Advances in Nursing Science
Vol. 34, No. 3, pp. E29–E51

Theories of Intimate Partner Violence: From Blaming the Victim to Acting Against Injustice

Intersectionality as an Analytic Framework

Ursula A. Kelly, PhD, MSN, ANP-BC, PMHNP-BC

Intimate partner violence (IPV) has garnered increasing public and academic attention in the past several decades. Theories about the causes, prevention, and intervention for IPV have developed in complexity. This article provides an overview of the historical roots of IPV, as well as a description and critique of historical and contemporary theories of IPV causes and women's responses to IPV. This is followed by a discussion of the most current theoretical developments and application of critical theories to the problem of IPV. The article concludes with theoretically based implications for nursing practice and research with women who are experiencing IPV. **Key words:** *critical theory*, *domestic violence*, *feminist intersectionality*, *intersectionality*, *intimate partner violence*, *nursing*, *nursing theory*, *social action*, *social justice*, *theory development*, *violence against women*

IN THE 40 YEARS or so since abuse and violence in intimate relationships came into the public eye, scholarship and lay discourse about this problem have increased dramatically. Intimate partner violence (IPV), previously considered a private matter between 2 adults, became recognized as a complex sociocultural problem and public health epidemic. Social activists and scholars in many disciplines continue to develop new and increasingly complex understandings of the causes of IPV and women's responses to being abused by an intimate partner. This article first provides an overview of the historical roots and scope of IPV. This is followed by a description and critique of historical and contemporary theories of IPV causes and women's responses to IPV, as well as a discussion of the most current theoretical developments and applications of critical theories to the problem of IPV. The article concludes with theoretically-based implications for practice and research with women who are being abused by an intimate partner.

The current state of theoretical and clinical knowledge about IPV includes an understanding of the inextricable link between IPV and other forms of violence against women (VAW). Contemporary theories of IPV apply to multiple forms of VAW; most women who experience IPV experience other forms of

Author Affiliation: *Atlanta VA Medical Center, Atlanta, Georgia; Emory University Nell Hodgson Woodruff School of Nursing, Atlanta, Georgia.*

This paper is a revision of a previously published book chapter; copyright permission obtained.

Kelly UA, Gonzalez-Guarda RM, Taylor JY. Theories of intimate partner violence. In: Humphreys J, Campbell JC, eds. Family Violence and Nursing Practice. *2nd ed. New York, NY: Springer Publishing Co; 2011:51-89.*

The author has disclosed that she has no significant relationships with, or financial interest in, any commercial companies pertaining to this article.

Correspondence: *Ursula A. Kelly, PhD, MSN, ANP-BC, PMHNP-BC, Emory University, Nell Hodgson Woodruff School of Nursing 1520 Clifton Rd. NE, Atlanta, GA 30322 (ukelly@emory.edu).*

DOI: 10.1097/ANS.0b013e3182272388

gender-based violence in their lifetime. Therefore, this article incorporates information and analyses of the causes of VAW beyond IPV.

IPV DEFINITION AND SCOPE

Intimate partner violence encompasses a variety of behaviors within adult intimate relationships. The Centers for Disease Control and Prevention definition of IPV can be summarized as follows: threats or intentional use of physical violence, sexual violence, or both with the potential to cause injury, disability or death; or psychological/emotional abuse, coercive tactics, or both when there has been prior physical violence, sexual violence, or both perpetrated by a current or former spouse or nonmarital partner, for example, dating, boyfriend, or girlfriend.[1] The World Health Organization's (WHO) definition of IPV does not necessitate the presence of physical or sexual violence in addition to psychological violence: "As well as acts of physical aggression such as hitting or kicking, violence by intimate partners includes forced intercourse and other forms of sexual coercion, psychological abuse such as intimidation and humiliation, and controlling behaviors such as isolating a person from family and friends or restricting access to information and assistance."[2(p24)]

Most reported IPV prevalence rates include physical and sexual violence only.[3,4] However, more recently, IPV researchers have included psychological abuse as they recognize its pervasive nature, severity, and harmful effects.[5] In the United States, most population-based estimates of lifetime physical and sexual IPV prevalence among women range from 1.9% to 70%, typically between 25% and 35%.[6] Among women worldwide, prevalence rates range from 15% to 71%, with most results between 30% and 60%.[3] Rates of past year IPV against women range from 1.8% to 14% in population-based studies and up to 44% in health care settings, although most reports of prevalence in health care settings are between 10% and 23%.[5] Data from 2001 to 2005 gathered in the National Violence Against Women Survey include nonfatal IPV prevalence rates of 21.5% and 3.6%, among women and men, respectively.[4] In this same study, intimate partner rape was reported by 7.2% of women versus 0.8% of men. Approximately two-thirds of nonfatal IPV assaults occurred at home for both women and men.[4]

Similar to research reports of the prevalence of IPV in heterosexual relationships, reports of IPV in lesbian and gay male relationships have a wide range, from less than 10% to more than 50%. Overall, available data suggest that the rates of IPV among heterosexual and same-sex couples are roughly equal, but that the prevalence of IPV among male same-sex couples is significantly higher than among female same-sex couples.[7]

The United States has the highest level of intimate partner homicide of any industrialized country.[2] From 2001 to 2005, intimate partners committed 30.1% of homicides of women and 5.3% of homicides of men.[4] The percentage of IPV-related femicide is even higher (40%–50%) when ex-boyfriends are included among perpetrators.[8]

HISTORICAL ROOTS OF IPV AND VAW

Intimate partner violence and other forms of VAW have existed as acceptable social norms and behaviors for centuries; they continue to be condoned and even legally sanctioned in many societies. A fundamental aspect of current cultural support for abusing women is embedded in the historical and contemporary context of the many forms of VAW that operate to maintain the patriarchal structure of most societies. bell hooks described the relationship between patriarchy and VAW when she observed that domestic violence is:

> inextricably linked to all acts of violence in this society that occur between the powerful and the powerless, the dominant and the dominated. While male supremacy encourages the use of abusive force to maintain male domination of women, it is the Western philosophical notion of hierarchical rule and coercive authority that is the root cause of

violence against women, of adult violence against children, of all violence between those who dominate and those who are dominated.[9(p118)]

This analysis of power dynamics allows us to better see the foundations upon which oppression is grounded. Isolated acts of female intimate partner abuse do not keep our society sexist, but when the acts are multiplied and coupled with the frightening incidence of rape, homicide of women, and genital mutilation and joined with the historical precedents of suttee, witch-burning, foot-binding, mutilating surgery, and female infanticide, the power of patriarchy can be seen as ultimately based upon violence.

The Bible provides the earliest written prescription for the physical punishment of wives. *Deuteronomy 22:13-21*[10] lists a law condemning brides to death by stoning if unable to prove virginity.[11] By medieval times, the widespread nature of wife-beating had been documented in several ways. In Spanish law, a woman who committed adultery could be killed with impunity. In France, female sexual infidelity was punishable by beating, as was disobedience. Italian men punished unfaithful women with severe flogging and exile for 3 years.[12] The close of the Middle Ages saw the rise of the nuclear family along with the development of modern states and the beginning of capitalism, all of which eroded the position of women and strengthened the authority of men. The basic unit of production moved outside of the family, and for the first time wages were paid for work on a regular basis. Domestic work performed by women received no wages and therefore became devalued.

The "witch-hunts" in Western Europe from the 1500s to the 1700s represent 1 of the best documented forms of systematic VAW. Though the actual number of women murdered can never be known, authoritative estimates range from 200 000 to 9 million, often by hanging or burning, as punishment for their perceived healing abilities, which were assumed to have been acquired through "consorting with Satan."[13] Feminist analysis of this practice is that the main crime of the women involved was a lack of submission to the stereotyped role of the subservient medieval woman.

