Domestic Violence: Intimate Partner Abuse

Part 1: Domestic Violence Basics

This section provides an overview of the definition, scope, and causes of domestic violence, along with the evolving societal responses. The material also provides a description of victims and perpetrators of domestic violence, highlighting prevalent misconceptions, common behaviors, and parenting issues.

What is Domestic Violence?

Historically, domestic violence has been framed and understood exclusively as a women's issue. Domestic abuse affects women, but it also has devastating consequences for other populations and societal institutions. Men can also be victims of abuse; children are affected by exposure to domestic violence; and formal institutions face enormous challenges responding to domestic violence in their communities.

The effects of domestic violence on victims are more typically recognized, but perpetrators also are impacted by their abusive behavior as they stand to lose custody of their children, damage important relationships, and face legal consequences. Domestic violence cuts across every segment of society and occurs in all age, racial, ethnic, socio-economic, sexual orientation, and religious groups. Domestic violence is a social, economic, and health concern that does not discriminate. As a result, communities across the country are developing strategies to stop the violence and provide safe solutions for victims of domestic violence.

Defining Domestic Violence

Domestic violence, also called intimate partner abuse, intimate partner violence, and domestic abuse, is a "pattern of coercive and assaultive behaviors that include physical, sexual, verbal, and psychological attacks and economic coercion that adults or adolescents use against their intimate partner."¹ Domestic violence is not typically a singular event and is not limited only to physical aggression. Rather, it is the pervasive and methodical use of threats, intimidation, manipulation, and physical violence by someone who seeks power and control over their intimate partner. Abusers use a specific tactic or a combination of tactics to instill fear in and dominance over their partners. The strategies used by abusers are intended to establish a pattern of desired behaviors from their victims. Certain behaviors often are cited by the perpetrator as the reason or cause of the abusive behavior. Therefore, abusive verbal and physical actions are often intended to alter or control that behavior.

Scope of the Problem

Currently, national crime victimization surveys, crime reports, and research studies indicate:

An estimated 85 to 90 percent of domestic violence victims are female.² (Throughout this program victims of domestic violence are often assumed to be female and the abuser is often assumed to be male - as reflected in the body of research on domestic violence. This is not meant to take away from instances where the victim and the abuser are of the same sex or where the victim is male and the abuser is female.)

Females are victims of intimate partner violence at a rate about five times that of males.³

Females between the ages of 16 and 24 are most vulnerable to domestic violence.⁴
Females account for 39 percent of hospital emergency department visits for violence-related injuries, and 84 percent of persons treated for intentional injuries caused by an intimate partner.\(^5\)

As many as 324,000 females each year experience intimate partner violence during their pregnancy, and pregnant and recently pregnant women are more likely to be victims of homicide than to die of any other cause.\(^6\)

Females experience the greatest assault rate (21.3 per 1000 females) between the ages of 20 and 24. This is eight times the peak rate for males (3 per 1000 males ages 25 to 34).\(^7\)

Domestic violence constitutes 22 percent of violent crime against females and 3 percent of violent crime against males.\(^8\)

Eight percent of females and 0.3 percent of males report intimate partner rape.\(^9\)

Approximately 33 percent of gays and lesbians are victims of domestic violence at some time in their lives.

Twenty-eight percent of high school and college students experience dating violence and 26 percent of pregnant teenage girls report being physically abused.

Seventy-five percent of intimate homicide victims are female, and females are twice as likely to be killed by their husbands or boyfriends than murdered by strangers. Intimate partner violence resulted in 1,544 deaths in 2004. Of these deaths, 25% were males and 75% were females.\(^10\)

On average, more than three women are murdered by their husbands or boyfriends in the United States every day. In 2000, 1,247 women were killed by an intimate partner. The same year, 440 men were killed by an intimate partner.\(^11\)

An estimated 5 percent of domestic violence cases are males who are physically assaulted, stalked, and killed by a current or former wife, girlfriend, or partner.

Domestic violence victims lose a total of nearly 8.0 million days of paid work—the equivalent of more than 32,000 full-time jobs—and nearly 5.6 million days of household productivity as a result of the violence.\(^12\)

The costs of intimate partner rape, physical assault, and stalking exceed $5.8 billion each year, nearly $4.1 billion of which is for direct medical and mental health care services.\(^13\)

Males are significantly more likely to be victimized by acquaintances (50 percent) or strangers (44 percent) than by intimates or other relatives.

Females experience over 5 times as many incidents of domestic violence than males. Also, In comparison to men, women have a significantly greater risk for being a victim of domestic violence and suffering chronic and severe forms of physical assaults.\(^14\)

According to results from the National Violence Against Women Survey\(^15\), the lifetime prevalence of physical assault among women who had ever lived with a same-sex intimate partner was 35.4%, compared to 20.4% among women who had lived only with opposite sex partners. Women who reported ever having lived with a same-sex intimate partner had a lifetime prevalence of rape of 11.4% compared to 4.4% who have lived with opposite sex partners. However, these are lifetime rates and do not imply that the perpetrator was also same sex.

Same-sex cohabiting women were nearly three times more likely to have been victimized by a male than by a female partner. Women reported less intimate partner violence in same-sex relationships than in heterosexual relationships.
Among men who had lived with same-sex partners, the prevalence of physical assault was 21.5%, compared to 7.1% among men who had lived only with opposite sex partners. Male same sex cohabiting partners were twice as likely to report being victimized by a male partner than by a woman. Thus, men in same sex partnerships have a somewhat greater risk of being abused than men in heterosexual relationships.

Men who had lived with same-sex intimate partners reported no relationship rape. Within the gay/lesbian community, many factors may mitigate against the reporting of relationship violence. For example, social stigma against homosexuality may prevent gay/lesbian individuals from feeling comfortable reporting relational violence.16 17 18

Fear of abandonment when one has HIV/AIDS is another factor mitigating against the reporting of relationship violence among gay males.19 Note that many states (18) have sodomy laws that make it illegal to engage in same sex activities so abused partners in same gender relationships may fear going to police or courts.20 21

**Domestic Violence Tactics**

Domestic violence actions perpetrated by abusers include physical, sexual, verbal, emotional, and psychological tactics; threats and intimidation; economic coercion; and entitlement behaviors. Examples of each are provided below. Some of the behaviors identified in the following lists do not constitute abuse in and of themselves, but are frequently tactics used in a larger pattern of abusive and controlling behavior.

**Physical Tactics**

- Pushing and shoving;
- Restraining;
- Pinching or pulling hair;
- Slapping;
- Punching;
- Biting;
- Kicking;
- Suffocating;
- Strangling;
- Using a weapon;
- Kidnapping;
- Physically abusing or threatening to abuse children.

**Sexual Tactics**

- Raping or forcing the victim into unwanted sexual practices;
- Objectifying or treating the victim like a sexual object;
- Forcing the victim to have an abortion or sabotaging birth control methods;
- Engaging in a pattern of extramarital or other sexual relationships;
- Sexually assaulting the children.

**Verbal, Emotional, and Psychological Tactics**

- Using degrading language, insults, criticism, or name calling;
- Screaming;
- Harassing;
- Refusing to talk;
- Engaging in manipulative behaviors to make the victim believe he or she is "crazy" or imagining things;
- Humiliating the victim privately or in the presence of other people;
- Blaming the victim for the abusive behavior;
Controlling where the victim goes, who he or she talks to, and what he or she does;
Accusing the victim of infidelity to justify the perpetrator's controlling and abusive behaviors;
Denying the abuse and physical attacks.

**Threats and Intimidation**

- Breaking and smashing objects or destroying the victim's personal property;
- Glaring or staring at the victim to force compliance;
- Intimidating the victim with certain physical behaviors or gestures;
- Instilling fear by threatening to kidnap or seek sole custody of the children;
- Threatening acts of homicide, suicide, or injury;
- Forcing the victim to engage in illegal activity;
- Harming pets or animals;
- Stalking the victim;
- Displaying or making implied threats with weapons;
- Making false allegations to law enforcement or CPS.

**Economic Coercion**

- Preventing the victim from obtaining employment or an education;
- Withholding money, prohibiting access to family income, or lying about financial assets and debts;
- Making the victim ask or beg for money;
- Forcing the victim to hand over any income;
- Stealing money;
- Refusing to contribute to shared or household bills;
- Neglecting to comply with child support orders;
- Providing an allowance.

**Entitlement Behaviors**

- Treating the victim like a servant;
- Making all decisions for the victim and the children;
- Defining gender roles in the home and relationship.

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**Part 1 adapted from:**


**Part 2: Understanding the Dynamics of Abuse**

To understand the dynamics of abuse, it is necessary to recognize the sequence and pattern of abuse.

**Abuse is based on power and control.** A person engages in relationship violence because he or she wishes to gain and/or maintain power and control over an intimate other, and believes he or she is entitled to do so.
Power and control wheels. The power and control wheel demonstrates the pattern of coercive behavior in a domestic violence relationship (See illustration). At the heart of the wheel is power and control. This is the motivation behind the abuse—the answer to the question: Why does a person engage in domestic violence? The abuser has a need to ensure that he gains/maintains control of how the partner thinks, feels, and behaves. The outside of the wheel contains the cement of the abusive relationship: the threat of or actual use of physical and sexual violence.

Physical and sexual abuse is the behavior most people think of as "the problem." It is the abuse most easily recognized or identified and often the only behavior that is illegal. However, the abuser may not need to use physical forms of abuse against the victim to maintain control because the victim attempts to do all she can to avoid the physical and sexual attacks. A victim need only be threatened or harmed once to know the abuser is willing and able to use physical and/or sexual abuse against her.

Inside the wheel are a variety of behaviors, known as tactics, which the abuser uses to gain and maintain control. Not all of these tactics are used in every relationship, and the tactics may be changed as the victim's response changes. The abuser will switch tactics when the victim learns to respond to one type of tactic or attack. When the struggle to challenge the abuser becomes too exhausting or too dangerous, the victim begins to modify her behavior - slowly giving up control of pieces of her life in order to avoid further abuse or to survive.

A victim advocate needs to be aware of these issues when dealing with a victim of domestic violence. First, most victims report they experience far greater shame and lasting effects as the result of psychological and emotional abuse than as the result of physical abuse. Victims report they feel less able to explain "crazy-making behavior" to others; they are more often disbelieved when they report forms of psychological and emotional abuse; and they do not have any visible injury to substantiate their allegations. Victims often report that the physical injuries heal and are forgotten - the psychological and emotional injuries repeatedly haunt their minds.

Power and Control Wheel

![Power and Control Wheel](http://pathwayscourses.samhsa.gov/vawp/vawp_supps_pg31.htm)
Abuse As A Systematic Pattern of Behavior

In most cases, abuse happens in a repetitive sequence, often referred to as the "cycle of violence" (Walker, 1979). The cycle of abuse follows a distinct sequence and pattern. Abused victims often go through phases of:

- Increasing fear,
- Isolation,
- Developing more and more complex adaptations (psychological and psychosocial), and
- Alternating periods of hope (that things will improve or change, that the violence will end, that she will escape) and increasing fear for herself and her children and their survival.

(Modeland, Bolaria and McKenna, 1995; Stark, 1994)

The Cycle of Violence

In 1979, Dr. Lenore Walker - in the landmark book *The Battered Woman* - identified three distinct phases that comprise the "cycle of violence." Dr. Walker determined that the phases vary in duration and intensity; as such, it is difficult to predict how long a batterer and victim will remain in any one phase or in the length of individual cycles.

- **Phase One** is described as the tension building phase in which the abuser becomes more and more prone to react to any stimulus negatively. The victim responds to the escalation in tension by trying to nurture or appease him—or to stay out of his way. In this phase, the abuser becomes fearful that the victim may leave him, which is reinforced as she avoids him in the hope of not triggering the impending explosion. He becomes more oppressive, jealous, threatening, and possessive. Victims often describe this phase as "walking on eggshells."

- **Phase Two** is the battering incident or explosive event. Phase two is the shortest phase, usually lasting from minutes to a few hours. When the acute attack is over, it is usually followed by initial shock, denial, and disbelief that it really happened. Both the batterer and the victim find ways of rationalizing the seriousness of such attacks. Many victims report reactions similar to those of
disaster victims. Victims of catastrophe usually suffer emotional collapse twenty-four to forty-eight hours after the disaster. Symptoms include listlessness, depression, and feelings of helplessness. Similarly, battered women often do not experience the full emotional impact of an attack until twenty-four to forty-eight hours after it has occurred.

- **Phase Three** is described as the "honeymoon phase." Just as phase two is characterized by brutality, phase three is characterized by the extremely kind, loving, and contrite behavior of the abuser. He knows he has gone too far and tries to make it up to his victim. It is a phase welcomed by both parties, but ironically it is the phase during which the woman's victimization becomes complete. In this phase, the batterer constantly behaves in a charming and loving manner. He is usually sorry for his actions in the previous phase. He conveys his remorse to the victim, promises that he will never do it again, and begs for her forgiveness. He is like a child caught with his hand in the cookie jar. The batterer truly believes that he will never again hurt the woman he loves, and that he will be able to control himself from now on. He also believes that he has taught his partner such a lesson that she will never again behave in a way that tempts him to physically assault her. He is quite sincere and can easily convince anyone involved that his behavior will change.

The batterer frequently begins an intense campaign to win forgiveness and to prevent his victim from separating herself from him permanently. It is common for an abuser in phase three to shower his victim with elaborate gifts and to attempt to "romance" her into forgiveness. He may enlist the aid of significant others - family, friends, clergy, even counselors - to persuade her that breaking up the relationship is a bad decision. Often, everyone involved believes the rationalizations - that he is sorry and will change, that his workload or his drinking is to blame, that the children need a father, that the abuser needs the help of the victim - and somehow the victim begins to assume responsibility for his behavior. She sees herself as the one who must stand by her man while he gets the help he so desperately needs.

In reality, it is very unlikely that the abuser will ever seriously seek professional help to change his violent behavior as long as the victim stays with him. Most often, the abuser will seek help only after his victim has left him and if he thinks seeking counseling will convince her to return. The battered woman chooses to believe that the behavior she sees during phase three is what her spouse/partner is really like. She chooses to believe that the contrite behavior is more indicative of the real person than the battering behavior.

**Root Causes of Domestic Violence**

Some people believe domestic violence occurs because the victim provokes the abuser to violent action, while others believe the abuser simply has a problem managing anger. In fact, the roots of domestic violence can be attributed to a variety of cultural, social, economic, and psychological factors. As a learned behavior, domestic violence is modeled by individuals, institutions, and society, which may influence the perspectives of children and adults regarding its acceptability. Abusive and violent behaviors can be learned through:

- Childhood observations of domestic violence;
- The abuser's experience of victimization;
- Exposure to community, school, or peer group violence;
- Living in a culture of violence (e.g., violent movies or videogames, community norms, and cultural beliefs).

Domestic violence is reinforced by cultural values and beliefs that are repeatedly communicated through the media and other societal institutions that tolerate it. The abuser's violence is further supported when peers, family members, or others in the community (e.g., co-workers, social service providers, police, or clergy) minimize or ignore the abuse and fail to provide consequences. As a result, the abuser learns that not only is the behavior justified, but it is also acceptable.

Psychopathology, substance abuse, poverty, cultural factors, anger, stress, and depression often are thought to cause domestic violence. While there is little empirical evidence that these factors are direct causes of domestic violence, research suggests that they can affect its severity, frequency, and the nature
of the perpetrator's abusive behavior. Although there is debate among researchers regarding a definitive theory to explain domestic violence, there is little disagreement that it is an insidious problem requiring a complex solution.

Part 2 adapted from:


Part 3: Victims of Domestic Violence

This section describes some common characteristics of victims of domestic violence, dynamics of the victimization (e.g., common barriers to leaving an abusive relationship, protective strategies), and the impact that domestic violence has on the individual and on parenting behaviors.

Who Is the Victim?

Vicims of domestic violence do not possess a set of universal characteristics or personality traits, but they do share the common experience of being abused by someone close to them. Anyone can become a victim of domestic violence. Victims of domestic violence can be women, men, adolescents, disabled persons, gays, or lesbians. They can be of any age and work in any profession. Normally, victims of domestic violence are not easily recognized because they are not usually covered in marks or bruises. If there are injuries, victims often learn to conceal them to avoid detection, suspicion, and shame.

Unfortunately, an array of misconceptions about victims of domestic violence has led to harmful stereotypes and myths about who they are and the realities of their abuse. Consequently, victims of domestic violence often feel stigmatized and misunderstood by the people in their lives. These people may be well-intended family members and friends or persons trained to help them, such as social workers, police officers, or doctors.

