

# DOMESTIC VIOLENCE

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## INTRODUCTION

Domestic violence – also known as “interpersonal violence”, “battering” and “family violence” is a widespread and serious public health problem, nationally in the United States and internationally as well. U. S. government surveys on violence against women show that at some point in their lifetimes more than a quarter of women in the United States are physically assaulted, stalked, or undergo one or more attempted or actual rapes by a current or former spouse, cohabiting partner or date and one third of all murdered women – three women a day in 2005- are killed by intimate partners (Tjaden and Thoennes 2000; Catalano 2007). The United Nations Development Fund for Women estimates that one in three women around the world will be beaten, coerced into sex, or otherwise abused in her own lifetime (Heise, Ellsberg et al. 1999). This entry will look at definitions of domestic violence, historical perspectives, gender issues surrounding DV, incidence, risk factors, putative causes, and effects of domestic violence.

## DEFINITIONS

The notion of a “battered woman” derives from the criminal violation known as “battery” or the willful or intentional touching of a person against that person’s will by another person, or by an object or substance put in motion by that other person. The notion of “battered women”, with its emphasis on physical violence, fails to entirely capture the various ways in which intimate partners of either gender can be manipulated and abused and as a consequence, the term has been largely replaced by “domestic violence” (DV), “intimate partner violence” (IPV) and the more generic “family violence”.

During the past fifteen years, there has been a growing recognition that intimate partner abuse (IPV) is a highly prevalent public health problem with devastating effects on individuals, families and communities. The term “family violence” has been used to describe acts of violence between family members, including adult and adolescent partners; between a parent and a child

(including adult children); between caretakers or partners against elders; and between siblings. While sometimes used interchangeably, the term “domestic violence” is generally seen as a subset of family violence between intimates so that the term “intimate partner violence” appears to be replacing “domestic violence” for the sake of definitional clarity.

Intimate partner violence has been defined as a pattern of assaultive and coercive behaviors that may include inflicted physical injury, psychological abuse, sexual assault, progressive social/physical/financial isolation, stalking, deprivation, extreme jealousy and possessiveness, intimidation and threats perpetrated by someone who is, was, or wishes to be involved in an intimate or dating relationship with an adult or adolescent, and are aimed at establishing control by one partner over the other. Threats may be directed at the partner, his/her friends, family members, pets or property. This term also includes children who are used by the perpetrator to intimidate and abuse the adult victim, as well as those who are forced by the perpetrator to participate in the abuse of an adult victim (Family Violence Prevention Fund 2004).

Legal definitions and remedies of IPV vary from state to state but generally refer specifically to threats or acts of physical or sexual violence including forced rape, stalking, harassment, certain types of psychological abuse and other crimes where civil or criminal justice remedies apply. Violence between intimates is notoriously difficult to measure largely because it usually occurs in private, and victims are often reluctant to report incidents to anyone because of shame, guilt or fear of reprisal (Catalano 2007).

## DOMESTIC VIOLENCE AND GENDER

The vast majority of victims of IPV are women. The latest United States Bureau of Justice Statistics report on intimate violence found that 85 percent of victims are female.<sup>5</sup> Most of the research that has been conducted to date has measured the prevalence and impact of abuse on women and children. However, it is important to note that IPV also occurs in same-sex relationships, and that some victims of IPV are men in heterosexual relationships. (Family Violence Prevention Fund 2004)

## DOMESTIC VIOLENCE AND CHILDREN

The impact of IPV on children varies greatly depending on the nature and frequency of the perpetrator’s abusive tactics, the development stage and gender of the child, and the presence of protective factors.

## HISTORICAL PERSPECTIVES

The battering of women can only be fully understood within a sociopolitical context that explores the status of women's rights throughout time. Not until the mid- to late 19<sup>th</sup> century did women acquire significant legal rights in the United States, and it was not until 1920 that women in the U.S. could even vote. Before women achieved suffrage, married women were largely considered to be a form of marital property while separated and divorced women were even more vulnerable to the whims of male authority figures. The battering of women, when publicly noticed, was largely attributed to the vagaries of unusually violent men or the pathology of the women involved.

