Spouse/ Partner Abuse

Presented by Lance Parks, LCSW

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

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/

Amanda's Story

I am one of those who found love after abuse.

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.

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 lead 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" didn't 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’s 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’m a blissful bride. And I’m 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)

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.

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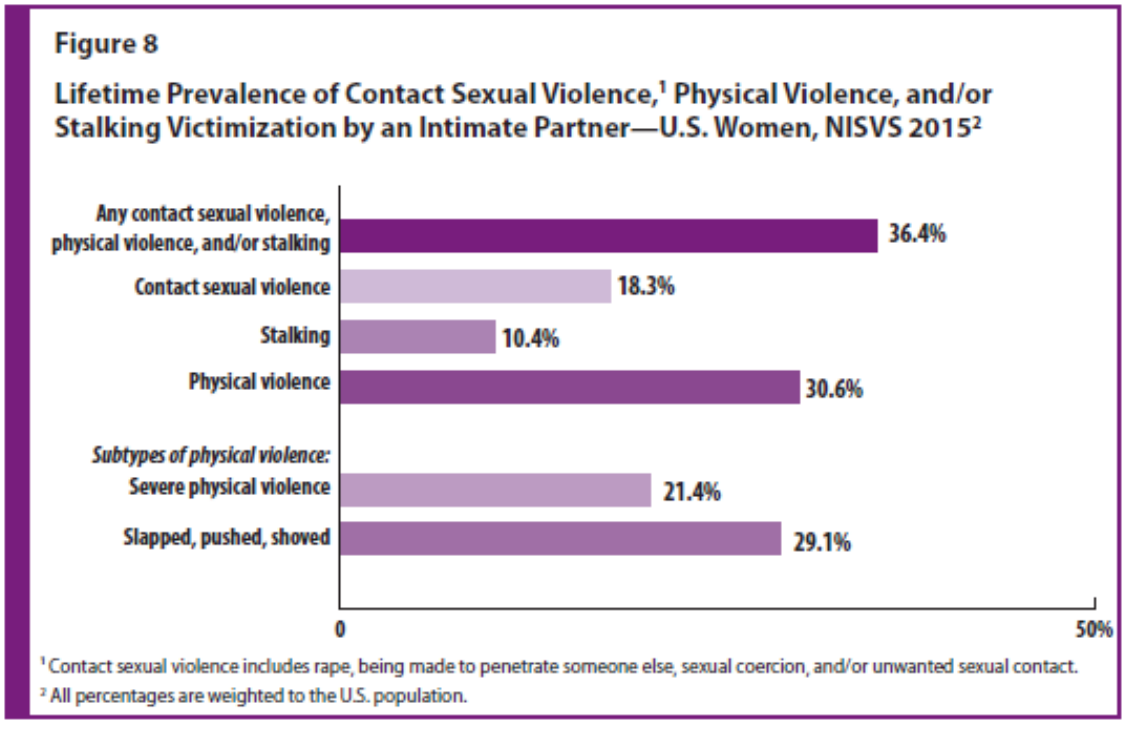
Intimate Partner Violence of Women

- 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).