Common Myths about Victims

- **Myth One: Only poor, uneducated women are victims of domestic violence.**

  Victims of abuse can be found in all social and economic classes and can be of either sex. They can be wealthy, educated, and prominent as well as undereducated and financially destitute. Victims of domestic violence live in rural towns, urban cities, subsidized housing projects, and in gated communities. The overrepresentation of underprivileged women in domestic violence crime reports may be due to several factors, including the fact that those seeking public assistance or services are subject to data tracking trends that often capture this information. Victims of domestic violence who have higher incomes are more likely to seek help from private therapists or service providers who can protect their identity through confidentiality agreements.
• **Myth Two: Victims provoke and deserve the violence they experience.**

An abusive tactic used by perpetrators is to accuse their partners of "making" them violent. This accusation is even more effective when the perpetrator and other people tell the victim that he or she deserved the abuse. As a result, many victims remain in the abusive relationship because they believe that the violence is their fault. Many victims make repeated attempts to change their behavior in order to avoid the next assault. Unfortunately, no one, including the victim, can change the behavior except for the perpetrator. The abuser is accountable for the behavior and is responsible for ending the violence.

• **Myth Three: Victims of domestic violence move from one abusive relationship to another.**

Although approximately one-third of victims of domestic violence experience more than one abusive relationship, most victims do not seek or have multiple abusive partners. Victims of domestic violence who have a childhood history of physical or sexual victimization may be at greater risk of being harmed by multiple partners.27

• **Myth Four: Victims of domestic violence suffer from low self-esteem and psychological disorders.**

Some people believe that victims of domestic violence are mentally ill or suffer from low self-esteem. Otherwise, it is thought, they would not endure the abuse. In fact, a majority of victims may suffer from the psychological effects of domestic violence, such as posttraumatic stress disorder or depression.28

Furthermore, there is little evidence that low self-esteem is a factor for initially becoming involved in an abusive relationship.29 In reality, some victims of domestic violence experience a decrease in self-esteem because their abusers are constantly degrading, humiliating, and criticizing them, which also makes them more vulnerable to staying in the relationship.

• **Myth Five: Victims of domestic violence are weak and always want help.**

Some victims of domestic violence are passive while others are assertive. Some victims actively seek help, while others may refuse assistance. Again, victims are a diverse group of individuals who possess unique qualities and different life situations. Victims of domestic violence may not always want help and their reasons vary. They may not be prepared to leave the relationship; they may be scared their partners will harm them; or they may not trust people if past efforts to seek help have failed.

• **Myth Six: Domestic violence only occurs in heterosexual relationships.**

According to the National Violence Against Women Survey (2000), 11% of lesbians reported violence by their female partner and 15% of gay men who had lived with a male partner reported being victimized by a male partner.30

In 2003, lesbians, gays, bisexuals, or transgender people experienced 6,523 incidents of domestic violence; 44% were men, 36% women and 2% transgender (National Coalition of Anti-Violence Programs, 2004).31

**Typical Development of a Domestic Violence Relationship**

Most victims describe the beginning of their relationship as being wonderful and intense. He pays a lot of attention to her; he wants to be with her all the time; he wants to be with her when she is with her friends and family members; he takes an active interest in where she goes, what she does, and how she spends her time; he suggests they spend most of their time doing things they both enjoy doing, rather than doing things on their own, so they can be together. He begins to make decisions for her, explaining he is happy to help her out; he is extremely attentive in public places, huddling over her, monitoring who she interacts with
and letting other guys know she is with him. Simultaneously, he flatters her, confides in her, and reveals that he really wants to make a life with her. Sometimes he admits he does not know how to live without her. Then he begins to pout or express concerns about her interest in him if she does things independently of him. He may also explain how glad he is that she is not like his former spouse/partner, who was really difficult and even forced him to leave or doesn't let him see his kids. He explains his former spouse/partner did not understand him and turned everyone against him.

For many victims, they mistake these behaviors as devotion to a relationship - rather than recognizing these behaviors as red flags that indicate an abusive personality. These red flags include his insistence on obtaining information about her whereabouts at all times. Other red flags include the rapidness with which he establishes himself in her life, including making decisions for her, stating his inability to live without her, and insisting on a commitment to a relationship. His discussion about his former spouse/partner is a red flag as he does not take responsibility for the problems he experienced with that person. Big red flags include saying things like "she had him arrested" or "she slapped a restraining order on him." He is already displaying abuser characteristics: signs of obsessive and controlling behavior. He is acting on his belief system which says he is to be in charge, make the rules, and can expect her to follow him and attend to his needs.

As the relationship continues, she is drawn to the positive side of his actions: his attentiveness and his interest in her activities and the people in her life. She may enjoy feeling doted upon and may be flattered by his initial bouts of jealousy. She makes a commitment to him - usually under pressure from him very early in their relationship - and is happy to be with someone who cares so much about her life. As time passes, she becomes aware of feeling discomfort around some of his behavior, such as his reactions when she discusses doing things with others, but dismisses these feelings due to her desire to make the relationship work. Like any person in a new relationship, she figures it will take time for them to develop a trusting relationship.

Domestic violence generally begins with forms of control through psychological and emotional abuse. He begins to suggest she ought not to do certain things or ought to do things a certain way if she loves him. He begins to subtly suggest she may wish to wear or not wear certain items of clothing. He tells her she may wish to change her hairstyle to look a certain way. He tells her he would prefer her to act or not act in certain ways, such as how she talks, walks, or smiles. Generally, these statements begin in a subtle manner by suggesting the changes he would like her to make, but the implication is that her appearance or behavior is not good enough. She also begins to experience his anger if she does something he does not like. He begins to demand that she never do that again, or if she does not make the suggested changes, he asks her if she does not love him or thinks she is too good for him. He believes any action she takes that draws positive attention from others, especially attention from other men, is a threat to him. Again, just as any person in a new relationship is apt to do, she tends to attribute his reactions to their not yet knowing each other very well. She believes she will earn his trust.

When confronted with the first incident of physical abuse, the victim will typically view the response as an aberration - a behavior that is not typical of this person and will not occur again. It is normal, then, for the victim to excuse or explain the behavior - to "forgive" the behavior. This is a normal response for anyone in a new relationship experiencing a new situation. The abuser's telling her that he is sorry and it will never happen again reinforces this response. She has no reason to think it will ever happen again, so she will, understandably, accept his apologies and/or explanation. Further, she is likely to question what caused this behavior and wonder what she did to prompt this behavior, since he has never acted in this manner before.

If an unacceptable form of psychological or physical abuse occurs again, the victim will respond as most persons do: She will likely ask why the person is repeating such behavior. In an abusive relationship, the abuser will quickly shift the focus from his behavior to her behavior - stating that his actions are "provoked," "triggered," and/or "caused" by something she did or did not do. This form of blaming can be quite subtle or very overt. He makes it clear that she is responsible "for setting him off" and it won't happen again if she just changes her behavior. She wants their relationship to return to the way things used to be, so she is likely to accept his statements, thinking she can easily change whatever behavior he now claims caused him to act as he did. This process, repeated over and over again, begins to erode her sense of confidence and self-esteem. In addition, she begins to internalize the blame.
Simultaneously, he is beginning the isolation process. He questions whom she spends time with, suggests family and friends are interfering with their relationship, and either asks or forbids her from seeing them again. Even if he does not prevent her from such contacts, he makes it very difficult either before or after (or both) she spends time with others by engaging in such behavior as questioning exactly what they did, where they went, and what they talked about. He acts in a suspicious manner and becomes uncomfortable if she describes doing anything that suggests she had a good time without him. After awhile, it is easier for her to simply quit seeing the people of whom he disapproves rather than face the consequences. She tries to figure out what will set him off so she can avoid those situations. It takes her a long time to realize nothing she does can please him or stop his constant barrage of criticism. As she becomes more isolated, she has fewer people with whom to check reality.

Additionally, she experiences a lot of emotional conflict. She is confused about what is happening to her, but she also feels responsible, resulting in feelings of shame, embarrassment, and humiliation. She does not want to believe she could be "one of those women" so she works to justify why he behaved in an abusive fashion, further reinforcing her sense of blame. She is grieving the loss of the person she has come to love and the life they intended to create, so she keeps struggling to change her behavior so he has no reason to become upset and act badly. She keeps trying to control him by changing her behavior to conform to his ever-growing list of complaints. All the while, he is engaged in the thinking pattern of denying he is doing anything unreasonable in making such demands, blaming his actions on her and believing she is responsible for the conflicts they experience. They become enmeshed in a pattern that stops only when she learns she is not responsible for his behavior and when he is held accountable for his behavior.

Adding to the complexity of this pattern is his increasing use of threats and force. This creates a new reaction - fear - which often keeps the woman trapped in the relationship. If she confronts him, he escalates his use of threats and force. If she states her intention to leave if he does not change his behavior, he engages in more severe forms of abuse, telling her that he will kill her if she tries to leave the relationship. She may find it takes less energy to stay and appease him than to try to leave. She may also come to realize it is safer to stay in the relationship than to leave.

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Part 3 adapted from:


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**Part 4: Barriers to Leaving an Abusive Relationship**

The most commonly asked question about victims of domestic violence is "Why do they stay?" Family, friends, co-workers, and community professionals who try to understand the reasons why a victim of domestic violence has not left the abusive partner often feel perplexed and frustrated. Some victims of domestic violence do leave their violent partners while others may leave and return at different points throughout the abusive relationship. Leaving a violent relationship is a process, not an event, for many victims, who cannot simply "pick up and go" because they have many factors to consider. To understand the complex nature of terminating a violent relationship, it is essential to look at the barriers and risks faced by victims when they consider or attempt to leave. Individual, systemic, and societal barriers faced by victims of domestic violence include:

- **Fear.** Perpetrators commonly make threats to find victims, inflict harm, or kill them if they end the relationship. This fear becomes a reality for many victims who are stalked by their partner after leaving. It also is common for abusers to seek or threaten to seek sole custody, make child abuse allegations, or kidnap the children. Historically, there has been a lack of protection and assistance from law enforcement, the judicial system, and social service agencies charged with responding to
domestic violence. Inadequacies in the system and the failure of past efforts by victims of domestic violence seeking help have led many to believe that they will not be protected from the abuser and are safer at home. While much remains to be done, there is a growing trend of increased legal protection and community support for these victims.

- **Isolation.** One effective tactic abusers use to establish control over victims is to isolate them from any support system other than the primary intimate relationship. As a result, some victims are unaware of services or people that can help. Many believe they are alone in dealing with the abuse. This isolation deepens when society labels them as "masochistic" or "weak" for enduring the abuse. Victims often separate themselves from friends and family because they are ashamed of the abuse or want to protect others from the abuser's violence.

Women living in rural or remote communities may feel that they would have to leave their communities - and everything familiar - to be safe. This isolation and lack of access to resources creates added barriers.

- **Financial dependence.** Some victims do not have access to any income and have been prevented from obtaining an education or employment. Victims who lack viable job skills or education, transportation, affordable daycare, safe housing, and health benefits face very limited options. Poverty and marginal economic support services can present enormous challenges to victims who seek safety and stability. Often, victims find themselves choosing between homelessness, living in impoverished and unsafe communities, or returning to their abusive partner.

- **Guilt and shame.** Many victims believe the abuse is their fault. The perpetrator, family, friends, and society sometimes deepen this belief by accusing the victim of provoking the violence and casting blame for not preventing it. Victims of violence rarely want their family and friends to know they are abused by their partner and are fearful that people will criticize them for not leaving the relationship. Victims often feel responsible for changing their partner's abusive behavior or changing themselves in order for the abuse to stop. Guilt and shame may be felt especially by those who are not commonly recognized as victims of domestic violence. This may include men, gays, lesbians, and partners of individuals in visible or respected professions, such as the clergy and law enforcement.

- **Emotional and physical impairment.** Abusers often use a series of psychological strategies to break down the victim's self-esteem and emotional strength. In order to survive, some victims begin to perceive reality through the abuser's paradigm, become emotionally dependent, and believe they are unable to function without their partner. The psychological and physical effects of domestic violence also can affect a victim's daily functioning and mental stability. This can make the process of leaving and planning for safety challenging for victims who may be depressed, physically injured, or suicidal. Victims who have a physical or developmental disability are extremely vulnerable because the disability can compound their emotional, financial, and physical dependence on their abusive partner.

- **Individual belief system.** The personal, familial, religious, and cultural values of victims of domestic violence are frequently interwoven in their decisions to leave or remain in abusive relationships. For example, victims who hold strong convictions regarding the sanctity of marriage may not view divorce or separation as an option. Their religious beliefs may tell them divorce is "wrong." Some victims of domestic violence believe that their children still need to be with the offender and that divorce will be emotionally damaging to them.

- **Hope.** Like most people, victims of domestic violence are invested in their intimate relationships and frequently strive to make them healthy and loving. Some victims hope the violence will end if they become the person their partner wants them to be. Others believe and have faith in their partner's promises to change. Perpetrators are not "all bad" and have positive, as well as, negative qualities. The abuser's "good side" can give victims reason to think their partner is capable of being nurturing, kind, and nonviolent.

- **Community services and societal values.** For victims who are prepared to leave and want protection, there are a variety of institutional barriers that make escaping abuse difficult and
frustrating. Communities that have inadequate resources and limited victim advocacy services and whose response to domestic abuse is fragmented, punitive, or ineffective can not provide realistic or safe solutions for victims and their children.

- **Cultural hurdles.** The lack of culturally sensitive and appropriate services for victims of color and those who are non-English speaking pose additional barriers to leaving violent relationships. Minority populations include African-Americans, Hispanics, Asians, and other ethnic groups whose cultural values and customs can influence their beliefs about the role of men and women, interpersonal relationships, and intimate partner violence. For example, the Hispanic cultural value of "machismo" supports some Latino men's belief that they are superior to women and the "head of their household" in determining familial decisions. "Machismo" may cause some Hispanic men to believe that they have the right to use violent or abusive behavior to control their partners or children. In turn, Latina women and other family or community members may excuse violent or controlling behavior because they believe that husbands have ultimate authority over them and their children.

A woman who is a recent immigrant may have additional fears, such as the fear of authority and deportation (for herself or her family) if she leaves her partner and/or her sponsorship relationship breaks down. She may feel marginalized from support systems available in her community. She may lack economic means to support herself. Language is often a common barrier experienced by immigrant women seeking help.

Examples of culturally competent services include offering written translation of domestic violence materials, providing translators in domestic violence programs, and implementing intervention strategies that incorporate cultural values, norms, and practices to effectively address the needs of victims and abusers. The lack of culturally competent services that fail to incorporate issues of culture and language can present obstacles for victims who want to escape abuse and for effective interventions with domestic violence perpetrators. Well-intended family, friends, and community members also can create additional pressures for the victim to "make things work."

**Leaving Does Not Mean Safety**

Those who work with victims of domestic violence often put their emphasis on pushing the victim to leave the relationship. This approach may, in fact, put the victim at higher risk of danger. An appropriate response is to help her determine what her risks are and to help her to problem-solve how to minimize those risks. In some cases, staying within the relationship may be the safest response.

Statistics indicate that women are at a greater risk of becoming victims of domestic homicide when they attempt to leave the relationship. In fact, women who leave their batterers are at a 75 percent greater risk of being killed by their batterer than those who stay.³³

Victims who attempt to leave are often hunted down - stalked, harassed, threatened, and pursued across county and state lines. Because abusers believe they are entitled to control the behavior of their partners, they may continue this behavior even after the petition for divorce is filed or granted. This is so common it is known as "separation violence."

The rate of attack against women separated from their husbands is about three times higher than that of divorced women and 25 times higher than that of married women.

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Part 4 adapted from:


Part 5: The Impact of Domestic Violence on Victims

As with anyone who has been traumatized, victims demonstrate a wide range of effects from domestic violence. The perpetrator's abusive behavior can cause an array of health problems and physical injuries. Victims may require medical attention for immediate injuries, hospitalization for severe assaults, or chronic care for debilitating health problems resulting from the perpetrator's physical attacks. The direct physical effects of domestic violence can range from minor scratches or bruises to fractured bones or sexually transmitted diseases resulting from forced sexual activity and other practices. The indirect physical effects of domestic violence can range from recurring headaches or stomachaches to severe health problems due to withheld medical attention or medications.

Many victims of abuse make frequent visits to their physicians for health problems and for domestic violence-related injuries. Unfortunately, research shows that many victims will not disclose the abuse unless they are directly asked or screened for domestic violence by the physician or other health care provider. It is imperative, therefore, that health care providers directly inquire about possible domestic violence so victims receive proper treatment for injuries or illnesses and are offered further assistance for addressing the abuse.

The impact of domestic violence on victims can result in acute and chronic mental health problems. Some victims, however, have histories of psychiatric illnesses that may be exacerbated by the abuse; others may develop psychological problems as a direct result of the abuse.

In general, victims of repeated violence over time experience more serious consequences than victims of one-time incidents.

