Intimate Partner Abuse and Relationship Violence

This document was developed by the Intimate Partner Abuse and Relationship Violence Working Group. The working group was comprised of members from the following divisions:

Division of Family Psychology (Division 43),
Society for the Psychology of Women (Division 35),
Society for the Psychological Study of Lesbian, Gay, and Bisexual Issues (Division 44),
Society for the Psychological Study of Ethnic Minority Issues (Division 45), and
Society for the Psychological Study of Men and Masculinity (Division 51).

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Dear Colleague:

This publication is designed to promote education about partner abuse and relationship violence. It represents our recommendation to faculty members who would like to develop courses focused on partner violence. Additionally, for those faculty members who would like to merely add information about partner violence to their existing courses, the present information will be useful.

Students who will be working in the mental health field will undoubtedly encounter issues of partner abuse and relationship violence, whether they recognize such violence or not. Consequently, learning about issues of prevalence, theories, how to detect such abuse across differing communities (including ethnic minority and gay/lesbian/bisexual communities), the consequences of partner violence, strategies for prevention, forensic issues, and therapeutic interventions and services are included in this document.

Publication of this booklet has been sponsored by the Committee on Divisions and the American Psychological Association Relations (CODAPAR). The divisions involved in the development of this booklet/curriculum are the Division of Family Psychology (Division 43), the Society for the Psychology of Women (Division 35), the Society for the Psychological Study of Lesbian, Gay, and Bisexual Issues (Division 44), the Society for the Psychological Study of Ethnic Minority Issues (Division 45), and the Society for the Psychological Study of Men and Masculinity (Division 51). The members are shown below:

Intimate Partner Abuse and Relationship Violence Working Group
Chair: Michele Harway, Ph.D.

Members:
Robert Geffner, Ph.D.—Division 43
David Ivey, Ph.D.—Division 43
Mary P. Koss, Ph.D.—Division 35
Bianca Cody Murphy, Ed.D.—Division 44
Jeffery Scott Mio, Ph.D.—Division 45.
James M. O’Neil, Ph.D.—Division 51

Thank you for your interest in including partner abuse and relationship violence in your curriculum. Please feel free to share this publication with others.
History of the Project

In June of 1999, the CODAPAR of the American Psychological Association awarded an interdivisional grant to a group comprised of representatives from Divisions 43, 35, 44, 45 and 51 to develop a curriculum on partner abuse and violence. Then President-elect of Division 43 (Family Psychology), Michele Harway, Ph.D., had written the grant application in collaboration with presidents-elect of the other four divisions; at that time this included Phyllis Katz, Ph.D., of Division 35 (Women), Esther Rothblum, Ph.D., of Division 44 (Lesbian, Gay and Bisexual), Joseph Trimble, Ph.D. of Division 45 (Ethnic Minorities) and Michael Andronico, Ph.D. of Division 51 (Men and Masculinity). Following the official awarding of the grant, each division nominated at least one representative to form the core work group. In August, 2000, the outline of the curriculum was presented at the annual convention of the American Psychological Association in Washington, D.C. It was also presented in September, 2000 at the 5th International Conference on Family Violence in San Diego, CA. Subsequent to revisions and input from other experts on partner violence, the curriculum was finalized; the revised outline was presented at the annual convention of the American Psychological Association in San Francisco, August, 2001.

This curriculum is not the only effort sponsored by the American Psychological Association (APA) that focuses on interpersonal and relationship violence. Since 1988, APA has appointed various task forces dealing with some aspect of interpersonal violence, including the Child Abuse and Neglect Working Group, the Task Force on Male Violence Against Women, and Violence Against Children in the Family and the Community. In 1994, the APA Taskforce on Male Violence Against Women issued its report, (No Safe Haven: Male Violence Against Women at Home, Work, and in the Community). Also in 1994, the APA Presidential Task Force on Violence and the Family was appointed, and a report was published by APA in 1996 (Violence and the Family). These reports are good resources for this curriculum. The Presidential Task Force also published Issues and Dilemmas in Family Violence, a pamphlet that would also be useful for the curriculum. Subsequently, an Ad Hoc Committee on Legal and Ethical Issues in the Treatment of Interpersonal Violence was appointed to specifically address some of the forensic and risk management issues involved in these situations. Two pamphlets were published in 1996 and 1997 that are good resources: Potential Problems for Psychologists Working with the Area of Interpersonal Violence, and Professional, Ethical and Legal Issues Concerning Interpersonal Violence, Maltreatment, and Related Trauma. Various Guidelines have also been published in APA journals that deal with this topic, and they are referenced throughout this guide. Most of the task forces and committees have recommended that graduate training and continuing education for psychologists concerning family violence be mandated or strongly urged in all states. The present document helps meet the need for a curriculum.

Note: We gratefully acknowledge the input of Janis Sanchez, Ph.D., Guy Seymour, Ph.D. and Yolanda Flores, Ph.D.
Training Curriculum in Relationship Violence

I. Introduction

Relationship violence, including physical, sexual, and psychological abuse, affects many millions of Americans. A US Department of Justice report of findings from the National Violence Against Women Survey involving 16,000 interviews (Tjaden & Thoennes, 1998) estimated that almost 2 million people are victimized in a 12 month period. The study estimates that there are close to 9 million incidents of violence annually. Over one-third of the rapes and close to half of the physical assaults of women result in injuries. About 1 in 5 male victims is injured. Other studies indicate that among women victims, 76% were assaulted by an intimate partner as were 18% of male victims (Tjaden & Thoennes, 1998). A third of abusive incidents took place between relatives, and more than half were between spouses or ex-spouses. Partner abuse is found in every ethnic group in the United States. A second report from a survey devoted to intimate partner violence reported that (Tjaden & Thoennes, 2000), 1 out of every 5 women reported having been assaulted by an intimate partner at some time in her lifetime, versus 1 out of every 14 men. In the previous 12 months, 1.3 million women and 835,000 men had been physically assaulted by an intimate partner. However, women were 7 to 14 times more likely to experience serious acts of partner violence, and were significantly more likely to sustain injuries than men who were victims of intimate violence. Thus, it is important to distinguish between acts of aggression and those of abuse. Abuse usually includes an ongoing pattern of behavior, attitudes, and beliefs in which a partner in an intimate relationship attempts to maintain power and control over the other through the use of psychological, physical and/or sexual coercion. Abuse usually produces fear and trauma in those being victimized, whereas isolated aggressive acts may not. With sexual assault, even one sexual aggression can produce fear of rape and fear of men for life.

Until recently most studies of partner violence have been almost exclusively of heterosexual partners, with only limited information about prevalence/incidence of partner violence among gay, lesbian, bisexual and transgendered people. There is a growing body of evidence which suggests that same-gender partner violence is as common as heterosexual partner violence (Farley, 1996; Renzetti, 1992). The dynamics and types of violence in same-gender relationships are similar to heterosexual partner violence (verbal threats, public humiliation, destruction of property, abuse of children, sexual abuse and life-threatening acts). Like most intimate partner violence, same gender partner violence is often invisible and hidden (Lobel, 1986). Many people don't recognize same gender partner violence because partner violence is often portrayed as male violence against women. Island and Letellier (1991a) estimate that as many as 500,000 gay men are victims of domestic violence. Estimates of the prevalence of abuse in lesbian relationships vary widely as researchers have used different methods and questions to measure abuse. We do not have statistics about intimate partner violence for transgendered individuals in either heterosexual or same gendered couples, although there is anecdotal evidence that it does occur. Traditional views of gender roles, heterosexism, negative attitudes toward homosexuality, prejudice and discrimination based on sexual orientation contribute to unique issues of same-gendered intimate partner violence. Transgendered individuals can be involved in heterosexual partner violence and same-gendered partner violence. Ignorance about transgender people, prejudice, and discrimination result in a lack of recognition of relationship violence and lack of
appropriate services. Issues are much more complicated for lesbian, gay and transgendered people of color. The interface of racism with heterosexism, negative attitudes toward homosexuality, prejudice and discrimination based on sexual orientation and "transphobia" must be considered at all levels, from causation through treatment and service provision.

In terms of people of color, the National Violence Against Women survey (Tjaden & Thoennes, 2000) reported that Hispanic and non-Hispanic women were nearly equally likely to report physical assault or stalking victimization. There was slightly more such violence in the Black community than in the White community (with violence in all other communities being much lower), but in examining the income levels and the prevalence of violence, quite clearly there is more violence in families distressed economically. To the extent that African American families earn less than their White counterparts, the difference in domestic violence can be accounted for by SES and not ethnicity. Although research in relationship violence has not found it to be more prevalent in ethnic minority communities (Bachman & Saltzman, 1995), available figures may underestimate the true numbers of affected ethnic minority persons due to linguistic/cultural differences, fear of losing one’s community support base, and ethnic minority populations’ suspicion of researchers.

In addition to those directly involved in relationship violence, there is a wide network of family members who are exposed to violence within the family and suffer from its effects, including 3.3 to 10 million children (Carlson, 1984; Straus & Gelles, 1990). The exact number is not clear though since there have been methodological questions concerning the derivation of the prevalence rates. However, recent research has documented the numerous consequences for children exposed to interparental violence (for reviews, see Geffner, Jaffe, & Suderman, 2000; Holden, Geffner & Jouriles, 1998).

We also know that intimate partner violence is not restricted to married couples or committed couples. Dating violence including sexual and physical assaults has been reported to affect 10% of high school students (Silverman, Raj, Mucci, & Hathaway, 2001), and up to 39% of college students (White & Koss, 1991). Between 1 in 4 and 1 in 5 college women will be raped during college according to most recent US Department of Justice data (Fisher, Cullen, & Turner, 2000). This rate has remained stable since the first national study in 1987 (Koss, Gidycz, & Wisniewski, 1987).

Because of their prevalence, physical, sexual and psychological abuse rank among the most pressing societal problems today. These forms of abuse not only often result in lifelong physical and mental health consequences for those involved, but they also can impact their interpersonal, social and economic functioning. The United Nations recently identified the mistreatment of women and girls as one of the top three global problems hindering development (United Nations General Assembly, 1993). In addition to affecting those most directly involved, partner abuse and violence also impacts medical, public health, criminal justice, and economic systems, and has wide-ranging public policy implications.

The prevalence of intimate partner abuse and relationship violence, combined with the severity of its impact at many levels, argues for the need for psychologists who are already engaged in their career, as well as those still in training, to be knowledgeable about a wide variety of issues
related to partner violence. It is the ethical and moral imperative of all mental health professionals, whether or not they intend to specialize in working with this population, to be informed and trained in appropriate assessment and intervention techniques. Moreover, psychologists must understand the coordinated community responses to partner violence and be aware of the roles they may play within it.

With this curriculum, we suggest that those involved in partner violence have special treatment needs and that those who treat them must do so with sensitivity and from a base of knowledge which comes from specialized training. Psychologists who do not have the requisite training potentially endanger their clients, and likely commit an ethical violation. Those who are teaching psychologists-to-be but who do not teach them about partner violence are abrogating their responsibility and risk perpetuating the conditions which foster this problem.

The curriculum which follows consists primarily of content areas which should be included in a course on intimate partner abuse and relationship violence. It is intended as a first step in the training of mental health professionals to understand, recognize, and intervene with this population. We do not expect that completion of a course that follows this curriculum will give a participant sophisticated expertise in this field. Rather, we see the contents of this curriculum as representing a minimum level of competence in partner abuse and violence.

**Special structural considerations for teaching a course on Intimate Partner Abuse and Relationship Violence**

While our intention in this document is to provide the content for this course, there are special structural issues that we believe are essential to consider in offering this curriculum. For example, personal experiences with relationship violence on the part of participants may require that instructors be especially sensitive to issues such as the right to privacy, and they should avoid teaching strategies that ask for public disclosure of trauma issues. The instructor should have clinical skills, ready referral sources and the ability to manage difficult interpersonal dynamics in the classroom. Participants should be made aware of the possible emotional impact of course materials prior to enrollment.

In addition to training in psychology and mental health practice, instructors should have specific training in family violence research, theory, assessment, and intervention. In addition, they should have a gender perspective of intimate relationships and special expertise or sensitivity to issues of cultural diversity and sexual orientation.

**II. Goals and Learning Objectives**

**Goals:**

This curriculum is designed to promote education at both undergraduate and graduate levels pertaining to partner abuse and relationship violence. It is developed as a model for faculty members and others who desire to incorporate material regarding partner violence into already existing courses and for faculty who desire to develop courses that focus explicitly on partner
violence. The curriculum seeks to enable future and current psychologists to recognize and address the issue of relationship violence.

**Learning Objectives:**

The objectives for both Undergraduate & Graduate Level courses are as follows:

1. To inform students/participants of the prevalence and consequences of partner violence.

2. To equip students/participants with definitions and a working knowledge of key concepts and terms. And a basic familiarity with nationwide surveys that document and track the frequency of the various forms of relationship violence.

3. To inform students/participants of the ethical and clinical significance of competency in recognizing, assessing, and responding to relationship violence.

4. To provide students/participants with knowledge pertaining to the historical and societal context of intimate partner violence within contemporary societies.

5. To inform students/participants of existing models for the conceptualization of relationship violence.

6. To provide students/participants with knowledge regarding risk factors for relationship violence.

7. To inform students/participants of the consequences of intimate partner abuse and relationship violence for victims, relationships, children, offenders, and society.

8. To inform students/participants of methods for screening and assessment in working with relationship violence.

9. To provide knowledge pertaining to prevention, community activation/advocacy, and existing clinical interventions in application with cases of relationship violence.

10. To inform students/participants of forensic and criminal justice issues relevant to cases involving intimate partner abuse and relationship violence.

11. To provide knowledge regarding ethical and legal issues relevant for work with relationship violence.

12. To provide information about special considerations in working with same-gendered couples in which there is relationship violence.

13. To provide information and knowledge about culturally competent practice
Generally speaking, the content areas included below are intended to be covered in overview fashion for undergraduate students and in greater depth at the graduate level. Some issues may be more relevant for graduate than undergraduate students. For example, using Content Area 6, graduate students may need to have extended exposure to a wide variety of assessment instruments, whereas undergraduates’ knowledge may be more appropriately limited to an understanding of the needs for assessment rather than the specific instruments used for that purpose.

III. Curriculum

There are a number of cross-cutting issues which affect this curriculum. Each of the following content areas is to be considered from the perspective of the victim, the perpetrator, and the larger relational context. The curriculum also considers the impact of gender, different cultures, and differing sexual orientations as well as the impact and interaction of disability, childhood victimization, and substance abuse on relationship violence and intimate partner abuse.

Nine content areas have been identified for this curriculum:
1) definitions of intimate partner abuse and relationship violence,
2) prevalence and incidence of relationship abuse/violence,
3) causal models of relationship violence: Mediating variables, risk factors (perpetrators) and vulnerability markers (victims),
4) effects of relationship abuse/violence,
5) community responses,
6) screening and assessing for the presence of relationship violence,
7) mental health intervention,
8) forensic issues, and
9) prevention of relationship violence and Promotion of Nonviolence.
Content Area 1: Definitions of Intimate Partner Abuse and Relationship Violence

Rationale

The course begins with a discussion of what relationship violence is, how the behaviors that comprise it are defined, and how it overlaps with violence against women and family violence, which are the parent fields of study.

Summary of issues to be covered in Content area 1

Key Definitions

• Relationship Violence

This term includes physical, sexual, psychological abuse and stalking committed by one partner against the other in a relationship (all of these terms are defined below). Although relationship violence affects both genders, women are victimized more often and sustain more severe injuries. For this reason, relationship violence is sometimes viewed within the scope of the field of violence against women. Relationship violence includes but is not limited to acts committed by family members against other family members, so it may also fall within the topics examined in the field of family violence. Specifically excluded from relationship violence are acts committed by parents or other adult family members against children or elderly persons (i.e., child maltreatment and elder abuse, respectively). Although these serious forms of abuse involve people who are “related,” they are not partners in an “intimate relationship” as it has been conceptualized for this curriculum. Thus, developing a working model of what constitutes relationship violence is informed by definitions of violence against women and family violence. Relationship violence also occurs in heterosexual, gay and lesbian relationships, and we recognize that not all relationship violence is perpetrated by men or committed on women.

• Violence Against Women

The APA Taskforce on Male Violence Against Women defined violence as, “Physical, visual, verbal, or sexual acts that are experienced by a woman or a girl as threat, invasion, or assault and have the effect of hurting her or degrading her and/or taking away her ability to control contact (intimate or otherwise) with another individual” (Koss, Goodman, Browne, Fitzgerald, Keita & Russo, 1994, p.xvi.). Among the forms of violence against women that fall outside the scope of relationship violence are workplace violence and sexual harassment. Other forms of violence against women are more common internationally than in the United States, including denying food and resources to girls in societies that favor male offspring, commercial trafficking in women and forced prostitution (sexual slavery, sexual torture and sexual humiliation) (Koss & Kilpatrick, 2001). The National Research Council Panel on Violence Against Women concluded that whether one uses a narrow definition or broader definition of violence
against women, definitions of the individual components are also needed. (Crowell & Burgess, 1996).

Family violence refers to acts of physical, sexual and psychological maltreatment on which one person controls or intends to control another person’s behavior. The misuse of power and control is usually involved and usually results in some type of harm to the family members involved (APA, 1996a). As stated above, there are important topics within family violence that fall outside of relationship violence in the context of the present curriculum, such as child neglect and maltreatment or elder abuse. There are also forms of family violence that are more common from a global perspective than in the United States, such as female genital mutilation, genital contact as part of cultural rituals, and child rapes occurring under the guise of arranged marriages. Definitions of common terms are shown below:

- **Victim** is a target of violence (Saltzman, Fanslow, McMahon, & Shelley, 1999).
- **Perpetrator** is a person who inflicts violence or abuse (Saltzman et al., 1999).
- **Relationship partners** - spouses (current and former), nonmarital partners (current and former), dates and girlfriends or boyfriends (heterosexual and same-sex; Saltzman et al., 1999). Persons who have just met and are in the preliminary stages of intimacy are considered within the scope of this definition of relationships.
- **Physical abuse** encompasses, but should not be limited to a continuum of acts that range from slaps to killing of men (homicide) and women (femicide). This includes pushing, shoving, hitting, punching, kicking, choking, assault with a weapon, tying down or restraining, leaving the person in a dangerous place, and refusing to help when the person is sick or injured.
- **Sexual assault** is a continuum from forcible rape to nonphysical forms of pressure that compel individuals to engage in sex against their will. Sexual assault takes many forms within relationships, including marital, date, and acquaintance rape. Three central elements characterize legal definitions of rape: lack of consent; penetration, no matter how slight or independent of whether ejaculation occurred; and compelling participation by force, threat of bodily harm, or with a person incapable of giving consent due to intoxication or mental incapacitation. Sexual assault also includes acts such as sexual degradation, intentionally hurting someone during sex, assaults upon the genitals, including use of objects intravaginally, orally, or anally, pursuing sex when someone is not fully conscious or afraid to say no, and coercing an individual to have sex without protection against pregnancy or sexually transmitted diseases.
- **Psychological abuse** refers to: acts such as degradation, humiliation, intimidation and threats of harm; intense criticizing, insulting, belittling, ridiculing, and name calling that have the effect of making a person believe they are not worthwhile and keep them under the control of the abuser; verbal threats of abuse, harm, or torture directed
at an individual, the family, children, friends, companion animals, stock animals, or property; physical and social isolation that separates someone from social support networks: extreme jealously and possessiveness, accusations of infidelity, repeated threats of abandonment, divorce, or initiating an affair if the individual fails to comply with the abuser’s wishes; monitoring movements, and driving fast and recklessly to frighten someone (American Medical Association, 1992).

- **Stalking** refers to repeated harassing or threatening behaviors that an individual engages in such as following a person, appearing at a person’s home or place of business, making harassing phone calls, leaving written messages or objects, or vandalizing a person’s property. These actions may be accompanied by a credible threat of serious harm, and they may or may not be precursors to an assault or murder (Tjaden & Thoennes, 2000).

- **Economic abuse** involves restricting access to resources such as bank accounts, spending money, funds for household expenses, telephone communication, transportation, or medical care.

**Why definitions are important**

They:
- determine the scope of inquiry and the questions included in surveys.
- affect the wording of questions.
- guide sample selection.
- prevent survey results that are uninterpretable because participants had to define violence for themselves, leading to uncertainty about what responses mean.
- have political ramifications: the broader the definition, the larger the number of cases. Major policy decisions about legislation, programs and allocation of resources are made on the basis of prevalence data. Narrow definitions lower the number of cases identified. Policy makers tend to listen only to large numbers. Narrow definitions also ignore abused victim’s subjective experiences by excluding from consideration categories like psychological abuse, which most victims find highly distressing. Broad definitions are more consistent with women’s subjective feelings about what is abusive. Broad definitions have been recognized/adopted by the Centers for Disease Control and Prevention for their surveillance and monitoring of violence against women. They show a rapprochement of feminist and mainstream empirical approaches to violence against women research.

**Outline of Content Area 1**

I. Relationship violence is part of the subject matter in the fields of violence against women and family violence.

II. Key Definitions
III. Why Definitions are Important

**Recommended Reading**


Content Area 2: Prevalence and Incidence of Relationship Abuse/Violence

Rationale

A logical starting point for a course is consideration of how serious a problem relationship violence is as reflected by the numbers of affected people.

Summary of issues to be covered in Content area 2

- **Incidence versus prevalence.** It is important to differentiate statistics that measure incidence (new cases in a fixed period, often one year) from those reflecting prevalence (cumulative number of people affected over a long time; in the case of violence, this is usually the lifetime). The various forms of relationship violence have a relatively low incidence, but because their effects are so long lasting, they add up to a large number of affected people. For example, the US Department of Justice recently estimated that 0.3% of American women are raped annually, which projects to 302,091 victims per year (Tjaden & Thonnes, 1998). Yet, the same report also reported that 17.6% of American women had been raped sometime in their lifetime, which projects to more than 17 million women whose lives were directly touched by rape. Similar statistics exist for other areas of intimate partner violence as well. Frequency data for relationship violence cannot be interpreted without knowing the reference time period for the figures.

- **Rates of crime reporting.** Reported crimes are incidence rates, so they are expected to be lower than prevalence numbers. Because tabulations of reported crimes depend on several processes taking place, all of which depend upon the victim’s or someone’s decision to inform law enforcement, they are universally understood to underestimate relationship violence (Kilpatrick, Edwards, & Seymour, 1992). The National Violence Against Women Survey (Tjaden & Thoennes, 1998; 2000) estimated that women’s rates of reporting physical assault (26.7%) and stalking (51.9%) to law enforcement were fractions of the total incidents that occurred. This significant under-reporting is likely to be similar or greater for male victims of intimate partner violence, and for lesbian, gay, bisexual, and transgendered victims. Thus, reported crime statistics paint a picture of the crimes law enforcement know about, but not about hidden crimes.

- **Victimization Surveys.** To complete the picture that is painted by reported crime rates, surveys and interviews are used to uncover crimes that occurred but were not reported. Here, persons are contacted in person or by telephone and questioned about crimes they may have experienced even if they were not reported to the police. The largest is the National Crime Victimization Survey (Bureau of Justice Statistics, 1997). The National Crime Victimization Survey reports the lowest rates of victimization. However, experts acknowledge that intimate crimes are underestimated in this survey because interviewers are not specially trained to handle sensitive material, the questions on intimate violence are placed in the context of street crimes involving attacks and escalated violence, and respondents may be mislead by terminology carried over from the street crimes to the intimate questions such as, “sexual attacks.” Finally, the design of the survey entails re-contacting respondents every 6 months for two years; all except the first contact is by
telephone. Data collection by telephone does not reach people unable to afford a telephone, or who live in group living situations such as university dormitories, military bases, hospitals and prisons, or who are denied access to the telephone by a controlling partner. The National Violence Against Women Survey was funded by the National Institute of Justice and the Centers for Disease Control and Prevention to overcome many of these problems (Tjaden & Thoennes, 1998, 2000). This survey involved a nationwide sample of 8,000 women and 8,000 men contacted by telephone. It is the source of much of the data provided in the remainder of this content area. Other important surveys are the National Family Violence Surveys (Straus, 1995; Straus & Gelles, 1987), the National College Student Behavioral Risk Factor Survey (Brener, McMahon, Warren & Douglas, 1999), and the National Survey of Naval Recruits (Merrill, Hervig, Milner, Newell & Koss, 1997; Merrill, Newell, et al, 1998; White, Merrill & Koss, 2001).

- **Cultural factors mitigating against answering survey questions.** Within ethnic minority and gay/lesbian communities, respondents may be suspiciousness of interview questions and interviewers. Thus, statistics based upon this form of data collection may be unreliable. Such mitigating factors include: (1) isolation from one’s community of support (e.g., when a woman reports her violent partner, she may not receive the support of her community who in fact may blame her for the outcome); (2) mistrust of the researcher or police, especially among gay and lesbian people and the less acculturated; (3) general mistrust of majority member researchers/data collectors; (4) religious factors (e.g., Catholicism within the Hispanic/Latino/Latina community informs thinking and operates to hold marriages together, even when they are violent; (5) cultural factors (e.g., the notion of karma suggesting that it is one’s duty to endure one’s fate or current circumstances; “gamman” in the Japanese community, suggesting that to endure current hardships is to be seen as being more mature); and (6) language barriers and other related culturally sensitive services.

**Measurement Issues.** It is important to be prepared to intelligently evaluate data on relationship violence prevalence. Prevalence rates vary depending on a wide range of design and methodological features of studies. These include how violence is defined, the group sampled, the method of data collection, whether questions are behaviorally-specific or vague, the context in which the questions are presented, availability of languages other than English, rapport between interviewer and respondent, cultural issues regarding disclosure, how repeated incidents of victimization by the same perpetrator are included or excluded, measurement issues, and methodological changes in ongoing data collection efforts that influence trend data. For example, in some scales, a respondent who has committed 100 acts of violence is scored as equivalent to one who has committed 5 acts. Scales sometime also ignore the context of the violence by not differentiating between those who aggress and those who defend themselves. Also, scales may focus on acts rather than on patterns of control in relationships. Going beyond acts, a pattern based approach focuses on who initiated the violence, levels of fear, amount of control over behavior that is experienced, and the level of injury caused by any violent acts. These issues are discussed in more detail elsewhere (Desai & Saltzman, 2001; Koss, 1996; Schwartz, 2000; White, Smith, Koss, & Figueredo, 2000).
• **Prevalence of Relationship Assault.** The lifetime prevalence of physical assault by intimates was 22.1% for women and 7.4% for men in the National Violence Against Women Survey (Tjaden & Thoennes, 1998; 2000). The 1975 and the 1985 National Family Violence surveys found that an intimate physically assaulted 11 to 12% of married/cohabiting women and 12% of men annually. Whereas, the former survey finds that women were 3 times more likely than men to be physically assaulted by an intimate partner, the latter suggested more equal rates. Reports of gender symmetry in intimate violence perpetration have been criticized on methodological grounds (see White et al., 2000). As stated above, it is important to make the distinction between aggression in relationships and an ongoing pattern of abuse and control. There appear to be more equivalent rates of aggression in relationships, but it is clear that control, intimidation, and serious injury are directed at women in much higher proportions. This accounts in part for the discrepancies in the statistics reported in different types of studies.

• **Prevalence of Relationship Rape.** The lifetime rates of rape by an intimate were estimated at 7.7% for women and 0.3% for men (Tjaden & Thoennes, 2000). Examining rates by sex of victim reveals that women were 26 times more likely than men to be raped by an intimate. Numbers estimating rape prevalence have become quite consistent, with most published numbers falling between 15-20%.

• **Prevalence of Stalking.** Using a definition of stalking that required the victim to report a high level of fear associated with the perpetrator’s behavior, the prevalence was 4.8% among women and 0.6% among men according to the National Violence Against Women Survey (Tjaden & Thoennes, 2000).

• **Exposure rates across multiple forms of violence.** Across their lives several different forms of violence can victimize people. A figure that reflects this cumulative exposure can reveal a truer picture of the toll of relationship violence. A total of 25.5% of American women and 7.9% of men have experienced rape, physical assault, or stalking by an intimate partner at least once in their lifetime.

• **Prevalence by Race/Ethnicity are Unreliable.** Statistics on the prevalence of relationship violence in the ethnic minority community are unreliable. One of the only published studies on this matter was reported by Bachman & Saltzman (1995). There was slightly more such violence in the Black community than in the White community (with all others being much lower), but in examining the income levels and the prevalence of violence, quite clearly there is more violence in families that are distressed economically. To the extent that African American families earn less than their White counterparts, the difference in domestic violence can be accounted for by SES and not ethnicity.

• **Prevalence of relationship violence among same sex partners.** According to results from the National Violence Against Women Survey (Tjaden & Thoennes, 1998; 2000), the lifetime prevalence of physical assault among women who had ever lived with a same-sex intimate partner was 35.4%, compared to 20.4% among women who had lived only with opposite sex partners. Women who reported ever having lived with a same-sex intimate partner had a lifetime prevalence of rape of 11.4% compared to 4.4% who have
lived with opposite sex partners. However, these are lifetime rates and do not imply that the perpetrator was also same sex. In fact, same-sex cohabiting women were nearly three times more likely to have been victimized by a male than by a female partner. Women reported less intimate partner violence in same-sex relationships than in heterosexual relationships. Among men who had lived with same-sex partners, the prevalence of physical assault was 21.5%, compared to 7.1% among men who had lived only with opposite sex partners. Male same sex cohabiting partners were twice as likely to report being victimized by a male partner than by a woman. Thus, men in same sex partnerships have a somewhat greater risk of being abused than men in heterosexual relationships. Men who had lived with same-sex intimate partners reported no relationship rape. Within the gay/lesbian community, many factors may mitigate against the reporting of relationship violence. For example, social stigma against homosexuality may prevent gay/lesbian individuals from feeling comfortable reporting relational violence (Renzetti, 1997a; Russo, 1999; Sanchez-Hucles & Dutton, 1999). Fear of abandonment when one has HIV/AIDS is another factor mitigating against the reporting of relationship violence among gay males (Burke, 1998). Note that many states (18) have sodomy laws that make it illegal to engage in same sex activities so abused partners in same gender relationships may fear going to police or courts (National Coalition of Antiviolence Programs [NCAVP], 1997; Fray-Witzer, 1999).

• **Prevalence of relationship violence in relationships in which one or both partners are transgendered.** We do not have statistics on relationships in which one of the partners is transgendered although there are anecdotal reports that violence occurs in heterosexual, gay and lesbian relationships in which one of the partners is transgendered. Transgendered people may be fearful of reporting abuse to the police. A batterer "might tell his or her transgendered partner that it doesn't matter if he or she calls the cops, ‘Do you think they're going to help a freak like you?'" (Allen & Leventhal, 1999, p.78).

• **Rape among College Students.** The latest estimates are that between 1 in 4 and 1 in 5 college women will be raped at least once during their college career (Fisher, et al., 2000). Only 4% of the completed rapes and 8% of the attempted rapes involved an offender who was a stranger to the victim. The largest numbers were classmates (35.5% of completed rapes), friends (34.2%) and boyfriends or ex-boyfriends (23.7%). Another nationwide study of college students sponsored by the US Centers for Disease Control and Prevention reported that the rate of completed rape since the 15th birthday is 15% (Brener et al., 1999). This rate is identical to that reported by Koss, et al. (1987) over 10 years earlier.