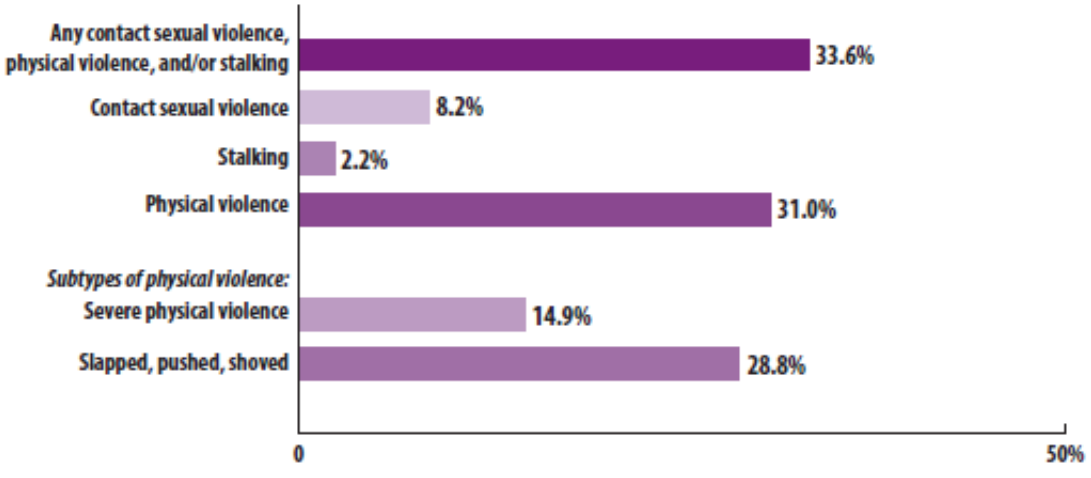
Regarding specific subtypes of intimate partner violence, 8.2% of men experienced contact sexual violence, 31.0% experienced physical violence (14.9% experienced severe physical violence), and 2.2% experienced stalking during their lifetime.

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

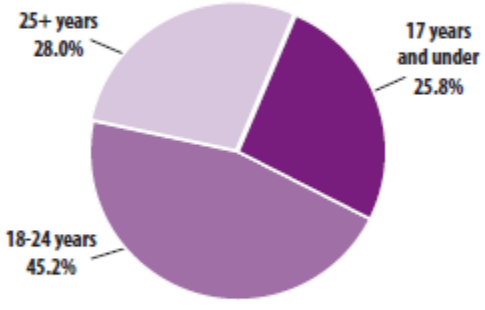
The majority of women who were victims of contact sexual violence, physical violence, and/or stalking by an intimate partner first experienced these or other forms of violence by that partner before age 25 (71.1% or nearly 31.0 million victims), and 1 in 4 female victims (25.8% or about 11.3 million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

Figure 10

Age at First Intimate Partner Violence Among Female Victims of Lifetime Contact Sexual Violence, Physical Violence, or Stalking by an Intimate Partner—NISVS 2015 [1,2,3,4]



[1] The reported age is the youngest age reported across all perpetrators.

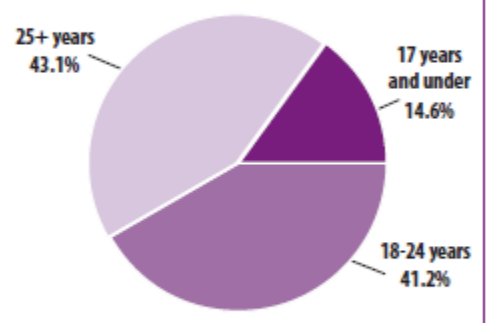
[2] All percentages are weighted to the U.S. population.

[3] Victims with unknown age are not represented in the figure.

[4] Represents the age at the first experience of IPV among women who experienced contact sexual violence, physical violence, and/or stalking by an intimate partner. IPV includes physical violence, all forms of sexual violence, stalking, and psychological aggression.

Figure 11

Age at First Intimate Partner Violence Among Male Victims of Lifetime Contact Sexual Violence, Physical Violence, or Stalking by an Intimate Partner—NISVS 2015 [1,2,3,4]



[1] The reported age is the youngest age reported across all perpetrators.

[2] All percentages are weighted to the U.S. population.

[3] Victims with unknown age are not represented in the figure.

[4] Represents the age at the first experience of IPV among men who experienced contact sexual violence, physical violence, and/or stalking by an intimate partner. IPV includes physical violence, all forms of sexual violence, stalking, and psychological aggression.

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

Executive Summary

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.

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 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.

2: 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. 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; $p < .05$).

3: 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 10Black 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.

4: Impact of 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 ($p < .05$).

5: 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 discretepsychologically 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.

6: 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.

7: 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.

8: 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.

9: 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.

10: 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).

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.

1. 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.

2. Emotional and Verbal Abuse

Sourced 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?” (See Gaslighting.)
- 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:[1]

- 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.**

Sources

1. National Domestic Violence Hotline. (2014). What is Gaslighting?

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.[1] Women are twice as likely to be stalked as men are.[2] Stalking is a crime.

