

WHAT CAN WE LEARN? EXAMINING INTIMATE PARTNER VIOLENCE SERVICE PROVISION IN THE DEAF COMMUNITY

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Recent community-based research indicates that the prevalence of intimate partner violence (IPV) in the Deaf community exceeds known rates among hearing individuals, yet little is known about services available to Deaf IPV victims. Given the inaccessibility of IPV services, providers (doctors, psychologists, and lawyers) who know American Sign Language become IPV providers while addressing myriad comorbid issues that affect Deaf clients. This article presents data drawn from transcripts of semistructured interviews with 12 interdisciplinary providers who serve the Deaf population. We sought to understand the etiology of abuse involving Deaf victims and what, if any, services are available. We explore similarities and differences between service provision for hearing and Deaf IPV victims. Findings suggest providers working with Deaf IPV victims typically (a) work with victims and perpetrators alike, (b) provide services to couples and families, (c) serve larger geographical areas, and (d) address stigmatization. Perhaps the most important finding is that standard terminology in IPV measures, without linguistic and cultural modifications, may be invalid for use with Deaf individuals. Policy implications are discussed. © 2015 Wiley Periodicals, Inc.

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INTRODUCTION

Intimate partner violence (IPV) has been recognized as a public health issue for almost three decades (Krug, et al., 2002; U.S. Department of Health and Human Services, Office of Disease Prevention and Health Promotion, 2000; Ludermir, Schraiber, D'Oliveira, França-Junior, & Jansen, 2008), resulting in overhauls of federal, state, and local statutes governing service provision (American Bar Association, 2013). Despite legislative mandates, coupled with millions of dollars in service provision and training (Violence Against Women Act, 2006), IPV remains a serious public health problem, with IPV-related deaths among certain groups of women occurring at the same rates as 20 years ago (Tjaden & Thoennes, 2000).

In 2000, the Centers for Disease Control (CDC) partnered with the National Institute of Justice to conduct the first known community-based telephone survey to gather estimates of IPV frequency. The study reported that IPV affects 20% of U.S. women and 7% of U.S. men during their lifetimes (Tjaden & Thoennes, 2000). Subsequently, rates in the United States and abroad have been reported as high as 50% (Dutton, 2009; Ludermir et al., 2008). The CDC conducted a second study 10 years later, and the findings show that rates are even higher among community samples than the earlier research demonstrated (Black et al., 2011).

People who access healthcare services report even higher IPV rates (Reid et al., 2008; Thompson et al., 2006). Female healthcare users report 44% lifetime abuse and 34% physical abuse (Thompson et al., 2006). Men report lifetime IPV rates at 30% and physical abuse at 18% (Reid et al., 2008). While these rates are staggering, they are likely underestimates because many of these national studies have omitted certain segments of the population due to the methodology employed, such as the use of phones and language barriers. As a result, little is known about IPV for important segments of the population, including certain ethnic and language minority groups, homeless individuals, people with disabilities, individuals living in group homes or institutions, and undocumented immigrants who may be afraid to respond to government surveys.

Deaf American Sign Language (ASL) users are members of a sociolinguistic minority as well as a disability population, and have been particularly understudied. Earlier work suggests greater than 80% of women with disabilities are victims of sexual assault (Obinna, Krueger, Osterbaan, Sadusky, & DeVore, 2006; Stimpson & Best, 1991). This finding has been replicated internationally, with reports that women with disabilities are up to twice as likely to be abused (Anello, 1998). Disabled women become targets for perpetrators who may seek out women with disabilities as more vulnerable and easy prey (Nosek, Howland, & Hughes, 2001). However, a serious methodological difficulty with these studies is the failure to distinguish between different disability groups, in which IPV risks may well vary. People who are blind, those with mobility impairments, those with intellectual disabilities, and the ASL-using Deaf population, for example, differ significantly and merit IPV risk and incidence study, as well as IPV services that are uniquely tailored to these populations (Cerulli, Polshuck, Raimondi, Veale, & Chin, 2012).

IPV risk has been studied extensively among hearing individuals, and the risk factors are varied, complex, and often intertwined. Though no racial or ethnic group is exempt from IPV risk, there are some populations that have greater incidence; according to the "National Intimate Partner and Sexual Violence Survey, 2010 Summary Report," non-Hispanic multiracial women, American Indian/Native Alaskan, and Black women have particularly high prevalence rates (Black et al., 2011). This same report shows greater likelihood of abuse for younger women, specifically women between 18 and 24 years

of age, which supports results from earlier studies that explored the relationship between young age and IPV risk (Black et al., 2011; Vest, Catlin, Chen, & Brownson, 2002; Walton-Moss, Manganello, Frye, & Campbell, 2005).

Another IPV risk factor for hearing women is low socioeconomic status, which includes being unemployed or having low income and utilizing welfare benefits (Vest et al., 2002; Breiding, Black, & Ryan, 2008). Moreover, low education levels are related to higher IPV rates (Breiding et al., 2008; Thompson et al., 2006).

