

Participatory Action Research in Practice

A Case Study in Addressing Domestic Violence in Nine Cultural Communities

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Participatory action research (PAR) is increasingly recognized as a viable approach to developing relationships with communities and working closely with them to address complex public health problems. In the case of domestic violence research, where ensuring the safety of women participants who are battered is paramount, participatory approaches to research that include advocates and women who are battered in research design, implementation, analysis, and dissemination are critical to successful and mutually beneficial projects. This article presents a case study of a PAR project that conducted formative qualitative research on domestic violence in nine ethnic and sexual minority communities. The article describes the specific ways in which a PAR approach was operationalized and discusses in detail how community participation shaped various stages of the research. Furthermore, specific actions that resulted from the research project are reported.

Keywords: *domestic violence; community-based participatory action research; immigrant women; intimate partner violence; methods*

Participatory action research (PAR) is increasingly recognized as a viable approach to developing relationships with communities and working closely with them to address complex public health problems (Minkler, 2000). PAR

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involves members from the affected communities in all stages of research including research design, implementation, analysis, and dissemination of findings. In addition, there is an explicit value that research lead to action (Whyte, Greenwood, & Lazes, 1991). Rationales for using a PAR approach include the opportunity for researchers and community members to learn from each other (Hatch, Moss, Saran, Presley-Cantrell, & Mallory, 1993), address power imbalances (Israel, Schulz, Parker, & Becker, 1998), empower participants (Fawcett et al., 1995), democratize knowledge (Sohng, 1996), enhance the relevance of research and connect research to larger social change efforts (Giachello et al., 2003). In the case of domestic violence research, where ensuring the safety of participants is paramount (Langford, 2000), participatory strategies that include advocates and women who are battered in designing and implementing the research can be critical to successful and mutually beneficial projects (Israel et al., 1998; Whyte et al., 1991).

A growing body of literature defines participatory research, outlines guidelines for conducting it, and describes benefits and challenges of this approach (Baker, White, & Lichtveld, 2001; Giachello et al., 2003; Israel et al., 1998; Schulz, Krieger, & Galea, 2002). However, fewer articles (Minkler, 2000; Mullings et al., 2001) discuss accounts of community participation in actual research and report on actions, especially in the arena of interpersonal violence. This article presents a case study of a PAR project that conducted formative research on domestic violence in ethnic and sexual minority communities. We describe the specific ways in which we operationalized a PAR approach and discuss in detail how community participation shaped various stages of the research. Furthermore, we report on specific actions that resulted from this research project.

Background

The research was funded by the National Institute of Justice under the Researcher-Practitioner Collaboration Program. This formative, qualitative research project explored three main themes: (a) understanding the cultural context of domestic violence, (b) examining access to and satisfaction with the range of services for women who are battered, and (c) identifying

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women's ideas for addressing domestic violence in their communities. Nine communities participated in the research: African American, American Indian, Latina, Filipina, Russian-speaking, Amharic-speaking (Ethiopian), Cambodian, Vietnamese, and lesbian/bisexual/transgender (LBT) people. During the 15-month project, we conducted 38 focus groups and 16 interviews with more than 254 women who were battered from the nine communities.

The research was conducted in King County, Washington, a large county of more than 1.7 million inhabitants that includes the city of Seattle (U.S. Census Bureau, 2000). Seattle and King County are relatively homogenous when compared to other metropolitan areas of similar size on the West and East Coasts of the United States with 73% of the population identifying as White (of European heritage) and non-Hispanic in the 2000 census. Nevertheless, this area has grown increasingly diverse, in part, because of an influx of immigrants and refugees. In the 2000 Census, 15.4% of the population or 268,285 people were foreign born. This was a dramatic increase with one half of the foreign born having entered the United States within the past 10 years. The foreign-born population is primarily non-White with 19.7% from Europe, 51.4% from Asia, 5.3% from Africa, 1.7% from Oceania, 15.3% from Latin America, and 6.6% from Northern America (U.S. Census Bureau, 2000). The number of refugees also grew to 73,000 in 2000 (Seattle-King County Workforce Development Council, 2000). The majority of refugees are from Southeast Asia; however, there are significant numbers of refugees from East African countries, the former Soviet Union, and eastern Europe. The growing diversity of Seattle presents challenges to providing domestic violence services that are linguistically and culturally competent. For many of these communities, little is known about the prevalence of domestic violence, the cultural context, and best ways to serve women and families.