What is stalking?

Stalking is any repeated and unwanted contact with you that makes you feel unsafe.[3] **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:[3]

- 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

1. Smith, S.G., Chen, J., Basile, K.C., Gilbert, L.K., Merrick, M.T., Patel, N., et al. (2017). The National Intimate Partner and Sexual Violence Survey: 2010-2012 State Report. Atlanta, GA: National Center for Injury Prevention and Control, Centers for Disease Control and Prevention.
2. National Center for Victims of Crime. (n.d.). Are You Being Stalked?(link is external)
3. Stalking Resource Center. (2012). What is stalking?

(OWH, 2020)

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3. 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:[1]

- 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." • "Come on; it's my birthday." • "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." • "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?" • "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."

Ways someone might use sexual coercion	What he or she may say
	• "I'll just tell everyone you did it anyway."
Making promises to reward you for sex	• "I'll make it worth your while." • "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." • "I haven't decided yet who's getting bonuses this year." • "Don't worry about the rent. There are other things you can do." • "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.

4. 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.[1]

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

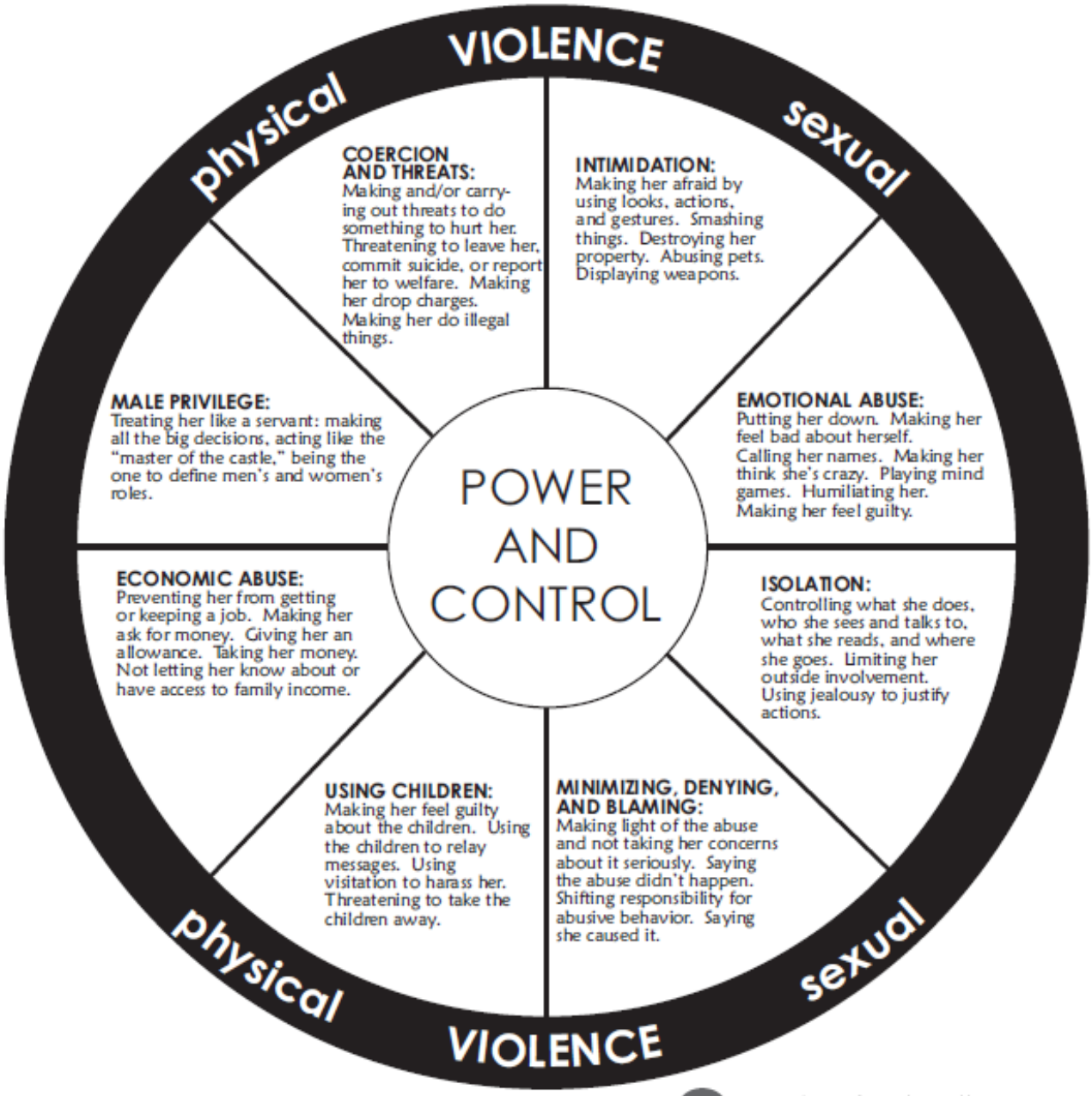
Regardless of your gender identity or sexual orientation, no one has the right to physically hurt you or threaten your safety.
(OWH, 2020)

