DOMESTIC VIOLENCE

Presented by

CONTINUING PSYCHOLOGY EDUCATION

8.4 CONTACT HOURS

"Victims of domestic violence must be helped to validate their sense of self-esteem and self-worth so that they feel able and competent to make decisions about their lives and carry their decisions through to action." D. Williams-White (1989)

Course Objective

The purpose of this course is to provide an understanding of the concept of domestic violence. Major topics include the prevalence and nature of intimate violence, cultural factors, theoretical explanations, assessment, detection, and intervention strategies, community resources, and a case study.

Accreditation

Provider approved by the California Board of Registered Nursing, Provider # CEP 14008, for 8.4 Contact Hours.
In accordance with the California Code of Regulations, Section 2540.2(b) for licensed vocational nurses and 2592.2(b) for psychiatric technicians, this course is accepted by the Board of Vocational Nursing and Psychiatric Technicians for 8.4 contact hours of continuing education credit.

Mission Statement

Continuing Psychology Education provides the highest quality continuing education designed to fulfill the professional needs and interests of nurses. Resources are offered to improve professional competency, maintain knowledge of the latest advancements, and meet continuing education requirements mandated by the profession.

Learning Objectives

Upon completion, the participant will be able to:

1. Explain the prevalence of intimate violence.
2. Clarify the nature of intimate violence.
3. Describe the effects of cultural factors upon partner violence.
4. Articulate theoretical explanations of domestic violence.
5. Discuss community resources addressing spousal/partner abuse.
6. Expound upon assessment, detection and intervention techniques.
7. Communicate batterer interventions.
8. Understand how domestic violence literature can be applied to a case study.

Faculty

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INTRODUCTION

Violence against women as a significant social problem began receiving attention in the late 1960s and early 1970s. Currently, the term *violence against women* describes a variety of behaviors, including emotional, sexual, and physical assault, threats, verbal abuse, humiliation, stalking, sexual harassment and murder by current or former intimate partners (Crowell & Burgess, 1996).

The National Violence against Women Survey conducted by the National Institute of Justice and the Centers for Disease Control and Prevention (CDC) indicated a greater amount of intimate partner violence than earlier thought. Results estimated that approximately 1.5 million women and 830,000 men are victims of intimate violence each year in the United States. Roughly 1.5% of the women surveyed reported having been physically assaulted and/or raped by a current or former intimate partner within the past year and about 25% had been assaulted or raped by an intimate partner within their lifetime (Tjaden & Thoennes, 2000); additionally, 8% of women had been stalked during their lives.

Battering in intimate relationships may result in broken bones, miscarriages, emotional harm, broken families and death. More than one million women seek medical care due to battering each year. Children who witness abuse may display somatic, psychological and behavioral problems along with school phobias, enuresis, stuttering and academic concerns (Nadelson & Sauzier, 1987).

Domestic violence affects not only the victims but also creates broader societal repercussions. "The structural, cultural, and social characteristics of our society continue to perpetuate the victimization of women on all levels" (Williams-White, 1989). Family violence reflects and helps to maintain cultural violence and oppression. Violent husbands maintain the level of societal violence and they reflect a "direct manifestation of socially learned sex-role behaviors" (Jennings, 1987, p. 195). Battering crosses race, ethnicity and socioeconomic status (Hotaling & Sugarman, 1986). Treatment of violence appears mandatory as Walker (1984) reveals that non-treatment can lead to more violence. Future generations may continue to revert to violence to solve issues, if not treated, and violence may escalate over time.

Despite the fact that over 20% of violent crimes against women between 1993 and 1998 were committed by current or former intimate partners, the rates of lethal and non-lethal intimate violence have decreased (Rennison & Welchans, 2000), however, Tjaden & Thoennes (2000) report the prevalence remains exceedingly high.

Studies of violence against women have not yielded clear solutions to the problem, however, research continues to facilitate development of theoretical explanations, risk factors and causes aimed at construction of prevention and intervention programs.

As yet, there is not a universally accepted single definition of violence against women; definitions are important though "because of the power conveyed by scientific authority" (Muehlenhard et al., 1992, p. 49). The following is suggested:

> Woman abuse is the misuse of power by a husband, intimate partner (whether male or female), ex-husband, or ex-partner against a woman, resulting in a loss of dignity, control, and safety as well as a feeling of powerlessness and entrapment experienced by the woman who is the direct victim of ongoing or repeated physical, psychological, economic, sexual, verbal, and/or spiritual abuse. Woman abuse also includes persistent threats or forcing women to witness violence against their children, other relatives, friends, pets, and/or cherished possessions by their husbands, partners, ex-husbands, or ex-partners (DeKeseredy & MacLeod, 1997, p.5).

Many researchers (i.e., Gelles & Cornell, 1985) argue that such definitions as above are problematic because they include "everything but the kitchen sink," suggesting almost every woman has been victimized. Nonetheless, increasing numbers of survey researchers and government agencies such as the Centers for Disease Control and Prevention are utilizing broader conceptions. Hall (1985) reinforces broad definitions by noting the following: Just "ask any woman" about her experiences with violence and other types of intimate abuse, and you will undoubtedly discover that she will call for a definition that includes many harmful non-physical and non-sexual behaviors.

PREVALENCE of INTIMATE VIOLENCE

Whereas strangers and acquaintances commit most crimes and assaults against men, women are more likely to be raped, beaten, stalked, or killed by their intimate partners than by strangers or any other type of assailant (Bachman & Saltzman, 1995). American women are murdered by intimate partners in at least 33% of all female-murder cases. Intimate violence causes more physical injury to women than violence by strangers and is a causal factor in development of female mental health problems such as depression, alcoholism and suicidality (Bachman & Saltzman, 1995; Campbell, Kub, Belknap, & Templin, 1997). Such violence is a major contributor to homelessness for women and children (Crowell & Burgess, 1996), and continues to be the single greatest health threat to American women under age 50. Roughly 35% of emergency room visits are made by women needing care due to domestic violence-related injuries (Valentine, Roberts, & Burgess, 1998). Bachman and Saltzman (1995) found that 41% of women experiencing intimate violence sustained injuries requiring medical care. Gazmararian et al. (1996) published in the Journal of the American Medical Association that up to 20% of pregnant women are abused by their partners during pregnancy. Such abuse endangers the woman and fetus in a number of ways (Carlson & McNutt, 1998, p. 237).

The continuum of abuse ranges from women being hit once or twice (and ending the relationship) to women who are beaten with increasing frequency over many years (Roberts & Burman, 1998). Research has revealed a strong correlation between women experiencing chronic abuse and onset of bipolar disorder, anxiety disorder, posttraumatic stress disorder (PTSD), panic disorder, and/or depression with suicide ideation (Petretic-Jackson & Jackson, 1996; Walker, 1985). Consequences of sexual assault may include contraction of sexually transmitted diseases, including HIV. Molina and Basinait-Smith (1998) discovered that 50% of a sample of battered women residing in shelters had been infected with at least one form of sexually transmitted disease. Economically, battering yielded absenteeism from work in 55% of battered women (Shepard & Pence, 1988). One annual estimate of cost of intimate violence to the health care industry, in 1980 dollars, included 21,000 hospitalizations, 99,800 days of hospitalization, 28,700 emergency room visits, and 39,900 physician visits totaling over $44 million (McLeer & Anwar, 1987). Other studies suggest that this estimate is low: Rand and Strom (1997) found that 37% of over 550,000 women's emergency room visits resulted from victimization by an intimate.

Violence against women in dating relationships is at least as common as violence against married women. Sugarman and Hotaling (1991) conclude that roughly 28% of both males and females are involved in dating violence during their lifetime.

Tjaden & Thoennes (1998) discovered that physical battering is widespread among all racial and ethnic groups; 52% stated they were physically assaulted as a child by a caretaker and/or an adult by any type of perpetrator; and 18% reported having experienced a completed or attempted rape in their lifetime.