• **Rape and Assault among Military Recruits.** Surveys of college students are criticized because the samples reflect individuals more privileged than the general population. A group of studies have focused on military recruits attending US Navy basic training in order to obtain a perspective on this type of relationship violence. These individuals are more ethnically and economically diverse than college students, although generally of the same age. The results revealed much higher prevalence data for rape, but not for physical assault, compared to data from college students. Furthermore, 85% of the men and 86% of the women reported being targets of verbal aggression, and 43% of the men and 40%
of the women experienced at least one instance of physical aggression (White, Merrill, & Koss, 1999). The comparable figures from college students were that 81% of men and 87% of women had received verbal aggression, and 39% of men and 32% of women had been victims of physical aggression. It is typical that the scale used identifies equal or slightly higher rates of physical violence perpetrated by women than by men.

- **Sex differences in risk of relationship violence.** Including both intimate and stranger perpetrators, 55% of women have been raped or assaulted in their lifetime compared to 66.4% of men. However, the identity of perpetrators differs by gender. Only 14% of women sustained violence perpetrated by strangers compared to 60% of men. Thus, victimization of women is primarily an intimate matter, whereas for men it more likely to involve strangers or non-intimate relationships.

- **Age at Victimization.** The highest rates of intimate violence affect women aged 16 to 24 years (Greenfield, et al, 1998). Victim age between 18 and 24 years significantly predicts receipt of greater injury than victims in other age groups (Tjaden & Thoennes, 2000).

- **Point in Relationship When Violence Occurs.** Most physical and sexual assault occurs during the relationship only (69.1% and 77.6%, respectively; Tjaden & Thoennes, 2000). However, a substantial group of women experienced it both during and after the relationship had ended (24.7% for rape and 18.2% for physical assault). Violence appearing only in the time period after the relationship has ended is rare for rape (6.3%) and physical assault (4.2%), but is common for stalking (42.8%).

- **Frequency and Duration of Violence.** Prevalence rates are based only on the first victimization, so they cannot capture the horror of living with ongoing violence. Intimate crime is often repetitive. Two-thirds of both men and women physically assaulted by an intimate partner experienced multiple incidents, and half of all women raped by intimates reported victimization by the same partner 2-9 times. Relationship physical assault involves 10 or more incidents for 19.8% of women and 10.6% of men. Relationship rape involves 10 or more incidents for 15.2% of women (Tjaden & Thoennes, 2000).

- **Cultural considerations.** Despite the fact that data concerning ethnic minority and gay/lesbian populations are not reliable with respect to relationship violence, the prevalence of this sort of violence may be overestimated when such violence is observed. This is due to at least two psychological phenomena: the ultimate attribution error and illusory correlation. As Ross (1977) noted, we have a tendency to overestimate dispositional factors and underestimate situational factors when attributing a cause to a certain behavior. This tendency is called the “fundamental attribution error” and is a well-documented phenomenon within the social psychological literature. For example, if we observe someone aggression against another, we have a tendency to attribute the aggression to an aggressive disposition as opposed to environmental factors such as poverty. Pettigrew (1979) coined the term “the ultimate attribution error” to describe the tendency to attribute the disposition of the individual to the entire group of which the individual is a member. For example, if we were to see an African American engage in an aggressive act, we will have a tendency to attribute aggression to African Americans.
in general. The ultimate attribution error is typically attributed to groups with minority status, so behaviors that occur within ethnic minority and gay/lesbian groups are often attributed to those groups as normative as opposed to simply residing within the individuals who exhibit the behaviors (or to situational/environmental factors). Hamilton and his colleagues (e.g., Hamilton, 1981; Hamilton & Gifford, 1976; Hamilton & Rose, 1980) discussed the phenomenon known as “illusory correlation.” What they found was that when two minority events co-occur, they are remembered as occurring more often than they actually did. Thus, to the extent that individuals in minority groups are considered “minority events,” and to the extent that aggression occurs less often than non-aggressive acts, when an individual in an ethnic minority or gay/lesbian group aggresses, it is remembered as occurring more often than it does in reality.

Outline of Content Area 2

I. Rationale

   A course on relationship violence begins by establishing the severity of the problem and outlining the forms it takes.

II. Summary of Topics

   Incidence versus prevalence
   Rates of reporting
   Victimization surveys
   Measurement issues
   Prevalence of relationship rape
   Prevalence of relationship assault
   Frequency of stalking
   Exposure rates across multiple forms of violence
   Relationship violence among same sex partners
   Relationship violence among college students
   Relationship violence among military recruits
   Prevalence by race/ethnicity
   Relationship of perpetrator
   Age at victimization
   Point in relationship that relationship violence occurs
   Frequency and duration of relationship violence

Recommended Reading


Content Area 3: Causal Models of Relationship Violence: Mediating Variables, Risk Factors (Perpetrators) and Vulnerability Markers (Victims)

Rationale

Multivariate, causal models explaining relationship violence have not been fully developed and there is a need to create such models (Harway & O’Neil, 1999). This content area discusses models of relationship violence, risk and vulnerability factors.

Summary of issues to be covered under Content area 3:

- Multivariate approaches are beginning to be discussed in a number of disciplines. Both the National Academy of Science and the American Psychological Association have convened task forces that recommend the study of multiple factors that cause relationship violence (APA, 1996a, b; Crowell & Burgess, 1996; Koss et al., 1994). The APA Task Force on Violence Against Women (Koss et al., 1994) and Violence and the Family Task Force (APA, 1996a) recommended the integration of biopsychological models with sociocultural and psychological determinants. Koss et al. reported few models that consider the “…multiple levels of confluence---from societal to individual (which) determine the expression of violence” (p.3). The National Academy of Science Task Force (Crowell & Burgess, 1996) stated that “the field appears to be developing toward an integrative, meta-theoretical model of violence that considers multiple variables operating at different times in probabilistic fashion” (p. 69).

- Controversies have existed on the causes of relational violence both in academia and among practitioners (Barnett, Miller-Perrin & Perrin, 1997; Dutton, 1994; Gelles & Loseke, 1993; Harway & O’Neil, 1999). The issues have related to the appropriateness of working with batterers in couple’s therapy (Bograd, 1988; Goldner, 1985; Hare Mustin, 1978; Pressman, 1989), whether men are battered as often as women (Steinmetz, 1987), the use of scales to assess relationship violence (Straus, 1990; Straus & Hamby, 1997), and the use of terminologies to discuss relationship violence (Harway & O’Neil, 1999). Moving from single mechanistic linear approaches to multidimensional interactive approaches appears appropriate.

- The data which allow us to predict violence in intimate relationships are not very clear or very robust. This may be because most researchers have considered only unidimensional or linear models, looking at the extent to which a particular variables predict violence (Miller, 1996). Our approach here is to emphasize interactive multivariate models which are more ecological.

- There is also a tendency to make personal attribution as to vulnerability and risk factors. However being at risk for suffering relationship violence is more likely the result of an interaction of factors (Harway & O’Neil, 1999). While we may point to specific vulnerability markers which appear to be characteristics of the individual, the potential
vulnerability markers we are identifying may in fact be societal or systemic factors rather than individual ones. For example, the attribution of blame to the victim is in fact a societal phenomenon rather than a characteristic of the individual in question. However, the individual blamed may in fact internalize the blame, and it then becomes perceived as an individual trait.

- An important issue is identifying which constructs increase the risk of victimization and which are the result of long-term victimization. With these risk and vulnerability factors, the state of science is not advanced enough to yield information which can directly predict the victimization of an individual without knowledge of possible additional mediating or protective factors. Understanding the causes of violence is also important because there may be variability in how the factors affect relationship violence across, age, race, class, ethnicity, and sexual orientations (Coleman, 1996; Kanuha, 1990; Letellier, 1996a; Sanchez-Hucles & Dutton, 1999; Waldron, 1996).

The causes of relationship violence include the effects of societal, racial, ethnic, cultural, and sexual orientation factors (Harway & O’Neil, 1999; Island & Letellier, 1991a; Sanchez-Hucles & Dutton, 1999). A prominent theory for explaining partner violence is feminist theory, which suggests that domestic violence is gender based. (Koss, et al, 1994; Yllo & Bograd 1988). However, same-gendered intimate partner violence cannot be explained by feminist theories of domestic violence which see it as a gender issue (Letellier, 1996a). Island and Letellier (1991a) argue that domestic violence is not a gender issue. Some theorists who write about same-gender partner violence suggest three components to abuse: 1) learning to abuse, 2) having the opportunity to abuse, 3) choosing to abuse (Gilbert, Poorman & Simmons, 1990 cited by Merrill, 1996). Some suggest that sexual orientation and feelings about sexual orientation may contribute to same-gender domestic violence (Byrne, 1996). Waldron (1996) and Kanuha (1990) discuss the interface of racism and homophobia for lesbians of color and same-gender partner violence. Any analysis of relationship violence has to consider how personal and institutional oppression (racism, classism, ethnocentrism, homophobia/heterosexism) contribute to the predisposition to and the actual triggering of relationship violence (Kanuha, 1990; O’Neil & Harway, 1999; Waldron, 1996).

- The current state of the research makes it very difficult to predict with any type of accuracy who will be a first time offender or a first time victim of relationship violence. At the same time, predictability is enhanced in cases of repeated violence, since the best predictor of future violence is still a history of past violence.

- Understanding the risk factors for perpetrating relationship violence (all definitions below taken from O’Neil & Harway, 1999):
  - Macrosocietal Factors, that is, all the conditions and values in the larger society that directly or indirectly predispose people to violence, including all the institutional structures developed during our history
  - Biological/Neuropsychological Factors, that is, the hormonal, neuroanatomical, genetic, and evolutionary dimensions of violence
- Psychological Factors, that is, all conscious and unconscious processes that imply deficits in cognitive and emotional functioning, interpersonal communication, problem solving, and behavior management
- Socialization and Gender Roles Factors, that is, overall conditioning over the lifespan and specifically, the role of restrictive gender roles that produce sexist attitudes, emotions and behaviors
- Relationship Factors, that is, the ongoing interpersonal and verbal interactions between partners including communication patterns and past family of origin experiences
- Individual Characteristics, Attitudes and Perceptions, that is, all other personality and personal qualities and values that are unique to a person.

- The need for understanding interacting risk factors
- Why there are no necessary, sufficient causes of relationship violence and no specific constellations of these factors that automatically produce domestic violence
- Understanding the vulnerability markers for victims of relationship violence
- Constructs studied in relationship to vulnerability
  - Being female
  - Past victimization
  - Growing up in a violent home
  - Exposure to chronic trauma
  - Substance abuse
  - Personality/attitudes
  - Self-image
  - Shame

- Characteristics of the relationship which relate to being victimized (perpetration may still occur even in the absence of any relationship characteristics)

Factors related to why women don’t necessarily leave, or leave and return, include (see LaViolette & Barnett, 2000):

- Power differentials
- Kin density for Latinos
- Public exposure with consequences
- Fear of disclosure of sexual orientation
- Learned hopefulness/learned helplessness
- Economic constraints
- Fear of being hurt seriously or killed
- Fear of losing children
- Psychological dependency
• Methodological problems which hamper our understanding of vulnerability markers

Outline of Content Area 3

I  Rationale

II. Past controversies over explaining relationship violence
   Need for multivariate, causal models
   Problems of predicting violence
   Role of vulnerability and risk factors
   Causes of violence based on diversity variables
   Societal, racial, ethnic, sexual orientation factors causing violence
   Personal and institutional oppression as causes of relational violence
   Understanding risk factors
   Interaction of risk factors
   Vulnerability markers for victims
   Relationship characteristics and becoming a victim
   Factors related to staying in an abusive relationship

Recommended Readings


Content Area 4: Effects of Relationship Abuse/Violence

Rationale

This section focuses on the impact of relationship violence on the victims. A major effect is post-traumatic stress disorder. Other effects are also discussed to increase understanding of the long-term trauma associated with intimate partner abuse.

Summary of issues to be covered under Content area 4:

- Partner violence can cause a number of effects upon victims of the abuse. Among the most common reactions are fear, learned helplessness, and post-traumatic stress disorder (Barnett et al., 1997). Fear is among the most common for those who have experienced partner violence (Barnett & Lopez-Real, 1985; Russell, Lipov, Phillips, & White, 1989). The fear is in two forms: (1) fear of staying and being beaten again, and (2) fear of leaving and being stalked and acted upon even more violently. Other ancillary fears are of loss, rejection, abandonment, and being alone.

- Walker (1977) adapted the notion of learned helplessness (Maier & Seligman, 1976; Seligman, 1975) to victims of partner violence. This notion suggests that a learning history that escape was not previously possible, results in victims of violence not even attempting to escape the violence. Thus, in applying this term to abused partners, these victims stay in their abusive relationships because their past attempts to leave were not successful. This view is somewhat controversial in that some people argue that a battered victim is proactively doing what s/he can to survive the trauma and maintain some semblance of safety. Others argue that victims of relationship violence have a “learned hopefulness” where they continue to hope the situation will improve because they wish this to be the case, and their partner often promises to change (LaViolette & Barnett, 2000).

- Stress has been connected with violence (Barnett et al., 1997). Violence-related stress has been associated with physical and mental illnesses (Koss, Koss, & Woodruff, 1991; Russo, 1985) and Posttraumatic Stress Disorder (PTSD) (American Psychiatric Association, 1994). PTSD is a stress-related disorder that can cause anxiety, depression, and psychological numbness. This condition is highly prevalent among victims of partner violence (Houskamp & Foy, 1991).

- Partner violence not only affects the victim of the violence; it has effects upon the relationship, the children exposed to the violence, and the society at large. To the extent that the violent partner is considered to be the dominant one, such abuse sets up a permanent complementary relationship (Hoffman, 1981). This kind of relationship, where one member has a dominant position and the other has a subordinate position, is unhealthy. Family therapists contend that marital/partner relationships should be based on equal power within the relationship (Hoffman, 1981; Minuchin, 1974). Although this does not suggest that every aspect of the relationship must be equal, on balance, there should be equal status within the relationship (Minuchin, 1974). In a study of married
heterosexual couples, partner violence is associated with lower marital/partner satisfaction than in nonviolent but also discordant couples (Rosenbaum & O’Leary, 1981, 1986). There is also some indication that partner violence leads to less satisfying parental relationships (Giles-Sims, 1998).

- Children who are exposed to relationship violence are frequently traumatized themselves (Geffner, Jaffe, & Sudermann, 2000; Jaffe, Wolfe, & Wilson, 1990; Peled, Jaffe, & Edelson, 1995; Sudermann & Jaffe, 1999). At minimum, exposure to this kind of violence is itself a form of psychological maltreatment (APA, 1996a; Echlin & Marshall, 1995). For example, some have suggested that a great preponderance of PTSD or PTSD symptoms are exhibited by children who are exposed to violence in their own home (Lehmann, 1997; Terr, 1991). Even more serious is the suggestion that when boys are exposed to relationship violence as children they are more likely to abuse their partners as adults (Hotaling & Sugarman, 1986; Kalmuss, 1984; Sudermann & Jaffe, 1999). More recent evidence (Kerig, 1999) has suggested that both boys and girls exposed to such abuse at home are more likely to engage in more aggressive activities.

- Relationship violence also comes with a societal cost. Much of our police and other community resources are expended for this issue (Thyfault, 1999). Moreover, issues such as domestic homicides resulting from relationship violence also cost society both monetarily and psychologically (Sonkin, 1987; Thyfault, 1999). Giles-Sims (1998) identified the cost to society as being on multiple fronts, including the criminal justice system, the mental health system, loss of work and lower worker productivity, and lower education and economic achievement for both victims and families. Finally, to the extent that such violence perpetuates itself in future relationships (Hotaling & Sugarman, 1986; Kalmuss, 1984; Sudermann & Jaffe, 1999), the cost to society continues to escalate.

- The effects of partner violence within ethnic minority and gay/lesbian populations is compounded by the fact that these populations often experience a greater need to keep their victimization silent (Barnett et al., 1997; Russo, 1999; Sanchez-Hucles & Dutton, 1999). Factors to consider that may contribute to the silence from ethnic minority communities are economic reasons for staying in abusive relationships among those who are economically disadvantaged (e.g., inner city African Americans), rural isolation among Native American populations, and stoicism and feelings of shame within Asian populations (Lum, 1998; Wiehe, 1998). Moreover, Song (1996) identified historical and cultural subordination and abuse among Korean immigrant populations that may prevent the reporting of abuse. Browne (1997) and Sorenson and Telles (1991) found that Mexican-born Mexican Americans have lower rates of partner violence than American-born Mexican Americans. Thus, socialization in America may lead to the development of aggressive behaviors towards family members. This is not to deny that partner violence exists in other cultures. However, the combination of socially sanctioned male dominance over females together with minority status in the United States may lead to an increased incidence of such forms of violence in this culture. This is particularly true when ethnic minorities are also lesbians or gay. Racism intensifies feelings of isolation of the battered woman of color (Hudgins, 1990; Waldron, 1996) due to negative and hostile attitudes toward homosexuality within communities of color. Within ethnic minority
gay/lesbian communities, there may be even less acceptance of gay/lesbian lifestyle than in the broader community, so victims of partner abuse may be even more reticent to report their abuse (Lum, 1998; Wiehe, 1998).

• In the larger society, gay/lesbian victims of abuse may be silent due to the fear that the larger society holds homophobic attitudes that will be unsympathetic to gay/lesbian battering. Even when individuals from these populations do report their victimization, they often do not receive the legal protections that are afforded their White heterosexual counterparts (Koss, 2000; Lundy, 1999). Unique stressors within gay/lesbian populations are the threats of “outing” abandonment by relatives and friends, the loss of a job, and a wide variety of other discriminatory behaviors (Allen & Leventhal, 1999; Burke, 1998; Jackson, 1998; Renzetti, 1997a, 1997b; Russo, 1999; West, 1992). Thus, an abuse victim may choose to stay in the abusive relationship for fear of being “outed” by their abusive partner.

• With respect to HIV/AIDS, many victims of abuse who have AIDS or are HIV positive may stay in their abusive relationship and not report it because they may be physically or financially dependent upon their abusive partner, they may fear dying alone, or they may believe that they will not be able to find another partner due to their medical condition (Burke, 1998; Hanson & Maroney, 1999; Letellier, 1996b). While HIV does not cause battering, some may attempt to explain the battering as related to the stresses of HIV and HIV status may impact on the decision to stay or leave abusive partner (Letellier, 1996b). Furthermore battered gay and bisexual men and heterosexual women are clearly at high risk for HIV infection; there is "little reason to believe that a man who will rape his partner will do so only using a condom" (Letellier, 1996b, p. 73).

Outline of Content Area 4:

I. Rationale

II. Impact of partner violence in each of the following areas:
   On victims:
   Physical
   Psychological
   Economic and employment productivity
   Health behaviors (e.g., substance abuse, unsafe sex)
   Revictimization
   Participation in the community/isolation
   Trauma issues and consideration of PTSD diagnosis for survivors, and strength and weakness of this approach
   Misdiagnosis of Borderline Personality Disorder
   Denial of health insurance claims
   Compounded effects of multiple forms of victimization in the relationship

On the couple relationship:
Separation and divorce
Stalking
Communication breakdown
Parenting issues
Stress
Impaired marital satisfaction
Impaired sexual functioning
Distrust
Emotional alienation
Isolation of the couple from family, friends

On the children exposed:
Psychological
Cognitive and developmental
Nutrition and health
Attachment impairment
Loss of parental support, availability and care
Substance abuse
Trauma
Neuropsychological impairment

On the larger society:
Impact on the workplace of employing a victim of relationship violence
Denial of health insurance
Economic and productivity
Criminal justice costs

For victims from other cultures, including victims in LGBT relationships.

**Recommended Readings**


Content Area 5: Community Responses

Rationale:

The multiple causes of relationship violence are not only involved in the behavior of the perpetrator but also shape the community response. The community itself is an ecosystem, that, like any other living environment, utilizes, conserves, and cycles resources in transactions that shape and preserve community identity (Harvey, 1996). All communities undergo change over time. In addition to individual interactions, a number of formal systems in the community have roles in responding to relationship violence. These include the specialized services such as rape centers, battered women’s shelters, the medical care system, the law enforcement and legal systems, prison and probation, the mental health system, and organized religion. Understanding the core services and interrelationship of the different community resources is necessary because psychologists have roles in every system, including specialized violence agencies, legal, medical, mental health and offender treatment.

No discussion about community response can be complete without acknowledgment that the majority of victims of relationship violence are unknown to any formal system. Thus, there is a responsibility to balance face-to-face services provision with public service campaigns that reach out to individual community members and the unidentified survivors of relationship violence in the community to normalize responses to victimization, inform them about useful recovery strategies including service availability, and foster support by significant others (e.g., Klein, Campbell, Soler & Ghez, 1997).

Summary of issues to be covered in Content area 5

- **How many are reached by formal community systems?**
The low rate of reporting these crimes to police has been previously noted. Victims of unreported crimes cannot benefit from any improvements that have been made in law enforcement response to relationship violence (Tjaden & Thoennes, 2000). Small proportions of survivors of violence consult any of the specialized services including shelters, crisis centers, legal aid, mental health or the clergy.

- **Dimensions on which community response are evaluated**
The dimensions on which the coordinated community response is assessed include the existence and quality of communication, collaboration, and protocols establishing each system’s responsibilities, means of transferring information and referring clients among systems, organization of services for different kinds of victims and accessing them for victims who are in multiple categories, and existence/effectiveness of a mechanism to continually evaluate and improve the interaction of systems on behalf of clients (Koss & Harvey, 1991; Shepard & Pence, 1999). The quality of community response is also linked to attention paid to serving all parts of the community: ethnicities, economic statuses, sexual orientations, physical and mental capabilities.

- **Qualities of effective victim assistance organizations**
Organizations that comprise the community response are evaluated on the basis of the availability, accessibility, quantity, quality, and legitimacy of services (Campbell & Ahrens, 1998; Koss & Harvey, 1991). Historically, sexual assault and physical assault services have been provided by separate agencies. Only recently have integrated women’s centers and crisis centers begun appearing, although research demonstrates that rape receives far fewer resources of staff and funding when treated in a setting also addressing battery (Campbell & Martin, 2001).

- **Comprehensive services for physical assault**

  Core services provided by advocacy programs/shelters for battered women include: (1) intake staff to answer inbound calls, and (2) volunteer or staff advocates to address immediate threats and arrange for shelter, medical care and family support (Sullivan & Gillum, 2001). Once a woman is in a shelter, the variety of services offered include assessment of needs, legal issues and orders of protection, financial and employment issues, transitional housing, services for children, nutrition, substance abuse referral and treatment, sexual assault services, and support groups. Most of the women who have used shelters found them supportive and effective (studies cited in Sullivan & Gillum, 2001). A study of advocacy services found that college students were effective in increasing battered women’s use of community resources. At two-year follow-up, those women who were assigned to receive advocates had predominantly ended their relationship and were in new relationships with lower levels of violence, although they were not necessarily violence free (Sullivan & Bybee, 1999). However, there are many unmet needs. Ethnic minority women may encounter shelters run by White women, language barriers, unfamiliar food, fear of deportation, lack of transportation, and lack of ethnically-appropriate grooming aids such as wide-tooth combs for African American women. Gay/lesbian/bi- and transsexual people feel shelters are for heterosexual people. Older women are underrepresented in shelters, feel unfamiliar with these services that did not exist until about 25 years ago, and perceive them as intended for married women not single or widowed women. Adolescents may not even be eligible for assistance. In addition, there are very few shelters for battered men in the United States, so they have even fewer resources for help or protection, as noted below.

- **Specialized sexual assault services**

  Funding sources often require sexual assault centers to offer a 24-hour hotline, counseling, and legal and medical advocacy (Campbell & Martin, 2001). However, review of exemplary centers revealed that their service components included: (1) crisis response including hotline, hospital accompaniment/crisis counseling and sexual assault nurse examiner programs, (2) police services including coordination/training initiatives with specialized officers who respond to rape and victim accompaniment, (3) district attorney and court services including coordination/training initiatives with specialized sex crime prosecutors, victim accompaniment and court monitoring, (4) mental health services including individual and group counseling, both short and long-term, (5) social services referrals and advocacy, and (6) community interventions including developing connections with other systems, social action, victim advocacy, law and policy reform, and anti-violence education in schools, community education, and media campaigns (Campbell & Martin, 2001; Koss & Harvey, 1991). Indirect evidence of effectiveness
has been published but no study has compared survivors who did and did not receive sexual assault services (Campbell & Ahrens, 1998). However, the anti-rape movement has won significant and demonstrable policy and law reforms. The considerable attention paid to interactions with the law enforcement and prosecution beyond that devoted to medical and mental health connections is notable. The wisdom of this distribution of energy must be assessed from the perspective of the small proportion of rapes that are reported to police and given survivors’ considerable medical and mental health issues. The material presented later on judicial responses to relationship violence will continue this discussion and have been recently reviewed (Koss, 2000).

- **Poverty of services for lesbian victims**
  Renzetti has summarized the availability of services for people who are battered by same sex partners. The "NCADV [National Coalition Against Domestic Violence] directory provides a 'profile of services' for each organization listed that includes information such as whether the service is wheelchair accessible, whether services for the deaf are available, and what languages other than English are spoken. Not included is information about whether services specifically designed to address the needs of battered lesbians are available. NCADV, however, does publish a brochure on violence in lesbian relationships” (Renzetti, 1996). Based on a study of 566 help providers, Renzetti (1996) noted the disparity between rhetoric and available services for battered lesbians. There are few services specifically for lesbian women (Cayoutte, 1999; Johnson, 1999). There is currently no place for the transgendered male to female to receive battered women services. From the perspective of shelters, these individuals are men. Most shelters bar males older than about 12-14 years, meaning that battered mothers even have to make arrangements for their own teenage sons to live elsewhere. Beyond a shortage of services, lesbian women have expressed fears about going to standard shelters because of rejection by other shelter residents and fear that in these settings, sensitive primarily to male threat, a female perpetrator could gain access (Renzetti, 1996). There are stories of lesbian victims whose abusers followed them to the shelter and were admitted by claiming to be a battered woman. Particularly lacking are services for lesbians of color who experience same-gender partner violence (Mendez, 1996).

- **Absence of services for gay, bisexual or transsexual male victims**
  There are almost no services for battered men. At one recent conference, police reported taking male victims to Denny's or to homeless shelters (Mueller, 2000). Battered women's programs by and large have been heterosexually focused in their services, outreach materials, and staff training. As programs for women, most advocacy services and shelters do not work with gay or bisexual men or transgendered persons (Allen & Leventhal, 1999). Groups for abused partners may not want to include members of same-gender violence. At one mental health center, the members of a group for survivors of abuse were all women and they were unwilling to have a male in their group. This problem extends to the dilemma of the male survivor in a heterosexual couple. Although a safe home network for male survivors is a solution to crisis needs, it does not address planning for group counseling and support groups (Johnson, 1999).

- **Response to Ethnic Minorities**
Culture impacts on how people define relationship violence, shape their attitudes towards disclosure of victimization, understands its causes, explain its effects, choose remedies for recovery, and accesses services. Therefore, no course in relationship violence is complete without considering what scholarship does exist on this important and understudied subject. Relevant readings include work with African-American women (Russo, Denious, Keita, & Koss, 1997; Wyatt, 1992), American Indian (Chrestman, Polacca, & Koss, 1999; Coker, 1999), Asians and Asian Americans (Lum, 1998; Song, 1996), and Mexican Americans (Ramos, Koss, & Russo, 1999). Tri-ethnic studies are also available that make comparisons in how different groups approach these issues (Klein, et al., 1997; Lefley, Scott, Llabre & Hicks, 1993; Sorenson, 1996) in the pregnancy year (O’Campo, Gielen, Faden, Xue, Kass & Wang, 1995). As stated above, Asian and Latino victims of partner violence may not utilize services due to limited fluency in English. The use of extended families, especially for Asian families, is another important issue. For lesbian, gay and transgendered people of color, the interface of racism with heterosexism, negative attitudes toward homosexuality, prejudice and discrimination based on sexual orientation and "transphobia" must be considered at all levels, from causation, through treatment and service provision.

• Medical care system
The medical care system offers multiple settings where victims of relationship violence interact with providers. These include emergency rooms, primary care or family medicine, well-women gynecology, prenatal and antenatal clinics for pregnant women and new mothers, chronic pain clinics, sexually transmitted infection clinics, HIV screening, mental health clinics, drug, alcohol, and smoking cessation programs, and programs aimed at raising physical activity levels and weight loss. Victimized women are much more likely to seek medical resources than legal, social, family or clergy services (Kimerling & Calhoun, 1994; Koss, Woodruff, & Koss, 1991). Good overviews of the range of health care interventions are available (Heise, Ellsberg, & Gottemoeller, 1999; Koss, Ingram, & Pepper, 2000; Stark, 2001) including emergency room interventions (Campbell & Bybee, 1997). Victims of relationship rape may request care at an emergency room or may be taken there by police. Evaluation of emergency medical services for rape victims has revealed cracks: many survivors have failed to receive attention to sexual disease and pregnancy preventative treatment in the past (Kilpatrick et al., 1992). As a result the field continues to move away from reliance on physicians in emergency settings and has developed programs where these services are provided by specially trained sexual assault nurse examiners. The need for special training is highlighted in working with lesbian, gay, and transgendered persons. For example, in emergency settings, there have been reports of staff panic and abuse when a rape victim they thought was a woman was revealed to have male genitals.

• Mental health system
Advocacy centers for battery and sexual assault have become increasingly professionalized in recent years so that many mental health practitioners now work within them. The centers provide services for multi-problem populations including the economically disadvantaged, immigrant, physically challenged, developmentally disabled, and chronically mentally ill. Given the high level of complexity of the cases
seen, more participation by the formal mental health system in staff development, and in refining referral systems are in order. The relative paucity of formal links has meant that some cutting edge and specialized therapies for survivors that have been empirically validated have been unavailable to survivors treated in the community and they have lacked convenient and timely access to advice about pharmacological therapies.

- **Law enforcement response**
  Anti-violence advocates have worked with law enforcement officers to prevent insensitive and inappropriate response, which has been termed the secondary assault or re-traumatization (although advocates have devoted less effort to the medical, mental health, and organized religion response, the concept of re-traumatization is relevant in these settings also). Women who have been sexually assaulted by people they know are particularly likely to receive a traumatizing police and medical response; Campbell & Bybee, 1997). Women physically assaulted in their relationships tell similar stories (Erez & Belknap, 1998). Only a minority of survivors of relationship violence report it to police. Survivors do not report violence if they fear discrimination by police or courts. Unfortunately, they may be correct in this fear. Some police officers allow their private prejudices about rape to enter into their decision making, and inappropriate cultural and social identities figure into the chances the case will be taken seriously. Among same sex couples, not only may the partners be subject to harassment or exposure of their sexual orientation, it is also more likely that both partners will be arrested. Law enforcement often relies on gender as a cue to identifying the perpetrator. They find themselves in a dilemma when dealing with same sex violence. Police officers may define the interaction as assault or mutual assault, and although this does also happen in with mixed gendered intimate partner violence, it is more common with same gender intimate partner violence.

