

Original Paper

Exploring Equity, Diversity, and Inclusion in Domestic Violence Service Provision

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Abstract

Background: The experiences of domestic violence survivors are unique, varied, and complex, and services for those seeking support must be responsive to these diverse needs. Methods: To understand equity, diversity, and inclusivity within domestic violence service provision, surveys were completed by 70 professionals belonging to a local domestic violence collective. Results: Using an intersectional lens, thematic analysis of survey data revealed a gap in the literature specific to equity in service delivery and limited understanding and provision of equitable, diverse, and inclusive services. Barriers to inclusive service delivery included a lack of cultural considerations and cultural competency while proposed solutions to barriers identified the need for ongoing cultural competence education and training, expanded partnerships, and refined agency policies and procedures. Conclusion: Future studies should explore the impact of implementing sector and system level changes on those who provide and receive DV services while examining the role of cultural humility, safety, and ethical space within the DV environment.

Keywords

domestic violence, equity, diversity, inclusion, cultural competency, cultural awareness, barriers

1. Introduction

The experiences of Domestic Violence (DV) survivors are unique, varied, and complex, and services for those seeking support must be responsive to these diverse needs. While DV services exist to provide

support to all individuals experiencing DV, the current landscape has created an unwelcoming environment for some including people from minority groups, resulting in barriers to equitable, diverse, and inclusive service provision (Lightfoot & Williams, 2009; Barrett, George, & George, 2005). These barriers may prevent individuals who are experiencing DV from reaching out for support and therefore, there is an urgent need to address this lack of diverse and inclusive support by understanding how DV services can be more engaged in delivery that is inclusive.

DV impacts individuals of all genders, ethnicities, abilities, sexual orientations, and economic status and can be defined as “the attempt, act or intent of someone within a relationship—where the relationship is characterized by intimacy, dependency or trust—to intimidate either by threat or by the use of physical force on another person or property” (CDVC, 2019). In addition to physical force, abusive behaviors can include verbal, sexual, emotional, spiritual, economic, psychological, and the violation of rights, with the ultimate goal of controlling, exploiting, and having power over another through fear, intimidation, and neglect (Government of Newfoundland and Labrador, 2018). Violence is often a reflection of the power imbalance between abusers and their victims, closely mirroring the inequities or differences within individuals’ experiences of violence and vulnerability (Government of Newfoundland and Labrador, 2018; Mackenzie, Rogers, & Dodds, 2014; Stanhope & Lancaster, 2014). Vulnerability can be understood as unequal power, dependency, capacity and need that can result in a person being exposed to harm, exploitation, and the reduced capacity to protect their own interests and safety and those of their dependents (Stanhope & Lancaster, 2014). Vulnerability is often associated with the susceptibility of a person to experience harms or threats from external factors that they cannot control (Magnussen et al., 2011). For those individuals from diverse ethnic and cultural backgrounds, exclusionary practices perpetuate inequitable, discriminatory practices; cultural consideration is a prerequisite when trying to provide services that are inclusive.

Support services for DV survivors are rooted in western-based knowledge systems and practices and often ignore the cultural needs and considerations of a diverse population, resulting in experiences of racism, discrimination, and stigmatization for ethnic minority groups (Magnussen et al., 2011; Klingspohn, 2018; Kasturirangan, Krishnan, & Riger, 2004; Martinson, 2001; Nnawulezi & Sullivan, 2014; Anderson & Aviles, 2006). Cultural values and norms around patriarchy, gender identity, relational worldviews, family structure, collectivistic obligations and specific cultural scripts are often not acknowledged in DV service provision (Kasturirangan, Krishnan, & Riger, 2004). For example, researchers suggests Indigenous women are more likely to experience violence than non-Indigenous women, yet services often fail to consider the impacts of colonization, intergenerational trauma, cultural values, and traditional family units when supporting Indigenous peoples (Klingspohn, 2018). Another example may be a woman who struggles with DV disclosure who comes from a culture which stresses collectivistic obligation. These women may choose to sacrifice individual needs in order to meet collectivistic expectation that view DV as a personal or family issue not a legal or social issue. Breaking the silence of violence could bring disgrace to the core family but also to the extended family

members. A lack of cultural competence within DV service provision perpetuates inequitable, discriminatory practices and must be considered.