Some specific relationship and household status factors have also had proven effects on IPV risk. For example, unmarried, separated, or divorced women have greater risk for abuse, and women living alone with children have highest risk for violent victimization (Catalano, 2012; Vest et al., 2002; Thompson et al., 2006). Sadly, in some studies pregnancy has also been shown to be a risk factor for IPV (Martin, Mackie, Kupper, Buescher, & Moracco, 2001; Silverman, Decker, Reed, & Raj, 2006). Children are often embroiled in partner conflicts and being exposed to, or direct sufferers of, such violence in childhood is yet another risk factor for IPV in adulthood (Lipsky, Caetano, Field, & Larkin, 2005; Schafer, Caetano, & Cunradi, 2004; Thompson et al., 2006).

There are some other factors related to both the victims' and the abusers' personal lives and experiences that significantly affect likelihood of violence. Alcohol and/or substance abuse problems are serious risks and are related to aggression and impulsivity (Lipsky et al., 2005). Finally, mental health problems, whether experienced by abusers, victims, or both, have had proven effect on IPV risk (Walton-Moss et al., 2005).

The particular ways that these risk factors affect Deaf individuals and the specific risk factors unique just to this population are much less clear. What is known is that Deaf individuals experience social and cultural oppression that often leads to isolation, socioeconomic inequities, and mistrust of the dominant hearing culture (Anderson & Leigh, 2011; Barnett, 1999; McKee et al., 2012). They experience higher rates of unemployment and have lower incomes and education levels than hearing individuals (McKee et al., 2012). As mentioned above, numerous IPV studies with the hearing population have shown that these very same disadvantages are distinct risk factors for IPV and influence victims' abilities to seek help and leave abusive relationships (Vest et al., 2002; Breiding et al., 2008; Thompson et al., 2006).

Further, Deaf individuals have limited access to and success with available services and care due to communication barriers, decreased likelihood of seeking medical care because of poor past experiences, and difficulty garnering personal health education and family history from hearing parents (Barnett, McKee, Smith, & Pearson, 2011). Familial social support has been a proven source of strength for hearing IPV victims (Coker et al., 2002), but Deaf victims may lack even this most basic and essential network if they come from hearing families, where communication barriers are often very significant (Padden & Humphries, 1988, 2005; Pollard & Rinker, 2001). Understanding the risk factors, disadvantages, and multiple barriers to help and relief that Deaf IPV victims experience is an essential first step toward offering adequate IPV service provision to this particular community, which has not fully benefited from the progress made in the general IPV community.

The development of the Deaf community's service provision for IPV can be traced back to the mid-1980s, alongside the hearing community's response, with the development of the first IPV intervention organization for Deaf victims in Seattle (Smith, 2000). Advocacy services that aid the Deaf community have been developed across the country and 18 of these joined forces to create the Justice for Deaf Victims National Coalition (Pollard, Sutter, & Cerulli, 2013), but empirical research has been considerably low due

to communication difficulties between hearing researchers and Deaf subjects, particularly in regard to the use of English language based oral and written measures (Barnett et al., 2011). However, empirical research on IPV in the Deaf community is in its nascent stage (Anderson, Leigh, & Samar, 2011), with some prevalence studies and literature about conducting research in the Deaf community comprising a solid base from which to build (Anderson & Leigh, 2011; Mason, 2010; Pollard, 2002).

Recently, a few researchers have begun to explore IPV in the Deaf community, although a dearth of information remains. Among Deaf college students, IPV rates are reported at twice the rate of hearing students (Anderson & Leigh, 2010). This finding duplicated an earlier study among Deaf individuals that resulted in IPV rates twice that of hearing individuals (Sabina & Straus, 2008). When psychological abuse is considered, rates are alarming: 91% of Deaf respondents reported emotional abuse (Anderson & Leigh, 2011).

Most recent studies continue to document the high rates of IPV among Deaf individuals (Anderson, Leigh, & Samar, 2011). While improvements have been made regarding the documentation of the prevalence of IPV among Deaf individuals, little remains known about the etiology of violence, the unique service needs of this population, and health and cost consequences. However, general population studies are beginning to examine service use among victims and perpetrators (Fishman, Bonomi, Anderson, Reid, & Rivara, 2010) and evaluate interventions, such as batterer's intervention programs (Feder & Wilson, 2005). For example, hearing women have escalating healthcare costs that last for up to 3 years after the abuse stops (Fishman et al., 2010), yet we know little about Deaf individuals' service needs and health consequences.

Resources for Deaf victims are still greatly needed across all sectors of service provision. As Muscat and Walsh (2007) note, underserved populations are "unique in the challenges they bring to the criminal justice, social service, and health care systems" (p. 315) and "face a number of barriers in accessing services, including geographic isolation, mobility, language and communication, and citizenship status, to name but a few" (pp. 315–316). Worth noting, the ability to find and access appropriate services is even more difficult when the victim has several unique needs. For example, if a victim is Deaf and not a citizen, then this victim encounters the compounded effects of a communication barrier and concerns regarding citizenship, both of which require specialized service providers and resources.

