

Intimate partner violence and physical health outcomes among Southeast Asian American women

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Ivy K Ho, Khanh T Dinh and Sable A Smith

Abstract

Although intimate partner violence is prevalent among Southeast Asian American women, little is known about the associations between the experience of intimate partner violence and negative health outcomes in this population. Resnick et al. proposed a model explaining the development of health problems following violent assault. This article assesses the applicability of Resnick et al.'s model to Southeast Asian American women who have experienced intimate partner violence by reviewing cultural, historical, and social factors in this population. Our review indicates that the applicability of Resnick et al.'s model to Southeast Asian American women is mixed, with some components of the model fitting well with this population and others requiring a more nuanced and complex perspective. Future studies should take into consideration cultural, historical, and social factors.

Keywords

intimate partner violence, physical health, Southeast Asian Americans

Intimate partner violence (IPV) is prevalent among Southeast Asian (SEA) Americans. In a survey of Cambodians in Massachusetts, almost half of the respondents reported they knew a woman who had been physically abused and 44 percent indicated they knew a woman who had been emotionally abused by her partner (Yoshioka and Dang, 2000). Similarly, 30 percent of Vietnamese women in Boston reported having experienced physical violence from their intimate partners in the past year and almost 50 percent in their lifetimes (Tran, 1997). Finally, although the Hmong population in the United States is relatively small, IPV does occur in this community, as evidenced by the incidents of IPV-related homicides in the United States (Dabby et al., 2009). These figures are consistent with the overall prevalence of IPV in the United States. According to the US Department of

Justice (2000), 26 percent of the women reported lifetime incidence of IPV. Although the prevalence of IPV within SEA communities is comparable to that of the general population, culturally specific issues need to be taken into account in order to understand the links between IPV and long-term physical health outcomes.

Little is known about physical health outcomes associated with IPV among SEA American women. This article examines the pathways between trauma from IPV and negative health

University of Massachusetts Lowell, USA

Corresponding author:

Ivy K Ho, Department of Psychology, University of Massachusetts Lowell, 113 Wilder Street, Suite 300, Lowell, MA 01854-3059, USA.

Email: Ivy_Ho@uml.edu

outcomes among SEA American women, with particular focus on women of Vietnamese, Cambodian, and Lao/Hmong backgrounds. Although these cultural groups are distinct from one another, they share various historical and social similarities (Dinh, 2009). As we will discuss later, the Vietnamese, Cambodian, and Hmong communities share a tumultuous history of political unrest, war, and genocide. Many refugees who left their homelands spent years in refugee camps where living conditions were harsh. Their journeys to the United States were also fraught with danger and trauma. Upon arrival, these communities encountered cultural and financial stressors. Therefore, the shared experiences of Vietnamese, Cambodian, and Hmong groups may underlie common associations between IPV and physical health outcomes across these populations.

We apply Resnick et al.'s (1997) model of the physical health sequelae of trauma and assess how well this model serves as a template to understand the associations between IPV and physical health outcomes among SEA American women. We selected this model because the authors provided broad and ample evidence from the literature to support the relationships the model purports. Furthermore, since its publication, Resnick et al.'s (1997) paper has been widely read and cited (312 citations to date, according to scholar.google.com). However, the model does not take into account contextual factors, such as culture and history, and has not been examined for its applicability to specific populations. As Lindhorst and Tajima (2008) argued, *context* is crucial in the assessment of IPV. Therefore, we begin by providing an overview of the social, cultural, and historical contexts in which IPV occurs among SEA American women. We then describe the components of Resnick et al.'s (1997) model while assessing how adequately and appropriately each component reflects the experience of IPV among SEA American women. Finally, we discuss issues that are not mentioned by Resnick et al. (1997), but that are crucial for consideration in research with these populations.

The SEA American context and IPV

Lindhorst and Tajima (2008) argued for the importance of contextual domains in the study of IPV. Of the five contextual domains they highlighted, three—*cultural context*, *context of systemic oppression*, and *historical context*—are particularly pertinent to SEA Americans.