Cultural competency can be defined as “individuals and organizations having the values, skills, knowledge, attitudes, and attributes to work effectively in cross-cultural situations” (Whitaker et al., 2007, p. 192). Culturally competent services are responsive to individuals’ cultures (Bell & Mattis, 2000) and both an individual’s and organization’s cultural competence are interrelated as context influences competency (Pyles & Kim, 2006). A lack of general outrage for culturally competent care and treatment for DV survivors (Bent-Goodley, 2007) highlights the urgent need for diverse and culturally competent service provision. Cultural competency is a process that involves collaboration and relationship-building with communities including those with lived experience, and agencies must examine existing policies and practices to ensure competencies are built at all levels and hold individuals at all levels accountable (Aboriginal and Torres Strait Islander Social Justice Commissioner, 2011; Perilla, Serrata, Weinberg, & Lippy, 2012; Bhuyan & Senturia, 2005; Senturia, Sullivan, Ciske, & Shiu-Thornton, 2000; Warriar, 2005). Furthermore, research suggests cultural competency training must be mandated, systematic, and ongoing (Klingspohn, 2018; Latta & Goodman, 2005; Lockhart & Danis, 2010; Bent-Goodley, 2005) ensuring diverse cultural understanding and experiences of DV are informing policy and shaping best practices that are diverse (Anderson & Aviles, 2006). Engaging in cultural competence allows those who work within the DV sector to understand the complexity of DV survivors’ experiences and adapt the provision of services accordingly.

1.2 Theoretical Framework

It is important to note that binary terms or discrete categories of race and ethnicity such as Black or White often influence how social experiences and identities are understood and shape the response to the issues that people with particular identities are living with (Munro, 2005). Experiences of DV are not universal and must be understood through an intersectional lens that addresses the historical and political contexts for a specific cultural group while acknowledging the complexities of power and privilege (Warriar, 2005). To fully understand diversity, it is important to recognize that binary or discrete notions of identity and experience are inadequate; therefore, an intersectional lens is required to recognize there are multiple ways people experience diversity and thus, the supports necessary to be diverse, inclusive and equitable should be understood as a spectrum that can be responsive to multiple ways of being.

1.3 The Current Study

Utilizing an intersectional lens, the purpose of this study is to explore how equity, diversity, and inclusion are understood within the DV sector while highlighting the barriers and potential solutions to providing services that are more equitable, diverse, and inclusive. The research questions are as follows: 1) How are equity, diversity, and inclusion understood within the DV service provision sector? 2) What are the barriers to inclusive service delivery within the DV service provision sector? 3) How can DV services be more inclusive within the DV service provision sector?

2. Methods

Participants for this study were recruited from a local DV collective in May 2019. Surveys were completed by a total of 70 professionals within the DV sector who were recruited through a snowball sampling method (organizations included addictions, children, disability, ethnocultural, funders, government, health, immigrant, justice, mental health, research, sexual abuse, treatment, and women's shelters). The survey asked participants about their own experiences with various forms of violence to better understand the extent to which barriers in the DV field can be assessed. Additionally, participants were asked to define their understandings of diversity, equity, and inclusion, identify barriers in providing DV services, and identify how DV service provision could be more inclusive. This study received ethics approval from the University of Calgary (REB19-1009).

3. Results

Data analysis was completed using SPSS.

3.1 Equity

Participants were asked to choose a definition of equity that made the most sense to them. The results are shown in Table 1. The most frequent understanding of equity (74.6%) was: "Equity is fairness achieved through (1) systematically assessing disparities in opportunities and outcomes caused by structures and systems and (2) by addressing these disparities through meaningful inclusion and representation of affected communities and individuals, targeted actions, and changes in institutional structures and systems to remove barriers and increase pathways to equal access to participation/being included."

Table 1. Defining Equity

Definition of Equity	Percentage of Respondents ¹
Equity is the quality of being fair and impartial.	7.1%
Equity is fairness and impartiality towards all concerned, based on the principles of even-handed dealing.	5.7%
Equity is just and fair inclusion into a society in which all can participate, prosper, and reach their full potential.	20%
Equity is fairness achieved through (1) systematically assessing disparities in opportunities and outcomes caused by structures and systems and (2) by addressing these disparities through meaningful inclusion and representation of affected communities and individuals, targeted actions, and changes in institutional structures and systems to remove barriers and increase pathways to equal access to	74.3%

participation/being included.

¹ Some respondents chose more than one definition, resulting in a cumulative total greater than 100%.

Following the definition of equity, participants were asked if they believed DV survivors were receiving equitable services based on their chosen definition. Results are shown in Figure 1. Over 50% of participants disagreed that DV survivors were receiving equitable services based on their understanding and definition of equity.