Examples of emotional and behavioral effects of domestic violence include many common coping responses to trauma, such as:

- Emotional withdrawal
- Denial or minimization of the abuse
- Impulsivity or aggressiveness
- Apprehension or fear
- Helplessness
- Anger
- Anxiety or hypervigilance
- Disturbance of eating or sleeping patterns
- Substance abuse
- Depression
- Suicide
- Post-traumatic stress disorder
- Engaging in high-risk sexual behavior
- Early sexual initiation
- Unhealthy diet-related behaviors

Some of these effects also serve as coping mechanisms for victims. For example, some victims turn to alcohol to lessen the physical and emotional pain of the abuse. Unfortunately, these coping mechanisms can serve as barriers for victims who want help or want to leave their abusive relationships. Psychiatrists, psychologists, therapists, and counselors who provide screening, comprehensive assessment, and treatment for victims can serve as the catalyst that helps them address or escape the abuse.

Parenting and the Victim

Emerging research indicates that the harmful effects of domestic violence can negatively influence parenting behaviors. Parents who are suffering from abuse may experience higher stress levels, which in
turn, can influence the nature of their relationship with and responses to their children.\textsuperscript{39} Victims who are preoccupied with avoiding physical attacks and coping with the violence confront additional challenges in their efforts to provide safety, support, and nurturance to their children. Unfortunately, some victims of domestic violence are emotionally or physically unavailable to their children due to injuries, emotional exhaustion, or depression.

Studies have found that victims of domestic violence are more likely to maltreat their children than those who are not abused by their partners.\textsuperscript{40} In some cases, victims who use physical force or inappropriate discipline techniques are trying to protect their children from potentially more severe forms of violence or discipline by the abuser. For example, a victim of domestic violence might slap the child when the abuser threatens harm if the child is not quiet. Seemingly, neglectful behaviors by the victim also may be a direct result of the domestic violence. This is illustrated when the abuser prevents the victim from taking the child to the doctor or to school because the adult victim's injuries would reveal the abusiveness.

The majority of victims of domestic violence are not bad, ineffective, or abusive parents, but researchers note that domestic violence is one of a multitude of stressors that can negatively influence parenting. However, many victims, despite ongoing abuse, are supportive, nurturing parents who mediate the impact of their children's exposure to domestic violence.\textsuperscript{41} Given the impact of violence on parenting behaviors, it is beneficial that victims receive services that alleviate their distress so they can support and benefit the children.\textsuperscript{42}

Part 5 adapted from:


Part 6: Perpetrators of Domestic Violence

This section presents common characteristics and behavioral tactics of perpetrators, indicators of dangerousness, and relevant parenting issues.

Who Is a Perpetrator of Domestic Violence?

As is the case with victims of domestic violence, abusers can be anyone and come from every age, sex, socioeconomic, racial, ethnic, occupational, educational, and religious group. They can be teenagers, college professors, farmers, counselors, electricians, police officers, doctors, clergy, judges, and popular celebrities. Perpetrators are not always angry and hostile, but can be charming, agreeable, and kind. Abusers differ in patterns of abuse and levels of dangerousness. While there is not an agreed upon universal psychological profile, perpetrators do share a behavioral profile that is described as "an ongoing pattern of coercive control involving various forms of intimidation, and psychological and physical abuse."\textsuperscript{43}

While many people think violent and abusive people are mentally ill, research shows that perpetrators do not share a set of personality characteristics or a psychiatric diagnosis that distinguishes them from people who are not abusive. There are some perpetrators who suffer from psychiatric problems, such as depression, post-traumatic stress disorder, or psychopathology. Yet, most do not have psychiatric illnesses, and caution is advised in attributing mental illness as a root cause of domestic violence.\textsuperscript{44} The Diagnostic and Statistical Manual of the American Psychological Association (DSM-IV) does not have a diagnostic category for perpetrators, but mental illness should be viewed as a factor that can influence the severity and nature of the abuse.\textsuperscript{45}
Examples of the most prevalent behavioral tactics by perpetrators include:

- **Abusing power and control.** The perpetrator's primary goal is to achieve power and control over their intimate partner. In order to do so, perpetrators often plan and utilize a pattern of coercive tactics aimed at instilling fear, shame, and helplessness in the victim. Another part of this strategy is to change randomly the list of "rules" or expectations the victim must meet to avoid abuse. The abuser's incessant degradation, intimidation, and demands on their partner are effective in establishing fear and dependence. It is important to note that perpetrators may also engage in impulsive acts of domestic violence and that not all perpetrators act in such a planned or systematic way.

- **Having different public and private behavior.** Usually, people outside the immediate family are not aware of and do not witness the perpetrator's abusive behavior. Abusers who maintain an amiable public image accomplish the important task of deceiving others into thinking they are loving, "normal," and incapable of domestic violence. This allows perpetrators to escape accountability for their violence and reinforces the victims' fears that no one will believe them.

- **Projecting blame.** Abusers often engage in an insidious type of manipulation that involves blaming the victim for the violent behavior. Such perpetrators may accuse the victim of "pushing buttons" or "provoking" the abuse. By diverting attention to the victim's actions, the perpetrator avoids taking responsibility for the abusive behavior. In addition to projecting blame on the victim, abusers also may project blame on circumstances, such as making the excuse that alcohol or stress caused the violence.

- **Claiming loss of control or anger problems.** There is a common belief that domestic violence is a result of poor impulse control or anger management problems. Abusers routinely claim that they "just lost it," suggesting that the violence was an impulsive and rare event beyond control. Domestic violence is not typically a singular incident nor does it simply involve physical attacks. It is a deliberate set of tactics where physical violence is used to solidify the abuser's power in the relationship. In reality, only an estimated 5 to 10 percent of perpetrators have difficulty with controlling their aggression. For example, most abusers do not assault others outside the family, such as police officers, co-workers, or neighbors, but direct their abuse toward the victim or their children. This distinction challenges claims that they cannot manage their anger.

- **Minimizing and denying the abuse.** Perpetrators rarely view themselves or their actions as violent or abusive. As a result, they often deny, justify, and minimize their behavior. For example, an abuser might forcibly push the victim down a flight of stairs, then tell others that the victim tripped. Abusers also rationalize serious physical assaults, such as punching or choking, as "self-defense." Abusers who refuse to admit they are harming their partner present enormous challenges to persons who are trying to intervene. Some perpetrators do acknowledge to the victim that the abusive behavior is wrong, but then plead for forgiveness or make promises of refraining from any future abuse. Even in situations such as this, the perpetrator commonly minimizes the severity or impact of the abuse.

- **Accepting responsibility.** It is equally important to acknowledge that abusers also possess positive qualities. There are abusers who are remorseful, accept responsibility for their violence, and eventually stop their abusive behavior. Perpetrators are not necessarily "bad" people, but their abusive behavior is unacceptable. Some perpetrators have childhood histories where they were physically or sexually abused, neglected, or exposed to domestic abuse. Some suffer from substance abuse and mental health problems. All of these factors can influence their psychological functioning and contribute to the complexity and severity of the abusive behavior. Perpetrators need support and intervention to end their violent behavior and any additional problems that compound their abusive behavior. Through specialized interventions, community services, and sanctions, some abusers can change and become nonviolent.
Risk Factors: Indicators of Dangerousness

Different levels of violence and types of abuse are perpetrated by domestic violence offenders. Some abusers rarely use physical violence, while others assault their partners daily. There are perpetrators who are only abusive towards family members and others who are violent toward a variety of people. There are abusers who are more likely to inflict serious injury or become homicidal. Some frequently degrade the victim, while some rarely, if ever, implement that particular tactic.

It is critical that professionals and community service providers who intervene in domestic violence cases engage in thorough and continuous assessment of the perpetrator's level of dangerousness. Evaluating this dangerousness involves identifying risk indicators that reflect the capacity to continue perpetrating severe violence. Although domestic violence homicides or severe assaults cannot be predicted, there are several risk factors that help determine the likelihood that severe forms of violence may be imminent. The greater the number or the intensity of the following indicators, the more likely a severe or life-threatening attack will occur:

- Threats or thoughts of homicide and suicide;
- Possession or access to weapons;
- Use of weapons in a threatening or intimidating manner;
- Extreme jealousy or obsession with the victim;
- Physical attacks, verbal threats, and stalking during a separation or divorce;
- Kidnapping or hostage taking;
- Sexual assault or rape;
- Prior abusive incidents that resulted in serious injury;
- History of violence with previous partners and children;
- Psychopathology or substance abuse.

The above factors pose a substantial risk to victims of domestic violence and possibly to their children. It also is important to ask for the victim's assessment of the abuser's dangerousness. Extremely dangerous perpetrators can be safety threats to people who are involved in the victim's life, individuals trying to help, or the children. It is crucial that community professionals who work with violent families incorporate these risk indicators into their assessments and interventions because failure to do so can seriously compromise the lives of everyone involved.

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Part 7: Co-occurrence of Child Maltreatment and Domestic Violence

Studies estimate that 10 to 20 percent of children are at risk for exposure to domestic violence. These findings translate into approximately 3.3 to 10 million children a year who are at risk for witnessing or being exposed to domestic violence, which can produce a range of emotional, psychological, and behavioral problems for children. This estimate is derived from an earlier landmark study that found approximately 3 million American households experienced at least one incident of serious violence each year. The broad range of this estimate highlights the fact that the exact number of domestic violence incidents is unknown, and there sometimes is incongruence or a lack of agreement about exactly what constitutes "domestic violence."

One study estimates that as many as 10 million teenagers are exposed to parental violence each year. This estimate comes from a survey in which adults were asked "whether, during their teenage years, their father had hit their mother and how often" and vice versa for the mother. The survey found that about one in eight, 12.6 percent of the sample, recalled such an incident. In these cases, 50 percent remembered their
father hitting the mother, 19 percent recalled their mother hitting the father, and 31 percent recalled the parents hitting each other.\textsuperscript{57}

These estimates are based on research that identified maltreated children who accompanied victims of domestic violence to shelters and identified adult victims via CPS caseloads. Additionally, research examining the relationship between victims and their own use of violence indicate that they are more likely to perpetrate physical violence against their children than caretakers who are not abused by a partner or spouse.\textsuperscript{58} Children who witness domestic violence and are victimized by abuse exhibit more emotional and psychological problems than children who only witness domestic violence.\textsuperscript{59}

**Children's Exposure to Domestic Violence**

Children who live in homes where a parent or caretaker is experiencing abuse are commonly referred to as "child witnesses" or "children who are witnessing" domestic violence. The term "children's exposure" to domestic violence, however, provides a more inclusive definition because it encompasses the multiple ways children experience domestic abuse. Although caretakers frequently believe they are protecting their children from witnessing their abuse, children living in these homes report differently. Researchers have found that 80 to 90 percent of children in homes where domestic violence occurs can provide detailed accounts of the violence in their homes.\textsuperscript{60} Research studies have proliferated regarding children's exposure to domestic violence, the problems associated with witnessing, and the protective factors that influence their responses to the violence.\textsuperscript{61} Children's exposure to domestic violence typically falls into three primary categories:

- Hearing a violent event;
- Being directly involved as an eyewitness, intervening, or being used as a part of a violent event (e.g., being used as a shield against abusive actions); and
- Experiencing the aftermath of a violent event.\textsuperscript{62}

Children's exposure to domestic violence also may include being used as a spy to interrogate the adult victim, being forced to watch or participate in the abuse of the victim, and being used as a pawn by the abuser to coerce the victim into returning to the violent relationship.\textsuperscript{63} Some children are physically injured as a direct result of the domestic violence. Some perpetrators intentionally physically, emotionally, or sexually abuse their children in an effort to intimidate and control their partner. While this is clearly child maltreatment, other cases may not be so clear. Children often are harmed accidentally during violent attacks on the adult victim. An object thrown or weapon used against the battered partner can hit the child. Assaults on younger children can occur while the adult victim is holding the child, and injury or harm to older children can happen when they intervene in violent episodes. In addition to being exposed to the abusive behavior, many children are further victimized by coercion to remain silent about the abuse, maintaining the "family secret."

**The Effects of Domestic Violence on Children**

Children who live with domestic violence face numerous risks, such as the risk of exposure to traumatic events, the risk of neglect, the risk of being directly abused, and the risk of losing one or both of their parents. All of these can lead to negative outcomes for children and clearly have an impact on them. Research studies consistently have found the presence of three categories of childhood problems associated with exposure to domestic violence:

- **Behavioral, social, and emotional problems** - higher levels of aggression, anger, hostility, oppositional behavior, and disobedience; fear, anxiety, withdrawal, and depression; poor peer, sibling, and social relationships; low self-esteem.

- **Cognitive and attitudinal problems** - lower cognitive functioning, poor school performance, lack of conflict resolution skills, limited problem-solving skills, acceptance of violent behaviors and attitudes, belief in rigid gender stereotypes and male privilege.
• **Long-term problems** - higher levels of adult depression and trauma symptoms, increased tolerance for and use of violence in adult relationships.\(^6^4\)

Children also display specific problems unique to their physical, psychological, and social development. For example, infants exposed to violence may have difficulty developing attachments with their caregivers and in extreme cases suffer from “failure to thrive.”\(^6^5\) It should be noted that there also are limitations and uncertainties to the research since some of the children in such studies do not show elevated problem levels even under similar circumstances.\(^6^6\) Preschool children may regress developmentally or suffer from eating and sleep disturbances. School-aged children may struggle with peer relationships, academic performance, and emotional stability. Adolescents are at a higher risk for either perpetrating or becoming victims of teen dating violence.\(^6^7\) Reports from adults who repeatedly witnessed domestic violence as children show that many suffer from trauma-related symptoms, depression, and low self-esteem.\(^6^8\)

**Possible Symptoms in Children Exposed to Domestic Violence**

- Sleeplessness, fears of going to sleep, nightmares, dreams of danger;
- Physical symptoms such as headaches or stomachaches;
- Hypervigilance to danger or being hurt;
- Fighting with others, hurting other children or animals;
- Temper tantrums or defiant behavior;
- Withdrawal from people or typical activities;
- Listlessness, depression, low energy;
- Feelings of loneliness and isolation;
- Current or subsequent substance abuse;
- Suicide attempts or engaging in dangerous behavior;
- Poor school performance;
- Difficulties concentrating and paying attention;
- Fears of being separated from the non-abusing parent;
- Feeling that his or her best is not good enough;
- Taking on adult or parental responsibilities;
- Excessive worrying;
- Bed-wetting or regression to earlier developmental stages;
- Dissociation;
- Identifying with or mirroring behaviors of the abuser.\(^6^9\)

**Children's Protective Factors in Response to Domestic Violence**

Studies documenting the types of problems associated with children who are exposed to domestic violence reveal a wide variation in their responses to the violence. Children's risk levels and reactions to domestic violence exist on a continuum where some children demonstrate enormous resiliency while others show signs of significant maladaptive adjustment.

Protective factors such as social competence, intelligence, high self-esteem, outgoing temperament, strong sibling and peer relationships, and a supportive relationship with an adult, are thought to be important variables that help protect children from the adverse effects of exposure to domestic violence.\(^7^0\) In addition, research shows that the impact of domestic violence on children can be moderated by certain factors, including:

- **The nature of the violence.** Children, who witness frequent and severe forms of violence, perceive the violence as their fault. Because they fail to observe their caretakers resolving conflict, these children may undergo more distress than children who witness fewer incidences of physical violence. The frequency with which they witness positive interactions between their caregivers also affects them.

- **Coping strategies and skills.** Children with poor coping skills are more likely to experience problems than children with strong coping skills and supportive social networks. Children who utilize
problem-solving strategies targeted directly at the source of disagreement demonstrate fewer maladaptive symptoms. Emotion-focused strategies, however, are less desirable because they often target internal responses to a stressful situation, which can result in less effective coping methods (e.g., children fantasizing that their parent's are "getting along").

- **The age of the child.** Younger children appear to exhibit higher levels of emotional and psychological distress than older children. Age-related differences might result from older children's more fully developed cognitive abilities to understand the violence and select various coping strategies to alleviate upsetting emotions.

- **The time since exposure.** Children are observed to have heightened levels of anxiety and fear immediately after a recent violent event. Fewer observable effects are seen in children the longer time has past after they have witnessed the violence.

- **Gender.** In general, boys exhibit more "externalized" behaviors (e.g., aggression or acting out) while girls exhibit more "internalized" behaviors (e.g., withdrawal or depression). In addition, boys identify more with the male abuser and girls identify more with the female victim; both may continue these roles throughout life if the issues are not addressed.

- **The presence of child abuse.** Children who witness domestic abuse and are physically abused demonstrate increased levels of emotional and psychological maladjustment than children who only witness violence and are not abused.

### Parenting and the Perpetrator

Can perpetrators be supportive parents when they are abusive towards the other parent? An emerging issue facing victims of domestic violence and child advocacy groups is the role and impact that perpetrators have in their children's lives. There are perpetrators who have positive interactions with their children, provide for their physical and financial needs, and are not abusive towards them. There also are perpetrators who neglect or physically harm their children. Although abusers vary tremendously in parenting styles, there are some behaviors common among perpetrators that can have harmful effects on children:

- **Authoritarianism.** Perpetrators can be rigid and demanding with their children. They often have high and unrealistic expectations and expect children to obey without question or resistance. This parenting style is intimidating for children and alters their sense of safety around the abuser. These perpetrators are more likely to use harsher forms of physical discipline, which can make the children increasingly vulnerable to becoming direct targets of violence.

