*Spousal / Partner Abuse*

*Presented by Lance Parks, LCSW*

**Study helps:** When you scroll over the yellow sticky notes you will receive study helps.

This course is divided into three parts.

# PART 1

## Chapter 1. Introduction

We begin with a story to make this course personal. Behind all the statistics, the names of abuse, the safety plans, are real people. This story was retrieved from the National Domestic Violence Hotline at his link:

https://www.thehotline.org/2013/09/30/amandas-story/

### A. Survivor's Story

| **Amanda's Story** |
| --- |
| *I am one of those who found love after abuse.*<br><br>*I was married to a physically, emotionally, and sexual abusive man for five years — I was choked, beaten, thrown into walls, raped, and made to feel completely worthless. In March 2010, I incorporated my "safety plan" and left my husband.*<br><br>*From March 2010 through March 2011 (while my divorce was going on), I spent A LOT of time reading books on domestic violence, reading blogs of survivors, researching information on websites like yours and also working closely with a therapist. I just read and learned everything I* |

*could about domestic violence as I knew that I wanted to one day be in a healthy relationship and not stay trapped in the "cycle." I wanted to become a healthy and happy domestic violence survivor.*

*In April 2011, I was asked out on a date by a man that I had known from a distance. I was terrified to trust again (yes, even if it was just a little date), but I knew from all of the research that I had done that he was a good and honest man. Our first dinner date turned into a picnic and hike which turned into several more weeks of dating which led to us becoming "a couple."*

*Being part of "a couple" — in a healthy relationship — was amazing and terrifying at the same. Amazing because I forgot how wonderful a healthy relationship was, but terrifying because I was afraid that (A) something in our relationship would cause him to "turn" and (B) I was afraid my ex would come after me or my boyfriend. However, through all of my healing and research, I knew that option "A" wasn't going to happen. And thankfully, option "B" did not happen either.*

*Through this relationship, I learned what a real man was — real men treat you with complete respect. They are caring, gentle and kind. They love you for who you are — your likes, dislikes, goals and ideas. They will NEVER EVER hurt you physically, emotionally, or sexually. And one of the most important things, especially for a domestic violence survivor, is that they are patient with you. I can't tell you how many times I had to either stop doing something, leave a place or just needed to be comforted due to some "trigger" from my past. A real man will be there for you, he will help you heal by showing you what real love is.*

*Two years later, on March 30th, 2013, I got to marry this absolutely amazing man. I have a husband that I (once) never thought existed. My marriage is wonderful, it is free of abuse, or fear. Our home is our happy place, filled with love.*

*Finding love, or even being willing to trust someone, after being in an abusive relationship is extremely scary. I do believe that my key to "finding love" was allowing myself time to heal, to grieve and to learn as much as possible about abusive personalities and what healthy relationships consist of.*

*I am a blissful bride. And I am so thankful that I can say that I HAVE found love after abuse!*

**Spouse/Partner Abuse, or sometime referred to as Intimate Partner Abuse (IPV) is an ongoing issue in the United States.**

**Every woman has the right to live her life safely and free of violence.**

Yet one in four women in the United States experiences violence from an intimate partner. **Intimate partner violence includes domestic abuse, sexual assault, verbal and emotional abuse, coercion, and stalking.** Violence and abuse can cause physical and emotional problems that last long after the abuse. If you've experienced violence or abuse, it is never your fault, and you can get help (OWH, 2020) Additionally, one in four gay men experience domestic violence (GMVDP, 2020).

As the CDC describes it, "Intimate partner violence (IPV) is a serious, preventable public health problem that affects millions of Americans. The term "intimate partner violence" describes physical violence, sexual violence, stalking, or psychological harm by a current or former partner or spouse. **This type of violence can occur among heterosexual or same-sex couples and does not require sexual intimacy."** (CDC,2000)

## B. How big is the problem?

IPV is common**.** It affects millions of people in the United States each year. Data from CDC's National Intimate Partner and Sexual Violence Survey (NISVS) indicate:

- **About 1 in 4 women and nearly 1 in 10 men have experienced contact sexual violence, physical violence, and/or stalking by an intimate partner during their lifetime and reported some form of IPV-related impact.**
- Over 43 million women and 38 million men experienced psychological aggression by an intimate partner in their lifetime.

**IPV starts early and continues throughout the lifespan.**

When IPV starts in adolescence, it is called teen dating violence (TDV). TDV affects millions of US teens each year. About 11 million women and 5 million men who reported experiencing contact sexual violence, physical violence, or stalking by an intimate partner in their lifetime said that they first experienced these forms of violence before the age of 18.




(CDC, 2020)

Results of National Intimate Partner and Sexual Violence Survey (CDC, 2015)

**How NISVS Measured Intimate Partner Violence**

**Four types of intimate partner violence are included in this report. These include sexual violence, stalking, physical violence, and psychological aggression.** In NISVS, an intimate partner is described as a romantic or sexual partner and includes spouses, boyfriends, girlfriends, people with whom they dated, were seeing, or “hooked up.”

- **Sexual violence** includes rape, being made to penetrate someone else, sexual coercion, and unwanted sexual contact. Contact sexual violence is a combined measure that includes rape, being made to penetrate someone else, sexual coercion, and/or unwanted sexual contact.
- **Stalking** victimization involves a pattern of harassing or threatening tactics used by a perpetrator that is both unwanted and causes fear or safety concerns in the victim.

- **Physical violence** includes a range of behaviors from slapping, pushing or shoving to severe acts that include hit with a fist or something hard, kicked, hurt by pulling hair, slammed against something, tried to hurt by choking or suffocating, beaten, burned on purpose, used a knife or gun.
- **Psychological aggression** includes expressive aggression (such as name calling, insulting or humiliating an intimate partner) and coercive control, which includes behaviors that are intended to monitor and control or threaten an intimate partner.


**Intimate partner violence-related impact** includes experiencing any of the following: being fearful, concerned for safety, injury, need for medical care, needed help from law enforcement, missed at least one day of work, missed at least one day of school. The following impacts were also included in the lifetime estimate only: any post-traumatic stress disorder symptoms, need for housing services, need for victim advocate services, need for legal services and contacting a crisis hotline. For those who experienced rape or made to penetrate by an intimate partner, it also includes a lifetime estimate of having contracted a sexually transmitted infection or having become pregnant (females only). Intimate partner violence-related impact questions were assessed among victims of contact sexual violence, physical violence, or stalking by an intimate partner either during the lifetime or in the last 12 months. The impacts were assessed for specific perpetrators and asked in relation to any form of intimate partner violence experienced in that relationship. By definition, all stalking victimizations result in impact because the definition of stalking requires the experience of fear or concern for safety. Because violent acts often do not occur in isolation and are frequently experienced in the context of other violence committed by the same perpetrator, questions regarding the impact of the violence were asked in relation to all forms of intimate partner violence experienced (sexual violence, physical violence, stalking, psychological aggression) by the perpetrator in that relationship.


**Intimate Partner Violence of Women**

- **In the U.S., over 1 in 3 (36.4% or 43.6 million) women experienced contact sexual violence, physical violence, and/or stalking by an intimate partner during their lifetime** (Figure 8).
- About 1 in 4 women (25.1% or 30.0 million) in the U.S. experienced contact sexual violence, physical violence, and/or stalking by an intimate partner during their lifetime and reported some form of IPV-related impact (Table 9).
- Regarding specific subtypes of intimate partner violence, about 18.3% of women experienced contact sexual violence, 30.6% experienced physical violence (21.4% experienced severe physical violence), and 10.4% experienced stalking during their lifetime.
- An estimated 1 in 18 (5.5% or about 6.6 million) women in the U.S. experienced contact sexual violence, physical violence, and/or stalking by an intimate partner during the 12 months preceding the survey.
- Over one-third of women (36.4% or 43.5 million) experienced psychological aggression by an intimate partner during their lifetime (Table 10).

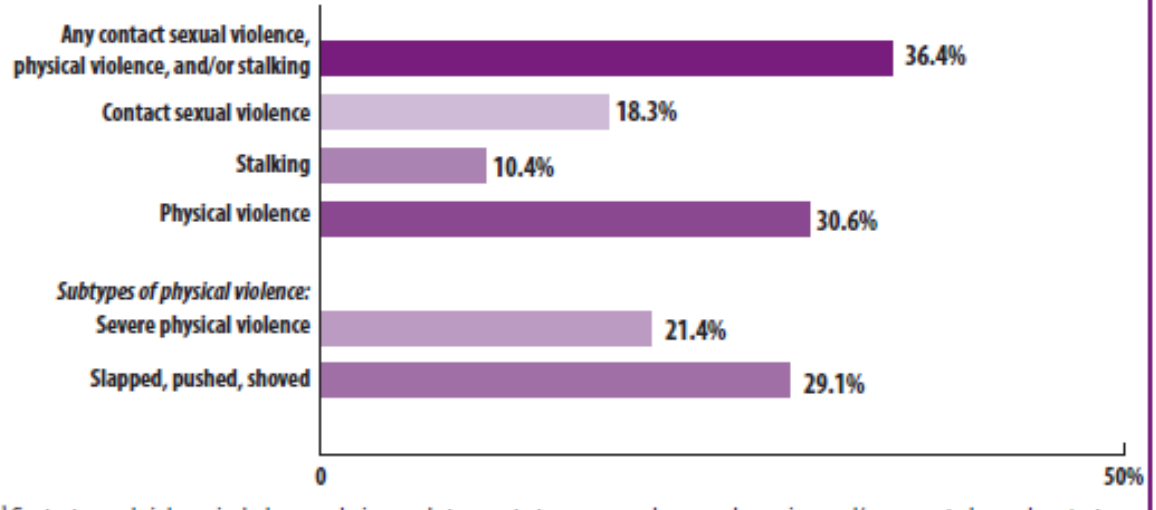
**Intimate Partner Violence of Men**

In the U.S., about 1 in 3 (33.6% or 37.3 million) men experienced contact sexual violence, physical violence, and/or stalking by an intimate partner during their lifetime (Figure 9).

Nearly 1 in 10 (10.9% or 12.1 million) men in the U.S. experienced contact sexual violence, physical violence, and/or stalking by an intimate partner during their lifetime and reported some form of IPV-related impact (Table 11).

**Figure 8**

**Lifetime Prevalence of Contact Sexual Violence,[1] Physical Violence, and/or Stalking Victimization by an Intimate Partner—U.S. Women, NISVS 2015[2]**




[1] Contact sexual violence includes rape, being made to penetrate someone else, sexual coercion, and/or unwanted sexual contact.
[2] All percentages are weighted to the U.S. population.

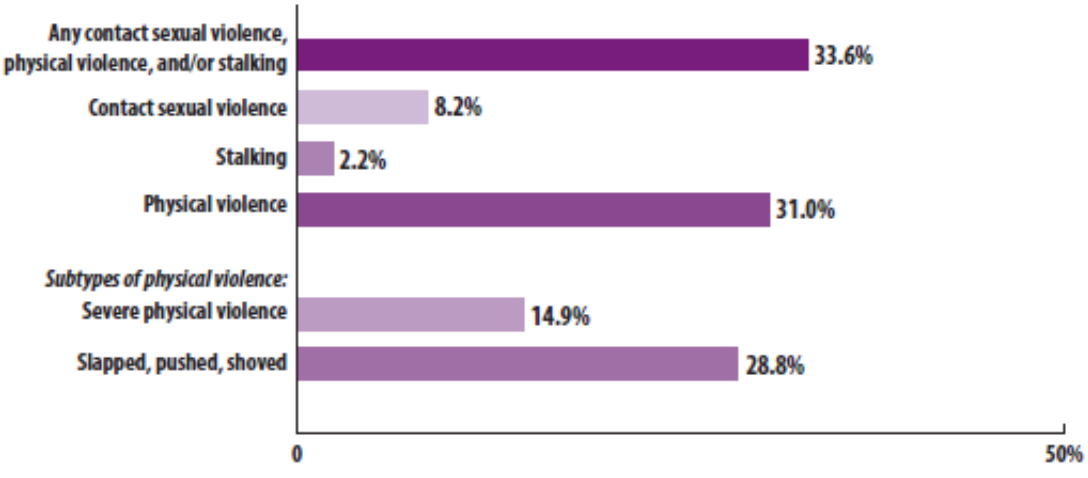
Regarding specific subtypes of intimate partner violence, 8.2% of men experienced contact sexual violence, 31.0% experienced physical violence (14.9% experienced severe physical violence), and 2.2% experienced stalking during their lifetime.

About 1 in 20 (5.2% or 5.8 million) men in the U.S. experienced contact sexual violence, physical violence, and/or stalking by an intimate partner during the 12 months preceding the survey.

**Over one-third of men** (34.2% or 38.1 million) experienced psychological aggression by an intimate partner during their lifetime (Table 12).

Figure 9

**Lifetime Prevalence of Contact Sexual Violence,[1] Physical Violence, and/or Stalking Victimization by an Intimate Partner—U.S. Men, NISVS 2015[2]**




[1] Contact sexual violence includes rape, being made to penetrate someone else, sexual coercion, and/or unwanted sexual contact.
[2] All percentages are weighted to the U.S. population.

## Age at First Contact Sexual Violence, Physical Violence, and/or Stalking by an Intimate Partner

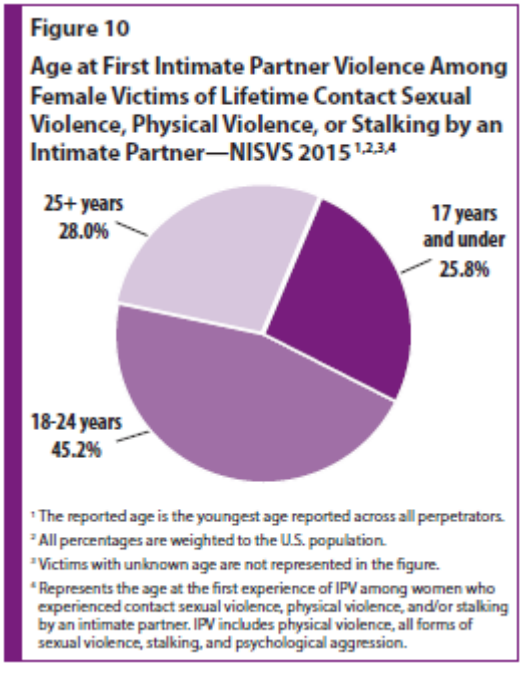
### Females

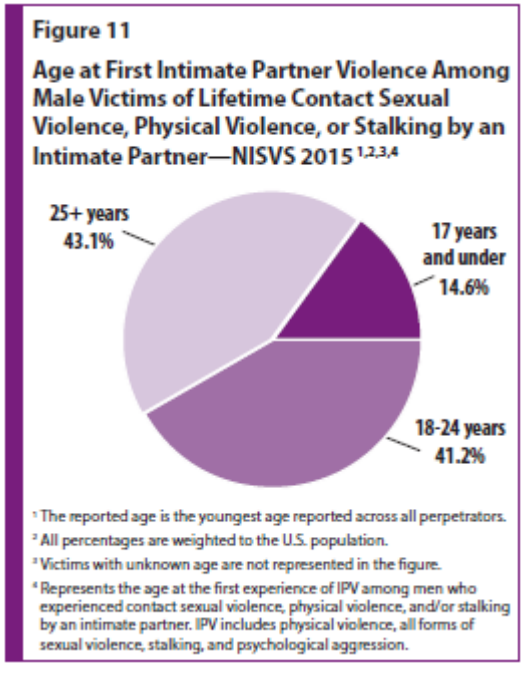
The majority of women who were victims of contact sexual violence, physical violence, and/or stalking by an intimate partner first experienced these or other forms of violence by that partner before age 25 (71.1% or nearly 31.0 million victims), and 1 in 4 female victims (25.8% or about 11.3 million victims) first experienced intimate partner violence prior to age 18 (Figure 10, Table 13).

### Males

Over half of men who were victims of contact sexual violence, physical violence, and/or stalking by an intimate partner first experienced these or other forms of violence by that partner before

age 25 (55.8% or 20.8 million victims), and 14.6% of male victims (5.4 million victims) first experienced intimate partner violence prior to age 18 (Figure 11, Table 14).




## Chapter 2. Intimate Partner Violence in the United States

This section is retrieved from:
https://www.cdc.gov/violenceprevention/pdf/cdc_nisvs_ipv_report_2013_v17_single_a.pdf

### A. Key Findings

**Sexual Violence by an Intimate Partner**

- Nearly 1 in 10 women in the United States (9.4%) has been raped by an intimate partner in her lifetime, including completed forced penetration, attempted forced penetration, or alcohol/drug facilitated completed penetration.

- Approximately 1 in 45 men (2.2%) has been made to penetrate an intimate partner during his lifetime.
- An estimated 16.9% of women and 8.0% of men have experienced sexual violence other than rape (being made to penetrate an intimate partner, sexual coercion, unwanted sexual contact, and non-contact unwanted sexual experiences) by an intimate partner in their lifetime.

## Physical Violence by an Intimate Partner

- Women and men experienced many types of physical violence ranging from being slapped to having a knife or gun used against them
- Women had a significantly higher lifetime prevalence of severe physical violence by an intimate partner (24.3%) compared to men (13.8%).
- Approximately 2.7% of women and 2.0% of men experienced severe physical violence in the 12 months preceding the survey.

## Stalking by an Intimate Partner

- Women had a significantly higher lifetime prevalence of stalking by an intimate partner (10.7%) compared to men (2.1%).
- Women had a significantly higher 12-month prevalence of stalking by an intimate partner (2.8%) compared to men (0.5%).

## Psychological Aggression by an Intimate Partner

- Nearly half of U.S. women (48.4%) and half of U.S. men (48.8%) have experienced at least one psychologically aggressive behavior by an intimate partner during their lifetime.
- Men had a significantly higher prevalence of experiencing psychological aggression from an intimate partner in the 12 months preceding the survey than women (18.1% and 13.9%, respectively).

## Overlap of Rape, Physical Violence, and Stalking

- Among those who experienced rape, physical violence, or stalking by an intimate partner in their lifetime, male victims (92.1%) were significantly more likely than female victims (56.8%) to experience physical violence only
- Among male victims, 6.3% experienced both physical violence and stalking in their lifetime; too few men reported other combinations of rape, physical violence, and stalking to produce reliable estimates.
- Among female victims, 14.4% experienced physical violence and stalking; 8.7% experienced both rape and physical violence; 12.5% experienced rape, physical violence, and stalking.

## Rape, Physical Violence, or Stalking by an Intimate Partner, by Race/Ethnicity

- Black non-Hispanic women (43.7%) and multiracial non-Hispanic women (53.8%) had a significantly higher lifetime prevalence of rape, physical violence, or stalking by an intimate

partner, compared to White non-Hispanic women (34.6%); Asian or Pacific Islander non-Hispanic women (19.6%) had significantly lower prevalence than White non-Hispanic women.

- American Indian or Alaska Native non-Hispanic men (45.3%), Black non-Hispanic men (38.6%), and multiracial non-Hispanic men (39.3%) had a significantly higher lifetime prevalence of rape, physical violence, or stalking compared to White non-Hispanic men (28.2%).

## Rape, Physical Violence, or Stalking by an Intimate Partner, by Sexual Orientation

- Bisexual women had a significantly higher prevalence of lifetime rape, physical violence, or stalking by an intimate partner (61.1%) compared to lesbian women (43.8%) and heterosexual women (35.0%).
- The lifetime prevalence of rape, physical violence, or stalking by an intimate partner was 29.0% among heterosexual men, 37.3% among bisexual men, and 26.0% among gay men.

## Rape, Physical Violence, or Stalking by an Intimate Partner by Food and Housing Insecurity

- Women and men who experienced food insecurity in the past 12 months (11.6% and 8.2%, respectively) had a significantly higher 12-month prevalence of rape, physical violence, or stalking by an intimate partner compared to women and men who did not experience food insecurity (3.2% and 4.0%, respectively).
- Women and men who experienced housing insecurity in the past 12 months (10.0% and 7.9%, respectively) had a significantly higher 12-month prevalence of rape, physical

violence, or stalking by an intimate partner compared to women and men who did not experience housing insecurity (2.3% and 3.1%, respectively).

## Impact of Violence by an Intimate Partner

- **Women were significantly more likely than men to experience rape, physical violence, or stalking by an intimate partner and report at least one impact related to experiencing these or other forms of violent behavior in the relationship (e.g., psychological aggression, being made to penetrate someone else, sexual coercion).**
- **Female victims of rape, physical violence, or stalking were significantly more likely than male victims to experience each of the IPV-related impacts measured including fear, concern for safety, need for medical care, injury, need for housing services, and having missed at least one day of work or school.**

## Maximum Number of Violent Behaviors Experienced in an Individual Relationship

- Among victims of sexual violence by an intimate partner, the proportion of female victims that experienced more than the median number (two or more) of unique sexually violent behaviors by an individual intimate partner was higher than the proportion of male victims.
- Among victims of physical violence by an intimate partner, the proportion of female victims that experienced more than the median number (three or more) of unique physically violent behaviors by an individual intimate partner was higher than the proportion of male victims.
- Among victims of psychological aggression by an intimate partner, the proportion of female victims that experienced more than the median number (four or more) of unique psychologically aggressive behaviors by an individual intimate partner was higher than the proportion of male victims.

## Age at the Time of First IPV Victimization

- Among those who ever experienced rape, physical violence, or stalking by an intimate partner, more than 1 in 5 female victims (22.4%) and more than 1 in 7 male victims (15.0%) experienced some form of intimate partner violence for the first time between the ages of 11 and 17 years.
- 47.1% of female victims and 38.6% of male victims were between 18 and 24 years of age when they first experienced violence by an intimate partner.

## Need for Services, Disclosure

- Female victims of rape, physical violence, or stalking were significantly more likely than male victims to report a need for services at some point during their lifetime due to their experience with IPV (36.4% and 15.6%, respectively).
- Among victims of rape, physical violence, or stalking who reported a need for services at some point during their lifetime, the proportion of men who reported that they always received those services (33.0%) was significantly lower than the proportion of female victims who reported that they always received those services (49.0%).
- Less than 50% of women who needed housing or victim's advocate services during their lifetime received them.
- Among victims of rape, physical violence, or stalking by an intimate partner, the proportion that disclosed their victimization to someone was higher among women (84.2%) than among men (60.9%). The proportion of men that described disclosure as "very helpful" was significantly lower than the proportion of women that described disclosure as "very helpful" for the following sources of disclosure: police, psychologists/counselors, friends, and family members.

- Among victims of lifetime rape, physical violence, or stalking by an intimate partner, 21.1% of female victims and 5.6% of male victims disclosed their victimization to a doctor or nurse.

**Health Conditions**

- Men and women with a lifetime history of rape, physical violence, or stalking by an intimate partner were more likely to report frequent headaches, chronic pain, difficulty sleeping, activity limitations, and poor physical health in general compared to those without a history of these forms of IPV. Women who have experienced these forms of violence were also more likely to report asthma, irritable bowel syndrome, diabetes, and poor mental health compared to women who did not experience these forms of violence.

## B. Implications for Prevention

**Centers for Disease Control and Prevention's (CDC's) key focus on preventing IPV is the promotion of respectful, nonviolent relationships through individual, relationship, community, and societal change. This strategy is focused on principles such as identifying ways to interrupt the development of IPV perpetration; better understanding of the factors that contribute to respectful relationships and protect against IPV; creating and evaluating new approaches to prevention; and building community capacity to implement strategies that are based on the best available evidence.** Community capacity can be enhanced by building upon and joining well-organized, broad-based coalitions that effectively create change in communities.

The principal focus of CDC is primary prevention, prioritizing the prevention of public health burdens, such as IPV, from occurring in the first place. This report suggests that IPV victimization begins at an early age with nearly 70% of female victims and nearly 54% of male victims having experienced IPV prior to age 25. This suggests that primary prevention of IPV must begin at an early age. CDC's

approach to primary prevention of IPV is the promotion of healthy relationship behaviors among young people, with the goal of reaching adolescents prior to their first relationships. By influencing relationship behaviors and patterns early through dating violence prevention programs, it is possible to promote healthy relationship behaviors and patterns that can be carried forward into adulthood.

This report identified groups that are at most risk for IPV victimization. While primary prevention programs exist, it is unknown whether they are effective within specific groups of people, particularly among those identified in this report as being most at risk. Further work needs to be done to adapt and test existing strategies for specific groups as well as develop and test other strategies to determine whether they are effective in preventing IPV.

Positive and healthy parent-child relationships can provide the foundation for the primary prevention of IPV. Children benefit from safe, stable, and nurturing familial environments that facilitate respectful interactions and open communication. Other opportunities to build parent-child relationships include programs to promote effective parenting skills and efforts to include and support relationships between fathers and children. Beyond providing children an opportunity to share with their parents the experiences they have had with dating violence and other forms of violence, parents who model healthy, respectful intimate relationships free from violence foster these relationship patterns in their children.

The focus of this report is on describing the public health burden of victimization. In order to better understand how to prevent partner violence, CDC also supports work that seeks to better understand the causes of IPV perpetration. Research examining risk and protective factors is important for understanding how perpetration of violence develops and to determine the optimal strategies for preventing intimate partner violence. While much is known about risks factors at the individual and couple level, there have been few studies examining community and societal-level factors related to perpetration of IPV. As risk and protective factors for IPV perpetration are better understood, additional research is needed to develop and evaluate strategies to effectively prevent the first-time perpetration of IPV. This includes research that addresses the social and economic conditions such as poverty, sexism, and other forms of discrimination and social exclusion that

increase risk for perpetration and victimization. Such research will complement efforts focused on preventing initial victimization and the recurrence of victimization.

Beyond primary prevention, secondary and tertiary prevention programs are essential for mitigating the short- and long-term consequences of IPV among victims, as well as reducing the violence-related health burden across the life span. This report examined a range of services that victims reported needing as a result of IPV at some point in their lifetime and whether they received them, including medical care, housing, victim's advocacy, legal and community services. The vast majority of women who were victims of IPV indicated that they needed medical services; nearly half needed housing, victim's advocacy, and community services; and a third needed legal services. Among the female victims who needed at least one of these services at some point during their lifetime, less than half indicated that they received any of the needed services. Among the male victims who needed at least one of these services, two-thirds stated that they did not receive any of the needed services. This indicates that, across the lifetime of the current U.S. adult population, a significant gap exists between a need for services and the receipt of those services. Future work is needed to understand the degree to which this gap exists currently, and whether an existing gap is due to services being unavailable or because available services are not being utilized. Better understanding the barriers to service utilization is important.

Disclosing victimization experiences is a necessary first step for victims to be able to obtain the resources and services they need. One primary method by which IPV victims may disclose victimization and receive appropriate help is through disclosure to medical professionals. The results in this report suggest that a majority of male and female victims did not disclose their victimization to a health care professional. While 84.2% of female victims and 60.9% of male victims disclosed their IPV victimization to someone, only 21% of female victims and 5.6% of male victims reported having disclosed their victimization to a medical professional at some point in their lifetime. These findings suggest a need to better understand how to overcome the barriers that may prevent victims from disclosing to a medical professional and those barriers that may make some medical professionals feeling reticent to inquire about IPV victimization, even among those patients that shown signs of victimization. This report provides updated, detailed information describing the public health burden of IPV in the United States. While progress has been made in understanding factors that contribute to IPV and how to prevent IPV from occurring, this report demonstrates that much

more needs to be done to reduce the negative impact of IPV on women and men in the United States.

## C. Prevalence and Frequency of Individual Forms of Intimate Partner Violence

### Sexual Violence by an Intimate Partner

| Lifetime Prevalence |
| --- |
| Nearly 1 in 10 women in the United States (9.4% or approximately 11.2 million) has been raped by an intimate partner in her lifetime. More specifically, 6.6% of women have experienced completed forced penetration by an intimate partner, 2.5% have experienced attempted forced penetration, and 3.4% have experienced alcohol/drug facilitated penetration. Too few men reported rape by an intimate partner to produce reliable estimates for overall rape or individual types of rape.<br><br>Approximately 1 in 6 women (15.9% or nearly 19 million) and 1 in 12 men in the United States (8.0% or approximately 9 million), have experienced sexual violence other than rape by an intimate partner in their lifetime. Women had a significantly higher lifetime prevalence of sexual violence other than rape by an intimate partner compared to men ($p < .05$). However, approximately 2.2% of men have been made to penetrate an intimate partner at some point in their lifetime; too few women were made to penetrate an intimate partner to produce a reliable estimate. The lifetime prevalence of sexual coercion, unwanted sexual contact, and non-contact unwanted sexual experiences by an intimate partner were all significantly higher for women than men ($p < .05$). |

| Twelve-month Prevalence |
| --- |
| |

In the 12 months prior to taking the survey, 0.6% or an estimated 686,000 women in the United States were raped by an intimate partner. Too few men reported rape by an intimate partner in the 12 months prior to taking the survey to produce a reliable estimate. Also, 2.3% of women, and 2.5% of men, experienced other forms of sexual violence by an intimate partner in the 12 months prior to the survey. Approximately 0.5% of men were made to penetrate an intimate partner in the 12 months preceding the survey, whereas too few women were made to penetrate an intimate partner to produce a reliable estimate. With the exception of sexual coercion, where the 12-month estimate was significantly higher for women than men ($p < .05$), none of the other estimates were significantly different.

**Physical Violence by an Intimate Partner**

**Lifetime Prevalence**

Approximately 32.9% of women in the United States have experienced physical violence by an intimate partner in their lifetime, compared to 28.1% of men, a statistically significant difference ($p < .05$). Examining the prevalence of more severe forms of physical violence, 24.3% of women (or approximately 29 million) have experienced severe physical violence by an intimate partner in their lifetime, compared to 13.8% of men (approximately 15.6 million), also a statistically significant difference ($p < .05$). Additionally, prevalence of the following severe physically violent behaviors were significantly higher ($p < .05$) for women than men: being hurt by pulling hair; being hit with a fist or something hard; being kicked; being slammed against something; being hurt by choking or suffocating; being beaten; being burned on purpose; and having a gun or knife used on them.

Approximately 1 in 3 women (30.4%) and 1 in 4 men (25.6%) in the United States has been slapped, pushed, or shoved by an intimate partner at some point in their lifetime. The lifetime prevalence of being slapped, pushed, or shoved by an intimate partner was significantly higher among women compared to men ($p < .05$).

## Twelve-month Prevalence

**The prevalence of physical violence victimization by an intimate partner in the 12 months prior to taking the survey was 4.0% among women compared to 4.7% among men.** The prevalence of severe physical violence victimization by an intimate partner in the 12 months prior to taking the survey was 2.7% among women compared to 2.0% among men. The 12-month prevalence of being slapped and being kicked was significantly higher for men, whereas the prevalence of being hurt by hair pulling, being slammed against something, and being beaten was significantly higher for women ($p < .05$). All other comparisons that were conducted were not statistically significant.

## Frequency of Individual Physically Violent Behaviors

Respondents who reported that they had experienced a particular physically violent behavior were asked how many times in their lifetime they had experienced that behavior by that specific intimate partner. Response options included once, two to five times, six to 10 times, 11 to 50 times, or more than 50 times. It displays the higher frequency categories (11 to 50, more than 50) of individual physically violent behaviors among victims of physical violence by an intimate partner. The proportion experiencing the following behaviors 11 or more times was significantly higher ($p < .05$) for female victims, in comparison to male victims: slapped, pushed, or shoved; hurt by pulling hair; hit with a fist or something hard; kicked; and beaten. Formal statistical testing comparing the frequency of being hurt by choking or suffocating 11 or more times, comparing women and men, was not undertaken because the number of men reporting this behavior 11 or more times within an individual relationship was too small to generate a reliable estimate.

Similarly, the number of women and men who reported the following behaviors 11 or more times was too small to generate reliable estimates for statistical testing between groups: being burned on purpose and having a knife or gun used on them.

## Stalking by an Intimate Partner

### Lifetime and 12-month Prevalence

The lifetime prevalence of stalking by an intimate partner in which the victim felt very fearful or believed that they or someone close to them would be harmed or killed was significantly higher for women (10.7% or an estimated 12.8 million) than for men (2.1% or an estimated 2.4 million), $p < .05$

Similarly, the 12-month prevalence of stalking by an intimate partner in which the victim felt very fearful or believed that they or someone close to them would be harmed or killed was significantly higher for women (2.8% or an estimated 3.4 million) than men (0.5% or an estimated 519,000), $p < .05$).

### Tactics Used in Lifetime Reports of Stalking Victimization by an Intimate Partner

Among lifetime victims of stalking by an intimate partner, the most commonly reported tactics experienced include: receiving unwanted phone calls (77.4% of female victims; 83.7% of male victims); being approached, such as at home or work (64.8% of female victims; 52.1% of male victims); and being watched or followed (37.4% of female victims; 28.1% of male victims) (Figure 2.4). There were no significant differences between female and male victims with respect to the likelihood of experiencing particular stalking tactics.

## Psychological Aggression by an Intimate Partner

### Lifetime Prevalence

Nearly half of all women (48.4%) and half of all men (48.8%) have experienced at least one psychologically aggressive behavior by an intimate partner during their lifetime (Figure 2.5). Four in 10 women (40.3%) and approximately 3 in 10 men (31.9%) have experienced at least one form of expressive aggression by an intimate partner during their lifetime. Four in 10 women (41.1%) and 4 in 10 men (42.5%) have experienced at least one form of coercive control by an intimate partner during their lifetime. The lifetime prevalence of experiencing expressive aggression by an intimate partner was significantly higher for women, compared to men ($p < .05$). With the exception of having an intimate partner keeping track of them by demanding to know where they were and what they were doing, the lifetime prevalence of individual psychologically aggressive behaviors was significantly higher among women, compared to men ($p < .05$).

### Twelve-month Prevalence

The prevalence of psychological aggression by an intimate partner was significantly higher among men (18.1%) than among women (13.9%) in the 12 months preceding the survey, $p < .05$ (Figure 2.6).

The overall prevalence of expressive aggression by an intimate partner in the 12 months prior to the survey was not significantly different ($p < .05$) between women and men (10.4% and 9.3%, respectively), although there were significant differences for specific behaviors. Women had a significantly higher 12-month prevalence ($p < .05$), compared to men, with respect to being told they were a loser, a failure, or not good enough; being called names like ugly, fat, crazy, or stupid; being insulted, humiliated, or made fun of; and being told no one else would want them ($p < .05$). There were no significant differences for the remaining specific expressive aggression behaviors.

The prevalence of coercive control by an intimate partner in the 12 months prior to taking the survey was significantly higher among men (15.2%) than among women (10.7%) ($p < .05$). With

respect to the specific coercive control behaviors, men had a significantly higher 12-month prevalence ($p < .05$) than women in relation to having a partner who made decisions that should have been theirs to make, and having a partner who kept track of them by demanding where they were and what they were doing. Women had a significantly higher 12-month prevalence ($p < .05$) than men with regard to having an intimate partner who made threats to physically harm them. There were no significant differences for the remaining specific coercive control behaviors.

## Frequency of Individual Psychologically Aggressive Behaviors

Respondents who reported that they had experienced a particular psychologically aggressive behavior were asked how many times in their lifetime they had experienced that behavior by that specific intimate partner. Response options included: once, two to five times, six to 10 times, 11 to 50 times, or more than 50 times. Figure 2.7 displays the percentage of women and men who experienced each of the individual psychologically aggressive behaviors 11 to 50 times, and more than 50 times, within an individual relationship. The proportion of female victims that experienced a particular behavior 11 or more times within an intimate relationship was significantly higher than the proportion of male victims that experienced a particular behavior 11 or more times with respect to the following psychologically aggressive behaviors: partner acted very angry in a way that seemed dangerous; were told they were a loser, a failure or not good enough; called names like ugly, fat, crazy, or stupid; were insulted, humiliated, or made fun of; told no one else would want them; partner made decisions that should have been theirs to make; partner kept track of them by demanding to know where they were and what they were doing; partner made threats to physically harm them; kept them from having their own money to use; partner destroyed something that was important to them; partner said things like “if I can’t have you then no one can.” The difference in the frequency of the following behavior was not tested as the number reporting a frequency of 11 or more times was too small to generate a reliable estimate for at least one of the comparison groups: partner threatened to hurt or take a pet away.

### Control of Reproductive or Sexual Health by an Intimate Partner

Approximately 4.8% of women in the United States had an intimate partner who tried to get them pregnant when they did not want to become pregnant, while 8.7% of men in the United States have had an intimate partner who tried to get pregnant when they did not want her to become pregnant, a statistically significant difference, $p < .05$ (data not shown). Approximately 6.7% of women in the United States had an intimate partner who refused to use a condom, while 3.8% of men in the United States have had an intimate partner who refused to use a condom, a statistically significant difference, $p < .05$.

### Overlap of Rape, Physical Violence, and Stalking across Relationships in Lifetime Reports of Violence by an Intimate Partner

Among those who experienced rape, physical violence, or stalking by an intimate partner in their lifetime, male victims (92.1%) were significantly more likely than female victims (56.8%) to experience physical violence only, ($p < .05$) (Figures 2.8 and 2.9). In addition, 14.4% of female victims and 6.3% of male victims experienced physical violence and stalking, a statistically significant difference ($p < .05$). Too few men reported other combinations of rape, physical violence, and stalking to produce reliable estimates. Among female victims, 12.5% experienced all three forms; 8.7% experienced both rape and physical violence; 4.4% experienced rape only; and 2.6% experienced stalking only.

Among those who experienced physical violence only, there were no significant differences in prevalence between female and male victims who reported experiencing severe physical violence only by a partner (10.3% and 8.7%, respectively). For victims who experienced a combination of severe physical violence and slapping, pushing, or shoving by a partner, the prevalence was significantly higher for female victims than male victims (55.4% and 37.5%, respectively; $p < .05$). The prevalence of experiencing slapping, pushing, or shoving only was significantly higher among male victims than female victims (53.8% and 34.3%, respectively; $p < .05$).

## D. Prevalence of Intimate Partner Violence by Sociodemographic Characteristics

Prior research has established that the prevalence of intimate partner violence can vary with respect to a number of sociodemographic characteristics. This section examines the prevalence of rape, physical violence, or stalking by an intimate partner by race/ethnicity, current household income, respondent age, sexual orientation, the experience of food or housing security within the preceding 12 months, and whether the respondent was born inside or outside of the United States. Both lifetime and 12-month prevalence are examined except in cases where a particular sociodemographic characteristic is unlikely to have bearing on a particular prevalence estimate (e.g., the experience of food or housing security within the preceding 12 months on lifetime prevalence) or if there are an insufficient number of reliable estimates in which to present a table (e.g., 12-month prevalence by sexual orientation).

As a point of reference for the demographic comparisons, approximately 35.6% of women and 28.5% of men in the United States have experienced rape, physical violence, or stalking by an intimate partner at some point in their lifetime ($p < .05$), and 5.9% and 5.0%, respectively, experienced rape, physical violence, or stalking by an intimate partner in the 12 months preceding the survey (data not shown).

### Prevalence of Rape, Physical Violence, or Stalking by an Intimate Partner by Race/Ethnicity

**Lifetime Prevalence among Women**

Approximately 4 out of every 10 Black non-Hispanic women (43.7%) and American Indian or Alaska Native women (46.0%), and 1 in 2 multiracial non-Hispanic women (53.8%) in the United States have been a victim of rape, physical violence, or stalking by an intimate partner in their lifetime (Table 3.1). About one-third of White non-Hispanic women (34.6%), more than one-third of Hispanic women (37.1%), and about one-fifth of Asian or Pacific Islander non-Hispanic women (19.6%) have experienced rape, physical violence, or stalking by an intimate partner in their lifetime. Black and multiracial non-Hispanic women had a significantly higher prevalence of rape, physical violence, or stalking by an intimate partner compared to White non-Hispanic women ($p < .05$); Asian or Pacific Islander non-Hispanic women had significantly lower prevalence compared to White non-Hispanic women ($p < .05$).

## Lifetime Prevalence among Men

Nearly half (45.3%) of American Indian or Alaska Native men and almost 4 out of every 10 Black and multiracial non-Hispanic men (38.6% and 39.3%, respectively) in the United States have experienced rape, physical violence, or stalking by an intimate partner during their lifetime (Table 3.2). The estimated prevalence of these forms of violence by an intimate partner among Hispanic and White non-Hispanic men was 26.6% and 28.2%, respectively. American Indian or Alaska Native men, Black non-Hispanic men, and multiracial non-Hispanic men had significantly higher prevalence of rape, physical violence, or stalking compared to White non-Hispanic men ($p < .05$).

## Twelve-month Prevalence among Women

Black non-Hispanic women had a significantly higher prevalence ($p < .05$) of rape, physical violence, or stalking by an intimate partner in the 12 months prior to the survey, compared to White non-Hispanic women (9.2% and 5.1%, respectively) (Table 3.3). Among other racial/ethnic groups, 8.7% of multiracial non-Hispanic women and 8.1% of Hispanic women experienced rape, physical violence, or stalking in the 12 months prior to the survey. Prevalence of these forms of violence were not significantly different than the prevalence among White non-Hispanic women ($p < .05$).

## Twelve-month Prevalence among Men

Approximately 9.9% of Black non-Hispanic men in the United States experienced rape, physical violence, or stalking by an intimate partner in the 12 months preceding the survey, as compared to 6.2% of Hispanic men and 4.2% of White non-Hispanic men. Black non-Hispanic men had a

significantly higher 12-month prevalence of rape, physical violence, or stalking as compared to White non-Hispanic men ($p < .05$).

**Lifetime Prevalence of Rape, Physical Violence, or Stalking by an Intimate Partner by Sexual Orientation**

**Prevalence among Women**

More than 4 in 10 lesbian women (43.8%), 6 in 10 bisexual women (61.1%), and over 1 in 3 heterosexual women (35.0%) have experienced rape, physical violence, or stalking by an intimate partner at some point in their lifetime (Table 3.4). This translates to 714,000 lesbian women, 2.0 million bisexual women, and 38.3 million heterosexual women. The prevalence of lifetime rape, physical violence, or stalking by an intimate partner was significantly higher among bisexual women compared to lesbian and heterosexual women ($p < .05$), whereas there was no significant difference in prevalence between lesbian and heterosexual women.

**Prevalence among Men**

More than 1 in 4 gay men (26.0%), more than 1 in 3 bisexual men (37.3%), and nearly 3 in 10 heterosexual men (29.0%) have experienced rape, physical violence, or stalking by an intimate partner at some point in their lifetime (Table 3.5). No significant differences in prevalence were found when comparing gay, bisexual, and heterosexual men. This translates to 708,000 gay men, 711,000 bisexual men, and 30.3 million heterosexual men. However, these numbers predominantly represent the experience of physical violence as too few men reported rape, and too few gay and bisexual men reported stalking, to produce reliable estimates. The prevalence of physical violence by an intimate partner was 25.2% among gay men, 37.3% among bisexual men, and 28.7% among heterosexual men.

More detailed information related to the prevalence of intimate partner violence by sexual orientation is available in *The National Intimate Partner and Sexual Violence Survey: 2010 Findings on Victimization by Sexual Orientation* (Walters, Chen, & Breiding, 2013).

**Twelve-month Prevalence of Intimate Partner Rape, Physical Violence, or Stalking by Current Household Income**

**Prevalence among Women**

The 12-month prevalence of rape, physical violence, or stalking by an intimate partner was significantly higher among women with a combined household income of $25,000 and $50,000, than for women with a combined income over $75,000, $p < .05$ (Table 3.6). The prevalence of rape, physical violence, or stalking by an intimate partner reported by women in these income groups was 9.7% and 5.9%, respectively, compared with 2.8% for women in the highest income group.

**Prevalence among Men**

The 12-month prevalence of rape, physical violence, or stalking by an intimate partner was significantly higher among men with a combined household income of less than $25,000, and between $25,000 and $50,000, than for men with a combined income over $75,000 ($p < .05$). The prevalence of rape, physical violence, or stalking by an intimate partner reported by men in these income groups was 6.9% and 6.6%, respectively, compared with 3.4% for men in the highest income group.

**Twelve-month Prevalence of Intimate Partner Rape, Physical Violence, or Stalking by Age at Time of Survey**

### Prevalence among Women

Approximately 14.8% of women who were 18 to 24 years old at the time of the survey experienced rape, physical violence, or stalking by an intimate partner in the 12 months preceding the survey, as compared to 8.7% of women 25 to 34 years of age, 7.3% of women 35 to 44 years of age, 4.1% of women 45 to 54 years of age, and 1.4% of women 55 years of age or older (Table 3.7). Women aged 25 years and older at the time of the survey had a significantly lower 12-month prevalence of rape, physical violence, or stalking by an intimate partner, compared to those in the 18 to 24 year old age group ($p < .05$).

### Prevalence among Men

Approximately 9.8% of men who were 18 to 24 years old at the time of the survey experienced rape, physical violence, or stalking by an intimate partner in the 12 months preceding the survey, as compared to 8.6% of men 25 to 34 years of age, 5.6% of men 35 to 44 years of age, 3.3% of men 45 to 54 years of age, and 1.4% of men 55 years of age or older. The 12-month prevalence of rape, physical violence, or stalking by an intimate partner was significantly lower among men in the three older age groups compared with 18 to 24 year old men ($p < .05$). There were no significant differences in prevalence between men in the 25 to 34 age group compared with 18 to 24 year old men.

## Twelve-month Prevalence of Intimate Partner Rape, Physical Violence, or Stalking by Experiences of Food and Housing Insecurity

### Prevalence among Women

Food and housing insecurity are two key measures of the potential influence of the social environment on health. In the National Intimate Partner and Sexual Violence Survey (NISVS) they were measured using two questions: “In the past 12 months, how often would you say you were worried or stressed about having enough money to buy nutritious meals?” and “In the past 12 months, how often would you say that you were worried or stressed about having enough money to pay your rent or mortgage?” Responses of “always,” “usually,” or “sometimes” were classified as a “yes” response; responses of “rarely” or “never” were classified as a “no” response.

The 12-month prevalence of rape, physical violence, or stalking by an intimate partner was significantly higher among women who experienced food insecurity in the 12 months prior to taking the survey (11.6%) compared to those who did not experience food insecurity (3.2%; $p < .05$). Similarly, women who experienced housing insecurity had a significantly higher prevalence of rape, physical violence, or stalking by an intimate partner in the 12 months prior to the survey (10.0%) compared with those who did not experience housing insecurity (2.3%) in the 12 months prior to taking the survey ($p < .05$).

**Prevalence among Men**

The 12-month prevalence of rape, physical violence, or stalking by an intimate partner was significantly higher among men who experienced food insecurity in the 12 months prior to taking the survey (8.2%) compared to those who did not experience food insecurity (4.0%; $p < .05$). Similarly, men who experienced housing insecurity had a significantly higher prevalence of rape, physical violence, or stalking by an intimate partner in the 12 months prior to the survey (7.9%), compared with those who did not experience housing insecurity (3.1%) in the past 12 months ($p < .05$).

**Prevalence of Rape, Physical Violence, or Stalking by an Intimate Partner among U S Natives and Foreign-Born Residents**

| Lifetime Prevalence |
| --- |
| The lifetime prevalence of rape, physical violence, or stalking by an intimate partner was significantly higher among those women born in the United States (37.3%), compared to women born outside of the United States (24.0%), $p < .05$ (Table 3.9). Similarly, men who were born in the United States were significantly more likely to experience rape, physical violence, or stalking by an intimate partner in their lifetime (30.2%), compared to men born outside of the United States (17.0%; $p < .05$). |

| Twelve-month Prevalence |
| --- |
| Approximately 6.1% of women born in the United States experienced rape, physical violence, or stalking by an intimate partner in the 12 months preceding the survey, compared to 4.1% of women born outside of the United States. Among men, 5.1% who were born in the United States experienced rape, physical violence, or stalking by an intimate partner in the 12 months preceding the survey, compared to 4.6% of men born outside of the United States. The differences between native and foreign-born populations were not statistical significant for women or men. |

## E. Impact of Intimate Partner Violence

To inform intimate partner violence prevention efforts and achieve a more complete picture of the true burden of intimate partner violence within populations, it is important to measure and

understand factors beyond whether or not a person has ever experienced IPV. 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 (Campbell, 2002; Cox, Coles, Nortje, Bradley, Chatfield, Thompson, & Menon, 2006). However, given that IPV victimization can range from a single act experienced once (e.g., one slap) to multiple acts of severe violence over the course of many years, it is difficult to represent this variation in the severity of violence experienced by victims in a straightforward manner.

To address these issues, the National Intimate Partner and Sexual Violence Survey (NISVS) included a number of questions to assess a range of impacts that victims of IPV may have experienced. This information provides not only a measure of the severity of the violence experienced, but also documents the magnitude of particular 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 IPV. IPV-related impact was assessed in relation to individual perpetrators, without regard to the time period in which impact occurred, and asked in relation to the totality of intimate partner violence experienced (sexual violence, physical violence, stalking, psychological aggression, and control of reproductive or sexual health) in that relationship. A description of the IPV-related impacts assessed is provided in Appendix A.

**Lifetime Prevalence of Rape, Physical Violence, or Stalking by an Intimate Partner with IPV-related Impact**

Nearly 3 in 10 women (28.8%) and nearly 1 in 10 men (9.9%) have experienced rape, physical violence, 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 (Figure 4.1). Women were significantly more likely than men to experience rape, physical violence, or stalking by an intimate partner during their lifetime and experience an IPV-related impact as a result of these or other forms of violence in that relationship ($p < .05$).

More than 1 in 4 women (25.7%) was fearful, more than 1 in 5 women (22.2%) was concerned for her safety, and more than 1 in 5 women (22.3%) experienced at least one post-traumatic stress

disorder (PTSD) symptom as a result of violence experienced in a relationship in which rape, physical violence, or stalking occurred. More than 1 in 7 women (14.8%) experienced an injury and 1 in 10 women (10.0%) missed at least one day of work or school, as a result of violence experienced in a relationship in which rape, physical violence, or stalking took place.

In contrast, 1 in 20 men (5.2%) was fearful, 1 in 25 men (4.0%) experienced an injury, and nearly 1 in 25 men (3.9%) missed at least one day of work or school as a result of violence experienced in a relationship in which rape, physical violence, or stalking occurred. Women had a significantly higher lifetime prevalence ($p < .05$) than men for a number of individual IPV-related impacts including: being fearful, being concerned for safety, experiencing one or more PTSD symptoms, being injured, needing medical care, needing housing services, needing legal services, and having missed at least one day of work or school.

**Distribution of IPV-related Impacts among Lifetime Victims of Rape, Physical Violence, or Stalking by an Intimate Partner**

Among victims of rape, physical violence, or stalking by an intimate partner, approximately 8 in 10 women (80.8%) and more than 1 in 3 men (34.7%) experienced one or more of the impacts measured within a relationship, a statistically significant difference ($p < .05$) (Figure 4.2).
Among women who experienced rape, physical violence, or stalking by an intimate partner, 72.2% were fearful, 62.3% were concerned for their safety, 62.6% experienced at least one PTSD symptom, 41.6% were injured as a result of the violence, and 28.0% missed at least one day of work or school as a result of these or other forms of violence in that relationship. In contrast, among men who experienced rape, physical violence, or stalking by an intimate partner, 18.4% were fearful, 15.7% were concerned for their safety, 16.4% experienced at least one PTSD symptom, 13.9% were injured, and 13.6% missed at least one day of work or school as a result of these or other forms of violence in that relationship.

Among victims of rape, physical violence, or stalking by an intimate partner, a significantly higher proportion of women than men experienced individual IPV-related impacts as a result of these or

other forms of violence in that relationship including: being fearful, being concerned for safety, experiencing one or more PTSD symptoms, being injured, needing medical care, needing housing services, needing legal services, and having missed at least one day of work or school ($p < .05$).

**Lifetime Prevalence of Rape, Physical Violence, or Stalking by an Intimate Partner with Physical Injury**

As mentioned previously, more than 1 in 7 women (14.8%) and 1 in 25 men (4.0%) in the United States experienced rape, physical violence, or stalking by an intimate partner and reported at least one injury related to experiencing these or other forms of violent behavior within that relationship. In terms of severity, 12.8% of women and 3.1% of men have experienced minor scratches or bruises; 10.4% of women and 2.3% of men have experienced cuts, major bruises, or a black eye; 3.2% of women and 0.6% of men have experienced broken bones or teeth; 5.2% of women and 0.5% of men have been knocked out; and 4.4% of women and 1.1% of men have experienced some other type of injury (Table 4.1). The prevalence of each type of injury was significantly higher for women compared to men ($p < .05$).

**Distribution of Physical Injury Types among Lifetime Victims of Rape, Physical Violence, or Stalking by an Intimate Partner**

As shown in Figure 4.2, 41.6% of female victims and 13.9% of male victims who experienced rape, physical violence, or stalking by an intimate partner reported at least one injury related to experiencing these or other forms of violent behavior in that relationship. Figure 4.3 shows the proportion of victims that experienced specific injuries as a result of violence within a relationship in which rape, physical violence, or stalking occurred. Female victims were significantly more likely than male victims to experience each of the individual types of injuries ($p < .05$).

## F. Accumulation of Intimate Partner Violence Behaviors Experienced by Individual Perpetrators

The unique method of data collection utilized by the National Intimate Partner and Sexual Violence Survey (NISVS) allows for an examination of the totality of a victimization experience related to individual intimate partners. Specifically, by linking violent behaviors experienced to specific intimate partner(s), NISVS is better able to describe the victim's experience within a particular relationship. Whereas previous methods only allow for an examination of a victim's experience across multiple perpetrators, they do not allow for the disentangling of violent behaviors by perpetrators. The method utilized by NISVS allows for a better understanding of the context in which an individual act of violence is experienced, specifically whether an act of violence occurred in isolation or whether the violence was part of a larger pattern of violent behaviors. This method can also be utilized to connect the combined victimization experiences within an individual relationship to specific impacts experienced as a result of victimization.

This section provides information related to:

- The total number of unique behaviors experienced by victims in an individual relationship, within each of the four violence subtypes (sexual violence, physical violence, stalking, and psychological aggression), with the maximum number utilized for those with multiple perpetrators
- The total number of unique impacts experienced by victims
- The prevalence of the overlap of rape, physical violence, and stalking within a single relationship

The following analyses examine violence experienced in individual relationships across the life span. For those with multiple perpetrators, the maximum number of violent behaviors experienced is analyzed. For example, if a respondent reported an intimate partner that perpetrated two unique physically violent behaviors, and another that perpetrated five unique physically violent behaviors, they would be considered to have experienced five unique physically violent behaviors within an individual relationship.

### Maximum Number of Sexually Violent Behaviors Experienced in an Individual Relationship

NISVS measures nine types of sexually violent behaviors: rape (completed forced penetration, attempted forced penetration, alcohol/drug facilitated penetration); being made to penetrate someone else (completed forced penetration, attempted forced penetration, alcohol/drug facilitated penetration); sexual coercion, unwanted sexual contact; and non-contact, unwanted sexual experiences. Figure 5.1 displays a distribution describing the largest number of discrete sexually violent behaviors experienced by an individual intimate partner. Across male and female victims, the median number of unique sexually violent behaviors experienced was one. Among victims of sexual violence by an intimate partner, the proportion of female victims that experienced more than the median number (two or more) of unique sexually violent behaviors by an individual intimate partner was higher than the proportion of male victims ($p < .05$).

### Maximum Number of Physically Violent Behaviors Experienced in an Individual Relationship

NISVS measures 10 discrete physically violent behaviors. Figure 5.2 provides a distribution of the maximum number of discrete physically violent behaviors experienced among victims of physical violence by an individual intimate partner. Across male and female victims of physical violence, the median number of unique physically violent behaviors experienced was two. Among victims of physical violence by an intimate partner, the proportion of female victims that experienced more than the median number (three or more) of unique physically violent behaviors by an individual intimate partner was higher than the proportion of male victims ($p < .05$).

### Maximum Number of Stalking Behaviors Experienced in an Individual Relationship

NISVS measures seven discrete stalking behaviors. Figure 5.3 provides a distribution of the maximum number of discrete stalking behaviors experienced by an individual intimate partner among stalking victims. Across male and female victims of stalking, the median number of unique stalking behaviors experienced was two. There was no significant difference between male and female victims of stalking with regard to having experienced more than the median number (three or more) of unique stalking behaviors by an individual intimate partner.

### Maximum Number of Psychologically Aggressive Behaviors Experienced in an Individual Relationship

NISVS measured a total of 18 discrete psychologically aggressive behaviors. Figure 5.4 provides a distribution of the largest number of discrete psychologically aggressive behaviors experienced by an individual intimate partner among victims of psychological aggression. Across male and female victims of stalking, the median number of unique psychologically aggressive behaviors experienced was three. Among victims of psychological aggression by an intimate partner, the proportion of female victims that experienced more than the median number (four or more) of unique psychologically aggressive behaviors by an individual intimate partner was higher than the proportion of male victims ($p < .05$).

### Maximum Number of IPV-related Impacts Experienced in an Individual Relationship

NISVS measures 11 different intimate partner violence (IPV)-related impacts for women and men, as well as pregnancy as a consequence of rape for women. Figure 5.5 displays the distribution of the largest number of discrete IPV-related impacts experienced by victims as a result of IPV perpetrated by an individual intimate partner. Examining the maximum number of IPV-related impacts experienced as a result of IPV perpetrated by an individual intimate partner, the median number was three unique impacts experienced. Among victims of rape, physical violence, or stalking by an intimate partner that experienced IPV-related impact, the proportion of female victims that experienced more than the median number (three or more) of unique impacts by an individual intimate partner was higher than the proportion of male victims ($p < .05$).

**Overlap of Rape, Physical Violence, and Stalking within Relationships in Lifetime Reports of Violence by an Intimate Partner**

In contrast to the analyses in Section 3 that examined the overlap of violence across the life span, NISVS data can also be used to look at the overlap of different forms of violence within an individual relationship. Approximately 6.2% of women in the United States have experienced rape and physical violence in the same relationship, whereas too few men reported both rape and physical violence in the same relationship to produce reliable estimates (Table 5.1). Approximately 3.9% of U.S. women have experienced rape and stalking in the same relationship during their lifetime, while too few men reported both rape and stalking in the same relationship to produce reliable estimates. Also, 8.7% of U.S. women have experienced physical violence and stalking in the same relationship, as compared to 1.7% of U.S. men, a statistically significant difference ($p < .05$). Finally, 3.5% of women experienced all three forms of violence (rape, physical violence, stalking) in the same relationship, whereas too few men reported all three forms in the same relationship to produce reliable estimates.

## G. Characteristics of Intimate Partner Violence Victimization

This section describes a number of characteristics of intimate partner violence (IPV) victimization, including the number of lifetime perpetrators among victims, the sex of perpetrators, and the age of victims of rape, physical violence, or stalking at the time of the first IPV victimization.

### Number of Perpetrators in Lifetime Reports of Violence by an Intimate Partner

The majority of women (70.8%) and men (73.1%) who ever experienced rape, physical violence, or stalking by an intimate partner were victimized by one partner only (Figure 6.1). Approximately 20.9% of female victims and 18.6% of male victims were victimized by two partners; and 8.3% of female victims and 8.3% of male victims were victimized by three or more intimate partners.

**Sex of Perpetrator among Victims of Rape, Physical Violence, or Stalking by an Intimate Partner**

Approximately 97.1% of female victims of rape, physical violence, or stalking by an intimate partner had only male perpetrators, whereas 2.1% had only female perpetrators (data not shown). Among men, 96.9% who experienced rape, physical violence, or stalking by an intimate partner had only female perpetrators, whereas 2.8% had only male perpetrators. The number of female and male victims reporting victimization by both male and female perpetrators was too small to produce a reliable estimate.

**Age at the Time of First IPV Experience among those Who Experienced Rape, Physical Violence, or Stalking by an Intimate Partner**

Among those who ever experienced rape, physical violence, or stalking by an intimate partner, more than 1 in 5 female victims (22.4%) and more than 1 in 7 male victims (15.0%) experienced some form of intimate partner violence for the first time between the ages of 11 and 17 years (Figures 6.2 and 6.3). Additionally, 47.1% of female victims and 38.6% of male victims were between 18 and 24 years of age when they first experienced violence by an intimate partner.

## H. Services and Disclosure Related to Intimate Partner Violence Victimization

In addition to understanding the number of people who are victims of intimate partner violence (IPV), it is also important to estimate the number of people who need services as a result of victimization, as well as the number who were able to receive the needed services. These estimates inform efforts to provide a coordinated community response for victims of IPV. It also provides information that is necessary to focus preventive services and allocate resources to the most heavily affected populations. This section estimates the proportion of IPV victims that needed services as a result of the violence experienced in a relationship and also their patterns of disclosure. Further, this section describes the proportion of victims who received services among those who needed them, as well as the perceived helpfulness of disclosure among victims that disclosed their victimization experience. Questions about services and disclosure were asked in relation to the violence experienced by an individual perpetrator and for any violence committed by that perpetrator. It is important to note that victimization experiences could have occurred several years ago and that the service needs reported relate to the victimization and not to any particular time period.


**Services Needed among Lifetime Victims of Rape, Physical Violence, or Stalking by an Intimate Partner**

Among lifetime victims of rape, physical violence, or stalking by an intimate partner, female victims (36.4%, or 15.5 million women) were significantly more likely than male victims (15.6%, or 5.0 million men) to report that they needed services as a result of these or other forms of violence they experienced in the relationship (Figure 7.1). With respect to specific service needs as a result of the violence experienced in the relationship, 22.1% of female victims needed medical care, 21.2% needed legal services, 7.5% needed victim's advocate services, 6.9% needed housing services, and 6.1% needed community services. Among men who were victims of rape, physical violence, or stalking by an intimate partner, 10.8% needed legal services, 5.5% needed medical care, 1.5% needed housing services, and 1.1% needed community services. For each of these services, except for advocacy services, the proportion of female victims reporting that they needed a particular service was significantly higher than the proportion of male victims who said they needed the same

service ($p < .05$). Formal statistical testing comparing the need for advocacy services was not undertaken because the number of men reporting the need for advocacy services was too small to generate a reliable estimate.

### Services Received among Victims who Needed Services

#### Female Victims who Needed Services

Among lifetime victims of rape, physical violence, or stalking, those who reported a need for each of the individual services were asked whether they ever received that service. Overall, approximately half of the female victims (49.0%) who needed services reported that they always received the services that were needed (Table 7.1). However, 44.9% of female victims who needed services reported that they did not receive any of the needed services. Additionally, 6.1% of female victims who needed services reported that they received some but not all of the needed services. With respect to specific services, among the 7.9% of women in the United States who experienced rape, physical violence, or stalking and reported they needed medical care, 89.5% said that they always received them. Among the 2.4% of women in the United States who experienced rape, physical violence, or stalking and reported they needed housing services, 48.3% always received them. Additionally, among the 2.7% of women in the United States who experienced rape, physical violence, or stalking and reported they needed victim's advocate services, 46.4% always received them. Among the 7.6% of women in the United States who experienced rape, physical violence, or stalking and reported they needed legal services, 33.1% always received them. Finally, among the women in the United States who experienced rape, physical violence, or stalking and reported they needed community services, 49.6% always received them.

#### Male Victims who Needed Services

Among victims of rape, physical violence, or stalking who reported a need for services, the proportion of men who reported that they always received those services (33.0%) was significantly lower than the proportion of female victims who reported that they always received those services (49.0%), $p < .05$. Nearly 2 in 3 male victims (65.7%) who reported a need for services never received any of the needed services (data not shown).

With respect to specific services, among the 3.1% of men in the United States who experienced rape, physical violence, or stalking and reported they needed legal services, 10.9% always received those services, significantly lower than the 33.1% of female victims that needed legal services and always received those services ($p < .05$). Too few male victims reported a need for other individual services to calculate reliable estimates that break down the degree to which individual services were received, and, therefore, formal statistical comparisons between women and men were not made.

**Disclosure among Lifetime Victims of Rape, Physical Violence, or Stalking by an Intimate Partner**

Among victims of lifetime rape, physical violence, or stalking by an intimate partner, 84.2% of women and 60.9% of men disclosed the violence they experienced to another person (Figure 7.2). The proportion of female victims who disclosed their IPV experience was significantly higher than the proportion of male victims who disclosed their experiences to someone else ($p < .05$). Some of the most common groups of people that victims of rape, physical violence, or stalking disclosed their victimization to included: a friend (70.6% of female victims, 48.4% of male victims); a family member (51.9% of female victims, 31.6% of male victims); a psychologist or counselor (36.5% of female victims, 18.7% of male victims); and the police (36.3% of female victims, 12.6% of male victims). Additionally, 21.1% of female victims and 5.6% of male victims disclosed their victimization to a doctor or nurse. The proportion of female victims who disclosed their experience with IPV was significantly higher than the proportion of male victims who disclosed their experience with IPV for each of the groups of people that were examined ($p < .05$). While 5.9% of female victims disclosed to a crisis hotline, formal statistical testing comparing disclosure to a crisis hotline was not

undertaken because the number of men reporting disclosure to a crisis hotline was too small to generate a reliable estimate.

**Degree of Helpfulness of Disclosure among those Who Disclosed Lifetime Rape, Physical Violence, or Stalking by an Intimate Partner**

It has been well established that disclosure of victimization experiences can be very helpful to IPV victims as a way to elicit support (Sylaska & Edwards, 2013). However, such disclosures also have led to negative reactions, such as victim-blaming, pressure to leave an abusive relationship, or minimizing the abuse (Sylaska & Edwards, 2013). In the National Intimate Partner and Sexual Violence Survey (NISVS), victims of IPV who disclosed their experience with IPV were asked about the degree of helpfulness of the disclosure (very helpful, somewhat, a little, not at all) in relation to each source of help consulted. Information about the helpfulness of each source was asked in relation to victimization from each perpetrator mentioned by the respondent.

Female victims of rape, physical violence, or stalking who chose to disclose their experiences generally found most sources to be “very helpful” or “somewhat helpful” (Table 7.2). With the exception of disclosure to police, the percentage of victims who found disclosure to the various sources to be “not at all helpful” ranged from 10% (psychologist/counselor/friend) to 15% (intimate partner). In contrast, 33.7% found disclosure to the police to be “not at all helpful.” A similar pattern was found for male victims.

The proportion of male victims who considered their disclosure being “very helpful” is significantly lower than the proportion of female victims who considered their disclosure being “very helpful” for the following sources of help: police, psychologist/counselors, friends, family members, and “other” ($p < .05$). The difference in proportions between male and female victims reporting disclosure to a doctor or nurse or to an intimate partner being “very helpful” is not significant. Formal statistical testing comparing disclosure to a crisis hotline was not undertaken because the number of men reporting disclosure to a crisis hotline was too small to generate a reliable estimate.

## I. Physical and Mental Health conditions by Victimization History


Previous research suggests that victims of intimate partner violence (IPV) 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 conditions over their lifetime compared to nonvictims (Black, 2011; Coker et al., 2002). Many studies document increased risk for a number of adverse physical, mental, reproductive, and other health conditions among those who have experienced intimate partner violence. Most studies that evaluate the adverse health consequences of intimate partner violence are based on female victims of such violence; less is known about the risk for adverse health events among men (Breiding, Black, & Ryan, 2008).

The cross-sectional nature of the National Intimate Partner and Sexual Violence Survey (NISVS) does not allow for a determination of causality or the temporality of violence victimization and associated health conditions. However, extensive research describes a number of mechanisms that link chronic stress to a wide range of adverse health conditions (Black, 2011). While some health conditions may result directly from a physical injury, others may result from the biological impacts

of stress on nearly all body systems (e.g., nervous, cardiovascular, gastrointestinal, reproductive, and immune systems). Furthermore, some research indicates that victims of violence are more likely to adopt health-risk coping behaviors such as smoking and the harmful use of alcohol or drugs (Campbell, 2002; Coker et al., 2002).

This section compares the prevalence of various health conditions among persons with a lifetime history of rape, physical violence, or stalking by an intimate partner in relation to those who have not experienced these forms of IPV in their lifetime. Respondents were asked about a number of health conditions: asthma, irritable bowel syndrome, diabetes, high blood pressure, frequent headaches, chronic pain, difficulty sleeping, activity limitations, and whether they considered their physical health and mental health to be poor. Verbatim health questions are available within the *National Intimate Partner and Sexual Violence Survey (NISVS)*: *2010 Summary Report* (Black et al., 2011).

### Among Women

With the exception of high blood pressure, the prevalence of reported adverse mental and physical health conditions was significantly higher among women with a history of rape, physical violence, or stalking by an intimate partner compared to women without a history of these forms of violence (Table 8.1). This includes a higher prevalence of asthma ($p < .001$), irritable bowel syndrome ($p < .001$), diabetes ($p < .05$), frequent headaches ($p < .001$), chronic pain ($p < .001$), difficulty sleeping ($p < .001$), and activity limitations ($p < .001$). Additionally, the percentage of women who considered their physical or mental health to be poor was significantly higher among women with a history of rape, physical violence, or stalking by an intimate partner, compared to women who have not experienced these forms of violence ($p < .001$). The experience of rape, physical violence, or stalking by an intimate partner was significantly associated ($p < .05$) with each of the health conditions except for high blood pressure, even after controlling for age, race/ethnicity, income, education, and the experience of rape and stalking by non-intimates (Table 8.2).

### Among Men

Compared to men without a history of rape, physical violence, or stalking by an intimate partner, men with such histories had a significantly higher prevalence of frequent headaches ($p < .001$), chronic pain ($p < .001$), difficulty sleeping ($p < .001$), activity limitations ($p < .001$), and considered their physical health to be poor ($p < .01$). Each of these health conditions was significantly associated ($p < .05$) with having experienced rape, physical violence, or stalking by an intimate partner, even after controlling for age, race/ethnicity, income, education, and the experience of rape and stalking by non-intimates. There were no significant differences between the two groups of men in the prevalence of asthma, irritable bowel syndrome, diabetes, high blood pressure, and self-assessed poor mental health.

## J. Discussion: Highlights and Cross-Cutting Findings

Beyond reporting the overall prevalence of individual forms of intimate partner violence (IPV), the National Intimate Partner and Sexual Violence Survey (NISVS) was designed to examine and describe in more detail the context of IPV victimization experienced by women and men. This report describes a number of these important contextual elements such as the frequency, severity, and the overlap of violence types, as well as the need for services, and impact of IPV victimization. Moving beyond the primary focus of IPV prevalence allows for a deeper understanding of the broad range of victimization experiences. From a public health perspective, a better understanding of the context in which intimate partner violence occurs is necessary to inform and focus preventive services and community responses to the needs of victims.

### Intimate Partner Violence Remains a Significant Public Health Problem

The results presented in this report indicate that IPV remains a public health issue of significant importance, affecting many women and men in the United States. Specifically, with regard to women's lifetime experience of violence by an intimate partner: nearly 1 in 10 has been raped; approximately 1 in 6 has experienced sexual violence other than rape; approximately 1 in 4 has experienced severe physical violence and nearly 1 in 3 has been slapped, pushed, or shoved; more than 1 in 10 has been stalked; and nearly 1 in 2 has experienced psychological aggression. With regard to men's lifetime experience of violence by an intimate partner: approximately 1 in 12 has experienced sexual violence other than rape; nearly 1 in 7 has experienced severe physical violence and 1 in 4 has been slapped, pushed or shoved; nearly 1 in 48 has been stalked; and nearly 1 in 2 has experienced psychological aggression.

Further, the results indicate that a significant proportion of IPV victims experience negative impacts as a result of IPV victimization. Although no demographic group is immune to these forms of violence, consistent patterns emerged with respect to the subpopulations in the United States that are most heavily affected.

## Women are Disproportionately Affected by Intimate Partner Violence

Consistent with previous national studies (Tjaden & Thoennes, 2000), the findings in this report indicate that women are disproportionately affected by IPV. While women have a significantly higher lifetime prevalence of rape, physical violence, or stalking by an intimate partner, compared to men, it is important to look beyond the overall numbers as they encompass a wide range of violence experiences and do not speak to differences in severity among victims.

In multiple ways, the data in this report indicate that IPV reported by women was typically more severe and resulted in a greater number of negative impacts than IPV victimization reported by men. Specifically, during their lifetime, women were more likely than men to experience: severe physical violence; sexual violence other than rape by an intimate partner; stalking by an intimate partner; and expressive aggression. Furthermore, women were more likely than men to experience: multiple forms of intimate partner violence (including rape, physical violence, and stalking), both across the life span and within individual violent relationships; a need for services in general; and at least one of the negative IPV-related impacts that were measured, including injury, and having missed at least one day of work or school.

Looking at the variation in IPV experiences among victims only, female victims were more likely than male victims to experience: a greater number of discrete physically violent, sexually violent, and psychologically aggressive behaviors within an individual violent relationship; each of the negative IPV-related impacts that was measured, including injury, need for housing services, need for victim's advocate services, and having missed at least one day of work or school; and a greater number of discrete IPV-related impacts within an individual relationship. Finally, female victims were more likely than male victims to experience more than the median number of violent behaviors in an individual relationship for: sexual violence (two or more sexually violent behaviors), physical violence (three or more physically violent behaviors), and psychological aggression (four or more psychologically aggressive behaviors).

## Many Men Experience Severe IPV and Negative Impacts

Despite numerous indicators suggesting that women are more likely to experience severe IPV compared to men, and are more likely to be negatively impacted, the data show that many men also experience severe forms of IPV and negative impacts. Specifically, in the United States:

- Nearly 14% of men have experienced severe physical violence by an intimate partner in their lifetime
- Nearly 10% of men have experienced rape, physical violence, or stalking by an intimate partner in their lifetime and experienced at least one IPV-related impact.
- Approximately 4% of men have been physically injured in their lifetime as a result of violence experienced in an intimate relationship.
- Approximately 4% of men have missed at least one day of work or school in their lifetime as a result of violence experienced in an intimate relationship.

Furthermore, a comparison of the differences in 12-month prevalence estimates show much smaller differences between men and women (e.g., unwanted sexual contact, various forms of severe physical violence) and, in some cases, more men than women experienced certain behaviors in the 12 months preceding the survey such as being slapped and being kicked. Additionally, men had a higher 12-month prevalence of psychological aggression than women.

## Racial/Ethnic Minorities are Disproportionately Affected by Intimate Partner Violence

Consistent with other studies, the burden of IPV is not shared equally among racial/ethnic groups. This report indicates that Black and multiracial non-Hispanic women had significantly higher lifetime prevalence of rape, physical violence, or stalking by an intimate partner, compared to White non-Hispanic women; Asian or Pacific Islander non-Hispanic women had significantly lower prevalence than non-Hispanic White women. Also, American Indian or Alaska Native men, as well as Black and multiracial non-Hispanic men, had a significantly higher lifetime prevalence of rape, physical violence, or stalking compared to White non-Hispanic men. These findings may be

a reflection of the many stressors that racial and ethnic minority communities continue to experience. For example, a number of social determinants of mental and physical health, such as low income and limited access to education, community resources, and services, likely play important roles.

### Women and Men with Lower Incomes are Disproportionately Affected by Intimate Partner Violence

The 12-month prevalence of rape, physical violence, or stalking by an intimate partner was significantly higher among women and men with a combined household income of less than $25,000 and between $25,000 and $50,000 than for women and men with a combined income over $75,000. The median U.S. household income in 2010 was $49,455, so the two lowest income groups combined roughly correspond to the bottom 50th percentile for household income (U.S. Census Bureau, 2011). This finding is consistent with previous studies demonstrating an inverse relationship between income and IPV prevalence (Breiding, Black, & Ryan, 2008).

### Victimization is More Prevalent among Young Adults

For women and men, the 12-month prevalence of rape, physical violence, or stalking was highest among the youngest age group (18 to 24). Prevalence decreased within each subsequent age group. Furthermore, nearly 60% of female victims and over 55% of male victims first experienced some form of intimate partner violence prior to age 18.

### Victimization is Associated with Recent Food and Housing Insecurity

Higher levels of 12-month prevalence of rape, physical violence, or stalking by an intimate partner were observed among those with food and housing insecurity. Additional analysis is needed to

fully understand the independent effects of income, education, employment status, and other sociodemographic variables that may be related to both food and housing insecurity and to IPV.

## Foreign-born Adults Experienced Lower Levels of Victimization

The lifetime prevalence of rape, physical violence, or stalking was significantly lower for adults that were born outside of the United States compared to those born in the United States. Additional analysis is needed to better understand whether this finding reflects a lower likelihood of experiencing IPV among immigrants in their country of origin, or whether it is the result of a lower likelihood of experiencing IPV since arriving in the United States. Another possible explanation is that there are cultural differences in reporting violence experiences, and that those cultural differences, and not a true difference in prevalence, may explain the differences found.

## Bisexual Women are at Greater Risk of Victimization

Bisexual women were significantly more likely to experience lifetime rape, physical violence, or stalking by an intimate partner, compared to lesbian and heterosexual women. While the prevalence of rape, physical violence, or stalking for bisexual men was somewhat elevated compared to gay men and heterosexual men, there were no statistically significant differences.

## Services and Disclosure

A range of services have been needed by a large number of people in the United States as a result of having experienced IPV at some point during their lifetime. The estimated number of men and women who reported that they needed services as result of victimization in their lifetime was more than 20 million. However, women, in particular, had a need for housing and victim's

advocate services, with millions of women needing each of these forms of assistance in their lifetime. Importantly, less than 50% of female victims who indicated a need for housing or victim's advocate services during their lifetime reported that they received them.

Overall, among female victims that needed services during their lifetime, 44.9% did not receive any services. For male victims, nearly 2 out of 3 (65.7%) that needed services during their lifetime did not receive any services. Clearly, there is a need to better understand the barriers to receiving these services for both women and men. Specifically, there is a need for an improved understanding of whether the barriers are largely due to lack of availability or other factors that lead to a victim choosing not to access available services.

A larger percentage of female victims disclosed their lifetime IPV experiences, in general, compared to men (84.2% and 60.9%, respectively), and a larger percentage of female victims disclosed their IPV to individual sources compared to men. However, among victims that disclosed their lifetime IPV victimization, the proportion of men who considered the disclosure as being "very helpful" was significantly lower than the proportion of women who considered the disclosure as being "very helpful." This was true for disclosure in general and for disclosure to particular sources such as police, psychologists/counselors, friends, family members, and "others."

**Intimate Partner Violence Is Associated with Negative Physical and Mental Health Conditions**

The findings in this report confirm and extend the literature by documenting the association between IPV and a wide range of adverse physical and mental health conditions as the findings presented here are the first to examine these associations in a nationally-representative dataset. The significant associations between IPV victimization and negative health outcomes remained after controlling for sexual violence and stalking by non-intimates, suggesting that IPV uniquely contributes to long-term health difficulties.

**Results Provide Greater Context Surrounding IPV Victimization**

The methodology used in the survey responds to calls from the field to add greater context to prevalence estimates that frequently do not explicate the range of severity that exists among victims. Specifically, by examining information related to individual perpetrators, including the overlap of types of IPV, discrete number of violent behaviors experienced, frequency and severity of the violence experienced, and the impact of violence perpetrated by a specific intimate partner, the results described in this report allow for a better understanding of the patterns of violence that exist within individual relationships, shedding light on the totality of the violence experienced. Additionally, this information allows for a description of the range in severity of victimization experiences that is not fully represented by IPV prevalence estimates that combine many diverse victimization experiences into a binary outcome measure.

Despite these methodological improvements that shed light on the context of IPV victimization, the data do not speak to other key aspects of context, specifically, motive on the part of perpetrator (e.g., self-defense) and whether the victim also engaged in perpetration of IPV. Prior research suggests that IPV is reciprocal in many relationships (Graham-Kevan & Archer, 2003). Consequently, it is likely that a certain number of victims identified within this report were themselves perpetrators of IPV who may or may not have acted in self-defense. It is also possible that some of the victims identified within this report may have been the primary perpetrator within the relationship and that the victimization they reported may have occurred solely when a partner was acting in self-defense. Perpetration of IPV is not measured within NISVS because data from the NISVS pilot found that perpetration was significantly underreported relative to victimization. Further, the motives of perpetrators were not assessed in NISVS, given the difficulties a respondent would have in accurately assessing the specific motives of another person. Not only is asking a victim to describe the motive of a perpetrator likely unreliable, but motives behind the violence are likely to change over time and change with the specific circumstances surrounding multiple episodes of IPV.

## Limitations

The findings of this report are subject to a number of limitations. Random digit dial (RDD) telephone surveys face two substantive challenges that have the potential to affect the national representativeness of the sample population. This includes declining response rates and an increasing number of households without landline telephones (Peytchev, Carley-Baxter, & Black, 2011). While the overall response rate for the 2010 National Intimate Partner and Sexual Violence Survey was relatively low, the cooperation rate was high. A number of efforts were also made to mitigate the potential for non-response and non-coverage bias. These include a non-response follow-up in which randomly selected non-responders were contacted and offered an increased incentive for participation. In addition, the inclusion of a cellphone component provided increased coverage of a growing population that would have otherwise been excluded. The cellphone-only population tends to be young, low income, and comprised of racial/ethnic minorities (Peytchev, Carley-Baxter, & Black, 2011). Importantly, these demographic groups have a higher prevalence of IPV.