Figure 1. Percentage of Respondents Who Believe DV Survivors Are Receiving Equitable Services

3.2 Diversity

Participants were asked to choose a definition of diversity that made the most sense to them. The results are shown in Table 2. The most frequent understanding of diversity (51.4%) was: “Diversity is the range of human differences, including but not limited to race, ethnicity, gender, gender identity, sexual orientation, age, language, social class, physical ability or attributes, religious or cultural beliefs/practices, national origin, immigration status, and political beliefs.”

Table 2. Defining Diversity

Definition of Diversity	Percentage of Respondents ¹
Diversity is a numerical representation of different types of people.	1.4%
Diversity is a trending buzz word that divides us rather than bringing us together.	1.4%
Diversity means to practice without discrimination, with respect, and with knowledge and skills related to age, class, color, culture, disability, occupation, education, ethnicity, family structure, gender,	8.6%

marital status, national origin, race, religion, sex, and sexual orientation.

Diversity means understanding that each individual is unique and recognizing our individual differences. These can be along the dimensions of race, language, ethnicity, gender, sexual orientation, socio-economic status, age, physical abilities, religious beliefs, political beliefs, or other ideologies. 42.9%

Diversity is the range of human differences, including but not limited to race, ethnicity, gender, gender identity, sexual orientation, age, language, social class, physical ability or attributes, religious or cultural. beliefs/practices, national origin, immigration status, and political beliefs. 51.4%

¹ Some respondents chose more than one definition, resulting in a cumulative total greater than 100%.

Following the definition of diversity, participants were asked if they believed DV survivors were receiving services that met diverse needs based on their chosen definition. Results are shown in Figure 2. Over 50% of participants disagreed that DV survivors were receiving services that met diverse needs based on their understanding and definition of diversity.



Figure 2. Percentage of Respondents Who Believe DV Survivors Are Receiving Diverse Services

3.3 Inclusion

Participants were asked to choose a definition of inclusion that made the most sense to them. The results are shown in Table 3. The most frequent understanding of inclusion (52.9%) was: “Inclusion promotes and sustains a sense of belonging; it values and practices respect for the talents, beliefs, backgrounds, and ways of living of its members.”

Table 3. Defining Inclusion

Definition of Inclusion	Percentage of Respondents ¹
Inclusion is the idea that everyone should be able to use the same facilities, take part in the same activities, and enjoy the same experiences.	7.1%
Inclusion is the action or state of including or being included within a group or structure ... inclusion involves an authentic and empowered participation and a true sense of belonging.	18.6%
Inclusion is involvement and empowerment, where the inherent worth and dignity of all people are recognized.	28.6%
Inclusion promotes and sustains a sense of belonging; it values and practices respect for the talents, beliefs, backgrounds, and ways of living of its members.	52.9%

¹ Some respondents chose more than one definition, resulting in a cumulative total greater than 100%.

Following the definition of inclusion, participants were asked if they believed DV survivors were receiving services that were inclusive based on their chosen definition. Results are shown in Figure 3. Over 50% of participants disagreed that DV survivors were receiving services that were inclusive based on their understanding and definition of inclusion.

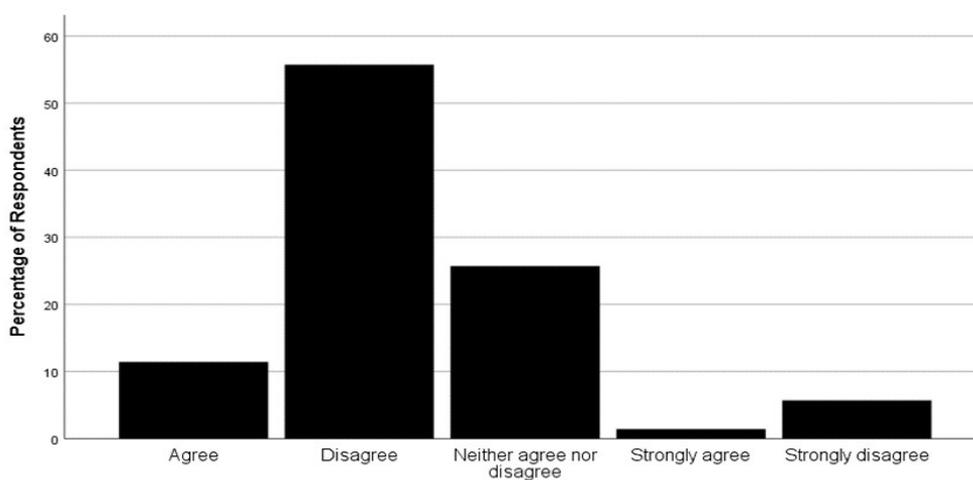


Figure 3. Percentage of Respondents Who Believe DV Survivors Are Receiving Inclusive Services

3.4 Barriers to Inclusive Services

Participants were asked to indicate the barriers they face when providing DV services that are fully

inclusive. Results are shown in Figure 4. The most frequent barrier to providing inclusive services was a lack of cultural considerations (73%), followed by a lack of cultural competency training (71%) and financial barriers (71%).