- **Neglect, irresponsibility, and lack of involvement.** Some abusers are infrequently involved in the daily parenting activities of their children. They may view their children as hindrances and become easily annoyed with them. Furthermore, the perpetrator's preoccupation with controlling the partner and meeting his or her own emotional needs leaves little time to engage the children. Unfortunately, the perpetrator's physical and emotional unavailability can produce unrequited feelings of anticipation and fondness in the children who eagerly await attention.

- **Undermining the victim.** The perpetrator's coercive and violent behavior towards the victim sometimes sends children a message that it is acceptable for them to treat that parent in the same manner. More overt tactics that weaken the victim's influence over the children include the perpetrator disregarding the victim's parenting decisions, telling the children that the victim is an inadequate parent, and belittling the victim in the presence of the children. Being victimized by abuse can lead children to perceive the parent in a weaker, passive role with no real authority over their lives.

- **Self-centeredness.** Some perpetrators use their children to meet their own emotional needs. Perpetrators may expect their children to be immediately available only when they are interested and often overwhelm them with their problems. This can result in children feeling burdened and responsible for helping their parent while their own needs are neglected.
• **Manipulation.** To gain power in the home, perpetrators may manipulate their children into aligning against the victim. Abusers may make statements or exhibit behaviors that confuse the children regarding who is responsible for the violence and coerce them into believing that they are the preferable parent. Abusers also may directly or indirectly use their children to control and intimidate the victim. Perpetrators sometimes may threaten to abduct, seek sole custody of, or physically harm the children if the victim is not compliant.\(^{72}\) Sometimes these are threats exclusively and the abuser does not intend or really want to carry out the action, but the threats are typically perceived as being very real.

Children's perception of the abuser's violence can play a significant role in the nature of their relationship. Children often feel anxious, scared, and angry when they witness abuse. At the same time, many children also feel affection, loyalty, and love for the abuser. It is common for children to experience ambivalent feelings towards the abuser and this can be difficult for them to resolve.\(^{73}\)

Domestic violence can influence the children's feelings toward the victim. Many children know the abuse is wrong and may even feel responsible for protecting the battered parent. Yet, they also experience confusion and resentment towards the victim for "putting up" with the abuse and are more likely to express their anger towards the victim rather than directly at the perpetrator.\(^{74}\)

Children need additional support as they struggle with their conflicting feelings towards the perpetrator. The responsibility of perpetrators as parents primarily focuses on preventing the recurrence of the violence. Some victims want their children to have a safe and positive relationship with the perpetrator, and some children crave that connection. Consequently, community service providers are confronted with the challenge of developing resources and strategies to help perpetrators become supportive and safe parents.\(^{75}\)

Examples of specific approaches that programs and service providers can use that will assist perpetrators in taking responsibility for the harm they pose to their children include:

- Educating abusers on the damaging effects of their behavior on their partners and children;
- Providing intensive parenting skills programs that emphasize the needs of children affected by domestic abuse;
- Offering safe exchange and supervised visitation programs;
- Encouraging abusers to support their children in attending groups for youths exposed to domestic violence;
- Recruiting nonviolent fathers to mentor domestic violence perpetrators.\(^{76}\)

A provocative issue for CPS caseworkers, service providers, and other community groups is determining the role abusers should have as parents or caretakers.\(^{77}\) Many voice legitimate concerns regarding the safety of the child victims.

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Part 8: Screening and Assessing for the Presence of Domestic Violence

**Points of Intervention**

The medical care system offers multiple settings where victims of relationship violence interact with providers. These include emergency rooms, primary care or family medicine, well-women gynecology, prenatal and antenatal clinics for pregnant women and new mothers, chronic pain clinics, sexually transmitted infection clinics, HIV screening, mental health clinics, drug, alcohol, and smoking cessation programs, and programs aimed at raising physical activity levels and weight loss.
Victims of abuse, particularly women, are much more likely to seek medical services than legal, social, family or clergy services, including emergency room visits. During these visits, health care providers have the opportunity to conduct screenings and assess for domestic abuse and sexual assault, as well as for alcohol abuse. Many providers, however, never ask questions or probe beyond the presenting problem to determine the underlying cause of a problem.

A number of studies show that mental health providers may not recognize intimate partner abuse and do not ask about its possible occurrence. For example, in one study mental health providers were asked how they would intervene in cases involving partner abuse. The majority did not identify violence as a presenting problem, and of those who did recognize violence, they often suggested interventions that were ineffective, or worse, harmful.

It is important that health care providers know about screening and assessment procedures for cases of relationship violence. This means knowing how to screen, what assessment instruments are available, how to understand the clinical presentations of individuals involved in abusive relationships, what methods are available for risk assessment, and what types of clinical interventions can be made based upon the assessment.

**Screening and Assessment Defined**

Screening and assessment are defined as follows:

- **Screening.** This is a brief procedure used to:
  1. Determine the presence of a problem (e.g., mental health disorder, domestic violence, substance abuse)
  2. Substantiate that there is a reason for concern
  3. Identify the need for further evaluation

Screening is done early in the process of collecting information. It may be done by a questionnaire or checklist. Screening tools are not meant to provide a mental health or substance abuse diagnosis. Instead, they are used to collect initial information that will help in further assessing the problem.

- **Assessment.** This is a more comprehensive diagnostic and treatment planning process typically based on screening information. A detailed assessment may take hours to complete and should help to prepare a treatment plan. Some goals of assessment are to:

  1. Examine the scope and/or severity of domestic violence, mental health or substance abuse problems
  2. Identify other possible psychosocial problems that may need to be addressed further
  3. Provide a foundation for treatment
  4. Identify possible strengths of the patient that can become part of the treatment planning process

**Victims Often Don't Volunteer Information about Violent Relationships**

Victims are often reluctant to give information about domestic abuse. For example, one study showed that during intake, fewer than 5% of couples seeking marital therapy volunteered that violence was even an issue. Yet, as many as 66% of couples reported some form of violence on a written self-report evaluation. Reasons for not reporting can include:

Individual's reluctance to identify themselves as victims.

Fear and shame because the victim feels responsible, or the perpetrator has underlying issues of shame.
Couples’ belief that violence is not the problem because it is infrequent and seen as secondary to other problems.88

Gay men and lesbian women are less likely to report relationship violence to the police than victims in heterosexual relationships because of fear that they will be further discriminated against. Research indicates that in the area of hate crime, many gay men and lesbian women do not report verbal harassment or physical violence against them to the authorities because they fear that they will be subjected to additional victimization at the hands of police or others who may learn of their sexual orientation as a result of their having reported the original attack.89

In some instances, it may be difficult to determine who the abuser is and who the victim is. However, it is important for the health provider to identify the abuser and the victim because the services provided to each party are necessarily different. With regard to same-sex couples, Tiffany Veinot provides useful questions to be used in screening for relationship violence. Information can be found at http://www.springtideresources.org/resource/archives-screening-who-abuser-screening-challenge90

Asking about Abuse

Although health care providers may discover that a person has been abused as a result of recognizing the signs and symptoms of abuse, being told by police or social services, reading the medical record, hearing about it in the community, or even witnessing it directly, the most important tool for identifying abuse is asking individuals directly if they have been harmed.91

Studies indicate that asking about abuse increases detection:

"Experience in office practices has shown that a single direct question asked routinely and non-judgmentally in the course of the social history, can significantly increase the detection of abuse"92

"...women are more likely to reveal abuse when asked by their primary care providers"93

"...in a study of 691 pregnant women, 8% self-reported abuse on an intake form, but 29% reported abuse when asked directly"94

Abused women report that one of the most important aspects of their doctor's visit was their ability to talk about the abuse.95

Asking women about abuse also increases the chance of preventing further abuse. It indicates to victims that they are being taken seriously and that help is available to them.

It tells an abused woman that:

- she is believed,
- she is respected,
- she is not alone,
- the professional is willing to hear about this topic,
- abuse happens to a lot of women,
- abuse has been encountered before,
- the issue is being taken seriously,
- she can get help.96 97

Creating a Safe Environment

When screening for domestic violence, health professionals should establish an environment of trust and safety, keeping in mind that protecting the victim's safety is of paramount importance. It is also important to remember that the abused person is the best judge of her personal safety.
Practical ways to foster a safe environment include ensuring that:

- all patients are routinely screened for domestic violence;
- there is a private space for interviewing and/or examining women. This means being prepared to offer "safe" reasons why it is necessary to see a woman in private (e.g., collection of a fresh urine specimen);
- there is access to appropriate translators or signers (who are not family members or someone she knows personally) if the woman speaks another language than the service provider, or if the woman has a hearing disability;
- women are informed about reporting requirements for child abuse and neglect before the screening so they can assess the implications for safety and confidentiality;
- there is a plan to enhance the safety of all staff involved in treating victims of abuse.

Who Should Be Screened Routinely?

- All females aged 12 years and older

Universal screening means asking every woman about abuse, not just asking women whose situations raise suspicions of abuse. Pregnant women should be asked about abuse as early as possible in their pregnancies.

There are many tools available to those professionals working with teenagers and dating violence. A few of them test acceptance of couple violence, gender stereotyping, and attitudes toward women.

Who Should Do the Screening?

At a minimum, screening should be done by a health care provider who:

- Has been educated about the dynamics of domestic violence,
- Is familiar with the effects of the violence on the victims, and
- Who is culturally competent.

This person should be trained to introduce the subject of abuse into conversation and should know how to intervene appropriately as well as have authorization to record in the medical record. The screener should attempt to establish a relationship or some level of trust with the patient before asking personal questions.

How Should Screening Occur?

Screening for domestic violence should be a regular part of a face-to-face encounter for the health care professional. Questions need to be direct and nonjudgmental, and the interview needs to be conducted in private. That means that no relatives or friends of the patient or children over the age of two years should be present.

Use professional interpreters, instead of a family member or friend, whenever possible.

Confidentiality and Reporting

Health care providers, social workers, psychologists, counselors, or any other professionals working with clients are required to follow their profession's rules for confidentiality and mandatory exceptions to confidentiality. Professionals should explain to clients/patients the limits to confidentiality before they begin a screening.
Generally, mandated reporters of child abuse, such as health care providers and mental health professionals, must report child abuse whenever they have knowledge of or observe a child whom they know or reasonably suspect has been the victim of child abuse or neglect. It is not required that the abuse be confirmed. A report is required whenever the mandated reporter has "reasonable suspicion" that abuse has occurred.

**When Should Screening Occur?**

- As part of a routine health exam or history
- During an initial visit for a new complaint
- During every new patient meeting
- At any visit after the client has started a new intimate relationship
- During every periodic comprehensive visit.

**Where Should Screening Occur?**

Trained health care providers should provide domestic violence screening as a routine part of patient care in at least the following settings: Primary care, urgent care, OB/GYN and family planning, mental health, and inpatient care.

**Domestic Violence Screening Statements**

In establishing a bond with the client or patient, the professional must achieve his or her goals in a way that is the least threatening or traumatic to the victim. The phrasing of the following statements can help defuse an otherwise uncomfortable (or even physically confrontational) atmosphere.

- "Because violence is so common in many people's lives, I've begun to ask all my patients about it."
- "I'm concerned that your symptoms may have been caused by someone hurting you."
- "Many of my clients are involved in abusive relationships. I don't know if this applies to you, but some people are too scared to bring it up themselves, so I now ask about it routinely." "Do you feel safe in your relationship?"
- "Statistics show some lesbian women are in abusive relationships. Does your partner ever try to hurt you?"

**Additional Statements of Support**

If someone declines to discuss domestic violence issues, consider whether the silence may be due to a fear of the batterer, or to cultural, race, or gender issues that make it difficult to talk about such personal experiences. Again, gentle, yet clearly worded statements will achieve the best results.

- "I am concerned about your safety."
- "You can talk to me about what is happening at home."
- "I am concerned about your children's safety. Domestic violence can harm your children."
- "Domestic violence is a crime."
Suggested Screening Tools

There are many abuse screening tools available. Professionals will need to select (or develop) the tool that is most appropriate for their work setting. Using appropriate screening tools, however, is only the first step. Appropriate information on options, resources and potential solutions must also be provided.

Below are samples of screening tools:

- **The "SAFE" Tool**
  
  Screening does not have to involve a long list of questions that may be inappropriate or difficult to use in some situations. The SAFE tool was designed to be memorized easily and used quickly:
  
  - S How would she describe her spousal relationship?
  - A What happens when she and her partner argue?
  - F Do fights result in her being hit, shoved or hurt?
  - E Does she have an emergency plan?

  (SAFE tool, n.d.)

- **The Psychological Maltreatment of Women Inventory (PMWI)**

  The PMWI is a 58-item test designed to measure the extent and nature of abuse toward women in a relationship. The questionnaire below is given to women survivors of abuse. The version for male perpetrators includes identical behaviors but reverses the pronouns and direction of abuse.

  **Women's Scale Items**

  How often, if at all, did the behavior described in each item occur within the past 6 months (never, rarely, sometimes, frequently, or very frequently)?

  1. My partner criticized my physical appearance.
  2. My partner insulted me or shamed me in front of others.
  3. My partner treated me like I was stupid.
  4. My partner was insensitive to my feelings.
  5. My partner told me I couldn't manage or take care of myself without him.
  7. My partner criticized the way I took care of the house.
  8. My partner said something to spite me.
  9. My partner brought up something from the past to hurt me.
  10. My partner called me names.
  11. My partner swore at me.
  12. My partner yelled and screamed at me.
  13. My partner treated me like an inferior.
  14. My partner sulked or refused to talk about a problem.
  15. My partner stomped away during a disagreement.
  16. My partner gave me the silent treatment, or acted as if I wasn't there.
  17. My partner withheld affection from me.
  18. My partner did not let me talk about my feelings.
  19. My partner was insensitive to my sexual needs and desires.
  20. My partner demanded obedience to his whims.
  21. My partner became upset if dinner, housework, or laundry was not done when he thought it should be.
  22. My partner acted like I was his personal servant.
  23. My partner did not do a fair share of household tasks.
  24. My partner did not do a fair share of childcare.
  25. My partner ordered me around.
26. My partner monitored my time and made me account for where I was.
27. My partner was stingy in giving me money to run our household.
28. My partner acted irresponsibly with our financial resources.
29. My partner did not contribute enough to supporting our family.
30. My partner used our money or made important financial decisions without talking to me about it.
31. My partner kept me from getting medical care that I needed.
32. My partner was jealous or suspicious of my friends.
33. My partner was jealous of other men.
34. My partner did not want me to go to school or other self-improvement activities.
35. My partner did not want me to socialize with my female friends.
36. My partner accused me of having an affair with another man.
37. My partner demanded that I stay home and take care of the children.
38. My partner tried to keep me from seeing or talking to my family.
39. My partner interfered in my relationships with other family members.
40. My partner tried to keep me from doing things to help myself.
41. My partner restricted my use of the car.
42. My partner restricted my use of the telephone.
43. My partner did not allow me to go out of the house when I wanted to go.
44. My partner refused to let me work outside of the home.
45. My partner told me my feelings were irrational or crazy.
46. My partner blamed me for his problems.
47. My partner tried to turn our family, friends, and children against me.
48. My partner blamed me for causing his violent behavior.
49. My partner tried to make me feel like I was crazy.
50. My partner's moods changed radically, from calm to angry, or vice versa.
51. My partner blamed me when he was upset about something, even when it had nothing to do with me.
52. My partner tried to convince my friends, family, children that I was crazy.
53. My partner threatened to hurt himself if I left him.
54. My partner threatened to hurt himself if I didn't do what he wanted me to do.
55. My partner threatened to have an affair with someone else.
56. My partner threatened to leave the relationship.
57. My partner threatened to take the children away from me.
58. My partner threatened to have me committed to a mental institution.


Other questions you can ask include:

- What happens when you argue with your partner?
- How safe do you feel with your partner? How safe do you feel when you leave here?
- How does your partner try to control you?
- How does your partner show respect to you?
- Can you tell me about a situation with your partner when: (1) yelling and screaming occurred, (2) things were destroyed, and (3) your partner pushed, slapped, or hit you?

Besides physical signs, professionals should listen for:

- Any statements that suggest her partner won't let her do something (e.g., attend counseling, support groups, see family/friends, go alone to appointments),
- Evidence or reports of child abuse, and
- Inconsistencies or evasiveness.

Healthcare providers can also screen for physical abuse, sexual abuse and psychological abuse by having clients fill out simple questionnaires such as the following:
Assessing Sexual Abuse

Assessing Psychological Abuse

Assessing Physical Abuse


Also, the Family Violence Prevention Fund and the American College of Obstetricians and Gynecologists have created general screening policies for all health care providers to use. For more information or detailed recommendations for specific health care settings, please go to http://www.endabuse.org or http://www.acog.org.

Assessment

Important Areas of Assessment:101

- **Assess the priority of safety for the victim.** Is there immediate danger? Where is the perpetrator now? Where will the perpetrator be when the patient/client is finished with the appointment?

