

CULTURALLY COMPETENT INTERVENTIONS FOR ABUSED AND SUICIDAL AFRICAN AMERICAN WOMEN

REVA L. HERON
University of Tennessee—Knoxville

HEATHER B. TWOMEY
Emory University School of Medicine

DIANA P. JACOBS
Georgia State University

NADINE J. KASLOW
Emory University School of Medicine

This article focuses on interventions with low-income, African American women who are survivors of domestic abuse and who have made one or more suicide attempts. We review the literature on domestic abuse and suicidal behavior in African American women, and discuss the association between abuse and suicide in this population. Next, we propose an integrated theoretical model for understanding suicidal behavior as one possible coping response to the stress of a domestic abuse situation. The model utilizes concepts from the literature on stress and coping as well as stages of change. We then present a culturally sensitive group treatment intervention that is based on our theoretical model. The intervention focuses on ensuring women's safety, increasing coping skills and resource mobilization, and promoting supportive relationships in a manner that is consistent with each woman's sociocultural context.

Culturally Competent Interventions for Abused and Suicidal African American Women

As clinicians, one of our primary concerns is the safety of the people who come to us for help. Two of the potentially volatile situations that endanger our clients are partner abuse (domestic violence) and suicidality. Obviously, the threat to our clients is magnified when both situations are present. Since domestic violence and suicidal behavior are associated and African American women are at elevated risk for domestic violence, culturally competent clinicians must have a plan for dealing with the myriad of clinical issues that arise in working with this population. To familiarize therapists with the unique issues associated with treating low-income, African American women with a history of domestic violence and suicidal behavior, this article reviews the empirical literature, offers a culturally informed theoretical model that employs the concepts of stress, coping, and stages of change, and presents an intervention derived from our model.

Domestic Violence and Suicidal Behavior in African American Women

Despite the recent proliferation of clinical, theoretical, and empirical interest in partner abuse, little attention has been paid to the role of domestic violence among women of color and women from disadvantaged backgrounds (Cazenave & Straus, 1979; Coley & Beckett, 1988; Goodman, Koss, Fitzgerald, Russo, & Keita, 1993; Hampton & Gelles, 1994; Kanuha, 1994; Lockhart, 1991; Reid, 1993; Straus, Gelles, & Steinmetz, 1980). This is concerning given that homicide by an intimate partner is the leading cause of death for African American women ages 15–34 (Council on Scientific Affairs, 1992). There are con-

This article was supported in part by an ASPH/CDC/ATSDR grant, "Interpersonal Violence, Discord, and Suicidality in Women," to Nadine Kaslow, Ph.D.

Correspondence regarding this article should be addressed to Nadine Kaslow, Ph.D., Emory Department of Psychiatry and Behavioral Sciences, Grady Health System, 80 Butler Street S.E., Atlanta, GA 30335; email: nkaslow@emory.edu

flicting data on the relative rates of domestic violence for African Americans and European Americans. National survey data from 1975 and 1985 revealed that severe violence toward wives among African Americans occurred at a rate of 113/1,000 versus 30/1,000 among European Americans (Stets & Straus, 1990; Straus & Gelles, 1986; Straus et al., 1980). More recently, similar findings were reported by Hampton and Gelles (1994); they found that African Americans were 1.2 times more likely to experience minor incidents of partner abuse, and 2.4 times more likely to experience severe violence within their primary relationship than were their European American counterparts. These between-group differences remained significant even when controlling for social class. Other authors, however, report no racial differences in the prevalence of partner abuse when socioeconomic status (SES) is statistically controlled (Coley & Beckett, 1988; Koss et al., 1994). Further, some researchers find that social class accounts for some of the discrepancies in prevalence rates between racial groups, but is not sufficient to explain all of the between-group differences (Cazenave & Straus, 1979). These contradictory findings may be due in large part to reporting biases. Some indicate that African American women are less likely to report abuse due to their desire to protect their partner from racism within the legal system, their concerns about being a "traitor" within the African American community, and their fears of losing their children. Others suggest that domestic violence is overreported in the African American community because these women are less able to protect their privacy, due to limited financial resources and a greater tendency to use public services, emergency rooms, community mental health clinics, and social welfare programs (Asbury, 1987; Kanuha, 1994; Sullivan & Rumpitz, 1994; Takagi, 1991).

Given that women of color are more likely than their respective counterparts to be of lower social class (Sullivan & Rumpitz, 1994), and that elevated levels of partner abuse have been reported in low-income couples (Hotaling & Sugarman, 1990; Sorenson, Upchurch, & Shen, 1996), low-income, African American women are at greater risk for experiencing domestic violence and its associated psychological sequelae than are women from middle- and upper-income groups (Belle, 1990). Data also suggest that women living in poverty have a particularly difficult time extricat-

ing themselves from an abusive relationship and are therefore vulnerable to persistent violence (Cardarelli, 1997). African American women residing in a battered women's shelter appear more likely than their nonminority counterparts to have experienced severe abuse, live below the poverty line, have children living with them, and are less likely to have a car (Sullivan & Rumpitz, 1994).

In addition to other negative sequelae associated with victimization by an abusive partner, women in abusive relationships are at increased risk for suicidal behavior (Abbott, Johnson, Koziol-McLain, & Lowenstein, 1995; Amaro, Fried, Cabral, & Zuckerman, 1990; Bergman & Brismar, 1991; Kaplan, Asnis, Lipschitz, & Chorney, 1995; Kaslow et al., in press; McCauley et al., 1997; Roberts, Lawrence, O'Toole, & Raphael, 1997; Stark & Flitcraft, 1996; Walker, 1979). One study conducted in an emergency room revealed that 26% of women exposed to partner abuse reported a history of suicidal behavior, but only 8% of women with no history of partner abuse acknowledged prior suicide attempts (Abbott et al., 1995). Another study conducted with individuals seeking outpatient psychological services at a depression and anxiety clinic found that even after controlling statistically for a history of childhood abuse, the severity of physical assaults during adulthood was related to higher lifetime rates of suicide attempts (Kaplan et al., 1995). Data from a study focusing on partner abuse in women suicide attempters conducted in Greece and Denmark revealed that 82% of Greek women suicide attempters and 32% of Danish women attempters reported being beaten by their current male partner (Arcel, Mantoukakis, Peterson, Jemos, & Kaliteraki, 1992).

Only two studies have examined the partner abuse-suicidal behavior link in low-income, African American women (Kaslow et al., in press; Stark & Flitcraft, 1996). Stark and Flitcraft (1996) reviewed the medical records of women suicide attempters for a history of partner abuse and found that African American women who attempted suicide were more likely than European American women to have a history of partner abuse. Kaslow and colleagues (in press) found that low-income, African American women suicide attempters were 3.6 times more likely to report physical abuse (42%) and 3.9 times more likely to report nonphysical partner abuse (45%) than their demographically similar nonsuicidal counterparts (16% physical abuse, 17% nonphysi-

cal abuse). The partner abuse–suicidal behavior link was mediated by psychological distress, hopelessness, and drug use, and moderated by social support. Further, nonphysical combined with childhood maltreatment was a more effective predictor of suicide attempt status than child maltreatment alone.