During the same time period as the witch burnings in Europe, the practice of suttee, or inclusion of the widow and concubines in the man's funeral pyre, was being carried out in India. Cultural beliefs held the widow to blame for the man's death, if not during her present life, then in her past ones. During the Reformation, the common saying of the times was, "Women, like walnut trees, should be beaten every day."[11(p14)] Throughout the 17th, 18th, and 19th centuries in the Western world, there was little objection to a husband using force as long as it did not exceed certain limits.

Western medicine in the late 19th century used the surgical procedures of clitoridectomy, oophorectomy, and hysterectomy to "cure" masturbation, insanity, deviation from the "proper" female role, heightened sexual appetites, and rebellion against husband or father. Control of reproductive rights, and the development and use of particularly risky and permanent methods of contraception, for example, Norplant and antifertility "vaccines," have come into question as part of an ongoing pattern of discrimination against women, especially poor women and women of color.[14]

Violence against women in the United States began with its founding on the equal rights of white men, not of women (and not of persons of color). The English law that upheld the husband's right to employ moderate chastisement in response to improper wifely behavior was used as a model for American law. In 1824, the state of Mississippi legalized wife-beating, and in 1886, a proposed law for punishment of husbands who beat their wives was defeated in Pennsylvania. North Carolina passed the first law against wife-beating, but the court pronounced that it did not intend to hear cases unless there was permanent damage or danger to life.[11] It was legal for men to rape their wives in every state in the United States until the early 1970s. Laws preserving the legality of marital rape were common in

the United States until the late 1980s and early 1990s. While there has been a clear cultural shift in the United States in the past 2 decades away from viewing domestic violence as acceptable and as a private matter, IPV continues to be an epidemic worldwide.[2]

CONTEMPORARY FORMS OF VAW

IPV: who does what to whom and how

Intimate partner violence occurs in all kinds of intimate relationships: heterosexual and same-sex relationships, committed and dating/casual relationships of adults and adolescents, and current and terminated relationships. Most commonly, men are the perpetrators and women are the victims, though women can be perpetrators and IPV can be bilateral, meaning both partners are violent. The use of severe violence and control, called "intimate terrorism," is more often perpetrated by men with more severe injuries inflicted on women than vice versa.[15,16] Low-level violence between intimate partners is often more bilateral and less often includes forced sex and controlling behaviors.

The kind of IPV that is seen in domestic violence shelters, the criminal justice system, among women with mental health problems related to IPV, and in emergency departments is primarily directed toward women, is severe and is characterized by coercive control. In addition, in nonemergency health care settings, for example, clinics, in-patient units, community settings, and schools, many patients are experiencing less visible but not necessarily less severe IPV, that is, psychological and emotional abuse, and less severe injuries for which they may not have sought formal assistance.

Battering has been defined as a pattern of deliberate and repeated physical aggression, sexual assault, or both inflicted on a woman within a context of coercive control by a man with whom she has or has had an intimate relationship. Although it is true that in some small proportion of cases a woman may be the primary perpetrator of battering against a male partner, the preponderance of evidence suggests that the incidence is very low.[4]

The concept of coercive control refers to the variety of strategies used by the abusive partner to keep the woman fearful of future harm to herself and her children, and, in fact, even doubtful of her own reality. Examples of controlling strategies include emotional and verbal abuse, restriction of her contact with others (social isolation), controlling her personal and household finances (economic abuse), and using coercive, intimidating, and threatening behaviors. These controlling behaviors are depicted in the "Power and Control Wheel" developed by the Duluth, Minnesota, Domestic Abuse Intervention Project, which is widely used as part of a curriculum for intervention with batterers and victims of IPV and in public and professional education literature (http://www.theduluthmodel.org/wheelgallery.php).

Research on the dynamics of IPV in same-sex couples is minimal. However, several researchers have challenged a reliance on heterosexually gendered theoretical and empirical analyses of IPV power dynamics in research with same-sex couples, particularly lesbian couples, arguing instead for analyses that consider the power dynamics of intersecting identities (race, socioeconomic status, age, disability, and sexual orientation) and minority stress.[17,18]

Violence against women takes many forms

Female infanticide, homicide of women, and genital mutilation are 3 forms of violence directed at females that are rooted in history and continue today. They are found in their most blatant forms in societies that rigidly adhere to male dominance. Because of the higher life expectancy of females, the proportion of women in the population should be higher than men; however, world population statistics show that the male population exceeds that of females. The worldwide male/female ratio is 102/100, with 105 male births for every 100 female births.[19] This

imbalance is highest in Arab and Islamic countries and India, with the United Arab Emirates having the highest male/female ratio of 205/100.[19]

India and Arabic and Islamic nations also practice "honor killings," murder committed by male family members against female family members who are perceived to have brought dishonor upon the family, either through "dishonorable acts," including divorce, premarital sex, or herself being the victim of a sexual assault or rape, or even because of rumor of impropriety. While data on honor killings are difficult to obtain, it is estimated that worldwide 5000 women are killed each year for "honor." For example, in 2008 in Afghanistan alone, there were 96 cases of so-called honor killings.[20]

Female genital mutilation, also called "cutting" and abbreviated as "FGM" or "FGM/C" is defined by the WHO as all procedures involving partial or total removal of the external female genitalia or other injury to the female genital organs for nonmedical reasons; it is considered a human rights violation.[21] Female genital mutilation/cutting is widespread in much of East, West, and Central Africa, in parts of the Middle East, and in certain immigrant communities in North America and Europe. The serious health consequences are both immediate and long-term. Between 100 and 140 million girls and women in the world have undergone FGM/C, and 3 million girls in Africa are considered at risk for FGM/C annually.[21] Female genital mutilation/cutting is deeply entrenched in inequitable social and political structures. In areas where FGM/C is widely practiced, it is supported by both men and women, reflecting the extreme social pressure to conform or risk ostracism and other social disadvantages.[21] International political and grassroots efforts, in addition to the work of the WHO and other nongovernmental organizations over the past few decades, are gradually increasing support for the abolition of FGM/C.

Rape is a well-known form of VAW and takes many forms: sexual abuse of children, gang rape, forced intercourse with wives, sexual torture of female prisoners, intercourse with therapists, forced sexual initiation, bride capture and group rape as a puberty rite, sexual assault during military service by fellow soldiers, as well as sexual assault on a female by an unknown male. In the United States, more than half of the women who are raped are younger than 18 years; more than two-thirds of female rape victims are raped by someone they know.[4] Rape is a crime of violence, not sex, and has long been used as systematic weapon of war. Recent systematic uses of rape as a war strategy and a form of genocide occurred in the former Yugoslavia (mainly in Bosnia and Kosovo) and in civil wars in Rwanda, Liberia, and Uganda. The United Nations estimated that a quarter of a million women were raped as part of the 1994 Rwandan genocide.[22]

Sex trafficking of women and children has existed for centuries, but has garnered public attention only recently. Sex trafficking, or human trafficking for the purposes of sexual exploitation, occurs internationally, as well as into and within the United States, primarily from Southeast Asia, the former Soviet Union and Latin America. Like other forms of sexual VAW, the physical and mental health consequences of sex trafficking are profound and long-lasting.