- **Assess the pattern and history of the abuse.** Assess the perpetrator's physical, sexual, and psychological tactics, as well as the economic status of the client. How long has the violence been going on? Has the perpetrator harmed the client sexually? Does the perpetrator control the client's activities, money, or children?

- **Assess the connection between domestic violence and the client's health issues.** What is the impact of the abuse on the victim's physical, emotional, and spiritual well-being? What degree of control does the perpetrator exercise over the victim? How is the abusive behavior affecting the victim's health? (See Health Outcomes Chart - http://www.athealthce.com/courses/B3007-B04/HealthOutcomesOfViolence.pdf).

- **Assess the victim's current access to advocacy and support resources.** What does the victim need? Are there community resources available to the client, such as information, support, shelter, counseling, support group, legal advocacy, mental health services, access to other resources? Has the client tried to use these resources in the past? If so, what happened? What additional resources (besides what you have been offered) are available now? Does the victim need help in accessing the resources? Are the resources you are suggesting sensitive to cultural and language issues, mental health concerns, substance abuse, and gay and lesbian issues?

- **Assess the patient's safety.** Is there future risk of death or significant injury? Ask about the perpetrator's tactics: use of weapons, frequency or severity of abuse, stalking or suicide threats, use of alcohol. Are their warning signs that indicate danger to her or the children? Does she have a safety plan? Who can help her develop a safety plan?

  If there are children, ask about their physical safety.102 Remember, a client must realize that if she tells the professional about child abuse or maltreatment, the professional is mandated, by law, to reveal the abuse to legal authorities or to Child Protection Services.

A compilation of assessment instruments for intimate partner violence, *Intimate Partner Violence and Sexual Violence Victimization Assessment Instruments for Use in Healthcare Settings*, can be found at [http://www.cdc.gov/NCIPC/pub-res/images/IPVandSVscreening.pdf](http://www.cdc.gov/NCIPC/pub-res/images/IPVandSVscreening.pdf) The document is divided into two sections. Section A includes intimate partner violence victimization tools. Section B includes sexual violence victimization tools. A table is included at the beginning of each section that lists each of the instruments included in the section. The actual instruments follow the table. Some instruments found in Section A are repeated in Section B if they include at least one item pertaining to sexual violence victimization.
Once it has been confirmed that a victim is being abused, it is important to validate the victim’s experience. Validation can include the following statements:

- I am concerned about your safety and well-being.
- I understand how difficult it is for you to make the necessary changes.
- You are not alone.
- The violence is not your fault. Only your abuser can stop his or her abusive behavior.
- No one deserves to be abused; there is no excuse for violence. You deserve better.
- There are options and resources available.

This material was adapted from the publication entitled, “Improving the Health Care System’s Response to Domestic Violence: A Resource Manual for Health Care Providers,” produced by the Family Violence Prevention Fund in collaboration with the Pennsylvania Coalition Against Domestic Violence. Written by Carole Warshaw, M.D. and Anne L. Ganley, Ph.D., with contributions by Patricia R. Salber, MD. Carole Warshaw, MD, is the author of the section that is adapted.

Part 8 adapted from:


Part 9: Intervention

The Importance of Intervention

Professionals can provide an abused victim with information about abuse and the options that are available to her. They should also provide, or guide her to, the appropriate source for support as she makes her own decisions and choices about what is best for her and her children. Continuity of service and follow-up are essential.

Education, Information, and Referral

Health care professionals should look at ways of providing information that are best suited to their work setting. This may include providing written information, discussing this information with the woman, and/or providing referrals to other services in the community.

Time Considerations in Primary Care

Although it usually takes less than a minute to ask initial questions about abuse, listening to the patient and providing adequate assessment and intervention takes more time. The time spent by a primary provider can be brief when a social worker or domestic violence advocate is available to complete the evaluation. If the primary provider is sufficiently knowledgeable and comfortable, he or she can provide a more thorough assessment, initial intervention, and follow-up.
For the primary provider that has neither time, training, nor on-site resources, there are several options for working with battered women. Support can be offered by saying something such as:

- "I'm glad you felt you could tell me about what has been happening to you. I am very concerned about the issues you brought up, especially your safety. Although I don't have time right now to fully address your concerns, there is someone we can call who has a lot of experience with this issue. I hope you can stay and talk with her today."

- "I will give you the numbers of some community agencies that provide counseling, shelter and legal help. There are people there who can discuss your situation and possible options with you. You can use my phone to make some calls. Before you leave here, however, let's discuss how dangerous your situation is right now and make sure that you have a way to be safe."

This material was adapted from the publication entitled, "Improving the Health Care System's Response to Domestic Violence: A Resource Manual for Health Care Providers," produced by the Family Violence Prevention Fund in collaboration with the Pennsylvania Coalition Against Domestic Violence. Written by Carole Warshaw, M.D. and Anne L. Ganley, Ph.D., with contributions by Patricia R. Salber, MD. Carole Warshaw, MD, is the author of the section that is adapted.

Written Information

Health care providers should compile and be prepared to offer an up-to-date list of community resources for referral and assistance, including shelter, crisis centers, hotlines, children's services, counseling, and legal options.

You may want to consider printing essential crisis hotline numbers or resources on business cards (small enough to be hidden in a wallet or shoe). These cards could be made available in restrooms, examination rooms, and any other private spaces.

Because it may be too dangerous for a victim to take written information, mention that resources to help abused women are listed in the phone book. She could also memorize numbers or leave a message at a friend's or at work.

Advise the victim that she should be careful about searching for information on her home computer as the batterer may be able to discover her search efforts.

While it is not recommended that professionals directly confront a potential batterer if abuse is suspected, they should look at ways of making information about local treatment programs for batterers available. This could include displaying information (such as posters, pamphlets on local programs, etc.) in examination or counseling rooms.

Safety Planning

Some women will decide that returning home is the safest option. Although each woman's options will depend on her particular situation, her priorities, and what she thinks will be best for her and her children, it may be possible to help her "problem solve" her concerns, including determining:

- whether to leave the situation;
- where she will stay if she leaves;
- how to protect herself and her children if she returns home;
- how she will protect herself if the abuser is removed from the home.

Encourage her to consider her options, which may include:

- going immediately to a shelter;
- going to stay with family or friends;
- taking home hidden information about resources that she could use later;
• getting a referral to counseling;
• going home, having arranged for a follow-up appointment;
• going home, having asked someone to stay with her;
• being referred to law enforcement, a lawyer or victim's services’
• applying for a protective order requiring the abuser not to contact the victim and her children.

However, do not:

• insist that she leave her partner;
• tell an abusive partner that the woman has revealed abuse;
• endanger her by providing information in an unsafe way (e.g., mailing it to her house or providing discharge instructions that an abuser may read);
• pressure her to report to police;
• call the police without her consent;
• delay telling her about a health provider's legal obligation to report child abuse until after she has already discussed the abuse.

The process of designing a personal safety plan may seem overwhelming, but there are four scenarios that will help the victim determine which actions are appropriate for her situation. Following these suggestions is not a guarantee of safety, but could help to improve the victim’s safety situation. These scenarios include:104

Safety During a Violent Incident

The victim may not be able to avoid all violence, but there are some things that may help her avoid being hurt and aid in her escape.

• If possible, plan a way to exit the house or room where the abuser is.
• If you think an argument may happen, do not stay in any room that may contain possible weapons, such as the kitchen, bathroom, and garage. Go to a room that has an exit.
• Practice getting out safely. What doors, windows, stairwells, and elevators will you use?
• 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 the numbers to call for help. Know where the nearest pay phone is located. Know your local battered women's shelter number.
• Don't be afraid to call the police.
• Keep your purse and car keys close by. Keep an extra copy of your car key hidden in a safe place.
• As hard as it may be, you will need to tell trusted neighbors, friends, or family so that they are able to call the police if they hear a suspicious noise from your house. Be careful not to tell someone who would share the conversation with your partner.
• If you have children who are old enough, teach them how to call 9-1-1. Choose a code word that your children and neighbors will recognize when you need them to call the police or when the children should leave the house.
• Practice how to get out safely. Practice with your children.
• Instruct them not to get involved in the violence between you and your partner.

• 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 cause the violence, and that when anyone is being violent, it is important to keep safe.

• Keep weapons like guns and knives locked up 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.

• Identify alternative places you can stay after you leave, even if you don't think you'll need them.

• Create several plausible reasons for leaving the house at different times of the day or night.

• Call a domestic violence hotline periodically to assess your options and get a supportive understanding ear.

Safety for Those Who Plan to Leave

Some women decide that they need to leave to ensure that they and their children are safe. Because men often become more violent when they suspect a woman is leaving (because it indicates that he is losing his control), it is important to prepare carefully.

• You may request a police stand-by or escort while you leave.

• If you need to sneak away, be prepared.

• Know where you can go to get help; tell someone what is happening to you.

• Leave money, an extra set of keys, and copies of important papers (see list below) with someone you trust.

• Leave extra clothes with someone you trust. Try to avoid using next-door neighbors, close family members and mutual friends.

• Open a bank account in your name only, if you do not already have one. Otherwise, try to set money aside or ask friends or family members to hold money for you.

• Determine who might be able to loan you money or give you a place to stay.

• Keep change for a pay phone with you at all times. Remember, if you use a credit card for phone calls, the numbers will appear on the next phone bill.

• Acquire job skills as you can, such as learning to type or taking courses at a community college.

• Keep any evidence of physical abuse, such as pictures, etc.

• Keep a journal of all violent incidences, noting dates, events and threats made, if possible. Put this in a place where your abuser will not find it.

• If you are injured, go to a doctor or an emergency room and report what happened to you. Ask that they document your visit.
• Contact your local domestic violence program or battered women's shelter and find out about laws and other resources available to you before you have to use them during a crisis.

• Plan for what you will do if your children tell your partner of your plan or if your partner otherwise finds out about your plan.

Items to Take When Leaving (Leave the items with someone you trust)

• Personal ID, licenses, Social Security cards
• Birth certificates of all children and yourself
• Keys (house, car, office, etc.)
• All bank cards, credit cards, savings and checking account information
• Lease, rental agreements, house deed, mortgage papers
• Insurance forms and information
• School forms/records of children's shots
• Medicine and any prescriptions for your children and yourself
• Immigration documents/green card/passport/visa
• Welfare documents
• Any documented evidence of physical abuse, such as photographs
• Clothing and comfort items for the children
• Valued photos, jewelry, or personal possessions
• Marriage license and divorce papers or other court documents (protective orders, etc.)
• Phone numbers and addresses of family, friends, and community resources

Women Who Leave are at High Risk

If a woman is planning to leave the situation, warn her not to tell her abuser. "Women are at greater risk of severe violence or even of being murdered just after they leave their husbands or partners. A large majority of murders occur when a woman attempts to leave the relationship in order to escape her partner’s attempts to control her."\(^{105}\) Assure her that the abuser will not be informed by the health provider that she is thinking about leaving.

Assessing the Risk of Domestic Homicide

The following "checklist" covers many identified risk factors for domestic homicide. Professionals should use appropriate language when asking risk assessment questions.

Have weapons been used or has there been a threat with weapons?

Is there access to, or ownership of, guns?

Have there been threats to kill?

Does the violence appear to be escalating or occurring more frequently?

Has there been destruction of property?

Has there been forced sex?

Has there been a threat to, injury of, or killing of a pet?

Is there a history of psychological problems?

Is there an obsessiveness to the partner?

Does the abuser manifest extreme jealousy?
Is there alcohol or drug abuse?

Has the relationship or marital situation changed recently? For example, has there been a separation (or threat of a separation), a job loss, a pregnancy or a change in finances?^{106}

For additional information on risk factors for Intimate Partner Homicide, see the Danger Assessment Tool which can be found at [http://www.ncjrs.gov/pdffiles1/jr000250e.pdf](http://www.ncjrs.gov/pdffiles1/jr000250e.pdf)

**Safety in Your Own Residence after Leaving the Relationship**

- Obtain an ex parte, civil protection order, or peace order. Generally, they are all court documents that provide relief to individuals who are experiencing partner abuse. All protective orders require an abuser to stop threatening or committing abuse and make an abuser end all contact with the victim.

- Keep the ex parte, civil protection order, or peace order with you at all times.

- If the abuser left the home, tell neighbors and/or your landlord that your partner no longer lives there and ask them to call the police if they see him at your home.

- Give copies of the restraining order to employers, neighbors, and schools along with a picture of the offender.

- Inform friends, neighbors and employers that you have a restraining order in effect.

- Call law enforcement to enforce the order.

- Change locks on all doors and windows.

- Change your phone number.

- Install or improve your security system to include window bars, locks, better outside lighting, movement detectors, fire extinguishers, and smoke detectors.

- Purchase rope or chain ladders to escape from a second story window.

- Change work hours and route taken to work.

- Change route taken to transport children to school.

- Consider renting a post office box or using the address of a friend for your mail.

- Talk to all schools and childcare providers about who has permission to pick up the children. Provide these entities with copies of the certified orders.

- Use different stores and frequent different social spots.

- Contact the local domestic violence center to get advice from a lawyer who knows about family violence.

- In rural areas where only the mailbox can be seen from the street, cover the mailbox with brightly colored paper to make it easier for the police to find the house.
Safety on the Job

At some point, victims may need to tell their boss, workmates, or Employee Assistance Program professionals about the abuse. The more people who know of the situation, the safer the victim may be.

- Make sure you list your workplace on the ex parte, civil protective order, or peace order. Give copies to your boss and security staff at your job.
- Provide a picture of the abuser to your boss, coworkers, and security.
- Give out the name of a person to contact in an emergency should your boss be unable to contact you or should something happen at your job.
- Review the safety of the parking lot or garage. If possible, arrange for someone to walk with you to and from the parking lot and the office.
- If your desk is located in a public area or can be seen from the street, try to relocate to a less visible spot.
- Try to change your schedule so that you arrive and leave work at different times. This may discourage a potential stalker or abuser from confronting you.
- Have caller ID put on your work phone and save all faxes and e-mails that may provide legal proof that the man is disobeying the no-contact rule of the protective order.
- Review the safety of your childcare plan. Make sure you have included all addresses on the protective order that the abuser is required to stay away from. This would also include your child's school and/or day care address.

Sample Personalized Safety Plan

This sample safety plan can be used to help victims plan for their safety and the safety of their children - http://www.athealthce.com/courses/B3007-B04/SampleSafetyPlan.pdf.

Part 9 adapted from:


Part 10: Respecting Diversity: Responding to Underserved Victims of Crime, Including Domestic Violence

The racial and ethnic diversity of the United States has changed considerably in the last few decades. An increasing proportion of Latino, Asian, and African-Americans have integrated with the European-American population. With this transition, victim assistance professionals are faced with new challenges. Recognizing and respecting individual cultural differences are important to sensitive and effective work with victims. In addition, differences in concepts of suffering and healing can influence how a victim may experience the effects of victimization and the process of recovery.
The term "culture" can be reasonably applied to various demographic categories. For example, cultures or subcultures can reflect differences by age, gender, sexual orientation, religion, and geographic region. Each of these groups has its particular self-identity and lifestyle and employs particular ways of viewing and meeting the traumas and triumphs of life. For this discussion, however, "culture" represents race and ethnicity. It is this diversity that both enriches and obstructs much of our involvement and interaction with others.

Aspects of Diversity

Two eternal truths about human beings are that people differ from one another and people are similar to one another. When highlighting the commonalities within cultural identities, overgeneralizations are often made at the risk of overlooking distinctions within these groups. The variety within cultural groups may be obscured by the emphasis placed on distinguishing among cultural groups. In other words, any aggregate labeling of people is part logic and part insult.

For example, the term "Indian" was a misnomer foisted upon the Arawak tribe of the southeastern United States by an errant Italian navigator who had set sail for India. It is now (mistakenly) used to describe all the native populations of the Western Hemisphere. "American Indians," preferably called "Native Americans," are now acknowledged by the Bureau of the Census to be over 500 separate nations and tribes with 187 different languages (U.S. Bureau of the Census 1997).

The term "Hispanic" refers to those who share a common language, i.e. Spanish. However, not everyone who is from a Spanish-speaking country speaks Spanish (for example, the native peoples from the central mountains in Mexico).

Just as it is presumptuous to consider a Boston Irishman, an Anglo-California yuppie, a Greenwich Village Jewish artist, a Texas rodeo star, and a Santa Fe New Age vegetarian as all the same because they are all "white," it would be just as inappropriate to consider all "Latinos" (or Asians or African-Americans) as inherently alike. As Ross, Millen, and Martinez have pointed out, "There are some ways in which any particular Chicano is like all other Chicanos, and there are some ways in which a particular Chicano is like no other Chicano."

Intertwined throughout our racial and ethnic identities are the distinctions of age, gender, generation, degree of acculturation, and socioeconomic status. "Ecological fallacy" (Robinson 1951, 351) occurs when one fails to consider variables between individuals.

