physical assault it is also all too often in about half the cases actual sexual assault and that that context of coercive control encases the whole relationship many times and in most physically abusive relationships we do find some measures of control and the next slide is the very famous power and control wheel and I'm sure that all of you have seen that so I won't go into it in detail but I think one of the things we need to think of in this presentation and in this forum is that the forms of control may vary by culture and may vary according to the individual couple or the individual man so that some women may find that their male partner never uses emotional abuse. That would be rare or never tries to -- is more likely to isolate her. For women of color sometimes they'll say they continue to have terrific connections with their social network so they're not isolated in any way, but rather that the control is more likely to be economic or intimidation. So there is a variety of means of control and for each woman she experiences these means of control differently and they also may differ by culture.

On the next slide I think it's important for us to realize that there is this overlap among physical, sexual and emotional abuse in intimate partner relationships. This was a sample of women from the metropolitan Washington, D.C. area recruited of health maintenance organization. These were middle class women. Almost all employed. They were half African-American and half white so one of the things that's important about this sample, which when you look at much of the research, you find that much of the research that is

on African-American women, women of color, it's also considering them -- the majority of the sample are also poor. In this sample the African-American women were just as much middle class, just as well off economically as were the white women and just as well educated. So this kind of a sample is important for us to realize that -- amongst ethnic women of color they aren't just all of one kind, obviously. But here we have that this overlapping circle in terms of physical, emotional and sexual abuse showing that about 20% of the women were experiencing all three kinds of abuse but that some women almost 20% said that physical violence was the only form of intimate partner violence they were experiencing and the emotional abuse here included controlling behaviors. These women were saying the physical violence was the only form of violence they were experiencing. Emotional abuse is another form that we see sometimes by itself and another 20% of these women. A very small slice, 3.6% said that forced sex or sexual violence was the only form of violence they were experiencing. As you can imagine the women in the middle experiencing all three forms had the most problematic health outcomes.

On the next slide this is the same sample that you can see in terms of the lifetime versus past year abuse and we see for lifetime abuse, as I mentioned, almost 35% of these women said that they were physically and/or sexually assaulted by an intimate partner in their lifetime and the prevalence of emotional abuse was about the same. However, the past year emotional abuse is much higher, 20%. Physical abuse was much lower, these were middle class women perhaps had the resources to be able to escape from an abusive relationship or somehow managed to make the violence end. The other thing that

was important on this study was that we did control for education, we did control for any income differences and still found a slightly increased risk for African-American women in terms of intimate partner violence both lifetime and past here and that again this is a relatively small increased risk but it was there among the middle class and employed women.

On the next slide is the continuum of forced sex because that forced sex aspect of intimate partner violence is so important both in terms of how much shame and stigma is associated with it for any woman and also in terms of the health outcomes that go along with it. So we see that we find forced sex where the sex is actually forced by physical force or threat of force, in other words, would qualified for terminology of criminal sexual assault would be a rape except that it's in an intimate relationship and in those contexts most women don't use the word rape. They also -- women will talk about having painful sex where sometime during the sexual act he is coercive, hurts them and indicate they don't want it that way. This is an ongoing relationship. Not all the sexual encounters are forced. Many of them are mutually consenting. Women who are abused report that sometimes they'll have the sexually abusive encounters. Sexual intimidation is when he would threaten other harm and has more sail yens for women. She's been beaten by a man before. We'll have sex my way or else. Sexual degradation. The emotional abuse they experience is around sex. Extremely humiliating. Extremely painful. Sex without protection, one of the things that many of these partners insist on is they get to control everything to do about sex. That means that they cannot negotiate safe sex in an abusive

relationship and that he wants to control all of the sexual behavior, which includes whether or not they use contraception.

And one of the other things that we -- on the next slide. There is also a continuum of relationships. They can all include forced sex. There is stranger relationships. A rape, but oftentimes women will say I've seen him before. He was kind of looking at me over time and then somewhere along the line he forced her to have sex. Acquaintances where there is maybe flirting or as some of the kids say talking. There is actual friends that end up forcing girls and young women into sex which seems a betrayal of friendship. A lot of our adolescents talk about hooking up. In some places it's called being cool. These are sexual relationships pretty much only. No other commitment. Not a lot of affection in them. But it's just for sex. Dating, kids still use this word. It doesn't look like my date but there are arranged times that kids use to date or go out together. When kids talk about having a boyfriend that usually means going together kind of thing. Live-in boyfriends with cohabitation. Talk about having a fiancé. Doesn't mean there is a promise of marriage but some commitment there. Obviously marriage and then ex-partners or ex-husbands. All of these relationships can involve forced sex and sometimes we think only in terms of either stranger rape or marital rape but we need to be aware of all of these other aspects of intimate partner forced sex and therefore intimate partner violence.

On the next slide some of the issues here, we used to think that date rapes occurred most often on a first date. Actually what we find now is that they're most likely to occur within an ongoing intimate relationship and again same kind of pattern where most of the sexual

encounters are not forced but occasionally there are forced sex. Forced first sex within an ongoing relationship can be a boyfriend/girlfriend. He decides he wants to have having sex. She resists and so her first sexual encounter is a forced sexual encounter from an intimate partner. One of the things, as I mentioned, 40 to 45% of relationships where there is physical violence there is also physically forced sex and forced sex, as we showed in the diagram, occasionally occurs by itself.