First, the *cultural context* affects one's attitudes about IPV and its victims. SEA cultures are generally male-dominated and place great emphasis on family cohesiveness (Wong et al., 2011). SEA women who experience IPV may be unwilling to reveal the abuse and may be discouraged from disrupting the family unit through help-seeking or divorce. Furthermore, many SEA children have been hit by a family member during childhood. Therefore, women may have experienced beatings as girls and perceive violence within the household as normative and something to be endured (Wong et al., 2011). In one study, 57 percent of Vietnamese Americans and 25 percent of Cambodian Americans endorsed the attitude that "some wives seem to ask for beatings from their husbands," and 30 percent of Vietnamese Americans and 44 percent of Cambodian Americans agreed that violence is warranted when the wife "refused to cook and keep the house clean" (Yoshioka et al., 2001). Among Cambodians, marital violence was considered by many to be "a normal issue for everyone," to be the wife's fault, and to be kept private within the family (Bhuyan et al., 2005). In response to IPV, women reported being told to "be a good wife" and remain stoic (Shiu-Thornton et al., 2005), fearing for their lives, and being worried about their communities' disapproval if they left their marriages or reported the abuse (Bhuyan et al., 2005).

Next, the *context of systemic oppression* experienced by SEA communities in the United States, as well as in their countries of origin, may contribute to a general mistrust of social service agencies and legal authorities. SEA Americans are disproportionately of low socioeconomic status (SES). According to the Southeast Asia Resource Action Center (SEARAC, 2011), 27 percent of Hmong,

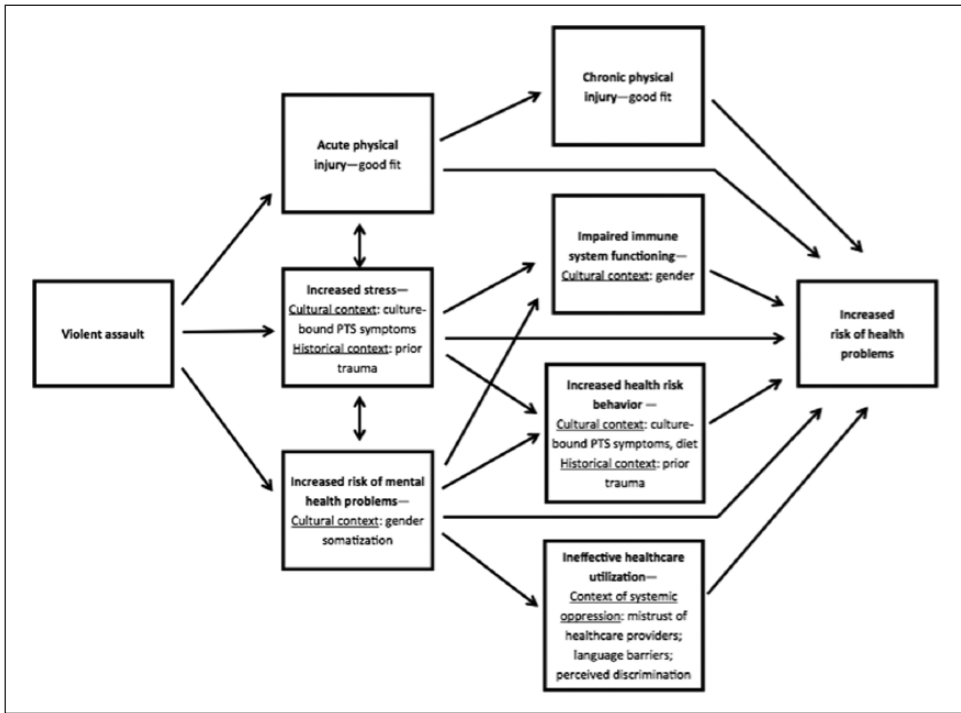


Figure 1. Resnick et al.’s (1997) model modified for application to SEA American women who have experienced IPV.