Historically, it has been purported that suicide completion rates are lower in women than in men (Canetto & Lester, 1995) and lower for African Americans than European Americans (Chance, Kaslow, Summerville, & Wood, 1998). An examination of official suicide statistics, however, revealed that the highest rates of misclassification of cause of death are for women and African Americans (Phillips & Ruth, 1993); a significant number of these deaths were not classified as suicides, despite evidence suggestive of suicide. Thus, women and African Americans are not as protected from suicide as previously thought. Research reveals the following risk factors for suicide in African Americans: sex (being male), age (25–34-year-olds are at the highest risk), substance abuse, depression, family dysfunction and violence, interpersonal discord/marital conflict, acting out/delinquency, psychiatric disorders, homosexuality, and AIDS (Gibbs, 1997). Protective factors in African American suicide include religiosity (church attendance or affiliation), age (being elderly), geographical region (living in the South), and strong social support (Gibbs, 1997).

Integrative Model: Stages of Change Perspective on Stress and Coping

In this section, we present an integrated theoretical model that informs our understanding of suicidal behavior in abused, low-income, African American women and that serves as the basis for our psychotherapeutic endeavors with these women. This gender-sensitive and culturally informed theoretical framework, which draws on the literature on stress and coping and stages of change, has been useful in guiding our attempts to address the following questions: (1) What leads a woman who is in a domestically violent relationship to choose a suicide attempt rather than other options for coping with the abusive relationship?; (2) How is this decision influenced by the socio-cultural context for the lives of inner-city, low-income, African American women?; and (3) What are the treatment implications for a low-income, African American woman in an abusive

relationship who has made one or more suicide attempts? While this is not the only viable framework for understanding a woman's response to domestic abuse, it is a useful adjunct to currently existing discussions of the treatment of domestic violence and is particularly useful for treatment with low-income, African American women who have made one or more suicide attempts.

Stress and Coping

Stress

Stressor. Psychological stress is “. . . a particular relationship between the person and the environment that is appraised by the person as taxing or exceeding his or her resources and endangering his or her well-being” (Lazarus & Folkman, 1984, p. 19). There are multiple stressors associated with domestic violence and coping with an abusive relationship, including but not limited to: the stress associated with the abuse (physical, sexual, emotional) itself, the decision to remain in or leave the relationship, the consequences of any action taken (e.g., increased violence, economic, social, occupational), and concerns regarding children's welfare. These stressors have the potential to tax a woman's physical, emotional, material, and cognitive resources. When we use the phrase “the abuse situation,” we are referring to all the aforementioned stressors and we consider them to be inextricably interwoven in the experience of the abuse survivor.

Appraisal. In their seminal work, *Stress, Appraisal, and Coping*, Lazarus and Folkman (1984) discuss the importance of appraisal in understanding one's response to stress. The appraisal process is influenced by the individual's commitments and beliefs about the world in general and about the stressor in particular. “Commitments express what is important to the person, what has meaning for him or her. They determine what is at stake in a specific stressful encounter” (Lazarus & Folkman, 1984, p. 56). Commitments reflect what the individual prefers or finds desirable. Beliefs, on the other hand, deal with what the individual thinks is true, whether or not this “truth” is considered desirable.

As a part of assessment and treatment, we must understand and respect the beliefs and commitments of abused women who make suicide attempts. For example, if a woman is strongly committed to the notion of maintaining her relationship despite any problems that exist therein,

her appraisal of incident(s) of domestic violence will likely be quite different from the appraisal of a woman who is not committed to the maintenance of the relationship. Likewise, the appraisal of various coping strategies (e.g., leaving the relationship, trying to improve the relationship, entering therapy, seeking shelter, enduring the abuse and remaining in the relationship with no change, and attempting suicide) will be influenced by the woman's commitments and beliefs about the world.

We must understand the woman's system of meaning as it exists within her sociocultural context. The sociocultural context of low-income, African American women in abusive relationships has been addressed by feminist theorists and by culturally sensitive clinicians. According to feminist views (Graham, Rawlings, & Rigsby, 1994; Graham, Rawlings, & Rimini, 1988; Hansen & Harway, 1997; Walker, 1979, 1984, 1994), the social-political context is generally devaluing of women, particularly low-income women of color. Feminists also underscore that abuse originates in and is perpetuated by inequality in the relationship due to traditional gender roles (Hare-Mustin, 1978) and institutionalized racism. Writers focusing specifically on racial considerations in understanding domestic violence note that many African American women are *unwilling* to leave an abusive relationship because of widely held cultural beliefs that it is the woman's duty to maintain the family and be a source of strength for her family, despite the resulting hardships (Asbury, 1987). In a related vein, African American women reside in a culture in which racial preservation is valued more highly than self-preservation, and loyalty to one's family and community is key (Asbury, 1987; Kanuha, 1994). Further, many African American women assert that they do not want to leave their partner because of the anticipated difficulty finding another African American partner, given that there are four African American women for every African American man (Braitwaite, 1981).

Coping

Coping strategies. Lazarus and Folkman (1984) distinguish between emotion-focused and problem-focused coping. Emotion-focused coping is based on the appraisal that nothing can be done to change the situation, and the coping processes are largely ones of which the woman is relatively unaware. Problem-focused coping is

based on the appraisal that change is possible, and the process typically involves a conscious decision about the most appropriate strategy. These coping approaches may facilitate or impede one another depending on the situation. A suicide attempt, insofar as it is a way of coping with domestic violence, may be an emotion- or problem-focused response to the abuse.

Resources. The coping strategies a woman uses in response to an abusive situation depend in part on the resources available to her. Major categories of coping resources include: health and energy, positive beliefs, problem-solving skills, social skills, social support (perceived and actual), and material resources (Lazarus & Folkman, 1984). Even when a woman possesses the aforementioned resources, she may have difficulty using them due to personal and/or environmental constraints. Further, when a woman feels threatened, as is usually the case for abused women, the mobilization of coping resources is likely to be impeded.

Many women in our treatment population have insufficient coping resources and/or profound constraints to mobilizing adaptive coping strategies (Stark & Flitcraft, 1996). Health and energy often are decreased as a result of poor nutrition, limited access to and utilization of healthcare, and/or abuse-related injury. Positive beliefs are undermined by a history of entrapment in a coercive and abusive relationship and by a daily struggle to deal with social inequities resulting from oppression, racism, and sexism. Often, problem-solving and social skills are limited by low-literacy levels and a lack of educational and employment opportunities. Social support is often unavailable, as the woman's partner coercively limits her access to family and social networks. This is particularly problematic for low-income, African American women as these women are more protected from both abuse and suicide when high levels of social support are available, and/or there are a greater number of people living in the household (Cazenave & Straus, 1979; Kaslow et al., in press). These women often do not have sufficient material resources such as money for basic necessities, housing, transportation, or child-care. Lack of material resources may be as important as the threat of physical retribution in deterring a woman from leaving an abusive relationship (Aguirre, 1985; Sullivan, Tan, Basta, Rumptz, & Davidson, 1992). Unfortunately, many low-income or unemployed, African Amer-

ican women do not seek outside intervention, or when they do seek assistance from outside sources (community service agencies, legal services, police), they often are disappointed with the results or unable to obtain the requested assistance (Kanuha, 1994; Strube, 1988).