Studies examining racial differences in intimate violence present varied results. Lockhart (1987, 1991) found that roughly 33% of both African American and white women in a community sample were physically abused. Researchers found comparable rates for African American and white women across shelter, urban prenatal clinic, high school, and undergraduate samples (McFarlane, Parker, Soeken, Silva, & Reed, 1999; O'Keefe, 1994; Rouse, Breen, & Howell, 1988; Symons, Croer, Kepler-Youngblood, & Slater, 1994). Researchers using community, clinical, and shelter samples discovered no intimate violence difference rates between Mexican American and Anglo women (Mirande & Perez, 1987; Neff, Holamon, & Schluter, 1995; Torres, 1991). The National Crime Victimization Survey indicated no significant differences between African American, Latino, and Anglo American groups in rates of serious violence committed by intimates (Bachman, 1994). Contrarily, many other studies have found higher rates for minority women than white women. The first National Family Violence Survey reported intimate violence against African American women at four times the rate for white women and the re-survey indicated twice the rate (Cazenave & Straus, 1979; Hampton & Gelles, 1994; Straus, Gelles, & Steinmetz, 1980). DeMaris (1990) found African American women experiencing more mild and severe dating violence, and Greenfield et al. (1998) report that African American women are three times more likely than white women to be killed by an intimate partner. Often, racial differences in intimate violence rates disappear when variables of age, social class, and husband's occupational and employment status are considered (Straus et al., 1980); people of color may be more likely than whites to be over-represented in demographic categories that are at greater risk for physical violence.

In 1974, there were seven emergency shelters for battered women (Roberts, 1981) and in 1998 there were more than 2000 shelters and crisis intervention programs for battered women and their children (Roberts, 1998). These programs help women regain control of their lives by identifying options and goals and striving to attain them. A woman with a prolonged abuse history experiencing a recent severe attack may be thrust into crisis (Young, 1995) due to intensified tension and distress, failed coping methods, and ensuing unbearable pain and anguish (Caplan, 1964; Janosik, 1984; Roberts, 1996b). This active crisis state can lead to change and growth facilitated by a 24-hour telephone crisis intervention service, police, hospital emergency room, or shelter for battered women.

The five most common precipitating events leading battered women in crisis to seek assistance from domestic violence programs are:

a. an acute battering incident resulting in serious injury.
b. major escalation in the degree of violence.
c. an impairment in hearing, sight, or thought process directly due to battering.
d. media attention to a brutally murdered woman who remained silent for years.
e. serious injury to the woman's child.

The precipitating event is often perceived by the woman as the "last straw" in a long history of violence (Roberts, 1998).

NATURE OF INTIMATE VIOLENCE

Weis (1989, p. 126) suggests that definitions of violence should include "actual, attempted, or threatened behavior that is intended to cause physical injury or create the fear of injury (particularly, to force someone to do something), and that actually does or is likely to cause injury or pain." Each assault act, however, may simply represent a temporary physical manifestation of a bigger issue, hence, the ongoing abuse and control of a woman by her intimate partner is examined and termed *battering*.

Battering describes behavior culminating in one individual continually reinforcing a power imbalance over another within an intimate/romantic relationship context.

The batterer generally uses assaultive and non-assaultive methods designed to dominate, control, and induce fear and/or subservience in the relationship partner. This complex pattern of behavior, called *coercive control*, can include physical/sexual violence, violence threats against the woman, children, or other loved ones, psychological/emotional abuse, economic exploitation, confinement and /or control over activity beyond home-life (social life, work), stalking, property destruction, burglary, theft, and homicide. Coercive control is generally manifested in numerous ways at one time (i.e., physical assault combined with verbal abuse within an economically exploitative relationship).

Feminist researchers (Currie, 1998; Johnson, 1995; Stark & Flitcraft, 1996; Yllo, 1993) acknowledge existence of violence by women against men (Straus & Gelles, 1990), however, they stress that such violence does not produce the degree of suffering or entrapment caused by intimate violence against women.

Physical abuse in relationships is defined as experiencing any act of physical aggression, including minor acts as slaps to severe acts as assault with a deadly weapon. Tjaden & Thoennes (1998a) project that 1.3 million women experience any intimate violence every year and 22 million women experience such in their lifetime.

Sexual abuse represents any sexual act that a woman submits to against her will due to force, threat of force, or coercion. Abraham (1999) offers a definition commonly found in research literature: “It includes sex without consent, sexual assault, rape, sexual control of reproductive rights, and all forms of sexual manipulation carried out by the perpetrator with the intention or perceived intention to cause emotional, sexual, and physical degradation to another person.” (p. 592)

Approximately 10% to 14% of ever-married or cohabited women experience such sexual violence in their lifetime (Finkelhor & Yllo, 1985; Russell, 1990). Tjaden and Thoennes (1998a) estimate that 7.7% of all women have been raped by an intimate partner in their lifetime suggesting 7.7 million American women. Rape by intimate partners accounts for over 25% of all rapes (George, Winfeld, & Blazer, 1992). Victims of sexual abuse often report that this act is an expression of power, domination, and control.

Research into psychological abuse is relatively new as greater focus has been on the immediate concerns of physical violence. Psychological abuse can have severe consequences, even after controlling for physical abuse effects (Arias & Pape, 1999; Marshall, 1996). Many battered women evaluate emotional abuse effects as worse than physical abuse effects (Follingstad, Rutledge, Berg, Hause, & Polek, 1990).

O’Leary (1999) defines psychological abuse as: “acts of recurring criticism and /or verbal aggression toward a partner, and /or acts of isolation and domination of a partner. Generally, such actions cause the partner to be fearful of the other or lead the partner to have very low self-esteem.” (p. 19)

Types of psychological abuse vary across studies, for example, Follingstad et al. (1990) included threats of abuse and divorce, ridicule, jealousy, restriction, and damage to property. Murphy and Hoover (1999) identified hostile withdrawal - acting cold or distant when angry; domination/intimidation - destroying victim possessions; denigration - calling partner names; and restrictive engulfment - isolation from friends.

Psychological abuse is common and chronic in battering relationships. More than 50% of a community sample of physically abused women reported a high frequency (at least once a week) of three types of emotional abuse involving restriction, jealously, and ridicule (Follingstad et al., 1990).

Domestic violence stalking behavior includes surveillance activities (i.e., monitoring phone calls, reading mail, and following victim outside the home), vandalism (i.e., breaking into the home, stealing belongings), and harassment (i.e., calling repeatedly at home or work). Most stalking definitions require that behaviors are repeated and produce a high level of fear in the victim (Tjaden & Thoennes, 1998b). One study estimated that over one million women are stalked annually; 59% of cases revealed the stalker as a former or current intimate partner; surprisingly, stalking behavior was more likely to begin during the relationship rather than after it ended (Tjaden & Thoennes, 1998b).

The perpetrator in cases of homicide of women (called *femicide*) is often a current or former intimate partner. Statistics indicate a range of 30% to 64% of femicide cases result from intimate violence (Campbell, 1992; Greenfield et al., 1998) and at least 1217 American women were victims in 1997 (Fox & Zawitz, 2000).

Some women report experiencing intimate violence as a relatively isolated event. Kurz’s (1996) study of divorced women indicated 16% reported only one violent act; violence was minor and did not affect the woman’s life in a major way. Stark and Flitcraft (1988) estimate that less than 33% of women are in this category. Johnson (1995) terms this type of intimate violence “common couple violence” which occurs when daily conflicts get “out of hand” leading to minor forms of violence equally initiated by men and women; escalation of the level of violence over time is unlikely.

In contrast, Plichta (1992) reviewed intimate violence studies and found 25% to 30% of physically abused wives experienced physical violence regularly. Bowker and Maurer (1987, cited in Plichta, 1992) discovered 46% of 1000 battered women reported 20 or more beatings throughout their relationship. From 69% to 83% of wife rape survivors reported being raped more than once, and from 33% to 50% reported 20 or more rapes during the relationship (Bergen, 1996; Finkelhor & Yllo, 1985).

The magnitude of intimate violence may be measured by chronicity, as indicated above, and by overlap of abuse types. A review of studies (Mahoney & Williams, 1998;

Hanneke, Shields, & McCall, 1986) reveals that approximately 50% to 70% of battered women experienced both physical and sexual abuse by their partner. One study of women stalked by an intimate partner revealed 81% reported physical assaults, and 31% reported sexual assaults by the same partner (Tjaden, 1997). Homicide by an intimate partner is infrequently an isolated act of violence (Stout, 1993). Life-threatening intimate violence is commonly associated with a high frequency of violence, injury-producing violence, sexual violence, threats to kill partner, the killing or abuse of pets, and controlling and psychological maltreatment. Browne (1987) noted that more than 75% of battered women who killed their partners were raped by their partner and 40% reported having been raped "often."

