Spousal/Partner Abuse Detection and Intervention CE Course

(15 hours/units)

***Course Objectives*:** In addition to the course objectives listed, this course addresses the following content areas related to spousal and partner abuse:

- ✓ Counseling theory and practice
- ✓ Social and Cultural Foundations
- ✓ Assessment
- ✓ Professional practice issues
- ✓ Wellness and prevention

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1. Intimate Partner Violence (IPV): Definitions

The Centers for Disease Control and Prevention (CDC) defines intimate partner violence (IPV) as actual or threatened physical, sexual, psychological, or stalking violence by current or former intimate partners (whether of the same or opposite sex). IPV is a major public health problem, reflected by both its prevalence and negative consequences. Researchers and prevention specialists are working to identify the factors that place intimate partners at risk for being victimized by or perpetrating violence, to find out which interventions are working, and to design more effective prevention programs. National data suggest that IPV is perpetrated against both women and men, although most research indicates that women are more likely than men to be victimized by almost every type of IPV, including rape, physical assault, and stalking by an intimate partner *(Tjaden and Thoennes).* The consequences of IPV are well documented and include substantial morbidity and mortality and physical and psychological health problems. Women are significantly more likely than men to be injured or killed by intimate partners. Approximately one in three females murdered in the United States is killed by a partner, whereas approximately one in twenty U.S. males murdered is killed by a partner *(Puzone et al.).* Psychological consequences include post-traumatic stress disorder, depression, substance abuse, and suicidal behaviors *(Caetano and Cunradi; Campbell; Coker et al))*

IPV can vary in frequency and severity. It occurs on a continuum, ranging from one hit that may or may not impact the victim to chronic, severe battering.
There are four main types of intimate partner violence *(Saltzman et al):*

- **Physical violence** is the intentional use of physical force with the potential for causing death, disability, injury, or harm. Physical violence includes, but is not limited to, scratching; pushing; shoving; throwing; grabbing; biting; choking; shaking; slapping; punching; burning; use of a weapon; and use of restraints or one's body, size, or strength against another person.
- **Sexual violence** is divided into three categories: 1) use of physical force to compel a person to engage in a sexual act against his or her will, whether or not the act is completed; 2) attempted or completed sex act involving a person who is unable to understand the nature or condition of the act, to decline participation, or to communicate unwillingness to engage in the sexual act, e.g., because of illness, disability, or the influence of alcohol or other drugs, or because of intimidation or pressure; and 3) abusive sexual contact.
- **Threats of physical or sexual violence** use words, gestures, or weapons to communicate the intent to cause death, disability, injury, or physical harm.
- **Psychological/emotional violence** involves trauma to the victim caused by acts, threats of acts, or coercive tactics. Psychological/emotional abuse can include, but is not limited to, humiliating the victim, controlling what the victim can and

> cannot do, withholding information from the victim, deliberately doing something to make the victim feel diminished or embarrassed, isolating the victim from friends and family, and denying the victim access to money or other basic resources. It is considered psychological/emotional violence when there has been prior physical or sexual violence or prior threat of physical or sexual violence. In addition, stalking is often included among the types of IPV. Stalking generally refers to "harassing or threatening behavior that an individual engages in repeatedly, 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".

Systematic research investigating marital violence began in the 1970's and, by the early 1980's, expanded to include courtship or relationship violence. Several studies using nationally representative samples from the United States have been conducted among married couples, and college couples. In general, these studies reported alarming rates of interpersonal conflict among married and unmarried couples in terms of verbal and physical aggression. Recently, on reviewing the previous 17 years of empirical research revolving intimate relationships, it is estimated that 54% of women will experience at least one physical assault inflicted by an intimate partner during adulthood *(American Journal of Drug and Alcohol Abuse).* The magnitude of this statistic may be difficult for some to grasp.

IPV perpetrators come from all lifestyles. They can be doctors or lawyers as well as workers in factories or stores. They come from all racial groups. They can be drunk or sober. Most abusers have no mental illness. In addition, most people who were abused as children grow up to become warm and loving adults. When people use violence in the family, it is because they think it will help them to get something they want. Some abusers use violence because they do not know how to get what they want in any other way. The most common cause of family violence is the desire to control others.

The effects of domestic violence are far-reaching, affecting not only families but also communities, institutions, and societies a whole. It adversely affects the criminal justice system, social services, the legal system, the educational system, and the workplace. Too often, we hear that some husband has massacred his wife and children and then killed himself, with the details vividly broadcast in national headlines and news clips. One outcome of such media coverage is the marginalization of the perpetrators: These men are portrayed as unusual, psychotic, and deranged. They are depicted as different from us. We like to believe that the unusual origins of their psychosis explain how they could perform such violent acts. These events appear to be random floating blocks of ice, rather than the tip of the iceberg. Also, the fact of what happened—the ultimate violence against a woman and her children—gets lost in the spectacle of the homicide/suicide. The daily violence against women—the slappings and beatings, controlling behaviors, streams of

verbal abuse, and denigration—seem disconnected from these juicy media stories. And we do not make the connection *(Journal of Family Practice)*.

Violence against females is considered a major health and human rights issue. In 1993, the United Nations General Assembly adopted a declaration on the elimination of violence against women. Yet, although family violence has been recognized as a public health problem for almost a decade, the research on family violence has produced results that are difficult to integrate either conceptually or empirically.

Multiple factors may account for the connection between poverty and intimate partner violence. Just as child abuse, elder abuse, and other forms of family violence are more common among those who are poor, so, too is wife abuse. When resources are scarce due to poverty, the stressors that our families face may be compounded. The family with the exception of the military in times of war and the police is society's most violent social institution. Some structural factors that may account for the frequency of violence within families include the greater amount of the time spent interacting with family members compared with others, the intensity of involvement with the family members, and the privacy accorded families, which lessens social control. Furthermore, the family is constantly undergoing changes and transitions, which may increase tensions. Although all families may face stress, the lower level of resources among those who are poor may make them more vulnerable to its effects. Moreover, poor women may have few options that would enable them to escape an abusive relationship *(American Journal of Community Psychology)*.

However, evidence indicates that some abuse is deliberately intended to prevent women from becoming economically self-sufficient. About 47% of abused women in a welfare-to-work program reported that their intimate partner tried to prevent them from obtaining education and training. Both abused and non-abused in this sample where discouraged from working by their partners, but women with abusive partners face active interference. Among women in three urban women's shelters, 46% of the male partners forbade women from getting job and 25% forbade them from going to school. Of those who worked and went to school anyway, 85% missed worked because of abuse and 56% missed school because of abuse; 52% where fired or quit because of abuse. Eight percent of randomly selected women in a low-income neighborhood in Chicago reported that their boyfriend or husband prevented them from going to school or work in the last 12 months. Psychological symptoms associated with abuse victimizations, such as depression, insomnia, nightmares, and flashbacks may interfere with employment or education *(Centers for Disease Control)*.

Domestic violence and emotional abuse is characterized by physically and/or psychologically dominating behaviors used by a perpetrator to control the victim. Partners may be married or unmarried; heterosexual, or homosexual; living together, separated or dating. Domestic violence occurs in all cultures; people of all races,

ethnicities, religions, sexes and classes can be perpetrators of domestic violence. Domestic violence is also known as domestic abuse, spousal abuse, or intimate partner violence. Domestic violence is perpetrated by both men and women. Domestic abuse is any form of abuse that occurs between and among persons related by affection, kinship, or trust. It can occur with youth, adults or elders of all ages and walks of life. The perpetrator often will use fear and intimidation as a method of control. The perpetrator may also threaten to use or may actually use physical violence. Domestic abuse that includes physical violence is called domestic violence. Domestic abuse is intentionally trying to control another person. The abuser intentionally uses verbal, nonverbal, or physical methods to gain control over the other person. Domestic abuse includes:

- Physical abuse
- Sexual abuse or sexual assault
- Verbal abuse
- Emotional Abuse
- Financial abuse
- Neglect
- Ritual abuse
- Spiritual abuse
- Criminal harassment
- Stalking, and Cyber stalking

There are many considerations in evaluating abuse including:

- *Mode*: physical, psychological, sexual and/or social.
- *Frequency:* on/off, occasional and chronic.
- *Severity:* in terms of both psychological or physical harm and the need for treatment.
- *Transitory or permanent injury:* mild, moderate, severe and up to homicide.

An area of the domestic violence field that is often overlooked is passive abuse leading to violence. Passive abuse is covert, subtle and veiled. This includes victimization, procrastination, forgetfulness, ambiguity, neglect, spiritual and intellectual abuse.

Increased recognition of domestic violence began during the women's movement. Awareness regarding domestic violence varies among different countries. Only about a third of cases of domestic violence are actually reported in the United States and the United Kingdom. According to the Centers for Disease Control, domestic violence is a serious, preventable public health problem affecting more than 32 million Americans, or more than 10% of the U.S. population.

There is increasing awareness and advocacy for men victimized by women. In a report on violence related injuries by the US Department of justice hospital emergency room visits related to domestic violence revealed that physically abused men represent just under one-sixth of the total patients admitted to hospital reporting domestic violence as the cause of their injuries. The report reveals that significantly more men than women did not disclose the identity of their attacker. This is likely due to shame, stigma, and embarrassment associated with men victimized by women.

According to a *Centers for Disease Control Report*, data from the *Bureau of Justice, National Crime Victimization Survey* consistently show that women are at significantly greater risk of intimate partner violence than are men. In May, 2007, researchers with the Centers for Disease Control reported on rates of self-reported violence among intimate partners using data from a 2001 study. In the study, almost one-quarter of participants reported some violence in their relationships. Half of these involved one-sided ("non-reciprocal") attacks and half involved both assaults and counter assaults ("reciprocal violence"). Women reported committing one-sided attacks more than twice as often as men (70% *versus* 29%). In all cases of intimate partner violence, women were more likely to be injured than men, but 25% of men in relationships with two-sided violence reported injury compared to 20% of women reporting injury in relationships with one-sided violence. Women were more likely to be injured in non-reciprocal violence

Physical Abuse

As mentioned earlier, physical abuse is characterized by aggressive behavior that may result in the victim sustaining injury. The abuse is rarely a single incident and typically forms identifiable patterns that may repeat more and more quickly, and which may become increasingly violent.

Additional forms of physical abuse can include:

- assault with a weapon
- biting, pinching
- burning
- choking
- kicking, pushing, throwing or shaking
- slapping, hitting, tripping, grabbing or punching
- tying down or otherwise restraining or confining
- homicide

Financial/Economic Abuse

Financial abuse occurs when one individual attempts to take total or partial control of another's finances, inheritance or employment income. It may include denying access to

one's own financial records and knowledge about personal investments, income or debt, or preventing a partner from engaging in activities that would lead to financial independence.

Financial or economic abuse includes:

- withholding economic resources such as money or credit cards
- stealing from or defrauding a partner of money or assets
- exploiting the partner's resources for personal gain
- withholding physical resources such as food, clothes, necessary medications, or shelter from a partner
- preventing a partner from working or choosing an occupation

Ritual Abuse

Ritual abuse is defined as a combination of severe physical, sexual, psychological and spiritual abuses used systematically and in combination with symbols, ceremonies and/or group activities that have a religious, magical or supernatural connotation. Victims are terrorized into silence by repetitive torture and abuse over time and indoctrinated into the beliefs and practices of the cult or group. Ritual abuse may also be linked to Satanism or devil worship.

Spiritual Abuse

Spiritual abuse may include:

- using the partner's religious or spiritual beliefs to manipulate them
- preventing the partner from practicing their religious or spiritual beliefs
- ridiculing the other person's religious or spiritual beliefs
- forcing the children to be reared in a faith that the partner has not agreed to

Spiritual and religious abuse is also abuse done in the name of, brought on by, or attributed to a belief system of the abuser, or abuse from a religious leader. This can include Priests, Ministers, cult members, family members, or anyone abusing in the name of a deity or perceived deity. Spiritual or religious abuse can find its way into every religion and belief system that exists. It may encompass many other forms of abuse, especially physical, sexual, emotional, psychological and financial (Warshaw, C., "Limitations of the Medical Model in the Care of Battered Women". in Bart, P., E. Moran. *Violence Against Women: The Bloody Footprints*. Sage).

Harassment, Stalking and Cyberstalking

Stalking is harassment of or threatening another person, especially in a manner that physically or emotionally disturbs them. Stalking of an intimate partner can take place during the relationship, with intense monitoring of the partner's activities, or it can take

place after a partner or spouse has left the relationship. The stalker may be trying to get their partner back, or they may wish to harm their partner as punishment for their departure. Regardless of the motive, the victim fears for their safety. Stalking may occur at or near the victim's home, near or in their workplace, on the way to any destination, or on the internet (cyberstalking). Stalking can be on the phone, in person, or online. Stalkers sometimes do not reveal themselves, or they may just “show up” unexpectedly. Stalking is often unpredictable and dangerous.

In the past decade, stalking victimization has received greater recognition as a problem affecting both women and men in the United States. Much of what we have learned about stalking is based on studies of intimate partner violence and special populations, such as college students (Fisher, et al.). In recent years, technological advances have dramatically increased the options available for communication between people. Less is known about the extent to which newer technologies (e.g., text messages, emails, instant messages) have been used for stalking and harassment of others. Further, there are few recent national level estimates of stalking victimization (*The National Intimate Partner and Sexual Violence Survey | Summary Report*).

Stalkers may utilize threatening tactics including:

- Unwanted phone calls, voice or text messages, hang-ups
- Unwanted emails, instant messages, messages through social media
- Unwanted cards, letters, flowers, or presents
- Watching or following from a distance, spying with a listening device, camera, or global positioning system (GPS)
- Approaching or showing up in places such as the victim’s home, workplace, or school when it was unwanted
- Leaving strange or potentially threatening items for the victim to find
- Sneaking into victims’ home or car and doing things to scare the victim or let the victim know the perpetrator had been there
- “showing up” wherever the victim is located
- monitoring the victim's phone calls
- monitoring the victim’s mail or internet use
- sifting through the victim's garbage
- contacting the victim's friends, family, co-workers, or neighbors to obtain information about the victim
- damaging the victim's property
- threatening to hurt the victim or the victim’s family, friends or pets

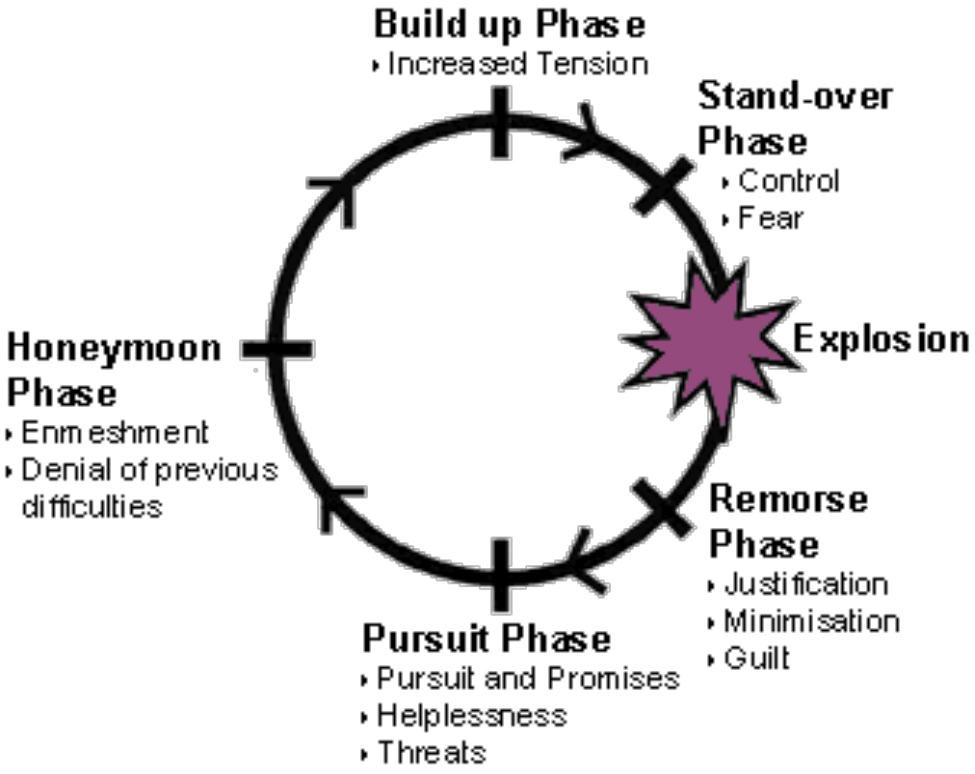
Cyberstalking is defined as utilizing the internet with the intention to harass and/or stalk another person. Cyberstalking is deliberate and persistent in nature. It may be an additional form of harassment, or the only method the perpetrator employs. The cyber stalker’s communication may be disturbing and inappropriate. Often, the more the victim

protests or responds, the more rewarding the cyberstalker experiences the stalking. The best way to respond to a cyberstalker is not to respond. Cyberstalking may graduate to physical stalking, aggression, and violence.

Battering relationships are often characterized by cyclical phases, sometimes referred to as *The Cycle of Violence*. A period of peace and calm is followed by escalating tension. A woman might feel as though she were walking on eggshells. Minor incidents may occur that the woman tries to minimize or deny, sometimes by taking the blame.

When the tension becomes unmanageable, aggression occurs. The victim may be kicked, thrown against a wall, raped, threatened at gun or knife point, slapped, punched or subjected to any of the endless mental and physical abuses that batterers use to intimidate and control their partners.

This then leads to *the honeymoon phase* where the relationship appears to be stable, the abusive incident is forgotten, and there is no active abuse. Of course, the abuse process remains unresolved and it is only a matter of time until tension develops, which leads to another explosion of violence, and the cycle continues.



Following the battering incident, the batterer is often remorseful and very loving. This is called the "honeymoon" phase. Because of the closeness the couple experiences during this phase and the promises the batterer makes, often the woman foregoes any plans to leave. She convinces herself that it will never happen again. Then the cycle repeats itself. However not everyone's experiences are the same. Sometimes a 'phase' does not occur, or two or more 'phases' can occur simultaneously.

The *build up phase* is characterized by mounting tension. In a non-violent relationship, these tensions may often be resolved. In a violent relationship, the build up phase usually leads to a *stand-over phase*, in which the perpetrator uses their strength and belief system including their 'right' to dominate, in order to control and put down the victim. This then leads to the *explosion phase* when violence occurs.

The perpetrator may then enter the *remorse phase* where feelings of shame are experienced, or they may fear the consequences. The perpetrator may also attempt to justify or minimize their actions such as claiming that "she made me do it", or "it was only a little slap". This may consequently lead to the *pursuit phase* where the perpetrator may try to win back their victim with honeymoon behavior including gifts and promises. The perpetrator may also behave helplessly such as claiming "I can't live without you", or "I'll kill myself". If these strategies are ineffective, the perpetrator may graduate to more and greater threats of violence.

The Power and Control Wheel illustrates the specific areas in which power and control are used in abusive relationships.

Conversely, the cycle of *Fairness and Equality* is characterized by negotiation and fairness, non-threatening behavior, respect, trust and support, honesty and accountability, responsible parenting, shared responsibility, and economic partnership.

2. Statistics

The Centers for Disease Control and Prevention's (CDC) National Intimate Partner and Sexual Violence Survey (NISVS) 2010 Summary Report presents the first year of NISVS data on the national prevalence of intimate partner violence (IPV), sexual violence (SV), and stalking among women and men in the United States. The 2010 survey is the first year of the survey and provides baseline data that will be used to track IPV, SV, and stalking trends.

IPV, SV, and stalking are widespread in the United States. The findings in the 2010 survey underscore the pervasiveness of this violence, the immediate impacts of victimization, and the lifelong health consequences. Women are disproportionately impacted. They experienced high rates of severe IPV, rape, and stalking, and long-term chronic disease and other negative health impacts, such as post-traumatic stress disorder symptoms *(CDC).*

Women are disproportionately affected by IPV, SV, and stalking.

- Nearly 1 in 5 women (18%) and 1 in 71 men (1%) have been raped in their lifetime.
- Approximately 1.3 million women were raped during the year preceding the survey.
- 1 in 4 women have been the victim of severe physical violence by an intimate partner, while 1 in 7 men have experienced the same.
- 1 in 6 women (16%) have been stalked during their lifetime, compared to 1 in 19 men (5%).

IPV, SV, and stalking victims experience short- and long-term chronic disease and other health impacts.

- Eighty-one percent of women who experienced rape, stalking, or physical violence by an intimate partner reported significant short- or long-term impacts, such as post-traumatic stress disorder symptoms and injury. Thirty-five percent of men report such impacts of their experiences.
- Women who experienced rape or stalking by any perpetrator or physical violence by an intimate partner in their lifetime were more likely than women who did not experience these forms of violence to report having asthma, diabetes, and irritable bowel syndrome.
- Men and women who experienced these forms of violence were more likely to report frequent headaches, chronic pain, difficulty with sleeping, activity limitations, poor physical health, and poor mental health than men and women who did not experience these forms of violence.

Female victims of IPV experience different patterns of violence than male victims.

- Female victims experienced multiple forms of these types of violence; male victims most often experienced physical violence.

The majority of this victimization starts early in life.

- Most female victims of completed rape (80%) experienced their first rape before the age of 25 and almost half (42%) experienced their first rape before age 18 (30% between 11 and 17 years old and 12% at or before the age of 10).
- About 35% of women who were raped as minors also were raped as adults compared to 14% of women without an early rape history.

- More than a quarter of male victims of completed rape (28%) were first raped when they were 10 years old or younger.

Impact of Violence by an Intimate Partner

- Nearly 3 in 10 women and 1 in 10 men in the United States have experienced rape, physical violence, and/or stalking by an intimate partner and reported at least one impact related to experiencing these or other forms of violent behavior in the relationship (e.g., being fearful, concerned for safety, post traumatic stress disorder (PTSD) symptoms, need for health care, injury, contacting a crisis hotline, need for housing services, need for victim's advocate services, need for legal services, missed at least one day of work or school).

Number and Sex of Perpetrators

- Across all types of violence, the majority of both female and male victims reported experiencing violence from one perpetrator.
- Across all types of violence, the majority of female victims reported that their perpetrators were male.
- Male rape victims and male victims of non-contact unwanted sexual experiences reported predominantly male perpetrators. Nearly half of stalking victimizations against males were also perpetrated by males. Perpetrators of other forms of violence against males were mostly female.

Health Consequences

- Men and women who experienced rape or stalking by any perpetrator or physical violence by an intimate partner in their lifetime were more likely to report frequent headaches, chronic pain, difficulty with sleeping, activity limitations, poor physical health and poor mental health than men and women who did not experience these forms of violence. Women who had experienced these forms of violence were also more likely to report having asthma, irritable bowel syndrome, and diabetes than women who did not experience these forms of violence.

Rape Victimization as a Minor and Subsequent Rape Victimization

More than one-third (35.2%) of the women who reported a completed rape before the age of 18 also experienced a completed rape as an adult, compared to 14.2% of the women who did not report being raped prior to age 18 (Figure 2.3). Thus, the percentage of women who were raped as children or adolescents and also raped as adults was more than two times higher than the percentage among women without an early rape history. Too few men reported rape victimization in adulthood to examine rape victimization as a minor and subsequent rape victimization in adulthood.

The majority of both female and male victims of rape knew their perpetrators. More than half of female victims of rape (51.1%) reported that at least one perpetrator was a current or former intimate partner. Four out of 10 of female victims (40.8%) reported being raped by an acquaintance. Approximately 1 in 8 female victims (12.5%) reported being raped by a family member, and 2.5% by a person in a position of authority. About 1 in 7 female

victims (13.8%) reported being raped by a stranger. In terms of lifetime alcohol/drug-facilitated rape, half of female victims (50.4%) were raped by an acquaintance, while 43.0% were raped by an intimate partner.

Prevalence of Stalking Victimization

Approximately 1 in 6 women (16.2%) in the United States has experienced stalking at some point in her lifetime in which she felt very fearful or believed that she or someone close to her would be harmed or killed as a result. This translates to approximately 19.3 million adult women in the United States. About 4%, or approximately 5.2 million women, were stalked in the 12 months prior to taking the survey. Approximately 1 in 19 men (5.2%) in the United States (approximately 5.9 million) has experienced stalking victimization at some point during his lifetime in which he felt very fearful or believed that he or someone close to him would be harmed or killed as a result, and 1.3% of men (about 1.4 million) reported being stalked in the 12 months prior to taking the survey.

Prevalence of Stalking Victimization by Race/Ethnicity

In the United States, approximately 1 in 5 Black non-Hispanic women experienced stalking in her lifetime (Table 3.2). The prevalence of stalking for White non-Hispanic and Hispanic women was similar (1 in 6 and 1 in 7, respectively). Additionally, approximately 1 in 3 multiracial non-Hispanic and 1 in 4 American Indian or Alaska Native women reported being stalked at some point during their lives.
Approximately 1 in 17 Black non-Hispanic men in the United States experienced stalking in their lifetime (Table 3.3). The prevalence of stalking for White non-Hispanic and Hispanic men was similar (about 1 in 20). The estimates for the other racial/ethnic groups of men were based upon numbers too small to produce a reliable estimate and therefore are not reported.

Tactics Used in Lifetime Reports of Stalking Victimization

A variety of tactics were used to stalk victims. More than three-quarters of female stalking victims (78.8%) reported receiving unwanted phone calls, including voice or text messages, or hang ups (Figure 3.1). More than half of female victims (57.6%) reported being approached, such as at their home or work, and more than one-third (38.6%) were watched, followed or tracked with a listening or other device.

Similarly, about three-quarters of male victims (75.9%) reported receiving unwanted phone calls, voice or text messages, or hang ups (Figure 3.2). Just under half (43.5%) reported being approached by the perpetrator. Nearly one-third of male victims (31.0%) reported being watched, followed, or tracked.

Type of Perpetrator in Lifetime Reports of Stalking Victimization

For both female and male victims, stalking was often committed by people they knew or with whom they had a relationship. Two-thirds of the female victims of stalking (66.2%) reported stalking by a current or former intimate partner and nearly one-quarter (24.0%) reported stalking by an acquaintance (Figure 3.3). About 1 in 8 female victims (13.2%) reported stalking by a stranger.

Approximately 4 out of 10 male stalking victims (41.4%) reported that they had been stalked by an intimate partner in their lifetime, with a similar proportion indicating that they had been stalked by an acquaintance (40.0%) (Figure 3.4). Nearly one-fifth of male victims (19.0%) reported stalking by a stranger and 5.3% reported being stalked by a family member.

Sex of Perpetrator in Lifetime Reports of Stalking Victimization

Among female stalking victims, 82.5% reported being stalked by only male perpetrators in their lifetime; 8.8% reported only female perpetrators; and 4.6% reported having been stalked by both male and female perpetrators (data not shown).
Among male stalking victims, almost half (44.3%) reported being stalked by only male perpetrators while a similar proportion (46.7%) reported being stalked by only female perpetrators. About 1 in 18 male stalking victims (5.5%) reported having been stalked by both male and female perpetrators in his life (data not shown).

Opportunities for Prevention and Action

Lifetime and one-year estimates for IPV, SV, and stalking are alarmingly high for adult Americans, with IPV alone affecting more than 12 million people each year. Collective action is needed to implement prevention approaches and ensure appropriate responses. It is important for all sectors of society, including individuals, families, and communities, to work together to end IPV, SV, and stalking. Opportunities for prevention and intervention include:

- Promote healthy, respectful relationships in families by fostering healthy parent-child relationships and developing positive family dynamics and emotionally supportive environments.
- Provide coordinated services for survivors of IPV, SV, and stalking to ensure healing and prevent recurrence of victimization.
- Hold perpetrators responsible by enforcing laws adequately and consistently.
- Implement strong data systems for the monitoring and evaluation of IPV, SV, and stalking to help understand trends in these problems, provide information on which to base development and evaluation of prevention and intervention programs, and monitor and measure the effectiveness of these efforts.

Prevalence of Sexual Violence Victimization

Rape

Nearly 1 in 5 women in the United States has been raped in her lifetime (18.3%) (Table 2.1). This translates to almost 22 million women in the United States. The most common form of rape victimization experienced by women was completed forced penetration, experienced by 12.3% of women in the United States. About 5% of women (5.2%) experienced attempted forced penetration, and 8.0% experienced alcohol/drug-facilitated completed forced penetration. One percent, or approximately 1.3 million women, reported some type of rape victimization in the 12 months prior to taking the survey.

Table 7.1a
Lifetime Prevalence of Rape by Any Perpetrator by State of Residence—U.S. Women

State	Weighted %	(95% C.I.)	Estimated Number of Victims[1]	(95% C.I.)[1]
United States Total	18.3	(17.2–19.5)	21,840,000	(20,346,000-23,334,000)
Alabama	17.1	(11.8–24.1)	321,000	(205,000-436,000)
Alaska	29.2	(21.3–38.6)	72,000	(49,000-96,000)
Arizona	18.0	(11.3–27.5)	441,000	(228,000-653,000)
Arkansas	20.4	(14.4–28.0)	230,000	(150,000-310,000)
California	14.6	(11.4–18.6)	2,024,000	(1,518,000-2,531,000)
Colorado	23.8	(16.8–32.6)	451,000	(286,000-616,000)
Connecticut	22.1	(14.8–31.5)	310,000	(183,000-437,000)
Delaware	14.2	(8.4–23.1)	50,000	(27,000-74,000)
District of Columbia	*	*	*	*
Florida	17.0	(12.3–23.1)	1,266,000	(860,000-1,672,000)
Georgia	17.6	(12.4–24.3)	655,000	(428,000-882,000)
Hawaii	*	*	*	*
Idaho	18.6	(12.9–26.1)	105,000	(66,000-144,000)

Illinois	18.6	(12.4–27.0)	930,000	(537,000-1,323,000)
Indiana	20.4	(14.7–27.5)	505,000	(336,000-674,000)
Iowa	16.9	(11.4–24.3)	198,000	(118,000-279,000)
Kansas	15.6	(9.5–24.6)	168,000	(82,000-254,000)
Kentucky	20.3	(14.4–27.8)	345,000	(223,000-467,000)
Louisiana	15.9	(10.1–24.1)	280,000	(153,000-406,000)
Maine	17.3	(11.9–24.5)	94,000	(61,000-126,000)
Maryland	20.5	(14.0–29.0)	466,000	(285,000-648,000)
Massachusetts	15.1	(9.2–23.8)	406,000	(201,000-612,000)
Michigan	25.6	(17.3–36.2)	1,005,000	(564,000-1,446,000)
Minnesota	22.2	(15.7–30.5)	452,000	(285,000-618,000)
Mississippi	*	*	*	*
Missouri	17.5	(11.5–25.6)	413,000	(235,000-591,000)
Montana	18.5	(12.5–26.5)	70,000	(43,000-98,000)
Nebraska	18.8	(13.2–26.1)	129,000	(84,000-174,000)
Nevada	26.1	(18.5–35.5)	252,000	(158,000-347,000)
New Hampshire	23.5	(15.4–34.2)	125,000	(66,000-183,000)
New Jersey	*	*	*	*
New Mexico	19.5	(13.2–28.0)	149,000	(88,000-211,000)
New York	17.7	(12.5–24.5)	1,398,000	(896,000-1,900,000)
North Carolina	21.6	(15.4–29.4)	794,000	(506,000-1,081,000)
North Dakota	19.3	(12.1–29.3)	48,000	(25,000-72,000)
Ohio	16.2	(10.9–23.4)	743,000	(456,000-1,030,000)
Oklahoma	24.9	(17.0–34.8)	353,000	(206,000-500,000)
Oregon	27.2	(20.0–36.0)	409,000	(268,000-550,000)
Pennsylvania	18.8	(13.1–26.1)	960,000	(603,000-1,316,000)
Rhode Island	14.8	(8.8–23.7)	64,000	(30,000-97,000)
South Carolina	15.0	(9.7–22.6)	273,000	(155,000-390,000)

South Dakota	*	*	*	*
Tennessee	13.6	(8.9–20.4)	340,000	(192,000-487,000)
Texas	21.7	(16.8–27.6)	1,963,000	(1,450,000-2,476,000)
Utah	18.1	(12.4–25.6)	174,000	(105,000-243,000)
Vermont	15.4	(9.9–23.1)	39,000	(22,000-56,000)
Virginia	11.4	(7.4–17.2)	354,000	(203,000-505,000)
Washington	23.7	(17.0–31.9)	608,000	(391,000-826,000)
West Virginia	18.9	(13.1–26.4)	139,000	(90,000-189,000)
Wisconsin	17.7	(12.4–24.6)	390,000	(252,000-528,000)
Wyoming	22.2	(14.2–33.1)	45,000	(24,000-67,000)

[1] Rounded to the nearest thousand.

Table 7.4
Lifetime Prevalence of Rape, Physical Violence, and/or Stalking by an Intimate Partner by State of Residence—U.S. Women

State	Weighted %	(95% C.I.)	Estimated Number of Victims[1]	(95% C.I.)[1]
United States Total	35.6	(34.1-37.1)	42,420,000	(40,310,000-44,529,000)
Alabama	31.0	(23.6-39.6)	582,000	(428,000-735,000)
Alaska	44.2	(34.9-53.9)	109,000	(81,000-137,000)
Arizona	36.5	(27.5-46.5)	891,000	(611,000-1,170,000)
Arkansas	37.3	(29.2-46.1)	420,000	(311,000-529,000)
California	32.9	(27.9-38.4)	4,563,000	(3,751,000-5,375,000)
Colorado	32.7	(24.8-41.6)	618,000	(439,000-797,000)
Connecticut	32.9	(24.4-42.7)	462,000	(317,000-607,000)
Delaware	34.9	(23.6-48.1)	124,000	(85,000-162,000)
District of Columbia	*	*	*	*

Florida	34.2	(27.1-42.2)	2,546,000	(1,878,000-3,214,000)
Georgia	35.1	(27.5-43.5)	1,310,000	(970,000-1,649,000)
Hawaii	35.7	(24.2-49.1)	179,000	(106,000-252,000)
Idaho	29.3	(22.3-37.4)	166,000	(122,000-209,000)
Illinois	37.7	(28.5-47.8)	1,882,000	(1,250,000-2,514,000)
Indiana	40.4	(32.7-48.5)	1,001,000	(771,000-1,232,000)
Iowa	31.3	(23.8-40.0)	368,000	(254,000-482,000)
Kansas	29.0	(20.3-39.6)	312,000	(187,000-437,000)
Kentucky	37.5	(29.9-45.8)	638,000	(482,000-794,000)
Louisiana	33.4	(24.9-43.0)	586,000	(408,000-765,000)
Maine	36.6	(26.5-48.1)	199,000	(120,000-277,000)
Maryland	42.1	(33.1-51.6)	957,000	(715,000-1,199,000)
Massachusetts	31.7	(23.2-41.5)	851,000	(565,000-1,138,000)
Michigan	41.8	(32.6-51.6)	1,638,000	(1,160,000-2,116,000)
Minnesota	33.7	(25.6-42.8)	684,000	(465,000-903,000)
Mississippi	40.1	(30.5-50.6)	460,000	(325,000-595,000)
Missouri	36.1	(28.0-45.1)	854,000	(618,000-1,089,000)
Montana	39.2	(30.7-48.4)	149,000	(111,000-187,000)
Nebraska	38.5	(30.3-47.4)	263,000	(197,000-330,000)
Nevada	48.1	(38.9-57.5)	465,000	(351,000-579,000)
New Hampshire	40.4	(30.8-50.7)	214,000	(143,000-286,000)
New Jersey	26.2	(18.0-36.5)	902,000	(562,000-1,241,000)
New Mexico	34.4	(26.7-43.0)	263,000	(193,000-333,000)
New York	32.3	(25.3-40.2)	2,544,000	(1,855,000-3,232,000)
North Carolina	43.9	(36.3-51.8)	1,615,000	(1,251,000-1,978,000)
North Dakota	25.3	(17.3-35.3)	64,000	(38,000-89,000)
Ohio	35.6	(26.9-45.2)	1,629,000	(1,140,000-2,118,000)
Oklahoma	49.1	(39.8-58.5)	697,000	(519,000-874,000)

Oregon	37.3	(29.7-45.7)	561,000	(423,000-698,000)
Pennsylvania	37.7	(30.2-45.9)	1,927,000	(1,453,000-2,401,000)
Rhode Island	29.9	(21.4-40.1)	129,000	(83,000-175,000)
South Carolina	41.5	(31.7-52.1)	752,000	(504,000-1,000,000)
South Dakota	33.7	(22.2-47.5)	104,000	(51,000-158,000)
Tennessee	40.0	(31.9-48.6)	997,000	(745,000-1,249,000)
Texas	34.5	(28.4-41.1)	3,116,000	(2,471,000-3,761,000)
Utah	36.9	(29.1-45.4)	355,000	(255,000-455,000)
Vermont	33.6	(25.2-43.1)	85,000	(60,000-110,000)
Virginia	31.3	(23.7-40.1)	971,000	(679,000-1,262,000)
Washington	42.6	(34.7-50.9)	1,094,000	(828,000-1,359,000)
West Virginia	33.6	(25.7-42.6)	249,000	(183,000-314,000)
Wisconsin	32.4	(25.3-40.4)	714,000	(529,000-898,000)
Wyoming	35.8	(26.4-46.4)	73,000	(49,000-97,000)

[1] Rounded to the nearest thousand.

Approximately 1 in 71 men in the United States (1.4%) reported having been raped in his lifetime, which translates to almost 1.6 million men in the United States. Too few men reported rape in the 12 months prior to taking the survey to produce a reliable 12 month prevalence estimate.

Sexual Violence Other than Rape

Nearly 1 in 2 women (44.6%) and 1 in 5 men (22.2%) experienced sexual violence victimization other than rape at some point in their lives (Tables 2.1 and 2.2). This equates to more than 53 million women and more than 25 million men in the United States. Approximately 1 in 20 women (5.6%) and men (5.3%) experienced sexual violence victimization other than rape in the 12 months prior to taking the survey.

Table 7.1b
Lifetime Prevalence of Sexual Violence Other Than Rape by Any Perpetrator by State of Residence— U.S. Women

State	Weighted %	(95% C.I.)	Estimated Number of Victims[1]	(95% C.I.)[1]
United States Total	44.6	(43.1-46.2)	53,174,000	(50,947,000-55,400,000)
Alabama	39.3	(31.2-48.1)	737,000	(575,000-899,000)
Alaska	58.0	(48.1-67.2)	143,000	(111,000-175,000)
Arizona	43.6	(34.1-53.5)	1,064,000	(779,000-1,350,000)
Arkansas	42.2	(33.9-51.0)	475,000	(373,000-577,000)
California	40.7	(35.3-46.2)	5,634,000	(4,819,000-6,448,000)
Colorado	47.4	(38.4-56.5)	897,000	(674,000-1,120,000)
Connecticut	48.6	(38.8-58.5)	683,000	(504,000-862,000)
Delaware	34.9	(23.8-47.8)	123,000	(88,000-159,000)
District of Columbia	43.0	(26.4-61.4)	112,000	(57,000-167,000)
Florida	41.8	(34.4-49.7)	3,111,000	(2,451,000-3,771,000)
Georgia	46.4	(38.0-54.9)	1,731,000	(1,340,000-2,121,000)
Hawaii	41.9	(29.7-55.2)	210,000	(135,000-285,000)
Idaho	46.9	(38.0-56.0)	265,000	(197,000-333,000)
Illinois	50.6	(41.2-59.9)	2,526,000	(1,960,000-3,093,000)
Indiana	43.9	(36.1-52.0)	1,091,000	(852,000-1,329,000)
Iowa	33.1	(26.0-41.1)	389,000	(292,000-486,000)
Kansas	39.4	(29.9-49.8)	424,000	(285,000-562,000)
Kentucky	47.7	(39.5-56.1)	812,000	(638,000-986,000)
Louisiana	28.9	(21.3-38.0)	509,000	(353,000-664,000)
Maine	42.5	(33.2-52.5)	231,000	(185,000-277,000)

Maryland	54.9	(45.4-64.1)	1,248,000	(916,000-1,580,000)
Massachusetts	41.1	(32.1-50.7)	1,105,000	(817,000-1,392,000)
Michigan	45.2	(36.0-54.8)	1,773,000	(1,300,000-2,247,000)
Minnesota	48.4	(39.9-57.0)	982,000	(745,000-1,219,000)
Mississippi	33.8	(24.8-44.1)	387,000	(262,000-511,000)
Missouri	39.8	(31.2-48.9)	939,000	(683,000-1,194,000)
Montana	40.2	(31.6-49.4)	153,000	(115,000-190,000)
Nebraska	47.5	(38.5-56.6)	325,000	(240,000-410,000)
Nevada	48.0	(38.8-57.3)	463,000	(352,000-575,000)
New Hampshire	51.2	(41.6-60.7)	272,000	(201,000-342,000)
New Jersey	46.7	(35.9-57.7)	1,606,000	(1,121,000-2,091,000)
New Mexico	49.0	(40.3-57.7)	374,000	(292,000-457,000)
New York	48.2	(40.5-56.0)	3,798,000	(2,998,000-4,598,000)
North Carolina	51.0	(43.2-58.7)	1,875,000	(1,499,000-2,251,000)
North Dakota	30.6	(22.1-40.6)	77,000	(50,000-104,000)
Ohio	41.2	(32.2-50.7)	1,886,000	(1,402,000-2,369,000)
Oklahoma	48.0	(38.6-57.4)	680,000	(503,000-856,000)
Oregon	55.7	(47.2-63.9)	837,000	(666,000-1,008,000)
Pennsylvania	45.3	(37.4-53.4)	2,313,000	(1,827,000-2,798,000)
Rhode Island	34.9	(26.7-44.3)	151,000	(114,000-187,000)
South Carolina	45.9	(36.0-56.1)	831,000	(584,000-1,079,000)
South Dakota	38.7	(27.1-51.7)	120,000	(65,000-174,000)
Tennessee	44.4	(36.2-52.9)	1,108,000	(847,000-1,368,000)
Texas	46.5	(39.8-53.3)	4,201,000	(3,475,000-4,928,000)
Utah	47.8	(39.9-55.8)	459,000	(368,000-551,000)
Vermont	43.3	(33.7-53.4)	110,000	(78,000-142,000)
Virginia	42.0	(33.5-50.9)	1,302,000	(979,000-1,626,000)
Washington	53.2	(45.0-61.2)	1,367,000	(1,096,000-1,637,000)

West Virginia	35.9	(27.8-44.9)	265,000	(202,000-329,000)
Wisconsin	41.3	(33.6-49.6)	912,000	(711,000-1,112,000)
Wyoming	43.8	(33.5-54.6)	89,000	(61,000-117,000)

[1] Rounded to the nearest thousand.
* Estimate is not reported

Being Made to Penetrate Someone Else
Approximately 1 in 21 men (4.8%) reported having been made to penetrate someone else in his lifetime (Table 2.2). Too few women reported being made to penetrate someone else to produce a reliable estimate (Table 2.1).