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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Duluth, MN 55802
218.722.4134

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NATIONAL CENTER
on Domestic and Sexual Violence
training · consulting · advocacy
4612 Shoal Creek Blvd. · Austin, Texas 78756
512.407.9020 (phone and fax) · www.ncdsv.org

B. 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.[1] Many children who witness violence in the home are also victims of physical abuse.[2] 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:**[3]

- **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:[5]

- **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.

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.[1]

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.[7]

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.[8]
- **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.[9]
- **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.[10] 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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Effects 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.[1] Children who witness domestic violence or are victims of abuse themselves are at serious risk for long-term physical and mental health problems.[2] 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.[3] 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.[4]

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.[5] 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.[6]

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.[7]

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:[8]

- 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.[9] 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.[10] CBT is especially helpful for children who have anxiety or other mental health problems as a result of the trauma.[11] 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.[12]

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.[13] These groups can help children by letting them know they are not alone and helping them process their experiences in a nonjudgmental place.[14]

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.[15] 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:[16]

- 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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Mental Health Effects

Long-term mental health effects of violence against women can include:[5]

- **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.

1. *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.[1]

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 that make 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:[2,3]

- **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:[4]

- 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.[5] 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.[4]

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.[6]

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.[1] 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.[7]

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.[8]

Women are about twice as likely as men to develop PTSD.[9] 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.[6]

Learn more about how trauma affects women.

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.[10]
- 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.[11] Women are about twice as likely as men to develop PTSD.[12]

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.[2,3]

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.[13]

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.[14]
- **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 symptoms
- 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 event
- 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 toilet
- Forgetting how to or being unable to talk
- 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 traumas
- Getting hurt
- Seeing another person hurt, or seeing a dead body
- 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.

2. Depression

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.[1] 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.[2] **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.[1] **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.[3]

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:[6]

- **Heart disease.** People with heart disease are about twice as likely to have depression as people who don’t have heart disease.[7]
- **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.[8] Women with depression are also more likely than men with depression to have obesity.[8]

- **Cancer.** Up to 1 in 4 people with cancer may also experience depression. More women with cancer than men with cancer experience depression.[9]

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.[10] 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.[11] 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.[12]

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.[13]

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.**[14] 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.[15] They also think that regular exercise can lower your risk of getting depression and help many depression symptoms get better.[16] Researchers do not know whether exercise works as well as therapy or medicine to treat depression.[15] 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.[17] 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.[18] 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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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” mood
- 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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3. 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.[1] **Women are more than twice as likely as men to get an anxiety disorder in their lifetime.**[2] 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.[3]
- **Panic disorder. Panic disorders are twice as common in women as in men.[4] 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.[5]

Women are more than twice as likely as men to get an anxiety disorder in their lifetime.[2] 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.[6]
- **Social phobia** and **panic disorder** affect more white women than women of other races and ethnicities.[7]

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.[2]

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.[2]

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.[2]

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.[8]**

- **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.[12] 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.[9] Many studies show that all types of physical activity, including yoga and Tai Chi, help reduce anxiety.[10]
- **Meditation.** Studies show meditation may improve anxiety.[11] 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.[12] 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.[13]
- **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.[14]

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.[15]

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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's 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).