On the next slide just to give us an idea in terms of how often forced first intercourse occurs and again, this is an aspect of domestic violence and intimate partner violence we often don't think about. But if you look in terms of various countries around the world, the rate of girls who say their first sexual intercourse was forced varies quite a bit. In the United States we say only 4% overall but it is 25% of young ladies who are sexually active before the age of 14 report that that first sexual encounter was forced. And in those studies those girls are more likely to be of minority ethnicity. The forced first sex is an important aspect of this issue.

On the next slide when I switch into my intersecting comments around health disparities, the Institute of Medicine report on equal treatment was sort of a landmark report in terms of documenting what many of us have known for a long time is that women of color and also men of color have higher occurrence and severity of many health conditions and some people say well, this must be genetic issues, but actually we know that behavior and environment strongly influence when and how and how strongly any genetic tendencies for any disease or condition are expressed. We also know that unmitigated stress is a

powerful influence on our entire bodies and oftentimes mean that those health conditions we get them at younger ages, we get them worse when we're under a lot of stress.

Women of color usually have multiple stressors. Not that we all don't but women of color are more likely to have stresses of poverty and oppression, stresses of trying to negotiate a very racist kind of society. And one of my dear friends and colleagues talks about it oftentimes in terms of destruction of dreams and what a powerful stressor that is in terms of economic inequalities. We also have women of color living more often in poverty neighborhoods with their environmental hazards that have been un-equally distributed in our cities and countries in terms of segregation of populations are accompanied by more environmental hazards and we also find these health disparities are also affected by disparities in educational levels and inequities in the criminal justice system.

On the next slide also referring to the unequal treatment report it's not only disparities in how severe and often you get a health problem or how early you get it. There are also disparities with the healthcare system. Inequalities in terms of the healthcare system and individual provider bias. I think it's ironic those are the most biased think they are the least.

And the next slide lists some of the identified health disparities in women. Women of color, African-American women are most likely -- more likely to have more low birth weight infants. More infant mortality, increased prenatal depression and substance abuse between African-American and Native American women. Low birth rate is higher among Puerto Rican women. On the next slide some other health disparities. African-American

women disproportionately affected by hypertension and. Lupus, drug abuse and STD and HIV/AIDS also true in Latino women.

On the next slide this is the intersection. The role of violence in producing these health disparities is seldom addressed and most of the areas I just whipped through are areas of women's health that have also been shown in a totally separate body of research to be related to violence. But seldom are these connections explored. What we do as researchers is tend to control for race, ethnicity and income and research showing the health effects of domestic violence and sexual assault rather than really demonstrating the differences that may be related to other causes of health disparity as well as violence and the unequal prevalence of domestic violence. The ACE study showed very importantly the increase in long term health problems related to the adverse child events of being abused as a child by your parents or witnessing domestic violence between your parents or there is also other adverse child events that were measured. Those two were particularly associated with many of the leading causes of death in the United States. Children that were abused as a child saw their father beat their mother were more likely to die early of hypertension and cardiovascular disease. These are conditions disproportionate among minority ethnic populations. It is not only adults it is the whole spectrum of trauma that women are most likely to experience.

On the next slide in terms of some of the evidence around physical health and intimate partner violence we see more physical injury that makes sense but we also when we look at trauma and use of emergency departments, those are higher amongst African-

American women and so again we see this intersection that is seldom explored. Homicide is the leading cause of death for African-American women age 14 to 34 and 40 to 50% of those cases the perpetrator was an intimate partner and 70% of those cases where the perpetrator was the intimate partner were preceded by domestic violence. We see more falls in young African-American women who come to the emergency department. Somebody says what happened to you and she says I fell but actually these are more likely to be the result of a violent attack by an intimate partner. We saw -- we see more neurological problems in women who have been abused. Oftentimes from old injury. And that's been shown both in African-American and white women in South Carolina and Mexico.

On the next slide another litany of chronic health effects that have been shown to be affected by intimate partner violence. Hypertension, especially in African-American abused women. More smoking in women overall who are abused and that leads to other health problems. More abuse during pregnancy. And most of these studies have not differentiated the risks between women of color and other women. One of the few studies that did was one that was from our data on that HMO study on the next slide. We did show that African-American women were overall more likely to go to the emergency department and if they were abused, that was the group that went to the emergency department most often of all. We also saw a difference in hypertension amongst African-American women who were abused versus those never abused. Again, this violence effect, stress effect interacting with other risk factors for hypertension. We also saw for the African-American

only a significant association between intimate partner violence and fibroids which is a chronic morbidity problem that especially affects African-American women.

And on the next slide we've got some of the risks of forced sex in intimate partner relationships and you can see the unintended pregnancy. We know these disproportionately naturally affect young women of color. More health effects of forced sex and intimate partner relationships, STD, HIV, urinary tract infection, the risk of homicide and one study showing an increased risk of cervical cancer which affects women of color more than white women in this country.