This research was initiated in response to concerns within the domestic violence provider community and government agencies overseeing community-based services. In particular, there was concern over the limited local information on ethnic and sexual minority communities and their interpretations and responses to domestic violence. There was also concern about how well local government and providers were reaching out and providing services to women of color, limited English speakers, refugee and immigrant women, and LBT people. The city has a Domestic Violence Council (DVC) that directly advises the mayor on domestic violence and whose ultimate goal is to create the conditions necessary to prevent domestic violence from occurring. The Public Health Department, Public Health—Seattle and King County is a member of the Council and also plays a lead role in providing research and data-related technical assistance to city efforts. The Health Department was asked to take a lead role in identifying funding for this work.

It was clear from the beginning that to competently design and conduct a research project on this sensitive topic in ethnic and sexual minority communities, representatives from these communities would need to be involved as full partners throughout. The researchers were committed from the beginning to a research approach that would have promise in leading to change that would benefit marginalized communities. Previous research by some of the authors on local relationships between communities of color and researchers and their institutions indicated that community members were tired of research projects simply documenting problems in communities and wanted to see tangible benefits from participating in research (Sullivan et al., 2001).

Therefore, with this in mind and with the commitment of five community-based agencies serving ethnic and sexual minority survivors of domestic violence collaborating, we developed a proposal to the National Institute of Justice articulating a PAR model for the research.

PROJECT STRUCTURE AND COMMUNITY INVOLVEMENT

For this project, community involvement was sought from the domestic violence community. The domestic violence community, in this case, meant representatives from community-based victims services organizations, government agencies, advocates, activists, and survivors who are working to serve women who are battered and to end domestic violence in our county. For this project, it was particularly important to collaborate closely with advocates representing the nine cultural groups. Thus we aimed to structure this project in a way that would maximize input and participation from diverse representatives of the domestic violence service community.

Researchers and community representatives worked together and shared ideas through two formal mechanisms. The Qualitative Research Team (QRT) was composed of the three Health Department and University researchers and bicultural, bilingual advocates from the five partner agencies representing each of the nine cultural groups (i.e., an Ethiopian advocate, a Cambodian advocate, an LBT advocate, etc., from each of the victim service partner agencies). In addition, a community activist and survivor of domestic violence, hired by Public Health to help coordinate the research, also participated on the QRT.

Beyond community involvement from partner agencies, broader participation was sought from the Seattle and King County domestic violence community. The Project Advisory Group (PAG) included participation from community-based victim services agencies, government, legal services, law enforcement, and health and social services agencies. The PAG gave overall

advice and guidance on such topics as which specific communities should be included and how to ensure the safety of survivors who participate in the project. This broader participation was sought so that local decision makers would be aware of the research, have input throughout, and be more likely to use the findings for systems change to improve domestic violence services for women who were nonmainstream.

This article is primarily concerned with the role of the QRT because this is the forum in which the research was designed and conducted. The QRT typically met bimonthly throughout the 15-month project, and it was in this group that the project was planned, instruments and protocols developed, team members were trained to conduct focus groups and interviews, discussions of working in a culturally competent way took place, recruitment strategies were developed, and data were analyzed and interpreted.

At the beginning of the project, QRT partner agencies were asked to specify their preference for their level of involvement with the project. Choices ranged from (a) assisting with recruitment of participants only, (b) participating on the QRT and helping to plan and conduct the research, and (c) taking part in all of the aforementioned tasks plus assisting with analysis and writing. None of the agencies chose to help only with recruitment. Three chose the second level of involvement, and two agencies worked with the researchers through data analysis and writing final reports. All participated in reviewing and confirming the findings based on advocacy and community knowledge. Agencies were reimbursed at an hourly rate plus overhead for the time their employees spent on the project.