18percent of Cambodians, and 3percent of Vietnamese live below the poverty line. Educational attainment is also low, with only two-thirds SEA Americans earning a high school diploma. Two avenues through which SEA American women may experience systemic oppression are poverty and immigrant status. Many of these women live in poor households and do not have the financial resources to leave an abusive relationship, and women who are undocumented immigrants may not report IPV, for fear of deportation (Bhuyan et al., 2005; Yoshioka et al., 2001). Multiple stressors, including acculturation, English language ability, lack of social support, and lack of resources, not only increase women’s vulnerability to IPV but also severely limit their ability to leave their intimate partner relationships and/or to seek help (Bhuyan et al., 2005; Wong et al., 2011).

Finally, the *historical context* is especially relevant for SEAs because trauma and posttraumatic stress disorder (PTSD) experienced before, during, and after migration may contribute to

IPV (Norton and Manson, 1992). Wong et al. (2011) argued that women’s vulnerability to IPV is exacerbated by the disruptiveness of leaving one’s home country and family, whether that migration is forced or voluntary. Prior to fleeing their countries of origin, Vietnamese, Cambodian, and Laotian people experienced tumultuous upheaval in their homelands. The Vietnam War lasted from 1959 to 1975 and resulted in an estimated loss of 2 million Vietnamese lives (Dinh, 2009). The Khmer Rouge in Cambodia, perpetuated by Pol Pot’s regime, occurred from 1975 to 1979 and led to the deaths of up to 1.5 million people as a result of genocide, illness, and starvation (Bhuyan et al., 2005). In the case of the Hmong from Laos, many worked closely with the US military and Central Intelligence Agency during the Vietnam War and fled after US forces withdrew from Southeast Asia, in order to escape repercussions from the new Laotian government (Dinh, 2009). Prior to departing for the United States, many SEAs spent time in overcrowded

refugee camps, where living conditions were harsh. The migration experience is fraught with distress, danger, and potential trauma. Refugees were often cramped in overcrowded fishing boats, and many encountered pirates who robbed, raped, and/or murdered them (Dinh, 2009).

The literature reviewed in this section underscores the unique circumstances that SEA women in the United States face with regard to IPV and the need to carefully and thoroughly consider these historical, cultural, and social issues when investigating the physical sequelae of IPV in these populations. With this in mind, we now turn to the components of Resnick et al.'s (1997) model.

Application of Resnick et al.'s model to SEA American women

Resnick et al. (1997) proposed two layers of factors between experience of a *violent assault* and the resultant *increased risk of health problems* (Figure 1). In the first layer, violent assault leads to three *direct outcomes*: acute physical injury, increased stress, and increased risk of mental health problems. These three direct outcomes in turn precipitate a second layer of *mediating factors*: chronic physical injury, impaired immune system functioning, increased health risk behavior, and ineffective healthcare utilization. These two layers—direct outcomes and mediating factors—jointly contribute to increased risk of health problems.

Direct outcomes

Acute physical injury. IPV results directly in physical injury that is often severe and may require immediate medical attention (Resnick et al., 1997). Not only does acute physical injury contribute to an increased risk for health problems but also it can develop into chronic injury, especially if not adequately treated.

Although there has not been research on injury post-IPV among SEA Americans specifically, research on other Asian American ethnic groups indicates that injury caused by IPV is

prevalent. These studies reported bruising, broken bones and teeth, miscarriages, and hospitalization among Korean American women (Song, 1986; cf Lee and Hadeed, 2009) and injuries that warranted medical care among South Asian American women (Raj and Silverman, 2003). Therefore, it is plausible that IPV among SEA American women also results in various forms of acute injuries, consistent with Resnick et al.'s (1997) model.

Increased stress. Victims of assault may experience increased stress and heightened arousal via classical conditioning (Resnick et al., 1997). The assault (the unconditioned stimulus) elicits physiological, cognitive, and behavioral responses (the unconditioned response; e.g. increased heart rate). When the victim associates the assault with environmental cues that coincide with the occurrence of the assault (the conditioned stimulus; e.g. physical surroundings), these cues alone may trigger similar responses (the conditioned response) in the future. Consequently, the victim experiences increased stress whenever she encounters similar environmental cues. Indeed, common somatic complaints among victims of violent assault include chronic conditions such as abdominal pain and headache (Koss and Heslet, 1992). Increased stress can have multiple consequences, leading to increased risk for health problems via impaired immune system functioning and increased health risk behavior.

