Final Report Summary

of

"Ethnocultural Influences on Women's Experience of and Responses to Intimate Partner Violence"

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PROJET GOALS AND OBJECTIVES

Research about ethnocultural influences on women's experience of and response to intimate partner violence (IPV) is scarce, contributing to culturally incongruent processes that may deter some survivors from engaging with community systems. To fill this gap in the literature, this project examined the ways that cultural beliefs and contexts serve as a lens through which European-American, Mexican-American, Korean-American, and Vietnamese-American women experience and respond to IPV in their lives. Four specific research aims guided this study:

1. To understand how ethnocultural beliefs affect the nature and interpretation of co-occurring violence in women's lives.
2. To understand how ethnocultural beliefs affect abuse-related mental and physical health.
3. To understand how ethnocultural contexts influence strategic responses to violence.
4. To understand the linkages between women's experiences of violence, health outcomes, and willingness to engage with the criminal justice system.

PARTICIPANTS, PROCEDURES, & PROTECTIONS

Recruitment Procedures. To achieve these aims, community based recruitment procedures were used to recruit women from four target ethnicities (European-American, Mexican-American, Korean-American, and Vietnamese-American) who were afraid of their partners or who had experienced physical or sexual abuse at the hands of an intimate partner in the past 5 years. Initial efforts focused on recruiting participants through community health clinics, but low response rates led us to ultimately recruit from the entire community. Flyers, pamphlets, and in-person presentations were used to recruit participants from community based organizations (e.g., social service organizations, health clinics, cultural organizations, legal clinics), community events (e.g., health fairs, neighborhood and cultural events), and local businesses (e.g., coffee shops, nail salons, child care facilities). To ensure wide coverage, we divided the Los Angeles and Orange County metropolitan area into nearly 100 tracts

covering 51 cities. Recruitment materials were delivered to over 1,500 establishments in these areas, and newspaper advertisements were placed in eight different newspapers.

All recruitment materials were available in all four target languages and invited adult women from our specified ethnicities to participate in a study about relationship conflict (see Appendix A). Some of the materials invited women to participate in in-person interviews for which they received a $50 gift card to Walmart. Participants who called for information were then guided through a screening procedure to determine whether they were over 18, from one of our target ethnicities, and were either afraid of their partner or had experienced physical or sexual abuse by a partner over the past 5 years (see Appendix B). Screening was conducted in the language of the survivors' choice (English, Spanish, Korean, or Vietnamese) by a staff member fluent in the chosen language. Qualified participants were then invited to schedule an in-person interview at a time and location of their choosing (including coming to campus or one of six partner organizations). Participants also indicated their language of choice at this time and interviewers were matched based on language and ethnicity.

Other recruitment materials invited women to participate in an online survey about relationship conflicts for which they received a $20 gift certificate to Amazon.com. Interested participants were guided to a website that provided a variety of resources to promote women's health, including links to our survey. Participants who clicked on the link were presented the option of taking the survey in English, Spanish, Korean, or Vietnamese. They were then taken to our screening page which assessed the same criteria as described above. Only those participants who met our screening criteria were allowed to proceed to the online survey.

Finally, service providers who encounter IPV survivors in the course of their work were also recruited to participate in focus groups about barriers and solutions for working with survivors from each of our ethnic groups. Flyers and emails were used to advertise these focus groups, and interested

participants contacted one of the PIs who then scheduled the focus groups on campus or at one of our partner locations. Participants were offered $30 gift cards to Target for their participation.

Participants. These recruitment procedures resulted 248 calls for more information. Of these, we were unable to screen 26 participants (mainly when they called after hours and we were unable to reconnect), 58 did not meet our screening criteria (due to age, ethnicity, time since the abuse, or the nature of their relationship conflicts), and 41 screened in but did not complete an interview (mainly because of cancelled interviews or no-shows that could not be rescheduled). The remaining 123 participants did complete an interview. All interviews were audio-taped and reviewed for quality control purposes, leading to the decision to drop 11 interviews from further analysis (as a result of audiotape malfunctions, experiences that did not meet our screening criteria, and extreme mental health issues). The remaining 112 interviews were divided among women of European (n = 30), Mexican (n= 43), Korean (n = 19), and Vietnamese descent (n = 20). As a result of some modifications made to the interview protocol, 23 of these interviews were conducted using an original version of the protocol, and 89 were conducted with a revised version of the protocol (see Protocol section below).