- **Civil protection orders**
  Also called stay away or restraining orders, these protection instruments are issued to victims by a judge and can now be obtained within shelters or from victim advocates. Previous requirements that victims pay a court fee were made illegal if states receive money from the Violence Against Women Act of 1994. Studies show that women felt these orders were helpful, although they didn’t believe that their batterer really thought he had to comply. Empirical evaluation demonstrates that orders of protection fail to moderate subsequent levels of physical violence, threats, or property damage. A majority of perpetrators offend within two years of being served with the order, 29% with severe violence (US Department of Justice, 1998). The legal system does not afford the same (or any) protection to members of same gender partner violence in many states (daLuz, 1994; Fray-Witzer, 1999; Lundy, 1999; NCAVP 1997): "Even where state laws cover domestic as well as heterosexual domestic violence, the chances are that laws are not enforced equally and that same-sex litigants are treated with less dignity, sympathy, and respect that their straight counterparts" (Lundy, 1999, p. 43).

- **Prosecution and incarceration of offenders**
  Nearly half of domestic violence incidents known to police were judged to have insufficient evidence for filing or acceptance of charges (McFarlane, Wilson, Lemmey & Malecha, 2000). Even under a mandatory arrest and no drop policy, it was estimated that
a very small percentage of domestic violence offenders were convicted (Zorza, 1994). The deterrence value of conviction must be questioned on the basis of data indicating that following case settlement, 40% of men arrested at the scene and convicted of domestic violence re-battered within 6 months (US Department of Justice, 1998). In this particular study, re-battering rate in warrantless on-scene arrests was nearly 40% and for cases initiated by formal victim complaints it was 29%. When there was arrest by warrant and the victim was allowed to drop charges, the re-battering rate was 13%. Many domestic violence victims nationwide are forced by no drop policies to testify against their partner, under subpoena. This law has created the spectacle of the uncooperative victim who may fear that the truth will lead her to lose her children as an unfit mother who exposed her children to violence, or conversely of having to raise the children alone without a social safety net if the partner is sent to prison (Goodman, Bennett, & Dutton, 1999). Similarly, half or more of all reported rapes are rejected for charging by prosecution (Frazier & Haney, 1996). The grounds used include social factors irrelevant to whether a crime has taken place including race, age, perpetrator-victim relationship, occupations, place of residence, and her risk-taking behavior, drug use, or reputation (Frohman 1997). The percentage of rape reports that ended with a guilty plea or verdict was 13% 20 years ago, and the picture is similar today (Frazier & Haney, 1996; McCahill, Meyer, & Fischman, 1979). Judicial outcomes for rape are equally disappointing. Juries are more lenient in cases of rape than in any other crime of equivalent severity where the parties were acquainted and when little physical injury resulted (Koss, 2000).

- Batterer’s diversion treatment programs
  The US Department of Justice has concluded that court-ordered treatment for battering (often called diversion programs) fails to affect the prevalence, severity, or frequency of battering. The highest re-battering rate (44%) is among men who serve jail time without counseling but the lowest rate is among those not treated at all (US Department of Justice, 1998). A recent comprehensive review notes a number of troubling issues with offender treatment, especially in regard to ethnic minority men (Bennett & Williams, 2001). Another issue is what to do with female perpetrators in either heterosexual or lesbian couples. Should they be put in a group with men (Hamberger, 1996)? In some jurisdictions, same-sex treatment groups are the only ones allowed. There is a critical need for specific intervention in gay male intimate partner violence aimed at treating the batterer. Programs are also needed to provide relationship counseling to couples in which there is same gender partner violence (Johnson, 1999).

- Reforms in justice response
  The significant gains in policy implementation, law reform, and judicial education won by anti-violence advocates over more than 25 years of effort have had little measurable effect on rates of reporting, arrest, or conviction. Native Canadian women reported that they felt they were denied justice to a greater extent after judicial education than before (Razack, 1998). Desired features of justice response to relationship violence include: (1) reduced time between crime and consequence so that violence is followed by a consequence quickly as psychological knowledge must happen according to theories of behavior control, (2) a process that addresses the problem addressed in its community/family context and does not remove it to state jurisdiction where the victim
has no input, (3) procedures where the victim is empowered to have input into the process and a wider range of options for the perpetrator than simply incarceration, diversion treatment, probation, or getting off with no requirements, (4) consequences that can address the structural and material imbalances that contribute particularly to women’s vulnerability to violence, (5) treatment options to which the perpetrator can agree voluntarily such as alcohol or drug treatment, or batterer interventions, (6) methods through which the damage to society the perpetrator has caused is symbolically and concretely repaid, (7) proceedings that move toward a dues paid endpoint for the perpetrator after which he is reintegrated into society, and likewise move toward a state endorsement of the wrong done to the victim so that the recovery community can respond more supportively and less ambivalently (8) a face-to-face opportunity to communicate directly with the perpetrator, (9) an institution such as probation that is charged with enforcing any consequences, and (10) above all that the process protects the safety of victims. Community conferencing has been recommended as a process that can accomplish these aims without rolling back gains in law and policy made by antiviolence advocates or being soft on crime (Koss, 2000).

- **How to respond to a friend or family members**
  The first thing to remember is that the reaction of the first person that a victim tells is very critical for the subsequent services that are accessed for recovery. Responses that blame the victim or minimize the offense so that it is disqualified as assault may have the effect of silencing the victim and discouraging use of community services. After all, why would a woman go to a battered woman’s shelter if the incident is defined by friends and family members as part of a “wife’s duties.” Why would someone try to access sexual assault services if friends focused on her drinking instead of the behavior of the man who took advantage of an opportunity to rape a drunk woman? Some of the more helpful responses are variations on: (1) I’m really sorry that happened to you, (2) It’s not your fault, s/he was very wrong to do it, and (3) I’m with you and you’re safe now. These same statements are equally appropriate for use by first responders who may be police, rape or battered victim center advocates, or medical personnel.

Outline of Content Area 5

I. **Rationale**

II. **Spectrum of services, not content**
   Portals of entry to services
   First responders
   Shelters
   Medical system
   Victim assistance programs
   How to respond to a friend or family member
   Models of community response
   Collaboration
   Mental Health Professional’s role in the larger community system
Civil Protection Orders
Prosecution and incarceration of offenders
Judicial system response
Who do people go to and different satisfaction levels
Organization of services for different kinds of victims and accessing them
Specialized services and interventions for victims and offenders

III. Effectiveness of interventions

Recommended Readings


One or both of these newspaper stories about lack of services for lesbians of color who are survivors of intimate partner violence can be read:
Content Area 6: Screening and Assessing for the Presence of Relationship Violence

Rationale

It is important to be aware of screening and assessment procedures for cases of relationship violence. This means knowing how to screen, what assessment instruments are available, what are some of the clinical presentations of individuals involved in abusive relationships, what methods are available for risk assessment, and then what are the types of clinical interventions which can be made based upon the assessment.

Issues to be covered in Content area 6

• One of the critical aspects of partner abuse is being able to identify its occurrence. There is a great deal of evidence that intimate partner abuse is not commonly recognized even by individuals close to those experiencing it. Because societal norms support the notion that “a man’s home is his castle,” neighbors, friends and family members routinely turn a “blind eye” to violence and abuse in the home. This is especially true when the occupants of the home are same gender couples or members of an ethnic minority. When friends or family are aware of the abuse, they tend to minimize its severity or encourage the victim of the violence to try harder to placate the partner. Similarly, clergy, medical, mental health and other professionals may miss the signs of abuse or underestimate its virulence. A number of studies support the premise that mental health professionals do not know how to recognize partner abuse, and do not often even ask about its possible occurrence. For example, Hansen, Harway and Cervantes (1991) report that the majority of mental health professionals in their study, when asked how they would intervene in cases involving partner abuse, did not identify the violence as a presenting problem. Even those who did recognize the violence often suggested interventions which at best would be ineffective, and at worst, harmful. Holtzworth-Munroe, Waltz, Jacobson, Monaco, Fehrenbach and Gottman (1992) report on several samples of mental health professionals who were asked to identify heterosexual couples with whom they were working who were maritally distressed but non violent. Upon enrollment in the study, 43-46% of the participants by the husband’s own admission, were found to have been violent in the prior year. These data suggest that if mental health professionals are not properly trained in how to screen and assess people coming for treatment, like the clinicians in the Holtzworth-Munroe et al., study, they will miss many people for whom violence is a serious problem. Of course, without appropriate screening, well-targeted interventions and appropriate referrals cannot be made.

• Screening and assessment issues:
  ▪ There are a number of reasons cited why people experiencing relationship violence do not volunteer the information. O’Leary, Vivian and Malone (1992) report that fewer than 5% of couples seeking marital therapy spontaneously
report violence during intake, yet as many as 66% report some form of violence on a written self-report measure. Reasons for not reporting include:

- Fear and shame, because the victim feels responsible (Harway, 1993), or the perpetrator has underlying issues of shame (Dutton, 1995b).

- Couples’ belief that violence is not the problem because it is unstable and infrequent and seen as secondary to other problems (Ehrensaft & Vivian, 1996)

- Gay men and lesbian women are even less likely to report intimate partner violence to the police than those in heterosexual couples for fear that they will be further discriminated. We know that in the area of hate crime, many gay men and lesbian women do not report verbal harassment or physical violence against them to the authorities because they fear that they will be subjected to additional victimization at the hands of police or others who may learn of their sexual orientation as a result of their having reported the original attack (Herek & Berrill, 1992). Herek, Gillis, Cogan, and Glunt (1997) found that while approximately two-thirds of lesbian and gay victims of non-bias crimes reported the incident to law enforcement authorities, only about one third of the hate crime victims did so. In a study on sexual orientation hate crimes in Los Angeles, Dunbar (1998) reported that gay and lesbian people of color were both more likely to be victimized and less likely to report the hate act than European white gay men and lesbian women. It is clear that same-sex couples will share that fear; in fact a local prosecutor has called this fear “the second closet door” (Maryanne Hinkle, 2001, personal communication).

- In terms of gender roles, the belief that “boys will be boys” and that “women aren’t violent” leads many people to ignore the issue of same gender intimate partner violence. Due to heterosexism, providers may ignore the fact that this is an issue of intimate partner violence. For women, they may decide that they really aren’t hurting each other. For men, they may feel discomfort with trying to figure out if there is a pattern of violence and coercion because in their minds men can take care of themselves and they may not like to think of men as “victims.” Thus, appropriate assessment may be the only way mental health professionals may know that they are dealing with a relationship violence issue.

- With same gender couples, it is sometimes difficult to ascertain who is abuser and who is abused. Advocates for Abused and Battered Lesbians (AABL) has developed an assessment model to distinguish between the abuser and the abused. (Veinot, n.d.).

- Importance of assessment:
  - If no specific questions are asked regarding relationship violence, then it is highly likely that important issues will not be treated. Holtzworth-Munroe et al. (1992) studied five samples of supposedly martially distressed but
nonviolent couples provided by therapists; 43-46% of men reporting they had been violent toward their wives in the last year and 55-63% reporting they had ever been violent toward their wives. Therapists had been treating couples as if they were not violent.

- Hansen et al., (1991) found that therapists have difficulty recognizing relationship violence and making appropriate interventions.

- Safety issues: Dangerousness and risk assessment

  - Once relationship violence is recognized, then assessment must be made of the level of risk (see Campbell, 1995, and Harway & Hansen, 1993, for checklists on assessing for lethality issues or physical violence predisposition). Assessment instruments include:

    Dangerousness Assessment (Campbell, 1995)
    Spousal Assault Risk Assessment (SARA) (Kropp & Hart, 1997)
    Propensity for Abusiveness Scale (Dutton, 1995a)
    Psychological Maltreatment of Women Inventory (Tolman, 1989)
    Revised Conflict Tactics Scale – 2 (Straus, Hamby, Boney-McCoy & Sugarman, 1996)
    Risk checklist/Psychological Violence Inventory (Sonkin, 2000)
    Relationship Conflict Inventory (Bodin, 1996)
    Dominance Scale (Hamby, 1995)
    Women’s Experiences with Battering (Smith, Earp, & DeVellis, 1995)

- Issues in screening children. Because of the overlap in symptoms, it is important to rule out other forms of trauma, depression, conduct disorder or attention deficit disorder (ADD). Use of family history can be useful.

- First responders’ training. Among those likely to be in contact first with those affected by relationship violence are the clergy, emergency medical personnel, other physicians, law enforcement personnel and psychotherapists. All of these individuals must be trained to properly assess for the existence of relationship violence and know how to make appropriate referrals. In the cases of same gender violence, first responders may have their own bias and require anti-homophobia training.

For certain ethnic minority groups, first responders and mental health professionals must be aware of the importance of providing services in the language of the clients. Mental health professionals must be sensitive to the fact that many ethnic minorities who experience relationship violence are isolated from their community and that the services which may be available serve to further isolate them from their ethnic group and its sources of support.

Since, victims of domestic violence and perpetrators seldom volunteer information about domestic violence, mental health professionals have to be proactive in assessing for the
existence of violence. Because the presentation of victims and perpetrators “mimics” that of other presentations, detailed descriptions are included below so that a differential diagnosis can be made.

• Presentations of victims:
  
  • Symptoms — Most related to Post-traumatic stress disorder (Houskamp & Foy, 1991). Victims may have one or more of the following symptoms (because these symptoms are common presentations, they suggest that it is important to assess for the existence of relationship violence with all who present with these):

  ✓ Depression
  ✓ Anxiety
  ✓ Sleep disorders
  ✓ Eating disorders
  ✓ Substance abuse
  ✓ Suicidality
  ✓ Intrusive thoughts
  ✓ Somatization
  ✓ Victimization of others
  ✓ Hypervigilence
  ✓ Panic attacks

  • Issues related to misdiagnoses, such as borderline or histrionic personality disorder occur too often in these cases because an adequate assessment was not conducted or the context of the situation was not considered. Caplan (1992) and Walker (1993) suggest that people who have been exposed to relationship violence develop symptoms that resemble those of individuals who are diagnosable as borderline or histrionic personality disorder. However as Root (1992) suggests, the development of these symptoms are normal reactions to abnormal situations and may have been developed to help the individual cope with these abnormal experiences.

  • Multiple victimization. Some victims of relationship violence have experienced multiple victimization. Some have been beaten as well as raped by their perpetrator. Some have experienced abuse at the hands of different perpetrators and at different points in their life (e.g., childhood abuse; Rosenbaum & O’Leary, 1981). The acuteness of symptoms can be expected to differ based on the amount of victimization and its duration.

• Presentation of perpetrators.

  • Researchers, clinicians and theorists have been searching for a comprehensive description of those who perpetrate violence in relationships. The consensus currently is that there is no “one-size fits all” model that fits all offenders. It is more likely that there are subtypes of batterers or a continuum of such offenders.
Holtzworth-Munroe and Stuart (1994) divide batterers into Family Only, Dysphoric/Borderline, Generally Violent Antisocial, and Holtzworth-Munroe have recently added a 4th category of Low-Level Antisocial; Saunders (1992) talks about batterers as being high dependency or high antisocial, and Sonkin (2000) describes the types as Borderline Personality Disorder, Cyclical, Psychopathic, and Overcontrolled. Dutton also focuses on the Borderline offender and attachments issues (Dutton, 1998).

- Gelles (1998) and others in describing effective treatment consider readiness to change (i.e., Grimley, Proshaska, Velicer, Blais & DiClemente, 1994) as one of the considerations in addition to severity of risk as applied to batterers.

- Violence or lethality proneness is always a consideration.
  
  - Psychological functioning (e.g., psychopathy, dominance, self-esteem, anger, hostility, depression, impulsivity, fear, empathy, social skills, communication/conflict resolution, gender stereotypes, parenting skills) are also factors to be considered (see Hamberger, in Barnett, Miller-Perrin & Perrin, 1997, for a review).
  
  - There is substantial agreement that a history of victimization (or of exposure to violence in the home as a child) is associated with the tendency to perpetrate (Dutton, 1995b; 1998).
  
  - History of head injuries or other neuropsychological impairments are also associated with perpetrators (Cohen, Rosenbaum, Kane, Warnken, & Benjamin, 1999; Rosenbaum, Geffner, & Benjamin, 1997; Rosenbaum & Hoge, 1989).

Recidivism continues to be a problem with batterers, although treated batterers seem to have a lower recidivism rate than non-treated (Dutton, 1995c). Gondolf (1997) seems to be skeptical about the impact of treatment on effecting lasting change on behavior and attitudes.

- Presentations of children

Children who are exposed to intimate partner abuse experience a wide range of effects which include:

- School and social competence issues
- Internalizing and emotional effects
- Externalizing behavior problems
- Low Self-esteem
- Depression and PTSD
- Anger
- Aggressiveness
Wolfe (cited in Barnett, Miller-Perrin and Perrin, 1997) and Geffner, Jaffe and Suderman (2000) present a complete overview and references to numerous studies that would be important for an evaluator to understand in developing screening batteries and procedures for assessment.

- **Appropriate assessment measures for victims and perpetrators**

  Instruments usually used to assess psychological functioning in each of the areas listed above (e.g., Beck Depression Inventory for depression, Beck, 1978; Tennessee Self-Concept Scale for self-esteem, Fitts & Roid, 1964, 1991), plus Minnesota Multiphasic Personality Inventory – 2 (MMPI-2) (Hathaway & McKinley, 1989), Millon Clinical Multiaxial Inventory – II (Millon, 1987), and Trauma Symptom Inventory (TSI; Briere, 1995).

- **For Parenting skills**

  Child-Rearing Practices Report (Block, 1965)
  Parent-Child Relationship Inventory (Gerard, 1994)

- **For Communication and Marital stress**

  Family Adaptability and Cohesion Evaluation Scale (FACES III; Olsen, 1985)
  Family Environment Scale (Moos, 1974)
  Dyadic Adjustment Scale (Spanier, 1976)
  Marital Satisfaction Inventory-Revised (MSI-R; Snyder, 1996)
  Locke-Wallace Marital Adjustment (Locke & Wallace, 1959)

- **Appropriate for perpetrators primarily but can be used for victims as well to assess anger, assertiveness, psychological functioning**

  Coolidge Assessment Battery (Coolidge & Merwin, 1992)
  Structural Anger Assessment Interview (Johnson & Greene, 1992)
  Aggression Questionnaire (Buss & Perry, 1992)

- **Neuropsychological screening (if suspect head injuries or other similar impairment) – must be trained in this area or refer to a neuropsychologist for a screening or a full neuropsychological evaluation if this is suggested by the testing**

  Trails Making Test A & B (from Halstead Reitan Neuropsychological Test, Reitan, 1988)
  Indiana-Reitan Aphasia Screening Test, (Reitan, 1984a, b)
  Wechsler Adult Intelligence Scales (WAIS 3; Wechsler, 1997)
Kaufman Short Neuropsychological Assessment Procedure (K-SNAP; Kaufman & Kaufman, 1994)
Bender Visual Motor Gestalt Test (Bender, 1946)

- Appropriate for children

Trauma Symptom Checklist for Children (TSCC, Briere, 1996)
Children’s Depression Inventory (CDI; Kovacs, 1992)
Children’s Inventory of Anger (Nelson & Finch, 2000)
Louisville Behavior Checklist (Miller, 1984)
Child Behavior Checklist (Achenbach, 1986, 1997)

Outline of Content Area 6

I. Rationale

II. Screening and assessment issues
   - Reasons why people don’t volunteer information about violent relationships
   - Relevant issues for gays, lesbians, bisexual and transgendered couples
   - Importance of assessment
   - Safety issues, dangerousness and risk assessment (including some instruments to make those assessments)
   - Issues in screening children
   - First responders’ training
   - Issues related to ethnic minorities
   - Assessment for victims, perpetrators and children
   - Some additional assessment instruments

Recommended Readings

Recommended sections are:
   - Responding to Marital Violence (pp. 200-207)
   - Marital Violence—Battered women (pp. 212-225)
   - Marital Violence—Batterers (pp. 236-245)
   - Intervention and prevention for children exposed to marital violence (pp. 149-151)
   - An interview with David Wolfe (pp. 135-136).
   - An interview with L. Kevin Hamberger (pp. 235-236).


Content Area 7: Mental Health Intervention

Rationale

Mental health practitioners universally recognize the deleterious individual, relational, and societal consequences stemming from the incidence of intimate partner abuse. As a result of the epidemic nature of the phenomenon (Straus & Gelles, 1990), clinicians typically encounter cases of relationship violence throughout the full range of their careers, at times without awareness that abuse is occurring and potentially without sufficient training and capability to adequately assess and intervene (Goodwin, 1993). Such exposure perhaps nowhere more readily occurs than in the practice of couples and family therapy where attention is drawn particularly to functioning and quality of intimate partner and familial relationships (Avis, 1992). It is also important to understand that there are many specific interventions and treatment programs for perpetrators and victims of relationship violence. In addition, treatment for the children exposed to intimate partner abuse is also important to reducing the effects of the long-term trauma that often occurs.

Issues to be covered in Content area 7

- The study of couple and family relationship processes has evolved substantially in recent decades, and considerable attention that has been given to the development and validation of treatment services to remedy intimate partner relational difficulties (Johnson & Lebow, 2000). However, a considerable void persists with respect to the clinician’s response to the incidence of relationship violence. Of the resources that are available for practitioners, many are based on anecdotal evidence while others are sufficiently narrow in scope so as to undermine their utility to real life applications. Those that are suitable are few in number and are generally unfamiliar to mainstream practitioners. Consequently, practitioners are vulnerable to a host of unfounded assumptions pertaining to the nature and treatment of partner abuse. Intimate partner violence may often be unrecognized and errantly addressed.

- Ethnic minorities and low income individuals receive more surveillance and often show higher rates of detection of relationship violence than do majority members. This is due to the fact that these groups often must use public health facilities and services that abide by mandatory reporting protocols to a greater degree than private health care providers. It also appears that health providers are susceptible to believing in stereotypes that the poor and ethnic minorities are at greater risk for violence than middle income majority members (APA, 1996a).

- Family practitioners may employ customary treatment methods for enhancing relational quality with little insight into the role by which such efforts may in actuality interfere with the discontinuance of abuse (Bograd & Mederos, 1999; Hansen & Goldenberg, 1993). Many ongoing treatment programs are not culturally sensitive and may actually promote harm. For example, many women of color are uncomfortable with feminist treatment programs because they feel that these programs pit them against their partner and advocate their leaving the relationship. Many of these women of color simply want the violence to stop but they don’t want to end their relationships or see their partners
prosecuted in the criminal justice system which they believe is already biased against them (Sanchez-Hucles & Dutton, 1999).

- Should the present status of the literature be any indication, clinicians are, in the main, poorly equipped to respond to the needs of clients who are experiencing violence within their intimate relationships unless they have had specific training in such techniques and dynamics.

- Intervention must be based in an understanding of the broader socio-cultural context in which intimate partner aggression is both permitted and perpetuated (Bograd, 1999; Crowell & Burgess, 1996; Harway & O’Neil, 1999; Jenkins & Davidson, 1999; Koss et al., 1994; Lundy & Grossman, 2001; Wiehe, 1998) and must continue to focus on the intersection of complex factors such as gender, race, sexual orientation, and class (Ritchie, 1996). Second, misguided, though well intended, intervention may serve to exacerbate trauma and enhance the dangerousness of the partner relationship (Bograd & Mederos, 1999; Geller, 1998; Hansen & Goldenberg, 1993). Third, the over-arching goal for intervention is the promotion of the health and welfare of individuals. We assume that relationship maintenance and enhancement is desired only when consistent with the best interests of the individual members. This becomes more complex for ethnic minorities who often feel extreme financial, cultural and familial pressure to remain in relationships. Last, multi-disciplinary methods for the treatment of partner violence, based upon an assessment, is the preferred mode of intervention for most cases.

- Of the available intervention methods, each can be categorized within one of five categories:
  - Crisis Intervention
  - Intervention for Victims
  - Interventions for Offenders
  - Interventions for Children Exposed to Relationship Violence
  - Interventions for Couples or Families

The initial category, Crisis Intervention, encompasses methods which are aimed at resolving immediate threats and other issues impairing the welfare and safety of the victims of intimate partner abuse. Crisis intervention methods include: the identification of community, medical, and social resources; facilitation of access to community resources; minimization or elimination of dangerousness; and the development and implementation of a safety protection plan (Roberts & Burman, 1998). Mental health practitioners also need to acknowledge that, during this stage, they might have to work with hostile, suspicious and resistant clients who do not trust authority figures or help givers, particularly if they are different from the clients in race, culture, and SES.

- Within the second category, Interventions for Battered Individuals, each form of intervention may emphasize both immediate or short-term objectives as well as the individual’s long-term adjustment. Immediate objectives emphasize assisting
victims in identifying the impact of violence and abuse, and to promote his or her personal sense of empowerment. Long-term objectives emphasize the resolution of the emotional and psychological difficulties consequent to the individual’s history of trauma. Certain models for treatment emphasize an integration of both immediate and long-range goals (Harway & Hansen, 1994; Monnier, Briggs, Davis & Ezzell, 2001; Register, 1993; Walker, 1994; 2000).

Interventions for battered individuals fall within five modalities: individual supportive counseling, group counseling with other battered individuals, individual psychotherapy, psychoeducational experiences, and community level interventions. A number of models of therapy specific to the treatment of battered individuals have been described in the literature. While each offers a unique approach, a fairly uniform model for promoting the healing and resolution from the effects from battering can be identified (Register, 1993). Advocated methods address several steps toward this end. Identified steps include: ensuring client safety; the provision of validation and support; the identification of the personal consequences and effects from partner violence; resolution of associated emotional and psychological difficulties; the promotion of insight and self empowerment; the facilitation of personal problem solving ability; the promotion of access and usefulness of social supports; and the provision of ongoing therapeutic support as needed.

These treatment goals can be particularly difficult for ethnic minority, refugee, and immigrant women who have been taught to value men more so than their own safety and well-being. These women are often advised by their families not to report violence and not to seek or accept services.

- The third category is comprised of Interventions for Battering Individuals. The main methods for intervening with batterers include: social control, psychoeducational programs, and psychotherapy. Social control interventions pertain to the civil and criminal consequences that can be applied for incidents of battering (Scott & Wolfe, 2000). Psycho-educational interventions are designed to address the attitudinal and related psychological factors which permit and perpetuate the incidence of intimate partner violence. Associated methods seek to promote a greater understanding by batterers of the causes and consequences of partner abuse and to redress personal attitudes and skill deficits which promote personal vulnerability to abuse. Psychoeducational methods can be administered in either an individual or group modality. The focus for such can include: power and control issues in relationships, behavior management, anger expression and management, feminist-informed socio-education, and other forms of education and skills training (e.g., Geffner & Mantooth, 2000; Gondolf, 1993; Harway & Evans, 1996). Psychotherapeutic methods can be administered in either an individual or group format. Group models of psychotherapy for Battering Individuals can be comprised of peers or, in some cases, include participants who have been the victims of partner abuse. Psychotherapeutic interventions employ
several approaches with the explicit intention to promote acceptance of responsibility and a commitment to refrain from further acts of violence. They also focus on changing attitudes and behaviors.

- The fourth category pertains to Interventions for Children Exposed to Family Violence. Methods in this area seek to resolve the emotional and psychological consequences suffered by children who have been exposed to intimate partner violence within their families. The consequences suffered by children can derive from the witnessing of violence itself as well as from an associated deterioration in parental capacity. Children in such situations may experience secondary or vicarious trauma which can result in both immediate and long-term emotional and psychological symptoms. Children may develop distorted and maladaptive views of couple and family relationships and may assume age-inappropriate roles and responsibilities within the context of their relationships with parents. The methods for intervention can include individual counseling, group counseling, as well as psycho-educational and other supportive experiences (Alessi & Hearn, 1998; Harway & Hansen, 1994; Lehmann & Carlson, 1998; O’Keefe & Lebovics, 1998; Peled, et al., 1995; Sudermann, Marshall, & Loosely, 2000).

- The final category pertains to interventions that incorporate a conjoint modality wherein the battering individual is seen in the company of the battered individual for treatment services. The conflicted status of the existing literature addressing this area (Greenspun, 2000; Hansen & Goldenberg, 1993; O’Leary, Heyman, & Neidig, 1999; Vivian & Heyman, 1996) reflects the controversial issues involved with such approaches in intimate partner violence. While some argue that conjoint methods are categorically inappropriate and prone to perpetuate further abuse, others suggest that conjoint models are preferable in certain cases and potentially essential. Advocates of conjoint methods contend that vulnerability to violence may persist without attention to the unique and dynamic aspects of the relationship in which violence has occurred. Geffner and Mantooth (2000), and Geller (1998) identify specific factors which should be considered in determining whether conjoint methods are indicated. Conjoint methods are not be considered appropriate under any of the following conditions:
  
  o perpetrator refuses to refrain from violence;
  o perpetrator refuses to accept responsibility for his or her actions;
  o failure to accept the discontinuance of abuse as the primary objective for treatment;
  o an inability to promote and preserve the safety of all parties;
  o a high level of lethality and dangerousness;
  o high levels of intimidation and fear;
  o stalking or other obsessive behaviors;
  o continued use of alcohol or other substances;
  o and the presence of disinterest or discomfort with conjoint services by either party.
Associated prerequisites for conjoint approaches include: maintenance of no violence; successful completion of individual therapeutic goals; and investment by both partners in preserving safety over resolution of couple issues. The primary goals for conjoint methods for the treatment of intimate partner abuse include promoting a continued absence of violence and the integration of adaptive couple interactions. The format for conjoint services can follow a traditional couples therapy structure as well as more innovative models such as multiple couple therapy groups. The orientation for conjoint treatment may be based in any of a number of models including: feminist-informed, narrative, solution-focused, and/or social-learning/cognitive behavioral. (Bograd & Mederos, 1999; Geffner & Mantooth, 2000; Jackson-Gilfort, Mitrani, & Szapocznik, 2000; Neidig & Friedman, 1984).

- It is not surprising that given the very slow maturation of treatment services for battering within traditional situations, even greater limitations are present in attempts to apply available models and methods for intervention with the diverse range of intimate relationship forms within contemporary society. Many individuals in interracial relationships, those without legal status, and individuals with disabilities do not feel included in current treatment approaches.

- Similar to vulnerability to bias and misguided intervention for general couple relationship difficulty, practitioners are often poorly equipped to respond to the issues and needs presented by the incidence of intimate partner abuse within gay, lesbian, and bisexual relationships (Byrne, 1996; Crane, LaFrance, Leichtling, Nelson & Silver, 1999; Grant, 1999; Renzetti, 1993). Batterers and battered individuals within same gendered relationships require a model of intervention and treatment which may poorly correspond with established programs. For instance, a female batterer within a same gender relationship will likely receive inadequate assistance by participation within a traditional batterers group. Many partners in same gender relationships report that they would not seek treatment unless they are sure it is in an environment where their sexual orientation will not be pathologized or be the focus of treatment. However, it is important that attitudes toward their sexual orientation, for both survivor and perpetrator, be explored. Specific treatment approaches have been discussed for gay men (Byrne, 1996), for separate services for lesbian and bisexual women (Elliott, 1990; Grant, 1999), and self-facilitated support groups have been developed by the SF Network for Battered Lesbians and Bisexual Women (Crane et al., 1999).