THEORIES EXPLAINING WOMEN REMAINING IN DOMESTIC VIOLENCE SITUATIONS

Walker (1979) noted a pattern of relationship abuse which she termed the "cycle of violence:" a period of tension building (may include verbal abuse, minor physical battering, and woman attempts to "placate" her partner, though rarely successfully) leads to a battering incident followed by perpetrator attempts to "make up" (expresses remorse, convinces her of his love, promises no further harm, gift-buying, and attends to her needs). The woman believes this is the man she loves, typically stays in the relationship, and convinces herself the honeymoon will last. The honeymoon period ultimately ends and leads to another tension building phase which starts the cycle once again. Over time, honeymoon periods get shorter and may become non-existent and violence increases in severity and frequency. This is but one possible pattern of violence, for example, as noted earlier, some women will experience intimate violence only once or twice.

The theory of learned helplessness offers rationale for women staying in abusive relationships. Parallels exist between dogs reactions in Seligman's learned helplessness study and battered women. As in domestic violence, the shocks administered to the dogs were not based on their behavior, attempted escape from the shocks failed, and they stopped trying to escape - even when it was possible, due to the onset of learned helplessness. Just as the dogs perceived that nothing they did would end the shocks, so battered women may perceive a lack of self-control over the situation as attempts to end abuse (threatening to leave, contacting police, securing a restraining order) are fruitless. Walker (1989) stresses that the woman will not leave the batterer, even if possible, if she believes she cannot leave or cannot survive independently.

Related to learned helplessness and the cycle of violence is the battered woman syndrome (BWS). Walker (1979) believed that some women remain in abusive relationships due to extreme fear, and beliefs that escape is not possible (leading to no choice but to remain with the abusive partner). The syndrome develops over time as the cycle of violence results in feelings of lost hope and inability to manage the situation. BWS describes a pattern of psychological components, including symptoms of PTSD (i.e., intrusive memories, flashbacks, fear, anxiety, sleep disturbances, avoidance, and hyper-vigilance) and learned helplessness. This syndrome affects women differently "depending upon a particular woman's previous exposure to other oppressors, mental health status, available support systems, frequency and severity of the abuse, and a quality best described as 'hardiness' of the individual woman" (Walker, 1993, p. 134).

The Stockholm syndrome or hostage syndrome suggests women stay in abusive relationships by developing a bond with their captor as a hostage might do given a situation of isolation from outsiders, occasional kindness, and dependency of survival upon the captor (Graham & Rawlings, 1991). The syndrome is named after an event in Stockholm, Sweden, in which four bank employees were held hostage in the bank vault for 131 hours by two escaped prisoners. Ultimately, the hostages feared the police more than their captors as they eventually identified with the offenders and their cause (Strentz, 1979). Some women may feel that there is no escape from the situation in which their intimate partner is in complete control.

Traumatic bonding theory proposes that strong emotional ties coupled with intermittent abuse lead women to remain in abusive relationships. Specifically, physical assault leads to victim needing affection and an ensuing openness to perpetrator remorse; intermittent abuse results in victim vulnerability and need for positive treatment; ultimately, perpetrator kindness reinforces victim's emotional bond to him (Dutton & Painter, 1993). Bowlby (1988) believes that some partners may have strong but unhealthy attachments to one another based on anxiousness and fear of abandonment, in turn, they may use violence to control the other or to avoid abandonment. In support, Holtzworth-Munroe, Stuart, and Hutchinson (1997) discovered that physically abusive male partners revealed unhealthy attachment styles more than non-violent men.

Psychological entrapment theory suggests the woman is unable to leave a domestic violence relationship because she has too much time, energy, and emotion invested toward attainment of a non-violent intimate relationship to give up.

The tendency for battered women to return to their abusers numerous times before permanently leaving may be due to weakness or contrarily, willingness to resolve relationship issues which takes persistence and strength. Campbell, Rose, Kub, and Nedd (1998) term this relationship phase the "in/out" period and indicate that most battered women move through this period en route to permanent separation. Stark and Flitcraft (1996) express that "linking the decision to stay in an abusive relationship with characterological dependency blames victims for problems they are desperately trying to resolve" (p. 164). Research indicates that most battered women leave their partner permanently (Campbell et al., 1998; Strube &

Barbouir, 1984). Unfortunately, leaving the relationship and ending the abuse may be two different processes (Campbell et al., 1998). Tan, Basta, Sullivan, and Davidson (1995) found that of women no longer with their partner, 28% were physically harmed and 35% sustained psychological abuse six months after leaving.

CHARACTERISTICS of BATTERERS

Holtzworth-Munroe and Stuart (1994) present three types of batterers. The *family-only batterer* is hypothesized to have poor communication and social skills, a history of exposure to family-of-origin aggression, and high levels of dependency on partner(s). The *dysphoric/borderline batterer* is thought to have a history of parental rejection, child abuse, high dependency on partner, poor communication and social skills, hostility toward women, and low levels of remorse for perpetrated violence. The generally violent *antisocial batterer* is viewed as having experienced family-of-origin violence, a history of delinquency, communication and social skill deficits, and believes violence is an appropriate response to provocation.

Jacobson and Gottman (1998) examined emotions of severely violent batterers during non-violent arguments and discovered two emotional types: “pit bulls” and “cobras.” Pit bulls are men whose emotions quickly reach boiling point, and they have deep insecurities and dependence on their partners. Cobras are cool and methodical, systematic, controlling, sadistic toward their partners and display severe antisocial and criminal-like traits.

Characteristics of the aggressor rather than the victim predict a potentially violent relationship (Hotaling & Sugarman, 1986), however, batterers are not a homogeneous group and different types of batterers may display different characteristics and risk factors. Research has illuminated several risk factors associated with partner violence. Alcohol abuse and binge drinking have revealed consistent association with partner violence incidents (Kantor & Jasinski, 1998). Suggested is that alcohol is a disinhibitor and drunkenness serves as an excuse for violence against female partners (Kantor & Straus, 1989). Witnessing parental violence and experiencing child abuse are associated with intimate partner violence (Hotaling & Sugarman, 1986); hypothesized is that such experiences may result in issues with attachment and forming relationships. Hamberger and Hastings (1986) found three major personality profiles of batterers: narcissistic/antisocial, schizoidal/borderline, and dependent/compulsive. O’Leary (1993) and O’Leary, Malone, and Tyree (1994) report that personality disorders characterize men in severely abusive relationships and aggressive and defensive personality style predicted later aggression. There is not a single personality profile which characterizes physical abusers, however, and many batterers are indistinguishable from non-batterers on a number of life history and personality measures.

In addition to the above-mentioned characteristics, Hotaling and Sugarman (1986) found that working-class occupational status, and low income/assertiveness/educational level were associated with battering behaviors. Unemployment and job dissatisfaction are risk factors (Gelles & Cornell, 1985; Straus et al., 1980) as is cohabitation relative to marriage (Hotaling & Sugarman, 1986); no religious affiliation (Straus et al., 1980); social isolation (Pagelow, 1981); and having a greater number of children at home (Straus et al., 1980). Marital violence is highest among those aged 18 to 29 years (Bachman & Pillemer, 1992). More than 20% of men between 18 and 25 years and 16.9% between ages 26 and 35 committed at least one domestic violence act in the past year (National Research Council Institute of Medicine, 1998). Values promoting sexual inequality and male-domination enable domestic violence (Koss & Gaines, 1993; Straus, 1980).

RELATIONSHIP RISK FACTORS

Reports of violence or aggression were the strongest predictors of divorce within the first four years of marriage, and quality of communication was the best predictor of marital satisfaction in a study by Rogge and Bradbury (1999); “psychological” aggression resulted in increased ability to predict divorce suggesting factors such as psychological abuse may be precursors to more serious violence. Longitudinal studies reveal that destructive marital conflict and negative communication are the leading risk factors for future marital distress (Gottman, 1994; Markman & Hahlweg, 1993). Destructive communication patterns include the demand-withdraw pattern (“demander” pressures partner through criticism or complaints and “withdrawer” retreats through defensiveness or avoidance (Christensen & Heavy, 1990)), escalation, invalidation, withdrawal, and negative interpretations (Markman, Stanley, & Blumberg, 2001).