Follow-up questions were designed to reflect the victim's experience with each perpetrator across the victim's lifetime. There are several limitations associated with how these questions were asked. First, respondents were asked about the impact from any of the violence inflicted by each perpetrator. Therefore, it is not possible to examine the impact of specific violent behaviors. However, results from the cognitive testing process undertaken in the development of NISVS suggested that victims who experienced multiple forms of violence with a perpetrator would have a difficult time distinguishing which type of violence from that perpetrator resulted in a particular type of impact. For example, a respondent may not be able to attribute their concern for safety to the psychological aggression or the physical violence that they experienced. Second, because we used victims' reports of their age and relationship at the time violence started with each perpetrator, it was not always possible to calculate the respondent's age or specify the relationship at the time specific types of violent behavior occurred. Based on the data we have about the relationship at the first victimization and last victimization, we estimate that less than 3% of perpetrators had a relationship with the victim that changed categories over time between the experience of the first and last victimizations (e.g., from acquaintance to intimate partner). All of the estimates in this report reflect the relationship at the time the perpetrator first committed any violence against the victim.

Even though NISVS captures a full range of victimization experiences, the estimates reported here likely underestimate the prevalence of intimate partner violence for a number of reasons. These include:

1) potential respondents that are currently involved in violent relationships may not participate in the survey or fully disclose the violence they are experiencing because of concern for their safety;
2) although the survey gathers information on a wide range of victimizations, it is not feasible to measure all of the violent behaviors that may have been experienced;
3) given the sensitive nature of these types of violence, it is likely that some respondents who had been victimized did not feel comfortable participating or did not feel comfortable reporting their experiences because of ongoing emotional trauma or the social stigma associated with being a victim of these forms of violence;
4) although potentially mitigated by the use of a cell phone sample, RDD surveys may be less likely to capture populations living in institutions (e.g., nursing homes, military bases, college dormitories), or those in prison, those living in shelters, or those who are homeless or transient; and
5) it is possible that some respondents could no longer recall violence experiences that were less severe in nature or that occurred long ago.

This report provides lifetime and 12-month prevalence estimates, as both estimates are important indicators of the burden of IPV. For an ongoing public health surveillance system, 12-month prevalence estimates are important indicators needed to determine the current public health burden of these forms of violence and to track trends over time. However, given the sensitivity of these outcomes, there are important limitations to consider when interpreting the 12-month prevalence of IPV. As mentioned, some respondents may be less likely to disclose IPV victimization due to ongoing emotional trauma or discomfort, or due to concern for their safety due to an ongoing relationship with a perpetrator. We would expect that this would particularly affect those who have experienced recent severe IPV. Additionally, it is possible that those who have experienced recent severe IPV may be less likely to participate at all. One study found that women who had experienced severe IPV within the past 12 months were less likely to participate in a study of IPV (Waltermaurer, Ortega, & McNutt, 2003). There are a number of potential reasons why those who have experienced recent severe IPV may be less willing to participate in a survey.

- First, a victim of severe IPV who is currently living with the perpetrator may fear for their safety.
- Second, a recent victim of IPV who has recently left a relationship may be in a less stable living arrangement, such as a shelter, or temporarily living with a friend or family member, and may be less likely to have the opportunity to participate.
- Third, those who are currently involved in a particularly controlling relationship may have restricted or no use of a telephone.

For these reasons, 12-month prevalence estimates of IPV victimization may be an underestimate of the current public health burden of IPV. Because women are more likely to experience severe IPV compared to men, women's 12-month prevalence may be particularly affected.

In addition to the possible causes of underestimation of the prevalence, it is important to consider other potential limitations related to the data being based on self-reports. For example, 12-month estimates may reflect a degree of recall bias with victims believing that victimization experiences occurred closer in time than they actually did (i.e., telescoping). Also, there may be reluctance for respondents to discuss specific types of violence (e.g., forced vaginal sex) or specific types of perpetrators (e.g., same sex). These are factors that might impact the accuracy of estimates in unpredictable ways and in a manner that could potentially vary across subgroups of victims (e.g., by age or sex). Despite these limitations, population-based surveys that collect information directly from victims remain one of the most important and most reliable sources of data on IPV. For example, the wide range of impacts of IPV that was measured by NISVS can only be captured from the victim directly. Furthermore, population-based surveys are likely to capture IPV victimization that does not come to the attention of police, as well as IPV victimization that does not require treatment or is not reported to a health provider. Population-based surveys that are carefully conducted, with well-trained interviewers who are able to build rapport and trust with participants, are essential to the collection of valid data and the well-being of respondents.

### Considerations Related to Combining Violence Types

Many of the results in this report focus on a summary measure that examined whether a victim experienced some combination of rape, physical violence, or stalking. This summary measure utilized is a conservative representation, including only those violence types for which there is broad agreement regarding inclusion, but most certainly excludes a number of violence types that in specific instances should be classified as IPV. The exclusion of certain forms of IPV from the summary measure is not meant to suggest these forms of IPV that were measured in NISVS (i.e., sexual violence other than rape, psychological aggression, control of reproductive or sexual health) are less important. One overriding concern about including all types of IPV measured by NISVS into a single summary measure is that by combining many forms of IPV, ranging from severe to less severe, the meaning of the summary measure is lost. Specifically, the summary measure may lead to the false impression that all experiences are equivalent under the umbrella of the summary measure. However, it is important to consider the variation in severity that exists and is represented by the other measures described in this report.

The reasons for not including specific types of IPV in the summary measure vary. For some types of IPV, such as psychological aggression, there is little agreement in the field from a measurement perspective about when psychological aggression becomes psychological abuse or violence. The prevalence estimate included in this report describes the number of people who experienced any form of psychological aggression at least once. As the understanding of psychological aggression improves (for example, how to make the distinction between psychological aggression and psychological abuse), the ability to appropriately describe and present this important data will improve. Similarly, another form of violence, being made to penetrate someone else, is a relatively new addition that may be particularly important to improve our understanding of the sexual violence that men and boys experience. With further research, and with broader agreement within the field, changes may be warranted to the summary measure by including some of the forms of IPV that are currently described outside of the summary measure. In so doing, a broader summary measure would describe a more comprehensive representation of IPV experiences.

## K. Implications for Prevention

This report documents the public health burden that intimate partner violence (IPV) exerts on a wide range of populations with differing demographic characteristics. Consequently, a community-level response is needed to implement effective and appropriate measures to prevent and respond to those who are affected by IPV.


**Primary Prevention**

The Centers for Disease Control and Prevention's (CDC's) core strategy for preventing IPV is the promotion of respectful, nonviolent relationships through individual, relationship, community, and societal change. This prevention strategy is organized around the following principles: understanding ways to interrupt the development of IPV perpetration; improving knowledge of factors that contribute to respectful relationships and protect against IPV; creating and evaluating new approaches to prevention; and building community capacity. Comprehensive community-based approaches building upon and joining well-organized, broad-based coalitions are important and can effectively create change in communities. One example of these efforts, The Domestic Violence Prevention Enhancement and Leadership Through Alliances (DELTA) FOCUS program seeks to prevent IPV at the national, state, and local levels by funding states and communities to implement and evaluate IPV prevention strategies. DELTA FOCUS grantees are working toward changing the conditions that lead to IPV through activities such as: promoting healthy relationships and communications skills, engaging men and boys in violence prevention, developing youth assets and leaders, and working with communities to implement and evaluate population-level strategies that prevent IPV.

CDC places an emphasis on primary prevention, prioritizing the prevention of IPV from occurring in the first place. This report indicates that IPV victimization begins early with nearly 70% of female victims and nearly 54% of male victims having experienced IPV prior to age 25. This suggests that primary prevention of IPV must begin at an early age. CDC's approach to primary prevention of IPV is the promotion of healthy relationship behaviors among young people, with the goal of

reaching adolescents prior to their first relationships. By influencing relationship behaviors and patterns early through dating violence prevention programs, the hope is to promote healthy relationship behaviors and patterns that can be carried forward into adulthood.

This report identified groups that are at most risk for IPV victimization. While primary prevention programs exist, it is unknown whether they are effective within specific groups of people, particularly among those identified in this report as being most at risk. Further work needs to be done to test existing strategies with specific groups, as well as to develop and test other strategies to determine whether they are effective in preventing IPV. One of the goals of CDC's Dating Matters™ program, which is a comprehensive program for youth, their parents, educators, and the neighborhoods in which they live, is to test evidence-based and evidence-informed strategies within high-risk urban communities (Teten Tharp, 2012). By making adaptations to existing evidence-based program components to make them more culturally relevant and developing and testing other strategies tailored for urban communities, this program will help identify potential strategies for groups at high-risk for teen dating violence. Outside of this specific program, continued efforts are needed to develop prevention strategies that address the culturally specific concerns of at-risk groups across the United States.

Efforts to build positive and healthy parent-child relationships are also important for the primary prevention of IPV. Children benefit from safe, stable, and nurturing familial environments that facilitate respectful interactions and open communication. Other opportunities to build parent-child relationships include programs to promote effective parenting skills and efforts to include and support relationships between fathers and children. Beyond providing children an opportunity to share with their parents the experiences they have had with dating violence and other forms of violence, parents who model healthy, respectful intimate relationships free from violence foster these relationship patterns in their children. Furthermore, children who have experienced adverse childhood events, such as witnessing violence between parents, are at increased risk of short- and long-term health and social problems (Felitti, et al., 1998). Reducing parental IPV is likely to decrease the risk of IPV and other forms of violence in the next generation, decrease the likelihood of children engaging in risky behaviors, and decrease the risk of a wide range of adverse health conditions.

The focus of this report is on describing the public health burden of victimization. To better understand how to prevent IPV, CDC also supports work that seeks to better understand the causes of IPV perpetration. Research examining risk and protective factors is key to understanding how perpetration of violence develops and to determine the optimal strategies for preventing intimate partner violence. While much is known about risks factors at the individual and couple level, there have been few studies examining community- and societal-level factors related to perpetration of IPV. Identifying community and societal-level factors, while difficult, could be most useful in identifying perpetration prevention strategies that have the most potential for broad impact. In addition, future research is needed to identify protective factors that decrease the likelihood of IPV perpetration. Protective factors are particularly critical to developing prevention programs as they are more likely to point to environments or situations that reduce the likelihood of violence perpetration, in general, or reduce the likelihood of IPV perpetration in the first place among those who are at high risk.

Finally, as the risk and protective factors for IPV perpetration are better understood, additional research is needed to develop and evaluate strategies to effectively prevent the first-time perpetration of IPV. This includes research that addresses the social and economic conditions that increase the risk for perpetration and victimization —such as poverty, food and housing insecurity, and sexism — as well as other forms of discrimination and social exclusion. Such research will complement efforts focused on preventing initial victimization and the recurrence of victimization.

## Secondary and Tertiary Prevention

Secondary and tertiary prevention programs and services are essential for mitigating the short- and long-term consequences of IPV among victims, as well as reducing the violence-related health burden across the life span. This report examined a range of services that victims reported needing as a result of IPV at some point in their lifetime and whether they received them, including medical care, housing, victim's advocacy, legal, and community services. The vast majority of women who were victims of IPV indicated that they needed medical services; nearly half said

they needed housing, victim's advocacy, and community services; and a third of women needed legal services. Among the female victims who needed at least one of these services at some point during their lifetime, nearly half did not receive any of the services that were needed. Among the male victims who needed at least one of these services, approximately two-thirds did not receive any of the needed services. This indicates that a significant gap has existed over time, and may still exist, between a need for services and the receipt of those services. Future work is needed to understand the degree to which this gap currently exists and, if so, whether this gap is due to services being unavailable or because available services were not utilized. Regardless, a better understanding of the current barriers to service utilization is always important.

Disclosing victimization experiences is a necessary first step for victims to be able to obtain the resources and services they need. One primary method by which IPV victims may disclose victimization and receive appropriate help is through disclosure to medical professionals. While 84.2% of female victims and 60.9% of male victims disclosed their IPV victimization to someone, only 21.0% of female victims and 5.0% of male victims reported having disclosed their victimization to a medical professional at some point in their lifetime. A number of medical associations (e.g., American Congress of Obstetricians [ACOG] and Gynecologists, American Medical Association [AMA]) recommend asking all patients about their experiences with IPV at every visit and providing referrals for services as indicated (AMA, 1992; ACOG, 1995). Further, in 2013, the U.S. Preventive Services Task Force recommended that clinicians should screen all women of childbearing age for IPV and provide or refer women who screen positive to intervention services (Moyer, 2013). The questions about disclosure in National Intimate Partner and Sexual Violence Survey were asked in relation to the violence experienced by an individual perpetrator and were not specific to any particular time period. However, the findings suggest a need to better understand any potential barriers that may prevent victims from disclosing to a medical professional or those that may make some medical professionals reluctant to assess patients' victimization experiences, even among those that show signs of victimization (Black, 2011).

Victims choosing to disclose to health care providers is likely to improve if clinicians are prepared and able to ask about IPV in a compassionate and non-judgmental manner. One of the largest barriers to physicians asking about IPV is that they frequently feel inadequate and unprepared to appropriately respond to a patient who reports experiencing IPV. A study of final-year primary care residents regarding "perceived preparedness" found that only 21% reported being prepared

to talk about IPV (Park, Wolfe, Gokhale, Winichoff, & Rigotti, 2005). The amount of time spent on IPV training remains quite limited and the majority of medical textbooks still do not contain adequate information on IPV (Hamberger, 2007). To train health care providers to effectively identify, treat, and provide secondary prevention for victims of IPV, there remains an urgent need to raise awareness about the pervasiveness of IPV and the far-reaching implications for patient health (Block, 2005).

## L. Conclusion

To reduce the burden of intimate partner violence in the United States, it is essential to have solid data to inform IPV prevention efforts and to provide services and resources to those who have been victimized. Additionally, it is critical for all sectors of society, including peer groups, schools, medical professionals, and communities, to work together to decrease IPV. Continued efforts are required to extend the gains that have been made in understanding and implementing IPV prevention strategies.

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## Chapter 3. Assessment of Abuse

### A. Types of Abuse (OWH, 2020)

There are many types of violence and abuse. Some of these signs are signs of physical abuse or domestic violence. Some are signs of emotional and verbal abuse or sexual abuse.

**Physical abuse**

**Physical abuse is using physical force that injures you or puts you in danger.** Physical abuse can happen in dating or married relationships, but it can also happen outside a relationship. No one — not a spouse, romantic partner, or family member — has the right to physically abuse you.

**Physical abuse is any physical force that injures you or puts your health in danger.** Physical abuse can include shaking, burning, choking, hair-pulling, hitting, slapping, kicking, and any type of harm with a weapon like a knife or a gun. It can also include threats to hurt you, your children, your pets, or family members. Physical abuse can also include restraining you against your will, by tying you up or locking you in a space. Physical abuse in an intimate partner (romantic or sexual) relationship is also called domestic violence.

Physical abuse is:

- **A crime.** Physical abuse is a criminal act, whether it happens inside or outside of the family or an intimate relationship. The police have the power and authority to

protect you from physical attack. If someone in a position of power or authority physically abuses you, there are always ways to report them. Physical abuse is a crime even if it happens just one time. You may think that the abuse will never happen again. Your partner may try to convince you that it will never happen again. The abuse may stop, but it is likely to continue. And no one has the right to harm you, even once.


- **Dangerous.** Victims whose partners physically abuse them are at a higher risk for serious injury and even death.

**How does physical abuse affect a woman's health in the long term?**

Physical abuse can have lasting effects on your physical and mental health. **Physical abuse can cause many chronic (long-lasting) health problems, including heart problems, high blood pressure, and digestive problems.**[1] Women who are abused are also more likely to develop depression, anxiety, or eating disorders. Women who are abused may also misuse alcohol or drugs as a way to cope.

**Emotional and Verbal Abuse**

Retrieved from: https://www.womenshealth.gov/relationships-and-safety/other-types/emotional-and-verbal-abuse

You may not think you are being abused if you're not being hurt physically. But emotional and verbal abuse can have short-term and long-lasting effects that are just as serious as

the effects of physical abuse. **Emotional and verbal abuse includes insults and attempts to scare, isolate, or control you.** It is also often a sign that physical abuse may follow. Emotional and verbal abuse may also continue if physical abuse starts. If you have been abused, it is never your fault.

**How can I tell if I'm being emotionally or verbally abused?**

You may be experiencing emotional or verbal abuse if someone:

- Wants to know what you're doing all the time and wants you to be in constant contact
- Demands passwords to things like your phone, email, and social media and shows other signs of digital abuse
- Acts very jealous, including constantly accusing you of cheating
- **Prevents or discourages you from seeing friends or family**
- Tries to stop you from going to work or school
- Gets angry in a way that is frightening to you
- Controls all your finances or how you spend your money
- Stops you from seeing a doctor
- Humiliates you in front of others
- Calls you insulting names (such as "stupid," "disgusting," "worthless," "whore," or "fat")
- Threatens to hurt you, people you care about, or pets
- Threatens to call the authorities to report you for wrongdoing
- Threatens to harm himself or herself when upset with you
- Says things like, "If I can't have you, then no one can"
- **Decides things for you that you should decide (like what to wear or eat)**

**How does emotional and verbal abuse start?**

Emotional and verbal abuse may begin suddenly. **Some abusers may start out behaving normally and then begin abuse after a relationship is established.** Some abusers may purposefully give a lot of love and attention, including compliments and requests to see you often, in the beginning of a relationship. Often, the abuser tries to make the other person feel strongly bonded to them, as though it is the two of them "against the world."

Over time, abusers begin to insult or threaten their victims and begin controlling different parts of their lives. When this change in behavior happens, it can leave victims feeling shocked and confused. You may feel embarrassed or foolish for getting into the relationship. If someone else abuses you, it's never your fault.

**What are the effects of emotional or verbal abuse?**

Staying in an emotionally or verbally abusive relationship can have long-lasting effects on your physical and mental health, including leading to chronic pain, depression, or anxiety.

You may also:

- Question your memory of events: "Did that really happen?"
- Change your behavior for fear of upsetting your partner or act more aggressive or more passive than you would be otherwise
- **Feel ashamed or guilty**
- Feel constantly afraid of upsetting your partner
- **Feel powerless and hopeless**
- Feel manipulated, used, and controlled
- Feel unwanted

Your partner's behavior may leave you feeling as though you need to do anything possible to restore peace and end the abuse. This can feel stressful and overwhelming.

Learn ways to cope and where to get help.

**What is gaslighting?**

**"Gaslighting" is the word used when an abuser makes you feel like you are losing your mind or memory.**

An abuser might:

- Deny an event happened
- Call you crazy or overly sensitive
- Describe an event as completely different from how you remember it

Gaslighting is a form of emotional abuse that abusers use to maintain power and control. **When a victim is questioning her memories or her mind, she may be more likely to feel dependent on the abuser and stay in the relationship.**

**Stalking**

A type of Emotional Abuse a Partner or Ex-partner may commit is Stalking.

**Retrieved from:** https://www.womenshealth.gov/relationships-and-safety/other-types/stalking

**Stalking is repeated contact that makes you feel afraid or harassed.** Someone may stalk you by following you or calling you often. Stalkers may also use technology to stalk you by sending unwanted emails or social media messages. About one in six women has experienced stalking in her lifetime. Women are twice as likely to be stalked as men are. Stalking is a crime.

**What is stalking?**

Stalking is any repeated and unwanted contact with you that makes you feel unsafe. You can be stalked by a stranger, but most stalkers are people you know — even an intimate partner. Stalking may get worse or become violent over time. Stalking may also be a sign of an abusive relationship.

Someone who is stalking you may threaten your safety by clearly saying they want to harm you. Some stalkers harass you with less threatening but still unwanted contact. The use of technology to stalk, sometimes called “cyberstalking,” involves using the Internet, email, or other electronic communications to stalk someone. Stalking is against the law.

Stalking and cyberstalking can lead to sleeping problems or problems at work or school.

**What are some examples of stalking?**

Examples of stalking may include:

- Following you around or spying on you

- Sending you unwanted emails or letters
- **Calling you often**
- Showing up uninvited at your house, school, or work
- Leaving you unwanted gifts
- Damaging your home, car, or other property
- Threatening you, your family, or pets with violence

**What are some examples of cyberstalking?**

Examples of cyberstalking include:

- Sending unwanted, frightening, or obscene emails, text messages, or instant messages (IMs)
- **Harassing or threatening you on social media**
- Tracking your computer and internet use
- Using technology such as GPS to track where you are

**Are there laws against stalking?**

Yes. Stalking is a crime. Learn more about the laws against stalking in your state at the Stalking Resource Center(link is external). If you are in immediate danger, call 911. You can file a complaint with the police and get a restraining order (court order of protection) against the stalker. Federal law says that you can get a restraining order for free. Do not be afraid to take steps to stop your stalker.

**What can I do if I think I'm being stalked?**

**If you are in immediate danger, call 911**. Find a safe place to go if you are being followed or worry that you will be followed. Go to a police station, friend's house, domestic violence shelter, fire station, or public area.

You can also take the following steps if you are being stalked:

- File a complaint with the police. Make sure to tell them about all threats and incidents.
- Get a restraining order. A restraining order requires the stalker to stay away from you and not contact you. You can learn how to get a restraining order from a domestic violence shelter, the police, or an attorney in your area.
- Write down every incident. Include the time, date, and other important information. If the incidents occurred online, take screenshots as records.
- Keep evidence such as videotapes, voicemail messages, photos of property damage, and letters.
- Get names of witnesses.
- Get help from domestic violence hotlines(link is external), domestic violence shelters, counseling services, and support groups. Put these numbers in your phone in case you need them.
- Tell people about the stalking, including the police, your employer, family, friends, and neighbors.
- Always have your phone with you so you can call for help.
- Consider changing your phone number (although some people leave their number active so they can collect evidence). You can also ask your service provider about call blocking and other safety features
- Secure your home with alarms, locks, and motion-sensitive lights.

For more information or emotional support, call the Stalking Resource Center National Center for Victims of Crime Helpline(link is external) at 800-FYI-CALL (394-2255), Monday through Friday, 10 a.m. to 6 p.m. ET.

**What can I do if someone is cyberstalking me?**

If you are being cyberstalked:

- Send the person one clear, written warning not to contact you again.
- **If they contact you again after you've told them not to, do not respond.**
- Print out copies of evidence such as emails or screenshots of your phone. Keep a record of the stalking and any contact with police.
- Report the stalker to the authority in charge of the site or service where the stalker contacted you. For example, if someone is stalking you through Facebook, report them to Facebook.
- If the stalking continues, get help from the police. You also can contact a domestic violence shelter and the National Center for Victims of Crime Helpline(link is external) for support and suggestions.
- Consider blocking messages from the harasser.
- Change your email address or screen name.
- Never post online profiles or messages with details that someone could use to identify or locate you (such as your age, sex, address, workplace, phone number, school, or places you hang out).

**Sources**

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**Sexual Abuse**

**Sexual Coercion**


**Sexual coercion is unwanted sexual activity that happens when you are pressured, tricked, threatened, or forced in a nonphysical way.** Coercion can make you think you owe sex to someone. It might be from someone who has power over you, like a teacher, landlord, or a boss. No person is ever required to have sex with someone else.

**What is sexual coercion?**

Sexual coercion is unwanted sexual activity that happens after being pressured in nonphysical ways that include:

- Being worn down by someone who repeatedly asks for sex
- **Being lied to or being promised things that weren't true to trick you into having sex**
- Having someone threaten to end a relationship or spread rumors about you if you don't have sex with them

- Having an authority figure, like a boss, property manager, loan officer, or professor, use their influence or authority to pressure you into having sex

In a healthy relationship, you never have to have sexual contact when you don't want to**.** Sexual contact without your consent is assault. Sexual coercion means feeling forced to have sexual contact with someone.

**Who commits sexual coercion?**

Anyone, **including friends, co-workers, bosses, landlords, dates, partners, family members, and strangers, can use coercion.** Sexual coercion is most likely to happen with someone you already have some type of relationship with. Sexual activity should always happen with your consent. If you are being pressured or coerced into sexual activity, that may be a type of sexual assault and it may be against the law.

**What are some examples of sexual coercion?**

Sexual coercion can be any type of nonphysical pressure used to make you participate in sexual activity that you do not agree to. See the chart below for ways someone might use sexual coercion:

**Examples of sexual coercion**

| Ways someone might use sexual coercion | What he or she may say |
|---|---|
| Wearing you down by asking for sex again and again or making you feel bad, guilty, or obligated | **"If you really loved me, you'd do it."**<br>**"Come on; it's my birthday."**<br>"You don't know what you do to me." |

| | |
|---|---|
| Making you feel like it's too late to say no | "But you've already gotten me all worked up."<br>"You can't just make someone stop." |
| Telling you that not having sex will hurt your relationship | "**Everything's perfect. Why do you have to ruin it?"**<br>**"I'll break up with you if you don't have sex with me."** |
| Lying or threatening to spread rumors about you | "Everyone thinks we already have, so you might as well."<br>"I'll just tell everyone you did it anyway." |
| Making promises to reward you for sex | "I'll make it worth your while."<br>"You know I have a lot of connections." |
| Threatening your children or other family members | "I'll do this to your child if you don't do it with me." |
| Threatening your job, home, or school career | "I really respect your work here. I'd hate for something to change that."<br>"I haven't decided yet who's getting bonuses this year."<br>"Don't worry about the rent. There are other things you can do."<br>"You work so hard; it'd be a shame for you not to get an A." |

| | |
|---|---|
| Threatening to reveal your sexual orientation publicly or to family or friends | “If you don’t do this, I will tell everyone you’re gay.” |

**How can I respond in the moment to sexual coercion?**

Sexual coercion is not your fault. If you are feeling pressured to do something you don’t want to do, speak up or leave the situation. It is better to risk a relationship ending or hurting someone’s feelings than to do something you aren’t willing to do.


If the person trying to coerce you is in a position of power over you (such as a boss, landlord, or teacher), it’s best to leave the situation as quickly and safely as possible. It might be difficult, but if you can report the person to someone in authority, you are taking steps to stop it from happening again. Some possible verbal responses include:

- **“If you really care for me, you’ll respect that I don’t want to have sex.”**
- **“I don’t owe you an explanation or anything at all.”**
- **“You must be mistaken. I don’t want to have sex with you.”**

Be clear and direct with the person trying to coerce you. Tell the person how you feel and what you do not want to do. If the person is not listening to you, leave the situation. If you or your family is in physical danger, try to get away from the person as quickly as possible.

**Financial Abuse**

*Retrieved from the office of Women's Health at this link:* https://www.womenshealth.gov/relationships-and-safety/other-types/financial-abuse

**Financial abuse happens when an abuser takes control of finances to prevent the other person from leaving and to maintain power in a relationship.** An abuser may take control of all the money, withhold it, and conceal financial information from the victim. Financial abuse happens often in physically abusive relationships. Financial abuse can also happen in elder abuse when a relative, friend, or caregiver steals money from an older person.

**What is financial abuse?**

Financial abuse happens when an abuser has control over finances in a relationship and withholds money from the victim. Often, a woman does not leave an abusive relationship because she fears she will not be able to provide for herself or her children. Financial abuse can make the victim feel as if she can't leave. This fear is often the main reason women don't leave an abusive relationship.

Financial abuse of older adults is also common. Read more about elder abuse.

**How can I tell if I am being financially abused?**

Often, financial abuse is subtle and gradual, so it may be hard to recognize. **Your partner may act as though taking over the finances is a way to make life easier for you, as if he or she is doing you a favor.** Your partner might explain that giving you a set amount of money will help keep your family on track financially. But slowly, the "allowance"

becomes smaller and smaller, and before you know it, you are asking for money and being refused.


Some of the common ways that financial abuse happens includes:

- Urging you to or demanding that you quit your job or preventing you from working
- Stalking or harassing you at work
- Refusing to give you access to bank accounts and hiding or keeping assets from you
- Giving you a set amount of money to spend and no more
- Constantly questioning purchases you make and demanding to see receipts
- Making financial decisions without consulting you
- Stealing your identity or filing fraudulent tax returns with your name attached to them
- Selling property that was yours
- Filing false insurance claims with your name on them
- Not paying child support so you can't afford rent, food, and other needed items
- Forcing you to open lines of credit

**What steps can I take to protect myself from financial abuse?**

If the abuser has access to your credit cards, bank accounts, or Social Security number, they may try to open accounts in your name or deliberately try to ruin your credit in order to make it harder for you to leave the relationship. But you can take steps to protect yourself and your money, whether you stay in the relationship or leave.

- **Keep your personal information safe.**
  - Call your credit card company and bank and ask them to change your PIN or access codes. Change your passwords on your personal computer or phone, including passwords you use to log into your bank or credit card accounts. Do not give the passwords to anyone else.


- **Don't co-sign a loan or another financial contract with an abuser.**
  - If the abusive partner doesn't make payments on time or at all, you may be held responsible for the debt.
- **Know the laws in your state before getting married.**
  - Laws are different in different states about how debt, money, and other assets are handled, legally, between married partners. In some states, any money earned, or debts incurred, during marriage belong to both spouses. If you're worried about a partner taking your money or hurting your credit, do not get married. Marriage is a legally binding contract between two people. If you're worried about keeping financial independence after marriage, talk to a lawyer before getting married.
- **Get a free credit report.**
  - A credit report can tell you if any accounts were opened using your name and Social Security number. Federal law says that you can get a free copy of your credit report every 12 months. Using your Social Security number, you can get your free credit report through the website annualcreditreport.com(link is external) or by calling **1-877-322-8228**.
- **Protect your credit.**
  - If your credit report shows activity that you don't recognize, you can report it to one of three credit bureaus (Equifax, Experian, or TransUnion). The credit bureau will start an investigation. You can ask the credit bureaus to

freeze your credit so that no one can open new accounts or loans in your name. You can also request the credit bureau to issue a “fraud alert” in your name. A fraud alert makes it harder for someone to open an account in your name.

- **Save your money.**
  - If you can do so safely, begin to save any money you can and put it in a place the abuser cannot get to. You might hide cash or items you can later sell, or you might open a bank account the abuser doesn’t know about. If you open a new account, be aware that mail associated with the account might come to your address.
- **Plan for a future job.**
  - You may worry that you don’t have enough education or job experience to get a good job without a partner. Child care or transportation might be a concern. Local domestic violence shelters can connect you to local resources to help with child care, transportation, health care, and job training. Many shelters can help you find work while you get new housing, food assistance, and other support in place.
- **Know your job rights.**
  - If you have a job, know that many states have laws that protect your right to take time off to go to court for violence and abuse issues. Many states also have laws to protect you against discrimination on the job if you have experienced domestic violence or sexual assault. The Women’s Legal Defense and Education Fund has a list of state laws(link is external) that may help you.

**What do I need to know about money when I’m ready to leave?**

When you are getting ready to leave an abusive relationship, money issues may seem overwhelming**.** But you can take steps to care for yourself and your children. **Gather important documents for you and your children, such as birth certificates and**

**Social Security cards**. **You might also try to get copies of health insurance cards and bank statements**. These will increase your independence, and they will help with your case if you have divorce or child custody hearings.

**In case the abuser has opened credit cards in your name or other types of illegal financial activity, you should get a copy of your credit report.**

You may not have time to gather much information before you go. That's OK. Collect what you can. The highest priority is getting out of the abusive relationship as safely as possible.

Learn more and see a safety packing list to help you prepare to leave an abusive relationship.

**How can I financially recover from financial abuse?**

Make a plan to leave the abuser. Once you are away from that person, you can take steps to repair your credit and become financially independent.

- **Protect your credit.**
  - **By freezing your credit accounts or having a credit bureau issue a fraud alert, you can make it harder for someone to open accounts in your name.**
- **Talk to a financial expert.**
  - You can get free financial education and advice about dealing with debt, a mortgage, or credit issues from the nonprofit National Foundation for Credit Counseling(link is external). An expert can help you make a step-by-step plan to repair your credit and rebuild your finances.

- **Use available resources.**
  - Most states have assistance programs to help survivors of domestic violence. Find the resources offered in your state at the National Coalition Against Domestic Violence(link is external).

- **Know your job rights.**
  - Many states have laws that protect your right to take time off from a job to go to court for violence and abuse issues. Many states also have laws to protect you against discrimination on the job if you have experienced domestic violence or sexual assault. The Women's Legal Defense and Education Fund has a list of state laws(link is external) that may help you. (OWH, 2020)

## B. Characteristics of an Abusive Relationship

**Am I being abused?**

**In a close relationship, it can be difficult to know whether you are being abused**, especially if your partner says they love you, gives you a lot of attention, or pays for the groceries or rent. People who are abusive sometimes act loving and supportive as a way to keep you in the relationship. **A partner's loving behavior does not make their abusive behavior OK**. Forced sex and cruel or threatening words are forms of abuse. Learn more about how to recognize abuse.

There are many types of violence and abuse. Some of these signs are signs of physical abuse or domestic violence. Some are signs of emotional and verbal abuse or sexual abuse.

Signs of abuse include:

- **Keeping track of everything you do**

  - Monitoring what you're doing all the time or asking where you are and who you're with every second of the day
  - Demanding your passwords to social media sites and email accounts
  - Demanding that you reply right away to texts, emails, or calls
  - Preventing or discouraging you from seeing friends or family
  - Preventing or discouraging you from going to work or school

- **Being jealous, controlling, or angry**

  - Acting very jealous, including constantly accusing you of cheating
  - Having a quick temper, so you never know what you will do or say that may cause a problem
  - Controlling how you spend your money
  - Controlling your use of medicines or birth control
  - Making everyday decisions for you that you normally decide for yourself (like what to wear or eat)

- **Demeaning you**

  - Putting you down, such as insulting your appearance, intelligence, or activities
  - Humiliating you in front of others
  - Destroying your property or things that you care about
  - Blaming you for his or her violent outbursts

- **Physically hurting or threatening to hurt you or loved ones**

- Threatening to hurt you, the children, or other people or pets in your household
- Hurting you physically (such as hitting, beating, pushing, shoving, punching, slapping, kicking, or biting)
- Using (or threatening to use) a weapon against you
- Threatening to harm himself or herself when upset with you
- Threatening to turn you in to authorities for illegal activity if you report physical abuse

- **Forcing you to have sex or other intimate activity**

  - Forcing you to have sex when you don't want to through physical force or threats
  - Assuming that consent for a sex act in the past means that you must participate in the same acts in the future
  - Assuming that consent for one activity means consent for future activity or increased levels of intimacy (for example, assuming that kissing should lead to sex every time)

**Signs of an unhealthy relationship**

Sometimes a romantic relationship may not be abusive but may have serious problems that make it unhealthy. If you think you might be in an unhealthy relationship, try talking with your partner about your concerns. If that seems difficult, you might also talk to a trusted friend, family member, counselor, or religious leader.

You might be in an unhealthy relationship if you:

- Focus all your energy on your partner
- Drop friends, family, or activities you enjoy

- Feel pressured or controlled by this person
- Have more bad times than good in the relationship
- Often feel sad or scared when with this person
- Know that this person does not support you and what you want to do in life
- Do not feel comfortable being yourself or making your own decisions
- Cannot speak honestly to work out conflicts in the relationship
- Cannot talk about your needs or changes in your life that are important

**What are signs of domestic violence or abuse in same-sex relationships?**

If you are in a same-sex relationship, many signs of domestic violence are the same as other people in an abusive relationship. Your partner may hit you, try to control you, or force you to have sex. But you may also experience additional signs of abuse, including:

- **Threatening to "out you" to your family, friends, employer, or community**
- Telling you that you have to be legally married to be considered a victim of domestic violence and to get help
- Saying women aren't or can't be violent
- Telling you the authorities won't help a lesbian, bisexual, transgender, or other nonconforming person
- Forcing you to "prove" your sexuality by performing sex acts that you do not consent to

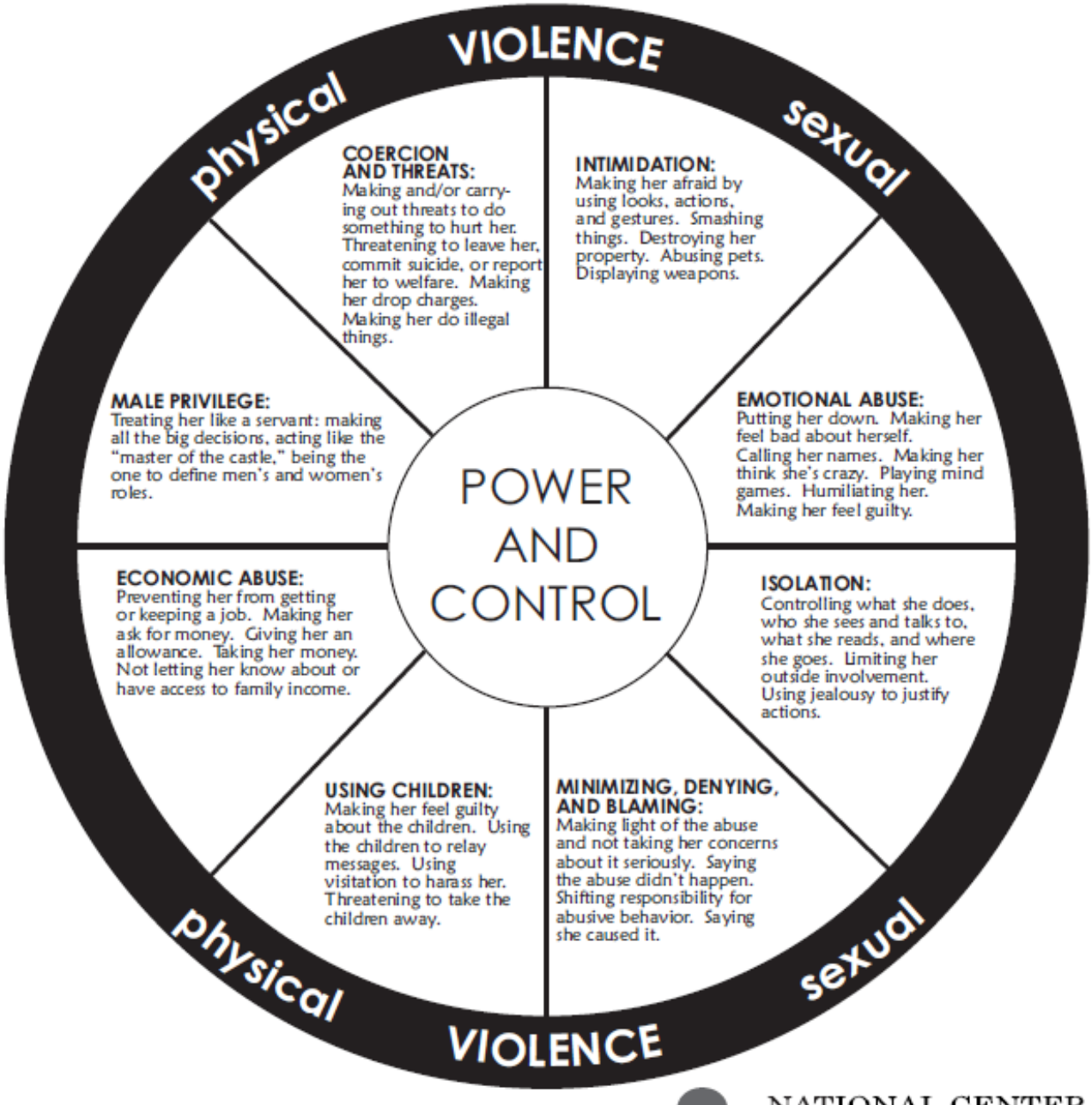
Regardless of your gender identity or sexual orientation, no one has the right to physically hurt you or threaten your safety.
(OWH, 2020)

As seen on the next page, The Power and Control Wheel, developed by the Domestic Abuse Intervention Project in Duluth, MN., helps explain the way the batterer/Abuser maintains control over their victim.

# POWER AND CONTROL WHEEL

Physical and sexual assaults, or threats to commit them, are the most apparent forms of domestic violence and are usually the actions that allow others to become aware of the problem. However, regular use of other abusive behaviors by the batterer, when reinforced by one or more acts of physical violence, make up a larger system of abuse. Although physical assaults may occur only once or occasionally, they instill threat of future violent attacks and allow the abuser to take control of the woman's life and circumstances.

The Power & Control diagram is a particularly helpful tool in understanding the overall pattern of abusive and violent behaviors, which are used by a batterer to establish and maintain control over his partner. Very often, one or more violent incidents are accompanied by an array of these other types of abuse. They are less easily identified, yet firmly establish a pattern of intimidation and control in the relationship.

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### C. Effects on Partners

PV is a significant public health issue that has many individual and societal costs. About 41% of female IPV survivors and 14% of male IPV survivors experience some form of physical injury related to IPV. IPV can also extend beyond physical injury and result in death. Data from U.S. crime reports suggest that 16% (about 1 in 6) of homicide victims are killed by an intimate partner. The reports also found that nearly half of female homicide victims in the U.S. are killed by a current or former male intimate partner.

There are also many other negative health outcomes associated with IPV. These include a range of conditions affecting the heart, digestive, reproductive, muscle and bones, and nervous systems, many of which are chronic in nature. Survivors can experience mental health problems such as **depression** and **posttraumatic stress disorder (PTSD)**. They are at higher risk for engaging in health risk behaviors such as **smoking, binge drinking, and sexual risk behaviors.**

Although the personal consequences of IPV are devastating, there are also many costs to society. The lifetime economic cost associated with medical services for IPV-related injuries, lost productivity from paid work, criminal justice and other costs, was $3.6 trillion. The cost of IPV over a victim's lifetime was $103,767 for women and $23,414 for men. (CDC, 2020)

**Effects of violence against women**

This section sourced from (OWH, 2020), at this link:

https://www.womenshealth.gov/relationships-and-safety/effects-violence-against-women

Violence against women can cause long-term physical and mental health problems**. Violence and abuse affect not just the women involved but also their children, families, and communities. These effects include harm to an individual's**

**health, possibly long-term harm to children, and harm to communities such as lost work and homelessness.**

**What are the short-term physical effects of violence against women?**

The short-term physical effects of violence can include minor injuries or serious conditions. They can include bruises, cuts, broken bones, or injuries to organs and other parts inside of your body. Some physical injuries are difficult or impossible to see without scans, x-rays, or other tests done by a doctor or nurse.

Short-term physical effects of sexual violence can include:

- Vaginal bleeding or pelvic pain
- **Unwanted pregnancy**
- Sexually transmitted infections (STIs), including HIV
- Trouble sleeping or nightmares

If you are pregnant, a physical injury can hurt you and the unborn child. This is also true in some cases of sexual assault.

If you are sexually assaulted by the person you live with, and you have children in the home, think about your children's safety also. Violence in the home often includes child abuse. Many children who witness violence in the home are also victims of physical abuse. Learn more about the effects of domestic violence on children.

If you are injured in a physical or sexual assault, call 911.

**What are the long-term physical effects of violence against women?**

Violence against women, including sexual or physical violence, is linked to many long-term health problems. These can include:

- Arthritis
- Asthma
- Chronic pain
- Digestive problems such as stomach ulcers
- Heart problems
- Irritable bowel syndrome
- Nightmares and problems sleeping
- Migraine headaches
- Sexual problems such as pain during sex
- Stress
- Problems with the immune system

Many women also have mental health problems after violence. To cope with the effects of the violence, some women start misusing alcohol or drugs or engage in risky behaviors, such as having unprotected sex. Sexual violence can also affect someone's perception of their own bodies, leading to unhealthy eating patterns or eating disorders. If you are experiencing these problems, know that you are not alone. There are resources that can help you cope with these challenges.

**How is traumatic brain injury related to domestic violence?**

A serious risk of physical abuse is concussion and traumatic brain injury (TBI) from being hit on the head or falling and hitting your head. TBI can cause:[4]

- **Headache or a feeling of pressure**
- **Loss of consciousness**
- Confusion
- Dizziness
- Nausea and vomiting
- Slurred speech
- Memory loss
- Trouble concentrating
- Sleep loss

**Some symptoms of TBI may take a few days to show up**. Over a longer time, TBI can cause depression and anxiety. TBI can also cause problems with your thoughts, including the ability to make a plan and carry it out. This can make it more difficult for a woman in an abusive relationship to leave. Even if you think you are OK after hitting your head, talk to you doctor or nurse if you have any of these symptoms. Treatment for TBI can help.

**What are the mental health effects of violence against women?**

If you have experienced a physical or sexual assault, you may feel many emotions — fear, confusion, anger, or even being numb and not feeling much of anything. You may feel guilt or shame over being assaulted. Some people try to minimize the abuse or hide it by covering bruises and making excuses for the abuser.

If you've been physically or sexually assaulted or abused, know that it is not your fault. Getting help for assault or abuse can help prevent long-term mental health effects and other health problems.

**Long-term mental health effects of violence against women can include:**

- **Post-traumatic stress disorder (PTSD).** This can be a result of experiencing trauma or having a shocking or scary experience, such as sexual assault or physical abuse. You may be easily startled, feel tense or on edge, have difficulty sleeping, or have angry outbursts. You may also have trouble remembering things or have negative thoughts about yourself or others. If you think you have PTSD, talk to a mental health professional.
- **Depression. Depression is a serious illness, but you can get help to feel better. If you are feeling depressed, talk to a mental health professional.**
- **Anxiety.** This can be general anxiety about everything, or it can be a sudden attack of intense fear. Anxiety can get worse over time and interfere with your daily life. If you are experiencing anxiety, you can get help from a mental health professional.

Other effects can include shutting people out, not wanting to do things you once enjoyed, not being able to trust others, and having low-esteem.

Many women who have experienced violence cope with this trauma by using drugs, drinking alcohol, smoking, or overeating. Research shows that about 90% of women with substance use problems had experienced physical or sexual violence.

Substance use may make you feel better in the moment, but it ends up making you feel worse in the long-term. Drugs, alcohol, tobacco, or overeating will not help you forget or

overcome the experience. Get help if you're thinking about or have been using alcohol or drugs to cope.

Victims of sexual assault can also talk for free with someone who is trained to help through the National Sexual Assault Hotline over the phone at 800-656-HOPE (4673) or online(link is external).

**What are some other effects of violence against women?**

Violence against women has physical and mental health effects, but it can also affect the lives of women who are abused in other ways:

- **Work.**
  - Experiencing a trauma like sexual violence may interfere with someone's ability to work. Half of women who experienced sexual assault had to quit or were forced to leave their jobs in the first year after the assault. Total lifetime income loss for these women is nearly $250,000 each.
- **Home.**
  - Many women are forced to leave their homes to find safety because of violence. Research shows that half of all homeless women and children became homeless while trying to escape intimate partner violence.
- **School.**
  - Women in college who are sexually assaulted may be afraid to report the assault and continue their education. But Title IX laws require schools to provide extra support for sexual assault victims in college. Schools can help enforce no-contact orders with an abuser and provide mental health counseling and school tutoring.

- **Children**.
    - Women with children may stay with an abusive partner because they fear losing custody or contact with their children.

Sometimes, violence against women ends in death. More than half of women who are murdered each year are killed by an intimate partner. One in 10 of these women experienced violence in the month before their death. If you have experienced abuse, contact a hotline(link is external) at **800-799-SAFE (800-799-7233)**, or learn more ways to get help. (OWH, 2020)

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## D. Effects of domestic violence on Children (OWH, 2020)

This section is sourced from: https://www.womenshealth.gov/relationships-and-safety/domestic-violence/effects-domestic-violence-children

Many children exposed to violence in the home are also victims of physical abuse. Children who witness domestic violence or are victims of abuse themselves are at serious risk for long-term physical and mental health problems. Children who witness violence between parents may also be at greater risk of being violent in their future relationships. **If you are a parent who is experiencing abuse, it can be difficult to know how to protect your child.**

**What are the short-term effects of domestic violence or abuse on children?**

Children in homes where one parent is abused may feel fearful and anxious. They may always be on guard, wondering when the next violent event will happen. This can cause them to react in different ways, depending on their age:

- **Children in preschool.**
  - Young children who witness intimate partner violence may start doing things they used to do when they were younger, such as bed-wetting, thumb-sucking, increased crying, and whining. They may also develop difficulty falling or staying asleep; show signs of terror, such as stuttering or hiding; and show signs of severe separation anxiety.
- **School-aged children.**
  - Children in this age range may feel guilty about the abuse and blame themselves for it. Domestic violence and abuse hurts children's self-esteem. They may not participate in school activities or get good grades, have fewer friends than others, and get into trouble more often. They also may have a lot of headaches and stomachaches.
- **Teens.**
  - Teens who witness abuse may act out in negative ways, such as fighting with family members or skipping school. They may also engage in risky behaviors, such as having unprotected sex and using alcohol or drugs. They may have low self-esteem and have trouble making friends. They may start fights or bully others and are more likely to get in trouble with the law. This type of behavior is more common in teen boys who are abused in childhood than in teen girls. Girls are more likely than boys to be withdrawn and to experience depression.

**What are the long-term effects of domestic violence or abuse on children?**

More than 15 million children in the United States live in homes in which domestic violence has happened at least once. These children are at greater risk for repeating the cycle as adults by entering into abusive relationships or becoming abusers themselves. For example, a boy who sees his mother being abused is 10 times more likely to abuse his female partner as an adult. A girl who grows up in a home where her father abuses her mother is more than six times as likely to be sexually abused as a girl who grows up in a non-abusive home.

**Children who witness or are victims of emotional, physical, or sexual abuse are at higher risk for health problems as adults. These can include mental health conditions, such as depression and anxiety. They may also include diabetes, obesity, heart disease, poor self-esteem, and other problems.**

**Can children recover from witnessing or experiencing domestic violence or abuse?**

Each child responds differently to abuse and trauma. Some children are more resilient, and some are more sensitive. **How successful a child is at recovering from abuse or trauma depends on several things, including having:**

- **A good support system or good relationships with trusted adults**
- **High self-esteem**
- **Healthy friendships**

Although children will probably never forget what they saw or experienced during the abuse, they can learn healthy ways to deal with their emotions and memories as they

mature. The sooner a child gets help, the better his or her chances for becoming a mentally and physically healthy adult.

**How can I help my children recover after witnessing or experiencing domestic violence?**

You can help your children by:

- **Helping them feel safe.**
  - **Children who witness or experience domestic violence need to feel safe. Consider whether leaving the abusive relationship might help your child feel safer. Talk to your child about the importance of healthy relationships.**
- **Talking to them about their fears.**
  - **Let them know that it's not their fault or your fault. Learn more about how to listen and talk to your child about domestic violence(link is external) (PDF, 229 KB).**
- **Talking to them about healthy relationships.**
  - Help them learn from the abusive experience by talking about what healthy relationships are and are not. This will help them know what is healthy when they start romantic relationships of their own.
- **Talking to them about boundaries.**
  - Let your child know that no one has the right to touch them or make them feel uncomfortable, including family members, teachers, coaches, or other authority figures. Also, explain to your child that he or she doesn't have the right to touch another person's body, and if someone tells them to stop, they should do so right away.
- **Helping them find a reliable support system.**
  - In addition to a parent, this can be a school counselor, a therapist, or another trusted adult who can provide ongoing support. Know that school

counselors are required to report domestic violence or abuse if they suspect it.

- **Getting them professional help.**
  - Cognitive behavioral therapy (CBT) is a type of talk therapy or counseling that may work best for children who have experienced violence or abuse. CBT is especially helpful for children who have anxiety or other mental health problems as a result of the trauma. During CBT, a therapist will work with your child to turn negative thoughts into more positive ones. The therapist can also help your child learn healthy ways to cope with stress.

Your doctor can recommend a mental health professional who works with children who have been exposed to violence or abuse. Many shelters and domestic violence organizations also have support groups for kids. These groups can help children by letting them know they are not alone and helping them process their experiences in a nonjudgmental place.

**Is it better to stay in an abusive relationship rather than raise my children as a single parent?**

Children do best in a safe, stable, loving environment, whether that's with one parent or two. You may think that your kids won't be negatively affected by the abuse if they never see it happen. But children can also hear abuse, such as screaming and the sounds of hitting. They can also sense tension and fear. Even if your kids don't see you being abused, they can be negatively affected by the violence they know is happening.

If you decide to leave an abusive relationship, you may be helping your children feel safer and making them less likely to tolerate abuse as they

get older. If you decide not to leave, you can still take steps to protect your children and yourself

**How can I make myself and my children safe right now if I'm not ready to leave an abuser?**

Your safety and the safety of your children are the biggest priorities. If you are not yet ready or willing to leave an abusive relationship, you can take steps to help yourself and your children now, including:

- Making a safety plan for you and your child
- Listening and talking to your child and letting them know that abuse is not OK and is not their fault
- Reaching out to a domestic violence support person who can help you learn your options

If you are thinking about leaving an abusive relationship, you may want to keep quiet about it in front of your children. Young children may not be able to keep a secret from an adult in their life. Children may say something about your plan to leave without realizing it. If it would be unsafe for an abusive partner to know ahead of time you're planning to leave, talk only to trusted adults about your plan. It's better for you and your children to be physically safe than for your children to know ahead of time that you will be leaving.

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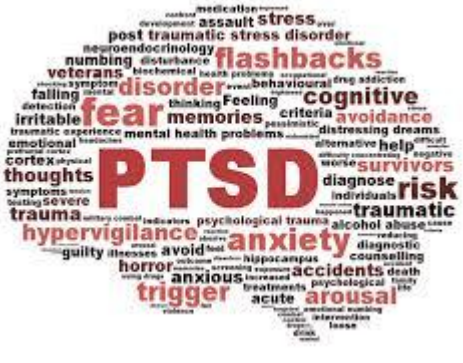
## E. Mental Health Effects

Long-term mental health effects of violence against women can include:

- **Post-traumatic stress disorder (PTSD).**
  - This can be a result of experiencing trauma or having a shocking or scary experience, such as sexual assault or physical abuse.[6] You may be easily startled, feel tense or on edge, have difficulty sleeping, or have angry outbursts. You may also have trouble remembering things or have negative thoughts about yourself or others. If you think you have PTSD, talk to a mental health professional.
- **Depression.**
  - Depression is a serious illness, but you can get help to feel better. If you are feeling depressed, talk to a mental health professional.




- **Anxiety.**
  - This can be general anxiety about everything, or it can be a sudden attack of intense fear. Anxiety can get worse over time and interfere with your daily

life. If you are experiencing anxiety, you can get help from a mental health professional. (OWH, 2020)

In this section we will further study these three mental health effects.

**Post-Traumatic Stress Disorder (PTSD)**

Sourced at:https://www.womenshealth.gov/mental-health/mental-health-conditions/post-traumatic-stress-disorder

After a dangerous or scary event, it is normal to feel upset, afraid, and anxious. For most people, these feelings fade within a few weeks. But some people continue to have these feelings for months or years afterward. They may keep reliving the event and avoid items and places that might remind them of what happened. This is called post-traumatic stress disorder (PTSD). Women are about twice as likely as men to develop PTSD in their lifetimes.

**What is post-traumatic stress disorder (PTSD)?**

PTSD happens when people who have experienced or witnessed a traumatic event continue to experience symptoms for more than a month which makes it difficult to live their lives normally. **Traumatic events can include physical or sexual assault, war, natural disasters, car accidents, or any event experienced as deeply scary and upsetting.** Although PTSD is often associated with military service members, PTSD may develop after any type of traumatic event.


People with PTSD may continue to experience the traumatic event through flashbacks, nightmares, or memories they cannot control. These thoughts can create serious emotional pain for the person and problems at home, work, or school or with relationships. Most often, the traumatic event happened to the person with PTSD, but sometimes PTSD can happen to a person who witnesses someone else experiencing a trauma. People who develop PTSD usually experience symptoms soon after the traumatic event, but sometimes symptoms don't appear for months or years afterward.[2]

**What are the symptoms of PTSD?**

PTSD causes the following symptoms:

- You relive the event, sometimes through nightmares or flashbacks. You may feel physical effects, such as a racing heart or sweating.
- **You avoid situations that remind you of the event**. For example, if you were in a car crash, you might avoid being in a car or at the location of the crash.

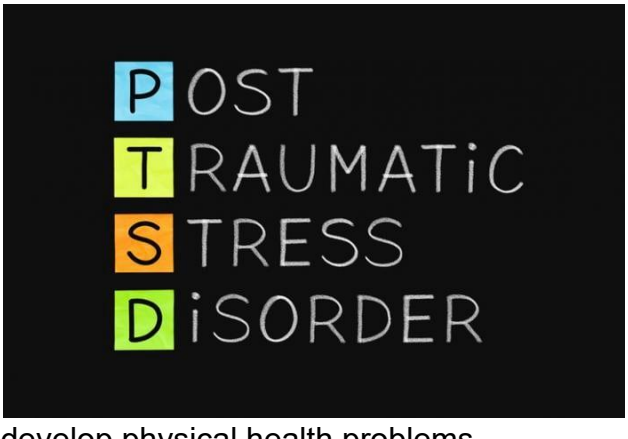
- You have negative thoughts and feelings that make it hard to live your life. You may have trouble remembering; feel anger, guilt, or shame; or have more negative thoughts about yourself. You might feel empty or numb. It might be hard to show interest or happiness in activities you used to enjoy.
- You feel jittery, nervous, or tense. This may make it hard to sleep or concentrate on everyday activities like work, school, or reading.

If you've experienced some or all of these symptoms for at least 1 month and they are making it hard to live your life normally, talk to a doctor, nurse, or mental health professional.

How are the symptoms of PTSD different for women than for men?

Women may experience PTSD differently from men. Women with PTSD may be more likely than men with PTSD to:

- Be easily startled
- Have more trouble feeling emotions or feel numb
- Avoid things that remind them of the trauma
- Feel depressed and anxious




Women usually have PTSD symptoms longer than men (on average, 4 years versus 1 year) before diagnosis and treatment. Women with PTSD are less likely than men to have problems with alcohol or drugs after the trauma. Both women and men who have PTSD may also develop physical health problems.

**What causes PTSD?**

Any dangerous or life-threatening event, trauma, or intensely scary situation can increase the risk of PTSD. These situations include:

- Violent crimes: being a victim of or seeing violent crimes, such as a mugging, shooting, physical abuse, or rape
- Loved ones in danger: hearing of someone you are very close to, such as a child or spouse, experiencing a trauma
- Sudden death or illness: the accidental or violent death or serious illness of a loved one
- War: being exposed to war or combat, either through military service or as a civilian
- Accidents: car accidents, plane or train crashes, or other types of serious accidents
- Natural disasters: hurricanes, tornadoes, earthquakes, floods, or fires

Many other types of trauma can increase the risk for PTSD, but being in an accident or being physically or sexually assaulted are the most common events that lead to PTSD. Women with PTSD are more likely than men with PTSD to have been physically or sexually attacked.

Not everyone who lives through a dangerous event develops PTSD. But anyone can develop PTSD at any age.

**How long after a traumatic event does PTSD usually start?**

PTSD starts at different times for different people. Symptoms of PTSD may start immediately after a traumatic event and then continue. But people may develop new or more severe PTSD symptoms months or even years later.

**Who is at risk of PTSD?**

Anyone who has been through an experience that was intensely scary, dangerous, or life threatening is at risk of PTSD. Experiencing this type of trauma is common: At least 4 in 5 people experience some type of trauma in their lifetimes. The majority of people who experience a trauma do not develop PTSD. The more serious the trauma was or the more directly it affected you, the higher your risk of developing PTSD afterward.

Military veterans as a group are at very high risk of PTSD. About 14% of veterans of the more recent conflicts in Iraq and Afghanistan developed PTSD after returning home.

Women are about twice as likely as men to develop PTSD. Women who have gone through trauma, including women in the military, are more likely than men who've experienced trauma to develop PTSD. Among women who are raped, about half develop PTSD.


**Are some women more likely to develop PTSD?**

Yes, although most women who go through trauma won't get PTSD. But you may be more likely to develop PTSD if you:

- Were directly exposed to the trauma as a victim or a witness. As many as half of women who are raped develop PTSD.
- Were seriously hurt during the traumatic event
- Went through a trauma that lasted a long time or was very severe
- Have another mental health condition like depression or anxiety
- Drink a lot of alcohol
- Don't have a good support network
- Experienced trauma during childhood

**How many women have PTSD?**

**About 1 woman in 10 will develop PTSD at some point in her lifetime**. Women are about twice as likely as men to develop PTSD.

**How is PTSD diagnosed?**

A mental health professional can diagnose PTSD. To be diagnosed with PTSD, an adult must have symptoms for at least 1 month, and the symptoms must be severe enough to affect that person's ability to function at work and at home.

Having some symptoms of PTSD does not always mean you have PTSD. You could have another mental health condition, or you could be having a natural response in the weeks following the traumatic event. If you think you might have PTSD, the following questions can help you find out whether you should see a mental health professional for PTSD. If you answer "yes" to any three of these questions, talk to your doctor or nurse.

In your life, have you ever had any experience that was so frightening, horrible, or upsetting that, in the past month, you:

- Have had nightmares about it or couldn't stop yourself from thinking about it, even when you did not want to?
- Went out of your way to avoid situations or people that reminded you of it?
- Were constantly on guard, anxious, or easily startled?
- Felt numb or detached from others, activities, or your surroundings?

**How is PTSD treated?**


A doctor, nurse, or mental health professional who has experience in treating people with PTSD can help you. Treatment may include therapy or counseling, medicine, or both.

- **Cognitive processing therapy (CPT) is a type of talk therapy that was developed specifically to treat PTSD. CPT helps you pay attention to and change your upsetting thoughts.**
- Prolonged exposure therapy is another type of talk therapy. A therapist will help you talk about and slowly remember the traumatic event repeatedly over time. Over time, the therapist will guide you through the difficult feelings and memories. By confronting the trauma, you may become less sensitive to the memories and related situations.
- Eye movement desensitization and reprocessing (EMDR) therapy is another type of therapy used to treat PTSD. During EMDR, you will be asked to remember and talk about the trauma while also focusing on a specific visual item, like the therapist's hand, or listening to a specific sound, like beeps.
- Medicines to treat PTSD symptoms may include antidepressants and anti-anxiety medicine.

Treatments can last weeks, months, or longer. Treatment is not the same for everyone. What works for you might not work for someone else with PTSD. Drinking alcohol or using other drugs will not help PTSD go away and may even make it worse.

**What if I have PTSD and another mental health condition, like depression or anxiety?**

Many people with PTSD have other mental health conditions, such as depression, anxiety, or even suicidal thoughts or behaviors. Getting treatment for PTSD and any other mental health conditions will help you get better. Treatment for PTSD works best when you and your doctor know about the effects of other mental health conditions and take steps to treat them at the same time. (OWH, 2002)

More about PTSD from the National Institute of Mental Health.

**Post-Traumatic Stress Disorder**

Sourced from https://www.nimh.nih.gov/health/topics/post-traumatic-stress-disorder-ptsd/index.shtml

**Overview**

Post-traumatic stress disorder (PTSD) is a disorder that develops in some people who have experienced a shocking, scary, or dangerous event.

It is natural to feel afraid during and after a traumatic situation. Fear triggers many split-second changes in the body to help defend against danger or to avoid it. This “fight-or-flight” response is a typical reaction meant to protect a person from harm. Nearly everyone will experience a range of reactions after trauma, yet most people recover from initial symptoms naturally. Those who continue to experience problems may be diagnosed with PTSD. People who have PTSD may feel stressed or frightened, even when they are not in danger.

**Signs and Symptoms**

While most but not all traumatized people experience short term symptoms, the majority do not develop ongoing (chronic) PTSD. Not everyone with PTSD has been through a dangerous event. Some experiences, like the sudden, unexpected death of a loved one, can also cause PTSD. Symptoms usually begin early, within 3 months of the traumatic incident, but sometimes they begin years afterward. Symptoms must last more than a month and be severe enough to interfere with relationships or work to be considered PTSD. The course of the illness varies. Some people recover within 6 months, while others have symptoms that last much longer. In some people, the condition becomes chronic.

A doctor who has experience helping people with mental illnesses, such as a psychiatrist or psychologist, can diagnose PTSD.

To be diagnosed with PTSD, an adult must have all of the following for at least 1 month:

- At least one re-experiencing symptom
- At least one avoidance symptom
- At least two arousal and reactivity symptom
- At least two cognition and mood symptoms

**Re-experiencing symptoms include:**

- Flashbacks—reliving the trauma over and over, including physical symptoms like a racing heart or sweating
- Bad dreams

- Frightening thoughts

Re-experiencing symptoms may cause problems in a person's everyday routine. The symptoms can start from the person's own thoughts and feelings. Words, objects, or situations that are reminders of the event can also trigger re-experiencing symptoms.

**Avoidance symptoms include:**

- Staying away from places, events, or objects that are reminders of the traumatic experience
- Avoiding thoughts or feelings related to the traumatic event

Things that remind a person of the traumatic event can trigger avoidance symptoms. These symptoms may cause a person to change his or her personal routine. For example, after a bad car accident, a person who usually drives may avoid driving or riding in a car.

**Arousal and reactivity symptoms include:**

- Being easily startled
- Feeling tense or "on edge"
- Having difficulty sleeping
- Having angry outbursts

Arousal symptoms are usually constant, instead of being triggered by things that remind one of the traumatic events. These symptoms can make the person feel stressed and angry. They may make it hard to do daily tasks, such as sleeping, eating, or concentrating.

**Cognition and mood symptoms include:**

- Trouble remembering key features of the traumatic even
- Negative thoughts about oneself or the world
- Distorted feelings like guilt or blame
- Loss of interest in enjoyable activities

Cognition and mood symptoms can begin or worsen after the traumatic event, but are not due to injury or substance use. These symptoms can make the person feel alienated or detached from friends or family members.

It is natural to have some of these symptoms for a few weeks after a dangerous event. When the symptoms last more than a month, seriously affect one's ability to function, and are not due to substance use, medical illness, or anything except the event itself, they might be PTSD. Some people with PTSD don't show any symptoms for weeks or months. PTSD is often accompanied by depression, substance abuse, or one or more of the other anxiety disorders.

**Do children react differently than adults?**

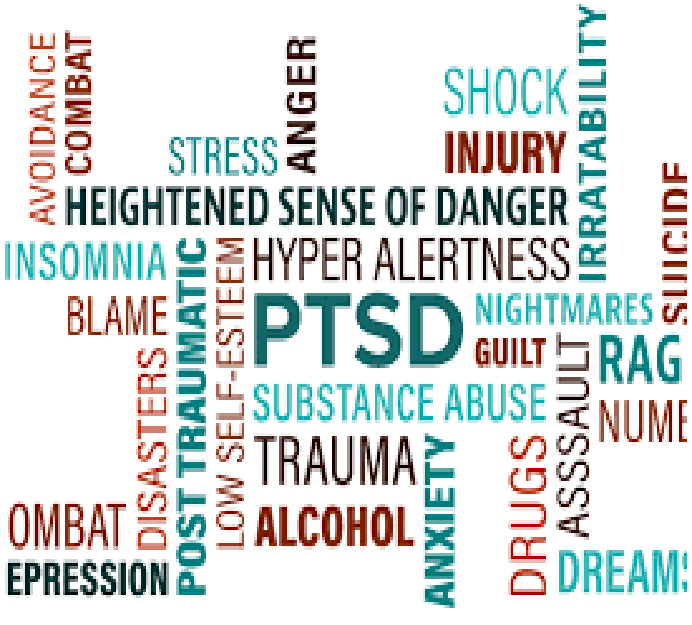
Children and teens can have extreme reactions to trauma, but some of their symptoms may not be the same as adults. Symptoms sometimes seen in very young children (less than 6 years old), these symptoms can include:

- Wetting the bed after having learned to use the toile
- Forgetting how to or being unable to tal
- Acting out the scary event during playtime
- Being unusually clingy with a parent or other adult

Older children and teens are more likely to show symptoms similar to those seen in adults. They may also develop disruptive, disrespectful, or destructive behaviors. Older children and teens may feel guilty for not preventing injury or deaths. They may also have thoughts of revenge.

**Risk Factors**

Anyone can develop PTSD at any age. This includes war veterans, children, and people who have been through a physical or sexual assault, abuse, accident, disaster, or other serious events. According to the National Center for PTSD, about 7 or 8 out of every 100 people will experience PTSD at some point in their lives. Women are more likely to develop PTSD than men, and genes may make some people more likely to develop PTSD than others.




Not everyone with PTSD has been through a dangerous event. Some people develop PTSD after a friend or family member experiences danger or harm. The sudden, unexpected death of a loved one can also lead to PTSD.

**Why do some people develop PTSD and other people do not?**

It is important to remember that not everyone who lives through a dangerous event develops PTSD. In fact, most people will not develop the disorder.

Many factors play a part in whether a person will develop PTSD. Some examples are listed below. *Risk factors* make a person more likely to develop PTSD. Other factors, called *resilience factors*, can help reduce the risk of the disorder.

Some factors that increase risk for PTSD include:

- Living through dangerous events and trauma
- Getting hurt
- Seeing another person hurt, or seeing a dead bod
- Childhood trauma
- Feeling horror, helplessness, or extreme fear
- Having little or no social support after the event
- Dealing with extra stress after the event, such as loss of a loved one, pain and injury, or loss of a job or home
- Having a history of mental illness or substance abuse

Some factors that may promote recovery after trauma include:

- Seeking out support from other people, such as friends and family
- Finding a support group after a traumatic event
- Learning to feel good about one's own actions in the face of danger
- Having a positive coping strategy, or a way of getting through the bad event and learning from it
- Being able to act and respond effectively despite feeling fear

Researchers are studying the importance of these and other risk and resilience factors, including genetics and neurobiology. With more research, someday it may be possible to predict who is likely to develop PTSD and to prevent it.

**Treatments and Therapies**

The main treatments for people with PTSD are medications, psychotherapy ("talk" therapy), or both. Everyone is different, and PTSD affects people differently, so a treatment that works for one person may not work for another. It is important for anyone with PTSD to be treated by a mental health provider who is experienced with PTSD. Some people with PTSD may need to try different treatments to find what works for their symptoms.

If someone with PTSD is going through an ongoing trauma, such as being in an abusive relationship, both of the problems need to be addressed. Other ongoing problems can include panic disorder, depression, substance abuse, and feeling suicidal.

**Depression**

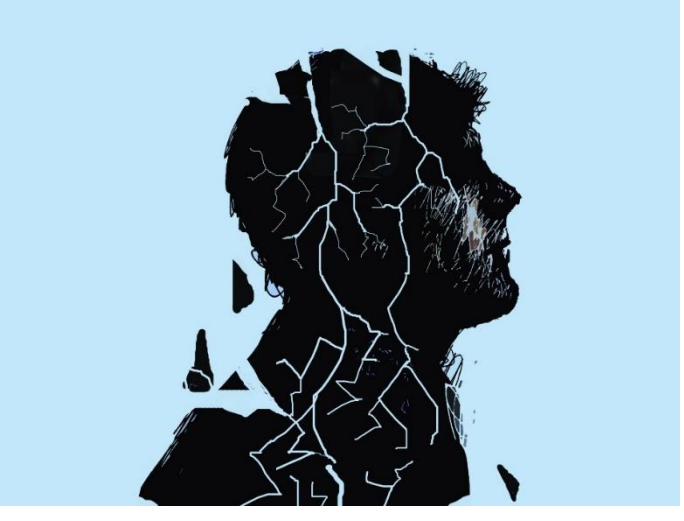
Retrieved form: https://www.womenshealth.gov/mental-health/mental-health-conditions/depression

Life is full of ups and downs, but when you feel sad, empty, or hopeless most of the time for at least 2 weeks or those feelings keep you from your regular activities, you may have depression**.** Depression is a serious mental health condition. In the past year, women were almost twice as likely as men to have symptoms of depression. Depression is not a normal part of being a woman. Most women, even those with the most severe depression, can get better with treatment.

**What is depression?**

Depression is a mental health illness when someone feels sad (including crying often), empty, or hopeless most of the time (or loses interest in or takes no pleasure in daily activities) for at least 2 weeks. Depression affects a person's ability to work, go to school, or have relationships with friends and family. Depression is one of the most common mental health conditions in the United States**.** It is an illness that involves the body, mood, and thoughts. It can affect the way you eat and sleep, the way you feel about yourself, and the way you think about things.

It is different from feeling "blue" or "down" or just sad for a few hours or a couple of days. Depression is also different from grief over losing a loved one or experiencing sadness after a trauma or difficult event. It is not a condition that can be willed or wished away. People who have depression cannot just "pull themselves" out of it.



**Are there different types of depression?**

Yes. Different kinds of depression include:

- **Major depressive disorder. Also called major depression, this is a combination of symptoms that affects a person's ability to sleep, work, study, eat, and enjoy hobbies and everyday activities.**
- **Dysthymic disorder.** Also called dysthymia, this kind of depression lasts for 2 years or more. The symptoms are less severe than those of major depression but can prevent you from living normally or feeling well.

Other types of depression have slightly different symptoms and may start after a certain event. These types of depression include:

- **Psychotic depression,** when a severe depressive illness happens with some form of psychosis, such as a break with reality, hallucinations, and delusions
- **Postpartum depression,** which is diagnosed if a new mother has a major depressive episode after delivery. Depression can also begin during pregnancy, called prenatal depression.
- **Seasonal affective disorder (SAD),** which is a depression during the winter months, when there is less natural sunlight
- **Bipolar depression,** which is the depressive phase of bipolar illness and requires different treatment than major depression

**Who gets depression?**

Women are twice as likely as men to be diagnosed with depression. It is more than twice as common for African-American, Hispanic, and white women to have depression compared to Asian-American women. Depression is also more common in women whose families live below the federal poverty line.

**What causes depression?**

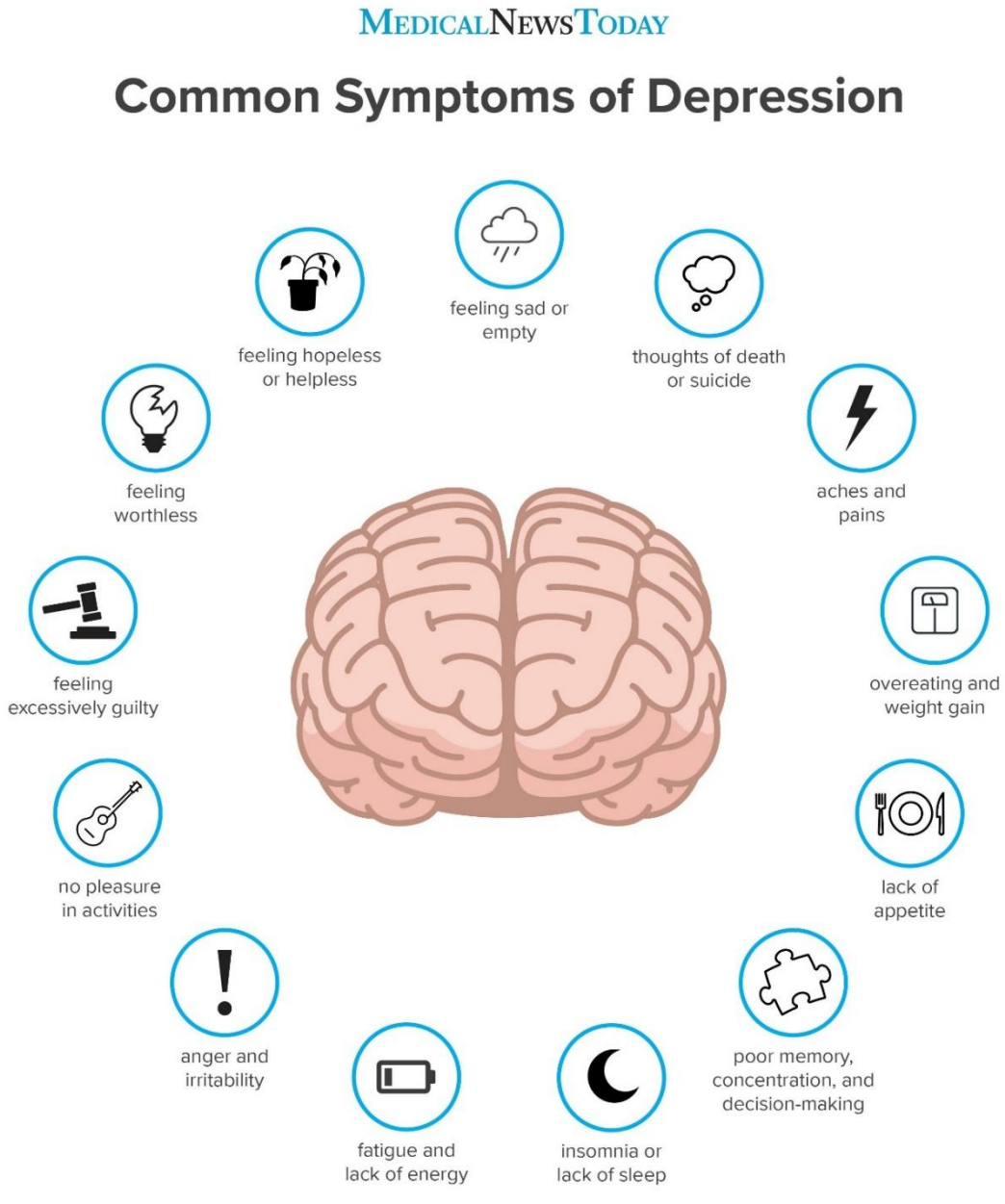
There is no single cause of depression. Also, different types of depression may have different causes. There are many reasons why a woman may have depression:

- **Family history.**
  - Women with a family history of depression may be more at risk. But depression can also happen in women who don't have a family history of depression.
- **Brain changes.**

- The brains of people with depression look and function differently from those of people who don't have depression.

- **Chemistry.**
  - In someone who has depression, parts of the brain that manage mood, thoughts, sleep, appetite, and behavior may not have the right balance of chemicals.
- **Hormone levels.**
  - Changes in the female hormones estrogen and progesterone during the menstrual cycle, pregnancy, postpartum period, perimenopause, or menopause may all raise a woman's risk for depression. Having a miscarriage can also put a woman at higher risk for depression.
- **Stress.**
  - Serious and stressful life events, or the combination of several stressful events, such as trauma, loss of a loved one, a bad relationship, work responsibilities, caring for children and aging parents, abuse, and poverty, may trigger depression in some people.
- **Medical problems.**
  - Dealing with a serious health problem, such as stroke, heart attack, or cancer, can lead to depression. Research shows that people who have a serious illness and depression are more likely to have more serious types of both conditions.[4] Some medical illnesses, like Parkinson's disease, hypothyroidism, and stroke, can cause changes in the brain that can trigger depression.
- **Pain.**
  - Women who feel emotional or physical pain for long periods are much more likely to develop depression.[5] The pain can come from a chronic (long-term) health problem, accident, or trauma such as sexual assault or abuse.

**What are the symptoms of depression?**




Not all people with depression have the same symptoms. Some people might have only a few symptoms, while others may have many. How often symptoms happen, how long they last, and how severe they are may be different for each person.

If you have any of the following symptoms for at least 2 weeks, talk to a doctor or nurse or mental health professional:

- Feeling sad, “down,” or empty, including crying often
- Feeling hopeless, helpless, worthless, or useless
- Loss of interest in hobbies and activities that you once enjoyed
- Decreased energy
- Difficulty staying focused, remembering, or making decisions
- Sleeplessness, early morning awakening, or oversleeping and not wanting to get up
- Lack of appetite, leading to weight loss, or eating to feel better, leading to weight gain
- Thoughts of hurting yourself
- Thoughts of death or suicide
- Feeling easily annoyed, bothered, or angered
- Constant physical symptoms that do not get better with treatment, such as headaches, upset stomach, and pain that doesn’t go away

**How is depression linked to other health problems?**

Depression is linked to many health problems in women, including:

- **Heart disease.**
  - People with heart disease are about twice as likely to have depression as people who don’t have heart disease.
- **Obesity.**
  - Studies show that 43% of adults with depression have obesity. Women, especially white women, with depression are more likely to have obesity

than women without depression are. Women with depression are also more likely than men with depression to have obesity.

- **Cancer.**
  - Up to 1 in 4 people with cancer may also experience depression. More women with cancer than men with cancer experience depression.

**How is depression diagnosed?**

Talk to your doctor or nurse if you have symptoms of depression. Certain medicines and some health problems (such as viruses or a thyroid disorder) can cause the same symptoms as depression. Sometimes depression can be part of another mental health condition.