Understanding Deaf victims' unique needs and barriers to accessing resources would improve how resource advertisement and service provisions were specifically tailored. In particular, Muscat and Walsh (2007) suggest that police have interpreters available when discussing incidents with Deaf victims and that service providers recognize that the abuser can provide intentionally incorrect information if he or she has dominant English-speaking abilities. Additional research with Deaf victims of sexual assault highlights the need for law enforcement training and education regarding the Deaf community and the importance of relationship building between the Deaf community and law enforcement (Obinna et al., 2006). However, it is difficult to create and implement appropriate trainings and interventions until more is known generally about IPV and the Deaf population.

The present study fills a gap in knowledge by providing insights into several areas worthy of further inquiry: (a) the etiology of violence affecting Deaf people, (b) what services are currently being provided, and (c) what IPV service needs remain. A group of concerned individuals founded the first Deaf IPV service organization in Seattle in 1986 (Smith, 2000). More than 20 such organizations now exist across the United States. The U.S. Department of Justice's Office on Violence Against Women has funded the Justice for

Deaf Victims National Coalition (Waddington, 2008). Yet, to date, no one has empirically studied these services to understand how they are working, how they are similar to or different from hearing IPV services, and what next steps the field of IPV Deaf service provision may need to take.

Using community-based participatory research principles (Israel, Schulz, Parker, & Becker, 2001), a unique interdisciplinary research team convened to learn more about the etiology of IPV affecting the Deaf community. Previously, this team had adapted an evidence-based IPV curriculum for training “key helpers” (e.g., civic and religious leaders, counselors, and teachers) from the Deaf community. As a result of this initiative, it became evident that the curriculum had not addressed the nuances of the types of violence Deaf individuals experience or their unique help-seeking experiences. The team subsequently received a 3-year CDC grant to further develop this work.

The research team sought to examine the etiology of IPV among Deaf victims using a three-phase, interview-based approach to data collection that included service providers who work with Deaf people, Deaf IPV survivors, and perpetrators of IPV in relationships where one or both individuals were Deaf ASL-users. This article reports on the first phase of the 3-year study. The service provider data reported herein provided guidance on conducting the interviews for the second and third stages of the project. In addition to the qualitative data gleaned through the interviews, we examined the utility of three risk assessment measures commonly used in IPV research and service provision with hearing victims to begin to understand their utility with Deaf victims. We also report on the similarities and differences among IPV service providers who work with Deaf versus hearing victims.

METHODOLOGY

This mixed-method study utilized semistructured interviews to assess Deaf IPV service providers’ perceptions on the etiology of violence among Deaf individuals. The study team was unique in that it had representation from the hearing and Deaf community, and it was interdisciplinary in nature. Fields of expertise represented on the team included psychology, law, anthropology, intimate partner violence, American Sign Language, Deaf sociocultural and psychological issues, and criminal justice. Experts from the Deaf IPV community were involved in all aspects of this project, including the grant application, construction of the field interview guide, recruitment, interview team, transcription, analysis, and data dissemination. The interdisciplinary research team created the interview guide, and the interview conduct team (all fluent in ASL) was trained on the use of the guide. The team piloted the guide, which was then modified pursuant to feedback from the interview staff and preliminary analyses of the first transcript.

The study advertised for participants through e-mail solicitations with providers serving the Deaf community nationwide, web-based video blogs (“vlogs” in ASL), and listservs, and mailed copies of recruitment letters and flyers to the members of the JDVNC. Those who selected to participate relayed their interest to the research team through an e-mail notification system. Because participants were providing information gained in their professional capacity and the data were anonymous and confidential, the Institutional Review Board at the University of Rochester deemed the study exempt. Participants were compensated \$40 for their participation.

All interviews except one (involving a sign-fluent hearing provider who was interviewed by telephone) were conducted in ASL via videophone technology and recorded

for later translation and transcription. The transcription team, comprised of certified ASL interpreters, translated the recorded ASL videos into English and transcribed them, using Word. The ASL-fluent individual who interviewed the subject audited the English transcript for accuracy, referring back to the original ASL recording as needed. A third team member de-identified the transcript before the analysis team discussed it.

The service providers were asked about IPV situations in which one or both partners of the IPV couple were a Deaf ASL user, prompted by the questions from the semistructured field interview guide. The interviews comprised four main parts: (a) “Tell me about the history of your organization,” which included how the agency defined abuse; (b) “How would you describe the local Deaf community in your area?”; (c) “Think about the most recent case you dealt with”; and (d) a final part prompting the participant to discuss controlling behaviors (including behaviors involving communication control) and physical, sexual, psychological, and economic abuse perpetrated by an adult intimate partner against another.