THEORETICAL FRAMEWORKS

Scholarly attention to IPV has increased exponentially in the past 3 decades as public and private funds have been allocated for research, education, treatment services, and prevention programs. Many theories have been offered to explain the social structures, cultural traditions, and personal behaviors that create and perpetuate abuse and violence. Feminist critiques remind us that focusing exclusively on individual and couple dynamics fails to explain why so many women are abused by their intimate partners. Additional important critiques of existing theoretical frameworks have come from those who point out their questionable

relevancy to persons of racial and ethnic minority groups and those exposed to other systems of oppression, such as heterosexism, classism, ageism, ableism, and religion/spirituality-based oppression.[23-25]

Only recently have researchers and policy makers begun to explore the adequacy of theories of IPV when applied to persons of color, and even less so to persons with disabilities. Ethnicity shapes the experience and interpretation of IPV in myriad ways, including culturally-based family structures and subordinate roles for women. Women with disabilities' experiences of IPV are uniquely colored by their impaired mobility, dependence on others for personal care, and physical and social isolation.[25] The poverty experienced by persons of racial and ethnic minorities and persons with disabilities in the United States clearly complicates women's experiences, particularly in terms of unequal access to health and social resources and financial independence.[24] Recent efforts to integrate research findings and theoretical explanations from many disciplines hold promise in our search for theories that help us explain, predict, ameliorate, and ultimately prevent IPV.

THEORIES OF THE CAUSES OF IPV

Historical theories

Theories of causation attempt to explain and predict the motivations, circumstances, and other factors that characterize individuals who perpetrate and are victims of abuse and violence within intimate relationships. Historically, frameworks for understanding the causes of IPV fall into one of several categories: (*a*) theories of psychopathology (eg, mental illness, substance abuse) of perpetrators and typologies of batterers, (*b*) theories of psychopathology of victims, (*c*) biological theories of aggressive and violent behavior, (*d*) family systems theories, and (*e*) social learning theories. A summary and critique of these theoretical approaches to IPV causation is provided in Table 1.

None of these theories fully explain why an individual perpetrates IPV. For example, although social learning theory proposes that aggression toward an intimate partner is a learned behavior that can be transmitted from generation to generation, not all children exposed to aggressive parents become perpetrators. Integration of scholarship from various disciplines led to more comprehensive and contemporary explanations for IPV, such as theories that describe gender-based inequities based on systems of oppression and power, and sociocultural models that draw from various traditional theories.

Contemporary theories

Early feminist theories

Second wave feminist theories of the causes of IPV, that is, those generated in the 1960s and 1970s, emphasize the need for power and control on the part of batterers and the societal arrangements of patriarchy and tolerance (not support for) of VAW that support individual abusers in considering this behavior as acceptable.[12,26] Historical and contemporary records of VAW associated with cultural norms of male ownership of women and lack of equal power relationships within families provide evidence that continues to support these feminist theories. Patriarchy, or male dominance, is established and maintained through male socialization to societal and cultural ideals of masculinity, that is, power and authority over women. The concept of machismo or compulsive masculinity can be found in psychological, sociological, and anthropological literature, and more recently in feminist scholarship and studies of masculinities,[27] all of which have influenced current thinking about gendered roles and gender-based violence.

In the past 2 decades, feminist scholars have developed theories that explain the ways in which power and oppression act in the lives of women along multiple social identities, for example, gender, race, class, age, disability, and sexuality. This "third wave" of feminist scholarship calls for social action to

Table 1. Historical Theories of the Causes of IPV

	Level of Focus	Explanations for IPV	Critique
Individual psychopathology	Perpetrator	Abusive behavior results from mood disorders (depression, anxiety), personality disorders (borderline, antisocial)	These disorders can involve aggression but they do not cause IPV nor explain how perpetrators' aggression is typically targeted toward intimate partners.
		Psychoneurological effects of brain injury and posttraumatic stress disorder	
	Victim	Abuse is deliberately provoked by women to meet their need for suffering (female masochism) or to benefit indirectly by being abused (secondary gain).	Blames the victim for IPV related to her pathology or ulterior motives.
Evolution	Perpetrator genetic or inherited predisposition	Extreme jealousy and violent male behavior date back to evolutionary forces to reproduce and pass along genes for survival of the species.	The majority of men do not exhibit violent behavior toward their intimate partners.
			IPV causes significant morbidity and mortality.
Alcohol and drug use	Perpetrator use	Serve as risk factors for IPV occurrence, more severe IPV, perpetrator reassault after intervention, and intimate partner femicide	Alcohol/drug use may potentiate abusive behaviors among perpetrators but do not cause the abuse.
		Leads to biochemical disinhibition whereby a person's usual voluntary behavior constraints are temporarily removed, resulting in aggression	Partners are not always intoxicated or impaired when abusive or abusive when they are intoxicated or impaired.
	Social norms	Socially unacceptable behaviors, for example, IPV, are rationalized by intoxication and are therefore tolerated.	

(*continues*)

Table 1. Historical Theories of the Causes of IPV (*Continued*)

	Level of Focus	Explanations for IPV	Critique
Family systems and family stress theories	Family members and their interactions	Family functioning, such as role expectations, communication patterns, and power status of family members are affected by the response and feedback of family members. Family violence is the result of behaviors of both perpetrator and victim; usually, all involved family members are culpable.	Minimizes the responsibility of the perpetrator and exaggerates the responsibility of the victim.
Social learning theory	Perpetrator individual learning	Abusive behaviors are learned by children during childhood; children observe and imitate the behaviors adults model for them.	Not all children who are exposed to abuse during childhood become abusive as adults; not all perpetrators were abused as children.
		As children grow, these behaviors are reinforced by society; for example, boys are taught to use aggression to cope with negative feelings.	Does not incorporate other risk or protective factors for IPV perpetration.

Abbreviation: IPV, intimate partner violence.

address the social injustices and inequities that power imbalances create and sustain. These theories are presented and applied to IPV later in this article.

Social cultural models

A multifactorial model of IPV, which combines elements of family systems theory, social learning theory, social structures, and cultural factors, was first developed by Murray Straus and his colleagues.[28] This social cultural model places family violence in the context of a high level of violence in our culture, the sexist organization of our society and family systems, and cultural norms legitimizing violence against family members. According to this model, family interactions inherently lead to violent behaviors, particularly due to the manifestation of these societal influences at the level of family structure, norms of parental behavior and childrearing, and individual interactions.[28] A summary and critique of these theories can be found in Table 2.

THEORIES OF WOMEN'S RESPONSES TO IPV

Historical theories

As IPV became publicly acknowledged, a common question in public and professional discourse was "Why does she stay?" Historically, this question about women's responses

Table 2. Contemporary Theories of the Causes of IPV

	Level of Focus	Explanations for IPV	Critique
Feminist theory: gender-based inequities	Social systems of power and oppression	Patriarchal societies, which support male domination and authority in family, social, and cultural systems, foster violence against women, particularly IPV, and threaten women's rights.	All systems of power and oppression are not based on gender, for example, racism, classism, ableism.
Socialization for masculinity	Social influence on boys/men	Boys are socialized for the male role from an early age. The ideal male is authoritative, has sexual prowess, is invulnerable, competitive, tough, brave, self-sufficient, and never discloses emotion.	Processes of male socialization vary within families and cultures. The majority of men do not perpetrate IPV. Positive male role attributes include protecting and providing for the family.
Social cultural model	Family member relationships within a broader societal context	Multifactorial model of IPV: combines elements of family systems theory, social learning theory, social structures, and cultural factors (norms). Family interactions within a social context of a highly violent culture, a sexist society and family systems, and cultural norms legitimizing violence against family members. The family is inherently at high risk for violence by virtue of the quantity and emotional intensity of interaction; the broad range of activities over which conflict can occur; the involuntary nature of family membership; the impingement of family members on each other's personal space, time, and lifestyles; and the assumption of family members that they have the right to try to change each other's behavior.	Does not fully account for the influence of the broader social context. Places significant responsibility for IPV on family dynamics; somewhat victim blaming.

Abbreviation: IPV, intimate partner violence.

to IPV has been addressed primarily from a psychopathological perspective, similar to historical theories of the causes of IPV. For the most part, these theories about women's responses take a victim-blaming stance through attributions of psychopathology.