- Similar issues involving females arrested for battering their male partners have occurred, and new treatment programs are needed to focus on the specific needs of these offenders (Koonin, Cabarcas, & Geffner, 2001). It is also important to make sure that women arrested for domestic violence are differentiated in treatment as to their own victimization history so there is not confusion between those who are dominant or primary aggressors and those who were primary victims who fought back. Many questions must be answered when working with people with different
orientations and cultures. Do you put a female perpetrator in a group with men, or a male victim in a group with women victims?

What is done with a transgendered male to female (i.e., living as a female but still with male genitals) in a group or must the intervention be done in an individual program? How is the hostility of some staff toward lesbian, gay, bisexual or transgendered people in community settings handled, and more importantly how is this handled by clients? There are specific interventions with lesbian couples (e.g., Istar, 1996) and for gay male couples (Hamberger, 1996).

- Clinicians need training about assessment and intervention that includes:
  1) information about same-gender couple violence,
  2) exploring the interface between the partner’s sexual orientation, their attitudes toward their sexual orientation and the partner violence,
  3) the need to provide or refer to services specifically designed for partners in same gender couples
  4) understanding issues of culture, ethnicity, interracial relationships, acculturation, migrant status, citizenship, SES, ability, geographic origin such as rural or urban and the intersection of these factors, and
  5) Culturally sensitive programs and culturally competent providers who recognize and build upon the unique strengths and weaknesses of individual clients.

Outline for Content Area 7

I. Rationale

II Clinical Intervention Approaches for:
   Victims
      Group
      Individual
      Advisability of couples/conjoint therapy; criteria
      
      Perpetrators
      Incarceration
      Group
         Anger management
         Cognitive-behavioral
         Feminist socio-educational
         Feminist psychotherapy
         Psychoeducational
         
         Narrative approaches
         Individual
         Advisability of couples/conjoint therapy; criteria of when this is appropriate

Children
   Group
Individual
In different settings (e.g., shelters)

III. Special issues and treatment for those from different cultures, and LGBT clients

**Recommended Reading**


Content Area 8: Forensic Issues

Rationale

Family violence cases often end up in various courts, either as the main legal issue or indirectly involved in other legal issues. The factors described in this content area could be relevant for criminal, civil, family, and/or dependency courts. Mental health professionals should understand the responsibilities of the different courts, the possible roles that they may play in different types of cases, and the increasing importance of relationship violence issues.

Issues to be covered in Content area 8

- Criminal justice courts deal with the crime of relationship violence, and mental health professionals may be asked to testify as expert witnesses with regard to dangerousness, appropriateness of treatment, or concerning the dynamics of intimate partner abuse. The latter could focus on the underlying issues when a victim strikes back in self defense and injures or kills the offender, or may focus on the possible reasons a victim of partner violence may recant her testimony and testify on behalf of the alleged perpetrator. Treating clinicians may also be called to testify as to progress in treatment for an offender who is pending sentencing in criminal court or may be called to testify as part of the offender’s conditions of probation. It is important for psychologists to be familiar with the general processes and procedures for testifying in court, and the roles they may be asked or required to carry out. Because the legal process is adversarial, there will be efforts made to win the clinician over to one side or the other. The clinician must be especially vigilant that his/her own ethnocultural identity is not manipulated to accomplish this goal.

- Family violence issues may be important in dependency and family courts. If partner violence has been alleged in child custody cases in family courts, psychologists may be asked to conduct a custody evaluation of the parties. The dynamics of partner violence discussed in prior content areas of this guide are important considerations in the evaluation procedures, the interpretation of testing results, and in recommendations that the evaluator may make. These issues have become very controversial, and have led to numerous laws in many states (APA, 1996a, b; APA Ad Hoc Committee, 1996, 1997; Jaffe & Geffner, 1998).

- Mental health professionals must be especially conscious of the influence of culture and race on the way in which partner violence is described and the traditional roles of male parents in both nuclear and extended families, depending on the ethnicity of the family constellation to be evaluated. Evaluating clinicians must have a clear understanding of the definitions of parent roles as they affect such contentious matters as family discipline and curfew for all family members and management of family finances. When testifying as expert witnesses, mental health professionals must also take account of the views held by the court concerning people of color and immigrants and present their testimony in such ways as to prevent it from being misused to further any negative stereotyping that may be part of the context of the court.
• Physical injuries and emotional distress that may have been inflicted in partner violence cases may be the crucial issues in malpractice or personal injury lawsuits. These types of cases occur in civil courts. Again, mental health professionals play an important role in evaluating the parties, explaining the dynamics of partner violence to judges or juries, or in providing information as to the seriousness and severity of possible emotional harm. In all such cases, mental health professionals should carefully consider the cultural expectations of all parties and not be distracted from identifying distress when it is salient even if this requires norm-dissonant education of the victim and the court.

• The evaluator may require the assistance of an individual of the other gender in order to obtain the most accurate information and to ensure cooperation of the victim and the extended family in preparation for court. Evaluators are encouraged to approach forensic examinations in family violence as a team activity rather than that of a sole practitioner.

• The legal system does not afford the same protection to members of same gender partner violence in many states (daLuz, 1994; Fray-Witzer, 1999, Lundy, 1999; NCVAP 1997). According to the National Coalition of Anti-Violence Programs (NCAVP, 1997), in 7 states same-gendered relationships do not qualify as "domestic." Even though state laws cover homosexual as well as heterosexual domestic violence, the chances are that laws are not enforced equally and that same-sex litigants are treated with less dignity, sympathy, and respect that their heterosexual counterparts (Lundy, 1999). Many lesbian, gay and bisexual individuals feel that the legal system supports violence against them. They may have lost custody of their children because of their sexual orientation and may receive no protection from discrimination in housing or employment. Sodomy laws and anti-gay legislation like the Defense of Marriage Act which denies marriage rights to same sex couples may further alienate lesbian, gay and bisexual people from the legal system (Allen & Leventhal, 1999). The applicability of battered woman's syndrome has been strongly contested in lesbian cases and we do not know much about its use with gay male cases (see Goldfarb, 1996). In many states, homosexuals are implicitly excluded from legal protections (i.e., civil protection order laws) and there are fewer social services available for battered lesbians and gay men. Forty-eight jurisdictions provide protection where the victim and abuser cohabit, but six of these laws explicitly exclude homosexual couples (Murphy, 1995) There are only 12 states that provide protection for homosexual victims of intimate violence (Murphy, 1995)

• For people from different ethnic groups and cultures there are significant issues involved in forensic cases. In relationship violence situations, there is a reluctance to press charges due to social isolation, due to cultural value of enduring hardships for Asians within the community, and due to suspicion of the legal system and fear of decreasing the male population for African Americans.

• Topics to include with respect to forensic issues for each type of court situation:
  • Different Court Systems: Criminal, Civil, Family, Dependency
  • Diagnoses in the context of victimization
• Criminal Court issues
  Restraining orders, and victim request for withdrawal of such orders
  Diversion vs. incarceration for offenders
  Treatment vs. education; probation oversight of interventions
  Misdemeanors vs. felony assaults
  Arrest issues, including mandatory and pro-arrest policies (pros and cons)
  Stalking issues
  Discussion of inherent problems with current legal response
  Disclosure issues
  Victim recantation and “Cycle of Abuse” issues
  Conviction, and myth of the “Batterer Profile”
  Inherent traumatizing features of adversarial justice
  Mitigating factors in criminal and capital cases
  “Battered Women Syndrome” defense in homicide or attempted homicide cases

• Civil Court
  Tort suits for injury and emotional anguish
  Protective Orders
  Sexual Harassment

• Family Court
  Divorce and child custody; visitation issues
  Rebuttable presumption when domestic violence has occurred
  Parental Alienation: The facts of alienation, the myth of a “Syndrome”
  Double bind when child abuse is disclosed in domestic violence cases:
    “Failure to protect” vs. “False/Programmed allegations”

• Dependency Court
  Overlap between Child Protective Services issues and relationship violence
  Removal of children exposed to relationship violence
  Pennell and Burford (2000) review the impact of the communitarian justice process in programs that divert families from Dependency Court in incest families.

• Unified Domestic Violence Courts

• Can victims get justice in the civil or criminal courts?

• Duty to protect, to warn, and standard of care issues
  Ethical issues and guidelines in conducting forensic evaluations and testifying in court cases
  Mandated reporting issues
Outline for Content Area 8

I. Rationale

II. Types of courts and cases involving relationship violence issues

Different Court Systems: Criminal, Civil, Family, Dependency
Diagnoses in the context of victimization
Criminal Court issues
  Restraining orders
  Diversion vs. incarceration for offenders
  Court culture: Prosecutorial and judicial bias
  Treatment vs. education
  Arrest issues, including mandatory and pro-arrest policies (pros and cons)
  Stalking issues
  Victim recantation and “Cycle of Abuse” issues
  Conviction, and myth of the “Batterer Profile”
  Mitigating factors in criminal and capital cases
  “Battered Women Syndrome” defense in homicide or attempted homicide cases
Civil Court
  Tort suits for injury and emotional anguish
  Protective Orders
  Sexual Harassment
Family Court
  Divorce and child custody; visitation issues
  Rebuttable presumption when domestic violence has occurred
  Parental Alienation: The facts, and the myth of a “Syndrome”
  Double bind when child abuse is disclosed in domestic violence cases:
    “Failure to protect” vs. “False/Programmed allegations”
Dependency Court
  Overlap between Child Protective Services issues and relationship violence
  Removal of children exposed to relationship violence
Unified Domestic Violence Courts

III. Ethical issues and guidelines in conducting forensic evaluations and testifying in court cases

Recommended Reading

American Psychological Association Ad Hoc Committee on Legal and Ethical Issues in the Treatment of Interpersonal Violence. (1996). *Potential problems for psychologists working with the area of interpersonal violence.* Washington, DC: APA.


Content Area 9: Prevention of Relationship Violence and Promotion of Nonviolence

Rationale

Intimate partner abuse has been a recognized epidemic and public health concern for nearly two decades. To have a significant impact upon the elimination of relationship violence, an organized effort in promotion of nonviolence is needed.

Issues to be covered in Content Area 9

- The prevention of violence is one of the highest priorities for psychologists (American Psychological Association, 1996a; Finkelhor, 1986; Swift, 1986). Romano and Hage (2000) provide a broad definition of prevention and specify how preventive interventions can be conceptualized and implemented. These broad definitions imply the traditional primary, secondary, and tertiary kinds of prevention (Caplan, 1964).

- When Romano and Hage’s definition is applied to relationship violence, prevention means:
  1) Stopping the violent behavior from ever occurring,
  2) Delaying the onset of violent behavior,
  3) Reducing the impact of existing violent behavior,
  4) Strengthening behaviors that promote emotional and physical well-being, thereby inoculating people from the negative effects of relationship violence, and
  5) Supporting institutional, community, and government policies that promote the prevention of relational violence.

- Violence prevention among high school and college students:
  1) Date rape prevention programming is one of the most commonly evaluated prevention approaches (Bachar & Koss, 2001). Students on most campuses are exposed to at least a rudimentary message intended to reduce date rape.
  2) Curriculum aimed at middle and high school students are also available for relationship aggression prevention (Wolfe, Wekerly, & Scott, 1996).
  3) A variety of programs have been formally evaluated for effectiveness including programs that last an entire semester, programs by men for men, and the most typical format, the 90-minute presentation. There is extensive evidence that these programs impact attitudes and knowledge, although in some cases the effect may not be long lasting. The evidence that they result in less victimization of women is weak.

The prevention of relationship violence implies focusing on special groups (gays, lesbian, bisexuals, ethnic minorities, immigrants) who have not previously been targeted for prevention interventions. In terms of preventing lesbian, gay, bisexual and transgendered (lgbt) relationship violence, there should be outreach to the lgbt community such as that described by Island and Letellier (1991b, c). In addition, if we hope that lgbt populations will feel more free to report domestic partner
abuse we should work toward changing laws which discriminate against people because of their sexual orientation.

- Education of immigrant populations of the value of nonabusive relationships is important. Improvement in language-relevant services is very important for those from different cultures and ethnic groups. Ethnic minority service providers must be better trained in abuse issues.

- Additionally, prevention interventions include:
  1) changing discriminatory laws against special groups that may cause relationship violence,
  2) educating immigrant populations about nonabusive relationships,
  3) providing language services to immigrant populations and others who need English (or other languages) to understand the complexity of relationship violence, and
  4) implementing systematic training of special group service providers in the area of relationship violence and abuse.

- Knowledge of theoretical perspectives on primary prevention

- Educational programs for children, teens, and adults related to:
  1) Alternative conflict resolution strategies,
  2) Gender-role issues,
  3) Countering prevailing media and societal norms around violence.

- Promoting resiliency among men and women

- Preventative interventions with batterers around predisposing factors to violence.

- Teaching men and women how to recognize and deal with feelings in more prosocial ways

- The role of gender role socialization in relationship violence

- Specific programs focused on helping men and women understand relationship violence

- Encouragement of advocacy groups

- Prevention as creating public policy and legislative initiatives

- Evaluation of primary prevention interventions

- Legal and societal changes needed
Outline for Content Area 9

I. Rationale

II. Prevention of violence and promotion of nonviolence as a priority
   Prevention of violence: Definitions
   Knowledge of theoretical perspectives on primary prevention
   Prevention of violence with special groups
   Theoretical perspectives on prevention
   Educational programs for children and teens
   Prevention interventions for men, women, and children
   Prevention as education on gender roles, sexism, homophobia and other forms of oppression
   Preventative interventions with batterers around predisposing factors to violence; teaching men how to recognize and deal with feelings in more prosocial ways
   Prevention through advocacy groups
   Prevention as public policy
   Prevention through societal and legal change
   Promoting resiliency among men and women

III. Counter prevailing media and societal norms around violence
   Prevention as creating public policy and legislative initiatives
   Evaluation of civil protection orders, mandatory arrest, court ordered treatment, etc.
   Effectiveness of medical interventions
   Effectiveness of clinical intervention programs
   Primary prevention and evaluation of primary prevention.
   Legal and societal changes needed

Recommended Readings


References


American Medical Association (1992). Diagnostic and treatment guidelines on domestic violence. *Archives of Family Medicine, 1*, 39-47. (also see the subsequent three issues for guidelines on child physical abuse and neglect, child sexual abuse, and elder abuse).


American Psychological Association Ad Hoc Committee on Legal and Ethical Issues in the Treatment of Interpersonal Violence. (1996). *Potential problems for psychologists working with the area of interpersonal violence*. Washington, DC: APA.


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Helpful Websites
Compiled by Jocelyn Townshend, Aria Grillo, Laura Steele
Wheaton College

National & International Sites On Family Violence

Family Violence & Sexual Assault Institute-
http://www.fvsai.org
FVSAI is an independent, non-profit organization used as an international resource center and maintains a clearinghouse of categorized references and unpublished papers concerning all aspects of family violence and sexual assault. This site disseminates vital information on improving networking among professionals, and also provides training that promotes violence free living.

National Center for Victims of Crime-
http://www.ncvc.org
NCVC strives to forge a national commitment to help victims of crime rebuild their lives. They are dedicated to serving individuals, families, and communities harmed by crime, and work with many grassroots organization and criminal justice agencies to promote awareness. Important links as well as the current issues can be found through searching the webiste on domestic violence.

National Clearinghouse for Alcohol and Drug Information-
http://www.samhsa.gov/centers/clearinghouse/clearinghouses.html
SAMHSAs sponsored clearinghouse which produces Making the Link- Domestic Violence & Alcohol and Other Drugs. Discusses links between alcohol and drugs to domestic violence. Must use search on website to find information.

National Coalition Against Domestic Violence -
http://www.ncadv.org/
The National Coalition Against Domestic Violence is “a grassroots non-profit membership organization working since 1978 to end violence in the lives of women and children.”

National Domestic Violence Hotline –
http://www.ndvh.org/
This cite provides 24-Hour access for all 50 states. Translators available. They link individuals to help in their area using a nation wide data base that includes detailed information on shelters, legal advocacy and many more things.

National Network to End Domestic Violence -
http://www.nndev.org
This site finds news and information for advocates about domestic violence. They give the national perspective on legislation and public policy, training conferences, employment opportunities and the latest advancements in the field, from the field.
National Organization of Women -
http://www.now.org
NOW takes action to bring women into full participation in the mainstream of American society, exercising all privileges and responsibilities thereof in truly equal partnership with men. They include links on domestic violence, providing information about what actions have been taken to promote awareness, the top issues of domestic violence, and ways for the public to take action.

National Training Center on Domestic and Sexual Violence -
http://www.ntcdsv.org
The NTCDSV is a non profit organization in Austin Texas with funding helped by US Defense Task Force on domestic violence. This site designs and provides innovative training and consultations, influences policy and promotes collaboration and diversity in working to end domestic violence and sexual violence.

National Violence Against Women Prevention Research Center –
http://www.vawprevention.org/
Sponsored by the Centers for Disease Control and Prevention, this site provides information on research, advocacy and practice, public policy, and education and training issues. Designed to be useful to scientists, practitioners, advocates, grassroots organizations, and anyone else interested in topics related to violence against women and its prevention.

Rape, Abuse, and Incest National Network (RAINN) –
http://rainn.org
RAINN is a non-profit, Washington, D. C. based organization that operates a national toll-free hotline for victims of sexual assault. This website provides statistical information.

Silent Witness National Initiative -
http://www.silentwitness.net
This website promotes peace healing and responsibility in adult relationships in order to eliminate domestic murders in the US by the year 2010. They show and discuss projects that are successful in reducing or eliminating domestic violence in courts, communities and churches.

Zonta International Strategies to Eradicate Violence Against Women and Children -
http://www.zisvaw.org
ZISVAW is dedicated to eliminating violence against women and children. Funded by the Zonta International Foundation, this site focuses on prevention, education awareness, and advocacy for legislative and political reform.
Prevention

American Medical Association's Violence Prevention Website -
http://www.ama-assn.org/ama/pub/category/3242.html
This website provides information on AMA's violence-related policies and reports, as well as its activities and projects. Links to other organizations are also provided in an effort to bring together information from organizations in many arenas who are working together against violence.

Center for the Prevention of Sexual and Domestic Violence –
http://www.cpsdv.org/
The Center is a Seattle-based, non-profit organization providing educational resources addressing issues of sexual and domestic violence.

Communities Against Violence Network -
http://www.cavnet.org
CAVNET is deeply committed to helping victims and survivors of violence and to help the public understand, end, and eliminate violence in our society. Includes information on domestic violence and gay and lesbian violence.

Domestic Violence Prevention Online -
http://www.dvponline.com
The latest on new preventative measures that the government as well as local officials are taking to prevent domestic violence. There are helpful sites and referrals for people who need help getting out of a abusive relationship.

Family Violence Prevention Fund –
http://www.fvpf.org/
The Family Violence Prevention Fund (FVPF) trains judges and police officers to respond appropriately when confronted with battering. Teaches healthcare providers how to identify and help victims of abuse and their children, and develops public education campaigns. Offers information on how to protect children, and achieve economic independence. Addresses health care and work issues related to domestic violence while also providing information specific to immigrant women.

New York State Office for the Prevention of Domestic Violence –
http://www.opdv.state.ny.us
Promoting effective cross-systems’ responses to DV through training, technical assistance and policy development.

Legal

American Bar Association -
http://www.abanet.org/domviol/home.html
This website provides links to domestic violence statistics, resource networks, and attorney referrals.
Family Violence Department Of the National Council of Juvenile and Family Court Judges - http://www.dvlawsearch.com
Dedicated to improving the way courts, law enforcement agencies and others respond to family violence with the ultimate goal of improving the lives of domestic violence survivors and their children.

NOW Legal Defense Fund and Educational Fund - http://www.nowldef.org
This site uses the power of the law to define and defend women’s rights. Working in congress, the courts, and through the media, they act strategically to secure equality and justice for all women across the country. Must type ‘domestic violence’ to receive information.

This website by the Violence Against Women Office, U. S. Department of Justice, provides information on community intervention strategies, grants possibilities, Federal VAW laws and regulations, Department of Justice research and statistical publications, VAW intervention resources on-line, state hotlines advocacy groups, and the National Advisory Council on Violence Against Women.

Violence by Intimates – http://www.ojp.usdoj.gov/bjs/pub/ascii/vbi.txt
This site is maintained by the Bureau of Justice Statistics and the Federal Bureau of Investigation and reports violence between intimates - spouses, ex-spouses, and former and current boyfriends and girlfriends.

Women’s Rights Network – http://www.wellesley.edu/WCW/wcw/viol_prev.html
The National Violence Against Women Prevention Research is a consortium of the Medical University of South Carolina (MUSC), the University of Missouri at St. Louis (UMSL), and the Wellesley Center for Women (WCW) at Wellesley College.

Gay and Lesbian

Gay Men’s Domestic Violence Project - http://www.gmdv.org
Founded by a survivor of domestic violence the Gay Men’s Domestic Project provides community education and direct services to gay, bisexual, and transgender male victims and survivors of domestic abuse.

LAMBDA is a non-profit, gay/lesbian/bisexual/transgender agency dedicated to reducing homophobia, inequality, hate crimes, and discrimination by encouraging self-acceptance,
cooperation, and non-violence. This website includes a fact sheet on domestic violence in lesbian/gay/bisexual relationships.

**National Coalition of Anti-Violence Programs** -
http://www.avp.org/ncavp/publications
This organization reports statistics on hate crimes with links to domestic violence, as well as programs generally for the LGBT community. Provides an annual report on lesbian, gay, bisexual, transgender domestic violence released October 6, 1998 by National Coalition of Anti-Violence Programs. The report provides general information about NCAVP, the prevalence of LGBT domestic violence, and the available protections.

**National Gay and Lesbian Task Force** -
http://www.ngltf.org
National progressive organization working for the civil rights of gay, lesbian, bisexual, and transgender people, with the vision and commitment to building a powerful political movement. Must type search to find information on domestic violence as well as same sex violence.

**Network for Battered Lesbians and Bisexual Women** -
http://www.nblbw.org
Addresses the issue of battering within Bisexual communities. Provides support to battered lesbians and bisexual women. The website is half in English, half in Spanish.

**New York City Gay and Lesbian Anti-Violence Project** -
http://www.avp.org
Provides services for gay, lesbian and/or bisexual crime victims. Counseling, police advocacy, court advocacy, short-term counseling, support groups, community education, 24-hour hotline. The AVP issues reports on domestic violence

**Multicultural**

**Asian Task Force** -
http://www.atask.org
The Asian Task force works to eliminate family violence and strengthen Asian families and communities. They work to educate Asian communities and battered women’s service providers to develop culturally appropriate resources for battered Asian women.

**Institute on Domestic Violence in the African-American Community** -
http://www.dvinstitute.org
This website provides resources, event announcements that specifically address community and family violence in the African-American population. The Institute is sponsored by the Office of Community Services, Administration for Children and Families, and the U.S. Department of Health and Human Services.

**Muslims Against Family Violence** -
http://www.steppingtogether.org/projects_mafv.html
This organization strives to eliminate domestic violence in the San Francisco bay area Muslim Communities by promoting a comprehensive educational campaign that will enhance community awareness.

National Latino Alliance -
http://www.dvalianza.org
Alianza is a group of nationally recognized Latina and Latino advocates, community activists, practitioners, researchers, and survivors of domestic violence working together to promote understanding, sustain dialogue, and generate solutions to move toward the elimination of domestic violence affecting Latino communities.

Intimate Partner Violence and Domestic Abuse

Domestic Violence Handbook –
http://www.domesticviolence.org/content.html
General information site hosted in Oakland County, Michigan. Site is joint effort of the Oakland County Domestic Violence Coordinating Council, Creative Communications Group, and the American Divorce Information Network, publishers of Divorce Online.

Domestic Violence Information Center –
http://www.feminist.org/other/dv/dvhome.html
Information and resources from the Feminist Majority Foundation. Gives new stories on domestic violence as well as internet resources.

Education Wife Assault -
http://www.womanabuseprevention.com
Provides information intending to inform and educate the community about the issues surrounding wife assault/woman abuse in order to decrease the incidence of physical, psychological, emotional, and sexual violence against women including teen dating and same sex relationship abuse.

Family Violence Awareness Page -
http://www.famvi.com
Developed to help end all forms of family violence, and to provide information about services that are available to families in need of assistance. Gives great links to other helpful sites.

Firearms and Domestic Violence –
http://www.vpc.org/fact_sht/domviofs.htm
The Violence Policy Center is a national 501(c)(3) educational organization working to show that firearm use is a widespread public health problem of which crime is merely the most recognized aspect. This website provides a fact sheet specifically on firearms and domestic violence.
Husband Battering -
http://www.vix.com/pub/men/battery.html
Provides information on husband battering and gives articles and political views on how to end husband battering.

Issues and Dilemmas in Family Violence -
This booklet outlines 12 issues and dilemmas that are defined by the APA Presidential Task Force on Violence and the Family and germane to those who work with family violence.

Jane Doe -
http://www.janedoe.org
Jane Doe brings together organizations and people committed to ending domestic violence and sexual assault. Addresses root causes of violence and promotes justice, safety and healing for survivors.

Mental Health Net -
http://www.mentalhelp.net/guide/abuse.htm
Mental Health Net gives web resources dealing with domestic violence services for male and female victims. Posts articles, publications, treatments, hotlines, as well as other support services.

Minnesota Coalition for Battered Women -
http://www.mcbw.org
This is a statewide membership program made up of local, regional, and statewide organizations advocating on behalf of battered women and their children. They promote social change for individuals, institutions, as well as cultural change to end oppression based on gender, race, age, affectional orientation, class and disability.

Violence and the Family: Report of the American Psychological Association Presidential Task Force on Violence and the Family -
http://www.apa.org/pi/violefam.html
This report summarizes the psychological knowledge pertaining to violence and the family, describes family violence problems that can be prevented or ameliorated through psychological approaches, ad makes recommendations based on their findings.

Miscellaneous

Abackans Diversified Computer Processing, Inc.--
http://www.abackans.com/dvresour.html
This private site by two psychologists contains resources for Intimate/Domestic Violence, an extensive list of Intimate/Domestic violence resources as well as important definitions and links.
Minnesota Center Against Violence and Abuse -
http://www.mincava.umn.edu
MINCAVA’s mission is to support research and education. Allows access to violence related resources. The Minnesota Center Against Violence & Abuse Electronic Clearinghouse provides a quick and user friendly access point to the extensive electronic resources on the topic of violence and abuse available online.

Stop Abuse For Everyone –
http://www.safe4all.org
SAFE provides resources and information on domestic violence, concentrating on battered straight men and lesbian women.

Wife, Marital, Spousal Rape Information Page -
http://www.unh.edu/student-life/sharpp/sharpp.html
The Wife Rape information page at the University of New Hampshire.
**Videos**

*Compiled by Jocelyn Townshend and Aria Grillo*

*Wheaton College*

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**Abused Women Who Fight Back: The Framingham Eight** — Distributed by Films of the Humanities and Sciences, 44 minutes, 1994 Available from: Films for the Humanities and Sciences, Box 2053, Princeton, NJ 08543-2053.

This program explores the problem of domestic violence through the dramatic stories of the women who became known as the "Framingham Eight." Each woman was imprisoned in Framingham, MA, for killing a spouse or partner they say abused them repeatedly. Each sought to have her sentence commuted, claiming Battered Woman Syndrome as a defense, and several have won their freedom. The program looks at both sides of this issue, speaking with women who say they would be dead now if they hadn’t killed their partners, and to prosecutors and family members of those who were killed who believe the use of Battered Woman Syndrome as a defense has gone too far.

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**A Social Reality** — Produced by Rob Ramsey, 30 minutes, 1998 Available from: Concept Media, PO Box 19542, Irvine, CA 92623-9542.

Defines domestic violence and explores the socially accepted myths about the causes of these destructive, sometimes lethal, behavior patterns. The definitions of the phenomenon focus on the problems in relationships and the socioeconomic scope of relationship issues.

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**Behind Closed Doors** — Produced by Frame Up Films, LTD, 46 minutes, 1993 Available from: Filmmakers Library, 124 East 40th Street, New York, NY 10016.

*Behind Closed Doors* is an in-depth examination of domestic violence from a very personal perspective. It focuses on David, an abuser, and Margaret, a victim, who each discuss their difficult childhoods, their low self-esteem, their feelings of shame, and their determination to break the patterns of violence that have governed their lives.

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Nurses, physicians, social workers and other healthcare workers, may be the first to observe the physical symptoms of abuse and, if they have good relationships with their patients, may be the ones victimized women choose to confide in. This film, with its accompanying Resource Manual, contains the basic information needed to diagnose, document, and refer victims for additional assistance.
Charting New Waters: Responding To Violence Against Women With Disabilities — Produced By the Justice Institute Of British Columbia, 35 minutes Available from: Terra Nova Films, 9848 S. Winchester Avenue, Chicago, IL 60601.

This 35-minute video with accompanying facilitator's guide has been designed to raise awareness of the barriers and issues faced by women with disabilities when they try to end the violence in their lives. The video combines interviews with disability advocates and criminal justice personnel with three dramatic vignettes portraying women with disabilities who have experienced or are currently experiencing violence in their lives.

De Tal palo, Tal Astilla (Like Father, Like Son) — Media Network Society, 27 minutes, 1996 Available from: Media Network Society, Box 5744.

_De Tal Palo, Tal Astilla_ realistically portrays the challenge that Latino men face when forced to evaluate beliefs and ideas that justify their abusive actions, often reinforced by culture. The video’s highlights include several men, in their own words, describing their abusive behaviors against women. Domestic violence programs that have an open group structure would benefit from utilizing this video as a mini-orientation to new group members. Overall, it is culturally sensitive and does not re-enforce stereotypes of Latin culture.


Bellevue, Washington developed a system in which first-time offenders can forego criminal charges and conviction in exchange for undergoing intensive treatment. This approach has resulted in a repeat offense rate of only 4% among those completing treatment. This documentary shows it is not only men who abuse. A family counselor discusses his own situation in which he was the victim of his wife's behavior.


Features interviews with former victims of domestic violence who discuss the various forms of violence, both physical and emotional, in abusive relationships, the psychological patterns that keep women from leaving abusive spouses or boy-friends, and related issues of fear and low self-esteem. In addition to commentary by a clinical psychologist, each of the women discuss how they finally awakened from the cycle of violence, made the difficult decision to leave the abusive relationship, sought help through a shelter or an outreach program, and experienced a healing process which has empowered them with newfound strength and courage to rebuild their lives.

Hostages at Home — Distributed by Intermedia Inc., 52 minutes, 1994 Available from: Intermedia Inc., 1700 Westlake Avenue North, Suite 724, Seattle, WA 98109.

This 52 minute video has been called the "Text-Book Video" on the subject of domestic violence. _Hostages at Home_ features 5 women from different ethnic and socioeconomic groups
who have survived domestic violence. This program dispels myths about domestic violence and examines the effects on the community as a health issue.


Jean Kilbourne’s pioneering work helped develop and popularize the study of gender representation in advertising. In this film, Kilbourne reviews if and how the image of women in advertising has changed over the last 20 years. Kilbourne uses over 160 ads and TV commercials to critique advertising’s image of women and how such images reflect violence against women.