Points To Reflect upon in Providing Services

- No one is just what we label or classify them.
- People are inseparable from their racial and ethnic backgrounds but not strictly determined by them.
- All crime victims deserve to be treated as individuals even as the nuances of race and culture (and the degrees of acculturation) are recognized.

Victim service providers must be aware of the cultural context of the victims with whom they are working, continually assess the adequacy of their communication styles and counseling methods, and be flexible enough to make adjustments on a case-by-case basis.

Culturally-Competent Services

- **Culture Destructiveness** is the conscious denial of another's culture, and/or the belief that one's own belief system is superior to all others.
- **Culture Incapacity** understands that there are differences among cultures but refuses or does not do anything to change.
• **Culture Blindness** overlooks differences as though they do not exist.

• **Culture Pre-competence** begins to realize that there is a world outside of oneself.

• **Culture Competence** values others and their differences; diversity is recognized and accepted.

• **Culture Proficiency** occurs when diversity works together.

### Multicultural Victim Services

Five core tenets of providing quality multicultural victim services are:

1. Acknowledgment of the different and valid cultural definitions of personal well-being and recovery from traumatic events.

2. Support of the sophisticated and varied cultural pathways to "mental health" and incorporation of these into appropriate victim services and referrals.

3. Extensive cultural awareness training and competency testing to enable victim assistance staff to have the capacity to understand persons whose thinking, behavior, and expressive modes are culturally different.

4. Multiethnic and multilingual teamwork as a resource to implement and monitor effective victim services.

5. Cross-cultural perspective to benefit from the principles and methods of other cultures.

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National Victim Assistance Academy June 2002
Chapter 8 Respecting Diversity: Responding to Underserved Victims of Crime
Available at https://www.ncjrs.gov/ovc_archives/nvaa2002/chapter8.html

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**Part 11: Abuse of Active Duty Military Women**

**An Interview with Dr. Jacquelyn Campbell**

Conducted by John H. Newby, MSW, PhD

Jacquelyn C. Campbell, PhD, RN, FAAN, is the Associate Dean for Faculty Affairs/Professor, at the Johns Hopkins University.

Dr. Campbell's research on family violence and violence against women has included risk factor assessment for intimate partner homicide, abuse during pregnancy, marital rape, physical and mental health effects of intimate partner violence, prevention of dating violence, and interventions to prevent and address domestic violence. She has been the principal investigator on numerous federal grants and served on the congressionally appointed U.S. Department of Defense Task Force on Domestic Violence. Her research results have been used for health policy recommendations to state, national, and international organizations. Dr. Campbell, a member of the National Institute of Medicine, is the recipient of the 2006 Pathfinder Award for Nursing Research from the Friends of the National Institute of Nursing Research. Dr. Campbell has authored and co-authored more than 50 articles and book chapters, as well as written and edited seven books on battered women and family violence.
Dr. Newby: Dr. Campbell, how did you become involved in the study of intimate partner violence (IPV) in the military?

Dr. Campbell: My first studies of domestic violence were of homicide against women. I found that the majority of women who were killed in this country were killed by a husband, boyfriend, ex-husband, or ex-boyfriend. I was collaborating with someone who was active duty Army when a request for proposals came out regarding the health of active duty military women. I was interested in how much abuse these women were experiencing. Up until then, research focused on active duty male service members abusing their civilian spouses. There was almost nothing in the literature about the abuse of active duty military women. Data for that study were collected from January 1998 through October 2000.

Dr. Newby: Would you give us a brief summary of that research?

Dr. Campbell: We found that the prevalence of physical and sexual interpersonal violence (IPV) among the military women sampled was 21.6% during their military service. It was not well known at the time that military women experienced abuse. During military service, perpetrators of abuse were: other active duty military members (43.2%), civilians (18.5%) and retirees (38.4%). Emotional abuse is not included in the 21.6% rate of abused women. In our survey of military women, in about 60% of the abused women, there was an overlap of at least two different types of abuse, physical and emotional, physical and sexual, or emotional and sexual. About 22% of the women experienced all three kinds of abuse. We also found that during military service IPV was more prevalent among enlisted women (30.6%) than officers (14.5%) and those with lower levels of education (high school=25.0%, post-graduate=15.0%). It is interesting to note, however, the percentage of IPV reported by officers, since a common belief is that such violence only occurs among the enlisted ranks.

Dr. Newby: What do you think about the reliability of your findings considering the limitations of your study?

Dr. Campbell: I would love to conduct the study again now that there is a DoD confidentiality policy. Our biggest limitation was a requirement by the institutional review board that we had to have a statement in the consent form that the research records could be reviewed by the participant's commanding officer. As a consequence our response rate was very low (13.2%).

Dr. Newby: Did they feel that it would be held against them or just did not want the information to be known.

Dr. Campbell: They were afraid of being considered less competent if they had a record of abuse even though they had been victimized. They also believed that having a personal record of being abused would hurt their chances for promotion.

Dr. Newby: Are there any specific risk factors for military women that could lead to violence?

Dr. Campbell: One risk factor was being separated or divorced. However, the cross-sectional aspect of the study did not tell us if the separation or divorce came before or after the IPV. We know from civilian studies that separation from an abusive partner may cause an escalation of abuse. Active duty military women and their commanders should be made aware of this danger. As I mentioned before, we saw an increased risk for women in the enlisted ranks, although there was still considerable abuse among officers. We also saw an increased risk for women who had three or more children. When there is a lot of stress in the household abusive situations can be exacerbated.

Dr. Newby: Are the risk factors different from what you would find in the civilian community?

Dr. Campbell: Oftentimes, in the civilian community we find lower income related to recent abuse. If women do not have sufficient resources, it is harder for them to escape from an abusive relationship. The low income factor may not be as important in a military context because of the economic floor below which
we hope most military families do not fall. We do not see the degree of poverty that we see sometimes in the civilian world.

**Dr. Newby:** What were some of the physical health and mental health consequences of IPV that you found in your study?

**Dr. Campbell:** We saw almost exactly the same pattern of physical health consequences for active duty women as we did among civilian women. Symptoms clustered around stress-related problems such as gastrointestinal symptoms and more overall physical symptoms. We also saw more chronic pain among women who were abused. The other cluster of symptoms that we saw included gynecological problems probably related to forced sex. There were also neurological problems such as headaches and other symptoms that were not so clearly defined.

**Dr. Newby:** Were there any distinct mental health consequences?

**Dr. Campbell:** We saw a different pattern of mental health consequences for the active duty women than we saw for the civilian women. The prevalence of mental health symptoms was higher among abused than non-abused women in both samples and also higher among the civilian sample compared to the military sample. Additionally, 34% of the abused civilian women versus 25% of the abused military women had symptoms that met criteria for a major depressive disorder, posttraumatic stress disorder (PTSD), or the co-occurrence of PTSD and depression. That compares with 18% and 15% of non-abused women in civilian and military groups, respectively. Military women, more than civilian women, were pretty resilient relative to mental health consequences.

**Dr. Newby:** What were the results of your research that addressed active duty females' perceptions of the positive and negative consequences of mandatory reporting and routine screening for IPV?

**Dr. Campbell:** About 57% of women thought that routine screening or the routine assessment for domestic violence in health care settings was a good idea, and 48% thought that there should be mandatory reporting. Non-abused women were more in favor of mandatory reporting than abused women. Both military and civilian women thought that they ought to be able to control the reporting process. The military women wanted to determine whether the abuse would be reported to the commander or military police. A powerful dimension of that research was its evidence-based link to the formulation of a confidentiality policy in DoD. During my time as a member of the congressionally appointed Defense Task Force on Domestic Violence, I used the data from our study to help persuade the committee to make a recommendation to give victims more say in whether or not domestic violence is reported. Starting in January 2006, there is now for the first time a restrictive reporting policy that applies to health care providers as well as domestic violence advocates. The reporting of domestic violence is restricted to those the victim specifically designates unless there is a likelihood of imminent harm to someone, child abuse, a subpoena for a directly relevant case, or a relevant disability hearing. Otherwise, neither the commanding officer nor the military police nor anyone else is notified of domestic violence if the victim so chooses. This is an example of an important policy change based, in part, on our research.

**Dr. Newby:** Were there other barriers to the self-reporting of IPV by active duty women.

**Dr. Campbell:** Yes, if a woman was on active duty and her husband was civilian, she wanted her partner to become non-violent without the risk of him getting a criminal record. If she was married to an immigrant, she was fearful that the reporting of IPV could possibly hurt her partner's chances of obtaining citizenship. Children may also serve as a barrier to self-reporting. Accordingly, women often feel that the reporting of IPV will negatively affect the perception of them as parents by various authorities.

**Dr. Newby:** Are these barriers different from those experienced by civilian women?

**Dr. Campbell:** The major difference for active duty military women was the role of the commander. If her partner is also active duty military, she may be afraid that he is going to be thrown out of the military. She may not want his career to be ended. She just wants the violence to end. It takes a woman a while to realize that these two goals may be incompatible.
Dr. Newby: Would you comment on the possible overlap of IPV and sexual assault issues among active duty military women?

Dr. Campbell: Many women are not only physically abused by their partners; they are also being forced to engage in sexual activities. It really is sexual assault or rape even though the assault is done by an intimate partner. In our study, 33% of the physically abused women also reported being forced into sex by the same partner. This type of sexual assault can be a very common part of intimate partner violence. There is a lot of shame that goes along with it, and it is difficult for a woman to admit that she is being raped by the person who is supposed to love her. Our questioning of victims should focus on "forced sex" rather than using rape or sexual assault language.

Dr. Newby: What are your current research interests relative to IPV?

Dr. Campbell: We have been looking at the occurrence of workplace violence relative to particular health-related outcomes. I would like to replicate that in the military. I am also interested in our returning combat-exposed male veterans and whether those veterans who have PTSD are more likely to abuse their wives and children.

Also, now that we have large numbers of combat-exposed females, I would also like to know whether there will be an increased risk for these women as either perpetrators or victims of domestic violence. One other thing I would like to study is whether or not the new DoD restricted confidentiality policy encourages more active duty women to come forward and report intimate partner violence. I would like to determine if the policy is really increasing the perception of safety by active duty military women.

Dr. Newby: Do you think the policy of providing soldiers and their families with post-deployment classes, briefings, counseling and other interventions will decrease the potential for negative repercussions?

Dr. Campbell: I certainly hope so. Oftentimes it is the non-abusing families that step forward and become involved in those programs. Unfortunately, families that need the services the most often do not ask for help. We need to determine how best we can reach them. I do hope that our current post-deployment interventions to help and support military families are effective. Sometimes we find that what we think is going to be helpful is not. There is a need for much more research in this area.

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Part 12: Elder Abuse

It is unlikely that many people in America envision that their "move toward the end of life" will include abuse, neglect, exploitation, or other types of victimization. However, with estimates that more than two-and-a-half million older people in America are victims of some form of reported or non-reported maltreatment each year, most often committed by a perpetrator known to the elderly victim, this seems to increasingly be the case.

Victim service providers can have a significant impact on preventing and intervening in cases of elder maltreatment, particularly through collaborative efforts with allied professionals. In many communities, victim advocates and justice professionals have forged important alliances with Adult Protective Services, mental health professionals, legal services, federal/state/local agencies that address elder issues, and the private sector to develop a wide range of adult protection, victim assistance, and crime prevention resources for elderly populations. In addition, public awareness initiatives have become a vital component of such collaborative efforts to educate communities about what far too often remains a hidden crime.
According to the National Center on Elder Abuse (NCEA), federal definitions of elder abuse, neglect, and exploitation appeared for the first time in the 1987 Amendments to the Older Americans Act. These definitions were provided in the law only as guidelines for identifying the problems and not for enforcement purposes.

Definitions in state law vary considerably from state to state in terms of what constitutes abuse, neglect, or exploitation of the elderly. Researchers also have used varying definitions to describe and study the problem.

Broadly defined, however, there are three basic categories of elder abuse. While state definitions may vary, in most states, definitions of elder abuse generally fall within these three categories:

- Domestic elder abuse
- Institutional elder abuse
- Self-neglect or self-abuse

Domestic elder abuse generally refers to any of several forms of maltreatment of an older person by someone who has a special relationship with the elder (a spouse, a sibling, a child, a friend, or a caregiver), that occur in the elder's home, or in the home of a caregiver.

Institutional abuse, on the other hand, generally refers to any of the above-mentioned forms of abuse that occur in residential facilities for older persons (e.g., nursing homes, foster homes, group homes, board and care facilities). Perpetrators of institutional abuse usually are persons who have a legal or contractual obligation to provide elder victims with care and protection (e.g., paid caregivers, staff, professionals).

Definitions and legal terms vary from state to state in regards to the types of domestic elder abuse that NCEA recognizes, as well as their signs and symptoms.

**Risk Factors for Elder Abuse**

Elder abuse, like other types of domestic violence, is extremely complex. Generally a combination of psychological, social, and economic factors, along with the mental and physical conditions of the victim and the perpetrator, contribute to the occurrence of elder maltreatment.

Although the factors listed below cannot explain all types of elder maltreatment, because it is likely that different types (as well as each single incident) involve different casual factors, they are some of the risk factors researchers say seem to be related to elder abuse.

- **Domestic Violence Grown Old**

  It is important to acknowledge that spouses make up a large percentage of elder abusers, and that a substantial proportion of these cases are domestic violence grown old: partnerships in which one member of a couple has traditionally tried to exert power and control over the other through emotional abuse, physical violence and threats, isolation, and other tactics.

- **Personal Problems of Abusers**

  Particularly in the case of adult children, abusers often are dependent on their victims for financial assistance, housing, and other forms of support. Oftentimes they need this support because of personal problems, such as mental illness, alcohol or drug abuse, or other dysfunctional personality characteristics.

  The risk of elder abuse seems to be particularly high when these adult children live with the elder.
• **Living with Others and Isolation**

Both living with someone else and being socially isolated have been associated with higher elder abuse rates. These seemingly contradictory findings may turn out to be related in that abusers who live with the elder have more opportunity to abuse and yet may be isolated from the larger community themselves or may seek to isolate the elders from others so that the abuse is not discovered. Further research needs to be done to explore the relationship between these factors.

• **Other Theories**

Many other theories about elder abuse have been developed. Few, unfortunately, have been tested adequately enough to definitively say whether they raise the risk of elder abuse or not. It is possible each of the following theories will ultimately be shown to account for a small percentage of elder abuse cases.

  - **Caregiver stress.** This commonly-stated theory holds that well-intentioned caregivers are so overwhelmed by the burden of caring for dependent elders that they end up losing it and striking out, neglecting, or otherwise harming the elder. Much of the small amount of research that has been done has shown that few cases fit this model.

  - **Personal characteristics of the elder.** Theories that fall under this umbrella hold that dementia, disruptive behaviors, problematic personality traits, and significant needs for assistance may all raise an elder's risk of being abused. Research on these possibilities has produced contradictory or unclear conclusions.

  - **Cycle of violence.** Some theorists hold that domestic violence is a learned problem-solving behavior transmitted from one generation to the next. This theory seems well established in cases of domestic violence and child abuse, but no research to date has shown that it is a cause of elder abuse.

**Who Are the Abusers?**

It has been estimated that roughly two-thirds of all elder abuse perpetrators are family members, most often the victim's adult child or spouse. Research has shown that the abusers in many instances are financially dependent on the elder's resources and have problems related to alcohol and drugs.

**Types of Abuse**

Some signs and symptoms are characteristic of several kinds of maltreatment and should be regarded as indicators of maltreatment. The following are the most important of these:

  - An elder's frequent unexplained crying.
  - An elder's unexplained fear or suspicion of person(s) in the home.

**Physical abuse** is the use of force that may result in bodily injury, physical pain, or impairment. Physical abuse may include such acts of violence as striking (with or without an object), hitting, beating, pushing, shoving, shaking, slapping, kicking, pinching, and burning. The inappropriate use of drugs and physical restraints, force-feeding, and physical punishment of any kind are also examples of physical abuse. Particularly alarming is the "hidden" nature of this physical abuse to the elderly. Incidence studies demonstrate that elderly helpers only report signs of physical abuse in one out of five of the cases examined.

Signs and symptoms of physical abuse include the following:

  - Bruises, black eyes, welts, lacerations, and rope marks.
  - Bone fractures, broken bones, and skull fractures.
  - Open wounds, cuts, punctures, and untreated injuries, and injuries in various stages of healing.
• Sprains, dislocations, and internal injuries/bleeding.
• Broken eye glasses/frames, physical signs of being subjected to punishment, and signs of being restrained.
• Laboratory findings of medication overdose or underutilization of prescribed drugs.
• An elder's report of being hit, slapped, kicked, or mistreated.
• An elder's sudden change in behavior.
• The caregiver's refusal to allow visitors to see an elder alone.

**Sexual abuse** is nonconsensual sexual contact of any kind with an elderly person. Sexual contact with any person incapable of giving consent also is considered sexual abuse. It includes unwanted touching; all types of sexual assault or battery such as rape, sodomy, coerced nudity; and sexually explicit photographing.