The Seattle and King County Public Health Department's Epidemiology, Planning and Evaluation Unit was the lead agency for this grant. The principal investigator is a medical anthropologist at the county public health department and affiliate clinical faculty at the University of Washington School of Public Health and Community Medicine (SPHCM). The coprincipal investigator is also an anthropologist and a faculty member at the University of Washington, School of Public Health and Community Medicine. The following community agencies were also represented on the QRT: Refugee Women's Alliance, Consejo Counseling Services, The Seattle Indian Health Board, The Northwest Network of Bisexual, Trans, and Lesbian Survivors of Abuse, and the East Cherry YWCA.

PARTICIPATION ACROSS EACH PHASE OF RESEARCH

Members of the QRT were involved in all phases of research from research design to dissemination of the findings, and significant decisions

about the development and conduct of the research were made by the QRT during biweekly meetings. The following examples of participation in the research project are drawn from QRT meeting notes, researchers' notes, and process evaluation interviews that were conducted separately the QRT members by the research coordinator. Details of our partners' participation in the research are discussed below for each stage of the research process.

Research Design

Our funding, from the National Institute of Justice (NIJ), specified that we would engage in qualitative, formative research with ethnic minority and LBT communities, with the explicit caveat that as a participatory project it would be shaped by our partners. In the original proposal, we specified that we would conduct a mixture of focus groups and interviews. When the QRT began to meet and the researchers outlined the basic framework written in the grant proposal, concern was raised about the appropriateness of using a focus group format with these particular groups, for this particular topic (domestic violence). Some advocates thought that women in their communities would be reluctant to talk about their abuse in groups but would share individually. Others thought that some women would be willing to talk about their experiences in groups but not willing to be interviewed individually. This issue was solved when one of the advocates suggested letting the women choose themselves between focus groups and interviews. Another advocate suggested we educate potential participants about confidentiality challenges in focus groups (in some small communities, women might know other participants in their focus groups). She explained that women would need to know about this during screening so that they could make an informed choice between focus groups and interviews. Finally, the QRT decided to present the study to the prospective participants as a focus group study with an option to do an individual interview if they preferred, with the caution about focus group confidentiality mentioned at recruitment. In the end, a few participants opted for individual interviews, and the majority of these participants identified as LBT.

Inclusion Criteria

QRT members shaped the inclusion criteria for the research project in a number of ways. At one of our early meetings, we discussed the need to agree on an operational definition of *domestic violence* so that all of us could be recruiting uniformly. The final definition of domestic violence decided on by the QRT was much broader than it might have been had the researchers made

the decision. At the most basic level, the project would include women older than age 18 years from any of the nine communities who experienced domestic violence by an intimate partner or other family member living in their household at anytime in their lifetime. Potential participants were asked “In the past 5 years have you been in a relationship where your partner threatened you with or hurt you physically, sexually or emotionally?” Examples of physical, sexual, and emotional abuse were also provided and participants were asked if they had experienced or used any of the suggested items (e.g., shouted, swore or called names; kept from leaving, taken money or checkbook, locked out of house; pushed, grabbed, scratched, or punched).

Included in the definition of domestic violence was abuse by a mother-in-law after the Southeast Asian advocates asserted that this was an important relationship in which domestic violence occurs in their communities. The inclusion criteria for the sexual minority group was also expanded from women who identify as lesbian to include bisexual, transgender, and transsexual people. This occurred at the request of the LBT QRT member and was particularly important to the LBT agency because they wanted the study to be inclusive of the entire queer community to which they serve.

Screening

All potential participants were screened on the above inclusion criteria before they were scheduled into focus groups or interviews. The researchers wrote a first draft of a screening protocol and shared it with the QRT. Significant revisions were made by QRT members. For the LBT group, the LBT advocate developed an augmented protocol that included a series of questions the LBT agency uses to screen people into services that help to differentiate batterers from victims. This was done because of the risk that a survivor and her batterer theoretically could be in the same focus group. This insight was an invaluable contribution made by the LBT advocate on an issue that was not immediately obvious to the researchers.

One of the QRT members raised the question of how we would deal with women who identify with more than one community. For example, what would we do with a prospective participant who identifies as lesbian and Latina? After some discussion, the QRT decided that it would be up to the woman to decide in which group she would prefer to participate, for the purposes of the current study. Furthermore, if a participant decided that she did not feel comfortable in any of the groups, she could opt to be interviewed one on one. This situation arose only once during recruitment, and the participant chose to take part in one of the focus groups.