It was not until the feminist movement of the 1960's and 1970's that domestic violence surfaced as an extremely common and significantly destructive social problem, not attributable to individual pathology. As a result of the Women's Liberation Movement, battered women came to be understood as the most extreme victims of the universal and systematic oppression of women that extends far back into recorded history. In 1979, psychologist Lenore Walker interviewed 1500 women who were victims of abuse perpetrated by their spouse and noticed that they all described a similar pattern that she called "*Battered Woman Syndrome*" in which the severity of the abuse escalates over time while both partners deny the severity of the abuse, are both convinced that each episode is a separate and isolated event. In such cases, as the abuse escalates, the husband stops apologizing for the behavior and becomes increasingly violent while his partner becomes increasingly depressed, fatalistic, self-blaming, helpless, and hopeless, developing a sense of personal entrapment and rejecting help from others (Walker 1979). It became clear that the victim's pre-existing personality was not a major factor in the development of "*Battered Woman Syndrome*" and was in fact not dissimilar to the adaptation that hostages make to their captors, also known as the "*Stockholm Syndrome*" (LaViolette and Barnett 2000).

Consistent with other efforts originating in the 20<sup>th</sup> century, the battering of women has become a fundamental national and international human rights issue. As a result, it is only in the last thirty years that the system response to domestic violence has significantly changed. The first responses to victims of battering originated as the grassroots efforts of women to help and support each other through the development of domestic violence shelters and other services, including political and social advocacy. The criminal justice responses to battering, although far from perfect, have included model police protocols, significant changes in prosecution and legal defense, and judicial education. Efforts to train health care professionals, mental health care professionals, childcare workers, child protective services, and other social services are still in their formative stages.

In an effort to avoid continuing to focus on the presumed pathology of the victim and thereby denying the criminal behavior of the men involved in

perpetrating acts of violence, the early originators of the domestic violence movement preferred to avoid interaction with the mental health system. However, in the last decade there has been a growing recognition that people exposed to repetitive violence are likely to suffer from a number of physical, psychological and social consequences of that violence that must be addressed if the individual is to recover from the battering (Warshaw, Gugenheim et al. 2003). Additionally, the impact on children of exposure to battering in the home has become a major focus of intervention and prevention efforts (Groves 2002).

## DOMESTIC VIOLENCE: THE STATISTICS

IPV is a health problem of enormous proportions. It is estimated that between 20 and 30% of women and 7.5% of men in the United States have been physically and/or sexually abused by an intimate partner at some point in their adult lives.<sup>6, 7, 8</sup> Heterosexual women are five to eight times more likely than heterosexual men to be victimized by an intimate partner.<sup>9</sup> From 1993 to 1998, victimization by an intimate accounted for 22% of the violent crime experienced by females and 3% of the violent crime sustained by males.<sup>10</sup> Women aged 16-24 experience the highest per capita rate of IPV. <sup>11</sup> For adolescents, the rates of experiencing some form of dating violence vary from 25-60%.<sup>12, 13, 14</sup> While studies indicate that boys and girls may accept physical and sexual aggression as normative in dating and intimate partner relationships, adolescent females are more likely to receive significant physical injuries than boys and are more likely to be sexually victimized by their partners.<sup>15</sup>

No one is immune from the risk of abuse. The National Center on Elder Abuse estimates that 818,000 elderly Americans were victims of domestic abuse in 1994.<sup>16, 17</sup> There are far fewer data on lesbian, gay, transgender, and bisexual (LGTB) victimization. However, the available literature suggests similarly high rates for LGTB adolescent and adult populations<sup>18, 19</sup> with higher rates in male same-sex relationships than female.<sup>20</sup> IPV occurs in every urban, suburban, rural and remote community; in all social classes, and in all ethnic and religious groups including immigrant and refugee populations. Consequently, all health care settings and professionals providing care to patients are treating patients affected by IPV and are in a position to identify and intervene on behalf of victims. The estimates of children exposed to IPV vary from 3.3 million to ten million per year, depending on the specific definition of witnessing violence, the source of interview, and the age of child included in the survey.<sup>21</sup> In the Adverse Childhood Experiences (ACE) Study, conducted on a large sample of members (30,000 adults) of the Kaiser Health Plan in California, 12.5% of respondents indicated childhood exposure to IPV and 10.8% indicated a personal history of child abuse including physical, sexual and emotional abuse.<sup>22</sup> This research and other studies indicate that children who

witness IPV are seen with both frequency and regularity in the health care system as children and as adults.(Family Violence Prevention Fund 2004)

The National Crime Victimization Survey (NCVS) gathers data about crimes using an ongoing, nationally representative sample of households in the United States. NCVS data include information about crime victims (age, gender, race ethnicity, marital status, income, and educational level), criminal offenders (gender, race, approximate age, and victim-offender relationships) and the nature of the crime (for example, time and place of occurrence, use of weapons and nature of injury). NCVS victimization data include incidents reported and not reported to police. The experiences and estimates of intimate partner violence reflect those of the individuals residing in households. It does not capture the experiences of homeless individuals or those living in institutional settings such shelters for homeless or battered persons. In 2005, 77,200 households and 134,000 individuals age 12 and older were interviewed. Between 1993 and 2005, response rates varied between 91% and 96% of eligible households and between 84% and 93% of eligible individuals. According to this survey, nonfatal intimate partner violence has declined since 1993. The rate of nonfatal intimate partner victimization for females was about 4 victimizations per 1,000 persons age 12 or older in 2005, down from about 10 in 1993. For females of most age categories, nonfatal intimate partner victimization declined over time.