These recruitment procedures also resulted in 634 people accessing our survey either online, through mailed surveys, or in-person. Of the 634 total response attempts, 219 did not meet our screening criteria (and therefore did not make it past our screening page), 32 were incomplete (defined as not completing any of the abuse scales), 75 were deemed to be inconsistent (defined as numerous contradictions in repeated factual questions such as age, gender, ethnicity, relationship status, and/or failure to correctly answer quality control questions such as the current year), 115 were duplicate data (i.e., most of which contained identical response patterns that were submitted at 10 minute intervals on one particular day), and 193 were deemed to be complete and consistent. It is these final 193 surveys that make up the dataset for this study, consisting of 50 European-, 62 Mexican-, 42 Korean-, and 39 Vietnamese-American IPV survivors.

A total of 37 service providers also participated in our focus groups about barriers and solutions for serving Mexican-American survivors (n = 9), Korean-American survivors (n = 7), Vietnamese-American survivors (n = 13), and survivors more generally (n = 8). Approximately half of these participants worked for domestic violence organizations while the remainder worked for cultural or social service organizations such as homeless shelters, health clinics, or WIC. All participants had extensive experience working with survivors from a particular ethnic group, and the majority of participants were themselves members of the ethnic group they spoke about.

Protections. In accordance with IRB guidelines, informed consent procedures provided a thorough description of the study, expectations of participants, participants' rights, and risks of participation (see Appendix C). Consent forms were distributed and signed at the beginning of each interview and focus group session, and the informed consent page was the first page displayed to survey participants who met our screening criteria. These forms guaranteed confidentiality and assured participants that they could refuse to answer any question that made them uncomfortable. Extensive lists of referrals were also provided, including hotline numbers that could provide immediate assistance to anyone in distress. Interviewers also completed 40 hours of training on sensitive interviewing skills and were trained to conduct a thorough safety planning session at the end of each interview to further ensure the safety of each participant.

PROTOCOLS & MEASURES

Interview Protocol. A semi-structured interview protocol was developed to assess the impact of culture on women's experiences of and response to intimate partner violence. Originally, a series of qualitative questions were nested among quantitative scales (see Appendix D), but the resulting interviews were taking 3-4 hours to complete and the quality of the data appeared to suffer as a result. We therefore decided to split the qualitative interview from the quantitative survey, leading to two versions of the interview data (24 participants who were interviewed with the original interview

protocol and 89 participants who were interviewed with the revised interview protocol). During the revision process, we also revamped how we asked about culture. Our experience during the first 24 interviews told us that participants had a hard time thinking about culture in relationship to their experiences of violence. We therefore decided to prime them by presenting more general questions about culture and then asking them to connect those concepts to their experiences of violence (see Appendix E).

Specific questions included in this revised interview protocol focused on *reasons for participating* (e.g., what made you decide to contact us for an interview?), *the participant's family* (e.g., would you mind telling me a bit about your family's background?), *relationship conflicts* (e.g., what was the most serious conflict you ever had with your partner?), *disclosure of abuse* (e.g., did you ever tell anyone about the stress in your relationship with your partner?), *how IPV is viewed by people in their community* (e.g., what types of acts do you think people from the [ethnicity] community typically view as domestic violence?), how *survivors from their community typically respond* (e.g., what do you think that women from your community typically do when they experience domestic violence), *how people from the community typically respond to survivors* (e.g., how do you think that other people from the [ethnicity] community typically respond to victims of domestic violence), and *recommendations for other support providers, service providers, and other survivors* (e.g., how can service providers best help women from the [ethnicity] community who are experiencing domestic violence). Each question was then followed up with more specific probes that delved deeper into participants' responses or prompted survivors to think about how culture affected their own experiences of IPV (e.g., how have these beliefs made it difficult for you to seek help about the conflicts in your own relationship?). Completion of the interview took approximately 2 hours and participants were paid $50 for their time.