Sexual Coercion
About 1 in 8 women (13%) reported experiencing sexual coercion in her lifetime, which translates to more than 15 million women in the United States (Table 2.1). Sexual coercion was reported by 2.0% of women in the 12 months prior to taking the survey. Six percent of men reported sexual coercion in their lifetimes (almost 7 million men), and 1.5% in the 12 months prior to taking the survey (Table 2.2). *Unwanted Sexual Contact*
More than one-quarter of women (27.2%) have experienced some form of unwanted sexual contact in their lifetime (Table 2.1). This equates to over 32 million women in the United States. The 12 month prevalence of unwanted sexual contact reported by women was 2.2%. Approximately 1 in 9 men (11.7%) reported experiencing unwanted sexual contact in his lifetime, which translates to an estimated 13 million men in the United States (Table 2.2). The 12 month prevalence of unwanted sexual contact reported by men was 2.3%.

Non-Contact Unwanted Sexual Experiences
Non-contact unwanted sexual experiences were the most common form of sexual violence experienced by both women and men (Tables 2.1 and 2.2). One-third of women (33.7%) experienced some type of non-contact unwanted sexual experience in their lifetime, and 1 in 33 women (3.0%) experienced this in the 12 months prior to taking the survey. This equates to 40 million women in the United States for the lifetime estimate and 3.5 million women in the last 12 months. Nearly 1 in 8 men (12.8%) reported non-contact unwanted sexual experiences in his lifetime, and 1 in 37 men (2.7%) experienced this type of sexual violence in the 12 months before taking the survey. These numbers translate to 14 million men in the United States who had these experiences in their lifetimes and 3 million men in the last 12 months.

Prevalence of Rape and Other Sexual Violence by Race/Ethnicity

Approximately 1 in 5 Black (22.0%) and White (18.8%) non-Hispanic women, and 1 in 7 Hispanic women (14.6%) in the United States have experienced rape at some point in their lives (Table 2.3). More than one-quarter of women (26.9%) who identified as

American Indian or as Alaska Native and 1 in 3 women (33.5%) who identified as multiracial non-Hispanic reported rape victimization in their lifetime (Table 2.3). Just under half of Black non-Hispanic (41.0%), White non-Hispanic (47.6%), and American Indian or Alaska Native (49.0%) women reported sexual violence other than rape in their lifetime and more than half of multiracial non-Hispanic women (58.0%) reported these experiences in their lifetime. Approximately 1 in 3 Hispanic (36.1%) and Asian or Pacific Islander (29.5%) women reported sexual violence other than rape. Between one-fifth and one-quarter of Black non-Hispanic (22.6%), White non-Hispanic (21.5%), Hispanic (26.2%), and American Indian or Alaska Native (20.1%) men experienced sexual violence other than rape in their lives (Table 2.4). About 1 in 6 Asian or Pacific Islander (15.7%) men and nearly one-third of multiracial (31.6%) men in the United States had these experiences during their lifetime. The only reportable estimate of rape was for White non-Hispanic men − 1.7% or an estimated 1.3 million men in this group reported being raped at some point in their lifetime. Four out of 10 of female victims (40.8%) reported being raped by an acquaintance. Approximately 1 in 8 female victims (12.5%) reported being raped by a family member, and 2.5% by a person in a position of authority. About 1 in 7 female victims (13.8%) reported being raped by a stranger. In terms of lifetime alcohol/drug-facilitated rape, half of female victims (50.4%) were raped by an acquaintance, while 43.0% were raped by an intimate partner.

Table 7.5
Lifetime Prevalence of Rape, Physical Violence, and/or Stalking[1] by an Intimate Partner by State of Residence—U.S. Men

State	Weighted %	(95% C.I.)	Estimated Number of Victims[2]	(95% C.I.)[2]
United States Total	28.5	(27.0-30.1)	32,280,000	(30,310,000-34,251,000)
Alabama	26.9	(17.5-39.1)	459,000	(242,000-677,000)
Alaska	25.0	(17.5-34.3)	67,000	(46,000-87,000)
Arizona	27.1	(19.0-37.1)	657,000	(418,000-896,000)
Arkansas	35.6	(26.8-45.5)	375,000	(258,000-491,000)
California	27.3	(22.4-32.9)	3,737,000	(2,966,000-4,509,000)
Colorado	28.6	(20.8-37.9)	545,000	(360,000-729,000)

Connecticut	33.9	(24.1-45.4)	442,000	(269,000-615,000)
Delaware	36.8	(23.9-51.9)	119,000	(58,000-180,000)
District of Columbia	24.4	(14.4-38.3)	55,000	(36,000-74,000)
Florida	24.6	(18.3-32.2)	1,731,000	(1,196,000-2,266,000)
Georgia	39.9	(28.6-52.3)	1,401,000	(806,000-1,996,000)
Hawaii	21.8	(13.5-33.3)	110,000	(62,000-157,000)
Idaho	33.3	(25.6-41.9)	187,000	(134,000-239,000)
Illinois	25.7	(18.5-34.4)	1,215,000	(808,000-1,623,000)
Indiana	26.8	(18.9-36.7)	631,000	(399,000-864,000)
Iowa	19.6	(13.5-27.5)	219,000	(140,000-298,000)
Kansas	23.0	(14.0-35.5)	239,000	(109,000-370,000)
Kentucky	31.0	(22.7-40.6)	495,000	(333,000-657,000)
Louisiana	28.4	(19.4-39.5)	457,000	(301,000-613,000)
Maine	26.7	(18.7-36.5)	135,000	(82,000-187,000)
Maryland	27.2	(19.8-36.0)	563,000	(384,000-742,000)
Massachusetts	19.2	(12.5-28.1)	474,000	(291,000-657,000)
Michigan	23.0	(15.8-32.2)	850,000	(532,000-1,168,000)
Minnesota	23.5	(15.7-33.7)	465,000	(258,000-672,000)
Mississippi	25.8	(16.4-38.3)	268,000	(134,000-403,000)
Missouri	40.4	(30.3-51.4)	886,000	(578,000-1,194,000)
Montana	32.6	(23.8-42.8)	122,000	(81,000-164,000)
Nebraska	26.1	(18.8-35.0)	172,000	(118,000-227,000)
Nevada	30.9	(22.9-40.1)	307,000	(220,000-394,000)
New Hampshire	37.8	(25.0-52.6)	191,000	(87,000-295,000)
New Jersey	29.3	(19.5-41.5)	944,000	(597,000-1,292,000)
New Mexico	29.1	(20.9-38.8)	214,000	(145,000-282,000)
New York	33.5	(26.2-41.7)	2,423,000	(1,764,000-3,083,000)

North Carolina	19.3	(13.6-26.6)	660,000	(430,000-890,000)
North Dakota	26.1	(17.4-37.2)	66,000	(39,000-92,000)
Ohio	30.0	(21.4-40.2)	1,274,000	(812,000-1,737,000)
Oklahoma	40.7	(31.3-50.9)	550,000	(382,000-718,000)
Oregon	33.6	(26.1-42.0)	487,000	(367,000-608,000)
Pennsylvania	27.5	(19.6-37.1)	1,298,000	(823,000-1,774,000)
Rhode Island	19.3	(12.6-28.5)	76,000	(44,000-109,000)
South Carolina	17.4	(11.0-26.5)	290,000	(153,000-427,000)
South Dakota	30.2	(21.0-41.4)	92,000	(55,000-129,000)
Tennessee	32.5	(24.4-41.8)	750,000	(523,000-977,000)
Texas	35.1	(28.5-42.3)	3,104,000	(2,407,000-3,802,000)
Utah	19.6	(14.2-26.4)	187,000	(126,000-248,000)
Vermont	*	*	*	*
Virginia	22.1	(15.5-30.4)	647,000	(409,000-885,000)
Washington	28.3	(21.0-37.0)	716,000	(480,000-951,000)
West Virginia	41.2	(31.8-51.3)	286,000	(200,000-373,000)
Wisconsin	23.0	(16.2-31.6)	492,000	(317,000-668,000)
Wyoming	35.8	(26.5-46.3)	75,000	(51,000-98,000)

[1]Most of the violence reported by men was physical violence; 2.1% of men, overall, experienced stalking by an intimate partner.
[2] Rounded to the nearest thousand.

Table 7.3
Lifetime Prevalence of Stalking Victimization by Any Perpetrator by State of Residence—U.S. Women

State	**Weighted %**	**(95% C.I.)**	**Estimated Number of Victims[2]**	**(95% C.I.)[2]**
United States Total	16.2	(15.1-17.4)	19,327,000	(17,916,000-20,738,000)
Alabama	24.1	(17.7-32.0)	452,000	(316,000-589,000)

Alaska	20.1	(13.5-28.8)	50,000	(29,000-70,000)
Arizona	14.9	(9.0-23.6)	364,000	(178,000-550,000)
Arkansas	18.6	(13.2-25.6)	210,000	(140,000-280,000)
California	14.0	(10.8-18.1)	1,943,000	(1,426,000-2,460,000)
Colorado	17.2	(11.2-25.4)	325,000	(182,000-468,000)
Connecticut	*	*	*	*
Delaware	*	*	*	*
District of Columbia	*	*	*	*
Florida	15.8	(11.0-22.2)	1,175,000	(742,000-1,608,000)
Georgia	14.8	(10.0-21.4)	554,000	(339,000-769,000)
Hawaii	*	*	*	*
Idaho	17.5	(11.9-25.1)	99,000	(60,000-138,000)
Illinois	13.8	(8.6-21.4)	691,000	(362,000-1,020,000)
Indiana	16.7	(11.6-23.3)	413,000	(264,000-563,000)
Iowa	17.3	(11.7-24.7)	203,000	(122,000-283,000)
Kansas	*	*	*	*
Kentucky	24.7	(18.2-32.6)	420,000	(285,000-555,000)
Louisiana	13.5	(8.5-20.7)	237,000	(128,000-345,000)
Maine	13.5	(8.8-20.2)	73,000	(44,000-103,000)
Maryland	15.5	(10.0-23.2)	352,000	(196,000-507,000)

Massachusetts	*	*	*	*
Michigan	18.2	(11.4-27.8)	715,000	(361,000-1,068,000)
Minnesota	18.4	(11.9-27.3)	373,000	(198,000-548,000)
Mississippi	20.1	(12.4-30.8)	230,000	(113,000-347,000)
Missouri	14.7	(9.9-21.2)	347,000	(214,000-481,000)
Montana	18.4	(12.0-27.1)	70,000	(39,000-101,000)
Nebraska	17.4	(12.1-24.5)	119,000	(76,000-162,000)
Nevada	24.4	(17.0-33.8)	236,000	(145,000-327,000)
New Hampshire	15.9	(10.3-23.7)	84,000	(48,000-121,000)
New Jersey	*	*	*	*
New Mexico	22.3	(15.6-30.9)	171,000	(105,000-236,000)
New York	13.9	(9.4-20.3)	1,099,000	(652,000-1,546,000)
North Carolina	21.3	(15.5-28.5)	784,000	(523,000-1,044,000)
North Dakota	*	*	*	*
Ohio	17.9	(11.4-26.9)	818,000	(432,000-1,203,000)
Oklahoma	22.3	(14.7-32.2)	315,000	(174,000-457,000)
Oregon	16.8	(11.9-23.2)	252,000	(166,000-338,000)
Pennsylvania	19.1	(13.4-26.5)	977,000	(620,000-1,335,000)
Rhode Island	13.5	(8.9-20.0)	58,000	(36,000-81,000)

South Carolina	19.0	(12.2-28.4)	345,000	(187,000-503,000)
South Dakota	*	*	*	*
Tennessee	20.0	(13.6-28.4)	498,000	(295,000-702,000)
Texas	15.6	(11.7-20.5)	1,407,000	(1,005,000-1,809,000)
Utah	21.1	(15.1-28.6)	203,000	(132,000-274,000)
Vermont	14.6	(9.1-22.6)	37,000	(20,000-55,000)
Virginia	11.3	(7.2-17.4)	352,000	(194,000-510,000)
Washington	17.0	(12.0-23.5)	437,000	(285,000-588,000)
West Virginia	14.7	(9.7-21.6)	108,000	(65,000-152,000)
Wisconsin	12.7	(8.3-18.9)	280,000	(162,000-398,000)
Wyoming	20.6	(12.6-31.8)	42,000	(20,000-64,000)

[1] State-level stalking estimates for men are not reported Rounded to the nearest thousand.
*Estimate is not reported.

Key Findings on Victimization by Sexual Orientation

Little is known about the national prevalence of intimate partner violence (IPV), sexual violence (SV), and stalking among lesbian, gay, and bisexual women and men in the United States. The Centers for Disease Control and Prevention's (CDC) National Intimate Partner and Sexual Violence Survey (NISVS): 2010 Findings on Victimization by Sexual Orientation is the first of its kind to present comparisons of victimization by sexual orientation for women and men.

The Sexual Orientation Report indicates that individuals who self-identify as lesbian, gay, and bisexual have an equal or higher prevalence of experiencing IPV, SV, and stalking as compared to self-identified heterosexuals. Bisexual women are disproportionally impacted. They experienced a significantly higher lifetime prevalence of rape, physical violence, and/or stalking by an intimate partner, and rape and SV (other than rape) by any perpetrator, when compared to both lesbian and heterosexual women.

Sexual minority respondents reported levels of intimate partner violence at rates equal to or higher than those of heterosexuals.

- Forty-four percent of lesbian women, 61% of bisexual women, and 35% of heterosexual women experienced rape, physical violence, and/or stalking by an intimate partner in their lifetime.
- Twenty-six percent of gay men, 37% of bisexual men, and 29% of heterosexual men experienced rape, physical violence, and/or stalking by an intimate partner at some point in their lifetime.
- Approximately 1 in 5 bisexual women (22%) and nearly 1 in 10 heterosexual women (9%) have been raped by an intimate partner in their lifetime.

Rates of some form of sexual violence were higher among lesbian women, gay men, and bisexual women and men compared to heterosexual women and men.

- Approximately 1 in 8 lesbian women (13%), nearly half of bisexual women (46%), and 1 in 6 heterosexual women (17%) have been raped in their lifetime. *This translates to an estimated 214,000 lesbian women, 1.5 million bisexual women, and 19 million heterosexual women.*
- Four in 10 gay men (40%), nearly half of bisexual men (47%), and 1 in 5 heterosexual men (21%) have experienced SV other than rape in their lifetime. *This translates into nearly 1.1 m*

3. Symptoms and Effects of Intimate Partner Violence

More than two decades of research has shown that sexual violence and intimate partner violence are major public health problems with serious long-term physical and mental health consequences, as well as significant social and public health costs. Elevated health risks have been observed in relation to multiple body systems, including the nervous, cardiovascular, gastrointestinal, genitourinary, reproductive, musculoskeletal, immune and endocrine systems. While less is known about the health impact of stalking, within the past decade stalking has been increasingly recognized as a significant public health issue. The few studies that have been conducted suggest that those who are stalked are more likely to report similar negative mental and physical health consequences.

In addition to the negative physical and mental health effects of sexual violence, intimate partner violence, and stalking, prior research has shown that experiencing these forms of violence during childhood and adolescence increases the likelihood of experiencing these forms of violence as an adult. Consequently, understanding sexual violence, intimate partner violence, and stalking experienced during childhood and adolescence is particularly important in order to prevent the reoccurrence of these forms of violence across the life course *(The National Intimate Partner and Sexual Violence Survey | Summary Report).*

Factors beyond whether a person has ever experienced intimate partner violence are important to measure and understand in order to achieve a more complete picture of the true burden of intimate partner violence. Evidence from several studies suggests a dose-response effect of violence; as the frequency and severity of violence increases, the impact of the violence on the health of victims also becomes increasingly severe.

However, given that intimate partner violence victimization can range from a single act experienced once to multiple acts, including acts of severe violence over the course of many years, it is difficult to represent the variation in severity experienced by victims in a straightforward manner. To this end, NISVS included a number of questions to assess a range of impacts that victims of intimate partner violence may have experienced. This information provides not only a measure of the severity of the violence experienced, but also documents the magnitude of negative impacts to better focus preventive services and response.

Impact was measured using a set of indicators that represent a range of direct impacts that may be experienced by victims of intimate partner violence. IPV-related impact was assessed in relation to specific perpetrators, without regard to the time period in which impact occurred, and asked in relation to the forms of intimate partner violence experienced (sexual violence, physical violence, stalking, expressive aggression, coercive control, and control of reproductive or sexual health) in that relationship.

Lifetime Prevalence of Rape, Physical Violence, and/or Stalking by an Intimate Partner with IPV-Related Impact — U.S.Women

	Weighted%	Estimated # of Victims
Any Reported IPV-Related Impact 2,3,4	28.8	34,273,000
Fearful	25.7	30,611,000
Concerned for safety	22.2	26,448,000
Any PTSD symptoms5	22.3	26,546,000
Injury	14.8	17,640,000
Needed medical care	7.9	9,362,000
Needed housing services	2.4	2,911,000
Needed victim’s advocate services	2.7	3,195,000
Needed legal services	7.6	8,998,000
Contacted a crisis hotline	2.1	2,496,000
Missed at least one day of work/school	10.0	11,887,000

Contracted a sexually transmitted disease[6]	1.5	1,804,000
Became pregnant[6]	1.7	2,053,000

Rounded to the nearest thousand.2 Includes experiencing any of the following: being fearful, concerned for safety, any PTSD symptoms, need for health care, injury, contacting a crisis hotline, need for housing services, need for victim's advocate services, need for legal services, missed at least one day of work or school. For those who reported being raped it also includes having contracted a sexually transmitted disease or having become pregnant. 3 IPV-related impact questions were assessed in relation to specific perpetrators, without regard to the time period in which they occurred, and asked in relation to any form of IPV experienced (sexual violence, physical violence, stalking, expressive aggression, coercive control, and control of reproductive or sexual health) in that relationship; 12-month prevalence of IPV-related impact was not assessed.4 By definition, all stalking incidents result in impact because the definition of stalking includes the impacts of fear and concern for safety.5 Includes: nightmares; tried not to think about or avoided being reminded of; felt constantly on guard, watchful, or easily startled; felt numb or detached.6 Asked only of those who reported rape by an intimate partner *(Source: The National Intimate Partner and Sexual Violence Survey | Summary Report)

Prevalence of Rape, Physical Violence, and/or Stalking with IPV-Related Impact Prevalence among Women

Nearly 3 in 10 women in the United States (28.8% or approximately 34.2 million) have experienced rape, physical violence, and/or stalking by an intimate partner and reported at least one measured impact related to experiencing these or other forms of violent behavior in that relationship (Table 5.1). Approximately one-quarter of women reported being fearful (25.7%), and more than 1 in 5 reported being concerned for their safety (22.2%), or reported at least one post-traumatic stress disorder (PTSD) symptom (22.3%) as a result of the violence experienced. More than 1 in 7 (14.8%) experienced an injury, while 1 in 10 (10.0%) missed at least one day of work or school as a result of these or other forms of intimate partner violence.

Table 5.1 Lifetime Prevalence of Rape, Physical Violence, and/or Stalking by an Intimate Partner With IPV-Related Impact — U.S.Women

	Weighted%	Estimated # of Victims
Any Reported IPV-Related Impact	28.8	34,273,000
Fearful	25.7	30,611,000
Concerned for safety	22.2	26,448,000
Any PTSD symptoms[5]	22.3	26,546,000
Injury	14.8	17,640,000
Needed medical care	7.9	9,362,000
Needed housing services	2.4	2,911,000

Needed victim's advocate services	2.7	3,195,000
Needed legal services	7.6	8,998,000
Contacted a crisis hotline	2.1	2,496,000
Missed at least one day of work/school	10.0	11,887,000
Contracted a sexually transmitted disease6	1.5	1,804,000
Became pregnant6	1.7	2,053,000

Includes experiencing any of the following: being fearful, concerned for safety, any PTSD symptoms, need for health care, injury, contacting a crisis hotline, need for housing services, need for victim's advocate services, need for legal services, missed at least one day of work or school. For those who reported being raped it also includes having contracted a sexually transmitted disease or having become pregnant. 3 IPV-related impact questions were assessed in relation to specific perpetrators, without regard to the time period in which they occurred, and asked in relation to any form of IPV experienced (sexual violence, physical violence, stalking, expressive aggression, coercive control, and control of reproductive or sexual health) in that relationship; 12-month prevalence of IPV-related impact was not assessed.4 By definition, all stalking incidents result in impact because the definition of stalking includes the impacts of fear and concern for safety.5 Includes: nightmares; tried not to think about or avoided being reminded of; felt constantly on guard, watchful, or easily startled; felt numb or detached.6 Asked only of those who reported rape by an intimate partner. *(Source: The National Intimate Partner and Sexual Violence Survey | Summary Report)

Prevalence of Rape, Physical Violence, and/or Stalking with IPV-Related Impact

Prevalence among Women

Nearly 3 in 10 women in the United States (28.8% or approximately 34.2 million) have experienced rape, physical violence, and/or stalking by an intimate partner and reported at least one measured impact related to experiencing these or other forms of violent behavior in that relationship (Table 5.1). Approximately one-quarter of women reported being fearful (25.7%), and more than 1 in 5 reported being concerned for their safety (22.2%), or reported at least one post-traumatic stress disorder (PTSD) symptom (22.3%) as a result of the violence experienced. More than 1 in 7 (14.8%) experienced an injury, while 1 in 10 (10.0%) missed at least one day of work or school as a result of these or other forms of intimate partner violence.

Table 5.2 Lifetime Prevalence of Rape, Physical Violence, and/or Stalking by an Intimate Partner With IPV-Related Impact — U.S.Men

	Weighted%	Estimated # of Victims
Any Reported IPV-Related Impact2,3,4	9.9	11,214,000

Fearful	5.2	5,925,000
Concerned for safety	4.5	5,080,000
Any PTSD symptoms[5]	4.7	5,304,000
Injury	4.0	4,489,000
Needed medical care	1.6	1,773,000
Needed housing services	0.4	489,000
Needed victim's advocate services	*	*
Needed legal services	3.1	3,477,000
Contacted a crisis hotline	*	*
Missed at least one day of work/school	3.9	4,397,000
Contracted a sexually transmitted disease	*	*

1 Rounded to the nearest thousand.
2 Includes experiencing any of the following: being fearful, concerned for safety, any PTSD symptoms, need for health care, injury, contacting a crisis hotline, need for housing services, need for victim's advocate services, need for legal services, missed at least one day of work or school. For those who reported being raped it also includes having contracted a sexually transmitted disease.
3 IPV-related impact questions were assessed in relation to specific perpetrators, without regard to the time period in which they occurred, and asked in relation to any form of IPV experienced (sexual violence, physical violence, stalking, expressive aggression, coercive control, and control of reproductive or sexual health) in that relationship; 12-month prevalence of IPV-related impact was not assessed.
4 By definition, all stalking incidents result in impact because the definition of stalking includes the impacts of fear and concern for safety.
5 Includes: nightmares; tried not to think about or avoided being reminded of; felt constantly on guard, watchful, or easily startled; felt numb or detached.
6 Asked only of those who reported rape by an intimate partner.
* Estimate is not reported; relative standard error >30% or cell size ≤ 20.
(*Source: The National Intimate Partner and Sexual Violence Survey | Summary Report)

Previous research suggests that victims of intimate partner and sexual violence make more visits to health providers over their lifetime, have more hospital stays, have longer duration of hospital stays, and are at risk of a wide range of physical, mental, reproductive, and other health consequences over their lifetime than non-victims). Many studies have documented increased risk for a number of adverse physical, mental, reproductive, and other health outcomes among those who have experienced intimate partner violence and sexual violence. A smaller body of research has also documented that stalking has a negative impact on health. Most studies that have evaluated the adverse health impact of intimate partner violence and sexual violence are based on female victims of such violence; less is known about the risk for adverse health events among men.

There may be a number of potential mechanisms by which violence is related to health over one's lifetime. For example, some health conditions may result directly from a physical injury. Other health conditions may result from the adoption of health-risk coping behaviors such as smoking and the harmful use of alcohol or drugs. Another explanation for the association between violence victimization and poor health is the harmful biologic response to chronic stress associated with experiences of violence.

Table 6.1 Prevalence of Physical and Mental Health Outcomes Among Those With and Without a History of Rape or Stalking by any Perpetrator or Physical Violence by an Intimate Partner — U.S.Women

	Weighted%		
Health Outcome	History	No History1	p value2
Asthma	23.7	14.3	<.001
Irritable Bowel Syndrome	12.4	6.9	<.001
Diabetes	12.6	10.2	<.001
High Blood Pressure	27.3	27.5	n.s.3
Frequent Headaches	28.7	16.5	<.001
Chronic Pain	29.8	16.5	<.001
Difficulty Sleeping	37.7	21.0	<.001
Activity Limitations	35.0	19.7	<.001
Poor Physical Health	6.4	2.4	<.001
Poor Mental Health	3.4	1.1	<.001

No history of rape, stalking, or intimate partner physical violence2 p-value determined using chi-square test of independence in SUDAAN™ 3 Non-significant difference. *****Source: The National Intimate Partner and Sexual Violence Survey | Summary Report

Prevalence of Physical and Mental Health Outcomes by Victimization History

Prevalence among Women

With the exception of high blood pressure, the prevalence of adverse mental and physical health outcomes was significantly higher among women with a history of rape or stalking by any perpetrator, or physical violence by an intimate partner, compared to women without a history of these forms of violence (Table 6.1). This includes a higher reported prevalence of asthma, irritable bowel syndrome, diabetes, frequent headaches, chronic pain, difficulty sleeping, and activity limitations. The percentage of women who considered their physical or mental health to be poor was almost three times higher among women with a history of violence compared to women who have not experienced these forms of violence. The observed differences in the prevalence of health outcomes were in most cases quite large. The largest differences in prevalence of health outcomes

between those with and without a violence history were observed for difficulty sleeping, activity limitations, chronic pain, and frequent headaches.

Prevalence among Men

Compared to men without a history of rape or stalking by any perpetrator, or physical violence by an intimate partner, men with such histories had significantly higher prevalence of frequent headaches, chronic pain, difficulty sleeping, activity limitations, and consider their physical and mental health to be poor (Table 6.2). There were no significant differences between the two groups of men in the prevalence of asthma, irritable bowel syndrome, diabetes, or high blood pressure.

Table 6.2 Prevalence of Physical and Mental Health Outcomes Among Those With and Without A History of Rape or Stalking by Any Perpetrator or Physical Violence by an Intimate Partner — U.S.Men

	Weighted%		
Health Outcome	History	No History1	p value2
Asthma	14.5	12.9	n.s.3
Irritable Bowel Syndrome	4.4	3.5	n.s.3
Diabetes	10.0	10.5	n.s.3
High Blood Pressure	30.1	29.3	n.s.3
Frequent Headaches	17.0	8.9	<.001
Chronic Pain	23.5	13.1	<.001
Difficulty Sleeping	33.0	18.4	<.001
Activity Limitations	29.7	17.9	<.001
Poor Physical Health	5.1	2.6	<.001
Poor Mental Health	2.7	1.2	<.01

1 No history of rape, stalking, or intimate partner physical violence
2 p-value determined using chi-square test of independence in SUDAAN™
3 Non-significant difference
*Source: The National Intimate Partner and Sexual Violence Survey | Summary Report

Intimate Partner Violence: Risk and Protective Factors

Risk factors are associated with a greater likelihood of intimate partner violence (IPV) victimization or perpetration. They are contributing factors and may or may not be direct causes. Not everyone who is identified as "at risk" becomes involved in violence.

Some risk factors for IPV victimization and perpetration are the same. In addition, some risk factors for victimization and perpetration are associated with one another; for example, childhood physical or sexual victimization is a risk factor for future IPV perpetration and victimization.

A combination of individual, relational, community, and societal factors contribute to the risk of becoming a victim or perpetrator of IPV. Understanding these multilevel factors can help identify various opportunities for prevention (Source: The National Intimate Partner and Sexual Violence Survey | Summary Report).

Risk Factors for Intimate Partner Violence

Individual Risk Factors

- Low self-esteem
- Low income
- Low academic achievement
- Young age
- Aggressive or delinquent behavior as a youth
- Heavy alcohol and drug use
- Depression
- Anger and hostility
- Antisocial personality traits
- Borderline personality traits
- Prior history of being physically abusive
- Having few friends and being isolated from other people
- Unemployment
- Emotional dependence and insecurity
- Belief in strict gender roles (e.g., male dominance and aggression in relationships)
- Desire for power and control in relationships
- Perpetrating psychological aggression
- Being a victim of physical or psychological abuse (consistently one of the strongest predictors of perpetration)
- History of experiencing poor parenting as a child
- History of experiencing physical discipline as a child

Relationship Factors

- Marital conflict-fights, tension, and other struggles
- Marital instability-divorces or separations

- Dominance and control of the relationship by one partner over the other
- Economic stress
- Unhealthy family relationships and interactions

Community Factors

- Poverty and associated factors (e.g., overcrowding)
- Low social capital-lack of institutions, relationships, and norms that shape a community's social interactions
- Weak community sanctions against IPV (e.g., unwillingness of neighbors to intervene in situations where they witness violence)

Societal Factors

- Traditional gender norms (e.g., women should stay at home, not enter workforce, and be submissive; men support the family and make the decisions)

Physical Abuse Indicators

The following lists indicators of possible physical abuse victimization:

- Bruises (often in multiple stages of healing), scrapes, minor cuts, fractures or sprains, Injuries to the head (particularly the back where hair will cover the injury), chest, neck, breasts and abdomen.
- Strangulation marks and effects.
- Sustained injuries during pregnancy.
- Repeated injuries or multiple injuries in multiple stages of healing.
- History of similar injuries.
-

IPV Warning Signs

- Vague and repeated complaints
- A Possessive and controlling partner
- An overtly attentive partner
- Repeated urinary infection
- Sexual complaints
- Irritable colon syndrome
- Depression
- Anxiety
- Repeated abortions
- Suicide attempts
- Substance abuse
- Attendance at prenatal care only after the first trimester

The Stress of Living with Ongoing Abuse May Cause:

- Imagined or real pain due to widely distributed trauma without physical evidence.
- Gynecologic problems, frequent vaginal or urinary tract infections, pelvic pain.
- Frequent use of prescribed tranquilizers or pain medications.
- Symptomology resulting from endured stress, PTSD, other anxiety disorders, or depression including: Fatigue, decreased concentration, chronic headaches, abdominal and gastrointestinal complaints, chest pain, palpitations, dizziness, numbness or tingling of extremities and difficulty breathing.

Behavioral Signs of Domestic Violence:

1. Perpetrator and/or victim denies and/or minimizes violence.
2. Victim is excessively apologetic.
3. Victim's self blame and an exaggerated sense of personal responsibility for the relationship,
4. Reluctance of victim to speak while in front of the perpetrator.
5. Perpetrator exhibits intense irrational jealousy.
6. Perpetrator constantly accompanies victim, insists on staying close, and/or answers questions on behalf of him/her.

Psychological Symptoms of Domestic Violence

1. Isolation and inability to cope.
2. Panic attacks and other anxiety symptoms.
3. Depression
4. Fearfulness
5. Suicide attempts or gestures.
6. Alcohol/drug abuse.
7. Post-traumatic stress reactions or disorder.
8. Insomnia
9. Anger
10. Shame

The Perpetrator's Attempts at Domination May Result in:

1. Not being allowed to obtain or take prescribed medication.
2. Limited access to routine or emergency medical care.
3. Lack of transportation, access to finances, or ability to communicate by telephone.

4. Noncompliance with treatment.

Battered Women Syndrome (BWS)

Battered Women Syndrome (BWS) is characterized by psychological, emotional and behavioral deficits arising from chronic and persistent violence. Characteristics of BWS include learned helplessness, passivity, and paralysis. PTSD may result from domestic violence. Symptoms may include fear, flashbacks, re-experiencing the trauma, nightmares, easily startled, and difficulty concentrating. Psychiatric illness, particularly PTSD, depression, and anxiety is greater among people who have experienced domestic violence compared to those who have not *(Saunders DG, "Wife Abuse, Husband Abuse, or Mutual Combat? A Feminist Perspective on the Empirical Findings". Bograd ML, Yllö K. Feminist perspectives on wife abuse. Thousand Oaks: Sage Publications).*

4. Screening, Evaluation, Intervention and Treatment

Guidelines for Assessing Violence

It is up to therapists to assess the potential for anger and violence and construct therapy so it can be conducted without endangering any family members. Because of the life-and-death nature of this responsibility, the consensus panel included recommended guidelines for the screening and treatment of people caught up in the cycle of domestic violence. These recommendations are adapted from TIP 25, *Substance Abuse Treatment and Domestic Violence* (*Center for Substance Abuse Treatment 1997*b*)*.
If, during the screening interview, it becomes clear that a batterer is endangering a client, the treatment provider should respond to this situation before any other issue, and if necessary, suspend the rest of the screening interview until the safety of the client can be ensured. The provider should refer the client to a domestic violence program and possibly to a shelter and legal services.

1. To determine if someone has endured domestic violence, look for physical injuries, especially patterns of untreated injuries to the face, neck, throat, and breasts. Other indicators may include
    - Inconsistent explanations for injuries and evasive answers when questioned about them
    - Complications in pregnancy, including miscarriage, premature birth, and infant illness or birth defects
    - Stress-related illnesses and conditions such as headache, backache, chronic pain, gastrointestinal distress, sleep disorders, eating disorders, and fatigue
    - Anxiety-related conditions, such as heart palpitations, hyperventilation, and panic attacks
    - A sad, flat affect or talk of suicide
    - History of relapse or noncompliance with substance abuse treatment plans
2. Always interview clients about domestic violence in private. Ask about violence using concrete examples and hypothetical situations rather than

vague, conceptual questions. Screening questions should convey to survivors that no battering is justified and that substance abuse is not an acceptable excuse for violent behavior.

3. As soon as it is clear that a client has been or is being battered, domestic violence experts should be contacted.
4. The provider should contact a forensics expert to document the physical evidence of battering.
5. Referrals should be made whenever appropriate for psychotherapy and specialized counseling. Staff training in domestic violence is important so that substance abuse treatment counselors can respond effectively to a domestic violence crisis.
6. A survivor of domestic violence who relocates to another community should be referred to the appropriate shelter programs within that community.
7. Because batterers in treatment frequently harass their partners (threatening them by phone, mail, and messages sent through approved visitors), telephone and visitation privileges of batterers and survivors in residential substance abuse treatment programs should be carefully monitored.
8. The discussion of family relationships, which is an element of all substance abuse screening interviews, can be used to identify domestic violence and gauge its severity.
9. A good initial question to investigate the possibility that a client is abusing family members is, “Do you think violence against a partner is justified in some situations?” A third-person example may be used, followed by specific, concrete questions that define the extent of the violence:
    - What happens when you lose your temper?
    - When you hit (person), was it a slap or a punch?
    - Do you take car keys away? Damage property? Threaten to injure or kill (person)?
10. Once it has been confirmed that a client has been abusive—whether physically, sexually, or psychologically—the provider should contact a domestic violence expert, either for referral or consultation. Treatment providers should ensure that the danger the batterer poses is carefully assessed.
11. The provider should be direct and candid, avoiding vague or euphemistic language, such as, “Is your relationship with your partner troubled?” Instead, ask about “violence,” and keep the focus on behavior.
12. Become familiar with batterers’ rationalization and excuses for their behavior:
    - *Minimizing:* “I only pushed her.” “She bruises easily.” “She exaggerates.”

- Claiming *good intentions:* "When she gets hysterical, I have to slap her to calm her down."
- Blaming *intoxication:* "I was drunk." "I'm not myself when I drink."
- Pleading *loss of control:* "Something snapped." "I can only take so much." "I was so angry, I didn't know what I was doing."
- *Faulting* the partner: "She drove me to it." "She really knows how to get to me."
- *Shifting blame* to someone or something else: "I was raised that way." "My probation officer is putting a lot of pressure on me." "I've been out of work." Substance abuse treatment providers should frame screening questions so that they do not allow a batterer to blame the person battered or a drug.

13. When treating a client who batters, providers should try to ensure the safety of those who have been or may be battered (partners and children, usually) during any crisis that precedes or occurs during the course of his treatment.
14. Treatment providers should mandate that batterers sign a "no-violence contract" stating that the client will refrain from using violence in- and outside the program.
15. Treatment providers should determine the relationship between the substance abuse and the violent behavior:
    - When you take/drink (substance), exactly when does the violence occur?
    - How much of your violent behavior occurs while you are drinking or on other drugs?
    - What substances lead to violence?
    - What feelings do you have before and during the use of alcohol or other drugs?
    - Do you use substances to get over the violent incident?
16. After identifying the chain of events that precedes or triggers violent episodes, the provider and client should formulate strategies for modifying those behaviors and recognizing emotions that contribute to violent behavior.
17. Providers of services to clients who batter should watch for signs that the clients are misinterpreting the 12-Step philosophy to excuse continued violence. For example, the first step is admitting powerlessness over alcohol. Thus the client may be one short rationalization away from excusing a violent act while intoxicated, which is later justified because the substance "made me do it." Another

danger is that batterers will call their partners “codependent” to shift blame for battering to the person harmed.

18. Referrals to self-help aftercare groups such as Batterers Anonymous should be made only after the client has completed a batterers’ intervention program and has remained nonviolent for a specified period of time.

- Inquiries into possible child abuse should not occur until the limits of confidentiality, as defined in Title 42, Part II, of the Code of Federal Regulations (or 42 C.F.R, II) have been explained and the client has acknowledged receipt of this information in writing. Clients also must be informed that mandated reporters (such as substance abuse treatment providers) are required to notify a child protective services agency if they suspect child abuse or neglect.
- During initial screening, the interviewer should attempt to determine whether a client’s children have been physically or emotionally harmed and whether their behavior has changed. Have they become mute? Do they scream, cry, or act out?
- The substance abuse treatment provider should not assess children for abuse or incest. Only personnel with special expertise should perform this delicate function. The treatment provider should, however, note any indications of child abuse occurring in a client’s household and pass these suspicions on to the appropriate agency.
- Indications of child abuse that can crop up in a client interview include:
    - Has a protective services agency been involved with anyone who lives in the home?
    - Do the children’s behaviors, such as bedwetting or sexual acting out, indicate abuse?
    - Is extraordinary closeness noted between a child and another adult in the household?
    - Does the client report blackouts? (Batterers often claim to black out during a violent episode.)
- If a treatment provider suspects that a client’s child has been violently abused, the provider must immediately refer the child to a health care provider. If the parent will not take the child to a doctor (who is required by law to report suspected abuse), the provider must contact home health services or child protective services.
- If the treatment provider reports suspected or definite child abuse or neglect, the provider must assess the impact on any client also being battered and develop a safety plan if one is deemed necessary.
- Providers should be aware that if a child has been or is being abused by the mother’s partner, it is likely that the mother is also being abused.