The unconditioned response described by Resnick et al. (1997) is characteristic of the Western conceptualization of PTSD, a family of psychopathological reactions to the experiences of trauma. Brown (2008) stated that trauma is a "multicultural reality" and proposed that the definition of "trauma" be broadened, and that treatment of trauma ought to take into account the multiple social identities a patient occupies, including gender, culture, and immigration history. When applying the notion of PTSD to SEA populations, an important issue to consider is that of culture-bound expressions of posttraumatic stress symptoms. For example, in Cambodian culture, metaphors are often used to describe somatic

manifestations of stress (Hinton et al., 2013). These metaphors include *khyal* attack (whereby blood and “wind” rise up through the body to cause neck soreness, headache, and dizziness) and the notions of *spinning* and *shaking* to signify feeling distressed and overwhelmed (Hinton et al., 2013). Cambodian refugees also experience post-traumatic stress symptoms in the form of *thinking too much*, known as *koucharang* (Frye and D’Avanzo, 1994), a state of anxiety characterized by rumination and intrusive memories and thoughts, by which is believed to lead to heart problems and cognitive impairment.

Increased stress in response to IPV among SEA American women must also be considered against the backdrop of prior trauma associated with political turmoil, refugee camp, and migration trauma. Resnick et al. (1997) stated that multiple traumas exacerbate health problems. Therefore, increased stress from prior trauma experienced by SEA Americans may increase the severity of physical health outcomes associated with IPV.

Increased risk of mental health problems. The experience of interpersonal trauma is associated with mental health problems such as PTSD, panic disorder, depression, and substance use. These mental health problems are, in part, due to the increased stress discussed earlier. Those with mental health problems may neglect their physical well-being, engage in risky behavior, avoid seeking medical care for post-assault injury, or misattribute mental health symptoms to physical health problems and therefore use healthcare services ineffectively (Resnick et al., 1997). Increased risk of mental health problems can contribute to increased risk for physical health problems directly, as well as via impaired immune system functioning, increased health risk behavior, and ineffective healthcare utilization.

Research on the mental health consequences of IPV among SEA American women is scarce. One study on Vietnamese American women reported increased anxiety and depression among IPV survivors (Tran, 1997). A paper that described three case studies (Norton and

Manson, 1992) suggested that SEA women in the United States who have experienced IPV typically presented for mental health services complaining of depression. Hence, it is likely that IPV does indeed increase the risk for mental health problems among SEA American women. In addition, predictors of psychological distress among these women included lack of formal education in their countries of origin, fewer years spent in the United States, low income, and not having made one’s own decision to flee one’s home country (Chung and Bemak, 2002). These sociocultural risk factors reflect the burden of a lack of autonomy and power and of becoming accustomed to living in an unfamiliar environment. Because SEA refugee women are already experiencing psychological distress, it is likely that experiencing IPV would increase their susceptibility to developing trauma-related mental health problems.

Another issue that contributes to mental health consequences is somatization. While there is variability across Asian cultures, it is common among Asian Americans for psychological distress to be manifested as physical ailments, such as fatigue, chest pain, sleep problems, and headaches (Lee and Hadeed, 2009). In contrast to the general US population of women, SEA American women who have experienced IPV may not report symptoms of mental distress as a result of IPV. Instead, their reactions to IPV may be manifested somatically in the form of pain, fatigue, and sleep difficulties. This makes it particularly challenging to conduct research on the risk of mental health problems associated with IPV among these women, as well as to diagnose and treat such problems.

Finally, how somatization and culture-bound posttraumatic stress symptoms play a role in mental health problems among US-born SEA American women—that is, second-generation SEA Americans who had never experienced the types of trauma faced by their refugee parents—are less clear. Nonetheless, we can glean from the literature on intergenerational transmission of trauma to make preliminary hypotheses about the second generation of SEA American women.