Each member of the analysis team read through each transcript and created concept maps that captured the key data revealed in the interviews. Victim, perpetrator, and service provider characteristics were noted. After each person coded the transcript, we met as a team and discussed the coding structure until consensus was reached. At the completion of the mapping, a grid was created that included the sociodemographic characteristics of the interviewees and key concepts for this article. The maps were reduced, using a socioecological coding framework (Pope, Ziebland, & Mays, 2000; Barg et al., 2006), to understand the individual, relational, societal, and cultural perspectives.

FINDINGS

Sample Description

Twelve providers specializing in psychosocial services to ASL-using Deaf individuals participated in the study. Eleven were Deaf and one provider was hearing. All providers were fluent in ASL. Due to the participation of only one hearing provider, we did not stratify the qualitative data on service provider’s hearing status. The study achieved national representation by soliciting participation from four broad geographic regions that make up the United States. Most participants had provided IPV services to Deaf men and women. The geographic areas served by 11 participants varied from a single college campus to an entire state. One participant provided services to individuals from more than one state, because of the lack of ASL-accessible services available in that region.

All the interviewees provided services to Deaf victims, and all but three provided services to perpetrators as well. One interviewee, who was a primary mental health provider, was unclear on the agency’s definition of the type of services it provided and did not appear to distinguish between “perpetrator” and “victim.” The sizes of the agencies represented ranged from one employee (the interviewee) to 55. The newest agency represented had been in existence for roughly 6 years, with two being more than 40 years old. These two agencies predate the creation of the first IPV-specific Deaf service program in Seattle, as noted earlier. The older agencies primarily serve hearing clients, but they also serve Deaf clients. Over the years, services for Deaf clients are not necessarily consistent due to changing funding patterns. Because of the complexity of service provision in the Deaf community, we did not stratify agencies by “IPV or non-IPV.” While some agencies are primarily mental health providers, they are the only local or regional IPV service provider as well.

The majority of agencies represented provide services to both Deaf and hearing individuals, especially if one member of the IPV-involved couple is hearing. Additionally, these service providers will typically offer services to victims' and perpetrators' Deaf or hearing family members.

Definition of Abuse

Service providers for Deaf IPV-involved individuals largely defined IPV similarly to those serving the hearing community. The World Health Organization (WHO) defines IPV as "behavior within an intimate relationship that causes physical, sexual or psychological harm, including acts of physical aggression, sexual coercion, psychological abuse and controlling behaviors" (Krug, et al., 2002, p. 89).

Among the service providers interviewed, there were similarities in how they defined IPV, revealing an understanding that the range of behaviors may include physical, emotional, sexual, financial, and – often relevant to Deaf individuals – abuse involving communication. However, given the range of different types of providers interviewed (e.g., their professional training), definitions varied. Some service providers relayed that their primary identity was that of a mental health provider, social worker, or other type of primary service provider, and not an "IPV service provider." As such, the participants reported that their agencies did not have a strict definition of IPV, but rather manifested a more naturalistic approach to service provision, allowing IPV issues to surface during other forms or foci of service provision.

A coordinator for a four-county service program for people who are Deaf, disabled, or elderly reported the following definition of abuse: "Yelling, pushing, hitting, kicking, monetary abuse, taking advantage, sexual molestation or rape, etc. I think anything that is not respectful." The providers also recognized the role of fear in defining abuse, which is lacking from the WHO definition. A coordinator for a statewide mental health service for Deaf people stated: "I think it's fair to say that abuse means fear. Fear and a feeling of threatening of your life, your money, emotionally, or physically, and so on. Anytime basically with fear. I think that's a relatively standard definition."

As noted earlier, some providers didn't identify as an IPV provider and, as such, do not have standard definitions in their operating protocols. A respondent explained: "[The] agency didn't focus on serving people who had been abused only and so we really didn't have that as a construct. We didn't sit down and say 'Let's talk about what abuse is' So I really thought, you know, the best way to answer it is to say we didn't have a definition for abuse." The respondent works both for a county agency that serves Deaf victims and in a private practice serving the mental health needs of Deaf clients at a different location.

In addition to fear, providers also noted the role of power and control. A counselor at a center for independent living remarked: "My professional definition of how I view abuse [is] someone who not only hits but takes away their power and their right to communicate to other people, and to make them less valued, and takes away their right to self-advocate. So that is abuse."

Participants also described abuse tactics that appear to be unique to the Deaf victims, as well as strategies to isolate the Deaf IPV victim, similar to those seen in the hearing community. Participants reported isolation techniques used by perpetrators who are abusing Deaf individuals that often involve restricting the victim's access to technology and communication with others.

Because of the wide variety of services provided by participants (education, drug and alcohol counseling, housing, etc.), they report IPV as one of myriad issues their clients

are facing. A counselor from a center certified for alcohol and drug treatment equated IPV with a new “drug of choice” and relayed that clients appear addicted to violent relationships:

It appears that the new drug of choice is violence, not that violence is new, but violence is an addiction . . . There is one man who has been in jail many times for domestic violence. He knows very little English. He attended a domestic violence class, which was court ordered in the past but that he never understood what was going on and feigned understanding. He abused again and the court didn’t care if he was sober, but I was saying that if he was drunk he would be abusive and so that sobriety was necessary. He had two drugs: drinking and violence.