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.

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.

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 symptoms
- 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.

Prevention

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

The following is sourced from the CDC (Niolon, et al., 2017) at this link: 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.

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.[2-4] 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)."[5] 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.[6]

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.[3]

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.3

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.7 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.9

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.11 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,2 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.13-14 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.13-16

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.15-16 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 neighbors roles and behavior of men and women).16-17

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.15 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.20-22

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.13,15,23 Additionally, adolescents who engage in bullying or peer violence are more likely to perpetrate IPV.15,24 Those who

experience sexual violence and emotional abuse are more likely to be victims of physical IPV.14 Research also suggests IPV may increase risk for suicide. Both boys and girls who experience TDV are at greater risk for suicidal ideation.25-26 Women exposed to partner violence are nearly 5 times more likely to attempt suicide as women not exposed to partner violence.27 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.4,13-14

The different forms of violence often share the same individual, relationship, community, and societal risk factors.29 The interconnections between the different forms of violence suggests multiple opportunities for prevention.30 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.6,31-33 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.34 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.35 Survivors of IPV also experience mental health consequences, such as depression and posttraumatic stress disorder (PTSD).36 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.3 IPV survivors are also at higher risk for engaging in health risk behaviors, such as smoking, binge drinking, and HIV risk behaviors.37

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 men report at least one measured negative

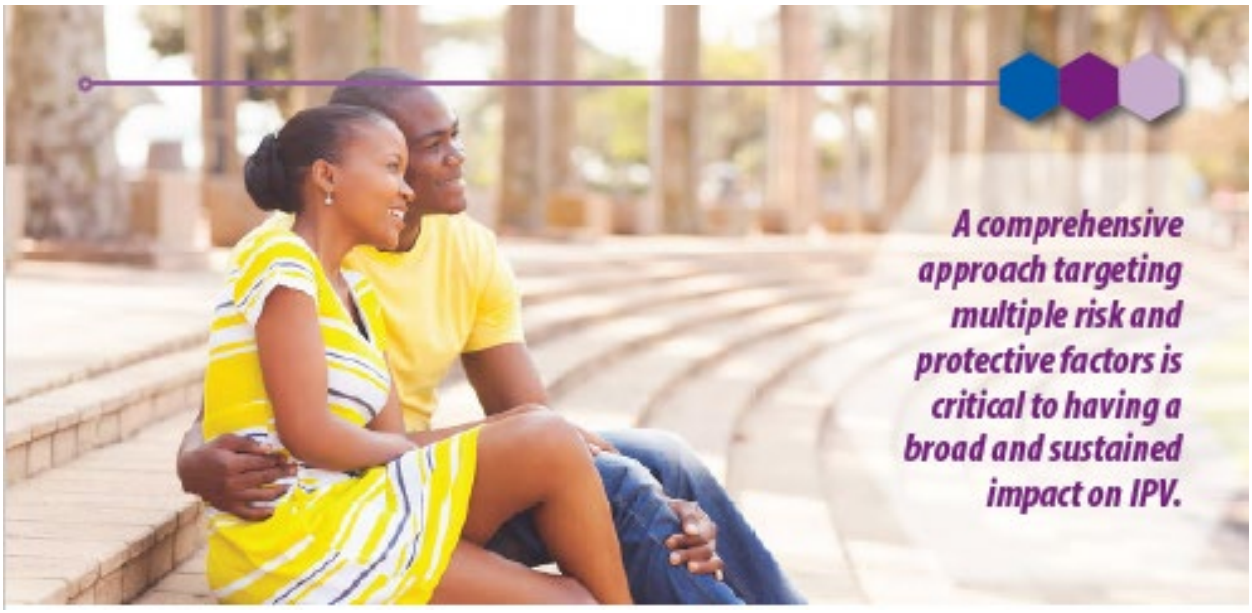
impact related to these victimization experiences (e.g., fear, concern for safety, missing school or work, needing services).3 Among the female IPV survivors, 62% reported feeling fearful, 57% reported being concerned for their safety, 25% missed at least one day of school or work from the IPV, 19% reported 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.3