Constraints to resource mobilization. In addition to a relative lack of coping resources, there are myriad constraints against utilization of resources. Personal constraints may include a commitment to the continuation of the relationship despite the presence of coercion and abuse, the belief that one has no personal control over the situation (learned helplessness), the cultural value of not sharing family problems outside the family system, or the belief that suicide is the only way out of the abusive relationship (Boyd-Franklin, 1989; Stark & Flitcraft, 1996; Walker, 1984). Environmental constraints include limited response by healthcare professionals, legislators and law enforcement agencies, and pervasive economic and social inequities. In addition, African American women are less likely than European Americans to turn to shelters unless the violence becomes severe, because they perceive shelters as being an institution designed by and serving primarily the majority culture (Coley & Beckett, 1988; Sullivan & Rumpitz, 1994). Further, African American women who use shelters take longer to acquire needed resources to return safely to the community (Sullivan & Rumpitz, 1994).

Finally, if the level of threat from the abuse is perceived to be high, this will limit the woman's ability to use other coping strategies. Unfortunately, since women are at higher risk for increased violence during periods of separation from the abuser (Walker, 1984), women often accurately perceive the risk for abuse to be particularly high as they take action to leave an abusive situation. Given that a woman's capacity to mobilize effective coping strategies and resources in response to stress changes over time, depending on whether she is anticipating the stressor, confronting it, or dealing with its aftermath (Lazarus & Folkman, 1984), a stress and coping model should be informed by an appreciation of the nature and timing of the change process.

Stages of Change

In their transtheoretical stages of change model, Prochaska, DiClemente, and Norcross (1992) suggest that change can be divided into five stages: precontemplation, contemplation,

preparation, action, and maintenance. Movement through the stages is circular rather than linear. It is not uncommon for a person to experience frequent "regression" to earlier stages and recycle through the stages.

Precontemplation

In precontemplation, the abused woman has no intention of changing her behavior or the situation and is relatively unaware that there is a problem. If she enters therapy, it is often at the behest of others. She may be relatively unaware of the reasons for her family's or friends' concerns. We may suspect that domestic violence is occurring, but the woman is reluctant to discuss this. In the case of a woman who has attempted suicide, such cases often come to our attention through referrals by medical personnel. When interviewing these women, they admit to conflicts in their relationships with their partners, but deny any abuse even when the evidence is highly suggestive that abuse is occurring. Their suicide attempt is perhaps best viewed as an emotion-focused coping attempt, a rather impulsive action based on little or no conscious deliberation.

Contemplation

The contemplation stage is one in which the individual is aware that there is a problem and is considering change, but has not yet made a commitment to take any action. A woman in a domestically violent relationship who is in the contemplation stage may come to therapy with vague complaints and a desire to change "something," but will require a great deal of support as she begins to identify the "something" as domestic violence. Again, the suicide attempt is likely part of an emotion-focused coping strategy, as the woman is unlikely to have clearly defined the problem or considered her coping options. Often the attempt is an effort to gain support from either one's partner or others in one's social and familial network, a wish to stop her suffering, and/or a cry for help. As such, it may reflect the woman's feeling of being trapped in a coercive relationship (Stark & Flitcraft, 1996).

Preparation

In the preparation stage, the woman intends to take action in the next month, has a plan for changing the situation, and has unsuccessfully taken action to end the abuse cycle at some time in the past year. These women often have sought

the advice of clergy or family, lived in a shelter for a brief period before returning home to their abuser, or asked the partner to get help. The suicide attempt may be an example of an unsuccessful action taken in an effort to end the abuse cycle, either by remaining in the relationship and having the battering stop or by leaving the relationship. In this stage, a suicide attempt may be either emotion-focused or problem-focused, as this phase is defined as one that combines both the intention to change and the implementation of some change behaviors.

Action

Action is the stage in which the woman makes concrete changes in her current situation, and maintains those changes for one day to six months. A woman is in the action stage if she has left her partner, taken legal action against her abuser, participated in individual or group therapy with a focus on feeling empowered to ensure her own safety and enhance her psychological well-being and self-worth, and/or entered couples therapy with the explicit intent of ending the violence in the relationship. For these women, a suicide attempt often is a problem-focused attempt at coping and may reflect an attempt at "control in the context of no control" (Stark & Flitcraft, 1996, p. 116).

Maintenance

Finally, in the maintenance stage, the woman is working to prevent a resurgence of the problem and consolidate the changes that have occurred during the action stage. For a woman who has left her partner, this stage may entail maintenance of her decision to not reenter the relationship, perhaps despite pressure from her former partner and/or members of a social network to do so. For a couple in therapy, maintenance may involve an abuser who has accepted responsibility for his abuse and is committed to changing along with a woman who is working on maintaining her own power in the relationship. It is probably less likely that a suicide attempt will occur during this stage of change; if such an attempt does occur, it may be due to reappraisal of the situation based on failure to maintain the gains attained in the action stage.

Treatment Outcome Research

This section briefly reviews the pertinent empirical research regarding effective interventions

for domestic violence, suicidal behavior, and suicidal behavior in abused women. Findings from these studies inform the intervention model that we have developed.

Domestic Violence

Well-designed empirical research on the treatment of domestically abused women is almost nonexistent, with a few exceptions (see Graham et al., 1988; Sullivan et al., 1992; Varvaro & Palmer, 1993). Varvaro and Palmer (1993) developed and implemented a 12-week, self-efficacy course for abused women in which they provided information on abuse and safety, and offered strategies for self-empowerment in order to decrease the women's sense of fear and to promote adaptive functioning. Self-report data revealed that self-efficacy could be increased through active learning and teaching in a group setting. While results are promising, the small sample size ($n = 6$) suggests caution in interpretation.

Sullivan and colleagues (1992) examined the short-term impact (10 weeks) of providing advocacy services to women leaving battered women's shelters. Advocates assisted women in obtaining community resources. At 10-week follow-up, women who received advocacy services as compared to women who did not receive these services reported being more effective in obtaining community and social resources, and endorsed greater improvements in quality of life and social support. These findings underscore the importance of assisting domestic abuse survivors with resource mobilization. The efficacy of this intervention with abused women not residing in shelters has yet to be determined, but is worthy of investigation.

Research examining programs designed for battered women of color are meager, despite the existence of curricula for service providers to enable them to address battering from a racially and culturally sensitive perspective (Kanuha, 1994), and at least one self-help book written for abused, African American women (White, 1985). We located only one study (Sullivan & Rumptz, 1994) that examined the effectiveness of the assistance received at a battered women's shelter in addressing the needs of African American women. Results from this study revealed that for African Americans, 10 weeks in a shelter was associated with decreased anxiety and depression, and reductions in fear, actual abuse, and emotional attachment to the abuser. In addition, the women

evidenced enhanced social support, a greater sense of personal control, and an improved quality of life. In addition, advocates were particularly helpful in facilitating these women's linkages with appropriate and needed community resources. It has been argued that existing programs and recommended intervention strategies for domestic violence may be insensitive to the ethnic diversity of female victims of abuse (Goodman et al., 1993). Thus, the development, implementation, and evaluation of interventions for specific ethnic, racial, and social class groups are essential.