**La Confianza Perdida** — Distributed by Intermedia, Inc., 22-minutes, 1999 Available from: Intermedia Inc., 1700 Westlake Avenue North, Suit 724, Seattle, WA 98109.

This resource is a Spanish language videotape on date and acquaintance rape. The title, utilizing the double entendre on the word “confianza,” means both “loss of self-confidence” and “loss of trust in another.” Designed to promote discussion, the video combines reenactments with first person testimony from survivors of rape. Also interviewed are professionals in law, forensic medicine, social work, and political activism. Topics addressed include: definitions of rape and sexual assault, special considerations faced by immigrant women, spousal rape, resisting sexual assault, medical and social services available to survivors, treatment for STD’s, and the pros and cons of filing a police report.

**Male Violence: A Room Full Of Men** — Produced by Ian Preston, 49 minutes, 1991 Available from: Films for the Humanities and Sciences, Box 2053, Princeton, NJ 08543-2053.

This program examines male violence towards women by following three men with a history of abuse who have joined a program to help them stop their abusive behavior. The issues of authority and control by men over women, both physically and mentally, are explored by the men and by domestic counselors as a major cause of male violence towards women. Popular misconceptions such as the woman’s role in “provoking” the violence are dispelled. Two women from different socioeconomic backgrounds describe their experiences in abusive relationships.

**Meeting at the Crossroads** — Distributed by The Sidran Traumatic Stress Foundation, 27-minutes, 2001 Available from: The Sidran Traumatic Stress Foundation, 200 East Joppa Road, Suite 207, Baltimore, Maryland 21286.

Portraits of trauma survivors interweave with discussions by individual counselors, therapists, policy makers and others for an engaging and motivational look at the differing ways in which mental health practitioners and domestic violence/sexual assault counselors seek to help survivors of trauma. The first video of its kind to raise awareness of the importance of collaboration between mental health providers and domestic violence/sexual assault agencies in the assessment and effective treatment of trauma survivors.
Safe: Inside a Battered Women’s Shelter — Distributed by Films for the Humanities and Science, 50 minutes, 2001 Available from: Films for the Humanities and Sciences, Box 2053, Princeton, NJ 08543-2053.

This program presents the experiences of three women who sought to break the cycle of violence by seeking refuge at a safe house, a place providing sanctuary for physically abused mothers and their children. Through their stories, Nancy, Jasmine, and Yenesia reveal a way of life in which the victims, hurt most by those who supposedly love them, often feel like the culprits. Safe at last, they realize that the abuse they suffered is not their fault; freed of guilt and fear, they can break the emotional ties that bind them to their abusers.


An emotional account based upon true stories, this video portrays survivors of sexual assault and abuse, molestation, incest, and date rape. It emphasizes the importance of counseling as a means of aiding the healing process, as demonstrated by the male and female survivors in each scenario. This video can also be used with perpetrators to help them understand the pain and emotional scars that their crimes leave on their victims.

Shifting the Paradigm: From Control to Respect — Produced by Ann Alter, 41 minutes, 1999 Available from: Family Violence & Sexual Assault Institute, 6160 Cornerstone Court East, San Diego, CA 92121

This video explores the roots of our present culture of violence in the home, and what it will take to reach the ultimate goal of zero tolerance for domestic violence. This video offers ideas and inspiration that reaffirm the importance of the individual in creating a future where relationships are based on partnership and mutual respect.

Small Justice: Little Justice in America’s Family Courts — Co sponsored by Our Children Our Future, 60 minutes, 2000 This not available for purchase. For information, Please contact Elize St. Charles at Our Children Our Future Charitable Foundation, PO Box 1111, Los Gatos, CA 95031.

This documentary explores the American family court system. Featuring national experts and legal advocate Diane Hofheimer, it shows how perpetrators of violence continue to beat the victims by beating the system. Just how and why the courts, often unwittingly, help these men is examined. A question and answer session with Diane and Charles Hofheimer will follow the showing of this film.


This documentary visits Gatesville Penitentiary in Texas, where three female inmates convicted of murder and serving sentences ranging from 25 to 40 years describe the domestic violence that
would eventually bring them to prison. Sonia, Brenda and Lee Ann relate in their own words stories of the isolation and fear that bound them to their threatening husbands. Combined with analysis by experts on domestic violence and the law, this film shows the difficulties victims of abuse have escaping the cycle of violence. It challenges our attitudes towards the victim who acts in violent self-defense.


This program uses powerful animated images to illustrate interviews of survivors of domestic violence and the counselors who work with them.


The Savage Cycle is a candid view of domestic violence told by men and women dealing with violence in relationships. Examining the issues of power and control, this video is an introductory video about the topic of domestic Violence. Using the widely implemented "Power and Control Wheel," this video demonstrates each of the 3 parts of the cycle, supported by the testimony of the individuals interviewed. A second video, The Savage Man is a follow up to this video, focusing on the male perspective of domestic violence.


The Savage Man examines the issues of domestic violence from the male perspective. Exploring the issue of why men use violence to control relationships, this video is an t overview for therapists, educators, and the abusers themselves. Companion piece to The Savage Cycle.


Presented in Vietnamese with English subtitles, this video addresses domestic violence from the unique perspectives of Vietnamese immigrants in the United States. It provides a culturally sensitive focus on domestic violence in the Vietnamese community by educating viewers on the destructive effects of domestic violence on women and children, and the need for shelters and protection. It delivers a strong message to abusers that violence violates community values. The video stresses that violence is a choice, and not something that one must tolerate in a relationship. The fact that domestic violence is illegal in the United States and may require mandatory arrest in many states is emphasized as well. The video also addresses issues about domestic violence that are important to immigrant women.

**Tough Guise: Violence, Media, and the Crisis in Masculinity** —Directed by Sut Jhally, 87 minutes, 1999 Available from: Media Education Foundation, 26 Center Street, Northampton, MA 01060.
"Tough Guise" examines the relationship between images of popular culture and the social construction of masculine identities in the U.S. This film utilizes racially diverse subject matter and examples and will enlighten and provoke students (both males and females) to evaluate their own participation in the culture of contemporary masculinity.


*When Women Kill* is a powerful documentary that places the personal stories of three battered women in a legal/historical context. Ann Jones, an authority on women and criminal justice and author of "Women Who Kill" explains the evolution of society attitude toward women who murder abusive spouses. In this film, three women tell why they killed. There are also sequences of counseling groups for violent men, which provide insight into why male violence continues and why initiatives taken by the police and the courts often fail.

This document was developed as an interdivisional grant project, funded by the Committee on Divisions/APA Relations (CODAPAR). Its contents are derived solely from the Working Group on Intimate Partner Abuse and Relationship Violence and do not reflect policies or positions of the American Psychological Association.
Violence Against Women: Identifying Risk Factors
Violence Against Women: Identifying Risk Factors

Editor's Note: This Research in Brief is based on two studies—

1) Jacquelyn W. White and Paige Hall Smith of the University of North Carolina–Greensboro conducted a study of victimization and perpetration of violence among college students. This study, “Developmental Antecedents of Violence Against Women” (NCJ 187775), was supported by grant number 98–WT–VX–0010 from the National Institute of Justice.

2) Jane A. Siegel of Rutgers University–Camden and Linda M. Williams of the Stone Center at Wellesley College conducted an analysis of interview data—collected previously—from women with contemporaneously documented histories of child sexual abuse and from a matched comparison group of women with no documented abuse. This study, “Risk Factors for Violent Victimization of Women: A Prospective Study” (NCJ 189161), was supported by grant number 98–WT–VX–0028 from the National Institute of Justice.

These unpublished reports are available from the National Criminal Justice Reference Service. The White and Smith report is online at www.ncjrs.org/pdffiles1/nij/grants/187775.pdf; the Siegel and Williams report is online at www.ncjrs.org/pdffiles1/nij/grants/189161.pdf.

Findings and conclusions of the research reported here are those of the authors and do not reflect the official position or policies of the U.S. Department of Justice.
Are sexual and physical abuse in childhood and adolescence risk factors for being a victim of violence against women in adulthood? This report summarizes two studies that used different methodologies and samples to determine the extent to which physical and sexual abuse as a child or adolescent contribute to later abuse. In one study, researchers followed college women and men for 4 years, asking them questions about past and current victimization each year. In the other study, researchers asked urban, low-income, mostly black women who had substantiated child sexual abuse about their adolescent and adult victimization.

What did the researchers find?

Despite different methods and samples, the findings were remarkably similar: Being sexually or physically abused both as a child and as an adolescent is a good predictor of future victimization. Child sexual abuse on its own, however, did not predict adult victimization. Women who were victims of both sexual and physical abuse before adulthood were more likely to become adult victims of physical or sexual abuse than women who had experienced only one form of abuse or women who had not been early victims of abuse.

What were the study’s limitations?

Both studies to some extent relied on accounts of victimization that occurred long ago. Over time some subjects may forget or confuse important details. Furthermore, adult rape victims may be more likely to remember and report incidents of child sexual abuse than adults who have not been raped and this factor may skew the results. In addition, participants from each study formed a narrowly defined sample—college students and low-income, primarily black urban women—which may limit how these findings can be applied to a general population.

Who should read this study?

Service providers and counselors working with adolescents and college students, victim and women’s advocacy groups, and researchers.
VIOLENCE AGAINST WOMEN: IDENTIFYING RISK FACTORS

Violence Against Women: Identifying Risk Factors

Studies investigating the root causes of violence against women devote more attention to perpetrators’ behavior than to identifying risk factors among victims, in part to avoid the appearance of “blaming the victim.” Responsibility for violence against women rests with the assailants, but identifying potential risk factors is essential to developing preventive strategies.

The National Institute of Justice (NIJ) funded two studies to identify factors that could predict which women were most likely to become victims of sexual or physical violence (see “Editor’s Note”).

The first, a study of college students (see “College Student Study: Methodology”), found that women who were physically or sexually abused (or witnessed violence) in childhood but not in adolescence were at no greater risk for physical or sexual victimization in college. Those who experienced both childhood and adolescent victimization were at greater risk to be victimized in college.

The second, a study of victims of child sexual abuse (see “Childhood Sexual Abuse Study: Methodology”), found that childhood sexual abuse was a risk factor only when combined with sexual abuse during adolescence. The similarity of these findings from two studies with different samples and methodologies reinforces their significance and should help practitioners and policymakers identify and prioritize children and adolescents most in need of appropriate interventions.

College Student Study: Findings about victims

Victimization. By the end of 4 years of college, 88 percent of women had experienced at least one incident of physical or sexual victimization in their lifetimes, and 64 percent had experienced both. Almost 78 percent experienced at least one incident of physical victimization in their lifetimes, and 79 percent experienced at least one incident of sexual victimization.
College Student Study: Methodology

Most studies of violence against women examine a sample at one point in time. Such studies are called cross-sectional. Although cross-sectional studies have identified several possible risk factors, they cannot assess how well certain risk factors can predict future events. For that, one needs a longitudinal study—one that follows a sample over time. This study is a longitudinal one designed to answer four questions:

- Do women who experience one form of violence experience others as well?
- Does early victimization put women at risk for future victimization?
- Are men who commit one form of violence against their partners likely to commit others?
- Are early perpetration or victimization experiences significant risk factors for future perpetration?

The data came from a 5-year study of the risk of sexual and physical assault among university students, funded by the National Institute of Mental Health. Both men and women were assessed annually from age 18 through age 22. Two incoming classes of women were surveyed regarding a variety of sexual experiences. Approximately 83 percent of the 1990 class (825 students) and 84 percent of the 1991 class (744 students) provided usable surveys. The sample of women was 71 percent white and 25 percent black; 4 percent came from other ethnic groups.

Three incoming classes of men (1990, 1991, and 1992) were also surveyed about a range of social experiences; 835 students initially participated. The sample of men was 68 percent white and 26 percent black; 6 percent belonged to other ethnic groups. Almost two-thirds of the men (65 percent) completed the first survey; 22 percent completed all phases of the study.

To address the low completion rate, researchers compared participants who completed the study with those who dropped out. They found no statistically significant differences between the groups. Higher attrition rates were related to self-reports from adolescents of alcohol use and delinquent behaviors, but not to rates of sexual perpetration. For both men and women, factors related to withdrawal from the study were similar to reasons students drop out of college.

Physical victimization was assessed using Straus’ (1979) Conflict Tactics Scales, which measures self-reported experiences of such behaviors as being hit, shoved, or pushed. Sexual victimization was measured using the Koss et al. (1987) Sexual Experiences Survey, which includes a range of victimization experiences from coerced sexual contact to rape.

Revictimization. Previous studies suggest that young women, and college students in particular, are at increased...
risk of becoming victims of sexual abuse (Koss et al., 1987). This study found that women who were physically or sexually abused or who witnessed domestic violence in childhood (before age 14) were at greater risk for physical and/or sexual victimization in high school. Women who were victimized in high school were at much greater risk for physical and/or sexual victimization in college. After controlling for victimization in high school, however, those who were abused or witnessed violence in childhood were not at greater risk for college victimization (see exhibit 1).

Women who were both sexually and physically abused during high school were most likely to suffer sexual abuse in college, followed by women who were abused sexually but not physically. Those who experienced physical abuse but no sexual abuse in high school were no more likely to suffer sexual abuse in college than women who had never been abused.

Women who experienced co-occurrence (both physical and sexual abuse) during high school were most likely to become victims of physical violence by their romantic partners, followed by women

### Exhibit 1. College Student Study—College victimization, by prior victimization status

<table>
<thead>
<tr>
<th>Victimization status</th>
<th>Type of abuse</th>
<th>Year 1 (%)</th>
<th>Year 2 (%)</th>
<th>Year 3 (%)</th>
<th>Year 4 (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>None before college</td>
<td>Only physical</td>
<td>7</td>
<td>11</td>
<td>7</td>
<td>5</td>
</tr>
<tr>
<td></td>
<td>Only sexual</td>
<td>13</td>
<td>4</td>
<td>8</td>
<td>5</td>
</tr>
<tr>
<td></td>
<td>Physical and sexual</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td></td>
<td>Total</td>
<td>23</td>
<td>19</td>
<td>20</td>
<td>16</td>
</tr>
<tr>
<td>Childhood victimization but no adolescent</td>
<td>Only physical</td>
<td>10</td>
<td>10</td>
<td>12</td>
<td>6</td>
</tr>
<tr>
<td>victimization</td>
<td>Only sexual</td>
<td>17</td>
<td>4</td>
<td>13</td>
<td>11</td>
</tr>
<tr>
<td></td>
<td>Physical and sexual</td>
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<td>7</td>
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<td>8</td>
</tr>
<tr>
<td></td>
<td>Total</td>
<td>32</td>
<td>21</td>
<td>30</td>
<td>25</td>
</tr>
<tr>
<td>Adolescent victimization but no childhood</td>
<td>Only physical</td>
<td>16</td>
<td>16</td>
<td>15</td>
<td>13</td>
</tr>
<tr>
<td>victimization</td>
<td>Only sexual</td>
<td>22</td>
<td>13</td>
<td>12</td>
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<td></td>
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<td></td>
<td>Total</td>
<td>42</td>
<td>36</td>
<td>34</td>
<td>31</td>
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<tr>
<td>Childhood and adolescent victimization</td>
<td>Only physical</td>
<td>17</td>
<td>16</td>
<td>20</td>
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<td></td>
<td>Only sexual</td>
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<td>Total</td>
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<td>53</td>
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<td>42</td>
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</tbody>
</table>
who had experienced physical violence in high school but no sexual abuse. Women who had experienced sexual abuse in high school but no physical violence were no likelier to become victims of physical violence in college than those who had never been abused.

Mental health. Women who experienced co-occurrence in high school and the first year of college reported the highest levels of psychological distress (a composite measure consisting of anxiety, depression, loss of control, and lack of emotional ties). Women who had not been abused reported the lowest levels, and other women reported intermediate levels.

Physical health. Women who experienced co-occurrence during high school and the first year of college reported more doctor visits than women with no assault experiences. Women who had experienced only physical assault, however, rated their overall general health lower than all other women.

Problem behaviors. Women who experienced co-occurrence during high school were likeliest to report suicidal thoughts during high school, although suicidal thoughts in college were not related to co-occurrence in high school. An increased number of sex partners (defined as men with whom women had sexual intercourse, consensual or not) was associated with all types of victimization. Women who experienced co-occurrence in high school and those who had been sexually victimized but not physically assaulted had the most sex partners, followed by those who had only been physically assaulted. By the end of the fourth year in college, women who had experienced co-occurrence were most likely to have engaged in unprotected sex. Alcohol use was highest for women who experienced co-occurrence in high school and the first year of college; it was lowest among those who had not been victimized.

College Student Study: Findings about perpetrators

Co-occurrence of assault. It is common for a man to commit both sexual and physical assault, although not necessarily against the same woman. The percentage of men who did so declined from 9 percent in high school to 5 percent in the first year.
of college to 2 percent in the fourth year of college. The relationship between sexual and physical assault is significant: A young man who committed one type of assault was five times more likely to commit the other during high school (the odds remained roughly the same over the college years).

**Family violence.** Young men who both sexually and physically assaulted women experienced more family violence and witnessed significantly more family violence than other men.

**Childhood sexual abuse.** A significant relationship was found between childhood sexual victimization and perpetration of sexual and physical assault in high school. Men who committed physical and sexual assault or sexual assault alone in high school reported more childhood sexual abuse than men who had no history of assault or who committed only physical assault.

**Factors associated with co-occurrence.** Men who sexually and physically assaulted women were significantly more likely to abuse drugs and alcohol, have many sexual partners, engage in delinquent behavior, and approve of male use of violence against women than men who committed neither form of assault. For some of these factors, however, there were no differences between those who committed both forms of assault and those who committed only one.

**Predictors of perpetration.** Men who committed sexual assault during high school were four times more likely to commit sexual assault during the first year of college than men with no history of sexual assault. The results of this study, however, show a decline in sexual aggression over time.

**Child Sexual Abuse Study: Findings**

**Risk of victimization.** The relationship between childhood and adult victimization is complex. Sexual abuse in childhood alone or adolescence alone was not found to be associated with a higher risk of adult physical or sexual victimization. Only women who had been sexually abused as both children and adolescents were found to be at increased risk of victimization as adults, with rates of both sexual and physical adult victimization significantly higher than those for all
CHILDHOOD SEXUAL ABUSE STUDY: METHODOLOGY

This study was designed to explore whether child abuse survivors have an increased risk of later victimization and, if so, whether certain factors in their lives, such as abusing alcohol and having numerous sexual partners between the ages of 13 and 17, heighten the risk of victimization.

The research also explored whether women who are themselves physically aggressive are at increased risk of violent victimization and whether a child abuse victim's family situation (an unstable family structure, harsh punishment, and witnessing violence) may significantly affect the risk of future victimization.

This study is a secondary analysis of data from interviews with women who were part of a prospective longitudinal study, begun in 1973 and sponsored by the National Institute of Mental Health, of a group of children who had been the victims of officially reported child sexual abuse. In 1990 and 1991, followup interviews funded by the National Center on Child Abuse and Neglect were conducted to investigate the adult consequences of child sexual abuse and the validity of children's disclosures of sexual abuse incidents. To investigate issues raised during those followup interviews, a third round of interviews was conducted in 1996 and 1997 with both the victims and a comparison group of women who had no documented history of abuse but who had been seen in the pediatric emergency room at the same time for nonabuse-related injuries or illnesses.

The study uses data from 174 women from the victim and comparison groups who were interviewed in 1996–97; 80 of the women from the victim group had also been interviewed in 1990–91. The analyses examined the effect of potential risk factors while controlling for familial background factors. Approximately 30 percent of the women in the comparison group self-reported having been sexually abused before age 13 and were reclassified into the victim group (see exhibit 2). Before doing so, however, a series of comparisons was made between self-reported and “official” victims that showed no statistically significant differences between the two groups. However, official victims were likelier to have been arrested for any offense and for drug offenses. In addition, a higher percentage of official victims experienced victimization by strangers and incidents that involved force or penetration, which may have been a factor in why they were officially reported in the 1970s.

Women. Three-quarters of these women were sexually assaulted when adults, and more than 8 in 10 (84 percent) experienced severe domestic violence. (Severe violence was defined as beating, punching, or hitting with something that could hurt; choking; burning or scalding on purpose; and having serious injuries or needing to see a doctor as a result of a fight with a partner.)

This is not to say, however, that few of the others were victimized as adults. Rates of reported sexual victimization and domestic violence were high: 28 percent of women
who experienced no childhood or adolescent sexual victimization reported being sexually assaulted as adults, and 60 percent reported experiencing at least minor violence perpetrated by an intimate partner (see exhibit 3).

**Situational risk factors.** Having multiple sexual partners significantly increased the risk of adult sexual abuse. Alcohol abuse was found to be statistically significant in predicting increased risk of adult sexual victimization but not domestic violence.

**“Double victims.”** Women who were double victims—victimized in both childhood and adolescence—differed from the other women interviewed in ways that could have contributed to their later behavior. They were significantly more likely to have reported being beaten by their mothers. They had a significantly higher number of living situations (distinct household compositions) and childhood caregivers between birth and age 18.

Double victims were more likely to have had a boyfriend and to have started drinking alcohol at an earlier age. They were also likelier to have engaged in at least two delinquent behaviors: running away from home and prostitution before the age of 18. Running away was one of two factors that significantly increased the odds of becoming a double victim once the other risk factors were taken into account together; the other was having a mother who had a criminal history. Nearly half (48 percent) of the double victims reported that their mothers had been arrested when the victims were children or teenagers—a rate 7 times greater than that reported for the mothers of women not abused as children. Some of these mothers may have been incarcerated, which would account for the significantly greater number of living situations and childhood caregivers the women reported having and their higher scores on a measure of parental neglect.

**Aggressive behavior and domestic violence.** Women who engaged in aggressive behavior themselves (i.e., the use of force—hitting, kicking, or punching—or a weapon against another person, including a domestic partner) were at increased risk of being severely abused by their partners. Aggression
Exhibit 2. Child Sexual Abuse Study—Victimization rates

<table>
<thead>
<tr>
<th>Groups</th>
<th>Adolescents (%)</th>
<th>Adults (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Comparison 1:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Experimental group (victims of documented child sexual abuse) (n = 87)</td>
<td>29</td>
<td>48</td>
</tr>
<tr>
<td>Control group (no officially reported child sexual abuse) (n = 87)</td>
<td>24</td>
<td>38</td>
</tr>
<tr>
<td>Comparison 2:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>“All” victims of child sexual abuse (n = 114)*</td>
<td>28</td>
<td>48</td>
</tr>
<tr>
<td>Not sexually abused in childhood (n = 60)</td>
<td>24</td>
<td>38</td>
</tr>
</tbody>
</table>

*Comparison 2 includes members of the control group who reported being sexually abused in childhood.

Exhibit 3. Child Sexual Abuse Study—Adult victimization, by prior victimization status

<table>
<thead>
<tr>
<th>Prior victimization status</th>
<th>Sexually abused as adults (%)</th>
<th>Experienced some domestic violence (%)</th>
<th>Experienced severe domestic violence (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not sexually abused in childhood or adolescence (n = 46)</td>
<td>28</td>
<td>60</td>
<td>42</td>
</tr>
<tr>
<td>Sexually abused in childhood but not in adolescence (n = 82)</td>
<td>38</td>
<td>62</td>
<td>42</td>
</tr>
<tr>
<td>Sexually abused in adolescence but not in childhood (n = 14)</td>
<td>50</td>
<td>79</td>
<td>64</td>
</tr>
<tr>
<td>Sexually abused in childhood and adolescence (n = 82)</td>
<td>75</td>
<td>97</td>
<td>84</td>
</tr>
</tbody>
</table>

was categorized as minor or severe depending on the type of force/weapon used and the degree of injury inflicted. One must be cautious, however, before concluding that female aggressive behavior is a risk factor for victimization; much of this violence was reported to be in self-defense. For example, 38 percent of those who used force against their partner said that they were never
the first to do so, and 40 percent said that they used force primarily or exclusively to protect themselves from imminent harm. This is especially true for victims of severe domestic violence: Only 27 percent of the victims interviewed reported initiating violence most or all of the time; 44 percent said that they never initiated violence. More than half reported using force primarily or exclusively to protect themselves, and only 5 percent said that their own use of force was never caused by the need to protect themselves.

Limitations of the studies

Although both studies present useful findings on groups that are important targets for intervention, each has several limitations. The analyses of “double victims” in the child sexual abuse study were exploratory and need to be replicated. These findings are more tenuous than the study’s other results.

Another limitation was that the analyses of childhood and adolescent victimization in the college student study were retrospective, and such analyses may be affected by the faulty memory of some participants. Although the child sexual abuse study was designed so that it would not have to rely on retrospective accounts of childhood victimization, some control group members had to be reclassified as victims based on retrospective accounts of being sexually abused before age 13.

In addition, although the child sexual abuse study provided information about a population traditionally neglected in research on violence against women, the fact that the sample is disproportionately poor, urban, and black and has very high victimization rates raises questions about whether it is sufficiently representative to draw meaningful general conclusions from the study’s findings. The same reservation applies to the college student study. Taken together, however, the findings of the two studies, substantiate each other.

Devising prevention strategies

The results of both studies, despite their limitations, indicate the need for directing interventions toward boys and girls who witness or experience violence. Boys who are victims of violence are especially in need of intervention, because they
are likely to grow up and mistreat their partners. Early intervention is likely to go a long way toward preventing further violence later in life.

The research suggests that professionals who have contact with children and adolescents should be educated about the importance of taking gender-based violence seriously. Prevention and intervention strategies can help potential victims and perpetrators overcome social influences that tend to support or condone violence against women by including gender-based violence prevention activities in other programs that target adolescent boys and girls, such as substance abuse and pregnancy prevention programs.

Prevention and intervention strategies should support girls and women who report abuse and promote psychological healing and social resolution. But programs for adolescent girls—especially those who have experienced childhood victimization—should, in addition, incorporate activities that could prevent violence against women.

References

The National Institute of Justice is the research, development, and evaluation agency of the U.S. Department of Justice. NIJ provides objective, independent, evidence-based knowledge and tools to enhance the administration of justice and public safety.

NIJ is a component of the Office of Justice Programs, which also includes the Bureau of Justice Assistance, the Bureau of Justice Statistics, the Office of Juvenile Justice and Delinquency Prevention, and the Office for Victims of Crime.
CHAPTER 4

Violence by intimate partners
Background

One of the most common forms of violence against women is that performed by a husband or an intimate male partner. This is in stark contrast to the situation for men, who in general are much more likely to be attacked by a stranger or acquaintance than by someone within their close circle of relationships (1–5). The fact that women are often emotionally involved with and economically dependent on those who victimize them has major implications for both the dynamics of abuse and the approaches to dealing with it.

Intimate partner violence occurs in all countries, irrespective of social, economic, religious or cultural group. Although women can be violent in relationships with men, and violence is also sometimes found in same-sex partnerships, the overwhelming burden of partner violence is borne by women at the hands of men (6, 7). For that reason, this chapter will deal with the question of violence by men against their female partners.

Women’s organizations around the world have long drawn attention to violence against women, and to intimate partner violence in particular. Through their efforts, violence against women has now become an issue of international concern. Initially viewed largely as a human rights issue, partner violence is increasingly seen as an important public health problem.

The extent of the problem

Intimate partner violence refers to any behaviour within an intimate relationship that causes physical, psychological or sexual harm to those in the relationship. Such behaviour includes:

- Acts of physical aggression – such as slapping, hitting, kicking and beating.
- Psychological abuse – such as intimidation, constant belittling and humiliating.
- Forced intercourse and other forms of sexual coercion.
- Various controlling behaviours – such as isolating a person from their family and friends, monitoring their movements, and restricting their access to information or assistance.

When abuse occurs repeatedly in the same relationship, the phenomenon is often referred to as “battering”.

In 48 population-based surveys from around the world, between 10% and 69% of women reported being physically assaulted by an intimate male partner at some point in their lives (see Table 4.1). The percentage of women who had been assaulted by a partner in the previous 12 months varied from 3% or less among women in Australia, Canada and the United States to 27% of ever-partnered women (that is, women who have ever had an ongoing sexual partnership) in León, Nicaragua, 38% of currently married women in the Republic of Korea, and 52% of currently married Palestinian women in the West Bank and Gaza Strip. For many of these women, physical assault was not an isolated event but part of a continuing pattern of abusive behaviour.

Research suggests that physical violence in intimate relationships is often accompanied by psychological abuse, and in one-third to over one-half of cases by sexual abuse (3, 8–10). Among 613 women in Japan who had at any one time been abused, for example, 57% had suffered all three types of abuse – physical, psychological and sexual. Less than 10% of these women had experienced only physical abuse (8). Similarly, in Monterrey, Mexico, 52% of physically assaulted women had also been sexually abused by their partners (11). Figure 4.1 graphically illustrates the overlap between types of abuse among ever-partnered women in León, Nicaragua (9).