Diagnosis of depression includes a mental health professional asking questions about your life, emotions, struggles, and symptoms. The doctor, nurse, or mental health professional may order lab tests on a sample of your blood or urine and do a regular checkup to rule out other problems that could be causing your symptoms.

**How is depression treated?**

Your doctor or mental health professional may treat depression with therapy, medicine, or a combination of the two. Your doctor or nurse may refer you to a mental health specialist for therapy.

Some people with milder forms of depression get better after a few months of therapy. People with moderate to severe depression might need therapy and a type of medicine called an antidepressant. Antidepressants change the levels of certain chemicals in your

brain. It may take several weeks for antidepressants to work. There are different types of antidepressant medicines, and some work better than others for certain people. Some people get better only with both treatments — therapy and antidepressants. Learn what you can do if these treatments don't help.

Having depression can make some people more likely to turn to drugs or alcohol to cope. But drugs or alcohol can make your mental health condition worse and can affect how antidepressants work. Talk to your therapist or doctor or nurse about any alcohol or drug use.

**What if the treatments I try for depression don’t work?**

Give treatments time to work. It may take several weeks for the antidepressants to start working. Do not suddenly stop taking medicine for depression without talking to your doctor or nurse first.

If you have major depressive disorder and have tried at least 2 types of antidepressants but your symptoms are not getting better, you may have treatment-resistant depression. If you have this type of depression, you may be able to try a treatment called esketamine. Esketamine is a nasal spray that has been approved by the Food and Drug Administration (FDA) for treatment-resistant depression when taken together with an antidepressant. Do not take esketamine if you are pregnant or breastfeeding. Talk to your doctor or nurse about the benefits and risks of esketamine. Learn more about esketamine from the FDA.

If you have severe depression, you can also ask your doctor or nurse if electroconvulsive therapy (ECT) and other brain stimulation therapies are treatment options. Learn more about ECT from the National Institutes of Mental Health.

**I think I may have depression. How can I get help?**

Talk to someone like a doctor, nurse, psychiatrist, mental health professional, or social worker about your symptoms. You can also find no-cost or low-cost help in your state by using the mental health services locator on the top left side (desktop view) or bottom (mobile view) of this page.


**What if I have thoughts of hurting myself?**

If you are thinking about hurting or even killing yourself, get help now. Call 911 or the National Suicide Prevention Lifeline(link is external) at 1-800-273-TALK (8255).
You might feel like your pain is too overwhelming to bear, but those feelings don't last forever. People do make it through suicidal thoughts. Many thoughts of suicide are impulses that go away after a short period of time.

**Can I take St. John's wort to treat depression?**

Taking St. John's wort for depression has not been approved by the Food and Drug Administration (FDA). Studies show mixed results about the plant's ability to treat depression.

It may be dangerous to take St. John's wort if you also take other medicines. St. John's wort can make many medicines not work at all or may cause dangerous or life-threatening

side effects. The medicines used to treat heart disease, HIV, depression, seizures, certain cancers, and organ transplant rejection may not work or may have dangerous side effects if taken with St. John's wort. St. John's wort may also make birth control pills not work, which increases the chance you will get pregnant when you don't want to. It is crucial that you tell your doctor or nurse if you take St. John's wort.

Depression is a serious mental illness that can be successfully treated with therapy and FDA-approved medicines. FDA-approved medicines and natural treatments can have side effects. It's best to talk to a doctor or nurse about treatment for depression.

**Does exercise help treat depression?**

For some people, yes. Researchers think that exercise may work better than no treatment at all to treat depression. They also think that regular exercise can lower your risk of getting depression and help many depression symptoms get better. Researchers do not know whether exercise works as well as therapy or medicine to treat depression. People with depression often find it very difficult to exercise, even though they know it will help make them feel better. Walking is a good way to begin exercising if you haven't exercised recently.

**Are there other natural or complementary treatments for depression?**

Researchers are studying natural and complementary treatments (add-on treatments to medicine or therapy) for depression. Currently, none of the natural or complementary treatments are proven to work as well as medicine and therapy for depression. However, natural or complementary treatments that

have little or no risk, like exercise, meditation, or relaxation training, may help improve your depression symptoms and usually will not make them worse.

**Will treatment for depression affect my chances of getting pregnant?**

Maybe. Some medicines, such as some types of antidepressants, may make it more difficult for you to get pregnant, but more research is needed. Talk to your doctor about other treatments for depression that don't involve medicine if you are trying to get pregnant. For example, a type of talk therapy called cognitive behavioral therapy (CBT) helps women with depression. This type of therapy has little to no risk for women trying to get pregnant. During CBT, you work with a mental health professional to explore why you are depressed and train yourself to replace negative thoughts with positive ones. Certain mental health care professionals specialize in depression related to infertility.

Women who are already taking an antidepressant and who are trying to get pregnant should talk to their doctor or nurse about the risks and benefits of stopping the medicine. Learn more about taking medicines during pregnancy in our Pregnancy section.

**Did we answer your question about depression?**

For more information about depression, call the OWH Helpline at 1-800-994-9662 or check out these resources from the following organizations:

- Depression(link is external) — Information from HelpGuide.org.
- Depression(link is external) — Information from the Depression and Bipolar Support Alliance.
- Depression in Women: 5 Things You Should Know — Brochure from the National Institute of Mental Health.
- Older Adults and Depression — Booklet from the National Institute of Mental Health.

- Postpartum Disorders(link is external) — Information from Mental Health America.
- St. John's Wort and Depression: In Depth — Information from the National Center for Complementary and Integrative Health.

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(OWH, 2020)

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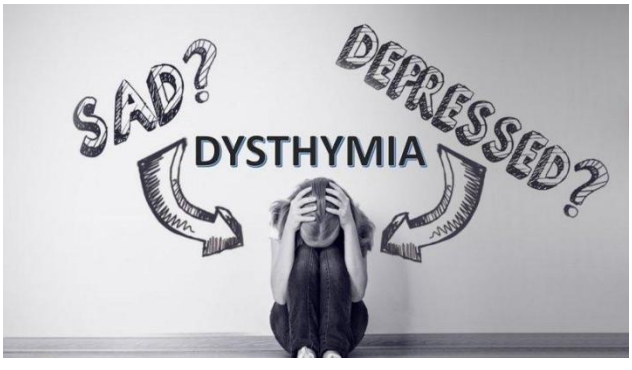



**The following is from the National Institute of Mental Health retrieved from:** https://www.nimh.nih.gov/health/topics/depression/index.shtml#part_145399

Depression (major depressive disorder or clinical depression) is a common but serious mood disorder. It causes severe symptoms that affect how you feel, think, and handle daily activities, such as sleeping, eating, or working. To be diagnosed with depression, the symptoms must be present for at least two weeks.

Some forms of depression are slightly different, or they may develop under unique circumstances, such as:

- **Persistent depressive disorder** (also called dysthymia) is a depressed mood that lasts for at least two years. A person diagnosed with persistent depressive disorder may have episodes of major depression along with periods of less severe symptoms, but symptoms must last for two years to be considered persistent depressive disorder
- **Postpartum depression** is much more serious than the “baby blues” (relatively mild depressive and anxiety symptoms that typically clear within two weeks after

delivery) that many women experience after giving birth. Women with postpartum depression experience full-blown major depression during pregnancy or after delivery (postpartum depression). The feelings of extreme sadness, anxiety, and exhaustion that accompany postpartum depression may make it difficult for these new mothers to complete daily care activities for themselves and/or for their babies

- **Psychotic depression** occurs when a person has severe depression plus some form of psychosis, such as having disturbing false fixed beliefs (delusions) or hearing or seeing upsetting things that others cannot hear or see (hallucinations). The psychotic symptoms typically have a depressive "theme," such as delusions of guilt, poverty, or illness
- **Seasonal affective disorder** is characterized by the onset of depression during the winter months, when there is less natural sunlight. This depression generally lifts during spring and summer. Winter depression, typically accompanied by social withdrawal, increased sleep, and weight gain, predictably returns every year in seasonal affective disorder.
- **Bipolar disorder** is different from depression, but it is included in this list is because someone with bipolar disorder experiences episodes of extremely low moods that meet the criteria for major depression (called "bipolar depression"). But a person with bipolar disorder also experiences extreme high – euphoric or irritable – moods called "mania" or a less severe form called "hypomania."

Examples of other types of depressive disorders newly added to the diagnostic classification of DSM-5 include disruptive mood dysregulation disorder (diagnosed in children and adolescents) and premenstrual dysphoric disorder (PMDD).

### Signs and Symptoms

If you have been experiencing some of the following signs and symptoms most of the day, nearly every day, for at least two weeks, you may be suffering from depression:

- Persistent sad, anxious, or “empty” moo
- Feelings of hopelessness, or pessimism
- Irritability
- Feelings of guilt, worthlessness, or helplessness
- Loss of interest or pleasure in hobbies and activities
- Decreased energy or fatigue
- Moving or talking more slowly
- Feeling restless or having trouble sitting still
- Difficulty concentrating, remembering, or making decisions
- Difficulty sleeping, early-morning awakening, or oversleeping
- Appetite and/or weight changes
- Thoughts of death or suicide, or suicide attempts
- Aches or pains, headaches, cramps, or digestive problems without a clear physical cause and/or that do not ease even with treatment


Not everyone who is depressed experiences every symptom. Some people experience only a few symptoms while others may experience many. Several persistent symptoms in addition to low mood are required for a diagnosis of major depression, but people with only a few – but distressing – symptoms may benefit from treatment of their “subsyndromal” depression. The severity and frequency of symptoms and how long they last will vary depending on the individual and his or her particular illness. Symptoms may also vary depending on the stage of the illness.

## Risk Factors

Depression is one of the most common mental disorders in the U.S. Current research suggests that depression is caused by a combination of genetic, biological, environmental, and psychological factors.

Depression can happen at any age, but often begins in adulthood. Depression is now recognized as occurring in children and adolescents, although it sometimes presents with more prominent irritability than low mood. Many chronic mood and anxiety disorders in adults begin as high levels of anxiety in children.

Depression, especially in midlife or older adults, can co-occur with other serious medical illnesses, such as diabetes, cancer, heart disease, and Parkinson's disease. These conditions are often worse when depression is present. Sometimes medications taken for these physical illnesses may cause side effects that contribute to depression. A doctor experienced in treating these complicated illnesses can help work out the best treatment strategy.

Risk factors include:

- Personal or family history of depression
- Major life changes, trauma, or stress
- Certain physical illnesses and medications

## Treatment and Therapies

Depression, even the most severe cases, can be treated. The earlier that treatment can begin, the more effective it is. Depression is usually treated with medications, psychotherapy, or a combination of the two. If these treatments do not reduce symptoms, electroconvulsive therapy (ECT) and other brain stimulation therapies may be options to explore.

**Quick Tip:** No two people are affected the same way by depression and there is no "one-size-fits-all" for treatment. It may take some trial and error to find the treatment that works best for you.

### Medications

Antidepressants are medicines that treat depression. They may help improve the way your brain uses certain chemicals that control mood or stress. You may need to try several different antidepressant medicines before finding the one that improves your symptoms and has manageable side effects. A medication that has helped you or a close family member in the past will often be considered.

Antidepressants take time – usually 2 to 4 weeks – to work, and often, symptoms such as sleep, appetite, and concentration problems improve before mood lifts, so it is important to give medication a chance before reaching a conclusion about its effectiveness. If you begin taking antidepressants, do not stop taking them without the help of a doctor. Sometimes people taking antidepressants feel better and then stop taking the medication on their own, and the depression returns. When you and your doctor have decided it is time to stop the medication, usually after a course of 6 to 12 months, the doctor will help you slowly and safely decrease your dose. Stopping them abruptly can cause withdrawal symptoms.

**Please Note**

In some cases, children, teenagers, and young adults under 25 may experience an increase in suicidal thoughts or behavior when taking antidepressants, especially in the first few weeks after starting or when the dose is changed. This warning from the U.S. Food and Drug Administration (FDA) also says that patients of all ages taking antidepressants should be watched closely, especially during the first few weeks of treatment.

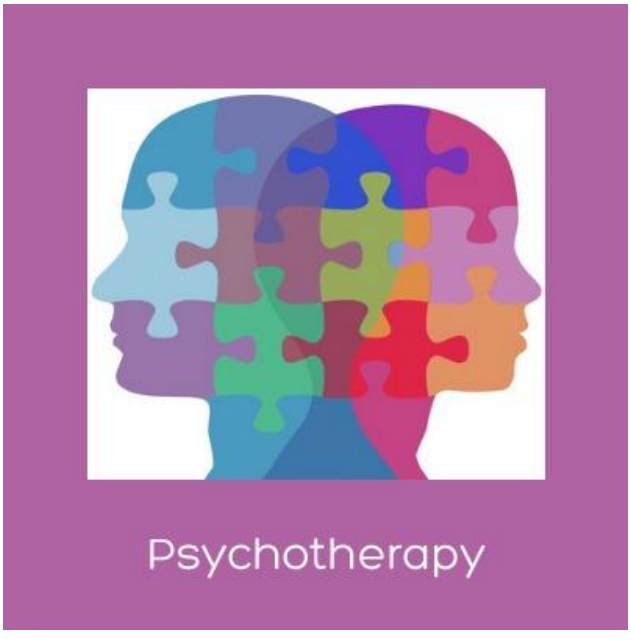
If you are considering taking an antidepressant and you are pregnant, planning to become pregnant, or breastfeeding, talk to your doctor about any increased health risks to you or your unborn or nursing child.

To find the latest information about antidepressants, talk to your doctor and visit www.fda.gov.

You may have heard about an herbal medicine called St. John's wort. Although it is a top-selling botanical product, the FDA has not approved its use as an over-the-counter or prescription medicine for depression, and there are serious concerns about its safety (it should never be combined with a prescription antidepressant) and effectiveness. Do not use St. John’s wort before talking to your health care provider. Other natural products sold as dietary supplements, including omega-3 fatty acids and S-adenosylmethionine (SAMe), remain under study but have not yet been proven safe and effective for routine use. For more information on herbal and other complementary approaches and current research, please visit the National Center for Complementary and Integrative Health website.

**Psychotherapies**

Several types of psychotherapy (also called “talk therapy” or, in a less specific form, counseling) can help people with depression. Examples of evidence-based approaches specific to the treatment of depression include cognitive-behavioral therapy (CBT), interpersonal therapy (IPT), and problem-solving therapy. More information on psychotherapy is available on the NIMH website and in the NIMH publication *Depression: What You Need to Know*.




**Brain Stimulation Therapies**

If medications do not reduce the symptoms of depression, electroconvulsive therapy (ECT) may be an option to explore. Based on the latest research:

- ECT can provide relief for people with severe depression who have not been able to feel better with other treatments
- Electroconvulsive therapy can be an effective treatment for depression. In some severe cases where a rapid response is necessary or medications cannot be used safely, ECT can even be a first-line intervention.
- Once strictly an inpatient procedure, today ECT is often performed on an outpatient basis. The treatment consists of a series of sessions, typically three times a week, for two to four weeks.
- ECT may cause some side effects, including confusion, disorientation, and memory loss. Usually these side effects are short-term, but sometimes memory

problems can linger, especially for the months around the time of the treatment course. Advances in ECT devices and methods have made modern ECT safe and effective for the vast majority of patients. Talk to your doctor and make sure you understand the potential benefits and risks of the treatment before giving your informed consent to undergoing ECT.

- ECT is not painful, and you cannot feel the electrical impulses. Before ECT begins, a patient is put under brief anesthesia and given a muscle relaxant. Within one hour after the treatment session, which takes only a few minutes, the patient is awake and alert.

Other more recently introduced types of brain stimulation therapies used to treat medicine-resistant depression include repetitive transcranial magnetic stimulation (rTMS) and vagus nerve stimulation (VNS). Other types of brain stimulation treatments are under study. You can learn more about these therapies on the NIMH Brain Stimulation Therapies webpage.

If you think you may have depression, start by making an appointment to see your doctor or health care provider. This could be your primary care practitioner or a health provider who specializes in diagnosing and treating mental health conditions. Visit the NIMH Find Help for Mental Illnesses if you are unsure of where to start.

**Beyond Treatment: Things You Can Do**

Here are other tips that may help you or a loved one during treatment for depression:

- Try to be active and exercise
- Set realistic goals for yourself
- Try to spend time with other people and confide in a trusted friend or relative
- Try not to isolate yourself, and let others help you

- Expect your mood to improve gradually, not immediately
- Postpone important decisions, such as getting married or divorced, or changing jobs until you feel better. Discuss decisions with others who know you well and have a more objective view of your situation
- Continue to educate yourself about depression.

(NIMH, 2018)

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**Anxiety**

Sourced from (OWH, 2020) at:

https://www.womenshealth.gov/mental-health/mental-health-conditions/anxiety-disorders

Anxiety is a normal response to stress. But when it becomes hard to control and affects your day-to-day life, it can be disabling. Anxiety disorders affect nearly 1 in 5 adults in the United States. Women are more than twice as likely as men to get an anxiety disorder in their lifetime**.** Anxiety disorders are often treated with counseling, medicine, or a combination of both. Some women also find that yoga or meditation helps with anxiety disorders.

**What is anxiety?**

Anxiety is a feeling of worry, nervousness, or fear about an event or situation. It is a normal reaction to stress. It helps you stay alert for a challenging situation at work, study harder for an exam, or remain focused on an important speech. In general, it helps you cope.

But anxiety can be disabling if it interferes with daily life, such as making you dread nonthreatening day-to-day activities like riding the bus or talking to a coworker. Anxiety can also be a sudden attack of terror when there is no threat.

**What are anxiety disorders?**

Anxiety disorders happen when excessive anxiety interferes with your everyday activities such as going to work or school or spending time with friends or family. Anxiety disorders are serious mental illnesses. They are the most common mental disorders in the United States. **Anxiety disorders are more than twice as common in women as in men.**

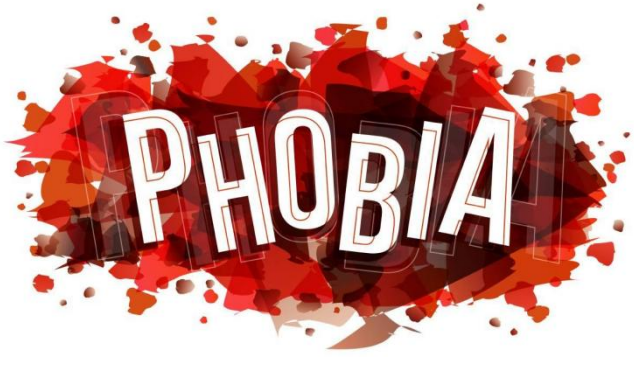
**What are the major types of anxiety disorder?**

The major types of anxiety disorder are:

- **Generalized anxiety disorder (GAD). People with GAD worry excessively about ordinary, day-to-day issues, such as health, money, work, and family. With GAD, the mind often jumps to the worst-case scenario, even when there is little or no reason to worry. Women with GAD may be anxious about just getting through the day. They may have muscle tension and other stress-related physical symptoms, such as trouble sleeping or upset stomach. At times, worrying keeps people with GAD from doing everyday tasks.** Women with GAD have a higher risk of depression and other anxiety disorders than men with GAD. They also are more likely to have a family history of depression.
- **Panic disorder. Panic disorders are twice as common in women as in men. People with panic disorder have sudden attacks of terror when there is no actual danger. Panic attacks may cause a sense of unreality, a fear of impending doom, or a fear of losing control.** A fear of one's own unexplained physical symptoms is also a sign of panic disorder. People having panic attacks sometimes believe they are having heart attacks, losing their minds, or dying.

- **Social phobia.** Social phobia, also called social anxiety disorder, is diagnosed when people become very anxious and self-conscious in everyday social situations. People with social phobia have a strong fear of being watched and judged by others. They may get embarrassed easily and often have panic attack symptoms.
- **Specific phobia. A specific phobia is an intense fear of something that poses little or no actual danger. Specific phobias could be fears of closed-in spaces, heights, water, objects, animals, or specific situations.** People with specific phobias often find that facing, or even thinking about facing, the feared object or situation brings on a panic attack or severe anxiety.

Some other conditions that are not considered anxiety disorders but are similar include:




- **Obsessive-compulsive disorder (OCD).** People with OCD have unwanted thoughts (obsessions) or behaviors (compulsions) that cause anxiety. They may check the oven or iron again and again or perform the same routine over and over to control the anxiety these thoughts cause. Often, the rituals end up controlling the person.
- **Post-traumatic stress disorder (PTSD).** PTSD starts after a scary event that involved physical harm or the threat of physical harm. The person who gets PTSD may have been the one who was harmed, or the harm may have happened to a loved one or even a stranger.

**Who gets anxiety disorders?**

Anxiety disorders affect about 40 million American adults every year. Anxiety disorders also affect children and teens. About 8% of teens ages 13 to 18 have an anxiety disorder, with symptoms starting around age 6.

Women are more than twice as likely as men to get an anxiety disorder in their lifetime. Also, some types of anxiety disorders affect some women more than others:

- **Generalized anxiety disorder** (GAD) affects more American Indian/Alaskan Native women than women of other races and ethnicities. GAD also affects more white women and Hispanic women than Asian or African-American women.
- **Social phobia** and **panic disorder** affect more white women than women of other races and ethnicities.

**What causes anxiety disorders?**

Researchers think anxiety disorders are caused by a combination of factors, which may include:

- Hormonal changes during the menstrual cycle
- Genetics. Anxiety disorders may run in families.
- Traumatic events. Experiencing abuse, an attack, or sexual assault can lead to serious health problems, including anxiety, post-traumatic stress disorder, and depression.

**What are the signs and symptoms of an anxiety disorder?**

Women with anxiety disorders experience a combination of anxious thoughts or beliefs, physical symptoms, and changes in behavior, including avoiding everyday activities they used to do. Each anxiety disorder has different symptoms. They all involve a fear and dread about things that may happen now or in the future.

**Physical symptoms may include:**

- Weakness
- Shortness of breath
- Rapid heart rate
- Nausea
- Upset stomach
- Hot flashes
- Dizziness


Physical symptoms of anxiety disorders often happen along with other mental or physical illnesses. This can cover up your anxiety symptoms or make them worse.

**How are anxiety disorders diagnosed?**

Your doctor or nurse will ask you questions about your symptoms and your medical history. Your doctor may also do a physical exam or other tests to rule out other health problems that could be causing your symptoms.

Anxiety disorders are diagnosed when fear and dread of nonthreatening situations, events, places, or objects become excessive and are uncontrollable. Anxiety disorders are also diagnosed if the anxiety has lasted for at least six months and it interferes with social, work, family, or other aspects of daily life.

**How are anxiety disorders treated?**

Treatment for anxiety disorders depends on the type of anxiety disorder you have and your personal history of health problems, violence, or abuse.

Often, treatment may include:

- Counseling (called psychotherapy)
- Medicine
- A combination of counseling and medicine

**How does counseling help treat anxiety disorders?**

Your doctor may refer you for a type of counseling for anxiety disorders called cognitive behavioral therapy (CBT). You can talk to a trained mental health professional about what caused your anxiety disorder and how to deal with the symptoms.

For example, you can talk to a psychiatrist, psychologist, social worker, or counselor. CBT can help you change the thinking patterns around your fears. It may help you change the way you react to situations that may create anxiety. You may also learn ways to reduce feelings of anxiety and improve specific behaviors caused by chronic anxiety. These strategies may include relaxation therapy and problem solving.

**What types of medicine treat anxiety disorders?**

Several types of medicine treat anxiety disorders. These include:

- **Antianxiety (benzodiazepines).**

- **These medicines are usually prescribed for short periods of time because they are addictive. Stopping this medicine too quickly can cause withdrawal symptoms.**

- **Beta blockers.**
  - **These medicines can help prevent the physical symptoms of an anxiety disorder, like trembling or sweating.**
- **Selective serotonin reuptake inhibitors (SSRIs).**
  - SSRIs change the level of serotonin in the brain.[2] They increase the amount of serotonin available to help brain cells communicate with each other. Common side effects can include insomnia or sedation, stomach problems, and a lack of sexual desire.
- **Tricyclics**.
  - Tricylics work like SSRIs. But sometimes they cause more side effects than SSRIs. They may cause dizziness, drowsiness, dry mouth, constipation, or weight gain.

- **Monoamine oxidase inhibitors (MAOIs).**

  - **People who take MAOIs must avoid certain foods and drinks (like Parmesan or cheddar cheese and red wine) that contain an amino acid called tyramine. Taking an MAOI and eating these foods can cause blood pressure levels to spike dangerously.** Women who take MAOIs must also avoid certain medicines, such as some types of birth control pills, pain relievers, and cold and allergy medicines. Talk to your doctor about any medicine you take.

All medicines have risks. You should talk to your doctor about the benefits and risks of all medicines. Learn more about medicines to treat anxiety disorders.

**What if my anxiety disorder treatment is not working?**

Sometimes, you may need to work with your doctor to try several different treatments or combinations of treatments before you find one that works for you.

If you are having trouble with side effects from medicines, talk to your doctor or nurse. Do not stop taking your medicine without talking to a doctor or nurse. Your doctor may adjust how much medicine you take and when you take it.

**What if my anxiety disorder comes back?**

Sometimes symptoms of an anxiety disorder come back after you have finished treatment. This may happen during or after a stressful event. It may also happen without any warning.

Many people with anxiety disorders do get better with treatment. But, if your symptoms come back, your doctor will work with you to change or adjust your medicine or treatment plan.

You can also talk to your doctor about ways to identify and prevent anxiety from coming back. This may include writing down your feelings or meeting with your counselor if you think your anxiety is uncontrollable.

**Can complementary or alternative medicine help manage anxiety disorders?**

Maybe. Some women say that complementary or alternative medicine (CAM) therapies helped lower their anxiety.

CAM therapies that may help anxiety include:

- **Physical activity.**
  - Regular physical activity raises the level of brain chemicals that control mood and affect anxiety and depression. Many studies show that all types of physical activity, including yoga and Tai Chi, help reduce anxiety.

- **Meditation.** Studies show meditation may improve anxiety.
  - Regular meditation may help by boosting activity in the area of your brain responsible for feelings of serenity and joy.

Learn more about CAM therapies for anxiety disorders.

**Will my anxiety disorder treatment affect my pregnancy?**

If your treatment is counseling, it will not affect your pregnancy.

If you are on medicine to treat your anxiety disorder, talk to your doctor. Some medicines used to treat anxiety can affect your unborn baby.

**If I take medicine to treat my anxiety disorder, can I breastfeed my baby?**

It depends. Some medicines used to treat anxiety can pass through breastmilk. Certain antidepressants, such as some SSRIs, are safe to take during breastfeeding.

Do not stop taking your medicine too quickly. Talk to your doctor to find out what medicine is best for you and your baby. Learn more about medicines and breastfeeding in our Breastfeeding section. You can also enter your medicine into the LactMed® database to find out if your medicine passes through your breastmilk and any possible side effects for your nursing baby.

**How do anxiety disorders affect other health conditions?**

Anxiety disorders may affect other health problems that are common in women. These include:

- **Depression. Anxiety disorders can happen at the same time as depression.** When this happens, treatment for both anxiety and depression may not be as effective. You may need a combination of treatments, such as counseling and medicine.
- **Irritable bowel syndrome (IBS).** IBS symptoms are common in people with anxiety disorders. Generalized anxiety disorder is also common among people with IBS. Worry can make IBS symptoms worse, especially gastrointestinal (GI) symptoms such as upset stomach or gas. GI symptoms can also be stressful and lead to more anxiety. Although treatments for IBS can help treat anxiety, it's important that you treat both conditions.
- **Chronic pain.** Anxiety disorders are common in women with certain diseases that cause chronic pain, including rheumatoid arthritis, fibromyalgia, and migraine.
- **Cardiovascular disease.** Anxiety and depression increase the risk for heart disease, the leading cause of death for American women. Anxiety can also make recovery harder after a heart attack or stroke.
- **Asthma.** Studies link asthma to anxiety disorders. Stress and anxiety can trigger asthma attacks while the shortness of breath and wheezing during asthma attacks

can cause anxiety. Studies show that breathing retraining may help asthma control and ease anxiety.

**What is the latest research on anxiety disorders and women?**

Researchers are studying why women are more than twice as likely as men to develop anxiety disorders and depression. Changes in levels of the hormone estrogen throughout a woman's menstrual cycle and reproductive life (during the years a woman can have a baby) probably play a role.

Researchers also recently studied the male hormone testosterone, which is found in women and men but typically in higher levels in men. They found that treatment with testosterone had similar effects as antianxiety and antidepressant medicine for the women in the study.

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Retrieved from the National Institute of Mental Health: https://www.nimh.nih.gov/health/topics/anxiety-disorders/index.shtml

## Anxiety Disorders

### Overview

Occasional anxiety is an expected part of life. You might feel anxious when faced with a problem at work, before taking a test, or before making an important decision. But anxiety disorders involve more than temporary worry or fear. For a person with an anxiety disorder, the anxiety does not go away and can get worse over time. The symptoms can interfere with daily activities such as job performance, school work, and relationships.

There are several types of anxiety disorders, including generalized anxiety disorder, panic disorder, and various phobia-related disorders.

### Signs and Symptoms

#### Generalized Anxiety Disorder

People with **generalized anxiety disorder (GAD) display excessive anxiety or worry, most days for at least 6 months, about a number of things such as personal health, work, social interactions, and everyday routine life circumstances.** The fear and anxiety can cause significant problems in areas of their life, such as social interactions, school, and work.

Generalized anxiety disorder symptoms include:

- Feeling restless, wound-up, or on-edge
- Being easily fatigued
- Having difficulty concentrating; mind going blank
- Being irritable

- Having muscle tension
- Difficulty controlling feelings of worry
- Having sleep problems, such as difficulty falling or staying asleep, restlessness, or unsatisfying sleep


**Panic Disorder**

**People with panic disorder have recurrent unexpected panic attacks**. Panic attacks are sudden periods of intense fear that come on quickly and reach their peak within minutes. Attacks can occur unexpectedly or can be brought on by a trigger, such as a feared object or situation.

During a panic attack, people may experience:

- Heart palpitations, a pounding heartbeat, or an accelerated heartrate
- Sweating
- Trembling or shaking
- Sensations of shortness of breath, smothering, or choking
- Feelings of impending doom
- Feelings of being out of control

People with panic disorder often worry about when the next attack will happen and actively try to prevent future attacks by avoiding places, situations, or behaviors they associate with panic attacks. Worry about panic attacks, and the effort spent trying to

avoid attacks, cause significant problems in various areas of the person's life, including the development of agoraphobia (see below).

**Phobia-related disorders**

**A *phobia* is an intense fear of—or aversion to—specific objects or situations.** Although it can be realistic to be anxious in some circumstances, the fear people with phobias feel is out of proportion to the actual danger caused by the situation or object.

People with a phobia:

- May have an irrational or excessive worry about encountering the feared object or situation
- Take active steps to avoid the feared object or situation
- Experience immediate intense anxiety upon encountering the feared object or situation
- Endure unavoidable objects and situations with intense anxiety

There are several types of phobias and phobia-related disorders:

**Specific Phobias (sometimes called simple phobias)**: As the name suggests, people who have a specific phobia have an intense fear of, or feel intense anxiety about, specific types of objects or situations. Some examples of specific phobias include the fear of:

- Flying
- Heights

- Specific animals, such as spiders, dogs, or snakes
- Receiving injections
- Blood

**Social anxiety disorder (previously called social phobia)**:

People with social anxiety disorder have a general intense fear of, or anxiety toward, social or performance situations. They worry that actions or behaviors associated with their anxiety will be negatively evaluated by others, leading them to feel embarrassed. This worry often causes people with social anxiety to avoid social situations. Social anxiety disorder can manifest in a range of situations, such as within the workplace or the school environment.

**Agoraphobia**

People with agoraphobia have an intense fear of two or more of the following situations:

- Using public transportation
- Being in open spaces
- Being in enclosed spaces
- Standing in line or being in a crowd

- Being outside of the home alone

People with agoraphobia often avoid these situations, in part, because they think being able to leave might be difficult or impossible in the event they have panic-like reactions or other embarrassing symptoms. In the most severe form of agoraphobia, an individual can become housebound.

### Separation anxiety disorder

Separation anxiety is often thought of as something that only children deal with; however, adults can also be diagnosed with separation anxiety disorder. People who have separation anxiety disorder have fears about being parted from people to whom they are attached. They often worry that some sort of harm or something untoward will happen to their attachment figures while they are separated. This fear leads them to avoid being separated from their attachment figures and to avoid being alone. People with separation anxiety may have nightmares about being separated from attachment figures or experience physical symptoms when separation occurs or is anticipated.

### Selective mutism

A somewhat rare disorder associated with anxiety is *selective mutism*. Selective mutism occurs when people fail to speak in specific social situations despite having normal language skills. Selective mutism usually occurs before the age of 5 and is often associated with extreme shyness, fear of social embarrassment, compulsive traits,

withdrawal, clinging behavior, and temper tantrums. People diagnosed with selective mutism are often also diagnosed with other anxiety disorders

**Risk Factors**

Researchers are finding that both genetic and environmental factors contribute to the risk of developing an anxiety disorder. Although the risk factors for each type of anxiety disorder can vary, some general risk factors for all types of anxiety disorders include:

- Temperamental traits of shyness or behavioral inhibition in childhood
- Exposure to stressful and negative life or environmental events in early childhood or adulthood
- A history of anxiety or other mental illnesses in biological relatives
- Some physical health conditions, such as thyroid problems or heart arrhythmias, or caffeine or other substances/medications, can produce or aggravate anxiety symptoms; a physical health examination is helpful in the evaluation of a possible anxiety disorder.

**Treatments and Therapies**

Anxiety disorders are generally treated with psychotherapy, medication, or both. There are many ways to treat anxiety and people should work with their doctor to choose the treatment that is best for them.

## Psychotherapy

Psychotherapy or “talk therapy” can help people with anxiety disorders. To be effective, psychotherapy must be directed at the person’s specific anxieties and tailored to his or her needs.

## Cognitive Behavioral Therapy

Cognitive Behavioral Therapy (CBT) is an example of one type of psychotherapy that can help people with anxiety disorders. It teaches people different ways of thinking, behaving, and reacting to anxiety-producing and fearful objects and situations. CBT can also help people learn and practice social skills, which is vital for treating social anxiety disorder.

Cognitive therapy and exposure therapy are two CBT methods that are often used, together or by themselves, to treat social anxiety disorder. Cognitive therapy focuses on identifying, challenging, and then neutralizing unhelpful or distorted thoughts underlying anxiety disorders. Exposure therapy focuses on confronting the fears underlying an anxiety disorder to help people engage in activities they have been avoiding. Exposure therapy is sometimes used along with relaxation exercises and/or imagery.

CBT can be conducted individually or with a group of people who have similar difficulties. Often “homework” is assigned for participants to complete between sessions.

## Medication

Medication does not cure anxiety disorders but can help relieve symptoms. Medication for anxiety is prescribed by doctors, such as a psychiatrist or primary care provider. Some states also allow psychologists who have received specialized training to prescribe psychiatric medications. The most common classes of medications used to combat anxiety disorders are anti-anxiety drugs (such as benzodiazepines), antidepressants, and beta-blockers.

| **Anti-Anxiety Medications** |
| --- |
| Anti-anxiety medications can help reduce the symptoms of anxiety, panic attacks, or extreme fear and worry. The most common anti-anxiety medications are called benzodiazepines. Although benzodiazepines are sometimes used as first-line treatments for generalized anxiety disorder, they have both benefits and drawbacks. |

Some benefits of benzodiazepines are that they are effective in relieving anxiety and take effect more quickly than antidepressant medications often prescribed for anxiety. Some drawbacks of benzodiazepines are that people can build up a tolerance to them if they are taken over a long period of time and they may need higher and higher doses to get the same effect. Some people may even become dependent on them.

To avoid these problems, doctors usually prescribe benzodiazepines for short periods of time, a practice that is especially helpful for older adults, people who have substance abuse problems, and people who become dependent on medication easily.

If people suddenly stop taking benzodiazepines, they may have withdrawal symptoms, or their anxiety may return. Therefore, benzodiazepines should be tapered off slowly. When you and your doctor have decided it is time to stop the medication, the doctor will help you slowly and safely decrease your dose.

For long-term use, benzodiazepines are often considered a second-line treatment for anxiety (with antidepressants being considered a first-line treatment) as well as an "as-needed" treatment for any distressing flare-ups of symptoms.

A different type of anti-anxiety medication is *buspirone*. Buspirone is a non-benzodiazepine medication specifically indicated for the treatment of chronic anxiety, although it does not help everyone.

## Antidepressants

Antidepressants are used to treat depression, but they can also be helpful for treating anxiety disorders. They may help improve the way your brain uses certain chemicals that control mood or stress. You may need to try several different antidepressant medicines before finding the one that improves your symptoms and has manageable

side effects. A medication that has helped you or a close family member in the past will often be considered.

Antidepressants can take time to work, so it is important to give the medication a chance before reaching a conclusion about its effectiveness. If you begin taking antidepressants, do not stop taking them without the help of a doctor. When you and your doctor have decided it is time to stop the medication, the doctor will help you slowly and safely decrease your dose. Stopping them abruptly can cause withdrawal symptoms.

Antidepressants called selective serotonin reuptake inhibitors (SSRIs) and serotonin-norepinephrine reuptake inhibitors (SNRIs) are commonly used as first-line treatments for anxiety. Less-commonly used — but effective — treatments for anxiety disorders are older classes of antidepressants, such as tricyclic antidepressants and monoamine oxidase inhibitors (MAOIs).

**Beta-Blockers**

Although beta-blockers are most often used to treat high blood pressure, they can also be used to help relieve the physical symptoms of anxiety, such as rapid heartbeat, shaking, trembling, and blushing. These medications, when taken for a short period of time, can help people keep physical symptoms under control. They can also be used “as needed” to reduce acute anxiety, including as a preventive intervention for some predictable forms of performance anxieties

**Please Note**

In some cases, children, teenagers, and young adults under 25 may experience an increase in suicidal thoughts or behavior when taking antidepressant medications, especially in the first few weeks after starting or when the dose is changed. Because of this, patients of all ages taking antidepressants should be watched closely, especially during the first few weeks of treatment.

**Choosing the Right Medication**

Some types of drugs may work better for specific types of anxiety disorders, so people should work closely with their doctor to identify which medication is best for them. Certain substances such as caffeine, some over-the-counter cold medicines, illicit drugs, and herbal supplements may aggravate the symptoms of anxiety disorders or interact with prescribed medication. Patients should talk with their doctor, so they can learn which substances are safe and which to avoid.

Choosing the right medication, medication dose, and treatment plan should be done under an expert's care and should be based on a person's needs and their medical situation. Your doctor may try several medicines before finding the right one.

You and your doctor should discuss:

- How well medications are working or might work to improve your symptom
- Benefits and side effects of each medication
- Risk for serious side effects based on your medical history
- The likelihood of the medications requiring lifestyle changes
- Costs of each medication
- Other alternative therapies, medications, vitamins, and supplements you are taking and how these may affect your treatment; a combination of medication and psychotherapy is the best approach for many people with anxiety disorders

- How the medication should be stopped (Some drugs can't be stopped abruptly and must be tapered off slowly under a doctor's supervision).

For more information, please visit Mental Health Medications Health Topic webpage. Please note that any information on this website regarding medications is provided for educational purposes only and may be outdated. Diagnosis and treatment decisions should be made in consultation with your doctor. Information about medications changes frequently. Please visit the U.S. Food and Drug Administration website for the latest information on warnings, patient medication guides, or newly approved medications.

**Support Groups**

Some people with anxiety disorders might benefit from joining a self-help or support group and sharing their problems and achievements with others. Internet chat rooms might also be useful, but any advice received over the internet should be used with caution, as Internet acquaintances have usually never seen each other and what has helped one person is not necessarily what is best for another. You should always check with your doctor before following any treatment advice found on the internet. Talking with a trusted friend or member of the clergy can also provide support, but it is not necessarily a sufficient alternative to care from a doctor or other health professional.

**Stress Management Techniques**

Stress management techniques and meditation can help people with anxiety disorders calm themselves and may enhance the effects of therapy. Research suggests that aerobic exercise can help some people manage their anxiety; however, exercise should not take the place of standard care and more research is needed.

## Chapter 4. Intervention and Treatment

Through many parts of this course Treatment potential treatments have been presented. These have included treatments for some of the emotional effects of abuse. This section will address what can be done to help prevent the cycle of abuse. Additionally, this section includes how to provide safety plans for a victim of abuse.

### A. Prevention

**Preventing Intimate Partner Violence Across the Lifespan: A Technical Package of Programs, Policies, and Practices**

The following is sourced from Niolon, P. H., Kearns, M., Dills, J., Rambo, K., Irving, S., Armstead, T., & Gilbert, L. (2017). Preventing Intimate Partner Violence Across the Lifespan: A Technical Package of Programs, Policies, and Practices. Atlanta, GA: National Center for Injury Prevention and Control, Centers for Disease Control and Prevention. Retrieved from: https://www.cdc.gov/violenceprevention/pdf/ipv-technicalpackages.pdf

**Overview**

This technical package represents a select group of strategies based on the best available evidence to help communities and states sharpen their focus on prevention activities with the greatest potential to prevent intimate partner violence (IPV) and its consequences across the lifespan. These strategies include teaching safe and healthy relationship skills; engaging influential adults and peers; disrupting the developmental

pathways toward IPV; creating protective environments; strengthening economic supports for families; and supporting survivors to increase safety and lessen harms. The strategies represented in this package include those with a focus on preventing IPV, including teen dating violence (TDV), from happening in the first place or to prevent it from continuing, as well as approaches to lessen the immediate and long-term harms of partner violence. Commitment, cooperation, and leadership from numerous sectors, including public health, education, justice, health care, social services, business and labor, and government can bring about the successful implementation of this package.

This technical package has three components. The first component is the ***strategy*** or the preventive direction or actions to achieve the goal of preventing IPV/TDV. The second component is the ***approach***. The approach includes the specific ways to advance the strategy. This can be accomplished through *programs, policies, and practices*. The ***evidence*** for each of the approaches in preventing IPV or TDV and/or associated risk factors is included as the third component.

### A. Preventing Intimate Partner Violence is a Priority

IPV is a serious preventable public health problem that affects millions of Americans and occurs across the lifespan. It can start as soon as people start dating or having intimate relationships, often in adolescence. IPV that happens when individuals first begin dating,

usually in their teen years, is often referred to as TDV. From here forward in this technical package, we will use the term IPV broadly to refer to this type of violence as it occurs across the lifespan. However, when outcomes are specific to TDV, we will note that.

IPV (also commonly referred to as *domestic violence*) includes "physical violence, sexual violence, stalking, and psychological aggression (including coercive tactics) by a current or former intimate partner (i.e., spouse, boyfriend/ girlfriend, dating partner, or ongoing sexual partner)." Some forms of IPV (e.g., aspects of sexual violence, psychological aggression, including coercive tactics, and stalking) can be perpetrated electronically through mobile devices and social media sites, as well as, in person. IPV happens in all types of intimate relationships, including heterosexual relationships and relationships among sexual minority populations. *Family violence* is another commonly used term in prevention efforts. While the term *domestic violence* encompasses the same behaviors and dynamics as IPV, the term *family violence* is broader and refers to a range of violence that can occur in families, including IPV, child abuse, and elder abuse by caregivers and others. This package is focused on IPV across the lifespan, including partner violence among older adult populations. The Centers for Disease Control and Prevention (CDC) has developed a separate technical package for the prevention of child abuse and neglect.

**IPV is highly prevalent.** IPV affects millions of people in the United States each year. Data from the National Intimate Partner and Sexual Violence Survey (NISVS) indicate that nearly 1 in 4 adult women (23%) and approximately 1 in 7 men (14%) in the U.S. report having experienced severe physical violence (e.g., being kicked, beaten, choked, or burned on purpose, having a weapon used against them, etc.) from an intimate partner in their lifetime. Additionally, 16% of women and 7% of men have experienced contact sexual violence (this includes rape, being made to penetrate someone else, sexual

coercion, and/or unwanted sexual contact) from an intimate partner. Ten percent of women and 2% of men in the U.S. report having been stalked by an intimate partner, and nearly half of all women (47%) and men (47%) have experienced psychological aggression, such as humiliating or controlling behaviors.

The burden of IPV is not shared equally across all groups; many racial/ethnic and sexual minority groups are disproportionately affected by IPV. Data from NISVS indicate that the lifetime prevalence of experiencing contact sexual violence, physical violence, or stalking by an intimate partner is 57% among multi-racial women, 48% among American Indian/Alaska Native women, 45% among non-Hispanic Black women, 37% among non-Hispanic White women, 34% among Hispanic women, and 18% among Asian-Pacific Islander women. The lifetime prevalence is 42% among multi-racial men, 41% among American Indian/Alaska Native men, 40% among non-Hispanic Black men, 30% among non-Hispanic White men, 30% among Hispanic men, and 14% among Asian-Pacific Islander men.

Additionally, the NISVS special report on victimization by sexual orientation demonstrates that some sexual minorities are also disproportionately affected by IPV victimization; 61% of bisexual women, 37% of bisexual men, 44% of lesbian women, 26% of gay men, 35% of heterosexual women, and 29% of heterosexual men experienced rape, physical violence, and/or stalking from an intimate partner in their lifetimes. In regards to people living with disabilities, one study using a nationally representative sample found that 4.3% of people with physical health impairments and 6.5% of people with mental health impairments reported IPV victimization in the past year.8 Studies also show that people with a disability have nearly double the lifetime risk of IPV victimization.

**IPV starts early in the lifespan.** Data from NISVS demonstrate that IPV often begins in adolescence. An estimated 8.5 million women in the U.S. (7%) and over 4 million men (4%) reported experiencing physical violence, rape (or being made to penetrate someone else), or stalking from an intimate partner in their lifetime and indicated that they first

experienced these or other forms of violence by that partner before the age of 18.3 A nationally representative survey of U.S. high school students also indicates high levels of TDV. Findings from the 2015 Youth Risk Behavior Survey indicate that among students who reported dating, 10% had experienced physical dating violence and a similar percentage (11%) had experienced sexual dating violence in the past 12 months.10 In an analysis of the 2013 survey where the authors examined students reporting physical and/or sexual dating violence, the findings indicate that among students who had dated in the past year, 21% of girls and 10% of boys reported either physical violence, sexual violence, or both forms of violence from a dating partner. While the YRBS does not provide national data on the prevalence of stalking victimization among high school students, we know from NISVS that nearly 3.5 million women (3%) and 900,000 men (1%) in the U.S. report that they first experienced stalking victimization before age 18.3 A study conducted in Kentucky suggests that nearly 17% of high school students in that state report stalking victimization, with most students indicating that they were most afraid of a former boyfriend or girlfriend as the stalker.12 Research also indicates that IPV is most prevalent in adolescence and young adulthood and then begins to decline with age, demonstrating the critical importance of early prevention efforts.


**IPV is associated with several risk and protective factors.** Research indicates a number of factors increase risk for perpetration and victimization of IPV. The risk and protective factors discussed here focus on risk for IPV perpetration, although many of the same risk factors are also relevant for victimization. Factors that put individuals at risk for perpetrating IPV include (but are not limited to) demographic factors such as age (adolescence and young adulthood), low income, low educational attainment, and unemployment; childhood history factors such as exposure to violence between parents, experiencing poor parenting, and experiencing child abuse and neglect, including sexual violence. Other individual factors that put people at risk for perpetrating IPV include factors such as stress, anxiety, and antisocial personality traits; attitudinal risk factors,

such as attitudes condoning violence in relationships and belief in strict gender roles; and other behavioral risk factors such as prior perpetration and victimization of IPV or other forms of aggression, such as peer violence, a history of substance abuse, a history of delinquency, and hostile communication styles.

Relationship level factors include hostility or conflict in the relationship, separation/ending of the relationship (e.g., break-ups, divorce/separation), aversive family communication and relationships, and having friends who perpetrate/ experience IPV. Although less studied than factors at other levels of the social ecology, community or societal level factors include poverty, low social capital, low collective efficacy in neighborhoods (e.g., low willingness of neighbor's roles and behavior of men and women).

Additionally, a few protective factors have been identified that are associated with lower chances of perpetrating or experiencing TDV. These include high empathy, good grades, high verbal IQ, a positive relationship with one's mother, and attachment to school. Less is known about protective factors at the community and societal level, but research is emerging indicating that environmental factors such as lower alcohol outlet density18 and community norms that are intolerant of IPV19 may be protective against IPV. Although more research is needed, there is some evidence suggesting that increased economic opportunity and housing security may also be protective against IPV.

**IPV is connected to other forms of violence.** Experience with many other forms of violence puts people at risk for perpetrating and experiencing IPV. Children who are exposed to IPV between their parents or caregivers are more likely to perpetrate or experience IPV, as are individuals who experience abuse and neglect as children. Additionally, adolescents who engage in bullying or peer violence are more likely to perpetrate IPV. Those who experience sexual violence and emotional abuse are more likely to be victims of physical IPV. Research also suggests IPV may increase risk for suicide. Both boys and girls who experience TDV are at greater risk for suicidal ideation. Women exposed to partner violence are nearly 5 times more likely to attempt suicide as

women not exposed to partner violence. Intimate partner problems, which includes IPV, were also found to be a precipitating factor for suicide among men in a review of violent death records from 7 U.S. states.28 Research also shows that experience with IPV (either perpetration or victimization) puts people at higher risk for experiencing IPV in the future.

The different forms of violence often share the same individual, relationship, community, and societal risk factors. The interconnections between the different forms of violence suggests multiple opportunities for prevention. Many of the strategies included in this technical package include example programs and policies that have demonstrated impacts on other forms of violence as reflected in CDC's other technical packages for prevention of child abuse and neglect, sexual violence, youth violence and suicide. Recognizing and addressing the interconnections among the different forms of violence will help us better prevent all forms of violence.

**The health and economic consequences of IPV are substantial.** Approximately 41% of female IPV survivors and 14% of male IPV survivors experience some form of physical injury related to their experience of relationship violence.2 IPV can also extend beyond physical injury and result in death. Data from U.S. crime reports suggest that 16% (about 1 in 6) of murder victims are killed by an intimate partner, and that over 40% of female homicide victims in the U.S. are killed by an intimate partner. There are also many other adverse health outcomes associated with IPV, including a range of cardiovascular, gastrointestinal, reproductive, musculoskeletal, and nervous system conditions, many of which are chronic in nature. Survivors of IPV also experience mental health consequences, such as depression and posttraumatic stress disorder (PTSD). Population-based surveys suggest that 52% of women and 17% of men who have experienced contact sexual violence, physical violence or stalking by an intimate partner report symptoms of PTSD related to their experience of relationship violence. IPV survivors are also at higher risk for engaging in health risk behaviors, such as smoking, binge drinking, and HIV risk behaviors.

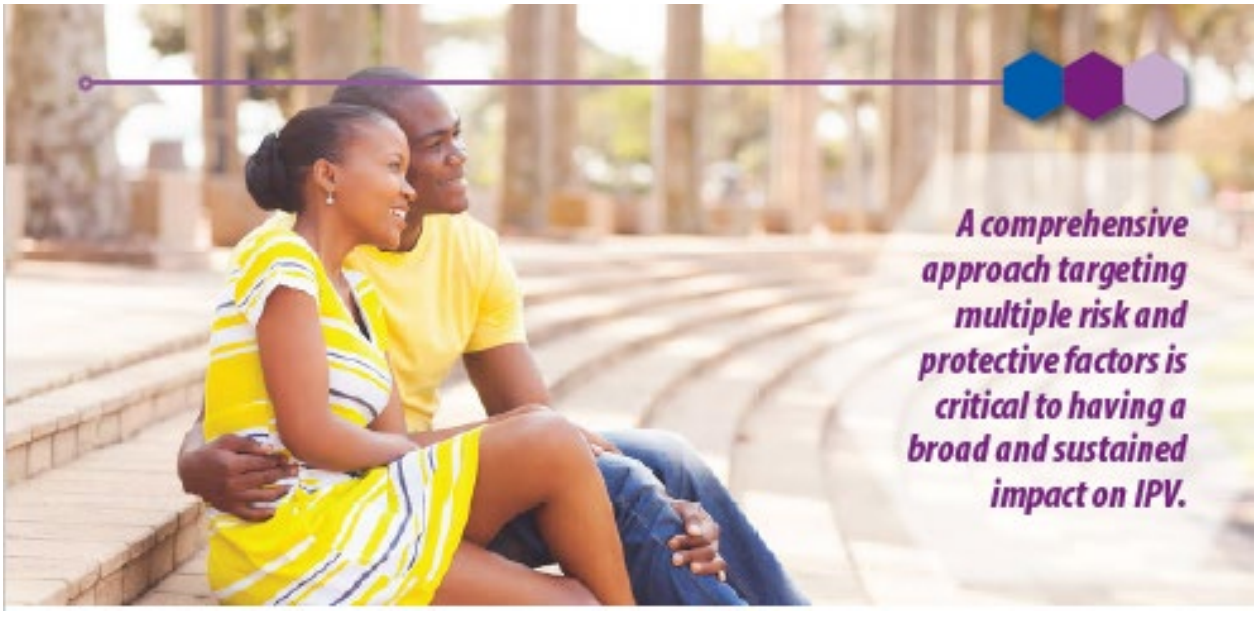
A substantial proportion of survivors also report other negative impacts as a result of IPV, and there is wide variation in the proportions of female and male survivors reporting these impacts. Population- based surveys indicate that among women and men in the U.S. who have experienced contact sexual violence, physical violence, or stalking by an intimate partner during their lifetimes, 73% of the women and 36% of the impact related to these victimization experiences (e.g., fear, concern for safety, missing school or work, needing services).3 Among the female IPV survivors, 62% reported feeling fearful, 57% reported being concerned for their safety, 25% missed at least one day of school or work from the IPV, 19% reported needing medical care, and 8% needed housing services. Among the male survivors, 18% reported feeling fearful, 17% reported being concerned for their safety, 14% missed at least one day of school or work from the IPV, 5% reported needing medical care, and 2% needed housing services.

Although the personal consequences of IPV are considerable, there are also considerable societal costs associated with medical services for IPV-related injury and health consequences, mental health services, lost productivity from paid work, childcare, and household chores, and criminal justice and child welfare costs. The only currently available estimates of societal costs of IPV are from the mid-1990s, but suggest that the annual costs even 20 years ago were estimated at $5.8 billion based on medical and mental health services and lost productivity alone.

**IPV can be prevented.** Primary prevention of IPV, including TDV, means preventing IPV before it begins. Primary prevention strategies are key to ending partner violence in adolescence and adulthood and protecting people from its effects. Partner violence in adolescence can be a pre-cursor or risk factor for partner violence in adulthood. Many strategies to prevent IPV therefore see adolescence as a critical developmental period for the prevention of partner violence in adulthood. It is also important to assist survivors and their children and protect them from future harm. Although there is less evidence of what works to prevent IPV compared to other areas of violence, such as youth violence or child maltreatment, a growing research base demonstrates that there are multiple strategies to prevent IPV from occurring in the first place and to lessen the harms for

survivors. Strategies are available that can benefit adolescents and adults regardless of their level of risk as well as individuals and environments at greatest risk.

A comprehensive approach that simultaneously targets multiple risk and protective factors is critical to having a broad and sustained impact on IPV. Even though more research is needed (e.g., to strengthen the evidence addressing community and societal level factors), we cannot let the need for further research impede efforts to effectively prevent IPV within our communities.




**Assessing the Evidence**

This technical package includes programs, practices, and policies with evidence of impact on victimization, perpetration, or risk factors for IPV. To be considered for inclusion in the technical package, the program, practice, or policy selected had to meet at least one of these criteria:

a) meta-analyses or systematic reviews showing impact on IPV victimization or perpetration;

b) evidence from at least one rigorous (e.g., randomized controlled trial [RCT] or quasi-experimental design) evaluation study that found significant preventive effects on IPV victimization or perpetration
c) meta-analyses or systematic reviews showing impact on risk factors for IPV victimization or perpetration, or
d) evidence from at least one rigorous (e.g., RCT or quasi-experimental design) evaluation study that found significant impacts on risk factors for IPV victimization or perpetration.

Finally, consideration was also given to the likelihood of achieving beneficial effects on multiple forms of violence; no evidence of harmful effects on specific outcomes or with particular subgroups; and feasibility of implementation in a U.S. context if the program, policy, or practice has been evaluated in another country.

Within this technical package, some approaches do not yet have research evidence demonstrating impact on rates of IPV victimization or perpetration but instead are supported by evidence indicating impacts on risk factors for IPV (e.g., child maltreatment, harsh parenting, attitudes accepting of violence, financial stress). In terms of the strength of the evidence, programs that have demonstrated effects on IPV outcomes (reductions in perpetration or victimization) provide a higher- level of evidence, but the evidence base is not that strong in all areas. For instance, there has been less evaluation of certain approaches on IPV outcomes, such as those described in the strategy to *Disrupt the Developmental Pathways to Violence*, and approaches at the outer levels of the social ecology, such as economic policy and interventions addressing community-level risk factors. Thus, approaches in this package that have effects on risk factors reflect the developmental nature of the evidence base and the use of the best available evidence at a given time.

There is a wide range in the nature and quality of evidence among the programs, policies, or practices that fall within one approach or strategy. Not all programs, policies, or practices that utilize the same approach (e.g., programs to teach young people skills to

prevent dating violence) are equally effective – some have impact on dating violence behaviors while others do not, and even those that are effective may not work across all populations. Few programs have been designed for and tested with diverse populations (e.g., racial/ethnic, sexual minority, incarcerated, and immigrant populations to name a few), so tailoring programs and more evaluation may also be necessary to address different population groups. The evidence-based programs, practices, or policies included in the package are not intended to be a comprehensive list for each approach, but rather to serve as examples that have been shown to impact IPV victimization or perpetration or have beneficial effects on risk factors for IPV. In practice, the effectiveness of the programs, policies and practices identified in this package will be strongly dependent on the quality of their implementation and the communities in which they are implemented. Implementation guidance to assist practitioners, organizations and communities will be developed separately.

**Context and Cross-Cutting Themes**

The strategies and approaches included in this technical package represent different levels of the social ecology, with efforts intended to impact individual behaviors and also the relationships, families, schools, and communities that influence risk and protective factors for IPV. The strategies and approaches are intended to work in combination and reinforce each other to prevent IPV (see box below). While individual skills are important and research has demonstrated preventive effects in reducing IPV, approaches addressing peer, family, school and other environments as well as societal factors are equally important for a comprehensive approach that can have the greatest public health impact.

## Preventing IPV

| Strategy | Approach |
|---|---|
| **Teach safe and healthy relationship skills** | • Social-emotional learning programs for youth<br>• Healthy relationship programs for couples |
| **Engage influential adults and peers** | • Men and boys as allies in prevention<br>• Bystander empowerment and education<br>• Family-based programs |
| **Disrupt the developmental pathways toward partner violence** | • Early childhood home visitation<br>• Preschool enrichment with family engagement<br>• Parenting skill and family relationship programs<br>• Treatment for at-risk children, youth and families |
| **Create protective environments** | • Improve school climate and safety<br>• Improve organizational policies and workplace climate<br>• Modify the physical and social environments of neighborhoods |
| **Strengthen economic supports for families** | • Strengthen household financial security<br>• Strengthen work-family supports |
| **Support survivors to increase safety and lessen harms** | • Victim-centered services<br>• Housing programs<br>• First responder and civil legal protections<br>• Patient-centered approaches<br>• Treatment and support for survivors of IPV, including TDV |

While each of the strategies and approaches in the package has a particular focus, several important themes are cross-cutting and are addressed by multiple strategies. One of these is an emphasis on creating safe, stable, nurturing relationships and environments in childhood and adolescence to prevent IPV across the lifespan. Approaches such as social-emotional learning, early childhood home visitation, preschool enrichment, parenting skill and family relationship programs, and efforts to create protective environments and lessen harms are intended to address exposures to violence, build skills, strengthen relationships, and create the context to prevent IPV across the lifespan. The strategies and approaches in this regard are intended to be complementary and have a potentially synergistic impact. Changing social norms, including harmful gender norms,

is another aspect that cross-cuts many of the strategies in this package. Social norms supportive of violence, including harmful gender norms, are demonstrated risk factors for IPV. Social tolerance of violence and harmful gender norms are learned in childhood and reinforced in different peer, family, social, economic, and cultural contexts. Challenging these norms is a key aspect of *Teaching Safe and Healthy Relationship Skills*, *Engaging Influential Adults and Peers*, and *Creating Protective Environments* in schools, neighborhoods, workplaces, and the broader community. Equally important is addressing the societal factors that serve to maintain harmful norms and inequality across gender, racial/ethnic, and income groups.

The strategies and approaches included in this technical package represent current best practices in the primary prevention of IPV and supporting survivors with the after effects of IPV. This package does not include approaches to prevent recidivism or treatment for offenders. *Batterer Intervention Programs (BIPs)* are widely used in communities and within the justice system, but the research findings on their effectiveness are mixed, and conclusions of reviews have differed based on the level of rigor required for study inclusion, study methodology, and on the outcome used to determine effectiveness (police records vs. victim reports). Due to the lack of clear evidence regarding the effectiveness of these programs in preventing further IPV, *BIPs* are not included in this technical package.

The example programs, policies, and practices in the package have been implemented within particular contexts. Each community and organization working on IPV prevention across the nation brings its own social and cultural context to bear on the selection of strategies and approaches that are most relevant to its populations and settings. Practitioners in the field may be in the best position to assess the nee and strengths of their communities and work with community mem to make decisions about the combination of approaches included he that are best suited to their context.

This package includes strategies where public health agencies are well positioned to bring leadership and resources to implementation efforts. It also includes strategies

where public health can serve as an important collaborator (e.g., strategies addressing community and societal level risks), but where leadership and commitment from other sectors such as business or labor (e.g., workplace policies) is critical to implement a particular policy or program. The role of various sectors in the implementation of a strategy or approach in preventing IPV is described further in the section on *Sector Involvement*. In the sections that follow, the strategies and approaches with the best available for preventing IPV are described.

## Teach Safe and Healthy Relationship Skills

**Fostering expectations for healthy relationships and teaching healthy relationship skills are critical to a primary prevention approach to the problem of IPV**. The evidence suggests that acceptance of partner violence, poor emotional regulation and conflict management, and poor communication skills put individuals at risk for both perpetration and victimization of IPV. Therefore, promoting expectations for healthy, non-violent relationships and building skills in these areas can reduce risk for perpetration and victimization of IPV. Previous research shows that strengthening social-emotional, conflict management, and communication skills can also reduce substance abuse, sexual risk behaviors, sexual violence, delinquency, bullying and other forms of peer violence.

### Approaches

There are a number of approaches that teach skills and promote expectations for healthy, non-violent relationships, including those that work with youth and with couples.

**Social-emotional learning programs for youth** promote expectations for mutually respectful, caring, non-violent relationships among young people and work with youth to help them develop social-emotional skills such as empathy, respect, and healthy communication and conflict resolution skills. Successful programs not only teach skills for safe and healthy relationships but also offer multiple opportunities to practice and

reinforce these skills. Although typically implemented with adolescent populations in school-based settings, these approaches and skills may also be useful with young adults.

**Healthy relationship programs for couples** focus on improving relationship dynamics and individual well-being by improving communication, conflict management, and emotional regulation skills. Some of these programs work with couples who are engaged or just entering committed relationships to increase relationship quality, relationship satisfaction and relationship skills, while others work with couples trying to address a problem, such as substance use. Couples-based approaches have historically been controversial in the field of IPV *intervention*, and most agree that treatment programs for couples where severe violence and fear are already occurring are not safe for survivors.46 For other couples, there is some evidence that relationship programs that focus on improving these relationship skills can demonstrate effectiveness in reducing the likelihood of IPV perpetration in the future.

**Potential Outcomes**

- Increases in the use of healthy relationship skills
- Reductions in perpetration of physical, sexual and emotional IPV and stalking
- Reductions in victimization of physical, sexual and emotional IPV and stalking
- Reductions in perpetration of peer violence, including bullying
- Reductions in high-risk sexual behaviors
- Reductions in attitudes that accept violence in relationships
- Increases in relationship satisfaction and well-being
- Reductions in substance abuse
- Reductions in weapon-carrying

**Evidence**

The current evidence suggests that both social-emotional programs for youth and relationship skills programs for adult couples can prevent IPV perpetration and victimization.

**Social-emotional learning programs for youth.** One program with evidence of effectiveness is *Safe Dates*, which is a school-based program focused on the promotion of healthy relationships and the prevention of TDV. Originally developed for 8th and 9th graders, the program offers opportunities for students to learn and practice skills related to conflict resolution, positive communication, and managing anger. The program includes 10 classroom sessions, which provide many opportunities for role play and skill practice, a play presented to the entire school, and a poster contest. *Safe Dates* was evaluated in a randomized controlled trial and found to reduce both perpetration and victimization of physical and sexual dating violence, and results were sustained at four-year follow-up, into late-adolescence. Students exposed to the program reported between 56% and 92% less perpetration and victimization, respectively, at four-year follow-up when compared to control students, and program effects were consistent across gender, race, and baseline experience with TDV. Students exposed to *Safe Dates* also reported a 12% reduction in peer violence victimization and a 31% reduction in weapon carrying at one-year follow-up compared to controls, demonstrating its effects on other violence outcomes associated with TDV.

Another example is *"The Fourth R: Strategies for Healthy Teen Relationships."* The program is named *"The Fourth R"* to indicate that teaching youth about "relationships" is as important as teaching them the three R's of "reading, writing and arithmetic." This 21-session manualized curriculum focuses on 1) personal safety and injury prevention; 2) healthy growth and sexuality, and 3) substance abuse. The program offers multiple opportunities to practice and rehearse skills. *The Fourth R* was evaluated in a randomized controlled trial, and significant program effects were found among boys: boys in the

intervention were almost three times less likely to report perpetration than boys in the control condition 2.5 years after baseline. However, there was no significant intervention effect on girls' perpetration.

***Expect Respect Support Groups (ERSG)* are a socio-emotional learning approach for students at higher risk of TDV. *ERSG* is designed for teens who are in an abusive relationship or who have experienced any form of violence or abuse.** Weekly support groups are led by trained facilitators. The 24-session curriculum focuses on developing communication skills, choosing equality and respect, recognizing abuse, learning skills for healthy relationships and becoming active proponents for safe and healthy relationships. Ball et al.50 found that teens who completed the *ERSG* reported an increase in relationship skills and a decrease in TDV victimization and perpetration from pre to post-test. In a recent controlled evaluation of *ERSG* using an accelerated longitudinal design, the number of *ERSG* sessions attended related to significant incremental declines for boys on multiple outcomes, including perpetration and victimization of

psychological TDV and sexual TDV, physical TDV victimization, and reactive and proactive aggression.51 Girls who participated in *ERSG* demonstrated significant reductions in reactive and proactive aggression compared to treatment as usual control participants, but did not differ from controls on the TDV outcomes. It appears that *ERSG* has beneficial effects for both boys and girls in regard to reactive and proactive aggression, but is most effective for at-risk boys in regards to TDV perpetration and victimization.

**Healthy relationship programs for couples.** Programs that work with couples to build and strengthen relationship skills, including communication and conflict management skills, show evidence for preventing later IPV. One example is the *Pre-marital Relationship Enhancement Program (PREP)*, which is a five session intervention for couples planning to marry that focuses on teaching couples skills, techniques, and principles designed to enhance positive relationship functioning and promote effective management of negative affect with the goal of maintaining high relationship functioning and preventing problems from occurring in the relationship. This program has been empirically tested with many populations (e.g., community-based, active duty military, incarcerated populations) and in various delivery formats (group delivery, computer-delivered). In the original randomized controlled trial of *PREP*, at five-year follow-up couples who completed all or most of the *PREP* intervention had significantly lower levels of physical relationship violence than couples in the control group. The intervention group also had significantly higher levels of positive communication skills and lower levels of negative communication skills than the control group. In a more recent RCT of *ePREP*, the computerized version of the *PREP* program, married couples receiving the intervention demonstrated significant reductions in reports of physical aggression and psychological aggression compared to individuals in a placebo-intervention control group at the 10-month follow-up.


Another example of a couples-based program is *Behavioral Couples Therapy*, or *BCT*, which is an individually- based substance abuse treatment program for substance-abusing individuals and their partners. The therapy consists of a combination of 12-20 weekly couple-based sessions. The program works with the couple on conflict management and other relationship skills as part of the substance abuse treatment. A substantive and methodological review of studies (mostly quasi-experimental studies employing a demographically matched, non-alcoholic comparison group) found that *BCT* is associated with significant reductions in perpetration of IPV among couples participating in treatment groups. The effects of *BCT* have been found for both male and female substance users and their partners, and these effects are particularly pronounced for individuals who successfully stopped drinking (remitted alcoholics). Thus, the intervention appears most effective at reducing IPV among those for whom it is effective in preventing further substance use.

**Engage Influential Adults and Peers**

| Rationale |
| --- |
| |

Programs that seek to engage influential adults and peers in promoting positive relationship expectations and condemning violent and unhealthy relationship behaviors among adolescents and young adults are critical to the prevention of IPV. Trusted adults and peers are important influencers of what adolescents and young adults think and expect and how they behave. Beliefs and attitudes about the acceptability of violence and about gender equity are predictive of IPV perpetration. Engaging adults and peers to promote social norms that support healthy relationship behaviors has great potential to change social contexts so that everyone knows that IPV is not acceptable and will not be tolerated, and people feel more willing and able to intervene when they see IPV. These types of social contexts can discourage potential perpetrators from thinking that violence will be seen as acceptable and increase their perception of the risk that there may be social consequences to such behavior. These types of social contexts may also increase positive bystander behaviors, which can directly interrupt violence as well as enforce norms unaccepting of violence.

## Approaches

There are a number of approaches that seek to influence the social context within which partner violence occurs by engaging influential adults and peers.

## Men and boys as allies in prevention

These approaches target men and boys and encourage them to be part of efforts to prevent IPV, including TDV. These approaches not only encourage men and boys to support actual and potential victims by intervening and speaking out, but also teach

skills and promote social norms that reduce their own risk for future perpetration. These approaches often target men in peer groups, such as athletic teams and fraternities.

## Bystander empowerment and education

These types of approaches attempt to promote social norms that are protective against violence and empower and encourage people to intervene to prevent violence when they see it. Participants in bystander empowerment and education programs learn specific strategies on how to intervene in situations that involve IPV. Types of bystanders targeted for intervention include: informal helpers (e.g., friends and roommates), popular opinion leaders (e.g., student government) or larger social groups (e.g., men on college campuses).

## Family-based programs

**Family-based programs** seek to involve parents and other caregivers in prevention of TDV. Family-based programs operate on the premise that the family is central to the development of norms and values, and therefore amenable to interventions that promote acceptable behavior. These approaches are designed to improve parental awareness and knowledge about TDV, change parental attitudes about the acceptability of TDV, improve parent communication skills around TDV and skills for helping their teens resolve relationship conflicts, and to improve their rule setting and monitoring skills.

## Potential Outcomes

- Increase in self-efficacy and intentions to engage in active bystander behavior
- Reductions in perpetration of TDV and IPV
- Reductions in victimization of TDV and IPV
- Reductions in peer norms supportive of TDV and IPV
- Increase in parental/caregiver efficacy in resolving teen relationship conflicts and engaging in rule setting
- Reductions in acceptance of dating abuse among adolescents

## Evidence

There is growing evidence that engaging men and boys, bystander approaches, and family-based programs can prevent IPV.

## Men and boys as allies in prevention

Several programs have been developed and implemented that focus on engaging men and boys as allies in the prevention of IPV. One such program with rigorous evaluation evidence is *Coaching Boys into Men (CBIM)*, an eleven session coach-led intervention with male high school athletes in grades 9–12. *CBIM* provides coaches with training tools to model and promote respectful, non-violent, healthy relationships with their male athletes, and sessions are conducted during regularly scheduled team practices throughout the sports season. *CBIM* was evaluated in a randomized controlled trial and was found to significantly reduce perpetration of TDV at the 12-month follow-up

assessment (including physical, sexual, and emotional aggression), as well as significantly reduce engagement in negative bystander behaviors (such as laughing or encouraging abusive behaviors).

## Bystander empowerment and education

Research focused on engaging bystanders has shown that efforts to increase bystander efficacy are beneficial in alcohol and drug use reduction and other health behaviors. More recently, these approaches have been applied to bullying, dating violence, and sexual assault. One example is *Bringing in the Bystander*. This program teaches college student participants about how relationship violence and sexual violence occur along a continuum from less aggressive to more severe behaviors, and teaches participants how to safely intervene, offering opportunities to practice these skills and create plans for how they will intervene to prevent violence as a bystander. Participants in the program demonstrated increased self-reports of likelihood to intervene and confidence in ability to intervene. In one recent study, higher levels of engaging in bystander behaviors were reported by program participants at the one-year follow-up, when the situation involved helping friends (but effects were not found for situations involving strangers). Higher intentions to intervene have been shown to be a protective factor for TDV, with one study finding these intentions to be associated with a 40% lower likelihood of perpetrating TDV.

Another example of a bystander program is *Green Dot*. This program educates and empowers participants to engage in both reactive and proactive responses to interpersonal violence, such as dating or sexual violence, to reduce likelihood of assault. Bystander training is conducted in groups by trained facilitators in four to six hour training sessions. An evaluation of *Green Dot* implemented with college students found that after three years of implementation, the intervention campus had a 9% lower rate of overall violence victimization, 19% lower rate of sexual harassment and stalking

perpetration, and 11% lower rate of sexual harassment and stalking victimization when compared with two non-intervention college campuses. Male students on *Green Dot* campuses reported lower rates of perpetration of overall violence and lower rates of psychological dating violence relative to control campuses.

Female students on *Green Dot* campuses reported significantly less sexual assault resulting from inability to resist due to drugs or alcohol than female students on control campuses. There were no significant program effects for physical dating violence for male or female students. An evaluation of the program across a four-year study period found similar results. A randomized controlled trial of the program with high school students found significant reductions in dating violence perpetration and victimization after three years of program implementation, as well as reductions in other related violence outcomes such as sexual violence (including sexual harassment) and stalking.

**Family-based programs**

Family-based programs have been successful in reducing teen risk behavior, such as high- risk sexual behavior, and may hold promise for prevention of TDV. One example is the *Families for Safe Dates (FSD)* program. *FSD* consists of six booklets delivered to families (five of which are designed with interactive activities that caregivers and teens complete together). Each booklet targets change in constructs associated with TDV, including teen conflict resolution skills, teen's acceptance of dating abuse, and caregiver knowledge about dating and efficacy to influence TDV behavior. A health educator follows up with the caregiver two weeks after each booklet is mailed to gauge progress in completing activities, encourage participation, and answer questions. *FSD* was evaluated in a randomized controlled trial and found to motivate and facilitate parent/caregiver involvement in teen dating abuse prevention activities, increase caregiver self-efficacy for talking about dating abuse, and decrease negative

communication with teens. At the 3-month follow-up, teens in the intervention group reported decreased acceptance of dating abuse, which is a risk factor for TDV perpetration and victimization, and significant reductions in reports of TDV victimization over time compared to no-treatment controls.

Findings from several longitudinal studies indicate that many of the factors associated with perpetrating violence against intimate partners are evident well before adolescence. These factors include poor behavioral control; social problem- solving deficits; early onset of drug and alcohol use; an arrest prior to the age of 13; and involvement with antisocial peers, crime and violence. Findings from these studies also point to academic problems, exposure to chronic stress and adverse experiences such as child abuse and neglect, witnessing violence in the home and community, and parental substance abuse, depression, criminality, and incarceration. Negative parenting behaviors (e.g., poor communication between family members, harsh and inconsistent discipline, poor parental monitoring and supervision, poor parent- child boundaries) and family environments that are unstable, stressful, and that lack structure are also risk factors for perpetration of TDV in adolescence and continued perpetration into adulthood. Approaches that can disrupt these developmental risks and pathways have the potential to reduce IPV.

### B. Disrupt the Developmental Pathway Toward Partner Violence

**Approaches**

There are a number of approaches for interrupting the developmental pathways contributing to partner violence, including those that address early childhood

environments, parenting skills, and other supports to prevent future involvement in violence.

## Early childhood home visitation

**Early childhood home visitation** programs provide information, caregiver support, and training about child health, development, and care to families in their homes. Home visiting programs may be delivered by nurses, professionals, or paraprofessionals. Many programs are offered to low-income, first time mothers to help them establish healthy family environments. The content and structure of programs vary depending on the model being utilized (e.g., some are highly manualized and others are more flexible in their delivery). Some programs begin during pregnancy, while others begin after the birth of the child and may continue up through the child entering elementary school. Some programs also include components to address co-occurring risks such as IPV in the home.

## Preschool enrichment with family engagement

**Preschool enrichment with family engagement** programs provide high-quality early education and support to economically disadvantaged families. These programs are designed to build a strong foundation for future learning and healthy development, and to lower the risks for future behavioral problems. Programs are generally available to children and families who meet basic qualifications, such as being residents in a high-poverty school area eligible for federal Title I funding, demonstrate need and agree to participate, or have incomes at or below the federal poverty level. Parental involvement

is an important component to these programs which often begin in infancy or toddlerhood and may continue into early or middle childhood.

**Parenting skill and family relationship programs**

**Parenting skill and family relationship programs** provide parents and caregivers with support and teach communication, problem-solving, positive parenting skills and behavior monitoring and management skills to reduce children's involvement in crime and violence and later risk of perpetrating IPV. Programs are typically designed for parents and families with children in a specific age range (e.g., preschool, and elementary school, middle and/or high school) with the content tailored to the developmental stage of the child. Programs may be self-directed or delivered to individual or groups of families. For families at high-risk for conflict and child behavior problems, tailored delivery to individual families yields greater benefits than group administration.

**Treatment for at-risk children, youth, and families.**

These approaches are designed for children and youth with histories of child abuse and neglect, childhood aggression and conduct problems, and prior involvement in violence and crime. They are intended to mitigate the consequences of these exposures and prevent the continuation and escalation of violence into adulthood including abuse directed toward partners and one's own children. Referrals for therapeutic interventions and other supports may come from social services, the juvenile justice system, schools, or other community organizations working with

children, youth, and families. Children of all ages may participate in these programs, although the specific age of children targeted depends on the specific program being implemented. Programs are often delivered by trained clinicians in the home or a clinic setting, and can be delivered to individual families or groups of families.

**Potential Outcomes**

- Reductions in child abuse and neglect
- Reductions in child welfare encounters
- Reductions in rates of out of home placement of children and youth
- Increases in parent-child engagement and interaction
- Reductions in harsh and ineffective discipline
- Increases in child health and development
- Reductions in rates of aggressive and social behavior problems in children and youth
- Improved social competency, pro-social behavior and interaction with peers
- Reductions in rates of deviant peer associations
- Reductions in rates of TDV and IPV
- Improvements in marital relationships
- Reductions in rates of involvement in crime, arrest, and incarceration
- Higher educational attainment
- Higher rates of full-time employment
- Higher socioeconomic status and economic self-sufficiency
- Reductions in rates of substance abuse

- Reductions in rates of depressive symptoms

**Evidence**

A large body of evidence highlights the importance of intervening early to prevent future involvement in violence, including future risk of perpetrating partner violence.

**Early childhood home visitation.** The evidence of effectiveness for home visiting programs is mixed, with some models showing few or no effects and others showing strong effects, potentially due to the varying content and delivery of these programs. *Nurse Family Partnership (NFP)*, for instance, has been evaluated in multiple randomized controlled trials and found to be effective in reducing multiple risk factors for IPV. It is associated with a 48% relative reduction in child abuse and neglect, which is a risk factor for both victimization and perpetration of IPV.84 The *NFP* program also reduced parental substance use, the use of welfare, and criminal behavior in women in the program compared to women in the comparison group. At 25 and 50 months of age, children who had received nurse home visits had 45% fewer behavioral problems and parent coping problems as noted in the physician record.86 By ages 15 and 19, participating youth had significantly fewer arrests, convictions, and probation violations and lower rates of substance use. Although the effectiveness of home visits on IPV needs more study, in one *NFP* trial, nurse-visited women reported significantly less exposure to IPV in the previous six months at the four-year follow-up compared with those in the control group.

**Preschool enrichment with family engagement.** These programs have documented positive impacts on the child's cognitive skills, school achievement, social skills, and conduct problems, and are effective in reducing child abuse and neglect and youth involvement in crime and violence, which are risk factors for perpetrating IPV. *Child*

*Parent Centers (CPCs)* and *Early Head Start (EHS)* are two examples of effective programs. *CPCs* have been evaluated in multiple, long-term studies. By age 20, youth who participated in the preschool program (relative to youth in other early childhood programs) had significantly lower rates of juvenile arrest (16.9% vs 25.1%), violent arrests (9.0% vs 15.3%), and multiple arrests (9.5% vs 12.8%).90 By age 24, those who participated in the program for four to six years (vs. preschool only) had significantly lower rates of violent arrests, violent convictions, and multiple incarcerations. Across studies, participating youth relative to comparison groups experienced lower rates of substantiated reports of child abuse and neglect, out-of-home placements, grade retention, special education services, depression, and substance use, as well as higher rates of high school completion, attendance in four-year colleges, health insurance, and full-time employment in adulthood.