Low self-esteem, various mental health problems, including symptoms of depression, posttraumatic stress disorder, and alcohol and drug abuse are strongly associated with IPV in women.[29] While these have often been presumed to be risk factors for IPV, a preponderance of evidence indicates that these problems are sequelae of the trauma of IPV rather than precursors to it. Mental health sequelae of IPV, particularly posttraumatic stress disorder, can lead to deficits in women's social functioning, which may impair their coping and problem solving abilities. The development of effective interventions to address symptoms of mental illness or psychological distress in women who have experienced IPV is an active area of research in nursing.

The theory of learned helplessness was applied in the late 1980s to battered women; as a result, abused women were considered deficient in motivational, cognitive and emotional skills. Women exposed to repeated abuse were seen as depressed, apathetic and without skills to leave the abusive relationship. The application of the theory of learned helplessness theory to IPV victims has been refuted by multiple nursing studies, which describe the proactive and skillful responses of women to IPV.

Contemporary theories

The past 3 decades of research have provided a robust description of the complexity and resourcefulness of women's coping behaviors and strategies in responding to IPV, either in attempts to end the abuse in their relationship or to break free and remain out of the abusive relationship. Contemporary understandings of women's responses to IPV are mainly derived from sociological and systems theories. The question of "Why does she stay?" no longer dominates discourse about IPV. Given the current state of knowledge relative to IPV, the questions "Why do so many men assault their partners?" and "What is getting in the way of women's safety and freedom from abuse?" are more salient and fruitful areas of inquiry.

Most research on women's responses to IPV has relied on samples of women who have sought some type of formal assistance, for example, health care, social services, and legal services. As a result, our knowledge of women who quickly break free from abusers without complications is very limited. Therefore, our current knowledge pertains to the responses of women who endure abuse over a longer period of time and whose abuse becomes public by virtue of their help-seeking behaviors and involvement with official agencies, rather than women who extricate themselves from relationships at the onset of abuse, or soon after, without seeking help outside of their own network. Research with the latter population from community-based samples is needed.

Contemporary theories about women's responses to IPV include resiliency and survivor models, both strengths-based approaches, and social support. Together, these theories provide a rich understanding of the processes involved in women's responses to IPV. Robust research has been reported about the emotional processes of being in, leaving, and recovering from abusive relationships, and more recently, adaptive responses and strategies used in these processes.[30,31] These historical and contemporary theories are presented and critiqued in Table 3. This scholarship has lead to a reformulation of the characteristics of women experiencing IPV and their responses to it (see Table 4).

Critical theories

Critical theory, also known as critical social theory (CST), originates from philosophy and has several meanings and applications across philosophy, the social sciences, nursing science, and other health sciences.

Table 3. Historical and Contemporary Theories of Women's Responses to IPV

	Historical Theories		
	Level of Focus	**Explanation**	**Critique**
Individual psychological pathology	Risk factors for being abused	Low self-esteem and mental health problems, for example, depression, anxiety, posttraumatic stress disorder, personality disorders, and substance abuse problems	Research does not support low self-esteem or mental health problems as being risk factors for IPV. Rather, the low self-esteem, mental health problems, and substance abuse seen in abused women are very likely the result of the violence rather than a precursor.
	Responses to IPV; remaining in the abusive relationship	Learned helplessness: repeated abuse leaves the victim unable to get out of the abusive relationship because of her depression, apathy, and poor problem solving.	Women's responses to abuse are not passive. Coping with the abuse is an active process that involves creativity, problem solving, and strategizing.
		Traumatic bonding: abused women develop strong emotional bonds to their abusers; similar to "Stockholm syndrome."	Typically, love precedes the abuse. The emotional bond may remain despite the abuse. Women want the abuse to end, not necessarily the relationship.
		Low self-esteem and mental health problems (as earlier)	Likely the result of IPV rather than the cause of remaining in the relationship.
	Contemporary Theories		
	Level of Focus	**Explanation**	**Challenges**
Resiliency	Victim's/survivor's individual strengths	Women's responses to IPV are active processes, requiring creativity and inner strength. Resiliency is defined as positive coping, adaptation, and persistence.	Identifying and assisting women who are abused but who do not seek services requires effective screening and community outreach, both of which are difficult to implement universally.

(continues)

Table 3. Historical and Contemporary Theories of Women's Responses to IPV (*Continued*)

	Contemporary Theories		
	Level of Focus	**Explanation**	**Critique**
		Women use various strategies to protect themselves and their children, seeking safety in whatever ways they can.	
		On-going IPV can erode women's sense of inner strength and resiliency. Their self-efficacy can be negatively impacted by the abuse, making moving toward change very difficult.	Assisting women who are abused to recognize and tap into their inner strengths can be difficult.
Survivor model	Victim/survivor of IPV	Women's responses to IPV vary over time as they adapt to individual circumstances and pragmatic concerns using multiple strategies.	Social agencies and health care settings are not adequately prepared to address the pragmatic needs of women subjected to IPV.
Social support	Interpersonal and community	Social support, both perceived and tangible, can increase a woman's ability to leave and remain out of an abusive relationship.	Accessing resources to provide abused women with tangible support is difficult, particularly women who are marginalized or in socially oppressed groups.
		Tangible social support is a protective factor for IPV-related mental health problems, including depression and posttraumatic stress disorder.	

Abbreviation: IPV, intimate partner violence.

Generally described, critical theory encompasses a spectrum of theories which take a critical view of society and the human sciences. Critical social theory scholarship in multiple disciplines continues to unfold as CST is applied by scholars to social, political, scientific, and health related phenomena. Feminist scholars in nursing and the social sciences have used CST to describe and expose the complexity of life experiences within

Table 4. Reformulations of Women's Responses to Intimate Partner Violence

	Historical	Contemporary
Personal attributes	Weak	Strong
	Helpless	Resilient
	Victim	Survivor
Definition of response	Decision to stay or leave	Ongoing process of seeking safety for self and children
Mental and emotional reaction	Psychologically dysfunctional	Complex of internal and external factors
Coping style	Passive	Active
	Static	Adaptive

intersecting oppressions that include (but are not limited to) race, class, gender, disability, sexuality, ethnicity, nationality, and religion (see eg Collins, 2000; Cramer & Plummer, 2009; and Samuels-Dennis et al, 2010).[25,32,33] The application of CST to IPV addresses the complexity, chronicity, and seeming intractability of IPV. Critical social theory applies to the phenomenon of IPV as a whole, as its various dimensions, for example, the causes, effects and potential remedies, are intertwined and interrelated.

One of the organizing principles of CST is that individuals and groups have different political, social, and historic contexts characterized by injustice. Although people seek to alter their social and economic situations, often they are constrained by multiple forms of social, cultural, and political domination. A second principle is that social critique of the status quo is essential so that constraining conditions can be exposed. In addition, critical social theorists advocate for empowerment, liberation, and emancipation from alienation and domination. Collins succinctly summarized the goal of CST, "What makes critical social theory 'critical' is its commitment to justice, for one's own group and/or for that of other groups." [32(298)]

Ecological frameworks

An ecological framework is used by the WHO to describe violence as a global public health problem.[34] This framework integrates research findings and theories from several disciplines, including feminist theory, into an explanatory framework of the origins of gender-based IPV. Within the ecological framework, IPV is understood as a multifaceted phenomenon that is the result of a dynamic interplay among individual, relationship, community, and societal factors that influence an individual's risk to perpetrate or become a victim of violence (see Figure 1). At the individual level, the person who perpetrates or is a victim of abuse and violence possesses a set of biological and personality traits and a personal history that shape his or her behaviors and interactions with other individuals, for example, with intimate partners and with the broader community and society. Individual-level factors that are associated with IPV perpetration include: (1) demographic factors such as age, education and income, (2) witnessing domestic violence as a child, (3) experiencing physical or sexual abuse as a child, and (4) substance use. A personal history of multiple interpersonal traumas, for example, IPV, child abuse, and rape, is associated with posttraumatic stress disorder and other negative health outcomes for victims; therefore, cumulative trauma is an individual factor influencing women's responses to IPV. Disability is widely described as an individual's restricted ability to perform a range of social, work-related, or cognitive or physical activities. Considered in this way,