Most women who are targets of physical aggression generally experience multiple acts of aggression over time. In the León study, for instance, 60% of women abused during the previous year had been attacked more than once, and 20% had experienced severe violence more than six times. Among women reporting physical aggression, 70% reported severe abuse (12). The average number of physical assaults during the previous year among women currently suffering abuse, according to a survey in London, England, was seven (13), while in the United States, in a national study in 1996, it was three (5).
### TABLE 4.1
Physical assault on women by an intimate male partner, selected population-based studies, 1982–1999

<table>
<thead>
<tr>
<th>Country or area</th>
<th>Year of study</th>
<th>Coverage</th>
<th>Sample</th>
<th>Proportion of women physically assaulted by a partner (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>Size</td>
<td>Study population*</td>
</tr>
<tr>
<td><strong>Africa</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ethiopia</td>
<td>1995</td>
<td>Meskanena Woreda</td>
<td>673</td>
<td>II</td>
</tr>
<tr>
<td>Kenya</td>
<td>1984–1987</td>
<td>Kisii District</td>
<td>612</td>
<td>VI</td>
</tr>
<tr>
<td>Nigeria</td>
<td>1993</td>
<td>Not stated</td>
<td>1 000</td>
<td>I</td>
</tr>
<tr>
<td>South Africa</td>
<td>1998</td>
<td>Eastern Cape</td>
<td>396</td>
<td>III</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Mpumalanga</td>
<td>419</td>
<td>III</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Northern Province</td>
<td>464</td>
<td>III</td>
</tr>
<tr>
<td></td>
<td></td>
<td>National</td>
<td>10 190</td>
<td>III</td>
</tr>
<tr>
<td>Zimbabwe</td>
<td>1996</td>
<td>Midlands Province</td>
<td>966</td>
<td>I</td>
</tr>
<tr>
<td><strong>Latin America and the Caribbean</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Antigua</td>
<td>1990</td>
<td>National</td>
<td>97</td>
<td>I</td>
</tr>
<tr>
<td>Barbados</td>
<td>1990</td>
<td>National</td>
<td>264</td>
<td>I</td>
</tr>
<tr>
<td>Bolivia</td>
<td>1998</td>
<td>Three districts</td>
<td>289</td>
<td>I</td>
</tr>
<tr>
<td>Chile</td>
<td>1993</td>
<td>Santiago province</td>
<td>1 000</td>
<td>II</td>
</tr>
<tr>
<td></td>
<td>1997</td>
<td>Santiago</td>
<td>310</td>
<td>II</td>
</tr>
<tr>
<td>Colombia</td>
<td>1995</td>
<td>National</td>
<td>6 097</td>
<td>II</td>
</tr>
<tr>
<td>Mexico</td>
<td>1996</td>
<td>Guadalajara</td>
<td>650</td>
<td>III</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Monterrey</td>
<td>1 064</td>
<td>III</td>
</tr>
<tr>
<td>Nicaragua</td>
<td>1995</td>
<td>Leon</td>
<td>360</td>
<td>III</td>
</tr>
<tr>
<td></td>
<td>1997</td>
<td>Managua</td>
<td>378</td>
<td>III</td>
</tr>
<tr>
<td></td>
<td>1998</td>
<td>National</td>
<td>8 507</td>
<td>III</td>
</tr>
<tr>
<td>Peru</td>
<td>1997</td>
<td>Metro Lima (middle-income and low-income)</td>
<td>359</td>
<td>II</td>
</tr>
<tr>
<td>Uruguay</td>
<td>1997</td>
<td>Two regions</td>
<td>545</td>
<td>II</td>
</tr>
<tr>
<td><strong>North America</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Canada</td>
<td>1991–1992</td>
<td>Toronto</td>
<td>420</td>
<td>I</td>
</tr>
<tr>
<td></td>
<td>1993</td>
<td>National</td>
<td>12 300</td>
<td>I</td>
</tr>
<tr>
<td>United States</td>
<td>1995–1996</td>
<td>National</td>
<td>8 000</td>
<td>I</td>
</tr>
<tr>
<td><strong>Asia and Western Pacific</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Australia</td>
<td>1996</td>
<td>National</td>
<td>6 300</td>
<td>I</td>
</tr>
<tr>
<td>Bangladesh</td>
<td>1992</td>
<td>National (villages)</td>
<td>1 225</td>
<td>I</td>
</tr>
<tr>
<td></td>
<td>1993</td>
<td>Two rural regions</td>
<td>10 368</td>
<td>II</td>
</tr>
<tr>
<td>Cambodia</td>
<td>1996</td>
<td>Six regions</td>
<td>1 374</td>
<td>III</td>
</tr>
<tr>
<td>India</td>
<td>1993–1994</td>
<td>Tamil Nadu</td>
<td>859</td>
<td>II</td>
</tr>
<tr>
<td></td>
<td>1995–1996</td>
<td>Uttar Pradesh, five districts</td>
<td>6 695</td>
<td>IV</td>
</tr>
<tr>
<td></td>
<td>1998–1999</td>
<td>National</td>
<td>89 199</td>
<td>III</td>
</tr>
<tr>
<td></td>
<td>1999</td>
<td>Six states</td>
<td>9 938</td>
<td>III</td>
</tr>
<tr>
<td>Papua New Guinea</td>
<td>1982</td>
<td>National, rural villages</td>
<td>628</td>
<td>III</td>
</tr>
<tr>
<td></td>
<td>1984</td>
<td>Port Moresby</td>
<td>298</td>
<td>III</td>
</tr>
<tr>
<td>Philippines</td>
<td>1993</td>
<td>National</td>
<td>8 481</td>
<td>V</td>
</tr>
<tr>
<td></td>
<td>1998</td>
<td>Cagayan de Oro City and Bukidnon Province</td>
<td>1 660</td>
<td>II</td>
</tr>
<tr>
<td>Republic of Korea</td>
<td>1989</td>
<td>National</td>
<td>707</td>
<td>II</td>
</tr>
<tr>
<td>Thailand</td>
<td>1994</td>
<td>Bangkok</td>
<td>619</td>
<td>IV</td>
</tr>
</tbody>
</table>
Various types of abuse generally coexist in the same relationship. However, prevalence studies of domestic violence are a new area of research and data on the various types of partner violence, other than physical abuse, are generally not yet available. The figures in Table 4.1, therefore, refer exclusively to physical assault. Even so, because of methodological differences, the data from these well-designed studies are not directly comparable. Reported estimates of abuse are highly sensitive to the particular definitions used, the manner in which questions are asked, the degree of privacy in interviews and the nature of the population being studied (14) (see Box 4.1). Differences between countries, therefore – especially fairly small differences – may well reflect methodological variations rather than real differences in prevalence rates.

### Measuring partner violence

In surveys of partner violence, women are usually asked whether they have experienced any abuse from a list of specific acts of aggression, including being slapped or hit, kicked, beaten or threatened...
BOX 4.1

Making data on intimate partner violence more comparable

Various factors affect the quality and comparability of data on intimate partner violence, including:

— inconsistencies in the way violence and abuse are defined;
— variations in the selection criteria for study participants;
— differences resulting from the sources of data;
— the willingness of respondents to talk openly and honestly about experiences with violence.

Because of these factors, most prevalence figures on partner violence from different studies cannot be compared directly. For instance, not all studies separate different kinds of violence, so that it is not always possible to distinguish between acts of physical, sexual and psychological violence. Some studies examine only violent acts from the previous 12 months or 5 years, while others measure lifetime experiences.

There is also considerable variation in the study populations used for research. Many studies on partner violence include all women within a specific age range, while other studies interview only women who are currently married or who have been married. Both age and marital status are associated with a woman’s risk of suffering partner abuse. The selection criteria for participants can therefore considerably affect estimates of the prevalence of abuse in a population.

Prevalence estimates are also likely to vary according to the source of data. Several national studies have produced estimates of the prevalence of partner violence — estimates that are generally lower than those obtained from smaller in-depth studies of women's experiences with violence. Smaller in-depth studies tend to concentrate more on the interaction between interviewers and respondents. These studies also tend to cover the subject matter in much greater detail than most national surveys. Prevalence estimates between the two types of studies may also vary because of some of the factors previously mentioned — including differences in the study populations and definitions of violence.

Improving disclosure

All studies on sensitive topics such as violence face the problem of how to achieve openness from people about intimate aspects of their lives. Success will depend partly on the way in which the questions are framed and delivered, as well as on how comfortable interviewees feel during the interview. The latter depends on such factors as the sex of the interviewer, the length of the interview, whether others are present, and how interested and non-judgemental the interviewer appears.

Various strategies can improve disclosure. These include:

■ Giving the interviewee several opportunities during an interview in which to disclose violence.
■ Using behaviourally specific questions, rather than subjective questions such as “Have you ever been abused?”.
■ Carefully selecting interviewers and training them to develop a good rapport with the interviewees.
■ Providing support for interviewees, to help avoid retaliation by an abusive partner or family member.

The safety of both respondents and interviewers must always be taken into account in all strategies for improving research into violence.

The World Health Organization has recently published guidelines addressing ethical and safety issues in research into violence against women (15). Guidelines for defining and measuring partner violence and sexual assault are being developed to help improve the comparability of data. Some of these guidelines are currently available (16) (see also Resources).
with a weapon. Research has shown that behaviourally specific questions such as “Have you ever been forced to have sexual intercourse against your will?” produce greater rates of positive response than questions asking women whether they have been “abused” or “raped” (17). Such behaviourally specific questions also allow researchers to gauge the relative severity and frequency of the abuse suffered. Physical acts that are more severe than slapping, pushing or throwing an object at a person are generally defined in studies as “severe violence”, though some observers object to defining severity solely according to the act (18).

A focus on acts alone can also hide the atmosphere of terror that sometimes permeates violent relationships. In a national survey of violence against women in Canada, for example, one-third of all women who had been physically assaulted by a partner said that they had feared for their lives at some time in the relationship (19). Although international studies have concentrated on physical violence because it is more easily conceptualized and measured, qualitative studies suggest that some women find the psychological abuse and degradation even more intolerable than the physical violence (1, 20, 21).

**Partner violence and murder**

Data from a wide range of countries suggest that partner violence accounts for a significant number of deaths by murder among women. Studies from Australia, Canada, Israel, South Africa and the United States of America show that 40–70% of female murder victims were killed by their husbands or boyfriends, frequently in the context of an ongoing abusive relationship (22–25). This contrasts starkly with the situation of male murder victims. In the United States, for example, only 4% of men murdered between 1976 and 1996 were killed by their wives, ex-wives or girlfriends (26). In Australia between 1989 and 1996, the figure was 8.6% (27).

Cultural factors and the availability of weapons define the profiles of murders of intimate partners in different countries. In the United States, more murders of women are committed by guns than by all other types of weapons combined (28). In India, guns are rare but beatings and death by fire are common. A frequent ploy is to douse a woman with kerosene and then to claim that she died in a “kitchen accident”. Indian public health officials suspect that many actual murders of women are concealed in official statistics as “accidental burns”. One study in the mid-1980s found that among women aged 15–44 years in Greater Bombay and other urban areas of Maharashtra state, one out of five deaths were ascribed to “accidental burns” (29).

**Traditional notions of male honour**

In many places, notions of male honour and female chastity put women at risk (see also Chapter 6). For example, in parts of the Eastern Mediterranean, a man’s honour is often linked to the perceived sexual “purity” of the women in his family. If a woman is “defiled” sexually – either through rape or by engaging voluntarily in sex outside marriage – she is thought to disgrace the family honour. In some societies, the only way to cleanse the family honour is by killing the “offending” woman or girl. A study of female deaths by murder in Alexandria, Egypt, found that 47% of the women were killed by a relative after they had been raped (30).

**The dynamics of partner violence**

Recent research from industrialized countries suggests that the forms of partner violence that occur are not the same for all couples who experience violent conflict. There would seem to be at least two patterns (31, 32):

- A severe and escalating form of violence characterized by multiple forms of abuse, terrorization and threats, and increasingly possessive and controlling behaviour on the part of the abuser.
- A more moderate form of relationship violence, where continuing frustration and anger occasionally erupt into physical aggression.

Researchers hypothesize that community-based surveys are better-suited to detecting the second, more moderate form of violence – also called “common couple violence” – than the severe type of abuse known as battering. This may help explain...
why community-based surveys of violence in industrialized countries frequently find substantial evidence of physical aggression by women, even though the vast majority of victims that come to the attention of service providers (in shelters, for instance) and the police or the courts are women. Although there is evidence from industrialized countries that women engage in common couple violence, there are few indications that women subject men to the same type of severe and escalating violence frequently seen in clinical samples of battered women (32, 33).

Similarly, research suggests that the consequences of partner violence differ between men and women, and so do the motivations for perpetrating it. Studies in Canada and the United States have shown that women are far more likely to be injured during assaults by intimate partners than are men, and that women suffer more severe forms of violence (5, 34–36). In Canada, female victims of partner violence are three times more likely to suffer injury, five times more likely to receive medical attention and five times more likely to fear for their lives than are male victims (36). Where violence by women occurs it is more likely to be in the form of self-defence (32, 37, 38).

In more traditional societies, wife beating is largely regarded as a consequence of a man’s right to inflict physical punishment on his wife—something indicated by studies from countries as diverse as Bangladesh, Cambodia, India, Mexico, Nigeria, Pakistan, Papua New Guinea, the United

<table>
<thead>
<tr>
<th>Country or area</th>
<th>Year</th>
<th>Respondent</th>
<th>She neglects children or house</th>
<th>She refuses him sex</th>
<th>He suspects her of adultery</th>
<th>She answers back or disobeys</th>
</tr>
</thead>
<tbody>
<tr>
<td>Brazil (Salvador, Bahia)</td>
<td>1999</td>
<td>M</td>
<td>—</td>
<td>—</td>
<td>19a</td>
<td>—</td>
</tr>
<tr>
<td></td>
<td></td>
<td>F</td>
<td>—</td>
<td>—</td>
<td>11a</td>
<td>—</td>
</tr>
<tr>
<td>Chile (Santiago)</td>
<td>1999</td>
<td>M</td>
<td>—</td>
<td>—</td>
<td>12a</td>
<td>—</td>
</tr>
<tr>
<td></td>
<td></td>
<td>F</td>
<td>—</td>
<td>—</td>
<td>14a</td>
<td>—</td>
</tr>
<tr>
<td>Colombia (Cali)</td>
<td>1999</td>
<td>M</td>
<td>—</td>
<td>—</td>
<td>14a</td>
<td>—</td>
</tr>
<tr>
<td></td>
<td></td>
<td>F</td>
<td>—</td>
<td>—</td>
<td>13a</td>
<td>—</td>
</tr>
<tr>
<td>Egypt</td>
<td>1996</td>
<td>Urban F</td>
<td>40</td>
<td>57</td>
<td>—</td>
<td>59</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Rural F</td>
<td>61</td>
<td>81</td>
<td>—</td>
<td>78</td>
</tr>
<tr>
<td>El Salvador (San Salvador)</td>
<td>1999</td>
<td>M</td>
<td>—</td>
<td>—</td>
<td>5a</td>
<td>—</td>
</tr>
<tr>
<td></td>
<td></td>
<td>F</td>
<td>—</td>
<td>—</td>
<td>9a</td>
<td>—</td>
</tr>
<tr>
<td>Ghana b</td>
<td>1999</td>
<td>M</td>
<td>43</td>
<td>—</td>
<td>—</td>
<td>—</td>
</tr>
<tr>
<td></td>
<td></td>
<td>F</td>
<td>33</td>
<td>—</td>
<td>—</td>
<td>—</td>
</tr>
<tr>
<td>India (Uttar Pradesh)</td>
<td>1996</td>
<td>M</td>
<td>—</td>
<td>—</td>
<td>10-50</td>
<td>—</td>
</tr>
<tr>
<td>New Zealand</td>
<td>1995</td>
<td>M</td>
<td>1</td>
<td>1</td>
<td>5c</td>
<td>1d</td>
</tr>
<tr>
<td>Nicaragua a</td>
<td>1999</td>
<td>Urban F</td>
<td>15</td>
<td>5</td>
<td>22</td>
<td>—</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Rural F</td>
<td>25</td>
<td>10</td>
<td>32</td>
<td>—</td>
</tr>
<tr>
<td>Singapore</td>
<td>1996</td>
<td>M</td>
<td>—</td>
<td>5</td>
<td>33d</td>
<td>4</td>
</tr>
<tr>
<td>Venezuela (Caracas)</td>
<td>1999</td>
<td>M</td>
<td>—</td>
<td>—</td>
<td>8a</td>
<td>—</td>
</tr>
<tr>
<td></td>
<td></td>
<td>F</td>
<td>—</td>
<td>—</td>
<td>8a</td>
<td>—</td>
</tr>
<tr>
<td>West Bank and Gaza Strip g</td>
<td>1996</td>
<td>M</td>
<td>28</td>
<td>71</td>
<td>57</td>
<td>—</td>
</tr>
</tbody>
</table>

Source: reproduced from reference 6 with the permission of the publisher.
M = male; F = female; — indicates question was not asked.
a “An unfaithful woman deserves to be beaten.”
b Also, 51% of men and 43% of women agreed “a husband is justified in beating his wife if she uses family planning without his knowledge.”
c “He catches her in bed with another man.”
d “She won’t do as she is told.”
e Also, 11% of urban women and 23% of rural women agreed “a husband is justified in beating his wife if she goes out without his permission.”
f “She is sexually involved with another man.”
g Also, 23% of men agreed “wife-beating is justified if she does not respect her husband’s relatives.”
h Palestinian population.
Republic of Tanzania and Zimbabwe (39–47). Cultural justifications for violence usually follow from traditional notions of the proper roles of men and women. In many settings women are expected to look after their homes and children, and show their husbands obedience and respect. If a man feels that his wife has failed in her role or overstepped her limits—even, for instance, by asking for household money or stressing the needs of the children—then violence may be his response. As the author of the study from Pakistan notes, “Beating a wife to chastise or to discipline her is seen as culturally and religiously justified . . . Because men are perceived as the ‘owners’ of their wives, it is necessary to show them who is boss so that future transgressions are discouraged.”

A wide range of studies from both industrialized and developing countries have produced a remarkably consistent list of events that are said to trigger partner violence (39–44). These include:

— not obeying the man;
— arguing back;
— not having food ready on time;
— not caring adequately for the children or home;
— questioning the man about money or girlfriends;
— going somewhere without the man’s permission;
— refusing the man sex;
— the man suspecting the woman of infidelity.

In many developing countries, women often agree with the idea that men have the right to discipline their wives, if necessary by force (see Table 4.2). In Egypt, over 80% of rural women share the view that beatings are justified in certain circumstances (48). Significantly, one of the reasons that women cite most often as just cause for beatings is refusing a man sex (48–51). Not surprisingly, denying sex is also one of the reasons women cite most often as a trigger for beatings (40, 52–54). This clearly has implications for the ability of women to protect themselves from unwanted pregnancy and sexually transmitted infections.

Societies often distinguish between “just” and “unjust” reasons for abuse and between “acceptable” and “unacceptable” levels of violence. In this way, certain individuals—usually husbands or older family members—are given the right to punish a woman physically, within limits, for certain transgressions. Only if a man oversteps these bounds—for example, by becoming too violent or for beating a woman without an accepted cause—will others intervene (39, 43, 55, 56).

This notion of “just cause” is found in much qualitative data on violence from the developing world. One indigenous woman in Mexico observed, “I think that if the wife is guilty, the husband has the right to hit her . . . If I have done something wrong . . . nobody should defend me. But if I have not done something wrong, I have a right to be defended” (42). Similar sentiments are found among focus group participants in north and south India. “If it is a great mistake,” noted one woman in Tamil Nadu, “then the husband is justified in beating his wife. Why not? A cow will not be obedient without beatings” (47).

Even where culture itself grants men substantial control over female behaviour, abusive men generally exceed the norm (49, 57, 58). Statistics from the Demographic and Health Survey in Nicaragua, for instance, show that among women who were physically abused, 32% had husbands scoring high on a scale of “marital control”, compared with only 2% among women who were not physically abused. The scale included a range of behaviours on the part of the husband, including continually accusing the wife of being unfaithful and limiting her access to family and friends (49).

How do women respond to abuse?

Qualitative studies have confirmed that most abused women are not passive victims but rather adopt active strategies to maximize their safety and that of their children. Some women resist, others flee, while still others attempt to keep the peace by giving in to their husbands’ demands (3, 59–61). What may seem to an outside observer to be a lack of positive response by the woman may in fact be a calculated assessment of what is needed to survive in the marriage and to protect herself and her children.
A woman’s response to abuse is often limited by the options available to her (60). In-depth qualitative studies of women in the United States and Africa, Latin America, Asia and Europe show that various factors can keep women in abusive relationships. These commonly include: fear of retribution, a lack of alternative means of economic support, concern for the children, emotional dependence, a lack of support from family and friends, and an abiding hope that the man will change (9, 40, 42, 62, 63). In developing countries, women also cite the stigmatization associated with being unmarried as an additional barrier to leaving abusive relationships (40, 56, 64).

Denial and the fear of being socially ostracized often prevent women from reaching out for help. Studies have shown that around 20–70% of abused women never told another person about the abuse until they were interviewed for the study (see Table 4.3). Those who do reach out do so mainly to family members and friends, rather than to institutions. Only a minority ever contact the police.

Despite the obstacles, many abused women eventually do leave violent partners, sometimes only after many years, once the children have grown up. In the study in León, Nicaragua, for example, 70% of the women eventually left their abusive partners (65). The median time that women spent in a violent relationship was around 6 years, although younger women were more likely to leave sooner (9). Studies suggest that there is a consistent set of factors leading women to separate from their abusive partners permanently. Usually this occurs when the violence becomes severe enough to trigger the realization that the partner is not going to change, or when the situation starts noticeably to affect the children. Women have also mentioned emotional and logistical support from family or friends as being pivotal in their decision to end the relationship (61, 63, 66–68).

According to research, leaving an abusive relationship is a process, not a “one-off” event. Most women leave and return several times before finally deciding to end the relationship. The process includes periods of denial, self-blame and suffering before women come to recognize the reality of the abuse and to identify with other women in similar situations. At this point, disengagement and recovery from the abusive relationship begin (69). Recognizing that this process exists can help people to be more understanding and less judgemental about women who return to abusive situations.

Unfortunately, leaving an abusive relationship does not of itself always guarantee safety. Violence can sometimes continue and may even escalate after a woman leaves her partner (70). In fact in Australia, Canada and the United States, a significant proportion of intimate partner homicides involving women occur around the time that a woman is trying to leave an abusive partner (22, 27, 71, 72).

### What are the risk factors for intimate partner violence?

Researchers have only recently begun to look for individual and community factors that might affect the rate of partner violence. Although violence against women is found to exist in most places, it turns out that there are examples of pre-industrial

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**TABLE 4.3**

Proportion of physically abused women who sought help from different sources, selected population-based studies

<table>
<thead>
<tr>
<th>Country or area</th>
<th>Sample (N)</th>
<th>Proportion of physically abused women who:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Never told anyone (%)</td>
</tr>
<tr>
<td>Australia a</td>
<td>6 300</td>
<td>18</td>
</tr>
<tr>
<td>Bangladesh</td>
<td>10 368</td>
<td>68</td>
</tr>
<tr>
<td>Canada</td>
<td>12 300</td>
<td>22</td>
</tr>
<tr>
<td>Cambodia</td>
<td>1 374</td>
<td>34</td>
</tr>
<tr>
<td>Chile</td>
<td>1 000</td>
<td>30</td>
</tr>
<tr>
<td>Egypt</td>
<td>7 121</td>
<td>47</td>
</tr>
<tr>
<td>Ireland</td>
<td>679</td>
<td>—</td>
</tr>
<tr>
<td>Nicaragua</td>
<td>8 507</td>
<td>37</td>
</tr>
<tr>
<td>Republic of Moldova</td>
<td>4 790</td>
<td>—</td>
</tr>
<tr>
<td>United Kingdom</td>
<td>430</td>
<td>38</td>
</tr>
</tbody>
</table>

Source: reproduced from reference 6 with the permission of the publisher.

a Women who were physically assaulted in the past 12 months.
b Refers to the proportion of women who told their family.
c Refers to the proportion of women who told their partners’ family.
societies where partner violence is virtually absent (73, 74). These societies stand as testament to the fact that social relations can be organized in such a way as to minimize violence against women.

In many countries the prevalence of domestic violence varies substantially between neighbouring areas. These local differences are often greater than differences across national boundaries. For example, in the state of Uttar Pradesh, India, the percentage of men who admitted beating their wives varied from 18% in Naintal district to 45% in Banda district. The proportion that physically forced their wives to have sex varied from 14% to 36% among the districts (see Table 4.4). Such variations raise an interesting and compelling question: what is it about these settings that can account for the large differences in physical and sexual assault?

Recently, researchers have become more interested in exploring such questions, although the current research base is inadequate for the task. Our present understanding of factors affecting the prevalence of partner violence is based largely on studies conducted in North America, which may not necessarily be relevant to other settings. A number of population-based studies are available from developing countries, but their usefulness in investigating risk and protective factors is limited by their cross-sectional design and by the limited number of predictive factors that they explore. In general, the current research base is highly skewed towards investigating individual factors rather than community or societal factors that may affect the likelihood of abuse.

Indeed, while there is an emerging consensus that an interplay of personal, situational, social and cultural factors combine to cause abuse (55, 75), there is still only limited information on which factors are the most important. Table 4.5 summarizes the factors that have been put forward as being related to the risk of perpetrating violence against an intimate partner. This information should, however, be viewed as both incomplete and highly tentative. Several important factors may be missing because no studies have examined their significance, while other factors may prove simply to be correlates of partner aggression rather than true causal factors.

### Individual factors

Black et al. recently reviewed the social science literature from North America on risk factors for physically assaulting an intimate partner (76). They reviewed only studies they considered to be methodologically sound and that employed either a representative community sample or a clinical sample with an appropriate control group. A number of demographic, personal history and personality factors emerged from this analysis, as consistently linked to a man’s likelihood of physically assaulting an intimate partner. Among the demographic factors, young age and low income were consistently found to be factors linked to the likelihood of a man committing physical violence against a partner.

Some studies have found a relationship between physical assault and composite measures of socio-economic status and educational level, although the data are not fully consistent. The Health and Development Study in Dunedin, New Zealand – one of the few longitudinal, birth cohort studies to explore partner violence – found that family poverty in childhood and adolescence, low academic achievement and aggressive delinquency at the age of 15 years all strongly predicted physical abuse of partners by men at the age of 21 years.
This study was one of the few that evaluated whether the same risk factors predict aggression by both women and men against a partner.

**History of violence in family**
Among personal history factors, violence in the family of origin has emerged as an especially powerful risk factor for partner aggression by men. Studies in Brazil, Cambodia, Canada, Chile, Colombia, Costa Rica, El Salvador, Indonesia, Nicaragua, Spain, the United States and Venezuela all found that rates of abuse were higher among women whose husbands had either themselves been beaten as children or had witnessed their mothers being beaten (12, 57, 76, 78–81). Although men who physically abuse their wives frequently have violence in their background, not all boys who witness or suffer abuse grow up to become abusive themselves (82). An important theoretical question here is: what distinguishes those men who are able to form healthy, non-violent relationships despite childhood adversity from those who become abusive?

**Alcohol use by men**
Another risk marker for partner violence that appears especially consistent across different settings is alcohol use by men (81, 83–85). In the meta-analysis by Black et al. mentioned earlier, every study that examined alcohol use or excessive drinking as a risk factor for partner violence found a significant association, with correlation coefficients ranging from $r = 0.21$ to $r = 0.57$. Population-based surveys from Brazil, Cambodia, Canada, Chile, Colombia, Costa Rica, El Salvador, India, Indonesia, Nicaragua, South Africa, Spain and Venezuela also found a relationship between a woman’s risk of suffering violence and her partner’s drinking habits (9, 19, 79–81, 86, 87).

There is, however, a considerable debate about the nature of the relationship between alcohol use and violence and whether it is truly causal. Many researchers believe that alcohol operates as a situational factor, increasing the likelihood of violence by reducing inhibitions, clouding judgement and impairing an individual’s ability to interpret cues (88). Excessive drinking may also increase partner violence by providing ready fodder for arguments between couples. Others argue that the link between violence and alcohol is culturally dependent, and exists only in settings where the collective expectation is that drinking causes or excuses certain behaviours (89, 90). In South Africa, for example, men speak of using alcohol in a premeditated way to gain the courage to give their partners the beatings they feel are socially expected of them (91).

Despite conflicting opinions about the causal role played by alcohol abuse, the evidence is that women who live with heavy drinkers run a far greater risk of physical partner violence, and that men who have been drinking inflict more serious violence at the time of an assault (57). According to the survey of violence against women in Canada, for example, women who lived with heavy drinkers were five times more likely to be assaulted by their partners than those who lived with non-drinkers (19).

**Personality disorders**
A number of studies have attempted to identify whether certain personality factors or disorders are 

### Table 4.5

<table>
<thead>
<tr>
<th>Individual factors</th>
<th>Relationship factors</th>
<th>Community factors</th>
<th>Societal factors</th>
</tr>
</thead>
<tbody>
<tr>
<td>Young age</td>
<td>Marital conflict</td>
<td>Weak community sanctions against domestic violence</td>
<td>Traditional gender norms</td>
</tr>
<tr>
<td>Heavy drinking</td>
<td>Marital instability</td>
<td>Male dominance in the family</td>
<td>Social norms supportive of violence</td>
</tr>
<tr>
<td>Depression</td>
<td>Economic stress</td>
<td>Economic stress</td>
<td>Low social capital</td>
</tr>
<tr>
<td>Personality disorders</td>
<td>Poor family functioning</td>
<td>Poor family functioning</td>
<td></td>
</tr>
<tr>
<td>Low academic achievement</td>
<td>Witnessing or experiencing violence as a child</td>
<td>Weak community sanctions against domestic violence</td>
<td></td>
</tr>
<tr>
<td>Low income</td>
<td></td>
<td>Poverty</td>
<td></td>
</tr>
<tr>
<td>Witnessing or experiencing violence as a child</td>
<td></td>
<td>Low social capital</td>
<td></td>
</tr>
</tbody>
</table>

(77).
consistently related to partner violence. Studies from Canada and the United States show that men who assault their wives are more likely to be emotionally dependent, insecure and low in self-esteem, and are more likely to find it difficult to control their impulses (33). They are also more likely than their non-violent peers to exhibit greater anger and hostility, to be depressed and to score high on certain scales of personality disorder, including antisocial, aggressive and borderline personality disorders (76). Although rates of psychopathology generally appear higher among men who abuse their wives, not all physically abusive men show such psychological disorders. The proportion of partner assaults linked to psychopathology is likely to be relatively low in settings where partner violence is common.

Relationship factors

At an interpersonal level, the most consistent marker to emerge for partner violence is marital conflict or discord in the relationship. Marital conflict is moderately to strongly related to partner assault by men in every study reviewed by Black et al. (76). Such conflict has also been found to be predictive of partner violence in a population-based study of women and men in South Africa (87) and a representative sample of married men in Bangkok, Thailand (92). In the study in Thailand, verbal marital conflict remained significantly related to physical assault of the wife, even after controlling for socioeconomic status, the husband’s stress level and other aspects related to the marriage, such as companionship and stability (92).

Community factors

A high socioeconomic status has generally been found to offer some protection against the risk of physical violence against an intimate partner, although exceptions do exist (39). Studies from a wide range of settings show that, while physical violence against partners cuts across all socioeconomic groups, women living in poverty are disproportionately affected (12, 19, 49, 78, 79, 81, 92–96). It is as yet unclear why poverty increases the risk of violence — whether it is because of low income in itself or because of other factors that accompany poverty, such as overcrowding or hopelessness. For some men, living in poverty is likely to generate stress, frustration and a sense of inadequacy for having failed to live up to their culturally expected role of providers. It may also work by providing ready material for marital disagreements or by making it more difficult for women to leave violent or otherwise unsatisfactory relationships. Whatever the precise mechanisms, it is probable that poverty acts as a “marker” for a variety of social conditions that combine to increase the risk faced by women (55).

How a community responds to partner violence may affect the overall levels of abuse in that community. In a comparative study of 16 societies with either high or low rates of partner violence, Counts, Brown & Campbell found that societies with the lowest levels of partner violence were those that had community sanctions against partner violence and those where abused women had access to sanctuary, either in the form of shelters or family support (73). The community sanctions, or prohibitions, could take the form either of formal legal sanctions or the moral pressure for neighbours to intervene if a woman was beaten. This “sanctions and sanctuary” framework suggests the hypothesis that intimate partner violence will be highest in societies where the status of women is in a state of transition. Where women have a very low status, violence is not “needed” to enforce male authority. On the other hand, where women have a high status, they will probably have achieved sufficient power collectively to change traditional gender roles. Partner violence is thus usually highest at the point where women begin to assume non-traditional roles or enter the workforce.

Several other community factors have been suggested as possibly affecting the overall incidence of partner violence, but few of these have been tested empirically. An ongoing multi-country study sponsored by the World Health Organization in eight countries (Bangladesh, Brazil, Japan, Namibia, Peru, Samoa, Thailand and the United Republic of Tanzania) is collecting data on a number of community-
level factors to examine their possible relationship to partner violence. These factors include:

- Rates of other violent crime.
- Social capital (see Chapter 2).
- Social norms to do with family privacy.
- Community norms related to male authority over women.