While the interview protocols used for each target ethnicity were identical in content, we did translate the interview protocols into each of our four target languages. A back translation process

involving translation from English into the new language and back translation from the new language into English was used to ensure accuracy of translation. A group consensus approach was used to resolve discrepancies and to ensure grammatical and conceptual accuracy.

While both the original interview protocol and the revised protocol contain valuable insights into the role of culture, the interview protocols were different enough that we have decided to keep the two datasets separate. Combining the datasets might make more sense for some research questions than for others, so we have decided to let future researchers make their own decisions about if and when to combine the datasets. The results presented in this report are based solely on data from our new interview protocol.

Survey Protocol. As noted above, we originally combined our survey and interview questions, but the decision was made to split that original protocol into separate survey and interview protocols. After consulting with our community partners, we decided to house the survey questions online in order to provide more anonymity for participants who were too ashamed to speak about their experiences in person (which was a barrier that was preventing many of our Korean and Vietnamese survivors from participating). Using an online survey format had its own challenges, however. Despite efforts to insert quality control checks into the survey protocol (e.g., what is the current year, please enter the following code into the box), it was clear that a number of participants were simply checking random boxes, and we even experienced a cyberattack where we received 139 surveys at 10 minute intervals over a period of 6 hours before we finally shut the survey down. These experiences led us to insert even more quality control checks in the form of repeated factual questions and to thoroughly review each survey for consistency and completeness prior to issuing any gift cards. When inconsistencies were noted, we followed up with participants via email and phone and were able to resolve some inconsistencies in that manner. As noted in the participant section above, this quality control process led to the elimination of

222 survey responses for incompleteness, inconsistencies, and/or repeated data, leaving a final dataset of 193 complete and consistent surveys.

The survey itself was housed on Qualtrics and contained 15 standardized scales (see Appendix F), including: 1) the *Multigroup Ethnic Identity Measure (MEIM)* (Phinney, 1992); 2) the *Patient Health Questionnaire (PHQ-15) Somatic Symptoms Inventory* (Kroenke et al., 2002); 3) the *Patient Health Questionnaire (PHQ-9)Depression Inventory* (Kroenke & Spitzer, 2002); 4) the *Trauma Symptom Inventory (TSI) Dissociation Scale* (Briere, 1995); 5) the *Revised Attitudes Toward Wife Abuse Scale* (Yoshioka et al., 2001); 6) the *Psychological Maltreatment of Women Short Form (PMWS-F)* (Tolman, 1995); 7) the *Coercive Control Scale* (Dutton et al., 2005); 8) the *Short Form of the Revised Conflict Tactics Scale (CTS2S)* (Straus & Douglas, 2004); 9) 4 items from the *Revised Stalking Behavior Checklist* (SBC) (Coleman, 1997); 10) the *Trauma Appraisal Questionnaire* (DePrince et al., 2010); 11) the *Posttraumatic Diagnostic Scale* (Foa et al., 1997); 12) the *Intimate Partner Violence Strategies Index* (Goodman et al., 2003); 13) the *Decision to Leave Scale* (Hendy et al., 2003); 14) the *Legal and Medical Secondary Victimization Scales* (Campbell, 2005); and 15) the *Social Reactions Questionnaire Short Form* (Ullman, 2000). Various categorical questions were also used to capture *details about the assault* (e.g., are you still romantically involved with this partner), *extent of system involvement* (e.g., did you file a restraining order?) and *demographic information* (e.g., in what country were you born?).

As with the interviews, the survey was translated into English, Spanish, Korean, and Vietnamese. Where possible, we used existing translations of standardized measures. When no translations were available, we used the back-translation process described above to translate the measures ourselves. Participants were able to select their language of choice at the beginning of the Qualtrics survey. Completion of the online survey took approximately one hour, and participants were paid $20.