In their study of trauma, parenting styles, and adolescents' anxiety among Cambodian refugee families, Field et al. (2013) found that, among mother-child pairs, the mother's total PTSD score was positively correlated with her child's depression and anxiety, and with a parenting style characterized by emotional abuse and emotional neglect. Therefore, it is possible that intergenerational transmission of trauma via parenting styles may render the daughters of these refugees more susceptible to mental health problems following traumatic experiences such as those associated with IPV.

Mediating factors

Chronic physical injury. Injuries that were not adequately treated at the time of an assault may develop into long-term debilitation, pain, and scarring (Resnick et al., 1997), which in turn lead to increased risk for health problems by contributing to a sedentary lifestyle and other unhealthful habits.

We argue that it is likely that SEA American women, too, are at risk for chronic physical injury. There are several reasons why injuries sustained during IPV may not be adequately treated. Increased stress and increased risk for mental health problems may become barriers to seeking and receiving treatment for injuries. Furthermore, as will be discussed later, inefficient healthcare utilization and health risk behaviors can also be substantial barriers to treatment.

Impaired immune system functioning. The experience of violent assault may alter one's endocrine system. Prolonged stress is linked to disruption in the hypothalamic-pituitary-adrenal axis, resulting in increased secretion of glucocorticoids such as cortisol. Long-term elevation in glucocorticoid levels suppresses the immune system by hastening natural cell death and decreasing production of new lymphocytes (Sapolsky, 2004). Immune system disruption puts an individual at risk not just through an increased susceptibility to infections but also increases risk for obesity, heart disease, and other chronic health problems.

In order to understand the role of physiological functioning as a mediating factor among SEA women with histories of IPV, we must review research on physiological reactivity among SEA Americans. Unfortunately, this literature is scarce. Two studies assessed physiological reactivity of Hmong American and European American women and men to emotional stimuli (Chentsova-Dutton and Tsai, 2007; Tsai et al., 2002). There was a main effect for gender; women demonstrated greater electrodermal reactivity than did men. There was no main effect for race; Hmong Americans and European Americans demonstrated similar electrodermal reactivity to emotional stimuli. The absence of a race main effect suggests that the results on physiological reactivity to emotional stress among White participants may be generalizable to SEA Americans. Finally, contrary to the prediction of a gender by race interaction, the magnitude of the gender difference in emotional reactivity was consistent across race. Overall, the findings of these studies imply that, compared to their male counterparts, SEA American women would demonstrate greater physiological reactivity to emotional stimuli. These findings suggest that negative affect associated with the experience of IPV would have a significant impact on physiological systems, including the endocrine and immune systems among SEA American women.

Increased health risk behavior. It is common for victims of assault to engage in maladaptive health behaviors, including substance use, eating a poor diet, and neglect of one's health. Substance use may be maintained by operant conditioning, whereby the substances provide temporary relief from mental distress precipitated by the assault (Resnick et al., 1997). Risky health behaviors can lead to long-term health consequences, including chronic diseases and infections.

There is a dearth of knowledge about substance use among SEA American women who have experienced IPV (Lee and Hadeed, 2009). D'Avanzo et al. (1994) did find that Cambodian American women used alcohol to cope with

stress and pain. Sleeping pills are also used frequently, both during the day and night, as a means of coping. In another study of 120 Cambodian refugee women, 47 women reported using sleeping pill, and 25 reported using alcohol to cope with *koucharang* (Frye and D'Avanzo, 1994). The use of sleeping pills and alcohol to cope with stress and the psychological aftermath of trauma is consistent with Resnick et al.'s (1997) suggestion that the use of these drugs is operantly maintained by providing relief from unpleasant emotional states.

Another important factor is the impact of trauma on SEA Americans' dietary habits. Trauma, including food-related experiences such as nutrition deprivation or starvation, is associated with harmful eating habits and eating disorders (Peterman et al., 2010). Reports from World War II prisoners of war and Holocaust survivors who experienced severe trauma documented high rates of binge eating, or preoccupation with food for decades following their traumatic experiences. Research also shows that 63 percent of the women with anorexia nervosa and 58 percent of women with bulimia nervosa experienced at least one trauma during their lifetime. A portion of these women also met clinical criteria for PTSD (Tagay et al., 2009). Therefore, SEA Americans may be at high risk for chronic health problems as a result of stressors that led to harmful eating behaviors.