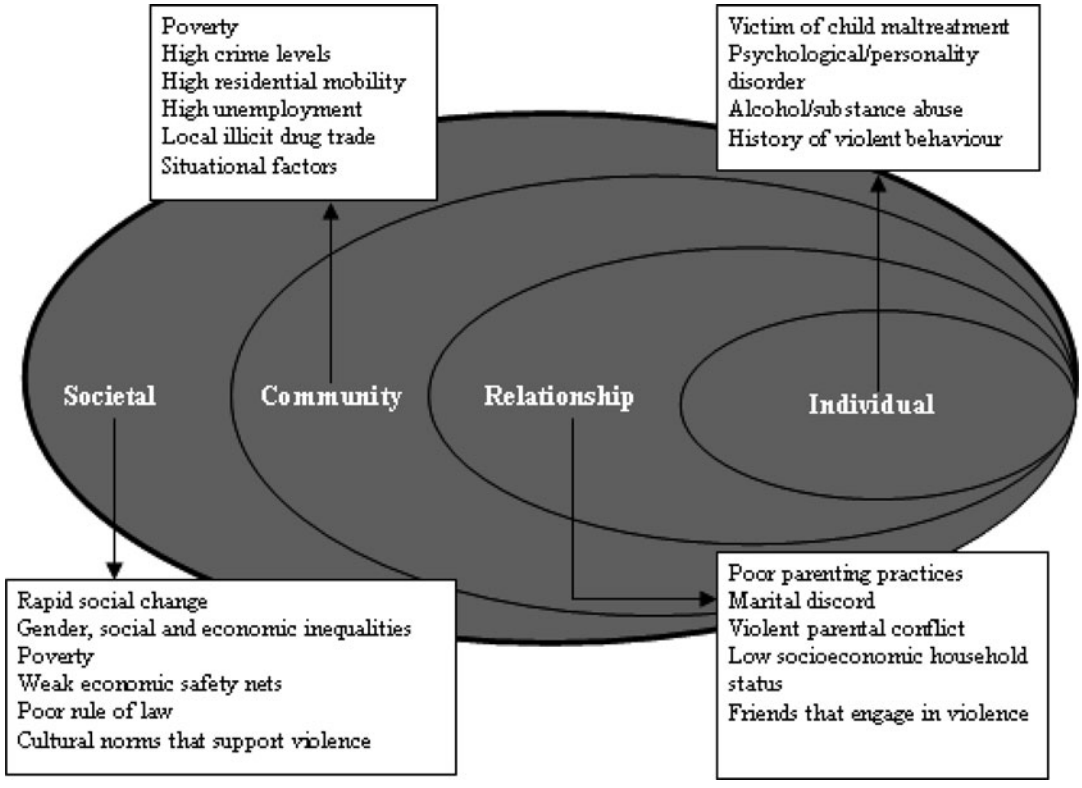

Figure 1. The ecological model of interpersonal violence.

it is an individual level factor that increases a woman's risk for IPV as well as an influencing factor on women's responses to IPV.

The second level of influence includes close relationships with partners, family members and peers that can influence the risk of the individual to perpetrate or become a victim of violence. Several aspects of the relationship level, especially in terms of family structure and functioning, have been identified as risk factors for the development of IPV. These include: (1) male economic and decision-making authority in the family, (2) male control of wealth and resources in the family, and (3) marital conflict, especially in relationships with asymmetrical power structures.

The third level of factors is the community and includes settings such as neighborhoods, schools, and workplaces. Research has demonstrated that communities with high levels of social disorganization, for example residential mobility, high population densities and lack of cohesion among residents, are associated with higher levels of violence.[35] Community poverty, unemployment, and alcohol outlets have also been identified as risk factors for the perpetration of violence, victimization by violence, or both.[36] According to social disorganization theory, poverty at the community level may underlie much stress and conflict within intimate couples, such that the influence of community poverty is manifested at the relationship level.

The fourth and last level of factors is the societal level. This includes broad societal factors that create a climate that encourages or discourages violence at the community, relationship and individual levels, including the rules, norms, and social expectations that govern personal behavior and

social inequities between groups, for example, patriarchal systems, oppression, poverty, sexism, and health disparities. For example, sources of support and formal assistance may not be readily available to socially marginalized women, thus making them vulnerable to IPV and impacting their responses to the violence. This ecological approach to understanding violence integrates research findings from various disciplines into a comprehensive framework that improves our understanding of the context, causes, and impact of IPV in the lives of women, as well as the environment in which they are responding to it. The implications of the ecological model for IPV intervention are that strategies must be developed that target multiple levels, that is, individual, family, community, and societal.

Feminist theory & feminist intersectionality

Feminist theory of gender-based oppression has evolved to account for additional factors and complexities that intersect with gender to place women and other vulnerable groups at a disadvantage in establishing equitable power relationships with their partners and in society. Much of this scholarship came from social scientists, domestic violence advocates, and minority women who have conceptualized VAW as much more than just a gender issue. Black Feminist Theory emerged in response to the predominately white women's feminist movement and predominately male black civil rights movement, neither of which completely represented the experience of both being Black and a woman. In Black Feminist Theory, the interaction between gender, race, and class are conceptualized as being part of an overarching structure of domination.[32]

Similarly, Chicanas and Latinas felt that their concerns were not being adequately represented by either the Chicano movement or the women's movement. Chicana Feminist Theory describes the dynamics between race/ethnicity, social class, linguistics, and nationalism. Chicana feminists also focused on approaches they felt were unique to their culture, such as the need to challenge traditional and exaggerated gender-roles that were present in Latino households, while still preserving strong family structures and the important role of women in the home.[37] Native American and other indigenous feminists find that postcolonial frameworks that emphasize the role of historical trauma, as well as the many different tribal traditions in male-female relationships, are important in understanding the often high rates of IPV among aboriginal peoples worldwide.[38]

Feminist scholars and activists have expanded the application of intersectionality theory to other socially constructed identities and social locations that marginalize people, beyond race, class and gender, for example, disability. Social justice models applied to women with disabilities distinguish between the biological state of impairment and the social construct of disability that is reflective of sociocultural and environmental restrictions, rather than individual limitations. Nixon[39] argued that women with disabilities who are being abused or who are vulnerable to being abused may be silenced or made invisible by intersecting aspects of oppression based on social identity, for example, disablism, sexism, ageism, and structural oppression by organizations, social movements and society in general.

Feminist intersectionality is built upon the assumptions that every social group has unique qualities; that individuals are positioned within social structures that influence power relationships; and that there are interactions between different social identities, for example, race, gender, and class, that have multiplicative negative effects on health and well-being. Feminist intersectionality is a body of knowledge that is driven by the pursuit of social justice and seeks to explain the processes by which individuals and groups in various oppressed social positions, such as gender, race, ethnicity, class, age, sexual orientation, disability status, and religion, result in inequitable access to resources, which in

turn results in societal inequities and social injustice.[23,32,40] Health disparities, which are gaps in access to and quality of health care in disaffected racial, ethnic, and socioeconomic groups, are 1 example of a social inequity.