Suicide

A number of efficacy studies have investigated intervention and prevention efforts for suicidal behavior (e.g., suicide hotlines and suicide prevention centers, hospital after-care programs, and individual, group, and family therapy) (Canetto & Lester, 1995; Diekstra, 1992; Linehan, 1993). Unfortunately, no studies could be located that examine the efficacy of intervention or prevention efforts specifically targeting African American women. To date, there are no clearly efficacious interventions for preventing suicidal behavior in at-risk groups (Diekstra, 1992). It is notable that the tested treatments have not attended to the ways in which suicidal behavior is socially constructed and culturally meaningful (Canetto & Lester, 1995).

Domestic Violence and Suicidal Behavior

No research specifically addressing interventions for suicidal women in abusive partner relationships could be located. Based on the relevant data, such an intervention must have as its paramount goal establishing safety from self-harm and from being harmed by one's partner. Given the high rates of severe violence against African American women living in poverty (Belle, 1990), as well as the fact that bilateral violence is prevalent (Steinmetz & Lucca, 1988), such interventions must assure the safety of all concerned.

A Culturally Sensitive Intervention Model

In this section, we present a treatment model for abused, suicidal, low-income, African American women that is based on an integration of the relevant theoretical and empirical research literatures. We begin by discussing some key considerations in the conduct of culturally competent interventions for these women. This is followed

by an articulation of the assessment phase of the preventive intervention based on a stress and coping model. Finally, intervention techniques and strategies are proposed based on the data gleaned from the assessment and in accordance with the women's stated goals and stage in the change process.

Treatment Considerations

Cultural, socioeconomic, interpersonal, and psychological issues pertaining specifically to African American women inform the treatment of those who are both suicidal and in abusive partner relationships. Two primary issues that influence treatment effectiveness are adherence and participation. Numerous factors influence the process of identifying and providing treatment for women in need of services. Low-income, minority women tend to be relegated to using public or emergency healthcare services for ongoing medical care, and thus, their entrance into the mental health system often is indirect. In contrast to European American women who are likely to seek services through private practitioners and health insurance programs, minority women tend to enter the mental health system through emergency rooms, community health centers, or collateral, public social services such as the child welfare system (Perales & Young, 1988). Additionally, women of color tend not to initiate mental healthcare unless under extreme duress, in crisis, or as a last measure, and thus, seek mental healthcare at rates much lower than those of their European American counterparts. Several authors contend that the reluctance on the part of African American women to seek services for themselves reflects a deeply held, historically based, and culturally reinforced belief that African American women are strong and should persevere under dire circumstances in order to take care of their families first (Burns, 1986; White, 1986). The degree of acculturation and assimilation into the majority culture likely also influences African American women's receptivity to services.

An additional obstacle to the use of mainstream mental health services is the fact that African American women often perceive helping professionals as insensitive to the racial and cultural contexts of their lives, and therefore when battered or suicidal, may not view such services as options and thus, will not seek them out (Asbury, 1987; Coley & Beckett, 1988). Indeed, there is a relative dearth of culturally informed community-

based services staffed by mental health practitioners who have been specifically trained to meet the diverse and complex service needs of battered women of color (Counts, Brown, & Campbell, 1992; Walker, 1984). Not only are battered, African American women hesitant to seek mental health services, when they do present to emergency rooms exhibiting intense distress through suicide attempts, their involvement with an abusive partner is rarely recognized (Stark & Flitcraft, 1996).

To address culturally determined barriers to treatment, significant efforts must be made to work collaboratively with the woman. This may be a particular challenge when the therapist and abused woman come from different cultural and economic backgrounds in which disparate values are figural. Indeed, African American women are more likely to disclose family violence when the healthcare provider is also African American (Coley & Beckett, 1988). Collaboration is most likely to develop when the therapist: (1) remains cognizant of her or his perspective, while at the same time listening carefully and acknowledging an appreciation of the legitimacy of the perspective of the abused, suicidal woman (Wheeler, 1985); (2) focuses on the competencies and strengths of the abused woman, recasts the image of the "battered" woman from "victim" to "survivor," and reframes the suicide attempt as an effort to cope with and change an unbearable situation (Campbell, Miller, & Cardwell, 1994; Gondolf, 1990; Hoff, 1990; Stark & Flitcraft, 1996); and (3) suspends judgment about the necessary goals of treatment. For example, leaving an abusive partner rarely is an initial goal for a low-income, African American woman and may be contradictory to her cultural values and beliefs. Indeed, the suicide attempt may be an effort to keep the partner from leaving the relationship. Thus, the therapist and client need to work together to determine treatment goals and steps toward their attainment. Otherwise, the woman will feel misunderstood and invalidated and as a result, will be unlikely to continue treatment.

Assessment

During the evaluation, we attend to joining with the woman and forming a working alliance. This is accomplished when we avoid imposing our own values and agenda and demonstrate an investment in understanding the battered woman's perspective on the situation. This includes decon-

structing the unique meaning of both the suicide attempt and the abuse within the woman's interpersonal and sociocultural contexts. In addition to the paramount importance of listening to and validating the woman's experience, given the potential lethality of both partner abuse and suicide, we evaluate issues of safety from the onset and throughout treatment. Plans to address safety concerns vis-à-vis both partner abuse and suicidal behavior are devised in the first meeting, as many of these women will not return (Walker, 1984). Culturally informed assessments that include an emphasis on safety can facilitate the development of an effective working alliance with, and intervention plan for, abused and suicidal women.

Consistent with the stress and coping model, we conduct a thorough assessment that attends to current stressors (e.g., severity and chronicity of the abuse, the suicide attempt itself and associated consequences, other recent life changes, employment status, financial hardship, childcare demands, and specific incidents of discrimination, as well as ongoing racism and sexism), appraisal, coping strategies, available resources, and constraints to resource mobilization. To comprehend the woman's appraisal of the situation and the meaning of the strategies she is choosing in an endeavor to cope, we explore her commitments and beliefs about the world, her relationships with others including the batterer, and herself (e.g., needs of family and community are placed over her needs, views self as the pillar of strength within the family and thus, seeking help is a weakness). After exploring the woman's system of commitments and beliefs, we identify the coping strategies she has used in the past, including her suicide attempts, and discuss other possible methods of coping with the stress of the domestic violence. The coping strategies used will differ depending on whether the woman is anticipating the stressor, confronting it, or dealing with its aftermath (Lazarus & Folkman, 1984).