The most obvious indicator of domestic violence is the presence of physical injuries, especially patterns of untreated injuries to the face, neck, throat, and breasts. Many survivors of domestic violence may be reluctant to seek medical treatment because they are afraid that documentation of violence in the household will result in their children being removed or because they are afraid of further violence as a result of the disclosure. These women may get their injuries treated at a number of different clinics or emergency rooms in order to avoid documentation of recurrent injuries.

Other indicators may include a history of relapse or noncompliance with substance abuse treatment plans; inconsistent explanations for injuries and evasive answers when questioned about them; complications in pregnancy (including miscarriage, premature birth, and infant illness or birth defects); stress-related illnesses and conditions (such as headache, backache, chronic pain, gastrointestinal distress, sleep disorders, eating disorders, and fatigue); anxiety-related conditions (such as heart palpitations, hyperventilation, and panic attacks); sad, depressed affect; or talk of suicide. According to Consensus Panelists and field reviewers, many batterers intensify their physical attacks when they learn their partner is pregnant.

Another clue is documented or reported child abuse perpetrated by the partner of a client. Evidence suggests that a father who abuses his children often abuses his wife as well. Providers should be alert to the possibility that the mother of a child who has been or is being abused by her partner is also being abused herself.

The provider can also glean information from a woman's description of her partner's treatment of her. Behaviors that suggest he may be abusing her include

- Isolating her (keeping her away from family, friends, and others who are supportive of her recovery from substance abuse)
- Forcing her to sell drugs or prostitute herself for drugs
- Preventing her from attending treatment or 12-Step meetings
- Threatening to harm her, himself, or others
- Engaging in reckless behavior that endangers himself or others
- Damaging property or belongings
- Harming other family members or pets
- Threatening to abandon her or to take children away.

During an initial interview, many survivors will deny that they have been battered. Therefore, treatment staff must be alert to indicators of possible domestic violence and must continue to pursue them, with sensitivity and tact, over the course of treatment.

Conducting the Interview

Screening for domestic violence should take into account the client's cultural background and environment. Interviewers should be knowledgeable about the social mores of

clients' groups and trained to avoid culturally bound stereotypes and jargon. Anecdotal evidence suggests that female interviewers may be more effective at working with survivors.

A provider who suspects that a client is being abused by her partner must use caution and tact in approaching this subject. Timing is important, too; in most cases, more information about a survivor's experience of violence will begin to emerge as she gains confidence and as treatment staff continue to foster an atmosphere of trust and respect. It is important not to ask potentially painful questions too soon; otherwise, a client may feel overwhelmed and reluctant to return.

Screening for domestic violence is more likely to be effective when the interviewer offers concrete examples and describes hypothetical situations than when the client is asked vague, conceptual questions. If using a yes/no questionnaire, interviewers should be prepared to follow up on "no" answers.

Another helpful screening technique is to focus questions on the behavior of the client's partner in order to ameliorate any discomfort she may feel in talking directly about herself. An important caveat to this recommendation, however, is that the interviewer should beware of "bad-mouthing" or otherwise attacking the batterer, as doing so may cause the abused client to defend the batterer and assume the role of his ally.

Setting is also important in asking clients sensitive questions about their home lives. Privacy and an atmosphere of trust and respect are necessary if the interviewer expects to obtain candid answers to screening questions, especially since survivors may for many reasons be unable to tell the whole truth about being abused. It is of utmost important for treatment staff to be aware that a client who may be a survivor of domestic violence should never be asked about battering when she is in the presence of someone who might be her batterer. In fact, providers should always interview clients about domestic violence in private, even if the woman requests the presence of another person who is unlikely to be her batterer. It is not uncommon for batterers to manipulate friends and family members into relaying information they heard in the interview that would put the client at risk. Her potential abuser may be a boyfriend or spouse, a stepfather or father, a mother's boyfriend, or a male sibling. Querying her in the presence of the abuser can seriously endanger her and may place her at risk of reprisal. In addition, obtaining accurate information from a survivor is highly unlikely in this situation.

Uncovering Past Sexual Abuse

When dealing with concurrent substance abuse, the treatment provider should ask about the substance-abusing client's family of origin in a way that gives the client "permission" to talk about it openly. For example, providers might preface their questions with, "In most homes where there is substance abuse, families have other problems, too. I'm going to ask some questions to see whether any of these things have happened to you or your

family." Again, the interviewer should keep reassuring the client of confidentiality and safety while asking the following questions:

- "Were you ever told by an adult to keep a secret and threatened if you did not?"
- "Were you ever forced to watch sex between other people?"
- "Were you ever touched in a way you didn't like?"
- "How old were you when you first had sex (including anal, vaginal, and oral penetration)?" Then, "How old was the person you had sex with?"

Uncovering Current Abuse

Discussion of childhood abuse may open the door to discussion of current violence. In moving the interview from past to current violence, the possibility that they are survivors should be explored first, before questions about perpetrating violence themselves. This initial screening can be done by asking questions such as

- "Do you feel safe at home?"
- "Has anyone in your family ever physically hurt you?"
- "Has anyone in your family made you do sexual things you didn't want to do?"
- "Have you ever hurt anyone in your family physically or sexually?"

At this point, the interviewer can ask more specific questions regarding the nature and circumstances of specific incidents. Three questions have been cited as key to identifying victims of domestic violence:

- "Have you been hit, kicked, punched, or otherwise hurt by someone within the past year? If so, by whom?"
- "Do you feel safe in your current relationship?"
- "Is there a partner from a previous relationship who is making you feel unsafe now?" *(Feldhaus et al.).*

The interviewer might go on to say, "We will be talking about these situations at different times throughout your treatment, and I want to know about any upsetting experiences that you may have had. Even if you don't feel like talking about this with me today, it is important that we eventually address all aspects of your life." The client should also be asked about her thoughts, feelings, and actions in particular situations. Questions (such as the following) about marital rape and nonconsensual sex should be included:

- "Do you feel comfortable with the ways you have sex?"
- "Has your partner ever forced you to do anything sexually that made you feel uncomfortable or embarrassed?"
- "Do you feel you can say no if you don't want to have sex?"
- "Are you ever hurt during sex?"
- "How do you feel about talking about safe sex and HIV with your partner?"

The interviewer needs to keep in mind that the client who has been sexually assaulted by her partner may normalize her experience, particularly if it has been a repeated one. If sex has always, or nearly always, been accompanied by violence or substance abuse, she may believe this is typical of all sexual relations.

If it becomes evident during a screening interview that a client has been or is being abused by her partner, the following four key questions can help delineate the frequency and severity of the abuse:

- "When was the first time you were [punished, hurt, or whatever word reflects the survivor's interpretation of abuse]?"
- "When was the last time you were abused?"
- "What is the most severe form of abuse you have experienced?"
- "What is the most typical way in which you are abused?"

Sometimes pointing to a body map is easier for a survivor client than naming where she has sustained injuries from battering (see Appendix C). It is also important to include questions about the extent of her injuries and the batterer's involvement in the criminal justice system.

Framing the Questions

The interviewer should be aware that many survivors of domestic violence see the batterer's substance abuse as the central problem or cause of the abuse, believing that "if he would just stop drinking (or taking drugs)," the violence would end. In framing screening questions, it is extremely important to convey to the survivor that there is no justification for the battering and that substance abuse is no excuse. Questions such as, "Does he blame his violence on his alcohol or other drug use?" or, "Does he use alcohol (or other drugs) as an excuse for his violence?" serve the dual purpose of determining whether the client's partner may be a substance abuser while reinforcing to her that substance abuse is not the real reason for his violence. Nor should questions feed into the batterer's excuse-making mechanism. The interviewer can shift the focus and the blame for the abuse away from the survivor by asking her questions about the batterer such as "Has he always handled problems by getting violent?"

Cultural Considerations

In keeping a client-centered perspective, treatment providers must be aware of cultural factors that bear on the survivor's view of her experience and her willingness to talk about it. For many survivors, being battered is often a source of great shame that must be kept secret at almost any cost. Others may be unaccustomed to talking about family matters openly and directly with nonfamily members. To put the client at ease as much as possible, it may be helpful and appropriate for the interviewer initially to seek her permission to ask the screening questions, using language such as: "In order to help you, I need to know about what has been happening in your home. May I ask you some

questions about you and your [partner, boyfriend, husband]? Or would you rather be asked these questions at another time?"

Respecting the survivor's sense of privacy in this way can boost her sense of control over her present situation. This can be especially important in light of the fact that most survivors present for services in a crisis. For example, a battered woman who seeks help with a substance abuse problem may have been abandoned by her abusive partner or may be in drug withdrawal. Her general feelings of powerlessness may be eased somewhat by this approach. Although most women who are victims of abuse appear to respond better to a female interviewer, a client should be asked, and granted, her preference (Bland, 1995; Minnesota Coalition for Battered Women, 1992). If translators or hand signers are needed, a neutral party (not a family member) should be enlisted to perform this function.

Barriers to an Accurate Screen

As mentioned previously, it is common for a survivor of domestic violence to evade the issue or lie when asked about her abusive experiences. Survivors' reasons for lying about being abused are numerous and varied. Many blame themselves for the violence and make excuses for the batterer's erratic or destructive behavior. For example, a client who has been battered by her partner may attempt to justify his behavior with comments such as, "I deserved it," "I nagged him," or, "It was my fault." It is common for a survivor to believe that if only she would stop upsetting the batterer, or "pushing his buttons," the abuse would stop. As one field reviewer noted, this self-blame may be more a mechanism to explain the violence that dominates survivors' lives than to justify it.

Some survivors go further than downplaying and self-blame and deny that there is abuse. Such denial may be a functional mechanism for her that helps her avoid dealing with problems that seem overwhelming and insurmountable. Denial is also, in some cases, an adaptive survival technique developed as a direct response to unsuccessful attempts to obtain help. Additionally, the survivor of domestic violence may not be entirely truthful because she may be accustomed to using manipulation as a survival mechanism. Because survivor clients do not know how interviewers will use information about battering, they do not always divulge it. Finally, as discussed previously, many survivors have concrete reasons for hiding domestic violence. A survivor could lose custody of her children if it is discovered that they live in a violent household. And the batterer may well have told her that he will beat or kill her or her children if she reports the abuse.

Screening for Domestic Violence: Batterers

Screening Techniques and Questions

A discussion of family relationships is an element of all screening interviews. Based on their experience, the Consensus Panel recommends using this component of the interview to address the issue of domestic violence with male clients. To initially gauge the possibility that the client is being abusive toward his family members, the interviewer can ask whether he thinks violence against a partner is justified in some situations. This is the

concept of "circumstantial violence." It is best to explore this possibility using a third person example so as not to personalize the question or make the client feel defensive; for example: "Some people think that, under certain circumstances, it's OK to hit your wife (girlfriend, etc.). Under what circumstances do you think violence might be justified?" The answer reveals clues about whether and when a client might use violence against his partner. The interviewer can now shift the questions to the client himself. The interviewer can ask questions to assess the client's sense of self-efficacy and self-control:

- "If you were faced with overwhelming stress (use a hypothetical situation), do you think you could keep your cool?"
- "What do you think you'd do?"

Specific questions about events in the client's family, particularly his own current worries, may provide a sense of the environment in which violence may be occurring.

Part of an interviewer's aim here is to give the client a good reason to discuss the violence in a manner similar to that described for interviewing survivors ...to help the client see that there are benefits to acknowledging the abuse. The interviewer may tell the client that violence toward a partner is not uncommon among the other people enrolled in a treatment program, opening the door for the client to respond truthfully.

By taking an open-ended social and family history, the interviewer can gradually move to specific, direct questions regarding violence and abuse in the current relationship. For example:

- "Have you ever been physically hurt by someone in your family?" If the client's partner has hurt him or her, the reverse may also be true.
- "Have you ever hurt someone in your family?"
- "Have you ever physically controlled, hit, slapped, or pushed your partner?" (If yes) "When was the last time this happened?"

Some batterers are so focused on their substance abuse problems that the violence is relatively unimportant to them. Others have lived with violence for so long that they have little understanding of the nature of their own behavior. Such individuals may provide information about their abusive behavior only incidentally or may dismiss it as unimportant. In their *Guidelines for Talking to Abusive Husbands* (*EMERGE, 1995*), experts from the EMERGE domestic violence support program recommend that providers:

- Ask specific, concrete questions (e.g., "What happens when you lose your temper?").
- Define violence (e.g., "When you hit her, was it a slap or a punch?" "Do you take her car keys away? Damage her property? Threaten to hurt or kill her?").
- Find out when the violence occurs and who the target is.

- Be direct and candid. (Resist the urge to use a euphemism such as, "Is your relationship with your partner troubled?" because you are uncomfortable asking the question. Instead, talk about "his violence" and keep the focus on "his behavior.")
- Become familiar with batterers' excuses for their behavior:
    - *Minimizing*: "I only pushed her." "She bruises easily." "She exaggerates."
    - *Citing good intentions*: "She gets hysterical so I have to slap her to calm her down."
    - *Use of alcohol and drugs*: "I'm not myself when I drink."
    - *Claiming loss of control*: "Something snapped." "I can only take so much." "I was so angry, I didn't know what I was doing."
    - *Blaming the partner:* "She drove me to it." "She really knows how to get to me."
    - *Blaming someone or something else:* "I was raised that way." "My probation officer is putting a lot of pressure on me." "I've been out of work."
- Don't be manipulated or misled by excuses. (Identify violence as a problem and hold the client responsible for his actions.)

Avoiding Collusion

Avoiding the implication that substance abuse is the "cause" of violence is as important in screening batterers as it is in screening survivors. Batterers often blame the victim, the victim's substance abuse, or their own substance abuse for the battering. In asking screening questions such as those just described, substance abuse treatment providers must be careful not to enable a batterer to place the blame for the battering on the victim or the drug. Interviewers must neither directly nor indirectly support the batterer's assertion that some other force has caused the violence or substance abuse.

An example of collusion would be the interviewer's assent that the client drinks because of some external source of stress, such as his job or his wife's "nagging." It is common for the survivor herself to think, feel, and act in accordance with this view, so often a tacit agreement exists between a batterer and a survivor to blame the latter for the violence. The client's failure to take responsibility for his behavior is further reinforced when a treatment provider or other team member speculates that circumstances, rather than the individual, are the cause.

Interviewing the Partner

Since clients who disclose their violence toward their partners often minimize its frequency and severity, experienced domestic violence staff may interview the batterer's

partner in order to obtain salient information about his dangerousness to himself, his partner, and others. In fact, many batterers' programs require batterers to give permission for staff to interview the female partner as a prerequisite for acceptance into the program. This type of collateral interviewing, however, is quite different from that practiced in the substance abuse treatment setting and *requires specialized skills and expertise*. Prior to conducting the interview, violence support staff and the involved partner carefully weigh the risks associated with participating in such an interview (e.g., the possibility that it may precipitate another battering incident). If the partner agrees to the interview, she will be interviewed alone. Her perspective will be compared with the batterer's and used carefully and sensitively by the violence specialist in working with the batterer.

Many substance abuse treatment providers routinely facilitate therapy sessions with substance abusers and their families. However, this approach *should not* be used with substance-abusing batterers and their partners. While substance abuse programs can cooperate with batterers' programs by reinforcing "no violence" messages and behaviors, providers should refer the client to a domestic violence specialist for further assessment and intervention. Some batterers' programs will not accept active substance abusers. In that case, participation in a batterers' program can become a specified part of the aftercare plan *(Source: Engelmann*).

Screening for Presence of Child Abuse

When family violence comes to the attention of the treatment provider, it is essential to determine whether children have been present or have been involved in any way. During the initial screening of the client, the Consensus Panel recommends that the interviewer should attempt to determine whether the children have been physically harmed and whether their behavior has changed (e.g., they have become mute or they scream or cry).

The confidentiality regulations spelled out in Title 42, Part 2, of the *Code of Federal Regulations* require that a client be given notice regarding the limitations of confidentiality ...orally and in writing ...upon admittance to a substance abuse treatment program (see Appendix B). *Inquiries into possible child abuse should not occur until this notice has been given and the client has acknowledged receipt of it in writing*. Great care must be taken when approaching either a batterer or a survivor of domestic violence about whether any children in the household have been abused.

There may be a number of barriers to obtaining a complete and accurate picture of the children's situation from these clients. First, adults who abuse children are generally aware of the laws that require substance abuse treatment providers, among others, to report suspected child abuse to agencies such as children's protective services (CPS), and they tend not to volunteer such information for fear of recrimination. Second, a survivor may be aware that her perceived "failure" to protect her children from violence may have implications for her retaining custody of them. Such fears are likely to be reinforced by

her feelings of shame and guilt over "letting it happen." Or she may be abusing the children herself.

It is not advisable for the substance abuse treatment provider to perform an assessment of children for abuse or incest; this function should be performed by personnel with special expertise. The substance abuse treatment provider should, however, note any indications of whether abuse of children is occurring in a client's household and pass on what they find to the appropriate agency.

Indications of Child Abuse

In the Consensus Panel's experience, clues to possible child abuse may be obtained by questioning the client regarding

- Whether CPS has been involved with anyone who lives in the home
- Children's behaviors such as bedwetting and sexual acting out
- "Special" closeness between a child and other adults in the household
- The occurrence of "blackouts": Batterers often claim blackouts for the period of time during which violence occurs.

This area of questioning need not be repeated for each child in the household, but rather can be done in a general way in order to get a sense of the overall family environment.

If a treatment provider suspects that the child of a client has been a victim of violence, he or she must refer the child to a health care provider immediately. If it appears that the parent will not take the child to a doctor (who is required by law to report the suspected abuse), the provider must contact home health services or CPS. This should be done even if a child appears to be unharmed, because some injuries may not be immediately apparent.

Immediate attention to the child's emotional state is also important. Emergency room physicians or nurses who conduct physical examinations may not be in a position to thoroughly assess the impact of abuse on the child's emotional status. Initially, it may be that the most that can be done is to reassure the child that he is safe and will be taken care of. Ideally, however, he should be referred to a therapist who specializes in counseling traumatized children.

Reporting Suspected Neglect or Abuse

Clients must be informed that mandated reporters, a category that includes substance abuse treatment providers, are required to notify CPS if they suspect child abuse or neglect. In addition, a client can be informed of the right to report his or her partner's abuse of children. Whatever decision is made concerning who will actually notify CPS, ultimately it is the mandated reporter's responsibility to ensure that this is done.

The treatment provider must assess the impact on a survivor client of reporting suspected or confirmed child abuse or neglect. If she cannot be protected from her abuser on a 24-hour basis, she may become the object of his violence if he blames her for the report, so a safety plan should be developed. It is equally important to prepare for the impact of reporting child abuse on the children and on the family as a whole. The possible results of such a report must be considered and explained to the client in advance. For instance, if CPS is unable to confirm that abuse or neglect has occurred, the children could be endangered if the abuser learns of the report. In other instances, CPS may remove the children from the home until further investigation can be undertaken. If the investigation confirms abuse or neglect, a series of court appearances will be required, and children may be placed in foster care either in the short or long term. In any case, it is imperative for professionals working with family members to provide information about what to expect and, if at all possible, talk with the CPS caseworker and accompany the family to court hearings. Child abuse and neglect is a complicated issue and will be discussed in detail in a pending Treatment Improvement Protocol.

Referral

When answers to screening questions suggest that clients may be either batterers or survivors of domestic violence, the Consensus Panel recommends an immediate referral to a domestic violence support program. When referrals are not possible, ongoing consultation with a domestic violence expert is strongly encouraged. In some instances, clients have been mandated into substance abuse treatment by the courts. Participation in a battering program may be another court-mandated requirement. Substance abuse treatment providers should not hesitate to use the leverage provided by the criminal justice system to ensure that clients who batter participate in batterers' treatment as well.

Referring Survivors

If, during the screening, the client reveals that she is in immediate danger, the counselor needs to attend to this danger before addressing other issues and, if necessary, should suspend the interview for this purpose. The treatment provider should be familiar with methods for de-escalating the situation or obtaining help (see Appendix D for a safety plan) and may advise the client to take some simple legal precautions and to safeguard important documents. If the client and counselor decide to involve the police, they should first discuss possible reprisal by the batterer and plan a response.

The provider may be the first person to whom the survivor has revealed her victimization. Whether she has previously disclosed the abuse to other agencies or programs will have a bearing not only on the level of danger she is in or perceives herself to be in, but will also have an impact on the process of establishing linkages with other agencies and sources of support.

If screening reveals domestic violence, then further assessment is required. Though the substance abuse treatment provider should help the client build a safety plan, assessment

is best performed by a domestic violence support program. Questions that will aid referral include

- "To whom have you talked about this in the past?"
- "Are you, or is anyone in your family, currently in danger from someone in your household? Do you think that being here now, talking to me, could put you in danger? If so, how?"

If a survivor client expresses concern about the safety of her children, especially if they are left in the care of the batterer while she is in treatment, this is the time to refer the client for shelter and legal advocacy. Resources can be identified by contacting a local domestic violence program, or, if one is not available, a State program. The National 24-Hour Domestic Violence Hotline (1-800-799-SAFE) is another resource for domestic violence programs. Substance abuse treatment facilities should ensure that these resources are readily available to their staff.

Referring Batterers

When suspected batterers are identified during the screening process, treatment providers should refer them to batterers' intervention programs as a key part of the treatment plan. With the client's signed consent to release information, substance abuse counselors can share pertinent information with domestic violence staff in an effort to ensure that both problems are addressed.

Well-run batterers' treatment programs may not be available in every community. Before initiating referrals, the Consensus Panel recommends that substance abuse treatment staff compile a list of potential programs and providers, check their credentials with domestic violence support programs for survivors or local battered women's shelters, and contact appropriate programs or specialists to establish agreed-upon referral procedures.
The confidentiality regulations do not inhibit such referrals as long as consent to release information has been obtained and the procedures detailed in Appendix B have been followed.

Treatment Concerns for Survivors and Batterers

Even though a provider has referred a client involved in domestic violence to a survivors' or batterers' program or incorporated participation in such programs as part of the aftercare plan, domestic violence remains an issue. The treatment provider should see that the following actions are taken, either by the substance abuse or violence program or by a case manager assigned responsibility for the client's holistic care.

The "No-Contact Contract"

Some survivors' programs require participants to sign a contract agreeing to have no contact with their batterers for the duration of the program. In addition to helping to ensure her safety, such contracts can provide opportunities for staff to evaluate a survivor's current attitudes toward and thinking about the batterer. Such "reality checks" can be helpful if, as is often the case, a survivor begins to believe the batterer's assurances

that he has changed and is no longer violent. The staff can point out the reality of the situation if the batterer is still abusing alcohol or other drugs and has not changed his life in any significant way.

The "No-Violence Contract"

Batterers entering treatment can be required to sign a contract agreeing to refrain from using violence. While such "no-violence contracts" are most effective when linkages with batterers' intervention programs are also in place, they can help structure treatment by specifying an achievable behavioral goal. It is more difficult for clients to play one agency against another when all those involved in a particular case prescribe common goals. When the court has a role in mandating treatment services and specifying sanctions for failure to comply, clients have an added incentive to adhere to such stipulations as "no-violence" contracts. Consensus Panel members believe that the prospects for positive outcome (e.g., reductions in substance abuse and domestic violence) will be improved when substance abuse and batterers' treatment programs and the courts collaborate to ensure that needed services are provided, consistent behavioral messages are communicated, and consequences for violating contracts and other programmatic stipulations are upheld.

Recovery Pitfalls for Batterers and Survivors

A number of violence support experts, including members of the Consensus Panel, have observed a tendency among some substance-abusing batterers to twist the messages of 12-Step programs in order to evade responsibility for their violent behavior: Men in recovery often gain more tools of abuse from their distorted interpretation of 12-Step and treatment programs. One of the most frequently used tools by batterers in groups has been the label of codependent. Men use it to put down their partners, saying this means battered women are as sick or sicker than them, to define victims as at least partly responsible for their violence, and to manipulate women into feeling guilty and ashamed of their expectations that men stop abusing.

Providers should be alert to signs that clients are misinterpreting the 12-Step philosophy to justify or excuse continued violence, especially since 12-Step programs can play a valuable role in supporting batterers' treatment as well as recovery from substance abuse when its principles are followed rather than distorted (*Wright and Popham, 1995)*. Men who have embraced the 12-Step model will often challenge the excuse-making of batterers, encouraging them to take responsibility for all their actions, including the domestic violence.

Group therapy is an essential feature of most substance abuse treatment programs. However, members of the Consensus Panel who have worked extensively with substance-abusing survivors observe that survivors "may have an especially difficult time talking about past experiences if men are included in the group. Often, the safest and most comfortable time for her to discuss violence is during one-on-one sessions with her

counselor. These sessions are also an opportune time to ask about her needs regarding the abuse" -Minnesota Coalition for Battered Women

Ongoing Attention to Issues of Domestic Violence

As discussed previously in this chapter, many survivors and batterers presenting at substance abuse treatment facilities do not disclose domestic violence on intake, and treatment providers must rely on signs of violence that become apparent as the client spends time in treatment. Ongoing attention to issues of domestic violence is particularly important in these clients not only because it may take time for them to begin talking about it, but also because as they become abstinent, additional issues arise that are integrally related to the violence. As with substance abuse, the full dimensions of a domestic violence problem are seldom immediately clear and may emerge unexpectedly at a later stage in treatment. If this happens, questions posed during screening can be asked again, and a referral to a violence support or batterers' intervention program can be initiated.

Appendix C -- Instruments

This appendix reproduces the following tools:

- Abuse Assessment Screen (in English and Spanish)
- Danger Assessment
- Psychological Maltreatment of Women Inventory (PMWI)
- Revised Conflict Tactics Scale (CTS2)

Although these instruments have been used extensively in research settings, they have not been validated as clinical tools; nor do they have instructions for scoring. The PMWI and the CTS2, in particular, were designed as research tools, not clinical tools, and do not have cutting scores (the score beyond which a person has a problem). All the instruments in this appendix can, however, serve to open dialogue with a client, elicit information, promote discussion, and help evaluate a program.

Abuse Assessment Screen *(English Version)*

1.	**WITHIN THE LAST YEAR**, have you been hit, slapped, kicked, or otherwise physically hurt by someone? If YES, by whom?_____ Total number of times _____	**YES**	**NO**
2.	**SINCE YOU'VE BEEN PREGNANT**, have you been hit, slapped, kicked, or otherwise physically hurt by someone? If YES, by whom? _____ Total number of times _____	**YES**	**NO**

MARK THE AREA OF INJURY ON THE BODY MAP, SCORE EACH INCIDENT ACCORDING TO THE FOLLOWING SCALE: **SCORE**

1 = Threats of abuse including use of a weapon _____

2 = Slapping, pushing; no injuries and/or lasting pain _____

3 = Punching, kicking, bruises, cuts and/or continuing pain _____

4 = Beating up, severe contusions, burns, broken bones _____

5 = Head injury, internal injury, permanent injury _____

6 = Use of weapon; wound from weapon _____

If any of the descriptions for the higher number apply, use the higher number.

3. **WITHIN THE LAST YEAR**, has anyone forced you to have sexual activities? **YES** **NO**

   If YES, by whom? _____

Developed by the Nursing Research Consortium on Violence and Abuse.

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Encuesta Sobre El Maltrato (*Spanish Version*)

1. **DURANTE EL LTIMO A O**, fu golpeada, bofeteada, pateada, o lastimada fisicamente de alguna otra manera por alguien? **SI** **NO**

   Si la respuesta es "SI" por quien(es)?_____

   Cuantas veces?_____

2. **DESDE QUE SALIO EMBARAZADA**, ha sido golpeada, bofeteada, pateada, o lastimada fisicamente de alguna otra manera por alguien?_____ **SI** **NO**

   Si la respuesta es "SI" por quien(es)? _____

   Cuantas veces?_____

EN EL DIAGRAMA ANAT MICO, MARQUE LAS PARTES DE SU CUERPO QUE HAN SIDO LASTIMADAS. VALORE CADA INCIDENTE USANDO LAS SIGUIENTE ESCALA: **GRADO**

1 = Amenazas de maltrato que incluyen el uso de un arma _____

2 = Bofeteadas, permanentel ompujones sin lesiones fisicas o dolor permanente _____

3 = Moquestos, patadas, moretones, heridas y/o dolor continuo _____

4 = Molida a palos, contusiones severas, quemaduras, fracturas de huesos _____

5 = Heridas en la cabeza, lesiones internas, lesiones permanentes _____

6 = Uso de armas, herida por arma _____

Si cualquiera de las situaciones valora un numero alto en la escala, selo.

3. **DURANTE EL LTIMO A O**, fu forzada a tener relaciones sexuales? **SI** **NO**

   Si la respuesta es "SI" por quien(es)_____

   Cuantas veces?_____

Appendix D -- Sample Personalized Safety Plan for Domestic Violence Survivors

Name: _____ Date: _____

Review dates: _____ _____

Personalized Safety Plan

The following steps represent my plan for increasing my safety and preparing in advance for the possibility for further violence. Although I do not have control over my partner's violence, I do have a choice about how to respond to him/her and how to best get myself and my children to safety.

Step 1: Safety during a violent incident. Women cannot always avoid violent incidents. In order to increase safety, battered women may use a variety of strategies.

I can use some or all of the following strategies:

A. If I decide to leave, I will _____. (Practice how to get out safely. What doors, windows, elevators, stairwells, or fire escapes would you use?)

B. I can keep my purse and car keys ready and put them (place) _____ in order to leave quickly.

C. I can tell _____ about the violence and request they call the police if they hear suspicious noises coming from my house. I can also tell _____ about the violence and request they call the police if they hear suspicious noises coming from my house.

D. I can teach my children how to use the telephone to contact the police and the fire department.

E. I will use _____ as my code word with my children or my friends so they can call for help.

F. If I have to leave my home, I will go _____. (Decide this even if you don't think there will be a next time.) If I cannot go to the location above, then I can go to _____ or _____.

G. I can also teach some of these strategies to some/all of my children.

H. When I expect we are going to have an argument, I will try to move to a space that is lowest risk, such as _____. (Try to avoid arguments in the bathroom, garage, kitchens, near weapons or in rooms without access to an outside door.)

I. I will use my judgment and intuition. If the situation is very serious, I can give my partner what he/she wants to calm him/her down. I have to protect myself until I/we are out of danger.

Step 2: Safety when preparing to leave. Battered women frequently leave the residence they share with the battering partner. Leaving must be done with a careful plan in order to increase safety. Batterers often strike back when they believe that a battered woman is leaving a relationship.

I can use some or all of the following safety strategies:

A. I will leave money and an extra set of keys with _____ so I can leave quickly.

B. I will keep copies of important documents or keys at _____.

C. I will open a savings account by _____ (date), to increase my independence.

D. Other things I can do to increase my independence include:
_____
_____
_____
_____

E. The domestic violence program's hotline number is _____. I can seek shelter by calling this hotline.

F. I can keep change for phone calls on me at all times. I understand that if I use my telephone credit card, the following month the telephone bill will tell my batterer those numbers that I called after I left. To keep my telephone communications confidential, I must either use coins or I might get a friend to permit me to use their telephone credit card for a limited time when I first leave.

G. I will check with _____ and _____ to see who would be able to let me stay with them or lend me some money.

H. I can leave extra clothes with _____.

I. I will sit down and review my safety plan every _____ in order to plan the safest way to leave the residence. _____ (domestic violence advocate or friend) has agreed to help me review this plan.

J. I will rehearse my escape plan and, as appropriate, practice it with my children.

Step 3: Safety in my own residence. There are many things that a woman can do to increase her safety in her own residence. It may impossible to do everything at once, but safety measures can be added step by step.

Safety measures I can use include:

A. I can change the locks on my doors and windows as soon as possible.

B. I can replace wooden doors with steel/metal doors.

C. I can install security systems including additional locks, window bars, poles to wedge against doors, an electronic system, etc.

D. I can purchase rope ladders to be used for escape from second floor windows.

E. I can install smoke detectors and purchase fire extinguishers for each floor in my house/apartment.

F. I can install an outside lighting system that lights up when a person is coming close to my house.

G. I will teach my children how to use the telephone to make a collect call to me and to (friend/minister/other) in the event that my partner takes the children.

H. I will tell people who take care of my children which people have permission to pick up my children and that my partner is not permitted to do so. The people I will inform about pick-up permission include

_____ (school),

_____ (day care staff),

_____ (babysitter),

_____ (Sunday school teacher),

_____ (teacher),

_____ and (others).

I. I can inform _____ (neighbor), _____ (pastor), and _____ (friend) that my partner no longer resides with me and they should call the police if he is observed near my residence.

Step 4: Safety with a protection order. Many batterers obey protection orders, but one can never be sure which violent partner will obey and which will violate protection orders. I recognize that I may need to ask the police and the courts to enforce my protection order.

The following are some steps that I can take to help the enforcement of my protection order:

A. I will keep my protection order _____ (location). (Always keep it on or near your person. If you change purses, that's the first thing that should go in.)

B. I will give my protection order to police departments in the community where I work, in those communities where I usually visit family or friends, and in the community where I live.

C. There should be a county registry of protection orders that all police departments can call to confirm a protection order. I can check to make sure that my order is in the registry. The telephone number for the county registry of protection orders is _____.

D. For further safety, if I often visit other counties in my state, I might file my protection order with the court in those counties. I will register my protection order in the following counties: _____, _____, and _____.

E. I can call the local domestic violence program if I am not sure about B, C, or D above or if I have some problem with my protection order.

F. I will inform my employer, my minister, my closest friend and _____ and _____ that I have a protection order in effect.

G. If my partner destroys my protection order, I can get another copy from the courthouse by going to [the office] located at _____

H. If my partner violates the protection order, I can call the police and report a violation, contact my attorney, call my advocate, and/or advise the court of the violation.

I. If the police do not help, I can contact my advocate or attorney and will file a complaint with the chief of the police department.

J. I can also file a private criminal complaint with the district justice in the jurisdiction where the violation occurred or with the district attorney. I can charge my battering partner with a violation of the protection order and all the crimes that he commits in violating the order. I can call the domestic violence advocate to help me with this.

Step 5: Safety on the job and in public. Each battered woman must decide if and when she will tell others that her partner has battered her and that she may be at continued risk. Friends, family and coworkers can help to protect women. Each woman should consider carefully which people to invite to help secure her safety.

I might do any or all of the following:

A. I can inform my boss, the security supervisor and _____ at work of my situation.

B. I can ask _____ to help screen my telephone calls at work.

C. When leaving work, I can _____.

D. When driving home if problems occur, I can _____.

E. If I use public transit, I can _____.

F. I can use different grocery stores and shopping malls to conduct my business and shop at hours that are different than those when residing with my battering partner.

G. I can use a different bank and take care of my banking at hours different from those I used when residing with my battering partner.

H. I can also _____.

Step 6: Safety and drug or alcohol use. Most people in this culture use alcohol. Many use mood-altering drugs. Much of this use is legal and some is not. The legal outcomes of using illegal drugs can be very hard on a battered woman, may hurt her relationship with her children and put her at a disadvantage in other legal actions with her battering partner. Therefore, women should carefully consider the potential cost of the use of illegal drugs. But beyond this, the use of any alcohol or other drugs can reduce a woman's awareness and ability to act quickly to protect herself from her battering partner. Furthermore, the use of alcohol or other drugs by the batterer may give him/her an excuse to use violence. Therefore, in the context of drug or alcohol use, a woman needs to make specific safety plans.

If drug or alcohol use has occurred in my relationship with the battering partner, I can enhance my safety by some or all of the following:

A. If I am going to use, I can do so in a safe place and with people who understand the risk of violence and are committed to my safety.

B. I can also _____.

C. If my partner is using, I can _____.

D. I might also _____.

E. To safeguard my children, I might _____ and _____.

Step 7: Safety and my emotional health. The experience of being battered and verbally degraded by partners is usually exhausting and emotionally draining. The process of building a new life for myself takes much courage and incredible energy.

To conserve my emotional energy and resources and to avoid hard emotional times, I can do some of the following:

A. If I feel down and ready to return to a potentially abusive situation, I can _____.

B. When I have to communicate with my partner in person or by telephone, I can _____.

C. I can try to use "I can . . ." statements with myself and to be assertive with others.

D. I can tell myself, "_____" whenever I feel others are trying to control or abuse me.

E. I can read _____ to help me feel stronger.

F. I can call _____, _____ and _____ as other resources to be of support to me.

G. Other things I can do to help me feel stronger are _____, _____, and _____.

H. I can attend workshops and support groups at the domestic violence program or _____, _____ , or _____ to gain support and strengthen my relationships with other people.

Step 8: Items to take when leaving. When women leave partners, it is important to take certain items with them. Beyond this, women sometimes give an extra copy of papers and an extra set of clothing to a friend just in case they have to leave quickly.

Items with asterisks on the following list are the most important to take. If there is time, the other items might be taken, or stored outside the home.

These items might best be placed in one location, so that if we have to leave in a hurry, I can grab them quickly.

When I leave, I should take:

* Identification for myself

* Children's birth certificates

* My birth certificate

* Social Security cards

* School and vaccination records

* Money

* Checkbook, ATM (Automatic Teller Machine) card

* Credit cards

* Keys-house/car/office

* Driver's license and registration

* Medications

*Welfare identification

*Work permits

*Green card

*Passport(s)

*Divorce papers

*Medical records-for all family members

*Lease/rental agreement, house deed, mortgage payment book

*Bank books

*Insurance papers

*Small saleable objects

*Address book

*Pictures

*Jewelry

*Children's favorite toys and/or blankets

*Items of special sentimental value

Appendix E -- Hotlines and Other Resources For Domestic Violence and Related Issues

This appendix provides addresses, phone numbers, and information on three types of domestic violence organizations and groups in related fields such as rape, child abuse and neglect, and victimization. *Hotlines* provide crisis counseling and referrals to victims and those in crisis and usually supply general information either by mail or over the phone. *General resources* send bulletins, pamphlets, manuals, and other publications by mail (sometimes at cost); sometimes they give information over the phone. They also may provide additional services, such as referrals. Most of them serve the general public, although some target professionals in specific fields. The *other services* category includes research and policy groups and those that provide technical assistance, training, and advocacy. Unlike those in the previous category, *other services* tend to target professionals in specific fields, as indicated, and *are not resources for the general public*. Many of the programs and organizations listed below provide more than one type of service, so they are categorized by their primary purpose.

Hotlines

National Domestic Violence Hotline
(800) 799-SAFE
(800) 787-3224 (TDD)
Suite 101-297
3616 Far West Boulevard
Austin, TX 78731-3074

The National Domestic Violence Hotline links individuals and services using a nationwide database of domestic violence and other emergency shelters, legal advocacy and assistance programs, and social services programs. The hotline provides crisis

intervention, information about sources of assistance, and referrals to battered women's shelters.

Rape, Abuse, and Incest National Network (RAINN)

(800) 656-4673

RAINN links 628 rape crisis centers nationwide. *Sexual assault survivors* who call will be automatically connected to a trained counselor at the closest center in their area.

Childhelp USA/National Child Abuse Hotline

(800) 4A-CHILD
15757 North 78th Street
Scottsdale, AZ 85260
(602) 922-8212

With a focus on *children* and the prevention of *child abuse*, this hotline provides crisis counseling, referrals, and reporting guidance to callers in crisis, including children, troubled parents, and adult survivors of abuse. All calls are answered by a staff of professional counselors. In addition, statistical and other informative materials can be ordered through this number.

General Resources

American College of Obstetricians and Gynecologists (ACOG)

ACOG Resource Center
409 12th Street, S.W.
Washington, DC 20024-2188
(202) 638-5577

ACOG has patient education pamphlets and bulletins for medical professionals on both domestic violence and substance abuse.

American Medical Association (AMA)

Department of Mental Health
515 State Street
Chicago, IL 60610
Contact: Jean Owens
(312) 464-5000
(312) 464-5066 (to order resources)
(312) 464-4184 (fax)

The AMA educates physicians through publications, conferences, and by serving as a resource center for physicians and other concerned professionals. Among its publications are six diagnostic and treatment guidelines on child physical abuse and neglect, child sexual abuse, domestic violence, elder abuse and neglect, mental health effects of domestic violence, treatment and prevention of sexual assault, and media violence.