Marital aggression may be caused by couples’ failure to resolve marital conflict by utilizing proactive coping mechanisms (Markman & Kraft, 1989); supportive is that violent individuals often lack problem-solving and conflict resolution skills (Holtzworth-Munroe & Anglin, 1991). This deficiency in marital conflict resolution, due to one or both partners, can lead to negative escalation resulting in violence (Holtzworth-Munroe, Smutzler, Bates, & Sandin, 1997).

Resource theory (presented in next section) suggests that men who lack power (i.e., income, education, job status) relative to their mate may resort to violence to regain or compensate for a lack of power. Risk of marital violence increases in relationships in which husband has relatively less power than wife (Babcock, Waltz, Jacobson, & Gottman, 1993). These researchers also found that husbands’ and wives’ poor communication skills, husbands’ low decision-making power, and high levels of the husband demand-wife withdraw communication

pattern all associated with increased violence against the wife.

Observational methods have shown that physically aggressive husbands show more negativity than maritally distressed but non-violent husbands, and women in violent relationships are more likely to reciprocate negative behavior than women in non-violent relationships (Burman, John & Margolin, 1992).

These studies suggest the importance of interpersonal and communication patterns within the dynamics of intimate violence. Ending negative interaction, emotional abuse, unresolved conflict, and male domination of the relationship is considered essential for change.

THEORETICAL EXPLANATIONS

A variety of disciplines attempt to explain violence against women, including psychology, social work, sociology, criminal justice and public health, in turn, competing theories exist with different resolution ideologies. Gelles and Straus (1979b) report three broad theoretical frameworks: intra-individual theory, social psychological theory, and sociocultural theory; a distinction between micro and macro-oriented theories is also offered (Barnett, Miller-Perrin & Perrin, 1997). Today, multi-dimensional models consisting of combinations of theories are commonly utilized to explain violence against women. This section reviews both the separate and multi-dimensional models involved.

MICRO-ORIENTED THEORIES: INTRA-INDIVIDUAL and SOCIAL PSYCHOLOGICAL VIEWS

SOCIAL LEARNING

Within the context of violence against women, social learning theory, termed *the intergenerational transmission of violence*, believes that violence is learned during socialization within the family, which is the main agent of socialization (Kalmuss, 1984; O'Leary, 1988; Straus et al., 1980). Specifically, those experiencing or witnessing violence in their family-of-origin learn that violence is a way of getting what they want when other methods have not worked. Doumas, Margolin, & John (1994) discovered that men exposed to violence in their family-of-origin were more likely to perpetrate domestic violence, and women who observed violence in their family-of-origin were more likely to be subjected to their partners' aggression. Straus and colleagues (1980) sense that each generation is conditioned to be violent by participating in a violent family. The family is the training ground for violence, highlighted by the idea that those who hit you are people who love you the most.

Bandura (1978) believed that violence is learned from three main sources: family, culture and subculture, and the media. He felt media was important because it desensitized viewers to violence by repeated acts, offered rationalizations for violence, and demonstrated methods of aggression. Ellis (1989) suggests that rape, for example, is aggressive behavior toward women learned by imitating rape scenes and other violent acts seen in the media which associate sexuality and violence and desensitize viewers to the pain of sexual aggression.

Critics of social learning theory argue that the rate of intergenerational transmission of violence is only 30%, therefore, 70% of people who witness or experience violence do not perpetrate violence (Kaufman & Ziegler, 1987). Social learning theory advocates counter this reasoning by emphasizing that although their theory does not explain all violence, individuals experiencing violence as children are at increased risk of engaging in violent behavior as adults (Straus, 1991). Hotaling & Sugarman (1986) suggest that victimization and witnessing of violence are consistent risk markers of adult violence.

PERSONALITY TRAITS and PSYCHOPATHY

A psychopathological explanation suggests that individuals who display violence toward women have a personality disorder or mental illness impeding inhibitions about using violence. Those committing violence are seen as sick individuals and different from others (Pagelow, 1984).

Analysis of violent men reveals that they have low self-esteem (Goldolf, 1988), are extremely jealous (Holtzworth-Munroe, Stuart, & Hutchinson, 1997), have aggressive or hostile personality styles (Heyman, O'Leary, & Jouriles, 1995), experience a high frequency of stressful life-events (Straus et al., 1980), are more likely than non-violent men to make dysfunctional and blaming attributions regarding partner behavior (Holtzworth-Munroe & Hutchinson, 1993), and use poor communication and social skills (Murphy, Meyer, & O'Leary, 1994). Additionally, Dutton and Strachan (1987) compared wife assaulters with non-assaultive men and found that assaultive men have greater needs for power; one explanation suggests that men who feel powerless due to low self-esteem, or feel low control over others or the events in their lives have great needs for power. Dutton and Strachan (1987) also postulate that men viewing intimacy with women as threatening, dangerous, and uncontrollable may lead to violence to control their partner and reduce their anxiety and anger.

Elevated depressive symptoms have been observed in individuals who have assaulted their partners (Vivian & Malone, 1997). Violence may be one way to eliminate or reduce feelings of helplessness associated with depression (Tolman & Bennett, 1990).

Dutton (1994a) found that abusive men have narcissistic personality styles; they are more anxious about abandonment than non-abusive men (Holtzworth-Munroe et al., 1997); and aggressive men take a longer time to commit to a relationship and have greater feelings of dependency as compared to men who are not aggressive

(Ryan, 1995).

Criticism of this theory being used exclusively suggests that the importance of social structure is minimized, and it decreases the abuser's responsibility for his actions which may lead to lessened consequences (Dutton, 1994b). A functional application of this theory has been development of male batterer typologies which attempt to match prevention, intervention, and treatment efforts with different types of batterers.

BIOLOGICAL AND PHYSIOLOGICAL MODELS

The evolutionary perspective believes that males are driven to reproduce as much as possible to increase the probability of passing on their genes. Rape is seen as an extreme response to natural selection pressure to reproduce in tandem with female attempts to control the identity of their mate. Males having trouble finding female partners with whom to reproduce are more likely to use force as in rape. Regarding intimate partners, this model suggests that male sexual jealousy, a characteristic common to male batterers, evolved to maximize their reproductive prowess (Burgess & Draper, 1989).

Researchers also study effects of childhood attention deficit disorders, head injuries, and various biochemical factors such as testosterone and serotonin upon relationship aggression. The connection between head injury and violence, for example, may result from lowered impulse control due to damage to various parts of the brain. Rosenbaum and associates (1994) discovered that more than 50% of the batterers in their study had sustained a closed head injury compared to 25% of non-violent men; males with head injury were almost six times more likely to be batterers than men without head injury, and greater than 90% of the males experienced head injury before the first sign of aggression.

Biological models, however, do not factor in social factors and they reduce offender responsibility for their actions.

THE ROLE OF ALCOHOL

Alcohol is the drug most often correlated with violent behavior (Fagan, 1993), and is consistently extant in many of the profiles of abusive males. Research has revealed a significant association between family history of violence and current use of alcohol and incidence of wife abuse (Kaufman, 1993). Alcohol has been correlated with rape (Schwartz & DeKeseredy, 1997).

The relationship between alcohol usage and rape is thought to result from several factors, including expectations regarding the effects of alcohol, sexual intent misperceptions, justification for inappropriate behavior, and stereotypes about female drinkers. Utilizing alcohol usage as an exclusive causal factor for violence, though, reduces offender accountability and misplaces the blame on the effects of drinking.