When working with this population, we conduct a thorough examination of available coping resources and constraints on the utilization of these resources. Specific attention is given to the woman's physical and emotional health and access to healthcare, competing demands on her time and limited resources to address such demands, the woman's beliefs about herself and her situation (including personal and religious beliefs), sense of self-efficacy and self-worth, strategies for problem identification and resolution,

interpersonal strengths and capacity for conflict resolution, and both intrafamilial and extrafamilial social connections. Given that many women in our target population live in an environment deficient in material resources, considerable attention is devoted to ascertaining their access to material resources such as money, adequate housing and transportation, quality childcare, educational and employment opportunities, and social and community services. When evaluating each of these resources, we determine the presence of factors that interfere with resource mobilization and the nature and extent of the interference.

Finally, prior to developing an intervention plan, we ascertain the stage at which a particular woman has progressed along the continuum of change and the degree to which she is committed to changing her current situation. In sum, we collaborate with the woman to formulate a treatment plan that is informed by the nature of the stressor, the meaning of both the abuse and the suicide attempt for that particular woman, and the resources available to the woman that will facilitate her addressing the abusive situation.

Intervention

We recommend a group treatment approach combined with the assignment of advocates. Adjunctive treatments (e.g., psychopharmacology, individual therapy, couples therapy, family therapy, substance abuse treatment) often are incorporated at various stages in the change process depending on the specific needs of each woman at a given time. We advocate a group intervention based on the fact that the availability of group support and the opportunity to hear other women share their experiences is an invaluable aspect of an empowerment intervention that fosters interpersonal connectedness and awareness of effective coping and problem-solving approaches and community resources. In addition, group therapy appears to be particularly efficacious for abused women and for depressed and suicidal women (e.g., Linehan, 1993; Ney & Peters, 1995). This intervention is most effective when we assume an engaged stance and overtly express our belief in the suicidal domestic abuse survivor's story (McGrath, Keita, Strickland, & Russo, 1990).

Women at all stages of the change process can benefit from group participation. Certain elements of the group, however, are salient for women at the earlier stages of the change process, whereas other aspects of the group are more bene-

ficial for women at later stages in the change process. In addition, the nature of appropriate adjunctive interventions is determined in part by the woman's phase in the change process. Obviously, the therapeutic focus differs depending on the stage at which a woman presents for therapy. It is unrealistic to expect that a woman in the precontemplation or contemplation stages will be able to consider leaving her relationship with her partner or make a serious commitment to not engaging in suicidal acts. A woman in the earlier stages is simply not ready to commit to a reasoned plan of action, and if we overlook this fact we are unlikely to maintain a therapeutic alliance. However, a client who remains in treatment typically moves from the stage of preparation to action, so a therapist and group who meets the woman in these earlier stages can forge a strong alliance, and over time see movement toward action. It is also important that therapists and group members realize that a "spiral progression" is normal, and allow flexibility in the plan of the therapy to accommodate such changes.

Precontemplation. Women in the precontemplation stage often come to our attention following a suicide attempt as part of emergency medical care. They frequently attend sessions at the behest of family, friends, healthcare, or social service providers, not out of a personal desire to seek help or make changes. When they seek treatment, they often request pharmacological interventions for symptom relief of depression and anxiety. They often deny that their suicide attempt was an effort to kill themselves or to change a conflictual or unsatisfying, interpersonal situation, and minimize the degree of conflict in their relationship.

Frequently, women in the precontemplation phase are reluctant to make a commitment to the group. Thus, the first step in working with these women is to engage them in the group process. Before a productive discussion of the abuse and suicide attempt can begin, the group often finds it useful to engage in a discussion about the legacy of racism and discrimination these women have faced (Coley & Beckett, 1988; Kanuha, 1994). Group engagement is further facilitated when the therapist(s) and group members attentively listen to the woman's story about both her suicide attempt and her primary relationship. To the extent that a woman is willing to engage in a discussion of safety plans, such a discussion should be pursued. The explicit goal is to ensure the well-being

and safety of the woman. The discussion, however, should avoid an aggressive attack on the woman's relationship with her partner, as this may impede the therapeutic alliance.

In the first session, we give information about general health and mental health resources, substance abuse treatment options if indicated, and relevant social service and community-based programs. The therapist and group members make an active and ongoing commitment to helping the women access basic material resources. To encourage continued participation in the group program, as well as to provide peer support, a "buddy" from the group is made available to each new member. Buddies at this stage initiate between-session contact with the group member as long as she remains in the precontemplation phase and is willing to be contacted. For all women in this phase, the leader and group members underscore that even if the woman is not interested presently in pursuing therapy, she is welcome to return to the group at a later point.

Contemplation. Women in the contemplation phase benefit from the educational components of the group. As a part of each group session, education is provided that enables the women to feel more efficacious and less hopeless and helpless in dealing with their abusive relationships. This component underscores that while the woman cannot control the occurrence of violence or change the behavior of the batterer, she can control her own responses and choices in dealing with the abusive relationship and whether she will work toward a violence-free lifestyle. During this phase, we frame the suicide attempt as a possible response to an unbearable situation and generate alternative coping responses. To begin to empower the woman and enhance her sense of efficacy, we provide information about battering and its effects, and suicidal behavior and its precipitants and sequelae. Attention is paid to available resources and strategies for obtaining help, as well as obstacles to seeking and utilizing interventions and support. Finally, the group efforts are directed toward refocusing the woman's self-blame by helping her to reattribute responsibility for the abuse to the perpetrator.

Preparation. For women in the preparation phase, teaching cognitive strategies is helpful. Useful cognitive techniques include reframing of the abuse and the suicide attempt, challenging minimization and denial, increasing affect modulation and decreasing emotional reactivity, reat-

tributing responsibility for the violence and for self-destructive acts to the appropriate parties, and increasing perceptions of viable alternatives (Dutton, 1992; Linehan, 1993). Self-hypnosis and desensitization hierarchies are useful in addressing the anxiety and avoidance that some women experience, and teaching cognitive strategies such as detection, examination and reality testing of automatic thoughts and images, reattribution of responsibility and blame, and a search for alternative solutions can help abused and suicidal women who are depressed.

Throughout the change process, women benefit from group discussions regarding enhancing their interpersonal relationships and improving their social support networks, as well as the value of peers, family, community and religious contacts, and mental healthcare providers in alleviating stress. During the preparation phase, however, we highlight active mobilization of social support. The involvement of others may counteract the alienation and isolation reported by many abused women, particularly those who resort to suicidal behavior. To enhance this process, we encourage the women to address interpersonal problem areas that may interfere with the mobilization of social support and be associated with the presence and maintenance of depressive symptoms.

A final element of the intervention for women in the preparation phase is the assignment of an advocate. This individual is available to an assigned woman throughout the remainder of the intervention. Advocates, who meet one-on-one with each woman, provide direct help in locating and accessing resources, and offer detailed instructions and plans for thorough resource identification and recruitment. The advocate can provide a woman with information regarding where and how to seek appropriate resources for dealing with specific abuse-related problems (e.g., legal services, childcare, housing, material goods and resources, education, employment, health, and transportation).