Focus Group Protocol. The focus group protocol was designed to elicit service providers' understanding of help-seeking barriers and solutions for women from different ethnic backgrounds (see

Appendix G). It contained four questions about *services for IPV survivors* (e.g., what types of services might be useful for [ethnicity] survivors of domestic violence?), *likelihood of help-seeking* (e.g., how likely are [ethnicity] victims of domestic violence to use these services?), the *impact of culture on help-seeking* (e.g., in what other ways do [ethnicity] cultural values affect domestic violence victims' willingness to seek help?), and *recommendations* (e.g., how can we improve the community's response to victims of domestic violence?). Each question was followed up with detailed probes to help generate a richer and more detailed discussion (e.g., what types of organizational changes are needed to make services more accessible to [ethnicity] victims of domestic violence?). As with the interview and survey protocols, the focus group protocols were also translated into each language. Each focus group was also focused on only one ethnic group which was led by a doctoral level facilitator who was fluent in that language.

DATA ANALYSIS

Quantitative survey data was entered into SPSS and analyzed with a variety of multivariate statistics (see Results section below). Qualitative interview and focus group data was analyzed using an inductive thematic analysis approach akin to Grounded Theory (Glaser, 1998). To do so, all interviews and focus groups were audio-recorded, transcribed, and translated into English. Inductive thematic analysis was then used to qualitatively code the data in seven stages, including: 1) paraphrasing of key ideas in the margins (marginal coding); 2) conceptual sorting of marginal codes into overarching themes and subthemes; 3) creating a hierarchically organized codebook based on the identified themes and subthemes; 4) excerpting segments of the transcripts that clearly represented each code; 5) having two coders independently code these excerpts using the codebook; 6) calculating interrater reliability and resolving discrepant coding using a consensus approach; and 7) using various data displays (e.g., figures, tables) to identify relationships between the codes or differences among participants.

RESULTS

Aim One. There were four stated goals of this project. Our first goal was to understand how ethnocultural beliefs affect how abuse unfolds and is interpreted by women from different backgrounds. To determine whether the type of abuse experienced differed across our four ethnic groups, we first examined mean differences in both individual items and overall scales. As can be seen in Appendix H, ethnic differences in psychological abuse emerged for virtually every psychological abuse item with Mexican-American survivors reporting consistently higher levels of psychological abuse than Vietnamese-American survivors (and Korean and European means ranging non-significantly in between). Mexican-American survivors were also more likely than Vietnamese-American women to think that their partners would engage in a variety of coercive control techniques. While the frequency with which participants experienced physical violence, sexual violence, injuries, and stalking did not significantly differ between ethnic groups, a handful of item-level differences did emerge (see Appendix H).

To further understand women's experiences of abuse, cluster analysis was used to identify patterns of abuse in our survey data. Using a combination of hierarchical and iterative cluster analysis techniques, we identified three patterns of abuse. As can be seen in Appendix I, the first group consisted of participants who experienced high levels of coercive control and psychological abuse but lower levels of physical abuse, sexual abuse, and stalking; we are calling these survivors our Controlling Relationship group. The second group consisted of survivors who experienced high levels of violence across the board; we are calling this group our Widespread Violence group. The third group consisted of survivors who experienced relatively low levels of all forms of violence, and the violence they endorsed tended to fall on the less severe ends of the scales; we are calling this group our Unhealthy Relationship group. A Discriminant Function Analysis was then run to determine whether ethnicity, ethnic identity, socioeconomic status, and the interactions between these variables could discriminate between our three groups. Results suggested that the first function significantly added to our ability to classify groups, $\Lambda = .89$, χ^2 ($df = 12$) = 21.14, $p = .048$, and most clearly discriminated between the three abuse

patterns. Examination of the canonical discriminant function and the pooled within group correlations suggested that ethnicity was the strongest contributor to this function (r = .75). Socioeconomic status had a moderate impact (r = .43) while ethnic identity (r = .003), and the interactions between ethnicity and SES (r= .19), ethnicity and ethnic identity (r = -.19), and ethnicity, identity, and SES (r = .-.02) did not contribute much to the function. As can be seen in Appendix J, this function most clearly discriminates between survivors experiencing Widespread Violence and our two other groups with a lower percentage of Vietnamese-American survivors and slightly lower SES in the Widespread Violence group.