Feminist theorists in nursing and other social sciences have recommended the use of feminist intersectionality as a means of not only obtaining a more comprehensive understanding of the multiplicative effects of social inequalities experienced by vulnerable and marginalized groups, but also of conducting research and developing interventions that address health disparities.[41]

Intersectionality operates at 2 levels: (1) as a tool for analyzing structural oppression, and (2) as a framework for understanding the ways in which individual's intersectional identities contour their lives.[42] Though these levels can be considered separately, they are intertwined and interrelated. The application of intersectionality to IPV involves: (1) examining the ways in which structural inequities enable and foster IPV, and (2) examining the influence of disadvantaged social identities on women's responses to IPV, which are inherently related to the responses of helping professionals and social agencies to women experiencing IPV (see Table 5).[25,43-48]

The first analysis addresses the question, "what is it about our society that makes IPV such a prevalent, persistent, and intractable problem?" The second analysis provides multiple lenses through which to consider women's responses to IPV; simply put, context is everything. For example, what does considering disability (or any other disadvantaged social identity) as a vector of analysis add to our understanding of IPV and a woman's response to it? What do we learn when we consider that this same woman is an immigrant? And that she is unemployed? And most important of all, what are the individual, organizational, social, and political remedies available to nurses who are working with survivors of IPV and other forms of VAW?

The influence of social systems, such as children's protective services, the police, court systems, and health care systems and providers, on abused women's responses have been well-described in the literature, often as oppressive and intrusive, even after women become free from the abuser.[43] These formal systems can be barriers to help-seeking for abused women, particularly those with multiple subordinate group identities.[44] Women's responses to IPV are inherently connected, and at times reliant, on the influence of these oppressive systems on their lives. For example, mothers' overt or public responses to the violence may depend on their perceptions of or experiences with children's protective services. They might not disclose the abuse to anyone for fear of having their children removed from their custody,[45] or they may be penalized for the abuser's behavior because of their (the women's) "failure to protect".[46] Ineffective responses by police or court systems will prompt women to respond differently than if they had received the legal assistance they were seeking, perhaps staying in the relationship and managing the violence as best they can. Women with disabilities may find that existing community resources are not accessible to them or that legal and health care systems and providers are incognizant and ill-equipped to address their particular needs. Understanding the complex and often oppressive contexts of women's responses to IPV is essential to understanding the complexity of their active and adaptive responses to it.

Consider, for example, a woman who is being abused who is an immigrant with limited English proficiency and a grade school education, who is in the United States with her husband and 3 children without her own family, and is unemployed. She will have a limited spectrum of possible responses to IPV relative to a white woman who is a US citizen, has a high level of education, is employed, and has a network of friends and family nearby. At the same time, if the white woman is in severe danger from the abuser, does not have access to household finances, and believes that she would lose custody of her children and her social network if she disclosed the abuse

Table 5. Intersectionality and IPV: Structural Inequalities, Social Identities, and Promoting Health

	Level of Focus	Explanation	Critique	Challenges	Nurses' Actions for Promoting Health
Structural inequalities	Context of individuals' lives: social, economic, cultural, political, health care access, historical	Women who are poor, from a minority ethnic group, or are immigrants, face compounded barriers to leaving the abuser and to recovering from the abuse due to the socially unjust contexts in which they live. Abused women face many external barriers to leaving or escaping an abusive intimate partner and to getting help from officials, including health care providers. Official helping agencies can perpetuate the abuse, treat abused women in demeaning and punitive ways, and become controlling and "intrusive," even after a woman has left the relationship.[43]	These theories do not take into account the ways in which women's inner emotional and psychological states also contribute to their responses to intimate partner violence.	Identifying points of immediate intervention is difficult when considering unjust systems at the societal level. Social action is a long-term intervention; effective short-term and immediate interventions need to be developed. Changing the responses of helping agencies universally to make it "safe" for women to seek services is challenging. As nurses, we cannot guarantee that there will not be negative ramifications from seeking services from formal systems, for example, loss of custody of children.[46]	Advocacy for the individual: Providing information on financial, legal, health care options Facilitating access to community resources, for example, shelters, government assistance programs, subsidized daycare Partner with IPV survivors as they cope and make adaptive choices about how they cope and respond to IPV Community advocacy: Partner with community and government agencies to support IPV survivors and their families without harmful intrusion or control Raise awareness among helping agencies of the social "locations" IPV survivors inhabit and develop innovative programs to address their specific needs

(*continues*)

Table 5. Intersectionality and IPV: Structural Inequalities, Social Identities, and Promoting Health (*Continued*)

	Level of Focus	Explanation	Critique	Challenges	Nurses' Actions for Promoting Health
Social identities	Identities based on location in disadvantaged/oppressed social group(s)	Individual and intersecting identities influence women's responses to IPV, for example, "Strong Black Woman,"[49] "mother,"[45] "Latina."[44] Individual and intersecting identities influence social systems' responses to abused women, for example, "bad mother," "welfare queen."[50]			Raising women's critical awareness of the impact of IPV, their intersectional location, and their personal strength and resilience

Abbreviation: IPV, intimate partner violence.

to anyone, she too will have a limited spectrum of responses available to her. If she is disabled, her dependence on her abuser could be a barrier to her seeking safety. Both women will also have their unique internal emotional and psychological responses to the abuse and violence.

An illustration of the relationship between various oppressive social systems and the oppressive and controlling behaviors and tactics enlisted by perpetrators of IPV was developed by Chavis and Hill,[23] in their adaptation of the Duluth Power and Control Wheel (see Figure 2). In the original Power and Control Wheel, battering is characterized by a pattern of abusive behaviors and tactics that are used to control and dominate an intimate partner, for example intimidation, using coercion and threats, emotional and economic abuse, and using children. Chavis and Hill added 7 distinct rings on the wheel surrounding these tactics to represent multiple forms of oppression that are connected with each other and with specific dynamics and behaviors in IPV. Nursing interventions with women who are being abused need to be developed in full recognition of this "multifaceted plight" in which they have been placed.[47(533)]

CLINICAL IMPLICATIONS

The application of the intersectionality framework to the problem of IPV provides a nuanced yet complex understanding of the multifaceted positions of inequity and injustice in which women who experience IPV are placed by oppressive social structures, IPV perpetrators, social agencies/professional helpers, and health care providers, including nurses. However, knowledge alone serves no purpose; in fact, given the opportunities for action that nurses have, inaction can be considered perpetuation of injustice, at individual, community and societal levels. In this light, it imperative that we answer the question posed earlier, "What are the individual, organizational, social and political remedies available to nurses who are working with survivors of IPV and other forms of VAW?"

In a recent systematic review of interventions initiated by health care professionals aimed at women who experienced IPV, Sadowski[51] reported that advocacy, career counseling coupled with critical consciousness awareness, peer support groups, safety planning, and cognitive psychotherapies are likely to be beneficial. All of these interventions can be used by nurses with individual and groups of women. Advocacy for the individual can take the form of information sharing, facilitating access to community resources, mobilizing her own internal and external resources, assisting in goal setting and making choices, validating her feelings and providing emotional support (see Table 5).