## GENDER AS A FACTOR

Females are more likely than males to experience nonfatal intimate partner violence. On average between 2001 and 2005, nonfatal intimate partner victimizations represented 22% of nonfatal violent victimizations against females age 12 or older 4% of nonfatal violent victimizations against males age 12 or older. For homicides, intimate partners committed 30% of homicides of females, 5% of homicides of males.

Nonfatal intimate partner violence is most frequently committed by individuals of opposite genders. On average from 2001 to 2005 — about 96% of females experiencing nonfatal intimate partner violence were victimized by a male and about 3% reported that the offender was another female. About 82% of males experiencing nonfatal intimate partner violence were victimized by a female and about 16% of males reported that the offender was another male.

## AGE AS A FACTOR

In general, females ages 12 to 15 and age 50 or older were at the lowest risk of nonfatal intimate partner violence. During 2005, females ages 35 to 49 were at a greater risk of nonfatal intimate partner violence than older females. Females ages 20 to 24 were at the greatest risk of nonfatal intimate partner violence. In

general, males ages 12 to 15 and age 65 or older experienced the lowest rates of nonfatal intimate partner violence.

## ETHNICITY AS A FACTOR

Between 1993 and 2005, rates of nonfatal intimate partner violence decreased for white females, white males, and black females. Intimate homicide rate has fallen for blacks in every relationship category, while the rate for whites has not changed for all categories. The average annual rate of nonfatal intimate partner violence from 2001 to 2005 was generally higher for American Indian and Alaskan Native females and similar for black females and white females. Between 1993 and 2005, the rate of nonfatal intimate partner victimizations declined for Hispanic females by two-thirds.

## INCOME AS A FACTOR

From 2001 to 2005, for nonfatal intimate partner victimization females living in households with lower annual incomes experienced the highest average annual rates. But females remained at greater risk than males within each income level.

## CHILDREN'S EXPOSURE

On average between 2001 and 2005, children were residents of the households experiencing intimate partner violence in 38% of the incidents involving female victims and 21% of the incidents involving male victims.

Similar to other types of nonfatal violent victimization, nonfatal intimate partner violence is primarily intraracial in nature. | About 84% of white victims were victimized by white offenders. | About 93% of black victims were victimized by black offenders Nonfatal intimate partner violence is more likely to occur between the hours of 6 p.m. and 6 a.m. | Females and males experienced nonfatal intimate partner victimization at similar times during the day and night. On average between 2001 and 2005 — | the majority of nonfatal intimate partner victimizations occurred at home; approximately two-thirds of females and males were victimized at home. | about 11% of female and 10% of male victims of nonfatal intimate partner violence were victimized at a friend's or neighbor's home. On average between 2001 and 2005 — | the presence of any alcohol or drugs was reported by victims in about 42% of all nonfatal intimate partner violence. | victims reported that approximately 8% of all nonfatal intimate partner victimizations occurred when a perpetrator was under the influence of both alcohol and drugs. | female and male victims of nonfatal intimate partner violence were equally likely to report the presence of alcohol during their victimization. | female and male victims of nonfatal intimate partner violence both reported their attacker was under the influence