Signs and symptoms of sexual abuse include the following:

• Bruises around the breasts or genital area.
• Unexplained venereal disease or genital infections.
• Unexplained vaginal or anal bleeding.
• Torn, stained, or bloody underclothing.
• An elder's report of being sexually assaulted or raped.

**Emotional or psychological abuse** is the infliction of anguish, pain, or distress through verbal or nonverbal acts. Emotional/psychological abuse includes verbal assaults, insults, threats, intimidation, humiliations, and harassment. Treating an older person like an infant; isolating an elderly person from his/her family, friends, or regular activities; giving an older person the "silent treatment;" and enforced social isolation also are examples of emotional/psychological abuse.

Signs and symptoms of emotional/psychological abuse may manifest themselves in the following such behaviors of an elderly person:

• Being emotionally upset or agitated.
• Being extremely withdrawn and non-communicative or nonresponsive.
• Exhibiting unusual behavior attributed to dementia such as sucking, biting, rocking.
• Reporting verbal or emotional mistreatment.

**Neglect** is the refusal or failure to fulfill any part of a person's obligation or duties to an elder. Neglect may also include a person who has fiduciary responsibilities to provide care for an elder (i.e., pay for necessary home care services or the failure on part of an in-home service provider to provide necessary care). Neglect typically means the refusal or failure to provide an elderly person with such life necessities as food, water, clothing, shelter, personal hygiene, medicine, comfort, personal safety, and other essentials included in the responsibility or agreement to an elder.

The following are signs and symptoms of neglect:

• Dehydration, malnutrition, untreated bedsores, and poor personal hygiene.
• Unattended or untreated health problems.
• Hazardous or unsafe living conditions/arrangements (i.e., improper wiring, no heat, or no running water).
• Unsanitary and unclean living conditions (i.e., dirt, fleas, lice on person, soiled bedding, fecal/urine smell, inadequate clothing).
• An elder's report of being mistreated.

**Abandonment** is the desertion of an elderly person by an individual who has assumed responsibility for providing care for an elder or by a person with physical custody of an elder.
Signs and symptoms of abandonment include the following:

- The desertion of an elder at a hospital, a nursing facility, or other similar institution.
- The desertion of an elder at a shopping center or other public location.
- An elder's own report of being abandoned.

**Financial or material exploitation** is the illegal or improper use of an elder's funds, property, or assets. Examples include cashing an elderly person's checks without authorization or permission; forging an older person's signature; misusing or stealing an older person's money or possessions; coercing or deceiving an older person into signing any document (i.e., a contract, a will); and the improper use of guardianship or power of attorney.

Signs and symptoms of financial or material exploitation include:

- Sudden changes in bank account or banking practices, including an unexplained withdrawal of large sums of money by a person accompanying the elder.
- The inclusion of additional names on an elder's bank signature card.
- Unauthorized withdrawal of the elder's funds using the elder's ATM card.
- Abrupt changes in a will or other financial documents.
- Unexplained disappearance of funds or valuable possessions.
- Substandard care or unpaid bills despite the availability of adequate financial resources.
- The forging of an elder's signature for financial transactions and for the titles of his or her possessions.
- Sudden appearance of previously uninvolved relatives claiming their rights to an elder's affairs and possessions.
- Unexplained sudden transfer of assets to a family member or someone outside the family.
- The provision of services that are not necessary.
- An elder's report of financial exploitation.

**Self-neglect** is characterized as the behavior of elderly persons that threatens their own health or safety. Self-neglect generally manifests itself in refusal or failure to provide themselves with adequate food, water, clothing, shelter, personal hygiene, medication (when indicated), and safety precautions. The definition of self-neglect excludes a situation in which cognitive or mentally competent older persons (who understand the consequences of their decision) make a conscious and voluntary decision to engage in acts that threaten their health or safety as a matter of personal preference.

Signs of self-neglect include the following:

- Dehydration, malnutrition, untreated or improperly attended medical conditions, and poor personal hygiene.
- Hazardous or unsafe living conditions or arrangements (i.e., improper wiring, no indoor plumbing, no heat or no running water).
- Unsanitary or unclean living quarters (i.e., animal/insect infestation, no functioning toilet, fecal/urine smell).
- Inappropriate and/or inadequate clothing, or lack of the necessary medical aids (i.e., eyeglasses, hearing aid, dentures).
- Grossly inadequate housing or homelessness.

**Elder Abuse and Culturally Diverse Populations**

Cultural demographics in the United States are undergoing significant change, with estimates that by the year 2030, the combination of African-Americans, Asians and Hispanics will make up nearly 49 percent of the U.S. population. Caucasians will become the “majority minority” by the year 2050, and the American profile will have changed to be dramatically multicultural.
According to Dr. Fernando Torres-Gil, Director of the Center for Policy Research on Aging, within the next fifty years there will be:

- A 160% increase in elder African-Americans.
- A 294% increase in elder Native Americans.
- A 570% increase in elder Hispanics.
- A 643% increase in elder Asian/Pacific Islanders (Torres-Gil 1997).

Considerations and issues specific to elderly victims of color are important to understand in a larger societal context that is based upon the entire history of the United States. The historical oppression of nonwhite people in America has left a residue that allows for continued subjugation of minority populations, most notably for this chapter, the elderly.

A thoughtful perspective on "micro" and "macro" elements in American society that continue to have a profound impact on how elderly persons of color are perceived and treated is offered by E. Percil Stanford, Ph.D., Professor and Director of the University Center on Aging at San Diego State University. Dr. Stanford presented a paper entitled "Diversity in an Aging Society - Abuse the Wild Card," sponsored in 1997 by the National Center on Elder Abuse with support from the Archstone Foundation. According to Dr. Stanford:

Diversity has been used as a concept to explain differences among and across population groups as well as age groups within. It provides a framework and backdrop for helping to explain many of the social situations and ills facing us today. It does not begin to define the universe of older people of multiple cultural and social backgrounds, but it helps explain their particular circumstances and social conditions. Gender, sexual orientation, religion, and other entities are powerful ingredients to consider when using diversity as a component to explain the universe of older people.

Older adults from diverse cultural backgrounds have historically confronted societal barriers of varying degrees. The multiple barriers have helped define who the older individual has become. The many life situations have helped shape the social, political, and economic outlook and status of older individuals from diverse cultural backgrounds.

As the older persons' position in society is closely examined, it becomes clear that they are easy targets for abuse and misuse. Older individuals from ethnic and minority communities are often at risk of being targets for a wide range of abuse. Their economic situations, in many instances, make them easy prey for those who are determined to be predators for personal and economic gain. Abusers and potential abusers often seek those who appear to be less capable of defending themselves and their property.

Throughout society, there are elements that can be described as micro and macro. For purposes of this discussion, micro barriers will be those issues, circumstances, and/or conditions that have an impact on a small number of people and are more personal in nature. Macro barriers have an impact on a wide range of individuals and are, from the very beginning, positioned to have an impact beyond the individual level. Macro barriers are often put in place through legislation or policy at several levels.

At the macro level, most older people from minority/ethnic backgrounds have experienced unbridled macro societal abuse. Macro abuse has come in many shapes and forms. Some of it has been subtle, and other aspects have been very blatant. Macro abuse has come in the form of Americans of African descent being used as slaves and/or forced to live in slave-like conditions. Being slaves and the residual which has perpetrated slave-like conditions for many, and the ever present memory of slavery on the part of the dominant society as well as the community of persons from African backgrounds, has helped set the stage for ongoing macro abuse.

Groups of American Indians, who have now grown old, have suffered isolation and near annihilation and have been subjected to a degree of macro abuse that has caused considerable social and psychological damage over the past century. Other individuals from diverse cultural backgrounds have been forced to relinquish land, give up their language, not practice their religion, and accept the deprivation of little or no education. In nearly all instances, older individuals from diverse cultural backgrounds have been forced to accept second and third class citizenship, or have found themselves in situations where they could not be the beneficiaries of citizenship at all.
It is too easy to define abuse in the traditional manner, which takes into consideration such areas as physical, sexual, fiduciary, and psychological abuse. Each form of abuse mentioned above has its roots in the community and society at large. These are very rudimentary aspects of abuse that come in the context of lifestyles of older persons...

...It cannot be emphasized enough that macro vulnerability leads to micro abuse and vulnerability in a variety of arenas. At another level, micro abuse begins at the home and community level through education. If families of certain cultural groups are seen as being less significant and having lower esteem in the community than those of majority families, it is in an indirect way setting the stage for the acceptance of abuses as individuals in the family unit age. If we advance from the family level to the educational system(s) and process, as it becomes clear that most younger people are not encouraged, as minorities, to expect that they are going to successfully compete in the open market for jobs. Therefore, education becomes yet another barrier that helps pave the way for the acceptance of macro abuse that may occur later in life. (Stanford 1997)

Dr. Stanford skillfully summarized three critical elements in effecting societal change to eliminate diversity abuse of the elderly:

- As of now, we must start by practicing diversity and eliminating abuse. The primary issue is not whether or not we like it, appreciate it, or understand it. Conventional wisdom says that the beginning point should be that common sense sets the standard. By using common sense in practicing diversity, we can learn to appreciate it and understand it.

- Second, there should be considerable attention given to the maintenance of dignity of all individuals, regardless of economic backgrounds or social standing in the community. Each older person should be accorded the opportunity to have his/her dignity maintained at all times. The maintenance of dignity is as important in the workplace as it is in the home of the older individual.

- Third, there should be an ongoing alert to understand what is obvious in terms of working with and relating to individuals from backgrounds different from our own. There is no reason to assume that all issues and circumstances are as they appear (Ibid.).

Mental Health Services

Mental health services that are commonly needed in elder abuse cases include the following:

- **Capacity/competency assessments**, which determine whether the victim may be suffering from some form of dementia that affects their capacity. Capacity refers to an individual's ability to understand the meaning, seriousness, consequences, and alternatives of a decision, to be able to reach a decision based upon an independent view of his or her own self-interest, and communicate that decision to others. Dementia is a clinical state, diagnosable only by clinical methods. Every elderly person with dementia deserves precise assessment of his or her mental status. This is imperative when working with an alleged case of elder abuse, as the ability of the elder to make his or her own informed decisions can be the determining factor as to how to proceed with interventions (i.e., advocacy and counseling versus guardianship and substituted judgment). It is extremely important to note that capacity may wax or wane for a particular individual according to environmental factors such as time of day; day of the week; physical location; acute, transient medical problems; other persons involved in supporting or pressuring the individual's decision; or reactions to medication. Capacity can fluctuate over days, hours within a day, and within different spheres of decision-making needs (i.e., an individual cannot balance a checkbook or understand money but can decide where he or she wants to live) (National Association on State Units on Aging 1999).

- **Crisis intervention**, which for elder abuse victims can include counseling about available options, emotional support, assistance in making arrangements, and the provision of information and referrals to supportive services in the community. Crisis intervention may be provided by special geriatric crisis teams, social workers, domestic violence programs, victim service professionals, or law enforcement personnel.
Because it is usually easier for people in crisis to rely on old coping behaviors rather than to learn new ones, crisis intervention in elder abuse cases often involves encouraging victims to build on their strengths and past experiences to cope with the abuse situation(s). This may be accomplished by asking them to describe past crises and how they handled them. If the action or coping behavior worked in the past, it may be applied to the current situation.

Working with elderly clients in crisis often involves being more directive than in other situations. When an older person is overwhelmed by a situation, it may be helpful to break down what seems to be overwhelming obstacles into manageable parts.Addressing the simple, non-emotional, factual aspects of a situation first and then proceeding into more sensitive areas of concern is often effective.

- **Counseling** commonly involves helping the elderly victim decide what course of action to take and how to deal with emotional distress he or she may be feeling. It may address his or her fears, loss of self-esteem, feelings of loss of control, anger, or depression. Depending on the nature of the abuse or neglect, family counseling may illuminate problems or dynamics that led to the abuse, and help families work through their difficulties.

- **Legal services** are extremely important in elder abuse cases. Civil attorneys can help victims obtain restraining orders or injunctions against harassment, set up trusts or powers of attorney, file lawsuits, and initiate conservatorships. Most communities have some type of free or low cost legal aid for the elderly; branches of the American (or state) Bar Association also may have local clinics or referral panels. It is important for victim service providers to be aware of, and collaborate with, allied professionals who provide legal services to victims of elder abuse and other crimes.

- **Education** may be extremely effective in preventing abuse and in encouraging victims to seek help. When neglect results from a family's inability to provide care, for example, the family may benefit from instruction on how to provide assistance and cope with frustration and stress. Experienced family violence professionals have found that educating victims about patterns of violence can be effective in reducing victims' unrealistic expectations. When victims are told, for example, that abuse is usually recurrent and likely to escalate, they may be more willing to accept help.

Victron service providers should incorporate issues relevant to elder abuse and other crimes against the elderly into their public education, internal staff training, and cross-training initiatives. They should seek opportunities to promote information about available programs, prevention efforts, and supportive services to address elder abuse and victimization.

- **Support services** can reduce the risk of elder abuse by providing the family with outside assistance that reduces the stress created by the family's caregiving responsibilities. At the same time, outside assistance reduces the elder person's dependence on his or her family caregiver. These include chore workers, home-delivered meals, transportation, attendant care, homemaker services, and personal care assistance. When elder abuse is observed but has not endangered the health or well-being of the person, and the parties involved want to work to improve the standard of caregiving in the household, victim advocates for the elderly should arrange for an outside psychological assessment to be made to determine the caregiver's capacity to provide a consistently, healthy and safe environment for the older person.

Support groups provide an encouraging environment for victims of elder abuse and other crimes to share their experiences in a safe and confidential environment. In Cook County (Chicago), Illinois, for example, elderly victims of crime and abuse meet regularly with a trained victim advocate to discuss and address their concerns, fears, and safety issues, and to work collaboratively toward solutions that promote safety, security, and a sense of hope for participants.
• **Respite care**, which provides caregivers with a break, comes in many forms, such as the following:
  
  o Providing a professional or volunteer to go to an older person’s home for a few hours a day to relieve the primary caregiver.
  
  o Taking the older person to a special facility or providing transportation to appointments.
  
  o Providing care and supervision for elderly clients for a few hours a day, or for longer periods of time, to allow caregivers to take extended breaks or vacations.

Shelters, which can be accessed in an emergency, are provided through domestic violence programs or through community-based initiatives and offer special shelter or temporary housing for the elderly. Some communities also have “safe homes,” which are private homes with families that offer shelter to elders in crisis. Safe homes provide emergency housing to victims until alternative housing can be found. Presently, there are few shelters that are suitably equipped to care for the elderly. Victim service providers should identify and assess the capabilities of various shelters in their communities in order to make quality referrals and, when possible, instigate the development of new shelters designed for the elderly (PERF 1993).

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Part 13: The Workplace and Domestic Violence

Until recently, domestic violence was not an issue that was high on the business community’s agenda. Even though almost half of the American workforce is made up of women, only a handful of workplaces have taken leadership roles on this issue in the last decade. This is changing, as a growing number of employers recognize the serious impact of domestic violence on both their employees’ lives and their bottom lines.

Women who have been abused take the violence with them to work, and it shows—in lost productivity, stress, increased health care costs, employee absenteeism, turnover, and sometimes, workplace violence. When an employee is the target of attack in the workplace by an intimate, other employees may also be placed at risk. Whether or not employers acknowledge it, domestic violence is a problem that does not disappear when women leave home and enter the workplace. In fact, a large percentage of abused women spend much of their time on the job. They work with long sleeves and high collars covering the bruises. They come to work in spite of headaches, physical injuries, depression, and chronic anxiety. Often they work because they have to in order to support their families.

While the following indicators could be explained by something other than domestic violence, they also could be possible signs that an employee is being battered:

- Bruises she may try to explain as being caused by an accident.
- Frequent or unexplained absences or lateness.
- Frequent personal phone calls that leave her upset.
- A decline in job performance—difficulty concentrating or working effectively.
- Withdrawal from co-workers.
The Role of Employers

Employers can help create a workplace environment supported by comprehensive, legally sound policies that both assist women employees affected by violence and ensure that workplaces address the serious legal issues raised as a result of violence against women. Employers who take action will not only avoid liability costs but also make an important difference in the lives of women and improve productivity and safety in their workplaces. As stated in a U.S. Office of Personnel Management guidebook for managers:

If somebody is threatening, harassing, or injuring another person, it is a criminal act. Forget all the polite rules about ignoring lovers’ quarrels, because this is another kind of situation altogether . . . Never underestimate the possible dangerousness of someone who batters, stalks, or otherwise mistreats another person, whatever their relationship may be (Tyler 1996, 33).

There are many steps employers can take depending on a workplace’s level of commitment, available resources, and size. Possible steps might include the following:

- **Training for managers and supervisors.** Because managers may be among the first to see the signs of abuse, training them to know what to look for and how to help victimized employees is a critical element of a workplace domestic violence strategy. Such training needs to include issues such as employee confidentiality, the dynamics and cycle of domestic violence, appropriate and inappropriate ways to approach a victim, and available in-house and community-based resources.