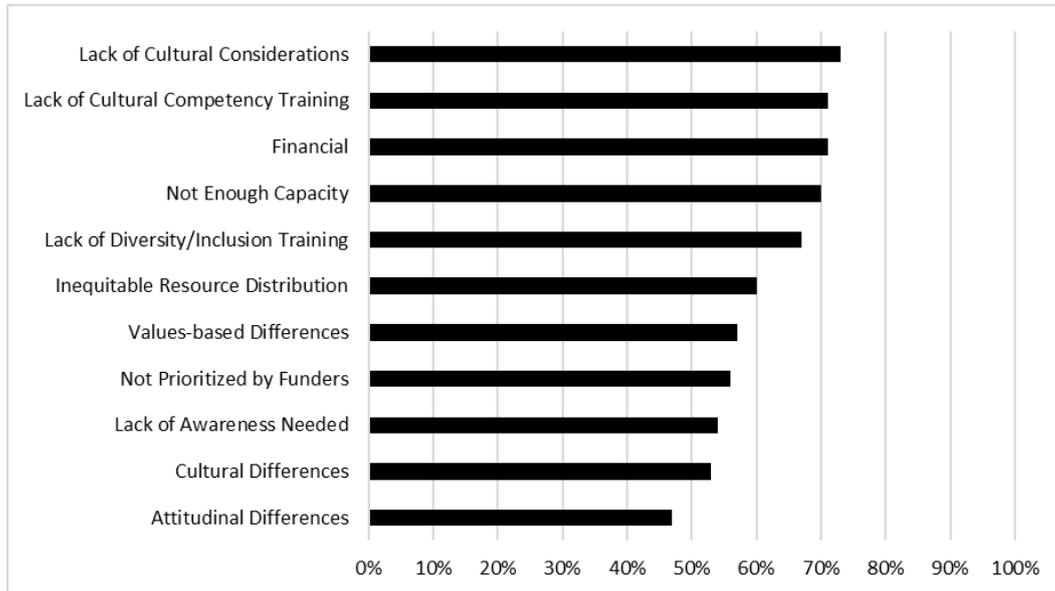


Figure 4. Barriers to Inclusive Service Delivery Identified by Participants

3.5 Solutions for Barriers to Inclusive Delivery

Participants were asked to indicate what they think is needed for service delivery to be more inclusive. Results are shown in Figure 5.

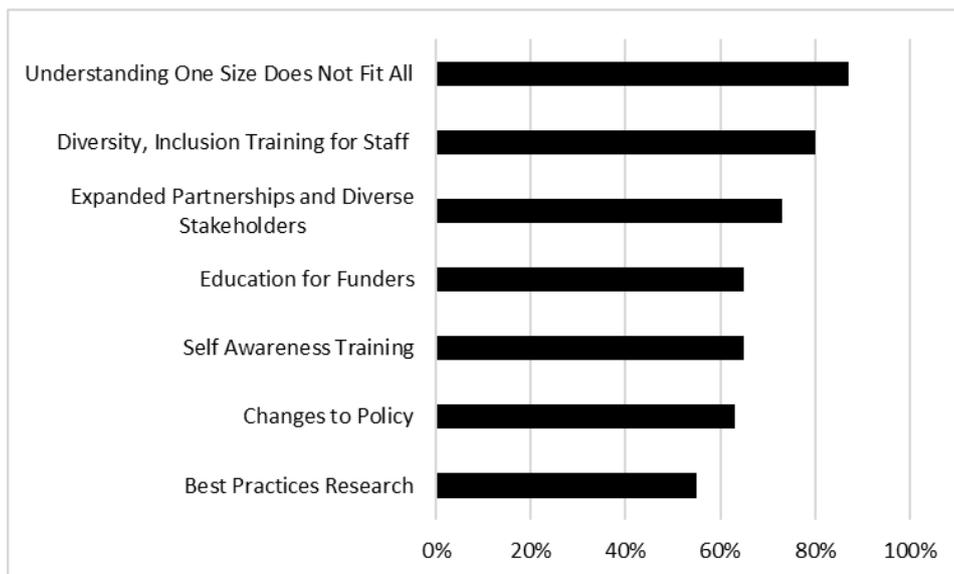


Figure 5. Solutions to Barriers to Inclusive Service Delivery Identified by Participants

87% of respondents identified understanding that one size fits all services do not work for everyone as a solution to providing inclusive service delivery.