of drugs in about 6% of all victimizations. Presence of weapons On average between 2001 and 2005, for nonfatal intimate partner violence — 1 male victims were more likely than female victims to face an offender armed with a weapon. 1 female victims were more likely than male victims to face an offender armed with a firearm. 1 about 6% of female and 10% of male victims faced an offender armed with a sharp weapon, such as a knife. The number of female and male nonfatal intimate partner victims killed with guns has fallen. For female victims, the number of intimate partner victims killed by other weapons has remained stable. males and females living in urban areas reported the highest levels of nonfatal intimate partner violence. 1 males and females residing in rural and suburban areas were equally likely to experience nonfatal intimate partner violence On average since 2001, for nonfatal intimate partner violence — 1 about one-third of female and male victims reported that they were physically attacked. 1 approximately two-thirds of female and male victims stated that they were threatened with attack. Between 2001 and 2005, for nonfatal intimate partner violence — 1 27% of female victims and 15% of male victims reported that the offender threatened to kill them. 1 23% of male victims were threatened with a weapon and 7% had an object thrown at them. 1 about 1 in 10 female and male victims reported that the offender tried to hit, slap, or knock them down. On average between 2001 and 2005, for nonfatal intimate partner violence — 1 about two-thirds of female and male victims reported they were hit, slapped, or knocked down. 1 male victims were more likely than female victims to be grabbed, held, or tripped. On average between 2001 and 2005, half of all females experiencing nonfatal intimate partner violence suffered an injury from their victimization. Of female victims — 1 about 5% were seriously injured and about 44% suffered minor injuries. 1 about 3% were raped or sexually assaulted. On average between 2001 and 2005, more than one-third of male victims of nonfatal intimate partner violence were injured; 4% were seriously injured and 36% suffered minor injuries. On average between 2001 and 2005 for nonfatal intimate partner violence — 1 less than one-fifth of victims reporting an injury sought treatment following the injury. 1 about 8% of female and 10% of male victims were treated at the scene of the injury or in their home. 1 females experiencing an injury were more likely than their male counterparts to seek treatment at a hospital. Between 1994 and 2005, reporting to police of nonfatal intimate partner victimization increased for female victims. For the 2001 to 2005 period, the percentage of nonfatal intimate partner victimizations reported to the police was — 1 higher for black females than white females. 1 higher for black females than black males. 1 about the same for black and white males. Between 2001 and 2005, the percentage of nonfatal intimate partner victimizations reported to the police was - 1 about the same for Hispanic and non-Hispanic females. 1 higher for male Hispanic victims than non-Hispanic males. Reasons for not reporting Private or personal matter was the most frequent reason given for not reporting nonfatal intimate partner violence to police. On average

between 2001 and 2005, almost 40% of male and 22% of female victims gave this reason. The reasons stated for not notifying police about the nonfatal intimate partner victimization were -- I fear of reprisal for 12% of female victims. I to protect the offender for 14% of female and 16% of male victims. I because the police would not do anything for 8% of female victims.(Catalano 2007)

Emerging research has not only confirmed earlier findings, but also has indicated that men in same-sex relationships experience domestic violence at rates at least equal to that of women in heterosexual relationships, and that lesbians and some men in heterosexual couples also experience abuse. Therefore, these Guidelines have been expanded to recommend assessment of all female and male adolescent and adult patients for domestic violence victimization (Family Violence Prevention Fund 2004).

U. S. government surveys on violence against women show that at some point in their lifetimes more than a quarter of women in the United States are physically assaulted, stalked, or undergo one or more attempted or actual rapes by a current or former spouse, cohabiting partner or date and one third of all murdered women are killed by intimate partners (Tjaden and Thoennes 2000). Around the world, studies have shown that 10-69 percent of women reported being physically assaulted by an intimate male partner at some point in their lives, while intimate partners commit 40-70 percent of homicides of women worldwide and around the world, 1 in 3 women have been beaten, coerced into sex, other otherwise abused in their lifetime. Most often, the abuser is a member of her own family (Family Violence Prevention Fund 2007).

Domestic violence is the leading cause of injury to women. Depending on the source, it is estimated that from 25% to 50% of all women in America have experienced domestic violence at some point in their lives. As a result, 4 million women in the United States experience a serious assault by a partner during a twelve-month period, while at least three women are murdered by their intimate partner every day. Battering appears to occur within every culture, and every religious orientation and all races are equally vulnerable. Battering may start when women are still quite young. Recent surveys show that 20% of teenagers and young women have already been exposed to some form of dating violence defined as controlling, abusive, and aggressive behavior in a romantic relationship. Twenty-three percent of pregnant women seeking prenatal care are battered. In a survey of pregnant low-income women, 65% of the women experienced either verbal abuse or physical violence during their pregnancies. Thirty-two percent of all women who seek emergency room care for violence-related injuries were injured by an intimate partner. Research has shown that victimized females are 2.5 times more costly to the health care system than women who have never been the victims of abuse. Three-quarters of employed battered women were harassed at work and domestic violence is

estimated to cost companies at least \$73 million a year in lost productivity. Women who co-habit with same-sex partners can also become victims of battering, although the incidence of violence is substantially lower than in opposite-gender relationships.