The study will shed light on the relative contributions of individual and community-level factors to rates of partner violence.

**Societal factors**

Research studies across cultures have come up with a number of societal and cultural factors that might give rise to higher levels of violence. Levinson, for example, used statistical analysis of coded ethnographic data from 90 societies to examine the cultural patterns of wife beating – exploring the factors that consistently distinguish societies where wife beating is common from those where the practice is rare or absent (74). Levinson’s analysis suggests that wife beating occurs more often in societies in which men have economic and decision-making power in the household, where women do not have easy access to divorce, and where adults routinely resort to violence to resolve their conflicts. The second strongest predictor in this study of the frequency of wife beating was the absence of all-women workgroups. Levinson advances the hypothesis that the presence of female workgroups offers protection from wife beating because they provide women with a stable source of social support as well as economic independence from their husbands and families.

Various researchers have proposed a number of additional factors that might contribute to higher rates of partner violence. It has been argued, for example, that partner violence is more common in places where war or other conflicts or social upheavals are taking place or have recently taken place. Where violence has become commonplace and individuals have easy access to weapons, social relations – including the roles of men and women – are frequently disrupted. During these times of economic and social disruption, women are often more independent and take on greater economic responsibility, whereas men may be less able to fulfil their culturally expected roles as protectors and providers. Such factors may well increase partner violence, but evidence for this remains largely anecdotal.

Others have suggested that structural inequalities between men and women, rigid gender roles and notions of manhood linked to dominance, male honour and aggression, all serve to increase the risk of partner violence (55). Again, although these hypotheses seem reasonable, they remain to be proved by firm evidence.

**The consequences of intimate partner violence**

The consequences of abuse are profound, extending beyond the health and happiness of individuals to affect the well-being of entire communities. Living in a violent relationship affects a woman’s sense of self-esteem and her ability to participate in the world. Studies have shown that abused women are routinely restricted in the way they can gain access to information and services, take part in public life, and receive emotional support from friends and relatives. Not surprisingly, such women are often unable properly to look after themselves and their children or to pursue jobs and careers.

**Impact on health**

A growing body of research evidence is revealing that sharing her life with an abusive partner can have a profound impact on a woman’s health. Violence has been linked to a host of different health outcomes, both immediate and long-term. Table 4.6 draws on the scientific literature to summarize the consequences that have been associated with intimate partner violence. Although violence can have direct health consequences, such as injury, being a victim of violence also increases a woman’s risk of future ill health. As with the consequences of tobacco and alcohol use, being a victim of violence can be regarded as a risk factor for a variety of diseases and conditions.

Studies show that women who have experienced physical or sexual abuse in childhood or...
adulthood experience ill-health more frequently than other women – with regard to physical functioning, psychological well-being and the adoption of further risk behaviours, including smoking, physical inactivity, and alcohol and drug abuse (85, 97–103). A history of being the target of violence puts women at increased risk of:

— depression;
— suicide attempts;
— chronic pain syndromes;
— psychosomatic disorders;
— physical injury;
— gastrointestinal disorders;
— irritable bowel syndrome;
— a variety of reproductive health consequences (see below).

In general, the following are conclusions emerging from current research about the health consequences of abuse:

- The influence of abuse can persist long after the abuse itself has stopped (103, 104).
- The more severe the abuse, the greater its impact on a woman’s physical and mental health (98).
- The impact over time of different types of abuse and of multiple episodes of abuse appears to be cumulative (85, 99, 100, 103, 105).

### Reproductive health

Women who live with violent partners have a difficult time protecting themselves from unwanted pregnancy or disease. Violence can lead directly to unwanted pregnancy or sexually transmitted infections, including HIV infection, through coerced sex, or else indirectly by interfering with a woman’s ability to use contraceptives, including condoms (6, 106). Studies consistently show that domestic violence is more common in families with many children (5, 47, 49, 50, 78, 93, 107). Researchers have therefore long assumed that the stress of having many children increases the risk of violence, but recent data from Nicaragua, in fact, suggests that the relationship may be the opposite. In Nicaragua, the onset of violence largely precedes having many children (80% of violence beginning within the first 4 years of marriage), suggesting that violence may be a risk factor for having many children (9).

Violence also occurs during pregnancy, with consequences not only for the woman but also for the developing fetus. Population-based studies from Canada, Chile, Egypt and Nicaragua have found that 6–15% of ever-partnered women have been physically or sexually abused during pregnancy, usually by their partners (9, 48, 49, 57, 78). In the United States, estimates of abuse during pregnancy range from 3% to 11% among adult...
women and up to 38% among low-income, teenage mothers (108–112).

Violence during pregnancy has been associated with (6, 110, 113–117):
— miscarriage;
— late entry into prenatal care;
— stillbirth;
— premature labour and birth;
— fetal injury;
— low birth weight, a major cause of infant death in the developing world.

Intimate partner violence accounts for a substantial but largely unrecognized proportion of maternal mortality. A recent study among 400 villages and seven hospitals in Pune, India, found that 16% of all deaths during pregnancy were the result of partner violence (118). The study also showed that some 70% of maternal deaths in this region generally went unrecorded and that 41% of recorded deaths were misclassified. Being killed by a partner has also been identified as an important cause of maternal deaths in Bangladesh (119) and in the United States (120, 121).

Partner violence also has many links with the growing AIDS epidemic. In six countries in Africa, for instance, fear of ostracism and consequent violence in the home was an important reason for pregnant women refusing an HIV test, or else not returning for their results (122). Similarly, in a recent study of HIV transmission between heterosexuals in rural Uganda, women who reported being forced to have sex against their will in the previous year had an eightfold increased risk of becoming infected with HIV (123).

Physical health

Obviously, violence can lead to injuries, ranging from cuts and bruises to permanent disability and death. Population-based studies suggest that 40–72% of all women who have been physically abused by a partner are injured at some point in their life (5, 9, 19, 62, 79, 124). In Canada, 43% of women injured in this way received medical care and 50% of those injured had to take time off from work (19).

Injury, however, is not the most common physical outcome of partner abuse. More common are “functional disorders” – a host of ailments that frequently have no identifiable medical cause, such as irritable bowel syndrome, fibromyalgia, gastrointestinal disorders and various chronic pain syndromes. Studies consistently link such disorders with a history of physical or sexual abuse (98, 125–127). Women who have been abused also experience reduced physical functioning, more physical symptoms and a greater number of days in bed than non-abused women (97, 98, 101, 124, 125, 128).

Mental health

Women who are abused by their partners suffer more depression, anxiety and phobias than non-abused women, according to studies in Australia, Nicaragua, Pakistan and the United States (129–132). Research similarly suggests that women abused by their partners are at heightened risk for suicide and suicide attempts (25, 49, 133–136).

Use of health services

Given the long-term impact of violence on women’s health, women who have suffered abuse are more likely to be long-term users of health services, thereby increasing health care costs. Studies in Nicaragua, the United States and Zimbabwe indicate that women who have experienced physical or sexual assault, either in childhood or adulthood, use health services more frequently than their non-abused peers (98, 100, 137–140). On average, abuse victims experience more operative surgery, visits by doctors, hospital stays, visits to pharmacies and mental health consultations over their lifetime than non-victims, even after controlling for potential confounding factors.

Economic impact of violence

In addition to its human costs, violence places an enormous economic burden on societies in terms of lost productivity and increased use of social services. Among women in a survey in Nagpur, India, for example, 13% had to forgo paid work because of abuse, missing an average of 7 workdays per inci-
dent, and 11% had been unable to perform household chores because of an incident of violence (141).

Although partner violence does not consistently affect a woman’s overall probability of being employed, it does appear to influence a woman’s earnings and her ability to keep a job (139, 142, 143). A study in Chicago, IL, United States, found that women with a history of partner violence were more likely to have experienced spells of unemployment, to have had a high turnover of jobs, and to have suffered more physical and mental health problems that could affect job performance. They also had lower personal incomes and were significantly more likely to receive welfare assistance than women who did not report a history of partner violence (143). Similarly, in a study in Managua, Nicaragua, abused women earned 46% less than women who did not report suffering abuse, even after controlling for other factors that could affect earnings (139).

Impact on children

Children are often present during domestic altercations. In a study in Ireland (62), 64% of abused women said that their children routinely witnessed the violence, as did 50% of abused women in Monterrey, Mexico (11).

Children who witness marital violence are at a higher risk for a whole range of emotional and behavioural problems, including anxiety, depression, poor school performance, low self-esteem, disobedience, nightmares and physical health complaints (9, 144–146). Indeed, studies from North America indicate that children who witness violence between their parents frequently exhibit many of the same behavioural and psychological disturbances as children who are themselves abused (145, 147).

Recent evidence suggests that violence may also directly or indirectly affect child mortality (148, 149). Researchers in León, Nicaragua, found that after controlling for other possible confounding factors, the children of women who were physically and sexually abused by a partner were six times more likely to die before the age of 5 years than children of women who had not been abused. Partner abuse accounted for as much as one-third of deaths among children in this region (149). Another study in the Indian states of Tamil Nadu and Uttar Pradesh found that women who had been beaten were significantly more likely than non-abused women to have experienced an infant death or pregnancy loss (abortion, miscarriage or stillbirth), even after controlling for well-established predictors of child mortality such as the woman’s age, level of education and the number of previous pregnancies that had resulted in a live birth (148).

What can be done to prevent intimate partner violence?

The majority of work carried out to date on partner violence has been spearheaded by women’s organizations, with occasional funding and assistance from governments. Where governments have become involved – as in Australia, Latin America, North America and parts of Europe – it has generally been in response to demands by civil society for constructive action. The first wave of activity has generally involved elements of legal reform, police training and the establishment of specialized services for victims. Scores of countries have now passed laws on domestic violence, although many officials are either still unaware of the new laws or unwilling to implement them. Those within the system (in the police or the legal system, for instance) frequently share the same prejudices that predominate in society as a whole. Experience has repeatedly shown that without sustained efforts to change institutional culture and practice, most legal and policy reforms have little effect.

Despite over 20 years of activism in the field of violence against women, remarkably few interventions have been rigorously evaluated. Indeed, the recent review of programmes to prevent family violence in the United States by the National Research Council found only 34 studies that attempted to evaluate interventions related to partner abuse. Of those, 19 focused on law enforcement, reflecting the strong preference among government officials towards using the criminal justice system to deal with violence (150). Research on interventions in developing countries is even more limited. Only a
handful of studies exist that attempt critically to examine current interventions. Among these are a review of programmes on violence against women in four states of India. In addition, the United Nations Development Fund for Women has reviewed seven projects across five regions funded by the United Nations Violence Against Women Trust Fund, with the aim of disseminating the lessons learnt from these projects (151).

Support for victims

In the developed world, women’s crisis centres and battered women’s shelters have been the cornerstone of programmes for victims of domestic violence. In 1995, there were approximately 1800 such programmes in the United States, 1200 of which provided emergency shelter in addition to emotional, legal and material support to women and their children (152). Such centres generally provide support groups and individual counselling, job training, programmes for children, assistance in dealing with social services and with legal matters, and referrals for treatment for drug and alcohol abuse. Most shelters and crisis centres in Europe and the United States were originally set up by women activists, though many are now run by professionals and receive government funding.

Since the early 1980s, shelters and crisis centres for women have also sprung up in many developing countries. Most countries have at least a few nongovernmental organizations offering specialized services for victims of abuse and campaigning on their behalf. Some countries have hundreds of such organizations. However, maintaining shelters is expensive, and many developing countries have avoided this model, instead setting up telephone hotlines or non-residential crisis centres that provide some of the same services as residential ones.

Where running a formal shelter is not possible, women have often found other ways to deal with emergencies related to domestic abuse. One approach is to set up an informal network of “safe homes”, where women in distress can seek temporary shelter in the homes of neighbours. Some communities have designated their local place of worship—a temple or church, for instance—as a sanctuary where women can stay with their children overnight to escape drunken or violent partners.

Legal remedies and judicial reforms

Criminalizing abuse

The 1980s and 1990s saw a wave of legal reforms relating to physical and sexual abuse by an intimate partner (153, 154). In the past 10 years, for example, 24 countries in Latin America and the Caribbean have passed specific legislation on domestic violence (154). The most common reforms involve criminalizing physical, sexual and psychological abuse by intimate partners, either through new laws on domestic violence or by amending existing penal codes.

The intended message behind such legislation is that partner violence is a crime and will not be tolerated in society. Bringing it into the open is also a way to dispel the idea that violence is a private, family matter. Aside from introducing new laws or extending existing ones, there have been experiments in some developed countries to back up legislation by introducing special domestic violence courts, training police and court officials and prosecution lawyers, and providing special advisers to help women deal with the criminal justice system. Although rigorous evaluation of these measures has so far been sparse, the recent review of family violence interventions by the United States National Academy of Sciences concludes: “Anecdotal evidence suggests that specialized units and comprehensive reforms in police departments, prosecutors’ offices and specialized courts have improved the experience of abused children and women” (150).

Similar experiments are under way elsewhere. In India, for example, state governments have established legal aid cells, family courts, lok adalat (people’s courts) and mahilla lok adalat (women’s courts). A recent evaluation notes that these bodies are primarily conciliatory mechanisms, relying exclusively on mediation and counselling to promote family reconciliation. It has, however, been suggested that these institutions are less than satisfactory even as conciliatory mechanisms, and
that the mediators tend to place the well-being of women below the state’s interest in keeping families together (155).

**Laws and policies on arrest**

After support services for victims, efforts to reform police practice are the next most common form of intervention against domestic violence. Early on, the focus was on training the police, but when training alone proved largely ineffective in changing police behaviour, efforts shifted to seeking laws requiring mandatory arrest for domestic violence and policies that forced police officers to take a more active stand.

Support for arrest as a means of reducing domestic violence was boosted by a 1984 research experiment in Minneapolis, MN, United States, that suggested that arrest halved the risk of future assaults over a 6-month period, compared with the strategies of separating couples or advising them to seek help (156). These results were widely publicized and led to a dramatic shift in police policies toward domestic violence throughout the United States.

Efforts to duplicate the Minneapolis findings in five other areas of the United States, however, failed to confirm the deterrent value of arrest. These new studies found that, on average, arrest was no more effective in reducing violence than other police responses such as issuing warnings or citations, providing counselling to the couples or separating them (157, 158). Detailed analysis of these studies also produced some other interesting findings. When the perpetrator of the violence was married, employed or both, arrest reduced repeat assaults, but for unemployed and unattached men, arrest actually led to increased abuse in some cities. The impact of arrest also varied by community. Men living in communities with low unemployment were deterred by arrest regardless of their individual employment status; suspects living in areas of high unemployment, however, were more violent following an arrest than they were after simply receiving a warning (159). These findings have led some to question the wisdom of mandatory arrest laws in areas of concentrated poverty (160).

**Alternative sanctions**

As alternatives to arrest, some communities are experimenting with other methods of deterring violent behaviour. One civil law approach is to issue court orders that prohibit a man from contacting or abusing his partner, mandate that he leave the home, order him to pay maintenance or child support, or require him to seek counselling or treatment for substance abuse.

Researchers have found that although victims generally find protection orders useful, the evidence for their effectiveness in deterring violence is mixed (161, 162). In a study in the cities of Denver and Boulder, CO, United States, Harrell & Smith (163) found that protection orders were effective for at least a year in preventing a reoccurrence of domestic violence, compared with similar situations where there was no protection order. However, studies have shown that arrests for violation of a protection order are rare, which tends to undermine their effectiveness in preventing violence (164). Other research shows that protection orders can enhance a woman’s self-esteem but have little effect on men with serious criminal records (165, 166).

Elsewhere, communities have explored techniques such as public shaming, picketing an abuser’s home or workplace, or requiring community service as a punishment for abusive behaviour. Activists in India frequently stage dharna, a form of public shaming and protest, in front of the homes or workplaces of abusive men (155).

**All-women police stations**

Some countries have experimented with all-women police stations, an innovation that started in Brazil and has now spread throughout Latin America and parts of Asia (167, 168). Although commendable in theory, evaluations show that this initiative has to date experienced many problems (155, 168–172). While the presence of a police station staffed entirely by women does increase the number of abused women coming forward, frequently the services that abused women require – such as legal advice and counselling – are not available at the stations. Furthermore, the assumption that female
police officers will be more sympathetic to victims has not always proved true, and in some places, the creation of specialized police cells for crimes against women has made it easier for other police units to dismiss women's complaints. A review of all-women police stations in India observes that “women victims are forced to travel great distances to register their complaints with all-women police stations and cannot be assured of speedy neighbourhood police protection.” To be viable, the strategy must be accompanied by sensitivity-training for police officers, incentives to encourage such work and the provision of a wider range of services (155, 168, 170).

Treatment for abusers
Treatment programmes for perpetrators of partner violence are an innovation that has spread from the United States to Australia, Canada, Europe and a number of developing countries (173–175). Most of the programmes use a group format to discuss gender roles and teach skills, including how to cope with stress and anger, take responsibility for one’s actions and show feelings for others.

In recent years, there have been efforts to evaluate these programmes, although they have been hindered by methodological difficulties that continue to pose problems in interpreting the results. Research from the United States suggests that the majority of men (53–85%) who complete treatment programmes remain physically non-violent for up to 2 years, with lower rates for longer follow-up periods (176, 177). These success rates, however, should be seen in the light of the high drop-out rate that such programmes encounter; overall, between one-third and one-half of all men who enrol in these programmes fail to complete them (176) and many who are referred to programmes never formally enrol (178). An evaluation of the United Kingdom’s flagship Violence Prevention Programme, for example, showed that 65% of men did not show up for the first session, 33% attended fewer than six sessions, and only 33% went on to the second stage (179).

A recent evaluation of programmes in four cities in the United States found that most abused women felt “better off” and “safe” after their partners had entered treatment (177). Nevertheless, this study found that after 30 months, nearly half the men had used violence once, and 23% of the men had been repeatedly violent and continued to inflict serious injuries, while 21% of the men were neither physically nor verbally abusive. A total of 60% of couples had split up and 24% were no longer in contact.

According to a recent international review by researchers at the University of North London, England (179), evaluations collectively suggest that treatment programmes work best if they:

— continue for longer rather than shorter periods;
— change men’s attitudes enough for them to discuss their behaviour;
— sustain participation in the programme;
— work in tandem with a criminal justice system that acts strictly when there are breaches of the conditions of the programme.

In Pittsburgh, PA, United States, for example, the non-attendance rate dropped from 36% to 6% between 1994 and 1997 when the justice system began issuing arrest warrants for men who failed to appear at the programme’s initial interview session (179).

Health service interventions
In recent years attention has turned towards reforming the response of health care providers to victims of abuse. Most women come into contact with the health system at some point in their lives — when they seek contraception, for instance, or give birth or seek care for their children. This makes the health care setting an important place where women undergoing abuse can be identified, provided with support and referred if necessary to specialized services. Unfortunately, studies show that in most countries, doctors and nurses rarely enquire of women whether they are being abused, or even check for obvious signs of violence (180–186).

Existing interventions have focused on sensitizing health care providers, encouraging routine screening for abuse and drawing up protocols for
the proper management of abuse. A growing number of countries – including Brazil, Ireland, Malaysia, Mexico, Nicaragua, the Philippines and South Africa – have begun pilot projects training health workers to identify and respond to abuse (187–189). Several countries in Latin America have also incorporated guidelines to address domestic violence in their health sector policies (190).

Research suggests that making procedural changes in patient care – such as stamping a reminder for the provider on the patient’s chart or incorporating questions on abuse in the standard intake forms – have the greatest effect on the behaviour of health care providers (191, 192).

Confronting deep-rooted beliefs and attitudes is also important. In South Africa, the Agisanang Domestic Abuse Prevention and Training Project and its partner, the Health Systems Development Unit of the University of Witwatersrand, have developed a reproductive health and gender course for nurses that has a strong domestic violence component. In these courses, popular sayings, wedding songs and role-plays are used in an exercise to dissect commonly held notions on violence and the expected roles of men and women. Following the exercise, there is a discussion on the responsibility of nurses as health professionals. Analysis of a survey completed after one of these courses found that participants no longer believed that beating a woman was justified and that most accepted that a woman could be raped by her husband.

Active screening for abuse – questioning patients about their possible histories of suffering violence by intimate partners – is generally considered good practice in this field. However, while studies repeatedly show that women welcome being queried about violence in a non-judgemental way (181, 182, 193), little systematic evaluation has been carried out on whether screening for abuse can improve the safety of women or their health-seeking behaviour – and if it does, under what conditions (194).

**Community-based efforts**

**Outreach work**

Outreach work has been a major part of the response to partner violence from nongovernmental organizations. Outreach workers – who are often peer educators – visit victims of violence in their homes and communities. Nongovernmental organizations frequently recruit and train peer workers from the ranks of former clients, themselves earlier victims of partner violence.

Both governmental and nongovernmental projects have been known to employ “advocates” – individuals who provide abused women with information and advice, particularly with help in negotiating the intricacies of the legal system and of family welfare and other benefits. These people focus on the rights and entitlements of victims of violence and carry out their work from institutions as diverse as police stations, legal prosecutors’ offices and hospitals.

Several outreach schemes have been evaluated. The Domestic Violence Matters project in Islington, London, England, placed civilian advocates in local police stations, with the task of contacting all victims of partner violence within 24 hours of their calling the police. Another initiative in London, the Domestic Violence Intervention project in Hammersmith and Fulham, combined an education programme for violent men with appropriate interventions for their partners. A recent review of these programmes found that the Islington project had reduced the number of repeated calls to the police and – by inference – had reduced the reoccurrence of domestic violence. At the same time, it had increased the use by women of new services, including shelters, legal advice and support groups. The second project had managed to reach greater numbers of women from ethnic minority groups and professional women than other services for victims of domestic violence (195).

**Coordinated community interventions**

Coordinating councils or interagency forums are an increasingly popular means of monitoring and improving responses towards intimate partner violence at the community level (166). Their aim is to:

- exchange information;
- identify and address problems in the provision of services;
promote good practice through training and drawing up guidelines;
— track cases and carry out institutional audits to assess the practice of various agencies;
— promote community awareness and prevention work.

Adapted from the original pilot programmes in California, Massachusetts and Minnesota in the United States, this type of intervention has spread widely throughout the rest of the United States, Canada, the United Kingdom and parts of Latin America.

The Pan American Health Organization (PAHO), for instance, has set up pilot projects in 16 Latin American countries to test this approach in both urban and rural settings. In rural settings, the coordinating councils include individuals such as the local priest, the mayor, community health promoters, magistrates and representatives of women’s groups. The PAHO project began with a qualitative research study — known as La Ruta Crítica — to examine what happens to women in rural communities when they seek help, and the results are summarized in Box 4.2.

These types of community interventions have seldom been evaluated. One study found a statistically significant increase in the proportion of police calls that resulted in arrests, as well as in the proportion of arrests that resulted in prosecution, after the implementation of a community intervention project (196). The study also found a significant increase in the proportion of men sent for mandatory counselling in each of the communities, though it is unclear what impact, if any, these actions had on rates of abuse.

Qualitative evaluations have noted that many of these interventions focus primarily on coordinating refuges and the criminal justice system, at the expense of wider involvement of religious communities, schools, the health system, or other social service agencies. A recent review of interagency forums in the United Kingdom concluded that while coordinating councils can improve the quality of services offered to women and children, interagency work can act as a smokescreen, concealing the fact that little actually changes. The review suggested that organizations should identify firm criteria for self-evaluation that cover user satisfaction and real changes in policies and practices (197).

Prevention campaigns

Women’s organizations have long used communication campaigns, small-scale media and other events in an attempt to raise awareness of partner violence and change behaviour. There is evidence that such campaigns reach a large number of people, although only a few campaigns have been evaluated for their effectiveness in changing attitudes or behaviour. During the 1990s, for instance, a network of women’s groups in Nicaragua mounted an annual mass media campaign to raise awareness of the impact of violence on women (198). Using slogans such as “Quiero vivir sin violencia” (I want to live free of violence), the campaigns mobilized communities against abuse. Similarly, the United Nations Development Fund for Women, together with several other United Nations agencies, has been sponsoring a series of regional campaigns against gender violence around the slogan, “A life free of violence: it’s our right” (199). One communication project that has been evaluated is the multimedia health project known as Soul City, in South Africa — a project that combines prime-time television and radio dramas with other educational activities. One component is specifically devoted to domestic violence (see Box 9.1 in Chapter 9). The evaluation found increased knowledge and awareness of domestic violence, changed attitudes and norms, and greater willingness on the part of the project’s audience to take appropriate action.

School programmes

Despite a growing number of initiatives aimed at young people on preventing violence, only a small number specifically address the problem of violence in intimate relationships. There is considerable scope, though, to integrate material that explores relationships, gender roles and coercion and control into existing programmes for reducing school violence, bullying, delinquency and other problem behaviours, as well as into reproductive and sexual health programmes.
The programmes for young people that do explicitly address abuse within intimate relationships tend to be independent initiatives sponsored by bodies working to end violence against women (see Box 4.3). Only a handful of these programmes have been evaluated, including one in Canada (200) and two in the United States (201, 202). Using experimental designs, these evaluations found positive changes in knowledge and attitudes toward relationship violence (see also 203). One of the programmes in the United States demonstrated a reduction in the perpetration of violence at 1 month. Although its effect on behaviour had vanished after 1 year, its effects on norms of violence within an intimate relationship, on skills for resolving conflict and on knowledge were all maintained (201).

**Principles of good practice**

A growing body of wisdom on partner violence, accumulated over many years by large numbers of service providers, advocates and researchers, suggests a set of principles to help guide “good
practice” in this field. These principles include the following:

- Actions to address violence should take place at both national and local level.
- The involvement of women in the development and implementation of projects and the safety of women should guide all decisions relating to interventions.
- Efforts to reform the response of institutions – including the police, health care workers and the judiciary – should extend beyond training to changing institutional cultures.
- Interventions should cover and be coordinated between a range of different sectors.

**Action at all levels**

An important lesson to emerge from efforts to prevent violence is that actions should take place at both national and local levels. At the national level, priorities include improving the status of women, establishing appropriate norms, policies and laws on abuse, and creating a social environment that is conducive to non-violent relationships.

Many countries, industrialized as well as developing, have found it useful to set up a formal mechanism for developing and implementing national plans of action. Such plans should include clear objectives, lines of responsibility and time schedules, and be backed by adequate resources.
Experience nevertheless suggests that national efforts alone are insufficient to transform the landscape of intimate violence. Even in those industrialized countries where national movements against partner violence have existed for more than 25 years, the options for help available to a woman who has suffered abuse, and the reactions she is likely to meet from institutions such as the police, still vary greatly according to the particular locality. Where there have been efforts in the community to prevent violence, and where there are established groups to conduct training and monitor the activities of formal institutions, victims of abuse fare considerably better than where these are lacking (204).

**Women's involvement**

Interventions should be designed to work with women – who are usually the best judges of their situation – and to respect their decisions. Recent reviews of a range of domestic violence programmes in the Indian states of Gujarat, Karnataka, Madhya Pradesh and Maharashtra, for instance, have consistently shown that the success or failure of projects was determined largely by the attitudes of organizers towards intimate partner violence and their priorities for including the interests of women during the planning and implementation of interventions (205). Women’s safety should also be carefully considered when planning and implementing interventions. Those that make women’s safety and autonomy a priority have generally proved more successful than those that do not. For example, concern has been raised about laws requiring health care workers to report suspected cases of abuse to the police. These types of interventions take control away from women and have usually proved counterproductive. They may well put a woman’s safety at risk and make it less likely that she will come forward for care (206–208). Such laws also transform health workers into arms of the judicial system and work against the emotional protection that the environment of the clinic is meant to provide (150).

**Changing institutional cultures**

Little enduring change is usually achieved by short-term efforts to sensitize institutional actors, unless there are also real efforts to engage the whole institution. The nature of the organization’s leadership, the way in which performances are evaluated and rewarded, and the embedded cultural biases and beliefs are all of prime importance in this respect (209, 210). In the case of reforming health care practice, training alone has seldom been sufficient to change institutional behaviour toward victims of violence (211, 212). Although training can improve knowledge and practice in the short term, its impact generally wears off quickly unless accompanied by institutional changes in policies and performance (211, 213).

**A multisectoral approach**

Various sectors such as the police, health services, judiciary and social support services should work together in tackling the problem of intimate partner violence. Historically, the tendency of programmes has been to concentrate on a single sector, which has been shown by experience very often to produce poor results (155).

**Recommendations**

The evidence available shows violence against women by intimate partners to be a serious and widespread problem in all parts of the world. There is also a growing documentation of the damaging impact of violence on the physical and mental health of women and their overall well-being. The following are the main recommendations for action:

- Governments and other donors should be encouraged to invest much more in research on violence by intimate partners over the next decade.
- Programmes should place greater emphasis on enabling families, circles of friends and community groups, including religious communities, to deal with the problem of partner violence.
- Programmes on partner violence should be integrated with other programmes, such as those tackling youth violence, teenage pregnancies, substance abuse and other forms of family violence.
Programmes should focus more on the primary prevention of intimate partner violence.

Research on intimate partner violence
The lack of a clear theoretical understanding of the causes of intimate partner violence and its relationship to other forms of interpersonal violence has frustrated efforts to build an effective global response. Studies to advance the understanding of violence are needed on a variety of fronts, including:

- Studies that examine the prevalence, consequences and risk and protective factors of violence by intimate partners in different cultural settings, using standardized methodologies.
- Longitudinal research on the trajectories of violent behaviour by intimate partners over time, examining whether and how it differs from the development of other violent behaviours.
- Studies that explore the impact of violence over the course of a person’s life, investigating the relative impact of different types of violence on health and well-being, and whether the effects are cumulative.
- Studies that examine the life history of adults who are in healthy, non-violent relationships despite past experiences that are known to increase the risk of partner violence.

In addition, much more research is needed on interventions, both for the purpose of lobbying policy-makers for more investment as well as to improve the design and implementation of programmes. In the next decade, priority should be given to the following:

- Documentation of the various strategies and interventions around the world for combating intimate partner violence.
- Studies assessing the economic costs of intimate partner violence.
- Evaluation of the short-term and long-term effects of programmes to prevent and respond to partner violence—including school education programmes, legal and policy changes, services for victims of violence, programmes that target perpetrators of violence, and campaigns to change social attitudes and behaviour.

Strengthening informal sources of support
Many women do not seek assistance from the official services or systems that are available to them. Expanding the informal sources of support through neighbourhood networks and networks of friends, religious and other community groups, and workplaces is therefore vital (6, 61, 183, 214). How these informal groups and individuals respond will determine whether a victim of partner violence takes action or else retreats into isolation and self-blame (214).

There is plenty of room for programmes that can create constructive responses on the part of family and friends. An innovative programme in Iztacalco, Mexico, for instance, used community events, small-scale media (such as posters, pamphlets and audio cassettes) and workshops to help victims of violence discuss the abuse they had undergone and to demonstrate to friends and other family members how best to deal with such situations (215).