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.38

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.39 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 • Healthy relationship programs for couples
Engage influential adults and peers	• Men and boys as allies in prevention • Bystander empowerment and education • Family-based programs
Disrupt the developmental pathways toward partner violence	• Early childhood home visitation • Preschool enrichment with family engagement • Parenting skill and family relationship programs • Treatment for at-risk children, youth and families
Create protective environments	• Improve school climate and safety • Improve organizational policies and workplace climate • Modify the physical and social environments of neighborhoods
Strengthen economic supports for families	• Strengthen household financial security • Strengthen work-family supports
Support survivors to increase safety and lessen harms	• Victim-centered services • Housing programs • First responder and civil legal protections • Patient-centered approaches • 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.[13-15] 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,[40-41] 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).[40] Due to the lack of clear evidence regarding the effectiveness of these programs in preventing further IPV,[40-42] *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 needs and strengths of their communities and work with community members to make decisions about the combination of approaches included her 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.15,43-44 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.31-32,45

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.47 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.47 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.48

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.49

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.52 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.53

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.54 A substantive and methodological review of 23 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.54 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).54-57 Thus, the intervention appears most effective at reducing IPV among those for whom it is effective in preventing further substance use.55-56

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.15, 58 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.59 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.59

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 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).60

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.61-62 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).63 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.58

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.64 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.64 An evaluation of the program across a four-year study period found similar results.65 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.66

Family-based programs. Family-based programs have been successful in reducing teen risk behavior, such as high- risk sexual behavior,67 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.68

Findings from several longitudinal studies indicate that many of the factors associated with perpetrating violence against intimate partners are evident well before adolescence.69-71 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.13,15,70-74 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.69-71 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.15,73-75 Approaches that can disrupt these developmental risks and pathways have the potential to reduce IPV.

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 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.76 Many programs are offered to low-income, first time mothers to help them establish healthy family environments.76 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).76 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 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.77 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 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.78-81 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.79,82-83

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.[76] *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.[84-85] 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.[87-88] 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.[89]

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.[91] 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.[90-93]

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.[95-96]

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.[97] 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.[98-99]

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,[100-101] 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.[102] 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.[103-104] Other benefits include increases in family socioeconomic status and greater rise out of poverty and improvements in the marital relationship.[101,105-106]

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.[107] *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.[110]

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.[113] Other benefits include decreased rates of child maltreatment,[114] improvements in family functioning, parent-child interactions, and positive parenting practices, and reductions in youth's substance use and involvement with gangs.[111-112,115]

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.[13,29, 116]

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.[13] 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.[19,118-119] 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.[119-120] 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.[121] 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%.[122] 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.[122] 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.[15] 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.[123] 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.[13]

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.[124] 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.[125] 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.[125] Additionally, research has also shown that green space in urban communities has been linked to higher levels of neighborhood collective efficacy[126] and reductions in violent crime,[127] which is a risk factor for IPV.[119]

Alcohol-related policies represent another potential way to reduce risk for IPV at the neighborhood/community level.[18] Alcohol outlet density, defined as the number of locations where alcohol can be purchased, has been consistently linked to higher rates of IPV.[18] 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.[128] 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.

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[129] 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.[13, 21] In addition, improving financial stability and autonomy could reduce financial dependence on a potential perpetrator and provide alternatives to unhealthy relationships.[21] Studies also show that gender inequality in education, employment, and income is a risk factor for IPV.[13, 130] Therefore, efforts to improve financial security for families and women's education, employment and income may reduce risk for IPV.[131]

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.[13] 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.[133-134] 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.[133] 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.[134]

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.[135] and Pronyk et al.[20] 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.[135] 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.[136] 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.[130] 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.[137] 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,[139] 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.[140] 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.