EXCHANGE THEORY

This model suggests that people act either to earn rewards or to escape punishment (Homans, 1967). Behavior is driven by calculated assessment of risk versus reward. Relative to relationships, each partner offers the other various services and benefits such as affection, money, love, and sex contingent upon the partner reciprocating with desirable responses such as appreciation, praise and love. Should a partner exert force to gain desired ends and not be consequenced then that partner perceives violence as a tactic to control the other (Gelles, 1983). Violence represents a behavior which can advance one's interests and violence against women by men can help maintain their position in the social structure. If the costs of acting violently do not outweigh the rewards then violence may occur. Exchange theory proposes that behavior can be shaped by rewards and punishments by others, specifically, battered women may attempt to avoid punishment (violence) by complying with their partner's desires. Additionally, periodic displays of kindness by the batterer act as reinforcement and the abused woman may be compliant to gain such reward. Historically, domestic violence has been summized as a private matter not involving police, which lowers the cost factor, and violence often is associated with the desired outcome, which acts as a reinforcer.

Research supporting exchange theory is demonstrated by a study of 1965 eighth and ninth-grade students who were more likely to perpetrate violence on their partners given more positive outcome expectations and fewer negative outcome expectations of violence (Foshee, Bauman, & Linder, 1999).

RESOURCE THEORY

The focus of this model is power which is defined as the ability of one person to influence the other (Blood & Wolfe, 1960). The family is seen as a power system in which violence may surface as the ultimate resource when other resources are lacking (Goode, 1971). The person offering the greatest resources in a relationship (i.e., income, property, social contacts, prestige) possesses more decision-making power. Men often have greater financial resources resulting in their female partners being more vulnerable. Those with few personal, economic or social resources may revert to violence as a way to control others (Gelles, 1993). Egalitarian relationships are least probable to manifest violence. Social norms which perpetuate violence as a way of maintaining power contribute to ongoing violence, for example, children learn that force is justified in certain situations, and that simply the threat of violence can yield control and attainment of desired goals.

MACRO-ORIENTED THEORIES: SOCIOCULTURAL MODELS

FEMINIST THEORY

Macro or sociocultural models focus on social and cultural conditions leading to violence. The feminist model mainly focuses upon the male-dominated culture (patriarchy) and the cultural institutions which support such, hence, power, gender, and the structure of relationships in a patriarchal culture are examined (Bograd, 1988). Major contributing factors to violence against women include the historically male-dominated social structure, socialization teaching males and females gender-specific roles (Smith, 1990), and women's limited access to resources. Chalk & King (1998, p. 37) believe this "violence" involves "physical violence, emotional abuse, sexual violence, social isolation, and withholding of financial resources" to "undermine a woman's autonomy and limit her power in the relationship." Violence maintains social control and male power over women - this perspective is supported by cross-cultural studies showing less violence in more egalitarian societies (Levinson, 1989).

The feminist perspective believes rape results from traditions of male dominance and this dominance is perpetuated by prostitution and pornography which degrades women. Rape is viewed as the male response to social inequality between the sexes with the objective of control and domination rather than sexual gratification (Ellis, 1989).

Critics argue that this model does not explain why only a small percentage of men use violence against women given a culture dominated by patriarchy, and this perspective cannot explain violence by women.

FAMILY VIOLENCE PERSPECTIVE

This view asserts that violence affects all family relationships and that the nature of family structure is the origin of the issue. Proponents of this theory suggest that women in heterosexual and lesbian relationships can be as violent as men (Stets & Straus, 1990), though violence is generally considered to be qualitatively different for men and women.

Straus (1990c) proposes that families legitimize violence by utilizing corporal punishment, accepting violence as a possible solution to resolving family conflict, and offering basic training in usage of violence through physical punishment thereby creating a link between love and violence. The marriage license becomes a license to hit. Further, a need for family conflict resolution exists due to family members not being in a position to leave easily.

SUBCULTURE OF VIOLENCE

This perspective arose to explain violence committed by young, lower-class, minority men (Wolfgang, 1958). Certain societal groups, more than others, are thought to accept violence in specific situations; these subcultures may accept and possibly encourage violence. Wolfgang & Ferracuti (1982) suggest that lower-class individuals more than higher social class members may use violence because such is a way of life for them. It is suggested that some subcultures may justify wife-beating. Bowker (1983a) suggests that violence against women is more probable when male peer subgroups reinforce values that approve of violent behavior.

CULTURAL ACCEPTANCE OF VIOLENCE

American society features high levels of violence and norms glorifying aggression and violence as evidenced by violent movies and sporting events. Baron and Straus (1989) assert that violence against women may increase as the society condones usage of violence or force as an acceptable way to achieve desired ends. This perspective, however, does not explain why only a percentage of men use violence against women.

STRESS

Farrington (1986) assesses stress as a significant risk factor for violence against women within family context; Farrington (1980) believes social status and organization of the family institution act as stressor stimuli, creating demands on individuals and families. Failure to master these stressors can lead to increased stress levels resulting in violence being used as an acceptable response. In fact, Straus (1990c) suggests that the institution of family contains high levels of conflict and stress.

MULTI-DIMENSIONAL THEORIES

Comprehensive explanations of violence against women might include both social factors such as race, class, gender, and culture, and individual or relationship characteristics such as social support, relationship dynamics, alcohol/drug use, and personality characteristics. For example, Gelles's (1983) multi-dimensional explanation for violence against women encompasses exchange theory and social control theory. Exchange theory (human interaction is guided by pursuit of rewards and avoidance of punishment) is coupled with Social Control theory (criminal or deviant behavior occurs without societal controls to sanction the behavior) to assert that violence and abuse are more probable when rewards of this behavior exceed the costs, and the cost of violence

is reduced given the private nature of family combined with the reluctance of institutions to intervene (control theory). Cultural approval of the use of violence increases rewards for this behavior, hence, men hit women because they can.

Anderson (1997) combines views of feminist and family violence perspectives to explain domestic violence. Gender theory is utilized by suggesting that males and females view violence differently and that violence is a way to construct masculinity. Aspects of the social system are thought to maintain a patriarchal system and thereby increase the risk of violence against women by influencing the power structure within intimate relationships and supporting relationships in which men possess a higher relative status than women.

Schwartz and DeKeseredy (1997) developed male peer-support theory which combines micro and macro factors to explain violence, especially rape, against college women. The model suggests that patriarchal social structure, male peer social support, social group membership, alcohol use, and lack of deterrence increase probability for rape. The patriarchal social structure conditions men to believe that women are to be objectified and can be dominated and controlled. Alcohol is included because often it is considered vital to male peer groups and is sometimes used to lower the female's resistance to sexual aggression. Male peer-support groups reinforce patriarchal values such as real men are not controlled by women, they secure sex when desired, and they do not accept attacks on their masculinity. The absence of deterrence by social sanctions increases chances of rape since date or acquaintance rape is difficult to prosecute. Thus, social structural and individual factors increase the chances of men raping women.

Heron, Javier, McDonald-Gomez, and Adlerstein (1994) outline a social etiological multi-dimensional model incorporating structural and personal factors. Violence against women, at the societal level, results from inherent inequalities in the structure of the social system such that domination and exploitation by one group over another exists. Specifically, the organization of the family is thought to increase chances of violence occurring. Personal factors include individuals who distort reality and morality by justifying violence as a form of punishment which they have the right to administer, and who use violence to resolve conflict and gain or regain control.

Advocates of the *ecological perspective* believe that abusive situations may result from interaction between personal, situational, social, political, and cultural factors (i.e., Heise, 1998; Perilla, 1999). Heise (1998) proposes an ecological model consisting of four levels: personal history, microsystem, exosystem, and the macrosystem. Within personal history, Heise highlights three consistent risk factors to be assessed: witnessing marital violence as a child, experiencing child physical or sexual abuse, and lack of a consistent father figure. The microsystem involves situational factors surrounding the abuse such as male dominance in decision-making and male economic control in the relationship, marital conflict, and alcohol use. The exosystem examines factors within the formal and informal social structure and institutions which impact the situation such as unemployment/low socioeconomic status (SES), social isolation, and "delinquent peer association" (attachment to others who legitimize violence against women). Buehler, Dixon, and Toomey (1998), for example, found that women in the lowest income bracket (under $20,000) were nine times more likely to have experienced partner violence than those in the highest group (over $50,000). Heise (1998) defines the macrosystem as the "broad set of cultural values and beliefs that permeate and inform the other three layers of the social ecology," and involves a definition of manhood that includes dominance and aggression, "adherence to" traditional gender roles, "sense of male entitlement/ownership over women," approval of "physical punishment of women," and cultural support for use of violence to resolve interpersonal conflicts.