Nurses can use the nonjudgmental, nonconfrontational, and non-adversarial strategies of motivational interviewing to facilitate IPV survivors' critical awareness of the impact of the intersections of disadvantage in their lives and of their strength, resilience, and adaptive coping skills in the face of living with IPV. This process requires that the nurse reflect on her/his personal and professional social location of power relative to survivors of IPV and guard against enacting the controlling dynamics often found in health care settings. Nurses can take action by addressing language and behaviors among co-workers that blame the victim and perpetuate negative stereotypes. In partnership with patients and clients, nurses can navigate a route out of the congested intersection in which these women have been living. As an example, rather than asking, "Why don't you leave?" a nurse might ask a patient who is experiencing IPV, "How have you kept yourself (and her children if applicable) safe?" "How is the abuse affecting you and your health?" "How are your children being affected?" "What is getting in the way of you being safe, healthy, and accomplishing what you want in life?" At the same time, the nurse would provide positive feedback on the woman's strength, resilience, and coping abilities to survive and

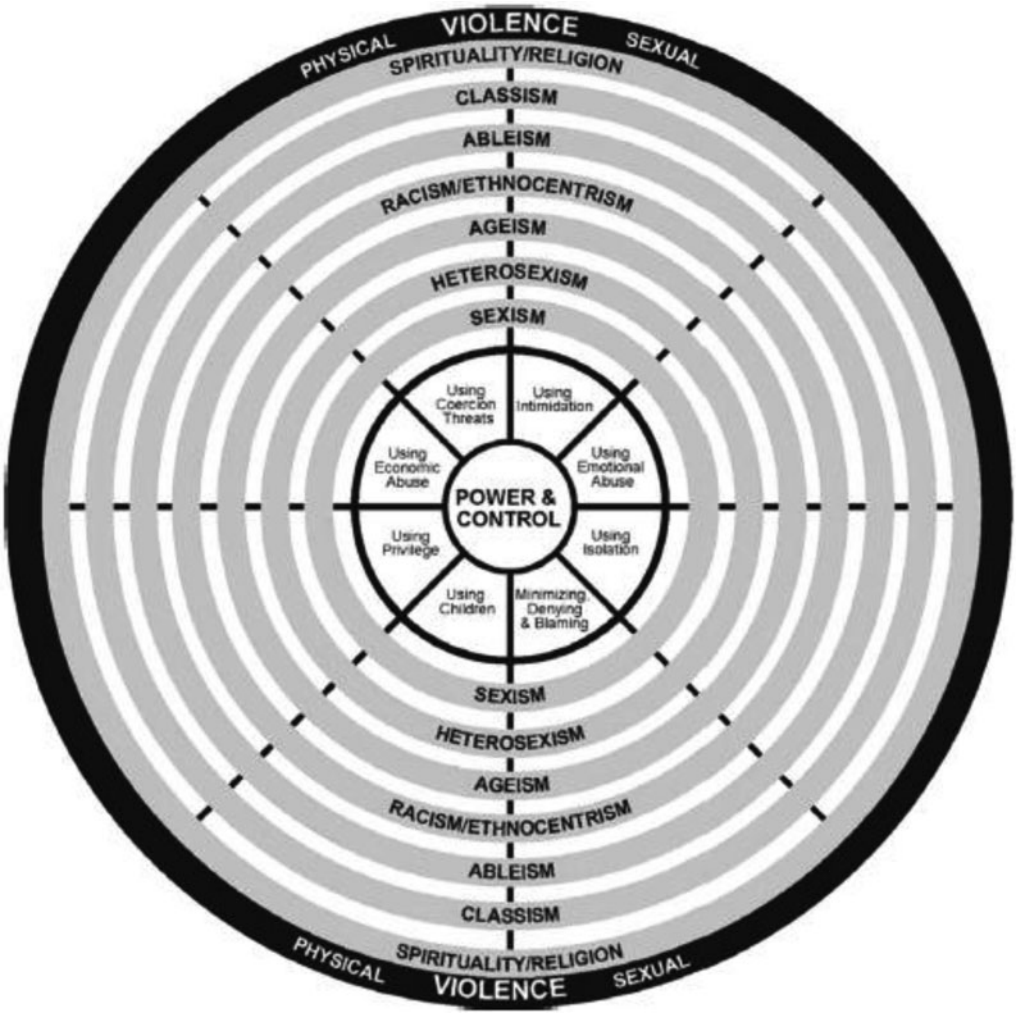

Figure 2. The multicultural Power and Control Wheel.

endure, whether she is in or out of the violent relationship.

Nurses can work within their organization to develop systems that recognize and respond to the needs of IPV survivors seeking health care, specifically targeting barriers to their safety, health, and healing. For example, an interdisciplinary IPV response team (eg, nurses, social workers, emergency department and primary care providers) can be developed, with procedures in place to respond to time sensitive situations and crises, as well as to provide on-going advocacy and support. Partnering with community agencies and resources can expand this team to include legal advocates, shelters, daycare providers, educational institutions, and governmental programs, such as Medicaid and financial entitlement programs (see Table 5 for a list of suggested nursing actions and interventions). Finally, nurses can take political action through professional organizations, in their personal lives, or both to address social inequities and barriers to IPV survivors' safety, health, and healing. This can include financial support for nonprofit organizations, lobbying for

legislative change and funding for programs that address social inequities, and being active in professional nursing organizations to address health disparities.

Within an intersectionality framework, nurse scholars are called to attend to the inherent power dynamics and ethics in conducting research with survivors of IPV.[41] The community-based participatory research approach is philosophically, conceptually, and practically aligned with an intersectional approach to advocacy and research. Community-based participatory research is a collaborative model in which researchers and community members partner to conduct research in areas of concern to the community and for the benefit of the community. Community-based participatory research intentionally addresses multilevel power relations and necessitates researcher reflexivity, active engagement, and social action.

CONCLUSION

This review of the historical roots of IPV and VAW and presentation and critique of the historical, contemporary, and evolving theoretical understandings of the causes of IPV and women's responses to violence illustrate the entrenched nature of the problem. Theoretical development related to IPV in the past several decades has coincided with and hopefully prompted some of the social and cultural shifts that have occurred relative to VAW, with widespread public acknowledgement of the problem, commitment of resources for intervention and research, and recognition among health sciences disciplines that IPV is a public health epidemic that requires prevention and intervention. However, despite this growing momentum among health and social scientists and clinicians, few effective interventions have been developed to prevent IPV, respond appropriately to survivors of IPV, and to mitigate its harmful effects on women. This is likely due to an overly simplistic rather than multidimensional understanding and approach to the problem.

Critical social theories have shifted causal attributions from purely internal, dysfunctional psychological processes to multidimensional frameworks, in which women being subjected to IPV are seen in the context of their families, communities and broader society. Critical analyses of the influences and interactive effects of oppressive social structures, for example, the political climate, the economy, social services and health care systems, and culture now appear in IPV-related nursing and social sciences literature.

Intersectionality is a body of knowledge that holds the most promise for providing a theoretical basis on which to base IPV multidimensional research and effective clinical interventions. The intersectionality framework is a call to action. Just as this framework guides analyses at the levels of social structural oppression and individual's intersectional identities, so must nursing clinical interventions, education, and research address IPV at individual and societal levels. Even though intersectional analyses of IPV portray IPV as entrenched and intractable, nurses have many opportunities to develop short-term interventions and to take action toward long-term change for individuals, communities, and society. Intimate partner violence is both an epidemic public health problem and a critical social justice issue—its resolution mandates nursing intervention, scholarship, and social action that address both of these dimensions.

REFERENCES

1. Saltzman LE, Fanslow JL, McMahon PM, Shelley GA. *Intimate Partner Violence Surveillance: Uniform Definitions and Recommended Data Elements, Version 1.0.* Atlanta, GA: Centers for Disease and Control; 2002.
2. Krug EG, Dahlberg JA, Mercy JA, Zwi AB, Lozano R. *World Report on Violence and Health.* Geneva, Switzerland: World Health Organization; 2002.
3. Garcia-Moreno C, Jansen HA, Ellsberg M, Heise L, Watts CH. WHO Multi-country Study on Women's