On the next slide briefly. I'm running out of time so I'll go very quickly. I want to spend a couple of minutes saying about how tragic, how unrecognized the epidemic of HIV is in young women of color. How now around the globe women are the fastest group contracting HIV and converting to AIDS. Not sure why that is. For every HIV positive male there is now 160 HIV-positive females in terms of new cases. In the United States African-American women are the most affected especially in the south. In Africa women are dying the most from AIDS, not men in 3 to 1 ratios directly associated with more intimate partner violence. Many of these women who are dying are heterosexual married women that have no behavioral risk factors except their husband is having sex with someone else and he's the one that infected them. And as I mentioned, women convert from H.I.V. to AIDS more quickly and we're not sure why.

The next slide gives some literature around why this increased risk for women who are abused. There is the immune system depression that comes with stress that's from the domestic violence. There is the trauma of forced sex which oftentimes includes anal sex, the perfect transmission venue for H.I.V... The increased STDs make H.I.V. more easily contracted. The idea of negotiating safe sex -- women can be accused of infidelity if they want to use safe sex measures if it's a jealous man who beats his wife he will often assume she wants to use safe sex practices because she's been unfaithful. Males are having other partners that are unknown to women both male and female partners. And the fear of being beaten for women if they say I want to be tested. If they come home and say I'm positive again he may assume she brought it to the family. She may delay treatment and there is also the connection through substance abuse.

On the next slide very briefly around the maternal mortality connection, African-American women are much more likely to die from maternal mortality. A lot of that is related to homicide. The Laci Peterson case was famous. We saw her face on television every day. At the same time after she was killed, there were at least two African-American young women who were killed by their partners while they were pregnant and yet neither of those cases attracted much attention in this country. So we also neglect this issue in maternal death reviews because we don't know who the perpetrator is when it's a homicide case and there is a tremendous amount of maternal mortality related to domestic violence.

On the next slide again briefly we find maternal mortality issues and there is now a new project that is going to link medical examiner data with homicide data so we'll be better

able to determine what exactly is going on. In our study we found abuse during pregnancy as a risk factor for intimate partner homicide of women and also unemployment was the most important of the demographic variables for the male perpetrator and when we looked at unemployment, put that in analysis race was no longer significant. But it was associated with abuse during pregnancy and the infant side of pregnant women. There is more on the Maternal and Child Health connections. Abuse during pregnancy linked to pre-term delivery and low birth weight. When we talk about the increased risk for African-American women and Puerto Rican women of low birth weight we seldom make that connection with intimate partner violence.

And the next slide shows a study that we did where we found that the highest risk for abuse during pregnancy was amongst Puerto Rican women. It was much lower amongst other Hispanic women. The groups in this country have the lowest rates of low birth weight also. Except for our study the linkage is not often made. It shows some of the findings from that study around physical abuse and low birth weight and it also shows that a culture with a risk factor for abuse during pregnancy amongst Latino women. The more cultured they were to our U.S. society the more likely they were to be abused during pregnancy. So the cultural values they brought with them were actually more protective if they kept to their original culture.

The next slide is the summary in terms of health disparities implications, intimate partner violence disproportion effects poor minority women. The lack of access to means to live independently if that's what she wants or to culturally appropriate interventions for her and

her male partner. Intimate partner violence affects the health of women and children but the extent to which it's responsible for health disparities to a large extent is unknown. I've given you some of the hints in the research but we certainly need much more to really make that case.

Then the next slide is, I think, the last of the summary slides. The healthcare system needs to do routine assessment for intimate partner violence. We need to do it for all women. If there is a small increase in intimate partner violence for women of color it does not justify only screening or assessing women who are low income or women of color that would be absolutely inappropriate. The intervention for women and children must be tested separately for different groups. Culturally appropriate and relevant and our studies need to be done with cultural humility, collaborative and information disseminated by strategic means to reach real women in real worlds. And our overall implications many conditions and health problems affect health disparities indirectly or affect our ability to get help for major conditions and we need to do more research to eliminate the connections and develop and test the interventions that will narrow that gap.

The next slide has a few innovative approaches that you can look @ your leisure. I'm out of time and we have other good speakers. I wanted to mention there is other specific research modes. There is specifically Native American post colonial approaches that have been used and the last couple of slides show a dating violence intervention program that we've used in the Baltimore city schools that is culturally specific. It's based on echo centric arts and there is a little outline of that slide and I can provide anybody more

information in the last two slides are some of the kids taking part in the visual arts components of that intervention. Thank you.

LISA KING: Thank you, for that very, very thorough overview. Next we have Heidi Beth Burns from the tribe of Chippewa Indians Bad River Band of Lake Superior in Wisconsin.

HEIDI BETH BURNS: Hello, everybody. My name is Heidi Beth Burns as stated and the first slide states that violence is not Anishinabe an tradition. The next slide is a Cheyenne proverb. The next slide states family violence is unacceptable behavior for the Anishinabe people in pre-reservation society. Ojibwa way philosophy considered men and women as equal. There was no battle for superiority or power and control used to dominate.

Battering or wife abuse was rare but there were explicit social laws to deal with the occurrence of abuse. Once a man battered his wife the woman was free to make him leave her lodge.

And the next slide states if a household was broken because of abuse, it was not considered a divorced family as it is today. The woman was considered honorable for having the self-respect to leave a destructive relationship. Domestic violence effects not only the victim and the children but also the families and the community in so many different ways without healthy change the cycle of violence continues not only in our lives but the lives of our children and continues to be passed on from generation to generation.