Because these service providers are often the only ASL-fluent provider that serves the Deaf population in a wide geographical region, they may serve both the perpetrator and the victim in a given IPV relationship. Additionally, they often see couples together and frequently identify cases of bidirectional violence between couples that result from communication breakdowns, which can complicate the distinction between categories of “perpetrator” and “victim.” Limited sign-language fluency among one or both partners is a contributing factor for communication breakdowns, and inadequate communication often escalates couples’ tensions and misunderstandings. One participant reported: “If the perp is Deaf and the victim is Deaf, there are communication break-downs or misunderstandings, so it’s more of a communication issue that I’m seeing. That’s the most common issue.”

Services Provided

The services provided by participants ranged from counseling, job training, education, housing, drug addiction counseling, couple’s counseling, securing disability services, and financial assistance, such as helping the client apply for SSI. This is true for services provided to both Deaf victims and Deaf perpetrators. A participant described: “Deaf perpetrators, for them in particular, they bring forms to me, including medical forms or insurance forms that are asking for the children’s second insurance payer. They bring these forms to me; which is interesting . . . I will have to explain to them in ASL and they are able then to fill it out.”

There was a focus among many of the agencies represented on advocacy and community outreach and education, with an effort to promote prevention of IPV. Some also provide emergency housing as well. One respondent remarked:

Every month, I get about five consumers, roughly five, who come in and agree that they have been experiencing abuse. Most of the time they come looking for hous[ing] because they were recently evicted or just been attacked and they need service immediately. Emotionally, they can’t find a job because the abuser won’t let them go out and I educate them what the abuse is so they understand it . . . We encourage them to go to [a certain agency] to get therapy if they need it. [I]n an emergency to call 911, or to help them to go to DSS for emergency housing.

There was very little mention of connectivity with police or court-related agencies as a primary focus for these providers. Rather, the connections with police-based agencies

appear more related to providers serving as interpreters for Deaf clients who are arrested or incarcerated. A participant related:

Now for the perp . . . when he was arrested, he didn't have an interpreter either when they were asking him questions. They didn't bring in an interpreter until he got to the police station. Before then, the Miranda rights were a little bit violated, because the perp was talking about everything before the police were able to tell him he could hold it and wait because whatever he says at that time could be held against him in court. You know? They took advantage.

The services our participants discussed seemed to have developed slowly over time, with grassroots helping or advocacy efforts later developing into more strategic services. One Deaf service agency was developed in response to a local tragedy, not uncommon in the hearing community.

DISCUSSION

Similar to IPV agencies serving hearing people, agencies serving Deaf IPV victims typically offer a continuum of services (hotline, shelter, etc.). Deaf versus hearing-focused agency histories are often similar as well (began with volunteers, expanded, and became more formalized over time) and employ from one to numerous providers.

Also similar to the IPV providers serving hearing people, providers serving Deaf people believe there are multiple forms of abuse and are passionate and committed employees, often defining themselves as advocates. Many participants discussed how often they must help victims identify that they are in an abusive relationship, especially when the victim is presenting for a different issue, such as mental health or housing assistance. Deaf service agencies are also providing services to male and female victims alike, similar to hearing agencies.

Like providers serving the hearing community, those serving the Deaf community also struggle with the presence of comorbid issues such as mental and physical health burdens, substance abuse, housing shortages, child custody issues, and legal involvement. Our participants find themselves similarly situated to many IPV providers serving hearing people in that there are not enough services available. However, despite these similarities between Deaf and hearing providers, there are some unique differences as well.

Figure 1 summarizes the differences we identified between providers serving IPV Deaf versus hearing IPV victims. The most unique difference, one with far-reaching

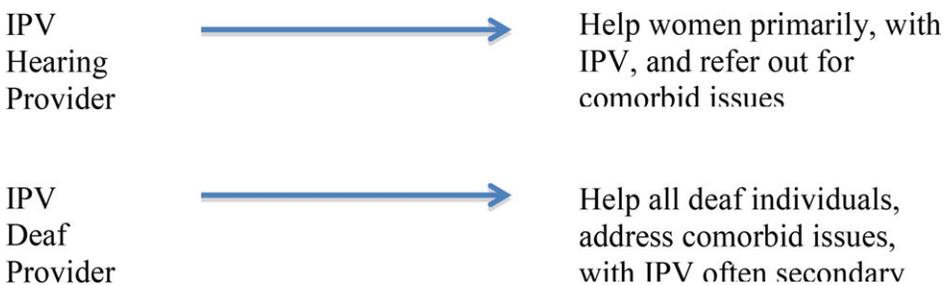


Figure 1. Differences between providers serving hearing victims and Deaf victims.

implications, is that most IPV providers serving hearing people are IPV specialists, whereas the providers serving Deaf people are usually generalists, required to address an array of complicated needs for their clients due to their unique accessibility to ASL users.