“I think we need to [be] mindful of whose experiences are chronically marginalized by one-size-fits-all and more passive (the people who show up are the people who care) approaches. I think for inclusion to be meaningful the process needs to be active, reflexive, ongoing, and likely uncomfortable as biases and assumptions always need to be checked.”

80% of respondents identified diversity and inclusion training (including oppression, racism, social justice, and discrimination) as essential for inclusive service delivery, while 65% identified the need for self-awareness training and training for funders. Responses to survey questions around building inclusive service delivery for DV survivors included ongoing education and training for staff around cultural competency and anti-racism. Suggestions included lunch and learns, increasing training opportunities, acknowledging other cultural groups, and having community members speak about their experience.

“Inclusion programs/lunch and learns to increase diversity and inclusion training.”

“Having members of the specific cultural community speak about the issues helps to break down stigma. Having members of the community who have an understanding of cultural norms work in health care program settings adds a level of understanding and comfort for the victim that is difficult for a worker to attain through short-term training/education.”

“Anti-racist training, learning about colonial violence in Canada.”

“Racial bias needs to be mandatory policy.”

73% of respondents identified expanded partnerships and stakeholder diversity as necessary for service delivery to be more inclusive. Responses to survey questions included systems/sector partners, specific subgroups, funders, and community to help build awareness, reduce silos, and build capacity through cross-training. The most common answer for expanded partnerships included ethno-cultural communities and service providers within the immigrant sector to ensure DV organizations have access to people with expertise in immigration/settlement, translation, and cultural sensitivity and awareness. Expanded partnerships with funders was suggested as another way to help build capacity, suggesting cost-free capacity building training opportunities for the organizations they fund. Finally, community partners were described as people with lived experience, in terms of formal and authentic engagement with those that have survived violence to inform decision making. A suggestion was also made to enhance public awareness and reduce stigma by engaging the community at large in discussions and debates about violence.

“Partnerships with accountability and shared vision that remains agile and adapts to the demand. United leadership around these partnerships that is involved and responsible. More inter-agency communication and information sharing in the best interest of the client/family. Building relationships with service providers and organizations so there is the trust and ability to work together for a client/family.”

“Expanding partnerships to support 'by and for' services - recognizing that communities know themselves best and cultural competency means supporting the voices of communities rather than speaking for them.”

“Having members of the specific cultural community speak about the issues helps to break down stigma. Having members of the community who have an understanding of cultural norms work in health care program settings adds a level of understanding and comfort for the victim that is difficult for a worker to attain through short-term training/education.”

63% of respondents identified the need for policy changes while 55% identified the need for more research on best practices. It was suggested that organizational policies should be in place to address procedures such as hiring, trauma-informed care, and cultural competency training while putting more accountability on the perpetrators.

“The theoretical frameworks in place to develop programs for issues such as domestic abuse are also based on principles that were not developed considering cultural/value differences. It is often difficult to develop tailored programs when the basis/literature supporting these programs itself is not culturally competent or exhaustive. It may be necessary to take several steps back to work towards culturally competent and effective programs addressing domestic violence.”

“Values based interviewing so that staff members that do not value diversity and inclusion are not hired.”

“Trauma Informed Service Delivery. Understanding trauma impacts all individuals in DV sector in various ways.”

“Policy change needs to include a recognition of the impacts of inequity on communities, the length of time and the amount of resources required to deal with those inequities and the way those inequities intersect with the issue of domestic violence.”

“Policies need to focus on holding the perpetrator accountable for family violence, and not the victim. We need to grow collaborations between mainstream and ethnocultural communities, to ensure our practices are inclusive.”