Heise identifies key risk factors found in domestic violence literature and the interaction among factors is considered more valuable in explaining partner violence than any factor alone.

Recently, research on violence against women has evolved from focusing upon only a part of the issue to multi-dimensional theories which consider social structural factors and individual characteristics. The hope is for comprehensive theories to assist in prediction, intervention and policy-making designed to end such violence.

ASSESSMENT TOOLS AND TECHNIQUES

Accurate assessment is vital to identify high-risk populations, track changes in incidence and prevalence, monitor the effectiveness of programs, identify and understand the consequences of victimization, allocate resources, and make policy decisions effectively to reduce violence (National Research Council, 1996). Defining violence against women is essential for its measurement. Most researchers agree that the major components of violence against women are emotional, sexual, physical, and verbal violence. The decision to include any or all of these components can differ across researchers (Gordon, 2000) which may result in varying estimates of incidence and prevalence. The Centers for Disease Control and Prevention (CDC) initiated a process to improve the quality of data about violence against women by focusing on developing definitions and data elements (variables) for public health surveillance (continued systematic collection, analysis, and interpretation of health data regarding intimate partner violence [CDC, 1988]). Saltzman, Fanslow, McMahon, & Shelley (1999) published the results of this work, entitled *Intimate Partner Violence Surveillance: Uniform Definitions and Recommended Data Elements*, Version 1.0. Types of intimate partner relationships include current and former intimate

relationships ranging from dating partners to spouses, of heterosexual and same-sex status; categories of violence in the uniform definitions are: physical violence, sexual violence, threat of physical or sexual violence, and psychological/emotional abuse (including coercive tactics) when there has also been prior/prior threat of physical or sexual violence.

Therapists can choose among several methods in assessing a traumatic event or battering experience and obtaining a history of battering. Agreed upon is that no single strategy can address all domestic violence issues and each method has its strengths and limitations. Often recommended is a multi-modal assessment of battering utilizing a combination of structured interview, open-ended interview, and standardized scale and questionnaire methods. Assessment is seen as an ongoing process which describes the battered woman's past, present, and probable future responses, symptoms, situations, and potential progress in treatment. Information can be obtained by direct contact with victims, perpetrators, family members, friends, and co-workers, and/or indirectly through reviewing records such as hospital or police files, social service data, and crisis lines.

Caution is advised when receiving victimization and perpetration information from family members and peers for several reasons. Individuals may be hesitant to disclose all pertinent facts due to the stigma associated with being a victim or perpetrator (Ammerman & Hersen, 1992); respondents may have trouble recalling specific events which is termed retrospective or recall bias; and definitions and context within which violence occurs can lead to inaccurate information (within marriage, a person may not consider forced sex to be a crime or violence).

Most clinicians begin with an open-ended interview which allows the woman to "tell her story." This method builds rapport and allows the victim to prioritize her issues. Contrarily, a structured interview may be used which facilitates greater assessment of contextual issues (Lewis & Roberts, 2001). A recommended option is to begin with an open-ended interview and follow up with a structured interview.

Therapists must attain information regarding the last several battering incidents, also, information on the initial and a representative incident is helpful in order to determine the pattern of abuse cycle, developmental progression, and potential escalation. One should phrase questions in a manner not blaming the victim.

SELECTED VIOLENCE AGAINST WOMEN MEASURES

Given the varied emotional and behavioral symptoms associated with battering, recommended is routine administration of a global measure of personality functioning. Dutton and Gondolf (2000) recommend the therapist to assess overall personality and psycho-pathology. The goal is to differentiate premorbid conditions versus post-abuse trauma responses yielding understanding of presenting symptoms - the Minnesota Multiphasic Personality Inventory-2 (MMPI-2; Butcher, Dahlstrom Graham, Tellegen, & Kaemmer, 1989) is considered effective.

The original Conflict Tactics Scale (CTS) (Straus, 1979) is a self-report questionnaire consisting of 14 or 18 items measuring the extent of psychological and physical attacks and negotiation and reasoning to deal with conflict. The Revised Conflict Tactics Scale 2 (CTS2) (Straus, Hamby, Boney-McCoy, & Sugarman, 1996) consists of 78 items and improved upon the original CTS by including sexual coercion, injury, and improvements in assessing negotiation, psychological and physical abuse.
The CTS and CTS2 are widely used and considered effective in abuse assessment.

The Danger Assessment Scale (Campbell, 1986, 1995) assesses danger of homicide to battered women. Fifteen yes-no items assess increased homicide risk factors such as firearms at home, use of drugs, sexual abuse, high level of control, violent jealousy and suicide threats/attempts by the woman. This quick and effective measure helps the woman make a decision regarding her safety and risk of danger.

The PTSD Symptom Scale (Foa, Riggs, Dancu, & Rothbaum, 1993), and the Posttraumatic Diagnostic Stress Scale (PDS; Foa, Cashman, Jaycox, & Perry, 1997) are considered effective measures linked to DSM-IV symptomology. The PDS contains 49 items assessing PTSD and level of functioning impairment and has been used in recent studies with severely battered women (Mechanic et al., 2000).

The Beck Depression Inventory II (BDI-II; Beck, Steer, & Brown, 1996) is considered an effective measure of depression. Severity of depressive symptoms is measured using 21 self-report items corresponding to symptoms found in the DSM-IV (American Psychiatric Association, 1994).

Briere (2000) developed the 40-item Cognitive Distortion Scales (CDS) which assess five types of cognitive distortions pertinent to battered women: self-criticism, self-blame, helplessness, hopelessness, and preoccupation with danger. It is helpful for initial assessment of dysfunctional cognitions common to battered women and in treatment planning.

The Abusive Behavior Inventory (ABI) (Shepard & Campbell, 1992) incorporates 20 items assessing psychological abuse (emotional violence, isolation, intimidation, and threats), and 10 physical abuse items which assess assaultive behavior, including sexual violence.

The above-mentioned assessment tools represent but a portion of available measures and may be used to gather relevant client information leading to treatment recommendations.

Petretic-Jackson and Jackson (1996) offer an assessment interview guide for battered women highlighted as follows:

1. Nature and Circumstances of the Assault
a. Determine who, what, when, where, and how; assess defensive violence by victim; ask victim's perceived threat of injury or death to self/others.
b. Examine why it happened; with whom is attribution of blame?
c. Look at nature of relationship other than abuse issues.
d. What coercion methods were used (verbal threats, use of children)?
e. Discuss level and nature of violence (battering, use of weapon, death threats); evaluate last several incidents to determine potential escalation; assess risk of lethality.
2. Post-Assault Interactions
a. What professional contacts were made (legal, medical, woman's shelter) and their level of effectiveness?
b. How much time elapsed before help-seeking and who made decision to do so?
c. Determine victim's social support system.
3. Victim's Initial Reaction
a. Facilitate disclosure of thoughts and feelings.
b. Assess symptoms being experienced (physical, cognitive, emotional, interpersonal); examine fear, vulnerability, anxiety, PTSD issues, depression, suicidal ideation/plan, sexual trauma.
c. Appraise daily functioning changes (work, socialization, residence, future plans).
d. Assess mental status changes (judgment, memory, cognitive functions).
e. Analyze personality or behavior changes reported by others; determine anger risk of homicide to partner.
4. Current Status
a. Evaluate mental status
b. Identify coping efforts and strategies, defenses, strategies to survive, and intellectual insight with or without emotional working through.
c. Estimate other personal/social factors possibly leading to more stress.
d. Continue to chart current psychological response pattern, including:
1. emotional: PTSD, fear, anxiety, anger, depression
2. cognitive: blame, safety, trust, intimacy, guilt, shame
3. biological: somatic issues, physiological hyperarousal
4. behavioral: aggressiveness, suicidal, substance abuse, impaired social functioning, personality disorders, sexual issues
e. Discuss self-perceived strengths and weaknesses.
5. Course
a. Evaluate premorbid psychological history, prior psychological treatment, psychotropics, depression, suicide attempts.
b. Review social functioning relative to significant others; consider leaving or staying in abusive relationship; trust; assertiveness.
c. Assess educational, occupational, social, and familial adjustment issues.
d. Examine symptom changes over time.
6. Attributions
a. Express attribution of blame to self, offender, or situation.
b. Do a self-efficacy rating, including questions such as: How well are you doing? Is it taking too long to adjust? Are you satisfied with your gains?
c. Discuss attributions to legal, medical, and psychological community: Was the helping community supportive or accusing? What could have been done differently?
7. Future Orientation
a. Determine short-term plans and goals.
b. Utilize self-statements designed to reinforce past successful problem-solving strategies.
c. Discuss realistic optimism toward relationships and recovery.