Slides five and six address understanding the loss of our traditional ways is loss of a nation. As quoted. We're going to skip them and go on to slide seven that states homicide, the second leading cause of death in native women. Violence is a learned pattern of behavior that has its roots in our early childhood experiences. We are all creatures of habit. If violence played a role in our childhood, it is very likely to play a role in our adult lives as well. Family violence serves as a training ground for our young children.

The next slide reads, children do not have the cognitive abilities to know what is right or wrong in adult behaviors. We have all heard the expression, monkey see, monkey do, if they see their family members yelling, screaming or hitting one another they're learning that this is acceptable behavior. Just because we have never hit a child does not mean that we are not abusing a child. Any behaviors that are displayed in a threatening or intimidating manner are abusive. Many abusive parents see a childhood secret they, too, were victims of abuse.

And the next slide it states sadly the family violence has become one of the most dangerous environments in Native American society. Family violence has risen to epidemic proportions. One American loses their life every 15 seconds to family acts of violence. Native American women are three times more likely to be killed in a family-related act of violence than women of any other nationality combined. Homicide has become the second leading cause of death for native American women in the United States. 75% of these women were killed by a former, current partner or closely related family member.

The next slide states the destructive pattern of family violence shatters families and continues to weaken the very fibers of our Native American tradition and values. Home is no longer a place of safety and sanctuary. Home is not a safe place where children can play, explore and learn about the world around them. They're growing up in war zones. Consequently the cycle of violence will continue from generation to generation. The cycle of violence can be stopped in our lifetime. The Anishinabe values of harmony and balance live on in the hearts and spirits of the Ojibwa people today. We can strengthen those values and begin caring for ourselves and each other.

Slide 11 and 12 states why Indian women stay and you can view them on your own so we're going to skip them and go on to the next slide which is one of my favorite comments. It was adapted from the victim witness assistance program that states so many people ask why does she stay. Too few ask, why does he beat her?

In the next slide entitled how can Anishinabe people take responsibility toward ending domestic violence in their community? Returning to traditional and spiritual values. Remembering to treat women in a sacred manner. Treat all women as if they were your female relatives. Speak out when friends or family are disrespectful. Life is sacred so Anishinabe people look upon women in a sacred manner. Make it clear abusive behavior and language towards women is not acceptable. When you're angry with your partner or children, do not hurt or belittle them. Behave in a non-violent, respectful way. We are caretakers of the children for the creator. They are his children, not ours, be an example

and teach your family. Encourage your tribal leaders to support the efforts of ending domestic violence within your tribal community is on the next page. It also states, speak to the elders in your community to seek their wisdom and direction toward making positive changes. Ask your spiritual or religious leaders to learn more about domestic violence and encourage them to support ending violence. Encourage your local schools to develop a program on positive dating and family violence. Monitor music, movies, video games your children watch. Write to companies about violent context. It's a learned behavior.

Volunteer at your local shelter. Every victim needs to have a safe and healthy place to heal. An Anishinabe woman's healing is an important process. Pages 16 is the violence power and control over others triangle that addresses physical, sexual and other life destroying powers. Age 17 is power and control regarding physical and sexual violence. Regarding institutional and cultural. Page 18 is the natural life way that is based on non-violent life supporting power and values. And supporting that natural life supporting power and values is page 19 regarding non-violent beliefs and equality is natural. Life support and power that is grounded in spirituality. I would like to thank everybody for allowing me to be part of this.

LISA KING: Thank you, Heidi. Thank you very much for your presentation. Next we have Hannah Sin the community outreach director. She's the community outreach director for the Asian Pacific Islander domestic violence resource project here in Washington, D.C.

Hannah Sin Thank you for having me. Today I would like to talk about domestic violence in Asian and Pacific Islander communities. As an overview and also some specific issues

to keep in mind when working in in that community. If there are specific questions about the work we do, and if there is time I would be happy to entertain those at the very end. The term Asian Pacific Islander is a very broad term. Under the U.S. Census Bureau it covers over 50 ethnicities. So that includes east Asia, south Asia, southeast Asia in terms of how Asia is defined and the Pacific islands includes Hawaii, Samoa, other islands. D.C. Metropolitan alone has several thousand residents of Asian Pacific islanders that cover any of those 50 ethnicities. In language alone there are hundreds if not thousands of different dialects spoken. In India there are over 16 national languages and over 1,000 dialects in that country alone. Not only does ethnic identity distinguish Asian Pacific islanders from one another but also religion, class, educational background. Urban and rural. Sexual orientation, marital status. These are all different markers of identity and can be even more important than an ethnic marker of identity.

So moving onto the next slide when we look at the context of domestic violence they aren't only looking at it as it exist between two individuals in isolation but really looking in which ways family, community and society play a role. Provide either sources of support and safety for the survivor or symptoms of accountability for the abuser. And so in looking at domestic violence in Asian Pacific Islander communities I want to take a look at those three circles that we just saw, family, community and society and look at specifically these issues. Multiple abusers in the home that might include in-laws. Also issue of confidentiality within the community and also the access to culturally and linguistically competent resources. To emphasize domestic violence is -- there are many commonalities across ethnicity and religion and class. So I want to emphasize again that

the experiences of violence are very similar with many other women. These are only to serve as some examples of what may happen in one person's specific situation.