Often women in the preparation phase request and can benefit from individual therapy. During individual sessions, focused attention is paid to the elements of the intervention already discussed. These individual sessions often continue throughout the action and maintenance phases. In addition, for those women who decide to try to improve their relationship with the batterer, conjoint therapy may be initiated as long as the bat-

terer has received services specific to perpetrators of abuse (Barrett, Trepper, & Stone Fish, 1990). Again, such a multiple-systems-perspective, intervention approach, based on an integration of perpetrator-victim models, feminist theory, and ecosystemic approaches, may be conducted as an adjunctive intervention to the group therapy during the preparation, action, and maintenance phases.

Action. A primary aim of the action phase is to improve the woman's methods of coping by presenting problem-solving strategies efficacious with minority women, abuse survivors, and women with a propensity to engage in suicidal behavior (Dutton, 1992). We emphasize adaptive, social, problem-solving strategies that women find most useful in dealing with the stresses associated with their abuse situation and the process of changing the relationship. Changes may involve either leaving the relationship or engaging with her partner in couples therapy (assuming that the partner is committed to ending the violence and has been engaged in his own therapy). The problem-solving strategies discussed in this intervention have been employed with minority women and with women suffering from depression (Bobo, Gilchrist, Cvetkovick, Trimble, & Schinke, 1988; Nezu, Nezu, & Peri, 1989). Specifically, the woman first learns to define her current stressors and identify the associated stress responses. Next, she is encouraged to articulate within the group, her thoughts and feelings about the stressors. The woman, the therapist, and the other group members then work together to generate alternative strategies and options for dealing with domestic violence and suicidal impulses. The obstacles to each choice and the consequences for each alternative are evaluated in detail. At this point, the woman selects a response and details a plan to implement the choice. After she implements the response and assesses the solution chosen, she praises herself and is praised by the therapist and the other group members. Attention is placed on using problem-solving strategies to decide whether to leave an abusive relationship (Strube, 1988), and education is provided about effective, solution-focused coping skills and negotiation techniques that will increase each woman's investment in ending the abusive relationship or having the abuse within the relationship terminated.

At this stage of change, women find the group particularly beneficial for developing interpersonal skills generalizable to their various relation-

ships (e.g., romantic, familial, and work-related). The group provides a context for these women to learn and try out new intimacy skills with each other and develop an increasing capacity for the validation and expression of their feelings (negative and positive) in an appropriately modulated way. For suicidal women, in particular, this includes an increased understanding of the interpersonal meaning of their suicidal behavior and the associated communications involved. For many women, the suicide attempt represents a plea for help, so one focus involves helping them learn more direct ways to communicate their distress and needs.

The ultimate goal is for each woman to develop new skills and heal past pain such that she can put the effects of the victimization behind her and create a satisfying, violence-free life. Group members and the therapist offer support and encouragement to the woman as she takes steps, regardless of how small, to change her situation. Women at this stage, although specifically focused on action plans to extricate themselves from a violent situation and to learn skills to reduce their own self-destructive acts, also begin to broaden the focus of their lives to include many areas of change (e.g., employment, educational, and community involvement). The enlargement of the focus for change continues to expand in the maintenance stage.

Maintenance. In this stage, we focus on assisting the woman to maintain the changes she has made. At this point in the change process, the woman often is ready to take steps to increase her level of self-sufficiency and thus, we collaborate with her in gaining additional resources, for example, vocational retraining and continuing education. Each woman's advocate can provide further assistance by coaching the woman in mock job interviews or by helping her put together a résumé. By becoming involved in these endeavors, the woman frequently gains self-confidence and learns valuable skills, both of which serve a preventive function in that the woman is empowered and is therefore less vulnerable to future abuse and suicidal behavior.

Women at this stage of change benefit very differently from a group intervention than women at an earlier stage of change. Their function in the group is often as mentors and guides. The active engagement in assisting women in earlier stages of the change process often strengthens these women's commitment to continued growth

and change. Through involvement with women who are still being victimized by the abuse cycle and suffering the associated psychological sequelae, women in the maintenance phase increase their understanding of the cycle of domestic battering and the associated coping strategies that women in these situations often implement. They come to have a deeper appreciation and understanding of their past circumstances, normative responses in the face of such extreme stressors, and the tremendous costs to their emotional, physical, and spiritual well-being. This increased awareness often fuels their conviction to take charge of their lives and improve their emotional and physical health. Likewise, for women who are mothers, preservation of the well-being of their children is a continual incentive to maintain the changes they have made. By this stage, women have developed effective strategies to alter and improve their situation, and have observed other empowered women take steps to eliminate the violence in their lives.

There are potential drawbacks for group participation for women at this level of change and therefore adjunctive treatment modalities often are useful. Women at this stage, because of the great strides they have made, are at risk for becoming overly burdened and responsible for the other women in the group. Culturally we know that there is a tendency for many African American women to feel the need to be a source of strength and support in their communities, often at their own expense (Asbury, 1987). Thus, as group therapists, we must be aware of these tendencies and take steps to ensure that the group remains a source of support and does not become a drain on existing resources. The emphasis at this stage is not only on obtaining resources necessary for independence but also on the need for healthy interdependence in violence-free relationships.

Concluding Comments

This article addresses some of the unique social, cultural, and economic factors affecting the lives of domestically abused and suicidal, African American women, and we have argued that these factors must be considered in any therapeutic intervention with this population. Although partner-perpetrated violence is stressful for most women, low-income, African American women live in a specific sociocultural and economic context that uniquely informs their appraisal of the abuse situation and its associated stressors. Atten-

tion to the sociocultural context of a woman's life is of utmost importance in attempting to understand her response to these stressors. The nature of coping strategies utilized, as well as the access to and availability of resources, is specific to the woman's situation. For African American women, access to resources is often severely limited. Thus, most critical in an approach to the treatment of suicidal behavior in domestically abused, low-income, African American women is the recognition that, due in part to their limited resources, these women may be "virtually imprisoned in settings where they are most likely to be victimized, and where the personal and institutional safeguards that they would be privy to in other places may not exist" (Harvey, 1986, p. 168). Our intervention, therefore, emphasizes the necessity of understanding the meaning of the abuse and the suicide attempt in the context of the woman's own beliefs and commitments, and accessing necessary resources given the context of these women's socially disenfranchised position.

A primary goal for effective intervention with this population involves establishing a strong positive rapport that allows each woman to believe in and trust the help offered to her. Only then can the therapist optimally facilitate the termination of both the violence in the woman's relationship and her self-directed violence in the form of suicidal behavior. The therapist must actively address the specific needs of each woman, given her specific stage in the change process and provide education about both the cycle of abuse and the process of change. Because the availability and access to resources is particularly compromised for domestically abused, low-income, African American women, our intervention incorporates the use of advocates who address these issues in an ongoing way throughout the intervention.