Facilitators

From the time of writing the originally grant, the researchers, at the request of the funding agency, developed a plan to avoid bias that could result from provider-client relationships. Because we were working with domestic violence service agencies and primarily recruiting through them, we realized that many of the participants would be clients of these agencies, though it was also our intention to recruit women who were not using agency services. The primary facilitators would be the bilingual and bicultural domestic violence advocates on the QRT. Our initial plan was to have two sets of facilitators—bilingual, bicultural advocates from the agencies (QRT members) facilitating focus groups and conducting interviews with participants who were not clients of the agency; and medical interpreters and/or other outside facilitators, also bilingual and bicultural, with no connection to the agencies who would conduct focus groups and interviews with participants who were agency clients. This was intended to reduce the bias of having an agency advocate interviewing her own clients about the services they had received. For some communities, this worked very well, including the African American, Native American, and LBT communities.

However, Ethiopian, Cambodian, and Vietnamese survivors were very uncomfortable participating in focus groups or interviews with someone they did not know facilitating or interviewing, and many would not divulge their stories. This was a topic of discussion at many QRT meetings where advocates and researchers brainstormed ways to improve recruitment in these communities. After several weeks of difficulty recruiting, the advocates suggested that they conduct the focus groups and interviews with their clients. When we made the change to the protocol, though it introduced a particular bias, recruitment ceased to be difficult. The researchers consulted with the funder who reasoned that some data were better than no data and allowed for the protocol change. This difference in protocol for these groups was taken into account in our analysis of the data.

Question Development

The focus group and interview guide was largely designed in QRT meetings. Although a sample focus group guide was composed for the purposes of writing the grant, this preliminary guide was set aside, to allow for the process of developing the questionnaire through brainstorming sessions with the QRT. We spent two meetings compiling topics that each of QRT member wanted to learn about through the research project. At the first brainstorming

meeting, more than 30 questions and/or topics were generated. Two weeks later, at a second meeting, we added to the list. Then, a member of the research team wrote a first draft of the questions and tried to prioritize and group issues and/or topics.

The interview questions fell into four main topics: (a) culturally specific ways that women and their communities talk about domestic violence, (b) women's experiences with services, (c) how being a parent affects women's experience with domestic violence, and (d) women's solutions for domestic violence. The first two topics were ones that had been included originally in the grant as potential topics. The concern about children and teens was brought to the table by the advocates because of their experience working with women. "Women's solutions" was a suggestion by one of the researchers as a way to end the focus group discussions on a positive and hopeful note. This topic was supported by the researchers and the advocates. Next, the researchers brought the first draft of the guide back to the QRT for another review. Then, we discussed and made suggested revisions. The guide was discussed further, and more revisions were made.

Cultural Competency

Designing the research to be culturally competent was an ongoing theme of QRT discussions. Drawing from Cross, Bazron, Dennis, and Isaacs (1989), *cultural competence* is defined as the state of being capable of functioning effectively in the context of cultural differences. This includes a set of congruent behaviors and attitudes, practices, skills, policies, and institutional structures that come together in a system or agency or among professionals working together. With this goal in mind, advocates took the lead in identifying and developing appropriate ways of working with their communities, and the researchers deferred to their knowledge and experience. QRT meetings were often focused on discussions of how various approaches would work in the nine communities. For example, when discussing how to frame the research to prospective participants, the advocates shared the different ways in which they talk about domestic violence in their communities. The American Indian advocate noted that she talks about healing and has stopped emphasizing violence and victimization. The Latina advocate shared that they tend not to use the word *domestic violence* at first but rather talk about hitting or controlling. Study protocols built in flexibility to reflect how different advocates frame the topic of domestic violence in their own communities.

Recruitment

Recruitment into this project varied significantly by cultural group. For some groups, recruitment was nearly effortless, we simply hung flyers in community locations, and women who were survivors of domestic violence called the study number and volunteered. This was true for African American and American Indian women. For other groups, recruitment was much more difficult and required a great deal of time on the part of the advocates. The QRT, thus, also spent more time addressing recruitment and developing various recruitment strategies. In most of the communities, recruitment was ultimately successful because of the trusting relationships and credibility the advocates and the agencies have with their clients and other community members. Recruitment was conducted via face-to-face interactions and word of mouth.