- **Implementation of domestic violence personnel policies.** Workplaces can develop personnel policies that accommodate the needs of battered women. Procedures that allow employees to disclose their abuse confidentially and guidelines that define managers' and employees' roles and responsibilities in working with abused workers further enhance the victim sensitivity of the workplace. Policies such as flexible working hours for medical and legal appointments and possible relocation to a new work site or change in work shift can provide an additional layer of safety without forcing women to leave their jobs.

- **Specialized employee assistance program (EAP) services.** When workplaces have such programs, they should make sure that services for victims of domestic violence are included. Local domestic violence specialists can be brought in to train EAP counselors or to conduct training for human resource personnel and supervisors and provide referrals to local battered women shelters and services.

- **Security.** Home phone numbers and addresses of employees should never be given out without specific authorization. Whenever possible, pictures of identified batterers should be kept at the front entrance to help prevent access. Security or other personnel can protect abused employees by escorting them to the parking lot, bus stop, or subway station. Some companies provide designated parking spaces close to the building for employees threatened by violence. Others offer silent alarms at desks or provide cellular telephones to women employees who are at risk. However, supervisors should always ask each victim what solutions best suit her particular circumstances.

- **Help employees develop a safety plan.** Trained employees, counselors, EAP staff, or community domestic violence advocates can assist women in developing a safety plan. Every victim's circumstances will be unique, but an objective, trained listener can help the victim develop an individualized safety plan to minimize the risk of continued violence or physical harm.

- **Document the abuse.** An employer can assist a victim of domestic violence by documenting her bruises or injuries and the fact that she reported a violent incident to someone at the work site. Local domestic violence advocates can help determine what documentation an employer should keep, what safeguards will help ensure that confidential information is not divulged, and help ensure that the victim's privacy is not compromised.

- **Know the law.** Workplaces should be familiar with the current domestic violence laws and ordinances of their city and state, as well as federal regulations and rulings. Local domestic violence programs or local law enforcement can provide the most current information. The legal
requirements in many cities and states are evolving, and increasingly the law is imposing a duty on employers to provide a safe workplace, including taking reasonable steps to prevent and stop violence against women at work.

- **Consider workplace orders of protection.** In some states, including California and Massachusetts, employers can apply for orders of protection on behalf of the workplace to keep batterers away from the victim's work site. This can be an important strategy in cases where the batterer may be enraged by such legal action and escalate the violence if he knows the victim obtained the protection order. However, this action should never be taken without careful and deliberate consideration of what is best for that victim in her particular circumstances and never without her consent.

- **Provide general education and prevention programs.** Seminars describing the nature and prevalence of domestic violence and options for getting help can let employees know that they are not to blame, that there are alternatives to violence, and that there is assistance available. Sponsoring seminars on company time demonstrates concretely that the workplace is committed to helping and ensures a greater level of participation. Because some victims may feel more comfortable learning about their options outside of a group setting, education can also be conducted through brochures and other information posted in visible places throughout the workplace, including cafeterias, restrooms, and lounges.

- **Provide resources and referrals.** Workplaces should provide an up-to-date list of national and local resources such as emergency shelters, counseling services, hotlines, and support groups that provide assistance and information for victims of domestic violence.

The business community is beginning to accept the reality that employers have both a legal obligation and a social responsibility to prevent violence against their employees and to respond to such violence and its effects when it occurs. By addressing the effects of domestic violence in the workplace, companies will reap the double benefits of limiting legal liability and maximizing employees' productivity and contributions to the company.

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Part 14 adapted from:

National Center for Victims of Crime (NCVC)
National Victim Assistance Academy June 2002
Chapter 22 Special Topics
Available at https://www ncjrs gov/ovc_archives/nvaa2002/chapter22_5.html#1

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**Part 14: Ethical and Legal Issues Related to Domestic Violence**

**Federal Domestic Violence Legislation**

- **Family Violence Prevention and Services Act of 1984 (P.L. 98-457)**

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

- **Violence Against Women Act (VAWA), Title IV of the Violent Crime Control and Law Enforcement Act (P.L. 103-322)**

  In 1994, Congress passed the Violence Against Women Act, which marked a turning point in Federal recognition of the extent and seriousness of domestic violence. This legislation demonstrated the Federal government's commitment to address domestic violence. There are four
titles within the Act—the Safe Street Act, Safe Homes for Women, Civil Rights for Women and Equal Justice for Women in the Courts, and Protections for Battered Immigrant Women and Children—and each act addresses domestic violence, sexual assault, stalking, and protection against gender-motivated violence. The provisions of VAWA call for improving law enforcement and criminal justice responses, creating new criminal offenses and tougher penalties, mandating victim restitution, and requiring system reform geared towards protecting victims of domestic violence during prosecution of the perpetrator. VAWA also authorized support for increased prevention and education programs, victim services, domestic violence training of community professionals, and protections from deportation for battered immigrant women.108

- **Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA) - Wellstone/Murray Amendment (P.L. 104-193)**

The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA) replaced the Aid to Families with Dependent Children (AFDC) program with the Temporary Assistance to Needy Families program. The Wellstone/Murray Amendment of PRWORA includes a provision entitled the Family Violence Option, which addresses the safety and economic barriers faced by victims of domestic violence. Through this amendment, each State has the option to enact procedures that temporarily exempt identified victims of domestic violence from meeting certain time limit and other work requirements.

**Federal Child Abuse and Neglect Legislation**

- **The Child Abuse Prevention and Treatment Act (CAPTA) of 1974 (P.L. 93-247)** was established to ensure that victimized children are identified and reported to appropriate authorities. The Act was most recently amended in 1996 (P.L. 104-235) and continues to provide minimum standards for definitions and reports of child maltreatment.

- **Family Preservation and Support Services Program** enacted as part of the Omnibus Budget Reconciliation Act of 1993 (P.L. 103-66) provides funding for prevention and support services for families at risk of maltreatment and family preservation services for families experiencing crises that might lead to out-of-home placement.

- **The Adoption and Safe Families Act (ASFA) of 1997 (P.L. 105-89)** was built on earlier laws and reforms in the field to promote the safety, permanency, and well-being of maltreated children. A component of ASFA is the Promoting Safe and Stable Families (PSSF) Program, which was developed from and expanded upon the Family Preservation and Support Services Program mentioned above. While the legislation reaffirms the importance of making reasonable efforts to preserve and reunify families, it also specifies instances where reunification efforts do not have to be made (e.g., when a child is not safe with his or her family), establishes tighter time frames for termination of parental rights, and promotes adoption initiatives.

- **Promoting Safe and Stable Families Program Reauthorization of 2002 (P.L.107-133)** continued to build upon ASFA by extending the PSSF Program for an additional 5 years and increasing discretionary funding. It also created several new programs including a new State grant program that provides education and training vouchers for youth aging out of foster care and a mentoring program for children with incarcerated parents.

**Reporting Child Abuse**

All States (and the District of Columbia) require a broad range of care providers—including substance abuse treatment programs—to report when there is reasonable cause to believe or suspect child abuse or neglect. While many State statutes are similar, each has different rules about what kinds of conditions must be reported, who must report, and when and how reports must be made. In most States, failure to report may result in civil or criminal charges. All States extend immunity from prosecution to persons reporting child abuse and neglect; in other words, a person who reports abuse cannot be sued.
Editors Note: Federal and State Statutes and Regulations - Child Abuse

The Federal Child Abuse Prevention and Treatment Act (CAPTA) was passed in 1974. All fifty states have passed laws that require the reporting of child abuse and neglect by mandated reporters.

Federal laws provide standards and guidelines. Specific issues are primarily governed by state laws and regulations. A summary of state statutes related to mandated reporting of child abuse and neglect can be found at [https://www.childwelfare.gov/systemwide/laws_policies/state/can/](https://www.childwelfare.gov/systemwide/laws_policies/state/can/)

Additional information can be found at [http://www.childwelfare.gov/systemwide/laws_policies/statutes/manda.cfm](http://www.childwelfare.gov/systemwide/laws_policies/statutes/manda.cfm)

Confidentiality

Honoring patient confidentiality is of primary importance in providing patient care. However, patients need to understand before treatment begins that there are some limits to confidentially and that the law requires health care providers to break patient-therapist confidentiality in some instances. Some examples include the duty to warn when a patient is a danger to self or others and the responsibility to report child abuse if the patient says something that raises the reasonable suspicion of child abuse (and in many states, elder abuse.)

Duty to Warn

Health care providers may face questions about their "duty to warn" if one of their clients threatens to harm a spouse or child or domestic partner.

This requirement started with the case of *Tarasoff v. Regents of the University of California*, 17 Cal.3d 425 (1976), in which the California Supreme Court held a psychologist liable for money damages because he failed to warn a potential victim his patient threatened to, and then did, kill. The court ruled that if a psychologist knows that a patient poses a serious risk of violence to a particular person, the psychologist has a duty "to warn the intended victim or others likely to apprise the victim of the danger, to notify the police, or to take whatever other steps are reasonably necessary under the circumstances."

In most States, therapists and other care providers must warn a victim or the police when a patient makes a credible threat of violence to another identified person. (Of course, not every threat uttered by a patient should be taken seriously. It is only when a patient poses a serious threat of violence toward a particular person that the duty to warn arises.) Counselors who fail to warn either the intended victim or the police may be liable for money damages or license revocation.

In California, the *Tarasoff* rule has been extended by *Ewing v. Goldstein* (120 Cal. App. 4th 807 [2004]) to include threats disclosed to the therapist by family members. In Ewing, the therapist received a communication from the patient's father that the son intended to kill his former girlfriend's new boyfriend. The therapist argued that he was not liable because the patient had never directly communicated this threat to the therapist. The court disagreed and held that "a communication from a family member to a therapist, made for the purpose of advancing a patient's therapy, is a "patient communication" within the meaning of section 43.92. Second, a therapist's duty to warn a victim arises if the information communicated leads the therapist to believe or predict that the patient poses a serious risk of grave bodily injury to another." The case was appealed to the California Supreme Court, but the Court let the decision stand. The American Psychological Association, the California Psychological Association, the California Association of Marriage and Family Therapists, and other professional groups are working to introduce legislation that will restore the original intent of the statute.

Part 14 adapted from:

Part 15: National and Community Resources

California

California Partnership To End Domestic Violence
P.O. Box 1798
Sacramento, CA 95812-1798
Phone: 916-444-7163
Toll Free: 800-524-4765
Fax: 916-444-7165
http://www.cpedv.org/

Women's Rights Handbook
Violent Crimes Committed Against Women and Children
http://caag.state.ca.us/publications/womansrights/ch7.htm#7
This chapter deals with sexual assault; battering of spouses, cohabitants and the parents of one's children; and child and elder abuse. The chapter discusses the legal definitions of each of these violent acts, and gives information on the legal, medical and counseling resources available to survivors of such abuse.

Futures Without Violence
100 Montgomery Street, The Presidio
San Francisco, CA 94129
Phone: (415) 678-5500
Fax: (415) 529-2930
http://www.futureswithoutviolence.org/

Florida

Community Action Stops Abuse (CASA)
PO Box 414
St. Petersburg, FL 33731
24-Hour Help Line: 727-895-4912
E-mail: info@casa-stpete.org
http://www.casa-stpete.org/

Florida Coalition Against Domestic Violence
425 Office Plaza Dr.
Tallahassee, FL 32301
Phone: 850-425-2749
Hotline: 800-500-1119
http://www.fcadv.org/

Florida Council Against Sexual Violence
1311-A Paul Russell Road, Suite 204
Tallahassee, FL 32301
Phone: 850-297-2000
Toll Free Information Line: 888-956-7273
E-mail: information@fcasv.org
http://www.fcasv.org/

Florida Health and Human Services
Department of Children & Families
Florida Domestic Violence Hotline: 800-500-1119
http://www.dcf.state.fl.us/domesticviolence/

Betty Griffin House
Serving St. Johns County
24-Hour Crisis Hotline: 904-824-1555
Refuge House
Serving 8 Counties: Franklin, Gadsen, Jefferson, Leon, Liberty, Madison, Taylor, Wakulla
24 Hour Crisis Line: 850-681-2111 (Collect calls accepted)
Phone: 850-922-6062
http://www.refugehouse.com/

General Resources

National Center for Injury Prevention and Control
Mailstop K65
4770 Buford Highway NE
Atlanta, GA 30341-3724
Phone: 770-488-1506
Fax: 770-488-1667
http://www.cdc.gov/injury/index.html

The U.S. Department of Health and Human Services
200 Independence Avenue, SW
Washington, D.C. 20201
Telephone: 202-619-0257
Toll Free: 877-696-6775
http://www.hhs.gov/

National Coalition of Anti-Violence Programs (NCAVP)
http://www.avp.org/

Asian & Pacific Islander Institute on Domestic Violence
http://www.apiidv.org/

National Latino Alliance for the Elimination of Domestic Violence
http://www.dvalianza.org

Institute on Domestic Violence in the African American Community
http://www.dvinstitute.org

Additional State Resources

- Alabama Domestic Violence Crisis and Support Resources
- Alaska Network on Domestic Violence and Sexual Assault
  http://www.andvsaa.org
- Arizona Domestic Violence Safety
- Arkansas Coalition Against Domestic Violence
  http://www.domesticpeace.com
- Colorado Domestic Violence Coalition
  http://www.ccadv.org
- Connecticut Coalition Against Domestic Violence
  http://www.ctcadv.org
- Delaware Domestic Violence Coordinating Council
  http://www.dccadv.org
- District of Columbia
  http://www.dccadv.org
- Florida Coalition Against Domestic Violence
  http://www.fcadv.org
• Georgia Coalition Against Domestic Violence
  http://www.gcadv.org
• Hawaii State Coalition Against Domestic Violence
  http://www.hscadv.org
• Illinois Coalition Against Domestic Violence
  http://www.ilcadv.org
• Indiana Domestic Violence Crisis & Support Services
• Iowa Coalition Against Domestic Violence
  http://www.icadv.org
• Kansas Coalition Against Sexual and Domestic Violence
  http://www.kcsdv.org
• Kentucky Domestic Violence Association
  http://www.kdva.org
• Louisiana Coalition Against Domestic Violence
  http://www.lcadv.org
• Maine Coalition to End Domestic Violence
  http://www.mcedv.org
• Maryland Network Against Domestic Violence
  http://www.mnadv.org
• Massachusetts Coalition Against Domestic and Sexual Violence
  http://www.janedoe.org
• Michigan Coalition Against Domestic and Sexual Violence
  http://www.mcadsv.org
• Minnesota Coalition for Battered Women Projects
  http://www.mc bw.org
• Mississippi Coalition Against Domestic Violence
  http://www.mcadv.org
• Missouri Coalition Against Domestic Violence
  http://www.mova.missouri.org
• Montana Coalition Against Domestic and Sexual Violence
  http://www.mcadsv.com/
• Nebraska Domestic Violence Sexual Assault Coalition
  http://www.ndvsac.org/
• Nevada Network Against Domestic Violence
  http://www.nnadv.org/
• New Hampshire Coalition Against Domestic and Sexual Violence
  http://www.nhcadsv.org
• New Jersey Coalition For Battered Women
  http://www.njcbw.org
• New Mexico Coalition Against Domestic Violence
  http://www.nmcdadv.org
• New York State Coalition Against Domestic Violence
  http://www.nyscadv.org/
• North Carolina Coalition Against Domestic Violence
  http://www.nccadv.org
• North Dakota Council on Abused Women's Services
  http://www.ndcaws.org/
• Ohio Domestic Violence Network
  http://www.odvn.org/
• Oklahoma Coalition Against Domestic Violence and Sexual Assault
  http://www.ocadvs.org
• Oregon Coalition Against Domestic and Sexual Violence
  http://www.ocadsv.com/index.asp
• Pennsylvania Coalition Against Domestic Violence
  http://www.pcadv.org
• Rhode Island Domestic Violence
  http://www.ricadv.org/en/
South Carolina Coalition Against Domestic Violence and Sexual Assault
http://www.sccadvasa.org
South Dakota Coalition Against Domestic Violence and Sexual Assault
http://www.southdakotacoalition.org
Tennessee Coalition Against Domestic and Sexual Violence
http://www.tcadsv.org
Texas Council on Family Violence
http://www.tcfv.org
Utah Domestic Violence Advisory Council
http://www.udvac.org/
Vermont Network Against Domestic Violence and Sexual Assault
http://www.vtnetwork.org
Virginia Against Domestic Violence
http://www.vadv.org
Washington State Coalition Against Domestic Violence
http://www.wscadv.org
West Virginia Coalition Against Domestic Violence
http://www.wcvadv.org
Wisconsin Coalition Against Domestic Violence
http://www.wcdv.org/
Wyoming Coalition Against Domestic Violence and Sexual Assault
http://www.wyomingdvsa.org/index1.htm

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Ibid.


American Bar Association