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.[35-36] IPV is also associated with unplanned pregnancy, preterm birth, low birth weight, and decreased gestational age.[35] 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*[142] and the *Family Violence Prevention and Services Act*[143] 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.[144-145] 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.

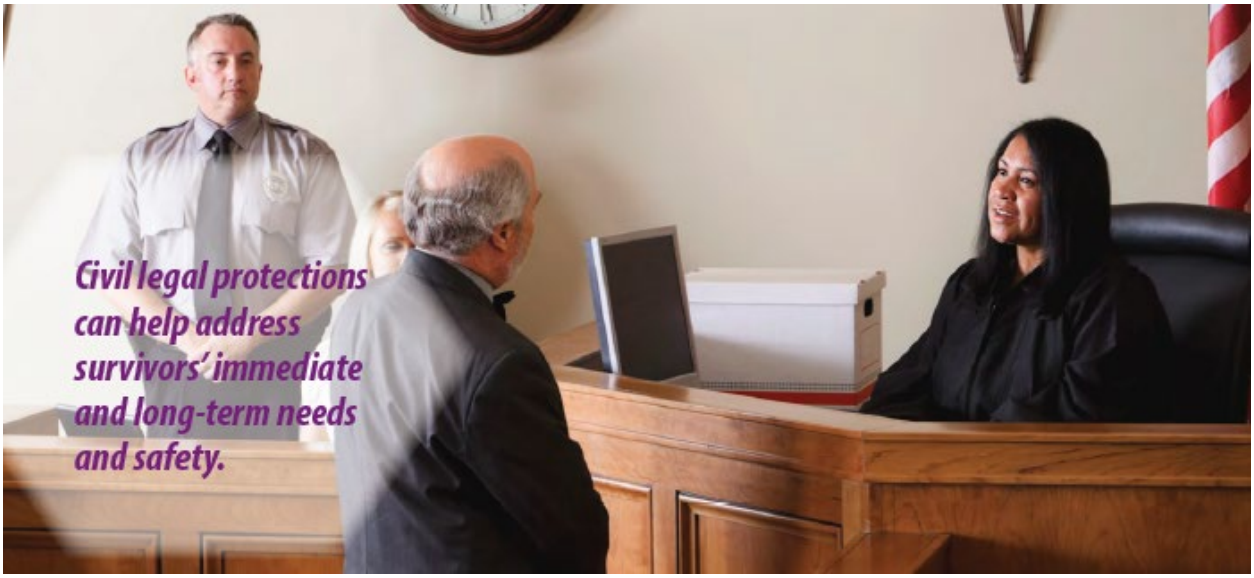
First responder and civil legal protections. *Lethality Assessment Programs* can be an important tool to help police responding to domestic violence and to decrease risk for survivors. Law enforcement officers responding to the scene of a domestic violence incident use a short risk assessment tool to 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.[150]
Given that leaving the relationship is one of the most potentially lethal times in an abusive relationship,[151] 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. [152] 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,[153] 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.[156] 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[157] 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.[158] However, research suggests that having a *PO* significantly increases feelings of well-being among survivors of IPV,[159] 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.[151] 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.[161] In a multiple time series design study, Zeoli and Webster[162] 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.[163-165] 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.[166] 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.[165]

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).[167] 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.[168] In a subsequent, larger cluster randomized controlled trial of the intervention across 25 family planning clinics, Miller et al.[169] 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.[170]

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.[171]

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.[172]

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.[173] 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.[174] 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.[30] 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.

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 Safey 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.

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 tells 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's 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 childrens' 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're 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's important to consider your emotional safety as well. Emotional safety can look different for different people, but ultimately it's 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 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.

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 don't 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's 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 don't 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 didn't really know anyone to call, besides I really didn't 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 couldn't 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's 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 couldn't go back but that didn't 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 couldn't 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 don't do well with them). I was sick to my stomach constantly worried that my work or my family would find out my secret. I didn't 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 couldn't 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 didn't 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 hadn't 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've 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 didn't 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 didn't 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 don't 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 couldn't. I don't 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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