Multiple evaluations of *EHS* also demonstrate significant program impacts on multiple risk factors for IPV among participants relative to comparison groups, including significantly fewer child welfare encounters, fewer reports of substantiated physical or sexual abuse,94 better cognitive and language development; home environments that are more supportive of learning; less aggressive and other social behavior problems; and stronger parent-child engagement.

**Parenting skill and family relationship programs.** *The Incredible Years*® and the *Parent Management Training Oregon Model (PMTO)* are two examples of effective parenting programs with impacts on risk and protective factors for perpetration of TDV and later partner violence. *The Incredible Years*® is designed for families with young children up to 12 years of age and can be implemented with additional components for teachers and children in school. A meta-analysis of program effects found significant decreases in child behavior problems, increases in prosocial behaviors, and improvements in parental monitoring, discipline, and mother-child interactions. A randomized controlled trial of an enhanced version of the program also found beneficial effects for the non-target siblings, such as reduced antisocial behavior and improved peer-relations.

*PMTO* is designed for parents of children ages 3 to 16. The program uses didactic instruction, modeling, role-playing, and home practice to teach parenting skills in encouragement, monitoring, limit setting, discipline, problem solving, and to foster parent-child engagement in activities. It is delivered in group and individual family formats in diverse settings (e.g., clinics, homes, schools, community centers, homeless shelters). *PMTO* is associated with reductions in coercive and harsh parenting of children, and increases in positive parenting practices and adaptive family functioning, including among parents with a history of hard drug use (e.g., cocaine, heroin, LSD), physical aggression toward a former or current partner, and a prior arrest. The program is also associated with reductions in child behavior problems and reductions in youth aggression, deviant peer associations, substance use, and rates of arrest. Other benefits include increases in family socioeconomic status and greater rise out of poverty and improvements in the marital relationship.

**Treatment for at-risk children, youth and families.** Several therapeutic programs have demonstrated impact on risk factors for later development of IPV, including reductions in violent behavior and substance use, and improvements in family functioning and positive parenting. A systematic review of therapeutic foster care approaches, such as *Multidimensional Treatment Foster Care (MTFC)*, demonstrate an approximate 72% reduction in violent crimes among participants. *MTFC* provides short-term placements of children and youth with persistent and significant behavioral challenges with extensively trained foster parents, family therapy for biological parents, and behavioral and academic supports to youth. Multiple studies show the benefit of *MTFC* in reducing behavioral problems, attachment issues, and neurophysiological changes due to stress in preschool aged children; and reductions in violent crimes, incarceration, and substance abuse among adolescents.108 For example, adolescent males who participated in *MTFC* were less likely to commit violent offenses than youth in service-as-usual group care. After controlling for age at placement, age at first arrest, official and self-reported prior offenses and time since baseline, 24% of group care youth had two or more criminal referrals for violent offenses in the two years following the baseline versus only 5% of MFTC youth.109

At 12 and 18 months of follow-up, *MTFC* boys also had lower levels of self-reported tobacco, marijuana, and other drug use.


*Multisystemic Therapy (MST)* is an intensive family and community-based treatment program for justice-involved youth that engages the youth's entire social network (e.g., friends, peers, family, teachers, school administrators, and members of the community). *MST* therapists meet with families and youth in their home, school, and community environments with the goal of strengthening family relationships, improving parenting skills, improving youths' academic achievement, and promoting prosocial activities and behavior. *MST* has been evaluated in numerous trials with samples of chronic and violent juveniles and is associated with significant long-term reductions in re-arrests (reduced by a median of 42%) and out-of-home placements (reduced by a median of 54%).111 *MST* participants, relative to youth receiving individual therapy had fewer violent felony arrests approximately 22 years later (4.3% vs. 15.5%).112 The siblings of these participants also had fewer arrests for any crime (43.3% vs. 72%) and felonies (15% vs. 34%)

approximately 25 years later. Other benefits include decreased rates of child maltreatment, improvements in family functioning, parent-child interactions, and positive parenting practices, and reductions in youth's substance use and involvement with gangs.

## C. Create Protective Environments

### Rationale

While many prevention strategies focus on individual and relationship-level factors that influence the likelihood of becoming a survivor or perpetrator of IPV, it is important to acknowledge the influence of community environments (i.e., schools, workplaces, and neighborhoods). Approaches that work to foster a broader social and physical environment that improves safety, social connections, and awareness of IPV can help create a climate that supports prevention of violence against intimate partners. These community-level approaches may encourage higher rates of disclosure of IPV, increase resources and support leveraged on behalf of IPV survivors, and promote social norms that are intolerant of IPV within the community, potentially increasing the likelihood that community members will intervene when they witness IPV.19 Although evidence on community-level approaches for IPV prevention is just beginning to emerge, there is support for the role of neighborhood and community characteristics (e.g., neighborhood social control, social cohesion, collective efficacy, tangible help and support for IPV survivors, social norms) as important protective factors against perpetration of IPV.

### Approaches

Community-level approaches for creating protective environments against the perpetration of partner violence include efforts to:

| Improve school climate and safety |
| --- |
| |

School environments offer a potentially influential context that can be changed or adapted to promote prevention of TDV. Approaches that increase support from school personnel and modify physical spaces in schools have potential to improve safety and raise awareness about dating violence and harassment. Creating a school environment that enhances safety and feelings of safety, promotes healthy relationships and respectful boundaries, and reduces tolerance for violence among students and school personnel can play an important role in reducing rates of TDV perpetration. While efforts have traditionally focused on middle and high school settings, there may be opportunities to adapt this type of approach to other school contexts, such as college and university settings.

**Improve organizational policies and workplace climate**

These types of approaches are designed to foster protective environments in the workplace through the creation of organizational policies and practices that promote safety and encourage help-seeking behavior. Workplace approaches can aid employees and managers in raising awareness about IPV, recognizing the potential for violence by an intimate partner of an employee occurring in the workplace, facilitate how incidents can be reported and handled, and demonstrate commitment to workplace safety (e.g., securing access points, visitor sign-in policies, crisis planning) while providing support and resources to employees experiencing IPV.117 These approaches have potential to encourage disclosure of IPV, normalize help-seeking, and increase tangible aid and social support to employees, which has been shown to be a protective factor for IPV. In addition, these approaches can facilitate positive changes in workplace climate, increase feelings of safety, and reduce perceived tolerance of violence towards intimate partners among managers and employees in the workplace.

## Modify the physical and social environments of neighborhoods

These approaches address aspects of neighborhood settings that increase the risk for IPV, including alcohol outlet density, physical disorder and decay, and social disorder. There are a number of mechanisms by which living in disadvantaged neighborhoods can place people at greater risk for IPV. These neighborhoods typically have higher rates of crime and violence. Exposure to neighborhood violence is a risk factor for IPV.116,119 Additionally, the stress associated with living in disadvantaged neighborhoods and social norms that govern violence in these communities are also possible mechanisms for this increased risk. Further, signs of neighborhood disorder may lead people, including potential perpetrators, to believe that consequences for IPV perpetration, such as police intervention, are less likely. These community-level factors can be addressed by changing, enacting, or enforcing laws and regulations (e.g., alcohol-related policies); improving the economic stability of neighborhoods; and by changing the physical environment to improve social interaction, and strengthen community ties and social cohesion in order to promote residents' willingness to monitor and respond to problem behavior (e.g., collective efficacy). These types of approaches have potential for population-level impact on IPV/TDV outcomes, often at relatively low cost for implementation.

## Potential Outcomes

- Reductions in rates of IPV and TDV perpetration
- Reductions in rates of IPV and TDV victimization

- Reductions in intimate partner homicides
- Reductions in rates of peer violence perpetration
- Reductions in sexual harassment perpetration
- Reductions in community violence
- Improvements in workplace climate towards reduction or prevention of IPV
- Increases in development of organizational policies and resource-seeking for IPV
- Increases in knowledge and awareness of IPV
- Reductions in excessive alcohol use at the community level
- Increases in neighborhood collective efficacy
- Increases in disclosure and reporting of IPV
- Increases in social support provided to survivors of IPV
- Reductions in violent crime

**Evidence**

Although still developing, there is some evidence supporting the use of community-level approaches to preventing partner violence.

**Improve school climate and safety.** The current evidence suggests that changing or adapting certain aspects of school settings to improve student safety has potential to reduce rates of TDV. For example, the building-level component of *Shifting Boundaries* is designed to improve safety in schools by increasing staff presence in "hot spots" (building areas designated by students and staff as unsafe); promoting awareness and

reporting of TDV to school for students at risk for TDV. In a rigorous evaluation of the intervention in New York City middle schools, the building-level component was found to reduce sexual violence victimization in dating relationships by 50%. No effects were found for sexual violence perpetration within teen dating relationships. However, the building level intervention was found to reduce the prevalence of sexual violence perpetration by peers (occurring outside of dating relationships) by 47% and sexual harassment perpetration by 34% compared to control schools that did not receive the classroom or building-level intervention. The prevention effects on sexual violence perpetration by peers and sexual harassment perpetration are important because peer violence is an empirically established risk factor for later TDV perpetration. This study was conducted in middle schools, so it is possible that it is too early developmentally to see effects on TDV perpetration. The fact that this intervention had an impact on risk factors for TDV perpetration, however, is promising.

Improve organizational polices and workplace climate. Similar to school settings, the workplace also represents an important context where safety and awareness around IPV could be addressed. For example, *IPV and the Workplace Training* is one intervention with evidence for significantly improving workplace climate towards IPV in county government organizations randomly assigned to receive the training, compared to a delayed control group. The number of supervisors providing information to employees on a state law that provides protected work leave to IPV survivors significantly increased after receiving the training. Organizations in the intervention group demonstrated more public postings about the state leave law for IPV survivors and were more likely to develop IPV policies and seek additional IPV resources for employees than organizations in the delayed control group. While impact on IPV outcomes has not yet been tested, these findings may translate into increases within the workplace of tangible help and social support, both of which have been found to be protective factors for victimization and perpetration of IPV.

Another organizational approach is the *United States Air Force Suicide Prevention Program*. While not explicitly focused on IPV prevention, this program was developed to reduce stigma and social norms that discourage help-seeking among U.S. Air Force

personnel. Eleven different prevention initiatives were put into practice within the Air Force to enhance education and training and create policies aimed at promoting help-seeking (e.g., enhanced patient privilege, greater coordination with mental health services, required training on suicide prevention). A longitudinal evaluation of the program showed a 30% reduction in moderate family violence (exposure to repeated instances of emotionally abusive behavior, neglect, or physical or sexual abuse) and a 54% reduction in severe family violence (a pattern of abusive behavior that requires placement of the victim in an alternative environment) in the years after the program launched.124 The program also significantly lowered rates of suicide. Creating an organizational culture that encourages help-seeking and increases service referrals for individuals and families in distress may benefit not only individuals at risk for suicide but also couples at risk for IPV.

**Modify the physical and social environments of neighborhoods.** Evidence suggests that changing or modifying environmental characteristics of neighborhoods may be an effective approach for preventing IPV. For example, one study found that residents of an urban public housing development randomly assigned to buildings in proximity to green conditions (i.e., trees and grass) reported significantly lower rates of partner violence in the past year than residents living in proximity to barren conditions. The researchers found that levels of mental fatigue (inattentiveness, irritability, and impulsivity) were significantly higher in buildings next to barren areas and that aggression accompanied mental fatigue. Additionally, research has also shown that green space in urban communities has been linked to higher levels of neighborhood collective efficacy and reductions in violent crime, which is a risk factor for IPV.

Alcohol-related policies represent another potential way to reduce risk for IPV at the neighborhood/community level. Alcohol outlet density, defined as the number of locations where alcohol can be purchased, has been consistently linked to higher rates of IPV. For example, in a population-level survey of U.S. couples, an increase of 10 alcohol outlets per 10,000 persons was associated with a 34% increase in male-to-female partner violence. Policies that work to reduce a community's alcohol outlet density are one example of an approach that might help reduce community rates of IPV.

## D. Strengthen Economic Supports for Families

**Rationale**

Addressing socioeconomic factors holds great potential for improving a wide range of health outcomes for neighborhoods, communities and states and also has the potential to prevent IPV. **Evidence suggests that poverty, financial stress, and low income can increase risk for IPV.** Reducing financial stress may decrease potential for relationship conflict and dissatisfaction, which are strong predictors of IPV. In addition, improving financial stability and autonomy could reduce financial dependence on a potential perpetrator and provide alternatives to unhealthy relationships. Studies also show that gender inequality in education, employment, and income is a risk factor for IPV. Therefore, efforts to improve financial security for families and women's education, employment and income may reduce risk for IPV.

### Approaches

Improving household financial security and work-family supports are ways to strengthen economic supports for families and potentially reduce IPV.

**Strengthen household financial security.** Improving ways to support families in the absence of employment or sufficient wages addresses several risk factors for IPV, including poverty, low income, financial stress, and gender inequality. Providing income supplements, income generating opportunities, and decreasing the gender pay gap target these risk factors directly. Examples of ways to strengthen household financial security include income supports such as *tax credits* and *child care subsidies*. These are designed to support parental employment, cover necessities, and offset the costs of childrearing as well as improve the availability of affordable high-quality child care to low-income families.

*Cash transfers* and other forms of assistance are another way to help families increase household income and meet basic needs (e.g., food, shelter, and medical care).

**Strengthen work-family supports.** Policies such as *paid leave (parental, sick, vacation)* provide income replacement to workers for life events such as the birth of a child, care of a family member during times of illness, or personal leave to refresh or recover from a serious health condition. Job-protected leave is also available in some states to help IPV survivors attend court hearings, seek medical treatment, or attend counseling. Paid and job-protected leave policies help individuals keep their jobs and maintain income to cover expenses or address other needs.

**Potential Outcomes**

- Reductions in poverty, financial stress, and economic dependency
- Increases in annual family income
- Reductions in earnings inequality
- Increases in annual earnings for women
- Increases in empowerment of women
- Reductions in relationship conflict
- Increases in relationship satisfaction
- Reductions in IPV

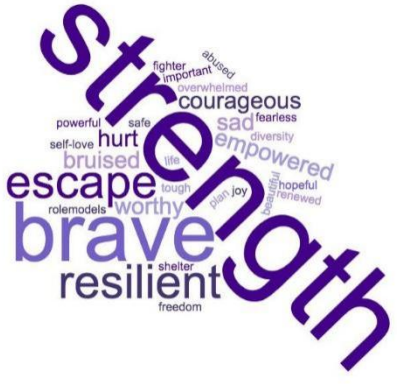
**Evidence**

There are a number of policies and programs aimed at strengthening economic supports with evidence of impact on risk factors for IPV.

**Strengthen household financial security.** *Temporary Assistance to Needy Families (TANF)* and the *Supplemental Nutrition Assistance Program (SNAP)* are examples of programs that can strengthen household financial security through providing cash benefits to low-income households. States can administer these programs in ways that maximize their impact on reducing poverty and financial stress, which are risk factors for IPV. For instance, states can implement policies allowing child support payments to be added (versus off-setting) to *TANF* benefits for custodial parents. The *Minnesota Family Investment Program (MFIP)*, for example, focuses on encouraging work, reducing long-term dependence on public assistance, and reducing poverty by continuing to provide financial supports to struggling families after parents have gained employment—e.g., by increasing the "earned income disregard," or the amount of income that is not counted in calculating welfare grants. An effectiveness study of the program, in which families were randomly assigned to *MFIP* or *Aid to Families with Dependent Children (AFDC)*, which was the predecessor of the *TANF* program, found a number of benefits. Families who received *MFIP* showed significant declines in IPV when compared to families receiving *AFDC* at three-year follow up (49% of *MFIP* participants v. 60% of *AFDC* recipients reported abuse during the three-year follow-up), as well as improved marriage rates for parents and improved school performance and reductions in behavior problems for children.132 This study suggests that increasing income supports to low-income families can lead to reductions in IPV.

Research on tax credits (*Earned Income Tax Credit (EITC)* and *Child Tax Credit*), shows that they can help lift families out of poverty, which is a risk factor for IPV, and are associated with long-term educational and health benefits to recipients and their children. Analyses of the use of tax credits shows that families mostly use them to cover necessities as well as to obtain additional education or training to improve employability and earning

power. Survivors of IPV often experience unemployment or underemployment, economic instability, and poverty as a result of the abuse they experience. The *EITC* is associated with increases in both maternal employment and earnings, both of which can help women leave an abusive relationship.




*Microfinance programs* provide a range of financial services and opportunities to low-income families often with the goal of improving a community's financial health by empowering women. Microfinance takes many forms ranging from communal borrowing to low- or no-interest startup loans for small, woman-owned enterprises to innovative savings plans. In some projects, microfinance is paired with training for women on relevant job skills, finances, entrepreneurship, and often on empowerment and social issues as well, including issues of gender, safe sex, and IPV. Kim et al. and Pronyk et al. found microfinance in combination with training on gender norms and health topics decreased the incidence of past-year physical and sexual IPV among participants in South Africa by almost half after two years in the program, from 11.4% to 5.9% in the intervention group (versus a slight increase in the control group from 9.0% to 12.1%). In addition, program participants showed increases in multiple indicators of female empowerment, compared to the control group. Although microfinance has primarily been studied in low-income settings in other countries, it holds promise for use in the United States. One U.S.-based study implemented a microfinance intervention with low-income, drug-using women involved in the sex trade with promising findings for HIV risk reduction. This study indicates that microfinance interventions may be feasible for implementation in the U.S. and that they have been successful in impacting outcomes with similar risk factors. There are also organizations providing this type of lending in the U.S.

*Comparable worth policies.* While most states have equal pay laws, these laws vary in terms of their provisions, populations covered, and remedies available to employees. The laws also vary in terms of comparable worth provisions, which determine pay rates

according to the skill level, working conditions, effort, and responsibility of positions. While these policies have not yet been evaluated for their impact on IPV, they could potentially have an impact on IPV by increasing economic stability of women and their families given that economic inequality is a known risk factor for IPV victimization. Studies of the potential impact of a national comparable worth policy on earnings inequality show decreases in overall earnings inequality, inequality between women and men, and inequality among women. Recent findings from an analysis of the 2010-2012 Current Population Survey Annual Social and Economic supplement show potential impacts on women's annual earnings, annual family income, and poverty rates even after controlling for labor supply, human capital, and labor market characteristics.138

**Strengthen work-family supports.** Employers can also adopt *paid leave policies* that allow parents to keep their jobs and thus maintain their incomes after the birth of a child, during an illness, or while caring for sick family members. Research demonstrates that women with paid maternity leave are more likely to maintain their current employment with the same employer after the birth of a child, and women who take maternity leave and delay return to work after the birth of a child have fewer depressive symptoms than those who return to work earlier. One study conducted in Australia found that women working during early pregnancy who qualified for paid maternity leave were significantly less likely to experience physical and emotional IPV in the first 12 months postpartum than women not working.141 This finding suggests that access to paid maternity leave may be protective against IPV, in addition to helping women maintain employment and potentially reduce mental health issues.

### E. Support Survivors to Increase Safety and Lessen Harms

| Rationale |
| --- |
| |

IPV survivors can experience long-term negative health outcomes, including HIV and other sexually transmitted infections, chronic pain, gastrointestinal and neurological disorders, substance abuse, depression and anxiety, PTSD, eating and sleep disorders, chronic diseases, suicide, and homicide. IPV is also associated with unplanned pregnancy, preterm birth, low birth weight, and decreased gestational age. Furthermore, individuals who have experienced violence and their dependent children are also at increased risk for housing instability and homelessness. *The Violence Against Women Reauthorization Act of 2013* and the *Family Violence Prevention and Services Act* address these issues by putting in place various supports for survivors. **Denial of housing based on an individual's status as a victim of abuse and lease termination as a result of violence are now prohibited.** However, obstacles to safe and affordable housing still remain when leaving a relationship. Efforts to address the psychological, physical, emotional, housing, and other needs of survivors and their children may help prevent future experiences of IPV and may lessen or reduce negative consequences experienced by IPV survivors.

**Approaches**

The current evidence suggests the following approaches to prevent future experiences of IPV and lessen or reduce the negative consequences experienced by IPV survivors:

**Victim-centered services** include shelter, hotlines, crisis intervention and counseling, medical and legal advocacy, and access to community resources to help improve outcomes for survivors and mitigate long-term negative health consequences of IPV. Services are based on the unique needs and circumstances of victims and survivors and coordinated among community agencies and victim advocates.

**Housing programs** that support survivors in obtaining rapid access to stable and affordable housing reduce barriers to seeking safety.22 Once this immediate need is met, the survivor can focus on meeting other needs and the needs of impacted children. These

programs can include access to emergency shelter, transitional housing, rapid re-housing into a permanent home, flexible funds to address immediate housing-related needs (e.g., security deposits, rental assistance, transportation), and other related services and supports.

**First responder and civil legal protections.** These approaches provide increased safety for survivors and their children after violence has occurred. Included here are law enforcement efforts designed to help survivors and decrease their immediate risk for future violence, orders of protection, and supports for children. These protections address survivors' immediate and long-term needs and safety.

**Patient-centered approaches** recognize the importance of universal prevention education, screening, and intervention for IPV, reproductive coercion, and other behavioral risks. The U.S. Preventive Services Task Force (USPSTF) recommends screening women of childbearing age for IPV and referring women who screen positive to intervention services.146 Women may be screened for IPV and other behavioral risk factors (e.g., smoking, alcohol, depression) and may also be screened for reproductive coercion and educated about how IPV can impact health and reproductive choices (contraceptive use, pregnancy, and timing of pregnancy). However, not all survivors disclose experiences with violence and there are also opportunities within health care settings to offer universal education on healthy relationships, potential signs of abuse, and available resources and support. Universal prevention education, screening, and intervention may occur in health care settings but may also be considered in the context of other intervention or program models. Intervention services may include counseling, health promotion, patient education resources, referrals to community services and other supports tailored to a patient's specific risks.

**Treatment and support for survivors of IPV, including TDV.** These approaches include a range of evidence-based therapeutic interventions conducted by licensed mental health providers to mitigate the negative impacts of IPV on survivors and their children. These interventions are designed to be trauma-informed, meaning that they are delivered in a way that is influenced by knowledge and understanding of how trauma impacts a survivor's life and experiences long-term.147 Treatments are intended to

address depression, traumatic stress, fear and anxiety, problems adjusting to school, work or daily life, and other symptoms of distress associated with experiencing IPV.

**Potential Outcomes**

- Increases in physical safety and housing stability
- Reductions in subsequent experiences of IPV
- Increases in access to services and help-seeking
- Reductions in short- and long-term negative health consequences of IPV, including injury, PTSD, depression, and anxiety
- Increases in positive parenting behaviors
- Decreases in the use of corporal punishment
- Decreases in verbal and physical aggression and increases in prosocial behavior among children of IPV survivors
- Reductions in IPV homicide and firearm IPV homicide
- Improvements in pregnancy outcomes for women experiencing IPV (i.e., higher birth weights, longer gestational age at delivery)
- Reductions in rates of reproductive coercion and unplanned pregnancy

**Evidence**

The evidence suggests that having supports and programs in place for survivors of IPV improve short- and long-term outcomes for health and safety.


**Victim-centered services.** Domestic violence shelters and outreach programs that connect survivors and their families with an advocate provide the survivor with the opportunity to navigate and use community resources more easily than they might be able to on their own. Domestic violence advocacy includes assessing a survivor's individual needs and supporting them in accessing community resources such as legal, medical, housing, employment, child care, and social support services. For children of survivors, advocacy includes meeting their needs around recreation, school supports, and material goods. In a randomized controlled trial of women and their children leaving abusive relationships, Sullivan et al.148 found that, after 16 weeks of client-centered advocacy services, women experienced less abuse from their former partners at immediate follow-up than control women. Women receiving advocacy services also reported less depression and greater self-esteem than controls, indicating an improvement in IPV survivors' overall safety and well-being.

**Housing programs.** Washington State's *Housing First* program is an example of a housing program for survivors of IPV. The program connects survivors to advocacy services and flexible financial assistance in order to quickly establish permanent housing and to cover transportation, child care, and other costs needed to establish a sense of safety and stability. In a pilot evaluation, 96% of participants remained stably housed after 18 months. Fully 84% of survivors reported an increase in physical safety for themselves and their children.149 Although this program has not been rigorously evaluated, these

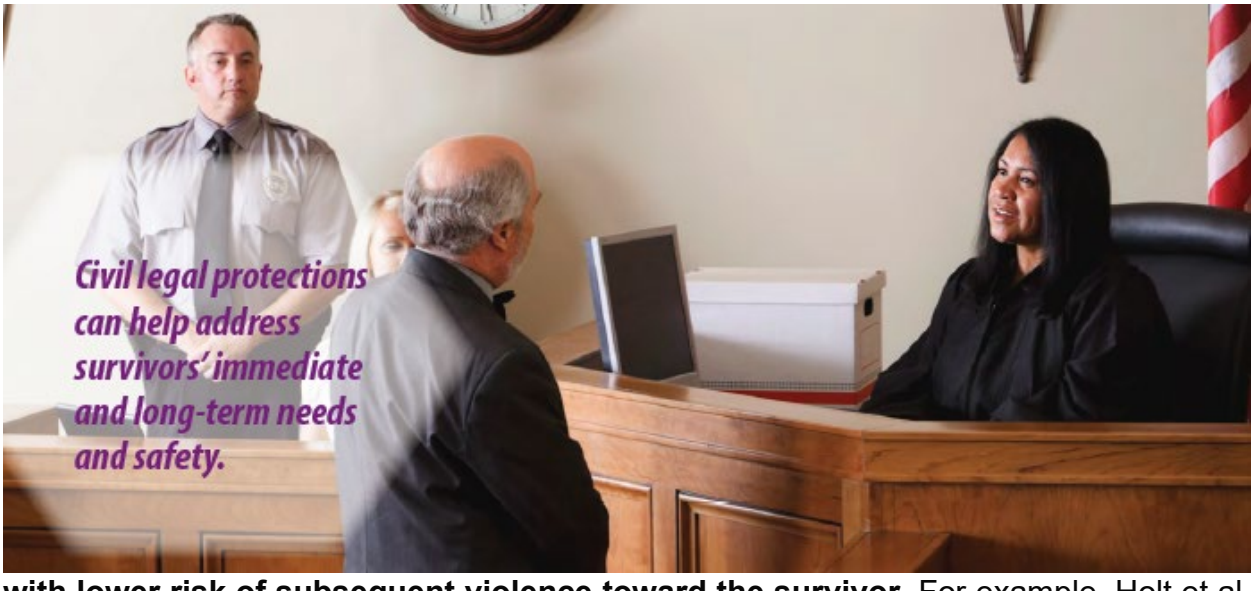
pilot findings indicate that providing stable housing to IPV survivors may reduce risk for homelessness and improve women's ability to keep themselves and their children safe from the abuser.

**First responder and civil legal protections.** *Lethality Assessment Programs* can be an important tool to help police responding to domestic violence and to decrease risk for survivors. Law enforcement officers responding to the scene of a domestic violence incident use a short risk assessment tool to screen for risk of homicide. The assessment tool includes the partner's access to firearms, the partner's employment status, previous threats, and acts of violence. Survivors who screen at high risk are put into immediate contact with an advocate and are provided safety planning, resources, and medical and legal advocacy. An evaluation of the *Lethality Assessment Program* indicated that at a 7-month follow-up interview, program participants receiving the intervention experienced a significant decrease in severity and frequency of physical and emotional violence. Help-seeking behavior also increased at follow-up and included actions such as applying for, and receiving an order of protection, removing or hiding their partner's weapons, and seeking medical care.

Given that leaving the relationship is one of the most potentially lethal times in an abusive relationship, an increase in safety for survivors leaving relationships is particularly salient. *Supervised Visitation and Exchange* is another example that seeks to decrease risk for survivors and their children by creating a safe space for non-custodial parent-child interaction monitored by a third-party. Flory et al. found participation in a supervised visitation program resulted in a 50% reduction in verbal and physical aggression between custodial and non-custodial parents (from an average of 12 incidents to an average of 6 incidents post-intervention). Additionally, parents referred to supervised services were significantly less likely to use corporal punishment after participation in the program, indicating a potential increase in positive parenting behaviors.

***Protection orders (POs)* are another support option available to survivors. *POs* are court-ordered injunctions aimed at limiting or prohibiting contact between an alleged perpetrator and survivor of IPV to prevent further violence from**

**occurring.154 Although the process varies considerably by state, it typically begins with a petition to immediately issue a temporary (or ex parte) order until a hearing can be scheduled for a judge to hear from both parties and evaluate whether issuing a permanent order is justified and what the terms should be.154 In a review of available research, Benitez et al.155 concluded that *POs* are associated**




**with lower risk of subsequent violence toward the survivor**. For example, Holt et al. examined a large sample of women who had experienced a police-reported episode of IPV and found that women with permanent *POs* experienced an 80% reduction in physical abuse during the follow-up period (compared to women with no *PO*). However, women with temporary *POs* were more likely than women without *POs* to be psychologically abused, highlighting the potential importance of longer-term *POs* at reducing risk for subsequent IPV. In addition, Spitzberg conducted a meta-analysis suggesting that an average of 40% of *POs* are violated, and one study found only a few differences when comparing IPV survivors with and without *POs*; women with *POs* had lower levels of hyperarousal and sexual re-abuse at 6-month follow-up than women without *POs*, but no differences were found for other PTSD symptoms, physical assault, injury, or psychological re-abuse. However, research suggests that having a *PO* significantly increases feelings of well-being among survivors of IPV, making *POs* a potentially important tool in supporting survivors.

Another existing protection for survivors is *reducing lethal means* for people who have been convicted of a crime related to IPV or who have a restraining or *PO* against them. Women are at increased risk for homicide when their violent intimate partner has access to a firearm. Federal law makes it unlawful for certain categories of persons to ship, transport, receive, or possess firearms. The law includes individuals subject to a court order restraining the person from harassing, stalking, or threatening an intimate partner or child of the intimate partner, and persons who have been convicted of a misdemeanor or felony crime of domestic violence. **In 2016, the U.S. Supreme Court upheld a lower court's decision that firearms may be removed from the possession of someone found guilty of misdemeanor domestic abuse (Voisine v. U.S., 2016).**160 State laws often mirror federal law and, in some cases, enact policy that further limits access or allows law enforcement to remove or seize firearms. Intimate partner homicide was reduced by 7% in states with laws limiting access to firearms for persons under domestic violence restraining orders. In a multiple time series design study, Zeoli and Webster found that in 46 of the largest U.S. cities with state statutes that reduce access to firearms for individuals with domestic violence restraining orders, intimate partner homicide and firearm intimate partner homicide risk decreased by 19% and 25%, respectively, between 1979 and 2003.

**Patient-centered approaches** are associated with a number of benefits including reduced IPV. The evidence, however, is mixed, potentially due to variability in the nature of intervention models tested, populations studied, loss to follow-up, and other methodological factors. A systematic review of primary care-based interventions for IPV found brief, women-focused interventions delivered mostly in the primary care office by non-physician healthcare workers were successful at reducing IPV, improving physical and emotional health, increasing safety-promoting behaviors, and positively affecting the use of IPV and community-based resources. Other systematic reviews have noted significant benefits of counseling interventions in reducing IPV and improving birth

outcomes for pregnant women, reducing pregnancy coercion, and women's involvement in unsafe relationships.

One rigorous study of a prenatal counseling intervention found that women in the intervention group (compared with usual care) were 52% less likely to have recurrent episodes of IPV during pregnancy and postpartum; had reduced rates of very low birthweight infants (0.8% vs 4.6%), and longer mean gestational age at delivery (38.2 weeks versus 36.9 weeks). In another rigorous intervention study conducted in four clinics, family planning counselors asked about IPV and reproductive coercion when determining reason for visit and then assisted patients in identifying strategies specific to the reason for the clinic visit (e.g., offering a more hidden form of birth control if partner has been influencing birth control use; offering emergency contraception if indicated; educating client about local IPV and sexual assault resources and facilitating their use). The control group received standard care consisting of a brief IPV screen without any questions on reproductive coercion and were provided a list of IPV resources. In this study, the intervention group was 71% less likely to experience pregnancy reproductive coercion among female patients who had experienced IPV within the past three months compared to a control group. In a subsequent, larger cluster randomized controlled trial of the intervention across 25 family planning clinics, Miller et al. found improvements in knowledge of partner violence resources and self-efficacy to enact harm reduction behaviors among the intervention group (relative to the control group) at the 12-month follow-up. While there were no differences in IPV or reproductive coercion among the full sample at follow-up, the intervention led to a significant reduction in reproductive coercion among women reporting the highest levels of reproductive coercion at baseline.

Another intervention study embedded an IPV intervention into home visitation programs for pregnant women and new mothers, where women in the intervention group were screened by home visitors who had received special training on IPV and the intervention. If women screened positively for IPV, the nurse delivered a brochure-based empowerment intervention during six sessions of the home visiting program. The intervention consisted of a standardized assessment of the level of danger from IPV, a discussion of safety and response options with the participant, assistance with choosing

a response, and provision of referrals to services. Women in the intervention group reported a significantly larger decrease in IPV from baseline to two or more year follow-up than women in a service-as-usual control group.

**Treatment and support for survivors of IPV, including TDV.** Supportive interventions are associated with improved psychological health and long-term positive impact for survivors of IPV. For example, ***Cognitive Behavioral Therapy (CBT)*** **is an example of a treatment for survivors of IPV who experience PTSD and depression.** ***CBT*** **includes treatments such as** ***Cognitive Processing Therapy (CPT)*** to help the patient learn to recognize and challenge cognitive distortions (i.e., negative ways of thinking about a situation that makes things appear worse than they really are). A randomized clinical trial that assessed participants before treatment, six times during treatment, and at a 6-month follow-up, found that women who received *CBT* for treatment of PTSD experienced reductions in PTSD and depression. Reductions in PTSD and depression, in turn, were associated with a decreased likelihood of IPV victimization at the 6-month follow-up controlling for recent IPV (i.e., IPV from a current partner within the year prior to beginning the study) and prior interpersonal traumas.

Another example is *Cognitive Trauma Therapy for Battered Women (CTT-BW)*, which is a cognitive behavioral approach used with survivors of IPV, who are no longer at risk for violence. Designed in collaboration with survivors and advocates, the goal of *CTT-BW* is to address the negative effects of IPV (e.g., PTSD, depression, anxiety, and emotional and behavioral problems). Of the women who completed treatment, 87% no longer met diagnostic criteria for PTSD, and 83% had depression scores in the normal range at the 6-month follow-up.

**Sector Involvement**

Public health can play an important and unique role in addressing intimate partner violence. Public health agencies, which typically place prevention at the forefront of efforts and work to create broad population-level impact, can bring critical leadership and resources to bear on this problem. For example, these agencies can serve as a convener, bringing together partners and stakeholders to plan, prioritize, and coordinate IPV prevention efforts. Public health agencies are also well positioned to collect and disseminate data, implement preventive measures, evaluate programs, and track progress. Although public health can play a leadership role in preventing IPV, the strategies and approaches outlined in this technical package cannot be accomplished by the public health sector alone.

Other sectors vital to implementing this package include, but are not limited to, education, government (local, state, and federal), social services, health services, business and labor, justice, housing, media, and organizations that comprise the civil society sector such as domestic violence coalitions and service providers, faith-based organizations, youth-serving organizations, foundations, and other non-governmental organizations. Multiple sectors working simultaneously across several strategies is key to taking a comprehensive approach to prevention. Collectively, all of the sectors can make a difference in preventing IPV by impacting the various contexts and underlying risks that contribute to partner violence.

The strategies and approaches described in this technical package are summarized in the Appendix along with the relevant sectors that are well positioned to bring leadership and resources to implementation efforts. For example, many of the approaches and programs for the first two strategies (*Teach Safe and Healthy Relationship Skills and Engage Influential Adults and Peers*) are delivered in educational settings, making education an important sector for implementation. Health departments across the country

often work in partnership with school districts, universities, and community-based organizations to implement and evaluate prevention programs in educational settings. Other approaches (e.g., healthy relationship programs for couples and family-based programs) are often delivered in community settings. Through their work with community-based organizations, local and state health departments can also play a leadership role in implementing and evaluating these programs.

Programs to *Disrupt the Developmental Pathways Toward Partner Violence* are implemented in a variety of settings and involve the collaborative work of public health, social services, justice, community organizations, and education. For instance, the social services, education and public health sectors are vital for implementation and continued provision of early childhood and parenting programs. Social services, for instance, can help families receive the skills training and services necessary to promote the physical, cognitive, social, and emotional development of children, thereby preparing youth for long-term academic success and positive behavioral and health outcomes. The public health sector can play a vital role by educating communities and other sectors about the importance of ensuring early childhood programs and continuing research that documents the benefits of these programs on health and development, family well-being, and prevention of violence against peers and dating partners, as this evidence is important in making the case for continued support of these programs for children, youth, and families in need.

The health care, justice, and social service sectors can work collaboratively to support children, youth and families with histories of child abuse and neglect, conduct problems, and prior involvement in violence and crime. As with other prevention programs, local and state public health departments can bring community organizations and other partners together to plan, prioritize, and coordinate prevention efforts and play a leadership role in evaluating these programs and tracking their impact on health, behavioral, and other outcomes.

The business and labor sectors, as well as government entities, are in the best position to establish and implement policies to *Strengthen Economic Supports* and *Create Protective Environments* in workplaces and community settings. These are the sectors that can more directly address some of the community-level risks and environmental contexts that make IPV more likely to occur. Public health entities can play an important role by gathering and synthesizing information, working with other agencies within the executive branch of their state or local governments in support of policy and other approaches, and evaluating the effectiveness of measures taken. Further, partnerships with domestic violence coalitions and other community organizations can be instrumental in increasing awareness of and garnering support for policies and programs affecting women, children, and families.

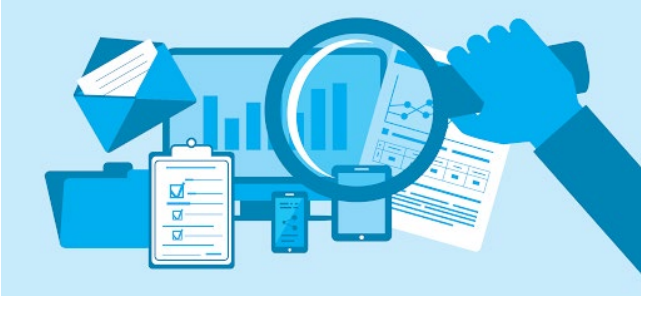
Finally, this technical package includes victim-centered services, criminal justice and social service protections, and a number of therapeutic approaches to *Support Survivors and Lessen Harms*. Domestic violence advocates, community organizations, and other professionals who work with survivors, in collaboration with justice, housing, social services, and the health care sector, are uniquely positioned to identify and deliver critical intervention support and victim-centered services in a manner that best meets the needs and circumstances of survivors. The health care sector, working with victim advocates and in collaboration with justice and social services, is also uniquely positioned to address trauma and the long-term consequences of IPV. In addition to having licensed providers trained to recognize and address trauma, the health care sector can also coordinate wrap-around behavioral health and social services to address the health consequences of IPV and also the conditions that may increase the risk of repeated violence.

Regardless of strategy, action by many sectors will be necessary for the successful implementation of this package. In this regard, all sectors can play an important and influential role in supporting healthy intimate relationship behaviors and contexts, and supporting survivors and their families when they do experience IPV.

## Monitoring and Evaluation

Monitoring and evaluation are necessary components of the public health approach to prevention. Timely and reliable data are essential for monitoring the extent of the problem and evaluating the impact of prevention efforts. Data are also necessary for program planning and implementation.

Surveillance data helps researchers and practitioners track changes in the burden of IPV. Surveillance systems exist at the federal, state, and local levels. Assessing the availability of surveillance data and data systems across these levels is useful for identifying and addressing gaps in these systems. The National Intimate Partner and Sexual Violence Survey (NISVS) and the National Crime Victimization Survey (NCVS) are examples of surveillance systems that provide data on IPV. NISVS collects information on IPV, sexual violence, and stalking victimization at both the state and national level, including data on characteristics of the victimization, demographic information on victims and perpetrators, impacts of the violence, first experiences of these types of violence, and health outcomes associated with the violence. The NCVS gathers information from a nationally representative sample of households on the frequency, characteristics, and consequences of criminal victimization among persons aged 12 and older in the United States. The Youth Risk Behavior Surveillance System is another source of data that collects information on TDV victimization (including physical and sexual), sexual violence victimization, youth violence victimization (including bullying) and suicidal behavior among high-school students. This information is available at the local, state, and national levels. In addition, there are data at the local level including school surveys, women's health surveys, criminal justice data and other data that are important in local efforts to monitor the problem of IPV.



It is also important at all levels (local, state, and federal) to address gaps in responses, track progress of prevention efforts and evaluate the impact of those efforts, including the impact of this technical package. Evaluation data, produced through program

implementation and monitoring, is essential to provide information on what does and does not work to reduce rates of IPV and its associated risk and protective factors. Theories of change and logic models that identify short, intermediate, and long-term outcomes are an important part of program evaluation.

The evidence-base for IPV prevention has advanced greatly over the last few decades. However, additional research is needed to evaluate the impact of strategies that we know relate to risk factors for IPV, such as disrupting the developmental pathways to aggression on IPV outcomes directly. Along the same lines, more research is needed to evaluate policies and other efforts at the outer levels of the social ecology on IPV outcomes. Consistent with DVP's *Strategic Vision for Connecting the Dots*, evaluation research could also be advanced by measuring IPV and TDV outcomes in studies that are intended to prevent other forms of violence, such as peer violence, bullying, child abuse and neglect, suicide, sexual violence, and problem behaviors such as drug and alcohol abuse, high-risk sexual behavior, among others. Lastly, it will be important for researchers to test the effectiveness of combinations of the strategies and approaches included in this package. Most existing evaluations focus on approaches implemented in isolation. However, there is potential to understand the synergistic effects within a comprehensive prevention approach. Additional research is needed to understand the extent to which combinations of strategies and approaches result in greater reductions in IPV than individual programs, practices, or policies.

## Conclusion

Intimate partner violence represents a significant public health issue that has considerable societal costs. Supporting the development of healthy, respectful, and nonviolent relationships has the potential to reduce the occurrence of IPV and prevent its harmful and long-lasting effects on individuals, families, and the communities where they live. This technical package contains a variety of strategies and approaches that ideally would be used in combination in a multi-level, multi-sector approach to preventing IPV. Consistent with CDC's emphasis on the primary prevention of IPV, the current package

includes multiple strategies intended to stop perpetration of partner violence before it starts, in addition to approaches designed to provide support to survivors and diminish the short- and long-term harms of IPV. The hope is that multiple sectors, such as public health, health care, education, business, justice, social services, domestic violence coalitions and the many other organizations that comprise the civil society sector will use this technical package to prevent IPV and its consequences.

The strategies and approaches identified in this technical package represent the best available evidence to address the problem of IPV. It is based on research which suggests that the strategies and approaches described have demonstrated impact on rates of IPV or on risk and protective factors for IPV. Although the research evidence on what works to stop IPV is not as expansive as it is for other areas (e.g., youth violence), ongoing monitoring and evaluation of existing or newly developed strategies and approaches will create opportunities for building upon the current evidence. As new evidence emerges, it will be incorporated into the technical package and used to inform and guide communities seeking to address the problem of IPV. Violence between intimate partners is a costly public health issue, but it is also preventable. Through continued research and evaluation of promising approaches for preventing IPV, we can strengthen our understanding of how to support healthy relationships between intimate partners and alleviate the burden of IPV to society as a whole.

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## F. Leaving an Abusive Relationship (OWH, 2020)

If you are thinking about leaving an abusive relationship, even if you don't leave right away, creating a Safety Plan can help you know what to do if your partner abuses you again. It can help you be more independent when you leave.
Your safety plan will help you be prepared:

- **Identify a safe friend or friends and safe places to go.** Create a code word to use with friends, family, or neighbors to let them know you are in danger without the abuser finding out. If possible, agree on a secret location where they can pick you up.
- **Keep an alternate cellphone nearby.** Try not to call for help on your home phone or on a shared phone. Your partner might be able to trace the numbers. If you don't have a cellphone, you can get a prepaid phone. Some domestic violence shelters offer free phones.
- **Memorize the phone numbers of friends, family, or shelters.** If your partner takes your phone, you will still be able to contact loved ones or shelters for a safe place to stay.
- **Make a list of things to take if you have to leave quickly.** Important identity documents and money are probably the top priority. See the Safety Packing List for a detailed list of items to pack. Get these items together, and keep them in a safe place where your partner will not find them. If you are in immediate danger, leave without them.
- **If you can, hide an extra set of car keys** so you can leave if your partner takes away your usual keys.
- **Ask the doctor how to get extra medicine or glasses, hearing aids, or other medically necessary items for you or your children.**
- **Contact your local family court** (or domestic violence court, if your state has one) for information about getting a restraining order. If you need legal help but don't have much money, your local domestic violence agency may be able to help you find a lawyer who will work for free or on a sliding scale.
- **Protect your online security** as you collect information and prepare. Use a computer at a public library to download information, or use a friend's computer or cellphone. Your partner might be able to track your planning otherwise.
- **Try to take with you any evidence of abuse or violence** if you leave your partner. This might include threatening notes from your partner. It might be copies of police and medical reports. It might include pictures of your injuries or damage to your property.

- **Keep copies of all paper and electronic documents on an external thumb drive.** Advocates at the National Domestic Violence Hotline(link is external), 800-799-SAFE (7233), can help you develop your safety plan. The National Center on Domestic and Sexual Violence provides a form(link is external) for developing your own safety plan. You can also find more tips on developing your safety plan(link is external). Every person deserves to be safe.


**G. Safety Plans** (NDVH, 2020)

The following is sourced from the National Domestic Hotline at this link:

https://www.thehotline.org/help/path-to-safety/

***Safety While Living with and Abusive Partner***

- Identify your partner's use and level of force so that you can assess the risk of physical danger to you and your children before it occurs.

- Identify safe areas of the house where there are no weapons and there are ways to escape. If arguments occur, try to move to those areas.
- Don’t run to where the children are, as your partner may hurt them as well.
- If violence is unavoidable, make yourself a small target. Dive into a corner and curl up into a ball with your face protected and arms around each side of your head, fingers entwined.
- If possible, have a phone accessible at all times and know what numbers to call for help. Know where the nearest public phone is located. Know the phone number to your local shelter. If your life is in danger, call the police.
- Let trusted friends and neighbors know of your situation and develop a plan and visual signal for when you need help.
- Teach your children how to get help. Instruct them not to get involved in the violence between you and your partner. Plan a code word to signal to them that they should get help or leave the house.
- Tell your children that violence is never right, even when someone they love is being violent. Tell them that neither you, nor they, are at fault or are the cause of the violence, and that when anyone is being violent, it is important to stay safe.
- Practice how to get out safely. Practice with your children.
- Plan for what you will do if your children tell your partner of your plan or if your partner otherwise finds out about your plan.
- Keep weapons like guns and knives locked away and as inaccessible as possible.
- Make a habit of backing the car into the driveway and keeping it fueled. Keep the driver’s door unlocked and others locked — for a quick escape.
- Try not to wear scarves or long jewelry that could be used to strangle you.
- Create several plausible reasons for leaving the house at different times of the day or night.

## Safety Planning with Children

If you are in an abusive relationship, a safety plan should include ways that your children can stay safe when violence is happening in your home. It is key to remember that if the violence is escalating, you should avoid running to the children because your partner may hurt them as well.

## Planning for Violence in the Home

- Teach your children when and how to call 911.
- Instruct them to leave the home if possible when things begin to escalate, and where they can go.
- Come up with a code word that you can say when they need to leave the home in case of an emergency — make sure that they know not to tell others what the secret word means.
- In the house: identify a room they can go to when they're afraid and something they can think about when they're scared.
- Instruct them to stay out of the kitchen, bathroom and other areas where there are items that could be used as weapons
- Teach them that although they want to protect their parent, they should never intervene.
- Help them make a list of people that they are comfortable talking with and expressing themselves to.
- Enroll them in a counseling program. Local service providers often have children's programs.

## Planning for Unsupervised Visits

If you have separated from an abusive partner and are concerned for your children's' safety when they visit your ex, developing a safety plan for while they are visiting can be beneficial.

- Brainstorm with your children (if they are old enough) to come up with ways that they can stay safe using the same model as you would for your own home. Have them identify where they can get to a phone, how they can leave the house, and who they can go to.
- If it's safe to do, send a cell phone with the children to be used in emergency situations — this can be used to call 911, a neighbor or you if they need aid.

**Planning for Safe Custody Exchanges**

- Avoid exchanging custody at your home or your partner's home.
- Meet in a safe, public place such as a restaurant, a bank/other area with lots of cameras, or even near a police station.
- Bring a friend or relative with you to the exchanges, or have them make the exchange.
- Perhaps plan to have your partner pick the children up from school at the end of the day after you drop them off in the morning – this eliminates the chances of seeing each other.
- Emotional safety plan as well – figure out something to do before the exchange to calm any nerves you're feeling, and something after to focus on yourself or the kids, such as going to a park or doing a fun activity.

**How to Have These Conversations**

Let your child know that what's happening is not their fault and that they didn't cause it. Let them know how much you love them and that you support them no matter what. Tell them that you want to protect them and that you want everyone to be safe, so you have to come up with a plan to use *in case of emergencies*. It's important to remember that when you are safety planning with a child, they might tell this information to the abusive partner, which could make the situation more dangerous (ex. "Mom said to do this if you get angry.") When talking about these plans with your child, use phrases such as "We're practicing what to do in an emergency," instead of "We're planning what you can do when dad/mom becomes violent."

***Safety Planning With Pets***

Statistics show that up to 65% of domestic violence victims are unable to escape their abusive partners because they are concerned about what will happen to their pets when they leave. Fortunately, there are more and more resources in place to assist with this difficult situation.

If you're creating a safety plan of your own to leave an abusive relationship, safety planning for your pets is important as well. Bring extra provisions for them, copies of their medical records and important phone numbers.

If possible, don't leave pets alone with an abusive partner. If you are planning to leave, talk to friends, family or your veterinarian about temporary care for your pet. If that is not an option, search by state or zip code for services that assist domestic violence survivors with safekeeping for their pets. Try zip code first, and if there are no results, try a search by state. If the none of the results are feasible for your situation, try contacting your local domestic violence or animal shelter directly. For help finding an animal shelter, visit the Humane Society website.

If you've had to leave your pet behind with your abusive partner, try to ask for assistance from law enforcement officials or animal control to see if they can intervene.

Take steps to prove ownership of your pet: have them vaccinated and license them with your town, ensuring that these registrations are made in your name (change them if they aren't).

If you're thinking about getting a protective order, know that some states allow pets to be a part of these.
If you've left your partner, ensure the safety of your pet by changing veterinarians and avoid leaving pets outside alone.

- The Animal Welfare Institute offers additional tips for safety planning with pets.
- Organizations like Georgia-based Ahimsa House and Littlegrass Ranch in Texas offer advice for safety planning with animals, especially with non-traditional animals like horses that are more difficult to transport.
- Red Rover offers different grant programs to enable victims to leave their abusive partners without having to leave their pets behind. The grants must be submitted by a shelter worker.

***Safety Planning During Pregnancy***

Pregnancy is a time of change. Pregnancy can be full of excitement but also comes with an added need for support. It's natural to need emotional support from a partner, as well as perhaps financial assistance, help to prepare for the baby and more.

If your partner is emotionally or physically abusive toward you, it can make these months of transition especially difficult. Thankfully, there are resources available to help expecting women get the support needed for a safe, healthy pregnancy.

According to the CDC, intimate partner violence affects approximately 1.5 million women each year and affects as many as 324,000 pregnant women each year. Pregnancy can be an especially dangerous time for women in abusive relationships, and abuse can often begin or escalate during the pregnancy.

**How can you get help?**

- If you're pregnant, there is always a heightened risk during violent situations. If you're in a home with stairs, try to stay on the first floor. Getting into the fetal position around your stomach if you're being attacked is another tactic that can be instrumental in staying safe.
- Doctor's visits can be an opportunity to discuss what is going on in your relationship.

- If your partner goes to these appointments with you, try to find a moment when they're out of the room to ask your care provider (or even the front desk receptionist) about coming up with an excuse to talk to them one-on-one.
- If you've decided to leave your relationship, a health care provider can become an active participant in your plan to leave.
- If possible, see if you can take a women-only prenatal class. This could be a comfortable atmosphere for discussing pregnancy concerns or could allow you to speak to the class instructor one-on-one.

## Emotional Safety Planning

Often, emphasis is placed on planning around physical safety, but it is important to consider your emotional safety as well. Emotional safety can look different for different people, but ultimately, it is about developing a personalized plan that helps you feel accepting of your emotions and decisions when dealing with abuse. Below are some ideas for how to create and maintain an emotional safety plan that works for you.

**Seek Out Supportive People**: A caring presence such as a trusted friend or family member can help create a calm atmosphere to think through difficult situations and allow for you to discuss potential options.

**Identify and Work Towards Achievable Goals**: An achievable goal might be calling a local resource and seeing what services are available in your area, or talking to one of our advocates at The Hotline. Remember that you don't have to do anything you aren't comfortable with right now, but taking small steps can help options feel more possible when you are ready.

**Create a Peaceful Space for Yourself**: Designating a physical place where your mind can relax and feel safe can be good option when working through difficult emotions that can arise when dealing with abuse. This can be a room in your house, a spot under your favorite tree, a comfy chair by a window or in a room with low lights.

**Remind Yourself of Your Great Value**: You are important and special, and recognizing and reminding yourself of this reality is so beneficial for your emotional health. It is never your fault when someone chooses to be abusive to you, and it has no reflection on the great value you have as a person.

**Remember That You Deserve to Be Kind to Yourself**: Taking time to practice self-care every day, even if it is only for a few minutes, really creates space for peace and emotional safety. It's healthy to give yourself emotional breaks and step back from your situation sometimes. In the end, this can help you make the decisions that are best for you.

***Preparing to Leave***

Because violence could escalate when someone tries to leave, here are some things to keep in mind before you leave:

- Keep any evidence of physical abuse, such as pictures of injuries.
- Keep a journal of all violent incidences, noting dates, events and threats made, if possible. Keep your journal in a safe place.
- Know where you can go to get help. Tell someone what is happening to you.
- If you are injured, go to a doctor or an emergency room and report what happened to you. Ask that they document your visit.
- Plan with your children and identify a safe place for them, like a room with a lock or a friend's house where they can go for help. Reassure them that their job is to stay safe, not to protect you.

- Contact your local shelter and find out about laws and other resources available to you before you have to use them during a crisis. WomensLaw.org has state by state legal information.
- Acquire job skills or take courses at a community college as you can.
- Try to set money aside or ask friends or family members to hold money for you.

## After You Leave

Make a plan for how and where you will escape quickly. You may request a police escort or stand-by when you leave. If you have to leave in a hurry, use the following list of items as a guide to what you need to bring with you. Our advocates can help you come up with a personalized safety plan for leaving.

**1) Identification**

- Driver's license
- Birth certificate and children's birth certificates
- Social security cards
- Financial information
- Money and/or credit cards (in your name)
- Checking and/or savings account books

**2) Legal Papers**

- Protective order
- Copies of any lease or rental agreements, or the deed to your home
- Car registration and insurance papers
- Health and life insurance papers
- Medical records for you and your children
- School records
- Work permits/green Card/visa
- Passport
- Divorce and custody papers
- Marriage license

**3) Emergency Numbers**

- Your local police and/or sheriff's department
- Your local domestic violence program or shelter
- Friends, relatives and family members
- Your local doctor's office and hospital
- County and/or District Attorney's Office

**4) Other**

- Medications
- Extra set of house and car keys
- Valuable jewelry
- Pay-as-you-go cell phone
- Address book
- Pictures and sentimental items
- Several changes of clothes for you and your children

- Emergency money

## Legal Information


***Restraining Orders/Protective Orders***

**There are some legal actions you can take to help keep yourself safe from your abusive partner. The Hotline does not give legal advice, nor are we legal advocates, but there are some great resources available to you in your community.**

Please call 1-800-799-SAFE (7233) or chat with us and our advocates can connect you with resources for legal help.

You can also visit WomensLaw.org and search state by state for information on laws including restraining orders and child custody information.

**Protective Orders/Restraining Orders**

A protective order can help protect you immediately by legally keeping your partner from physically coming near you, harming you or harassing you, your children or your family members. This legal documentation to keep your abusive partner away from you can often contain provisions related to custody, finance and more.

While protective orders *may* be able to put a stop to physical abuse, psychological abuse is still possible — so a protective order should never replace a safety plan.

If you already have a protective order, it should be kept on you at all times — and copies should be given to your children and anyone they might be with — especially when you're leaving your partner.

You can get an application for a protective order at:

- Courthouses
- Women's shelters

- Volunteer legal services offices and some police stations.

**Other Legal Actions:**

You also have the right to file a charge against your partner for things such as criminal assault, aggravated assault, harassment, stalking or interfering with child custody. Ask a volunteer legal services organization (attorneys who provide free legal services to low-income individuals) or an advocacy group in your area about the policies in your local court.

## H. Course Conclusion—Survivor's Story

Unfortunately, Spouse/Partner or Intimate Partner Abuse, continues to be prevalent. Victims of such abuse will often feel helpless and not know where to turn or what to do. Sometimes they must leave to save their own lives, and/or the lives of their children.

After reading this course you have been trained in various ways you can assist victims of abuse become safe physically, but also assist them emotionally and with their mental health needs.

To finish the course, we are finishing where we started:  a true from a survivor.

Again from the National Domestic Violence Hotline

https://www.thehotline.org/2013/09/30/shanas-story/

| **Shana's Story** |
| --- |
| This is something that you just do not hear enough about. Survivors speak and they go from their abuse to what they are currently doing, not describing enough of the true gut-wrenching feelings that you have in the days weeks or months after you leave. Life |

after abuse is so positive, but truth be told, sometimes you feel like it is harder than the abuse. There are many great programs that will help you with the transition from where you have been to where you will be. The Victim Compensation Fund is a great program that will help with Mental Health Therapy, relocation, and many other things, plus some cities have at least one shelter to turn to. There are many options for assistance; you just need to safely find them.

After almost 8 years since the abuse, I still deal with my after. There are still days that I apologize incessantly, cry at the drop of a hat, feel totally worthless and take the weight of the world on my shoulders. I still do not let people see beyond the mask of total happiness — if you met me, you would never know the past that I am hiding. This is the truth about life after abuse. I married my Prince Charming at 19 after a year of dating. We were married about 15 months before he became physically abusive. I became withdrawn from my family and long-term friends out of fear they would find out. I left after 3 ½ years of marriage following a huge fight.

I had no money except for an ATM card that I was just sure he would cancel quickly, no place to go and no clothes. I left with a bag that had no makeup, hair brush or deodorant – only a toothbrush and a change of clothes. I did not really know anyone to call, besides I really did not want anyone to know. So, I drove to the only hotel in town. The hotel was booked! How in the world could a Days Inn in a town of 30,000 people, mostly farm laborers, be BOOKED?! NO WAY was my thought. I begged and pleaded for a room with no luck. I could not go to a shelter for fear I would lose my job if they found out, so I slept in my car that night. Ok, let us be honest, I didn't sleep. I waited for him to find me – and then went into work the next day and acted as if everything was normal. My husband worked 30 minutes from our house so I knew that I could, safely, go home at lunch without him there to get something for the next day. I didn't go home the day after I left because I didn't know if he would expect that and be there. I knew what the consequence would be for leaving.

I met someone at my gym who let me sleep on the couch until I got on my feet. For three months I hid. For three months, my abuser came to my work to 'take care of me,' bringing me little things like protein shakes, soup, and money, all to entice me back into my old life. I was so secretive about my separation that people I worked with thought we were still happily married until after my divorce was final. Even through it all I wanted to make him happy. I wanted to make everything ok. I knew that I could not go back but that did not mean that I wanted anything negative to happen to him or me. I just wanted to move on; I wanted a healthy life and chance to be more than just So & So's wife – I wanted to be Shana.

Most victims would say that you become the queen of appearance. You know how to smile regardless of what just happened and act like everything is fine. The months after I left were horribly hard. I thought it would never get better. I thought I would never be able to support myself, be able to pay my own bills and be a successful adult without him. I often thought about going back because that would have been so much easier, at least in that arena I knew what to expect.

I could not handle most loud noises. A slamming cupboard in the next apartment would make me jump and TV shows with violence would give me horrible nightmares (I still do not do well with them). I was sick to my stomach constantly worried that my work or my family would find out my secret. I did not sleep very well; always worried that he would come to get me. There were days that I would cry – just sob – because I felt like I failed. I was getting divorced at 23 years old. I could not handle the reality in my mind as a complete failure. To this day I feel like that sometimes.

Two months after I left, I finally went to our apartment to move my things into storage and on that day, he tried to kill me. I remember thinking that I would die by strangulation. Thankfully, he let me go and I eventually moved to San Diego where I eventually found a job. To forget the past, I drank and had little self-worth. I did anything to try and forget the past. I thought that forgetting it was better than dealing with it. Most people seem to shy away from people after being in an abusive relationship, but I ran head first into

as much attention as I could. I went to therapy and tried to talk to my friends, but no one believed that the man I was married to would do anything to hurt me. I felt so isolated and only two people stuck by me through all of this.

I moved to Orange County in 2003, and it was my big chance for a future. I got a job with a temporary agency, making barely enough money to pay my bills, but everything was MINE. The best part was that HE did not know where I lived. Until the day he called and begged to get back together, he had changed.

We had been apart for 18 months so I wanted to believe him. I made the mistake of allowing HIM to come down and spend a weekend to talk and see if there was anything left of the relationship and to see if he had changed. How perfect! I could be with him and have no violence and then I hadn't really failed at marriage, right? After spending time with him, I realized he had not changed. He was still the same person. I asked him to leave and he did. Over the past several years he has emailed me and contacted me on MySpace and Facebook. I have come to realize he will never stop trying to reach me.

After a while, I started working on myself, realizing that my unhappiness was not good for me. I deserved to be happy. What I went through with him was not a reflection of who I am or what I am worth. I started writing again and encourage others to write about their day and feelings and then reflect on what you have written.

I began to feel like my old self again. I started looking at dating again and I even stopped drinking occasionally. I did not feel the need to be numb any more. In 2006, I had the amazing opportunity to become a mother through adoption. Every moment of my life became about this little girl. I knew that everything had to change but I never realized that I had pushed my past so far back in my mind. I did not realize how much changing my life would require me to deal with things. I have been the mother to my beautiful daughter for 3 years and 5 months. Two and a half years ago I married an amazing man, a man that would never raise his hand to me. To this day, I do not like scarves

around my neck, or really anything touching the front of my neck. I apologize for everything, my fault or not. I worry that my daughter will follow in my footsteps, just as I followed in my mother's. I worry that no matter how many times I say I am a SURVIVOR of domestic violence that I will have nightmares for the rest of my life. Surviving domestic violence is one day at a time. I believe that forgiveness is important in moving on but not forgetting because this made you a stronger person.

You lived through something that most people could not. I do not like people to pity me or apologize for what HE did to me. I want people to see me as a strong woman, a mother, and a wife – a woman that survived and is thriving. A woman with a mission to help educate others on domestic violence.

Are you supposed to be terrified to leave? YES. Are you supposed to think about him afterwards? YES. Are you supposed to be able to move on and have a happy and healthy relationship? YES. There is no one way to deal with the after trauma of domestic violence but know you can do it. There are so many people here to help, so many organizations that want you to succeed!

You can do it. Each person deals with this in their own way, none of them are any better – only different. (NDVH, 2013)

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**Risk and protective factors for intimate partner and sexual violence**

The ecological model of violence

As noted by the United States Centers for Disease Control and Prevention (CDC, 2004), in order to prevent sexual violence, it is crucial to understand the circumstances, and the risk and protective factors, that influence its occurrence. Many different theoretical models attempt to describe the risk and protective factors for intimate partner and sexual violence, including those based upon biological, psychological, cultural and gender equality concepts. Each of these models contributes to a better understanding of intimate partner and sexual violence and helps to build programs that aim to reduce modifiable risk factors and strengthen protective factors. Risk factors increase the likelihood of someone becoming a victim and/or perpetrator of intimate partner and sexual violence and their reduction should therefore be a key target of prevention efforts, as well as an integral concept in program monitoring and evaluation efforts. Similarly, protective factors, which buffer against the risk of becoming a victim and/or perpetrator of intimate partner and sexual violence, may need to be fostered – including through structural and other interventions for achieving gender equality and the empowerment of women.

The ecological model organizes risk factors according to the following four levels of influence:


- **Individual**: includes biological and personal history factors that may increase the likelihood that an individual will become a victim or perpetrator of violence.
- **Relationship**: includes factors that increase risk as a result of relationships with peers, intimate partners and family members. These are a person's closest social circle and can shape their behavior and range of experiences.

- **Community**: refers to the community contexts in which social relationships are embedded – such as schools, workplaces and neighborhoods – and seeks to identify the characteristics of these settings that are associated with people becoming victims or perpetrators of intimate partner and sexual violence.
- **Societal**: includes the larger, macro-level factors that influence sexual and intimate partner violence such as gender inequality, religious or cultural belief systems, societal norms and economic or social policies that create or sustain gaps and tensions between groups of people.

Building such a model offers a framework for understanding the complex interplay of all the factors that influence intimate partner and sexual violence, and can therefore provide key points for prevention and intervention (Dahlberg & Krug, 2002).

The ecological model also supports a comprehensive public health approach that not only addresses an individual's risk of becoming a victim or perpetrator of violence, but also the norms, beliefs and social and economic systems that create the conditions for intimate partner and sexual violence to occur. At the core of the approach is a strong emphasis on the multiple and dynamic interactions among risk factors within and between its different levels. For example, structural inequalities between women and men, social constructions of masculinity and gender norms are risk factors for intimate partner and sexual violence that would primarily be situated at the societal level of the model. Clearly, however, they also manifest themselves within other levels – for example, in communities and relationships – and are likely to be linked with other risk factors such as the witnessing of violence between parents and alcohol abuse by male perpetrators.

Using the ecological model also helps to promote the development of cross-sectoral prevention policies and programs by highlighting the links and interactions between different levels and factors. As a result, when designing comprehensive approaches to prevent intimate partner and sexual violence, the embedding of effective strategies into mainstream programs addressing such issues will increase both their relevance and

sustainability. Viewing the ways in which these risk factors come together and influence patterns of behavior throughout the life-course provides insights into the key points at which interventions to break the cycle should be implemented.

### Identifying risk factors

The identification of risk factors is critically important for informing strategies and programs to ameliorate or buffer against risk – and ultimately to guide prevention policy. The causes of intimate partner violence and sexual violence are best investigated through the use of longitudinal studies. These studies track people over time to document their experiences of such violence and how these experiences relate to other factors at various stages of their life. Unfortunately, few such studies exist – so much of the information in this section is derived from cross-sectional population surveys. These are good at providing a snapshot of how frequently something occurs and its associated factors, but they usually cannot provide information on whether an observed association actually "caused" a particular outcome.

This chapter draws on two main sources of information: first, the World report on violence and health chapters on intimate partner violence (Heise & Garcia-Moreno, 2002) and sexual violence (Jewkes, Sen & Garcia-Moreno, 2002) which reviewed the literature until 2002; and, second, a systematic review of more recent peer-reviewed literature on risk and protective factors associated with either the perpetration or experiencing of intimate partner violence, sexual violence or both.


Most of the literature is from high-income countries (HIC), and it is unclear whether factors identified in HIC also apply to low- and middle-income countries (LMIC) due to differences in economies, ecologies, histories, politics and cultures. Any primary studies from LMIC that identified factors associated with

intimate partner violence and/or sexual violence were also included in the review of more recent literature.

As a result of this process, over 50 risk factors were identified for intimate partner violence and/or sexual violence – most at the individual and family/relationship levels. The paucity of risk factors that have currently been identified at the community and societal levels is probably due to a lack of research on risk factors at these levels rather than reflecting a true absence of risk factors.


**J. Domestic violence and abuse in intimate relationship from public health perspective**

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**The extent and nature of Domestic Violence and Abuse**

As domestic violence cases increasingly enter the court system, and consequences of aggressive accidents threaten the functioning, well-being and health of victims, in family or outside systems, it is important to describe extent and nature of this phenomenon. Although both men and women initiate violence, the violence enforced by women is less frequently and has less severe consequences compared to male offenders. Straus and Gelles, using the National Family Violence Survey found that the injury rate for women was 6 times higher than for men. Worldwide, 10-50 per cent of women report having been hit or physically assaulted by an intimate partner at some time in their lives. Some estimates suggest that as many as one-third of all women are victims of domestic violence during their lifetime. Four million women each year are assaulted by a domestic partner. For those aged from 18 to 59 around one in four women and one in

eight men reported experiencing partner abuse in year 2008 to 2009. Woman's pregnancy is high-risk period for the initiation and escalation of intimate partnership violence, and is leading cause of maternal mortality in the UK, USA and Australia. Same risk period for the outbreak of violence against women in intimate partner relationship was also found in research of Jasinski and Kantor. Another period that is especially dangerous for women is at the ending of relationship because their partners become threatened by a clear indication of a change or loss in the relationship. It could occur in all social strata, but there is some evidence of population disparities, across socio-economic and ethnic groups, and particular a higher prevalence for learning-disabled people. Cooper *et al*. note that about 5.6 per cent of older couples reported physical violence in their relationship in the past year and that for vulnerable elders (dependent on a carer, disabled) rates were much higher, with nearly 25 per cent reporting significant abuse.

**Theoretical perspectives of domestic violence and abuse**

There are three broad theoretical approaches explaining the phenomenon of domestic violence: feminist, conflict, and social learning theories. Feminist theory argues that wife abuse is directly connected to the patriarchal organization of society, which is reflected in the pattern of behaviors and attitudes toward women. In addition, masculinity is often characterized as being authoritative and controlling of women. A feminist approach emphasizes the significance of gender inequality and contends that it is a major factor in male-female violence. Violence and abuse are viewed as an expression of social power and become used as a way of men to control and dominate their female partners. Men could resort to aggressive forms of control over women particularly when they experience powerlessness. Important social institutions have tolerated the use of physical violence by men against women in the past. The patriarchal arrangement of families, ideals of masculinity, and a cultural acceptance of the use of force to gain control over others, all create and also foster a social environment for wife abuse and other forms of family violence. While feminist theory describes the patriarchal nature of family and society, conflict theoretical approach exposes family and society as a place involving a conflict between their members and their divergent interests. When different interests produce

conflicts, aggression and violence are the way that individuals may utilize to resolve the situation in their favor, particularly when other strategies fail. This theoretical approach could be helpful especially in explaining the causes of violence between siblings. A conflict between siblings is often believed to be driven by jealous rivalry with siblings competing for parental attention and affection. The study of adults revealed that two thirds of them perceived their siblings as rivals during childhood, and perpetrators of sibling violence may be driven by feeling of powerlessness brought on by favoritism. The feminist and conflict perspectives address social structural condition in society and family, whereas social learning theory provides an explanation for family interaction patterns that foster violence and abuse. It contends that behavior is learned in large part through observation, imitation, and reinforcement. Prior to engaging in an observed behavior, an individual generates ideas about probable rewards and punishments. Reactions from others are used to develop implicit rules that are applied to future in similar situation.

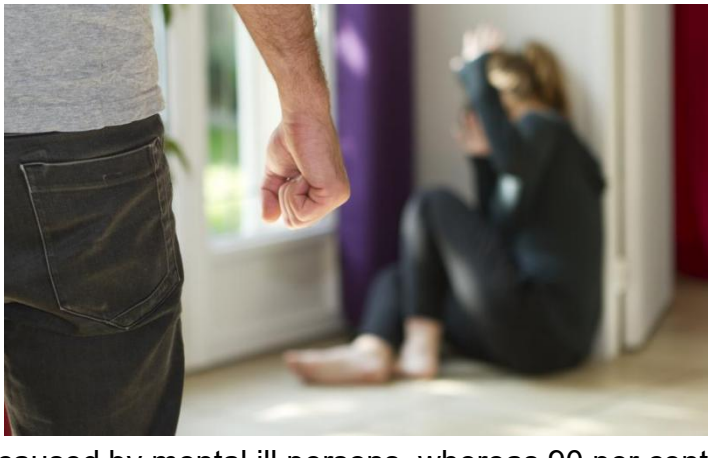
As a result, learning often occurs through direct experience, with individuals learning guidelines for many behavior forms that are more complex than the specific action observed. So, aggressive behavior is adopted as a response because direct and indirect experience suggests that the desired rewards, not negative sanctions, will be the anticipated outcome or reaction from others. Consequently, modeling and reinforcement are two of the most important processes in learning aggressive behavior. Individuals with intimate and frequent contacts, and those with higher social power, are the most likely to be observed and imitated. Consequently, learning often occurs through interactions with significant others. Children are more likely to imitate when they strongly identify with person, when this person is familiar and demonstrates approval. Bandura also found that when adult males performing aggressive acts were more likely to be modeled by children, and he found also that familiarity much more influenced boys than girls. If a father uses aggressive behavior against his wife or child with successful results, children, particularly sons, are more likely to model this behavior with siblings.

**K. The risk factors of domestic violence and abuse**

**The perpetrators**

In context of the domestic violence in intimate partner relationship between men and women the oldest and still widely adopted perspective is psychological based. It focusses on personality disorders and early experiences that increase the risk of violent behaviour. Moffitt et al. report that while men exhibit more aggression overall, gender is not a reliable predictor of interpersonal aggression, including psychological aggression. Their study found that whether male or female, aggressive people share a cluster of traits, including high rates of suspicion and jealousy, sudden and drastic mood swings, poor self-control, and higher than average rates of approval of violence and aggression.

They also argue that antisocial men exhibit two distinct types of interpersonal aggression: against strangers, and against intimate female partners, while antisocial women are rarely aggressive against anyone other than intimate male partners. Dutton and Bodnarchuk, Carney and Buttell, and Henning and Feder reported that male and female perpetrators of emotional and physical abuse exhibit high rates of personality disorders. Studies have found incidence rates of personality disorders to be 80-90 per cent in both court-referred and self-referred wife assaulters, compared to estimates in the general population, which tend from 15-20 per cent.



As the violence becomes more severe and chronic, the like hood of psychopathology in these men approaches 100 per cent reported Hart, Dutton, and Newlove, and Dutton and Hart. But Gelles stated that only 10 per cent of violently incidents might be labeled as primary caused by mental ill persons, whereas 90 per cent are not amenable to merely psychopathological explanations. It should be noted that many personality dysfunctions, for example low impulse control, are not considered pathological but rather a personality disorder.

Dutton (1988) argued that three specific forms of personality disorders were prevalent among wife assaulters: antisocial, borderline and over-controlled. In series of studies, he described associated psychological features of abusiveness that clustered around Oldham et al. measure of Borderline Personality Organization: shame-based rage, a tendency to project blame, attachment anxiety manifested as rage, and sustained rageful outbursts, primary in intimate relationships. Profile of an abuser correlate with the Cluster B personality disorders: Anti-Social Personality (a pervasive pattern of disregard for and violation of the rights of others, lack of empathy), Borderline Personality (a pervasive pattern of instability in relationships, self-image, identity, behavior and affects often leading to self-harm and impulsivity), and Narcissistic Personality (a pervasive pattern of grandiosity needs for admiration, and a lack of empathy).

These disorders display characteristics that involve grandiose delusions and a self-inflated sense of importance which are critical behaviors for an abuser to have in order to maintain strict and severe control over their victim. The abuser also needs to have a very low affect and low sense of empathy so that they do not have remorse for the abuse and actions they are inflicting on their victim. All of these qualities are characteristics found on the Axis II disorders in the DSM-IV.23

Abusers may aim to avoid household chores or exercise total control of family finances. They can be manipulative, often recruiting friends, law officers and court officials, even the victim's family to their side, while shifting blame to the victim. They deny the violence and abuse or rationalize it and tend to use such types of defenses: total outright denial (It never happened. You are just imagining it. You want to hurt me), alloplastic defense (It was your fault, your behavior provoked me into such reactions), altruistic defense (I did it for you, in your best interests!), transformative defense (What I did to you, it was common and accepted behavior)

Perpetrators are usually concerned with their reputation and image in the community – among neighbors, colleagues, co-workers, bosses, friends, extended family, and therefore they use in the public the specific forms of denial: family honor stricture (We don't do dirty laundry publicly, the family's honor and repute must be preserved, what will

the neighbors say?), and family function stricture (If you snitch and inform the authorities, they will take me away, and the whole family will be disintegrate).29,30

**The victims**

The victims of violence and abuse in intimate relationship between man and woman can be found in all social and economic classes and can be wealthy, educated, and prominent as well as undereducated and financially destitute. They live in rural areas, urban cities, subsidized housing projects, and in gated communities. In general, domestic violence affected largely women, children of both sexes, but men are also raped and experience domestic violence.

The fact that the victim could be a male partner is confirmed by recent research. On the delusion that arises around this question inside our heads have recently exposed Dutton and White: The stereotype invoked when one mentions domestic violence is a bulling, domineering man who is hyper-reactive to jealousy and has a drinking problem. And to continue: The gender paradigm stereotype also holds that female violence is less serious, only what Johnson calls common couple violence. In fact, the data again say something else. It was simply that easier research was driven by paradigm that avoided asking the right question of men. When these questions are asked, the results are surprising.

An emergency clinic in Philadelphia found that 12,6 per cent of all male patients over thirteen-week period were victims of domestic violence. Same results also reported Hines and Douglas. Authors Williams and Frieze agree that terms of battered women do not explain all of the patterns of violence that occur in couples. Data from their research shown that women can be equally violent or display even more frequent violent acts than

men toward partners: 21.6 per cent victims were male, 28.7 per cent victims were women, bilateral violent and abusive were 49 per cent of couples. They considered that many studies in the past were based only on women's reports. Brown and also Henning and Renauer found that men compared to female offenders were likely to be arrested. They are also treated more harshly by criminal justice system. Brown found that in case where only the male partner was injured, the female was charged in 60.2 per cent of the cases, however, when the female partner was injured, the male was charged 91.1 per cent of the time. In no-injury cases, the male was charged 52.5 per cent of the time, the female 13.2 per cent of the time. Brown also found that women were more likely to have used weapons and caused injuries and also to have received more serious charges (more than twice as likely to be charged with aggravated assault or assault with a weapon), and that those who were prosecuted tended to have inflicted higher levels of injury against their victim than prosecuted men and, as with arrested women, were more likely than men to have used weapons. In severe injury cases, 71.4 per cent of men and 22.2 per cent of women were found guilty. The low percentage of women found guilty was due to witness problems (few men being willing to testify).

Fontes believes that men have more difficulty in expressing their hardship if they are victims of violence. He identifies several reasons and one of them is dilemma because they are socialized to be strong, physically and emotionally, to be provider, especially women and children. So, they are early trained to suppress their fear and pain and have later difficulty in expressing emotions because they are aware that patriarchal society and men in general do not want view males as victims (to be vulnerable, to be weak, to be unmanly because it means be a wimp). Other reasons he found in feminism and gender politics. Even if a man decides that he wants support, he often doesn't have such a social network as a woman and cannot so easily complain, what is happening to him. In practice, he can also be afraid that if he was to report his wife to the police, the police would not take his allegation seriously.

**The family violence theories**

The family is a major socializing institution and a likely context for relatively high level of aggression. Many researchers have found a link between childhood experiences of aggression behind the domestic walls and violence and abuse in adulthood. Phenomenon was called as intergenerational transmission of violence. Important part of such process is learning through modeling. Social learn theory suggests that a child learns not only how to commit violence but also learns positive attitudes about violence when he/she sees it rewarded. So, he/she learns destructive conflict resolution as also patterns of interpersonal communication. However, the Theory of Intergenerational Transmission of Violence provokes some criticism and opens several questions. One is in the potential different effects of experiencing aggression during childhood. Another element of complexity lies in whether one who grows up in a violent home is at risk for becoming a perpetrator or a victim of spouse abuse as some studies have provided empirical support for the notion that growing up in an aggressive family increases the probability of being a victim of spouse abuse, whereas other studies have provided support for the notion that growing up in an aggressive home increases the probability of being a perpetrator of spouse abuse. A third element of complexity relates to gender. Recently, theorists have suggested that the intergenerational transmission of violence may operate differently for men and women. The need for a gender sensitive application of the intergenerational transmission of violence theory has been supported empirically in a number of studies. Contradictory findings have emerged from gender-sensitive research examining the intergenerational transmission of marital aggression.