March of Dimes Birth Defects Foundation

1275 Mamaroneck Avenue
White Plains, NY 10605
Attn: Resource Center
(914) 428-7100
http://www.modimes.org/

The March of Dimes provides general information on prenatal care and on the first few years of life through its resource center and its fulfillment center.

March of Dimes Resource Center
(888) 663-4637
(914) 997-4763 (fax)
resourcecenter@modimes.org
Contact: Beverly Robertson, Director

Callers to this number can speak to someone about pregnancy, pre-pregnancy, drug use during pregnancy, birth defects, genetics, and other issues related to prenatal care.

March of Dimes Fulfillment Center
(800) 367-6630

Callers to this number can only place an order for materials. Two domestic violence materials are available at cost: *Abuse During Pregnancy Nursing Module*, which provides continuing education units to nurses, and a video titled *Crime Against the Future*.

National Center for Missing or Exploited Children (NCMEC)

Suite 550
2101 Wilson Boulevard
Arlington, VA 22201-3052
Hotline: (800) THE LOST, (800) 843-5678, (800) 826-7653 (TDD)
Business office: (703) 235-3900, (703) 235-4067 (fax)
http://www.missingkids.org/

NCMEC leads national efforts to locate and recover missing children and raises public awareness about ways to prevent child abduction, molestation, and sexual exploitation. The hotline is available to report information on missing or exploited children or to request information or assistance. NCMEC publishes materials, including handbooks, pamphlets containing parental and professional guidelines on runaways and missing or exploited children, and publication packages aimed toward families, child care and social service practitioners, and law enforcement, legal, and criminal justice professionals.

National Clearinghouse on Child Abuse and Neglect

P.O. Box 1182
Washington, DC 20013-1182
(800) FYI-3366
(703) 385-7565
(703) 385-3206 (fax)

nccanch@calib.com

This clearinghouse offers child abuse and neglect information in the form of manuals, research reports, studies, directories, grant compendia, literature reviews, annotated bibliographies, fact sheets, database searches, CD ROM databases, and on-line services. It is sponsored by the National Center on Child Abuse and Neglect.

National Coalition Against Domestic Violence

P.O. Box 18749
Denver, CO 80218
(303) 839-1852
(303) 831-9251 (fax)

The National Coalition Against Domestic Violence serves as an information and referral center for the general public, the media, battered women and their children, and agencies and organizations. Among its purposes are to enhance coalition-building at the local, State, and national levels; support the provision of community-based, nonviolent alternatives such as safe homes and shelters for battered women and their children; provide information and referral services, public education, and technical assistance; and develop public policy and innovative legislation. The coalition maintains a public policy office in Washington, DC, and maintains a National Directory of Domestic Violence Programs.

The "Duluth model," as it is commonly called, was developed at the Domestic Abuse Intervention Project in Duluth, Minnesota, and is probably the most widely used model for batterers' intervention programs in the United States. There are many variations on the Duluth model, but all feature victim safety and community coordination as cornerstones and require batterers' programs to be accountable to victims and to victim advocates. The Duluth model is based on confronting the denial of violent behavior, exposing the manifestations of power and control, offering alternatives to dominance, and promoting behavioral changes. It calls for communitywide intervention that employs the resources of law enforcement, courts, domestic violence shelters and advocates, health providers, and batterers' programs. A batterers' program cannot, in this model, exist without the other components in the network. Although some experts feel that the Duluth model tends to encourage shame and guilt rather than real change, it sees domestic violence not as a form of personal pathology, anger and hostility, or substance-induced behavior, but as an outcropping of men's socially sanctioned domination of women. Batterers' programs developed under this model are designed to educate men about power and control, not merely to assist them in managing anger or personal problems. Community wide coordination ensures that batterers are arrested and prosecuted and that victims are protected.

The psycho-educational model promotes responsibility for violent behavior and the development of mechanisms for self-regulation, empathy or compassion for others, and appropriate emotional vocabulary to express intimacy. Safety precautions for significant others, no-violence contracts, provision of information, changing attitudes toward women, reinforcement or development of values via modeling, anger and stress management, and assertiveness skills are key features of this cognitive-behavioral approach. Group and individual treatment can be utilized within this model, although single-sex groups tend to be the norm. Results of one study suggest that highly structured groups (with defined curricula, homework assignments, and skilled facilitation) work more effectively than less structured groups.

Couples therapy treats men who batter together with their partners, often in a group setting. This is a controversial approach to batterers' intervention that has fallen into disrepute because of concerns about partner safety, its "implicit message that both partners are equally responsible for the violence," and its failure to acknowledge the role of gender and historical power inequities (McKay, 1994, p. 36). Substance abuse treatment providers should not treat batterer-and-victim couples together without consulting a domestic violence expert.

5. Children and Intimate Partner Violence

Many factors influence children's responses to domestic violence. As you have probably observed in your work, not all children are equally affected. Some children do not show obvious signs of stress or have developed their own coping strategies. Others may be more affected. A child's age, experience, prior trauma history, and temperament all have an influence. For example, an adolescent who grew up in an atmosphere of repeated acts of violence may have different post-traumatic stress reactions than a 12-year-old who witnessed a single violent fight. A six-year old girl who saw her mother bleeding on the floor and feared she would die would likely have more severe reactions than a child who perceived the incident she witnessed to be less dangerous.

A child's proximity to the violence also makes a difference. Consider the very different experiences of a 12-year-old child who was in another room with headphones on while her parents battled; an eight-year-old who had to call 911 despite a raging parent's threats against him; and a teenager who has frequently put himself at risk by getting into the middle of fights to protect his mother from her estranged boyfriend.
Here are some of the factors that can influence children's reactions to domestic violence:

- The *severity* of the violence (Was it life-threatening? Did the victim express terror in front of the child? Was a weapon used or brandished? Was there a serious injury?)
- The child's *perception* of the violence (A child may perceive violence as life-threatening even if adults do not.)
- The *age* of the child (see table, *Possible Reactions to Domestic Violence*)
- The quality of the child's *relationships* with both parents (or involved parties)
- The child's *trauma history* (What other traumatic events has the child experienced? Was the child also a victim of physical abuse?)
- Secondary *adversities* in the child's life, such as moving, changing schools, or leaving behind support systems

Typical short-term responses

Children commonly respond to domestic violence as they do to other traumatic events. Short-term traumatic stress reactions include

- *Hyperarousal.* The child may become jumpy, nervous, or easily startled.
- *Reexperiencing.* The child may continue to see or relive images, sensations, or memories of the domestic violence despite trying to put them out of mind.
- *Avoidance.* The child may avoid situations, people, and reminders associated with the violence, or may try not to think or talk about it.
- *Withdrawal.* The child may feel numb, frozen, or shut down, or may feel and act as if cut off from normal life and other people.

- *Reactions to reminders.* The child may react to any reminder of the domestic violence. Sights, smells, tastes, sounds, words, things, places, emotions, even other people can become linked in the child's mind with the traumatic events. For example, a school-age child may become upset when watching a football game because the violent contact between players is a reminder of domestic violence. Sometimes behavior that seems to come out of nowhere, such as a sudden tantrum, is actually a reaction to a trauma reminder.
- *Trouble going to sleep* or staying asleep, or having *nightmares.*
- *Repetitive talk or play* about the domestic violence. For example, a young girl may act out violence when playing with her dolls.

Other short-term symptoms may include anxiety (for example, separation anxiety); depression; aggression (perhaps reenactment of the witnessed aggression); physical complaints (stomachaches, headaches); behavioral problems (fighting, oppositional behavior, tantrums); feelings of guilt or self-blame; and poor academic performance.

Children's Responses in the Long Term

Research suggests that in the long term, children who have been exposed to domestic violence—especially those children who do not receive therapeutic intervention—may be at increased risk of

- Depression and anxiety
- Substance abuse
- Self-destructive or suicidal behaviors
- Self-destructive or suicidal behaviors
- Impulsive acts, including risky sex and unintended
- Pregnancy
- Chronic health problems
- Low self-esteem
- Criminal and violent behavior (including perpetration of domestic violence)
- Victimization by an intimate partner

Possible Reactions to Domestic Violence

<u>Birth to Age 5</u>

- Sleep or eating disruptions
- Withdrawal or lack of responsiveness
- Intense and pronounced separation anxiety
- Crying inconsolably
- Developmental regression, loss of acquired skills such as toilet training, or reversion to earlier behaviors, such as asking for a bottle again
- Intense anxiety, worries, or new fears
- Increased aggression or impulsive behavior
- Acting out witnessed events in play, such as having one doll hit another

Ages 6-11

- Nightmares, sleep disruptions
- Aggression and difficulty with peer relationships in school
- Difficulty with concentration and task completion in school
- Withdrawal and emotional numbing
- School avoidance or truancy
- Stomachaches, headaches, or other physical complaints

Ages 12-18

- Antisocial behavior
- School failure
- Impulsive or reckless behavior, such as
  - Truancy
  - Substance abuse
  - Running away
  - Involvement in violent or abusive dating relationships
- Depression
- Anxiety
- Withdrawal
- Self-destructive behavior such as cutting

It is important to remember that any of these symptoms can also be associated with other stress, traumas, or developmental disturbances. They should be considered in the context of the child's and family's functioning.

(*National Child Traumatic Stress Network, Domestic Violence and Children: Questions and Answers for Domestic Violence Project Advocates)*

Factors That Help Children Recover

Most children are resilient if given the proper help following traumatic events. Research has shown that the support of family and community are key to increasing children's capacity for resilience and in helping them to recover and thrive. Crucial to a child's resiliency is the presence of a positive, caring, and protective adult in a child's life. Although a long-term relationship with a caregiver is best, even a brief relationship with one caring adult—a mentor, teacher, day-care provider, an advocate in a domestic violence shelter—can make an important difference.

Here are some other protective factors for children:

- Access to positive social supports (religious organizations, clubs, sports, group activities, teachers, coaches, mentors, day care providers, and others)
- Average to above average intellectual development with good attention and social skills

- Competence at doing something that attracts the praise and admiration of adults and peers
- Feelings of self-esteem and self-efficacy
- Religious affiliations, or spiritual beliefs that give meaning to life

(Source: National Child Traumatic Stress Network, Domestic Violence and Children: Questions and Answers for Domestic Violence Project Advocates, November 2010)

What Parents Should Tell Their Children about Domestic Violence

Some parents may be reluctant to tell you that their children have witnessed domestic violence. Others may try to minimize the children's actual exposure to the violence (saying, for example, "They didn't know it was happening," or "They were always asleep or at school"). A victimized parent may also avoid talking to a child about domestic violence. The parent may assume that a child is too young to understand, or that it's better to just move on. But *many children who've experienced domestic violence need to talk about it*. They may misunderstand what happened or why it happened. They may blame themselves, blame the victim, or blame the police or other authorities who intervened. They may have fantasies about how they can "fix" their family. They may take parental silence as a signal to keep silent themselves or to feel ashamed about what happened in their family.

As a domestic violence advocate, you may be in the position of speaking to children yourself. If not, you can support the parents in breaking the silence. Start by assuming that children know more than we think they know. Talk to them about what happened, listen openly to what they have to say, and offer the following key messages:

- "The violence was not and is not okay."
- "It is not your fault."
- "I will listen to you."
- "You can tell me how you feel; it is important."
- "I'm sorry you had to see (or hear) that."
- You do not deserve to have this in your family."
- "It is not your job or responsibility to prevent or change the situation."
- "We can talk about what to do to keep you safe if it happens again" (such as staying in the bedroom, going to neighbors, calling a relative or 911).
- "I care about you. You are important."
- "It is the job of adults to keep kids safe. There are adults who will work to keep you and your family safe."

How Much Information Is Enough But Not Too much?

Parents often struggle with how much specific information to share with children about what happened during a domestic violence incident. To gauge the right level of discussion, parents will find it helpful to

- Think about how to present the information in a form the child will understand. The amount of detail shared will often depend on the age and developmental stage of the child.
- Start by providing straightforward messages of support (see above), or by asking what the child saw, feels, or thinks about what happened.
- Ask the child if he or she has questions. Children will often stop asking questions when they have enough information to feel safe and secure. Refrain from giving them more information than they need or want.
- Remember that *it is always okay to ask children what they know and what they think.*
- Understand that giving children an opportunity to talk openly and ask questions about what they experienced can be more effective than reviewing the details from the adult's perspective.

What Should a Parent Tell a Child about the Parent Who Was abusive?

Parents who have experienced domestic violence often seek guidance on what to tell their children about the parent or partner who was abusive. Here are some key messages for children:

- The abusive behavior was not okay; violence is not okay.
- The abusive person is responsible: "It's not your fault. It's not my fault."
- It's okay to love and want to spend time with the person who was abusive.
- It's okay to be mad at or scared of the person who was abusive.
- It's also okay to feel mad at but still love the person who was abusive.

How Can Advocates Protect Children From Adult Information?

As an advocate, you may find yourself filling out legal paperwork, discussing details, and reviewing domestic violence incidents with clients in the presence of their children. Hearing the specific details of events can act as a trauma reminder for children. The descriptions themselves can be disturbing, as can the parent's distress in recounting them. A child too young to understand the content can still become upset. Even babies react to a caretaker's emotional distress with their own increased heart rates and signs of stress. The situation presents a challenge for advocates, but the following strategies can guide you in protecting children:

- If at all possible, avoid talking about the specifics of the domestic violence in front of children.
- Maintain a child-friendly waiting area for children old enough to wait on their own.
- Offer toys and games that may distract or comfort children if they have to be in the room with adults.
- Inform children that the advocate and parent are going to be talking about what happened, and that they might have some feelings about this. Check in on the child's feelings throughout the conversation, and offer comfort and reassurance.

- Encourage parents whenever possible to use natural supports for child care (such as friends, families, or familiar service providers), or ask if there is someone who can come and stay in the waiting room with the children for at least part of the time.
- Seek volunteers to provide child care during regularly scheduled hours in outreach offices and shelters.

How Should Parents Respond to and Cope with Their Children's Feelings about Them?

Children who have witnessed domestic violence often have confused and contradictory feelings. They may worry about the safety of the parent who has been abused. They may also worry that their parents won't be able to protect them. They may see the parent who was abusive as generous and loving some of the time, and terrifying and dangerous at other times. They may even blame the abused parent for causing the abuse that led to separation from the other parent. Often, children feel torn over loyalties and caught in the middle. Here are some messages to offer children to help them explore and cope with these feelings:

- It is okay to feel more than one emotion at the same time (such as anger and love).
- It is normal to feel angry at either or both parents when violence happens.
- You can love someone and hate that person's behavior.
- It's okay to love both parents at the same time.
- Violence is an adult problem and it is not your fault or responsibility. You can't fix it.

A parent who has experienced domestic violence may expend a lot of energy simply surviving and helping the children survive. Other aspects of parenting may suffer as a consequence. The parent may become either overly permissive or too rigid and harsh in applying discipline. Or the parent may be inconsistent and fluctuate between permissiveness and harshness. Roles in the family may have become reversed. Children may have taken on parenting responsibilities in an effort to care for and protect family members.

In addition to providing emotional support and safety for families following domestic violence, advocates may need to model better parenting and offer strategies for behavior management. Indeed, these strategies may be needed immediately for some families in offices and shelters. Basic strategies include:

- *Active ignoring or "picking your battles."* Children's negative behaviors may be efforts to get attention from adults. An effective strategy is to identify the behaviors that can be ignored. Of course, a parent cannot ignore unsafe behaviors, but withdrawing attention from other negative or unwanted behaviors should eventually decrease them.

- *Specific praise.* Using very specific praise to reward positive behavior not only increases the likelihood that the behavior will be repeated, but helps children feel valued and proud of themselves. *Active ignoring is often most effective when paired with specific praise.*
- *Rules and routines.* Structured, consistent, and predictable rules and routines can be extremely helpful. Children living with domestic violence often see the world as unpredictable and unsafe. Maintaining consistent rules and routines teaches children that life can be predictable. It also helps improve behavior problems and contributes to the child's sense of safety.
- *Relaxation.* Teaching children simple relaxation skills, such as deep breathing, and providing the space for them to practice relaxing, can be very effective in helping them manage fear and anxiety. Relaxation can decrease acting-out behavior that may be due to anxiety and exposure to trauma reminders. For younger children, providing a safe and quiet place to play and explore can be helpful.
- *Adequate support.* Parents who get help and support in coping with their own feelings are better equipped to help their children. They should be encouraged to seek help from mental health professionals or other support systems.

How Advocates Can Determine when a Child Needs More Help

Exposure to domestic violence can place children at risk for a variety of emotional, social, and behavioral problems. Some children, including those who exhibit the following warning signs, may require additional professional help to achieve recovery. If parents describe these signs, you should consider talking with them about seeking additional help:

- The child's traumatic stress reactions—such as re-experiencing, withdrawal, arousal, sleep disturbances, and reactions to trauma reminders—are severe enough to interfere with daily life.
- The child doesn't seem like herself. The child's behavior or mood has changed.
- The child is having significant trouble eating or sleeping, or complains of a lot of physical symptoms that have no apparent medical cause.
- The child's behaviors are becoming more risky and less predictable.
- The child seems sad, depressed, clingy, hopeless, or withdrawn from activities that were once loved.
- The child talks about dying or engages in self-injurious behaviors such as substance abuse, unhealthy sexual activity, cutting, or head banging.
- The child is increasingly worried, anxious, or fearful, or exhibits increased anger or aggression.

Secondary Trauma and How it Can Impact Clinicians

Caring for survivors of domestic violence and their children can exact a toll. In the process of hearing the vivid details of domestic violence, and responding with empathy, advocates themselves can experience traumatic stress reactions. A victim's story may

even serve as a trauma reminder if you have experienced domestic violence or other traumatic events in your own life. Repeated exposure to trauma reminders can compromise your health and well-being. For example, you may feel overwhelmed by what you have heard or seen, and perhaps find yourself losing patience with a demanding mother or child. Reactions like these are often referred to as signs of *secondary traumatic stress* (or compassion fatigue, or vicarious trauma). *Secondary trauma is not a sign of weakness or lack of skill.* It is a normal response to working in the field of domestic violence advocacy. Possible signs of secondary traumatic stress include:

- Increased irritability or impatience with clients
- Intense feelings and intrusive thoughts (including nightmares) about a client's trauma
- Changes in how you experience yourself, others, and the world
- Persistent anger or sadness
- Increased fatigue or illness
- Disconnection from your colleagues or loved ones

If you notice these or other signs of secondary trauma, take steps to care for yourself and get support relevant to your work. Consider these possible strategies:

- Talk to a professional if your symptoms are affecting your day-to-day functioning at work or at home.
- Seek professional help to address your own history of domestic violence or other trauma.
- Reach out to team leaders, managers, and colleagues for support.
- Renew your commitment to creating a work-life balance.
- Identify and use coping strategies to manage stress.
- Utilize personal support systems.
- Attend to your physical, spiritual, and emotional health needs.
- Take some time off.

For further information about the impact of domestic violence on children and families, these Web sites offer valuable resources for advocates and parents:

National Child Traumatic Stress Network
http://www.nctsn.org

National Center for Children Exposed to Violence
http://www.nccev.org

Safe Start Center
http://www.safestartcenter.org

National Coalition Against Domestic Violence
http://www.ncadv.org

Office on Violence Against Women
http://www.enditnow.gov

(Source: National Child Traumatic Stress Network, Domestic Violence and Children: Questions and Answers for Domestic Violence Project Advocates)

- ✓ 15.5 million U.S. children live in families in which partner violence occurred at least once in the past year, and seven million children live in families in which severe partner violence occurred.

- ✓ The majority of U.S. nonfatal intimate partner victimizations of women (two-thirds) occur at home. Children are residents of the households experiencing intimate partner violence in 43 percent of incidents involving female victims.

- ✓ In a single day in 2007, 13,485 children were living in a domestic violence shelter or transitional housing facility. Another 5,526 sought services at a non-residential program.

- ✓ The UN Secretary-General's Study on Violence against Children conservatively estimates that 275 million children worldwide are exposed to violence in the home.

- ✓ Children of mothers who experience prenatal physical domestic violence are at an increased risk of exhibiting aggressive, anxious, depressed or hyperactive behavior.

- ✓ Females who are exposed to their parents' domestic violence as adolescents are significantly more likely to become victims of dating violence than daughters of nonviolent parents.

- ✓ Children who experience childhood trauma, including witnessing incidents of domestic violence, are at a greater risk of having serious adult health problems including tobacco use, substance abuse, obesity, cancer, heart disease, depression and a higher risk for unintended pregnancy.

- ✓ Physical abuse during childhood increases the risk of future victimization among women and the risk of future perpetration of abuse by men more than two-fold.

- ✓ Psychotherapy designed for mothers and children together can increase the quality of parenting and increase positive outcomes for children.

- ✓ Many abusive men are concerned about the effect of violence on their children and the children of their partners. Some may be motivated to stop using violence if they understand the devastating effects on their children.

- ✓ A safe, stable and nurturing relationship with a caring adult can help a child overcome the stress associated with intimate partner violence.

Evaluative clinical information should be carefully entered in the client's record, since there may be future legal implications, including child custody determination. Mental health care professionals should remember that while there is no legal obligation to report cases of adult abuse, the law requires that all cases of child abuse must be reported to official child protective services. At the same time, mental health professionals should be sensitive to the possibility that victimized women may lose custody of their victimized children to the abuser. Positive aspects of parenting should be recorded as well *(Warshaw, C."Limitations of the Medical Model in the Care of Battered Women". in Bart, P., E. Moran. Violence Against Women: The Bloody Footprints, Sage.).*

6. Intimate Partner Violence and the Law

All jurisdictions in the United States have implemented regulations and laws designed to protect victims of domestic violence. The Violence against Women Act (VAWA), which was signed into law by President Clinton in September 1994, strengthens many of these protections and outlines Federal as well as State enforcement provisions and penalties. This legislation demonstrated the Federal government's commitment to address domestic violence. The Federal penalties mandated by VAWA are more stringent than existing State penalties: The bill, for example, makes it a Federal offense to cross State lines in violation of a civil protection order. In order to provide useful advice and support, substance abuse treatment providers should be familiar with VAWA and with relevant State and local regulations as well as with the legal resources available to victims of domestic violence (Source: Center for Substance Abuse Treatment. Substance Abuse Treatment and Domestic Violence. Rockville (MD): Substance Abuse and Mental Health Services Administration (US); Treatment Improvement Protocol (TIP) Series).

There are four titles within the Act—the Safe Street Act, Safe Homes for Women, Civil Rights for Women and Equal Justice for Women in the Courts, and Protections for Battered Immigrant Women and Children—and each act addresses domestic violence, sexual assault, stalking, and protection against gender-motivated violence. The provisions of VAWA call for improving law enforcement and criminal justice responses, creating new criminal offenses and tougher penalties, mandating victim restitution, and requiring system reform geared towards protecting victims of domestic violence during prosecution of the perpetrator. VAWA also authorized support for increased prevention and education programs, victim services, domestic violence training of community professionals, and

protections from deportation for battered immigrant women (Source: Center for Substance Abuse Treatment. Substance Abuse Treatment and Domestic Violence. Rockville (MD): Substance Abuse and Mental Health Services Administration (US); Treatment Improvement Protocol (TIP) Series)

Besides strengthening prevention and prosecution of violent crimes against women and children, the law made domestic violence a civil rights violation. What this means is that a victim of "crimes of violence motivated by gender" can bring a suit for damages in civil court in addition to any charges made in criminal court.

Some of the more important provisions of the law include

- Greater penalties for sex crimes
- Funding for States to improve law enforcement, prosecution, and services for female victims of violent crimes
- Increased security in public transportation systems and national and urban parks
- Funding for rape prevention and education programs, targeted to, among others, middle and senior high school students
- Enhanced treatment for released sex offenders
- The development of model confidentiality legislation
- Funding for programs for victims of child abuse as well as for individuals who are homeless, for runaways, and for street youth at risk of abuse
- The creation of a national domestic violence hotline
- Funding to improve mandatory arrest or proarrest (a policy stating that police will make arrests in domestic violence incidents) programs, to improve tracking of domestic violence cases, to increase coordination of services, to strengthen legal advocacy, and to educate judges
- The prohibition of the purchase of firearms by individuals subject to a final civil protection order
- The implementation of more protections for battered immigrant women and children, including liberalization of the "battered spouse waiver" enforced by the Immigration and Naturalization Service (INS).

Some provisions of VAWA may be particularly important to women in substance abuse treatment who are also survivors of domestic violence. Under VAWA,

- Past sexual behavior or alleged sexual predisposition of the victim is no longer admissible evidence in civil or criminal proceedings involving sexual misconduct.
- New Federal criminal penalties apply to anyone who crosses a State line in order to commit domestic violence or to violate a civil protection order.

- Anyone who forces a spouse or domestic partner to cross a State line for these purposes also is subject to penalties.
- States are required to enforce civil protection orders issued by the courts of other States.
- Victims must have the opportunity to testify regarding the potential danger of the pretrial release of a defendant.
- Defendants are required to make financial restitution to victims.
- The U.S. Postal Service is required to maintain the confidentiality of shelters and individual abuse victims by not disclosing addresses or other locating information.

One of the most important aspects of VAWA is the civil rights remedy for gender-motivated violence mentioned above. Relief in civil court may include monetary damages, injunctions, or declaratory judgment to redress the civil rights violation. (*Source: Center for Substance Abuse Treatment. Substance Abuse Treatment and Domestic Violence. Rockville (MD): Substance Abuse and Mental Health Services Administration (US). Treatment Improvement Protocol (TIP) Series*)

Local Laws: Civil Protection and Restraining Orders

The most common and easily obtainable mechanism of relief for victims of domestic violence is the civil protection order. This general term includes any injunction or other order (such as a restraining order) that is issued for the purpose of preventing violent or threatening acts against another person. Generally, these orders prohibit harassment, contact, communication, or physical proximity. Protection orders may be temporary or final and may be issued by a civil or a criminal court. Protection orders can be issued independently or as part of another proceeding, such as a divorce or criminal complaint, but are separate from support or child custody orders.

Statutes and case law in all States and the District of Columbia allow an abused adult to petition the court for an order of protection, and in most State courts, a parent or another adult can file for a civil protection order on behalf of a minor child. Depending on the relevant statutes and case law on the books of any given jurisdiction, conduct sufficient to support issuance of a civil protection order can include.

(*Source: Center for Substance Abuse Treatment. Substance Abuse Treatment and Domestic Violence. Rockville (MD): Substance Abuse and Mental Health Services Administration (US). Treatment Improvement Protocol (TIP) Series*)

Family Violence Prevention and Services Act

The Family Violence Prevention and Services Act of 1984 (FVPSA) was Congress' first attempt to address domestic violence in the country. The legislation was designed to assist States with their efforts to increase public awareness about domestic violence and to provide Federal funding for domestic violence shelters and victim services. States and nonprofit organizations also were awarded grants to develop domestic violence and child maltreatment programs and to provide training and technical assistance for law enforcement officers and community service providers.

The Office on Violence against Women is a component of *the United States Department of Justice.* In recognition of the severity of the crimes associated with domestic violence, sexual assault, and stalking, Congress passed the Violence against Women Act of 1994 (VAWA 1994) as part of the Violent Crime Control and Law Enforcement Act of 1994. VAWA is a comprehensive legislative package designed to end violence against women and was reauthorized in both 2000 and 2005. The legislative history of VAWA indicates that Congress seeks to remedy the legacy of laws and social norms that serve to justify violence against women. Since the passage of VAWA, there has been a paradigm shift in how the issue of violence against women is addressed.

The Office on Violence against Women (OVW) was created specifically to implement (VAWA) and subsequent legislation. OVW administers financial and technical assistance to communities around the country to facilitate the creation of programs, policies, and practices aimed at ending domestic violence, dating violence, sexual assault, and stalking.

VAWA was designed to improve criminal justice responses to domestic violence, sexual assault, and stalking and to increase the availability of services for victims of these crimes. VAWA requires a coordinated community response (CCR) to domestic violence, sexual assault, and stalking, encouraging jurisdictions to bring together players from diverse backgrounds to share information and to use their distinct roles to improve community responses to violence against women. These players include, but are not limited to: victim advocates, police officers, prosecutors, judges, probation and corrections officials, health care professionals, leaders within faith communities, and survivors of violence against women. The federal law takes a comprehensive approach to violence against women by combining tough new penalties to prosecute offenders while implementing programs to aid the victims of such violence.

The Violence Against Women Act of 2000 (VAWA 2000) and the Violence Against Women and Department of Justice Reauthorization Act of 2005 (VAWA 2005) reauthorized the grant programs created by the original VAWA and subsequent legislation, as well as established new programs. Specifically, the new programs of VAWA 2005 include the Court Training and Improvements, Child Witness, and Culturally Specific programs. The VAWA 2000 reauthorization strengthened the original law by improving protections for battered immigrants, sexual assault survivors, and victims of dating violence. In addition, it enabled victims of domestic violence that flee across state lines to obtain custody orders without returning to jurisdictions where they may be in

danger. Furthermore, it improved the enforcement of protection orders across state and tribal lines. VAWA 2005 continued to improve upon these laws by providing an increased focus on the access to services for underserved populations.

(*Source: Center for Substance Abuse Treatment. Substance Abuse Treatment and Domestic Violence. Rockville (MD): Substance Abuse and Mental Health Services Administration (US). Treatment Improvement Protocol (TIP) Series*)

All States have mandatory reporting laws for child abuse, but only some have or are developing such laws for reporting domestic violence. Some battered women's advocates support such laws because they "take the pressure off" the victims to report their batterers. Some domestic violence service providers also believe that it is the community's responsibility -- not the victim's -- to stop the batterer's behavior. Some States mandate the arrest of batterers whether or not their victims press charges, and some are proposing mandatory physician reporting of battering. Concerns have been raised, however, about preserving victims' ability to decide whether they want to become involved in the criminal justice system or in domestic violence programs. For this reason, such laws are opposed by some battered-women's groups, who believe they put women at greater risk.

Regardless of whether a survivor elects to pursue legal remedies, she is well-advised to document the nature and extent of the domestic violence she and her family have experienced by compiling copies of

- Criminal justice reports, including prior legal actions (e.g., restraining orders) against batterers
- Any previous CPS reports that can be obtained
- Hospital records and health history of the client

Complete criminal justice and medical records may be difficult to obtain. In the case of medical records, for example, survivors may have made visits to numerous institutions (e.g., clinics and emergency rooms) in order to avoid raising the suspicion of domestic violence. Issues of confidentiality also may be an impediment to obtaining these records. (See Appendix B for more information on confidentiality.) When clients are unsuccessful in compiling information from standard sources, their self-reports to substance abuse treatment providers, documented in their program records, can be used to fill in the gaps and to help support their claims. When entering notes into the client's record, however, it is important to include the facts as presented or observed. Records can be subpoenaed and "gratuitous comments or opinions" may be used against survivors in custody cases (Source: Center for Substance Abuse Treatment. Substance Abuse Treatment and Domestic Violence. Rockville (MD): Substance Abuse and Mental Health Services Administration (US); Treatment Improvement Protocol (TIP) Series; Minnesota Coalition for Battered Women).

7. Implications for Prevention

The findings of the *National Intimate Partner and Sexual Violence Survey* underscore the heavy toll that sexual violence, stalking, and intimate partner violence places on women, men, and children in the United States. Violence often begins at an early age and commonly leads to negative health consequences across the lifespan. Collective action is needed to implement prevention approaches, ensure appropriate responses, and support these efforts based on strong data and research *(Source: The National Intimate Partner and Sexual Violence Survey | Summary Report).*

Prevention efforts should start early by promoting healthy, respectful relationships in families by fostering healthy parent-child relationships and developing positive family dynamics and emotionally supportive environments. These environments provide a strong foundation for children, help them to adopt positive interactions based on respect and trust, and foster effective and non-violent communication and conflict resolution in their peer and dating relationships. It is equally important to continue addressing the beliefs, attitudes and messages that are deeply embedded in our social structures and that create a climate that condones sexual violence, stalking, and intimate partner violence. For example, this can be done through norms change, changing policies and enforcing existing policies against violence, and promoting bystander approaches to prevent violence before it happens (*Source: The National Intimate Partner and Sexual Violence Survey | Summary Report*).

Promote Healthy, Respectful Relationships among Youth

Relationships with Parents

Building healthy parent-child relationships can address a range of risk factors for sexual violence, stalking, and intimate partner violence. These relationships can benefit from efforts to build positive, effective parenting skills; include and support fathers; increase positive family relationships and interactions; and develop emotionally supportive familial environments, which facilitate respectful interactions and open communication. Further, parents who model healthy, respectful intimate relationships free from violence or aggression foster these relationship patterns in their children. It is also important to give adults, particularly parents, the skills and resources to prevent child sexual abuse (*Source: The National Intimate Partner and Sexual Violence Survey | Summary Report*).

Relationships with Peers and Dating Partners

Characteristics of respectful relationships include: a belief in nonviolent conflict resolution; effective communication and conflict resolution skills; the ability to negotiate and adjust to stress and safely manage emotions such as anger and jealousy; and a belief

in a partner's right to autonomy, shared decision-making, and trust. From preschool through the teen years, young people are refining the skills they need to form positive relationships with others. It is important to promote healthy relationships among young people and prevent patterns of dating violence that can last into adulthood. It is also important to reinforce respectful relationships among peers to prevent sexual harassment and bullying (*Source: The National Intimate Partner and Sexual Violence Survey | Summary Report*).

Prevention strategies that engage parents and youth in skill-building activities and encourage or reward respectful, healthy peer interactions and dating relationships can be implemented in the home, community, or school to ensure more youth experience and practice healthy relationships during this key developmental phase *(Source: The National Intimate Partner and Sexual Violence Survey | Summary Report).*

Address Beliefs, Attitudes, and Messages that Condone, Encourage, or Facilitate Sexual Violence, Stalking, or Intimate Partner Violence

The promotion of respectful, nonviolent relationships is not just the responsibility of individuals and partners, but also of the communities and society in which they live. It is important to continue addressing the beliefs, attitudes and messages that are deeply embedded in our social structures and that create a social climate that condones sexual violence, stalking, and intimate partner violence. One way is through norms change. Societal and community norms, policies, and structures create environments that can support or undermine respectful, nonviolent relationships. Such beliefs and social norms are reinforced by media messages that portray sexual violence, stalking, or intimate partner violence as normative and acceptable, that reinforce negative stereotypes about masculinity, or that objectify and degrade women *(Source: The National Intimate Partner and Sexual Violence Survey | Summary Report).*

Further, failure to enforce existing policies and laws against these forms of violence may perpetuate beliefs that these behaviors are acceptable. It is important for all sectors of society to work together as part of any effort to end sexual violence, stalking, and intimate partner violence, both to change norms, attitudes, and beliefs, as well as support women and men in rejecting violence *(Source: The National Intimate Partner and Sexual Violence Survey | Summary Report).*

Another strategy involves engaging bystanders to change social norms and intervene before violence occurs. In many situations, there are a variety of opportunities and numerous people who can choose to step forward and demonstrate that violence will not be tolerated within the community. For instance, bystanders may speak out against beliefs, attitudes, and behaviors that support or condone sexual violence, stalking, and intimate partner violence − such as media portrayals that glamorize violence − and

change the perceptions of these social norms in their peer groups, schools, and communities *(Source: The National Intimate Partner and Sexual Violence Survey | Summary Report).*

Ensure Appropriate Response

An emphasis on primary prevention is essential for reducing the violence-related health burden in the long term. However, secondary and tertiary prevention programs and services are also necessary for mitigating the more immediate consequences of violence. These programs and services are valuable for treating and reducing the sequelae and severity of violence and for intervening in the cycle of violence. Sexual violence, stalking, and intimate partner violence are often repetitive and can recur over long time periods. Several strategic foci for the secondary and tertiary prevention of violence have emerged from the existing knowledge base *(Source: The National Intimate Partner and Sexual Violence Survey | Summary Report).*

Provide Survivors with Coordinated Services and Develop a System of Care to Ensure Healing and Prevent the Recurrence of Victimization

The effects of sexual violence, stalking, and intimate partner violence on survivors and communities are profound. For example, survivors of sexual violence are at a higher risk for a number of physical and mental health problems and other adverse life events, including further victimization. The health care system's response must be strengthened and better coordinated for sexual violence, stalking, and intimate partner violence survivors to help navigate the health care system and access needed services and resources in the short and long term. For instance, more physicians and other health care professionals need training on forensic and patient care issues related to sexual violence. The health care response can be enhanced—and survivors can be better served—if more providers are equipped with the specific knowledge and skills necessary to provide good forensic medical care, direction, supervision, and leadership, as well as provide respectful, sensitive care and guidance to survivors. Education and training should be targeted specifically to stakeholders who may be involved in Sexual Assault Response Teams (SARTs), as these first responders set the tone for the victim's experience in the criminal justice, health care, and legal systems. It is also important that health professionals be alert to the signs and symptoms of sexual violence and intimate partner violence at initial, follow-up, and annual visits. When signs and symptoms of violence are present, it should be required that an appropriate history is taken, assessment of symptoms is conducted, and appropriate treatment, counseling, protection referrals, and follow-up care are provided. A recent report by the Institute for Medicine (IOM, 2011) also called upon the U.S. Department of Health and Human Services to require coverage for screening and counseling for all women and adolescent girls for interpersonal and domestic violence as a preventive service in health insurance plans. The IOM recommends that these services be carried out in a culturally sensitive and supportive manner as part of women's preventive services without charging a co-payment, co-

insurance or a deductible *(Source: The National Intimate Partner and Sexual Violence Survey | Summary Report)*.

Much progress has been made in the prevention of violence. There is strong reason to believe that the application of effective strategies combined with the capacity to implement them will make a difference. The lessons already learned during public health's short experience with violence prevention are consistent with those from public health's much longer experience with the prevention of infectious and chronic diseases. Sexual violence, stalking, and intimate partner violence can be prevented with data-driven, collaborative action *(Source: The National Intimate Partner and Sexual Violence Survey | 2010 Summary Report)*.

Primary prevention of intimate-partner violence and sexual violence
(Source: World Health Organization WHO)

For more than a decade intimate-partner violence and sexual violence against women have been recognized as major global public health problems, as well as serious human rights abuses. The impact of these forms of violence on acute and long-term health and well-being has been documented in publications such as WHO's World report on violence and health, the WHO Multi-country study on women's health and domestic violence against women, and various other population-based studies. Intimate-partner violence and sexual violence have a damaging impact on physical, mental and reproductive and sexual health, with consequences such as physical injuries, depression, post-traumatic stress disorder, suicide attempts, substance abuse, unwanted pregnancy, gynecological disorders, sexually transmitted infections, increased HIV/AIDS risk, and others. Intimate-partner violence, sometimes called domestic violence or spouse abuse, includes acts of physical aggression, sexual coercion, psychological/emotional abuse and controlling behaviors by a current or former partner or spouse. It can happen within marriage, long-term partnerships or short-term intimate relationships, and can be perpetrated by ex-partners when these relationships have ended. It has been documented as largely perpetrated by men against women, although such violence also occurs in same-sex couples and can be perpetrated by women against men. As a category of interpersonal violence, intimate-partner violence includes dating violence that occurs among young people, although the pattern of such violence may be different to that experienced in the context of long-term partnerships, and studies often examine the two issues separately. Sexual violence occurs both within intimate partnerships and outside them. It has a significant impact on both girls and boys, although among adults women are at substantially greater risk of victimization than men. Sexually violent acts can be perpetrated by intimate partners, family members, friends, acquaintances, authority figures such as teachers or clergy, or strangers. In most communities however intimate partners and people known to the victim are by far the most common category of perpetrator. Sexual violence takes different forms over the life course, from child sexual abuse to forced sexual initiation to sexual coercion within and outside intimate relationships.

Definitions from the World report on violence and health

Intimate partner violence: Any behavior within an intimate relationship that causes physical, psychological or sexual harm to those in the relationship. Sexual violence: any sexual act, attempt to obtain a sexual act, unwanted sexual comments or advances, or acts to traffic, or otherwise directed, against a person's sexuality, using coercion, threats of harm or physical force, by any person regardless of relationship to the victim, in any setting, including but not limited to home and work.