So the next slide highlights a statistic that was based off of a study we did with 178 Asian women here in the D.C. Metropolitan area in 2001. According to this research project 28.5% of women knew of another woman who was being abused by her in-laws. To provide some further background to this specific statistic, many women -- not necessarily all women but many women are once they marry they may be considered part of their husband's family and their in-laws may or may not be living with them. The in-laws in working with the women we work with we've seen women whose in-laws whether it's the mother-in-law, father-in-law or extended family either participating in abuse or being perpetrated or supporting the abuse in some way. So in thinking about things like safety planning and providing whether it's healthcare services or other social services, providers may not be aware that in-laws may also be perpetrators or taking the information back to the abuser that may further endanger her.

The next slide highlights how confidentiality really plays an important role in one, how a survivor of domestic violence perceives their sources of support and also, in terms of their safety, what level of danger they're facing once either their location or their plans to leave the home are shared within the community and go back to the abuser or the multiple abusers. Particularly in the immigrant community, when you have a small community whether that's a small ethnic or linguistic or religious community, confidentiality is something that is magnified because what might be more of an anonymous issue because

everyone's issue and knowledge in a small community. There may be survivors who may be unwilling to seek help or to leave because of stigma or because of lack of resources. So I can't emphasize enough the issue of confidentiality in terms of how safe people feel in reaching out for help but also in terms of if their information will be shared and therefore endanger them. Particularly in relation to TABOO in teen relationship. There are those perceived by the mainstream population as not being sexually active or not engaging in dating relationships but there are many Asian Pacific Islander teens who are engaging in dating and sexual relationships who may not be open with parents or relatives about what is going on because they aren't allowed to date or because there may be an emphasis on preserving a young woman's virginity, which may reflect the family's honor. But also in terms of service providers not sort of being aware that Asian Pacific Islanders teens may be dating and at risk for dating violence. In terms of same-sex relationships, in communities where it may not be openly talked about and families where it may not be openly talked about there may be less reason to ask for help especially if there are stereotypes around who abuses and does abuse exist in same-sex relationships and fear of discrimination also from service providers and maybe Asian Pacific Islanders who may be homophobic or heterosexist. Small service provider communities what we see specifically around language access issues, so there may be in one county one Thai speaker who works within the domestic violence field but -- and maybe a very prominent member of the community. So the community may be very small. In addition to the communities very small the service provider community is also very small especially when there are very few bilingual individuals who do the work. It isn't to say that service providers don't operate in their own communities. There may be a fear of working with service providers who are

from the same ethnic, religious or linguistic community saying they'll take it back and share it with other people or I'll see them in public. Really emphasizing both with service providers who do the work within the context of domestic violence and also in the community, the confidentiality is really, really, very important on multiple levels.

Moving on to the next slide in looking at language needs. Immigrant women who are limited English proficient need and deserve access to multi-lingual services. It's vital they're available on every level on the healthcare level, law enforcement, emergency shelters, in terms of the whole spectrum of services that Asian Pacific Islanders survivors of domestic violence need that is so critical that they have access to services in their own language and not to say that all women want to use those services because again fear of losing confidentiality or not feeling -- or feeling -- fearful of judgment from other people in their community but at least to have the option open to women is extremely important. Also in terms of providing multi-lingual services it's important to be sensitive to interpretation services provided by family members whether it's screening for domestic violence within the healthcare setting or whether it's a police visit or any setting where there are family members providing interpretation services that there is no way to know for sure if that person is a perpetrator. Even though it may be a mother-in-law. She may be a perpetrator for even a son or daughter, they may also be a perpetrator. Males take the information back to the abuser about what sort of information is being shared. In terms of using multi-lingual services using third party members. Emphasize confidentiality even if they are third party members who should know the values of confidentiality but it is always best to emphasize that even if it needs emphasizing it several times. Moving on, looking at

cultural competency and how it is -- how Asian Pacific Islanders survivors of domestic violence can access those services it's important to know the difference. Cultural sensitivity is more the sort of openness to learning about new cultures and it's more sort of that open-minded attitude. Cultural awareness is having specific information about how certain populations or groups have practices or beliefs amongst themselves but cultural competency is different from both of those things. Cultural competency is more about skill building and not about having a laundry list of the dos and don'ts with Korean survivors or Muslim survivors. Whether or not we have the information about specific cultures it doesn't mean we can predict behavior. Really that cultural competency is based on the relationship a provider has with a particular individual. That begins with a self-awareness of the service provider in terms of biases and stereo types that may be projected to the individual and might result in not sharing specific resources, pressuring the survivor to make certain decisions that otherwise a survivor wouldn't make and also pitting the person against sort of the mainstream or having to choose between their own quote, unquote, culture and their safety, which is something that none of us would want. Really, the cultural competency is a continual process. It is never being 100% culturally competent but working at it constantly and part of the process is the self-awareness but having the survivor of domestic violence as the guide. Really improving skills such as communication skills and also -- both verbal an non-verbal communication skills. So that concludes my presentation and my personal contact information is at the end. Considering that there is so much information to give if any of you have follow-up questions, feel free to contact me. Thank you.

LISA KING: Thank you, Hanna. Next we have Dr. from Howard University School of Social Work.