Furthermore, because most of the literature focuses on first-generation immigrants and refugees, it is not yet known whether experience of IPV would predispose second-generation SEA American women to substance use. The literature suggests that SEA American communities are at high risk for substance use and abuse because of poverty, targeted advertising, and the increasing normalization of substance use by family or peers (e.g. Friis et al., 2006). Additionally, alcohol and drug companies target low-income ethnic minorities, placing a majority substance-selling outlets in close proximity to such populations (Lee et al., 2013). The potential generational transmission of substance use, in addition to the multitude of exposure to advertising, may predispose second-generation

SEA Americans to use drugs as a way of coping with stress, including stress stemming from IPV.

Ineffective healthcare utilization. Compared to non-victims, victims of violent assault utilize healthcare services at a greater rate. Among those who have experienced multiple assaults, healthcare costs are 2.5 times greater compared to non-victims (Koss et al., 1991). Several factors may account for this difference, including unresolved injury and health problems, impaired immune functioning, maladaptive health behaviors, and attribution of mental health symptoms as physical health problems (Koss and Heslet, 1992). Ineffective utilization of health services not only increases healthcare costs in terms of time and expenses but also increases risk for iatrogenic health problems.

Whether or not IPV among SEA American women would lead to increased healthcare utilization is unclear. Healthcare utilization is disproportionately low among SEA Americans (Centers for Disease Control and Prevention, 2004). The Hmong's experiences of American healthcare system are characterized by misunderstanding and mistrust (Johnson, 2002). Because traditional Hmong conceptualization of health and illness is incompatible with that of Western medicine, it is often difficult, if not impossible, to translate and explain Western diagnoses and treatments to Hmong patients. These cultural and language barriers have an adverse impact on healthcare utilization. In addition, in a qualitative study of Hmong residents (Johnson, 2002), participants reported that they perceived discrimination from healthcare providers (such as neglect and rudeness from the provider), and believed doctors and "student doctors" (i.e. residents) used Hmong patients for practice and experimentation. Together, this mistrust and misunderstanding may result in avoidance of healthcare services among the Hmong, including those who have experienced trauma from IPV. In addition, the use of healthcare services among Hmong women may be hindered by their lack of decision-making autonomy within their families, as

healthcare decisions are usually made by the oldest male member of the family (Johnson, 2002). Hmong women who have experienced IPV may be reluctant to seek medical care for acute injuries following assault, as well as for long-term health problems that may develop.

The context of systemic oppression, including cultural and language barriers, mistrust of the healthcare system, and perceived discrimination within the healthcare system, needs to be taken into consideration. Future research needs to take these factors into account in order to understand healthcare utilization among SEA American women with histories of IPV.

Discussion

Taking contextual factors into consideration, the applicability of Resnick et al.'s (1997) model to IPV and health among SEA American women is mixed, with some components of the model fitting well with this population and others requiring a more nuanced and complex perspective.

The components that pertain to physical injury, both acute and chronic, are generalizable to SEA American women: IPV does result in acute physical injury among Asian Americans, and underutilization of healthcare services may increase the likelihood that these acute injuries would develop into chronic ones. Nonetheless, there is a need for research on acute and chronic injury among SEA Americans specifically. Asian Americans are not a monolithic racial group, consisting instead of multiple ethnicities that differ from one another in terms of immigration history, SES, culture, and so on (Asian American Center for Advancing Justice, 2011). Indeed, there has been a call to disaggregate data on Asian Americans, particularly in the field of health disparities (Wong et al., 2012). On the other hand, contrary to Resnick et al. (1997), it is unlikely that experience of IPV would lead to overutilization of healthcare services among SEA American women, given the barriers to seeking healthcare and perceived discrimination from healthcare providers. SEA American victims of IPV are reluctant to seek

non-medical help as well. Lack of awareness of available services and mistrust of law enforcement were two of the reasons for lack of help-seeking (Bhuyan et al., 2005).