4. Discussion

There was limited consensus over how equity, diversity, and inclusion are defined; however, regardless of the definition, participants overwhelmingly agreed that service provision was not equitable, diverse, or inclusive. Furthermore, workers identified a lack of cultural considerations and cultural competence as the most significant barriers to providing inclusive services. These results suggest there is a disconnect between how equity, diversity, and inclusion are defined and understood versus putting these concepts into meaningful and concrete action. This finding is timely as there has recently been an influx of organizational statements and responses to systemic racism and discrimination, and yet time will tell if organizations remain committed to their response by taking concrete actions to embed equitable practices into organizational policies. Future research could evaluate if and how organizations

can be held accountable to their responses on equity, diversity, and inclusion, and explore if those who experience racism and discrimination experience fundamental changes in the care they receive.

4.1 Education and Training

When respondents were asked to expand on practices they believed should be adopted for inclusive service delivery, they overwhelmingly responded with the need for ongoing education, training, and action on cultural competency. Although agencies may already have cultural competency training in place, many tools lack the substance or analysis needed for individual's to truly understand the complex interconnectedness of power systems and structures and the impact these systems have on people of different ethnicities, races and cultures (Bent-Goodley, 2007; Warriar, 2005). Without cultural competence, the experiences of different groups are ignored, dismissed, and invalidated, resulting in care that is incomplete, unethical, and ineffective (Warrior, 2005). Cultural competence must not simply be a one-time mandatory training session. Instead, cultural competency must be acknowledged as an active, ongoing learning process that really challenges and shifts one's thoughts, assumptions, and prejudices around power and culture when survivors are seeking DV support services (Warrior, 2005). In fact, without an analysis of one's thoughts and assumptions, there is a danger that cultural competency training will further instill a sense of the "other", position "culture" as only for ethnic minorities, achieving complete competence of a different culture, and ignore the need to address humanity and actively transform inequalities (Fisher-Borne, Cain, & Martin, 2014). Some researchers argue for cultural humility rather than cultural competence as cultural humility critiques and mitigates power imbalances, requires critical reflection and lifelong learning, and demands accountability from both individuals and organizations to address social inequity (Fisher-Borne, Cain, & Martin, 2014). Future studies could examine if focusing on cultural humility rather than cultural competency significantly shifts the way DV services are understood and put into practice. Furthermore, future studies could explore how organizations can embrace the principles of cultural competency as a foundation and framework for all their policies and practices while determining how both practitioners and organizations can be held accountable to these principles. Accountability is key in providing ongoing services that are fully and authentically inclusive and must be built into organizational procedures and practices.

4.2 Expanded Partnerships and Diverse Stakeholders

For DV services to be fully inclusive, expanded partnerships and collaboration with diverse stakeholders must be prioritized. Responses included formalizing partnerships with ethno-cultural communities and agencies to help reduce stigma, build cultural awareness, reduce silos, bridge service gaps and ensure access to those who have expertise in cultural sensitivity and protocols. Other suggestions included more interagency communication and building formal and authentic relationships with community members who have lived experience. Additionally, organizations within the DV sector must develop strategies to formalize partnerships outside of the DV sector such as mental health agencies to allow for seamless referral and shared service delivery between providers. These findings

support the research that suggests DV service providers must engage and collaborate with partners to ensure the interdisciplinary complexities of DV survivors are acknowledged and addressed (Bent-Goodley, 2007). Furthermore, collaboration with the community ensures diverse voices and perspectives are heard while ensuring individuals with lived experiences of DV are informing program response and delivery provision (Perilla, Serrata, Weinberg, & Lippy, 2012). As Warrier (2005) says, “It is essential to reach out to, work with, and collaborate with different communities and encourage contradictory and diverse perspectives from a variety of people and resource. One voice cannot speak or represent any particular group of people” (p. 541). Approaching DV service provision as a collective, rather than individual agencies, ensures multiple experiences, voices, and perspectives are informing policy and procedures that are appropriate, while ensuring that when DV survivors are seeking out support, they are able to receive care and resources that are highly respectful of their own unique journey and support them in the best way possible. Future research could explore if expanded agency partnerships result in care to DV survivors that is more equitable while mitigating the barriers they face when trying to receive supports are fully inclusive.