There is no estimate of the global prevalence of either intimate-partner violence or sexual violence. Estimates vary by country, and according to study methodology (i.e. how these types of violence are measured), and which behaviors or experiences are included in the prevalence estimate. For example, estimates of the prevalence of intimate-partner violence based on physical abuse alone, miss important dimensions of intimate partner violence, and thus are lower than estimates that also include sexual and psychological abuse. Population-based studies from various countries indicate that between 10% and 69% of women report that an intimate partner has physically abused them at least once in their lifetime, and between 6% and 47% of women report attempted or completed forced sex by an intimate partner in their lifetime. According to international crime victimization surveys, between 0.8% and 8% of women aged 16 years and older report having experienced sexual assault in the previous five years). Population-based studies indicate that young people—both girls and boys—experience significant levels of sexual coercion; studies of forced sexual initiation, for example, have found that between 7% and 48% of adolescent girls and between 0.2% and 32% of adolescent boys report that their first experience of sexual intercourse was forced. In fact a growing body of research suggests that the younger the age of sexual debut, the more likely it is that the first sexual experience is coerced).

WHO’s Multi-country study on women’s health and domestic violence against women supports the findings of other research that the prevalence of intimate-partner violence and sexual violence varies widely between and within countries and is disturbingly high in many places (GarciaMoreno et al., 2005). This variance was found even after controlling for methodological comparability across sites, indicating that the variance was real and not simply the result of methodological differences. Based on interviews with more than 24 000 women from rural and urban areas in 10 countries, the study found that: • Across the different study sites, between 13% and 61% of ever-partnered women reported physical abuse by a partner at some point during their lives, with results from most study sites falling between 23% and 49%. • Lifetime prevalence of sexual violence by an intimate partner ranged from 6% to 59%, with the prevalence in the majority of study sites falling between 10% and 50%. • Prevalence of sexual violence by a non-partner in those older than 15 years ranged from 1% to 12%. • Prevalence of sexual abuse in those younger than 15 years ranged from 1% to 21%. In recent years the findings of high levels of victimization of men by their intimate partners, in some industrialized countries, has resulted in a demand for an increased focus on male victims. Some studies, particularly among samples of students and couples in dating relationships,

in high-income countries have found that a significant proportion of men experience physical aggression and violence from their intimate partners, some of which results in physical injury. The high levels of men's victimization found in these studies, however, are not typical of the pattern of intimate-partner violence seen in low- and middle income countries where women’s status remains low. Rather cross-sectional studies show that higher levels of female intimate partner violence victimization are found in countries with less gender equality, and higher levels of male intimate partner violence victimization in countries with greater gender equality. Furthermore, while sexual violence also appears to be predominantly perpetrated by males against females, there is growing evidence that boys and men are also victims of rape by other men. This needs to be studied more. While the situation of male victims is a concern, it is appropriate to retain policy and program emphasis on intimate partner violence and sexual violence against women in countries with lower levels of gender equality. This paper explores what can be done to prevent violence against adolescent and adult women that occurs within intimate relationships, and sexual violence that occurs outside intimate relationships. While recognizing the high prevalence of child sexual abuse throughout the world, its impact on health and development, and the importance of child sexual abuse prevention for its own sake, this paper examines the prevention of child sexual abuse as a strategy for reducing involvement in and exposure to intimate partner violence and sexual violence during adolescence and adulthood. 1.1 What do we mean by primary prevention? In a public health framework, primary prevention means reducing the number of new instances of intimate-partner violence or sexual violence by intervening before any violence occurs. The impact of primary prevention is measured at population level by comparing the frequency with which either victimization or perpetration occurs. This approach contrasts with other prevention efforts that seek to reduce the harmful consequences of an act of violence after it has occurred, or to prevent further acts of violence from occurring once violence has been identified. Primary prevention relies on identification of the underlying, or “upstream”, risk and protective factors for intimate-partner violence and/or sexual violence, and action to address those factors. Its aim is to reduce rates of intimate partner violence and sexual violence. The meaning of taking action “upstream” is illustrated by a scenario commonly taught in public health courses.1 Some people are fishing on the riverbank. Suddenly they see a person swept by in the current, half-drowned and struggling to stay afloat and swim to shore. They wade into the water and grab hold of the person, who continues on her way by land once she has caught her breath and dried off a bit. Just as they get her to shore they see another person in trouble or hear a cry for help. All afternoon they continue saving people from drowning by pulling them out of the river, until someone decides to walk upstream to find out what is causing people to be swept away in the river in the first place. Taking action upstream to prevent intimate partner violence and sexual violence involves understanding and intervening against those factors that place people at risk for becoming victims and perpetrators of such violence. One does not have to look far to find women struggling in the river of intimate partner violence and sexual violence. Advocates and activists from the women’s movement have fought long and hard to gain recognition for these women and to

establish their right to recognition, assistance, and justice. Their labor has placed violence against women on the international agenda and generated political will to address it. Without their efforts there would be no opportunity to contemplate primary prevention. The upstream approach does not mean discounting the importance of downstream interventions that occur “on the riverbank”. The choice is not between primary prevention or interventions to assist survivors—both are needed. This paper gives particular emphasis to the primary prevention approach because it has received comparatively little attention, investment, and commitment internationally. Several approaches commonly understood to be intimate partner violence and sexual violence prevention strategies do not fall under primary prevention as understood here, including working with known perpetrators to stop their use of violence, safety planning for women living in situations of ongoing violence, shelters for abused women, and risk reduction or self-defense strategies intended to prevent the completion of an act of violence. These approaches would be considered secondary and tertiary prevention in public health terminology. Unless otherwise stated, use of the term prevention in this paper refers exclusively to primary prevention. Prevention approaches for intimate partner violence and sexual violence are not limited to programs or policies whose stated objective is to reduce these forms of violence. Structural and policy approaches to improve gender equality are likely to have effects on rates of intimate partner violence and sexual violence, although their impact is not yet well understood and needs to have stronger scientific evidence. A broad understanding of approaches to the prevention of intimate partner violence and sexual violence requires examination of factors over the life course, as well as beyond the individual, which can be modified to result in less intimate partner violence and sexual violence (see section 2.1. on risk factors and the ecological model). For example, reductions in intimate partner violence and sexual violence may result from policy interventions to reduce alcohol-related harm, or early childhood strategies to prevent child maltreatment and promote healthy development. 1.2 A global picture of intimate-partner violence–sexual violence prevention International responses to intimate partner violence and sexual violence against women have been grounded mainly in the human rights framework, which understands the pervasiveness of violence against women to be an obstacle to equality, development, and women’s full enjoyment of their fundamental rights and freedoms (Beijing Declaration). A variety of international instruments and agencies provide a mandate for taking action to end violence against women. The call for prevention is not absent among them:

- The United Nations Declaration on the Elimination of Violence against Women calls on States to exercise due diligence to, among other things, prevent acts of violence against women whether they are perpetrated by the State or private actors (Article 4.c), and to develop comprehensive preventive approaches (Article 4.f).
- The Beijing Declaration and Platform for Action calls on States to take integrated measures to prevent and eliminate violence against women (Strategic objective D. 1), and specifically to exercise due diligence to prevent acts of violence against

women (124.b), to adopt, implement and review legislation to ensure its effectiveness in ending violence against women—emphasizing prevention (124.d), and to adopt measures to modify social and cultural patterns of conduct of men and women (124.k).

- United Nations General Assembly Resolution 61/143 - in response to the Secretary General's in-depth study on all forms of violence against women (United Nations) - urges States to take positive measures to address structural causes of violence against women and to strengthen prevention efforts that address discriminatory practices and social norms (8.f), and to exercise due diligence to prevent all acts of violence against women, including by improving the safety of public environments (8.h).
- UNIFEM, a United Nations agency that provides financial and technical assistance to foster gender equality and operates the UN Trust Fund to Eliminate Violence Against Women has noted that "Strategies to stop [violence against women] before it starts are essential, but lack resources and visibility." (See http://www.unifem.org/gender_issues/violence_against_women/at_a_glance.php
- The World Health Organization has called for increased attention to primary prevention of intimate partner violence and sexual violence, through the recommendations of the World report on violence and health , World Health Assembly Resolution 56.24 on implementing the report's recommendations (*WHA*), and in the recommendations of the WHO Multi-country study on women's health and domestic violence against women (*Garcia-Moreno et al.*).

In response to this call, remedies promoted by the international community have focused on recommendations such as legal and judicial reform, ending impunity for perpetrators, providing survivors with access to justice mechanisms, and improving access to services such as shelters for abused women and quality medico-legal care. These efforts are positive and have improved the situations of many women living with violence, but they may be of limited value in their ability to address the underlying factors that cause intimate partner violence and sexual violence. They may have value for preventing further acts of violence after violence has been disclosed, and for reducing harmful consequences, but there is little scientific evidence they can prevent new instances of intimate partner violence and sexual violence, due in part to a lack of evaluations. The few primary prevention approaches that have been widely adopted include extensive advocacy campaigns and efforts to enact and implement laws to deter potential perpetrators. Other initiatives have emphasized interventions to protect and assist women who have already experienced violence. UNIFEM, for example, notes that its campaigns generated more demand for services for survivors than many countries could meet. Keeping in mind the downstream/upstream scenario, this type of response to awareness-raising is natural. When people become aware of the true extent of intimate partner violence and sexual violence, the instinct of most is to demand justice and care for the survivors, and punishment for the perpetrators. It is

difficult to look beyond the sheer numbers of people who are struggling with violence now, to the more remote factors that would need to be altered to prevent more people from ending up in the position of being victims or perpetrators. This paper discusses efforts being made around the world to stop new instances of intimate partner and sexual violence occurring by addressing factors that can increase the risk of these acts. It is not intended to be a systematic review, but rather an overview of existing approaches, the evidence base behind them, and what is needed to scale up primary prevention, particularly in low- and middle-income countries.

2. Primary prevention framework

The public health approach to the primary prevention of intimate partner violence and sexual violence is grounded in four stages:

1. Define intimate partner violence and sexual violence and document their scope and magnitude.

2. Identify factors that increase the risk of intimate partner violence and sexual violence or have a protective effect.

3. Design prevention strategies using knowledge of risk and protective factors and grounded in social science theory for modification of those factors. Evaluate the impact of any strategy.

4. Implement proven and promising strategies on a larger scale, in various settings, continuing to monitor their impact.

2.1 Problem definition and measurement

Globally, problem definition and measurement is the best-developed component. Awareness of intimate partner violence and sexual violence has sparked numerous initiatives to measure the extent of the problem, particularly of violence by intimate partners, in different countries. The global evidence base on prevalence and consequences, particularly of intimate partner violence, has expanded greatly in the last five years, including research such as the WHO Multi-country study on women's health and domestic violence against women, and the availability of data from an increasing number of Demographic and Health Surveys, Reproductive Health Surveys (led by the United States of America Centers for Disease Control and Prevention) and other national surveys of violence against women. Further work is needed to improve measurement and reach consensus on operational definitions, particularly in respect of sexual and emotional violence. Most recommendations for addressing intimate partner violence and sexual violence include recommendations for strengthening data collection and research. At a national level this may the first necessary step before the next stages can occur.

2.2 Risk factors

Although the global evidence base on the prevalence of intimate-partner and sexual violence is substantial, the same cannot be said for the global evidence base on risk and protective factors. Current understanding of factors associated with intimate partner

violence and sexual violence derives mainly from research in high-income countries, and from cross-sectional studies that do not allow for determination of causality. Primary prevention strategies in low and middle-income countries would be much strengthened by more and better research on risk and protective factors in diverse socioeconomic and cultural contexts. Intimate partner violence and sexual violence result from the interaction of a number of factors. No single factor can explain why some people are at a high risk while others are not or why it is more common in some contexts than in others. Figure 1 presents an ecological model for understanding this interplay of factors at various levels (*Krug et al., 2002*). This model illustrates how an individual's exposure to violence is influenced by factors at the individual, relational, community and societal levels. The individual level of the model encompasses biological factors, beliefs and attitudes, and personal history factors that influence an individual's likelihood of becoming a victim or perpetrator. The relationship level reflects how an individual's close social relationships influence the risk of violence. Factors at the community level relate to the settings of social relationships, such as neighborhoods, workplaces and schools, and characteristics of those environments that contribute to or protect against violence. Societal level factors refer to those underlying conditions of society that either encourage or inhibit violence. The interaction of factors at various levels of the model must also be taken into account.

The Annex summarizes current knowledge about the causes and risk factors found to be associated with intimate-partner violence and sexual violence at the different levels of the ecological model. 2 Risk groups for both forms of violence include young people, people who have witnessed family violence as children, and people with a prior history of victimization or perpetration. Generally, women are at greater risk of victimization, and men at greater risk of perpetration. Little is known about the relative importance of these factors as underlying causes, and the role of various factors may differ from country to country. Some factors are unique to intimate partner violence or sexual violence, but there are several important factors in common: — gender inequality; — social norms supportive of traditional gender roles, intimate partner violence and sexual violence, and macho male gender roles; — poverty, economic stress and unemployment; — lack of institutional support from police and judicial systems; — weak community sanctions; — dysfunctional, unhealthy relationships characterized by inequality, power imbalance and conflict; — alcohol and substance misuse; and — witnessing or being a victim of violence as a child. This overlap indicates the importance of addressing intimate partner violence and sexual violence in tandem rather than in isolation, while still giving attention to those factors unique to one or the other. Most of the research on factors associated with these forms of violence has been conducted in high-income countries and therefore needs to be tested to determine its relevance in low- and middle-income countries (*Heise & Garcia-Moreno, 2002*), especially given recent findings that the nature and strength of the association between intimate partner violence and sexual violence, and variables such as women's education levels and status disparities within the couple, varies from country to country (*Kishor & Johnson, 2004*). With that caveat, the existing research suggests that effective primary prevention approaches for intimate-

partner and sexual violence would include strategies to improve gender equality; to change social norms regarding violence, masculinity and gender roles and relationships; to reduce poverty and to strengthen economic and social safety nets; to promote healthy and equal relationships; to reduce alcohol and drug misuse; to have a particular focus on young people; and to prevent exposure to violence in childhood.

2.3 Design, evaluate and implement proven strategies

As mentioned above, efforts to prevent intimate-partner violence and sexual violence are being made and are becoming more numerous in certain regions. The majority of such approaches that are documented in the public domain, however, are not grounded in an understanding of risk factors or in social science theory regarding behavior and social change. Furthermore, the evidence base for prevention approaches suffers from the following deficits (*Krug et al.,; Dahlberg & Butchart,*):

- few outcome evaluations, and even fewer from low and middle-income countries;
- few systematic evaluations of the same program over time;
- evaluation designs are often weak, relying on pre-test and post-test measurements of individuals' knowledge, attitudes and behavioral intent over short follow-up periods and without comparison groups. Efforts to measure the impact of interventions on actual violent behavior and rates of intimate-partner violence and sexual violence are extremely limited;
- few evaluations of the impact of community and society-level change strategies. The only prevention approaches implemented on a large scale thus far are public awareness campaigns and reforms of the criminal justice sector, but their impact is not well-understood. Evaluations of awareness campaigns too often stop at process indicators such as quantity of materials disseminated, exposure to materials, or measures of changes in knowledge only, and few attempts have been made to measure the impact of criminal justice responses on rates of intimate-partner violence or sexual violence. There is an urgent need for outcome evaluations of evidence-based strategies and a systematic approach to primary prevention that ensures widespread implementation of strategies delivered as early as possible at the appropriate developmental stage, over the life course, and addressing factors at all levels of the ecological model. The remainder of this paper explores several approaches currently used in prevention of intimate-partner violence and sexual violence.

2.4 Scale up effective interventions and monitor their effects

The fourth step of the public health approach is to implement effective and promising interventions in a wide range of settings and, through ongoing monitoring of their effects on the risk factors and the target problem, to evaluate their impact and cost-effectiveness. To date, as already noted, public awareness campaigns and reforms of the criminal justice sector are the only interventions implemented on a large scale, but their impact remains poorly understood due to inadequate monitoring and evaluation.

3. Primary prevention approaches

Although the complexity of prevention approaches for intimate-partner violence and sexual violence preclude neat categorization, several broad categories become apparent when examining the different programs and strategies utilized to date. Current strategies for the primary prevention of intimate-partner violence and sexual violence, reviewed below, include early childhood and family-based approaches; school-based approaches; interventions to reduce alcohol and substance misuse; public information and awareness campaigns; community-based approaches such as community mobilization; and structural and policy approaches such as strengthening gender equality and improving criminal justice system responses. There is also a growing trend towards working with men and boys to prevent intimate-partner violence and sexual violence. Although this work relies on many of the approaches listed above, it is often treated as a separate approach in the literature, and is therefore reviewed separately in this paper.

3.1 Early childhood and family-based approaches

Experiences in early childhood have a major impact on physical, cognitive, emotional and social development throughout the lifespan. During the early years of life, children learn from their immediate family and community environment how to interact with the world and how to relate to other people. Although few early childhood development, health promotion or violence prevention programs have the prevention of intimate-partner violence and sexual violence as an explicit goal, approaches that aim to develop physically, emotionally, and socially healthy children and reduce exposure to violence and other adverse events have the potential to significantly reduce the prevalence of all forms of violence, including intimate-partner violence and sexual violence. The strength of the relationship between a child's exposure to maltreatment and risk of involvement in intimate-partner violence and sexual violence later in life suggests that the prevention of child maltreatment could be an important component of the prevention of intimate partner violence and of sexual violence (*Mercy, Sleet & Doll, 2005; Farrington, 2006*). Strong evidence exists to support the effectiveness of home visits and parent training programs in preventing child maltreatment (*Olds et al., 1999, Oleg et al., 2005; Farrington, 2006*). To our knowledge, the impact of these strategies specifically on the risk of intimate-partner violence and sexual violence over the life course of the visited child has not been directly investigated. However, these strategies may be effective in reducing intimate-partner violence and sexual violence by reducing child maltreatment and the cognitive, social and behavioral consequences of child maltreatment that affect risk. Olds and colleagues found that, 15 years after the intervention, children whose mothers were visited by nurses had been arrested fewer times, consumed less alcohol, and had fewer sexual partners than children whose mothers had not received the intervention. Given the association between delinquent behavior, alcohol use, high-risk sexual behavior and intimate-partner violence and sexual violence, one might reasonably expect to find lower rates of intimate-partner violence and sexual violence as well. Child maltreatment is not the only early childhood factor that influences later risk of intimate partner violence and sexual violence. In early childhood children learn problem-solving, emotional

management, and social skills that form the basis of their relationships later in life, and it is also the time when children form views on gender roles, relationships, and the acceptability of aggression and violence. Children learn much of this from the people around them, so that positive parenting and home environments free from intimate-partner violence are crucial to the development of positive skills that facilitate pro-social behavior and healthy relationships. Programs that seek to reduce children's aggressive behavior and promote the development of positive skills have been effective in thwarting the developmental trajectory of ongoing violent and delinquent behavior. Promising strategies include home visitation programs; parent training programs (covering positive reinforcement, non-violent disciplinary techniques, problem-solving and behavior management skills); cognitive–behavioral skills training for children, social development programs to reduce antisocial and aggressive behavior; and multi-component programs with some combination of training for parents, children and teachers. Early childhood interventions are important not only for securing the health and well-being of children, but for promoting healthy behavior and social functioning—including non-violent intimate partnerships and respectful, consensual sexual activity—throughout the lifespan. Key elements of this approach include teaching parents to model healthy relationships, to manage their children's behavior positively and without harsh physical punishment, and fostering children's anger management, impulse control, problem-solving, conflict resolution and social skills. 3.2 School-based approaches School-based violence prevention programs have been used to tackle a range of issues including child sexual abuse, bullying, dating violence, and sexual assault. These range from intensive, long-term programs integrated into formal curricula to single-session activities. School-based interventions with younger children have focused mainly on child sexual abuse. These interventions typically aim to build children's knowledge about child sexual abuse and their capacity to protect themselves. Such programs have become widespread in high-income countries and are implemented in some low- and middle-income countries. Key components include educating children about different kinds of touch, self-esteem, secrets, and self-protection strategies such as shouting, insisting on being left alone, threatening to tell and telling a trusted adult. Examples of such curricula include Good-Touch/Bad-Touch® (USA), Feeling Yes, Feeling No (Canada), and My Body Belongs to Me (Thailand). The impact of these curricula has most often been evaluated using a pre-test/post-test design to measure changes in children's knowledge, attitudes and skills, and such evaluations have found the approach to be effective on these measures. The question remains, however, as to whether these programs lead to actual reduction in victimization. The evidence on this is not clear. In a survey of a nationally representative sample of American 10–16 year-olds, Finkelhor, Asdigian and Dziuba-Leatherman found that children who had received the school-based prevention programs—compared to those who had not—had more accurate knowledge about sexual abuse, were more likely both to use the recommended self-protection strategies and to feel they were empowered to protect themselves, and were more likely to report abuse incidents. However, these children did not report lower levels of completed assault measured as a percentage of total attempted and completed assaults, and they experienced more injuries in the course

of sexual assault.5 Gibson and Leitenberg took this research a step further and undertook to determine whether sexual victimization rates differed between female university students who had and had not received child sexual abuse prevention training at school. They found that girls who had not participated in a child sexual abuse prevention program were twice as likely to report that they had been sexually abused as a child. International research increasingly shows that violence within intimate relationships is not a phenomenon unique to adulthood, but rather a disturbingly common feature of adolescent dating relationships (*Pinheiro, 2006*). To date the most common approach to preventing dating violence among adolescents in high-income countries has been school-based programs with preadolescents and adolescents. A randomized control trial of the Safe Dates program in the USA found that adolescents exposed to the intervention reported less perpetration of psychological, sexual and moderate physical dating violence, and less victimization involving moderate physical dating violence. However, the program showed no effects on severe physical violence. The effects of the program on behavior and mediating variables continued at four years' follow-up. The program needs to be further tested in diverse cultural contexts, but the results suggest that school-based interventions with adolescents can shift the norms and attitudes that influence violent behavior in intimate relationships among some young people. The high levels of sexual assault experienced by women at American universities have prompted the development of a number of rape prevention programs. Some focus on increasing women's knowledge, self-protection skills, and awareness of available services for victims, while others seek also to address men's knowledge, attitudes and behavior. Several evaluations comparing groups before and after they received such interventions have demonstrated an immediate positive effect on students' knowledge and attitudes towards rape, including decreased acceptance of rape myths. Evaluations that have included a follow-up assessment, however, have found that these changes are no longer in evidence at follow-up a few months after exposure to the program. Few published evaluation studies measure change in behavior as the dependent variable, focusing instead on changes in knowledge, attitude and behavioral intent. Those that have measured change in behavior found that the positive effects of the program on knowledge and attitude did not translate into changes in behavior, perhaps due in part to men's and women's (mis)perceptions of risk and of the personal relevance of the program content.

The lessons learned from programs using this approach are as follows:

- ➢ School-based programs for prevention of childhood sexual abuse should be part of larger community-based prevention strategies. Children, however, should not bear the primary responsibility for protecting themselves from victimization.
- ➢ Gaining access to schools can be difficult (e.g. because programs take time away from academic studies and parent's may raise objections).
- ➢ Multi-session programs delivered over some time are more effective than single awareness-raising or discussion sessions.

- ➢ Programs that aim to change attitudes and norms are more effective than those that solely provide information.
- ➢ Programs should address both girls and boys, although the program should use separate sessions for girls and boys.
- ➢ The effects of the programs are greater when the intervention is age-appropriate and includes skill-building components that require the active involvement of participants.
- ➢ Program efforts need to address the concerns of teachers and school staff to ensure their support and involvement.

3.3 Interventions to reduce alcohol and substance misuse

Alcohol and drug misuse is a situational factor that contributes to intimate-partner violence and sexual violence and increases their severity, rather than being a primary cause of such violence (*Leonard, 2005*). The relationship between alcohol and intimate-partner violence and sexual violence is mediated by social norms regarding gender, alcohol use, and violence. It can be difficult to determine whether alcohol is a situational factor contributing to intimate-partner violence and sexual violence, or a coping mechanism adopted in situations of ongoing violence, or both. While reduction of harmful alcohol and drug use is an important component of violence prevention, it does not address the root causes and therefore cannot, on its own, eliminate intimate-partner violence and sexual violence. Nonetheless, substantial gains in the prevention of intimate-partner violence and sexual violence may be achieved through general measures to reduce alcohol-related harm (*WHO*). Promising structural interventions to reduce alcohol related harm include regulation of alcohol pricing and taxation, regulating alcohol availability and modifying drinking contexts. The impact of such measures on rates of intimate-partner violence and sexual violence has not been widely studied, but a few studies indicate promising results:

- ➢ Pricing: Markowitz estimated that a 1% increase in the price of alcohol would decrease intimate-partner violence against women by 5%.
- ➢ Restricting availability:
  - o A community intervention in Australia that included restricting the hours of sale of alcohol reduced the number of victims of intimate-partner violence presenting to hospital.
  - o In Greenland, a coupon-based alcohol rationing system implemented in the 1980s that entitled adults to the equivalent of 72 beers-worth of alcohol per month saw a subsequent 58% reduction in the number of police call-outs for domestic quarrels.
  - o In Diadema, Brazil, prohibiting the sale of alcohol after 23:00 helped prevent an estimated 273 murders (almost all victims were male) over 24 months, and

was associated with lowered rates of assaults against women leading to an estimated average reduction of nine such assaults per month.

3.4 Public information and awareness campaigns

Public information and awareness campaigns are a common approach to the primary prevention of intimate-partner violence and sexual violence. Public awareness campaigns have been used throughout the world to break the silence that surrounds these forms of violence, to inform, to try to influence individuals' attitudes and social norms about its acceptability, and to build political will to address the problem. Many have used a human rights framework. The 16 Days of Activism Against Gender Violence Campaign is a movement that has generated a variety of awareness-raising activities around the world. Approximately 1700 organizations in 130 countries have participated in the annual campaign since 1991, many organizing public awareness campaigns. Such campaigns often disseminate messages through mass media channels (television, radio, newspapers, magazines, posters, and billboards) and may include other mechanisms such as town meetings or community theatre. Campaign goals might include raising public awareness (e.g. about the extent of the problem, about intimate-partner violence and sexual violence as violations of women's human rights, about men's role in ending violence against women), providing accurate information and dispelling myths and stereotypes about intimate-partner violence and sexual violence, and changing public opinion. These campaigns have the potential to reach large numbers of people. While good campaigns can increase knowledge and awareness, influence perceptions and attitudes, and foster political will for action, the link between public awareness campaigns and behavior change is not at all well-established. Basic principles of good communications practice should be applied to public awareness campaigns on intimate-partner violence and sexual violence. Effective campaigns are grounded in evidence of the problem and the risk and protective factors; define clear and measurable objectives; identify indicators to measure the impact of the campaign, how they will be assessed, and ensure baseline measurement is taken; select the intended audience; use consumer research with the intended audience to develop messages and identify the best sources, channels and materials to reach them; build in an evaluation mechanism from the start; and continuously use research to monitor impact and improve the campaign. Campaigns that use a social marketing framework apply the principles of commercial marketing to develop and adapt communications strategies to effect behavioral and social change. The social marketing framework seeks to develop persuasive messages by understanding the behavior of the intended audience and involving them in program development, rather than focusing primarily on the dissemination of information, as many health communications efforts have done. This framework is increasingly being utilized to address men's social norms and behavior, including in relation to intimate-partner violence and sexual violence (see section on working with men

and boys). Lessons learned about public awareness campaigns: • Public information campaigns, in isolation, cannot normally effect sustained change in complex behaviors such as intimate-partner violence and sexual violence, although they can reach large numbers of people. Campaigns targeting behavior change should therefore be used in conjunction with other strategies for the primary prevention of intimate-partner violence and sexual violence. • Campaigns should be based on social science theories and models of behavior change and an understanding of the particular beliefs, perceptions, and behavior of the intended audience. • Communications strategies based on a social marketing framework are more likely to be effective in changing individuals' knowledge, attitudes, and social norms.

3.5 Community-based prevention

Community-level activism and leadership from the women's movement has been essential, specifically for increasing the visibility of violence against women and placing it on the international agenda. Likewise, community efforts will be key to the primary prevention of intimate-partner violence and sexual violence, particularly in settings where resources are limited. Two commonly used forms of community-based prevention include interventions targeted at subgroups of the population, and comprehensive community-wide interventions delivered in multiple settings. The former includes approaches such as group education sessions for people at risk of intimate-partner violence and/or sexual violence. Comprehensive interventions deal with the community as a whole or with multiple subgroups of the population, have several components, and are designed to effect social change by creating an enabling environment for changing individual attitudes and behavior. This approach often utilizes a combination of participatory education or training, public awareness campaigns, and social marketing techniques. Objectives may include improvement of communication and relationship skills, promotion of equitable gender norms and respect for rights (especially women's rights), equipping bystanders to speak out and act to prevent violence, and challenging the social norms and individual beliefs at the root of intimate-partner violence and sexual violence. Community interventions in low and middle-income countries frequently use a human rights framework, may introduce intimate-partner violence and sexual violence as one of many issues, and can be effective in opening the door to talk about women's and children's status and their value as human beings (*Raising Voices*). Community mobilization (or empowerment) approaches emphasize the role of individuals as agents of change, rather than passive program beneficiaries, and place priority on community ownership and leadership of the change process. The success of such programs depends on the quality of the facilitator. If the facilitator is not perceived as trustworthy, capable of understanding the group, and a good listener, then program objectives are unlikely to be achieved. Ideally facilitators should be able to model more equitable gender norms, healthier reflections on masculinity,

and ways of relating that are based on respect and dialogue. Facilitators must be able to take a stand and hold the group accountable to certain standards of attitudes and behavior, while at the same time maintaining rapport and not judging the group members harshly. This too presents a challenge, as it requires facilitators to be carefully chosen, well-trained and in most cases supervised. Evaluations of this approach in sub-Saharan Africa have found that it shows promise for having a positive impact on attitudes, social norms, and behavior change. Lessons learned from community-based approaches are as follows:

- Such approaches are most effective when there is community ownership, repeated exposure to ideas through multiple channels over time, and multiple components delivered in different community settings (e.g. combining media outreach with group education).
- Participatory methods are well-accepted and effective for engaging participants.
- Fostering an enabling social environment may increase the likelihood that positive behavior change at the individual level will be sustained.
- The success of community programs hinges on the quality of the facilitators, and high quality training of facilitators can substantially increase program costs.
- Effective social marketing strategies require preliminary research to identify existing norms and to identify the optimal messages and channels through which to reach the target audience.
- Follow-up is required to sustain changes brought about by the program. In situations of unpredictable funding, staff turnover, and high levels of unemployment or residential mobility, this becomes difficult.
- Impact is heightened by combining activities aiming at education and individual change with wider advocacy and community mobilization activities.

The challenges posed by this approach include the following:

➢ Community mobilization approaches and community-driven programs do not easily fit within donor timeframes.

➢ Measuring the program effects specifically attributable to community-wide interventions can be difficult given the range of other influences and changes in community situations over time.

➢ There is a need to move beyond measuring individual behavior change to measuring social change at the community level, and to determine how this could be done.

- ➢ Structured comprehensive interventions (e.g. Stepping Stones) are intended to be a coherent whole. However, they are sometimes implemented piecemeal, probably diminishing or even eliminating any beneficial impact.
- ➢ Programs are time-consuming; consistent attendance is a challenge.
- ➢ Facilitators need adequate support to address their own beliefs and issues.
- ➢ These approaches can work well with men, but getting men involved can be difficult.

3.6 Structural and policy approaches

Given the societal factors that shape the behavior of communities and individuals, it is widely believed by both public health and human rights advocates that structural interventions hold great promise for significant achievements in the prevention of intimate-partner violence and sexual violence. The promise of such approaches urgently needs testing. Four such factors are discussed below:

- fostering gender equality and women's empowerment;
- legal reform and strengthening criminal justice responses;
- integrating intimate-partner and sexual violence prevention into other program areas;
- improving the safety of physical environments.

Foster gender equality and women's empowerment. Women's low status in society is closely linked with high rates of intimate-partner violence and sexual violence against women in a variety of ways. Fostering gender equality is therefore an integral part of the prevention of intimate-partner violence and sexual violence; some advocates even take the view that other approaches to preventing intimate-partner violence and sexual violence will not be effective without improvements in gender equality. It is beyond the scope of this paper to describe in detail the various measures that may be used to foster gender equality, but the following are some key points. Women's human rights should be respected, protected and fulfilled. As a first step towards this, governments should honor their commitments to implement the Convention on the Elimination of all Forms of Discrimination against Women (1979), and various other human rights instruments, as well as the recommendations made in the Millennium Declaration (2000), the Beijing Declaration and Platform for Action (1995), the Cairo Program of Action (1994), the Declaration on the Elimination of Violence against Women (1993), and the Vienna Human Rights Conference (1993), as well as other regional conventions and consensus agreements. Women's enjoyment of their rights to political participation, to education, to work, to social security, to adequate standards of living, to freely enter and end marriage, to various forms of financial credit, and to own and administer property correlates with their status in society and with the risk of intimate-partner violence and sexual violence. Legal reform and concrete social policy measures in the areas of education, employment, and social protection are needed to raise women's status, fulfill their rights, increase their

access to and control over resources, and ensure that laws do not discriminate against them. Gender equality should be mainstreamed into the policy development process in these areas and into development and poverty reduction strategies. As difficult as it can be to measure the impact of prevention programs on rates of intimate partner violence and sexual violence, understanding and measuring the impact of structural policy measures on both gender equality and these types of violence is even more challenging. There is a great need to develop a better understanding and a stronger evidence base on how laws and policies at different levels (e.g. from laws on property and inheritance rights to parental leave policies or policies to improve women's access to paid and safe employment) contribute to gender equality and to the empowerment of women and, in turn, the potential of these measures to reduce intimate-partner violence and sexual violence.

Legal reform and strengthening criminal justice system responses (including police training). Most criminal justice system responses to intimate-partner violence and sexual violence do not qualify as primary prevention, but rather are focused on intervening once violence is disclosed, to prevent further violence and to facilitate recovery and access to justice (e.g. sexual assault response teams, specialized police units, restraining orders and pro-charging policies). Legal protection against intimate-partner violence and sexual violence reinforces non-violent norms by sending the clear message that such acts will not be tolerated. The power of laws to act as a deterrent relies on their enforcement; if potential offenders perceive that their violent acts will be reported and they will be prosecuted, that perception might deter them. There is little evidence however regarding the deterrent effect of criminal justice system responses to intimate-partner violence and sexual violence, and reporting and conviction rates continue to be minimal, particularly for sexual violence. The criminal justice response must include clear laws and policies with effective enforcement; training for police, prosecutors and judges; appropriate sentences; input from women; and coordinated, interagency responses for victims. However, this should be part of a more comprehensive societal strategy, used in combination with other interventions discussed in this paper. Integrate prevention of intimate-partner violence and sexual violence into a range of program areas. Intimate-partner violence and sexual violence cross-cut and interact with many other health and development issues. Combined programming should therefore be considered where appropriate. It has been recommended that prevention of intimate-partner violence and sexual violence be integrated with program areas such as HIV/AIDS prevention, sexual and reproductive health, adolescent health promotion, prevention of child maltreatment and youth violence, urban planning, poverty reduction, and development, as well as in post-conflict and refugee situations. Several interventions described in this paper have occurred in the context of HIV/AIDS or adolescent health programming. The systematic integration of prevention in related program areas can widen the scope of people reached by interventions and can create synergies by addressing critical intersections. The impact of such integration will need to be evaluated. Improving safety of physical environments, both urban and rural. Aspects of the physical environment of communities may be altered

to improve safety and prevent violence. Such strategies include improving street lighting and providing safe routes to communal water collection, bathing and toilet facilities, they are likely to have more impact on sexual violence by non-partners than on intimate-partner violence. However, very few outcome evaluation studies have investigated the impact of these strategies on violence rates. A systematic review of the effects of improved street lighting on violence and crime showed an overall reduction in crime of 20% after improved lighting in experimental areas compared with control areas. Violent crime (which some studies specified as including “sexual assault” and “sexual proposition”) showed an equal level of decrease to other crimes, and since night-time crimes did not decrease more than daytime crimes, a theory focusing on the role of street lighting in increasing community pride seems more plausible than a theory focusing on increased surveillance. Future research should be designed to test the main theories of the effects of improved lighting more explicitly and should measure violent crime using police records, surveys of victims, and self-reports of offending.

3.7 Working with men and boys

Over the past decade there has been growing recognition of the value of working with men and boys to prevent intimate-partner violence and sexual violence. Advocates of this approach propose that since most sexual violence and intimate-partner violence is perpetrated by men, men must be involved in the solution. Work of this nature is based on an understanding of power imbalances, inequitable gender norms, and norms related to masculinity as driving factors behind intimate-partner violence and sexual violence. Violence prevention may be the explicit goal of the intervention, or it might be only one of many objectives of a broader approach such as increasing men’s involvement in sexual and reproductive health. Programs working with men to promote gender equality and end violence against women have sprung up in many countries of all income levels around the world.

Working with men and boys to end violence uses many of the prevention approaches previously discussed, and frequently takes the form of school-based initiatives, community mobilization or public awareness campaigns. The objectives may include increasing individuals' knowledge, changing individuals' attitudes about gender norms and violence, and changing social norms related to masculinity, power, gender and violence. Programs taking this approach often focus on adolescent males or younger boys, based on evidence that attitudes and norms related to gender and gender equality and violence may be more malleable during this time than later in life.

In addition to targeting reductions in violent behavior, some interventions aim to develop the capacity and confidence of boys and young men to speak up and intervene against violence when they are not involved as perpetrator or victim, with the goal of changing the social climate in which violence occurs. This set of skills helps young men not to be silent or complicit when they are indirectly involved in violence as family, friend, or member of a group or crowd. Using these skills requires overcoming common attitudes such as “it’s none of my business” and “this is something private between them”.

Evidence regarding the effectiveness of group education work with young men and boys is sparse, but suggests this approach can have a positive impact on knowledge, awareness, and attitudes. Future evaluations should use longer follow-up periods to determine whether gains persist after the intervention, and should measure the impact on behavior change. In addition to working with men individually and in groups, some efforts in this area have included a component to address social norms. A social norms approach uses communication techniques such as social marketing to foster healthier norms regarding gender roles, relationships and violence, and sometimes to correct misperceptions men may have about their peers' social norms on these issues. It can be universal or targeted to specific groups. The social norms approach has been effective in changing other unhealthy attitudes and behavior. For instance, US research on young peoples' perceptions of alcohol and tobacco use by their peers shows that students overestimate the frequency of use and that these misperceptions are positively correlated with drinking and smoking behavior. The social norms approach has been used in schools and universities and has been successful in shifting attitudes and changing behavior with respect to alcohol and tobacco use. Similarly, a number of studies have shown that many young men in high school and universities overestimate the adherence of their peers to rape myths and underestimate the discomfort of their peers with remarks or actions demeaning to women, the importance they give to seeking consent in sexual relations, and their willingness to intervene to prevent sexual assault. Misperceptions such as these may facilitate men's violence against women, and may reduce men's willingness to intervene as bystanders. Evaluations of several small pilot programs—all in American universities—suggest that using a social norms approach to correct misperceptions and foster healthier norms and behavior shows promise for altering attitudes and behaviors associated with intimate-partner and sexual violence, although the utility of an approach focused on correcting misperceptions of social norms may be limited in contexts where the prevailing social norm is permissive of intimate-partner violence and sexual violence. The lessons learned from working with men and boys are summarized below:

- ✓ Men should be approached to play a positive role in the health and well-being of their partners, families, and communities.
- ✓ Approaching men as abusers or potential abusers is not an effective way forward, since many men do not perceive such messages as relevant to them.
- ✓ Finding appropriate entry points that will facilitate open discussion, rather than cause men to become defensive or close up, is imperative. Mentors in Violence Prevention uses the concept of the empowered bystander as an entry point (*Center for the Study of Sport in Society)*. The Guy to Guy project in Brazil found that so many of the young men they worked with had witnessed or experienced violence in their own home that family violence became a natural entry point for wider discussions of power, gender, and violence. In her work with male university students, Hong found that group participants were much more prepared and open to discuss issues of gender and gender-based violence after there had been opportunity to discuss the violence they had faced in their own lives and families.

- ✓ Discussions of gender equality, power, and violence are most open and effective in single sex groups. This presents a challenge, since young men and women alike may be skeptical about the need for and desirability of single-sex groups (*Center for the Study of Sport in Society*).
- ✓ Social norms marketing may be more effective when based on an understanding of the nature and extent of men's misperceptions of norms related to gender, relationships, and violence, and the impact of these misperceptions. Methods for measuring the effects of social norms intervention deserve careful attention.