## DOMESTIC VIOLENCE IN THE LGBT COMMUNITY

Gay and bisexual men experience abuse in intimate partner relationships at a rate of 2 in 5, which is comparable to the amount of domestic violence experienced by heterosexual women (Greenwood 2002). In a report describing incidents of domestic violence (DV) against people of lesbian, gay, bisexual, and transgender (LGBT) experience that were reported during the year 2006 to community-based anti-violence organizations in 12 regions throughout the U.S., approximately 50% of the lesbian population had experienced or will experience domestic violence in their lifetimes (Fountain and Skolnik 2007). In one year, 44% of victims in LGBT domestic violence cases identified as men, while 36% identified as women.<sup>1</sup> 78% of lesbians report that they have either defended themselves or fought back against an abusive partner. 18% of this group described their behavior as self-defense or "trading blow for blow or insult for insult." (Renzetti 1992)

All of the above tactics may be used by a batterer. There are additional concerns for LGBT survivors. LGBT domestic violence is as prevalent as heterosexual domestic violence. And perpetrators often attempt highly specific forms of abuse, including: "Outing" or threatening to out a partner's sexual orientation or gender identity to family, employer, police, religious institution, community, or in child custody disputes; ~ Reinforcing fears that no one will help a partner because s/he is lesbian, gay, bisexual or transgender, or that for this reason, the partner "deserves" the abuse ~ Alternatively, justifying abuse with the notion that a partner is not "really" lesbian, gay, bisexual or transgender; i.e., s/he may once have had or may still have relationships with other people, or express a gender identity, inconsistent with the abuser's definitions of these terms; Telling the partner that abusive behavior is a normal part of LGBT relationships, or that it cannot be domestic violence because it is occurring between LGBT individuals (Fountain and Skolnik 2007)

It is important to note that all barriers present in both prevention and intervention of LGBT intimate partner violence are rooted in sexism, heterosexism and transphobia. These attitudes, though often unspoken, are still pervasive in our police departments, court systems, medical centers, shelters, and organizations. The butch lesbian survivor in shelter who is watched more closely by staff than her fellow more feminine heterosexual fellow residents; the gay man who stays at all-night diners and couch hops with friends because he cannot access DV shelter or homeless shelter; the

transwoman who is arrested and placed in a men's jail cell along with her abusive boyfriend because the officer "believes" she provoked a fight; the trans man who is denied an order of protection in court because the judge refuses to acknowledge that his girlfriend is a real threat to his safety. Policy and legislation change alone will not eliminate these barriers for our communities.(Fountain and Skolnik 2007)

Intimate Partner Violence services that rely solely or predominantly on the rule, that "men beat women while they are in relationship" misses the centrality

of the workings of power and control in domestic violence. Rather than focusing on the dynamics of power and control, they focus upon the gender relationships and the assumed roles within the relationships. This method misses the thousands of victims that do not fit this model. It also misses the nuances of how power and oppression affect each of us individually, from the moment we are born. For a survivor who accesses services, their identities will also impact many aspects of these experiences. Differences between the material and symbolic experiences of LGBT victims and those of heterosexual victims are held in tension through the heteronormative imperative within the prevailing discourse on IPV that frames LGBT victims ultimately as less than or an additional burden. Difference becomes the focus of exclusion and reinforcement of normal behavior rather than an opportunity to expand the scope of services. Far too little is done to compensate for the discrepancies in services, leaving already vulnerable populations subject to further harm. An enormous shift must occur that allows providers to identify how power and oppression work in the lives of individuals with intersecting identities(Fountain and Skolnik 2007)

## CAUSES OF BATTERING

As is the case for all complex social phenomena, there is no one single cause of battering. The first – and perhaps the most important influence – is learning. The vast preponderance of violent acts in our culture are perpetrated by males and acted out against women, children, and other men. In about 95% of the cases of domestic violence, the perpetrator is male and even in situations where women are violent, the violence tends to be less damaging and far less lethal.

The dominant influence on male behavior is social expectation. Children learn the basics about how to relate to other people within the context of their own family. When they witness violence being used as a method for resolving problems, they learn violence as a fundamental intervention with other people. Boys are expected to both give and take physical violence as part of routine male conditioning. As adults, men are expected to control their violence and

the amount of control that is expected has varied over time and historical period, but nonviolence has never been the social norm.

In the large Adverse Childhood Experiences study, the greater the likelihood that children were exposed to intimate partner violence, the greater the likelihood that they were also physically, sexually, or emotionally abused. Among women, the ACEs study found a strong graded relationship between the number of adverse experiences they had survived as children and the risk of becoming a battering victim. Similarly, among men, the study found a strong graded relationship between the number of these types of experiences as children and the risk of subsequently becoming a batterer.

It has been repeatedly substantiated that children who are exposed to violence are far more likely to become violent themselves. Exposure to violence in childhood is a serious risk factor for adolescent and adult violent and criminal behavior. Over many studies, the most consistent risk factor for men becoming abusive to their own female partners is growing up in a home where their mother was beaten by their father.