For the LBT community, we tried to recruit by posting flyers in a variety of community locations in the geographically identified LBT community. This approach was ineffective. In the end, nearly all of the LBT participants had a prior relationship with the LBT agency and were recruited by advocates at the agency. The LBT community in Seattle is relatively small, and potential participants may have feared coming forward and having their confidentiality violated.

Analysis

Data analysis and interpretation also occurred in the QRT. Two of the agencies agreed for their advocate employees to continue to work with us on this stage of the research. The team closely read the transcripts to identify main themes. Then, main themes and concepts were organized into codes that gave structure to analyzing and compiling the data. To organize and retrieve coded data, transcripts were entered into NUD*IST (QSR NUD*IST, 1996), a software package for analyzing text-based data. NUD*IST assists the researcher in organizing, searching, and retrieving text-based data and is useful for analyzing the large amounts of data generated by this type of project. QRT members participated in analysis by reviewing an initial draft of the codebook and expanding and refining it, coding transcripts, and initial write-up of findings. Advocate participation in coding turned out to be central to the analysis. Advocates had a much more nuanced understanding of domestic violence and some of the cultural aspects and were able to bring this to the analysis and interpretation of the data. Specifically, advocates were quicker to recognize perpetrators' subtle behaviors as examples of control and abuse. Those QRT members who did not participate

in the analysis were consulted after the initial findings were written to determine whether the findings accurately reflected the issue of domestic violence within their cultural groups.

For the urban American Indian groups, preliminary findings were also shared with participants in the Seattle Indian Health Board's Native Women's Support Group to confirm and provide feedback on the initial findings. Many of the Native Women's Support Group participants had also participated in the focus groups, which provided an insightful critique of the findings. By including survivors in the process of reviewing and discussing early findings, we were able to acknowledge their contributions to the project and to solicit feedback from them.

Final reports on all of the groups were approved by the QRT members before distribution.

Focus Group Logistics

QRT members provided a great deal of advice on the logistical issues with respect to conducting the groups. QRT members recommended best places to hold the groups that would be convenient and feel comfortable to women in different communities. The most convenient, well-known, and safe locations tended to be public health clinics and victim service agencies. Public health clinics provided a plausible cover story (e.g., women could say they were taking children for health care services). As for child care, the advocates all agreed that providing onsite child care during the focus groups would be preferable than giving women money to pay for and arrange their own. QRT members also recommended paying women in cash because some participants might not be able to cash checks, and checks would create a paper trail that could potentially threaten a participant's confidentiality. QRT members also recommended the best times of day to hold the groups. For example, Russian groups tended to occur in the evening, while most of the Ethiopian groups occurred during the day. All of these were important details that made it possible for survivors, particularly those with children, to attend.

Safety Protocols

The PAG and the QRT assisted and advised on all issues affecting the safety of the participants and the research staff. One of the most important features of the project was that advocates had much of the direct contact with the participants (e.g., during recruitment activities, focus groups, and interviews). In many cases, the advocates knew the particular situation of the women and helped them devise cover stories if necessary. Other safety pre-

cautions that were taken largely as a result of PAG and QRT consultation included blocking the study telephone numbers; choosing safe locations; having a crisis counselor on site for all of the focus groups; and having resources for domestic violence, emergency shelter, and so on onsite at all of the focus groups and interviews. After business hours, focus group locations were kept locked, with site security personnel notified about the groups when applicable.

Dissemination

QRT members played key roles in disseminating the research. They participated in numerous presentations to various audiences at the community level, at local domestic violence conferences, at national conferences and trainings and on a keynote panel at an international domestic violence conference. Both the advocates and researchers copresented whenever possible. The advocates, with their cultural and domestic violence expertise, were best suited to speak to the research findings for their communities whereas the researchers presented background, design, methods, and analysis.

Advocate and Agency Involvement and Action

Because of the close involvement of advocates and their agencies, there was a great deal of interest by the QRT in putting the findings into action. A frequent theme of QRT discussions was what we would do with the findings when the research was completed. When our preliminary findings were available, the researchers held individual meetings with the executive directors and advocates from each agency that participated on the QRT. The agencies were asked if there were any findings from the research on which they would like to act and if they would like assistance from the researchers to obtain funding. Four agencies expressed interest in this type of follow-up. Within a year of releasing our findings, two grants were obtained for programs that were developed based on the findings of the research.