TRICIA BENT-GOODLEY: Thank you so much. I would like to thank my fellow presenters for their important and cross cutting contributions as I listen to the presentations I could already hear some of the cross cutting kinds of issues that I think are relevant for women of color from diverse communities. So that will allow me to better hone in on some of the unique considerations for African-American women. African-American women experience some unique considerations related to intimate partner violence that heighten their risk and render particular challenges worthy of our consideration. I want to thank Jackie for having really discussed and contextualized what I meant by heightened risk. That will allow me to focus on some of the reasons why we think that risk exists. Challenges both internal and external to African-American women warrant a more targeted -- there is great diversity within from African-American communities that should be considered and I just want to ensure that we're cognizant that there is great diversity. For example, women who may be of Caribbean descent might have a different perspective for African-American women who have been born in this country.

Next slide. Intimate partner violence has been regarded as the number one public health issue for African-American women by the black women's health project. Now the black women's health imperative and this accentuates the point that intimate partner violence is a serious health issue for African-American women. African-American women are three

times more likely to be killed as a result of intimate partner violence compared with white women.

Next slide. Compared to white women, African-American women are more likely to sustain life threatening and lethal injuries, have children removed from the home, contract H.I.V. and become incarcerated due to incident partner violence. I think Dr. Campbell gave us excellent examples of why we see some of those heightened risks. The role of trauma again we can't ignore. Far too many African-American women have experienced sexual assault, childhood sexual abuse, physical and emotional abuse and that was discussed earlier in the presentations.

Next slide. The impacts of historical trauma is also particularly important for African-American women. There have been a number of studies that have documented participants' perception about how slavery, discrimination and racism have impacted African-American male/female relationships today and I want to point you to look at particularly a publication through the institute on domestic violence in the African-American community that provides some documentation of studies done across the country where the perceptions of African-Americans towards domestic violence were considered. And in those studies it was clearly found that the participants felt that historical trauma was relevant to what we see in terms of heightened risk for African-American women. We still are really trying to better understand how historical trauma has impacted current relationships today. But across many studies we've found that participants definitely see the linkage and have that perception. The intersection of

violence is particularly relevant. Dr. Campbell talked about that intercession of oppression related to gender, race and class. It is important we understand the complexity of these intersections in order to context -- they're health seeking behavior pattern. One of the things we found is that African-American women are more likely to go to friends, family and faith-based providers before they seek other sources for assistance. And I'll talk a bit about the importance of community and faith-based networks. Typically when African-American women seek services, it is to stop the violence and obtain concrete services, but not as they see it to put men at greater risk for negative or perceived discriminatory treatment so it's important to understand that African-American women, when they often are reaching out for assistance outside of their friends, family, community and faith-based networks, they're really reaching out to put a stop to the violence at that time in that moment and to obtain concrete services. So they aren't necessarily looking for long-term counseling or even safety planning but really looking to obtain a concrete service such as assistance with food and clothing, housing and those types of concrete services.

Next slide. It's been defined as when 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. African-American women have received many messages of taking care of the family at all costs, protecting African-American men from further discrimination. There has also been great shame and embarrassment associated with intimate partner violence. For so many African-American women they've been taught that intimate partner violence doesn't occur in black communities. That black women do not allow men to abuse them. And so when

an African-American woman may find herself in an abusive relationship, she may find it even more difficult to reach out because of the shame and embarrassment of being in the situation. Another issue that we're seeing is that of the imbalance between the different -- the two genders. As it was discussed earlier, the notion that there are so few marriageable African-American men available to African-American women. There has been some research, particularly by one person that has looked at how the sex imbalance has impacted African-American women's decision to stay in relationships because there are fewer choices that might be available to her.

Next slide. Geographic accessibility of services is also an issue that we have found that has heightened risk. Many services are not based in communities. Funding for being able to go out of the community to receive services might be limited. There are often transportation constraints. So, for example, while we may provide a woman with a voucher or some type of support to be able to use public transportation to get to a service, we may not take into account the challenges of that woman being able to manage her children via public transportation, arrange for babysitting services or just deal with the challenges of even getting out of the house to go to the many services that we expect women to participate in. Fear of going into neighborhoods outside of the community is also real. For some women they may not have convenient routes outside of their neighborhood and it becomes an intimidating factor just to venture outside of the community to receive services. So the geographic and accessibility of services is an important consideration for us.

Next slide. Discriminatory treatment has been found in a number of different areas related to African-Americans and intimate partner violence. We found providers who have turned African-American women away from shelter treatment due to stereo types and labels. Some examples of that that have been given include African-American women being told that they didn't look upset enough. That black women are strong and that they can withstand abuse or even comments that you're as big as he is and you can take him. We've heard that type of treatment come from providers and that can certainly turn a woman off to receiving services. African-Americans are also more likely to experience dual arrests due to intimate partner violence and Dr. Campbell talked a bit about some of what we're seeing in terms of why it occurs but it is an important consideration. So that if a woman believes that she might, in fact, be arrested even though she was the victim of a particular incident or circumstance, it may discourage her from wanting to reach out to receive assistance and the lack of cultural competence as to isolation and in the effective treatment was also discussed by the previous speaker. In terms of cultural competence, even though African-American women might speak the same language as the provider, the context of the language has to be considered. So defining abuse becomes really important. The woman may not define abuse the same way the provider does. So it's important to understand what the differences might be and how to best use language and understand the context of the language to further the helping relationship.