Although substance abuse does not cause battering, it can play a role in exacerbating battering incidents. One fourth to one half of men who commit acts of domestic violence also have substance abuse problems. Women who abuse alcohol and/or drugs are more likely to be victims of battering and victims of domestic violence are more likely to receive prescriptions for and become dependent upon tranquilizers, sedatives, stimulants, and painkillers and are more likely to abuse alcohol.

Poverty, homelessness, racism are all stressors that in and of themselves do not cause violence but alone and in combination they do put enormous stress upon families. Families that are stressed, isolated and socially unsupported are more likely to be violent. Many women and children are made homeless as a result of domestic violence when they flee the perpetrator. The system of domestic violence shelters and services was initially created largely by and for white, middle-class women. As a result, the issue of systematic oppression based not just on gender but also on race and class has not necessarily informed services for battered women. Women from lower socioeconomic classes have far fewer opportunities to leave abusive partners because they have less available resource to support themselves and their children.

## EFFECTS OF BATTERING

In addition to injuries sustained by women during violent episodes, physical and psychological abuse are linked to a number of adverse medical health effects including arthritis, chronic neck or back pain, migraine or other types of headache, sexually transmitted infections (including HIV/AIDS), chronic pelvic pain, peptic ulcers, chronic irritable bowel syndrome, and frequent indigestion,

diarrhea, or constipation.<sup>23</sup> Six percent of all pregnant women are battered and pregnancy complications, including low weight gain, anemia, infections, and first and second trimester bleeding, are significantly higher for abused women, as are maternal rates of depression, suicide attempts, and substance abuse.<sup>24</sup> Optimal management of other chronic illnesses such as asthma, HIV/AIDS, seizures, diabetes, gastrointestinal disorders, and hypertension can be problematic in women who are being abused or have been abused in the past. Often times the perpetrator controls the victim's access to and compliance with health protocols. Emerging research shows that women who are abused are less likely to engage in important preventive health care behaviors such as regular mammography and are more likely to participate in injurious health behaviors including smoking, alcohol abuse, and substance abuse.<sup>25</sup> In many controlled studies, IPV significantly increases the risk for serious mental health consequences for victims including depression, traumatic and posttraumatic stress disorder, anxiety, and suicidal ideation.<sup>26, 27, 28, 29, 30</sup> The health consequences of abuse can continue for years after the abuse has ended. IPV can also result in homicide; in 1996, 1,800 murders were attributed to intimates.<sup>31</sup> Adolescents also suffer devastating and often lifelong effects from dating violence. In one study, female adolescents who reported experiencing sexual or physical dating violence were 2.5 times as likely to report smoking, 8.6 times more likely to attempt suicide, and 3.4 times more likely to use cocaine than their non-abused peers. In addition, abused teens were 3.7 times more likely to use unhealthy weight control behaviors such as using laxatives or vomiting.<sup>32</sup> The experience of interpersonal violence is also correlated with repeated pregnancy and higher rates of miscarriage among low-income adolescents.<sup>33</sup> More than 100 studies have explored the short and long-term effects of IPV on children.<sup>34</sup> In 30 to 60% of families affected by IPV, children are also directly abused.<sup>35</sup> Children exposed to IPV, particularly chronic abuse, often show symptoms associated with posttraumatic stress disorder. One study found that a child's exposure to IPV (without being directly assaulted) was sufficiently traumatic to precipitate moderate to severe symptoms of posttraumatic stress in 85% of the children surveyed.<sup>36</sup> Although physical health problems have seldom been measured in children exposed to IPV, one study found that they are more likely to exhibit physical health problems including chronic somatic complaints, and behavioral problems such as depression, anxiety, and violence towards peers.<sup>37</sup> Another study found that children exposed were also more likely to attempt suicide, abuse drugs and alcohol, run away from home, engage in teenage prostitution, and commit sexual assault crimes.<sup>38</sup> There is a growing body of research regarding the impact of violence on early brain development that could have implications for children growing up in violent homes.<sup>39</sup> There is an urgent need to address family violence over the lifespan because the health effects of victimization often persist for years after the abuse has ended.<sup>40</sup> Adults who were abused as children, witnessed IPV, had a parent with a mental illness, or

parental substance abuse are at significantly high risk for obesity, heart disease, hepatitis, diabetes, depression, and suicide.<sup>41</sup> These adverse childhood experiences frequently cluster in households and have a cumulative effect—the more adverse exposures in a household, the higher the likelihood of long-term health problems as an adult. (Family Violence Prevention Fund 2004)

There are immediate, short-term and long-term effects of being battered and there are many studies connecting a wide variety of physical, psychological, social, and existential problems with domestic violence. Typically, a woman who is battered lives with constant terror and anxiety with fears of imminent doom. To others she may appear passive and lacking in energy, seemingly helpless to take charge of her own life. She may suffer from chronic depression, exhibit suicidal behavior, and develop overt post-traumatic stress disorder. She may turn to the use of drugs and alcohol to afford herself some relief, thus compounding existing problems. She is likely to feel hopeless and powerless to make any significant changes, fearing that anything she does will lead to something worse. She may be unable to relax and have difficulty sleeping. Her sleep may be interrupted by violent nightmares.