Making common cause with other social programmes
There is a considerable overlap between the factors that increase the risk of various problem behaviours (216). There also appears to be a significant continuity between aggressive behaviour in childhood and a range of problem behaviours in youth and early adulthood (see Chapter 2). The insights gained from research on these types of violence overlap as well. There is an evident need to intervene early with high-risk families and to provide support and other services before dysfunctional patterns of behaviour within the family set in, preparing the stage for abusive behaviour in adolescence or adulthood.

Unfortunately, there is at present little coordination between programmes or research agendas on youth violence, child abuse, substance abuse and partner violence, despite the fact that all these problems regularly coexist in families. If true progress is to be made, attention must be paid to the development of aggressive behaviour patterns—patterns that often begin in childhood. Integrated
prevention responses that address the links between different types of violence have the potential to reduce some of these forms of violence.

**Investing in primary prevention**

The importance of primary prevention of violence by intimate partners is often overshadowed by the importance of the large number of programmes that, understandably, seek to deal with the immediate and numerous consequences of violence.

Both policy-makers and activists in this field must give greater priority to the admittedly immense task of creating a social environment that allows and promotes equitable and non-violent personal relationships. The foundation for such an environment must be the new generation of children, who should come of age with better skills than their parents generally had for managing their relationships and resolving the conflicts within them, with greater opportunities for their future, and with more appropriate notions on how men and women can relate to each other and share power.

**Conclusion**

Violence by intimate partners is an important public health problem. Resolving it requires the involvement of many sectors working together at community, national and international levels. At each level, responses must include empowering women and girls, reaching out to men, providing for the needs of victims and increasing the penalties for abusers. It is vital that responses should involve children and young people, and focus on changing community and societal norms. The progress made in each of these areas will be the key to achieving global reductions in violence against intimate partners.

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Domestic Violence:
Older Women Can Be Victims Too

“Many forms of verbal and psychological abuse appear relatively harmless at first, but expand and grow more menacing over time, sometimes gradually and subtly. As victims adapt to abusive behavior, the verbal or psychological tactics can gain a strong ‘foothold’ in victims’ minds, making it difficult for them to recognize the severity of the abuse over time.”

— Witness Justice, Maryland

Domestic violence, regrettably, knows no age limits. Every hour of every day, some woman somewhere faces the horror of physical, emotional, financial, or sexual abuse by someone they know well and with whom they have an ongoing relationship—a spouse or companion, son, daughter, or other family member.

Education and support are vital to older women’s safety—Secrecy is an abuser’s best protection.

Facts on Late Life Domestic Violence

• Domestic elder abuse is primarily family abuse. Studies repeatedly show that the overwhelming majority of confirmed cases occur in domestic settings.¹

• A significant portion of elder abuse cases reported in the United States involve spouse/partner violence.²

• Older women are likelier than younger women to experience violence for a longer time, to be in current violent relationships, and to have health and mental health problems.³

Signs That Something May Be Wrong

What follows is a chart listing some of the warning signs of domestic abuse in later life. All of the signs need not be present for abuse to be occurring. Answering yes to one or several may be the cue to further questioning.
## Recognizing Domestic Violence in Later Life

### A Victim May . . .

- Have _injuries that do not match explanation of how they occurred._
- Have repeated "accidental" injuries.
- Appear _isolated._
- Say or hint that she is _afraid._
- Give _coded communications about what is occurring._
- Attempt or think about _suicide._
- Have a history of _alcohol or drug abuse_ (including prescription drugs).
- Be "_difficult_" or hard to get along with.
- Have vague, chronic, _non-specific complaints._
- Be emotionally and/or financially _dependent on her abuser._
- Miss appointments.
- Delay seeking _medical help._
- _Show signs of depression, stress, or trauma._

### A Perpetrator May . . .

- _Minimize or deny_ the victim’s injuries or complaints.
- Attempt to convince others that she is _incompetent or crazy._
- _Blame_ the victim for being clumsy or difficult.
- _Physically assault or threaten violence_ against the victim or victim’s family, friends, pets, or others.
- _Forbid the victim from contacting family, friends, service providers._
- _Threaten or harass_ the victim.
- _Stalk_ the victim.
- Act _overly attentive_ toward the victim.
- Act _loving, kind, compassionate_ to the victim, especially in presence of others.
- Attempt or think about _suicide._
- _Have a history of alcohol or drug abuse._
- _Speak on behalf of the victim, insist on being present during every interaction._
- Say the victim is _incompetent, unhealthy, or crazy._
- Be emotionally and/or financially _dependent on the victim._
- Cancel _the victim’s appointments_ or refuse her the use of a car or other transportation.
- Cover _up the abuse_ by taking victim to different doctors, hospitals, or pharmacies.
- Refuse to purchase _needed prescription drugs, medical supplies, and/or assistive devices._
- Turn _family members against_ the victim.
- Talk about her as if she is not there or not a person (_de-humanize victim)._
Domestic Violence Knows No Age Limits

Why Do Women Stay? Why Do Women Return?

- **Fear that disclosure** will lead to something far worse—mental or physical anguish, deprivation, or even death.
- **Fear of the unknown** or of going it alone.
- **Economic dependence** — Who will take care of her? Where will she live? What will she do if she has no health insurance?
- **Fear of institutionalization** — If she is frail, ill, or disabled, will she be forced to move to a nursing home?
- **Values/culture** — Separation, divorce, and legal orders of protection are not an option.
- **Shame and guilt** — Victims often blame themselves for any crime perpetrated against them. She may feel she is responsible.
- **Denial and minimization** — She may feel she needs to protect her abuser by refusing to press charges or by changing her story of what really happened.
- **Lack of information** about alternatives.

What Every Woman Should Know

- Domestic violence is a crime. Abusers are apt to play the blame game, make excuses, or deny wrongdoing. But their behavior can never be justified.
- From belittling and bullying to isolation, threats, and coercion, abusing others is a way to exert power and control. Abusers choose to act this way. It is not about loss of control, it is about getting control.
- Older women have both a right and a need to protect themselves.

Help Is Available

If you or someone you know is being abused, **tell someone.** You are not alone.

If you are in immediate danger, call 9-1-1 or your local police department right away.
Domestic Violence Knows No Age Limits

For emergency safety services, support, or shelter, call your local hotline or the National Domestic Violence Hotline at 1-800-799-SAFE (1-800-799-7233). Some local domestic violence programs have specialized services for older women. You don’t have to stay in a shelter to get help.

If you suspect elder abuse and are concerned about your well-being or another woman’s safety, call your state or local Adult Protective Services hotline.

To find help in your area, call the national Eldercare Locator at 1-800-677-1116 or go to the National Center on Elder Abuse Web site at www.elderabusecenter.org and then click “Where to Report Abuse.”

What Others Can Do

- **Familiarize yourself with the signs** of elder abuse and the dynamics of late life domestic violence.
- **Share this information** with older women.
- **Learn about services for domestic violence** in the community. Make referrals and offer to advocate.
- **Post literature about late life domestic violence** in places where women are likely to visit and not be under the influence of the suspected abuser — doctors’ offices, senior centers, restrooms, and other safe places.
- **Ask and listen.** Open the lines of communication. Ask her if there is something wrong, if she feels isolated, or if she is worried about something, and then listen to her story.
- **Offer friendship and support.** Women who have experienced domestic violence often cite as most helpful the person who took the time to listen, or who said, “You do not deserve to be treated like this.”
Domestic Violence Knows No Age Limits

Sources


The National Center on Elder Abuse (NCEA) serves as a national resource for elder rights advocates, adult protective services, law enforcement and legal professionals, medical and mental health providers, public policy leaders, educators, researchers, and concerned citizens. It is the mission of NCEA to promote understanding, knowledge sharing, and action on elder abuse, neglect, and exploitation.

National Center on Elder Abuse
National Association of State Units on Aging
1201 15th Street, NW, Suite 350
Washington, DC 20005
202.898.2586 / Fax 202.898.2538

Special appreciation to Bonnie Brandl, Wisconsin Coalition Against Domestic Violence, for consultation on domestic violence in later life.

Major funding for the National Center on Elder Abuse is provided by the U.S. Administration on Aging, Department of Health and Human Services, Grant No. 90-AM-2792.

September 2005
Safety Planning List

Here are some helpful items to get together when you are planning on leaving an abusive situation. Keep these items in a safe place until you are ready to leave, or if you need to leave suddenly. If you have children, take them. And take your pets, too (if you can).

Identification for yourself and your children

- birth certificates
- social security cards (or numbers written on paper if you can’t find the cards)
- driver’s license
- photo identification or passports
- welfare identification
- green card

Important personal papers

- marriage certificate
- divorce papers
- custody orders
- legal protection or restraining orders
- health insurance papers and medical cards
- medical records for all family members
- children’s school records
- investment papers/records and account numbers
- work permits
- immigration papers

Funds

- cash
- credit cards
- ATM card
- checkbook and bankbook (with deposit slips)

Keys

- house
- car
- safety deposit box or post office box

A way to communicate

- phone calling card
- cell phone
- address book

Medications

- at least 1 month’s supply for all medicines you and your children are taking, as well as a copy of the prescriptions

A way to get by

- jewelry or small objects you can sell if you run out of money or stop having access to your accounts

Things to help you cope

- pictures
- keepsakes
- children’s small toys or books

Current as of January 2006
On September 17, 2008, 70 out of 113, or 62%, of identified domestic violence programs in California participated in the 2008 National Census of Domestic Violence Services. The following figures represent the information provided by 70 participating programs about services provided during the 24-hour survey period.

### 3,872 Victims Served In One Day
2,012 domestic violence victims found refuge in emergency shelters or transitional housing provided by local domestic violence programs.

1,860 adults and children received non-residential assistance and services, including individual counseling, legal advocacy, and children’s support groups.

### 686 Unmet Requests for Services In One Day
Many programs reported a critical shortage of funds and staff to assist victims in need of services such as transportation, childcare, language translation, mental health and substance abuse counseling, and legal representation. Of these unmet requests, 310 were from victims seeking emergency shelter or transitional housing.

Programs reported that lack of staffing was a reason that they could not meet domestic violence victims’ request for services. 49% of programs have less than 20 paid staff, including 16% of programs that have less than 10 paid staff. The average starting salary of a full-time, salaried front-line advocate is $27,793.

### Attorneys
Victims of domestic violence often need legal assistance with restraining orders and civil and family court matters. Of programs that participated in the Census, only 15% of programs reported being able to regularly connect a victim requesting legal assistance with an attorney.

> “Today our staff attended the funeral of a woman who had been killed by her husband.”

> “A domestic violence and sexual assault victim was in the hospital for a sexual assault exam. She had no where to go despite having called every shelter in the county and finally had to travel 45 minutes to get to a hotel.”
CALIFORNIA
DOMESTIC VIOLENCE HOTLINES

(UPDATE SUMMER, 2006)

Produced and Distributed by:

Please note: This is not a complete listing of domestic violence hotlines in California. For more information or to locate a shelter in your community contact the National Domestic Violence Hotline at (800)799-Safe (7233) or the California Partnership to End Domestic Violence toll free number (800)524-4765.
The California Partnership to End Domestic Violence is a catalyst and advocate for social change through innovative solutions to ensure safety and justice for victims and survivors of domestic violence and their children.

### CALIFORNIA DOMESTIC VIOLENCE HOTLINES

#### ALAMEDA

<table>
<thead>
<tr>
<th>Service</th>
<th>Location</th>
<th>Contact Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>A Safe Place</td>
<td>Oakland</td>
<td>510-536-7233</td>
</tr>
<tr>
<td>Building Futures with</td>
<td></td>
<td></td>
</tr>
<tr>
<td>DeafHope</td>
<td>San Leandro</td>
<td>TTY 510-733-3133; email hotline also available</td>
</tr>
<tr>
<td>Emergency Shelter Program, Inc.</td>
<td>Hayward</td>
<td>510-786-1246/1-888-339-SAFE</td>
</tr>
<tr>
<td>SAVE Shelter Against Violent</td>
<td>Fremont</td>
<td>510- 794-6055</td>
</tr>
<tr>
<td>Environment to Safe Alternatives to</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Violent Environments</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tri Valley Haven</td>
<td>Livermore</td>
<td>925-449-5842;1- 800-884-8119</td>
</tr>
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</table>

#### AMADOR

<table>
<thead>
<tr>
<th>Service</th>
<th>Location</th>
<th>Contact Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Operation Care</td>
<td>Jackson</td>
<td>209-223-2600; 209-223-2897</td>
</tr>
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#### ALPINE

<table>
<thead>
<tr>
<th>Service</th>
<th>Location</th>
<th>Contact Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>South Lake Tahoe Women’s Center</td>
<td>Markleeville</td>
<td>1-888-750-6444</td>
</tr>
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</table>

#### BUTTE

<table>
<thead>
<tr>
<th>Service</th>
<th>Location</th>
<th>Contact Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Catalyst Domestic Violence</td>
<td>Chico</td>
<td>1-800-895-8476</td>
</tr>
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#### CALAVERAS

<table>
<thead>
<tr>
<th>Service</th>
<th>Location</th>
<th>Contact Information</th>
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</thead>
<tbody>
<tr>
<td>Calaveras Women's Crisis Center</td>
<td>San Andreas</td>
<td>209-736-4011</td>
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#### CONTRA COSTA

<table>
<thead>
<tr>
<th>Service</th>
<th>Location</th>
<th>Contact Information</th>
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<tbody>
<tr>
<td>STAND! Against Domestic Violence</td>
<td>Concord</td>
<td>1-888-215-5555; 925-676-2845</td>
</tr>
</tbody>
</table>

#### DEL NORTE

<table>
<thead>
<tr>
<th>Service</th>
<th>Location</th>
<th>Contact Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rural Human Services</td>
<td>Crescent City</td>
<td>707-465-3013</td>
</tr>
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#### EL DORADO

<table>
<thead>
<tr>
<th>Service</th>
<th>Location</th>
<th>Contact Information</th>
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</thead>
<tbody>
<tr>
<td>El Dorado Women's Center</td>
<td>Placerville</td>
<td>530-626-1131</td>
</tr>
<tr>
<td>South Lake Tahoe Women's Center</td>
<td>South Lake Tahoe</td>
<td>530-544-4444; 1-888-750-6444</td>
</tr>
</tbody>
</table>
# California Domestic Violence Hotlines

<table>
<thead>
<tr>
<th>County</th>
<th>Organization</th>
<th>City</th>
<th>Phone Numbers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fresno</td>
<td>Marjaree Mason Center</td>
<td>Fresno</td>
<td>559-233-HELP</td>
</tr>
<tr>
<td>Humboldt</td>
<td>Humboldt Women for Shelter</td>
<td>Eureka</td>
<td>1-866-668-6543; 707-443-6042</td>
</tr>
<tr>
<td>Imperial</td>
<td>Center for Family Solutions/Women Haven</td>
<td>El Centro</td>
<td>760-353-8530</td>
</tr>
<tr>
<td>Kern</td>
<td>Alliance Against Family Violence/Sexual Assault</td>
<td>Bakersfield</td>
<td>661-327-1091; 1-800-273-7713</td>
</tr>
<tr>
<td>Kings</td>
<td>Women's Center High Desert, Inc</td>
<td>Ridgecrest</td>
<td>760-375-7525</td>
</tr>
<tr>
<td>Lake</td>
<td>Sutter Lakeside Community Services</td>
<td>Lakeport</td>
<td>1-888-485-7733</td>
</tr>
<tr>
<td>Lassen</td>
<td>Lassen Family Services, Inc</td>
<td>Susanville</td>
<td>530-257-5004; 1-888-289-5004</td>
</tr>
<tr>
<td>Los Angeles</td>
<td>1736 Family Crisis Center</td>
<td>Los Angeles</td>
<td>213-745-6434</td>
</tr>
<tr>
<td></td>
<td>1736 Family Crisis Center</td>
<td>Long Beach</td>
<td>562-388-7652; 1-877-367-7752</td>
</tr>
<tr>
<td></td>
<td>1736 Family Crisis Center</td>
<td>Redondo Beach</td>
<td>310-370-5902</td>
</tr>
<tr>
<td></td>
<td>Angel Step Inn</td>
<td>Downey</td>
<td>323-780-HELP; 1-800-655-2226</td>
</tr>
<tr>
<td></td>
<td>Antelope Valley DV Council</td>
<td>Lancaster</td>
<td>661-945-6736; 1-800-282-4808</td>
</tr>
<tr>
<td></td>
<td>Center for the Pacific-Asian Family (aka CPAF)</td>
<td>Los Angeles</td>
<td>1-800-339-3940</td>
</tr>
<tr>
<td></td>
<td>CSAC Chicana Service Action Center</td>
<td>Los Angeles</td>
<td>1-800-843-9675; 1-800-548-2722</td>
</tr>
</tbody>
</table>

The California Partnership to End Domestic Violence is a catalyst and advocate for social change through innovative solutions to ensure safety and justice for victims and survivors of domestic violence and their children.
The California Partnership to End Domestic Violence is a catalyst and advocate for social change through innovative solutions to ensure safety and justice for victims and survivors of domestic violence and their children.

### CALIFORNIA DOMESTIC VIOLENCE HOTLINES

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<thead>
<tr>
<th>Service Name</th>
<th>Location</th>
<th>Contact Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Domestic Violence Center of Santa Clarita Valley</td>
<td>Santa Clarita</td>
<td>661-259-HELP</td>
</tr>
<tr>
<td>Family Violence Project/ Jewish Family Services</td>
<td>Sherman Oaks</td>
<td>1-818-505-0900</td>
</tr>
<tr>
<td>Good Shepard Shelter</td>
<td>Los Angeles</td>
<td>323-737-6111</td>
</tr>
<tr>
<td>Haven Hills</td>
<td>San Fernando Valley</td>
<td>1-818-887-6589; 1-800-978-3600</td>
</tr>
<tr>
<td>Haven House</td>
<td>Pasadena</td>
<td>323-681-2626</td>
</tr>
<tr>
<td>House of Ruth</td>
<td>Claremont</td>
<td>909-988-5559</td>
</tr>
<tr>
<td>Interval House</td>
<td>Long Beach</td>
<td>562-594-4555</td>
</tr>
<tr>
<td>Jenesse Center, Inc.</td>
<td>Los Angeles</td>
<td>323-731-6500; 1-800-479-7328</td>
</tr>
<tr>
<td>Peace &amp; Joy Care Center</td>
<td>Carson</td>
<td>310-898-3117</td>
</tr>
<tr>
<td>Rainbow Services, Ltd.</td>
<td>San Pedro</td>
<td>310-547-9343</td>
</tr>
<tr>
<td>Sojourn Services</td>
<td>Santa Monica</td>
<td>310-264-6644</td>
</tr>
<tr>
<td>Su Casa ~ Ending Domestic Violence</td>
<td>Artesia</td>
<td>562-402-4888</td>
</tr>
<tr>
<td>Women's &amp; Children's Crisis Center</td>
<td>Whittier</td>
<td>562-945-3939</td>
</tr>
<tr>
<td>WomenShelter of Long Beach</td>
<td>Long Beach</td>
<td>562-437-4663</td>
</tr>
<tr>
<td>YWCA of Glendale, DV Project</td>
<td>Glendale</td>
<td>1-818-242-1106</td>
</tr>
<tr>
<td>YWCA Wings, Domestic Violence</td>
<td>West Covina</td>
<td>(626) 967-0658</td>
</tr>
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</table>

### MADERA

<table>
<thead>
<tr>
<th>Service Name</th>
<th>Location</th>
<th>Contact Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Madera County Action Committee</td>
<td>Madera</td>
<td>559-661-1000; 1-800-355-8989</td>
</tr>
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</table>

### MARIN

<table>
<thead>
<tr>
<th>Service Name</th>
<th>Location</th>
<th>Contact Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Marin Abused Women's Services</td>
<td>San Rafael</td>
<td>415-924-6616; 415-924-3456</td>
</tr>
</tbody>
</table>

### MARIPOSA

<table>
<thead>
<tr>
<th>Service Name</th>
<th>Location</th>
<th>Contact Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mountain Crisis Services</td>
<td>Maripos</td>
<td>209-966-2350; 1-888-966-2350</td>
</tr>
</tbody>
</table>

### MENDOCINO

<table>
<thead>
<tr>
<th>Service Name</th>
<th>Location</th>
<th>Contact Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Project Sanctuary, Inc.</td>
<td>Ukiah</td>
<td>707-463-HELP; 707-462-9196</td>
</tr>
</tbody>
</table>
# California Domestic Violence Hotlines

<table>
<thead>
<tr>
<th>County</th>
<th>Organization</th>
<th>City</th>
<th>Phone Numbers</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Merced</strong></td>
<td>A Woman's Place of Merced County</td>
<td>Merced</td>
<td>209-722-4357; 1-800-799-SAFE</td>
</tr>
<tr>
<td><strong>Modoc</strong></td>
<td>Modoc Crisis Center (T.E.A.C.H.)</td>
<td>Alturas</td>
<td>530-233-4575; 1-800-291-2156</td>
</tr>
<tr>
<td><strong>Mono</strong></td>
<td>Wild Iris</td>
<td>Mammoth Lakes</td>
<td>1-877-873-7384</td>
</tr>
<tr>
<td><strong>Monterey</strong></td>
<td>Shelter Outreach Plus</td>
<td>Marina</td>
<td>831-422-2201; 1-800-339-8228</td>
</tr>
<tr>
<td></td>
<td>YWCA of Monterey County</td>
<td>Seaside</td>
<td>831-372-6300; 1-800-YWCA-151</td>
</tr>
<tr>
<td><strong>Napa</strong></td>
<td>Napa Emergency Women's Services (NEWS)</td>
<td>Napa</td>
<td>707-255-6397</td>
</tr>
<tr>
<td><strong>Nevada</strong></td>
<td>Domestic Violence/Sexual Assault Coalition</td>
<td>Grass Valley</td>
<td>530-272-3467; 530-272-2046</td>
</tr>
<tr>
<td><strong>Orange</strong></td>
<td>Human Options, Inc</td>
<td>Irvine</td>
<td>949-854-3554; 1-877-854-3594</td>
</tr>
<tr>
<td></td>
<td>Interval House</td>
<td>Seal Beach</td>
<td>714-891-8121</td>
</tr>
<tr>
<td></td>
<td>Laura's House</td>
<td>San Clemente</td>
<td>949-498-1511</td>
</tr>
<tr>
<td></td>
<td>Women’s Transitional Living Center (WTLC)</td>
<td>Orange</td>
<td>714-992-1931</td>
</tr>
<tr>
<td><strong>Placer</strong></td>
<td>P.E.A.C.E. for Families</td>
<td>Auburn</td>
<td>1-800-575-5352</td>
</tr>
<tr>
<td></td>
<td>Tahoe Women's Services</td>
<td>Kings Beach</td>
<td>1-800-736-1060</td>
</tr>
<tr>
<td><strong>Plumas</strong></td>
<td>Plumas Rural Services, Inc.</td>
<td>Quincy</td>
<td>1-800-485-8099</td>
</tr>
</tbody>
</table>

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<table>
<thead>
<tr>
<th>LOCATION</th>
<th>ORGANIZATION NAME</th>
<th>CITY</th>
<th>PHONE NUMBERS</th>
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</thead>
<tbody>
<tr>
<td>RIVERSIDE</td>
<td>Alternatives to Domestic Violence</td>
<td>Riverside</td>
<td>(951) 683-0829; 1-800-339-SAFE (7233)</td>
</tr>
<tr>
<td></td>
<td>Shelter From the Storm, Inc.</td>
<td>Palm Desert</td>
<td>760-328-7233; 1-800-775-6055</td>
</tr>
<tr>
<td>SACRAMENTO</td>
<td>My Sister's House</td>
<td>Sacramento, Davis</td>
<td>916-428-3271</td>
</tr>
<tr>
<td></td>
<td>WEAVE</td>
<td>Sacramento</td>
<td>916-920-2952; 1-866-920-2952</td>
</tr>
<tr>
<td>SAN BERNARDINO</td>
<td>Desert Sanctuary, Inc.</td>
<td>Barstow</td>
<td>760-256-3441; 1-800-982-2221</td>
</tr>
<tr>
<td></td>
<td>DOVES of Big Bear Valley, Inc.</td>
<td>Big Bear Lake</td>
<td>1-800-851-7601</td>
</tr>
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<td></td>
<td>High Desert Domestic Violence Program</td>
<td>Victorville</td>
<td>760-949-4357; 1-866-770-7867</td>
</tr>
<tr>
<td></td>
<td>Morongo Basin Unity Home</td>
<td>Joshua Tree</td>
<td>760-366-9663</td>
</tr>
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<td></td>
<td>Option House</td>
<td>San Bernardino</td>
<td>909-386-1647</td>
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<tr>
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<td>Victor Valley Domestic Violence Center</td>
<td>Victorville</td>
<td>760-955-8723</td>
</tr>
<tr>
<td>SAN DIEGO</td>
<td>Center for Community Solutions</td>
<td>San Diego</td>
<td>1-888-385-4657; 1-888-272-1767</td>
</tr>
<tr>
<td></td>
<td>Community Resource Center</td>
<td>Encinitas</td>
<td>1-877-633-1112</td>
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<td>South Bay Community Services</td>
<td>Chula Vista</td>
<td>1-800-640-2933</td>
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<td>Women's Resource Center</td>
<td>Oceanside</td>
<td>760-757-3500</td>
</tr>
<tr>
<td></td>
<td>YWCA of San Diego County</td>
<td>San Diego</td>
<td>619-234-3164</td>
</tr>
<tr>
<td></td>
<td>Community Resource Center - Libre!</td>
<td>Encinitas</td>
<td>1-877-633-1112</td>
</tr>
<tr>
<td>SAN FRANCISCO</td>
<td>Asian Women's Shelter</td>
<td>San Francisco</td>
<td>415-751-0880; 1-877-751-0880</td>
</tr>
<tr>
<td></td>
<td>Community United Against Violence</td>
<td>San Francisco</td>
<td>415-333-HELP</td>
</tr>
</tbody>
</table>

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# California Domestic Violence Hotlines

The California Partnership to End Domestic Violence is a catalyst and advocate for social change through innovative solutions to ensure safety and justice for victims and survivors of domestic violence and their children.

<table>
<thead>
<tr>
<th>Location</th>
<th>City</th>
<th>Hotline Numbers</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>La Casa de les Madres</strong></td>
<td>San Francisco</td>
<td>877-503-1850/1-877-923-0700</td>
</tr>
<tr>
<td><strong>Riley Center/St. Vincent de Paul</strong></td>
<td>San Francisco</td>
<td>415-255-0165</td>
</tr>
<tr>
<td><strong>W.O.M.A.N., Inc</strong></td>
<td>San Francisco</td>
<td>415-864-4722/877-384-3578</td>
</tr>
</tbody>
</table>

**San Joaquin**

| Women's Center of San Joaquin County | Stockton | 209-465-4878 |

**San Luis Obispo**

| North Co. Women's Resource Center/Shelter | Atascadero | 805-461-1338; 1-800-549-8989 |

| Women's Shelter Program | San Luis Obispo | 805-781-6400; 1-800-549-8989 |

**San Mateo**

| Community Overcoming Relationship Abuse | San Mateo | 650-312-8515; 1-800-300-1080 |

**Santa Barbara**

| Domestic Violence Solutions | Lompoc | 805-736-0965 |
| Domestic Violence Solutions | Santa Barbara | 805-964-5245 |
| Domestic Violence Solutions | Santa Maria | 805-925-2160 |
| Domestic Violence Solutions | Santa Ynez | 805-686-4390 |

**Santa Clara**

| Asian Women's Home (AACI) | San Jose | 408-975-2739 |
| Community Solutions | Morgan Hill | 408-683-4118 |
| Next Door Solutions to Domestic Violence | San Jose | 408-279-2962 |
| Support Network for Battered Women | Sunnyvale | 1-800-572-2782; 408 541-6100 |

**Santa Cruz**

| Defensa de Mujeres | Watsonville | 831-MUJERES |
| Walnut Avenue Women's Center | Santa Cruz | 866-2MYALLY |

The California Partnership to End Domestic Violence is a catalyst and advocate for social change through innovative solutions to ensure safety and justice for victims and survivors of domestic violence and their children.
# California Domestic Violence Hotlines

<table>
<thead>
<tr>
<th>Women's Crisis Support</th>
<th>Santa Cruz</th>
<th>831-685-3737</th>
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<td><strong>SHASTA</strong></td>
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<tr>
<td>Shasta County Women's Refuge, Inc.</td>
<td>Redding</td>
<td>530-244-0117</td>
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<td><strong>SISKIYOU</strong></td>
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<tr>
<td>Siskiyou Domestic Violence &amp; Crisis Center</td>
<td>Yreka</td>
<td>1-877-842-4068</td>
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<td><strong>SOLANO</strong></td>
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<tr>
<td>SafeQuest Solano</td>
<td>Fairfield</td>
<td>707-425-73422</td>
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<td><strong>SONOMA</strong></td>
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<tr>
<td>YWCA of Sonoma County</td>
<td>Santa Rosa</td>
<td>707-546-1234</td>
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<td><strong>STANISLAUS</strong></td>
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<tr>
<td>Haven Women's Center of Stanislaus</td>
<td>Modesto</td>
<td>209-577-5980; 1-800-834-1990</td>
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<td><strong>SUTTER</strong></td>
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<tr>
<td>Casa de Esperanza, Inc.</td>
<td>Yuba City</td>
<td>530-674-2040</td>
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<td><strong>TEHAMA</strong></td>
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<tr>
<td>Alternatives to Violence</td>
<td>Red Bluff</td>
<td>530-528-0226; 1-800-324-6473</td>
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<td><strong>TRINITY</strong></td>
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<tr>
<td>Human Response Network</td>
<td>Weaverville</td>
<td>530-623-4357</td>
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<td><strong>TULARE</strong></td>
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<tr>
<td>Central California Family Crisis Center, Inc.</td>
<td>Porterville</td>
<td>559-784-0192</td>
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<tr>
<td>Family Services of Tulare County</td>
<td>Visalia</td>
<td>559-732-5941; 1-800-448-2044</td>
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<td><strong>TUOLUMNE</strong></td>
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<tr>
<td>Kene Me-Wu Family Healing Center, Inc.</td>
<td>Sonora</td>
<td>1-800-792-7776</td>
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<tr>
<td>Mountain Women's Resource Center</td>
<td>Sonora</td>
<td>209-533-3401</td>
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The California Partnership to End Domestic Violence is a catalyst and advocate for social change through innovative solutions to ensure safety and justice for victims and survivors of domestic violence and their children.
## CALIFORNIA DOMESTIC VIOLENCE HOTLINES

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<tr>
<th>VENTURA</th>
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<tbody>
<tr>
<td>Coalition to End Domestic &amp; Sexual Violence</td>
<td>Oxnard</td>
<td>805-656-1111; 1-800-300-2181</td>
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<tr>
<td>Interface Children Family Services</td>
<td>Camarillo</td>
<td>1-800-339-9597</td>
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<th>YOLO</th>
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<td>Sexual Assault &amp; Domestic Violence Center</td>
<td>Woodland</td>
<td>530-662-1133; 916-371-1907</td>
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<th>STATEWIDE</th>
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<tr>
<td>Domestic Violence &amp; Employment Project of The Legal Aid Society - Employment Law Center</td>
<td>All Cities</td>
<td>1-888- 864-8335 (toll-free in CA)</td>
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</tbody>
</table>

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