Similar patterns emerged in the qualitative interview data. As can be seen in Appendix J, nearly all of the participants described experiences of psychological abuse, coercive control, and physical abuse while only half described sexual abuse. Overall, there were few ethnic differences in the number of women who discussed such incidents. While some minor ethnic differences did emerge among some specific forms of abuse, the most notable differences arose for Vietnamese-American women who described severe physical abuse less often, sexual abuse more often, and abuse by proxy more often than women of other ethnic backgrounds.

Aim Two. Our second goal was to understand how ethnocultural beliefs affect mental and physical health consequences of abuse. Once again, a series of one-way ANOVAs examined differences at the item and scale level. While ethnic differences did not emerge at the scale level for any of our physical, mental health, or appraisal measures, Appendix H lists a handful of differences that emerged at the item level relating primarily to dissociation, depression, and self-blame. To further understand health outcomes related to abuse, cluster analysis was used to identify patterns of health symptoms in our survey data. Results yielded three patterns of symptomology in our data: high symptomology, moderate symptomology, and low symptomology (see Appendix I). Results of a Discriminant Function Analysis to determine whether ethnicity, ethnic identity, socioeconomic status, and the interactions between these variables could discriminate between our three groups was non-significant, $\Lambda = .93$, χ^2

(*df*= 12) = 12.01, *ns,* suggesting that our predictor variables did not significantly add to our ability to classify health symptom patterns.

These findings coincide with our qualitative findings. The majority of survivors described negative consequences of abuse, and there were few differences in the nature or amount of physical and mental health problems described. Of the slight differences that do exist, the most notable are the lower number of European-American survivors who expressed anger and the higher number of Mexican-American survivors who were concerned about the impact of abuse on their children (see Appendix J). Very few survivors discussed the impact of cultural values on the types of physical or mental health outcomes they experienced.

Aim Three. Our third aim was to understand how ethnocultural beliefs affect women's perstrategic response to abuse. As can be seen in Appendix H, differences in survivors' personal strategic responses did not emerge at the scale level, and the only item level difference to emerge was higher rates of fighting back among Mexican-American participants. These findings were supported by our qualitative data which revealed few differences in strategic responses. Of the few differences that emerged, the most notable was less placating behavior and restraint by Mexican-American participants and more descriptions of leaving the relationship and safety planning by European-American survivors. The qualitative findings also revealed additional coping strategies not assessed in our survey. As can be seen in Appendix J, maladaptive coping strategies were described more often than adaptive coping strategies, and Korean- and Vietnamese-American participants described emotional expression, positive self-talk, and emotional suppression less often than other survivors.

Overall, 97% of our interviewees and 93% of our survey respondents had disclosed to at least one person, but only half described interactions with the legal system, fewer than 1/3 described interactions with advocacy organizations, and just over 1/5 described interactions with medical, mental health, or religious personnel. By contrast, about 2/3 of survivors described interactions with family and

¾ described interactions with friends. To further understand ethnic differences in survivors' strategic reactions and help-seeking choices, a three-way between subjects MANOVA was conducted to test main effects and interactions between ethnicity, ethnic identity, and socioeconomic status. As can be seen in Appendix I, only ethnicity was significantly related to our set of strategic reactions and disclosure choices. Tests of the between-subjects effects for ethnicity suggested that this result was driven primarily by ethnic differences in criminal justice disclosure, $F(3, 157) = 5.67$, $p < .01$, $\eta^2 = .098$, and extra-legal service disclosures, $F(3, 157) = 11.05$, $p < .001$, $\eta^2 = .174$. Follow-up post-hoc comparisons indicate that Vietnamese-American survivors had significantly lower rates of disclosure to both the criminal justice system and other service providers than survivors from our other three ethnicities.