Application of most of the other components of Resnick et al.'s (1997) model must be done with special attention to gender roles, social disadvantages, and culture-bound expressions of stress and mental health difficulties. These components include increased stress, increased risk for mental health problems, and increased health risk behavior. The literature reviewed here suggests that while Resnick et al.'s framework is generally applicable and relevant to SEA Americans and IPV, trauma and health researchers who wish to explore this topic, but are unfamiliar with SEA communities, must consult closely with experts in SEA American studies.

Recommendations

Future research

In light of the gaps in knowledge about IPV and health outcomes among SEA American women, we suggest the following avenues for future research:

1. More work is needed to understand *mental health consequences* of IPV among SEA American women. This research ought to take into account culture-bound expressions of psychological distress as well as sociocultural risk factors, such as poverty and lack of autonomy.
2. Studies on *physiological correlates of stress* among SEA Americans are needed. This is particularly important given the role of psychosocial factors in endocrine and immune functioning. Cohen and his colleagues demonstrated that one's susceptibility to the common cold—an indicator of immune functioning—was predicted by current psychological stress (Cohen et al., 1991) and childhood SES (Cohen et al., 2004). Given financial and

other daily stressors SEA Americans face, women who experience IPV in the midst of these stressors may be at higher risk for disruption in the functioning of their immune and other physiological systems.

3. *Healthcare utilization* among SEA American IPV survivors is unclear. Previous work on help-seeking behavior suggested that whether women sought out counseling and legal services following IPV was influenced by their social and religious networks (Bui and Morash, 2007), and that these networks tended to discourage victims from seeking help so as not to risk disrupting the family. These interpersonal networks may also have an impact on the women's decisions to seek medical care.
4. We highlighted areas where more research on *second-generation* SEA American women is needed. Most of the studies reviewed here are on foreign-born SEA women who came to the United States as refugees or immigrants. Because these women came to the United States in the 1970s and 1980s, their offspring who either migrated with them as young children or were born in the United States are now young adults who may be in intimate partner relationships of their own. New research that focuses on this younger generation would be timely.

Clinical recommendations

Cultural competency is an important ingredient in reducing health disparities among minority groups (Anderson et al., 2003; Brach and Fraserirector, 2000). In this section, we adopt the cultural competency techniques provided by Brach and Fraserirector (2000) to make clinical recommendations:

1. Establish *interpreter services* to enhance communication between patients and providers, which can in turn address problems with conveying medical

terminology and with reducing mistrust of providers.

2. Increase *recruitment and retention* of SEA American staff in healthcare settings. These staff members are better able to interpret culture-bound expressions of physical and mental health problems that arise from IPV, including somatization and culturally specific experiences of posttraumatic stress.
3. Provide cultural competence *training* to providers. Such training can raise awareness about one's biases, increase knowledge about SEA American cultures, and build communication skills. Training should include education about the cultural context, historical context, and context of systemic oppression with regard to SEA American women.
4. *Coordinate with traditional healers* in order to incorporate traditional methods of healing with conventional medicine. Traditional healers can also reduce mistrust and enhance healthcare utilization among SEA American women.
5. Employ *community health workers* with whom SEA American women can better identify and who can serve as a liaison between patients and the mainstream healthcare system. SEA American women may be more likely to seek healthcare services via a health worker from their own communities.
6. Healthcare and health promotion for SEA American women need to *include family members*. This is especially important as SEA American women may not be the sole or primary decision-maker about their healthcare.

Conclusion

Given the prevalence of IPV among SEA Americans, more attention needs to be shifted to the physical health sequelae of IPV within these populations. The model proposed by Resnick et al. (1997), with its sound empirical grounding, provides a foundation for such investigations.

Researchers should be mindful of the contextual factors—cultural, systemic, and historical—that can add layers of complexity to the links between IPV and increased risk for health problems among SEA American women.

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