The manner in which a battered woman will be individually affected by battering will be determined by a number of interactive factors including her previous exposure to violence as a child and adolescent; genetic, constitutional, and psychobiological factors; the presence of co-existing physical, psychological or social problems; the presence of substance abuse; her belief systems as well as the belief system(s) of her family, ethnic group, religious affiliation; the supports that exist within the community.

## THE CHILDREN OF BATTERED WOMEN

Children exposed to domestic violence show many different responses that negatively impact their physical and mental health, their social adjustment and their school performance. For children, the more severe the violence, the more severe their problems are likely to be. Childhood exposure to violence also has serious consequences for adult physical health as well as mental health and social adjustment. When compared to people who had safe and secure childhoods, people who had experienced four or more categories of childhood adversity - including witnessing domestic violence - had a 4- to 12-fold increased health risks for alcoholism, drug abuse, depression, and suicide attempt; a 2- to 4-fold increase in smoking, poor self-rated health, sexual promiscuity, and sexually transmitted disease; and a 1.4- to 1.6-fold increase in physical inactivity and severe obesity. The number of categories of adverse childhood exposures showed a graded relationship to the presence of adult diseases including ischemic heart disease, cancer, chronic lung disease, skeletal fractures, and liver disease. The seven categories of adverse childhood

experiences were strongly interrelated and persons with multiple categories of childhood exposure were likely to have multiple health risk factors later in life.

## RESPONSE AND PREVENTION

Studies show that assessing for IPV in medical settings has been effective in identifying women who Most Americans are seen at some point by a health care provider, and the health care setting offers a critical opportunity for early identification and even the primary prevention of abuse are victims<sup>1</sup> and that patients are not offended when asked about current or past IPV.<sup>2</sup> A host of professional health care associations have issued position statements to their members describing the impact of IPV on patients and suggesting strategies for assessment and identification of abuse. These statements represent important steps in raising awareness about IPV in health care settings. Generally, however, they offer neither specific guidelines for intervening and responding, nor criteria that promote the utilization and evaluation of recommended practice. These guidelines offer specific recommendations for assessing for and responding to IPV that may be applied to multiple health settings.

Regular, face-to-face screening of women by skilled health care providers, markedly increases the identification of victims of IPV, as well as those who are at risk for verbal, physical, and sexual abuse.<sup>43, 44</sup> Routine inquiry of all patients, as opposed to indicator-based assessment increases opportunities for both identification and effective interventions, validates IPV as a central and legitimate health care issue and enables providers to assist both victims and their children. When victims or children exposed to IPV are identified early, providers may be able to break the isolation and coordinate with DV advocates to help patients understand their options, live more safely within the relationship, or safely leave the relationship. Expert opinion suggests that such interventions in adult health settings may lead to reduced morbidity and mortality.<sup>45</sup> Talking with patients about IPV provides a valuable opportunity for providers to learn about their experiences with abuse. Battered women report that one of the most important aspects of their interactions with a physician was being listened to about the abuse.<sup>46</sup> Even if a patient chooses not to disclose being abused, the provider's inquiry can often communicate support and increase the likelihood of future discussion of the issue. Assessment for exposure to lifetime abuse has major implications for primary prevention and early intervention to end the cycle of violence. Victims are often unaware of the cooccurrence of incest in homes with IPV. Assessing for IPV provides an opportunity to educate victims about the increased risk of child abuse and the health effects of childhood exposure to violence. Adolescents who grow up in violent households are more likely to engage in fighting, carry a weapon, attempt suicide, and become part of an escalating epidemic of dating violence.<sup>47,48,49</sup> Adolescent males who witnessed IPV are more likely to become teen fathers.<sup>50</sup> Adolescent girls who witness IPV are more likely have

unintended and rapid, repeat pregnancies, have sex with a partner who have multiple partners, and use alcohol or drugs before having sex.<sup>51,52,53</sup> Routine assessment for lifetime abuse is part of a larger trend to meet the psychosocial needs of patients while moving towards prevention. Asking about IPV and having resource and referral materials in health settings also sends a prevention message that IPV is unacceptable, has serious health consequences, and provides the patient with important community referral information and resources. In most counties, programs serving victims of IPV include hotlines, walk-in services and shelters. These programs typically provide safety planning, confidential emergency housing, short time focused counseling, legal advocacy, housing support and help identifying financial support.