**The impact of domestic violence and abuse**

Certainly, the violence, and abuse have not positive effects in both cases, if the victim of violence and abuse in intimate relationship is a woman or a man. According to the surveys

data that women victims predominate, it is expected that much more researches verify the relationships between women's health and their violently experiences compared to those which study health consequences by the male victims.

Intimate partnership violence and battering as its frequently part, has specific, long-term negative health consequences for victims, even after the abuse has ended. Battering is meant as repeated physical or sexual assault within a context of coercive control and emotional abuse as it's frequently part. Measures of the coercive control include verbal threats, financial control, emotional abuse, sexual abuse, and threats against the children, belongings, or pets. Negative effects can manifest as poor health status, poor quality of life, and high use of health services. Orem, author of Self Care Deficit Theory, whose central concept of self-care agency is defined as individuals' ability to engage in self-care, considers the battering as a threat to one of the identified universal self-care requisites, prevention of hazards to life, functioning, and well-being. The model importantly includes as outcomes a women's physical as well psychological health.

Battering is a significant direct and indirect risk factor for various physical health problems frequently seen in health-care settings and is one of the most common causes of injury in women. Plichta states that intimate partner violence and abuse is associated with increased mortality, injury and disability, worse health status, chronic pain, substance abuse, reproductive disorders, and proper pregnancy outcomes. It is also associated with overuse of health services. Campbell indicates the fact that 40-60 per cent of murders of women in the USA perpetrated by their intimate partners. Battering in intimate partnership violence is also one of the most common causes of injury in women. An injuries, fear, and stress can result in chronic health problems as chronic pain by headache, back pain. It was also found that battered women have significantly more than average self-reported gastrointestinal symptoms and diagnosed functional gastrointestinal disorders. This was found also as past, in childhood experiencing sexual abuse, or both. Gynecological problems, among them chronic pelvic pain and urinary-tract infections, are the most consistent, long lasting, and largest physical health difference between battered and non-battered women. The combination of physical and sexual abuse that characterizes at least 40-45 per cent group of battered women puts these women at an even higher risk

for health problems than women only physical assaulted. It was also found that experiencing psychological intimate partner violence is associated with significant increase in risk of development such conditions: disabilities preventing work, chronic neck or back pain, arthritis, migraines or other frequent headaches, stammer or stutter, problem seeing with glasses, chronic pelvic pain, transmitted infections, stomach ulcers, spastic colon, indigestion, constipation, and diarrhea. Psychological intimate partner violence was defined as woman's constantly feeling of susceptibility to danger, loss of power and control, and entrapment. Physical intimate partner violence was found to be correlated to hearing loss, angina, with cardiovascular problems, gastric reflux, and bladder or kidney infections.

Others' evidence suggests that women who are exposed to violence by their partners show also psychological consequences: higher level of depression, anxiety and phobias than no abused women. It was found also higher level of emotional distress, thoughts, or attempts of suicide among women who had ever experienced physical or sexual violence than those who had not. In addition, intimate partnership violence has also been linked with: alcohol and drug abuse, eating and sleep disorders, physical inactivity, a poor self-esteem, a post-traumatic stress disorder, smoking, self-harm, unsafe sexual behavior, the increased exposure to injuries. Golding found that in studies examining the prevalence of posttraumatic stress disorders among victims of domestic violence 63.8 per cent women suffered from it. His meta-analysis also found that 18.5 per cent battered women experienced alcohol abuse and 8.9 per cent of them suffered from drug abuse. Stark and Flitcraft estimated that battered women were at five times greater risk for a suicide attempt than women who were not in abusive relationship. Furthermore, to the both physical and psychological abuse is related also lowered selfesteem as found many researchers, among them Aguilar and Nightingale. O'Leary concluded that psychological abuse has more severe long term psychological effects than physical abuse and that the psychological abuse normally occurs prior to the physical abuse. At this point it should be noted that different authors mention slightly different major forms of psychological abusive behavior. Sacket and Saunders submit four major forms including criticizing behavior, ridiculing personal traits, jealous control behavioral pattern, and ignoring while Murphy and Cascardi proposed four factor model which include hostile withdrawal,

domination/intimidation, denigration, and restrictive engulfment. Even victims believe that the psychological abuse is more damaging to them found Follinstad, Rutledge, Berg, and Hause.

But domestic and intimate violence and abuse are not traumatic only for adults in a family. Osofsky notes that several studies have found that 60-75 per cent families in which a woman is battered, children are also battered. She presents also his research data and states that in homes where domestic violence occur children are physically abused and neglected at the rate 15 times higher than is national average. She mentions some authors who identify adverse effects on children's physical, cognitive, emotional, and social development. Existing researches show association between child exposure to violence and his/her emotional and behavioral disorders, even for this in the earliest phase of development. Such children are excessive irritable, show immature behavior patterns, sleep disturbances, emotional distress, fears of being alone and regression in toiling and language. Exposure to violence in family interferes with child's normal development of trust and later exploratory behavior, which lead to autonomy.

Both experiencing and witnessing domestic violence produced in children symptoms of posttraumatic stress disorders and reduces the sense of security. Campbell and Lewandowski cite the research results of Slusi, who has been found that violence becomes traumatic when victim does not have ability to consent or dissent and are passive observer with feeling of helplessness and hopelessness. They also highlight the research of Mc Closky et al., who have found that many children of battered women aged 6 to 12 had observed their mother being choked, threaded with weapon, or threaded with death in other way and noted that those children were living under the shadow of lethal threat. They note Terr's conclusions that traumatized children response to violence and abuse with: strongly visualized or otherwise repeatedly perceived memories; repetitive play or behavior enactments of trauma; trauma specific fears as well as fears of mundane things (the dark or certain animals); changed attitudes about people, life, and future.

Later controlled studies indicated cognitive and emotional responses such as higher level of internalizing (anxiety, social withdrawal, depression), fewer interests and social

activities, preoccupation with physical aggression, withdrawal and suicidal ideation; behavioral disorders (aggressiveness, hyperactivity, conduct problems), reduced social competence, school problems, truancy, bulling, excessive screaming, clinging behaviors, speech disorders; physical symptoms (headache, bed wetting, disturbed sleeping, vomiting, failure to thrive, diarrhea).

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**Violence against women World Health Organization**

Retrieved from: https://www.who.int/news-room/fact-sheets/detail/violence-against-women


The United Nations defines violence against women as "any act of gender-based violence that results in, or is likely to result in, physical, sexual, or mental harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or in private life."

**Intimate partner violence** refers to behavior by an intimate partner or ex-partner that causes physical, sexual or psychological harm, including physical aggression, sexual coercion, psychological abuse and controlling behaviors.

Health consequences

Intimate partner (physical, sexual and emotional) and sexual violence cause serious short- and long-term physical, mental, sexual and reproductive health problems for women. They also affect their children, and lead to high social and economic costs for women, their families and societies. Such violence can:

- Have fatal outcomes like homicide or suicide.
- Lead to injuries, with 42% of women who experience intimate partner violence reporting an injury as a consequence of this violence.
- Lead to unintended pregnancies, induced abortions, gynecological problems, and sexually transmitted infections, including HIV. The 2013 analysis found that women who had been physically or sexually abused were 1.5 times more likely to have a sexually transmitted infection and, in some regions, HIV, compared to women who had not experienced partner violence. They are also twice as likely to have an abortion.
- Intimate partner violence in pregnancy also increases the likelihood of miscarriage, stillbirth, pre-term delivery and low birth weight babies. The same 2013 study showed that women who experienced intimate partner violence were 16% more likely to suffer a miscarriage and 41% more likely to have a pre-term birth.
- These forms of violence can lead to depression, post-traumatic stress and other anxiety disorders, sleep difficulties, eating disorders, and suicide attempts. The 2013 analysis found that women who have experienced intimate partner violence were almost twice as likely to experience depression and problem drinking.
- Health effects can also include headaches, back pain, abdominal pain, gastrointestinal disorders, limited mobility and poor overall health.
- Sexual violence, particularly during childhood, can lead to increased smoking, drug and alcohol misuse, and risky sexual behaviors in later life. It is also associated with perpetration of violence (for males) and being a victim of violence (for females).

**Impact on children**

- Children who grow up in families where there is violence may suffer a range of behavioral and emotional disturbances. These can also be associated with perpetrating or experiencing violence later in life.

- Intimate partner violence has also been associated with higher rates of infant and child mortality and morbidity (through, for example diarrheal disease or malnutrition).

**Social and economic costs**

The social and economic costs of intimate partner and sexual violence are enormous and have ripple effects throughout society. Women may suffer isolation, inability to work, loss of wages, lack of participation in regular activities and limited ability to care for themselves and their children.

**Prevention and response**


There are a growing number of well-designed studies looking at the effectiveness of prevention and response programs. More resources are needed to strengthen the prevention of and response to intimate partner and sexual violence, including primary prevention – stopping it from happening in the first place.

There is some evidence from high-income countries that advocacy and counselling interventions to improve access to services for survivors of intimate partner violence are effective in reducing such violence. Home visitation programs involving health worker outreach by trained nurses also show promise

in reducing intimate partner violence. However, these have yet to be assessed for use in resource-poor settings.

In low resource settings, prevention strategies that have been shown to be promising include: those that empower women economically and socially through a combination of microfinance and skills training related to gender equality; that promote communication and relationship skills within couples and communities; that reduce access to, and harmful use of alcohol; transform harmful gender and social norms through community mobilization and group-based participatory education with women and men to generate critical reflections about unequal gender and power relationships.

To achieve lasting change, it is important to enact and enforce legislation and develop and implement policies that promote gender equality by:

- ending discrimination against women in marriage, divorce and custody laws
- ending discrimination in inheritance laws and ownership of assets
- improving women's access to paid employment
- developing and resourcing national plans and policies to address violence against women.

While preventing and responding to violence against women requires a multi-sectoral approach, the health sector has an important role to play. The health sector can:

- Advocate to make violence against women unacceptable and for such violence to be addressed as a public health problem.
- Provide comprehensive services, sensitize and train health care providers in responding to the needs of survivors holistically and empathetically.
- Prevent recurrence of violence through early identification of women and children who are experiencing violence and providing appropriate referral and support
- Promote egalitarian gender norms as part of life skills and comprehensive sexuality education curricula taught to young people.

- Generate evidence on what works and on the magnitude of the problem by carrying out population-based surveys, or including violence against women in population-based demographic and health surveys, as well as in surveillance and health information systems.

World Health Organization (WHO), United Nations Population Fund (UNFPA), United Nations High Commissioner for Refugees (UNHCR). Clinical management of rape and intimate partner violence survivors: developing protocols for use in humanitarian settings. Geneva: World Health Organization; 2020. License: CC BY-NC-SA 3.0 IGO.

**Retrieved from:** https://apps.who.int/iris/bitstream/handle/10665/331535/9789240001411-eng.pdf?ua=1

**Sexual violence**

This refers to “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, by any person regardless of their relationship to the victim, in any setting”. Sexual violence includes rape, defined as non-consensual penetration – even if slight – of the vulva, mouth or anus, using a penis, other body part or an object. The attempt to do so is known as “attempted rape”. The term “sexual assault” is often used interchangeably with rape. Sexual violence and intimate partner violence (IPV) – which may be physical, sexual and/or emotional/psychological – are global problems, occurring in every society, country and region. In humanitarian settings, as a result of mass displacement and the breakdown of social protections, women and children who are refugees, internally displaced persons (IDPs), or otherwise affected by conflict-related or natural humanitarian crises, are at increased risk. The high rates of sexual violence and

IPV are well documented and constitute a serious violation of international humanitarian law and human rights law.

**Intimate partner violence (IPV)**

This refers to ongoing or past violence and abuse by an intimate partner or ex-partner – a husband, boyfriend or similar. Women may suffer several types of violence by a male partner, including physical violence, emotional/psychological abuse, controlling behaviors and sexual violence (see Table 1).

Table 1: Examples of different types of intimate partner violence (IPV)

| Physical violence | Emotional/ psychological abuse | Controlling behaviors | Sexual violence |
|---|---|---|---|
| • Hitting, kicking, beating, pushing, burning, choking, and hurting with or without a weapon, which can cause injury or harm to the body | • Criticizing her repeatedly<br>• Insulting her or making her feel bad about herself<br>• Threatening to hurt her or people she cares about, such as her children<br>• Threatening to destroy things she cares about<br>• Belittling or humiliating her in front of other people | • Not allowing a woman to go out of the home, or to see family or friends<br>• Insisting on knowing where she is at all times<br>• Becoming angry if she speaks with another man<br>• Not allowing her to seek health care | • Forcing her to have sex or perform sexual acts when she does not want to; this may involve the use of physical force or coercion and intimidation<br>• Reproductive coercion – forcing her to have sex without protection from pregnancy or infection, or controlling her |

| | | | |
|---|---|---|---|
| | | without permission<br>• Blocking her access to services<br>• Withholding money needed to run the home | use of contraception |

**Violence Against Women and Girls Data Collection during COVID-19, Published on 17 April 2020**

**World Health Organization**

Retrieved from: https://www.unwomen.org/-/media/headquarters/attachments/sections/library/publications/2020/vawg-data-collection-during-covid-19-compressed.pdf?la=en&vs=2339


**Violence Against Women and Girls Data Collection during COVID-19**

**INTRODUCTION**

This is a living document that summarizes principles and recommendations to those planning to embark on data collection on the impact of COVID-19 on violence against women and girls (VAWG). It was informed by the needs and challenges identified by colleagues in regional and country offices and has benefited from their input. It responds to the difficulties of adhering to methodological, ethical and safety principles in the context of the physical distancing and staying at home measures imposed in many countries. This

note complements UN Women's brief and WHO's paper on COVID-19 and violence against women and girls.

**About COVID-19 and VAWG**

VAWG occurs across all regions and is widely underreported, in stable as well as emergency contexts. Emerging data indicates that it is increasing during the COVID-19 pandemic. The measures put in place to address the pandemic such as confinement and physical distancing that affect livelihoods and access to services are likely to increase the risks of women and girls experiencing violence. Examples include health and financial stresses in the home, including a woman's loss of livelihood or earnings, restricted access to basic services and ability to leave an abusive situation; stress related to social isolation and/ or quarantines; and confinement of women within the home with violent partners who may use the COVID-19 restrictions to further exercise power and control over their partners. Some reports indicate that calls to domestic violence helplines, police and shelters are increasing during the COVID-19 outbreak. In other cases, reporting, calls and service use are decreasing as women find themselves unable to leave the house or access help online or via telephone. Pandemics like COVID-19 can exacerbate not only violence within the home, but other forms of VAWG. Violence against female healthcare workers as well as migrant or domestic workers increases. Xenophobia-related violence, harassment and other forms of violence in public spaces and online is more prevalent and the risk of sexual exploitation and abuse in exchange for health care services and social safety net benefits becomes more likely. Some groups of women may experience multiple and intersecting forms of discrimination making them even more vulnerable to violence. Access by women survivors of violence to informal support networks (friends and family), as well as to quality essential services, including psychosocial support, may be limited or need to be delivered differently as a result of physical distancing regulations. VAWG remains a serious human rights violation and an important health concern during this pandemic. Addressing it must be a priority.

## WHY DATA COLLECTION DURING COVID-19 IS IMPORTANT

Data is a crucial tool for understanding how and why pandemics such as COVID-19 may result in an increase in VAWG. It can help identify the risk factors; how availability of services for women survivors of violence is being affected; how women's access to such services and help-seeking from formal and informal sources is affected; what new short and medium-term needs arise. These data are critical to designing evidence-based policy and programs that respond to women's needs, reduce risks, and mitigate adverse effects during and after the pandemic. These data can also provide important insights into and inform the development of tailored strategies and interventions that may be particularly effective in preventing VAWG during emergencies and public health crises in the future.

## CHALLENGES IN DATA COLLECTION

Conventional data collection methods may not be feasible: The COVID-19 pandemic may affect ongoing and planned data collection efforts, particularly those requiring face-to-face contact and travel, such as population-based surveys, focus group discussions or other qualitative approaches. Remote data collection options are often considered when face-to-face contact is not possible. The pandemic may also affect the way in which service-based data are collected and stored, particularly if services are being provided remotely. For example, when psychosocial support is being provided from providers' homes, it may be challenging to find a drawer with a lock, or access to a computer with a proper data protection system, to store a survivor's data and information.

**The use of remote data collection methods on VAWG can entail serious safety risks:**

Technologies such as mobile phones or web-based platforms may facilitate remote data collection and the documentation of evidence of VAWG during the COVID-19 pandemic. The use of these technologies during confinement and staying at home measures, however, may increase the risk of violence to women and their children as ensuring privacy and guaranteeing confidentiality will be nearly impossible. Electronic communications can leave a trail. If a perpetrator learns that a woman is sharing her experience it increases her risk of further and even more severe abuse.[7]

**Understanding what data can -and cannot- be collected and what data can -and cannot- tell us:**

As mentioned above, implementing face-to-face population-based surveys on VAWG during the acute phase of the COVID-19 pandemic may not be possible, and using remote data collection methods may pose serious safety risks to those interviewed. Prevalence data on VAWG8 during the COVID-19 pandemic, therefore, will likely not be collected. Nevertheless, comparing service-use data and examining patterns from pre, during and post- COVID-19 reports (to helplines, police, shelters or other services) may be useful to inform policy and program responses. These data, however, need to be interpreted with caution. A decrease in calls to helplines, or other support services for women survivors of violence, for example, may not imply a decrease in the number of violence incidents, but an increase in women's difficulties accessing telephones while being confined in the same space with the perpetrator. It may also be due to lower availability and functioning of helplines and other support services, because of the pandemic. Data on calls and reports to the police, helplines, shelters or other services will need to be triangulated with data coming from service providers and others and should not be interpreted as reflecting the prevalence of VAWG during the pandemic.

**GUIDING PRINCIPLES FOR DATA COLLECTION**

**Protecting and supporting women and girls who experience violence:**

While we need robust data and large-scale evidence on VAWG, in a crisis situation the priority initially is to target resources to ensure that women survivors of violence have access to quality services and support.

**Existing data can already provide strong evidence to inform the response to COVID-19:**

Prior to embarking on a data collection exercise, especially during crises, it is important to first explore existing data resources and repositories and ensure they have been optimally used to address the questions we are seeking to address. Secondary data (data collected by others) could be available for further analysis, and lessons learned from similar crises can be drawn upon. Existing data can include service-based data; data from population-based prevalence surveys (even if conducted prior to the pandemic they can inform about magnitude, populations most affected, risk factors and help-seeking behaviors); data from rapid assessments of service provision (they can provide information on e.g. changes in types or severity of violence, survivors' difficulties in seeking help), academic and media reports.


**Ethical and safety principles for VAWG data collection remain paramount important during a crisis:**

The globally agreed ethical and safety principles for data collection on VAWG,10 are even more relevant and critical in a crisis. This is particularly important when data are collected remotely, including during confinement and staying at home measures, and if it involves interviewing women who are potentially in abusive relationships and precarious situations. Doing no harm should be the highest priority. If in doubt, do not proceed with the data collection. It is of paramount importance to ensure, as a minimum:

- Safety, privacy and confidentiality of women respondents.

- No harm to the women respondents and the interviewers/research team.
- Properly trained interviewers/research team that understand the ethical and safety principles.
- Mechanisms and strategies to reduce any possible distress caused by the data collection.
- Availability of services and sources of support for women respondent survivors who need them.

**RECOMMENDATIONS FOR DATA COLLECTION**

Do not proceed with data collection if there are any risks of harm Be clear about the objectives and rationale for data collection and weigh the risks of harm against the anticipated benefit. Do not prioritize data over women's safety. If the data collection exercise cannot ensure privacy and confidentiality; if referral of women to support services if needed is not possible; if it puts the woman at greater risk of harm or causes undo distress, do not proceed with data collection.

**Choose the most appropriate data collection method and source for your context and objectives, always ensuring the safety of women respondents**

Besides secondary data, data and evidence from the following sources are also useful to assess the situation and inform interventions, including support and service provision, during the crisis:

- Key informant interviews with service providers and frontline workers.
- Rapid assessment/mapping of services.
- Service-based data.
- Qualitative data (e.g. case reports).
- Media reports.
- Participatory data collection approaches.

**Do not include questions about women respondents' experiences of violence as part of population-based rapid assessments**

- When implementing rapid assessments on the socio-economic impact of COVID-19, do not include questions about the respondents' experience of violence, particularly when using remote data collection methods, i.e. SMS/phone calls/web platform, as it can potentially put survivors at risk.
- Questions about violence experienced by third parties/others, that are often used as an alternative to avoid putting interviewed women at risk of violence, are unlikely to yield useful data and responses are not easy to interpret.
- If questions to understand the impact of the pandemic on VAWG are considered necessary, broader questions about the respondents' feelings of safety in different situations, e.g. when walking alone in the community, and at home are safer.

**Advocate for the needs of women and girls who are often marginalized**

This includes adolescent girls, older women, women and girls with disabilities, refugee women, female migrant workers, and racial and ethnic minorities. They should be included not only in the data collection exercise, but the research design and instruments should be tailored to better capture their experiences. This will inform interventions that meet the needs of groups which are often left out.

**ENDNOTES**


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**NATIONAL CENTER ON DOMESTIC VIOLENCE, TRAUMA & MENTAL HEALTH**

Retrieved from: http://www.nationalcenterdvtraumamh.org/wp-content/uploads/2014/10/FactSheet_IPVTraumaMHChronicIllness_2014_Final.pdf

**Current Evidence: Intimate Partner Violence, Trauma-Related Mental Health Conditions & Chronic Illness**

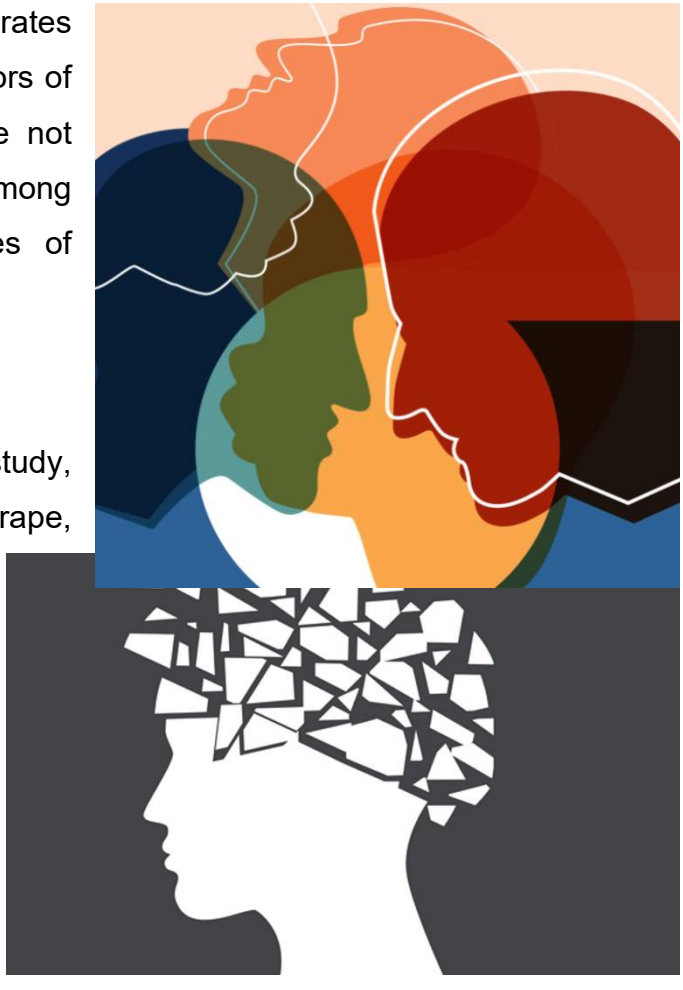
Intimate partner violence (IPV) is associated with a range of trauma-related health and mental health effects. Research conducted over the past 30 years has consistently demonstrated that being victimized by an intimate partner increases one's risk for developing depression, PTSD, substance abuse, and suicidality as well as a range of chronic health conditions. For some survivors, abuse by an adult partner is their first experience of victimization. However, many survivors experience multiple forms of trauma over the course of their lives (e.g. child abuse; sexual assault; historical, cultural, or refugee trauma), further increasing their risk for developing trauma-related health and mental health conditions. In addition, individuals who perpetrate IPV often actively undermine their partners' wellness, mental health, and sobriety and control their access to treatment and other supports which also contributes to the adverse health and mental health effects of IPV (1). The purpose of this information sheet is to present current evidence on the physical and mental health consequences of IPV most consistently found in the literature.

**Mental Health in the Context of Trauma and IPV**

There is a large and growing body of evidence documenting the associations between IPV and mental health conditions, including substance abuse (substance use disorders). This includes findings from population-based studies, meta-analyses, and systematic reviews, along with evidence from smaller community-based studies.

**Posttraumatic Stress Disorder (PTSD) and Depression**

Studies have consistently found higher rates of PTSD and depression among survivors of IPV, as compared to those who have not experienced IPV, and rates are higher among survivors who experience other types of trauma in addition to IPV. For example:



**PTSD**

- As part of a large nationwide study, 80% of women who experienced rape, stalking, or physical violence by an intimate partner reported significant short- or long-term effects including posttraumatic stress disorder (2). The results of another study indicate that women who have experienced IPV are three times as likely to meet criteria for PTSD as those who had no such experience (3).

**Depression**

- Results of a meta-analysis suggest that, as compared to women who have not experienced IPV, survivors have nearly double the risk for developing depressive symptoms, and three times the risk for developing major depressive disorder (24).
- Mothers who experience IPV are nearly twice as likely to develop post-partum depression (24). Compared to mothers who have not been abused by an intimate partner, mothers reporting IPV are more likely to have a current diagnosis of depression (12).

**The Co-occurrence of PTSD and Depression**

- In the context of IPV, PTSD is associated with an increased risk of experiencing other mental health conditions, in particular depression (3, 7, 16). Furthermore, PTSD symptoms may affect the relationship between IPV and depression, in part due to the ways that PTSD symptoms can disrupt survivors' use of important personal and social resources (3, 8).
- Depression and PTSD may be influenced by other factors, including the type, duration, severity, and chronicity of the abuse. For example:

    - Experiencing multiple types of abuse (e.g. physical, sexual, psychological) may significantly magnify the risk of developing mental health symptoms; one study suggests that experiencing multiple forms of abuse can increase the odds for depression, PTSD, and suicidality by 6-17 times (4).
    - Increased risk of depression has been found both among women who have experienced any recent IPV (physical, sexual, or non-physical) and among women and men who have experienced any lifetime IPV (10, 11, 21, 23). However, the development of depression and PTSD may be influenced by the type of abuse experienced; a community-based study suggests that experiencing psychological abuse is a more significant predictor of both PTSD and depression than experiencing physical aggression (16).

## IPV and Other Mental Health Conditions

In addition to depression and PTSD, evidence strongly suggests that experiencing IPV increases the risk of other mental health conditions, including:

- **Deliberate self-harm:** Women exposed to IPV are up to three times more likely to engage in deliberate self-harm than non-abused women, with factors such as PTSD numbing symptoms or more severe sexual violence associated with current deliberate self harm.
- **Suicidality**: IPV also associated with increased suicidal ideation (4) and suicide attempts (11). A large study conducted by the World Health Organization found that women who reported partner violence at least once in their lifetime are nearly 3 times as likely to have suicidal thoughts and nearly 4 times as likely to attempt suicide, compared to women who have not been abused by a partner (29).
- **Eating disorders:** The results of a systematic review suggest a relationship between experiencing IPV and having a diagnosis of an eating disorder. As compared to those without such a diagnosis, women and men with an eating disorder are significantly more likely to have experienced any lifetime IPV.
- **Other anxiety and mood disorders:** Both community-based studies and systematic reviews have found evidence for increased risk of other anxiety and

mood disorders among survivors. Compared to those who have not experienced IPV, survivors have a nearly three times greater risk of having an anxiety disorder diagnosis.

- **Substance use and abuse:** Exposure to IPV is associated with increased odds of substance abuse, binge drinking, and tobacco use for both female and male survivors. One study suggests that survivors are nearly 6 times as likely to have a substance use disorder, as compared to those who have never been abused.
- **Poor Sleep:** Experiencing IPV is associated with poor overall sleep quality, frequent disruptive nighttime behaviors (e.g. memories or nightmares of a traumatic experience; anxiety or panic), and sleep disorders.

Furthermore, domestic violence advocates and survivors have voiced concerns about the ways that survivors' mental health- and substance use-related needs are used against them, not only by abusers but also by the systems in which they seek help (e.g. batterers using mental health-related needs to control their partners; undermine them in custody battles; discredit them with friends, family, child protective services and the courts). In turn, considerable evidence suggests that individuals who experience mental health-related needs or have a psychiatric disability are at increased risk for being victimized by an abusive partner.

**IPV and Chronic Health Conditions**

As documented through numerous systematic reviews, meta-analyses, and population-based studies, there is clear and consistent evidence suggesting a relationship between experiencing IPV and chronic health conditions. In addition to the immediate effects of injury, IPV is associated with a range of physical health problems and poorer reported physical health in general. Experiencing any IPV has been shown to decrease survivors' overall physical health, with both longer duration of abuse and ongoing exposure to IPV associated with even poorer physical health. Furthermore, compared to those who have not experienced IPV, women who have ever experienced IPV are

more than twice as likely to report a disability, and women living with disabilities have also been shown to be at a higher risk for being abused.

**IPV and HIV**

Numerous studies have documented both increased rates of HIV among survivors of IPV, as well as ways that abuse leads to poorer HIV-related health outcomes. For example,

- Among U.S. women, those who have experienced any IPV in the past year are three times as likely to have an AIDS/HIV diagnosis, as compared to women who have not experienced IPV, even when adjusting for risky sexual behaviors and sociodemographic factors. Furthermore, nearly 12% of cases of HIV infection among U.S. women are attributable to IPV in the past year (33).
- IPV is associated with substance use [including substance use coercion], which can increase the risk of HIV transmission.
- Abusers pose HIV-related risks to their partners through a range of mechanisms, including HIV transmission via forced sex and coercive or violent behavior that compromises the negotiation of condom use or safer sex practices.


- The disclosure of HIV status to a partner increases the risk of experiencing violence, particularly within the context of already abusive relationships.
- A recent study suggests that experiencing trauma and abuse can significantly increase the odds of antiretroviral failure, further compromising the health of women living with HIV and IPV.

## IPV and Other Chronic Health Conditions

A number of large, population-based studies have found an association between IPV and increased risk for a range of health conditions. Chronic stress, which has been demonstrated to increase susceptibility to disease via changes in endocrine and immune functioning, likely mediates this relationship. Experiencing IPV has been associated with:

- Musculoskeletal/neuromuscular conditions, including degenerative joint disease, low back pain and other back problems, arthritis, nerve damage, trauma-related joint pain, and acute sprains and strains;
- Gynecological and urinary conditions, including menstrual disorders, vaginitis, cervicitis, pelvic pain, and urinary tract infections;
- Respiratory conditions, including asthma, emphysema, and acute respiratory tract infections;
- Gastrointestinal disorders, including irritable bowel syndrome and gastroesophageal reflux disease;
- Cardiovascular conditions, including heart disease, heart attacks, strokes, high cholesterol, circulatory disease, and hypertension (which, in one study, was significantly related to experiencing emotional abuse);
- Sexually transmitted infections, including HIV;
- Cancer, particularly especially cervical cancer, and poorer cancer outcomes in general;
- Diabetes, with both physical and psychological violence associated with an increased risk of Type 2 diabetes;
- Other physical health symptoms, such as frequent headaches, chronic pain, and activity limitations, and increased odds of memory loss, dizziness, difficulties walking, and difficulties with daily activities.

While IPV increases the risk for a range of health and mental health conditions, survivors' health status may vary based on a number of factors. This includes survivors' own personal strengths and resources; their genetic susceptibility to various conditions; the duration and severity of abuse; their experience of other lifetime traumas such as historical trauma or stressors such as poverty; and their access to ongoing and preventive healthcare, appropriate services, and social support. In fact, evidence suggests that access to safety, services, and social support significantly enhance survivors' resilience and well-being and mitigate the trauma-related effects of IPV.

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**These women survived domestic violence. Now they're taking a stand to help others**

Retrieved from: https://www.amnesty.org/en/latest/news/2019/10/gun-violence-report/

The brave women in this article are from Louisiana, USA. All of them endured years of physical, emotional, and sexual abuse. Several survived being shot. And they didn't always get the help they needed from the system.

Amnesty International's new report, *Fragmented and Unequal,* shows how the justice system in Louisiana is failing survivors of domestic violence. From failing to take violence seriously, to arresting survivors who call for help, the response from the authorities is frequently inadequate and discriminatory.

By telling their stories, these survivors are letting others know that it's possible to overcome both the trauma of domestic violence and the injustice of the system. They are using their experiences to help others, and showing that there is a way out.

These stories are powerful, heartbreaking, and inspiring.

**Angela's story**

*Angela, a survivor of gun and domestic violence, and her two sons*

In my case, it started as verbal abuse. I had known my partner for 20 years and he was a good person. He started changing in 2015. After his mum died, he bought several guns including a machete and a shotgun.

He became more combative, not only with me but with others and through his social media. I could not do anything right.

One evening in early November it turned physical. We were having a conversation and at some point, it escalated and I asked him to leave. I walked over to the door, opened it and said we could have the conversation another day. He grabbed me by the hood

of my sweatshirt, threw me out my door and got on top of me and started choking me. I managed to yell for our oldest son and he got off of me and left.

“He shot me and said 'look what you made me do' “

We had broken up, but we were starting to work things out again, when one morning we had a disagreement. I was in the bathtub, when he came in and shot me. I can only remember the last two gunshots. I look up at him and he says “‘Look what you made me do Angie”, ‘You made me shoot you.’

He returned with my cell phone and I told him to dial 911. I felt as though I was dying. My legs felt prickly. I did not realize he’d shot me in the back and I was already paralyzed.

I can remember being loaded into the paramedic’s truck and saying to the female paramedic, “please don’t let me die, I have four children to raise." I spent 3 weeks in hospital. During that time around 400 people came to visit me. That is when I realized I had a message I wanted to share.

Since then, I have been doing a lot of public speaking – not just about gun violence and domestic violence, but about gun control and mental health. If people are willing to listen, I want to talk about the things that matter.

I survived nine gunshots, but I have never cried about being paralyzed. I still have pity parties, but it is because I have to rely on others, when all I want is to be a mother again. This year, I will be partnering with the IRIS domestic violence centre, where I will be talking to people about what to do if you’re experiencing an abusive relationship.

Let’s not just point people in the right direction, let’s walk with them.

**Elizabeth's story**


*Elizabeth, gun and domestic violence survivor. Her daughter, in the poster behind her, was killed by Elizabeth's ex-partner*

"His behaviour changed rapidly. I know I should have recognized it, but when you're inside a situation it's hard to get perspective.

One day my daughter called me crying saying my ex had threatened to hit her in the head with a hammer. I called the police and they removed him from the house and I got a restraining order the next day.

After a month, I went to the judge and asked him to rescind the order because I couldn't imagine this man hurting us. Then on January 13, my whole life changed.

“I heard a policeman say, “Oh this is just a domestic violence case", five feet from where my child lay dead”

When my ex entered the house, my daughter was awake. I heard an argument. I came into the living area to try and calm her down. Her eyes were wide with fear - she could see him approaching with a gun. When I turned around shots rang. I managed to dial 911. I couldn’t talk because [my face] was shot up, but they traced the call home. The police came, then the medical team.

I heard a policeman say, “Oh this is just a domestic violence case.” He was just five feet from where I was fighting for my life and where my child lay dead. There was nothing “just” about it.

My entire face was reconstructed because the bullets tore it apart. I was in a coma for almost a month. When I woke up, I was hit with the reality of the situation. My brother and sister refused to bury my daughter without me. I had to go to therapy to learn to use my muscles, but a lot of it they couldn’t fix. I can’t blow my nose. My lips are still numb and when I’m eating and drinking I don’t know if something is too hot until I get a blister. It’s been a struggle.

I’ve talked to women who dated my ex and they’ve mentioned he was violent with them. Had I known he’d been abusive with other women, I wouldn’t have made him a part of my life.

The first time somebody asked me to talk about what happened, it was hard. It’s hard every time. But if it changes one life, it matters to me. Domestic violence is such a personal issue and it’s a secret. We must get people to understand that they’re not in it by themselves.

I’ve met young women and men who’ve heard my story and said it changed them. It gives them the courage to reach out and ask for help.

**Twahna's story**


*Twahna, founder of the Butterfly Society, a grassroots organization raising awareness of domestic violence*

I was a sophomore in college. I fell in love with a wonder guy, my prince charming. It was the perfect relationship - until one day I felt his hand on my face. He said, "Bitch if you had kept mouth closed, it wouldn't have happened."

From that moment, my life was turned upside down. I was mentally, emotionally and sexually abused. He degraded me, he talked about me being overweight, and he stripped me of all of my power. I began to question my self-worth, self-confidence, and

my true purpose in life. I thought of committing suicide many times. It was a way out for me.

I told no one in the beginning. I was too embarrassed and ashamed to share what I was going through - my family and friends adored him. He isolated me from my support system, those who loved and cared for me dearly. Lines of communication with family and friends were limited. He monitored my every move.

Eventually I built up enough courage and strengthen to tell a relative. She said, “I believe you. You deserve better. What can I do to help?"

I left him and went to live with her for a while, but my abuser convinced me to return to him. He swore that he would seek counselling, an anger management program, but he never did. He said all the right things to get me back in his possession. I believed him with all of my heart. I gave in to another chance.

Change never came. One day he put his hands around my neck and began strangling me. It was like he was possessed. He said to me, “I will kill you if you every leave again”. I saw myself dying at his hands.

I woke up and a voice said me, “today’s the day you leave”.

I went to bed that night and prayed. I heard this soft spoken voice in my ear and I knew it was voice of God. The next morning, I woke up and the voice said to me, “today’s the day you leave”. I couldn’t believe what I was hearing. I told him I was leaving for work and gave him a kiss goodbye. I hid behind a building across from our apartment building and when I saw him get into his car I returned to the apartment to gather my things. I never went back!!

It was the scariest time of my life. Starting over without him was very challenging, but I pressed forward determined to live again. I got busy volunteering at a local shelter and speaking out against domestic violence in some uncomfortable spaces.

I began dating again, and decided to return to university. I had the opportunity to share my story with a gathering of young women an event remembering those who had lost

their lives due to domestic violence. That night my story impacted several of the women and I realized my story could inspire me.

The Butterfly Society came to be through my personal journey. We're a grassroots organization - boots on the ground, meeting people where they are. We go to barbershops, neighbourhood schools, and churches. We aim to educate, empower and engage the community.

There's still so much work to be done and it's up to us as a team to make an impact. One person can't do this alone. It takes many hands and many voices to do this work.

**Kirby's story**

*Kirby, a survivor of domestic violence and activist*

I met someone in high school and we started dating. I fell pregnant 3 months before graduating and moved in with him. The first time he put his hands on me was while I was pregnant. I wanted my daughter to have a father so I stayed with him.

The violence progressed. It was sexual, physical and emotional abuse. No one knew what went on behind closed doors. He treated me like I was his property.

I got my first restraining order after he showed up at my apartment, threw me around, choked me. I got another one four years later, but I ended up dropping it because I didn't have anyone to represent me and I was afraid of his threats.

In June 2017 I woke up to him sexually assaulting me in my bed. I stood up for myself and told him that what he was doing was rape. He told me he would show me what it was really like to be raped. He threw me onto the bed, I swung at him and bit him hard. He got back on top of me and started strangling me. My daughter came and yelled at him to stop.

I was able to call the police. They treated me like a delusional, hysterical, uncooperative person because I didn't want to repeat what I had already said four times in front of different men. The police report says I refused to write a statement, but I was never asked to do so. They told me I needed to decide if I wanted to press charges of breaking and entering or if I wanted them to call whoever does rape kits.

One police officer talked to my daughter, then told me my husband he was being arrested for domestic abuse and battery by strangulation based on her statement. They told me: "Just sign the paper Ma'am, I'm done handling you with kid gloves."

I met with my counsellor and next thing, I have Child Protective Services called on me for allowing my children to see spousal abuse. I was instructed to get a Protective Order for me and the kids. At the hearing, he was granted supervised visitation and required to take 26 weeks of family violence intervention classes. He was arrested four times while he was taking the classes, but he still got his certificate.

After that he decided to file for sole custody of the kids. The closer it gets to trial, the more I fear that he will kill me and my kids and flee to another country. He used to have an AK 47 and a Glock, always loaded. I don't know if he surrendered his guns. He's probably just hiding them in his garage. Yet I am determined to fight him every step of the way.

I co-founded VOICES of Acadiana, an organization which advocates for victims of domestic violence.

A women's abuse group was started at the Bayou church – and that's where I broke my silence for the first time. Now I am a trained facilitator. I spoke in front of a group of 150 women and shared my story of domestic abuse. It was an incredible feeling when these women stood up and clapped for me – it made me feel as though my chains were broken.

**Tiffany's story**

*Tiffany, domestic violence survivor and activist*

I met my abuser when I was 14. At first there was not physical abuse, it was emotional. He would embarrass me or make feel inferior in front of other people. It went from verbal to physical real fast. When I was seven months pregnant, he beat me until I was on the floor, curled in a ball.

While I was in the hospital having my child, he cashed my mom's cheque and bought drugs to sell. We were behind on rent, and the landlord took everything I owned out of the home and put it on the curb.

Finally, I made up my mind: I was not going back. He managed to track me down. He showed up at my doorway, and just like that, it was on again. Mentally I was broken. He made me believe he was the only person who would ever love me.

When I was seven months pregnant with my sixth child, he pulled a gun on me. I saw a big flash of light and my jaw swayed. I saw my shirt. It was red. The doctors told me that the only reason that the shot did not kill me was because he had the wrong caliber bullet in the gun.

While I was sat on my doorstep, bleeding from a bullet hole in my jaw, the police came and threatened to lock me up if I did not tell them who shot me. I gave the name of my abuser, but later recanted my statement because I was scared and told the prosecutor that I shot myself. They dropped all the charges against him, but he ended up going to jail for three years because of a probation violation from a previous offense.

I have had six surgeries, and I am still living with the physical effects of the shooting as well as the trauma. I have been diagnosed with post-traumatic stress disorder. I shake in crowds; I'm always looking for an exit. I cannot read a book anymore because I can't retain information, my mind is constantly scrambling. My kids suffer.

Despite everything that has happened I am determined to raise awareness about domestic violence. I posted a video on Facebook - I was crying but I wanted to tell people what I had been through. I did not realize how many people had watched it, but

doors started opening. I do a lot of public speaking and have even been asked to work on a play about my story.

It is important for women in that situation to hear from someone who understands. A lot of people might say, “You’re so stupid, you should have stayed gone.” They do not understand the hold an abuser has on his victim.

**Brandie’s story**

*Brandie, a domestic violence survivor and activist for VOICES of Acadiana, a network of survivors raising awareness*

We were married at 18, had three children and stayed together for nearly 15 years. I didn't realize what I was in an abusive marriage.

After we divorced, he always knew where I was. Once my co-worker texted me and said, 'He is down the street just sitting in his company vehicle'. The police escorted me back to my office.

I took out a protective order against my ex. A couple of weeks later, he left the severed leg of a pig in our boys' diaper bag with a note saying that the boys wanted it as a souvenir. He had gone hunting and cut off the leg. There was blood all over it.

Even with the protective order in place, he stalked and harassed me. I was still too scared to call the police. He barged into my house and threatened to kill himself, to kill other people. I had entered a new relationship and that made things 10 times worse. Those few years after leaving were hell. I was unaware that I could renew my protective order, so it expired.

After getting remarried and divorced twice, my ex got engaged again. His new fiancé filed for a protective order because he was abusing her and she was scared for her life. She asked me if I would go to the hearing to testify about past abuse.

Using my voice to break the silence against domestic violence was difficult but getting my life back has been worth it!

She had approached his second and third wives as well, so we came together to take a united stand. When he heard we were all there along with two other witnesses, he dropped the petition he had filed for a reciprocal protective order.

My ex had been acting aggressively towards my kids for years, and judging from the escalating violence with other women, I knew that my children needed protection. I met with the staff attorney at Faith House and we filed for sole custody. It was traumatic

going through it all again, but the judge ruled in my favor and now I have sole custody of my kids, and a permanent protective order for us all.

Since then, I co-founded VOICES of Acadiana. Our mission is to advocate for victims of domestic violence by actively working towards systems change, educating and raising awareness around domestic violence and survivor outreach to break the generational cycle of abuse.

Using my voice to break the silence against domestic violence was difficult but getting my life back has been worth it!

**End of Part 1**

## PART 2

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**A note of explanation:**

This is the second Part of this 15-hour course. It addresses the concurrence of Substance Abuse and Male on Female Domestic Violence. This is part of the Treatment Improvement Protocol (TIP) Series that is produced by the Substance Abuse and Mental Health Services Administration's (SAMHSA) Center for Substance Abuse Treatment (CSAT). A further explanation of the TIP is below. In addition, as a help in taking the test, the information is highlighted font a comment bubble on the right margin. The correct answer is in bold. The first 20 questions are from Part 1. The last 40 questions are from Part 2.

We hope this is helpful to you in identifying the information needed for taking the test.

### Chapter 1. Effects of Domestic Violence on Substance Abuse Treatment

Domestic violence is the use of intentional emotional, psychological, sexual, or physical force by one family member or intimate partner to control another. Violent acts include verbal, emotional, and physical intimidation; destruction of the victim's possessions; maiming or killing pets; threats; forced sex; and slapping, punching, kicking, choking, burning, stabbing, shooting, and killing victims. Spouses, parents, stepparents, children,

siblings, elderly relatives, and intimate partners may all be targets of domestic violence (Peace at Home, 1995).

This Treatment Improvement Protocol (TIP) focuses on heterosexual men who abuse their domestic partners and on women who are abused by men, because these individuals constitute a significant portion of the population seeking substance abuse treatment. Though domestic violence encompasses the range of behaviors above, the TIP focuses more on physical, or a combination of physical, sexual, and emotional, violence. Therefore men who abuse their partners are referred to throughout as *batterers*; women who are abused are called *survivors*.

Child abuse and neglect, elder abuse, women's abuse of men, and domestic violence within same-sex relationships are important issues that are not addressed in depth in this document, largely because each requires separate comprehensive review. Other patterns of domestic violence outside the scope of this TIP are abused women who in turn abuse their children or react violently to their partners' continued attacks and adult or teenage children who abuse their parents.

The primary purpose of this document is to provide the substance abuse treatment field with an overview of domestic violence so that providers can understand the particular needs and behaviors of batterers and survivors as defined above and tailor treatment plans accordingly. This requires an understanding not only of clients' issues but also of when it is necessary to seek help from domestic violence experts. The TIP also may prove useful to domestic violence support workers whose clients suffer from substance-related problems.

As the TIP makes clear, each field can benefit enormously from the expertise of the other, and cooperation and sharing of knowledge will pave the way for the more coordinated

system of care discussed in Chapter 6. Future publications will examine aspects of the problem that concern

such special populations as adolescent gang members, the elderly, gay men and lesbians, and women who batter. The first of these is an upcoming TIP that addresses substance abuse by victims of child abuse and neglect.

## A. Defining the Problem

In the United States, a woman is beaten every 15 seconds (Dutton, 1992; Gelles and Straus, 1988). At least 30 percent of female trauma patients (excluding traffic accident victims) have been victims of domestic violence (McLeer and Anwar, 1989), and medical costs associated with injuries done to women by their partners total more than $44 million annually (McLeer and Anwar, 1987). Much like patterns of substance abuse, violence between intimate partners tends to escalate in frequency and severity over time (Bennett, 1995). "Severe physical assaults of women occur in 8 percent to 13 percent of all marriages; in two-thirds of these relationships, the assaults reoccur (Dutton, 1988)" (Bennett, 1995, p. 760). In 1992, an estimated 1,414 females were killed by "intimates," a finding that underscores the importance of identifying and intervening in domestic violence situations as early as possible (Bureau of Justice Statistics, 1995).

An estimated three million children witness acts of violence against their mothers every year, and many come to believe that violent behavior is an acceptable way to express anger, frustration, or a will to control. Some researchers believe, in fact, that "violence in the family of origin [is] consistently correlated with abuse or victimization as an adult" (Bennett, 1995, p. 765; Hamberger and Hastings, 1986a; Kroll et al., 1985). Other researchers, however, dispute this claim. The rate at which violence is transmitted across generations in the general population has been estimated at 30 percent (Kaufman and Zigler, 1993) and at 40 percent (Egeland et al.,

1988). Although these figures represent probabilities, not absolutes, and are open to considerable interpretation, they suggest to some that 3 or 4 of every 10 children who observe or experience violence in their families are at increased risk for becoming involved in a violent relationship in adulthood.

## Identifying the Connections

Researchers have found that one fourth to one half of men who commit acts of domestic violence also have substance abuse problems (Gondolf, 1995; Leonard and Jacob, 1987; Kantor and Straus, 1987; Coleman and Straus, 1983; Hamilton and Collins, 1981; Pernanen, 1976). A recent survey of public child welfare agencies conducted by the National Committee to Prevent Child Abuse found that as many as **80 percent of child abuse cases** are associated with the use of alcohol and other drugs (McCurdy and Daro, 1994), and the link between child abuse and other forms of domestic violence is well established. Research also indicates that women who abuse alcohol and other drugs are more likely to become victims of domestic violence (Miller et al., 1989) and that victims of domestic violence are more likely to receive prescriptions for and become dependent on tranquilizers, sedatives, stimulants, and painkillers and are more likely to abuse alcohol (Stark and Flitcraft, 1988a). Other evidence of the connection between substance abuse and family violence includes the following data:

- About 40 percent of children from violent homes believe that their fathers had a drinking problem and that they were more abusive when drinking (Roy, 1988).
- Childhood physical abuse is associated with later substance abuse by youth (Dembo et al., 1987).
- Fifty percent of batterers are believed to have had "addiction" problems (Faller, 1988).

- Substance abuse by one parent increases the likelihood that the substance-abusing parent will be unable to protect children if the other parent is violent (Reed, 1991).
- A study conducted by the Department of Justice of murder in families found that more than half of defendants accused of murdering their spouses -- as well as almost half of the victims -- had been drinking alcohol at the time of the incident (Bureau of Justice Statistics, 1994).
- Teachers have reported a need for protective services three times more often for children who are being raised by someone with an addiction than for other children (Hayes and Emshoff, 1993).
- Alcoholic women are more likely to report a history of childhood physical and emotional abuse than are nonalcoholic women (Covington and Kohen, 1984; Miller et al., 1993; Rohsenow et al., 1988; Hein and Scheier, 1996).
- Women in recovery are likely to have a history of violent trauma and are at high risk of being diagnosed with posttraumatic stress disorder (Fullilove et al., 1993).

### B. The Societal Context

Clearly, substance abuse is associated with domestic violence, but it is not the only factor. As discussed above, witnessing or experiencing family violence during childhood is a risk factor as is a history of childhood aggression. Another factor that must be acknowledged is societal norms that indirectly excuse violence against women (tacit support for punishing unfaithful wives, for example, or stereotyped views of women as obedient or compliant) (Kantor and Straus, 1987; Reed, 1991; Bennett, 1995; Flanzer, 1990).

The overt or covert sexism that contributes to domestic violence also bears on connections between violence and substance abuse. Manifestations of that sexism vary across social classes and cultural groups: Some groups more than others accept

domestic violence or intoxication as a way of dealing with frustration or venting anger. Though they range from subtle to blatant, sexist assumptions persist and are reflected by society's different responses to domestic violence and substance abuse among men and among women.

For example, **substance abuse treatment providers have observed that society tolerates a man's use of alcohol and other drugs more readily than a woman. They note that batterers often blame a woman they have victimized for the violence, either implicitly or explicitly, and other people, including police, judges, and juries, often accept this argument.** Research suggests that intoxicated victims are more likely to be blamed than sober victims and that aggression toward an inebriated victim is considered more acceptable than aggression toward a sober one (Aramburu and Leigh, 1991). At least one other research team (Downs et al., 1993) argues that sexist attitudes may in fact contribute to the alcoholism of some women. "The alcoholic woman," they write, "may internalize previous negative stigmatization and subsequently use alcohol to cope with negative feelings resulting from the stigma. Conversely, the partner may use the woman's drinking as a rationale to label her negatively" (p. 131).

Attitudes toward rape are another example of how this rationalization works. Even when alcohol or other drugs are not involved, women victims frequently are assumed to have provoked their rapists by the way they behaved or dressed. This widely accepted misperception is often internalized and accounts for the guilt and shame that many rape victims experience. Not surprisingly, some victims of rape and other violence report using alcohol and other drugs to "self-medicate" or anesthetize themselves to the pain of their situations.

### C. The Connection Between Substance Abuse and Domestic Violence

Though experts agree there is a connection between the two behaviors, its precise nature remains unclear. One researcher writes, "Probably the largest contributing factor to domestic violence is alcohol. All major theorists point to the excessive use of alcohol as a key element in the dynamics of wife beating. However, it is not clear whether a man is violent because he is drunk or whether he drinks to reduce his inhibitions against his violent behavior" (Labell, 1979, p. 264).

Another expert (Bennett, 1995) observes that [I]f substance abuse affects woman abuse, it does so either directly by disinhibiting normal sanctions against violence or by effecting changes in thinking, physiology, emotion, motivation to reduce tension, or motivation to increase interpersonal power (Graham, 1980). Despite its popularity, the disinhibition model of alcohol aggression is often discredited because of experiments that have found expectation of intoxication a better predictor of aggression than intoxication itself (Lang et al., 1975). An alternative to disinhibition, is 'learned disinhibition,' or expectancy of a drug and violence relationship ... Drug and alcohol use occur in a cultural context in which behavior can be attributed to 'I was loaded' (MacAndrew and Edgerton, 1969). (p. 761)

Within this theoretical framework, the societal view of substance abusers as morally weak and controlled by alcohol or other drugs actually serves some batterers: Rather than taking responsibility for their actions, they can blame their violent acts on the substance(s) they are abusing. Although drugs or alcohol may indeed be a trigger for violence, the belief that the violence will stop once the drinking or drug use stops is usually not borne out. The use of alcohol or other drugs may increase the likelihood that a batterer will commit an act of domestic violence -- because it reduces inhibitions and distorts perceptions, because alcohol is often used as an excuse for violence, and because both alcohol abuse and domestic violence tend to follow parallel escalating patterns -- but it does not fully explain the behavior (Pernanen, 1991; Leonard and Jacob, 1987; Steele and Josephs, 1990). The fact remains that nondrinking men also attack their partners, and for some individuals, alcohol actually inhibits violent behavior (Coleman and Straus, 1983).

Batterers -- like survivors -- often turn to substances of abuse for their numbing effects. Batterers who are survivors of childhood abuse also frequently say that they use drugs and alcohol to block the pain and to avoid confronting that memory. It is a self-perpetuating cycle: Panel members report that batterers say they feel free from their guilt and others' disapproval when they are high.

### D. The Impact of Violence on Substance Abuse Treatment

Though it cannot be said that substance abuse "causes" domestic violence, the fact remains that substance abuse treatment programs see substantial numbers of batterers and victims among their patient populations and increasingly are compelled to deal with issues related to abuse (Flanzer, 1993). As substance abuse treatment programs have grown more sophisticated, the treatment offered patients has become more comprehensive and more effective. Questions about vocational, educational, and housing status; coexisting mental disorders; and presence of human immunodeficiency virus (HIV) and other infectious diseases are routinely raised during the assessment process. Treatment providers now recognize the importance of addressing issues that affect clients' patterns of substance abuse (and vice versa) so that these issues do not undermine their recovery. Today, mounting evidence about the varied associations between domestic violence and substance abuse attests to the need to add violent behavior and victimization to the list of problems that should be explored and addressed during treatment. Based on their clinical experience, members of the Consensus Panel who developed this TIP conclude that failure to address domestic violence issues interferes with treatment effectiveness and contributes to relapse.

Practitioners in both fields must be attuned to the connections between the two problems. By sharing knowledge, substance abuse treatment providers and domestic violence workers can understand the complexity of the problem, address their own misperceptions and prejudices, and better serve individual clients -- as well as lay the foundation for a coordinated community response. Building bridges between the fields requires an

understanding of the way each problem can interfere with the resolution of the other and of the barriers posed by the two fields' differing program priorities, terminology, and philosophy.

## E. Barriers to Addressing Domestic Violence in the Treatment Setting

### *Battering, victimization, and treatment effectiveness*

Battering and victimization undermine substance abuse treatment in both direct and indirect ways. Consensus Panel members report that a substance-abusing woman often finds that her abusive partner becomes angry or threatened when she seeks help, and his violence or threats of violence may push her to drop out of treatment. Panel members have also seen a violent partner sabotage a woman's treatment by appearing at the program and threatening physical harm unless she leaves with him or by bullying or manipulating her to use alcohol or other drugs with him. Another variation on this theme occurs when a woman manages to continue in treatment, a violent episode occurs, and, as part of "making up," is persuaded to take alcohol or other drugs.

Although these patterns occur in nonviolent relationships as well, the threats of physical harm, withholding of financial support, or abuse directed toward children can lead survivors to resort to using substances to buffer their distress. For this reason, recovery from a substance use disorder may not be possible unless client survivors improve their self-esteem, sense of competence, and ability to make sound decisions. Survivors must get to the point where they can recognize and take advantage of their options and alternatives before they can replace their substance use with positive coping strategies.

When batterers enter treatment, their partners also may subvert their efforts to achieve sobriety. Some batterers are less violent and easier to handle when they are drunk or high. If a batterer is more violent when sober or abstinent, his partner may encourage drinking or taking drugs. "Enabling" is actually a safety measure in these cases.

Another complicating factor is some women's perception that they are responsible for their partners' substance abuse, a perception that often is reinforced by their partners, friends, and family. In the same way that they hold
themselves culpable for their battering, those women believe that their "bad" behavior prompts their partners' use of alcohol or other drugs, a position that abusers exploit to rationalize their continued substance abuse.

## Program priorities, terminology, and philosophy

The problems of substance abuse and domestic violence intersect in destructive ways; furthermore, differences in priorities, terminology, and philosophy have hampered collaboration between providers in the two fields. For substance abuse, attaining abstinence is a key goal; for domestic violence programs, ensuring survivors' safety is of paramount concern. While both goals are valid, the reality is that they may be difficult to balance. The problem for substance abuse and domestic violence staff then lies in the perception that one goal invariably must be selected to the exclusion of the other for a program to preserve its identity and thereby carry out its mission.

A heightened awareness of the two problems, however, reveals that programs can forego an "either/or approach," shift priorities to accommodate a client's situation, and still retain program identity and orientation. A female substance abuser's living arrangements, for example, may be so dangerous that regular attendance at treatment will be impossible until safety issues are resolved. In this case, substance abuse treatment could be temporarily postponed and then reinitiated after a more secure environment can be achieved. Conversely, some survivors remain in traumatic relationships because of their addiction. Their batterer is their supplier, and they endure the intolerable in order to feed their habit. Delaying development of a safety plan until the drug problem is addressed could be a more effective strategy under those circumstances.

Adjusting priorities on a case-by-case basis does not undermine a particular program's philosophy; instead it recognizes the need for flexibility in responding to individual client needs.

Differences in terminology pose another potential barrier to effective networking. Domestic violence programs try to avoid negative language by using such positive terms as *empowerment* to encourage battered women to move forward and build a new life. *Denial*, *enabling*, *codependency*, and *powerlessness* -- terms widely used in the substance abuse field to describe typical client behaviors and aspects of recovery -- strike some domestic violence workers as stigmatizing, repressive, and counter to appropriate goals for violence survivors.

Increasingly, substance abuse is considered a brain disorder that deserves treatment in much the same way as hypertension and diabetes do. In contrast, domestic violence counselors tend to distance themselves from medical models that imply that survivors are "sick" when, in fact, they have been battered by someone else. To forestall divisions between the two fields, etiological differences must not only be recognized, but accepted as legitimate.

Other features of substance abuse treatment that have posed problems for domestic violence programs and have inhibited collaboration between the two fields are the largely male clientele, the emphasis on family involvement, and the use of confrontational group therapy. Some domestic violence professionals worry that the male orientation in many substance abuse treatment programs makes these programs irrelevant to the realities of women's lives, insensitive to their needs, and inapplicable to the issue of domestic violence. They also believe that enlisting the help of family members and significant others in the treatment process can, in the case of violent partners, endanger the survivor. Likewise, domestic violence professionals who work with survivors consider the confrontational techniques used by some substance abuse treatment providers to overcome denial and resistance to treatment as "bullying" and inappropriate.

Although there is some validity to these characterizations (as well as to the claim that domestic violence staff are uninformed and naive about substance abusers and the manipulative behaviors they sometimes employ), education, communication, and cross-training can help to overcome barriers between substance treatment and domestic violence programs. Increased understanding within both disciplines will equip practitioners to address the particular problems of substance abusers who are victims or perpetrators of domestic violence.

### F. A New Way of Thinking

The disagreements between experts in the fields of substance abuse and domestic violence can inhibit the exchange of essential information to the detriment of the client's recovery. This TIP represents an initial effort to bridge that gap. In the chapters that follow, experts in the respective arenas share their understanding about the impact of domestic violence on batterers and survivors. In addition, this TIP provides suggestions for screening and assessing for past and current experience with domestic violence, offers ideas for intervening with survivor and perpetrator clients, and summarizes legal and ethical issues that substance abuse providers should consider when working with this population. In addition to presenting guidelines to improve client outcomes, the information included in this document is intended to begin a dialogue between domestic violence and substance abuse treatment staff about the larger issue of systemic reform.

Currently, domestic violence and substance abuse treatment function as parallel programs within the overall social services system. In the short term, the ideas presented in this TIP should enhance the responses of both programs to the problems of domestic violence survivors and batterers who are also substance abusers. However, to effect lasting change and reduce morbidity, people working in both fields must accept the fact that the two problems often exist together, must recognize the importance of a holistic treatment approach, must be willing to set aside concerns about "turf," and must learn to

collaborate effectively on the client's behalf. Impediments to systemic reform are scattered throughout substance abuse and domestic violence programs and in the public and private funding organizations supporting them. The insistence on identifying a single problem as primary or the need to conceal a problem in order to receive services can complicate admission to treatment, interfere with the development of appropriate treatment plans, and ultimately derail progress.

In the concluding chapter of this TIP, Chapter 6, the Panel offers ideas for forging system-wide linkages that exemplify a new, collaborative way of thinking about problems and their solutions. This chapter builds on the practical suggestions described in earlier chapters to create a blueprint for a system of coordinated care. Such a unified system would be better equipped than the current fragmented one to interrupt the cycle of violence, fear, intimidation, guilt, and relapse to substance abuse that jeopardizes clients' recovery.

## Chapter 2 Survivors of Domestic Violence: An Overview

This chapter presents an overview of those issues likely to affect survivors of domestic violence seeking treatment for substance abuse. Its purpose is to help substance abuse treatment providers understand the impact of this experience on the treatment and recovery process and appreciate the differences in approach between the fields of substance abuse and domestic violence as they affect the survivor, so that treatment programs can respond more appropriately to this client group. The primary focus of substance abuse treatment services is to initiate the recovery process and reinforce the skills needed to stay sober or abstinent, while domestic violence programs seek to interrupt the cycle of violence and help the survivor client access the information and resources she needs to increase her safety and to develop and implement a safety plan. Holistic care is impossible if a treatment provider cannot understand the profound effect of domestic violence on a survivor. The battered woman lives in a war zone: She rarely knows what will trigger an abusive episode, and often there is little, if any, warning of its

approach. She spends a great deal of time and energy trying to read subtle signs and cues in her partner's behavior and moods in order to avoid potential violence, but she is not always successful. Financial constraints and fear that the batterer will act on his threats to harm family members or continually harass, stalk, and possibly kill her often inhibit victims from leaving (Rodriguez et al., 1996). If the batterer is also the victim's drug supplier, that further complicates the situation. Assuming all these issues can be resolved, the effects of continual abuse and verbal degradation can be so inherently damaging to self-esteem that the survivor may believe that she is incapable of "making it" on her own.

## A. Entering the Treatment System

### Crisis Intervention

When a client presents for substance abuse treatment and informs staff that she is a victim of domestic violence, treatment providers should focus on:

1. *Ensuring her safety:* Whether a client is entering inpatient or outpatient treatment, the immediate physical safety of her environment must be the chief concern. If inpatient, security measures should be intensified; if outpatient, a safety plan (which may include immediate referral to a domestic violence or battered women's shelter) should be developed. In both cases, staff should be cautioned about the importance of vigilantly guarding against breaches in confidentiality.
2. ***Validating and believing her, and assuring her that she is believed****:* Reinforcement of the counselor's belief of a survivor's victimization is a critical component of ongoing emotional support. Affirming the survivor's experience helps empower her to participate in immediate problem solving and longer term treatment planning.
3. *Identifying her options:* Treatment providers should ask the survivor to identify her options, share information that would expand her set of available options, explore with her the risks associated with each option, and support her in devising a safety plan.

These three goals remain important for a survivor throughout treatment.

Other needs that must be addressed immediately are

- Stabilizing detoxification (including withdrawal symptoms, if any).
- Evaluating and treating any health concerns, including pregnancy. The latter is especially important for a survivor client because batterers often intensify their abuse when they learn their partner is pregnant (Hayes and Emshoff, 1993; Stark et al., 1981). Injuries should be documented for any future legal proceedings that might occur.
- Attending to immediate emotional and psychological symptoms that may interfere with the initiation of treatment, such as acute anxiety and depression.

Once survivor clients' physical safety and symptoms have been addressed, treatment providers can obtain the information necessary to design a treatment plan.

**Obtaining a History**

A number of issues unique to domestic violence survivors must be considered by substance abuse treatment providers who work with these clients. Chief among these is the need to uncover the extent of the client's history of domestic violence. The survivor client's current substance abuse problems must be placed in the context of whatever violence and abuse she may have experienced throughout her life, both within her current family and in her family of origin.

Childhood sexual abuse has been associated with a higher risk for "revictimization" later in life (Browne and Finkelhor, 1986). (See Chapter 4 for a discussion on how to elicit information regarding domestic violence.)

Studies have found a higher incidence of substance abuse among women who were victims of childhood sexual abuse and sexual assault (Ryan and Popour, 1983; Reed, 1985). Data suggest that substance abuse often begins at an early age and may become part of a self-destructive coping style that is sometimes seen in incest victims (Harrison et al., 1989; Conte and Berliner, 1988; Briere, 1989). It is not unusual for the abuser to foster the child's initiation into alcohol and drugs in order to make the child more compliant.

A discussion of substance abuse in the client's history should cover her current use, her treatment history, and alcohol or other drug use in her family of origin. In addition, patterns and frequency of alcohol or other drug use by her batterer are key to understanding the relationship of substance abuse to the violence.

Substance abuse counselors should be aware that survivors often are reluctant to disclose the extent of violence in their lives. Often a survivor's denial that violence occurs is so pervasive that it has become an integral element of her psyche. And, especially if violence existed in her family of origin, she may simply consider it a normal part of an intimate relationship.

At the same time, it is important to recognize that many survivors consciously keep the fact or extent of their battering concealed for good reasons, such as fear for themselves, their children, or other family members. When a battered woman leaves her abuser, her chances of being killed increase significantly (Wilson, 1989; Casanave and Zahn, 1986; Rasche, 1993; Dutton-Douglas and Dionne, 1991). Furthermore, the batterer may be the primary source of income, so his incarceration could leave her destitute (Rodriguez et al., 1996).

**Treatment Planning for The Survivor Client**

Treatment providers can best serve clients by establishing strong linkages to domestic violence referral and intervention services and by employing staff who are thoroughly familiar with local and State laws regarding domestic violence and with the unique needs of the domestic violence survivors. Ideally, counselors should be able to refer to those services and staff members when domestic violence is suspected and call on them for consultation as needed. If a client denies a history of domestic abuse but the treatment provider still suspects it is possible, additional attempts to discuss it with the client should be made and documented. Once the client has entered treatment, a treatment plan that includes guarantees of safety and a relapse prevention plan should be developed. Considerations specific to domestic violence survivors should be integrated into each phase of the treatment plan.

**Safety from the Batterer**

In the early stages of the survivor's treatment, the substance abuse counselor should help her develop a long-term safety plan either by referring the client to or employing domestic violence service providers. If substance abuse counselors have been well trained in this area, they can work with clients to develop such a plan as part of intake.

**One of the purposes of screening is to assess the degree to which the survivor is in physical danger**. Screening for this purpose should be conducted early in the treatment process. However, domestic violence and safety issues do not always arise in the early stages of treatment of these clients. Thus, substance abuse treatment providers are wise to be prepared to develop a safety plan whenever the need becomes known or acknowledged. (See Chapter 4 on screening and assessment for a discussion on assessing danger and). In this regard, it is also important to remember that the client's sobriety may threaten the batterer's sense of control. In response, he may attempt to sabotage her recovery or increase the violence and threats in order to reestablish control. It is important to address this issue in treatment and to help the client minimize her risk of

harm so that she can continue to comply with her treatment plan. In addition, although involving the family in counseling is usually a precept of successful substance abuse treatment, couples and family therapy may be dangerous for domestic violence survivors and should be undertaken cautiously, if at all.

It is also important for the substance abuse provider to assess the degree to which an addicted client's drug problem is tied to the abusive partner: Her batterer may be her supplier. A survivor client who relies on a batterer to obtain or administer drugs may have a difficult time remaining in treatment or avoiding the batterer. A batterer who understands his partner's addiction may simply wait for the victim to resurface. The treatment provider should be alert to the possibility that a survivor client may sabotage both her treatment and her safety in the service of her addiction.

**Physical Health**

Domestic violence survivors often present with acute injuries and long-term sequelae of battering as well as the physical health problems more commonly associated with substance abuse (e.g., skin abscesses and hepatitis). Cuts and bruises from domestic violence tend to be on the face, head, neck, breasts, and abdomen (Randall, 1990). The body map in the Abuse Assessment Screen (see Appendix C) can help identify these injuries. Abdominal pain, sleeping and eating disorders, recurrent vaginal infections, and chronic headaches are also common among survivors (American Medical Association, 1992; Beebe, 1991; Stark et al., 1981; Randall, 1990). While it may be necessary to attend to pressing legal and financial concerns before chronic health problems can be addressed, medical staff should be available to assess the client's most immediate physical, emotional, and mental health needs.

When a woman presents for treatment with obvious signs of or complaints about physical battering or sexual abuse, staff should consider enlisting a forensic expert to help the survivor client obtain proper medical documentation of her injuries. Forensic medicine programs have been employed successfully in pediatric populations (Corey Handy et al.,

1996), and are now being expanded to include adult victims of abuse. Forensic examiners are medicolegal experts (e.g., nurses, emergency room physicians, and forensic pathologists) specially trained to evaluate, document, and interpret injuries for legal purposes (Corey Handy et al., 1995). They can assess whether an injury is consistent with events as described by the victim or perpetrator client, information especially valuable when the victim is unable to accurately recount the circumstances surrounding her injuries because she was using alcohol or other drugs at the time of the assault. Forensic examiners frequently are called to testify in court and may be viewed as a valuable asset in any court proceeding relating to the assault (Corey Handy et al., 1995).

Other health concerns that need attention early in treatment include screening and care for pregnancy, HIV infection, and other sexually transmitted diseases (STDs). Battered women are at extraordinarily high risk for STDs because they are frequently unable to negotiate the practice of safe sex with their partners and are often subjected to forced, unprotected sex. They also may have been forced by their partners to share needles. Not only do STDs and pregnancy require immediate medical attention, but they can also be triggers for more battering.

One of the coping mechanisms used by many survivors is the repression of physical sensations, including physical pain. Often the survivor's awareness of physical pain and discomfort resurfaces only when the traumatic effects of the abuse have been relieved. An increase in a client's somatic symptoms is also common as emotional issues surrounding her victimization begin to emerge. Such a newfound awareness can be confusing and frightening for the survivor, and it is important to ensure that this awareness is addressed both in her medical care and through psychotherapeutic counseling.

## Psychosocial Issues

### *Shift of focus and responsibility to the abuser*

A key aspect of treatment for substance abuse is encouraging the client to assume responsibility for her addiction. For a survivor client, it is critical at the same time to dispel the notion that she is responsible for her partner's behavior*. She is only responsible for her own behavior.*

The survivor client must realize that she does not and cannot control her partner's behavior, no matter what he says. Treatment should help move her toward becoming an autonomous individual who is not at the mercy of external circumstances. Concrete steps to ensure her safety or, if she decides to leave the batterer, to set up a new life will do more toward this end than anything else. As she frees herself from the violence, she will feel more independent. A counselor can help reinforce the client's view of herself as capable and competent by eliciting information about her efforts to address the violence, even if they were unsuccessful. A counselor can point out that her efforts reflect determination, creativity, resourcefulness, and resilience, many of the same qualities that will equip her to take responsibility for her substance abuse.

**Improving decision-making skills**

Poorly developed decision-making skills are a problem for many substance abusers. When a client is a battered woman, that inadequacy may be compounded by the domestic abuse (American Medical Association, 1993). For some battered women, every aspect of their lives has been controlled by the batterer, and a "wrong" decision (as perceived by the batterer) may have served as another excuse to batter her. The paralyzing effect of being battered for making independent decisions must be overcome as the survivor begins to exercise choices without fear of reprisal.

Thus, one of the first steps in the process of empowering the survivor client is to help her develop, strengthen, focus, or validate her decision-making skills. For a proportion of domestic violence survivors, decision-making is a new skill that must be acquired for the first time rather than a lost skill that must be relearned. Exploring her own wants, needs, and feelings, although an unfamiliar and sometimes uncomfortable process, can be a stepping stone to making larger and longer term decisions. It is important for the treatment

provider to avoid underestimating the importance to the survivor of making even seemingly mundane decisions, such as what to wear or when to eat.

Like most substance abusers, the survivor client must examine those areas of her life that will either support or undermine her recovery. Like others in treatment, she must disengage from drug-using friends, and she will need support as she begins the task of making new social contacts who support her recovery. Reevaluating relationships with partners who support and encourage drinking or drug-taking is another therapeutic task for those undergoing substance abuse treatment. In a pattern that parallels the experience of many survivors of domestic violence, female substance abusers are often introduced to and supplied with drugs by male partners. Among the myriad reasons for continuing use are to maintain a relationship, to please a partner, or to share a common activity.

Since safety poses such a serious problem for survivor clients, reevaluating ties to her significant other in the context of her goals for recovery requires careful consideration. For many of these women, recovery will not be possible without separation from their partners -- a reality that may be extremely difficult for them to acknowledge, accept, and translate into action. Furthermore, because of the toll that the battering has taken on many survivor clients' belief in their ability to make decisions, they are likely to need additional help in evaluating and identifying sources of stress in their relationships. Despite the time and effort involved in working through this issue, however, it is not uncommon for survivor clients to change their views about which relationships feel safe as they begin to make choices that support recovery.

When working with some survivor clients, substance abuse treatment providers may have to discard traditional notions about the wisdom of making major life decisions, such as moving, early in the course of treatment. For a domestic violence survivor who fears being pursued by a batterer, relocation to another community may be a priority. As part of treatment, the stress of uprooting herself and her children and the accompanying risk of relapse must be weighed against safety issues. Should a client decide to move, every

effort should be made to refer her to appropriate resources and supportive services within the new community.

**Ensuring emotional health**

Posttraumatic stress disorder

Posttraumatic stress disorder (PTSD) is a psychiatric diagnosis described in the *Diagnostic andStatistical Manual of Mental Disorders*, Fourth Edition (DSM-IV) (American Psychiatric Association, 1994). The first diagnostic criteria are being "exposed to a traumatic event in which

1. The person experienced, witnessed, or was confronted with an event or events that included actual or threatened death or serious injury, or a threat to the physical integrity of self or others [and]
2. The person's response involved intense fear, helplessness, or horror" (American Psychiatric Association, 1994, pp. 427-428). Other criteria include recurrent nightmares, difficulty sleeping, flashbacks, hypervigilance, and increased startle responses – symptoms shared by many battered women (Walker, 1991; Douglas, 1987; Follingstad et al., 1991; Woods and Campbell, 1993). One study of 77 battered women in a shelter found that 84.4 percent of them met the PTSD criteria in the DSM-IV (Kemp et al., 1991).

Though the DSM-IV states that the disorder is "more commonly seen in association with an interpersonal stressor (e.g., childhood sexual or physical abuse, domestic battering,

being taken hostage, incarceration as a prisoner of war or in a concentration camp, torture)" (p. 425), some domestic violence support workers have been reluctant to acknowledge PTSD among survivor clients. Their fear is that thus labeling the victim moves the onus for the violence from the abuser to the victim and provides another excuse for the batterer's behavior (e.g., "she's crazy"). A treatment provider, however, must be aware of the possibility that a survivor may be suffering PTSD and must make the appropriate referral.

## D. Emergence of trauma from childhood abuse

Many survivor clients also suffered abuse as children (Browne and Finkelhor, 1986). Emotional and psychological trauma from childhood abuse is often repressed and may surface once the client is in a safe setting, such as an inpatient substance abuse treatment facility. The emergence of this memory can be an overwhelming experience, and treatment providers should not attempt to address it before the survivor is ready or if program staff are unprepared to handle the results.

If the issue surfaces in a group setting, the substance abuse counselor should allow the survivor client to express her emotions initially. Thereafter, however, a client should be referred if possible to a therapist with special training in treating victims of childhood abuse.


**Life event triggers**

Recovering substance abusers are trained to deal with relapse triggers -- events or circumstances that produce cravings and predispose them to resume their use of alcohol or other drugs. A potential trigger for relapse can be something as seemingly benign as

walking through a neighborhood where the recovering individual once purchased drugs. A domestic violence survivor is vulnerable to an additional set of triggers -- situations or experiences that may unexpectedly cause her to feel the fear and victimization she experienced when being battered.

Such life event triggers may cause the client to relapse and should be addressed directly by counselor and client. Examples of life event triggers are sensory stimuli (sights, sounds, smells); the close physical proximity of certain people, particularly men; or situations that trigger unpleasant memories (such as witnessing a couple arguing). They also include stressful situations that evoke trauma responses and recreate the sense of victimization (Craine et al., 1988). Such triggers may push these feelings to the surface many years later, after the survivor is out of the abusive relationship; some disappear over time, but others may always be present to some degree. Counselors should help patients identify these stressful situations and rehearse alternative responses, just as they should for substance use triggers.

**Increased stress with abstinence**

Survivors of domestic violence usually experience strong emotional reactions when they stop abusing alcohol or other drugs, which may have been a form of self-medication. They may be flooded by formerly repressed emotions and physical sensations.

Abstaining from substance abuse, which often helps a survivor repress her responses, may also eradicate her ability to psychologically dissociate (distance herself emotionally so she does not "experience" feelings) from what was happening during the abuse. This dissociation may have provided her with an effective coping mechanism that allowed her to function on a day-to-day basis, despite the abuse.

Its elimination may give rise to somatic symptoms, such as headaches or backaches, as formerly blocked physical sensations and experiences reenter her awareness.

Another issue for the survivor upon becoming abstinent may be the freeing of time and energy formerly spent procuring alcohol or other drugs, leaving her feeling empty or directionless and with too much time to dwell on her life situation. Other problems may surface as well. In the Panel's experience, eating disorders as well as other kinds of obsessive-compulsive behavior tend to reemerge after substance abuse ceases. Treatment providers should be alert to this possibility and prepared to refer survivor clients for specialized help (such as a local eating disorders program or chapter of Overeaters Anonymous).

**Perceptions of safety**

Paradoxically, the very concept of "safety" may itself seem "unsafe" to a survivor of domestic violence. As one survivor expressed it, "The minute you (think you) are safe, you are not safe." For these clients, feeling safe from the perpetrator, even if he is dead or incarcerated, is equated with letting one's guard down and making oneself vulnerable to attack. Survivors tend to be hyper-vigilant and are accustomed to always being on guard. The substance abuse treatment provider needs to understand and respect the domestic violence survivor's concept of and need for safety. Helping a client rebuild a more appropriate general level of trust is an important long-term therapeutic goal.