One of the projects that grew out of the research partnership took place in the LBT community. Together, the agency staff and researchers wrote a grant for the FAR OUT project. The FAR OUT project (Friends Are Reaching Out) was a 1-year pilot project, funded for US \$60,000 that worked with survivors and their social networks to break the isolation that so often is a feature of battering relationships. The project mobilized LBT community members to play a role in keeping survivors safe and resisting domestic violence in their communities.

Another program that was developed based on the research findings involved participants from Refugee Women's Alliances. We Can Help Each Other was a collaborative effort of Refugee Women's Alliance (ReWA) and the provided language- and culture-specific social support and skill-building for immigrant and refugee survivors of domestic violence. This program responded to participants' recommendations for culture- and language-specific support groups that would help women learn skills to cope with abuse and to develop social networks to reduce isolation. Support and skill-building groups were conducted between 2000 and 2002 in four communities (Cambodian, Ethiopian, Russian, and Somali). ReWA conducted the intervention, and Public Health Department and University researchers conducted a participatory evaluation of the support groups. Funding was obtained through Seattle's Urban Research Center grant that was funded by the Centers for Disease Control.

In addition to these funded programs, other actions were taken by QRT partner agencies and others in the community in response to the research findings. In the urban American Indian community, two members of the Native Women's Support Group made a presentation to the Board of Seattle's Urban Indian Health Clinic about their experiences as survivors. The Native Women's Group then obtained a small grant for participants to attend a Native women's healing conference. In addition, with the leadership of one of the researchers, the Seattle Indian Health Board composed a grant proposal to develop a video with urban Indian women to educate health care providers about domestic violence and urban Indian women to counter stereotypes so that women will feel comfortable disclosing abuse in health care settings.

DISCUSSION

PAR seeks to democratize research by including all stakeholders, from informants all the way to the principal investigator, in all research activities. As described in this article, we employed PAR strategies to share decision making with community partners in all aspects of a research project on domestic violence. In addition, we report on actions that grew out of the research and partnerships. Consistent with the experiences others have reported (Minkler, 2000; Parker, Schulz, Israel, & Hollis, 1998), PAR provided a viable model for developing relationships with community members, fostering diverse participation, sharing decision making, and developing culturally competent research methods and data analysis.

In the practical implementation of this project, adherence to PAR's goals were negotiated alongside the varying degrees of investment each stakeholder had in the research process from the amount of time that people had available to devote to the research to assessing the potential risks and benefits of degree of taking part in all research activities, given issues of safety, confidentiality, and privacy. In our assessment, the group that had the most limited participation in the research process were the research informants, in this case immigrant and ethnic minority women who took part in the focus groups and interviews. Although these informants reported having enjoyed taking part in the focus groups and interviews, the structure of the project did not facilitate them to be further involved. In particular, constraints arose because of the demands on informants' lives as related to possible ongoing abuse, parenting responsibilities, and employment. We thus sought the expertise of community partners, several of whom were themselves survivors of domestic violence, in addition to incorporating the knowledge and experiences of community-based advocates who work directly with women who are responding to abuse in their lives.

While there were some constraints to realizing the full participation of all stakeholders, several specific factors contributed to the overall success of the research. This discussion will reflect on structural aspects of the research project that set the stage for collaboration and contributed to successful conduct of the research and putting the findings into practice.

Community Infrastructure and Capacity

First and foremost was the capacity of the community-based agencies that participated on the QRT. Agency partners had capacity to participate in the research and to take a leadership role in follow-up (see Goodman et al., 1998, community capacity). Infrastructure also provided the means for follow-up, particularly with those agencies whose future plans were in concordance with the research findings. ReWA and the LBT domestic violence providers had long-term goals of implementing the kinds of projects that were identified in the project. However, even beyond the institutional support, the individual advocates who participated in the research were able to utilize their strong connections to their communities, thus building on previously developed trusting relationships. Though the advocates on the research team did not necessarily all know each other, they shared common commitment in their work with women and domestic violence.