Among those who did disclose to each class of support providers, there were virtually no quantitative differences in the types of reactions received by women of each ethnicity or their ratings of how harmful these interactions were. A second MANOVA examining main effects and interactions between ethnicity, ethnic identity, and socioeconomic status on the frequency of social reactions and secondary victimization suggested that only socioeconomic status was significantly related to our set of social reactions and secondary victimization (see Appendix I). Tests of the between-subjects effects suggested that this result was driven primarily by socioeconomic differences in reactions from extra-legal service providers, although this effect was only marginally significant, $F(1, 32) = 3.40$, $p = .07$, $\eta^2 = .096$, and follow-up post-hoc comparisons only yielded a marginally significant difference in means with survivors in the lower half of our SES distribution receiving more negative reactions from extra-legal personnel than those in the upper half of our SES distribution (see Appendix I).

Some ethnic differences were evident in our qualitative data, however, with Korean-American survivors describing fewer negative reactions from the legal system, and Mexican-American survivors describing more positive reactions (and fewer negative reactions) from extra-legal personnel. While survivors described positive and negative reactions from legal personnel at fairly equal rates,

interactions with extra-legal personnel were described positively about twice as often as negatively. Although fewer Mexican-American participants disclosed to friends, those who did tended to describe more positive reactions and fewer negative reactions than survivors from other ethnicities. Conversely, more Mexican- and European-American survivors told family members than either Asian group; of those survivors who did tell family, most described an even mixture of positive and negative reactions.

Survivors also spoke quite extensively about the impact of culture on their interpretation of abuse, response to the abuse, and support providers' responses to abuse. As can be seen in Appendix J, cultural beliefs about the unacceptability of disclosure, the acceptability of violence, victim responsibility, and gender roles were discussed most often. Beliefs about the unacceptability of disclosure primarily affected survivors' response to the abuse, particularly for Vietnamese- and Mexican-American survivors. Beliefs about the acceptability of violence primarily affected survivors' interpretation of abuse, particularly for Vietnamese-American survivors. Beliefs about victim responsibility primarily affected support received from others, particularly for Korean-American survivors. And beliefs about gender roles primarily affected survivors' interpretation of abuse, particularly for Korean- and Vietnamese-American survivors.

Aim Four. Our fourth and final aim was to understand the linkages between experiences of abuse, health symptoms, and women's strategic response to abuse. To accomplish this goal, we ran a 3-way MANOVA with ethnic group membership, abuse cluster membership, and health cluster membership as our independent variables and six of our strategic responses and disclosure variables as our dependent variables. Results suggested that all of the main effects but none of the interactions were statistically significant (see Appendix I). Tests of the between-subjects effects for ethnicity suggest that this effect was driven primarily by ethnic differences in criminal justice system disclosure, $F(3, 146) = 2,89$, $p = .04$, $\eta^2 = .056$, and extra-legal service provider disclosure, $F(3, 147) = 4.66$, $p = .04$, $\eta^2 = .087$, with Vietnamese-American survivors disclosing less frequently to both criminal justice personnel and

other service providers. In contrast, the main effect for abuse pattern was driven primarily by differences in resistance strategies, $F(2, 146) = 14.80$, $p < .001$, $\eta^2 = .169$, placating strategies, $F(2, 146) = 13.60$, $p < .001$, $\eta^2 = .157$, safety strategies, $F(2, 146) = 13.06$, $p < .001$, $\eta^2 = .152$, and criminal system disclosure, $F(2, 146) = 3.44$, $p < .05$, $\eta^2 = .045$. Post-hoc comparisons suggest that survivors in unhealthy relationships used fewer of these coping strategies than survivors experiencing more severe patterns of abuse (see Appendix I). Finally, the main effect for health pattern was driven primarily by safety planning, $F(2, 146) = 5.06$, $p < .01$, $\eta^2 = .065$, and extra-legal service provider disclosure, $F(2, 146) = 7.60$, $p < .01$, $\eta^2 = .094$, with survivors experiencing high symptomology engaging in more safety planning and disclosing to extra-legal service providers more often than other survivors.