3.8 Key elements for successful prevention programs

In a review of prevention programs in the areas of substance abuse, risky sexual behavior, school failure, and juvenile delinquency and violence, Nation and colleagues identified common characteristics of effective prevention programs. The strengths, challenges and lessons reviewed in this paper indicate that these attributes are also characteristic of strong, successful programs for the prevention of intimate-partner violence and sexual violence. Effective programs are:

- ✓ Comprehensive: multiple components affecting multiple settings and addressing a range of risk and protective factors.
- ✓ Use varied teaching methods: it is important to include a skill-development component and interactive/"hands-on" methods.
- ✓ Provide sufficient dosage: provide more contact with participants through longer sessions, multiple sessions, and follow-up. Participants at greater risk require a greater dosage.
- ✓ Theory driven: effective programs are based in scientific theories of how problem behaviors develop and how behaviors can be changed.
- ✓ Promote positive relationships: foster strong, positive relationships between children and adults, intimate partners, men and women.
- ✓ Appropriately timed: participants are exposed to the program during the developmental stage when it will have the most impact.
- ✓ Socially and culturally relevant: flexibility, adaptability, and content tailored to be relevant to cultural context of participants. This must go beyond translation and may require structural modifications to a program.
- ✓ Evaluated: outcome evaluation should be included to measure the impact of the program.
- ✓ Use well-trained staff: programs delivered by staff who are sensitive, competent, trained, supported and supervised. A high turnover negatively affects the continuity and effectiveness of programs.

Successful programs for the prevention of intimate-partner violence and sexual violence also use participatory education and training approaches, well-trained and competent

facilitators for group work, and build individual and collective efficacy. The ability to understand not only the gravity and extent of intimate-partner violence and sexual violence but also to be able to say “Now we know what to do” is important for enabling individuals and communities to take action. The lessons learned from existing approaches yield some clear directions about what is required for future success in the prevention of intimate-partner violence and sexual violence:

- To achieve and sustain large reductions in rates of intimate-partner violence and sexual violence, social attitudes, norms and behavior must be changed, particularly among men. Primary prevention strategies will not be effective if they focus on women and girls alone—men and boys must be included. Programs working with men should approach men as partners and agents of change.
- Given that successful approaches are based on understanding of the norms and culture of the target population, and that social marketing approaches are more effective than traditional public education campaigns, scaling up prevention of intimate-partner violence and sexual violence requires a shift in the methods used to try to change people’s knowledge and attitudes.
- Changes in behavior at the individual level cannot be sustained without an enabling social environment; therefore attention must be given to fostering social change and not only change in individuals.
- Prevention efforts at all levels of the ecological model are required to produce systemic and long-lasting changes that will reduce the rates of intimate-partner violence and sexual violence.
- Much work is needed to determine the effectiveness of various policy and structural approaches, which have different characteristics to those of programs delivered to individuals and groups.
- The gender dimensions of intimate-partner violence and sexual violence, including norms related to sexual relationships and norms related to masculinity, must be incorporated into any prevention approach.

WHO has convened an expert meeting on the primary prevention of intimate-partner violence and sexual violence. The need to address gaps in the evidence base on intimate-partner violence and sexual violence was a major theme of the discussions. Participants noted that more and better research is needed to describe the non-injury health outcomes of intimate-partner violence and sexual violence, its costs, and its risk and protective factors—including their relative contributions to risk. Research is needed to identify what works for prevention and what can be done most effectively. There is a need for more rigorous outcome evaluation studies and a better understanding of how to present the results in a convincing way. These research needs apply worldwide, but the evidence gap is especially large for low- and middle-income countries. In addition to strengthening the evidence base, work is needed to identify a strategy for marketing primary prevention based on existing evidence, and for convincing community-based organizations to take a

more evidence-based approach. Discussions identified promoting gender equality and equity, creating enabling community environments, changing social norms (particularly norms that promote and reward macho, aggressive behavior), reducing exposure to child maltreatment and promoting healthy child development, reducing harmful alcohol and drug consumption, and building skills for healthy relationships as key strategies for reductions in intimate-partner and sexual violence. The objective is to reduce aggressive behavior by individuals, but change is required at the relationship, community and societal levels to catalyze and sustain such change.

WHO proposed, and meeting participants agreed, that the Organization's role in advancing primary prevention of intimate-partner violence and sexual violence includes several aspects:

1. Strengthen understanding of long-term health impacts, costs of this violence and cost effectiveness of interventions, and provide technical assistance for measuring these.
2. Support international research on risk and protective factors, and assist with identification of what is universal and what is context-specific, as well as the relative importance of various factors in different contexts.
3. Promote the implementation of evidence-based and evidence-generating approaches to primary prevention to:
    - ✓ change individuals' knowledge, attitudes and behavior;
    - ✓ promote healthy and equal relationships;
    - ✓ create enabling social environments including gender-equitable and non-violent social norms, and responsive and protective community institutions; and
    - ✓ promote gender equality and strengthen protective factors at the societal level.
4. Promote systematic primary prevention efforts:
    - ✓ Provide technical assistance for the development of plans of action for the primary prevention of intimate-partner and sexual violence or for incorporating primary prevention into plans of action to address violence against women.
    - ✓ Work on integrating prevention of intimate-partner violence and sexual violence into existing programs such as those for reduction of HIV/AIDS and alcohol and substance abuse, adolescent sexual and reproductive health, and others, as appropriate.
    - ✓ Address intimate-partner violence and sexual violence as part of more integrated violence prevention programs.

- ✓ Continue advocacy for multi sectoral action on factors at the individual, relationship, community, and societal level.

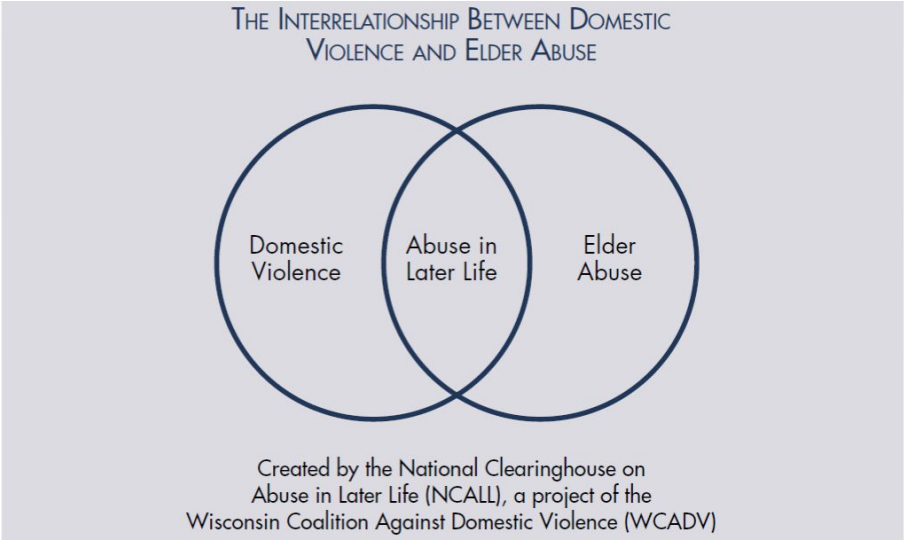
5. Build political will by advancing the dialogue on the prevention of intimate-partner violence and sexual violence.

- ✓ Continue advocacy, at the local, national, regional, and global levels, to convince various stakeholders about the feasibility and desirability of primary prevention.

8. Intimate Partner Violence in Later Life

The World Health Organization defines elder abuse as “a single, or repeated act, or lack of appropriate action, occurring within any relationship where there is an expectation of trust, which causes harm or distress to an older person.” (www.who.int/ageing/projects/elder_abuse/en)

Domestic abuse is a pattern of coercive tactics that abusers use to gain and maintain power and control over their victims. Abusers believe they are entitled to use any method necessary to control their victims. Domestic violence and sexual abuse in later life are subsets of elder abuse. For more information on domestic abuse in later life, go to the Web site of the National Clearinghouse on Abuse in Later Life (NCALL) at www.ncall.us.



For this section, abuse in later life is defined by the following components: Age. Victims are age 50 or older. NCALL chose this age because many domestic abuse programs serve primarily women in their 20s to 40s. By age 50, there may already be a significant drop off in the number of women accessing services. In addition, women ages 50–62 may need economic assistance to acquire safe housing and care so they may leave an abuser. However, they are likely to be ineligible for the Temporary Assistance for Needy Families welfare program and Social Security, leaving these women with distinct issues

that are important for service providers to identify. Gender. Abuse in later life, especially physical and sexual violence, affects older women more often than older men, although some men may be victims as well. The Wisconsin Coalition Against Domestic Violence's (WCADV) Domestic Abuse Homicide Report found that a significant percentage of women killed in Wisconsin during this period were over 50 years old (www.wcadv.org). Furthermore, homicide suicides generally involve older couples in which the male first kills his partner and then himself. For more information about homicide-suicide, see the research by Malphurs and Cohen,1 of the University of South Florida and the Miami Veteran's Administration Health Care System, respectively, at www.news-medical. net/?id=10573. Although older women often experience more significant violence and are more apt to change their lives to stay safe or accommodate the abuser, some older men are also victims of abuse, neglect, and exploitation. Some data2 suggest that in cases of exploitation or neglect, a significant portion of the victims may be male. For more information on older male victims, go to www.jrf.org.uk/knowledge/findings/ socialcare/362.asp. Relationship. Victims and abusers have an ongoing relationship with an expectation of trust. These relationships may include a spouse or partner, an adult child, a grandchild, another family relationship, or some caregivers. Spousal and partner relationships can include long-term relationships of 50 years or more, with the abuse present throughout that time. Spousal or partner relationships may also be new, often following the death of a previous partner or a separation or divorce. A final category of spousal or partner abuse is late-onset abuse, in which a long term relationship that had not been abusive previously becomes so in later life. In some cases, a medical or mental health condition may have led to aggressive or violent behavior. In other cases, power and control dynamics may have been present throughout the relationship but were not named or identified by the victim, so the situation is not late-onset but rather a long-term domestic violence case. In these training materials, abuse between strangers (e.g., scams and identity theft) is not considered domestic abuse in later life. Location. The abuse generally occurs where the victim lives, in either a residential or facility setting. Forms. The abuse can be physical, sexual, emotional, or verbal; it also can encompass neglect or financial exploitation, including threats of harm. Most of these cases exhibit a combination of one or more of these tactics. NCALL's Abuse in Later Life Power and Control Wheel can be found in tab 12: Additional Resources.

What Causes Domestic Abuse in Later Life?

In many cases of domestic abuse in later life, one person uses power and control to get what he or she wants out of the relationship with the older person. Even if physical abuse is not used, the threat of harm is generally present. The person with the power typically uses many tactics to maintain control, including emotional and psychological abuse, threats of physical violence or abandonment, isolating the individual from family and friends, limiting the victim's use of the telephone, breaking assistive devices, and denying health care. Individuals who use power and control tactics in a relationship can be very persuasive, and often try to convince family, friends, and professionals that they are only

trying to help. Abusive individuals rarely take any responsibility for their inappropriate behavior.

Issues That Often Co-Occur but Do Not Cause Abuse

A number of issues co-occur with abuse and are often mistaken as causes of abuse, neglect, or exploitation. These issues include anger, stress/ caregiver stress, medical conditions or mental health issues, substance abuse, or prior poor relationships. In most cases, however, these are issues that should be dealt with separately because they do not cause abusive behavior. Resolving these issues may deal with one problem but generally will not enhance victim safety or hold the abuser accountable. Anger is a normal and healthy emotion but it does not cause abuse. Even though abusers can be angry at times, abuse happens when an individual chooses manipulative, threatening, or physically violent behavior to gain power and control over another individual. Abusive tactics may occur without any evident anger in the abuser. In some instances, displays of anger are just one of many tactics used by an abusive person to gain control over another. Originally, researchers thought that abuse of older adults was caused by caregiver stress. Although stress is a commonly used rationale for abuse, stress does not cause abuse. Everyone experiences stress. Most stressed people do not hurt others. Most abusers under stress do not hit their bosses or law enforcement officers. They choose their victims (such as family members) from those who have less power. Providing care for an ill or frail older person can be stressful. Some abusers suggest that their negative behavior is due to caregiver stress because they are physically and emotionally overwhelmed by the demands of providing care. However, research does not support caregiver stress as a primary cause of elder abuse. Instead, it is considered an excuse used by abusers so they can continue their behavior without consequences such as intervention by social services or law enforcement. For more information confirming that caregiver stress is not the primary cause of elder abuse, go to www.ncall.us. Challenging or violent behaviors may occur as a symptom of some medical or mental conditions or as a side effect of combinations of medications. In these circumstances, medical or mental health professionals need to be consulted for a diagnosis and recommended treatment. In other situations, some abusers may use a medical condition as an excuse for their behavior to avoid arrest or otherwise being held accountable. Professionals are encouraged to request a medical diagnosis to ensure that effective interventions are considered in these cases. Victim safety should always be paramount. Drugs and alcohol are commonly used as excuses for abusive behavior (e.g., “I was so drunk, I didn’t know what I was doing”). Yet, many people use drugs and alcohol and are never abusive. Drugs and alcohol do not cause abuse or violence; however, they may intensify the violence. Although abusers will sometimes use drugs or alcohol as an excuse for their behavior, abusers who misuse drugs and alcohol have two separate problems: abusive behavior and substance abuse. Drug and alcohol treatment programs are designed to help an individual stay sober, not to eliminate abusive behavior. Abuse also does not occur because a victim of child abuse grows up and then abuses his or her parents. Abusive parents can unknowingly teach children that abuse is an effective way to control another individual. However, abusive

behavior is a choice. Individuals who grew up with abuse can choose to behave abusively or they can choose to stop the pattern of violence that may be all too familiar for them. Many adults who were victims of child abuse or who witnessed domestic abuse growing up have healthy, happy adult relationships and do not hurt their children, spouse/partner, or parents. Some individuals who were abused as children experience emotional problems and trauma related symptoms as adults. They may require specific treatment to deal with the effects of their victimization; however, this is not an excuse for someone to continue abusive behavior.

The Older Victim's Dilemma: To Remain In or End a Relationship With an Abuser—Challenges and Barriers to Living Free From Abuse

Victims of abuse often love or care about the people who harm them, including spouses, adult children, additional family members, or others. Keeping the family together may be very important to the victim for many reasons, including religious and cultural beliefs. Victims may want to maintain a relationship with the abuser—they simply want the abusive behavior to end. Victims often have a difficult time deciding whether or not to continue to have contact with an abuser. This ambivalence may be connected to very real fears and safety concerns. It is not unusual for victims to change their minds; at times they will leave a relationship, only to return later. Many factors affect the victims' decision-making process, and those who decide to end the relationship often face significant barriers. Some issues, challenges, and barriers include, but are not limited to—

- Fear of
  - ➢ Being seriously hurt or killed if they leave their abuser.
  - ➢ Retaliation for seeking assistance.
  - ➢ Being alone.
  - ➢ Losing their independence, autonomy, and even the ability to live in their own home.
- Economic issues:
  - ✓ Lack of access to financial resources.
  - ✓ Lack of available, affordable housing if they leave.
- Emotional concerns and connections:
  - ✓ Compassion and love for the abuser; not wanting to get a family member into trouble.
  - ✓ Not wanting to involve an outsider in their family's private business.
  - ✓ Embarrassment and shame, both that they are victims and that a family member (including a spouse or adult child) is the perpetrator.
  - ✓ Not wanting to leave behind a home, cherished possessions, or a pet.
  - ✓ A sense of responsibility to continue parenting an abusive adult child.

- ✓ A belief that they failed as a parent if their child is abusive.

- Medical conditions and disabilities:
  - ✓ The victims' medical needs may make living on their own difficult or impossible.
  - ✓ The abusive individual may need the victim's care.
- If the abuser is an adult child or grandchild, it can be difficult to cut ties completely because of—
  - ✓ A sense of responsibility as a parent or grandparent.
  - ✓ Love for the adult child or grandchild.
  - ✓ Memories of good times.
  - ✓ Shame or embarrassment.
  - ✓ Hope that things will get better.
  - ✓ Lack of a process for divorcing or completely severing the relationship with the adult child, as with a spouse.

Effective Interventions

Older victims of domestic abuse may require assistance to break their isolation and live more safely. Some older victims may need more time to heal physically and emotionally and may need different types of support than younger victims. They may need a safe place to be heard, emergency and transitional housing, transportation, support groups and counseling, legal assistance, and medical assistance or services. In addition, older victims may need more time to sort out their affairs and rebuild their lives, which could involve rekindling old friendships or acquiring new friends; obtaining assistance with financial planning, benefits, and insurance; and securing permanent housing. Cases of abuse in later life are often complex and require services from various organizations. The chart below lists some agencies that may be helpful for older victims and a few of the services they offer.

Collaboration Is Essential

Collaboration among community agencies is crucial to addressing domestic abuse in later life. Informal relationships among staff from various agencies may exist where professionals work together on specific cases or broader community initiatives. Many communities have created more formal teams, such as coordinated community response teams, fatality review teams, or elder abuse interdisciplinary teams. These teams may focus on reviewing individual cases, coordinating the efforts of the various agencies involved, identifying gaps in services, and defining ways the public and private sectors can work together to meet victims' needs. Communication is often an issue among professionals from various disciplines. Each system has its own definitions and understanding of the problem and its own guiding principles, policies, and laws about how best to respond. These various approaches can sometimes lead to conflict and a

breakdown in communication and collaboration. Information sharing can be another area of contention. When victim safety is a concern, maintaining the victim's confidentiality can be imperative. Yet this means not sharing the victim's personal identifying information with other professionals who may be involved with the case, unless the victim gives his or her permission. Many states require that elder abuse cases be reported to APS/elder abuse agencies and/or law enforcement. However, mandatory reporting by domestic violence and sexual assault advocates is often controversial because it diminishes victims' autonomy and compromises victim advocate confidentiality. Advocates who are mandated reporters can find more information about considerations regarding mandatory reporting at www.ncall.us/docs/Mandatory_ Reporting_EA.pdf. Meeting regularly with collaborators can minimize conflicts and encourage communication. In addition, creating memorandums of understanding between agencies can do much to create smooth working relationships. A well-executed memorandum of understanding can facilitate all of the following: sharing knowledge and resources; eliminating duplication of services; creating an effective system for referring, assessing, and responding to clients; and fostering a shared commitment to victim safety and to holding abusers accountable. Most elder abuse cases are too complex for professionals from any one system to handle alone. Training and cross-training can help professionals understand the dynamics of abusive relationships and the interventions available for older victims of domestic abuse. Working together as an interdisciplinary team is also effective. Note to Trainers: Both "multidisciplinary team" and "interdisciplinary team" describe a group of professionals from different disciplines who work collaboratively to accomplish common goals. The term "elder abuse interdisciplinary team" is used in this guide to incorporate both concepts.

TACTICS USED BY ABUSERS

- Physical Abuse
- Slaps, hits, punches
- Throws things
- Burns
- Chokes
- Breaks bones
- Creates hazards
- Bumps and/or trips
- Forces unwanted physical activity
- Pinches, pulls hair, and twists limbs
- Restrains

Sexual Abuse

- ➢ Makes demeaning remarks about intimate body parts
- ➢ Is rough with intimate body parts during care giving
- ➢ Takes advantage of physical or mental illness to engage in sex
- ➢ Forces sex acts that make victim feel uncomfortable or are against victim's wishes
- ➢ Forces victim to watch pornography on television or computer

Psychological Abuse

- ➢ Withholds affection
- ➢ Engages in crazy-making behavior
- ➢ Publicly humiliates or behaves in a condescending manner

Emotional Abuse

- ➢ Humiliates, demeans, ridicules
- ➢ Yells, insults, calls names
- ➢ Degrades, blames
- ➢ Uses silence or profanity

Threatening

- ➢ Threatens to leave and never see older individual again
- ➢ Threatens to divorce or to refuse divorce
- ➢ Threatens to commit suicide
- ➢ Threatens to institutionalize the victim
- ➢ Abuses or kills pet or prized livestock
- ➢ Destroys or takes property
- ➢ Displays or threatens with weapons

Targeting Vulnerabilities

- ➢ Takes or moves victim's walker, wheelchair, glasses, dentures
- ➢ Takes advantage of confusion
- ➢ Makes victim miss medical appointments

Neglecting

- ➢ Denies or creates long waits for food, heat, care, or medication
- ➢ Does not report medical problems
- ➢ Understands but fails to follow medical, therapy, or safety recommendations

- ➢ Refuses to dress the victim or dresses inappropriately

Denying Access to Spiritual Traditions and Events

- ➢ Denies access to ceremonial traditions or church
- ➢ Ignores religious traditions
- ➢ Prevents victim from practicing beliefs and participating in traditional ceremonies and events

Using Family Members

- ➢ Magnifies disagreements
- ➢ Misleads family members about extent and nature of illnesses/conditions
- ➢ Excludes family members or denies the victim access to family members
- ➢ Forces family members to keep secrets
- ➢ Threatens and denies access to grandchildren
- ➢ Leaves grandchildren with grandparent against grandparent's needs and wishes

Ridiculing Personal and Cultural Values

- ➢ Ridicules victim's personal and cultural values
- ➢ Makes fun of a victim's racial background, sexual preference, or ethnic background
- ➢ Entices or forces the victim to lie, commit a crime, or engage in other acts that go against the victim's value system

Isolation

- ➢ Controls what the victim does, whom the victim sees, and where the victim goes
- ➢ Limits time with friends and family
- ➢ Denies access to phone or mail
- ➢ Fails to visit or make contact

Using Privilege

- ➢ Treats the victim like a servant
- ➢ Makes all major decisions
- ➢ Ignores needs, wants, desires
- ➢ Undervalues victim's life experience
- ➢ Takes advantage of community status, i.e., racial, sexual orientation, gender, economic level

Financial Exploitation

- ➢ Steals money, property titles, or possessions
- ➢ Takes over accounts and bills and spends without permission
- ➢ Abuses a power of attorney
- ➢ Tells victim that money is needed to repay a drug dealer to stay safe

9. Prevalence and Characteristics of Sexual Violence, Stalking, and Intimate Partner Violence Victimization

Sexual violence, stalking, and intimate partner violence are important public health problems that affect the lives of millions of persons in the United States. These forms of violence can lead to serious short- and long-term consequences including physical injury, poor mental health, and chronic physical health problems . For some persons, violence victimization results in hospitalization, disability, or death. Furthermore, previous research indicates that victimization as a child or adolescent increases the likelihood that victimization will reoccur in adulthood .

Before implementation of the National Intimate Partner and Sexual Violence Survey (NISVS), the most recent data on the national public health burden of sexual violence, stalking and intimate partner violence victimization came from the National Violence Against Women Survey, which was administered one time during 1995–1996 . This report examines these three forms of violence from the second year of NISVS data collection. The report describes overall prevalence of sexual violence, stalking, and intimate partner violence victimization by sex; racial/ethnic variation in prevalence; how the type of perpetrator varies by violence type; and the age at victimization typically begins for each violence type. For intimate partner violence, this report also examines a range of negative impacts experienced as a result of victimization, including the need for various community and health services. The purpose of this report is to describe the most recent data on the public health burden of sexual violence, stalking, and intimate partner violence victimization and the characteristics of victimization. Researchers, advocates, and policymakers can use the findings in this report to inform efforts to prevent and address these forms of violence.

Methods

NISVS is an ongoing nationally representative random- digit–dial telephone survey of the non-institutionalized English- and Spanish-speaking U.S. population aged ≥18 years. NISVS uses a dual-frame sampling strategy that includes both landline and cellular telephones and is conducted in 50 states and the District of Columbia. A total of 14,155 interviews were conducted (7,758 women and 6,397 men). A total of 12,727 interviews were completed, and 1,428 interviews were partially completed. A total of 6,879 women

and 5,848 men completed the survey. The estimates presented in this report are based on completed interviews. An interview is defined as having been completed if the respondent completed the demographic and general health questions as well as all of the violence victimization questions. Approximately 40.0% of completed interviews were conducted by landline telephone, and 60.0% of completed interviews were conducted by using a respondent's cellular telephone. The American Association for Public Opinion Research (AAPOR) response rate RR4 was computed by using weighted case counts (5). The overall weighted response rate for the 2011 NISVS survey was 33.1%. The weighted cooperation rate, which reflects the proportion of persons contacted who agreed to participate in the interview and who were determined to be eligible, was 83.5%.

The questionnaire included behaviorally specific questions that assessed being a victim of sexual violence, stalking, and intimate partner violence over the respondent's lifetime and during the 12 months before interview. A list of the verbatim questions used in the 2011 survey can be found at http://stacks.cdc.gov/view/cdc/24726.

The specific types of sexual violence assessed included rape (completed or attempted forced penetration or alcohol- or drug-facilitated penetration) and sexual violence other than rape, including being made to penetrate a perpetrator, sexual coercion (nonphysically pressured unwanted penetration), unwanted sexual contact (e.g., kissing or fondling), and noncontact unwanted sexual experiences (e.g., being flashed or forced to view sexually explicit media).

Respondents were classified as stalking victims if:
1) they experienced multiple stalking tactics or a single stalking tactic multiple times by the same perpetrator and
2) they felt very fearful or believed that they or someone close to them would be harmed or killed as a result of a perpetrator's stalking behaviors.

Examples of stalking tactics measured by NISVS included receiving unwanted e-mail messages, instant messages, or messages through social media; being watched or followed; and having someone approach or show up in the victim's home, workplace, or school when unwanted. This report examines the four subtypes of intimate partner violence that comprise CDC's definition of being a victim of intimate partner violence: sexual violence, physical violence, stalking, and psychological aggression. Intimate partner violence can be perpetrated by current or former spouses (including married spouses, common-law spouses, civil union spouses, and domestic partners), boyfriends/ girlfriends, dating partners, and ongoing sexual partners. Questions concerning physical violence victimization included items regarding the experience of being slapped, pushed, or shoved, as well as items categorized as severe physical violence in the literature. These include being hurt by pulling hair, being hit

with something hard, being kicked, being slammed against something, attempts to hurt by choking or suffocating, being beaten, being burned on purpose, and having a partner use a knife or gun against the victim. Psychological aggression includes expressive aggression (e.g., name calling, or insulting or humiliating an intimate partner) and coercive control, which includes behaviors that are intended to monitor, control, or threaten an intimate partner. Intimate partner violence-related impact was measured by using a set of questions that assessed a range of direct impacts that might be experienced by victims of intimate partner violence. Intimate partner violence–related impacts include fear, concern for safety, having experienced at least one post-traumatic stress disorder (PTSD) symptom, injury, having contacted a crisis hotline, needing health care, needing housing services, needing victim's advocate services, needing legal services, and having missed at least 1 day of work or school. For those who reported being raped, it also includes contracting a sexually transmitted infection or, for women only, becoming pregnant. This information not only serves as an indicator of the range in severity of victimization experiences but also documents the need for particular preventive services and responses. Intimate partner violence–related impact was assessed in relation to specific perpetrators, without regard to when the impact occurred. It also was asked in relation to all forms of intimate partner violence experienced in that relationship. The prevalence of intimate partner violence–related impact was calculated among those who experienced contact sexual violence, physical violence, or stalking by an intimate partner. Contact sexual violence includes not only rape but also being made to penetrate a perpetrator, sexual coercion, and unwanted sexual contact. Analyses were stratified by the respondent's sex. Prevalence by race and ethnicity also were estimated. No formal statistical comparisons of the prevalence estimates between demographic subgroups were made. Statistical inference for prevalence and population estimates were made on the basis of weighted analyses, in which complex sample design features (including stratified sampling, weighting for unequal sample selection probabilities, and non response adjustments) were taken into account to produce nationally representative estimates. The estimated number of victims affected by a particular form of violence is based on U.S. population estimates from the census projections by state, sex, age, and race/ethnicity. The relative standard error (RSE) is a measure of an estimate's reliability and was calculated for all estimates in this report. If the RSE was >30%, the estimate was deemed unreliable and is not reported. Consideration was also given to the case count. If the estimate was based on a numerator that was ≤20, the estimate also is not reported. A more complete description of the methods is available at http://stacks.cdc.gov/view/cdc/12362. Several of the sexual violence and stalking questions were modified between the 2010 and 2011 survey. Specifically, questions from 2010 regarding rape and being made to penetrate a perpetrator that combined several behaviors were split into separate questions in 2011. Also, the wording of a question measuring public sexual harassment was changed from "harassed" to "verbally harassed." In addition, a question from 2010 asking about a perpetrator having fondled or grabbed the respondent's sexual body parts was modified to ask about a perpetrator having fondled, groped, grabbed, or touched the

respondent in a way that made the respondent feel unsafe *(National Intimate Partner and Sexual Violence Survey, Centers for Disease Control, United States).*

Results

Sexual Violence Victimization

Prevalence of Sexual Violence Victimization

In the United States, an estimated 19.3% of women (or >23 million women) have been raped during their lifetimes (Table 1). Completed forced penetration was experienced by an estimated 11.5% of women. Nationally, an estimated 1.6% of women (or approximately 1.9 million women) were raped in the 12 months before taking the survey. An estimated 1.7% of men (or almost 2.0 million men) were raped during their lifetimes; 0.7% of men experienced completed forced penetration. The case count for men reporting rape in the preceding 12 months was too small to produce a statistically reliable prevalence estimate.

An estimated 43.9% of women experienced sexual violence other than rape during their lifetimes, and an estimated 5.5% of women were victims of sexual violence other than rape in the 12 months preceding the survey. For men, an estimated 23.4% experienced sexual violence other than rape during their lifetimes, and 5.1% experienced sexual violence other than rape in the 12 months before completing the survey. An estimated 0.6% of women (>700,000 women) were made to penetrate a perpetrator during their lifetimes. The case count for women reporting being made to penetrate a perpetrator in the preceding 12 months was too small to produce a statistically reliable prevalence estimate. For men, the lifetime prevalence of being made to penetrate a perpetrator was an estimated 6.7% (>7.6 million men), while an estimated 1.7% of men were made to penetrate a perpetrator in the 12 months preceding the survey. An estimated 12.5% of women experienced sexual coercion during their lifetimes. Sexual coercion was experienced by an estimated 2.0% of women in the 12 months before taking the survey. An estimated 5.8% of men experienced sexual coercion during their lifetimes while an estimated 1.3% of men experienced sexual coercion in the 12 months before taking the survey. Approximately one in four women (27.3%) is estimated to have experienced some form of unwanted sexual contact during their lifetimes. In the 12 months preceding the survey, an estimated 2.2% of women experienced unwanted sexual contact. An estimated 10.8% of men experienced unwanted sexual contact during their lifetimes, with an estimated 1.6% of men having experienced unwanted sexual contact in the 12 months before taking the survey. Approximately one in three women (32.1%) is estimated to have experienced some type of non-contact unwanted sexual experience during their lifetimes, and an estimated 3.4% of women experienced this in the 12 months before taking the survey. An estimated 13.3% of men experienced non-contact unwanted sexual experiences during their lifetimes, and an estimated 2.5% of men experienced this type of victimization in the previous 12 months.

Prevalence of Sexual Violence Victimization by Race/Ethnicity

In the United States, an estimated 32.3% of multiracial women, 27.5% of American Indian/Alaska Native women, 21.2% of non-Hispanic black women, 20.5% of non-Hispanic white women, and 13.6% of Hispanic women were raped during their lifetimes (Table 2). The case counts of other racial/ethnic categories of women were too small to report statistically reliable estimates. Lifetime estimates of rape for men by race/ ethnicity were also not statistically reliable for reporting because of a small case count, with one exception: an estimated 1.6% of non-Hispanic white men were raped during their lifetimes.

An estimated 64.1% of multiracial women, 55.0% of American Indian/Alaska Native women, 46.9% of non-Hispanic white women, and 38.2% of non-Hispanic black women experienced sexual violence other than rape during their lifetimes. In addition, an estimated 35.6% of Hispanic women and 31.9% of Asian or Pacific Islander women experienced sexual violence other than rape during their lifetimes. Among men, an estimated 39.5% of multiracial men experienced sexual violence other than rape during their lifetimes. In addition, 26.6% of Hispanic men, 24.5% of American Indian/Alaska Native men, 24.4% of non-Hispanic black men, and 22.2% of non-Hispanic white men experienced sexual violence other than rape during their lifetimes, and an estimated 15.8% of Asian or Pacific Islander men experienced this type of sexual violence during their lifetimes.

Characteristics of Sexual Violence Perpetrators

For female rape victims, an estimated 99.0% had only male perpetrators. In addition, an estimated 94.7% of female victims of sexual violence other than rape had only male perpetrators. For male victims, the sex of the perpetrator varied by the type of sexual violence experienced. The majority of male rape victims (an estimated 79.3%) had only male perpetrators. For three of the other forms of sexual violence, a majority of male victims had only female perpetrators: being made to penetrate (an estimated 82.6%), sexual coercion (an estimated 80.0%), and unwanted sexual contact (an estimated 54.7%). For non-contact unwanted sexual experiences, nearly half of male victims (an estimated 46.0%) had only male perpetrators and an estimated 43.6% had only female perpetrators.

The majority of victims of all types of sexual violence knew their perpetrators. Almost half of female victims of rape (an estimated 46.7%) had at least one perpetrator who was an acquaintance, and an estimated 45.4% of female rape victims had at least one perpetrator who was an intimate partner (Table 3). More than half (an estimated 58.4%) of women who experienced alcohol/drug facilitated penetration were victimized by an acquaintance. An estimated 44.9% of male victims of rape were raped by an acquaintance, and an estimated 29.0% of male victims of rape were raped by an intimate

partner. The estimates for male victims raped by other types of perpetrators are not reported because the case counts were too small to calculate a reliable estimate. For sexual violence other than rape of both women and men, the type of perpetrator varied by the form of sexual violence experienced. The majority of female victims of sexual coercion (an estimated 74.1%) had an intimate partner as a perpetrator, and nearly half of female victims of unwanted sexual contact (an estimated 47.2%) had an acquaintance as a perpetrator.

About half of the female victims of non-contact unwanted sexual experiences had a stranger as a perpetrator (an estimated 49.3%). Among men who were made to penetrate a perpetrator, an estimated 54.5% were made to penetrate an intimate partner and an estimated 43.0% were made to penetrate an acquaintance. The majority of male victims of sexual coercion (an estimated 69.5%) had an intimate partner as a perpetrator. Among male victims of unwanted sexual contact, about half (an estimated 51.8%) had an acquaintance as a perpetrator. Finally, among male victims of non-contact unwanted sexual violence, an estimated 39.2% had an acquaintance as a perpetrator, followed by an intimate partner (an estimated 30.9%), or a stranger (an estimated 30.9%).

Stalking Victimization

Prevalence of Stalking Victimization

In the United States, an estimated 15.2% of women (18.3 million women) have experienced stalking during their lifetimes that made them feel very fearful or made them believe that they or someone close to them would be harmed or killed (Table 4). In addition, an estimated 4.2% of women (approximately 5.1 million women) were stalked in the 12 months before taking the survey.

Prevalence of Stalking Victimization by Race/Ethnicity

An estimated 24.5% of American Indian/Alaska Native women experienced stalking during their lifetimes, and an estimated 22.4% of multiracial women were stalked during their lifetimes (Table 4). An estimated 15.9% of non-Hispanic white women experienced stalking during their lifetimes, and the prevalence of stalking for Hispanic and non-Hispanic black women was an estimated 14.2% and 13.9%, respectively. The estimate for Asian or Pacific Islander women was not reported because the case count was too small to produce a reliable estimate. An estimated 9.3% of multiracial men experienced stalking during their lifetimes, as did an estimated 9.1% of non-Hispanic black men, 8.2% of Hispanic men, and 4.7% of non-Hispanic white men. The estimates for the other racial/ethnic groups of men are not reported because case counts were too small to produce a reliable estimate.

Frequency of Stalking Acts Among Stalking Victims

A variety of tactics were used to stalk victims during their lifetimes. An estimated 61.7% of female stalking victims were approached, such as at their home or work; over half (an estimated 55.3%) received unwanted messages, such as text and voice messages; an estimated 54.5% received unwanted telephone calls, including hang-ups (Table 5). In addition, nearly half (an estimated 49.7%) of female stalking victims were watched, followed, or spied on with a listening device, camera, or global positioning system (GPS) device. An estimated 58.2% of male stalking victims received unwanted telephone calls, and an estimated 56.7% received unwanted messages. An estimated 47.7% of male stalking victims were approached by their perpetrator, and an estimated 32.2% were watched, followed, or spied on with a listening or other device

Characteristics of Stalking Perpetrators

Among persons who were victims of stalking during their lifetimes, the sex of the perpetrator varied somewhat by the sex of the victim. Among female stalking victims, an estimated 88.3% were stalked by only male perpetrators; an estimated 7.1% had only female perpetrators. Among male stalking victims, almost half (an estimated 48.0%) were stalked by only male perpetrators while a similar proportion (an estimated 44.6%) were stalked by only female perpetrators. Both female and male victims often identified their stalkers as persons whom they knew or with whom they had an intimate relationship. Among female stalking victims, an estimated 60.8% were stalked by a current or former intimate partner, nearly one-quarter (an estimated 24.9%) were stalked by an acquaintance, an estimated 16.2% were stalked by a stranger, and an estimated 6.2% were stalked by a family member (Figure 1). Among male stalking victims, an estimated 43.5% were stalked by an intimate partner, an estimated 31.9% by an acquaintance, an estimated 20.0% by a stranger, and an estimated 9.9% by a family member.

Intimate Partner Violence Victimization

Prevalence of Intimate Partner Violence Victimization

The lifetime and 12-month prevalence of rape by an intimate partner for women was an estimated 8.8% and 0.8%, respectively. Nationally, an estimated 15.8% of women experienced other forms of sexual violence by an intimate partner during their lifetimes, while an estimated 2.1% of women experienced other forms of sexual violence by a partner in the 12 months before taking the survey. The lifetime prevalence of physical violence by an intimate partner was an estimated 31.5% among women and in the 12 months before taking the survey, an estimated 4.0% of women experienced some form of physical violence by an intimate partner. An estimated 22.3% of women experienced at least one act of severe physical violence by an intimate partner during

their lifetimes. With respect to individual severe physical violence behaviors, being slammed against something was experienced by an estimated 15.4% of women, and being hit with a fist or something hard was experienced by 13.2% of women. In the 12 months before taking the survey, an estimated 2.3% of women experienced at least one form of severe physical violence by an intimate partner. The lifetime and 12-month prevalence of stalking by an intimate partner for women was an estimated 9.2% and 2.4%, respectively. Finally, an estimated 47.1% of women experienced at least one act of psychological aggression by an intimate partner during their lifetimes; an estimated 14.2% of women experienced some form of psychological aggression in the 12 months preceding the survey. Nationally, an estimated 0.5% of men experienced rape by an intimate partner during their lifetimes. However, the case count for men reporting rape by an intimate partner in the preceding 12 months was too small to produce a statistically reliable relevance estimate. An estimated 9.5% of men experienced other forms of sexual violence by an intimate partner during their lifetimes, while an estimated 2.1% of men experienced other forms of sexual violence by an intimate partner in the 12 months before taking the survey. The lifetime prevalence of physical violence by an intimate partner was an estimated 27.5% for men, and in the 12 months before taking the survey, an estimated 4.8% of men experienced some form of physical violence by an intimate partner. An estimated 14.0% of men experienced at least one act of severe physical violence by an intimate partner during their lifetimes. With respect to individual severe physical violence behaviors, being hit with a fist or something hard was experienced by an estimate10.1% of men, and 4.6% of men have been kicked by an intimate partner. In the 12 months before taking the survey, an estimated 2.1% of men experienced at least one form of severe physical violence by an intimate partner. The lifetime and 12-month prevalence of stalking by an intimate partner for men was an estimated 2.5% and 0.8%, respectively. Finally, an estimated 46.5% of men experienced at least one act of psychological aggression by an intimate partner during their lifetimes; an estimated 18.0% of men experienced some form of psychological aggression in the 12 months preceding the survey.

Prevalence of Intimate Partner Violence Victimization by Race/Ethnicity

Nationally, an estimated 11.4% of multiracial women, 9.6% of non-Hispanic white women, 8.8% of non-Hispanic black women, and 6.2% of Hispanic women were raped by an intimate partner during their lifetimes (Table 7). The case counts for men reporting rape by an intimate partner during their lifetimes were too small to produce statistically reliable prevalence estimates by race/ethnicity. An estimated 26.8% of multiracial women, 17.4% of non-Hispanic black women, 17.1% of non-Hispanic white women, and 9.9% of Hispanic women experienced sexual violence other than rape by an intimate partner during their lifetimes. The case counts of other female racial/ethnic groups (Asian or Pacific Islander and American Indian/Alaska Native) were too small to report statistically reliable estimates. In addition, an estimated 18.2% of multiracial men, 14.8% of non-Hispanic black men, 13.5% of Hispanic men, and 7.6% of non-Hispanic white

men experienced sexual violence other than rape by an intimate partner at some point during their lifetimes. The case counts of other male racial/ethnic groups (Asian or Pacific Islander and American Indian/Alaska Native) were too small to report statistically reliable estimates.