**Medications**

For some survivors, anxiety, depression, suicidal thoughts, and sleep disorders are severe enough to require medication during their treatment for substance abuse. In such cases, it is of utmost importance to strike a balance between the need for medication and the avoidance of relapse. On the one hand, the recurrence of the physical and emotional sequelae of abuse may tip a survivor into emotional trauma; on the other hand; however, the client may risk relapse with the possible misuse or abuse of the medication. Physicians should weigh carefully the risks and benefits of prescribing drugs to battered

women for symptom relief. For battered women who use or are dependent on alcohol or other drugs, the drug may affect their awareness, cognitive reasoning, or motor coordination, which can, in turn, reduce their ability to protect themselves from future incidents of physical abuse. A thorough medical and psychological assessment should be conducted by a trained clinician experienced in addiction medicine before any psychoactive medications are prescribed. As with other medicated substance abusers, regular monitoring and reassessment of symptoms are essential.

**Later Post-Abstinence Issues**

Practical concerns overwhelm many survivors of domestic violence after they become abstinent. These include resolution of legal problems, housing, transportation, employment or supported vocational training, and child care, among others. Linkages with other programs and agencies become extremely important in meeting these clients' needs. (See Chapter 6 for a discussion of the importance of forming collaborative relationships.) In addition, there are some special concerns that merit particular attention when working with survivor clients. "Welfare to Work," "Workfare," and other initiatives designed to rapidly move welfare recipients into employment may prove especially problematic for these clients. Both Panel members and reviewers described the inordinate pressure survivors experience when they are compelled to accept several new responsibilities at the same time. Panel members recommended developing, if possible, a schedule for the graduated assumption of responsibilities. Field Reviewers concurred and observed that providers should plan on providing extra support during this crucial post-abstinence period.

In addition, survivor clients are likely to need education or reeducation about meeting sexual needs without drugs or alcohol. Referral to or staff training by experts in this area is recommended to ensure that this topic is approached sensitively. In addition, classes in healthy nutrition are a useful adjunct to treatment for survivor clients as for other substance abusers.

## Social functioning

Although a strong family or friendship support system can be invaluable to substance abusers as they reenter the mainstream from the drug culture, the domestic violence survivor who is recovering from substance abuse may find it especially hard to reestablish ties, make new friends, or, in some cases, build a completely new life for herself.

Social isolation is common among domestic violence survivors, as batterers curtail their victims' contacts with friends and family members. While a survivor client will likely need help and advice about creating a new nondrug, nonviolent social milieu, treatment providers should be careful not to make decisions for her, but rather support her in finding new activities and pastimes. Many women who are victims of domestic violence are surprised to discover that they have a continuum of choices, especially in social situations: The idea of enjoying a party without getting intoxicated, for

example, may not have occurred to a survivor in the past.

## Parenting

Parenting is an issue for many substance abusers but may be a special challenge for survivor clients. The time spent in treatment initially may provide a respite from the concerns of parenting for many mothers, and the resumption of child care may be a source of additional stress. Some children become extremely needy after separation from their mother, and their demands could trigger a relapse or provoke an episode of violent behavior on her part.

An additional stressor may be the fact that some children are not supportive of their mother's choices. For example, they may not like her decision to separate from her

abusive partner. They may pressure her, become depressed, act out, and try to coerce her into going home. This can create extreme conflict as the survivor client struggles to act in the best interests of her children. To further complicate the situation, it is not uncommon for older children (particularly boys) to ally with the batterer and become verbally or physically abusive to their mother.

To handle these issues effectively, a post-abstinent domestic violence survivor may need to learn new parenting skills that take into account the realities of her status as a domestic violence survivor. These clients and their children commonly have a great deal of suppressed rage; handling frustration and anger is a crucial life skill that must be addressed directly in treatment. If treatment providers have not been trained in anger management and violence prevention, survivor clients should be referred to domestic violence support programs for these services.

**Financial and legal concerns**

Discussing the realities of everyday living and plans for the future that may increase the client's chances of a successful recovery is essential to the design of an effective treatment plan. Treatment providers should explore with the client her plans for future education and employment and should have information available about a variety of options. Through linkages with other agencies, the treatment provider can also help the client develop realistic plans for addressing any legal issues that may be unresolved and are interfering with recovery.

## D. Relapse prevention

Domestic violence survivors who are newly abstinent may feel overwhelmed by pressures inherent in the responsibilities just described. For many, harassment and threats from their partners will be a continuing concern, and custody disputes and divorce hearings may further complicate their lives. All of these factors are potential triggers for relapse to which the provider should remain attuned. However, as a number of Field Reviewers pointed out, revictimization by their abusive partners poses the greatest risk of relapse for battered women. Whether these women remain in the relationship or not, the likelihood of revictimization is great – domestic violence is a highly recidivistic crime (Zawitz et al., 1993; Browne, 1993). Careful attention to recurring episodes of violence is essential to working with survivor clients to prevent relapse and, if relapse does occur, to minimizing its negative effects.

## E. Issues for Children of Survivors

Children of domestic violence survivors have special problems and needs that may not be readily apparent to the substance abuse treatment provider. Often this is because the more obvious, acute needs of the mother tend to eclipse those of her children. Children's issues must be addressed; if ignored, they can become antecedents to more severe problems, such as conduct disorders or oppositional defiant disorders.

### Emotional and Behavioral Effects of Violence on Children


Children of survivor clients typically display strong feelings of grief and loss, abandonment, betrayal, rage, and guilt. Older children also may have feelings of shame.

Some indications that such feelings may be developing into serious problems for the child include:

- Emotional lability
- Aggression
- Hostility
- Destructive behavior
    - Toward others
    - Toward objects or animals
    - Toward self; self-mutilation
- Inappropriate sexual behavior
- Regressive behavior
    - Bedwetting
    - Thumb-sucking or wanting a bottle (older child)
    - Rocking
    - Needing security objects (i.e., blankets)
    - Not speaking
    - Dependent behavior (i.e., demanding to be carried)

(Kalmuss, 1984; Arroyo and Eth, 1995; Bell, 1995).

The child of a survivor may have his or her own, less apparent triggers for emotional trauma that may be quite different from the mother's. Children's triggers generally have to do with abandonment and separation issues, particularly if the children have been in foster care. Possible problem behaviors include the child's becoming overly clinging and needy upon reuniting with the mother, being fearful of a separation from her again, and acting out with hostility and violence to gain attention.

Children of survivors may also become "parentified," trying to be "perfect." Often this is the result of the child's feelings that he or she is somehow to blame for a parent's anger and subsequent violence. These children may also become extremely protective of their

mothers. Other children may have somatic complaints, such as hives, headaches, stomachaches, or other unexplained aches or pains.

Children's responses to family violence vary according to individual temperaments and their age at the time the violence occurred. Posttraumatic symptoms, including sleeplessness and agitation, are common among children who experience violence within the family home (Pynoos, 1993). Some young children exposed to domestic violence may demonstrate regression in toileting behaviors and emotional distress (Arroyo and Eth, 1995). Developmental delays and language disorders also have been linked to parental domestic violence (Kurtz, 1994; Arroyo and Eth, 1995). Some school-aged children become more aggressive and anxious and lose ground academically (Pynoos et al., 1987).

Adolescents who have observed their fathers abusing their mothers exhibit high levels of aggression and acting out, anxiety, learning difficulties in school, revenge seeking, and truancy. Children who witness or experience domestic violence are at increased risk of adopting these same strategies in their interactions with their partners and children (Bell, 1995; Kalmuss, 1984). They may also become hypervigilant to the point of immobility or, in extreme cases, catatonia.

**Assessment of Children's Needs**

Some substance abuse programs allow children to accompany the mother to the facility where she receives services. Depending on the program's resources, children can be assessed at that time, treated onsite with counseling groups that coincide with adult sessions, or referred to a qualified children's treatment or counseling program for concerns such as

- Foster or kinship care (relative or nonrelative)
- Separation issues

- Behavioral, mental health, or emotional problems
- Physical health problems
- Safety.

**Collaboration with Children's Services**

Ideally, substance abuse treatment programs will establish collaborative relationships with children's programs available through public and private, nonprofit, family service mental health and developmental assessment agencies. In many areas, these programs provide sophisticated case management services that access respite care, home aid, and parenting skills training that are beyond the scope of most substance abuse treatment programs. Collaboration with such specialized programs would free substance abuse counselors to concentrate on providing treatment to their survivor clients.

The family services case manager would assume responsibility for making linkages with the myriad institutions that affect the mother through the child, including:

- The school system
- The health care system
- Social services and employment programs
- The child welfare system
- The criminal justice and civil court system
- Other community-based agencies (including family preservation and support).


**Children's protective services agencies**

Some survivor clients may be or will become involved with children's protective services (CPS) agencies because their children have been or are being abused and neglected.

Since many battered women fear that CPS will take their children from them, they may resist efforts to involve CPS, and some will undermine their treatment to do so. Treatment providers must adhere to the laws in their States regarding mandated reporting of child abuse and neglect even though clients may perceive those actions as a betrayal of trust. One way to minimize problems is to discuss reporting requirements and the procedures the treatment program follows prior to treatment. Providers should also establish working relationships with CPS to ensure an appropriate and best-case response to the family situation and the child's protection.

**The Role of Treatment Providers in Supporting the Mother**

The substance abuse counselor is involved with the children -- directly or indirectly – through the mother. A key responsibility, then, is to understand how to interact with and support the mother in her parenting role.

Substance abuse treatment counselors must understand that the mother may be involved with multiple agencies, all of which make demands on her limited time and energy. To help her focus on her abstinence, treatment providers should:

- Help the mother identify and coordinate the various services she needs via external case management services or, if unavailable, by acting as an advocate on her behalf.
- Support her efforts to participate in and take advantage of these services.
- Listen empathetically as she voices her frustration about the difficulties of meeting the demands made by the various agencies and service programs with which she is involved.
- Help her clarify the sometimes mixed messages she receives from these agencies, each of which tends to consider its "problem area" a priority (and, as a corollary,

ensure that the substance abuse program's messages do not contribute to her confusion and frustration).

- Serve as an intermediary and advocate when other agency providers ask her to do more than is reasonable given her progress in treatment (e.g., resume custody before she is prepared to take on responsibility for her children or begin working while still striving to maintain abstinence).

Treatment providers also can assist survivor clients by inviting staff from domestic violence agencies such as Homebuilders and from CPS, jobs training agencies, and other organizations involved with domestic violence survivors to the substance abuse program so they can better understand the treatment and recovery process. Substance abuse treatment counselors also should request cross-training in domestic violence support as well as in-service training on the mission and operation of those agencies that come in contact with survivor clients.

### F. Summary

As the chapter makes clear, survivors of domestic violence present unique substance abuse treatment challenges. Because domestic violence can be so psychologically damaging, particularly if it has been sustained since a client's childhood, a treatment provider should refer to domestic violence experts whenever possible. The treatment provider must also be careful not to unintentionally place the survivor client in danger by making inappropriate recommendations.

Central to the discussion of survivors' issues is the overarching need for informed, ongoing collaboration with the agencies that can help the survivor rebuild her life. Substance abuse treatment providers should try to facilitate this collaboration to the greatest extent possible. Treatment outcomes are substantially improved when interventions encompass all the relevant areas of a client's life, services are coordinated, inconsistent messages and expectations are reduced, and the effects of both domestic

violence and substance abuse are well understood by all those interacting with the survivor client.

**Case Scenario: Profile of a Survivor**

Judy, a white high school graduate in her late 20s, is a recovering substance abuser and a survivor of domestic violence. Her story is typical of the many problems and circumstances faced by women who enter both the domestic violence support and substance abuse treatment systems. She was molested by her uncle from the age of 3 until she was 10; the molestation included vaginal penetration. Like many victims of sexual abuse, Judy was threatened by her abuser and never disclosed the abuse. On one occasion, her mother asked whether her uncle had ever touched her, and she replied, "No, he does nice things for me."

At age 15, she became sexually active with her 23-year-old boyfriend, Alex. Alex and she began using marijuana. When she was 18, she started using cocaine with Alex, who was now occasionally slapping her and forcing her to have sex. At that time, she also discovered that she was pregnant. She decided to have the baby but received only sporadic prenatal care. During her pregnancy, both Judy and Alex used cocaine and marijuana and drank alcohol. The infant, a girl named Candace, was born at full term but was small for her gestational age.

Alex left Judy soon thereafter, and she and Candace moved in with a new boyfriend, Billy. He used drugs and was both extremely possessive and violent. He intimidated Judy and sometimes threatened to kill her, Candace, and himself. When Candace was 3, Judy, then 21, became pregnant again. Billy did not welcome the pregnancy and began hitting her in the abdomen and breasts when he was angry. Judy received no prenatal care during her second pregnancy and delivered a preterm, small-for-gestational-age baby whom she named Patricia. Neither Judy nor her baby was screened for drugs or HIV before or immediately after the birth.

By the time Patricia was born, Judy's drug use had escalated to include crack and increasing amounts of alcohol. Despite her mounting problems, Judy recognized that her new baby was a poor feeder. Judy was frightened enough to keep a 6-week post-delivery pediatric visit during which Patricia was diagnosed as "failing to thrive." At the same visit, 3-year-old Candace was weighed and found to be only in the 10th percentile of weight for her age. Two weeks later, Judy and Billy were arrested on drug charges -- Judy for possession and Billy for dealing. She received probation, and she and her children moved in with her mother, Vivian. Billy was incarcerated, and Judy was required by the court to participate in substance abuse treatment.

In a group therapy session in her substance abuse treatment program, Judy acknowledged her history of family violence, childhood sexual abuse, and battering. Her case manager in this program wanted her to join another group of childhood incest survivors, but Judy felt ashamed and did not want to discuss the incest further.

She began attending treatment sessions sporadically and, after 2 months, dropped out. In the meantime, tension developed between Judy and Vivian. Judy felt that her mother cared more for her granddaughters than she had about Judy when she was a child. Now that Judy had acknowledged her history of sexual abuse, she found herself blaming her mother for "allowing" it to happen. She also was jealous because she felt that Vivian was a better mother to Patricia and Candace than she was.

After a series of violent fights with her mother, Judy moved out and got a minimum-wage job, leaving her children with Vivian. Around this time, Judy met Cody, a drug dealer. Cody moved in with her, but their relationship was characterized by frequent arguing and mutual battering. Judy's work habits became erratic; she often had bruises and sprains that she refused to discuss when her concerned coworkers questioned her about them. Although she saw her children infrequently, she would call late at night when she was high and criticize Vivian for keeping her children from her.

Meanwhile, under Vivian's care, Candace gained weight but exhibited a language delay. Her preschool teacher called Vivian repeatedly about Candace's problem

behavior and acting out; she was having trouble paying attention in school, was defiant to her teachers, and was domineering with her peers. The school also reported that Candace had language problems and that she frequently cried for her mother.

Meanwhile, Vivian had quit her job in order to care for her grandchildren and was receiving Aid to Families with Dependent Children (AFDC). At this time, Vivian's health began to deteriorate, and she asked for help with Candace and Patricia. When a social worker began to talk about sending the children to a foster home, Judy was scared into action. Developmental evaluations were recommended for both children, and Judy took them to those appointments. Both children were found to have marginal developmental problems, possibly due to Judy's drug use during pregnancy. In response to the psychologist's advice, Judy enrolled Candace in a developmentally more appropriate preschool program that required parental involvement. Judy participated in this program with her daughter and resumed treatment.

For a brief time, Judy's life appeared to stabilize. Although she had not finished her substance abuse treatment program, she and Cody were both working, and she continued to receive negative screens for drugs (although she was still using occasionally). At the next CPS hearing, the children were returned to Judy's custody with the stipulation that she participate in parenting classes as well as continue in treatment.

Once her two children moved in with her and Cody, the situation began to deteriorate. Cody could not tolerate the children, and his episodes of violent behavior increased. He put his fist through the wall and kicked the door down. He became increasingly angry at Judy's frequent absences as a result of "all this kid stuff" (parenting classes and Candace's preschool program).

He began to "spank" the children or grab them roughly by their arms when he wanted their attention. They showed up at their respective day care and preschool programs with bruises, which were attributed to "accidents." No one at the day care or preschool

programs was aware of Judy's history or her disclosures of childhood abuse and battering in the treatment program.

Cody's violence continued to escalate and, increasingly, was directed at the children. While Judy was concerned about his hitting and yelling at the children, she didn't know what to do about it. She was feeling overwhelmed by her job, the parenting classes, her meetings with social services workers and her probation officer, and her child care responsibilities. In time, however, she began intervening when Cody yelled at or hit the children, deliberately provoking him in order to divert his attention away from the children and onto herself. The neighbors called 911 frequently, but the police never found any substantial evidence of violence.

A year passed with no improvement. The children continued to attend school, but Judy appeared only sporadically at her parenting classes and the preschool program. She was now beginning to suspect that Cody was sexually abusing 5-year-old Candace. She had begun to notice the same kinds of behavior in her daughter that she remembered in herself when she was sexually abused at that age. One day she asked Candace whether Cody had ever touched her in certain ways. Candace replied, "No, he is always nice to me." Judy remembered using almost identical words to her own mother years before and was certain that her daughter was being victimized in the same way.

All the rage from her own abuse by her uncle erupted. She verbally and physically confronted Cody, and a battle ensued, which Candace witnessed. (Later this episode became a major treatment issue for the child, who believed that the violence in her household was her fault.) Both Judy and Cody sustained injuries in their fight. Candace ran next door with her little sister, screaming about "all the blood." The neighbors called the police; Judy and Cody were both taken to the hospital, and the children were taken to a CPS emergency shelter. Judy and Cody were arrested for disturbing the peace and for possessing drug paraphernalia. Cody was charged with
first degree (later reduced to third degree) assault, for which he eventually received a suspended sentence.

In the hospital, a social worker referred Judy and the children to a program for domestic violence survivors. After she was treated and released from the hospital, Judy stayed overnight in jail. The next day she was given a court appearance date, and a domestic violence advocate arranged transportation to the domestic violence program for her and her children. Program staff also assisted Judy in obtaining a restraining order against Cody and accompanied her to court to obtain it. When Candace and Patricia were reunited with their mother in the domestic violence facility, they clung to her, crying. Over the ensuing days, they experienced nightmares.

Despite the minor drug charge, the domestic violence program agreed to accept Judy because her drug screens were negative; the program had no knowledge of Judy's substance abuse treatment history. During intake, staff explained the program's drug use policy: If Judy used while in the program, her choices were to leave the facility or participate in treatment. The domestic violence program advocates did not think Judy was using drugs at the time of her admission and did not believe that she would use during her stay.

One day, Judy returned to the domestic violence program intoxicated, and a joint fell out of her purse. The program staff members saw and reported it to CPS. CPS then took away her children and again sent them to live with their grandmother. Judy's choices were now to either get substance abuse treatment or leave the facility. She entered a 1-year residential treatment program and was assigned to a counselor who was not only a recovering addict but a survivor of domestic abuse and with whom Judy felt an immediate rapport. The counselor and Judy together developed a treatment plan that took Judy's concerns and goals as well as the needs of her children into account. Although they agreed that intensive outpatient treatment would have been preferable, she had no place to stay where she would have been safe from Cody. She could not stay at the domestic violence program for that long, and Cody knew where her mother lived.

Without a safe haven, her recovery and her life would have been in jeopardy, so Judy and her counselor decided on residential treatment. The counselor walked her through the admissions process.

Judy has been in recovery for 2 years, and her mother -- who was encouraged to participate in family sessions -- is supportive. Judy goes to work every day and has begun to date an older, recovering alcoholic she met at an AA meeting. She is more established and sees her children regularly. Vivian has again quit her job and is receiving AFDC. Cody is receiving substance abuse treatment and counseling for domestic violence, which were conditions of his suspended sentence. Another condition was that he remain in treatment and make no attempt to contact Judy or the children. The children are seen on a daily basis in the domestic violence program. But because the program can provide only supportive care and play activities, the children have been referred to a local agency with special supportive and mental health services for children.

## Chapter 3 Batterers:

### A. An Overview

There are myriad reasons why substance abuse counselors should address the domestic violence of clients who batter their partners. Consensus Panel members have observed that the violent behavior of a batterer client can interfere with his treatment for substance abuse, and conversely, his substance abuse can interfere with interventions aimed at changing his violent behavior (Bennett, 1995). Clients who are incarcerated, for example, or accused of assault or murder have limited access to substance abuse treatment. Practitioners have observed that for those clients in treatment, battering may precipitate relapse and thwart the process of true recovery, which includes "adopting a lifestyle that

enhances one's emotional and spiritual health, a goal that cannot be achieved if battering continues" (Zubretsky and Digirolamo, 1996, p. 225).

Use of psychoactive substances, on the other hand, may interfere with a client's capacity to make a safe and sane choice against violence by impairing his ability to accurately "perceive, integrate, and process information" about another's behavior toward him (Bennett, 1995, p. 761).

Intoxication appears to increase the likelihood that a batterer may misinterpret or distort a partner's remarks, demeanor, or actions by "blunting whatever cognitive regulators the abuser possesses" (Stosny, 1995, p. 36). While abstinence from drugs and alcohol does not alter

battering behavior, substance abuse problems negatively affect a batterer's capacity to change and increase the chance that violence will occur (Tolman and Bennett, 1990; Bennett, 1995).

Both battering and substance abuse result in harm to the client and others. Responding to a client's penchant for violent behavior is as vital as responding to his depression or to the array of other conditions that may impede progress in treatment and interfere with recovery.

**Perspectives on Substance Abuse and The Batterer Client**

Although domestic violence occurs in the absence of substance abuse, there is a statistical association between the two problems. Alcohol use has been implicated in more than 50 percent of cases involving violent behavior (Roy, 1982). Research by Kantor and Straus suggested that approximately 40 percent of male batterers were heavy or binge drinkers (Kantor and Straus,

1987). A recent study found that more than half of defendants accused of murdering their spouses had been drinking alcohol at the time (Bureau of Justice, 1994). Another study of incarcerated batterers found that 39 percent reported a history of alcoholism and 22 percent reported a history of other drug addiction. A total of 50 percent self-reported current addiction; however, this figure rose to 89 percent when the researchers examined court documents. All but one of the subjects admitted to having been drunk at the time the battering occurred (Bergman and Brismar, 1994). Higher rates of substance abuse consistently correlate with higher rates of domestic violence, although one important study concluded that "[c]hronic alcohol abuse by the male rather than acute intoxication is a better predictor of battering" (Tolman and Bennett, 1990, p. 91). As one field reviewer noted, however, "Assaultive men, in general, have high alcohol use scores. Indeed the more a man matched the gauge for having an abusive personality, the greater his alcohol consumption. When a batterer says, 'the alcohol made me do it,' he's blaming one symptom -- violence -- on another -- alcohol abuse."

Most Consensus Panelists and field reviewers concur that the exact nature of the correlation between battering and substance abuse remains unclear.

Anger and hostility are more frequently generated by interactions between people, and alcohol or other drug use is likely to be linked to violent behavior through a complicated set of individual, situational, and social factor ... The prevalence of violence between partners cannot be adequately explained merely as the consequence of alcohol and other drug abuse, nor can it be understood outside the context within which it occurs. (Gorney, 1989, p. 231)

Current research supports the finding that substance abuse is only one of many factors that influence a batterer's violent behavior (Collins and Messerschmidt, 1993). As with substance abuse, other factors are also correlated, such as depression, psychopathology, violence in the family of origin, social norms approving of violence (especially toward women), high levels of marital and relationship conflict, and low income (Tolman and Bennett, 1990; Bennett, 1995; Hotaling and Sugarman, 1986; Hotaling and

Sugarman, 1990; Bograd, 1988). Although intoxication may trigger an individual episode of violence, addiction does not predispose one to be a batterer. This distinction is crucial for a provider to understand when treating batterer clients, because *a batterer's violence does not necessarily end when he stops abusing alcohol or other drugs.*

In characterizing substance abuse and domestic violence, practitioners have observed that the two problems are "separate but similar, and they each interact and exacerbate each other. For example, both problems are passed on from generation to generation; both involve denial, with substance abusers and batterers blaming victims for their behavior; usually, neither problem decreases until a crisis occurs; and secrecy is often the rule, with victims of abuse (wrongly) blaming themselves for their partner's substance abuse or violent behavior" (Engelmann, 1992, p. 6).

**Profiling Batterers**

In the past, research has focused more on attempts to identify characteristics of victims rather than perpetrators of violence (Hotaling and Sugarman, 1990). While information about batterers is relatively sparse and subject to some debate, it can provide the basis for a rudimentary understanding of their behavior. One caution is in order, however. Exploring batterers' individual characteristics addresses only one dimension of the domestic violence phenomenon. Some experts believe that battering is driven by socially supported sexism and inequitable distributions of power that feed the batterer's belief that he has an inherent right to control his partner's behavior. Others contend that analysis of batterers' characteristics has limited value if attention is not also directed to the larger culture of violence and social injustice in which battering occurs (Adams, 1988; Tolman and Bennett, 1990; Stosny, 1995).

Research has clearly asserted the importance of socioeconomic factors in understanding battering: Approval of violence against women, low income, and belief in gender-based stereotypes emerge repeatedly as correlates of domestic violence (Bennett, 1995). As in the case of substance abusers, multiple internal and external risk factors appear to influence problem development among men who batter.

**Individual Characteristics**

Although batterers are a heterogeneous group, research has uncovered a number of characteristics that differentiate men who batter from men who don't. Many batterers (particularly those who engage in severe physical assaults against their partners) witnessed parental violence when they were children (Hotaling and Sugarman, 1990; Pagelow, 1984). While not replicated, findings from the large-scale National Family Violence Survey that included over 6,000 families suggest that experiencing corporal punishment as an adolescent may be a risk factor for later partner abuse (Straus and Kantor, 1994).

As mentioned above, chronic alcohol abuse is another predictor of violence (Tolman and Bennett, 1990), and some studies have found that batterers are more likely to suffer from depression (Hamberger and Hastings, 1986a; Saunders and Hanusa, 1986).

***Need for power and control***

Many experts believe that batterers use violence or the threat of violence to achieve a sense of control, both over their victims and generally (Gondolf, 1995). Violence may also reflect a personal need for power and domination over others. Gondolf, building on McClelland's theory of alcohol and power motivation (McClelland, 1975), suggested that the need for personal power (reinforced by societal norms of male dominance) may be the factor that accounts for the high correlation between substance abuse and spousal abuse. According to this theory, men who have a high need for power over others are

more likely to abuse alcohol and to use violence. Alcohol provides an illusion of power; so does beating one's wife. In some cases, a batterer who is drunk can gain instant control of his wife -- and in a sense his entire marital situation -- by terrorizing her. Furthermore, if the violent incidents are stopped through intervention, arrest, or treatment, the lack of control perceived by the batterer often increases not only the frequency of assault, but its severity as well.

In addition to inflicting physical pain and injury, a batterer may also abuse his partner psychologically and emotionally. A batterer attempts to control the thoughts and feelings of the partner by monitoring her behavior, making her accountable for his emotional highs and lows, denigrating her, criticizing and blaming her, and calling her names. Nonphysical abuse generally targets the victim's sense of self-esteem, well-being, and autonomy.

*Psychological abuse* can be defined as behavior intended to control the victim's actions and functioning in everyday life (often by making her fearful). It may take the form of isolating her from her friends, family, and other sources of support or keeping her from having money to pay bills and other expenses. Another form is threatening physical harm -- not only to the victim but to family members, friends, or himself. It can also be the "silent treatment": The batterer may refuse to speak directly to the victim for extended periods, such as days or weeks, leaving her guessing about how she has displeased or offended him.

*Emotional abuse* is denigrating, shaming, ridiculing, or criticizing the victim and otherwise attempting to damage or destroy her self-esteem. These types of abuse often accompany physical violence to some degree, although they can also occur in relationships that are not physically violent. It is unclear how men who batter differ from those who don't in the use of nonphysical forms of abuse.

Any intervention with a batterer that does not concomitantly address issues of power and control may simply allow the batterer to become more sophisticated at other, nonphysical kinds of manipulation. To interrupt these types of abuse, couples and/or family therapy may be recommended once domestic violence experts ascertain that the victim is out of danger.

***Role of anger***

The precise role of anger in battering is unclear. When treatment for batterers was first being developed, some practitioners viewed anger as a primary cause of abuse and believed that imparting anger management skills would curtail and ultimately eliminate battering behavior; others viewed anger as just another excuse for violent behavior. Today, many researchers and practitioners consider anger as only one of a number of antecedents or precipitants for violence.

Addressing the anger is not the same as addressing the larger problem of violence, but it may be a useful technique in preventing the expression of violence against intimate partners (Tolman and Saunders, 1988; Tolman and Bennett, 1990). Consensus Panelists and field reviewers concur that although anger is a common emotional theme among violent batterers, a batterer's violence is not "caused" by anger. They also agree that while anger management groups can play an important treatment role, they caution that if such groups are not judiciously mediated by highly trained specialists in domestic violence, they may indirectly *reinforce* violent behavior. Inadequately facilitated groups can turn into "gripe sessions" that fuel batterers' anger instead of educating them about how to handle their feelings without resorting to violence. (For an informative debate about anger management and batterers' interventions, see Gondolf and Russell [1986] and Tolman and Saunders [1988].)

Another anger-related issue concerns the false belief that "explosive anger" is a hallmark of batterers (Stosny, 1995, p. 65), whereas, in reality, many batterers are afraid to reveal their anger to the outside world and successfully present themselves as victims to the clinicians charged with treating them ("nothing I do is right; she's always criticizing me"). Some clinicians look for overt anger and fail to find it, then label batterers as "in denial" about their anger.

Treatment revolves around "getting batterers in touch with their anger and letting it out." Too often, this ill-conceived approach (which has been debunked by much contemporary literature) has had "disastrous consequences for both batterers and their loved ones" (Stosny, 1995, p. 66). When responding to batterers, it is important to understand the complex role that anger plays in both precipitating and sustaining violent behavior. Responsible treatment incorporates techniques for regulating as opposed to revealing anger (Stosny, 1995).

Substance abuse also skews the motivational mix of anger and battering in a variety of ways. Alcohol and other drugs often serve as mood regulators and anger management tools, which sometimes exert a calming effect, but also may intensify angry feelings. The Consensus Panel did not discuss the specific psychopharmacological effects of cocaine, amphetamine/methamphetamine, or phencyclidine or other hallucinogens on violence, because there is no evidence to suggest that these drugs have any effect on *domestic violence* (although a few studies suggest that chronic use may influence aggressive behavior in general [Brody, 1990]). Much like efforts to understand the links with alcohol, both research and experience indicate that personality, preexisting brain disorders, and environment also play important roles in the relationship between substance abuse, anger, and violence (Brody, 1990).

### *Attachment deficit and affect regulation*

As clinicians and researchers have learned more about battering, some have begun to consider it within the context of an individual's total personality rather than as an isolated

behavior. In this view, problems with attachment when young, compounded by the experience of growing up in a home environment marred by a father's violent behavior and shaming "put-downs," contribute to the development of a "violence-prone borderline personality [who is] ... addicted to brutality to keep his shaky self-concept intact. The only time he feels powerful and whole is when he is engaged in violence" (Dutton, 1995, p. xi). At the same time, the painful experience of rejection as a child has also bred a deep-seated fear of intimacy or "engulfment" (Dutton, 1988; Dutton and Browning, 1988).

Practitioners of psychologically based approaches to understanding and treating batterers are acutely sensitive to the criticism that they are excusing batterers on the basis of their underlying psychological problems (Dutton, 1995). Supporters of what is often termed the psychoeducational approach are quick to assert that psychological insights help to explain batterers' behavior; they do not justify or excuse it (Dutton, 1995; Stosny, 1995).

**Group Typologies**

While experts agree that the relationship between substance abuse and battering is far more complicated than cause and effect, some attitudes and patterns reappear in men who abuse their partners. In an effort to better understand and improve treatment for batterers, researchers have attempted to group them on the basis of common characteristics (Gondolf, 1988; Hamberger and Hastings, 1986a; Dutton, 1995; Saunders, 1992). Gondolf organizes batterers into three clusters:

1. "*Typical batterers"* (the largest group in Gondolf's sample, 52 percent) generally confine their violence to their families. For the most part, these men are not substance abusers, are unlikely to have significant mental disorders, have no arrest history, and tend to be remorseful after battering episodes. In contrast to other batterers, their behavior usually results in less severe abuse.
2. *Antisocial batterers* (41 percent of the sample) are extremely abusive and may be violent outside the home. This type of batterer is emotionally volatile; has some

mental health problems, such as antisocial personality disorder, depression, or anxiety; and may be a substance abuser. He may be under the care of a physician or in mental health therapy. He may have difficulty attending or completing a batterers' program without receiving additional mental health services.

3. *Sociopathic batterers* (7 percent of the sample) comprise the most violent group. Although these men are likely to be heavy substance abusers, they are the hardest type to engage in substance abuse treatment. They have little empathy for others, no self-insight, and no feelings of guilt or remorse for their actions. They are the most likely of the three groups to have been arrested (Gondolf, 1988).

Hastings and Hamberger characterize batterers as having borderline personality disorder, antisocial personality disorder, or a form of compulsive personality disorder (Hamberger and Hastings, 1986a). Saunders looked at a range of variables including extent and levels of violence inside and outside the home, levels of anger and depression, attitudes toward women, substance abuse, conflicts in relationships, and need for power. According to his analysis, those who were violent outside the home were the most brutal batterers. They also were the most likely to abuse alcohol and to have been abused as children (Saunders, 1992).

In his work, Dutton has observed three types of batterers that he classifies as

1. *Psychopathic wife assaulters* (40 percent of the men in Dutton's program). These men meet the diagnostic criteria for antisocial behavior and resemble Gondolf's sociopaths as well as those men in Saunders' cluster of men who are violent outside the home. Dutton believes that the prognosis for treatment is poor for this group. In his words, "psychopaths don't look back. As a result, they never learn from past mistakes" (Dutton, 1995, p. 27).
2. *Overcontrolled assaultive males* (about 30 percent of the men in the program). This group consists of men with an overriding need for control. In Dutton's experience, they tend to be "perfectionistic" and "domineering." They tend to use emotional abuse, including verbal attacks, harassment, and withholding of

affection to "generate submission" (Dutton, 1995, p. 30). Overcontrolled assaulters are usually the most compliant clients in treatment.

3. *Cyclical/emotionally volatile wife abusers* (about 30 percent of the men in the program). These men fear intimacy and suffer from recurrent feelings of abandonment and engulfment. They are overly dependent on their partners and, as a result, are literally "either at their wives' knees or at their throats" (Dutton, 1995, p. 42). Common traits include "flat affect, noncommittal response, and limited emotional lexicon" (Dutton, 1995, p. 44). They are incapable of describing what they feel and tend to repeat the same complaints and accusations about their partners over and over again. However, it is this group of batterers who calculate exactly how severely they can injure their partners without leaving obvious signs of abuse. It is also this group who best fits the "phases of abuse" theory first described by Lenore Walker in her pioneering work on domestic violence (Walker, 1979). These men typically undergo a buildup of tension that explodes in an episode of acute battering and is followed by a remorseful apology and so-called "honeymoon period" of concern and attention (Dutton, 1995).

By their very nature, typologies are artificial constructs, subject to change as new information develops. Despite their limitations, however, these groupings suggest that substance abuse programs will encounter those batterers who are among the most difficult to treat. As an example, members of the Consensus Panel observed that unlike the cyclical/emotionally volatile wife abuser (above), many severe batterers, among whom substance abusers are overrepresented (Roberts, 1988), do not fit the patterns of behavior seen by Dutton and Walker. Instead of

following up a battering episode with a period of remorse (Walker, 1979; Dutton, 1995), they use the postviolence period as an opportunity to blame the victim for starting the abuse or to break up with her, or both.

The following section of this chapter focuses on the batterer who is more likely to be seen in a substance abuse program. These men have multiple problems and function, for the most part, in socially and economically impoverished environments. Involvement with the

criminal justice system is almost a certainty, although domestic violence may not be the cause. At this time, few evaluations exist of batterers' treatment and even the developers of the popular "Duluth model," "have no illusion that most men will stop their violence and give up their power" (Pence and Paymar, 1993, p. xiv). Nevertheless, efforts by Consensus Panel members, field reviewers, and Statewide Networks Against Domestic Violence (such as those in Virginia and Maryland, to name just two) indicate that batterers' treatment can be effective if programs place a premium on survivor safety (even though the batterer is the client), insist that batterers take personal responsibility for their behavior, mandate "no-violence contracts," impart emotional regulation techniques, follow up on treatment completers and dropouts, and evaluate program outcomes regularly (Stosny, 1995).

**Treatment Issues for the Substance-Abusing Batterer**


**Crisis Intervention and The Victim's Safety**

Like any client entering substance abuse treatment, the batterer is typically in a crisis state when he first presents for services. He may have been referred to treatment by the courts after being arrested for drug- or violence-related charges, or he may have been left alone by a battered partner seeking safety for herself and the children. Even when his outward demeanor is calm and accepting, violence may be imminent.

Substance abuse counselors typically regard a crisis situation as a prime opportunity to intervene with a client and engage him in the treatment process. In this context, a crisis is frequently transformed into a positive event for both the substance abuser and those who care about him.

With substance-abusing batterers, the situation is different. Because batterers tend to defer responsibility and to project their anger onto others, a crisis situation may spur a violent incident at home.

Examples of crises that may precipitate violence include loss of employment, the impending loss of family relationships through separation or divorce, emotional and psychological breakthroughs during psychotherapy, a citation for driving while intoxicated, court-mandated treatment for substance abuse, being served with a restraining order, a partner's pregnancy, or the birth of a child. For this reason, when a substance-abusing batterer experiences a crisis, treatment providers should have a plan in place for addressing the fallout. Although it requires a shift in focus from the client to the family, the most immediate concern when a crisis occurs is the safety of those who have been or may become the batterer's victims, in particular his partner and children, whether they remain with the batterer or not (see Chapter 5 for specifics on notification procedures and conformance with Federal and State confidentiality regulations).

Family members, and in particular the client's partner, should be consulted regarding what is best for their safety (although the provider should bear in mind that their version of the situation may be somewhat skewed). Extreme caution and tact should be used to avoid further endangering the victim(s). If available, substance abuse counselors should refer and defer to trained violence support professionals or the partner's advocate to develop a safety plan that includes logistics for leaving the home quickly or, if she does not want to leave him, other strategies for increasing her safety.

### Fostering Accountability

Because batterers tend to shift responsibility and blame onto others, the degree to which a client begins to assume responsibility for his actions can serve as a barometer for his substance abuse treatment progress. To that end, assessment and monitoring can be

incorporated into the treatment plan to evaluate the degree to which the batterer is taking responsibility for his violent actions. The batterer's accountability can be highlighted by linking his actions with tangible consequences. One way to achieve this is through the use of a "no-violence contract" with clearly delineated sanctions for violation (see Chapter 4).

### Batterers' Intervention Program Models

If available, collaboration with, and referral to batterers' intervention programs, can facilitate the treatment of substance abusing batterers.

### Abstinence

During screening and throughout the treatment process, substance abuse counselors should explore the context in which the batterer client uses alcohol and other drugs in order to identify the chain of events and emotions that preceded or accompanied particular instances of substance abuse and violent episodes. Based on their experience, the Consensus Panelists recommend eliciting the following information about the relationship between the substance abuse and the violent behavior:

- Exactly when in relation to an instance of substance abuse the violence occurs
- How much of the violent behavior occurs while the batterer is drinking or on other drugs
- What substances are used before the violent act
- What feelings precede and accompany the use of alcohol or other drugs
- Whether alcohol or other drugs are used to "recover" from the violent incident.

By understanding the dynamics of intoxication and abstinence as a precursor to violence, the treatment provider can formulate a treatment plan that incorporates strategies for

ensuring the partner's and other family members' safety and for helping the batterer focus on modifying the behaviors and events that precipitate substance abuse and violence. The focus in treatment must be on encouraging the batterer client to develop enough self-awareness to recognize the beliefs and attitudes as well as to control the emotions that contribute to his violent behavior.

**Bonding With Peers**

Friendships with members of the same sex are generally seen as a positive expression of self-development in both male and female clients being treated for substance abuse. Treatment staff must be on the alert, however, for signs of collusion among male batterer clients who have formed close friendships during treatment. Although such bonds often help clients learn about forming close and trusting relationships with others and examine their behavior in relation to that of their peers, in some cases, violent behavior can be instigated or condoned among batterer clients who reinforce each other's excuse-making mechanisms.

One field reviewer who works with batterers writes that In our anger management class, we pursue a new definition of manhood through the proper exercise of personal power. Personal power does not include violence of any kind, except for self-defense. Personal power involves the negotiation of a system that is often seen as indifferent and hostile in a productive way ...giving the batterer an opportunity to feel powerful in a rational manner. We redefine manhood in terms of emotional cost-benefit analysis and problem solving. Clinically, it appears to be working.

**Parenting**

Many substance abusers, male and female, have poor parenting skills, whether or not they are in a battering relationship. An examination of the client's parental role is essential to understanding his violent behavior, since a batterer may use alcohol, other drugs, or

violence to respond to conflict within the family structure. Young boys often learn violent behavior from male role models.

Among the challenges in substance abuse treatment for batterer clients are to

- Raise the batterers' awareness of the impact of their violence on their children's future behavior
- Help batterers adopt other, nonviolent modes of behavior through anger management and coping skills training
- Reinforce the importance of modeling nonviolent behavior in their interactions with their partners as well as their children.

The effect of a batterer's violence on his children has important implications for his treatment plan. Although family therapy is often an effective component of substance abuse treatment, this approach is inadvisable for the violent batterer until he has learned to take responsibility for his behavior and has learned how to respond to crises without using violence.

Given the potential for harm to both partner and children, the Consensus Panel recommends postponing family and couples counseling until the batterer has demonstrated a pattern of nonviolent and non-coercive behavior for a given period of time (usually a year). The decision to provide or refer for family or couples therapy also should be conditional upon whether or not the victim freely chooses to participate in counseling (the request should be made privately; *a victim should never be asked to make that decision in a batterer's presence*). Until these conditions are met, the batterer should be treated independently of other family members.

**Ongoing Support**

Over the past 50 years, the substance abuse treatment field has grown and developed into a national network of 12-Step groups, church affiliations, and social systems. In contrast, there are no ongoing organizations that support change for men who batter or for their victims. Although some batterers may enter an aftercare program following substance abuse treatment, most do not.

Widely scattered groups called Batterers Anonymous (BA) (Goffman, 1984) have not been totally embraced by domestic violence workers because their emphasis on participant anonymity appears to be incompatible with the violence field's focus on accountability. Some Consensus Panel members fear that, unless a batterer has already successfully completed a batterers' program, groups like BA may unwittingly encourage misogyny. On the other hand, some field reviewers who work with violent substance-abusing clients have found that the antiviolence messages of BA and similar groups appear to help batterers contain their violence by emphasizing the consequences of violent behavior. Accredited or certified domestic violence programs are sound resources for information and referrals to appropriate batterer self-help support groups.

A number of batterers' intervention programs are beginning to offer aftercare services. Some are experimenting with mentors, who fulfill roles similar to sponsors in 12-Step programs. In this approach, a recovering batterer, under the supervision of a batterers' program or shelter that ensures his accountability, mentors a batterer who has completed a batterers' program. Continuing contact is essential because program completion is not necessarily an indication of whether a participant has stopped or even reduced his use of violence and coercion.

It is crucial for substance abuse treatment providers to learn if their clients are either perpetrators or victims of domestic violence as early as possible in the treatment process. This chapter details signs to look for and techniques for eliciting information about domestic violence, which many affected clients are understandably reluctant to discuss. The suggestions and recommendations in this chapter are presented primarily for substance abuse treatment providers who work with clients involved in domestic violence as either batterers or survivors. They may also prove helpful to those providing domestic violence support services to their clients who have concomitant substance abuse problems.

## Screening

Because of the well-documented relationship between domestic violence and substance abuse (Leonard and Jacob, 1987; Kantor and Straus, 1989; Amaro et al., 1990; Pernanen, 1991; Windle et al., 1995), and because domestic violence affects survivors' and batterers' recovery from substance abuse (Cronkite and Moos, 1984; Smith and Cloninger, 1985), the Consensus Panel recommends that all clients who present for substance abuse treatment services be questioned about domestic violence. Questions should cover childhood physical and sexual abuse as well as current abuse. Screening for domestic violence in substance abuse treatment settings is undertaken to identify both survivors and batterers. The domestic violence assessment, like the other elements of a substance abuse assessment, gathers the specific and detailed information needed to design appropriate treatment or service plans (Sackett et al., 1991). While the Consensus Panel believes that addictions counselors can be trained relatively easily to screen clients for domestic violence, assessment services are more complex and require in-depth knowledge and skill. Assessment should be conducted by a domestic violence expert if possible.

Once it is determined that a client is a victim of domestic violence, a provider must determine the client's needs for violence-related services such as medical care and legal advocacy. In addition to identifying violence as an issue affecting substance abuse treatment planning, another important purpose of screening for domestic violence is to ensure the safety -- both physical and psychological -- of a survivor client. (A word of caution: There is a tendency to think of residential treatment as a safety zone for both batterers and survivors with substance abuse problems. Domestic violence experts, however, note that batterers in treatment frequently continue to harass their partners by circumventing program rules and threatening them by phone, by mail, and through contacts with other approved visitors. Telephone and other communication and visitation privileges should be carefully monitored for identified batterers and survivors in residential programs.)

**Methods of Screening For Domestic Violence: Survivors**

Substance abuse treatment providers and domestic violence support staff use different terms to describe the screening process. Domestic violence programs refer to the initial contact with a client as *intake*, which is roughly analogous to what substance abuse treatment providers refer to as *screening*. Once a woman has been accepted to the program, domestic violence staff will conduct a *psychosocial intake*, which is similar to *assessment* in the substance abuse treatment field.

**Clues for the Substance Abuse Treatment Provider**

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 (McKay, 1994). 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 (Bowker et al., 1988). 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 substance abuse treatment 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 "badmouthing" 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***

The Consensus Panel recommends that treatment providers 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., 1997).

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 orembarrassed?"
- "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. 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 (American Medical Association, 1994). 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 in Chapter 2, 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 substance abuse 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 (Kantor and Straus, 1987). 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 (Cayouette, 1990).

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 (Engelmann, 1992).

**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. *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 for 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 (see Chapter 5, Legal Issues). 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.

**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 (Sullivan and Evans, 1994). The treatment provider should be familiar with methods for de-escalating the situation or obtaining help 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.


A substance abuse treatment 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, substance abuse 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 proper procedures…have been followed.

## B. 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 for substance abuse 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. (Cayouette, 1990, p. 3)

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. (Cayouette, 1990).

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, 1992, p. 39). Survivors also appear to benefit by participating in same-sex groups that do not use confrontational techniques (Minnesota Coalition for Battered Women, 1992; Wright and Popham, 1995).

**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 (Prochaska et al., 1992, 1994a, 1994b; Snow et al., 1994; Velicier et al., 1990). 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.

## Chapter 5 Legal Issues

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. 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. Substance abuse treatment providers should also have working relationships with the criminal justice system and local providers of legal and domestic violence services to whom they can refer a client with such problems.

### A. Federal Law

#### The Violence Against Women Act

VAWA is a civil rights statute that was passed as part of the Violent Crime Control and Law Enforcement Act (Public Law 103-322). 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. As of this writing, at least one district court decision has been issued that upholds the provisions of VAWA. In *Doe v. Doe* (929 F.Supp.608 D.Conn. 1996), a woman sought damages for 17 years of "physical and mental abuse and cruelty" by her husband. He moved to dismiss the case on the grounds that VAWA was unconstitutional. The Federal district court denied the motion to dismiss and upheld VAWA's constitutionality. If VAWA withstands other pending challenges, it may become an important weapon for women seeking to break free from battering partners.

**Welfare Reform**

The issue of preventing domestic violence has important implications for welfare reform; when considered in conjunction with issues involving substance abuse treatment, the overall picture becomes extremely complicated. In fact, some States (such as Kansas) have established laws that require people receiving welfare to be screened, assessed, and treated for substance abuse. It is important for treatment providers to be aware of the issues involved; careful coordination of services with domestic violence workers can help to avoid serious problems (Raphael, 1996).

The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (Public Law 104-193), signed into law on August 22, 1996, calls for greater use of paternity

determinations to enforce child support regulations. This can be problematic for welfare recipients who are victims of domestic violence. Abuse is often exacerbated or reactivated when legal action is taken against the batterer for child support. Many abused women are afraid to seek child support because they fear that doing so will result in the batterer being given visitation rights, which would force disclosure of their new location. Although current Federal law does provide "good cause" exemptions in a number of situations, including domestic violence, this option is used by fewer than 1 percent of welfare applicants nationally (Raphael, 1996; Zorza, 1995b). Providers should tell survivor clients concerned about confidentiality that these exemptions exist.

### B. 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 (Klein and Orloff, 1993). 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:

- Criminal acts (most commonly battery, but also criminal trespass, robbery, burglary, kidnapping, malicious mischief, and reckless endangerment)
- Sexual assault and marital rape
- Interference with personal liberty
- Interference with child custody
- Assaults involving motor vehicles
- Harassing behaviors
- Stalking
- Emotional abuse
- Damage to property
- Transferred intent (in which someone other than the petitioner is injured by violence directed toward the petitioner) (Klein and Orloff, 1993).

State courts have consistently upheld the constitutionality of domestic violence statutes. Civil protection order statutes have been held to rationally and reasonably uphold the State's interest in preventing domestic abuse, because these statutes do not:

- Deprive abusers of liberty and interest in their homes
- Deprive abusers of their families or reputations
- Inflict cruel and unusual punishment
- Violate equal protection, due process, freedom of association, or free space.

In addition, courts have found that procedural aspects of civil protection orders do not violate the defendant's right to a jury trial.

Most jurisdictions allow an individual to petition for civil protection with or without the aid of a lawyer. In fact, some courts have upheld laws that permit court clerks to assist petitioners in filing for protection orders.

Although the assistance of legal counsel is preferable, *pro se* representation -- or self-representation -- is an option for victims who cannot afford the services of an attorney.

Pro se actions allow domestic violence survivors to seek the immediate protection of the courts, and it can also empower them as they seek to gain control of their lives. Furthermore, many areas lack attorneys who are able and willing to act as advocates for battered women, although in some jurisdictions lay advocates are available to counsel victims of domestic violence, help prepare court papers, and handle uncomplicated cases in court.

**Other Legal Issues**

For many clients, treatment for substance abuse includes an effort to acknowledge – to themselves and perhaps to others -- the harm they have visited on family and friends. A victim of domestic violence will explore the role substance abuse played in the abusive relationship. A perpetrator of domestic violence may have agreed to enter treatment in lieu of trial or incarceration; he will need to examine that aspect of his behavior as well as his substance abuse.

Finally, a client who enters treatment presenting an entirely different constellation of issues may disclose during the course of counseling that he or she has either assaulted or been assaulted by a spouse. During the course of counseling victims -- or perpetrators -- of domestic violence, substance abuse program staff will hear about violent behavior. What is the program's legal obligation in such circumstances? How should programs deal with inquiries from lawyers or criminal justice officials? What should a program do when a counselor or client records are subpoenaed or the police come armed with a search warrant? This section discusses these issues and the tension between the need to protect people from harm and the need to respect the client's confidentiality. Confidentiality is protected under 42 *Code of Federal Regulations* (C.F.R.), Part 2, implementing 42 U.S.C. §290dd-2. (All references to §2 . . . below refer to these regulations.)

Although the Federal confidentiality regulations may prohibit reporting domestic violence to law enforcement authorities, substance abuse treatment providers should still ask about it. Whether the information is passed along or not, it still bears on treatment. Providers should acknowledge the abuse; help the client separate her responsibility from that of the batterer; counsel her that the violence may escalate; help assess her safety and offer available options; clearly document the abuse (enlisting the aid of a forensic examiner, if necessary); provide referrals to shelter, legal services, and counseling; and facilitate such referrals with her consent. *Treatment providers must not let confidentiality restrictions prevent them from routinely inquiring about domestic violence in the course of providing appropriate care to clients*.

**Reporting Child Abuse and Domestic Violence**

What should a program do when a client admits he has battered his spouse at some time in the past -- or during his participation in treatment? Does the program have a duty to call law enforcement officials if a woman threatens to assault her husband or child -- an act the counselor knows she has committed in the past? What can a program do if a client attacks his wife at the program? These are three very different questions that require separate analysis.

***Is there a legal duty to report past crimes?***

The general question about the duty to report past criminal activity is one that arises frequently for substance abuse treatment programs. Many substance abusers engage in criminal behavior while they are abusing drugs and even during the course of treatment. In a situation in which a client has told a substance abuse counselor that he or she has battered a spouse or child in the past, there are generally three questions the program needs to ask as it considers whether to make a report:

(1) Does State law require the program to make a report?

(2) Does State law permit the program to make a report?

(3) How can a report be made without violating the Federal law and regulations governing confidentiality of patients' records (42 U.S.C. §§290dd-2 and 42 C.F.R. Part 2)?

First, under State law, is there a legal duty to report child abuse or other domestic violence? For substance abuse counselors the answer to this question is "yes" if child abuse is involved and generally "no" if battering of a spouse is involved.

***Reporting child abuse***

All States (and the District of Columbia) require a broad range of care providers – including substance abuse treatment programs -- to report when there is reasonable cause to believe or suspect child abuse or neglect. While many State statutes are similar, each has different rules about what kinds of conditions must be reported, who must report, and when and how reports must be made. In most States, failure to report may result in civil or criminal charges. All States extend immunity from prosecution to persons reporting child abuse and neglect; in other words, a person who reports abuse cannot be sued.

While all States require agencies to report child abuse, most alcohol and drug programs are limited by Federal law in the kind and amount of information they may disclose to anyone without a patient's written consent.

However, the Federal confidentiality regulations do permit substance abuse treatment programs to comply with State mandatory child abuse reporting laws. Note, however, that this is a narrow exception to the regulation's general rule prohibiting disclosure of any information about a client. It permits only initial reports of child abuse or neglect. Programs may not respond to follow-up requests for information or subpoenas for

additional information, even if the records are sought for use in civil or criminal proceedings resulting from the program's initial report, unless the client consents or the appropriate court issues an order under §2.64 or §2.65 of the regulations.

***Reporting domestic violence against adults***

Assault of another person, including a spouse, is a crime. Few States impose a duty to report a crime committed in the past, although some States do require physicians treating certain types of injuries incurred as the result of a violent criminal act (e.g., a shotgun wound) to make a report to the police. Even those States that still have laws that require reports of past criminal acts rarely prosecute violations of the law. Therefore, unless a particular State should mandate reporting of spousal abuse by health care providers and mental health counselors, it is unlikely that a substance abuse treatment counselor will have a legal obligation to report.

***When is reporting permitted?***

Does State law permit counselors to report a crime involving domestic violence to law enforcement authorities? Whether or not there is a legal obligation imposed on citizens to report past crimes to the police, occasions may arise when counselors feel a personal obligation to report an admission of domestic violence to law enforcement authorities. However, State law may protect conversations between counselors of substance abuse programs and their clients (by making them privileged) or exempt counselors from any requirement to report past criminal activity by clients. Such laws are important to clients in substance abuse treatment, many of whom have committed offenses during their years of alcohol or drug abuse.


If part of the therapeutic process for clients includes acknowledging the harm they have

done others, substance abuse programs that routinely reported clients' admissions of past criminal activity would have limited ability to work with clients in the recovery process. Laws protecting conversations between counselors of substance abuse programs and their clients are designed to protect that relationship, an important part of the treatment process. Survivor clients as well as batterers need to know that their disclosures are protected.

State laws vary widely in the protection they accord communications between patients and counselors. In some States, admissions of past crimes may be considered privileged and counselors may be prohibited from reporting them; in others, admissions may not be privileged. Moreover, each State defines the kinds of relationships protected differently. Whether a communication about past criminal activity is privileged (and therefore cannot be reported without the patient's consent) may depend on the type of professional the counselor is and whether he or she is licensed or certified by the State.

Any program that is especially concerned about this issue should ask a local attorney for an opinion letter about whether there is a duty to report and whether any counselor-patient privilege exempts counselors from that duty.

***Complying with Federal and State law***

Any program that decides to report a client's admission of past spousal abuse must do so without violating either the Federal confidentiality regulations or State laws. A program that decides to report a client's admission of battering or any other criminal activity can comply with the Federal regulations by following one of these three methods:

1. If a criminal justice agency has required the batterer to enter treatment in lieu of prosecution or incarceration, and the batterer has signed a criminal justice system

consent form that is worded broadly enough to allow this sort of information to be disclosed, the program can report the client's admission of a crime to the referring criminal justice agency. Generally, programs that treat such mandated patients agree to report progress in treatment, failure to attend treatment, and certain categories of criminal acts to the referring criminal justice agency. Mandated patients sign a special consent form permitting programs to do so. Note, however, that the Federal regulations limit what the criminal justice agency can do with the information. Anyone receiving information pursuant to a criminal justice system consent "may re-disclose and use it only to carry out that person's official duties with regard to the patient's conditional release or other action in connection with which the consent was given" (§2.35(d)). Thus the disclosure can be used by the criminal justice agency that ordered the offender to enter treatment to revoke his or her participation in treatment in lieu of criminal justice processing, but most likely not to prosecute the batterer for a separate crime (in other words, for making the assault the program is reporting). Only if a special court order is obtained pursuant to §2.65 of the regulations can information obtained from a program be used to investigate or prosecute a patient (42 U.S.C. §290dd-2(2)(C) and 42 C.F.R. §2.12(d)(1)).

2. The program can make a report in a way that does not identify the individual as a client in a substance abuse program. (Disclosures that do not identify the offender as someone with a substance abuse problem are permitted). This

can be accomplished either by making an anonymous report or -- for a substance abuse program that is part of a larger entity, say, a managed care organization -- by making the report in the larger entity's name. For example, a counselor employed by a program that is part of a mental health facility could phone the police, identify herself as "a counselor at the Palm County Health Center," and report the assault. This would convey the vital information without identifying the client as an alcohol or drug abuser. Counselors at free-standing substance abuse programs cannot give the name of the program.

3. The program can obtain a court order under §2.65 of the regulations, permitting it to make a report if the crime is "extremely serious." The program must take care that the court issuing the order abides by the requirements of the regulations.

By using any one of these methods, the program will have discharged its reporting responsibility without violating the Federal regulations. Before reporting, however, the program should also be sure that a report would not violate any State laws making communications between clients and counselors privileged. Because of the complicated nature of this issue, any program considering reporting a batterer's admission should seek the advice of a lawyer familiar with local law as well as the Federal regulations.

***Is there a duty to report threats?***


In working with batterers, substance abuse treatment programs may face questions about their "duty to warn" someone of a client's threat to harm his spouse or child. Even when a counselor has no legal obligation to report a client's threat, a treatment professional may feel an ethical, professional, or moral obligation to try to prevent a crime.

Over the past 20 years, States across the nation have adopted a principle -- through legislation or court decision -- requiring psychiatrists and other therapists to take "reasonable steps" to protect an intended victim when they learn that a patient presents a "serious danger of violence to another." This trend started with the case of *Tarasoff v. Regents of the University of California*, 17 Cal.3d 425 (1976), in which the California Supreme Court held a psychologist liable for money damages because he failed to warn a potential victim his patient threatened to, and then did, kill. The court ruled that if a psychologist knows that a patient poses a serious risk of violence to a particular person, the psychologist has a duty "to warn the intended victim or others likely to apprise the

victim of the danger, to notify the police, or to take whatever other steps are reasonably necessary under the circumstances."

In most States, therapists and other care providers must warn a victim or the police when a patient makes a credible threat of violence to another identified person. (Of course, not every threat uttered by a patient should be taken seriously. It is only when a patient poses a serious threat of violence toward a particular person that the duty to warn arises.) Counselors who fail to warn either the intended victim or the police may be liable for money damages or license revocation.

In a situation where a client threatens to assault a spouse, and the counselor believes he is serious, the counselor must ask him- or herself at least two -- and sometimes three -- questions:

1. Is there a legal duty to warn in this particular situation under State law?
2. Even if there is no State requirement that the program warn an intended victim or the police, do I feel a moral obligation to do so?

The first question can only be answered by an attorney familiar with the law in the State in which the substance abuse program operates. If the answer to the first question is "no," it is advisable to discuss the second question with a knowledgeable lawyer too.

3. If the answer to the two questions above is "yes," can the counselor warn the victim or someone likely to be able to take action without violating the Federal confidentiality regulations?

The problem is that there is an apparent conflict between the "duty to warn" imposed by the many States that have adopted the principles of the *Tarasoff* case and the Federal

confidentiality requirements. Simply put, the Federal confidentiality law and regulations prohibit the type of disclosure that *Tarasoff* and similar cases require unless a substance abuse program can use one of the Federal regulations' narrow exceptions. These aside, the Federal regulations make it clear that Federal law overrides any State law that conflicts with the regulations (§2.20). In the only case, as of this writing, that addresses this conflict between Federal and State law (*Hasenie v.United States*, 541 F. Supp. 999 (D. Md. 1982)), the court ruled that the Federal confidentiality law prohibited any report.

There are five ways a substance abuse treatment program can report a client who makes a serious threat to harm someone (or himself).

The first three of those methods have already been outlined above in the discussion about reporting admissions of past crimes:

1. The program can make a report to the criminal justice agency that mandated the batterer into treatment so long as there is a criminal justice system consent form signed by the batterer that is worded broadly enough to allow this sort of information to be disclosed. (As noted above, the Federal regulations limit what the criminal justice agency partner can do with the information.)
2. The program can make a disclosure to the potential victim or law enforcement officials that does not identify the individual who has made the threat as a patient in substance abuse treatment. This can be accomplished either by making an anonymous report or -- for a substance abuse treatment program that is part of a larger entity, such as a managed care organization -- by making the report in the larger entity's name.
3. The program can go to court and request a court order in accordance with §2.64 of the Federal regulations, authorizing the disclosure to the intended victim, or in accordance with §2.65, authorizing disclosure to a law enforcement agency. The regulations limit disclosures to law enforcement agencies for the purpose of investigating or prosecuting a patient to "extremely serious" crimes, "such as one which causes or directly threatens loss of life or serious bodily injury, including

homicide, rape, kidnapping, armed robbery, assault with a deadly weapon, and child abuse and neglect" (§2.65).

4. The program can make a report to medical personnel if the threat poses an immediate danger to the health of any individual and requires immediate medical intervention (§2.51). Thus, for example, a program could notify a private physician about a suicidal patient so that medical intervention can be arranged.
5. The program can obtain the client's consent. This is extremely unlikely if the client is the batterer, and even survivor clients often do not want their batterer's threats reported to the law.

If none of these options is practical, what should a program do? If a program believes there is clear and imminent danger to a client or another person, it is probably prudent to report the danger to the authorities or the threatened individual, particularly in States that follow the *Tarasoff* rule. While each case presents different questions, it is doubtful that any prosecution (or successful civil lawsuit) under the confidentiality regulations would be brought against a program or counselor who believed in good faith that there was real danger to a particular individual.

On the other hand, a civil lawsuit for failure to warn might well result if a threat were actually carried out. In any event, the program should try to make the warning in a manner that does not identify the individual as a substance abuser. As in other areas where there are no clear-cut answers and the law is in flux, programs should find a lawyer familiar with State law who can provide advice on a case-by-case basis. Programs would also be well advised to establish a protocol ensuring that the clinical or program director has a chance to review the situation before a report is made. "Duty to warn" issues are an area in which staff training may be helpful.

***What should a program do if an assault occurs on the premises?***

The answer is more straightforward when a client has committed or threatens to commit a crime on program premises or against program personnel. In this situation, the Federal regulations permit the program to report the crime to a law enforcement agency or to seek its assistance.

Moreover, in these circumstances, the program can disclose details about the incident, including the suspect's name, address, last known hereabouts, and status as a client at the program (§2.12(c)(5)).

**Communicating With The Legal System**

Counselors working with victims -- or perpetrators -- of domestic violence may find that lawyers, law enforcement officials, and others view them as a good source of information. A call from a lawyer asking about a client, a visit from a law enforcement officer asking to see records, or the arrival of a subpoena to testify or produce treatment records -- what should a program do in each of these circumstances?

The answer is (1) consult the client, (2) use common sense, and (3) as a last resort, consult State law (or a lawyer familiar with State law).

**Responding to Lawyers' Inquiries**

Starting with the first scenario -- a lawyer calls and asks about Jane White's treatment history or treatment. As a first approach to the question, Jane's counselor must tell the lawyer, "I don't know that I have a client with that name. I'd have to check my records." This is because the Federal confidentiality regulations prohibit any other response without the client's written consent. The regulations view any response indicating that Jane White is the counselor's client as an unauthorized disclosure that Jane White is in substance abuse treatment. Even if the counselor has the client's written consent to speak with the lawyer, she may find it helpful to consult with the client before having a conversation about

her: "I'm sure you understand that I am professionally obligated to speak with Jane White before I speak with you." It will be hard for any lawyer to disagree with this statement.

The counselor should then speak with the client to ask whether the client knows what information the caller is seeking and whether the client wants her to disclose that or any other information. She should leave the conversation with a clear understanding of the client's instructions -- whether she should disclose the information, and if so, how much and what kind.

It may be that the lawyer is representing the client and the client wants the counselor to share all the information she has. On the other hand, the lawyer may represent the client's spouse or some other party with whom the client is not anxious to share information. There is nothing wrong with refusing to answer a lawyer's questions, but a polite tone is best. If confronted by what could be characterized as "stonewalling," a lawyer may be tempted to subpoena the requested information and more. The counselor will not want to provoke the lawyer into taking action that will harm the client. If the lawyer represents the client and the client asks the counselor to share all information, the counselor can speak freely with the lawyer once the client signs a proper consent form. However, if the counselor is answering the questions of a lawyer who does not represent the client (but the client has consented in writing to the disclosure of some information), the counselor should listen carefully to each question, choose her words with care, limit each answer to the question asked, and take care not to volunteer information not called for.

**Visits by Law Enforcement**

A police officer, detective, or probation officer who asks a counselor to disclose information about a client or a client's treatment records must be handled in a similar manner. The counselor should give a noncommittal response, such as "I'll have to check my records to see whether I have such a patient." Of course, if the patient was mandated

into treatment in lieu of prosecution or incarceration, program staff may be obligated to speak with someone from the referring criminal justice agency, and the client will have signed a criminal justice system consent form authorizing the program to do so.

If the officer's inquiry has come "out of the blue," the counselor should speak with the client to find out whether the client knows the subject of the officer's inquiry, whether he wants the counselor to disclose information and if so, how much and what kind and whether there are any particular areas the client would prefer she not discuss with the officer. Again, the counselor must get written consent from the client before speaking with the officer.

If the counselor knows that a client is a fugitive from justice, a refusal to assist or give officers information is a criminal offense in some States.

**Responding to Subpoenas**

Subpoenas come in two varieties. One is an order requiring a person to testify either at a deposition out of court or at a trial. The other -- known as a subpoena *duces tecum* -- requires a person to appear with the records listed in the subpoena. Depending upon the State, a subpoena can be signed by a lawyer or a judge. Unfortunately, it can neither be ignored nor automatically obeyed. In this instance, the counselor's first step should be to call Jane White -- the client about whom she is asked to testify or whose records are sought -- and ask what the subpoena is about.

It may be that the subpoena has been issued by or on behalf of Jane's lawyer with Jane's consent. However, it is equally possible that the subpoena has been issued by or on behalf of the spouse's lawyer (or the lawyer for another adverse party). If that is the case, the counselor's best option is to consult with Jane's lawyer (after getting Jane's written consent) to find out whether the lawyer will object -- ask the court to "quash" the subpoena -- or whether the counselor should simply get the client's written consent to testify or turn

over her records. An objection can be based on a number of grounds and can be raised by any party, including the person whose medical information is sought. Often, the counselor may assert the client's privilege for the client.

**Dealing With the Police**

A program may unknowingly admit a client who is sought by the police. If the police discover that someone they are seeking is at the program and come armed with an arrest warrant, what should the program do? How should programs handle search warrants? The answers to these questions are quite different.

**Arrest Warrants**

An arrest warrant gives police the authority to search the program facilities; however, the program is not authorized to help the police by pointing out the client they are seeking unless the client is being sought because he or she committed a crime on program premises or against program personnel. The unfortunate result is that the confidentiality of all clients in the program may be compromised when the police enter and search for a fugitive. There is no solution to this problem unless the police secure a court order under §2.66, which would authorize the program to disclose the identity of the client, or the program convinces the client to surrender. (Voluntary surrender by a client is a disclosure by the client, not the program.)


It is usually in the client's best interest to surrender voluntarily, since arrest is probably inevitable and his cooperation may weigh in his favor with the prosecutor and judge when the question of bail arises. The risk is that the client will attempt to escape, which might

expose the program to a charge of assisting unlawful escape. To reduce this possibility, the program should work with the police so that law enforcement personnel have secured the area around the program.

**Search Warrants**

A search warrant does not authorize the program to permit the police to enter the premises. Even if signed by a judge, a search warrant is not the kind of "court order" that the Federal regulations require before the program can allow anyone to enter and see clients or client records when clients have not consented. Law enforcement officials are unlikely to know about the restrictions of the Federal regulations, however, and they will probably believe that a search warrant permits them to enter and search the program.

***What should a program do?***

Presented with a search warrant, program staff should show the officer a copy of the Federal regulations and explain their restrictions. Staff can suggest that the officer obtain a court order that will authorize the program to make the disclosure called for in the search warrant. No harm will ordinarily be caused by resultant delay (although the police may not agree with this view). The program should call its lawyer and let him or her talk with the police. Failing that, a program could try to call the prosecutor who has sent the police, explain the regulations, and point out that any evidence seized without the proper court order may be excluded at trial, since it will have been seized illegally. If none of these steps works, the program must permit the police to enter. Refusal to obey a direct order of the police may be a crime, even if the police are wrong, and forcible resistance would be unwise. If the program has made a good faith effort to convince the law enforcement authorities to pursue the proper route, it is unlikely that it would be held liable for allowing entry when argument fails.

## E. Conclusion

Programs should develop protocols for dealing with the constellation of legal issues that may arise during the treatment of victims -- or perpetrators -- of domestic abuse. Programs should have a copy of the Federal regulations available at all times to show law enforcement officials and establish a relationship with an attorney who can be called upon to help in these situations. Finally, programs should reach out to law enforcement agencies before a crisis arises and work with them to develop ways of dealing with these kinds of issues. If the regulations are explained when there is no emergency and there can be no suspicion that the program is hiding anyone or anything, and a protocol is established, unpleasant confrontations may be avoided.

## Chapter 6 Linkages: A Coordinated Community Response


Isolation is a salient characteristic of domestic violence: It occurs in isolation and it isolates its victims from community life. Countering this pervasive isolation with a coordinated community response is perhaps the strongest way to eliminate domestic violence from our society (Clark et al., 1996).

"If we are ever to eradicate domestic violence, the whole community must become alerted to the problem and how best to support the victims and convey to the abusers that abuse is a crime that is never justified," (Zorza, 1995a, p. 54).

Although the primary focus of this Treatment Improvement Protocol is on linking substance abuse treatment and domestic violence support services, the linkages cannot stop there: Other efforts to link and integrate community resources are essential -- not only to ensure that the needs of individual survivors and batterers are met but also to raise public awareness and to begin to create the coordinated community response that is necessary for change. Coordinated intervention is crucial. These efforts must address needs for housing, child care, emotional and physical safety, health and mental health care, economic stability, legal protection, vocational and educational services, parenting training, and support and peer counseling, among others.

Linkages will also help each agency fulfill its own mission. Few programs have the resources available to address the sometimes overwhelming number of problems faced by substance abuse treatment clients who are affected by domestic violence. Increasingly, programs are looking to strong collaboration and linkages with other service agencies to meet their clients' needs. Such collaboration is particularly important in isolated rural communities where lack of resources and distance from services are significant problems.

In all communities -- urban, rural, and suburban -- individuals who provide substance abuse and domestic violence services in the public sector generally have experienced the negative consequences of fragmented and un-integrated service systems. Historically, their resourcefulness in obtaining necessary care for their clients has created an informal system of referrals and unofficial case management. Such linkages are becoming more formalized as system administrators realize the cost-effectiveness of collaboration and coordination of services and as public sector purchasers of Medicaid managed care become more sophisticated in contracting with managed behavioral health care organizations to ensure a continuum of services for clients served in the public sector.

Thus the current behavioral health care environment may be one especially open to change in the direction of linkages, collaboration, coordination, and service integration. This chapter calls on providers to be especially positive and creative in thinking about these issues and designing action plans. Those who have seen past efforts at service integration fail, who are skeptical about structural change within State service delivery systems, and who may be ambivalent about giving up turf are encouraged to support coordination and collaboration -- that is, separate agencies planning together and working together to create new delivery approaches with support at the State level.

This chapter focuses on two approaches to building linkages; the first based on systemic reform and the second rooted in the community. Two crucial linkages are highlighted -- that between substance abuse treatment and domestic violence support services and that between these services and the criminal justice system.

### A. Systemic Reform

Linkages are frequently conceived of as local program-to-program relationships, and much of the remainder of this chapter is devoted to such linkages. While not disputing the importance of community-based interagency networking, the Consensus Panel believes that a new way of thinking about linkages on the systems level can help address the multiple social service needs of substance-abusing victims and perpetrators of violence. In calling for substantive, top-down reform, the Panel allies itself with those domestic violence experts (Hart, 1995b; Hart et al., 1995) and mental health experts (Stroul, 1993) advocating a new approach to organizing and institutionalizing coordinated social service delivery systems.

Under this new paradigm, the familiar concept of a "continuum of services" is elevated to the State level and substantially expanded to include a formal structure and process to oversee system-level coordination among agencies. While specific goals would vary from

State to State, the Panel believes that such systemic reform would enable States to create a collaborative infrastructure that, in turn, would allow programs to deliver care that is:

- Client-centered -- focused on meeting clients "where they are" and matching their needs with appropriate services as opposed to fitting clients into a predefined program; wraparound services follow the client.
- Holistic -- offering comprehensive services from a variety of agencies that are designed to respond to a client's multiple needs: substance abuse treatment, mental health counseling, domestic violence support, parenting skills training, housing.
- Flexible -- the service mix changes as the client's needs change
- Collaborative -- multiple agencies can work together freely on behalf of a client without having to consider agency funding or other administrative issues that may interfere with the assistance process
- Coordinated -- individualized service plans are developed for each client and monitored via case management
- Accountable -- encourages the client's input to the comprehensive treatment plan, adheres to standards or accepted best practices for treatment, establishes and tracks qualitative and quantitative outcome measures, and evaluates services on the basis of client and community satisfaction.

Currently, most social services -- including substance abuse treatment and domestic violence support -- function as a series of parallel programs with their own sources of funding, leadership, and constituencies (Hart, 1995b; Hart et al., 1995; Stroul, 1993). Clients needing services from more than one program not only face a number of hurdles (e.g., differing eligibility requirements, hours of operation, and locations), but may also receive services that are counterproductive because they are not part of a coordinated treatment plan (Hart, 1995b).

In the environment that would emerge after converting from parallel services to an integrated delivery system, cooperation on the client's behalf would replace competition for the client and for the attendant funding that follows admission to a specific program or to a treatment slot or bed. Collaboration would eliminate duplication of services and receipt of inappropriate services.

With a client-centered philosophy prevailing, the provision of adjunctive support services like child care, transportation, and housing would assume greater importance and would more likely be funded (Stroul, 1993).

Systemic reform on this scale requires structural, administrative changes at the State level. As a first step toward revamping service delivery to multiple-needs clients, the Panel envisions a mechanism that would:

- Coordinate planning among disparate agencies based on client and community needs assessments
- Devise financing strategies that would allow for blended funding and strive for equitable allocation of resources among agencies
- Establish a vehicle for resolving any problems that emerge in the course of providing integrated services (e.g., development of compatible management information systems, cross-training, and support and authority for case management).

In its assessment of systems of care for children (Stroul, 1993), Georgetown University's Child Development Center discovered that, as expected, integrated systems of care expanded access to services, including adjunctive support, and increased the use of case management to monitor service delivery and advocate for individual clients and their families. The study also found that this approach, in some instances, reduced costs. For example, three counties in California saved more than $35 million over 4 years for residential care by using a systems model of service delivery. Similarly, Fort Bragg, North

Carolina, reduced the costs of caring for children with serious emotional disturbances by 51 percent through the systems of care approach. The State of Kentucky likewise reduced the cost of services from $13.5 million to $9.5 million (Stroul, 1993).

Although these models have yet to be applied to the substance abuse and domestic violence fields, the Consensus Panel believes they hold promise for redefining the existing service delivery system to ensure more appropriate and effective care for substance-abusing domestic violence victims and perpetrators. The Panel strongly recommends that Federal and State policymakers consider a series of demonstrations designed to test the feasibility of changing the current system to institutionalize a formal administrative structure for promoting and supporting collaboration and linkages among social service programs.

**Community-Based Linkages**

The health care environment is increasingly forced to respond to the demand for cost containment; therefore, undertaking collaborative endeavors is critical to the future of many programs, especially at the community level. As noted, few have the resources to offer under one roof all the specialty services that clients need. Creative linkages can supplement and complement programs, building on their strengths and compensating for their weaknesses. Linkages can open avenues to diverse sources of funding to offset the inevitable ebb and flow of resources. And in a practical vein, a growing number of funding sources are granting funds *only when presented with evidence of coordinated activities among grant applicants*.

## Community Assessment

Before linkages can be developed, it is necessary to know what resources exist within the community. Each entity has its own organization and its own culture that must be understood for collaboration to be successful. Every State has a unique infrastructure for housing the health care, legal, social, and other services related to substance abuse treatment and domestic violence services. Communities themselves also vary in government structure, available resources, and funding streams. Some combine alcohol treatment with treatment for other substance abuse, whereas others separate the two. Some locate services for victims of domestic violence in the criminal justice system, which affects the tone and procedures used to deliver services, while others locate such services in a hospital system linked to the emergency department. A program within a nonprofit entity in the private sector has far different restraints than one housed in a government agency.

Disciplines also differ dramatically in structure and orientation. Some substance abuse treatment programs, for example, are staffed by nurses, and others are staffed by certified addiction counselors. Many existing programs, such as Minnesota's Turning Point and African American Services, have incorporated family violence issues into substance abuse treatment, and communities throughout the United States are increasingly integrating the two areas (Clark et al., 1996). A single treatment approach would be enhanced by making programs accountable to the local community, strengthening the linkages between the two fields and the court system, and improving evaluation procedures.

## The Argument for Case Management

In the current early stage of development of linkages between the fields of substance abuse treatment and domestic violence services, it has been suggested that "the linkage

mechanism that seems most appropriate is case management" (Collins et al., 1997, p. 400). Increasingly, the substance abuse treatment field has recognized that case management may be a key contributor to successful treatment (Ridgely and Willenbring, 1992). In the case management approach, a specially trained single practitioner or case management team is responsible for coordinating linkages to the wide variety of services -- including domestic violence support -- needed by many if not most clients in substance abuse treatment (Sullivan, 1994).

Although locating and gaining initial access to these services can be challenging, many programs have found that use of case management is well worth the effort, since it helps clients work through problems that may trigger use of alcohol and other drugs or that interfere with progress in treatment. Such problems may include homelessness, mental illness, HIV infection, lack of vocational skills, and unemployment (Willenbring, 1994). An additional advantage is that the case manager serves as a client advocate, representing the client's interests in both accessing other agencies and ensuring that their services are used effectively (Rapp et al., 1994).

**Linking Substance Abuse Treatment and Domestic Violence Services**

Several locales have attempted to develop model programs integrating substance abuse and domestic violence services. These include the Amend Program in several Colorado communities (Rogan, 1985-1986), the intercede Program of Longford Health Sources in Ohio (Burkins, 1995), and the Pittsburgh Veterans Affairs Medical Center (Gondolf, 1995). A study of linkage efforts in Illinois found that staff cross-training is inadequate to meet the goals of these efforts (Bennett and Lawson, 1994).

This TIP takes some of the first steps in formalizing linkages between the two fields. Chapters 2 and 3 present substance abuse treatment providers, who may lack knowledge about this population, with psychosocial profiles of survivors and batterers and their needs

for specialized care. Such training is a key ingredient in bringing the two fields closer. Chapter 4 stresses the need for screening for domestic violence early in the substance abuse treatment process and the importance of timely referral of clients affected by domestic violence to the appropriate agencies. Routine screening for cross-problems by both types of programs is a major step toward linkage.

**Linkages with the Criminal Justice System**

One of the first linkages that must be identified by a substance abuse treatment program that is working with domestic violence survivors is with the legal system (see Chapter 5). A legal professional or legal service is the best resource for resolving problems that pertain to individual clients' involvement in the justice system and may be the best resource for information and guidance regarding the Violence Against Women Act (VAWA). Many of the Act's provisions -- such as those relevant to immigrants -- are complex and detailed. In addition, other Federal and State statutes may include provisions that appear to contradict those of the VAWA.