Because these providers are fluent in ASL, they report wearing many hats, which include working with both perpetrators and victims. This has the potential to create conflicts of interest and increase the chances that victims may have unwilling encounters with their abusers in service organizations, and it may require different counseling strategies. Noticeably, these providers did not demonize perpetrators, but instead they had more empathy for the etiology of the violence and the services needed as a result. Some of these service providers noted that Deaf children might not witness or hear IPV activity in a home, and thus have less awareness of how the IPV risk factors may be present in their adult relationships.

Many Deaf-focused providers reported working with the victim or perpetrator's family as a whole, and engaging in a significant amount of couples and family work, more so than do providers who work with hearing IPV victims. While there is a body of IPV literature that supports the effectiveness of couples work in limited circumstances, including relationships with no substance abuse or no misdemeanor or felony violence (Hrapczynski, Epstein, Werlinich, & LaTaillade, 2012; Sprenkle, 2012; Stith, McCollum, Amanor-Boadu, & Smith, 2012), this topic merits further exploration in relation to IPV and the Deaf community, where couples counseling approaches may be the default.

The providers in this study reported having fewer relationships with police and courts than do hearing-focused IPV agencies. This may be due to the large geographical areas they often covered. For participants providing services to multiple states, creating and sustaining such relationships may be barriers. These providers appear to be struggling to keep up with serving their clients' many and diverse needs, and dealing with the stigmatization many of their clients feel about being an IPV victim, as well as the discrimination they encounter from being Deaf.

Some Deaf individuals may not want to receive services specifically established for Deaf individuals because of concerns that these service providers are usually part of the close-knit Deaf community and that their privacy might therefore be compromised. Similar concerns also can arise even when hearing (nonsigning) IPV service providers engage sign language interpreters to work with Deaf clients. Interpreters, too, are well-known and active members of most Deaf communities. Accordingly, Deaf individuals with such heightened privacy concerns may essentially be precluded from receiving any IPV services.

Overall, these service providers seem to understand that their Deaf clients' violence issues stem from a host of potential causes: childhood witnessing and victimization, lack of information about the nature of IPV, lack of communication skills, lack of access to prevention and intervention services, and marginalization.

As with any study, there are limitations with this project. This article reports the results from the first portion of a three-phase project. Latter phases of the project will be edified by the insight these key informants shared. Our sample size was small and it is possible that snowball sampling may have occurred, with participants telling others about the study. Strengths of our study included its conceptualization and methodological design by an interdisciplinary team of Deaf and hearing experts, a geographically diverse national sample, ASL-fluent interviewers, and its unique topical focus and study sample. While there are weaknesses to the methodology, the strengths suggest a foundation from which to learn more.

CONCLUSION

The findings regarding IPV and the Deaf community have demonstrated that it may be important for IPV care to be more broadly client-centered, and for IPV screening to take into account childhood experiences, bidirectional violence, and this special population's unique communication and information needs. There is no way to know, as with the hearing population, how many IPV-involved Deaf individuals are not served or are underserved. But it is likely that many are not receiving the services they need. It is imperative for all service disciplines that cater to the Deaf community to be prepared to address IPV, and for all providers who address violence to understand the needs of the Deaf community. The lessons learned from this small qualitative study provide future directions for research, especially in light of national policy changes.

The Affordable Care Act (ACA) has the potential to change the way we consider IPV in healthcare settings (The Patient Protection and Affordable Care Act, 2010). The Act will allow the screening, assessment, and referral for IPV to be a reimbursable prevention event. Given the traditional labels of "perpetrator" and "victim" and society's propensity for categorizing women as victims and men as perpetrators, we may miss opportunities to intervene if IPV-involved couples are not considered within the context of their lives. If providers were to accept the perspective of the Deaf providers, that anyone can be a victim or perpetrator and that IPV care needs to be interwoven into other services, then we may have better opportunities to intervene with IPV-involved individuals earlier.

To that end, this study also demonstrated the need for more licensed, ASL-fluent providers, including providers who are Deaf themselves. With the increased demand for screening for IPV, it is possible that more Deaf men and women will be identified as victims. We must be able to provide appropriate referrals to providers who are not only well prepared to serve Deaf people but also knowledgeable about IPV.

Work is underway at the Deaf Wellness Center to address some of these issues, and findings from interviews with Deaf victims and perpetrators in the second and third phases of this study will shed light on how we can better serve this sociocultural and linguistic minority.