Although community members who are advocates and services providers were integrated throughout the project, participation of women who were

battered, or women who are members of the community but not also working at one of the partner agencies, had more limited and specific participation. With the exception of the Native women's group, there was not a formal structure within which to include women who were battered. Some of the advocates had the experience of abuse themselves in addition to their knowledge and experience working with victims and/or survivors of domestic violence in their respective communities. The limited participation of women who were battered in each phase of the project raises questions of what is the appropriate and realistic level of participation from everyone involved.

Institutional Infrastructure and Capacity

Although our NIJ grant did not fund follow-up and actions resulting from the research, there was an institutional commitment from Seattle and King County Public Health Department to allow the researchers to take an active role in these activities. Without specific funding, Public Health staff assisted with writing two grants, organized conference participation, gave more than 30 presentations on the project to a variety of community, academic, institutional, and/or governmental audiences and continued to consult with community partners on future work. The Seattle and King County Public Health Department has been the recipient of a CDC Urban Research Center grant through Seattle Partners for Health Communities, first established in 1995. Ongoing support from Seattle Partners helped us to develop significant local infrastructure for community based research and seek funding opportunities for follow-up action steps.

Methods and/or Design Flexibility

Through qualitative data the power of the women's stories galvanized the group. Even advocates who had worked in the field for years learned new information from listening to the women's stories. Hearing, reading, and rereading the stories also developed a strong sense of responsibility to the participants. Several advocates expressed the feeling that the research accurately gave voice to the experiences of women and did not try to interpret and label their experiences through a mainstream lens. This was particularly important because the focus groups recruited from nonmainstream communities of color, immigrant communities, and sexual minority communities that each have histories of exclusion and misrepresentation in research as well as service delivery (Sullivan et al., 2001).

Implications for Practice

This article has implications for researchers, health educators, other public health professionals and community workers interested in participatory approaches to domestic violence research. Others have discussed the intersection of participatory research approaches with practice implications. Gondolf, Ylloe, and Campbell (1997) asserted that collaborative research projects are more likely to ensure women's safety. In our project, we did not experience any safety problems; special attention was given to working with women to devise cover stories, establishing guidelines for confidentiality in the focus groups, suggesting locations that were known to participants and secure, and providing follow-up to participants upon request.

Edleson and Bible (1999) discussed several important practice implications for participatory research overall, which include enhancing relevance of research findings and enhancing its legitimacy in the research and local communities. Through this project, partners reported that the cultural relevance and the relevance to practice were enhanced by community participation. Agency and advocate participation led to enhanced legitimacy of the research within the broader domestic violence community in Seattle and King County, and Health Department and University involvement also added legitimacy to the findings. As described above, the findings were utilized in a number of different ways for various collaborative projects. It is likely that this would not have occurred without partners' close involvement and investment in the research. In general, we hope this work encourages public health professionals to collaborate closely with domestic violence advocates for any program or research project addressing domestic violence.

Edleson and Bible (1999) also noted that collaborating in research may increase exposure of practitioners to national-level research and practice. This has been the case for advocates who worked on this project. Advocates from each of the agencies participated in a keynote panel at an international domestic violence conference, and ReWA advocates were able to hold their first session on domestic violence at an annual East African Refugee Conference to report on the research and intervention.

CONCLUSION

Community-based researchers have documented the need for longer timelines, the importance of building trust, and sharing power among members (Israel et al., 1998). In our experience, one of the most significant difficulties is that although funding agencies are increasingly supporting collabo-

rative research projects, the funding is for research only, and the action portion of a participatory action research project remains largely unsupported. Often, it is only through the diligence of community partners and researchers that actions will result. In our case, our community partners continually reminded us that they wanted something to come out of our research that would benefit their communities.

One way to address this dilemma could be for funders to allocate resources for follow-up on what is learned through formative research. Ideally, formative research would lead to the development of programs that, in turn, would lead to implementation and evaluation of promising approaches. Grants could be structured to allow for a progression of activities so that researchers could build long-term relationships with communities and communities would experience tangible benefits from research. Approaches such as this would go a long way toward building and restoring trust and would lead to better programs, better dissemination of research findings, and programs that are grounded in research and strengthened by evaluation.

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