Investigating violence requires asking clients how they fight, what happens given tension at home, and if forms of battering occur. Upon therapist awareness of violence, recommended is to assess the danger level and other related variables such as severity, length of time, identifying the direct recipients of violence, and history of family-of-origin. Investigating substance abuse or other related contributing factors is relevant. Assessment may suggest need to establish safety measures for victims and may indicate particular treatment plans. This process can have therapeutic value by increasing client awareness of the severity of the problem and beginning the sensitization process for batterer.

Frequently, therapists may not detect physical/sexual violence during the typical intake and assessment process because client may be in denial or she may fear partner retaliation through further violence, withdrawal of affection, or threats to end the relationship. Awareness of abuse and trauma symptoms may be needed to draw the correct conclusion. Symptoms may include high anxiety, depression, intense shame and guilt, sexual problems, low self-esteem in either partner, alcohol use, male pathological jealously manifested in attempts to isolate the woman, male belief in rape myths, and history of family abuse.

COMMUNITY RESOURCES

Community-based services for women with abusive partners were essentially non-existent before 1976. Available shelters were mainly restricted to the Salvation Army, church homes, and homeless shelters used primarily for catastrophe victims, alcoholics, and homeless individuals. Often, these assistance centers were full and turned battered women and their children away; many shelters blamed the women for their victimization and were insensitive to their needs (Schechter, 1982).

The first shelters for women with abusive partners stemmed from the 1970's feminist movement which produced a climate of consciousness-raising leading to women sharing their home abuse. Over the past 25 years, the battered women's shelter movement has educated the

public and demanded increased services for this population culminating in over 2000 domestic violence programs nationally providing emergency shelter, 24-hour crisis lines, and many support services. Still, available programs cannot meet current needs.

Generally, domestic violence shelter residents are under age 35, have two children, little income, and limited options. The average maximum domestic violence shelter stay is 30 days, but extensions are granted. Counselor advocates work individually with women to help resolve issues, find housing, employment, and health care, and assist with personal protection orders and legal rights. Today, many domestic violence programs have expanded services to include support groups for women not residing at the shelter, advocacy services, individual and group counseling, programs for children, referrals to other community-based services, and financial assistance. A common intervention for children is the domestic violence support and education group whereby participants learn about labeling feelings, and dealing with anger and safety issues. New innovations include offering transitional housing (often, an apartment) with rent being only a small percentage of resident's income, and a visitation center at the domestic violence agency whereby abuser can see his children with limited contact between parents. Resident evaluations of these programs are often very positive (Tutty, Weaver, & Rothery, 1999). Most programs are free and were created to empower and respect women (Ridington, 1977-1978; Schechter, 1982).

Many battered women services are also being offered within various community systems such as health care settings, police stations, prosecutor's offices, family service organizations, and college campuses. The first-response team, for example, is often comprised of volunteers associated with the police department who visit the victim's home offering immediate support and assistance. Further, community intervention projects (CIPs) coordinate criminal justice system and community efforts to ensure perpetrators are held accountable for their behavior. Procedurally, police agree to contact the CIP after responding to a domestic violence call and perpetrators are held in jail (usually, at least overnight). The CIP sends female volunteers to victim's home and male volunteers to perpetrator in jail. Victims are given information, referrals, and transportation to a shelter, if needed, and perpetrators are encouraged to accept responsibility for their behavior and to attend a batterer intervention program. Prosecutors agree to aggressively pursue domestic violence charges and judges agree to mandate jail time and/or batterer intervention. Probation officers hold perpetrator accountable for not attending mandatory batterer intervention meetings. Steinman (1990) found that perpetrators were significantly less likely to re-offend when police action was coordinated with other systems (this is a vital component of coordinated community intervention), and perpetrator violence increased upon police action not being coordinated with other system components. This comprehensive intervention model has become known as a Coordinated Community Response (Shepard & Pence, 1999). Thousands of communities have utilized components of this model with varying amounts of success.

In the early 1980's, the Domestic Abuse Intervention Project (DAIP), in Duluth, Minnesota, became nationally recognized as the first community-based reform project to effectively utilize a community coordinated response to address domestic violence (Pence, 1983). The response involved the police, criminal and civil court systems, advocates, and battered women working together to address domestic violence. Incorporating the work of Pablo Freire (1970), DAIP developed a "cultural offensive" against domestic violence and confronted the belief system that legitimizes men's abuse through pro-feminist, psycho-educational models (Mederos, 1999). Currently, the coordinated response involves the court system referring many perpetrators into batterer intervention programs, and pro-arrest policies classify domestic violence as criminal behavior rather than poor communication between partners or mental illness. Physically abusive men are arrested, tried, and may opt to serve their sentence or be placed on probation with need to refrain from further violence while attending a mandatory batterer intervention program (Mederos, 1999). Programs apply many cognitive-behavioral interventions, including anger-management, problem-solving, skill training, and development of communication, social skills, assertiveness, stress-reduction, and self-observation.

An example of effective college campus involvement is Michigan State University which offers a free community advocacy program for battered women and their children. Funding by the National Institute of Mental Health and local support facilitates training of female undergraduate students to work as community advocates for this population. Students provide advocacy in housing, employment, education, transportation, child care, health care, legal assistance, and social support, and they earn college credit. Women who worked with advocates experienced less violence than those not working with advocates (Sullivan, 2000; Sullivan & Bybee, 1999).

A growing number of hospitals are utilizing emergency room staff to perform crisis assessment and intervention to battered women. The involved staff (triage nurse, physician, and crisis clinician) are recommended to use an adult abuse protocol which contains specific assessment information. The protocol is designed to alert staff to provide appropriate clinical care and it documents the violent incident creating "reliable, court-admissible evidence" - including photographs (Klingbeil & Boyd, 1984).

Some battered women in imminent danger may benefit from recent technological advancements, including alarm/security systems; panic alarms in conjunction with electronic bracelets; cell phone pre-programmed to 911 for emergency police response; and instant point-and-shoot

cameras which offer an immediate photographic record documenting the violence.

Alarm/security systems can be installed in the abused woman's residence by law enforcement officers; upon danger, she transmits an alarm directly to the police radio channel. Some women may participate in the Abused Women's Active Response Emergency Program (AWARE) in which women selected by prosecutors, law enforcement officials or shelter directors wear an electronic pendant around the neck that sends a silent alarm to an agency which notifies police to respond to the emergency. The security system is installed in the woman's home and the pendant is operational within a radius of 100 feet from the home system.

Some prosecutor's offices and battered women's shelters have linked with mobile phone companies to offer abused women pre-programmed cell phones which automatically connect to a 911 police emergency system.

Due to funding limitations, and the expense of latest technology, criminal justice agencies and battered women's shelters allocate these resources only to women at highest risk of a life-threatening assault.

Resulting from battered women needing a variety of services (often, three or more agencies), therapists are recommended to have a list of referral services readily available. Common referrals include but are not limited to: medical care, police, legal services, crisis intervention unit, social service agencies, psychiatric screening unit, 24-hour hotline, job bank, day care programs, housing assistance, drug/alcohol treatment programs, women's self-help centers, support groups, outreach programs, community advocates, Literacy Council, dental care, GED program, victim assistance program, and domestic violence shelters.