REFERENCES

- American Bar Association, Commission on Domestic & Sexual Violence. (2013). Retrieved from http://www.americanbar.org/groups/domestic_violence.html.
- Anderson, M. L., & Leigh, I. W. (2010). Internal consistency and factor structure of the Revised Conflict Tactics Scales in a sample of deaf female college students. *Journal of Family Violence*, 25, 475–483. doi:10.1007/s10896-010-9308-6
- Anderson, M. L., & Leigh, I. W. (2011). Intimate partner violence against deaf female college students. *Violence Against Women*, 17(7), 822–834.
- Anderson, M. L., Leigh, I. W., & Samar, V. J. (2011). Intimate partner violence against deaf women: A review. *Aggression and Violent Behavior*, 16, 200–206.
- Anello, B. (1998). Inter-sectoral workshop on violence against women with disabilities and deaf women and access to the justice system. Retrieved from <http://dawn.thot.net/workshop.html>.
- Barg, F. K., Huss-Ashmore, R., Wittink, M. N., Murray, G. F., Bogner, H. R., & Gallo, J. J. (2006). A mixed-methods approach to understanding loneliness and depression in older adults. *Journal of Gerontology*, 61B(6), S329–S339.
- Barnett, S. (1999). Clinical and cultural issues in caring for Deaf people. *Family Medicine*, 31(1), 17–22.

- Barnett, S., McKee, M., Smith, S. R., & Pearson, T. A. (2011). Deaf sign language users, health inequities, and public health: Opportunity for social justice. *Preventing Chronic Disease*, 8(2).
- Black, M. C., Basile, K. C., Breiding, M. J., Smith, S. G., Walters, M. L., Merrick, M. T., . . . Mark, S. R. (2011). The National Intimate Partner and Sexual Violence Survey (NISVS): 2010 summary report. Atlanta, GA: National Center for Injury Prevention and Control, Centers for Disease Control and Prevention.
- Breiding, M. J., Black, M. C., & Ryan, G. W. (2008). Prevalence and risk factors of intimate partner violence in eighteen U.S. states/territories, 2005. *American Journal of Preventive Medicine*, 34(2), 112–118.
- Catalano, S. (2012). Special report: Intimate partner violence, 1993–2010. Washington, DC: U.S. Department of Justice, Office of Justice Programs, Bureau of Justice Statistics.
- Cerulli, C., Poleshuck, E., Raimondi, C., Veale, S., & Chin, N. (2012). "What fresh hell is this?" Victims of intimate partner violence describe their experiences of abuse, pain, and depression. *Journal of Family Violence*, 27, 773–781.
- Coker, A. L., Smith, P. H., Thompson, M. P., McKeown, R. E., Bethea, L., & Davis, K. E. (2002). Social support protects against the negative effects of partner violence on mental health. *Journal of Women's Health and Gender-Based Medicine*, 11(5).
- Dutton, M. A. (2009). Pathways linking intimate partner violence and posttraumatic disorder. *Trauma, Violence & Abuse*, 10(3), 211–224.
- Feder, L., & Wilson, D. B. (2005). A meta-analytic review of court-mandated batterer intervention programs: Can courts affect abusers' behavior? *Journal of Experimental Criminology*, 1(2), 239–262.
- Fishman P. A., Bonomi A. E., Anderson M. L., Reid, R. J., & Rivara, F. P. (2010). Changes in health care costs over time following the cessation of intimate partner violence. *Journal of General Internal Medicine*, 25(9), 920–925.
- Hrapczynski, K. M., Epstein, N. B., Werlinich, C. A., & LaTaillade, J. J. (2012). Changes in negative attributions during couple therapy for abusive behavior: relations to changes in satisfaction and behavior. *Journal of Marital and Family Therapy*, 38(Suppl 1), 117–132.
- Israel, B. A., Schulz, A. J., Parker, E. A., & Becker, A. B. (2001). Community-based participatory research: Policy recommendations for promoting a partnership approach in health research. *Education for Health*, 14(2), 182–197.
- Krug, E. G., et al., eds. (2002). *World report on violence and health*. Geneva, World Health Organization.
- Lipsky, S., Caetano, R., Field, C. A., & Larkin, G. L. (2005). Psychosocial and substance-use risk factors for intimate partner violence. *Drug and Alcohol Dependence*, 78(1), 39–47.
- Ludermir, A. B., Schraiber, L. B., D'Oliveira, A. F., França-Junior, I., & Jansen H. A. (2008). Violence against women by their intimate partner and common mental disorders. *Social Science & Medicine*, 66(4), 1008–1018.
- Martin, S. L., Mackie, L., Kupper, L. L., Buescher, P. A., & Moracco, K. E. (2001). Physical abuse of women before, during and after pregnancy. *Journal of the American Medical Association*, 285, 1581–1584.
- Mason, T. C. (2010). Does knowledge of dating violence keep deaf college students at Gallaudet University out of abuse relationships? *Journal of the American Deafness and Rehabilitation Association*, 43(2), 74–91.
- McKee, M., Thew, D., Starr, M., Kushalnagar, P., Reid, J. T., Graybill, P., & Pearson, T. A. (2012). Engaging the deaf sign language community: Lessons from a community-based participatory research (CBPR) center. *Progress in Community Health Partnerships: Research, Education, and Action*, 6, 319–328.
- Muscat, B. T., & Walsh, J. A. (2007). Reaching underserved victim populations: Special challenges relating to homeless victims, rural populations ethnic/racial/sexual minorities, and victims