## WORKING CROSS CULTURALLY

IPV affects people regardless of race, ethnicity, class, sexual and gender identity, religious affiliation, age, immigration status and ability. The term culture is used in this context to refer to those axes of identification and other shared experiences. Because of the sensitive nature of abuse, providing culturally relevant care is critical when working with victims of abuse. In order to provide care that is accessible and tailored to each patient, providers must consider the multiple issues that victims may deal with simultaneously (including language barriers, limited resources, homophobia, acculturation, accessibility issues and racism) and recognize that each patient who is a victim of IPV will experience both the abuse and the health system in culturally specific ways. Disparities in access to and quality of health care may also impact providers abilities to help abused patients. For example, women who are members of racial and ethnic minority groups are more likely than white women to experience difficulty communicating with their doctors, and often feel they are treated disrespectfully in the health care setting.<sup>54</sup> English-speaking Latinos, Asians and Blacks report not fully understanding their doctors and feeling like their doctors were not listening to them.<sup>55</sup> People with cognitive or communication disabilities may be dependent on an abusive intimate partner and thus at especially high risk. In addition, some patients may experience abuse from the health care system itself and this may impact their approach to and utilization of the health care system.<sup>56</sup> Providers also enter patient encounters with their own cultural experiences and perspectives unique from those of the victim. In a successful health care interaction within a diverse client population, the provider effectively communicates with the patient, is aware of personal assumptions, asks questions in a culturally sensitive way and provides relevant interventions. Eliciting specific information about the patient's beliefs and experience with abuse, sharing general information about IPV relevant to that experience and providing culturally accessible resources in the community, improves the quality of care for victims

of violence. In addition, having skilled interpreters who are trained to understand IPV (and who are not family members, caregivers or children) is crucial when helping non-English speaking patients. Culturally sensitive questions for all patients can also facilitate discussion and help providers offer appropriate and effective interventions.(Family Violence Prevention Fund 2004)

These guidelines reflect an important shift in terminology. “Assessment” has replaced the word “screening” throughout this document. The concept of screening in the medical model usually involves use of a standardized clinical test to detect disease in asymptomatic patients. Psychosocial health issues like IPV do not fit well into a disease-based approach, particularly when identification of the health concern relies primarily on the patient’s response to questions. The U.S. Preventive Services Task Force (USPSTF) uses the term “assessment” in their recommendations for many psychosocial issues such as tobacco use and alcohol consumption. The USPSTF and other prominent medical organizations have identified problems with fitting IPV into a traditional screening paradigm. The FVPF believes that using the term “assessment” will lead to a more appropriate evaluation of the importance of routine inquiry for IPV in the health care setting. With growing recognition of the connection between IPV and other risk factors, there is a trend to integrate routine inquiry for IPV into assessment tools addressing a wide range of psychosocial issues associated with current or past victimization such as tobacco use, weight control, and access to preventive health care. This has led to innovative strategies for more comprehensive assessment and integrated service delivery. The Maternal and Child Health Bureau has funded several perinatal demonstration projects to develop an assessment tool for IPV, depression, and substance abuse. Another exciting initiative through the Substance Abuse and Mental Health Services Administration (SAMHSA) promotes coordinated services for women who experience violence, mental health problems, and have substance abuse issues(Family Violence Prevention Fund 2004)

It is clear that a problem cannot be solved until it is properly recognized. In the last thirty years, public awareness of battering as a significant social problem has radically increased. Nonetheless, there is still a great deal of work to be done in educating health care and mental health care providers, social service workers, educators, criminal justice officials, and the general public about the reality of domestic violence, including the costs to society of failing to adequately address the problem. Adequate responses require that the community provide sufficient legal, health, mental health and other community resources to protect victims and ensure that they receive the services that lead to healing and recovery. This includes sufficient resources to treat the physical, emotional, and social consequences of battering in the victim, the child witnesses and the perpetrators. In order to efficiently deliver these resources,

research is needed to discover those interventions that are the most effective. Ultimately, although individual suffering must be addressed, the solution to the problem of battering resides in cultural transformation so that intimate violence and all forms of interpersonal violence are no longer considered acceptable.

## FOR FURTHER READING

For more information and a complete reading list see the website of the National Coalition Against Domestic Violence [www.ncadv.org](http://www.ncadv.org).

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