In conclusion, existing services intended to detect, prevent, and treat domestic abuse are in large part inappropriate and inadequate to address the needs of low-income, African American women and other minority groups (Pinn & Chunko, 1997). For a low-income population that largely seeks services through public healthcare, this problem is exacerbated by the negligence of the majority of healthcare providers to inquire about the presence of domestic violence in the lives of women presenting for medical services following either a physical injury or a suicide attempt (Fontanarosa, 1995). Thus, adequate provision of healthcare requires an increased awareness of and

commitment to the identification of women in domestically abusive relationships. Mental health and social service providers carry the additional burden of designing, as well as addressing the effectiveness of interventions targeting specific, understudied, low-income, minority groups of domestically abused women.

On a broader social level, we must attend to inequities in power associated with sex, gender roles, race, and culture, and socioeconomic status (SES). These imbalances of power contribute to the victimization of women and minorities and low-income, African American women in particular (Gelles & Straus, 1979). Clearly, strong legislation and law enforcement are needed if perpetrators are to be held accountable for their actions. Although this article proposes an intervention for women in abusive relationships, the fact remains that it is the perpetrators who are at fault and it is the perpetrators who should be responsible for stopping the abuse. Our goal is to facilitate the growth of abused women and increase their options, not to absolve their abusers from responsibility.

References

- ABBOTT, J., JOHNSON, R., KOZIOL-MCLAIN, J., & LO-WEINSTEIN, S. R. (1995). Domestic violence against women: Incidence and prevalence in an emergency department population. *Journal of the American Medical Association*, 273, 1763–1767.
- AGUIRRE, B. E. (1985). Why do they return? Abused wives in shelters. *Social Work*, 30, 350–354.
- AMARO, H., FRIED, L., CABRAL, H., & ZUCKERMAN, B. (1990). Violence during pregnancy and substance abuse. *American Journal of Public Health*, 80, 575–579.
- ARCEL, L. T., MANTONAKIS, J., PETERSON, B., JEMOS, J., & KALITERAKI, E. (1992). Suicide attempts among Greek and Danish women and the quality of their relationships with husbands or boyfriends. *Acta Psychiatrica Scandinavica*, 85, 189–195.
- ASBURY, J. (1987). African Americans in violent relationships: An exploration of cultural differences. In R. L. Hampton (Ed.), *Violence in the black family: Correlates and consequences* (pp. 89–105). Lexington, MA: Lexington Books.
- BARRETT, M. J., TREPPER, T., & STONE FISH, L. (1990). Feminist-informed family therapy for the treatment of intra-family child sexual abuse. *Journal of Family Psychology*, 4(2), 151–165.
- BELLE, D. (1990). Poverty and women's mental health. *American Psychologist*, 45, 385–389.
- BERGMAN, B., & BRISMAR, B. (1991). Suicide attempts by battered wives. *Acta Psychiatrica Scandinavica*, 83, 380–384.
- BOBO, J. K., GILCHRIST, L. D., CVETKOVICK, G. T., TRIMBLE, J. E., & SCHINKE, S. P. (1988). Cross-cultural service delivery to minority communities. *Journal of Community Psychology*, 16, 263–272.
- BOYD-FRANKLIN, N. (1989). *Black families in therapy: A multisystems approach*. New York: Guilford.
- BRAITWAITE, R. L. (1981). Interpersonal relations between black males and black females. In L. E. Gary (Ed.), *Black men* (pp. 83–97). Beverly Hills, CA: Sage.
- BURNS, M. C. (Ed.). (1986). *The speaking profits us: Violence in the lives of women of color*. Seattle, WA: Center for the Prevention of Sexual and Domestic Violence.
- CAMPBELL, J. C., MILLER, P., & CARDWELL, M. M. (1994). Relationship status of battered women over time. *Journal of Family Violence*, 9, 99–111.
- CANETTO, S. S., & LESTER, D. (Eds.). (1995). *Women and suicidal behavior*. New York: Springer.
- CARDARELLI, A. P. (Ed.). (1997). *Violence between intimate partners: Patterns, causes and effects*. Needham Heights, MA: Allyn & Bacon.
- CAZENAVE, N., & STRAUS, M. (1979). Race, class, network embeddedness, and family violence: A search for potent support systems. *Journal of Comparative Family Studies*, 10, 281–299.
- CHANCE, S. E., KASLOW, N. J., SUMMERVILLE, M. B., & WOOD, K. (1998). Suicidal behavior in African American individuals: Current status and future directions. *Cultural Diversity and Mental Health*, 4, 19–37.
- COLEY, S., & BECKETT, J. (1988). Black battered woman: A review of the empirical literature. *Journal of Counseling and Development*, 66, 266–270.
- Council on Scientific Affairs. (1992). Violence against women: Relevance for medical practitioners. *Journal of the American Medical Association*, 267, 3184–3189.
- COUNTS, D. A., BROWN, J. K., & CAMPBELL, J. (Eds.). (1992). *Sanctions and sanctuary: Cultural perspectives on the beatings of wives*. Boulder, CO: Westview Press.
- DIEKSTRA, R. F. W. (1992). The prevention of suicidal behavior: Evidence for the efficacy of clinical and community-based programs. *International Journal of Mental Health*, 21, 69–87.
- DUTTON, M. (1992). *Empowering and healing the battered women: A model for assessment and intervention*. New York: Springer.
- FONTANAROSA, P. B. (1995). The unrelenting epidemic of violence in America: Truths and consequences. *Journal of the American Medical Association*, 273, 1792–1793.
- GELLES, R. J., & STRAUS, M. A. (1979). Determinants of violence in the family: Toward a theoretical integration. In W. R. Burr, R. Hill, I. K. Nye, & I. L. Reiss (Eds.), *Contemporary theories about the family* (pp. 549–581). New York: Free Press.
- GIBBS, J. T. (1997). African American suicide: A cultural paradox. *Suicide and Life-Threatening Behavior*, 27, 68–79.
- GONDOLF, E. W. (1990). *Battered women as survivors*. Holmes Beach, FL: Learning Publications.
- GOODMAN, L., KOSS, M., FITZGERALD, L., RUSSO, N., & KEITA, G. (1993). Male violence against women: Current research and future directions. *American Psychologist*, 48, 1054–1058.
- GRAHAM, D. L. R., RAWLINGS, E. I., & RIGSBY, R. K. (1994). *Loving to survive: Sexual terror, men's violence, and women's lives*. New York: New York University Press.
- GRAHAM, D. L. R., RAWLINGS, E. I., & RIMINI, N. (1988). Survivors of terror: Battered women, hostages, and the Stockholm syndrome. In K. Yllo & M. Bogard (Eds.),