- with disabilities. In R. C. Davis, A. J. Lurigio, & S. Herman (Eds.), *Victims of crime* (3rd ed., pp. 315–336). Thousand Oaks, CA: Sage Publications.
- Nosek, M. A., Howland, C. A., & Hughes, R. B. (2001). The investigation of abuse and women with disabilities: Going beyond assumptions. *Violence Against Women*, 7(4), 477–499.
- Obinna, J., Krueger, S., Osterbaan, C., Sadusky, J. M., & DeVore, W. (2006). Understanding the needs of the victims of sexual assault in the deaf community. Retrieved from <https://www.ncjrs.gov/pdffiles1/nij/grants/212867.pdf>.
- Padden, C., & Humphries, M. (1988). *Deaf in America: Voices from a culture*. Cambridge, MA: Harvard University Press.
- Padden, C., & Humphries, T. (2005). *Inside Deaf culture*. Cambridge, MA: Harvard University Press.
- The Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 - 124 Stat. 1025, (2010).
- Pollard, R. Q., & Rinker, N. C. (2001). The misfit: A deaf adolescent struggles for meaning. In S. H. McDaniel, D. D. Lusterman, & C. Philpot (Eds.), *Casebook for integrating family therapy* (pp. 191–204). Washington, DC: American Psychological Association.
- Pollard, R. Q., Sutter, E., & Cerulli, C. (2013). Intimate partner violence reported by two samples of deaf adults via a computerized American Sign Language survey. doi:10.1177/0886260513505703.
- Pope, C., Ziebland, S., & Mays, N. (2000). Qualitative research in health care: Analyzing qualitative data. doi:http://dx.doi.org/10.1136/bmj.320.7227.114.
- Reid, R. J., Bonomi, A. E., Rivara, F. P., Anderson, M. L., Fishman, P. A., Carrell, D. S., & Thompson, R. S. (2008). Intimate partner violence among men: Prevalence, chronicity, and health effects. *American Journal of Preventative Medicine*, 34(6), 478–485.
- Sabina, C., & Straus, M. A. (2008). Polyvictimization by dating partners and mental health among U.S. college students. *Violence and Victims*, 23(6), 667–682.
- Schafer, J., Caetano, R., & Cunradi, C. B. (2004). A path model of risk factors for intimate partner violence among couples in the United States. *Journal of Interpersonal Violence*, 19(2), 127–142.
- Silverman, J. G., Decker, M. R., Reed, E., & Raj, A. (2006). Intimate partner violence victimization prior to and during pregnancy among women residing in 26 U.S. states: Associations with maternal and neonatal health. *American Journal of Obstetrics and Gynecology*, 195, 140–148.
- Smith, M. (2000). Supporting deaf women in Seattle: Abused deaf women's advocacy services. In W. Abramson, E. Emanuel, V. Gaylord & M. Hayden (Eds.), *Impact: Feature issue on violence against women with developmental or other disabilities*. Minneapolis, MN: University of Minnesota, Institute on Community Integration. Retrieved from <http://ici.umn.edu/products/impact/133/>.
- Sprenkle, D. H. (2012). Intervention research in couple and family therapy: A methodological and substantive review and an introduction to the special issue. *Journal of Marital and Family Therapy*, 38(1), 3–29.
- Stimpson, L., & Best, M. C. (1991). *Courage above all: Sexual assault against women with disabilities*. Disabled Women's Network, Toronto.
- Stith, S. M., McCollum, E. E., Amanor-Boadu, Y., & Smith, D. (2012). Systemic perspectives on intimate partner violence treatment. *Journal of Marital and Family Therapy*, 38(1), 220–240.
- Thompson, R. S., Bonomi, A. E., Anderson, M., Reid, R. J., Dimer, J. A., Carrell, D., & Rivara, F. (2006). Intimate partner violence: Prevalence, types, and chronicity in adult women. *American Journal of Preventive Medicine*, 30(6), 447–457.
- Tjaden, P., & Thoennes, N. (2000). Full report of the prevalence, incidence, and consequences of violence against women: Findings from the National Violence Against Women Survey. Washington, DC: National Institute of Justice, Office of Justice Programs.

- U.S. Department of Health and Human Services, Office of Disease Prevention and Health Promotion. (2000). *Healthy people 2010: Understanding and improving health* (2nd ed.). Washington, DC: Government Printing Office.
- Vest, J. R., Catlin, T. K., Chen, J. J., & Brownson, R. C. (2002). Multistate analysis of factors associated with intimate partner violence. *American Journal of Preventative Medicine*, 22(3), 156–164.
- Violence Against Women and Department of Justice Reauthorization Act of 2005, H.R. 3402, 109th Cong. (2006).
- Waddington, L. (2008). Iowa group lands grant to help deaf assault survivors. *RH Reality Check*. Retrieved from <http://rhrealitycheck.org/article/2008/08/12/iowa-group-lands-grant-help-deaf-assault-survivors/>.
- Walton-Moss, B., Manganello, J., Frye, V., & Campbell, J. (2005). Risk factors for intimate partner violence and associated injury among urban women. *Journal of Community Health*, 30(5), 377.