Health and Domestic Violence against Women Study Team. Prevalence of intimate partner violence: findings from the WHO multi-country study on women's health and domestic violence. *Lancet.* 2006;368(9543):1260-1269.
4. Catalano S. *Intimate Partner Violence in the United States*. Washington, DC: Office of Justice Programs, Bureau of Statistics, US Department of Justice; 2007.
5. Thompson RS, Bonomi AE, Anderson M, et al. Intimate partner violence: prevalence, types, and chronicity in adult women. *Am J Prev Med.* 2006;30(6):447-457.
6. Alhabib S, Nur U, Jones R. Domestic violence against women: systematic review of prevalence studies. *J Fam Violence.* 2010;25(4):369-382.
7. Tjaden P, Thoennes N, Allison C. Comparing violence over the life span in samples of same-sex and opposite-sex cohabitants. *Violence Vict.* 1999;14(4):413-425.
8. Campbell JC, Webster D, Koziol-McLain J, et al. Risk factors for femicide in abusive relationships: results from a multisite case control study. *Am J Public Health.* 2003;93(7):1089-1097.
9. hooks b. *Feminist Theory: From Margin to Center*. Boston, MA: South End Press; 1984.
10. The Holy Bible, King James Version. New York: American Bible Society; 1999.
11. Davidson T. *Conjugal Crime: Understanding and Changing the Wifebeating Pattern*. Bristol, United Kingdom: Hawthorn Books; 1978.
12. Dobash R, Dobash R. *Violence Against Wives: A Case Against the Patriarchy*. New York, NY: E. P. Dutton; 1978.
13. Achterberg J. *Woman as Healer*. Boston, MA: Shambala; 1991.
14. Roberts D. *Killing the Black Body: Race, Reproduction, and the Meaning of Liberty.* Vol 166. New York, NY: Pantheon; 1997.
15. Johnson MP. Conflict and control: gender symmetry and asymmetry in domestic violence. *Violence Against Women.* 2006;12(11):1003-1018.
16. Johnson MP, Leone JM. The differential effects of intimate terrorism and situational couple violence: findings from the National Violence Against Women Survey. *J Fam Issues.* 2005;26(3):322-349.
17. Balsam KF, Szymanski DM. Relationship quality and domestic violence in women's same-sex relationships: the role of minority stress. *Psychol Women Q.* 2005;29(3):258-269.
18. Brown C. Gender-role implications on same-sex intimate partner abuse. *J Fam Violence.* 2008;23:457-462.
19. United Nations. *World Population Prospects: The 2008 Revision, Highlights*. New York, NY: Population Division, Department of Economic and Social Affairs, United Nations Secretariat; 2009.
20. Human Rights Watch. "*We Have the Promises of the World." Women's Rights in Afghanistan*. New York, NY: Human Rights Watch; 2009.
21. World Health Organization. *Eliminating Female Genital Mutilation: An Interagency Statement. OHCHR, UNAIDS, UNDP, UNECA, UNESCO, UNFPA, UNHCR, UNICEF, UNIFEM, WHO*. Geneva, Switzerland: World Health Organization; 2008.
22. Diken B, Laustsen CB. Becoming abject: rape as a weapon of war. *Body Soc.* 2005;11(1):111-128.
23. Chavis AZ, Hill MS. Integrating multiple intersecting identities: a multicultural conceptualization of the power and control wheel. *Women Ther.* 2009;32(1):121-149.
24. West C. Lifting the "political gag order": breaking the silence around partner violence in ethnic minority families. In: Jasinski JL, Williams LM, eds. *Partner Violence: A Comprehensive Review of 20 Years of Research*. Thousand Oaks, CA: Sage; 1998:184-209.
25. Cramer EP, Plummer S-B. People of color with disabilities: intersectionality as a framework for analyzing intimate partner violence in social, historical, and political contexts. *J Aggression, Maltreatment Trauma.* 2009;18(2):162-181.
26. Stark E. *Coercive Control: How Men Entrap Women in Personal Life*. New York, NY: Oxford University Press; 2007:464.
27. Schrock D, Schwalbe M. Men, masculinity, and manhood acts. *Sociol.* 2009;35(1):277.
28. Straus M, Hotaling G. *The Social Causes of Husband-Wife Violence*. Minneapolis, MN: University of Minnesota Press; 1980.
29. Golding JM. Intimate partner violence as a risk factor for mental disorders: a meta-analysis. *J Fam Violence.* 1999;14(2):99-132.
30. Ford-Gilboe M, Wuest J, Merritt-Gray M. Strengthening capacity to limit intrusion: theorizing family health promotion in the aftermath of woman abuse. *Qual Health Res.* 2005;15(4):477-501.
31. Riddell T, Ford-Gilboe M, Leipert B. Strategies used by rural women to stop, avoid, or escape from intimate partner violence. *Health Care Women Int.* 2009;30(1-2):134-159.
32. Collins PH. *Black Feminist Thought: Knowledge, Conciousness, and the Politics of Empowerment.* New York, NY: Routledge; 2000.
33. Samuels-Dennis JA, Ford-Gilboe M, Wilk P, Avison WR, Ray S. Cumulative trauma, personal and social resources, and posttraumatic stress symptoms among income-assisted single mothers. *J Fam Violence.* 2010;25(6):603-617.
34. World Health Organization. The ecologic framework. http://www.who.int/violenceprevention/approach/ecology/en/index.html. Accessed January 10, 2011.
35. Frye V, Galea S, Tracy M, Bucciarelli A, Putnam S, Wilt S. The role of neighborhood environment and risk of

intimate partner femicide in a large urban area. *Am J Public Health.* 2008;98(8):1473.
36. Cunradi CB. Neighborhoods, alcohol outlets and intimate partner violence: addressing research gaps in explanatory mechanisms. *Int J Environ Res Public Health.* 2010;7(3):799-813.
37. Anzaldua G. *Making Face, Making Soul, Haciendo Caras: Creative and Critical Perspectives by Women of Color*. San Francisco, CA: Aunt Lute Books; 1990.
38. Hamby SL. The importance of community in a feminist analysis of domestic violence among Native Americans. In: Sokoloff N, Pratt C, eds. *Domestic Violence at the Margins: Readings on Race, Class, Gender and Culture*. New Brunswick, NJ: Rutgers University Press; 2006:174-193.
39. Nixon J. Domestic violence and women with disabilities: locating the issue on the periphery of social movements. *Disabil Soc.* 2009;24(1):77-89.
40. Schulz A, Mullings L. *Gender, Race, Class, and Health: Intersectional Approaches*. San Francisco, CA: Jossey-Bass; 2006.
41. Kelly UA. Integrating intersectionality and biomedicine in health disparities research. *Adv Nurs Sci.* 2009;32(2):E42-E56.
42. Syed M. Disciplinarity and methodology in intersectionality theory and research. *Am Psychol.* 2010;65:61-62.
43. Wuest J, Ford-Gilboe M, Merritt-Gray M, Berman H. Intrusion: the central problem for family health promotion among children and single mothers after leaving an abusive partner. *Qual Health Res.* 2003;13(5):597-622.
44. Kelly UA. "What will happen if I tell you?" Battered Latina women's experiences of health care. *Can J Nurs Res.* 2006;38(4):78-95.
45. Kelly UA. "I'm a mother first": The influence of mothering in the decision-making processes of battered immigrant Latino women. *Res Nurs Health.* 2009;32(3):286-297.
46. Kopels S, Sheridan MC. Adding legal insult to injury: battered women, their children, and the failure to protect. *Affilia.* 2002;17(1):9-29.
47. Vidales GT. Arrested justice: the multifaceted plight of immigrant Latinas who faced domestic violence. *J Fam Violence.* 2010;25(6):533-544.
48. Sokoloff NJ, Dupont I. Domestic violence: examining the intersections of race, class and gender - An introduction. In: Sokoloff NJ, Pratt C, eds. *Domestic Violence at the Margins: Readings on Race, Class, Gender and Culture*. New Brunswick, NJ: Rutgers University Press; 2005:1-13.
49. Woods-Giscombé C. Superwoman schema: African American women's views on stress, strength, and health. *Qual Health Res.* 2010;20(5):668.
50. Hancock A. *The Politics of Disgust: The Public Identity of the Welfare Queen*. New York, NY: NYU Press; 2004.
51. Sadowski L. Intimate partner violence towards women. *Clin Evid.* 2009;2(1013):1-15.