To treat substance abuse clients who are either survivors or batterers, treatment providers must be knowledgeable about policies and laws related to domestic violence; they must understand the roles of police, judges, probation staff, and other representatives of the justice system and be able to interact effectively with these individuals when necessary. As one field reviewer noted, "Integrating the criminal justice system's efforts should be the first step in forming linkages. If a provider wants assistance protecting a woman or getting a batterer to attend treatment, it is the criminal justice system that can get this done."

Specialized courts to process domestic violence cases, which combine intensive survivor services, treatment for batterers, and an active judicial role in the social contexts of the community, have been established. The Dade County, Florida, Domestic Violence Court,

which commenced in late 1992, is a noteworthy example, and outcomes are still being evaluated

(Fagan, 1996). However, some early data indicate that recidivism rates among treated batterers processed through these courts are high and comparable to rates found in studies of the deterrent effects of protective orders and arrests. Failure rates are strongly correlated with lengthy prior records and a history of abuse in the batterer's family of origin (Fagan, 1996).

In pursuing victim protection goals, criminal justice agencies have been required to expand their traditional focus on the detection and punishment of crimes. Placing these expectations on police and prosecutors may require tasks and roles for which they are not well trained. Such role and policy ambiguities can affect the performance of agencies with respect to their missions. As Fagan notes:


*There is no doubt that linkages between legal institutions and services for domestic violence victims are critical to stopping violence. However, these linkages may best be accomplished through a strategic division of roles among institutions that tap the strengths of each organization. . . . Although legal systems should be open and accessible to battered women, these institutions should not take on the role of managing the coordination of services that involve social service, shelter, and other interventions. (Fagan, 1996, pp. 39-40)*

### C. Collaborative Treatment Planning For Survivors and Batterers

Treatment plans for substance abuse clients who are survivors or batterers must incorporate all the issues surrounding both sets of problems and ideally will be

coordinated by a case manager. Treatment planning for matters such as time sequencing (e.g., when to start support for a domestic violence survivor in substance abuse treatment) and goals of treatment is not effective without consideration of all the factors that have a bearing on the client's best interests.

Substance abuse treatment providers, domestic violence experts, and legal or other relevant professionals should plan treatment collaboratively. Because treatment plans for domestic violence survivors are built around the premise that safety must always be the first priority, substance abuse treatment may initially take a back seat. For example, a client who lives with a violent partner may report being pressured or coerced by him to use alcohol or other drugs. In these instances, some degree of relapse may need to be tolerated in light of the threat to the client's safety. A survivor's frequent reporting of such a situation, however, signals the need for substance abuse treatment and domestic violence staff to jointly reconsider treatment priorities.

A batterer entering treatment for substance abuse can be required to sign a contract agreeing, among other stipulations, to refrain from using violence (see Chapter 4). Such "no-violence contracts" are most effective when linkages are made with other agencies involved with his case, and violations should be reported to all involved agencies, especially the criminal justice system. Treatment providers can help persuade the courts to consider alternative sanctions that take the victim's circumstances into account. Incarcerating batterers can actually harm their victims by taking away the family income. On the other hand, not incarcerating the batterer may give him the false message that his behavior is not that bad and thus tacitly give him "permission" to continue his violence. Courts may order the batterer to receive counseling, perform public service, or a variety of other sanctions.

**Establishing a Linkage Relationship**

All relationships begin with a "getting-to-know-you" phase; initial, face-to-face interactions often establish the tone for future interaction. These initial meetings should include a discussion of the origins of both communities in order to help each understand the other's beliefs and attitudes. Other topics for discussion include each program's goals for its clients, the barriers routinely faced with clients, typical interactions with clients, and expected outcomes. Key individuals in each system can coach the staff of the other in working with and understanding that system and the needs of its clients.

During the initial phase, it also may be helpful to acknowledge some of the stereotypes held by each field about the other and to discuss them frankly.

At these initial meetings, using a staff member with strong facilitation skills can be invaluable. An alternative is to use a facilitator from an outside agency not affiliated with either program (e.g., from a university or community college). The facilitator can recognize burgeoning problems and defuse them before group members become defensive and uncooperative, and he or she can help participants bridge gaps in understanding by clarifying terminology and asking for feedback to ensure that all parties are interpreting information the same way. A follow-up memo documenting the understandings that emerged from the meeting and listing areas of agreed-upon responsibility can also assist the collaborative process.

**Airing and Addressing Grievances**

In collaborative relationships, difficulties can arise if one entity feels taken advantage of, perceives that the other is deriving more benefits from the association, receives more credit, or believes that power is unequal between the two groups. Balance is central to an effective collaboration that satisfies the expectations and needs of all involved. When a collaborative domestic violence effort, for example, **used the letterhead of one participating organization, the other partners were displeased because their participation was not acknowledged**. To give equal recognition to all partners, a new project-specific letterhead reflecting all the collaborators was designed. Not all solutions

will be so simple, but this example demonstrates the importance of frank communication, responding to the concerns of all the partners in the network, and moving quickly to resolve problems.

## Readiness for Collaboration: Program Evaluation

Many programs have in place a system for periodic internal evaluation of their success in meeting their goals. Decision-makers may find it useful to reexamine a program or organization specifically in terms of its readiness to take advantage of and maintain a collaborative association.

### *Staff roles*

For successful linkages, program staff -- beginning with boards of directors -- must be sensitive to the other program's requirements and culture. A board that consists of members who are committed to supporting program goals and overcoming challenges is essential to effective operation. Motivated and well-connected directors can, for example, help identify community funding sources that will support the development of collaborations.

Administrators can promote linkages by identifying conflicts or economies of scale in the areas of fiscal management, accounting, contract management, funding development, program evaluation and organizational audits, human resources and payroll management, management information systems, and other technology. They can also enhance linkages and develop funding sources by working with other agencies and programs to compete for block grant funds and to split funding for substance abuse and domestic violence. Program managers should appoint a staff member as a contact and liaison for each linkage. Administrators and managers should seek to create an organizational environment that encourages and supports staff members' collaboration activities, which are often time-consuming. Staff members' new collaborative

relationships, as well as their existing relationships with other agencies, are critical to success.

***Cultural competence***

Substance abuse treatment and domestic violence professionals also must educate themselves on issues particular to each cultural or ethnic subgroup their clients represent. Failure to do so diminishes outcomes and completion rates for minority populations. Cultural competence is more important than ever now, as the country moves toward a "majority-less" ethnic composition and major cities become pluralities of cultures rather than majority-minority paradigms.

Responding to the needs of clients will require an awareness of practice and attitude and an organizational structure that continually monitors:

- How are services provided to diverse groups?
- What is the environment in which services are offered?
- What is the composition of the group?
- How included do diverse clients feel during the treatment process, and what cultural activities are directed to a specific population?
- How can treatment be tailored to a particular group?
- Are there staff members who know the language of non-English-speaking clients?
- What networks have been created with other experts and members of the community to provide services to this population?

Lastly, cultural competence implies that agencies are equipped to respond to "insensitivity" and that they make inclusiveness an institutionalized value, in part by employing highly skilled multicultural staff (Cross et al., 1989).

### *The critical role of evaluation*

Evaluation helps programs measure how effective they are in achieving their goals and gives them information to redesign and improve program components. Increasingly, funding sources require documentation of the program's success and of individual outcomes. However, in the fields of substance abuse treatment and domestic violence, outcomes may not always be as clear-cut or as measurable as funders would like.

Administrators must be aware that a funding source or other outsider to the field may not agree with or approve of a program's criteria for success.

For example, relapse is an expected part of recovery from substance abuse, and abstinence may not be the sole indicator of treatment success. Treatment effectiveness should also be measured by larger social indicators, such as higher employment rates, better personal relationships, and

fewer legal entanglements (Wolk et al., 1994). After treatment, some people will not be drug-free for the rest of their lives, but they will experience more stability and more productive lives, resulting in significant benefits to society.

## Understanding the True Costs of Collaboration

Even if an organization takes all the steps above, the path to collaboration is still paved with unforeseen difficulties. The importance of differences in perspectives between the two fields, as discussed in Chapter 1, should not be underestimated. One survey of staff in both types of program found that more than half of all staff cited "conflicting beliefs about personal responsibility" as a reason for noncooperation between programs (Bennett and Lawson, 1994).

Service delivery structure and funding also can block collaboration.

Furthermore, confidentiality and informed-consent practices vary among fields. Large programs may have trouble linking with small programs, especially if documentation and tracking procedures are incompatible. Conversely, small grassroots programs may have problems following the formal procedures required by larger organizations or may lack staff to ensure that paperwork is completed in a timely fashion. Professionally led and staffed organizations may doubt the competence of paraprofessional staff members who are in recovery and may discount their suggestions in the course of treatment planning. Similarly, untrained staff may fail to recognize the validity of the insights and suggestions proffered by professional social work and mental health care givers.

Other issues affecting the costs of collaboration include the number of approvals and layers of bureaucracy that must be negotiated to obtain services from a linked agency, requirements for research and evaluation that may be attached to participation in a network, and the amount of staff time required to maintain linkages and resolve problems.

## D. Other Linkage Strategies

### Funding Sources and Reimbursement

Funding sources for domestic violence support include the criminal justice system through Federal block grants, State money, or fines levied against perpetrators. Private and community organizations also represent funding sources. Employee assistance programs (EAPs) can serve as both allies and access points to solicit and obtain corporate funding. Third party reimbursement for domestic violence services is slowly gaining some acceptance. At one time, insurers might have refused to pay for these services for a woman who was covered under the batterer's policy, reasoning that the woman's injury was self-inflicted because she chose to stay with the batterer.

In some cases, the batterer must authorize payment for treatment for the survivor if medical, health, or disability coverage is in his name. One reason domestic violence has not been incorporated into concepts of managed care is that, as discussed in Chapter 1, some advocates for domestic violence survivors have rejected the use of a medical model to define the problem. In addition, most managed care companies have specific requirements about who can deliver services; if no program staff meet those requirements, it is not likely that the program will be reimbursed.

Domestic violence support encompasses services such as housing and job training that are outside the realm of health care and that have outcomes difficult to measure in terms of health improvement, which are the outcomes of interest to health maintenance organizations (HMOs). However, many managed care organizations are investing funds to help their enrollees deal with issues that are not traditionally medical; many HMOs offer stress management and exercise programs. All health systems are increasingly recognizing the cost-effectiveness of early detection and prevention in general in their covered populations, and some have set up routine screening for substance abuse.

Furthermore, increased interest in outcomes measurement and consumer satisfaction has broadened the spectrum of behaviors monitored and outcomes measured by health care providers. Reimbursement from managed care organizations and other third parties relies on diagnostic classifications and treatment categories. Advocates for reforms in health care and social welfare must find ways to classify joint substance abuse-domestic violence problems to ensure reimbursement. Although some domestic violence programs use the classification "trauma" and receive reimbursement for treatment, services are frequently provided as non-reimbursable advocacy or coaching. Victims who are thought to have underlying problems are typically referred to other programs (e.g., for psychological or substance abuse treatment).

Research indicates that there are no psychological risk markers for becoming a victim of adult domestic violence (Hotaling and Sugarman, 1990). However, certain characteristic symptoms are seen in many people following highly traumatic life events. Some battered women experience these symptoms as a result of violence-associated trauma, and they are normal psychological responses to stressful life events. Often, these symptoms dissipate as women achieve greater safety from the abuse. Other women may require more intensive therapeutic interventions to heal from the effects of violence.

The American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders*, Fourth Edition (DSM-IV) (American Psychiatric Association, 1994), offers some diagnoses that may be helpful in classifying survivors' symptoms and helping programs receive reimbursement for treatment. Some survivors may meet criteria for posttraumatic stress disorder (see Chapter 2) or for depressive and anxiety disorders.

**Licensing, Credentialing and Certification**

Credentialing processes for substance abuse treatment providers must assess their ability to screen for violence and create a safety plan, as well as their knowledge of legal issues related to domestic violence. They should demonstrate knowledge of child abuse and neglect, child sexual abuse, partner violence, elder abuse, extended family violence, and violence as an issue in relationships other than marital or partner relationships.

**Examples of Effective Community-Based Linkages**

In Bismarck, North Dakota, the Federation of Family Funding promoted and supported the development of a multiagency partnership plan to help families experiencing domestic violence. All providers involved with the family meet face-to-face every month to share information, make plans, and discuss strategies for ensuring progress. In a Los Angeles

program for pregnant or substance-abusing battered mothers, a team of providers involved in all aspects of a client's treatment meets as a group with the client. Children's grandmothers, if they are the formal court-appointed caretakers of the children, are included in the case conferences; perpetrator fathers are not. Interagency agreements are made in advance to protect confidentiality.

**Examples in Health Care Settings**

Many of the linkages between domestic violence support services and other service organizations that have been most effective have occurred in health care settings, especially in hospitals. Linkages of the type described here might benefit from involvement of staff from substance abuse treatment programs. At the Dekalb Medical Center in Atlanta, emergency room nurses who suspect that a woman has been battered call a patient representative with specialized knowledge to interview the patient after medical treatment is provided (Dekalb Medical Center, 1993). The representative, who is able to spend more time with the patient than the nurses, refers the patient to a community shelter or makes other referrals and also provides feedback to the emergency room staff.

Other examples of hospital-based service linkages come from Boston, Minneapolis, and Seattle (Loring and Smith, 1994). At Children's Hospital in Boston, staff from AWAKE, an advocacy program for battered women and their children, are called in to provide safety planning and support for patients who are violence survivors. In Minneapolis at the Hennepin County Medical Center, an advocate from a battered women's shelter makes rounds in all services -- not just the emergency room -- to speak directly with medical staff and interview violence survivors. In this way the hospital administration and medical staff are assured that in addition to receiving appropriate medical care, survivors are assisted in other areas, such as locating the batterer, obtaining legal protection, and proceeding

with assault charges when appropriate. Harborview Hospital in Seattle employs an "adult abuse protocol" with components of various systems to ensure comprehensive services to the battered woman patient.

Finally, health maintenance organizations, many of which maintain detailed databases to track service utilization and outcomes, may find it easier than general hospital systems to identify and reach out to survivors of domestic violence.

**Promising Activities and Future Directions**

In 1994 the Board on Children and Families, the National Research Council, and the Institute of Medicine sponsored a 3-day workshop, Violence and the American Family (Chalk, 1994). Although the focus was a broad one and included child and elder abuse as well as other forms of family violence, many of the participants suggested action ideas for linkages among agencies involved in the treatment of domestic violence survivors and batterers. As can be readily seen, no single agency or system can successfully undertake the broad tasks and initiatives outlined below that were suggested by workshop participants. Rather these projects invite broad collaboration and cooperation.

In the area of *social services*, tasks to be undertaken included (Chalk, 1994):

- Developing a set of principles for designing violence interventions that would ensure client empowerment, build on family strengths, and be based on effectiveness evaluations
- Creating violence intervention and prevention systems at the community level that build on formal and informal social networks in diverse neighborhoods
- Requiring schools to make violence prevention education mandatory
- Exploring new methods of cash payments to families to deter violence resulting from economic stress. In the area of *health*, the workshop participants identified three specific initiatives (Chalk, 1994):

- A national campaign against violence to focus on health aspects and costs of family violence to society
- Improvement of screening and diagnosis among health and mental health professionals of risks and injuries associated with family violence
- Consensus-building about what is known about family violence, leading to the formation of a constituency to serve as an advocacy group to educate public officials.

In the area of *criminal justice*, three issues were raised as fruitful areas for activities (Chalk, 1994):

- Effectiveness research on the use and enforcement of restraining orders to deal with domestic violence; new methods of offender control, such as electronic monitoring may be effective
- Research on the availability and effectiveness of court-ordered treatment and on returning abusers to their families
- Consideration of new proposals that experiment with the development of a one-family, one-judge court system.

In addition to these recommendations, the workshop participants outlined three broad steps necessary to establish a much-needed basis for future research and program plans (Chalk, 1994):

- Develop a broad-based public education campaign to foster understanding of family violence
- Bridge the gap between research resources and policy needs, especially by developing rigorous evaluations of public sector programs to reduce domestic violence
- Integrate preventive measures for domestic violence into a comprehensive, community-based program of family support services across a spectrum of developmental milestones. The goal goes beyond information sharing and seeks to simplify access to services.

## A Public Health Approach

A public health approach has been effective in reducing morbidity and mortality by modifying behavior in many areas (e.g., campaigns to reduce smoking, to reduce alcohol abuse among pregnant women, and to prevent head injuries by wearing helmets). A public health approach to violence has been suggested (Koop and Lundberg, 1992) in response to the surge in morbidity and mortality due to violence (Prothrow-Stith, 1991). As the epidemiological evidence mounts that society's rising mortality figures are due in large part to violence, public health professionals acknowledge the destruction of "quality years of life" as well as the expensive healing process and now study the problem in terms of understanding and changing unhealthy outcomes (Koop and Lundberg, 1992).

Public health officials, generally solution-driven rather than theory-driven, view domestic violence as the result of a complex array of causal factors. By focusing on "risk factors," they can identify structural, cultural, and situational conditions that accompany, precede, and follow events of interpersonal violence (Moore, 1995). They also monitor public health, identify at-risk groups, and implement programs with evaluation components.

Education is a critical component of a public health campaign. In Houston, for example, the March of Dimes targeted both health care professionals and the public with educational interventions and brochures about battering during pregnancy; public service announcements were developed for the media.

## Coordination of Care

Though the examples above do not include substance abuse treatment as one of their linkages, they provide a blueprint for the coordination of care that the Consensus Panel recommends. While the Panel believes the current system of parallel services should be

integrated at the State level, meaningful change can occur at the community level. For either substance abuse treatment or domestic violence support services to be successful, the two fields must pool their energies to address gaps in client services *outside* the immediate networks of substance abuse treatment and violence support. Enduring linkages with other agencies and programs must be established to supply those ancillary services essential for positive client outcomes.

**THE END!!!!!** ☺

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# Part 3

## Chapter 1.

## A. Domestic Abuse in the LGBT Community

Boston, Nomeil H., "Intimate Partner Violence in the LGBTQ Community" (2019). University Honors Program Theses. 419.

**Retrieved from:** https://digitalcommons.georgiasouthern.edu/cgi/viewcontent.cgi?article=1504&context=honors-theses

**IPV in LGBTQ Relationships**

Aspects of IPV in LGBTQ relationships are similar with those of heterosexual and/or cisgender relationships, such as the manipulation of power and control dynamics and tactics of abuse such as physical, sexual, emotional, or economic abuse, use of privilege, and isolation. However, there are some aspects of IPV that are unique to the LGBTQ communities. “Outing” of the IPV survivor’s sexual/gender identity may be used as a tool of abuse and a barrier to seeking help. This may result in isolation of the survivor from family members and other social support.

LGBTQ people often experience multiple instances of discrimination and violence due to their sexual orientation or gender identity. Discrimination maybe further exacerbated for LGBTQ individuals a part of racial/ethnic minority groups and those from socioeconomically disadvantaged backgrounds. These forms of discrimination and bias have attributed to heightened rates of depression, anxiety, and suicide completed in lesbian, gay, bisexual, and transgender individuals.

Understanding the history of stigma and prejudice towards this community, may provide insight on the unique circumstances of IPV in LGBTQ relationships. It may also shed insight into the potentially complicated and conflicting options presented to survivors when seeking safety and assistance from general or LGBTQ-specific providers.

Due to stigma and prejudice, LGBTQ IPV survivors may be hesitant to seek treatment because:

- Fear that it would further negative stereotypes or perceptions of LGBTQ people.
- Fear of disclosing the abuse to family members or friends who are resistant to the LGBTQ relationship but not rejecting of the LGBTQ person themselves.
- Fear that disclosure of the abuse may result in a dismissive or negative response to their identity or potential future partners.
- **Fear of health care professionals/institutions not fully accepting of LGBTQ people or viewing LGBTQ relationships as inferior to straight and/or cisgender relationships.**

Intimate partner violence is a serious problem that affects people of all backgrounds regardless of race, gender, social class, or sexual orientation. According to the Centers for Disease Control and Prevention (2018:1), intimate partner violence (IPV) is defined as “physical, sexual or psychological harm by current or former partner or spouse.”

When someone hears intimate partner violence they do not usually think of lesbian, gay, bisexual, transgender, and/or queer (LGBTQ) couples due to the heteronormative nature of society. The world views heterosexuality as the norm and it's the preferred sexual orientation in our society Indeed, most of the existing research has focused on heterosexual couples, which is problematic given that IPV is prevalent within the LGBTQ community. Given the paucity of research in this area, the current study will examine the health concerns and barriers to receiving help placed on those in the LGBTQ community experiencing IPV.

**Important Terms**

**Asexual** - Describes someone who feels little or no sexual attraction. Asexual people may want close emotional or romantic relationships, but they are not drawn to sex as a way to express closeness. Asexual people may identify in combination with another sexual orientation. For example, a gay asexual man may not have sexual attraction for any gender but feel emotional or romantic attraction to other gay men.

**Ally** - Describes someone who does not identify as LGBQ or TGNC yet supports the gay, lesbian, bisexual, queer, questioning, transgender, and gender non-conforming communities.

**Bisexual** - An umbrella term that describes people who are physically, emotionally and/or romantically attracted to men and women, or more than one gender. Some view this term as limiting and dependent upon a gender binary. Others promote this term as inclusionary.

**Biphobia** – Describes the oppression of bisexual people because they do not identify as gay or straight. Biphobia can be perpetrated by others within the LGBTQ community as well as by straight people. Biphobia is often exemplified by assertions that bisexual people are unsure about their true sexual orientation, have personality disorders, are hypersexual, or untrustworthy.

**Cisgender** - A person whose gender identity and expression align with what is typically associated with the sex they were assigned at birth. An example of a cisgender person is a woman who was assigned the female sex at birth after the (often superficial) examination of genitalia, and who identifies and lives as a woman.

**Drag** - Gender expression or hyper-expression for the sake of theatric performance. People performing drag can be of any sexual orientation and the performance does not indicate any specific sexual orientation or daily gender expression.

**Gay** - Describes men who are physically, emotionally and/or romantically attracted to other men. While many people use this word only to refer to men, others use it as a general term to include many genders.

**Gender –** A term describing the complex interrelationship of a person's sex assigned at birth, gender identity, gender expression, and gender roles.

**Genderqueer** – Describes an identity of someone whose gender identity does not conform to traditional norms associated with their sex assigned at birth. Genderqueer people may identify as a combination of, both, or neither woman or man.

**Gender Binary** - The classification of sex and gender into two distinct, opposite, and disconnected forms of masculine and feminine.

**Gender Expression** - The external appearance or perception of one's gender often conveyed through clothing, behavior, voice, mannerisms and/or speech.

**Gender Identity** - One's personal view or understanding of one's own gender.

**Gender Non-Conforming** - Describes a person whose gender expression is, or appears to be, different from what others may expect and may not be masculine or feminine in appearance.

**Gender Pronouns or Preferred Gender Pronouns** - Words that replace someone's name while sharing their gender (she, her, him, his, they, them, ze, zir, etc.). Some people use different pronouns in different situations.

**Gender Role** - A set of norms or expectations of a society dictating what types of behaviors or activities are acceptable for a person based upon their perceived sex or gender.

**Heterosexism** – Describes a system of attitudes and beliefs that heterosexual relationships and people are the norm and better than or superior to LGBTQ relationships or people.

**Homophobia** – Describes the oppression of lesbians and gay men based on their perceived or actual sexual orientation. Homophobia may present in a variety of ways, including negative feelings or perceptions of gay people, as well outwardly hostile or violent behavior. Homophobia can present at an internalized, individual, institutional, or ideological level.

**Homosexual** - Refers to any person whose physical, emotional and/or romantic feelings and attractions are for individuals of the same gender. The word is often seen negatively as it has a clinical origin and was previously used to pathologize LGBTQ people and their relationships.

**Intersex** - An umbrella term used for a variety of conditions in which a person is born with a reproductive or sexual anatomy that does not seem to fit the typical definitions of "male" or "female."

**LGBTQ** - An abbreviation and umbrella term often used to refer to lesbians, gay men, bisexual, transgender, queer, and questioning people.

**Lesbian** – Describes women who are physically, emotionally and/or romantically attracted to other women.

**Pansexual** – A term that describes people who are physically, emotionally and/or romantically attracted to more than one or all genders. Some view this term as more inclusive than 'bisexual' in that it does not depend upon the gender binary. Others find this view to be perpetuating biphobia.

**Queer** - An umbrella term that describes people who are not straight and/or cisgender. In the past this word was used to put-down LGBTQ people. Today the word can be used in a positive way within the LGBTQ community.

**Questioning** - Describes someone who is not sure about their sexual orientation or gender identity, or is learning more, before identifying as LGB, transgender, queer, straight or any other identity.

**Same Gender Loving** - A term used in some Black and African-American communities as an alternative to Eurocentric gay and lesbian identities that may not culturally affirm or engage the histories of people of African descent.

**Transgender (Trans)** - An umbrella term used to describe people for whom the binary sex (male or female) assigned at birth is a misleading or incomplete description of themselves. While many identities fall under this umbrella, not all genderqueer, non-binary and non-conforming people identify this way.

**Transphobia** - Describes the violence or discrimination against and oppression of transgender and gender non-conforming people. Transphobia may present in a variety of ways, including negative feelings or perceptions of transgender people, as well outwardly hostile or violent behavior. Transphobia can present at an internalized, individual, institutional, or ideological level.

**Two-Spirit** – A term referring to some indigenous, First Nations, or Native American people's culturally distinct understanding gender and sexual orientation. This term has been reclaimed by some as a way to honor heritage outside of the Eurocentric labels

of gay, lesbian, bisexual, and transgender, which may not culturally affirm or engage the traditions or histories of indigenous, Native American, or First Nations people.

**Transitioning** - The social, legal and/or medical processes a transgender person might go through to align their gender identity, gender expression, gender presentation and/or sex assigned at birth. Not all transgender people chose to transition in any or all of these realms.

**Health Concerns**

Individuals experiencing IPV are at high-risk for physical and psychological health damages, including HIV/STDs, Post-Traumatic Stress Disorder, stress and other complex traumas. Research has been conducted to explain why and how these health concerns manifest for those experiencing IPV. Melendez and Heintz (2006) examined HIV/STD risk among LGBTQ individuals who have experienced intimate partner violence. The researchers surveyed a total of 58 individuals who identified as being lesbian, gay, bisexual or transgender who were questioned about their partner and relationship including any current and past abuse. **The results made it clear that these members of the LGBTQ community were at greater risk for HIV and sexually transmitted infections (STIs).** The results revealed that almost one-half of all the participants were forced to have sex with an abusive partner (Melendez & Heintz, 2006). Results also revealed that safe sex was often declined in attempt to avoid problems with their significant other (Melendez & Heintz, 2006).

Furthermore, some participants reported experiencing abuse because of them asking for safer sex, placing them at a greater risk for HIV/STI because they are afraid to protect themselves from their abusive partner. Health-care professionals should be more cautious and understanding when dealing with a LGBTQ patient who maybe experiencing

IPV. Having understanding helps health-care professionals provide victims with a safe environment and information about available assistance.

**Buller, Devries, Howard, & Bacchus (2014) examined health risks among men who have sex with men (MSM). Their research included 13,797 participants from 13 electronic databases. They found that MSM who have been exposed to IPV have higher rates of depression symptoms.** Buller et al. (2014) also found that unprotected sex is high among MSM, which also correlates with a higher risk of contracting HIV. HIV risks are greater within this population because MSM are afraid of what their partner may do or say if they know their HIV results.

HIV and STIs are not the only health concerns for those with abusive partners; they also endure a great amount of stress. In same-sex relationships along with being abused, they also deal with homophobia, discrimination, stigma, and victimization (Ristock, 2005). Carvalho et al. (2011) explored the stress faced by minorities in abusive same sex relationships. Carvalho et al. (2011) surveyed a total of 581 gay men and lesbians and found higher levels of stigma consciousness among victims and perpetrators. They found that discrimination based on sexual orientation is also linked to IPV.

Understanding the hardships faced by many in the LGBTQ community essential to reducing IPV and increasing help for victims. Edwards and Sylaska (2013), also studied minority stress among LGBTQ individuals, focusing on college youth. Their research consisted of 391 college students who were involved in same-sex relationships. Their results showed that sexual, physical, and psychological violence were all related to one another. The overwhelming majority (73%) of participants reported being harmed because of their sexual orientation (Edwards & Sylaska, 2013). Findings also revealed that, internalized homo-negativity was the stress variable that was closely linked to same-sex partner violence. However, to fully determine factors there must be more research done to examine and have a better understanding of minority stressors that affect the LGBTQ community.

**Barriers to receiving assistance**

Clearly IPV in LGBTQ relationships does not receive the same level of attention or support compared to heterosexual couples, despite similar rates of victimization between groups. According to Ristock (2005), IPV in the LGBTQ community occurs at the same rate or even higher than heterosexual relationship violence. Many studies have examined the barriers they face while dealing with IPV and why they are less likely to reach out for help and receive it. Research shows that homophobia, biphobia, transphobia, and heterosexism make it more difficult to address and fix the problem of IPV in the LGBTQ community. Duke and Davidson (2009), discussed how abusers use outing as a tool to manipulate the victim. Specifically, the abuser may threaten to reveal that the victim is closeted gay. These barriers only prevent the LGBTQ community from speaking up about IPV. IPV in the LGBTQ community is viewed differently from heterosexual couples because being a part of that community is not the norm. In our society anyone who is deemed different can be subject to hate and discrimination. Many people in the LGBTQ community are discriminated against, making it difficult to receive the support they need.

Ristock (2005) examined current research on IPV in the LGBTQ community and discussed several barriers to support services. **Ristock (2005:5) stated that the LGBTQ community is reluctant to report abuse because "they do not want to be seen as betraying the LGBTQ community and/or they may be concerned with homophobic and/or transphobic responses."** Because same-sex couples are viewed as unusual in today's society, many do not report the abuse because they feel as if it will only hurt the community. It is also difficult for victims to know who accepts them and genuinely wants to help. Ristock (2005) also notes that they fear the abuse will prove that samesex relationships are unhealthy, which serves to prevent victims telling friends and family.

Pattavina et al. (2007) compared police response to IPV incidents for heterosexual and same-sex couples. This is another barrier the LGBTQ community faces along with the

previous barriers. Their data was collected from the National Incident-Based Reporting System database and included 19 states and 176,488 incidents. The results showed that incidents involving same-sex couples and heterosexual couples were equally likely to result in arrest. One variable that plays a role in these results is the number of heterosexual couples and same-sex couples. Fewer than 1% of the sample were same-sex couples. Even though this data shows the most accurate results, the LGBTQ community is sometimes skeptical about reporting their incidents to the police.

The LGBTQ community receives little to no support when dealing with intimate partner violence. Healthcare professionals can include resources and pamphlets on IPV, as well as provide patients information about HIV/STD risks. Ristock (2005) suggested that we must be willing to listen to the concerns and experiences of the LGBTQ community. In order to understand, we must know. Ristock (2005) also suggested that service providers create a safe environment for all who experience discrimination.

More research must be done to better understand issued faced by the LGBTQ community face and the barriers they endure in order to receive help. There will always be people who have issues with same-sex couples but the LGBTQ community should not have to continue to be scared to speak up about violence. With the help of the police, community, service providers, and health care providers, the LGBTQ community will be able to overcome and reduce intimate partner violence.

**Psychological consequences**

Psychological consequences of IPV can include from anxiety disorders, depression, sleep deprivation, bipolar related disorders, and trauma related stress disorders. “Many LGBT individuals experience high levels of anxiety about being rejected by friends and family members before disclosure, and for many rejections is what they experience once they do disclose identifying as LGBT” (Stevens, 2012:30). Research has shown that prejudice and discrimination can be linked to various forms of mental health. LGBTQ individuals face serval forms of prejudice and discrimination. They experience homophobia, outing,

and harassment which can take place anywhere. Schumacher, Bishop, and Capezza (2014), examined how prejudice and discrimination can affect the mental health status of an LGBTQ individual. Schumacher et al. (2014:125) stated, "Events of discrimination, prejudice, and stigmatization, have long been empirically linked to many mental health consequences and disparities." Their research supports the assumption that LGBTQ individuals who have experienced discrimination suffer from mental health symptoms. One mental health disorder they discuss is mood disorders. It's reported that LGBTQ individuals are two times more likely to suffer from mood and anxiety disorders compared to heterosexual individuals. (Schumacher et al, 2014:127) Substance Abuse.

According to Stevens (2012), substance abuse is a major problem in the United States. Recent research has shown an increase in the use of drugs and alcohol in the past years. Substance abuse is also another major problem prevalent in the LGBTQ community. Chaney & Brubaker (2012), examined substance abuse present in the LGBTQ community and found that addiction is not properly treated. In particular they note, “substance abuse and addictive disorders are typically not talked about within the LGBTQ communities, and there is little discussion about LGBTQ issues among addiction providers and researchers” (Chaney & Brubaker: 234). These authors suggest that more research be done to better understand the motivation behind the substance abuse and addiction.

Prior research indicates that drug and alcohol use is higher among the LGBTQ community compared to heterosexual individuals. Stevens (2012), examined current research about alcohol and drug use among lesbian, bisexual, and transgender (LBT) individuals. The author also examined possible causes for higher rates of substance abuse within the LBT community. Stevens (2012) found that LBT women are more likely to report dealing with substance abuse than heterosexual women. Research also shows that LBT women deal with substance abuse at a higher rate than heterosexual women. Harassment and IPV could be one cause of substance abuse. Stevens (2012) found that IPV and individuals who abuse alcohol and drugs had a positive relationship. Stevens (2012) has also found that rejection from family and peers is associated with higher use of alcohol and drugs.

This shows that family and friends can have a huge impact on an individual's life and decisions.

**Discussion**

This current study examines and compares IPV in LGBT and heterosexual college students. The study's primary focus was alcohol and drug use, psychological issues and prior victimization. I found that although more heterosexual students reported using more drugs and alcohol, the results for LGBT were still statistically high for the sample of LGBT students. Compared to heterosexual students, LGBT students self-reported more psychological issues. For the sample that reported being LGBT, the percentage was statistically significant for all issues except anxiety.

LGBT are an at-risk group because of the negative connotation attached to their community. From prior research we've learned that homophobia, discrimination, and rejection are just three of many barriers the LGBT community face. Prior research has shown that LGBT individuals consume more alcohol and drugs, have more psychological issues and have a higher rate of prior victimization. Shorey, Stuart, Brem, & Parrott (2018), examined and found that IPV and alcohol use is as high in LGBT communities as it is and heterosexual communities. Even though IPV is not discussed as much in the LGBT community, it's prevalent in their community. Members of the LGBT community are exposed to a variety of stressors that can play a major role on their mental state. Miller and Irvin (2017), LGBT victims were more likely diagnosed with depression and anxiety than their heterosexual counterparts.

Based on my findings the LGBT community are at a higher risk for psychological issues. More resources should be brought forth that are specifically available to the LGBT community. There are many shelters but LGBT individuals are afraid to seek help because of discrimination, rejection, and bullying. There needs to be places that addresses the LGBT community individual needs. All responses concerning psychology issues were statistically significant except anxiety. The differences in the use of

recreational drugs were statistically significant as well. Alcohol and drug awareness should be a topic discussed with anyone experiencing IPV.

### Screening and Risk Assessment

Treating LGBTQ Patients Who Have Experienced Intimate Partner Violence

### Client Self-Determination and Self-Assessment

In a situation with a LGBTQ-identified survivor of IPV, a provider should not assume that the routes and avenues for assistance mirror those of straight and/or cisgender survivors. Courts and systems are advancing in accessibility; however, depending on the survivor's geographic and social location, the systems available to assist may unintentionally place a survivor at greater risk of harm or violence – from their abusive partner or from the institutions themselves.

### Primary Aggressor Assessments

Heteronormative understandings of IPV can be dangerous for LGBTQ survivors seeking services. Providers should be aware of the pervasive misunderstanding of IPV as being perpetuated by a masculine-presenting person against a feminine-presenting person. This trope can reduce access to assistance for survivors who exist outside of the gender binary or who present in a manner that is incongruent with the typical narrative of a man abusing a woman, regardless of their sexual orientation or gender identity.

Methods helpful in determining whether a person is experiencing or perpetrating IPV in their relationship should focus not on the sex, gender identity, or gender expression of the person but instead focus on a thorough assessment of empathy, agency, and entitlement. Individual actions taken in a relationship may betray the overall dynamic of the exertion of power and control by one partner over another.

Primary aggressor assessments must consider detailed information about the entirety of the relationship as opposed to a myopic view of a single incident. It is recommended that providers:

1) Ask questions about the presenting person's feelings or reactions to an incident
2) Inquire about the nature of the decision making in the relationship, and
3) Assess whether the person's access to supports, power, and self-determination are increasing or decreasing over time

Only with understanding the larger context of the relationship – use of power or privilege, controlling access to money, how fear or dread may influence actions or decisions, the ability to make decisions about basic functions such as sleeping, eating, or bathing, or engaging with others freely – can one determine if dynamics of IPV exist.

**Best Practices**

**Clinical**

Providers should inquire about sexual behavior and desire in a nonjudgmental manner during the clinical history-taking of all patients.

Studies report that gay and bisexual men who experience IPV are more likely to suffer from substance misuse and engage in unsafe sexual behaviors, such as unprotected intercourse. Therefore, providers should evaluate IPV survivors for substance misuse, HIV, and other sexually transmitted diseases.

**Use Inclusive and Non-Judgmental Language**

In order to avoid the use of incorrect names, pronouns, or terms, providers should ask each patient how they would like to be referred to and which pronouns they use.

- Instead of using gendered language such as husband/wife, boyfriend/girlfriend, brother/sister, mother/father, a provider should ask about one's spouse, partner, siblings, or parents. If a patient explains, for example, that they, a cisgender man, are sexually attracted to other cisgender men, the provider should not automatically label this person or their attraction as "gay." Instead, the provider should ask the patient how they identify and use the language they request to be used.
- While it is acceptable to ask clarifying questions of patients if the information is vital to understanding their experience, it is important for providers to avoid "sight-seeing" into their patient's life out of curiosity.
- When meeting with a patient for the first time, providers should not assume that the name or sex indicated on their identification or insurance documents correctly aligns with their identity. If a person chooses to pursue a transition process, that person may have paperwork with conflicting name and sex or gender marker information. Additionally, even if a person would like to legally change their name and sex or gender marker on their documents, the ability, and rules to do so vary depending on the locations of their birth and current residency. If clarifying information is needed about a name, one can ask, "what name is the insurance listed under" or "could the records be under a different name?"
- If a provider uses an incorrect word or pronoun, they should apologize for the misuse and move on. Providers should not over-apologize for an error as it shows their own discomfort and it creates a complicated dynamic where the patient may feel responsible for reassuring or taking care of the provider or their feelings.
- The physical manner in which patient first presents may not be a true representation of their gender identity or their desired gender expression. Gender identity refers to one's inner experience with and sense of themselves and their gender. Gender expression refers to how one chooses to present themselves to the world and can include the manner of dress, voice, or names and pronouns used.

- At times, it may be safer for someone who is transgender or gender non-conforming (TGNC) to interact with systems displaying the gender expression that is typically associated with the sex that they were assigned at birth. A TGNC person may do this to prevent potentially dangerous interactions and unwanted disclosures of their transgender identity. If a transgender person initially presents in an expression that does not align with their identity, this does not indicate anything about the person's understanding of their identity but may be a survival or safety mechanism.

**Safety Planning**

- Safety planning for LGBTQ-identified survivors of IPV has many similarities to safety planning for cisgender and straight survivors, such as assisting the survivor in collecting important documents, planning for a violent incident by identifying areas in the home where escape may be easier or where access to potential weapons are limited, reviewing technological safety, and creating a "go-bag" if the survivor needs to flee their location in a moment's notice.
- Survivors with disabilities may need to pack specific medications, treatments, or devices.
- TGNC survivors may need to pack or ensure access to items such as hormones, prosthetics, or clothing in difficult to find sizes.
- If possible, assist survivors in identifying safe places to store such items or strategies to procure them if they choose to leave their abusive partner.
- When assisting LGBTQ survivors of IPV in identifying locations available to seek safety, it is important to keep in mind the ongoing history of violence against these communities, especially TGNC communities of color. Discuss with the survivor where they would feel safe going if they were not able to go back to their home. Do not assume that the police or the hospital would be locations of safety.
- The survivor may not wish to engage with law enforcement as a self-protective measure and, if the survivor's partner is also LGB- or TGNC-identified, as a protective measure of their abusive partner. Laws and protections vary across the

country; depending on the region where the survivor attempts to access services, the LGB or, especially, TGNC survivor may be informed that they are not allowed into women's domestic violence shelters or spaces regardless if they identify as women.

- Providers can research available resources or contact LGBTQ-focused networks and coalitions, such as the National Coalition of Anti-Violence Projects or the NW Network, in order to learn about the regional rights and regulations for accessing shelter or services.
- Providers can research and discuss anti-discrimination protections with survivors, and how to enforce them, but it is important to respect survivor-agency above all. LGBTQ survivors of violence are the experts on their own lives and will best be able to judge the appropriateness of a service or remedy.

**Connecting Survivors to Community Support**

- LGBTQ-identified survivors may want options to connect with agencies and organizations that work specifically within LGBTQ communities. Hence, providers should familiarize themselves with resources available at their institutions and within their communities for LGBTQ victims of IPV.
- Sometimes, survivors may not want to work directly with these agencies. Providers should be sure to present working with a LGBTQ-specific organization as an option available to the survivor, not a requirement for treatment.
- LGBTQ survivors find it helpful and affirming to reach out to networks of people with similar identities, whether through the internet or in person. Providers should discuss potential technology-related safety issues with survivors seeking support via the internet. More information on tech abuse and safety can be found from national organizations working to prevent domestic violence, such as the National Network to End Domestic Violence.

### Create Inclusive Materials and Increase Visibility

Providers may take following steps to make the physical locations of their practice more inviting and affirming for LGBTQ people:

- Adapt institutional pamphlets, posters, and other materials on IPV to incorporate LGBTQ person
- When appropriate, incorporate inclusive materials into sessions with survivors, such as the Power and Control Wheel in Lesbian, Gay, Transgender and Bisexual Relationships.
- Provide cultural sensitivity training to the staff interacting with LGBTQ patients
- Providers who are involved in developing clinical resources and practice guidelines surrounding IPV should revise their materials to reflect the impacts of violence in the LGBTQ community.

### Conclusion

More research must be done about IPV and how it affects the LGBT community. There are very limited number of studies regarding this particular topic. There is also little research done that addresses transgender. Further research must be done to effectively address the issues concerning LGBT and IPV. This study along with prior research contributes to the literature by examining alcohol and drug use, psychological issues and prior victimization. It's important for physicians, college professors, and university officials to be education on the barriers and issues faced by the LGBT community. In order to help the LGBT community successfully, one must understand the things they go through and the steps it took for them to get this far.

## B. Examining Access Barriers to Emergency Domestic Violence Shelter Services for Transgender Identified Survivors of Intimate Partner Violence in New York State

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**IPV Experiences and Transgender Identified Individuals**

In order to comprehend the possible barriers to emergency domestic violence shelter faced transgender identified survivors, it is important to understand the unique dynamics experienced within this population group. Intimate partner violence has been broadly defined as “a pattern of behavior where one intimate partner coerces, dominates, or isolates another intimate partner to maintain power and control” (National Coalition of Anti-Violence Programs, 2012, p.10).

Tactics to maintain control can include physical, sexual, economic, psychological, cultural, or emotional forms of abuse (Goodmark, 2013; National Coalition of Antiviolence Programs (NCAVP), 2012; 2013). Ristock and Timbang (2005) argue that transgender identified survivors are typically subjected to multiple forms of abuse within the context of their relationship.

Several studies have measured the rates in which these experiences among transgender identified survivors have been reported. One such resource on data has been compiled and published by the National Coalition of Anti-Violence Programs. Their reports are believed to contain the most comprehensive data available on intimate partner violence in the LGBTQ and HIV-affected communities in the United States (National Coalition of Anti-Violence Programs, 2013).

The National Coalition of Anti-Violence Programs (NCAVP) identified dramatic increases in reports of intimate partner violence (http//:www.avp.org). In 2011, a total of 1437 transgender identified individuals reported incidents of abuse by an intimate partner. This figure increased to 1863 reported cases in 2012 (National Coalition of Antiviolence

Programs, 2012; 2013). This suggests a 29.6% increase over a one-year period (National Coalition of Anti-Violence Programs, 2012; 2013).

To further aggravate the experience, recent data revealed that transgender survivors are also more likely to face threats and intimidation, and harassment by police and the criminal justice system (National Coalition of Anti-Violence Programs, 2013). Transgender identified women of color reported experiencing even higher increases than in previous years (National Coalition of Anti-Violence Programs, 2012; 2013). These annual reports include findings from approximately half the states and therefore may underestimate the national problem (National Coalition of Anti-Violence Programs, 2012; 2013).

The Survivor Project conducted a national study which found high prevalence of rape and physical assault by an abusive partner (Courvant, 2005). The Survivor Project has estimated a prevalence rate of 50% (Courvant, 2005), while other studies have documented rates ranges between 10 and 69% (Xavier, 2000; Kenegy, 2005a).

A 2009 study conducted in Japan revealed significantly higher levels of intimate partner abuse at 56% for individuals who identified as gay men. By comparison, domestic violence was reported at lower rates by those identified as transgender (15%), lesbian (15%), and bisexual (8%) (Distephano, 2009). The Japanese study revealed physical abuse ranging from slapping, and other life threatening tactics to stabbing (Distephano, 2009).

Despite research limitations such as small sample sizes, findings confirm that transgender identified survivors are subjected to many of the same abusive tactics experienced by cisgender identified survivors. Findings also asserted that transgender identified individuals experience additional forms of abuse specifically tied to their gender identity. According to both Brown (2011) and Ristock (2013) these tactics have been

designed to “exploit identity-based vulnerabilities” (Brown, 2011, p.153) and have been reported to include genital mutilation, destruction of personal identity-based property, outing, denial of medical care or hormone treatment, gender specific insults and intentional misuse of gender pronouns (Goodmark, 2013).

The NCAVP (2013) has associated some of the aforementioned abusive tactics with transphobia, homophobia, heterosexism, and HIV-related stigma. The coalition reported that 12.2% of the victims reported that their abusive partners used heterosexist and anti-LGBTQ methods to oppress, while 6.2% used transgender-gender specific insults that degraded them as being neither male nor female and undesirable to others (National Coalition of Anti-Violence Programs, 2013).

Unlike the cisgender population, the identity specific experiences of transgender individuals have resulted in the need to confront a multitude of additional barriers in accessing supportive services (Goodmark, 2013). Within the context of this research, both institutional and social barriers have been examined.

## C. Help-Seeking Behavior among Same-Sex Intimate Partner Violence Victims: An Intersectional Argument

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### Intimate Partner Violence and Barriers to Social Services

### Relationship and Individual Barriers to Help-Seeking

**The cycle of violence.**

The cycle of violence, a term first coined by Lenore Walker (1979) to describe the progression of violence in abusive relationships, has been found in both abusive opposite-sex and same-sex relationships (Burke & Owen, 2006). Both types of relationships

experience a tension building phase, followed by abusive behavior, and a cooling down phase--often referred to as the “honeymoon” stage (Walker, 1979). The abuse present in the second phase takes many forms, ranging from physical and sexual violence to emotional and psychological abuse, and is not limited to any single type of abuse (Lundy, 1993). The honeymoon stage of IPV is a period of resolution that can take place immediately after or a few days following a severe incident (Walker, 1979).

Throughout this period, the abuser appears remorseful and caring, promising not to assault their partner in the future. This behavior can result in the victim placing blame on themselves, deciding not to report the incident or dropping any legal charges, or actually believing that the history of abuse has come to an end (Kovach, 2004).

Given the nature of the cycle of violence and the manipulation that occurs during the honeymoon phase, it is no surprise that most IPV incidents go unreported (Kay & Jefferies, 2010; Lundy, 1993; Wolf, Ly, Hobart, & Kernic, 2003). It is estimated that almost half of all IPV incidents remain unreported to the police (Wolf et al., 2003), making it one of the lowest reported crimes (McCart, Smith, & Sawyer 2010; Wolf et al., 2003). Victims detail a number of reasons as to why they decide to not report IPV victimization. For example, Wolf and colleagues (2003) compiled an extensive list that included apprehensions about law enforcement personnel as well as emotional barriers such as fear, shame, and embarrassment. Moreover, victims report avoiding contact with the police due to feelings of privacy and the belief that IPV is not a matter serious enough to warrant professional intervention (McCart et al., 2010; Wolf et al., 2003).

Another reason preventing individuals from reporting and seeking help for IPV victimization includes fears that their abuser may harm or even kill family pets. In fact, Ascione and colleagues (2007) reported that concern for the wellbeing of pets and companion animals factored into victims’ decision to leave. This may be due to the fact that most IPV shelters do not have the proper facilities to provide shelter and protection for the pets of IPV victims. (Ascione et al., 2007), complicating the help-seeking process.

**Fear of outing.**

Threats of outing, or exposing an individual's previously private sexual orientation to others, create a unique barrier to social services for same-sex IPV victims (Chan, 2005). Outing can be used by perpetrators as a tool for abuse, creating a barrier to help-seeking. In circumstances where victims hide their outward expression of sexuality—in fear of societal stigma or other repercussions—the perpetrator may exploit this decision by threats of forced outing. This can result in the manipulation of victims, where they remain in abusive relationships due to fears of isolation and rejection from the community (for a discussion of gay male relationships and threats of outing see Ashton, 2008). Additionally, closeted individuals may be reluctant to seek help from family, friends, and formal service providers due to anticipated discrimination or rejection (Hammond, 1988; Kulkin, Williams, Borne, de la Bretonne, & Laurendine, 2007). For example, Hardesty, Oswald, Khaw, and Fonseca (2008) found that closeted lesbian IPV victims often modified their help-seeking efforts due to foreseen stigmatizing responses. It is clear that IPV help-seeking by samesex victims is complicated by the unique stressors they encounter regarding outing.

Turell and Herrmann (2008) found that lesbians' biggest concerns were to maintain anonymity regarding this victimization within the lesbian and gay community as well as avoiding homophobic and heterosexist responses when seeking out services. Until societal attitudes become more positive and tolerant, threats of outing will continue to be a tool used by perpetrators of violence in sexual minority relationships (see Burke, Jordan, & Owen, 2002).

Fears of outing are complicated when considering the economic consequences that can result when an individual's previously private sexual orientation is involuntarily made public. Research suggests that employers are willing to discriminate against gay and lesbian individuals and that their willingness translates into actual discriminatory practices in areas such as hiring and promotion (for reviews, see Levine, 1979; Levine & Leonard, 1984; Pizer, Sears, Mallory, & Hunter, 2011). The inability to gain or maintain viable employment can directly influence experiences of IPV and help-seeking practices which can lead to reciprocal effects; individuals who have less access to economic resources

are more likely to be severely battered and suffer prolonged IPV (Alcade, 2006). In addition, Guadalupe-Diaz (2013) found that lesbian and gay male IPV victims were less likely to seek out help if they were of lower economic class. The multifaceted relationship between outing and financial consequences indicates that it is insufficient to examine IPV help-seeking without considering the fact that sexual orientation can influence the distribution of economic resources through workplace discrimination.

**Misinterpretation that abuse is mutual.**

Misguided beliefs that same-sex IPV perpetration is shared or equal between partners (Kulkin et al., 2007) cause another help-seeking barrier that is relatively unique to same-sex victims. Turell and Herrmann (2008), in their qualitative study of lesbian IPV victims, found that participants were concerned that the violence would be perceived as mutual. These concerns are not unwarranted. Research indicates that service providers often assume that same-sex IPV is mutual, which influences agency responses (Simpson & Helfrich, 2007). This results in lesbian and gay male victims being turned away by helping professionals due to beliefs that genuine IPV does not occur in same-sex relationships (McClennen, 2005). The police, for example, have been found to dismiss same-sex IPV reports due to misconceptions regarding mutual combat (Letellier, 1994).

In addition, gay men report negative perceptions of police helpfulness due to learned expectations of officer rejection. These learned expectations are often fueled by heteronormative views that women, not men, are the sole victims of IPV (Finneran & Stephenson, 2013). Unfortunately, this troubling type of response does not end with the police. Hammond (1988) found that judicial system members often (mis)interpreted lesbian battering as mutual, despite their general sympathy toward battered women. Inappropriate responses have real-life consequences; when police cannot identify the true abuser, due to lack of training and/or institutionalized homophobia, both parties are either arrested or left to remedy the problem on their own (Hodges, 2000). It must be noted that, despite the myth that same-sex relationships are teemed with mutual abuse, research suggests that bilateral battering is not common. Merrill and Wolfe (2000) found that, similar to IPV between opposite-sex couples, violence in same-sex relationships is not mutual. Misconceptions may arise due to the fact that that gay males are more likely

to physically defend themselves from assaults by their intimate partner; however, this should not be conceptualized or understood as mutual combat (Letellier, 1994).

Accepting the notion of mutual battering in same-sex IPV can result in the victim self-identifying as a batterer due to efforts aimed at self-defense; this further complicates help-seeking behavior (for a discussion of lesbian IPV, see Renzetti, 1992).

**Homophobia and racism.**

The small body of literature exploring the attitudes of racial/ethnic minority groups toward gay men and lesbians indicates that many have negative views of sexual minorities (Greene, 1994; Herek & Capitanio, 1995). This causes gay and lesbian people of color to feel isolated within their racial and ethnic communities (Greene, 1994) while racism often prevents them from fully identifying with the lesbian and gay community (Kanuha, 1990). This can result in conflicting loyalties between the two communities of identity (Greene, 1994; Kanuha, 1990). In addition, minority stress—the negative life events that result from living in a racist and heterosexist society—is twofold due to their double minority status (Brooks, 1981). Minority stress can result from visible incidents of discrimination, including hate crimes, but may also result from covert incidents of prejudice (Balsam, Molina, Beadnell, Simoni, & Walters, 2011) including denied access to social services. Because of their double minority status and the negative attitudes present in both communities of identity, gay and lesbian people of color are at an increased risk for experiencing negative responses when attempting to access social services. These deleterious responses can include loss of employment or custody of children as well as anti-gay/race-based discrimination (Loiacano, 1993). This research suggests the salience of considering the connection between both racial-ethnic and sexual identities in terms of help-seeking (Crawford, Allison, Zamboni, & Soto, 2002).

**Institutional Barriers to Social Services**

**Gender norms and the preservation of hegemonic masculinity.**

“Hegemonic masculinity" is other subordinated or less dominant masculinities as well as in relation to women (Carrigan, Connell, & Lee, 1985; Connell, 1995). Hegemonic masculinity is the term used to describe the criteria for ideal maleness within certain societies: “There is only one complete unblushing male in America: a young, married, white, urban, northern, heterosexual, Protestant, father [….] Any male who fails to qualify in any one of these ways is likely to view himself– during moments at least– as unworthy, incomplete and inferior” (Kimmel & Aronson, 2008, p. 4).

Although numerous multifaceted performances of masculinity exist that inform gay male masculinities, help-seeking is likely to be hindered by dominant societal beliefs surrounding the ways in which men “should” act. Therefore, a discussion of traditional gender norms surrounding hegemonic masculinity is most relevant here.

Traditional gender norms surrounding masculinity often shape the way male same-sex IPV victims seek out social services (Ball, 2011). Western society imposes strict gender norms on men that require them to be heterosexual and homophobic (Cruz, 2000). When men deviate from this hegemonic ideal, they are in danger of facing social stigma and even violent retaliation (Kay & Jeffries, 2010). Gay men are sometimes vulnerable to IPV because their relationships necessarily involve two men; this may result in heightened levels of dominance, power, and control (Landolt & Dutton, 1997). First, gender norms surrounding masculinity that emphasize independence and self-efficacy can influence the way gay men seek out social services.

Research indicates that gay men are more likely to solve personal problems independently than seek informal or formal help (Cruz, 2003; Guadalupe- Diaz, 2013; Meyer, 2008; Turell, 2000; for review, see Ball, 2011). Second, hegemonic ideals surrounding toughness--beliefs that men should be tough and strong--may be particularly salient in the discussion of barriers to help-seeking. Gay male victims may be less likely to reach out for help due to general belief systems regarding strength; research suggests that attitudes toward traditional male toughness are correlated with negative attitudes toward gay men (Davies, 2004). These two examples are by no means exhaustive, but

they provide illustrations of the barriers gay men may encounter when seeking IPV help. Generally, when gay male victims do reach out for formal help they are often met with adversity due to violations of hegemonic masculinity and violations of rigid gender expressions (Barbour, 2011).

Female gender norms also shape lesbian help seeking as societal beliefs can result in lesbian IPV being viewed as less severe. Indeed, some lesbian IPV victims have reported that they feared violence would not be taken seriously (Turell & Herrmann, 2008). Societal beliefs surrounding gender norms posit that women are less violent and aggressive than their male counterparts. Because of this, when violence occurs within a relationship, the male is typically assumed to be the perpetrator (Brown, 2008). This assumption is sometimes applied to lesbian IPV incidents. Typically, the perpetrator is often presumed to be masculine or "butch" individual while the victim is expected to be the feminine partner (Brown, 2008). This heterosexist way of thinking may result in individuals avoiding reporting if they present a gender or role that deviates from what is labeled "ideal" for the victim. The abovementioned gender roles are frequently reinforced by numerous sectors of society including families, communities, and the media. In the community context, norms of nonintervention (i.e. the failure to intervene or offer help) in cases of IPV can impart messages about how to respond—or ignore— violence (Miller, 2008). The following section discusses how community can act as barrier to IPV help seeking.

**Isolation: Denial in the lesbian and gay community.**

Social networks are defined as the structure of personal ties that serve various functions including emotional, social, and economic support (Barrera, 1986). Numerous studies have examined the link between lack of support networks—or social isolation—and violence against women (Bauer, Rodriques, Quiroga, & Flores-Ortiz, 2000; Heise, 1998; Menjivar & Salcido, 2002). This research, which overwhelmingly examines the experiences of heterosexual women and the racially marginalized, indicates that fewer social networks prevent IPV victims from gaining access to social services. Help seeking researchers, however, fail to consider the unique ways isolation affects gay and lesbian individuals. For example, "family" is a term used by gay and lesbian individuals to designate members of the community. Unfortunately, despite the underlying assumption

that this community is a cohesive one, gay men and lesbians often ignore IPV within the family and can respond in unsupportive ways (Istar, 1996; Turell & Hermann, 2008). Research indicates that friends of lesbian and gay male victims sometime minimize violence, convince victims to stay in abusive relationships, or outright deny IPV incidents to evade marginalizing stereotypes (Fahmy & Fradella, 2014; Ristock, 2003). The widespread denial of IPV in this community is complicated by the fact that lesbians often feel the need to hide abuse in efforts of maintaining intact images of lesbian relationships, or what has been coined “lesbian utopia” (Turell & Herrmann, 2008). Denial of the problem is even more ubiquitous and problematic when discussing the experiences of gay men. Due to the overall invisibility of male victims, lack of recognition results in feelings of isolation by victims who have experienced and continue to experience IPV in their relationships (Barbour, 2011).

Denial within the community is twofold for gay and lesbian racial/ethnic minorities, making a discussion of this intersection particularly relevant. Miller (2008), in her study of gendered violence, found that nonintervention was common in areas characterized by urban inequality (Miller's work focused on the experiences of African American girls). She found that bystanders often justified their neutralization and reluctance to intervene by denying the victim. The problem of nonintervention is also perpetuated in the Latina/o community through assertions that IPV is a “private matter” where exposure can result in the division of community (Rivera, 1994, pg. 255). This is problematic, as norms of nonintervention are linked to an increased prevalence of severe nonlethal partner violence (Browning, 2002). Therefore, it is important to recognize how norms of nonintervention (among gay/lesbian and racial/ethnic communities) and gender norms shape violence against gay and lesbian individuals. For example, Agoff and colleagues (2007) found that Latina/o family members often justified IPV by blaming the victim for not fulfilling gendered family duties. In order to understand the role of social isolation as it applies to gay and lesbian IPV victimization, it is necessary to move discussion beyond one community and explore the problematic norms of nonintervention that can be present in multiple communities of identity.

Reaching a deeper understanding of the ways social isolation and support networks affect gay and lesbian victims of IPV is necessary for comprehensive service efforts. Using an intersectional approach, where various aspects of identity are considered, can aid in gaining insight into the unique experiences of these individuals. For example, the discussion of social isolation and IPV is complicated when considering the many spaces gays and lesbians are denied access (e.g. see employment discussion above). This intersection of isolation and denied access results in exclusion that fosters abusive situations by making gay and lesbian individuals more vulnerable. For example, Renzetti (1996) found that, although the majority of IPV shelters reported that they accepted lesbian clients, only 10% offered services or educational material specifically designed for lesbian victims. Moreover, research suggests that IPV service providers are least likely to provide services to sexual minority males (for a review, see Hines & Douglas, 2011). According to Knauer (1999), "[f]or abused men, there are simply no shelters" (p. 346). The lack of appropriate resources, due to the overall lack of recognition, can perpetuate feelings of isolation among gay male victims (Burke, 1998).

Due to the unequal distribution of social support prescribed by sexual orientation, social isolation must be examined using an intersectional approach, where various aspects of identity are considered. In other words, it is necessary to consider the unique ways same-sex IPV victims are isolated through denial in the lesbian and gay community, nonintervention in racial/ethnic communities, as well rejection in traditional shelter settings. This can aid in gaining insight into the unique experiences and barriers facing same-sex IPV victims.

## Legal Barriers to Social Services

### Inappropriate law enforcement response.

The justice system has historically used legal criteria to avoid formal responses to IPV incidents (Phillips & Sobol, 2010). Government-sanctioned homonegativity continues to shape the experiences of gays and lesbians who attempt to access justice system

services (Murray, Mobley, Buford, & Seaman-DeJohn, 2007). Existing literature on the legal issues facing gay and lesbian IPV victims has primarily, and narrowly, focused on whether lesbians have legal rights to interventions (Aulivola, 2005). In terms of legal social services, gay and lesbian individuals often cite fear of homophobia as a barrier to help-seeking (Balsam, 2001). Legal help-seeking among this group is complicated by the fact that openly gay and lesbian individuals were once branded criminals because of their sexual activity and their refusal to comply with gender norms (that is currently no longer the case; however, the stigma and cultural memory remain; Merrill & Wolfe, 2000).

Discrimination based on sexual orientation and gender has affected how law enforcement officials respond to victims of same-sex IPV (Little, 2008; Potoczniak et al., 2003). Gay and lesbian victims report fear and mistrust of justice system personnel due to issues of past conflict, a culture of heterosexism, and institutionalized homophobia and homonegativity (Eaton et al., 2008; Hammond, 1988; Murray et al., 2007). Sexual minority crime victims often report inadequate and inappropriate police response in the forms of mocking, blaming, and laughing (Wolff & Cokely, 2007). Renzetti (1992) reported that police are less likely to intervene in same-sex IPV situations due to prejudice and attachment to gender norms and stereotypes (e.g., beliefs that men are the only IPV perpetrators).

Likewise, Seelau and Seelau (2005) found that sexual orientation affected law enforcement response as well as other legal interventions. This is demonstrated by the gay and lesbian individuals who have long reported both verbal and physical abuse at the hands of police (Renzetti, 1992; Wolff & Cokely, 2007). These types of abusive law enforcement activity influence help-seeking behaviors. Sexism and homophobia can prevent lesbians from reporting incidents of abuse because prejudice “disempowers” them from seeking formal assistance (Potoczniak et al., 2003). In addition, research indicates that helpseeking gay men are often met with homophobic attitudes from law enforcement officials (Cruz, 2003; Merrill & Wolfe, 2000). Police responses to IPV between gay men are further complicated due to beliefs about the male body and its inability to be victimized in the domestic sphere. Consider Barbour’s (2011) relevant scenario: police officers respond to an IPV call and assess the situation as a fair fight

between two men and, as a result, do nothing to assist the male victim. These reasons may prevent an individual from reaching out for help when victimized.

Police responses to complaints of IPV must also be contextualized through the historical relations between racial/ethnic minorities and law enforcement officers. Despite positive reforms surrounding the police response to IPV—resulting from outcries made by feminists, advocates, and the overall community regarding inappropriate tactics (see Sherman, 1992; Smith, 2001)—legal changes have often been called narrow-minded for failing to consider the experiences of racial and ethnic minorities (Rivera, 1994). For example, research indicates that people of color often avoid contact with law enforcement officials due to feelings of fear, frustration, and distrust, coupled with perceptions of ineffectiveness (Erez, 2000; Miller, 2008).

Avoidance may be the result of the long history of discrimination towards ethnic and racial minorities by law enforcement officials (Rivera, 1994). Overall, stereotypes based on racism, ethnic discrimination, homophobia, and sexism create unique experiences for victims of IPV. Therefore, in order to understand the role law enforcement play in preventing sexual minority victims from accessing social services, it is important to also recognize how experiences are shaped by race/ethnic relations.

**Anti-gay/lesbian beliefs and laws.**

Stereotypes, which are fundamental to the construction of sexual orientation-based discrimination, result in the differential treatment of gay and lesbian individuals in social service settings. Law enforcement officials, for instance, sometimes believe that lesbians and/or gay men are promiscuous or dissolute; they view same-sex partnerships as illegitimate and ephemeral, rather than valid relationships where IPV can happen (Hill, 2000). In addition to the police, research suggests that therapist trainees hold negative stereotypes about gay men in relation to their mental health (Boysen, Vogel, Madon, & Wester, 2006) resulting in the differential treatment of same-sex IPV victims in healthcare settings. Wise and Bowman (1997) found that graduate-level counseling students

categorized lesbian IPV incidents as less violent compared to heterosexual incidents; they were also less likely to suggest charges be pressed against lesbian batterers. These findings suggest the importance of examining help-seeking using an intersectional framework, as gay and lesbian victims encounter unique barriers when attempting to access competent law enforcement and mental health services.

Anti-LGBTQ legal policies, like stereotypes, also create barriers to social services. When laws are created that burden gays and lesbians, they result in collateral consequences, where individuals become victim to not only the impact of law, but their intimate partners as well (for a discussion of race, anti-immigration laws, and IPV, see Crenshaw, 1991). States have historically adopted laws and measures that explicitly excluded same-sex IPV victims and perpetrators from the legal interventions that opposite-sex victims and perpetrators receive (Hardesty et al., 2011; National Gay and Lesbian Task Force, 2005). Barbour (2012) argues that these types of laws demonstrate that "power and recognition to homosexual men by society is much
less than that given to heterosexual men" (p. 4).

Overall, when laws are passed that exclude same-sex IPV victims from accessing services, such as legal intervention, they are prevented from using services that directly impact their experiences of IPV. Although the legal landscape for gay and lesbian couples has become more favorable (e.g., the majority of states grant same-sex couples the right to marry; National Conference of State Legislators [NCSL], 2014), several states are currently challenging the laws that allow gay men and lesbians
to marry. Additionally, because these laws are in their infancy, it is unclear how changes will affect laws governing other legal spheres such as tax- and inheritance-related issues as well as those surrounding IPV.

It is salient to discuss anti-LGBTQ laws and policies in relation to the laws that prevent racial and ethnic minority IPV victims from help-seeking. Like anti-LGBTQ laws and policies, anti-immigration laws create obstacles to social services that primarily burden

individuals of color. For example, Dugan and Apel (2003) theorized that immigrant individuals may be hesitant to disclose victimization if the offender is undocumented, fearing deportation of their significant other. In addition, when antiimmigration laws are passed that prohibit undocumented immigrants from accessing service such as health care and public education, undocumented victims are prevented from using institutions that directly impact their experiences. For example, Bauer and colleagues (2000), in their study of health care barriers encountered by battered minority women, found that some respondents feared deportation. Participants believed that simply entering the health care system presented a risk for deportation. If undocumented immigrant individuals are unable to seek medical attention (due to either real or perceived policy-based barriers) for the violence experienced in their relationships, they are further prevented from exiting the partnership. In order to understand the role anti-LGBTQ laws and policies play in preventing sexual minority victims from accessing social services, it is important to also recognize how race-based laws shape the help-seeking of racial/ethnic minorities. Gay and lesbian IPV victims of color may encounter laws that burden both of their communities of identity by systematically preventing them from seeking formal help.

## Directions for Service Providers and Future Research

The general refusal to recognize IPV in the context of same-sex relationships—coupled with the barriers identified above—suggests that gay and lesbian victims may feel that their experiences of abuse are not legitimate. This can result in assumptions that their help-seeking will not be taken seriously. Lesbians often believe that community services are solely available to serve heterosexual women (Renzetti, 1996), and research suggests that IPV agencies are least likely to provide services to sexual minority males (for review, see Hines & Douglas, 2011). Therefore—similar to the movement to improve the response to heterosexual IPV—police training, legal changes to afford more protections, and increased community services appear critical in providing same-sex IPV victims avenues for exiting abusive relationships. Based on the literature review above, we now offer recommendations for service providers and future research.

### Recommendation I: Law Enforcement

Individuals receive subtle, yet powerful, messages regarding their social standing as citizens through their interactions with legal authorities (Tyler 1989; Tyler, Degoey, & Smith, 1996). These interactions are significant because they provide worthiness in the community and in relation to authorities (Tyler et al., 1996). When an individual is treated fairly, messages of respect and value are communicated whereas unfair treatment communicates disrespect and reinforces marginalization (Tyler et al., 1996).

Due to their contentious history with law enforcement and other governmental institutions, gay and lesbian individuals may avoid reporting IPV victimization or minimize the seriousness of an incident when police are called (Little, 2008; Potoczniak et al., 2003). Underreporting may be a result of prior ubiquitous negative treatment resulting in anticipated unfavorable treatment (Tesch, Bekerian, English, & Harrington, 2010). Conversely, research suggests that citizens are more likely to reach out when they feel supported and valued by authorities (Tyler, 1989).

To this end, it is our recommendation that law enforcement personnel receive adequate training to better understand the historical mistreatment of gay and lesbian individuals to encourage empathizing with the population. In efforts to reduce real and potential police-community problems between officers and sexual minority complainants, some police departments (e.g., Atlanta Police Department, Metropolitan Police Department of the District of Columbia, Phoenix Police Department, Salem Police Department, Dallas Police Department ) have developed programs that include gay and lesbian liaisons, specialized units that respond to hate crimes aimed at minorities (racial/ethnic, gender), and special outreach teams that work to strengthen the relationship between sexual minorities and officers.

These programs represent first steps in addressing service accessibility problems as they work to create an atmosphere that acknowledges intersections and the variety of factors that shape IPV experiences. Although more research is required to identify the most

effective types of outreach programs, it makes sense that communities with growing lesbian and gay male populations should develop specific programs to address their needs.

### Recommendation II: Shelters

Gay and lesbian shelter services are limited and even non-existent in some areas, resulting in the invisibility of sexual minorities in this setting (Hammond, 1988; Pattavina, Hirschel, Buzawa, Faggiani, & Bentley, 2007). As mentioned above, Renzetti (1996) surveyed United States IPV shelters and found that only 10% offered services or educational material specifically designed for lesbian victims. This could be due to the fact that some state laws expressly exclude gay individuals from receiving state funded assistance (Knauer, 1999; Murray et al., 2007). Extant research *should* guide shelter services. For example, Turell and Herrmann (2008) found that lesbian help-seeking IPV victims wanted their first contact to be with a trained IPV advocate sexual minority woman. In addition, crisis hotline workers often assume that the perpetrator is male and the victim is female, sending subtle marginalizing messages to gay individuals when they call for service (for a discussion on lesbians' crisis line experiences, see Turell & Herrman, 2008).

Furthermore, although shelters now admit lesbian women, many shelters have historically either turned away lesbian victims or made them feel unwelcome
(Lundy, 1993).

Shelters that provide services for gay males are even more lacking, resulting in hundreds of thousands of male victims remaining in abusive homes because they have limited formal options when seeking safety (Letellier, 1994). Most shelters devote their resources to assisting female victims of IPV (Ashton, 2008). The lack of formal protection for gay males stems from the misconception that females are the sole victims of IPV (Burke, 1998; Merrill & Wolfe, 2000; Turell, 2000); women's shelters often turn away male help-seekers due to safety concerns for the women present (Island & Letellier, 1991; Merrill & Wolfe, 2000). As a result, gay male victims are typically forced to rely on HIV/AIDS treatment centers or homeless shelters— an environment that can foster hate-based violence—when attempting to flee violent relationships (Barbour, 2011). Even more

disheartening, women's shelters often report that serving gay men is not a priority (Short, 1996 as cited in Merrill & Wolfe, 2000). It is no wonder that men who seek help from shelters report that the services they receive are not very helpful (McClennen, Summers, & Vaughan, 2002). These findings suggest that IPV shelters should work to overcome this marginalizing history and mend relations.

It might prove helpful for shelters to draw inspiration from the various anti-violence campaigns that outline best practices for stopping violence in the lesbian and gay community (e.g., Anti-Violence Project, "Lifting the Mask off of Domestic Violence," Jane Doe, Inc., Aids Council of New South Wales). One way to achieve this goal is to develop trainings that help service professionals understand the factors that shape the experiences of same-sex IPV victims. For example, research suggests that closeted lesbian IPV victims often modify their help-seeking attempts in fear of stigmatizing responses (Hardesty et al., 2011).

Shelters can encourage help-seeking through campaigns targeted at same-sex victims. Educational public service announcements that communicate welcoming atmosphere may promote help-seeking. In addition, Ard and Makadon (2011) have suggested several steps that providers can take to address IPV among lesbian and gay male clients including adapting institutional IPV pamphlets, posters, and visual material to include same-sex relationships.

### Recommendation III: Support Networks

Research has established a link between the lack of support networks and interpersonal violence (Heise, 1998; Menjivar & Salcido, 2002). IPV between gay and lesbian partners is more invisible compared to abuse occurring in heterosexual relationships; this has resulted in a lack of support systems (Ashton, 2008). According to Guadalupe-Diaz (2013), gay men may not have the supportive networks that are critical to exiting abusive relationships. In addition, Turell and Herrmann (2008) found that lesbian and bisexual women rarely used services provided by the general community.

This suggests that agencies should help same-sex IPV victims form support networks through unconventional approaches. Service providers could assist sexual minority victims in joining community groups through local organizations. By joining such groups, individuals would have access to social and emotional support while creating networks of opportunity. Building strong support networks is a salient service technique for *all* IPV victims. More important still, is creating partnerships between official services and the victim's social support networks (Goodman & Smyth, 2011). Using intersectional thinking and recognizing the unique factors that prevent same-sex IPV victims from forming strong support networks will result in services that are more responsive to their specific needs. For example, coordinated projects that work to establish community networks and strengthen organized efforts include projects such as National Lesbian and Gay Health Association and The Domestic Violence Program of the Gay and Lesbian Community Action Council. These organizations advocate change by drawing on established community resources and educating the public about same-sex partner violence. Recognizing the unique barriers that sexual minority IPV victims encounter coupled with using joint approaches through community collaboration can help distribute problem-solving efforts more evenly throughout the community. This signals to victims that stopping violence within the community is a cooperative and unified effort. It also communicates to victims that support networks are more evenly distributed throughout their residential community.

### Recommendation IV: Future Research

Future research that examines the experiences of lesbian and gay male IPV victims using an intersectional framework can increase meaningful discussion regarding barriers to service. Specifically, future inquiry should aim to

(1) uncover the ways sexual minority IPV victims reach out for formal and informal assistance (e.g., non-profit organizations, traditional IPV service providers, LGBTQ service providers, friends, family),

(2) identify the unique barriers that sexual minority IPV victims face when help-seeking (e.g., homophobia, disbelief, fears of outing),

(3) gain knowledge surrounding their overall experiences (e.g., ease of service attainment, assessments of service helpfulness), and
(4) understand the barriers to help-seeking that transgender and bisexual IPV victims encounter when reaching out for assistance. Gaining insight into these areas will help inform the development of antiviolence strategies that cater to the specific needs of sexual minority IPV victims.

To point number four, the dearth of research examining the help-seeking behavior and experiences of transgender IPV victims is particularly problematic as research indicates that these individuals may experience increased risk of IPV compared to other sexual minorities (Landers & Gilsanz, 2009). Transgender respondents have reported a lifetime IPV rate of 34.6%, versus 14.0% for gay and lesbian individuals (Landers & Gilsanz, 2009).

Additionally, transgender individuals experience unique barriers to service not experienced by other sexual minorities. For example, individuals that identify as female but were born male may encounter barriers when attempting to access women's shelters (Hines & Douglas, 2011; Pattavina et al., 2007). A recent study of IPV service professionals in Los Angeles found that non-LGBT affiliates reported feeling inadequately prepared to assist transgender persons (Ford, Slavin, Hilton, & Holt, 2012). The higher prevalence rate of IPV found in transgender relationships coupled with underdeveloped service provisions signal the need for increased scholarly attention investigating the unique experiences of this historically understudied group.

Another area of particular concern is the lack of research directed at understanding the specific needs of bisexual victims of IPV. This research neglect may be due in part to the fact that bisexuals run the risk of being defined based on their current relationship or, more specifically, their partner's gender. For example, a bisexual woman who is dating a woman may be labeled as a lesbian whereas if she were dating a man she may be classified as straight by outsiders (James, 1996). The lack of focus on bisexuals is particularly troublesome given that the limited research on bisexual women and IPV has shown that they represent a particularly at-risk population. They are more likely to

experience IPV victimization than their lesbian or gay counterparts; however, this victimization most often occurs in the context of their opposite-sex relationships (Messinger, 2011). The unique status that bisexuals occupy may present additional barriers for IPV victims, as they may not be welcomed or feel comfortable accessing resources designed specifically for opposite-sex or same-sex victims. In addition, bisexuality has a history of being completely disregarded or unacknowledged by service providers (for a discussion on the dismissal of bisexuals and the overall denial of bisexuality see James, 1996). Overall, further research should address the specific needs, as well as the potential risk factors, associated with bisexual men and women in relation to IPV victimization.

Integrating qualitative methodologies, such as focus groups, may prove useful in the study of IPV in sexual minority relationships as these approaches allow individuals to assign meaning to their experiences (Adler & Adler, 1987) while extensively examining the topic under discussion (Gerbert, Caspers, Bronstone, Moe, & Abercrombie, 1999).

Focus-group methodology can tap into shared experiences of marginalization and help develop a structural examination of individual experiences (Pollack, 2003). Feminist scholars have long advocated the use of focus-group methodology for researchers interested in investigating context-driven gendered processes and experiences (Pollack, 2003).

This methodology is particularly salient with interviews of sexual minority victims because it has the ability to transfer power from the researcher to the interviewees (Madriz, 2001), which is appropriate for work with oppressed, marginalized, and previously ignored research subjects.

From a feminist perspective, qualitative approaches are significant in IPV research as they offer a voice for marginalized groups (Davis, Taylor, & Furniss, 2001). Qualitative methods help to uncover the unique ways individuals function in dynamic social situations and are better equipped to draw on the numerous factors that shape individual experiences (Tewksbury, 2009), which is especially salient for intersectionality-driven

work. Certainly, qualitative methodologies often do not result in generalizable findings. This limitation, however, is balanced by gaining in-depth knowledge (Tewksbury, 2009). Qualitative methods tap into the aspects of identity that shape the experiences of victims. Overall, further research on this historically
ignored group—possibly with a focus on gay men and transgender/sexual individuals given the scant literature—is necessary to inform service providers regarding their needs, perceptions, and experiences.

## Chapter 2: Intimate Partner Violence against Men

**Intimate Partner Violence, Sexual Violence, and Stalking Among Men**
**Retrieved from:** Intimate Partner Violence, Sexual Violence, and Stalking Among Men |Violence Prevention|Injury Center|CDC

### A. Understanding Violence Against Men

Male victimization is a significant public health problem, according to estimates in the National Intimate Partner and Sexual Violence Survey (NISVS) indicate that.

Across U.S. states, nearly a quarter of men reported some form of contact sexual violence in their lifetime. Approximately 1 in 10 men in the U.S. experienced contact sexual violence, physical violence, and/or stalking by an intimate partner during their lifetime and reported some form of IPV-related impact. Commonly reported IPV-related impacts among male victims were fear, concern for safety, and symptoms of post-traumatic stress disorder, among others.

**Facts about Male Victimization**

Survey data have found that men experience a high prevalence of intimate partner violence, sexual violence, and stalking. Most first-time victimizations occur before the age 25, with many victims first experiencing violence before age 18.