Next slide. I'm going to conclude. I know I've gone through quite a bit a little quickly but I understand there will be some time for questions at the end of the presentations. So I just want to emphasize the importance of cultural competence which would include -- including

more community-based services. Understanding how racial loyalty impacts choices and decision making for African-American women. The importance of understanding how systemic oppression and discrimination impacts choices, looking at the role of communities, grassroot communities and faith-based networks is so crucial within the African-American community and not just looking at how we intervene but also how we assess for intimate partner violence is critically important. While there are a number of risks and challenges that have been identified, the increasing willingness to identify and confront intimate partner violence press signs of hope that we can turn the tide of intimate partner violence among women of color. Thank you.

LISA KING: Thank you, Dr. Bent-Goodley for your presentation. Next we have Dr. Linda Laras. An assistant professor of the School of Medicine in San Juan, Puerto Rico. Hula. I appreciate the opportunity to share with you. I would like to begin with a couple of the messages given by the prior speakers before starting because I think they're very important. And first one is recognition of the form of abuse. I think that is similar for all groups of women. And not everybody seems abused in the same manner. The second one is about pattern behavior versus repeated actions. We believe that maybe the first physical abuse should be the last so thinking in the context of a pattern behavior that maybe there is emotional abuse, followed by physical abuse that we don't have to have two hits to define domestic violence. Another of the issues, and I think that in the certain way different groups have mentioned them, is that women seen socially as a special components -- I don't know the word is, advancement of society as responsible for the family and therefore given more responsibility and expected more tolerance for the

different issues that go around the family life. I'll start my talk with slide number two and talk about women in Puerto Rico. It is an island in the Caribbean. 52% of the population is women and they are the majority of the whole families, the head of the families. Their life expectancy is greater than men. The job rate is a lot lower than men but they're unemployment rate is similar to men. Woman as head of the family are greater percent part of the below poverty level. And this is like three at the level of political influence Puerto Rico is divided into 78 counties. Only one of these counties mayor is a female and only 19% of the representatives and senators at the legislative level are composed by women. Educational-wise more women have doctoral degrees and health-wise more women suffer from diabetes and hypertension than men. With respect to the domestic violence in 2004 the police department reported 51% of the women what were murdered, these were related to domestic violence issues. Every 12 days in 2004 a woman was murdered because of domestic violence and every day 52 women suffer some type of trauma from domestic violence. Slide five we have the numbers since 1990-2004 and we can see domestic violence incidents have been going on the rise. Slide six we can see the difference between male and female victims, which we can establish the inequity between females and males. We're going to jump to slide eight and our question would be do women born Hispanic have a different set of risks for domestic violence or does a particular cultural ethnic background environment surrounding her define her added risk? In Puerto Rico everybody is Hispanic and we're a majority, different from the main land where Puerto Ricans are minorities. Maybe I'll take advantage to say that I think it's a mistake to speak of Hispanics and group them all together because their cultural and ethnic backgrounds are very different. And even the meaning of the same words in

Spanish can be different. All Puerto Ricans are different to other Hispanics that come from other countries, Puerto Ricans are born U.S.A. Citizens so there are no immigration issues. Different to the populations that speak Spanish. The lifestyle here on the island is very similar to the main land. Language-wise there is a barrier, a lot of Puerto Ricans don't speak English. It's a lack of practice because the schools in Puerto Rico teach English since the first grade. Politically we are not in the United States and not independent. It impacts our everyday life in diverse manner I won't go into. It does make a difference. So Puerto Rican -- women in Puerto Rico have a different situation. It's hard to say how much the Latino/Hispanic influence has in our perception of domestic violence as a problem. This has been changing very rapidly because of education and public policy. At this time there are many public policy issues at the level of government agencies and private sectors which incorporate inequity in gender issues with the message of zero tolerance to violence. We go onto slide 11, we can see that in spite of this, we continue like I said before, to have a rise in domestic violence. The slide 11 is showing us the difference between how many protective orders are requested versus how many protective orders are granted. As we see, the requests have been increasing but they're being granted in the same level. So I think that in Puerto Rico we might need to start looking at who gives the services. How are the agencies working? Are we really operationally as a team? An interdisciplinary team when we're working with violence? Domestic violence is a power issue beyond ethnicity and culture. Ethnicity and culture changes over time as we share information. Within the same ethnic group there are different factions that favor domestic violence. The factors surrounding women impact her depending on the fact of education. I think here in Puerto Rico it's less a Hispanic man issue and more power gender inequity

issue but still there are people that believe that women's place is at home cleaning and cooking, serving and it's not seen as inequity but rather a woman's privilege to have a partner. And that the woman's duty is to have sex with her partner. This still occurs. I think that it occurs a lot in the way we're being brought up but as more and more people getting educated, we're seeing more and more -- less of this. We go to slide 16, I want to point out two big things that happen in Puerto Rico was the law for prevention and intervention of domestic violence and the law for the creation of the women's advocate office. The law in 1989 established a whole new set of protocols and services and treatment options for people in these situations and in the Office of women's advocacy, an office at the governor's level. This office has the mission to oversee all government agencies to make sure that their policies are non-discriminatory against women. Change does take time so we still need to work on issues like history of child maltreatment. I was really happy to see that one of the speakers brought up the ACE study. I think from the health perspective, we are so way behind in managing violence as a health issue. I think that there is a lot of strategies that we haven't touched bases yet like we do with other health issues. We also need to work on behavior modification, early educational levels as we get more technological and our children with being brought up by machines, we're forgetting how to -- how they're going to learn the value of respect for another human being. When all the cartoons, songs and videos are showing the contrary to this. And then again the next point public health intervention, we need to do more in posters and more in handouts. We really need health professionals to ask that question to every patient. I agree with one of the speakers who said we need to ask everybody. I think if we don't ask everybody, we're doing an unethical work.