An estimated 51.7% of American Indian/Alaska Native women, 51.3% of multiracial women, 41.2% of non-Hispanic black women, 30.5% of non-Hispanic white women, 29.7% of Hispanic women, and 15.3% of Asian or Pacific Islander women experienced physical violence by an intimate partner during their lifetimes. An estimated 43.0% of American Indian/Alaska Native men, 39.3% of multiracial men, 36.3% of non-Hispanic black men, 27.1% of Hispanic men, 26.6% of non-Hispanic white men, and 11.5% of Asian or Pacific Islander men experienced physical violence by an intimate partner during their lifetime. An estimated 13.3% of multiracial women, 9.9% of non-Hispanic white women, 9.5% of non-Hispanic black women, and 6.8% of Hispanic women were stalked by an intimate partner during their lifetimes. The case counts of other female racial/ethnic groups (Asian or Pacific Islander and American Indian/Alaska Native) were too small to report statistically reliable estimates. In addition, an estimated 1.7% of non-Hispanic white men were stalked by an intimate partner during their lifetimes. The case counts of all other male racial/ethnic groups were too small to report statistically reliable estimates.

Prevalence of Intimate Partner Violence–Related Impact

An estimated 27.3% of women have experienced contact sexual violence (rape, being made to penetrate, sexual coercion, or unwanted sexual contact), physical violence, or stalking by an intimate partner during their lifetimes and have experienced at least one measured negative impact related to these or other forms of violence (noncontact unwanted sexual experiences, psychological aggression, or control of reproductive or sexual health) experienced in that relationship (Table 6). More specifically, an estimated 23.7% of women were fearful, 20.7% were concerned for their safety, 20.0% experienced one or more PTSD symptoms, 13.4% were physically injured, 6.9% needed medical care, 3.6% needed housing services, 3.3% needed victim advocate services, 8.8% needed legal services, 2.8% contacted a crisis hotline, 9.1% missed at least 1 day of work or school, 1.3% contracted a sexually transmitted infection, and 1.7% became pregnant as a result of the violence experienced by an intimate partner.

Nationally, an estimated 11.5% of men have experienced contact sexual violence, physical violence, or stalking by an intimate partner during their lifetimes and have experienced at least one measured negative impact related to these or other forms of violence experienced in that relationship. More specifically, an estimated 6.9% of men were fearful, 5.2% were concerned for their safety, 5.2% experienced one or more PTSD symptoms, 3.5% were physically injured, 1.6% needed medical care, 1.0% needed housing services, 4.0% needed legal services, and 4.8% missed at least 1 day of work or

school. The case counts for men needing victim advocacy services, having contacted a crisis hotline, or contracting a sexually transmitted infection as a result of these types of violence were too small to produce statistically reliable estimates.

Age of First Victimization

Completed Rape

Among female victims of completed rape (completed forced penetration and completed alcohol- or drug-facilitated penetration), this form of sexual violence was first experienced by an estimated 78.7% before age 25 years, by an estimated 40.4% before age 18 years (28.3% at ages 11–17 years and 12.1% at age ≤10 years), and by an estimated 38.3% at age 18–24 years (Figure 3). In addition, among female victims of completed rape, an estimated 15.2% first experienced this at age 25–34 years, an estimated 4.6% at age 35–44 years, and an estimated 1.5% at age ≥45 years. The case counts for men reporting lifetime completed rape were too small to produce statistically reliable estimates for all age categories.

Being Made to Penetrate a Perpetrator

Among males who were made to penetrate a perpetrator, this was experienced first by an estimated 71.0% before age 25 years, with an estimated 21.3% having first experienced this before age 18 years (18.6% at age 11–17 years) and an estimated 49.7% at age 18–24 years (Figure 4). In addition, among male victims who were made to penetrate a perpetrator, this was experienced first by an estimated 15.3% at age 25–34 years and by an estimated 7.9% at age 35–44 years. The case count for men reporting first being made to penetrate a perpetrator at age ≥45 years was too small to produce a statistically reliable estimate. In addition, the case counts for women reporting being made to penetrate a perpetrator during their lifetimes were too small to produce statistically reliable estimates for all age categories.

Stalking

Among female victims of stalking, an estimated 53.8% were first stalked before age 25 years, with an estimated 16.3% first experiencing this before age 18 years (13.5% at ages 11–17 years) and an estimated 37.5% at ages 18–24 years (Figure 3). In addition, among female victims of stalking, this was experienced first by an estimated 28.8% at ages 25–34 years, by an estimated 11.5% at ages 35–44 years, and by an estimated 5.9% at age ≥45 years. Among male victims of stalking, an estimated 47.7% were first stalked before age 25 years, with an estimated 20.5% having first experienced stalking before age 18 years (16.2% at ages 11–17 years) and an estimated 27.2% having first experienced this at age 18–24 years (Figure 4). In addition, among male victims of stalking, this was experienced first by an estimated 21.3% at age 25–34 years, by an estimated 17.9% at age 35–44 years, and by an estimated 13.1% at age ≥45 years.

Intimate Partner Violence

Among female victims of contact sexual violence, physical violence, or stalking by an intimate partner, an estimated 71.1% first experienced these or other forms of intimate partner violence before age 25 years, with an estimated 23.2% having first experienced this before age 18 years (23.1% at age 11–17 years) and an estimated 47.9% at age 18–24 years (Figure 3). In addition, among female victims of contact sexual violence, physical violence, or stalking by an intimate partner, these or other forms of intimate partner violence were experienced first by an estimated 20.7% at age 25–34 years, by an estimated 5.9% at age 35–44 years, and by an estimated 2.3% at age ≥45 years. Among male victims of contact sexual violence, physical violence, or stalking by an intimate partner, an estimated 58.2% first experienced these or other forms of intimate partner violence before age 25 years, with an estimated 14.1% having first experienced this before age 18 years (14.0% a age 11–17 years) and an estimated 44.1% at age 18–24 years (Figure 4). In addition, among male victims of contact sexual violence, physical violence, or stalking by an intimate partner, these or other forms of intimate partner violence were first experienced by an estimated 26.7% at age 25–34 years, by an estimated 10.4% at age 35–44 years, and by an estimated 4.7% at age ≥45 years.

Discussion

The results presented in this report indicate that a significant number and proportion of female and male U.S. adults have experienced sexual violence, stalking, or intimate partner violence during their lifetimes or in the 12 months preceding the survey. Because of the broad range of short- and long-term consequences associated with these forms of violence, the public health burden of sexual violence, stalking, and intimate partner violence is substantial.

The results provided in this report indicate that the burden of sexual violence, stalking, and intimate partner violence is not distributed evenly in the U.S. population. Consistent with previous studies, the results suggest that women, in particular, are impacted heavily during their lifetimes. However, the results indicate that many men also experience sexual violence, stalking and, in particular, physical violence by an intimate partner. Although there are relatively smaller differences in the overall prevalence of physical violence by an intimate partner when comparing women and men, there is greater differentiation between women and men in terms of the prevalence of negative intimate partner violence–related impact. This suggests the need to look beyond the overall prevalence estimates when comparing the total burden of men's and women's intimate partner violence victimization. Previous research indicates that characteristics (e.g., frequency, severity, and impact) of men's and women's intimate partner violence victimization differ in ways that might not be reflected in overall prevalence estimates. However, any focus on differences between men and women should not obscure the fact

that nearly 16 million men have experienced some form of severe physical violence by an intimate partner during their lifetimes and >13 million men have experienced intimate partner violence during their lifetimes that resulted in a negative impact. The results also suggest that certain racial/ethnic groups experience a comparatively higher burden. Although statistical testing was not undertaken, an examination of the pattern of lifetime prevalence estimates suggests that multiracial and American Indian/Alaska Native women experience elevated levels for most of the types of violence examined in this report.

These findings are consistent with previous reports indicating that multiracial and American Indian/Alaska Native women are at greater risk for rape, stalking, and intimate partner violence. These findings underscore the importance of prevention efforts and services that address the needs of multiracial and American Indian/Alaska Native women. Although previous research has suggested explanations for elevated rates of violence among American Indian/Alaska Native women (e.g., elevated poverty, social and geographic isolation, and a higher likelihood of alcohol use by the perpetrator), little is known about why multiracial women are at greater risk for these forms of violence. Research is needed to identify risk and protective factors for violence victimization among multiracial persons.

By definition, all victims of intimate partner violence knew their perpetrator; however, the majority of sexual violence and stalking victims also knew their perpetrators. Despite frequent depictions in the media of sexual violence and stalking perpetrated by strangers, strangers were reported as the perpetrator by less than one fourth of stalking victims and by less than one fourth of victims of each form of sexual violence except non-contact unwanted sexual experiences. For stalking and for all forms of sexual violence except non-contact unwanted sexual experiences, two frequently reported perpetrators were intimate partners and acquaintances. This pattern suggests that prevention efforts for sexual violence and stalking need to focus on preventing violent interactions between persons who are intimate or are known to each other in another capacity. Female victims of sexual violence and stalking reported predominantly male perpetrators, whereas for male victims, the sex of the perpetrator varied by the specific form of violence examined. Male rape victims predominantly had male perpetrators, but other forms of sexual violence experienced by men either were perpetrated predominantly by women (i.e., being made to penetrate a perpetrator or sexual coercion) or were split more evenly among male and female perpetrators (i.e., unwanted sexual contact and non-contact unwanted sexual experiences). In addition, male stalking victims also had a more even mix of males and females who had perpetrated stalking against them. Prevention efforts should take into consideration that female sexual violence and stalking victimization is predominately perpetrated by men and that a substantial proportion of male sexual violence and stalking victimization (rape, unwanted sexual contact, non-contact unwanted sexual experiences, and stalking) also is perpetrated by men.

For each of the violence types assessed, ≥53.8% of all female victims and ≥47.7% of all male victims experienced their first victimizations before age 25 years, with many first experiencing victimization in childhood and adolescence. These findings suggest that primary prevention of sexual violence, stalking, and intimate partner violence should take place at an early age. CDC's approach to the primary prevention of violence is in keeping with this finding. Specifically, CDC supports the development of safe, stable, and nurturing relationships and environments for children as a precursor to healthy parent-child relationships (http://www.cdc.gov/violenceprevention/pdf/efc-01-03-2013-a.pdf); healthy peer relationships among adolescents; healthy dating relationships among adolescents before their first experience with dating (http://www.cdc.gov/violenceprevention/DatingMatters); and the engagement of bystanders to intervene before violence occurs. CDC also supports the development, evaluation, and widespread adoption of empirically supported teen dating violence prevention programs. For example, the school-based Safe Dates program, which focuses on enhancing conflict management skills and changing norms about dating violence, has been shown to prevent perpetration of physical and sexual violence as well as psychological aggression in teen dating relationships. When parental, peer, and dating relationships are influenced early in life, healthy relationship behaviors and patterns and healthy social environments can be promoted while these behaviors are relatively modifiable. In so doing, adolescents can be equipped with healthier behaviors to use in place of violence within adult relationships. In addition to primary prevention efforts, secondary prevention is also important. The results suggest that a substantial number of women and men also have experienced a range of negative impacts as a result of the intimate partner violence they have experienced. Most notably, nearly 13.4% of women and 3.5% of men have been injured physically, and 9.1% of women and 4.8% of men have missed at least 1 day of work or school because of experiencing intimate partner violence. Previous research has established that in addition to these near-term impacts, those who experience intimate partner violence are at greater risk for a range of long-term health consequences. For the negative effects of intimate partner violence, sexual violence, and stalking to be mitigated, it is important to ensure that relevant services are available to victims. The findings in this report suggest that many adults are in need of these types of services as a result of intimate partner violence victimization. During their lifetimes 6.9% of women and 1.6% of men needed medical services, 8.8% of women and 4.0% of men needed legal services, and 3.6% of women and 1.0% of men needed housing services (e.g., shelters). Analyses of 2010 NISVS data suggest that nearly half of female victims and approximately two thirds of male victims who indicated a need for services did not receive any of the services needed as a result of intimate partner violence experienced during their lifetimes. Research is needed to examine the degree to which needed services are not being received and to determine whether any existing gap is attributable to services being unavailable, inaccessible, or inadequate, or to victims choosing not to use available services.

10. Predictors of Intimate Partner Violence Re-victimization: The Relative Impact of Distinct PTSD Symptoms, Dissociation, and Coping Strategies

Psychological distress and coping strategies following intimate partner violence (IPV) victimization may impact survivors' risk for future IPV. The current study prospectively examined the impact of distinct post-traumatic stress disorder (PTSD) symptom clusters (re-experiencing, avoidance, numbing, and hyper arousal), dissociation, and coping strategies (engagement and disengagement coping) on IPV re-victimization among recently abused women. Women (N = 69) who were seeking services for IPV and experienced their most recent episode of physical IPV between 2 weeks and 6 months prior to study enrollment completed measures of physical IPV, psychological distress, and coping strategies at baseline and at 6-month follow-up. The women averaged 36 years of age and 67% of the sample was African American. Separate Poisson regression analyses revealed that PTSD hyper arousal symptoms, dissociation, engagement coping, and disengagement coping each significantly predicted physical IPV re-victimization at the 6-month follow-up (with effect sizes ranging from a 1.20–1.34 increase in the likelihood of Time 2 physical IPV with a 1 *SD* increase in the predictor). When these significant predictors were examined together in a single Poisson regression model, only engagement and disengagement coping were found to predict physical IPV re-victimization such that disengagement coping was associated with higher re-victimization risk (1.29 increase in the likelihood of Time 2 physical IPV with one *SD* increase in disengagement coping) and engagement coping was associated with lower re-victimization risk (1.30 decrease in the likelihood of Time 2 physical IPV with one *SD* increase in engagement coping). The current findings suggest that coping strategies are important and potentially malleable predictors of physical IPV re-victimization.

Intimate partner violence (IPV) is a substantial public health problem (Center for Disease Control, 2011). Recent findings from the National Intimate Partner and Sexual Violence Survey indicate that approximately 33% of American women experience physical IPV during their lifetime, with 25% reporting severe physical violence victimization by an intimate partner. Women victims of IPV often experience psychological difficulties such as post-traumatic stress disorder (PTSD), depression, anxiety, substance use disorders, eating disorders, somatic complaints, and suicidality. Although the prevalence and adverse consequences of IPV are clearly documented, little is known about how to reduce

IPV survivors' risk for future violence from an intimate partner. This is a significant gap in the literature because IPV re-victimization is an all too common experience for women, even among those who have left abusive partners. For instance, Krause, Kaltman, Goodman, and Dutton found that approximately 37% of women reported IPV re-victimization from an index partner within a year of seeking help for the abuse. Because this study did not include IPV re-victimization from a new intimate partner, it is likely that the re-victimization rate may be even higher given that 27%–56% of IPV survivors are involved in more than one abusive intimate relationship during adulthood. Thus, it is important to identify and understand risk factors for IPV re-victimization, particularly those that survivors can influence, to help reduce survivors' risk for future partner violence. Mental health symptoms and coping strategies, in particular, stand out as promising risk factors to investigate to inform our prevention efforts because they are amenable to change. PTSD is a particularly common consequence of IPV that may be associated with women's risk for subsequent IPV. PTSD symptom severity is a significant longitudinal predictor of future IPV above and beyond the effects of previous interpersonal violence experiences. Additionally, Krause, et al., prospectively examined the role of distinct PTSD symptom clusters (hyper arousal, re-experiencing, numbing, and avoidance) on IPV re-victimization risk among help-seeking women. Only numbing symptoms significantly increased the likelihood of IPV re-victimization at a 1-year follow-up. In a study of sexual re-victimization among a large sample of women, however, hyper arousal was the only PTSD symptom cluster to predict re-victimization. Although there are too few studies to determine which PTSD symptom clusters are most predictive of IPV re-victimization, the relationship between PTSD symptoms and re-victimization appears dynamic. Iverson et al. found that female interpersonal trauma survivors who experienced substantial reductions in PTSD symptoms during cognitive–behavioral therapy for PTSD were significantly less likely to report IPV at a 6-month follow-up relative to women who did not experience similar reductions in PTSD. It is possible that decreases in PTSD symptoms reduced IPV risk through improvements in women's ability to identify and respond to danger cues from current or potential partners. Together, these findings highlight the importance of examining PTSD as a risk factor for re-victimization, including the different influences of distinct PTSD symptom clusters.

Dissociation is also a frequent consequence of IPV that may play a role in increasing women's risk for IPV re-victimization. Dissociation may provide women survivors of IPV a mechanism by which to detach, or emotionally separate themselves, from the pain of being harmed by an intimate partner. Due to its negative reinforcing properties, this tendency to dissociate may generalize into one's everyday life, hindering information processing during potentially risky situations. Consistent with this notion, in one of the few studies examining the role of dissociation in IPV re-victimization, Alexander found that women who experienced IPV in two or more relationships reported

more severe dissociation symptoms than women who experienced IPV in a single relationship. Although there is limited research examining dissociation and IPV re-victimization, there is a larger literature demonstrating a significant association between dissociation and sexual re-victimization among women.

Coping is another important process that may be related to re-victimization. Coping refers generally to cognitive and behavioral efforts to manage internal and external stressors that are perceived as taxing or exceeding an individual's resources. Researchers have differentiated between "engagement" and "disengagement" forms of coping: engagement coping refers to proactive steps to manage the abuse and its consequences and includes strategies such as problem-solving, cognitive restructuring, emotional expression and eliciting social support; whereas disengagement coping refers to more passive attempts at coping and encompasses strategies such as problem avoidance, wishful thinking, self-criticism, and social withdrawal . In the aftermath of IPV, women may understandably avoid abuse-related triggers in an effort to reduce experiencing overwhelming and painful emotions. Therefore, in the short-term, disengagement coping may be viewed as a helpful coping strategy. Overemphasis on wishful thinking, social withdrawal, or avoidant coping, however, can result in a sense of detachment, which may increase risk for PTSD symptoms and dissociation as well as re-victimization.

Prior research has shown that IPV frequency is positively associated with disengagement coping, whereas frequency of abuse is not significantly associated with engagement coping. Thus, both of these general coping strategies may have differing impacts on IPV re-victimization risk. In fact, several studies have shown that disengagement coping is a predictor of re-victimization. In one of the more comprehensive evaluations of coping in re-victimization, Filipas and Ullman found that when disengagement coping, severity of previous abuse, self-blame, and PTSD symptoms were examined together as predictors of sexual re-victimization, disengagement coping was found to be the only significant predictor. Although there is little research examining engagement coping and IPV re-victimization, engagement coping may help protect women from future IPV through reduced distress and more effective use of personal and social resources.

Research suggests that PTSD, dissociation, and coping strategies may be risk factors for IPV re-victimization; however, longitudinal data are limited and we are unaware of any studies that have compared the relative risk of these factors. The purpose of this study was to investigate the relative impact of specific PTSD symptom clusters, dissociation, and coping strategies on likelihood of physical IPV re-victimization among a sample of female IPV survivors. Based on the extant literature, we hypothesized that PTSD symptom clusters, dissociation, and disengagement coping would each be significantly associated with increased risk for physical IPV re-victimization at the 6- month follow-up, and that engagement coping would be significantly associated with decreased risk for re-victimization. Consistent with prior research on sexual re-victimization, which

identifies disengagement coping as a particularly important predictor of re-victimization, we also hypothesized that when all three sets of variables were entered simultaneously into the regression model, disengagement coping would emerge as the strongest predictor of IPV re-victimization.

Method

Participants and Procedures

Participants were 69 women who completed baseline and 6- month follow-up assessments as part of a larger study assessing the psychological and psychophysiological correlates of recent IPV among women seeking help for the abuse from shelters and community agencies. Participants were included in the parent study if they reported involvement in an intimate relationship with a perpetrator for at least 3 months during the past year, experienced their most recent act of physical IPV between 2 weeks and 6 months prior to baseline, and reported at least two severe acts or four minor acts of physical IPV within the previous year. Participants were included in the current study if they completed the baseline assessment and the planned smaller sample 6-month-follow-up assessment. Women were excluded from the study if they were judged by the assessor to be under the influence of drugs or alcohol or exhibited psychotic symptoms at the time of either assessment. On average, participants were 35.9 years of age (*SD* = 8.6) and had completed 12.9 years of education (*SD* = 1.8). Two thirds of participants were African American (66.7%), 30.4% were Caucasian, and 2.9% identified themselves as belonging to other racial groups. Many participants were economically disadvantaged; 58.2% reported an annual income of less than $20,000 per year and approximately 33.3% of the women were living in a shelter at baseline. During their most recent abusive relationship as reported at baseline, 6 (8.7%) participants were dating the perpetrator, 30 (43.5%) were living with the perpetrator, 21 (30.4%) were married to the perpetrator, and 12 (17.4%) were separated or divorced from the perpetrator. Nearly all (97.1%) participants identified their perpetrators as male. The average relationship length between participants and the abuser was 6.5 years (*SD* = 6.3). Participants reported that they had experienced physical IPV from the abuser for an average of 4.5 years (*SD* = 5.7), and at baseline, an average of 49.5 days had passed (*SD*=42.9) since the most recent incident of physical IPV. Women receiving services at domestic violence shelters and victim agencies were informed about the parent study and invited to contact study personnel if they were interested in participating. Following a phone screen, eligible participants reported to a Trauma Recovery Center in a large city in the midwestern United States for two baseline appointments that typically occurred within several days of each other. During these visits, participants completed self-report questionnaires, clinical interviews, and physiological measures. The Conflict Tactics Scale-2 (CTS-2), the Post-traumatic Diagnostic Scale (PDS), the Dissociative Experiences Scale-II (DES-II), and the Coping Strategies Inventory (CSI) were administered as part of this

larger assessment. Participant tracking procedures for the 6- month follow-ups included monthly phone contact to attempt to maintain contact and obtain updated contact information. Participants completed the 6-month follow-up interviews at the same location as the baseline assessment. During this session, participants were re-administered various outcome measures, including the CTS-2, in a similar manner as the baseline assessment. After each of the assessments, participants were debriefed and were provided with safety planning and referrals for supportive services. All procedures described in this study were approved by the Institutional Review Board at Saint Louis University.

Measures

Intimate partner violence. The 12-item Physical Assault sub-scale of the CTS-2 (Straus, Hamby, Boney-McCoy, & Sugarman) was used to assess physical IPV at baseline and the 6-month follow-up. At baseline, respondents reported on the frequency of abusive behaviors perpetrated by their current or most recent abusive partner within the previous 12 months (i.e., the abuser for which they were seeking help). At the 6-month follow-up, respondents were asked about physical IPV perpetrated by a current or former partner within the past 6 months. If they had more than one partner who engaged in physical IPV in the past 6 months, they were asked to respond in terms of the one who most frequently used IPV. The Physical Assault sub-scale has good reliability and validity (Straus). Intimate partner violence scores were computed by summing the number of positively endorsed items, with total scores ranging from 0 to 12. This computation method, known as the variety score, has desirable psychometric properties, reduces estimation errors common in the recall of high-frequency behaviors, and circumvents the need to weight different acts by their presumed severity (Moffitt et al.). Internal consistency was $\alpha = .91$ and .89, for Time 1 and Time 2, respectively.

PTSD symptoms. The PDS (Foa, Cashman, Jaycox, & Perry) is a self-report measure that assesses *Diagnostic and Statistical Manual of Mental Disorders* (4th ed.; *DSM-IV*; American Psychiatric Association) criteria for PTSD. Participants rated the frequency of experiencing each of the 17 PTSD symptoms within the past month on a 4-point scale ranging from 0 = *not at all or only one time* to 3 = *5 or more times a week/almost always*. The PDS has established psychometric properties (Foa et al.). Consistent with research on the factor structure of PTSD (King, Leskin, King, & Weathers), four scores were calculated by summing for the items assigned to each of the separate symptom clusters: re-experiencing (five items; $\alpha = .83$), effortful avoidance (two items; $\alpha = .71$), numbing (five items; $\alpha = .84$), and hyper arousal (five items; $\alpha = .83$), which represent a modification to the standard scoring recommended by Foa et al.

Dissociative symptoms. The DES-II (Carlson & Putnam) is a 28-item self-report scale that assesses the frequency of dissociative symptoms in clinical and nonclinical samples.

In this updated version of the original DES (Bernstein & Putnam), participants indicate the percentage of time they experience each symptom by circling a number from 0–100. The DES-II score is an index of the average frequency of dissociative experiences, with higher scores indicating higher levels of dissociation symptoms. The DES-II has good overall psychometric properties (Carlson & Putnam). Internal consistency for the DES-II in this sample was $\alpha = .87$.

Coping strategies. The CSI (Tobin et al.) is a 72- item measure of coping strategies employed in response to recent stressful events. The CSI has eight subscales, with two overarching factors that were used in the current study: engagement coping and disengagement coping. Engagement coping includes Problem Solving, Cognitive Restructuring, Express Emotions, and Social Support subscales, and disengagement coping includes Problem Avoidance, Wishful Thinking,
Self-Criticism, and Social Withdrawal subscales. Responses to the CSI are provided on a 5-point Likert scale ranging from 0 = *not at all* to 4 = *very much*, and summed scores indicate a greater likelihood of using the method of coping in question. The CSI has strong psychometric properties (Cook & Heppner, Tobin et al.). Internal consistency for the engagement and disengagement subscales were $\alpha = .89$ and .90, respectively.

Data Analysis

First, descriptive statistics and bivariate associations were computed for all study variables. Pearson correlations were computed to evaluate the associations between PTSD symptom clusters, dissociation symptom severity, and coping strategies.
The IPV measure was a count of different physical acts of IPV experienced over a specific period of time, which was substantially positively skewed. Therefore, we used Poisson regression, which is the most appropriate analytic procedure when analyzing count or frequency outcomes, to examine the associations between study variables with physical IPV at baseline (T1) and 6-month follow-up (T2). Second, Poisson regression analyses were conducted to test the hypotheses, while adjusting for physical IPV at T1. Four sets of regressions were conducted to predict physical IPV re-victimization: Model 1 included the four PTSD symptom clusters; Model 2 included dissociation; and Model 3 included disengagement and engagement coping. The final model included all significant variables from Models 1–3 in predicting IPV re-victimization at T2. Incidence density ratios (IDRs) were calculated from these Poisson regressions. IDRs are a measure that indicates how much an event is likely to increase or decrease with each increase in a predictor. In this study, an IDR greater than 1 indicates that participants are more likely to experience additional instances of IPV with each increase in the predictor of interest, an IDR less than 1 indicates that participants are less likely to experience additional instances of IPV with each increase in the predictor of interest, and an IDR equal to 1 indicates that there is no change in the rate of IPV with each increase in the predictor of interest.

Results

Table 1 presents descriptive statistics and bivariate associations for all study variables. At T1, participants reported experiencing an average of seven different acts of physical IPV within the past year. Approximately 46% of participants reported at least one act of physical IPV re-victimization at the 6-month follow up (T2). Participants who reported re-victimization experienced an average of 5.3 (*SD* = 2.1) acts of physical IPV between T1 and T2. As shown in Table 1, Poisson regression coefficients indicated significant bivariate associations between T2 IPV and four of the predictor variables (hyper arousal, dissociation, disengagement coping, and T1 physical IPV). Notably, the IDRs calculated from these Poisson regressions indicate that each additional act of IPV reported at T1 was associated with a 1.11 times greater likelihood of reporting an instance of IPV at T2. Thus, someone reporting seven different acts of physical IPV at T1, which was the average response on this measure, was 6.6 times more likely to report an act of IPV at T2 than someone reporting one act of physical IPV at T1. Findings fromModels 1–3 are presented in Table 2. As shown in Model 1, the first Poisson multiple regression analysis revealed that after controlling for T1 physical IPV, hyper arousal was the only PTSD symptom cluster to significantly predict IPV re-victimization. Higher levels of hyper arousal symptoms at T1 were associated with a higher likelihood of physical IPV re-victimization at T2 even after controlling for the other PTSD symptom clusters (IDR = 1.09, $p = .013$). The results of Model 2 also identified dissociation as a significant predictor of physical IPV re-victimization such that greater dissociation symptoms at T1 were associated with a higher likelihood of physical IPV re-victimization at T2 (IDR = 1.01, $p = .002$). Model 3 indicated that both disengagement coping (IDR = 1.01, $p < .001$) and engagement coping (IDR = 0.99, $p = .022$) were significant predictors of physical IPV re-victimization at T2. Specifically, disengagement coping was associated with higher likelihood of re-victimization, whereas higher levels of engagement coping was associated with lower likelihood of re-victimization.

Next, we examined the significant predictors of physical IPV re-victimization at T2 found in the previous analyses in a single Poisson regression model to evaluate the relative impact of these variables on re-victimization risk (see Model 4 in Table 2). The only significant predictors of physical IPV re-victimization at T2, after accounting for the significant contribution of T1 physical IPV, were disengagement coping (IDR = 1.01, $p = .006$) and engagement coping (IDR = 0.99, $p = .015$), such that higher levels of disengagement coping were predictive of higher likelihood of IPV re-victimization, whereas higher levels of engagement coping were predictive of lower likelihood of IPV re-victimization. Hyper arousal and dissociation symptoms were no longer significant predictors of re-victimization in this larger model.

Discussion

The critical need for research on modifiable predictors of re-victimization is underscored by the high rates of IPV re-victimization observed in this study, with nearly half of the

sample (46%) reporting physical IPV re-victimization within 6 months of seeking help for abuse from an intimate partner. The proportion of re-victimization is striking considering the relatively short timeframe and the help-seeking nature of the sample. Consistent with our hypotheses, the findings generally indicate that PTSD, dissociation, and coping strategies are all important factors that contribute to IPV survivors' risk for physical IPV re-victimization. When all of the study variables, however, were examined simultaneously to evaluate the relative impact of each variable on IPV re-victimization risk, only disengagement and engagement coping strategies were significant predictors of re-victimization. Because PTSD has received substantial attention in the re-victimization literature), we first evaluated the impact of distinct PTSD symptoms clusters on IPV re-victimization. When all four PTSD symptom clusters were entered simultaneously into the regression model, only the hyper arousal cluster significantly predicted IPV re-victimization. This finding is consistent with empirical work demonstrating that hyper arousal was the only PTSD symptom cluster to predict sexual re-victimization among a sample of women. The hyper arousal symptoms of PTSD, which involve heightened physiological arousal and emotion disregulation, may lead a survivor to be in a constant state of alert and thereby impede survivors' ability to detect and/or respond to actual risk. It is noteworthy that the current findings were discrepant from those of a previous study that found that only numbing symptoms predicted IPV re-victimization among recently abused women (Krause et al., 2006). It is important to remember, however, that the Krause et al. study examined IPV re-victimization by an index partner (i.e., the partner from whom they were seeking help), whereas the current study included IPV from the index partner and new partners. It is possible that numbing symptoms are more relevant when predicting re-victimization only from an index partner because this type of symptomatology (e.g., general analgesia) may increase vulnerability to staying in or returning to an abusive situation. Because of the modest sample size, we were unable to examine if distinct PTSD symptom clusters were differentially associated with risk for IPV from an index versus new intimate partner in the current study due to a lack of power. This question warrants attention in future research. Dissociation was also predictive of physical IPV re-victimization such that when examined independently in a regression model, higher levels of dissociation symptoms were associated with higher re-victimization risk. This finding is consistent with theoretical work positing that a woman's tendency to dissociate subsequent to interpersonal violence increases her vulnerability to re-victimization (e.g., Chu). Additionally, this finding aligns with several previous studies documenting a relationship between dissociation and sexual re-victimization. The current findings extend beyond the previous literature, providing support for the role of dissociation in IPV re-victimization using a prospective research design. Dissociation may impede risk detection and this might contribute to the association between dissociation and re-victimization. Ultimately, disengagement and engagement coping strategies were found to be the most influential contributors to physical IPV re-victimization. As hypothesized, disengagement coping

was associated with increased risk for re-victimization. This finding is consistent with several studies that have evaluated predictors of sexual re-victimization. Furthermore, in a study of predictors of sexual victimization, disengagement coping was the only significant predictor when simultaneously examining multiple factors that individually have been shown to be correlated with sexual re-victimization, such as PTSD symptoms. Disengagement coping may increase women's vulnerability to additional partner violence through the negative effects of avoidance and withdrawal on survivors' internal and external resources, which may impede prevention efforts.

Complementing the findings for disengagement coping, this study also demonstrated that engagement coping may reduce risk for physical IPV re-victimization. Women who engaged in higher levels of engagement coping had lower risk for IPV re-victimization, even after accounting for the effects of previous IPV frequency, PTSD symptoms, dissociation, and disengagement coping. Thus, the use of problem-solving, cognitive restructuring, expressing emotions, and seeking social support appear to be protective factors for acutely abused women in terms of reducing vulnerability to future IPV. Such forms of engagement coping may help protect women from future IPV through reduced distress and more effective use of personal and social resources, which in turn may allow them to engage in more prevention efforts (Johnson et al., 2007; Krause et al., 2008; Macy, 2007). This is consistent with research showing that an increase in engagement coping among female physical and sexual assault survivors predicts improvements in psychological functioning. This finding is important because it increases our understanding of resilience factors associated with lower risk for re-victimization. Clearly, understanding protective factors that reduce women's risk for re-victimization is an area of research that deserves increased attention. Although findings from this study illuminate important predictors of IPV re-victimization among acutely abused women, there are several limitations of the current study that can be addressed in future research. Because this is a help-seeking sample, the current findings may not generalize to women who are not seeking help for IPV. For example, disengagement coping may be protective against re-victimization for women not receiving social and mental health services by enabling them to maintain a relatively safe stance in abusive relationships. Although lesbian and bisexual women were not excluded from the current study, the majority of women in this sample were seeking help for abuse by male perpetrators. It is important that future studies also focus on predictors of re-victimization among lesbian, gay, bisexual, and transgendered male and female survivors of IPV. The reliance on self-report measures of all of the variables examined in this study raises concerns of shared-method variance. More comprehensive and multisource assessments of theoretically relevant variables (e.g., clinical interviews, ecologically valid measures of coping) will enhance future research aimed at examining predictors of different forms of IPV re-victimization. Future inquiries should test moderators of the models examined in this study, such as the risk of IPV re-victimization from an index versus new partner. Similarly, longitudinal research designs including three or more time points are needed to evaluate the full temporal dynamics of all of the variables examined in the current study

given the dynamic relationship documented among psychiatric distress and coping among interpersonal trauma survivors. Additionally, this study found that two broad classes of coping strategies, specifically, engagement and disengagement coping, affected women's risk for IPV re-victimization. Further characterization of how coping processes are associated with IPV risk is critical to gaining a more comprehensive understanding of risk and protective factors impacting survivors' safety subsequent to seeking help for IPV. It is hoped that the current findings will inform preventative interventions and psychosocial treatment for IPV survivors by encouraging researchers to further elucidate the many different ways in which IPV survivors cope during and following abusive relationships, and how such coping strategies impact women's mental health and safety. Such research should also examine which resources (e.g., social support, financial assistance effective coping skills while addressing psychological distress have been found to be well-received by IPV survivors. It is important to remember, however, that although advocates and clinicians can assist survivors' in reducing their risk for IPV re-victimization, prevention of future IPV also necessitates effective interventions with individuals who engage in IPV.

11. Intimate Partner Violence and Incident Depressive Symptoms and Suicide Attempts

Depression and suicide are responsible for a substantial burden of disease globally. Evidence suggests that intimate partner violence (IPV) experience is associated with increased risk of depression, but also that people with mental disorders are at increased risk of violence. We aimed to investigate the extent to which IPV experience is associated with incident depression and suicide attempts, and vice versa, in both women and men.

More than 22,000 records from 20 databases were searched for studies examining physical and/or sexual intimate partner or dating violence and symptoms of depression, diagnosed major depressive disorder, dysthymia, mild depression, or suicide attempts. Random effects meta-analyses were used to generate pooled odds ratios (ORs). Sixteen studies with 36,163 participants met our inclusion criteria. All studies included female participants; four studies also included male participants. Few controlled for key potential confounders other than demographics. All but one depression study measured only depressive symptoms. For women, there was clear evidence of an association between IPV and incident depressive symptoms, with 12 of 13 studies showing a positive direction of association and 11 reaching statistical significance; pooled OR from six studies=1.97 (95% CI 1.56–2.48,I 2=50.4%,p heterogeneity =0.073). There was also evidence of an association in the reverse direction between depressive symptoms and incident IPV (pooled OR from four studies=1.93, 95% CI 1.51–2.48, I 2=0%,p=0.481). IPV was also associated with incident suicide attempts. For men, evidence suggested that IPV was associated with incident depressive symptoms, but there was no clear evidence of an association between IPV and suicide attempts or depression and incident IPV.

Conclusions: In women, IPV was associated with incident depressive symptoms, and depressive symptoms with incident IPV. IPV was associated with incident suicide attempts. In men, few studies were conducted, but evidence suggested IPV was associated with incident depressive symptoms. There was no clear evidence of association with suicide attempts.

Background

Unipolar depressive disorders are the second leading cause of disease burden in women aged 15–44 y worldwide, and self- inflicted injuries are the seventh leading cause of disease burden [1]. Intimate partner violence (IPV) is also common, being reported by 15%–71% of women over their lifetime [2]. These conditions are linked—IPV experience is strongly and consistently associated with depression, including depressive symptoms and depressive disorders, and suicide in cross-sectional studies of women in both high- and lower-income settings [3–7]. There is less research on men, but cross-sectional studies also show that depressive symptoms are associated with IPV experience.

Several authors have speculated that the increased exposure to various forms of violence among women relative to men may help to explain the greater prevalence of depression, suicide attempts, and other common mental disorders in women versus men [9,10]. While it is easy to assume that IPV is causally related to subsequent depression and suicidal behavior, evidence suggests a more complex relationship. There are three modes of association, which are possible in any combination: (1) IPV exposure causes subsequent depression and suicide attempts, (2) depression and/or suicide attempts cause subsequent IPV, and (3) there are common risk factors for both IPV and depression and suicide attempts that explain the association between them. Traumatic stress is the main mechanism by which IPV might cause subsequent depression and suicide attempts. Traumatic events can lead to stress, fear, and isolation, which in turn may lead to depression and suicidal behavior [9]. A recent meta- analysis of three longitudinal studies provides support for this direction of association with depression, but this analysis pooled depressive disorders, depressive symptoms, and postpartum depression; included only a subset of known studies; and examined only one direction of association (that IPV is a risk factor for depression) [5]. To our knowledge there are no meta-analyses of the associations between IPV and suicide attempts. Conversely, other studies suggest that women with severe mental health difficulties are more likely to experience violent victimization [11,12]. The same may hold for more minor forms of depression. Studies among US teenagers suggest that depression precedes first incidents of dating violence [13]. It is plausible that depressive symptoms may influence partner selection, such that young men and women are more accepting of partners with poor impulse control, conduct disorders, or other factors that predispose partners to use violence. Although it is clear that violence must precede completed suicides, most studies on violence and suicide actually measure suicide attempts, which could precede violent experiences.

Developmental and early life exposures to violence and other traumas may also play a role in predicting both violence and depression, for example, by contributing to the formation of insecure or disorganized attachment styles, which are associated with both increased IPV and depression risk [14,15]. Although the mechanism remains unclear, women who have experienced childhood sexual abuse (CSA) also have an increased risk of subsequent experience of IPV [16]. Usually, longitudinal twin studies provide the best means of ruling out the confounding effect of early life factors, and two twin studies that have investigated exposure to general trauma suggest that traumatic events are causally associated with increased risk of major depressive disorder and suicide [9,10,17,18]. However, to our knowledge no twin studies have examined the role of IPV victimization specifically. To assess the magnitude and direction of the relationship between IPV and depression and suicide attempts, we conducted a systematic review and meta-analysis of longitudinal studies examining the association of depression and suicide attempts with IPV experience in women and men. This study was conducted as part of the work of the Expert Working Group on Violence, for the Global Burden of Disease Study 2010 [19]. We aimed to (1) describe the characteristics of included studies, (2) report on magnitude and direction of association, and (3) document and explore potential sources of heterogeneity.