## Intimate Partner Violence

- About 1 in 3 men experienced contact sexual violence, physical violence, and/or stalking by an intimate partner during their lifetime.
- Nearly 56% of men who were victims of contact sexual violence, physical violence, and/or stalking by an intimate partner first experienced these or other forms of violence by that partner before age 25.

## Sexual Violence

- Nearly 1 in 4 men in the U.S. experienced some form of contact sexual violence in their lifetime.
- About 1 in 14 men in the U.S. were made to penetrate someone during their lifetime.
- More than 1 in 38 men in the U.S. experienced completed or attempted rape victimization in their lifetime.
- Among male victims of completed or attempted rape, about 71% first experienced such victimization prior to age 25.

## Stalking

- About 1 in 17 men in the U.S. were victims of stalking at some point in their lifetime.
- Nearly 41% of male victims first experienced stalking before age 25.

**Rape vs. Made to Penetrate (MTP)**

MTP is a form of sexual violence that some in the practice field consider similar to rape. CDC measures rape and MTP as separate concepts and views the two as distinct types of violence with potentially different consequences. Given the burden of these forms of violence in the lives of Americans, it is important to understand the difference in order to raise awareness.

- **Rape** entails any completed or attempted unwanted penetration of the victim through the use of physical force or when the victim was unable to consent due to being too drunk, high, or drugged (e.g., incapacitation, lack of consciousness, or lack of awareness) from their voluntary or involuntary use of alcohol or drugs.
- Being **MTP** occurs when the victim was made to, or there was an attempt to make them, sexually penetrate someone without consent as a result of physical force or when the victim is unable to consent due to being too drunk, high, or drugged, (e.g., incapacitation, lack of consciousness, or lack of awareness) from their voluntary or involuntary use of alcohol or drugs.

### B. Type and Sex of Perpetrators of IPV, SV and Stalking of Male Victims

Perpetrators are usually known to their victims. Among male victims of stalking and sexual violence, perpetrators were most often a current or former intimate partner or an acquaintance.

The sex of the perpetrator depends on the type of violence. According to NISVS, perpetrators of rape and unwanted sexual contact against male victims were mostly other men, while perpetrators of other forms of SV such as MTP and sexual coercion against men were most often women. Both women and men perpetrate stalking of men. Women were mostly the perpetrators of intimate partner violence against men.

**Sexual Violence:**

- **87%** of male victims of (completed or attempted) rape reported only male perpetrators.
- **79%** of male victims of being MTP reported only female perpetrators.
- **82%** of male victims of sexual coercion reported only female perpetrators.
- **53%** of male victims of unwanted sexual contact reported only female perpetrators.
- **48%** of male victims of lifetime non-contact unwanted sexual experiences reported only male perpetrators.

**Stalking**

- **46%** of male victims reported being stalked by only female perpetrators.
- **43%** of male victims reported being stalked by only male perpetrators.
- **8%** of male victims reported being stalked by both male and female perpetrators.

**Intimate partner violence:**

- **97%** of men who experienced rape, physical violence, or stalking by an intimate partner had only female perpetrators.

### C. Battered Men: The Hidden Side of Domestic Violence

Often we tend to think of domestic violence as something that happens to women. Investigators at the Group Health Center for Health Studies, however, say domestic violence against men is "under-studied and often hidden". In a study published in the June American Journal of Preventative Medicine, the researchers presented data which contradicts five commonly held misconceptions about domestic violence against men:

1. **Few men experience domestic violence.** The truth is that it is more common than believed. When 400 randomly sampled men were interviewed by phone, lead researcher Dr. Robert J. Reid and his colleagues found that 5% had experienced domestic violence in the previous year, 10% in the past five years and 29% at some time during their lifetime. Domestic violence was defined as both physical abuse (slapping, hitting, kicking or forced sex) and non-physical abuse (threats, constant disparaging remarks or controlling behavior).
2. **Abuse of men has no serious effects.** Even though women are more likely to be physically abused than men, the researchers found that men who were abused - even if the abuse was non-physical - suffered serious, long-term effects on their mental health. Depressive symptoms were nearly three times as common in older men who had experienced abuse than in those who had not.
3. **Abused men don't stay with their abusers.** Women, especially those who have children or are financially dependent upon their husbands, often stay in abusive relationships. The expectation held, however, is that men would be better able to leave their abusers. "We were surprised to find that most men in abusive relationships also stay, through multiple episodes, for years," said Dr. Reid.
4. **Domestic violence only affects the poor.** Not so, say the researchers. Their study showed that people from all walks of life are affected. 5. Ignoring it will make it go away. Ignoring a problem does not make it go away, however, many men are ashamed to speak out about abuse because of society's expectations that men are strong and in control. The researchers found that older men were less likely to speak out about their abuse than younger men.

## D. Serving Male-Identified Survivors of Intimate Partner Violence

**Technical Assistance Guide, Serving Male-Identified Survivors of Intimate Partner Violence**

**Retrieved from:** NRCDV_TAG-ServingMaleSurvivors-July2017.pdf (vawnet.org)

> There are many effects of the abuse that are particular to males. Men are not supposed to be victims. Society tells us: men don't get depressed, men don't seek help, men don't need therapy…
>
> – Male survivor

Historically, domestic violence programs were born from the women's liberation movement of the 1970s to address the needs of female survivors, who still represent the majority of victims seeking services today. Generally, the domestic violence movement has framed its work on a gender binary with men as perpetrators and women as victims. We have come to learn, however, that a woman-centered approach to advocacy only addresses the needs of a portion of survivors and largely fails to acknowledge and address male victimization. This Technical Assistance Guidance supports advocates seeking to build capacity to recognize and respond to survivors across the gender spectrum, while honoring the gender analysis that helps us understand the root causes of violence and oppression.

While data continues to show that girls and women are disproportionately impacted by intimate partner violence, boys and men are also victims and deserve survivor-centered and holistic services. One of the most reliable sources of information on the prevalence of the victimization of men in the United States is the National Intimate Partner and Sexual Violence Survey (NISVS). The CDC's most recent NISVS data, as reported in Prevalence

and Characteristics of Sexual Violence, Stalking, and Intimate Partner Violence VictimizationNational Intimate Partner and Sexual Violence Survey, United States, 2011 underscores that “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 over 13 million men have experienced intimate partner violence during their lifetimes that resulted in a negative impact” (Breiding, 2014).

| VAWA Non-Discrimination Grant Condition |
| --- |
| No person in the United States shall, on the basis of actual or perceived race, color, religion, national origin, sex, gender identity (as defined in paragraph 249(c) (4) of title 18, United States Code), sexual orientation, or disability, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity funded in whole or in part with funds made available under [VAWA], and any other program or activity funded in whole or in part with funds appropriated for grants, cooperative agreements, and other assistance administered by the Office on Violence Against Women. (42 U.S.C. 13925(b)(13))2014.) |

The Violence Against Women Reauthorization Act of 2013 amended the Violence Against Women Act (VAWA) of 1994 by adding a grant condition that prohibits discrimination on the basis of gender identity or sexual orientation (in addition to sex and other categories) by recipients of certain Department of Justice (DOJ) funds. The Family Violence Prevention and Services Act (FVPSA) Final Rule similarly indicates that all survivors must have access to services and programs and must receive comparable services. More specifically, it states that “no person shall on the ground of actual or perceived sex, including gender identity, be excluded from participation in, be denied the benefits of, or

be subject to discrimination under, any program or activity funded in whole or in part through FVPSA" (Department of Health and Human Services, 2016).

Providing services to male-identified survivors is not only required by law, but is the ethical and right thing to do. Most domestic violence programs adhere to a survivor-centered approach when designing, developing and implementing programing. This approach ensures that survivors' rights and needs are first and foremost – that each survivor's experience of violence, culture, life circumstances, and identity (gender, age, race, ethnicity, ability, sexual orientation, religion, HIV status or other self-identification) determines the direction and focus of advocacy and safety strategies. As advocates, if we want to effectively meet our mission to end domestic violence, we must be attentive to the unique needs of all survivors.

This paper offers guideposts for responding to the needs of male-identified victims of intimate partner violence. It is meant to be a resource to foster meaningful dialogue around supporting inclusive services for all victims and survivors seeking safety and healing.

**Exploring the following questions may offer useful reflections on our work:**

1. How many stories of domestic violence have you heard in the last 6 months?
2. How many of these stories include a male aggressor and a female or child victim? In how many of those stories is the male described as the victim of domestic violence?
3. What is the gender identity make-up of the employees at your agency?
4. When you think about male victims of abuse, who comes to mind?

5. How many victim/survivors have you served over the last year that do not identify as female?
6. What inspired you to work to address and prevent domestic violence?

**Challenges to Serving Males**

Challenges to serving those who identify as male often stem from our lived experiences. It can be difficult to question what we have learned through education or daily practice. When it comes to serving male-identified survivors of domestic violence, the lack of knowledge and experience creates a vacuum for many who have learned and practiced from a survivor-centered model that lacked attention to serving such victims.

As advocates we bear witness to stories of victimization throughout our careers where males are perpetrators and women and children are victims. Studies reflect the reality that intimate partner violence most often looks this way, and most research, education, resources, and tools have been created within this paradigm. But limiting our exposure to and understanding of the gender variations that can and do occur has a profound impact on our ability to meet the needs of all victim/survivors. We as a movement need to examine and expand beyond the one-size-fits-all model.

Additionally, advocates bring personal experiences to the work, which are often an important source of inspiration and passion. While our stories add value to this movement, we must always be mindful that each is unique and therefore not representative of all.

As a product of the feminist movement, it is not surprising to find that most community-based domestic violence programs are staffed primarily by female-identified advocates and volunteers. It is important to explore the gender composition of agency staff and its impact on organizational culture, including the voices of and roles available to and held by male-identified employees.

When we consider our previous histories of trauma, the stories that we take in, and gender-specific composition of the field, we find an environment that may stifle our growth as advocates in working with those who identify as male, and can foster mistrust of males in general. We are charged as advocates to take stock of these experiences and to adjust in how we meet the needs of others. This self-awareness is a key aspect of responsible and ethical practice, and requires ongoing reflection, both internally and in conversation with others, to promote continued growth.

Self-awareness is a cornerstone of competent practice that requires deliberate and ongoing effort. As part of this work, seeking counseling/supervision related to your own history of trauma is important when working with males or any other population. For more, see the Guidebook on Vicarious Trauma from the Centre for Research on Violence Against Women and Children (2001).

**Defining Male Identity**

Gender identity and expression exists on a spectrum. In this document, we will use the term male to describe both those who identify as male and those who have never had to think about their gender identity as being anything other than male. Male identity includes a vast group of individuals spanning every age, race, ethnicity, culture, sexual orientation, religion, ability and socio-economic status, each of whom have their own needs based on their unique experiences. When you examine or reflect on your agency practices or inside yourself and think about male victims of abuse, who comes to mind? What are the characteristics of these males?

Who have you missed? You may not have considered male-identified veterans or active service members as victims of domestic violence, those who are incarcerated, teen boys who have experienced abuse in dating relationships, men in later life, men in same sex relationships, or individuals who identify as transmen. These are just a few examples.

Write down your answers and share them with your peers/coworkers to help identify capacity building opportunities to address services to male-identified victims.

**Men's Experiences of Intimate Partner Violence**

The statements below illustrate some of the impacts of males' experiences of victimization and challenges in seeking assistance.

- It's hard, people don't believe you. I told one doctor my partner was beating me up and he immediately thought that I was gay. Society can't believe that a heterosexual man can be a victim of abuse.
- An officer said to me, 'She must be a really big woman, and stronger than you.' Society doesn't believe men like me that go through things like these.
- What has happened to me is not the same as what happens to a woman.
- The police told me that if they received another phone call about us they would arrest us both.
- When I started to talk about this with my friends they just make jokes.
- It is not like what I watched my mom go through.
- I must have done something wrong. I know that he will change, he was the only one who was there for me when I came out.
- Where do I even go for help? I am not a woman.

Males face unique barriers to accessing services that are mostly rooted in the lack or perceived lack of male-serving organizations or tailored services for men in their local community. In addition, many male victims do not recognize or define their experience as domestic violence. While many of the ways in which domestic violence affects males may be similar to female experiences, they may be expressed, received, or labeled differently for men.

- **Diminished self-worth.** This can be entangled with feelings about what society says it means to be a man. Typically men are expected to be able to protect themselves, and to be abused challenges this belief that is reinforced by many different cultures.
- **Fear**. This can be expressed in a wide emotional range, from a flat affect to one filled with rage. It may not even be expressed at all.
- **Shame**. This is different than guilt, which is a healthy response to having done something one considers wrong. Guilt can inspire behavior change. Shame, on the other hand, is a static feeling about one's core self-image ("I am bad"). Shame is often a reflection of messages imposed by family, friends, culture or social norms. It may surface as a male's overwhelming refusal to share what happened and to defend their offender.
- **Minimizing the violence perpetrated against them.** This may surface as qualifying the pain or severity of the abuse as not as "bad" as others.
- **Using substances to cope.** Those around the male may perceive him as "damaged" or not worthy of support because of substance use to numb, escape, or forget the pain they have experienced.
- **Risk of physical harm or death.** Abused men may describe their partner as angry, and either understate or omit their own fear unless asked directly. They can often minimize the impacts of these risks by blaming themselves to be at fault for creating anger in their partner or by minimizing the previous physical and/or emotional trauma they have experienced from their partner.

**Review Your Awareness Materials**

The images and messages you share in both traditional and social media make an impact. Create a focus group of male identified volunteers, staff, board members, community partners, and former clients. Ask them to review the images and messages that you put out in the community. Inform them of the intended audience and use of each image or message and ask them to consider the following questions.

1. What are your initial thoughts?
2. What do you feel when seeing the image/message?
3. Do you think it reaches the intended audience?
4. How might an individual who identifies as a male victim/survivor react this image/message?
5. Do the images reflect diversity in both sexual orientation and gender presentation?
6. What images or messages are lacking in what you have seen?
7. What message would you like an individual who identifies as a male victim/survivor to receive from this agency?
8. What would be effective strategies or venues for sharing this image/message with male-identified audiences?

**Reaching Out to Males**

It's been a great investment. Now we're seeing a lot more men call, particularly gay men. The need is out there, men don't think [shelter] is available to them. Word of mouth is getting out, and I've consistently seen at least 1-2 men all of the time in shelter. It's a worthwhile step. Since we've done it, no one thinks we should go back to how it was.

*– Gender-integrated domestic violence agency (FORGE, 2016, p. 17)*

This section offers strategies for creating an agency that feels welcoming to male identified survivors and raising awareness in your community about the services you offer to male populations by exploring a few key marketing elements.

- **Know your intended audience.** This is key whether you are seeking to address a group of professionals, community members, or victims/survivors. There are many socio-economic, religious, and cultural variables that need to be considered to effectively market your message and your agency. This includes previous history with another agency or community. Most organizations experience periods where they may be helpful or harmful to individuals, systems, or other agencies. This may be due to a variety of factors such as lack of understanding your audience, lack of realistic or common goals or previous directives from leadership. Consider that each internal or external meeting with new stakeholders is an opportunity to create strategic partnerships, and mistakes are part of the process. It takes time and intentional efforts to build trust and authentic relationships. In any setting, always remember that many families have been impacted by domestic violence and be aware that victims, including males, are likely part of your audience.
- **Create inclusive awareness materials**. Be attentive to the images and messages used in your agency's posters, brochures, and campaigns so that male victims can see reflections of their experiences, faces, and voices. Be mindful of the language you use when speaking to traditional media or engaging with social media audiences. These are places to express your genuine desire to meet the needs of male-identified survivors in your community.
- Think about the name of your organization. Is it focused solely on women? If so, begin conversations with your staff, board, volunteers and outside trusted partners on how they think your name may be received by male victims/survivors. Names have power and send a clear message about who and what your agency stands for. Is the name of your organization reflective of the mission and welcoming for all survivors?
- Host focus groups. Invite agency partners to do a walk through of your program, and engage them in a focus group around how the populations they work with might experience your agency. Talk to male survivors who accessed your services in the past and ask them what they found most useful or challenging. Work with partner agencies to organize listening sessions with males at conferences or other

settings. Ask other male serving agencies to invite clients to engage with you around their needs for trauma informed domestic violence services.

## Engaging Male Victims in Crisis

For many advocates/hotline volunteers it is difficult to determine what the caller's needs are based on the few details they are given over the phone. The Respect Toolkit: Work with male victims of domestic violence (January 2013) suggests asking the following questions to help advocates/hotline volunteers identify male victims/survivors (see page 23).

- Can you tell me about the last time something violent or frightening happened?
- Can you tell me about the worst time there has been?
- Can you tell me what you usually do when this happens?
- Do you ever feel afraid to make certain decisions or do certain things because of what you think your partner/abuser might do?
- Have you ever been injured by your partner/family member – tell me more about that?
- Has your partner/family member ever been injured during an incident? Can you tell me more?
- Are you frightened of your partner/abuser? Are you frightened of what they might do to the children?
- What are you frightened of in relation to your situation?
- Do you think your partner is frightened of you? Have they ever said that they are frightened of you?
- What do you want to happen now?

## Gender Inclusive Service Provision

It has always been our philosophy to help men. They are abused, neglected, and need help.

*– Gender-integrated domestic violence agency (FORGE, 2016, p. 12)*

With limited resources, this section leans on ways in which we can provide support through a trauma-informed, victim-centered approach focused on meeting the survivor where they are.

Shifting to embrace trauma-informed approaches requires a critical look at your organization's service delivery model. Historically, many victim service providers have adopted a reactive approach to service delivery where we wait for victims to reach out to us for services that are centered around the provision of safe spaces for women and children. This model has served many people well for many years, however it does not serve all members of the communities in which we live. Trainings, awareness initiatives, and outreach materials are generally built on a male/offender, female/victim gender paradigm. The names of our agencies are women-centered. And media and popular culture reflect this limited understanding of who victims of domestic violence are. This narrow perspective limits males' ability to see themselves as victims and find their way to service providers.

The first step to gender inclusiveness is to take a proactive approach to providing services to males, characterized by community outreach to meet the populations that you seek to serve. Consider providing community-based services in settings other than your own agency. We must be creative in our approaches to meet the needs of all members of our communities.

**8 Reasons to Integrate Shelter Services for All Genders**

In 2015, FORGE interviewed 135 gender integrated shelters and allied agencies who identified their reasons for doing so:

1. It aligns with the values of the domestic violence field.
2. It creates new access for survivors with nowhere to turn.

3. It's rewarding.
4. It helps dispel gendered stereotypes about perpetrators and survivors.
5. It leads to learning opportunities for residents and staff alike.
6. It avoids revictimization of trans people.
7. It's the law.
8. It saves money. Read more in Why Include People of All Genders in Shelters (2016).

**Crisis/helpline services** are usually based within a shelter in response to the caller's immediate needs, which may not allow for the unique needs of males. When greeted by a male voice, a hotline advocate may be on alert to see if the caller is a perpetrator who has abused someone already receiving their services. While this is a protective step in assisting the females that reside in shelter or utilize services, it fails to consider abuse in same sex relationships, females who offend against their male partners, or individuals who may have had experiences as both a victim and offender of domestic violence, perhaps at different points in their lives.

Advocates/hotline volunteers should be trained on the diverse experiences and needs of male-identified victims and strategies for receiving and processing men's crisis calls. Additionally, agencies should regularly revisit their screening process for callers, with careful attention to men's unique barriers and challenges when reaching out and accessing services.

There was a cisman [non-transgender man] who was eternally grateful for all of the resources that we provided to him. He was an educated man who had little power in the community whose partner kept him as a stay-at-home father and sort of locked him away and he was able to get validated there and be successful.

*– Gender-integrated domestic violence agency (FORGE, 2016, p. 13)*

**Residential services** may include a shelter operated by the domestic violence program, one that is in partnership with the agency, rapid rehousing, or an offsite location such as a local hotel. Shelter programs have been historically gender specific, and in some areas may still be segregated by gender identity in an effort to protect the safety and security of women and girls. Males are typically accommodated at an off-site hotel or partner shelter (homeless shelter). These options may worsen the victim's feelings of isolation, expose them to further harm, or limit their access to additional supportive services. Hotel stays are short term and lack the constant staff presence and support needed to help victims fully process their experiences. This may leave the victim to feel alone and vulnerable to being found by their offender, especially in communities that don't value or understand the experiences of male-identified survivors. Additionally, homeless shelters may not have the capacity to manage trauma reactions or safety and privacy concerns in the context of domestic violence, and often pose a new threat or perceived threat of violence from other individuals in the shelter. This can be especially true for those from marginalized groups such as the gay/bisexual and transgender communities, who experience harmful expressions of homophobia and transphobia. Other populations such as those with physical disabilities, mental illness, cognitive challenges, language barriers, or immigration status may also face unsafe conditions often in homeless shelters.

Agencies can explore ways to reasonably meet the safe housing needs of males on site, and enhance staff capacity to provide true parity in services. This can be done through candid dialogue within the agency board, staff, volunteers, and those they serve in conjunction with outside partners. There is currently not a one-size-fits all model for providing supportive residential services for male-identified victims, although FORGE offers helpful guidance in Gender-Integrated Shelters: Experience and Advice (2016). As a starting point, see the Tip sheet How Shelters Prepare for Gender Integration (FORGE, 2016).

> One man, who I assume was trans or gender non-conforming, had a lot of concerns about coming into shelter. He expressed a lot of relief about how welcoming the space was and how safe he was there. He sent pictures of the space to his mom and his family felt good about where he was at. His anxiety level was so high! And he was able to breathe and feel good about where he was at.
>
> *– Gender-integrated domestic violence agency (FORGE, 2016, p. 13)*

**Counseling services** help meet the needs of individuals as they cope with and heal from the abuse they have suffered and plan for the next stage of their life. Males from diverse backgrounds and cultures may struggle with the concept of accepting counseling because it may challenge their ideal of masculinity, making them feel as though they are weak or worthless as a man.

Agencies can seek training on alternative counseling styles and approaches that may be more effective with males. Advocates can explore other ways of providing similar support in a different setting, like playing basketball, talking at a kitchen table over coffee, or in a setting where the counseling may be folded into another activity.

"Almost every man who comes through we consider a success. It's nice for them to have people who understand what they've been going through, and talking about their situation is new and good for them. They recognize they're not alone and they're not the only man who goes through this." – Gender-integrated domestic violence agency (FORGE, 2016, p. 15)

**Support groups** offer facilitated peer support, usually with an educational component, over a period of several months to a year. Groups are typically gender specific in an effort to create a safe space for sharing. However, groups for males are very rare, if they exist at all. This reinforces a sense of isolation and further promotes the invisibility of male experiences of victimization. Agencies can implement male support groups, even on a

short- term basis. Alternatively, advocates can seek out training on how to integrate gender-specific groups together at times to work on similar concerns or create a new sense of trust. Expressive arts may be one unifying avenue to explore.

**Legal services** include obtaining protection from abuse/restraining orders, legal accompaniment in the courtroom, assistance with name changes, divorce, custody matters, immigration services, and others. Agencies can explore their own processes for supporting males' legal needs as well as the capacity and readiness of partner agencies to do so.

**Peer support** offers opportunities for male-identified survivors to network and build community. Develop and promote informal opportunities and social activities for survivors to network and include them in the planning stages for these activities.

**Speaking out** and sharing one's story of survival can be a helpful part of the healing journey, offering personal empowerment and fostering resilience. Agencies should support male survivors who wish to build their capacity to speak publicly or tell their story through various creative outlets.

**Building Collaborations to Improve Services to Males**

Building new partnerships is an essential step in effectively meeting the needs of male-identified victims of domestic violence. You may consider looking for possible partnerships within these common community programs/institutions:

- Alcoholics Anonymous and Narcotics Anonymous groups
- Colleges and university-based centers
- Cultural community centers
- Drug and alcohol treatment facilities
- Faith-based organizations
- Foster/group homes

- Homeless Shelters
- Hospitals or health clinics
- LGBT community centers
- Reentry programs for those who have been incarcerated
- Sports leagues
- Teen residential treatment facilities
- Veteran's assistance programs

**Consider Individuals' Personal Experiences of Abuse**

Always approach new individuals being mindful that you may be talking with male victims/survivors of domestic violence. This assists you in calibrating your interactions, and avoiding messages that may trigger feelings of shame and helplessness.

When meeting with new partners, find out about their structure. What is their organizational culture regarding male-identified victims of abuse? Do they have the capacity to work with all survivors of domestic violence, including maleidentified victims? How do they interact with male victim/survivors of domestic violence? How do they assess males for victimization? What do they identify as supports or barriers to males sharing their stories freely? Find out what your agency can do to support their work. Can you assist them in training efforts? Can you assist them in facilitating joint group sessions?

Schedule time throughout the year to follow up with these organizations. Send staff, volunteers, and board members to their events. Invite them to share their expertise through training. Offer seats at the table to meetings where they may not have been invited in the past. Create brave spaces to talk about current and historical relationships, and find ways of correcting past missteps. Provide opportunities to jointly create awareness materials and resources for survivors and the community. Find ways to otherwise support their work and demonstrate your genuine commitment to building a strong relationship.

Effective and sustainable efforts to build and maintain strong relationships between agencies will involve more than one person, and will occur on multiple levels. Encourage direct lines of communication between leadership and agency staff.

**Enhancing Organizational Policies**

This checklist offers a starting point for reviewing and enhancing your agency's policies toward inclusive services. Be sure to seek out guidance, and engage all levels of staff, throughout the change process.

1. How often do you engage in policy review to ensure non-discrimination standards are met? Does this include reviewing policies about serving male identified victims/survivors specifically?
2. Who can review and provide input to policies, procedures, or organizational messaging about serving specific cultural groups or populations? Is all staff, including direct services staff, included in this process? Is there a process in place for partners/focus group to do this work?
3. What is your policy on inviting/hiring male-identified employees/board members/volunteers? Are there any positions that they cannot hold? Where are these positions advertised? How are they recruited?
4. Are there questions on initial and/or exit interviews for staff about how they perceive the work environment for males colleagues?
5. Do interview questions explore capacity to work with individuals from specific cultural groups or populations?
6. What is your policy on providing shelter to those who identify as male?
7. What are your policies on training board, staff, and volunteers about working with males?
8. How does your agency track and report the number of males seeking and receiving services? Are service denials and referrals recorded as well?
9. What are your policies about serving males in all service areas? Do they align with VAWA and FVPSA guidance?

10. What are your policies, processes, or goals around mending/creating new partnerships in the community? Is this part of your agency's workplan?

**Conclusion**

By reading this document you are opening the door to enhancing your capacity to meet the needs of male-identified victims of domestic violence. While this may feel daunting at times, we have a solid foundation of trauma-informed, victim-centered advocacy efforts to build from, and there are growing resources out there to support this process. Remember that we are part of a movement, which requires growth and progress in its very definition. Shifting to allow space for inclusivity can only make our movement stronger. Just as we empower survivors to learn a new way of life on their path to healing from abuse, we must feel empowered to examine long-held approaches and be brave enough to change course when necessary. Take a few breaths and reach out for help.

## E. Help Men Who Are Being Abused

**Retrieved from:** Help for Men Who are Being Abused - HelpGuide.org

Domestic abuse against men can take the form of physical violence, emotional, verbal, or sexual abuse. Whatever your circumstances, though, you can find help and break free from an abusive relationship.

**Domestic violence against men: You're not alone**

If you're a man in an abusive relationship, it's important to know that you're not alone. Abuse of men happens far more often than you might expect—in both heterosexual and same sex relationships. It happens to men from all cultures and all walks of life, regardless of age or occupation. Figures suggest that as many as one in three victims of domestic violence are male. However, men are often reluctant to report abuse because they feel embarrassed, fear they won't be believed, or are scared that their partner will take revenge.

An abusive partner may hit, kick, bite, punch, spit, throw things, or destroy your possessions. To make up for any difference in strength, they may attack you while you're asleep or otherwise catch you by surprise. They may also use a weapon, such as a gun or knife, or strike you with an object, abuse or threaten your children, or harm your pets.

Of course, domestic abuse is not limited to violence. Emotional and verbal abuse can be just as damaging. As a male, your spouse or partner may:

- Verbally abuse you, belittle you, or humiliate you in front of friends, colleagues, or family, or on social media.
- Be possessive, act jealous, or harass you with accusations of being unfaithful.
- Take away your car keys or medications, try to control where you go and who you see.
- Try to control how you spend money or deliberately default on joint financial obligations.
- Make false allegations about you to your friends, employer, or the police, or find other ways to manipulate and isolate you.
- Threaten to leave you and prevent you from seeing your kids if you report the abuse.

As an abused man, you may face a shortage of resources, a lack of understanding from friends and family, and legal obstacles, especially if trying to gain custody of your children from an abusive mother. Whatever your circumstances, though, you can overcome these challenges and escape the violence and abuse.

| **If you're gay, bisexual, or transgender** |
| --- |
| You may be in an abusive relationship if your partner: |

- Threatens to inform friends, family, colleagues, or community members about your sexual orientation or gender identity.
- Insists that the police won't help someone who's gay, bisexual, or transgender.
- Ridicules your attempts to escape the relationship by labeling you as someone who deep-down believes that gay, bisexual, or transgender relationships are aberrant or unnatural.
- Accuses you of not really being gay, bisexual, or transgender.
- Justifies their abuse with the excuse that all men are naturally aggressive and violent.

**Why men don't leave abusive relationships**

Regardless of gender, ending a relationship, even an abusive one, is rarely easy. It becomes even harder if you've been isolated from friends and family, threatened, manipulated, and controlled, or physically and emotionally beaten down.

You may feel that you have to stay in the relationship because:

- **You feel ashamed.** Many men feel great shame that they've been abused, been unable to stand up for themselves, or somehow failed in their role as a male, husband, or father
- **Your religious beliefs dictate that you stay** or your self-worth is so low that you feel this abusive relationship is all you deserve.
- **There's a lack of resources.** Many men worry they'll have difficulty being believed by the authorities, or that their abuse will be minimized because they're male, or find there are few resources to specifically help abused men.

- **You're in a same sex relationship but haven't come out** to family or friends, and are afraid your partner will out you.
- **You're in denial.** Just as with female domestic violence victims, denying that there is a problem in your relationship will only prolong the abuse. You may still love your partner when they're not being abusive and believe they will change or that you can help them. But change can only happen once your abuser takes full responsibility for their behavior and seeks professional treatment.
- **You want to protect your children.** You worry that if you leave, your spouse will harm your children or prevent you from having access to them. Obtaining custody of children is always challenging for fathers, but even if you are confident that you can do so, you may still feel overwhelmed at the prospect of raising them alone.

**Protecting yourself as an abused male**

Domestic violence and abuse can have a serious physical and psychological impact. The first step to protecting yourself and stopping the abuse is to reach out. Talk to a friend, family member, or someone else you trust, or call a domestic violence helpline.

Admitting the problem and seeking help doesn't mean you have failed as a man or as a husband. You are not to blame, and you are not weak. As well as offering a sense of relief and providing some much-needed support, sharing details of your abuse can also be the first step in building a case against your abuser.

When dealing with your abusive partner:

- **Leave if possible**. Be aware of any signs that may trigger a violent response from your partner and be ready to leave quickly. If you need to stay to protect your children, call emergency services. The police have an obligation to protect you, just as they do for a female victim.

- **Never retaliate.** An abusive partner may try to provoke you into retaliating or using force to escape the situation. If you do retaliate, you're putting yourself at risk of being arrested or removed from your home.
- **Get evidence of the abuse.** Report all incidents to the police and get a copy of each police report. Keep a journal of all abuse with a clear record of dates, times, and any witnesses. Include a photographic record of your injuries and make sure your doctor or hospital also documents your injuries. Remember, medical personnel aren't likely to ask if a man is a victim of domestic violence, so it's up to you to ensure that the cause of your injuries are documented.
- **Keep a mobile phone, evidence of the abuse, and other important documents close at hand**. If you have to leave instantly in order to escape the abuse, you'll need to take with you evidence of the abuse and important documents, such as a passport and driver's license. It may be safer to keep these items outside of the home.
- **Obtain advice from a domestic violence program** or legal aid resource about getting a restraining order or order of protection against your partner and, if necessary, seeking temporary custody of your children.

**Moving on from an abusive relationship**

Support from family and friends as well as counseling, therapy, and support groups for domestic abuse survivors can help you move on from an abusive relationship. You may struggle with upsetting emotions or feel numb, disconnected, and unable to trust other people. After the trauma of an abusive relationship, it can take a while to get over the pain and bad memories but you can heal and move on.

Even if you're eager to jump into a new relationship and finally get the intimacy and support you've been missing, it's wise to take things slowly. Make sure you're aware of any red flag behaviors in a potential new partner and what it takes to build healthy, new relationships.

**To Hell and Back: A survivor's Story**

**Retrieved from:** To Hell and Back: A Survivor's Story - CityAttorney | seattle.gov

**Editor's Note:** Ricci Gay tells her first-person story of being a victim of domestic violence who persevered, with the help of CAO's Domestic Violence Unit, to lead a much safer life now. Her ex-partner pleaded guilty in Seattle Municipal Court to domestic violence property destruction in August and received a suspended sentence with 5 days of work crew imposed (leaving 359 days in jail available to revoke if he violates his conditions). He is not allowed any contact with her for 5 years; he cannot commit any new criminal law violations and cannot possess weapons. He has to pay her $3,954 restitution, do a mental health evaluation and follow any treatment recommendations. The court has the discretion to order him to do domestic violence batterers treatment and will be under its jurisdiction for 5 years. A resource for anyone experienced domestic violence is the Washington State Domestic Violence hotline at 1(800)562-6025.

My very first memories are like a stack of Polaroid pictures. The colors are hazy; none of the scenes are in themselves, a full memory. I remember speaking to my mother as a young adult, describing a chair by the door, a Christmas tree, the brick fireplace, a phone being slammed down, police coming to take my father away. Although surprised by my memories of that event, she colored in the lines, telling me that her husband, my father, broke her nose and she ran away with us and never looked back. We spent that Christmas in a home for battered women. I was three years old.

My childhood story is, unfortunately, not unusual. In fact there are many battered men, women and children in the world who suffer in silence every day. But those victims of domestic violence are ones that the general public understands. If I were to share the horrific stories of my grandmother being beat up by my alcoholic grandfather, the story of my mother's nose broken by her angry husband or even the sexual abuse of a childhood friend, most would agree that they too have experienced something similar or have stories of their own friends and family members who have suffered the same. However, I am here to talk about being a victim of another kind of domestic violence -- the kind that has no face. I realize now that I have the perfect personality fit for sociopathic behavior as well as perpetrators. My eagerness to please, kind smile and trusting attitude help me make a lot of friends but also lead predators to my door. I was raised in a good Christian home with a loving stepfather who had a kind smile. I was the second oldest of eight children and a natural worker, so I was immediately entrusted with my younger siblings and responsibilities in the home. Because I found joy in serving others, I really didn't miss out on the social activities and events that most normal teenagers had. Since we were poor, we also didn't have much money for those things so I found solace in my church youth group and artistic endeavors. As a Midwestern believer, I was taught that my body belonged to Christ, and that I was to only give it to a man in marriage -- dating and such was a sin. In some ways, this sheltered life protected me from many of those earlier bad choices that one makes; however, I was definitely not prepared for the real world when I moved out on my own at 18.

I moved in with my grandparents several states away, to Seattle, in the summer of 1998. I had one friend who lived two doors down who I had spent summers with since I was a kid, swimming in her family pool. That summer, I remember looking up from the grass and her father was staring at me. I felt a bit self-conscious but I was always a chubby girl and not entirely comfortable being looked at in my bathing suit. I came by one day and found him in the garage. I asked when my friend would be home and he asked if I wanted to go for a ride in his new Mustang. I knew that he wouldn't even let his daughter drive it so I eagerly accepted and jumped in the passenger seat. As we drove around he asked me if he could ask me a question. Being the polite child that I was, I answered, of course. He asked me if I would have an affair with him. I panicked; I could feel bile rising in my throat. I couldn't breathe and I was trapped in this car. He stopped at this lake and tried holding my hand as we walked. I started skipping and acting like a child so that he promptly dropped my hand. As we returned to his house he asked if I was offended. I tried to convince him to try counseling or something with his wife and when we got to his house, his wife and daughter asked us how the ride was. That was the first time I realized that I had to live in a silent lie. I went home and sat in the bath crying, scrubbing my hand and body clean as if I had been raped by this 50-year-old man with alcohol on his breath. He did not punch me or rape me or even touch me other than holding my hand, yet to this day I cannot pass by that house without wanting to puke my guts out. I am the face of sexual violence.

Eventually, I chose a lifestyle path separate from the church. My nurturing heart fell in love with for a sexually abused man who cried in my arms and struggled with anger and seemed to soften to my touch. As I discovered my own sexuality with him I was also introduced to what the words, "I am just having a couple of beers to relax" meant.

He convinced me that he was not an alcoholic and that he was a changed man. It wasn't until I lost a close friend over the relationship that I was able to see what it was doing to me. I no longer lived the life I wanted to. I was coerced into breaking many boundaries that I would not normally have done. This is the face of emotional abuse.

I was drugged and raped by two men who took me from a club on my 29th birthday; I was still technically a virgin and was left behind by a "friend" who couldn't afford to pay the entrance fee. When I woke up the next morning I was in a rage and screamed that I was a virgin! As they ran out the door they yelled back, you aren't anymore! I didn't report it to the police because of my own feelings of shame and self-loathing. I chose to go to the club unsupervised, I chose to put my drink down, I chose to dress provocatively. This is the face of sexual abuse.

My next few "boyfriends" gave equal trade, love and companionship for sex. I didn't seem to take note of my boundaries being pushed so far; I didn't even recognize them anymore. One day a boyfriend choked me while pleasuring himself; his hand crept around my neck and his look was violent towards me. He loved making me answer the questions, "Who does this belong to?" "This belongs to me, right?" When I tried to break that relationship off he wouldn't stop calling me, showing up at my door with flowers and treats, texting me all hours of the night, trying to win be back and abuse me again. This is the face of domestic violence.

My last relationship started out very different. The "cool guy" acted like he really didn't care whether I called him. Then he jumped full in, telling me that he risked getting fired to spend New Year's Eve with me. He showed up in a tuxedo and swept me off my feet. His stories about being in the military and a sniper even didn't bother me too much at first. He knew my stance against weapons but he had a strong voice for gun education and I accepted his stories as truth. Within a month he was declaring love to me, telling my friends he wanted to marry me and asking permission for my hand from my family. He would say things "in confidence" about his work that he was under cover, that he did government contract work and such things that made me question his words every day.

When I ran a background check on him to stand up for what I believed were lies, nothing came up and he presented documentation for a few of the things that I had questioned. Manipulating my embarrassment, he made me feel shame for not trusting him and I rarely questioned his past again. I remember the time he told me that he killed over 35

people in war, and got teary-eyed talking about one of them being a child soldier. I cried over these lost souls and my tears fell on his face and I felt we had truly bonded in that moment. I again took on the role of savior and felt that he had entrusted me with his wounded heart. Within a few months more and more lies came out and it was hard to trace any truths to the words that he was saying. As he appeared more and more delusional, I requested some space, for him to move out. That night when I didn't come home for fear of retaliation he destroyed our home with his bare hands and smeared his own blood all over the place. He texted me his bloody hand saying, "Look, I bled for you." This is the face of emotional and manipulating abuse.

Recently, two friends, Lindy West and Ijeoma Oluo, started the Twitter campaign, I Believe You | It's Not Your Fault. As I read some of the stories of other women and their accounts with physical, sexual and emotional abuse, I began to feel really angry. In my own life, the only person who had seen justice for domestic violence was my ex-fiancé and that took 10 months of legal battles and the support of the prosecuting attorney's office. If I hadn't had their support and a court advocate, perhaps I wouldn't have gone all the way through to seeing justice. I am sure there are many more victims who just have to give up because they feel it is not worth the trouble. But most importantly, are you one of those who don't see the domestic violence that you are in right now?

I have found my voice after five long years. It is still too quiet at times and I make mistakes that do not always help us survivors claim back the rights to our bodies. But I keep trying. I keep my head held high. When someone pushes beyond my boundaries, I push back. It is time that we all join together and push back. You are not a victim; you are a survivor who has a story to tell. So tell your story, and tell it loud! Practice saying No loud and strong and teach our young ones to do the same. We are just one person amid a world of influence but our voice counts. And in the words of my friend, Lindy West, I Believe You- It's Not Your Fault.

## Chapter 3: Homelessness after Spousal Abuse

### A. A safe space for survivors of Domestic Violence

**Retrieved from:** A Safe Space for Survivors of Domestic Violence | SAMHSA

Nancy Kline works primarily behind the scenes supporting a team of, as she put it, "far more skilled and important people in this effort than me." Nancy has been married for 38 years to a person in recovery and is one of those rare individuals who have never experienced dependence on anything, including tobacco, which she has tried on occasion. She refers to herself as a "normie"—that is, someone with no "lived experience" with substance use. Nancy says her husband considers her “the most non-addictive personality he’s ever met.” Her life with a person in recovery and her own personal history gives Nancy a unique perspective in which to support her team. She's is quick to make sure they receive the credit and kudos for what they've all been able to accomplish.

Nancy has held a variety of positions related to development in the nonprofit world, but her work with domestic violence survivors set the stage for involvement in the Recovery Association Project (RAP), a nonprofit group that provides at-risk populations with housing that is safe, supportive and affordable.

As Nancy began working alongside others with survivors of domestic violence in Oregon, she quickly discovered that given the available resources in her area, and exacerbated by the high cost of providing services, only about 20% of the total number of women reaching out for support and help actually received it. This didn’t sit well with Nancy and her colleagues because not only were they feeling powerless to help, they realized that the 80% who were not being served were most likely forced to return out of financial necessity to the environment where the domestic violence had been occurring. Nancy joined in with her husband and her teammates to find a cheaper and better way to provide housing and services to survivors of domestic violence.

They began establishing housing for domestic violence survivors based on a slightly modified Oxford House model. The program was so successful that county officials noticed, and asked if they were able to replicate the model to house individuals experiencing homelessness. Not ones to back down from a challenge, the team opened five homeless housing units for women and children who were leaving local homeless shelters. They knew too that although Oregon state officials were pleading with Oxford Houses to open their units to medication-assisted treatment (MAT) patients, Oxford's 12-step programs balked at the idea because MAT patients were technically not drug free due to their use of either methadone or suboxone.

The solution was simple. Service providers created MAT-friendly housing in conjunction with RAP, which emphasizes accountability, responsibility and safety for others. The RAP manual states that:

"Life in a RAP house is about accountability and responsibility, not rules. Most of our members come from abusive environments with many, many rules. They have not had the opportunity to internalize the idea that they have rights and that with those rights come certain responsibilities. Given the chance, they will re-create the environment they know and understand—a rule-based environment. We want them to outgrow their past and internalize a sense of responsibility by insisting on responsibility."

Nancy and her team established three housing units based again on the Oxford House model but revised slightly. Nancy states that her team has found the MAT-friendly housing model to be the "trickiest" to manage, for several reasons.

The housing is currently for women with children only, which brings its own challenges. Many of the women are suffering from co-occurring mental and substance use disorders. Some are poly-drug users who continue battling substance use while engaged in MAT. Many of the women have significant trauma histories and suffer from post-traumatic stress disorder (PTSD) coming into the houses.

Each woman has adapted coping skills that served her well on the streets and in the drug lifestyle, but those same survival strategies and skills are maladaptive and can be dysfunctional when applied to group housing settings. As a result, boundary and power

control issues, and multiple medication management needs intermingle and create their own unique demands and approaches to resolve within the units. Add in the challenges of overseeing multiple children interacting in the midst of these homes, it is easy to understand Nancy's point about "trickiness."

It has not been easy, but the RAP team believes that the approach is working. RAP teaches the women in the houses how to mentor themselves and shape their lived experience into a tool for peer mentoring. Nancy states that this is perhaps one of the biggest challenges, because she believes it is incredibly difficult to bring women with serious trauma histories together with each other. RAP's growing experience in MAT-friendly housing, coupled with the general tenets of Oxford House management, has helped Nancy and her team shape several key strategies for the houses:

- **All houses are democratically run.** House members meet weekly to decide house policy, deal with house issues, pay bills, and work on interpersonal issues. RAP staff may attend meetings to provide support and requested information, but the house votes to make decisions. This gives house members a vested interest in the house and provides an opportunity for members to develop decision-making skills.
- **All houses are expected to be self-supporting.** Members pay an "equal expense share," which includes rent, utilities, common household goods such as toilet paper or dish soap, and $15 a month, which goes into the system. This also pays for staff time in supporting and facilitating house business, which usually costs $380 to $420 per month.
- **All houses are self-managed. Intrinsic to the housing model is a structured program of house management.** Housing for at-risk populations usually is "managed" housing. RAP believes in "self-managed" housing. This involves teaching house members how to run a financially responsible household, how to solve interpersonal issues, and how to become self-reliant.

The team believes this last component, "self-management," is key to the success of working with women with trauma and PTSD histories in this type of housing. RAP staff tries to remain uninvolved in the direct interactions as much as possible, providing instead guidance and trauma-informed care, as well as person-centered tools and strategies to the residents to help them along their recovery journey.

For all the challenges that these homes face, Nancy and her teammates knows that they are working. They see the progress and knows the barriers and obstacles each of the women face along their paths to recovery. But the most important aspect of any recovery or survivor home is not what the staff tells you.

It's what those who come as guests tell about their journey from when they were feeling hopeless and often scared to look at themselves in the mirror, fearing what they would see in their reflection.

Chelsea's quote provides the resident perspective. "It is nice to have a safe place to come home to. I know there's not going to be fighting or unwanted people or drugs or alcohol. And we have the support of each other when we feel triggered or unstable in our sobriety. My kids, they love it."

### B. Partners Address Domestic Violence and Homelessness

Retrieved from: Partners Address Domestic Violence and Homelessness | SAMHSA

Karen Jarmoc of the Connecticut Coalition Against Domestic Violence (CCADV) and Lisa Tepper-Bates of the Connecticut Coalition to End Homelessness (CCEH) described the overlap between domestic violence and homelessness.

Service providers responding to survivors of domestic violence were not fully aware of rapid rehousing resources or their proven effectiveness; homelessness service providers did not fully comprehend the social, economic, physical and emotional vulnerability of survivors of domestic violence. They resolved this issue by working together to educate each other, agreeing upon a common core set of principles and best practices, and finding ways to better serve their respective clients.

“We take our cue from the National Alliance to End Homelessness, who recommended that homelessness advocates establish a relationship with mainstream providers of services for victims of domestic violence,” said Lisa Tepper-Bates of the CCEH. “We want to establish universal principles and provide coordinated access for domestic violence victims. They come in and get in a single pipeline and get the ‘A’ team immediately. Our objective is to really work together.”

Jarmoc spoke about how she saw the collaboration taking shape. “First, we want to capture data more efficiently. Second, we want to find common principles and form a stronger collaboration around those principles. We know that housing needs can keep domestic violence victims in place. So, three, we need rapid rehousing money to get these people immediately stabilized in temporary housing and get permanent housing resources within two to three months. And then, fourth, we link to community-based services like counseling and court advocates.”

“It makes for a better end-of-story for those who have endured this trauma. More collaboration means better outcomes. We have a better understanding and we get quick triage and they get the correct resources in a timely way. It is about breaking down the silos,” Tepper-Bates said.

Headlines reporting an increase in homelessness linked to domestic violence, as indicated through a CCEH point-in-time survey for 2013, made news across the state in

October. Many stories noted that the CCDAV's report of serving 56,000 domestic violence clients in 2013 seemed to be a lot for a small state. "These numbers have been very stable. We saw a slight increase in 2009. But economic hard times mean that families don't have 'extra' money for counseling and there are additional money-related stressors," Jarmoc said.

Tepper-Bates fully understands the resource that she and Connecticut housing advocates have available to them in the CCADV. "They are the experts for those people who are not safe. They are uniquely positioned to determine who needs to be treated within the domestic violence framework, whose needs can best be met with shared, mainstream resources, not agency by agency."

Both Jarmoc and Tepper-Bates are determined to harness all the resources available. "This is a new collaboration, but we must achieve. She [Jarmoc] has a very wide angle," Tepper-Bates stated.

In 2014, CCADV received a $10,000 grant from Verizon Wireless to help it reach its partnership goals. The funds would help implement a screening tool to better identify domestic violence within their patient population. CCADV's comprehensive approach to victim services offers counseling, group support, safety planning, court advocacy, and emergency shelter, among other forms of assistance.

This article was originally published to highlight the theme of Minority Behavioral Health Issues.

## Chapter 4: Closing the Gap: Integrating Services for Survivors of Domestic Violence Experiencing Homelessness

DeCandia, C.J., Beach, C.A., & Clervil, R. (2013). Closing the Gap: Integrating Services for Survivors of Domestic Violence Experiencing Homelessness. Needham, MA: The National Center on Family Homelessness.

**Retrieved from:**
https://www.air.org/sites/default/files/downloads/report/Closing%20the%20Gap_Homelessness%20and%20Domestic%20Violence%20toolkit.pdf

### A. Introduction

The United States Department of Justice reports that one in four homeless women is homeless because of violence committed against her. Whether families receive assistance from domestic violence (DV) or homeless service systems is often a matter of chance, availability of beds, and knowledge of services in a community.

Despite similarities in the population served, the DV and homeless service systems are generally not integrated, operate in silos, and are not connected to mainstream services in most communities. While there are well-established links in the literature on DV and homelessness, integration of the two systems in policy and practice is still emerging.

This toolkit was created to address the gap between DV and homeless service systems. By laying the groundwork to understand the intersection between DV and homelessness, this toolkit offers practical strategies that providers can follow to improve service integration. The toolkit was informed by:

1) a comprehensive literature review conducted to understand the extent and nature of the problem;
2) a national survey of the field; and

3) in-depth interviews of key stakeholders. Survey respondents were from all regions of the country and included both DV-focused programs and non-DV-focused programs. Based on the results of the survey, in-depth interviews were completed with 15 individuals. Interviewees included survivors of DV and homelessness, federal policy advocates, state and local level advocates and providers, research experts, and project consultants.

The literature review, survey, and interviews revealed three main levels for improving collaboration across DV and homeless systems: Awareness and Understanding; Communication and Coordination; and Collaboration. This toolkit discusses each level and highlights practical strategies that providers can apply in each. The toolkit also offers a framework for understanding levels of integration that will help close the gap between the DV and homeless service systems. The ultimate goal is to improve the lives of DV survivors who experience homelessness through enhanced service integration.

## Understanding the problem

### *The Relationship between Domestic Violence and Homelessness*

Domestic violence (DV) and homelessness are deeply intertwined for women and their children. Although DV is common at all socioeconomic levels, it occurs disproportionately to women with incomes below the poverty levels.

Lifetime prevalence of DV among women in the general population is estimated to be between 23% and 30%; 3 while prevalence of DV among homeless women is over 60%. One-third report severe physical violence by their current or most recent intimate partner 4 in the form of physical abuse, rape, or stalking. Compared to the general population, violence among homeless women is usually more severe and often accompanied by economic domination and threats.

The impact of violence against mothers is staggering. Homeless mothers suffer from post-traumatic stress disorder (PTSD) at rates that are three times that of the general

female population. In addition, many become depressed and medicate their distress with substances. These findings are especially concerning since a mother's emotional distress is a strong predictor of her children's mental health and behavioral problems.

**Overall, DV results in two million injuries and approximately 1,200 homicides among women each year.**

It is estimated that DV results in an estimated loss of nearly eight million days of paid work - the equivalent of more than 32,000 full-time jobs - 5.6 million days of household productivity, and results in $4.1 billion annually for direct medical and mental health care services.

The U.S. Conference of Mayors Report states that 44% of the cities surveyed identified DV as a major cause of homelessness.12 A major issue facing all families experiencing homelessness is a lack of affordable housing stock.13 In addition, recent studies indicate that DV contributes significantly to repeat episodes of homelessness by decreasing a survivor's chance of receiving a housing voucher, decreasing job stability, and interfering with women's abilities to form supportive relationships.

Women often flee their abusers to live in cars or motels, enter shelter, or double-up with family or friends. Those fleeing DV are more likely to have a problem finding housing because of their unique and often urgent circumstances, poor credit, rental and employment histories, and limited income due to inability to collect and/or enforce child support and alimony payments. In addition, as batterers isolate their partners, women become increasingly vulnerable to social and economic isolation. Lacking the social capital or supports to buffer stressful life events, survivors often find themselves on a pathway to homelessness.

**Regardless of the pathway to homelessness, it has devastating consequences for families and children.**

A home provides a safe haven as well as connection to family, friends, neighborhood, and community. Homelessness itself is intensely traumatic and often exacerbated by multiple losses, abrupt family separations, serious illness, and violent victimization.

For many mothers, the experience of becoming homeless is just another major stressor amid many adverse experiences. Many homeless mothers do not have high school diplomas and face limited work opportunities that pay a livable wage.

Violence and homelessness among women also affects children. By age 12, 83% of homeless children have been exposed to at least one serious violent event and nearly 25% have witnessed acts of violence within their families. An estimated three to ten million children are exposed to DV annually. Problems for these children manifest in many areas such as lowered social competence, difficulty learning in school, and increased rates of post-trauma responses including anxiety and depression.

***Systems and Services: The Need for Integration***

There is a strong connection between DV and homelessness, however historically, services provided by the two systems have not been well integrated. While the two systems often serve the same population and aim to achieve similar outcomes for families (stability and safety, housing and recovery), they operate philosophically and practically under different principles.

DV shelters arose in the late 1970's in response to the need for "safe havens" for survivors and have long represented a critical first step of moving away from an abusive situation into longer term stability. In contrast, the main goal of the homeless service system has been to help those who have lost housing, or are living in places not appropriate for human habitation, obtain housing and achieve residential and economic stability. While homeless programs may offer support and referrals to facilitate

emotional recovery from the factors associated with homelessness, they are not designed to address the immediate safety needs of those experiencing domestic violence.

**Domestic violence and homeless service providers face many of the same challenges.**

Providers in both systems are confronted daily with families who have complex needs and must often operate in environments where resources are scarce. Both workforces must address individual and family trauma, DV, children's needs, and parenting issues, as well as assist families with employment, education, and housing. Whether DV survivors enter the DV system or the homeless system, they require safety and permanent housing.

While DV and homeless service systems have much in common, differences in workforce knowledge, funding sources, policies, and procedures create obstacles to systems collaboration. Differences in training and practice also persist. One study found that public assistance benefits workers were less likely to receive training on DV, and thus less likely to regularly screen clients for DV. This happened despite the fact that a high percentage of clients were DV survivors seeking assistance after fleeing abusive situations. This absence of training can lead to a lack of awareness of client needs and an ineffective approach to service delivery.

Similarly, many homeless service providers have limited training and receive little supervision in formal intervention approaches. As a whole, the homeless system is just beginning to integrate trauma-informed care into service models. Homeless service providers would benefit from training on the dynamics of DV, screening and safety planning, and policies that impact survivors.

Conversely, the DV workforce, while better trained in trauma, would benefit from becoming more knowledgeable about the dynamics of homelessness, housing policies and eligibility requirements, and housing resources in their community. Cross training has been recommended as an effective strategy to promote sharing of expertise and resources across service systems.

### B. Exploring the Issue

This toolkit was created to address the gap between the DV and homeless service systems, and provide practical concrete strategies for providers to enhance service integration. The toolkit was informed by three sources of information:

- First, a comprehensive literature review was conducted to provide background information on the intersection of DV and homelessness.
- Second, a national survey was completed of practitioners, policy advocates, and researchers.
- Lastly, based on the results of the survey, in-depth interviews were completed with survivors of DV and homelessness, federal policy advocates, state and local level advocates and providers, research experts, and project consultants. The goal of the interviews was to follow-up on the concerns and gaps in the system identified by survey respondents and explore the underlying issues.

Several themes related to service integration and areas for improvement were identified by this inquiry:

1. Familiarity with service systems.
2. Types of services provided.
3. System collaboration.

It is clear that progress towards increased service collaboration has been made. Providers in both the DV and homeless system reported a good level of familiarity with the other system, and were highly focused on helping survivors and their families search for and achieve housing stability. However, differences between programs were reported in the level of focus on DV related safety concerns, and understanding and incorporating trauma-informed care into program services.

Most striking was that despite the high familiarity with one another's programs; providers in both systems reported low to moderate levels of actual communication and sharing of resources and expertise. Reasons for this included challenges due to confidentiality and differences in policies and practices.

Lastly, both groups reported that their greatest need for training was within their own service system, but also reported a desire to learn about best practices to address both DV and homelessness. For more detailed information, see Appendix A.

***Voices from the Field***

To better understand the themes identified in the survey, individual interviews were conducted with survivors of DV and homelessness, policy advocates, service providers, and researchers. They were chosen to ensure adequate geographic representation.

Overall, interview data indicated that while many local agencies are collaborating in basic ways (i.e., making referrals), collaboration is generally not a system-wide effort. Interviewees reported a lack of awareness and understanding between DV and homeless systems about the needs of families and how issues of DV and homelessness intersect.

Challenges to collaboration were identified on both local and federal levels. Locally, providers reported difficulty coming together to cross-train or build relationships due to lack of time and resources, formal organizational mechanisms for collaborating, trust between systems, leadership that supported collaboration, and perceived differences in service philosophies and goals.

***On the federal level, integration was reportedly hampered by discrete and separate funding sources, policies that are not coordinated, and issues related to safety and confidentiality***

Interviewees reported that confidentiality was a challenge in working across service systems.

Interviewees provided many recommendations for fostering collaboration:

1. Federal support of collaboration through policy and funding.
2. Adopting a consumer driven, culturally competent, and trauma informed approach across both service systems.
3. Regular, ongoing cross-training between the two systems.
4. Sharing expertise across systems (i.e. DV providers train homeless providers on the specific safety issues faced by DV survivors).
5. Developing "woven interventions" such as team meetings between collaborating agencies that bridge services so everyone does not need to be an expert on everything.

**The Need for Federal Leadership**

One of the largest roadblocks to local collaboration identified from the field was conflicting policies and guidelines from the federal level. Competing values, policies, goals, funding streams, and definitions limit the extent to which community agencies can collaborate, even when there is a strong desire to do so. These conflicting factors may not necessarily reflect organizational differences at the local level, but rather differences between federal agencies. Actual services provided on the ground are often dictated by federal funding streams and regulatory structures.

Interviewees voiced that change is needed at the federal level to align policies and funding streams to support collaboration across local systems, while maintaining the safety and confidentiality of survivors.

This toolkit is designed for community organizations interested in integrating domestic violence and homeless services at the local or regional level. Strategies are offered to support these efforts. However, full systems integration requires a shift that is guided by federal leaders and policymakers.

### C. Strategies to Improve Integration

Collaboration across service systems is increasingly common at this time of expanding service demands and reduced financial resources. Integrating services for survivors of DV who are experiencing homelessness has been achieved successfully in communities across the country. However, because of their historical roots, short-term missions, practical matters of safety, and funding streams, full integration of the DV and homeless systems remains a challenge.

Based on the information gathered from the literature and the field, three levels of integration needed to improve service collaboration across the DV and homeless systems were identified.

- **The first level - Awareness and Understanding** - focuses on the need for all providers to carefully assess the DV and homeless histories of the people they serve, organizational capacity to address both DV and homeless issues, and community resources and reasons for partnering to meet the full range of families' needs.
- The second level - Communication and Coordination - outlines strategies to facilitate open communication and coordinate services across both systems for DV survivors experiencing homelessness.

- The third level - Collaboration - identifies the most advanced stage of service integration where agencies set joint goals, adjust policies, and make joint organizational commitments to meet survivors' needs for safety while also working together to achieve residential stability and self-sufficiency.


Strong collaborations between service providers can have a significant impact on the quality of care available to survivors of DV experiencing homelessness. The three levels of integration should be considered by organizations who want to integrate services, while understanding that the level of integration in a community will depend on the goals of the organizations involved.

> "There has been more community bridging in recent years, and part of that has to do with a greater awareness of the issues and realization that the systems need to work together."
> ***- Sandra Park, New York***

***<u>Level 1: Awareness and Understanding</u>***

Awareness and understanding provide the basis for successful collaborations. A lack of shared knowledge and misperceptions can lead to poorly coordinated services and working in silos. Those working in DV and homeless service systems sometimes use different languages, and may be unaware of the definitions, philosophy, policies, and procedures that guide each other's services. (See Appendix B for common definitions and terms).

Building awareness and understanding of the population served, organizational capacity, and community resources, as well as assessing current and past partnerships is the first step towards integrating services.

**Domestic Violence and Homeless Populations**

Homeless and DV service systems often intersect. DV is often the immediate cause of homelessness among survivors in DV shelters and transitional housing programs. In addition, some survivors have past histories of homelessness that may or may not be associated with DV. Depending on the community, each system may provide housing and services to similar or the same populations.

It is important for providers in both systems to be aware of how DV and homelessness intersect, and how to access available resources. Knowing the population served helps providers better address survivors' needs, and helps organizations identify gaps in services, setting the stage for future collaborations and partnerships.

For DV providers, it is important to know survivors' histories of homelessness in order to offer appropriate housing options and services. For example, those who experience multiple instances of homelessness or extended periods of homelessness may require different supports than families who are experiencing a brief or first episode of homelessness.

Likewise, it is imperative for homeless service providers to understand families' histories of DV to identify safety concerns and support recovery.35 Understanding survivors' history with DV will help guide homeless service providers in their housing placement and service plans.

**Organizational Capacity**

Prior to initiating a collaborative relationship, DV, transitional housing and homeless service agencies should assess their capacity to meet the needs of the populations they serve. Partnerships should not be formed just for the sake of partnering. They should offer opportunities for improved or expanded programming and increased organizational capacity.

For example, DV providers may seek partners in the homeless service system that offer long-term housing options or expertise in accessing permanent housing. Homeless service systems may seek partners who specialize in DV, and can provide recovery counseling for survivors or consultation on how to address concerns on safety and confidentiality.

Collaborations work best when they evolve directly from the partnering agencies' complementary areas of expertise. Organizations should revisit their mission and goals, assess their strengths, and conduct a needs assessment of their current service capacity.

Key points to explore include:

1. understanding how well the organization's current internal capacity aligns with the needs of the population; and
2. identifying where services can be enhanced through partnerships.

**Integration Strategy: Assessment of Domestic Violence and Homelessness**

**Assessment** is a critical process for identifying survivors' and their families' needs and appropriately targeting services. Not a one-time event, assessment is a process that begins upon arrival and continues throughout a family's stay in shelter or transitional housing. During the assessment process, providers should include questions that support a better understanding of a survivor's history of homelessness and DV. Questions should be framed to allow survivors to feel safe and comfortable sharing their stories. This may mean gathering information slowly over time, providing a confidential and safe meeting space, allowing for breaks, and pacing the assessment according to the survivors' needs. The goal of the process is to build a strong trusting relationship with the survivor, and obtain relevant information about DV and homelessness to inform and target services to each family's specific needs.

| Sample Questions on Homelessness | Sample Questions on Domestic Violence |
|---|---|
| Have you experienced homelessness as a child? If so, how many times? | Were you exposed to domestic violence in your household as a child? |
| How many different places have you lived in the past year? | Do you have any past experiences with domestic violence as an adult? |
| Have you lived in a shelter, motel, campground, car, on the street, or with family or friends because you had nowhere else to stay? | When was the most recent instance of domestic violence have you experienced? |
| Have you lived in a shelter, motel, campground, car, on the street, or with family or friends because you had nowhere else to stay? | Are you currently concerned for your safety or your child's safety? |

| | |
|---|---|
| What are your greatest concerns about your children's needs? [Or, "Do your children have special needs that are not met right now?"] | Have your children witnessed, been exposed to, or directly experienced violence? If yes, what type of violence? (e.g., domestic violence, sexual violence, community violence) |

**Integration Strategy: Organizational Needs Assessment**

**Identify and evaluate current services by asking the following questions:**

**Sample Organizational Capacity Questions**

1. What are the organization's strengths?
2. What are areas that could use improvement?
3. What additional services could be beneficial to survivors?
4. What are the different types of services that can be accessed in-house?
5. Are there restrictions or regulations on who can access in-house services?
6. What services require a referral to an outside organization?
7. Are there any services that would benefit survivors that are not provided in-house or via referral?

**Integration Strategy: Construct Capability Statement**

Families experiencing homelessness and survivors of DV often need a wide range of services. A capability statement of the services and programs offered is a helpful way to present an organization's areas of expertise to potential partners. Capability statements should include an overview of the population the organization serves, and a summary of programs and supports provided. Potential partners can exchange capability statements to help identify whether or not collaboration will be mutually beneficial.

***Service Delivery***

Policies, procedures, and service delivery models vary between service systems and organizations. Partnerships and collaborations between organizations with different philosophies of service delivery, while not impossible, do pose extra challenges. The ability to communicate an organization's core principles will be important during the formation phase of integration.

For survivors of DV, confidentiality is of paramount concern to ensure safety. Policies and practices should be designed with safety and confidentiality in mind across organizations in both systems.

> It would be interesting to see a unified continuum rather than two separate continuums (one for domestic violence and one for homeless shelters)."
>
> - Katheryn Preston, Georgia

**Integration Strategy: Outline Service Delivery Model**

The way in which services are provided is an important part of organizational culture. Some DV organizations, transitional housing programs, and homeless service agencies may provide similar services, but in different ways. For example, all may provide services to address trauma and recovery, but with different frameworks. Be prepared to share information on service delivery models with potential partners during initial planning phases. This will help to ensure a solid understanding and awareness of each other's model of care, and work towards complimenting and not duplicating services.

| Sample Service Delivery Questions |
| --- |
| Has the organization adopted a specific case management model? |
| What is the goal of case management and how are services delivered? |
| What evidence-based practices are employed and why? |
| Do providers use a strengths-based approach to working with survivors? |

| |
|---|
| Are services for directly addressing homelessness a core part of the program? |
| Are services for directly addressing domestic violence a core part of the program? |
| How are survivors' needs for culturally competent services addressed? (See Box, page 19) |
| Is the organization trauma-informed? How are issues of trauma addressed for survivors, children, and/or families? (See Box, page 20) |

**The Importance of Cultural and Linguistic Competence**

healing takes place within one's own cultural beliefs. Survivors of DV come from a wide range of backgrounds. It is important for providers in both DV and homeless service systems to recognize that each person's diverse experiences, values, and beliefs will impact how they access services. It is equally important to recognize that the cultural values of providers and service delivery systems have an effect on how services are delivered and accessed.

Cultural competence implies having the capacity to function effectively as an individual and an organization within the context of the cultural beliefs, behaviors, and needs presented by survivors and their communities. A culturally competent approach helps to create a respectful environment in which survivors can begin to rebuild a sense of self and a connection to their communities.

"Cultural competency for both women of color and LGBT populations is very limited in shelters. Training and technical assistance is needed for all shelter settings on underrepresented populations."

- Rebecca Balog, Pennsylvania

"Trauma-informed practice is a critical component of culturally relevant services, and provides a deeper and broader understanding of people's experiences of homelessness and violence. As more practitioners, across systems and issues, incorporate this approach, values and philosophy become more aligned and ultimately people are better supported."

– Anna Melbin, Maine

## The Importance of Trauma-Informed Care

A traumatic experience involves an overwhelming threat to one's physical or emotional well-being and survival, and elicits intense feelings of helplessness, terror, and lack of control.40 Many families have experienced trauma in the form of DV and the trauma associated with the loss of home, safety, and sense of security.41 Given the high rates of exposure to traumatic stress among families experiencing homelessness, understanding trauma and its impact is essential to providing quality care.

Trauma-informed care is a "strengths-based framework that is grounded in an understanding of and responsiveness to the impact of trauma, that emphasizes physical, psychological, and emotional safety for both providers and survivors, and that creates opportunities for survivors to rebuild a sense of control and empowerment."

Trauma-informed care involves "understanding, anticipating, and responding to the issues, expectations, and special needs that a person who has been victimized may have…at minimum, trauma-informed service endeavors to do no harm – to avoid re-traumatizing or blaming [survivors] for their efforts to manage their traumatic reactions."

Becoming trauma-informed means learning how traumatic experiences impact the ways that people think, feel, respond, and cope. It means viewing people's behaviors and responses through a "trauma lens."

A trauma-informed program is a strengths-based service whose overall framework is based on an understanding of and responsiveness to the impact of trauma, emphasis on physical and emotional safety, and opportunities to rebuild a sense of control and empowerment.

### *Community Resources*

Very few, if any, organizations can serve all of a family's needs. Referrals to services that are not provided in-house are an important component in both the DV and homeless service systems. Knowing what resources are available in the community, and expanding referral networks, is helpful for providers to connect families to appropriate services systems for shelter or housing assistance. In the homeless service system, providers may make referrals to counselors that specialize in DV or to agencies that provide safe and confidential shelter or transitional housing. Both systems may make referrals for mental health care, job training, financial assistance, or a myriad of other services. Organizations should be clear about what types of service referrals survivors may need and where to access needed services in their communities.

**Integration Strategy: Understand the Referral Experience**

It is important to be aware of survivors' needs, but also of their experience with the referral process. Providers can learn from survivors what they liked or did not like about the referral process and partner with them to identify challenges in accessing referral services. Questions to ask include:

Are there services that are especially beneficial? How comfortable do survivors feel at referral agencies? Do they feel they have choice in the referral process and in receiving services? How can this process be improved?

Getting feedback from survivors on their experiences with the referral process can help organizations identify strengths and weakness in their current network.

## Integration Strategy: Awareness and Understanding of Community Capacity

An organization can conduct an environmental scan of the community to find additional supports for survivors. Start with current partners and ask them to share their experiences with other agencies in the area. Ask survivors about their experiences with other service organizations. Try to think outside of the “normal” DV and homeless systems. Schools, health care providers, and city/town governments may all have services to offer families. By scanning the environment, an organization can create a list of potential partners to work with in the future.

## Domestic Violence and Homelessness: Impact on Children

More than 1.6 million children experience homelessness each year in the United States: one in every 45 children.Most are part of single-parent, female-headed households,and in the sheltered population, two-thirds of mothers have histories of DV.Domestic violence is the immediate cause of homelessness among survivors living in DV shelters and transitional housing programs.

Many of these children have witnessed violence and are also victims.Children exposed to DV are at high risk of developing emotional and behavioral problems50 and damage to their self-regulatory skills.Adverse emotional impacts of DV are compounded by the severe stress caused by housing instability and living in a chaotic shelter setting.These dynamics may lead young children to form insecure attachments to their mothers while school-aged children may react with self-blame, depression, anxiety, and aggression.

Protective factors that facilitate resilience and promote recovery in children are self-regulation of emotions and behaviors, secure attachments to caregivers, and a solid social support network for the family.Historically, DV and homeless shelters have focused on the needs of the mother. However, best practices in these systems are emerging for children, including practices around group and individual therapy, strengthening parent/child attachments, and mental health care.Schools have a critical role to play in meeting the needs of children who are homeless as the result of domestic violence. Providers should make themselves aware of the educational rights of and services for these children, and include schools in their partnerships.

"Domestic violence is a devastating experience for all family members. Many mothers flee their abusive partners and end up on the streets. Their children witness the violence and often develop a range of post trauma responses that may have long-lasting impact. We must develop interventions that protect these families and most important, prevent the violence from occurring."

- Dr. Ellen Bassuk, Massachusetts

***Current Partnerships***

Lessons can be learned from an organization's current and past partnerships with other community agencies. Understanding what types of collaborations have worked well in the past can prepare an organization for future partnerships that may advance service integration.

**Integration Strategy: Assessment of Current Partnerships**

| Sample Partnership Questions |
| --- |
| What were the motives for partnering? |

| |
|---|
| Does the partnership continue to support families of participating agencies? |
| How formal is the partnership? |
| What has been successful about the partnership? |
| What are the challenges? How are the challenges addressed? |
| What levels of staff are involved in the partnership? |
| How is the leadership structure set up? |
| Is the partnership or collaboration being evaluated in any way? |
| What could be done to improve the partnership? |

**Level 2: Communication and Coordination**

**Successful integration across service systems requires extensive communication within and between partnering agencies**. When moving towards service integration, the most important goal is supporting survivors' need for safety and stability. Once awareness and understanding of the population, organizational capacity, and community resources has been achieved, the next level of services integration is improved communication and coordination among potential partners. The following section outlines strategies to improve communication and coordination across service systems for DV survivors experiencing homelessness.

| **Communication** |
|---|
| In many communities, homeless service and DV systems work in silos with minimal communication between agencies. Agencies are often underfunded, staff are overstretched, and there may be a feeling that forming partnerships takes time, a luxury that an agency cannot afford. Working alone, however, can impede a program's ability to provide essential services, impacting survivors' progress toward stability.<br><br>Opening communication channels can be a simple process that brings agencies to an initial level of partnership which can greatly benefit the families they serve.57 This is |

especially true in the DV and homeless systems where many families have overlapping needs and challenges.

Sharing information in a helpful and open-minded way is important. Providers can start by approaching a potential partner agency and informing them of interest in learning about their services and resources. Potential partners that are not used to working with other community agencies may be apprehensive to share information at first. It is important in these initial encounters to maintain an open, learning, and flexible position, and be willing to find common ground to work together.

**Integration Strategy: Meet with Agency Leadership**

Integrated services coordination requires buy-in from agency leaders. Communication is an initial element of partnership; planned collaboration should begin at this level. Express interest in meeting with agency leaders to discuss opportunities for sharing information and resources. During the meeting, share capability statements and identify partnership areas of common interest.

**Integration Strategy: Provide Staff with Information**

Once agency leaders agree to work together, one effective next step is to start making referrals to one another for services. Provide all staff with information on services and resources available at the partner agency. Explain how the referral process will work and offer key names and contact information at the partnering agency. This presents a good opportunity to provide staff with resources about both homeless and DV service systems to start creating a culture of awareness and understanding of the two systems.

**Integration Strategy: Organize a Joint Agency Meeting**

It is important to ensure that all agency partners are on board and committed to agencies' collaborative goals. If possible, organize a joint agency meeting and invite all staff to attend. Given budget implications and under-staffing in many agencies, it is important to have representatives from each agency discuss what they will bring to the partnership. Allow time for staff to ask questions about the partnership or referral process. This meeting does not have to be long, but should provide an overview of each organization and allow time for staff to meet one another to begin to forge more direct working relationships.

**Coordination**

Communication is a necessary step towards integrating services for survivors of DV experiencing homelessness. However, agencies interested in moving towards full services and systems integration need to move beyond basic communication and referrals.

Coordination takes partnerships across systems to the next stage. Partners working in coordination establish more formal relationships, create multi-agency teams where appropriate, and develop mechanisms for feedback on how the partnership is working.

For example, when a family enters a homeless shelter and presents a history of DV, staff may automatically connect the family with a mental health counselor from a partnering DV agency. A team of providers from both agencies then can then work together to meet the multiple needs of the family. Staff at both agencies have opportunities to provide feedback to leadership on how the partnership is supporting the family.

At this stage, partners do not have to make changes to their own policies or eligibility requirements, but they do need to agree on a plan to coordinate their work to address the unique needs of specific families.

"Meeting together on a regular basis and understanding the requirements of each other's programs is very important for ongoing successful collaboration."

- Hank Hughes, New Mexico

### Integration Strategy: Establish Formal Memorandums of Understanding

Memorandums of understanding (MOUs) formalize collaborations between agencies. Usually designed as a written, non-binding agreement, MOUs outline each agency's role in working towards a common goal. MOUs should be constructed by leadership from all partnering agencies, and include specific outcomes expected of each agency and the overall partnership. All parties should sign the MOU to make it binding.

### Integration Strategy: Provide Cross-Training to Staff

Cross-site training is imperative for staff at partnering agencies once they reach the coordination level. Partnering to support specific families across both organizations requires a higher level of understanding of each organization's staffing and resources. Staff at all levels should participate in the training, with more detailed support given to those staff member who work directly with families and will be part of cross-site teams.

### Integration Strategy: Form Cross-Site Teams

Consider forming cross-site teams to support survivors who will benefit from accessing services at both agencies. Designate staff to be part of these teams and establish a framework for staff to follow when working as part of the team. Identify how these teams will be coordinated and what leadership structure is needed to support participating staff.

**Integration Strategy: Create Feedback Mechanisms**

Schedule cross-site team meetings on a regular basis to support ongoing communication between agency staff members. This is a good opportunity for providers to identify challenges and work through them together as well as an opportunity to discuss successes. Leaders from both agencies should be available to moderate these discussions. Agencies should also consider setting up opportunities for families to provide feedback on their experiences of working within this partnership structure. Surveys, focus groups, or more informal meetings are some examples of ways to seek survivor input.

**Integration Strategy: Coordinate Policies and Procedures**

Organizations should examine current confidentiality policies and be able to discuss with potential partners what guides these practices. This will create a shared understanding from which to coordinate service delivery. Partners can then work together to explore opportunities to adjust current policies and institute procedures across systems to maintain safety while allowing for sharing of resources.

**Level 3: Collaboration**

"Our partners are clear about each other's policies and procedures. Given the longstanding collaborations here in the Mid-South, key partners are at the table to discuss systemic successes as well as issues; therefore all have a comprehensive understanding of partner policies and procedures."

- Julie Sanon, Tennessee

Built upon a solid foundation of awareness and understanding, effective collaborations develop from clear and open communication, and coordination of practices across organizations and service systems. At this level, agencies set joint goals, adjust their own policies and procedures to complement the collaboration, and evaluate outcomes and the partnership itself.

Collaboration requires organizational commitment; it cannot rely on any one person or team. If key staff people are promoted or leave their positions, others must replace them—which entails buy-in from all levels of an agency.

For DV agencies, transitional housing programs, and homeless service providers, collaboration will involve some level of system change. The following section outlines specific strategies to develop collaborations across systems that serve survivors of DV experiencing homelessness.

| **Integration Strategy: Develop Shared Goals** |
| --- |
| Prior to collaboration, organizations may have already coordinated some services to support individual agency goals. At the collaboration stage, agencies often create new programs or expand their services to better support survivors. For successful collaborations, leadership from all participating agencies must come together to jointly develop shared goals for the partnership. By creating a goal statement and a set of outcomes specific to the collaboration, leaders acknowledge the extent to which the collaboration is an opportunity to support both families and project stakeholders. |

| **Integration Strategy: Align Policies and Procedures** |
| --- |
| |

In addition to developing shared goals, collaborating organizations should create protocols that complement the work of the partnering agencies.63 At the beginning of a collaborative process, differences between participating agencies may be apparent. Policies and procedures and service delivery models will need to be considered, and possibly adjusted to create an environment in which the collaboration can thrive.64 Partnering agencies will need to decide how they will deal with issues of confidentiality and differences in organizational culture. Staff from all levels should be consulted to make sure the new protocols are realistic on both mid- and ground- levels. Leaders should determine what form of collaboration will work best for their agencies.

**Integration Strategy: Create a Leadership Structure**

Collaboration is a partnership, but needs a leader. A team management structure, with co-leads or multi-agency managers, will allow DV, transitional housing programs, and homeless service agencies to feel confident their voice is being heard. However, a single representative should be considered for communicating with outside partners, such as funders or referral network agencies. This leader represents the interests of the project's leadership team. Additionally, proper mechanisms should be in place for teamwork and consensus-based decision-making. These decisions should be made prior to implementing the collaboration.

**Integration Strategy: Evaluate the Collaboration**

More and more, funders are focused on measurable project outcomes. It is important to plan for evaluation of service outcomes and agency collaboration from the start. The development of a well-defined framework will help partners measure progress and make mid-course adjustments. When evaluating the collaboration itself, the approach

should be structured to focus on the shared goals and set of outcomes that have been determined by partnering agencies for the collaboration. Establishing guidelines for data collection and analysis is a multi-step process that requires buy-in from all partners.

Staffing structure for collaborations will vary. Depending on the type of collaboration, partnering agencies may want to consider providing extra supervision to those who will be implementing the collaboration and/or co-locating staff.

**Integration Strategy: Staffing and Supervision**

Once program parameters and staffing structures are determined, it is essential that all direct service and management staff understand their roles. Extra supervision may be required at first as staff become familiar with the collaborative program. Team members should be given authority over the service areas they know best, and encouraged to expand their own knowledge and skills by working closely with staff from the partnering agencies. Successful collaborations provide agency teams with opportunities for deeper staff engagement and professional growth.

**Integration Strategy: Co-Location**

Co-locating staff from partnering agencies can benefit the collaboration in many ways. Staff can work even more closely together to support survivors and their families. Co-location could include one staff person from each agency working out of the partnering agency's office a few days a week. In other cases, co-location could involve setting up a new office where staff focuses solely on the collaborative partnership programs.

**End of the Course!**