4.3 Policy and Best Practices

Agency policies, processes, and best practices must be tailored to better account for the complexity of DV survivors’ experiences. Responses to the questions specific to policy changes included mandating cultural competence and refining hiring guidelines. As mentioned previously, cultural competence training is crucial to ensure all staff are engaging in the process of deepening their understanding around the complexities of DV survivors’ experiences and reasons for seeking or not seeking support. Thus, policies must ensure cultural competence be integrated at all levels of DV service provision including re-examining the appropriateness of service access, screening, assessment, evaluation, and intervention tools (Bent-Goodley, 2005). Some tools and measurement scales may not be culturally appropriate for all DV survivors and adapting these practices to support all individuals will help break down the barriers some feel. Not only does cultural competence need to be integrated, it is important to find ways to evaluate the efficacy of cultural competence integration (Bent-Goodley, 2005). Authentic cultural competence fosters a critical exploration of one’s thoughts and actions and encourages the willingness to be open to others’ experiences and perspectives. Cultural competence is not a fast, quick solution to address gaps in equity, diversity, and inclusion; therefore, ongoing evaluative efforts of policy to practice need to be in place to help highlight what is working and what is not. This evaluative component may help individuals and organizations shift towards a place of cultural humility that is deeply ingrained in both policy and practice. Future research should explore how cultural competence can be measured and evaluated while establishing ways in which individuals and agencies can be held accountable. Furthermore, more research is required to understand how cultural competency and cultural humility vary and if there are significant differences in service provisions when providing one over the other. With regards to hiring practices, agencies must ensure their hiring policies are reflective of the equitable, diverse, and inclusive services they aim to provide. Hiring staff from diverse

backgrounds, ethnicities and cultures ensures that diverse voices are represented (Kasturirangan, Krishnan & Riger, 2004). For example, language can be a barrier for those seeking support, interpretation and translation are essential services to support survivors to articulate their needs and experience. Having staff members who speak the language can help a survivor feel understood and emotionally supported. Not only does hiring diverse staff members help ensure DV survivors are receiving inclusive care, research suggests those with lived experience must be included within the development of organizational policy and practices (Klingspohn, 2018). As experts with lived experience, hiring staff members from diverse backgrounds with personal experience helps ensure their expertise is informing and guiding the provision of equitable services.

4.4 Limitations

This study was limited by the use of surveys which can be open to interpretation and/or subject to bias while limiting the range of responses from participants (Simon & Goes, 2013). Although respondents were invited to expand on their thoughts about barriers and solutions to equitable, diverse, and inclusive service delivery, focus groups or interviews may have garnered a deeper engagement and understanding with these ideas. Similarly, much of the literature is not reflective of the full spectrum of services that are needed to respond to the intersections of culture and race, limiting the knowledge around providing services that are equitable and inclusive. Furthermore, the literature is largely centered around cultural competency and awareness, with little focus on ethical spaces, safety, and cultural humility.

5. Conclusions

Responding to the intricate experiences of DV survivors requires the provision of services that acknowledge and address the intersecting barriers of diverse identities. Barriers to equitable DV services include service gaps, a lack of consensus on what diversity, inclusion, and equity are, and a lack of awareness around cultural considerations and cultural competence within all levels of organizations. These barriers can be addressed by ongoing education and training on cultural competence and cultural humility, engaging with community members and agencies to foster deeper relationships and expanded partnerships, engaging in meaningful discussions to explore how current DV service provision works or does not work for their community. Future research should explore how accountability for true cultural competence and cultural humility can be implemented as the foundational framework for diversity, equity and inclusion within the DV sector.

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References

- Aboriginal and Torres Strait Islander Social Justice Commissioner. (2011). *Social justice report*. Retrieved from https://www.humanrights.gov.au/sites/default/files/content/social_justice/sj_report/sjreport11/pdf/sjr2011.pdf
- Anderson, T. R., & Aviles, A. M. (2006). Diverse faces of domestic violence. *ABNF Journal*, 5.
- Barrett, K., George, W. H., & George, W. (2005). *Race, culture, psychology, and law*. SAGE.
- Bell, C. C., & Mattis, J. (2000). The importance of cultural competence in ministering to African American victims of domestic violence. *Violence Against Women*, 6(5), 515-532. <https://doi.org/10.1177/10778010022182001>
- Bent-Goodley, T. B. (2005). Culture and domestic violence. *Journal of Interpersonal Violence*, 20(2), 195-203. <https://doi.org/10.1177/0886260504269050>
- Bent-Goodley, T. B. (2007). Health disparities and violence against women: Why and how cultural and societal influences matter. *Trauma, Violence, & Abuse*, 8(2), 90-104. <https://doi.org/10.1177/1524838007301160>
- Bhuyan, R., & Senturia, K. (2005). Understanding domestic violence resource utilization and survivor solutions among immigrant and refugee women: Introduction to the special issue. *Journal of Interpersonal Violence*, 20(8), 895-901. <https://doi.org/10.1177/0886260505277676>
- CDVC (Calgary Domestic Violence Collective). (2019). *About domestic violence*. Retrieved from <http://cdvc.ca/about-domestic-violence>
- Fisher-Borne, M., Cain, J. M., & Martin, S. L. (2014). From mastery to accountability: Cultural humility as an alternative to cultural competence. *Social Work Education*, 34(2), 165-181. <https://doi.org/10.1080/02615479.2014.977244>
- Government of Newfoundland and Labrador. (2018, May). *Defining violence and abuse*. Retrieved from <https://www.gov.nl.ca/VPI/types>
- Kasturirangan, A., Krishnan, S., & Riger, S. (2004). The impact of culture and minority status on women's experience of domestic violence. *Trauma, Violence, & Abuse*, 5(4), 318-332. <https://doi.org/10.1177/1524838004269487>
- Klingspohn, D. M. (2018). The importance of culture in addressing domestic violence for First Nation's women. *Frontiers in Psychology*, 9. <https://doi.org/10.3389/fpsyg.2018.00872>
- Latta, R. E., & Goodman, L. A. (2005). Considering the interplay of cultural context and service provision in intimate partner violence: The case of Haitian immigrant women. *Violence Against Women*, 11(11), 1441-1464. <https://doi.org/10.1177/1077801205280273>
- Lightfoot, E., & Williams, O. (2009). The intersection of disability, diversity, and domestic violence: Results of national focus groups. *Journal of Aggression, Maltreatment & Trauma*, 18(2),