- Feminist perspectives on wife abuse* (pp. 217–233). Beverly Hills, CA: Sage.
- HAMPTON, R. L., & GELLES, R. J. (1994). Violence towards black women in a nationally representative sample of black families. *Journal of Comparative Family Studies*, 25, 105–119.
- HANSEN, M., & HARWAY, M. (1997). Theory and therapy: A feminist perspective on intimate violence. In A. Cardarelli (Ed.), *Violence between intimate partners: Patterns, causes, and effects* (pp. 165–176). Needham Heights, MA: Allyn & Bacon.
- HARE-MUSTIN, R. T. (1978). A feminist approach to family therapy. *Family Process*, 17, 181–194.
- HARVEY, W. B. (1986). Homicide in young black adults: Life in a subculture of exasperation. In D. F. Hawkins (Ed.), *Homicide among black Americans* (pp. 153–171). Lanham, MD: University Press of America.
- HOFF, L. A. (1990). *Battered women as survivors*. London: Routledge.
- HOTALING, G. T., & SUGARMAN, D. B. (1990). A risk marker analysis of assaulted wives. *Journal of Family Violence*, 5, 1–13.
- KANUHA, V. (1994). Women of color in battering relationships. In L. Comas-Diaz & B. Greene (Eds.), *Women of color: Integrating ethnic and gender identities in psychotherapy* (pp. 428–454). New York: Guilford.
- KAPLAN, M. L., ASNIS, G. M., LIPSCHITZ, D. S., & CHORNEY, P. (1995). Suicidal behavior and abuse in psychiatric outpatients. *Comprehensive Psychiatry*, 36, 229–235.
- KASLOW, N. J., THOMPSON, M. P., MEADOWS, L. A., CHANCE, S., GIBB, B., BORNSTEIN, H., HOLLINS, L., RASHID, A., & PHILLIPS, K. (in press). Factors that mediate and moderate the link between partner abuse and suicidal behavior in African American women. *Journal of Consulting and Clinical Psychology*.
- KOSS, M. P., GOODMAN, L. A., BROWNE, A., FITZGERALD, L. F., KEITA, G. P., & RUSSO, N. F. (1994). *No safe haven: Male violence against women at home, at work, and in the community*. Washington, DC: American Psychological Association.
- LAZARUS, R. S., & FOLKMAN, S. (1984). *Stress, appraisal, and coping*. New York: Springer.
- LINEHAN, M. M. (1993). *Cognitive-behavioral treatment of borderline personality disorder*. New York: Guilford.
- LOCKHART, L. L. (1991). Spousal violence: A cross-racial perspective. In R. L. Hampton (Ed.), *Black family violence: Current research and theory* (pp. 85–102). Lexington, MA: Lexington Books.
- MCCAULEY, J., KERN, D., KOLODNER, K., DILL, L., SCHROEDER, A., DECHANT, H., RYDEN, J., DEROGATIS, L., & BASS, E. (1997). Clinical characteristics of women with a history of childhood abuse. *Journal of the American Medical Association*, 277, 1362–1368.
- MCGRATH, E., KEITA, G. P., STRICKLAND, B. R., & RUSSO, N. F. (1990). *Women and depression: Risk factors and treatment issues*. Washington, DC: American Psychological Association.
- NEY, P. G., & PETERS, A. (1995). *Ending the cycle of abuse: The stories of women abused as children and the group therapy techniques that helped them heal*. New York: Brunner/Mazel.
- NEZU, A. M., NEZU, C. M., & PERI, M. G. (1989). *Problem-solving therapy for depression*. New York: John Wiley.
- PERALES, C., & YOUNG, L. (Eds.). (1988). *Too little too late: Dealing with the health needs of women in poverty*. New York: Harrington Press.
- PHILLIPS, D. P., & RUTH, T. E. (1993). Adequacy of official suicide statistics for scientific research and public policy. *Suicide and Life-Threatening Behavior*, 23, 307–319.
- PINN, V. W., & CHUNCO, M. A. (1997). The diverse faces of violence: Minority women and domestic abuse. *Academic Medicine*, 72, S65–S71.
- PROCHASKA, J. O., DICLEMENTE, C. C., & NORCROSS, J. C. (1992). In search of how people change: Applications to addictive behaviors. *American Psychologist*, 47, 1102–1113.
- REID, P. (1993). Poor women in psychological research: Shut up and shut out. *Psychology of Women Quarterly*, 17, 133–150.
- ROBERTS, G. L., LAWRENCE, J. M., O'TOOLE, B. I., & RAPHAEL, B. (1997). Domestic violence in the Emergency Department: I: Two case-control studies of victims. *General Hospital Psychiatry*, 19, 5–11.
- SORENSEN, S. B., UPCHURCH, D. M., & SHEN, H. (1996). Violence and injury in marital arguments: Risk patterns and gender differences. *American Journal of Public Health*, 86, 35–40.
- STARK, E., & FLITCRAFT, A. (1996). *Women at risk: Domestic violence and women's health*. Thousand Oaks, CA: Sage.
- STEINMETZ, S. K., & LUCCA, J. (1988). Husband battering. In V. B. van Hasselt, R. L. Morrison, A. S. Bellack, & M. Hensen (Eds.), *Handbook of family violence* (pp. 233–246). New York: Plenum.
- STETS, J. E., & STRAUS, M. (1990). Gender differences in reporting marital violence and its medical and psychological consequences. In M. A. Straus & R. J. Gelles (Eds.), *Physical violence in American families: Risk factors and adaptations to violence in 8,145 families* (pp. 151–166). New Brunswick, NJ: Transaction.
- STRAUS, M., & GELLES, R. (1986). Societal change and change in family violence from 1975 and 1985 as revealed by two national samples. *Journal of Marriage and the Family*, 48, 465–479.
- STRAUS, M., GELLES, R., & STEINMETZ, S. (1980). *Behind closed doors: Violence in the American family*. Garden City, NJ: Doubleday.
- STRUBE, M. L. (1988). The decision to leave an abusive relationship: Empirical evidence and theoretical issues. *Psychological Bulletin*, 104, 236–250.
- SULLIVAN, C., & RUMPTZ, M. (1994). Adjustment and needs of African American women who utilized a domestic violence shelter. *Violence and Victims*, 9, 275–286.
- SULLIVAN, C., TAN, C., BASTA, J., RUMPTZ, M., & DAVIDSON, W. (1992). An advocacy intervention program for women with abusive partners: Initial evaluation. *American Journal of Community Psychology*, 20, 309–332.
- TAKAGI, T. (1991). Women of color and violence against women. In C. Moliner (Ed.), *National network of women's funds and foundations corporate philanthropy, violence against women supplement* (pp. S1–S6). St. Paul, MN: National Network of Women's Funds and Foundations Corporate Philanthropy.
- VARVARO, F., & PALMER, M. (1993). Promotion of adaptation in battered women: A self-efficacy approach. *Journal of the American Academy of Nurse Practitioners*, 5, 264–270.
- WALKER, L. (1979). *The battered woman*. New York: Harper & Row.
- WALKER, L. (1984). *The battered woman syndrome*. New York: Springer.

- WALKER, L. (1994). *Abused women and survivor therapy: A practical guide for the psychotherapist*. Washington, DC: American Psychological Association.
- WHEELER, D. (1985). The fear of feminism in family therapy: The risk of making waves. *Family Therapy Networker*, 9, 53–55.
- WHITE, E. (1985). *Chain, chain, change. For black women dealing with physical and emotional abuse*. Seattle, WA: Seal Press.
- WHITE, E. C. (1986). Life is a song worth singing: Ending violence in the black family. In M. Burns (Ed.), *The speaking profits us: Violence in the lives of women of color* (pp. 11–13). Seattle, WA: Center for the Prevention of Sexual and Domestic Violence.