Methods

Searches

We searched 20 different health and social science databases, including Medline, Embase, CINAHL (Cumulative Index to Nursing and Allied Health Literature), and region-specific databases from first record. This initial search was conducted as part of a larger set of systematic reviews, and included studies looking at health conditions in addition to depression and suicide. Strategies were designed in consultation with a librarian. Controlled vocabulary terms related to study design, violence, depression, and suicide were used for each database. The search and screening process is summarized in Figure 1. A list of databases and an example search strategy are provided in Text S2, and a PRIMSA checklist in Text S inclusion Criteria Longitudinal studies in any population of male and/or female participants were considered. Studies were deemed longitudinal if either the exposure or the outcome was measured at more than one time point. Papers reporting data from existing cohorts where both the exposure and outcome were assessed at the same time point were not included. All author definitions of IPV experience and all author definitions of depression (including symptoms and diagnoses) and measures of suicide attempts were eligible for inclusion. Papers reporting only on postpartum or antenatal depression were not included. Papers reporting only on suicidal thoughts or plans were not included.

Screening and Data Extraction

For the original search, abstracts were screened by one reviewer; full text articles were appraised by JM, JC, GF, or LB and re-appraised by KMD. Data were extracted by one reviewer (JM, JC, GF, or LB) onto a standardized form, and checked by KMD. For the update, all steps were performed by KMD. Information about study population, exposure and outcome definitions, length of follow-up, effect estimates and uncertainty, analysis and control for confounding, and study quality were extracted.

Quality Assessment

We appraised the quality of each effect estimate. We considered the definitions of the violence and depression/suicide measures and whether these were measured using valid, reliable instruments. We considered how the reference groups for each exposure were constructed (if they were truly unexposed or if there could potentially have been some misclassification). This is especially important for research examining the effects of IPV, as different forms of IPV (physical and sexual) are often only moderately correlated [2]. Studies measuring only one form of violence therefore potentially have a comparison group with exposure to the other form of violence. We also considered control for potential confounders in key areas. First, because both IPV and depression commonly occur episodically over a period of time, events of either that are incident over the study period could be a continuation of previous violence/depression. Thus, we examined whether time one levels (at the beginning of the study period) of the outcome variable were adjusted for. Second, both IPV and depression/suicide attempts are associated with childhood adverse events, substance use, demographics, and other common risk factors that may explain the association between them. Because of the complexity of the potential causal pathways involved, we did not define a minimum set of confounders or common risk factors that should be adjusted for, but we aimed to consider results in light of which variables were included in analyses.

Data Synthesis

Overall results on study characteristics and quality are summarized descriptively. Studies reported a range of different types of effect estimates (for example, relative risks, odds ratios [ORs], and correlation coefficients). They also varied on whether violence and depression outcomes were measured as binary or continuous variables, making it difficult to quantitatively summarize results. Where information was not reported, we calculated effect estimates and uncertainty as far as possible. Therefore, we present (1) results of all studies meeting the inclusion criteria in original metrics in tabular format, and (2) where possible, pooled measures of effect using random effects meta-analysis. Heterogeneity was measured using Higgins I 2, with p, 0.10 taken to indicate possible heterogeneity. For each meta-analysis, only one estimate per data source was included. The estimate least subject to bias according to the quality criteria above was selected. We had too few studies to quantitatively examine sources of heterogeneity.

Results

Study Characteristics

Sixteen studies with 36,163 participants met the inclusion criteria. These were reported in 17 papers and contained 55 relevant effect estimates. Ten of these studies were from the US, two from Australia [20,21], one from Sweden [22], one from India [23], one from Nicaragua [24], and one from South Africa [25]. Three studies from the US [13,26,27] included adolescents and focused on dating violence; all of the other studies focused on IPV in adults. Four studies sampled participants from secondary schools [13,22,26,27], four studies were individual or household surveys of the general population [20,21,23,28], one was conducted at a college [29], one was conducted among hospital employees [30], and three sampled from a variety of venues [25,31,32]. The three remaining studies recruited pregnant women, two from hospitals [33,34] and one from households in the general population [24]. Details of study characteristics are described in Table S1. The median follow-up time was 36 mo (interquartile range 12– 60 mo) (range 2 mo [29] to 14 y [31]). Median attrition rate was 22.5% (interquartile range 17%–28.6%) (range 4.5% [31] to 57.1% [34]). Ten studies made use of two waves of data collection, two had three waves [23,34], two had four waves [26,30], one had five waves [33], and one had 14 [31]. The majority of studies included only female participants; the four studies that recruited from secondary schools also included males. IPV measurement and potential misclassification. Nearly all (14 of 16) studies used measures of experience of specific acts of violence based in whole or in part on the Conflict Tactics Scale [35] or the World Health Organization instrument [24,25]; one was based on the Abuse Assessment Screen [30] and one on the Severity of Violence Against Women Scales [33]. All of these instruments measure self- reported experience of specific acts of violence, for example, ‘‘Have you ever been slapped, punched, kicked, hit with an object’’, and so on. Although measuring specific acts avoids misclassification associated with participants having different perceptions of whether what they have experienced constitutes ‘‘violence’’ or not [2], nearly half of all studies (six studies; seven papers) measured exposure to physical violence or sexual violence only [13,28,29,31,36,37], leaving open the possibility of substantial misclassification of total violence exposure. Loxton et al. asked only if the respondent had ‘‘been in a violent relationship with a spouse’’ [20] and Jonsson et al. asked if participants ‘‘had ever been physically abused or had their life threatened’’ [22] Depression. Sixteen studies (reported in 17 papers—two papers used data from Add Health [13,37]) provided 47 estimates of association between IPV and depressive symptoms or disorder. Forty-one estimates from 16 studies were for women, and six estimates from four studies were for male populations. Taking only the least biased estimate from each study gives 23 estimates from 16 studies. These 23 estimates are outlined in Table 1 and considered below; more detailed study information, including other effect estimates, is presented in Table S1.

Depression measurement

Of the 16 studies included, eight measured depressive symptoms over a defined time period (five were over the 1 wk prior to the survey, three were over the past year, and the remainder did not specify). Seven studies used the Center for Epidemiologic Studies Depression Scale (CES-D) [13,20,21,25,28,30,36], two used the Beck Depression Inventory [29,33], one used the Self-Report Questionnaire–20 (SRQ-20) [24], one used the Brief Symptom Inventory [31], one used the Composite International Diagnostic Interview–Short Form [34], one used a scale from K. S. Kendler [26], and one used a scale from D. B. Kandel and M. Davies [27]. The one study that measured incident depressive disorders [23] used the Clinical Interview Schedule–Revised. Jonsson et al. used the CES-D and Beck Depression Inventory but also the Diagnostic Interview for Children and Adolescents–Revised–Adolescents and the Mini- International Neuropsychiatric Interview. All measures were combined for analysis [22].

Common risk factors/confounding

Of the estimates for women, presented in Table 1, most were adjusted for time one measures of the outcome, but five estimates were unadjusted. Chowdhary and Patel [23] excluded lifetime suicide and depressive disorder diagnosis at baseline from analyses; however, this likely resulted in the exclusion of many cases of violence that preceded suicide attempts or depressive symptoms or disorder at baseline—the resulting cases of violence being few and not representative of women experiencing IPV. Nearly all studies (14 of 16) also controlled for demographic factors, but in general, other confounders were not comprehensively controlled. Often the estimates included in the meta-analyses, only two controlled for CSA and/or other early life experiences [13,22]. None controlled for alcohol use. Of the seven studies not included in the meta-analyses (those with continuous measures of depression), 5/7 controlled for demographic factors [28–31,37], but only 2/7 for CSA [29,30], one for early life factors [30], and one for early risk behavior [37]. Despite these differences in variables controlled for across analyses, there were no discernible differences in effect estimates: regardless of which confounders were adjusted for, all studies found similar directions and varying magnitudes of association. For men (Table 2), the picture was similar: most studies adjusted for time one levels of the outcome, but other key confounders were not adjusted for. Effect estimates for depressive disorder and symptoms in women. Of the 16 studies looking at depressive symptoms or disorder and IPV in women, 13 provided estimates of IPV and incident depressive symptoms or disorder and six provided estimates of depressive symptoms and incident IPV (Table 1). Twelve of 13 estimates showed a positive direction of association between experience of IPV and incident depressive symptoms, with 11 reaching statistical significance. All six estimates looking at depressive symptoms and incident IPV also showed positive associations, which were statistically significant We were able to include all estimates reporting binary violence measures and binary depressive symptoms or disorder measures in meta-analyses (Figure 2). For IPV and incident depressive symptoms or disorder, the pooled OR from six estimates was1.97 (95% CI 1.56–2.48). This was heterogeneous

(I2=50.4%,p=0.073), although almost all studies had a positive direction of effect. Removing the outlier (Chowdhary and Patel [23]) did not improve heterogeneity estimates. Four estimates were included in the meta-analysis of the relationship between depressive symptoms and incident IPV, resulting in a pooled OR of 1.93 (95% CI 1.51–2.48,I2=0%,p=0.481).

Effect estimates for depressive symptoms in men

For men (Table 2), two studies [27,37] examined experience of IPV and incident depressive symptoms, and both studies showed a significant association in a positive direction. Foshee et al. examined depressive symptoms and time to onset of physical and sexual victimization, as well as ‘‘chronic victimization’’, and found non-significant relationships in a positive direction (bivariate model) [26]. Jonsson et al. found that 2.5% of adult men reporting depressive symptoms as adolescents also reported adult experiences of IPV, versus 0% of adult men who did not report depressive symptoms in adolescence [22].

Suicide Attempts

Three studies investigating suicide attempts met our inclusion criteria [23,27,37]. These studies reported eight estimates of association of experience of IPV with incident suicidal attempts. Six were for female populations, and two were for male populations. Ackard et al. and Roberts et al. both sampled US adolescents and the IPV measured was dating violence (for both male and female adolescents) [27,37]. Chowdhary and Patel sampled a cohort of adults from Goa, India, comprising adult women only [23]. No studies examined suicide attempts and incident IPV.

Suicide measures

All studies modeled lifetime suicide attempts as a binary variable, and assessed attempts with a single question. No studies had completed suicides as an outcome.

Common risk factors/confounding

Ackard et al. [27] and Roberts et al. [37] controlled for time one suicide attempts; Chowdhary and Patel [23] excluded participants with lifetime suicide attempts at baseline. None controlled for early life factors, including experience of CSA.

Effect estimates for suicide attempts in women. Chowdhary and Patel [23], Ackard et al. [27], and Roberts et al. [37] examined violence and incident suicide attempts : all three studies showed positive relationships, of which two were statistically significant and one was of borderline significance (Table 3).

Effect estimates for suicide attempts in men

Two studies examined violence and incident suicide attempts [27,37]: both found non-significant relationships, one in a positive direction and the other with exactly no association (Table 4). Both of these studies included adolescent or young adult US men; both also controlled for time one suicide attempts.

Discussion

Summary of Main Findings

Our review provides evidence that experience of IPV increases the odds of incident depressive symptoms and of suicide attempts among women. We also found evidence that depressive symptoms can increase the odds of incident IPV in women. However, our ability to draw firm conclusions is limited by the quality of the available studies, in particular the lack of adjustment for common risk factors. Relatively few studies included men, but these studies suggested a relationship between IPV and incident depressive symptoms. For men, there was no clear evidence of an association between IPV and incident suicide attempts, or between depressive symptoms and incident IPV.

Limitations of This Review

Our review employed extensive searches of global literature in multiple languages. Despite this, our review has some limitations. Because of the large volume of search results returned, we were unable to employ double screening of abstracts, and for our update, double data extraction. We also did not contact authors for additional information. The different scales of measurement (binary or continuous) employed across various studies meant that we were unable to combine all measures of effect, which limited the number of studies in our meta-analyses. However, studies that
we could not include in meta-analyses showed a positive direction of effect consistent with that of the studies included in the meta- analyses. Too few studies met the inclusion criteria to meaningfully assess publication bias.

Sources of Bias and Limitations of Included Studies

The main limitation of included studies relates to lack of comprehensive control of potential confounders. Both IPV and depression can be conceptualized as chronic episodic conditions, and most studies controlled for time one levels of the outcome variable or excluded baseline cases in their analyses. However, alcohol use and childhood adversity, including early experiences of violence and trauma, were generally not controlled for, making it difficult to rule out these other factors as contributors to the causation of outcomes. We did find that studies generally showed a positive direction of association regardless of which potentially confounding variables were adjusted for, and there was also no clear pattern of differing magnitude of association, indicating that
the relationships between IPV and depressive symptoms and suicide are not likely to be entirely accounted for by shared risk factors. Almost all included studies on depression measured depressive symptoms rather than major depressive disorder, dysthymia, or the depressive disorders using Diagnostic and Statistical Manual of Mental Disorders or International Classification of Diseases diagnostic criteria. Only around one-third to one-half of people who score above recommended CES-D cutoffs are diagnosed with

major depressive disorder [38,39]. The relationship between violence experience and depressive disorders may differ from the relationship between violence experience and depressive symptoms. Major depressive disorder has a substantial heritability [40] and has been shown to be more heritable than less severe forms of depression [41]; situational causes such as violence may therefore play a more important etiological role in the less severe forms of depression. Conversely, experiences of violence may predict more severe depression and thus have a stronger association with depressive disorders than with depressive symptoms. When examining violence in relation to depression, including sub-threshold depressive symptoms and depressive disorders could either dilute or inflate effect estimates. Most studies were from high-income countries, and four were of adolescents or college students. In high-income contexts, in these samples, relationships will be primarily in dating relationships. In dating relationships where there is no cohabitation, there may be a lower likelihood of chronic exposure to violence within the intimate partnership [42,43], which may lessen any subsequent mental health impact. Other studies of the features of intimate partner abuse have shown that fear, entrapment, and feelings of inability to escape from violent situations specifically contribute to increased adverse mental health outcomes [42]—these relationship features are likely to be less pronounced in dating relationships, which could mean that effects are underestimated in studies including only adolescents

Emotional violence, which we did not include here, may also be an important predictor of adverse mental health outcomes [44]. The epidemiological study of emotional IPV is in its infancy, but at least one study that has modeled combined measures of physical, sexual, and emotional IPV has shown a relationship between these forms of abuse and incident suicide attempts in Indian women[45]. Most studies also measured exposure only to physical violence, or modeled exposure to physical violence and sexual violence separately. Most studies constructed reference categories as binary opposites, meaning that some participants in the reference group may have been exposed to other forms of violence by intimate partners that were not measured or modeled. This approach may bias the effect estimates towards the null, and underestimate the magnitude of the association between violence experience and depression outcomes. Several studies also included only women who were in relationships for all time points of data collection. The relevance of IPV is usually higher in women who no longer have a partner versus women currently in a partnership. Not including these women may bias associations towards the null. Similarly, it is conceivable that women who are no longer in a partnership may have higher or lower odds of depression/suicide attempts. If they are not surveyed in subsequent waves, associations may be biased in different directions.

Is the Relationship between IPV, Depression, and Suicide Causal?

Cross-sectional evidence suggests that lifetime experience of IPV is consistently associated with both SRQ-20 score (representing probable cases of depression and/or anxiety) and suicide attempts among women in a range of low- and middle-income countries. Several studies have shown a dose–response relationship, where IPV is associated with increased frequency of depressive episodes, and other studies have shown

that depression is more strongly predictive of incident severe IPV than it is of less severe IPV. Twin studies provide evidence for a plausible causal mechanism, that exposure to traumatic events, including sexual assault and violence, can cause increased risk of depression, ruling out early life confounders. Our review presents evidence for a temporal relationship between IPV experience and depressive symptoms, but also shows that women with existing depressive symptoms are more likely to subsequently experience IPV. Our finding is consistent with other longitudinal studies that have considered combined measures of IPV perpetration and experience, which found that women with depression were more likely to be in an abusive relationship, but also that being in an abusive relationship predicted incident major depressive disorder. In summary, it seems that the relation- ship between IPV and depression is bidirectional, with women who are exposed to IPV being at increased risk of depression symptoms, and women who report depressive symptoms being more likely to subsequently experience IPV. For young men, we found no clear evidence of a relationship between IPV, depressive symptoms, and suicide, but very few studies included men. Further studies that include male participants are needed to clearly establish whether or not there is an association.

Implications

The different forms of depression—major depressive disorder, dysthymia, and mild depression—as well as suicidal behavior, are some of the largest causes of disease burden in women globally. Our findings suggest that interventions to prevent violence need to be explored for their efficacy in reducing different forms of depression. Similarly, for women already receiving mental health treatments or presenting with symptoms of depression, attention must be paid to experiences of violence and risk of future violence. Because IPV often occurs as a pattern of ongoing events, treatment strategies that fail to address women's' experience of violence may do harm. For example, if violence is not suspected as a potential causative factor, patients who have attempted suicide may be encouraged to return to partners/relatives, which could increase the risk of further violence and eventual suicide. Anti-depressant medication may also interfere with women's ability to make decisions about how to respond to violence. Further research is needed to explore why having depressive symptoms can lead to incident violence—it may be that young women with depressive symptoms are predisposed to choose partners who use violence. Depression can also lead to maladaptive coping with stress, cognitive distortions about risk, and loss of self-efficacy. Young people who have experienced early traumatic events, including violence in their families, are at higher risk for poor mental health as adolescents. Longitudinal studies where both violence exposure and depression are measured at multiple time points are needed to more clearly elucidate causal mechanisms. It is clear that addressing the burden of untreated mental disorders in a population could have substantial effects on the prevalence of violence.

Conclusion
Interventions to prevent violence should be explored for their efficacy in reducing the burden of depressive symptoms and disorders as well as suicide attempts in women. Women who have experienced violence may benefit from tailored interventions that address the changes that come with prolonged exposure to trauma in order to prevent future depression and suicidal behavior.

12. Figures and Tables (Safeguarding Important Documents, Gathering Documentation, and Sample Safety Plan)

Safeguarding Important Documents

As part of the survivor's safety plan, it may be helpful to advise the survivor client to keep important documents in a safe deposit box or in a place where her partner cannot gain access to them. These materials may include some or all of the following:

- Social security documents
- Marriage license
- Passport(s)
- Copies of any protective orders or divorce or custody papers
- Green card
- Children's birth certificates
- Information about medical history, including vaccination schedules for children and records on health care visits
- Extra sets of home and car keys
- Photographic documentation of abuse
- Deeds or leases that document residence, titles to cars
- Other financial documents such as savings deposit books and payment books

Figure 4-2: Gathering Documentation

All States have mandatory reporting laws for child abuse, but only some have or are developing such laws for reporting domestic violence. Some battered women's advocates support such laws because they "take the pressure off" the victims to report their batterers. Some domestic violence service providers also believe that it is the community's responsibility -- not the victim's -- to stop the batterer's behavior. Some States mandate the arrest of batterers whether or not their victims press charges, and some are proposing mandatory physician reporting of battering. Concerns have been raised, however, about preserving victims' ability to decide whether they want to become involved in the criminal justice system or in domestic violence programs. For this reason,

such laws are opposed by some battered-women's groups, who believe they put women at greater risk.

Regardless of whether a survivor elects to pursue legal remedies, she is well-advised to document the nature and extent of the domestic violence she and her family have experienced by compiling copies of

- Criminal justice reports, including prior legal actions (e.g., restraining orders) against batterers
- Any previous CPS reports that can be obtained
- Hospital records and health history of the client

Complete criminal justice and medical records may be difficult to obtain. In the case of medical records, for example, survivors may have made visits to numerous institutions (e.g., clinics and emergency rooms) in order to avoid raising the suspicion of domestic violence. Issues of confidentiality also may be an impediment to obtaining these records. (See Appendix B for more information on confidentiality.) When clients are unsuccessful in compiling information from standard sources, their self-reports to substance abuse treatment providers, documented in their program records, can be used to fill in the gaps and to help support their claims. When entering notes into the client's record, however, it is important to include the facts as presented or observed. Records can be subpoenaed and "gratuitous comments or opinions" may be used against survivors in custody cases (Minnesota Coalition for Battered Women).

Sample Personalized Safety Plan for Domestic Violence Survivors

Name:_____

Date:_____

Review Dates:_____

Personalized Safety Plan

The following steps represent my plan for increasing my safety and preparing in advance for the possibility for further violence. Although I do not have control over my partner's violence, I do have a choice about how to respond to him/her and how to best get myself and my children to safety.	
Step 1: Safety during a violent incident. Women cannot always avoid violent incidents. In order to increase safety, battered women may use a variety of strategies.	
I can use some or all of the following strategies:	
A.	If I decide to leave, I will _____. (Practice how to get out safely. What doors, windows, elevators, stairwells, or fire escapes would you use?)

B.	I can keep my purse and car keys ready and put them (place) _____ in order to leave quickly.
C.	I can tell _____ about the violence and request they call the police if they hear suspicious noises coming from my house. I can also tell _____ about the violence and request they call the police if they hear suspicious noises coming from my house.
D.	I can teach my children how to use the telephone to contact the police and the fire department.
E.	I will use _____ as my code word with my children or my friends so they can call for help.
F.	If I have to leave my home, I will go _____. (Decide this even if you don't think there will be a next time.) If I cannot go to the location above, then I can go to _____ or _____.
G.	I can also teach some of these strategies to some/all of my children.
H.	When I expect we are going to have an argument, I will try to move to a space that is lowest risk, such as _____. (Try to avoid arguments in the bathroom, garage, kitchens, near weapons or in rooms without access to an outside door.)
I.	I will use my judgment and intuition. If the situation is very serious, I can give my partner what he/she wants to calm him/her down. I have to protect myself until I/we are out of danger.
Step 2: Safety when preparing to leave. Battered women frequently leave the residence they share with the battering partner. Leaving must be done with a careful plan in order to increase safety. Batterers often strike back when they believe that a battered woman is leaving a relationship.	
I can use some or all of the following safety strategies:	

A.	I will leave money and an extra set of keys with _____ so I can leave quickly.
B.	I will keep copies of important documents or keys at _____.
C.	I will open a savings account by _____ (date), to increase my independence.
D.	Other things I can do to increase my independence include: _____ _____ _____ __
E.	The domestic violence program's hotline number is _____. I can seek shelter by calling this hotline.
F.	I can keep change for phone calls on me at all times. I understand that if I use my telephone credit card, the following month the telephone bill will tell my batterer those numbers that I called after I left. To keep my telephone communications confidential, I must either use coins or I might get a friend to permit me to use their telephone credit card for a limited time when I first leave.
G.	I will check with _____ and _____ to see who would be able to let me stay with them or lend me some money.
H.	I can leave extra clothes with _____.
I.	I will sit down and review my safety plan every _____ in order to plan the safest way to leave the residence. _____ (domestic violence advocate or friend) has agreed to help me review this plan.
J.	I will rehearse my escape plan and, as appropriate, practice it with my children.

Step 3: Safety in my own residence. There are many things that a woman can do to increase her safety in her own residence. It may impossible to do everything at once, but safety measures can be added step by step.	
Safety measures I can use include:	
A.	I can change the locks on my doors and windows as soon as possible.
B.	I can replace wooden doors with steel/metal doors.
C.	I can install security systems including additional locks, window bars, poles to wedge against doors, an electronic system, etc.
D.	I can purchase rope ladders to be used for escape from second floor windows.
E.	I can install smoke detectors and purchase fire extinguishers for each floor in my house/apartment.
F.	I can install an outside lighting system that lights up when a person is coming close to my house.
G.	I will teach my children how to use the telephone to make a collect call to me and to (friend/minister/other) in the event that my partner takes the children.
H.	I will tell people who take care of my children which people have permission to pick up my children and that my partner is not permitted to do so. The people I will inform about pick-up permission include _____ (school), _____ (day care staff), _____ (babysitter), _____ (Sunday school teacher), _____ (teacher), _____ and (others).

I.	I can inform _____ (neighbor), _____ (pastor), and _____ (friend) that my partner no longer resides with me and they should call the police if he is observed near my residence.
Step 4: Safety with a protection order. Many batterers obey protection orders, but one can never be sure which violent partner will obey and which will violate protection orders. I recognize that I may need to ask the police and the courts to enforce my protection order.	
The following are some steps that I can take to help the enforcement of my protection order:	
A.	I will keep my protection order _____ (location). (Always keep it on or near your person. If you change purses, that's the first thing that should go in.)
B.	I will give my protection order to police departments in the community where I work, in those communities where I usually visit family or friends, and in the community where I live.
C.	There should be a county registry of protection orders that all police departments can call to confirm a protection order. I can check to make sure that my order is in the registry. The telephone number for the county registry of protection orders is _____.
D.	For further safety, if I often visit other counties in my state, I might file my protection order with the court in those counties. I will register my protection order in the following counties: _____, _____, and _____.
E.	I can call the local domestic violence program if I am not sure about B, C, or D above or if I have some problem with my protection order.
F.	I will inform my employer, my minister, my closest friend and _____ and _____ that I have a protection order in effect.

G.	If my partner destroys my protection order, I can get another copy from the courthouse by going to [the office] located at _____
H.	If my partner violates the protection order, I can call the police and report a violation, contact my attorney, call my advocate, and/or advise the court of the violation.
I.	If the police do not help, I can contact my advocate or attorney and will file a complaint with the chief of the police department.
J.	I can also file a private criminal complaint with the district justice in the jurisdiction where the violation occurred or with the district attorney. I can charge my battering partner with a violation of the protection order and all the crimes that he commits in violating the order. I can call the domestic violence advocate to help me with this.
Step 5: Safety on the job and in public. Each battered woman must decide if and when she will tell others that her partner has battered her and that she may be at continued risk. Friends, family and coworkers can help to protect women. Each woman should consider carefully which people to invite to help secure her safety.	
I might do any or all of the following:	
A.	I can inform my boss, the security supervisor and _____ at work of my situation.
B.	I can ask _____ to help screen my telephone calls at work.
C.	When leaving work, I can _____.
D.	When driving home if problems occur, I can _____.
E.	If I use public transit, I can _____.
F.	I can use different grocery stores and shopping malls to conduct my business and shop at hours that are different than those when residing with my battering partner.

G.	I can use a different bank and take care of my banking at hours different from those I used when residing with my battering partner.
H.	I can also _____.
Step 6: Safety and drug or alcohol use. Most people in this culture use alcohol. Many use mood-altering drugs. Much of this use is legal and some is not. The legal outcomes of using illegal drugs can be very hard on a battered woman, may hurt her relationship with her children and put her at a disadvantage in other legal actions with her battering partner. Therefore, women should carefully consider the potential cost of the use of illegal drugs. But beyond this, the use of any alcohol or other drugs can reduce a woman's awareness and ability to act quickly to protect herself from her battering partner. Furthermore, the use of alcohol or other drugs by the batterer may give him/her an excuse to use violence. Therefore, in the context of drug or alcohol use, a woman needs to make specific safety plans.	
If drug or alcohol use has occurred in my relationship with the battering partner, I can enhance my safety by some or all of the following:	
A.	If I am going to use, I can do so in a safe place and with people who understand the risk of violence and are committed to my safety.
B.	I can also _____.
C.	If my partner is using, I can _____.
D.	I might also _____.
E.	To safeguard my children, I might _____ and _____.
Step 7: Safety and my emotional health. The experience of being battered and verbally degraded by partners is usually exhausting and emotionally draining. The process of building a new life for myself takes much courage and incredible energy.	

To conserve my emotional energy and resources and to avoid hard emotional times, I can do some of the following:	
A.	If I feel down and ready to return to a potentially abusive situation, I can _____.
B.	When I have to communicate with my partner in person or by telephone, I can _____.
C.	I can try to use "I can . . ." statements with myself and to be assertive with others.
D.	I can tell myself, "_____" whenever I feel others are trying to control or abuse me.
E.	I can read _____ to help me feel stronger.
F.	I can call _____, _____ and _____ as other resources to be of support to me.
G.	Other things I can do to help me feel stronger are _____, _____, and _____.
H.	I can attend workshops and support groups at the domestic violence program or _____, _____ , or _____ to gain support and strengthen my relationships with other people.
Step 8: Items to take when leaving. When women leave partners, it is important to take certain items with them. Beyond this, women sometimes give an extra copy of papers and an extra set of clothing to a friend just in case they have to leave quickly.	
Items with asterisks on the following list are the most important to take. If there is time, the other items might be taken, or stored outside the home.	
These items might best be placed in one location, so that if we have to leave in a hurry, I can grab them quickly.	

When I leave, I should take:	
*	Identification for myself
*	Children's birth certificates
*	My birth certificate
*	Social Security cards
*	School and vaccination records
*	Money
*	Checkbook, ATM (Automatic Teller Machine) card
*	Credit cards
*	Keys-house/car/office
*	Driver's license and registration
*	Medications
	Welfare identification
	Work permits
	Green card
	Passport(s)
	Divorce papers
	Medical records-for all family members
	Lease/rental agreement, house deed, mortgage payment book
	Bank books
	Insurance papers
	Small saleable objects
	Address book
	Pictures
	Jewelry
	Children's favorite toys and/or blankets
	Items of special sentimental value

Telephone Numbers I Need to Know

Police department-home	_____
Police department-school	_____
Police department-work	_____
Battered women's program	_____
County registry of protection orders	_____
Work number	_____
Supervisor's home number	_____
Minister	_____
Other	_____

13. Resources and Referrals

Hotlines

National Domestic Violence Hotline

(800) 799-SAFE
(800) 787-3224 (TDD)
Suite 101-297
3616 Far West Boulevard
Austin, TX 78731-3074

The National Domestic Violence Hotline links individuals and services using a nationwide database of domestic violence and other emergency shelters, legal advocacy and assistance programs, and social services programs. The hotline provides crisis intervention, information about sources of assistance, and referrals to battered women's shelters.

Rape, Abuse, and Incest National Network (RAINN)

(800) 656-4673

RAINN links 628 rape crisis centers nationwide. *Sexual assault survivors* who call will be automatically connected to a trained counselor at the closest center in their area.

Childhelp USA/National Child Abuse Hotline

(800) 4A-CHILD
15757 North 78th Street
Scottsdale, AZ 85260
(602) 922-8212

With a focus on *children* and the prevention of *child abuse*, this hotline provides crisis counseling, referrals, and reporting guidance to callers in crisis, including children, troubled parents, and adult survivors of abuse. All calls are answered by a staff of professional counselors. In addition, statistical and other informative materials can be ordered through this number. *Access to information on partner violence is limited.*

Childhelp, one of the largest national, nonprofit child abuse treatment and prevention agencies in the country, also runs the nation's first residential treatment facility for abused children, provides prevention services and training, and participates in advocacy and education efforts.

NATIONAL HOTLINE 1**-800-799-SAFE**

Arkansas 1-800-332-4443

Florida 1-800-500-1119

Indiana 1-800-334-7233

L.A. County 1-800-978-3600

Michigan 1-800-996-6228

Montana 1-800-655-7867

Nevada 1-800-922-5757

New Hampshire 1-800-852-3311

New Jersey 1-800-572-7233

New York 1-800-942-6908 (English)

New York 1-800-942-6908 (Spanish)

North Dakota 1-800-472-2911

Oklahoma 1-800-522-7233

Pennsylvania 1-800-642-3150

Texas area 1-800-876-4808

Vermont 1-800-228-7395

Virginia 1-800-838-8238

West Virginia 1-800-352-6513

Washington 1-800-562-6025

Wisconsin 1-800-333-7233

Wyoming 1-800-445-7233

The National Resource Center on Domestic Violence has a listing of every domestic violence coalition: 1-800-537-2238.

The Academy of Facial Plastic and Reconstructive Surgery and the National Coalition Against Domestic Violence will provide free reconstructive surgery to any domestic violence victims: 1-800-842-4546

CALIFORNIA	California Partnership to End Domestic Violence Post Office Box 1798 Sacramento, CA 95812 Phone: 916-444-7163 Toll-Free: 1-800-524-4765 Fax: 916-444-7165 Website: www.cpedv.org Email: info@cpedv.org
TEXAS	Texas Council on Family Violence Post Office Box 161810 Austin, TX 78716 Phone: 512-794-1133 Toll-Free: 1-800-525-1978 Fax: 512-794-1199 Website: www.tcfv.org

WASHINGTON	Washington State Coalition Against Domestic Violence – Olympia Office 101 North Capitol Way, Suite 302 Olympia, WA 98501 Phone: 360-586-1022 Hotline: 1-800-562-6025 Fax: 360-586-1024 Website: www.wscadv.org Email: wscadv@wscadv.org Washington State Coalition Against Domestic Violence – Seattle Office 1402 - 3 rd Avenue, Suite 406 Seattle, WA 98101 Phone: 206-389-2515 Hotline: 1-800-562-6025 Fax: 206-389-2520 Website: www.wscadv.org Email: wscadv@wscadv.org
FLORIDA	Florida Coalition Against Domestic Violence 425 Office Plaza Tallahassee, FL 32301 Phone: 850-425-2749 Toll-Free: 1-800-500-1119 Fax: 850-425-3091 Website: www.fcadv.org
OREGON	Oregon Coalition Against Domestic and Sexual Violence 380 Southeast Spokane Street, Suite 100 Portland, OR 97202 Phone: 503-230-1951 Fax: 503-230-1973 Website: www.ocadsv.com

General Resources

American College of Obstetricians and Gynecologists (ACOG)

ACOG Resource Center
409 12th Street, S.W.
Washington, DC 20024-2188
(202) 638-5577

ACOG has patient education pamphlets and bulletins for medical professionals on both domestic violence and substance abuse.

American Medical Association (AMA)

Department of Mental Health
515 State Street
Chicago, IL 60610
Contact: Jean Owens
(312) 464-5000
(312) 464-5066 (to order resources)
(312) 464-4184 (fax)

The AMA educates physicians through publications, conferences, and by serving as a resource center for physicians and other concerned professionals. Among its publications are six diagnostic and treatment guidelines on child physical abuse and neglect, child sexual abuse, domestic violence, elder abuse and neglect, mental health effects of domestic violence, treatment and prevention of sexual assault, and media violence.

March of Dimes Birth Defects Foundation

1275 Mamaroneck Avenue
White Plains, NY 10605
Attn: Resource Center
(914) 428-7100
http://www.modimes.org/

The March of Dimes provides general information on prenatal care and on the first few years of life through its resource center and its fulfillment center. *The March of Dimes does not have a hotline.*

March of Dimes Resource Center
(888) 663-4637
(914) 997-4763 (fax)
resourcecenter@modimes.org
Contact: Beverly Robertson, Director

Callers to this number can speak to someone about pregnancy, pre-pregnancy, drug use during pregnancy, birth defects, genetics, and other issues related to prenatal care.

March of Dimes Fulfillment Center
(800) 367-6630

Callers to this number can only place an order for materials. Two domestic violence materials are available at cost: *Abuse During Pregnancy Nursing Module*, which provides continuing education units to nurses, and a video titled *Crime Against the Future*.

National Center for Missing or Exploited Children (NCMEC)

Suite 550
2101 Wilson Boulevard
Arlington, VA 22201-3052

Hotline: (800) THE LOST, (800) 843-5678, (800) 826-7653 (TDD)
Business office: (703) 235-3900, (703) 235-4067 (fax)
http://www.missingkids.org/

NCMEC leads national efforts to locate and recover missing children and raises public awareness about ways to prevent child abduction, molestation, and sexual exploitation. The hotline is available to report information on missing or exploited children or to request information or assistance. NCMEC publishes materials, including handbooks, pamphlets containing parental and professional guidelines on runaways and missing or exploited children, and publication packages aimed toward families, child care and social service practitioners, and law enforcement, legal, and criminal justice professionals.

National Clearinghouse on Child Abuse and Neglect

P.O. Box 1182
Washington, DC 20013-1182
(800) FYI-3366
(703) 385-7565
(703) 385-3206 (fax)
nccanch@calib.com

This clearinghouse offers child abuse and neglect information in the form of manuals, research reports, studies, directories, grant compendia, literature reviews, annotated bibliographies, fact sheets, database searches, CD ROM databases, and on-line services. It is sponsored by the National Center on Child Abuse and Neglect.

National Coalition Against Domestic Violence

P.O. Box 18749
Denver, CO 80218
(303) 839-1852
(303) 831-9251 (fax)

The National Coalition Against Domestic Violence serves as an information and referral center for the general public, the media, battered women and their children, and agencies and organizations. Among its purposes are to enhance coalition-building at the local, State, and national levels; support the provision of community-based, nonviolent alternatives such as safe homes and shelters for battered women and their children; provide information and referral services, public education, and technical assistance; and develop public policy and innovative legislation. The coalition maintains a public policy office in Washington, DC, and maintains a National Directory of Domestic Violence Programs.

Family Violence Prevention Fund
383 Rhode Island Street, Suite 304
San Francisco, CA 94103-5133
Phone: 415-252-8900
TTY:800-595-4889

FAX: 415-252-8991
E-mail: info@endabuse.org
Washington, DC Office
1101 14th Street, NW #300
Washington DC 20005
Phone: 202-682-1212
Fax: 202-682-4662

Boston Office
67 Newbury Street, Mezzanine Level
Boston, MA 02116
Phone: 617-262-5900
Fax:617-262-5901

National Coalition Against Domestic Violence
Main Office:1120
Lincon Street
Suite 1603
Denver, CO 80203
Phone: 303 839 1852
TTY: (303) 839-8459
Fax: (303) 831-9251
E-mail: mainoffice@ncadv.org

Public Policy Office
1633 Q Street NW, Suite 210
Washington, DC 20009
Phone: (202) 745-1211
TTY: (202) 745-2042
Fax: (202) 745-0088
E-mail: publicpolicy@ncadv.org

National Battered Women's Law Project
275 7th Avenue, Suite 1206
New York, NY 10001
Phone: 212-741-9480
FAX: 212-741-6438

Safe Horizons
2 Lafayette Street, 3rd Floor
New York, NY 10007
Crime Victims HOTLINE: 800-621-4673
Rape and Sexual Assault & Incest HOTLINE: 212-227-3000
TYY (for all HOTLINES) 866-604-5350

Fax:212-577-3897
E-mail: help@safehorizons.org

Domestic Violence Shelter Tour
2 Lafayette Street 3rd Floor
New York, NY 10007
Phone: 212-577-7700
Fax: 212-385-0331
24-hour hotline: 800-621-HOPE (4673)

National Resource Center on Domestic Violence
Pennsylvania Coalition Against Domestic Violence
6400 Flank Drive, Suite 1300
Harrisburg, PA 17112
Phone: 800-537-2238
Fax: 717-545-9456

Legal Office:
Phone: 717-545-6400
TOLL FREE: 800-932-4632
TTY:800-533-2508
Fax: 717-671-5542

National Resource Center on Domestic Violence
Phone: 800-537-2238
TTY:888-Rx-ABUSE; 800- 595 -4889
Fax: 717-545-9456

Health Resource Center on Domestic Violence
Family Violence Prevention Fund
383 Rhode Island Street, Suite 304
San Francisco, CA 94103-5133
Phone: 800-313-1310
FAX: 415-252-8991

Battered Women's Justice Project
Minnesota Program Development, Inc
1801 Nicollet Ave, Suite 102
Minneapolis, MN 55403
Phone: 800-903-0111, ext.1
Phone: 612-824-8768
Fax: 612-824-8965

Resource Center on Domestic Violence, Child Protection, and Custody
NCJFCJ
P.O. Box 8970
Reno, NV 89507
Office: 775-784-6012
Phone: 800-527-3223
Fax: 775-784-6628
Email: staff@ncjfcj.org

Battered Women's Justice Project
c/o National Clearinghouse for the Defense of Battered Women
125 South 9th Street, Suite 302
Philadelphia, PA 19107
TOLL-FREE: 800-903-0111 ext. 3
Phone: 215-351-0010
FAX: 215-351-0779

National Clearinghouse on Marital and Date Rape
2325 Oak Street
Berkeley, CA 94708
Phone: 510-524-1582
Faith Trust Institute
(Formerly Center for the Prevention of Sexual and Domestic Violence)
2400 N. 45th Street #10
Seattle , WA 98103
Phone: 206-634-1903, ext. 10
Fax: 206-634-0115
Email: info@faithtrustinstitute.org
National Network to End Domestic Violence
2001 S Street NW, Suite 400
Washington, DC 20009
Phone: 202-543-5566
HOTLINE:800-799-SAFE (7233)
TTY: 800-787-3224
FAX: 202-543-5626

Womenspace National Network to End Violence Against Immigrant Women
1212 Stuyvesant Ave.
Trenton, NJ 08618
Phone: 609-394-0136
24 Hour Mercer County Hotline: 609-394-9000
Fax:609-396-1093
Email: info@womenspace.org

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Course Presenter Nicole Hiltibran, MA, LMFT, is a graduate from Pepperdine University, where she earned her Masters Degree in Clinical Psychology with an emphasis in Marriage and Family Counseling, and is a Licensed Psychotherapist. Nicole has 25 years of experience serving adults, children, couples and families both in the public sector and private practice. Nicole has written state licensing exams for the California State Board of Behavioral Sciences for 10 years as well as offering continuing education courses to licensed mental health and social work professionals including LMFT's, LCSW's, LPCCs, RN's, and PhD's.