The qualitative data then added to our understanding of survivors' decision-making process. The most common reason cited by survivors for seeking help was emotional support, particularly among Korean and Vietnamese participants. The most common barrier to help-seeking was a fear of negative consequences (although this was less common among Vietnamese-American participants). Other barriers such as shame, inaccessible services, and ineffective services were more common among Korean- and Vietnamese-American survivors. These findings are supported by our focus group data. As can be seen in Appendix K, service providers discussed barriers related to attitudes toward help-seeking and acceptability of services far more often than other more logistical barriers. They were more likely to discuss the social/emotional consequences of disclosure when considering concerns of Korean- and Vietnamese-American survivors and more likely to discuss concerns about what service providers would actually say or do when considering the concerns of Mexican-American survivors.

Differences in barriers to leaving also emerged in both our quantitative and qualitative data. At the quantitative level, Vietnamese-American survivors endorsed more barriers to leaving. At the qualitative level, the most common barriers to leaving were a sense of responsibility and feelings of

helplessness (although these were less commonly discussed by European-American survivors), and almost half of all Korean survivors described fear as a barrier to leaving.

Additional Findings. Although not initially proposed in our grant, we also collected information about survivor and service provider recommendations for supporting survivors. As can be seen in Appendix J, the two most common recommendations that survivors had for other survivors is to seek help and protect oneself, and the most common recommendation for service providers was to respond more appropriately to survivors' needs. Korean- and Vietnamese-American survivors also stressed the importance of raising awareness about IPV and existing services. These findings are mirrored by our focus group data with service providers who emphasized the importance of framing service provision more clearly around survivors' needs and creating more culturally competent services. Service providers working with Korean- and Vietnamese-American survivors also stressed the importance of breaking through cultural barriers that normalize abuse and discourage help-seeking.

IMPLICATIONS

Taken together, these results reveal few ethnic differences in women's experiences of abuse or mental health outcomes associated with abuse. While a few item-level differences did emerge, there were virtually no differences at the scale level. Although Vietnamese-American survivors were less likely to be represented in our Widespread Violence group and were less likely to describe physical violence in the qualitative interviews, caution should be used in interpreting this finding due to the low sample size and convenience sampling method of recruitment. Future research using more rigorous sampling techniques is clearly needed before true ethnic comparisons of abuse prevalence can be made. Furthermore, the fact that the Vietnamese-American survivors in our sample tended to experience less severe forms of abuse should also be considered when interpreting other ethnic differences in this study. It is quite possible that the Vietnamese-American survivors in our sample were less likely to disclose to the criminal justice system and cited more barriers to leaving because the abuse they were

experiencing was less severe, not because of Vietnamese cultural values. Future research with Vietnamese-American survivors who are experiencing a wider range of abusive experiences is needed before final conclusions about ethnic differences can be made.

That being said, there are several implications that can be drawn from the current study. First, cultural values appear to affect survivors' interpretation of abuse, strategic responses to abuse, and support providers' responses to abuse more than they affect experiences or outcomes of abuse. This finding is consistent with previous research that suggests abuse is both common and hurtful for women of all backgrounds. This finding is also consistent with research that suggests that cultural values can affect what is defined as abuse and what is considered to be appropriate responses to abuse. To help reduce cultural barriers to help-seeking, safety planning, and leaving the relationship, more community outreach is clearly needed, particularly to Korean- and Vietnamese-American communities. To be most effective, these outreach efforts should directly address cultural concerns and provide alternative narratives about violence and help-seeking that are nonetheless culturally congruent.

Efforts should also be made to improve the perceived effectiveness of services. Fewer than half of the survivors in our sample disclosed to criminal justice personnel, and those that did were as likely to receive negative reactions as positive reactions. Such high rates of negative experiences likely intersects with survivors' fears of negative consequences to reduce subsequent disclosures. While survivors' experiences with extra-legal service providers were much more positive, very few survivors actually accessed these services, and concerns about the cultural competency of such services remained high. Survivors and service providers alike thus recommended more services that respond appropriately to survivors' needs. Services that provide emotional support, safety, tangible aid, and recovery options in a culturally competent and accessible manner were considered to be of the utmost importance and could go a long way to addressing the barriers and cultural disparities that arose in this study.