- 133-152. <https://doi.org/10.1080/10926770802675551>
- Lockhart, L., & Danis, F. (2010). *Domestic violence: Intersectionality and culturally competent practice* (Foundations of social work knowledge). New York: Columbia University Press.
- Mackenzie, C., Rogers, W., & Dodds, S. (2014). *Vulnerability: New essays on feminist philosophy*. Oxford University Press; Oxford. <https://doi.org/10.1093/acprof:oso/9780199316649.001.0001>
- Magnussen, L., Shultz, J., Richardson, K., Oneha, M. F., Campbell, J. C., Matsunaga, D. S., ... Arias, C. (2011). Responding to the needs of culturally diverse women who experience intimate partner violence who experience intimate partner violence. *Hawaii Medical Journal*, 70(1), 9-15.
- Martinson, L. M. (2001). An analysis of racism and resources for African-American female victims of domestic violence in Wisconsin. *Wisconsin Women's Law Journal*, 16, 259-286.
- Munro, S. (2005). Beyond male and female; Poststructuralism and the spectrum of gender. *International Journal of Transgenderism*, 8(1), 3-22. https://doi.org/10.1300/J485v08n01_02
- Nnawulezi, N. A., & Sullivan, C. M. (2014). Oppression within safe spaces. *Journal of Black Psychology*, 40(6), 563-591. <https://doi.org/10.1177/0095798413500072>
- Perilla, J. L., Serrata, J. V., Weinberg, J., & Lippy, C. A. (2012). Integrating women's voices and theory: A comprehensive domestic violence intervention for Latinas. *Women & Therapy*, 35(1-2), 93-105. <https://doi.org/10.1080/02703149.2012.634731>
- Pyles, L., & Kim, K. M. (2006). A multilevel approach to cultural competence: A study of the community response to underserved domestic violence victims. *Families in Society*, 87(2), 221-229. <https://doi.org/10.1606/1044-3894.3515>
- Stanhope, M., & Lancaster, J. (2014). *Foundations of nursing in the community: Community-oriented practice*. Elsevier Health Sciences.
- Senturia, K., Sullivan, M., Ciske, S., & Shiu-Thornton, S. (2000). *Cultural issues affecting domestic violence service utilization in ethnic and hard to reach populations*. Retrieved from https://www.kingcounty.gov/depts/health/data/~/_media/depts/health/data/documents/cultural-issues-domestic-violence-november-2000.ashx
- Simon, M. K., & Goes, J. (2013). *Scope, limitations and delimitation. Dissertation and Scholarly Research: Recipes for Success*. Seattle, WA: Dissertation Success LLC.
- Warrier, S. (2005). *Culture handbook*. Retrieved from <http://www.futureswithoutviolence.org/userfiles/file/ImmigrantWomen/Culture%20Handbook.ppt>
<https://doi.org/10.1037/e601642012-001>
- Whitaker, D. J., Baker, C. K., Pratt, C., Reed, E., Suri, S., Pavlos, C., ... Silverman, J. (2007). A network model for providing culturally competent services for intimate partner violence and sexual violence. *Violence Against Women*, 13(2), 190-209. <https://doi.org/10.1177/1077801206296984>