The next slide, slide 18, health professionals have a unique position to identify victims of personal abuse and for prevention and management. Everybody goes to the health professionals sometime in their life, everybody. Everybody sees a health professional as a person to help, a person that you can go more than one time, and is not there to punish you. Everyone accepts that you can go for follow-up. Nobody is going to question that you go once, you go twice, you go three times to the healthcare service like if you went to the police two or three times everybody would question you with that. We also need to start talking about health and wellness, which is more acceptable to the victims than crime. A lot of people just shut off. You tell them that he can go to jail for this. Change it for him to get help. For him to get help he needs to acknowledge the problem that he has. We also need to -- we go jump to slide 21, we can see how holding the offender accountable isn't as much a task for the victim as the professionals that provide services to the victim. I think this should remind us all, it is not giving out a brochure or putting a poster on the wall. It is asking the question. Once I have the answer I have to get up, get the phone, do the coordinating for services and I have to sit with her there if I need to.

Slide 22 is a little complicated but I believe that we can go through it real quick. It is a way of how to get through doing these questions for all the patients that we see. This is what we do in our service. We do have information for those patients that don't want to talk at the beginning but they know that in our office they can talk about it. Violence is as important as menopause, as osteoporosis or anything else.

We also talk about direct questions, indirect questions and questions with messages in slide 24. Because not all patients can be asked the same way. That's important that the health professional develop skills to ask questions.

Slide 25 is the question that we like the most, which is the message question, because with this one we let her know that these things are happening. That it's not healthy. That she's not alone and that there is help. We always ask them would you know what to do if it happens to you? If the patient says yes, then we tell them well, there is some new stuff out and there are some new programs and we give her the information. If she says no, we give it to her, too. No matter what happens, even if she's not suffering violence at that time she doesn't leave the office without some information.

Slide 26 we kind of enumerate the different aspects that need to be asked if the patient does do it. I remind the residents a lot. If we ask if there are weapons in the home to remember that anything can be a weapon. So he threatens her with the fan, the fan becomes a weapon. So it's a different way of seeing health issues. On slide 27 I tell all my residents you need to have your internal medicine list, your ENT list, your dental list but you also need to have a list of free legal services, of community services for women who are victim, of shelters, like you have any other healthcare strategy for the victim.

Slide 28 I just go to the point that sometimes we don't know what to do. Because the patient is in danger but she doesn't want to do anything about it and I tell them it's okay to consult with somebody else and that's why it's very important that health professionals

and community programs know each other before there is a victim in the office so that we have that contact already and facilitate any interaction we need to do. We jump into slide number 30, this is a table, a graph for questionnaire that we sent out to the police, to the district attorney's and the social services people and we asked them what is it that you think that a health service should have to provide to victims? They told us that they needed the doctors to write out the documents. They needed confidentiality; they needed the victims to wait less time. I'm not talking about two or three hours. Not to wait 10 or 12 hours. They needed that we facilitate an interaction, the case discussions with the other disciplines. That we facilitate the exams, the forensic exams. That we knew the protocols. They were saying doctors didn't know the protocols. They were asking for health insurance coverage for victims. They were asking that the health professionals know victims' needs. 88% they were saying there weren't enough doctors that knew what they were doing. Just saying oh my god, this is so bad this happened to you is not enough. Forensic science has come a long way and we need to know, you need to have the skills and you need to be committed with this population. 55% asked the health service to stop revictimizing. So I think that as I say, the health services needs to really jump on a train to get up to date with community programs for identifying and intervening with domestic violence. We jump to slide 36 and I'll just end it there so we can have time for some questions, here in Puerto Rico if we talk about minorities, we have a small group of Dominican Republic that are risking their lives to cross the waters to get to us for a better life and a lot of women are being connected with men that are abusers and because of their immigrant situation they can't do anything. And I would say there is another issue of trafficking for sex of young women. Those are issues that they are very hard to identify

and our government services are very lacking in help for them. So I'll leave it there for questions.

>> Thank you, Dr. Laras. I want to thank everyone for tuning in. Our speakers for such excellent presentations. And you all were a wealth of information. Unfortunately we don't have time for questions today but we will forward the questions on -- from the audience to the individual speakers to get their responses so that you can get answers to your questions. Again, I want to thank everyone for participating.

>> Thank you.

>> Thank you.

>> And I would also like to thank Ms. Bradfield for her assistance in helping put together this presentation.

>> Thank you, Lena.

>> One other thing, the presentation will be archived in a few days. Today is what, Tuesday? I would give it maybe until Monday. And go to [mchcom.com](http://mchcom.com) and look for the title and it will be there for you to view. Okay. Thank you all again.

>> Thank you.

>> You're welcome. Bye-bye now.