Many changes have occurred within legislative and criminal justice systems, in fact, by 1980, 47 states had passed some type of domestic violence legislation (Kalmuss & Straus, 1983). Efforts to enact legislation were facilitated in the mid-1970's when class-action suits were brought against police departments for failure to arrest in domestic violence cases (Gelles & Straus, 1988). Legislation is designed to assure victims' rights, increase victims' legal options, and protect all concerned from further assault (Schechter, 1982). For example, courts may issue civil protection orders (also called restraining orders, injunctions, protection-from-abuse orders, harassment orders, stalking orders, no-contact orders, etc.) for women in danger of further abuse. The Family Violence Prevention and Services Act, enacted in 1984, is a federal program which provides states with grant money to develop shelters, child care programs, and related services for domestic violence victims and their children.

The Violence Against Women Act of 1994 is considered the most comprehensive legislation addressing domestic violence, sexual assault, and stalking. Several key provisions include the following:

1) Given abuser following victim across state lines, an abuser can no longer avoid prosecution because it is unknown in which state the harm to victim began; abuser may not use interstate travel "as a loophole in the system of law enforcement" (United States v. Helem, 1999; United States v. Page, 1999).

2) A provision within the Immigration Act allows foreign individuals in abusive relationships with American citizens to leave their abuser before two years have passed without risking deportation.

3) Congress recognized the risk of firearms to victims of domestic violence and amended the Gun Control Act making it a federal crime for people subject to certain protection orders or who have been convicted of certain types of misdemeanor domestic violence crimes to possess a firearm or ammunition.

4) Three grant programs, administered by the U.S. Department of Justice's Violence Against Women Office, have delivered hundreds of millions of dollars to state, tribal, territorial, and local programs for direct services to victims of domestic violence, sexual assault, and stalking. The Grants to Encourage Arrest funds programs in the law enforcement and criminal justice fields, including training for police officers, prosecutors, and judges. The Rural Program funds programs in rural areas which protect victims' rights and safety. The Law Enforcement and Prosecution Grants to Reduce Violent Crimes Against Women (commonly called the STOP Formula Grant Program) sends money to the states and tribal/territorial governments to improve and coordinate services for victims of violence against women.

Before 1994, few specialized units existed within police departments, prosecutor's offices, or courts of law combating domestic violence, however, these grant programs now afford more assistance and support for such victims.

Unfortunately, despite an informed national perception, policy changes in arrest and prosecution, and civil remedies, domestic violence remains. Ferraro (1995, p. 269) states, "Women are being told that police will arrest, that temporary protection orders will keep abusers away, and that judges will send them to prison if the women will only be consistent and cooperative with prosecutors. In the majority of cases, women do not experience these outcomes and continue to be abused, harassed, and threatened." It can be argued that cultural and economic inequalities exist which foster male domination and, in turn, battering.

INTERVENTION STRATEGIES

The essential goal of therapy for batterers and their families is to end the violence. Some therapists recommend all family members participate in this goal and others focus on batterer gaining self-control. Most agree that holding batterer responsible for the abuse and helping victim regain control of her life and pursuing safety are the

key goals.

Walker (1984) believes abused women will experience low self-esteem, guilt, anger, fear, isolation from support, and learned helplessness; they comply with gender-related stereotypes; and have difficulty making decisions. These symptoms may alert therapist to examine possible violence if not already known.

The feminist perspective recommends validating and supporting experiences of battered women while holding batterer responsible for the violence. Bograd (1988, p. 15) writes, "When men's lives, values, and attitudes are taken as the norm, the experiences of women are often defined as inferior, distorted, or are rendered invisible. To counteract this, feminists believe that a basic step toward understanding the factors contributing to wife abuse is illuminating the experiences of women from their own frames of reference."

Essential goals in working with an abused spouse include facilitating her acknowledgment of the existence of abuse, encouraging her to stop the battering by removing herself (or legally removing abuser) from the site, improving coping skills and sense of power, and clarifying her mixed emotions (Williams-White, 1989). "Victims of domestic violence must be helped to validate their sense of self-esteem and self-worth so that they feel able and competent to make decisions about their lives and carry their decisions through to action" (Williams-White, 1989, p. 51). The combination of love and hate within an intimate relationship experienced by spouse creates uncertainty and ambivalence which therapist can address in a sensitive manner.

One of the first treatment goals is to implement a safety plan. Discussion generally focuses upon options available to spouse, such as finances, family and/or friends who can offer shelter, transportation, willingness to involve authorities, motivation to leave batterer, temporarily or permanently, and client estimate of husband's willingness for treatment. Given husband interest in treatment, therapist can offer therapeutic and group referrals or arrange for individual session. Spouse can invite to session people who will support implementation of the safety plan. Therapist might need to refer spouse and children to the area domestic violence shelter.

Therapists are recommended to allow client to implement the plan rather than supportive people to avoid client disempowerment and to encourage regaining power and control in her life. This growth can be achieved by supporting client decisions, accepting her ambivalence, and allowing her to determine goals in therapy and life. Helping client recognize cognitions which lower feelings of power and trust in self is beneficial. These treatment goals can be realized by informing client that she is not at fault, that domestic violence is a major social problem, and validating her experiences (Bograd, 1984; Yllo & Bograd, 1988).

Victim's feelings of responsibility for the abuse may be addressed by advising that husband makes a choice every time he batters. Helping abused spouse transform from victim to survivor takes time and may require moving through client ambivalence regarding remaining in the relationship or leaving. Given client wishing to return to or remain with batterer, and therapist in disagreement, practitioner can remind client of the potential battering reality and ensuing impact of her decision while being supportive of her decision. Therapist support of client "unhealthy" decisions may be relevant to the evolution from victim to survivor.

Assisting client to construct inner strength and deconstruct thoughts that she cannot survive or act independently is important. Toward this end, therapist can allow client to disclose situations within family-of- origin and previous relationships in which she acted on behalf of herself, and how those beliefs are incongruent with the current situation. Discussing sources of personal strength can facilitate growth and deconstruct the prisoner belief.

Upon abused spouse recovering from battering and protecting self and children, family work can expose the violence to family members. Couple therapy is often not recommended unless batterer is in treatment, is not displaying extreme psychopathology, is abiding by his non-violence contract, and abused spouse desires him present. Working with this population can be potentially hazardous not only to the abused spouse and children, but also to therapist him/herself, therefore, trusting client's and therapist's own instincts is important.

Treatment of spousal sexual abuse begins with addressing the woman's safety. A physical and/or sexual contract between partners is recommended and assurance that wife has a place of safety, if needed. Upon client feeling safe and stable, common symptoms such as depression and anxiety may be treated using cognitive, rational-emotive, or cognitive-behavioral techniques focusing on breaking thought/behavior patterns which maintain these symptoms. Due to similar issues of power, boundary, and sexual violation, therapists may benefit by utilizing various treatment methods for adult survivors of incest.

Finkelhor and Yllo (1985) indicate that sexual dysfunction is a consistently reported symptom. Sexual aversions or phobias, inhibited sexual desire, and anorgasmia may be present. Treatment can include referral to a sex therapist, utilizing sensate focus technique in which client may explore her sensuality in a safe setting without expectations, and utilizing cognitive restructuring or cognitive-behavioral therapy (Leiblum & Rosen, 1989; LoPiccolo & Friedman, 1988) whereby thoughts and feelings regarding love, sex, intimacy and power are examined and possibly modified by "thought stopping," education and experiential exercises.

Relationship issues, including trust, need to be addressed. In addition, finding or re-establishing supportive and enduring intimate relationships is recommended for client social and emotional adjustment (Burr & Christensen, 1992).

BATTERER INTERVENTIONS

Batterer programs mainly utilize education or treatment groups but may include other interventions as personal counseling or case management. Despite this variance, the common purpose is to prevent men's violent and controlling behavior against women. Most programs accept voluntary and court referrals and the batterer attends weekly groups for three to six months. Groups are recommended because they foster peer feedback, reduce the isolation and private behavior typical of batterers, confront denial in an environment conducive to peers challenging one another (Ganley, 1981), and offer opportunity to practice communication skills and manage anger and conflict. Most batterer programs are connected to a coordinated community violence prevention effort which includes the criminal justice system, battered women's agencies, substance abuse programs, behavioral health services, and various social service agencies.

Batterer program goals include rehabilitation, justice, and victim safety. Programs differ by their emphasis on each of these goals. Rehabilitation groups focus on pro-social, non-violent skill building, for example, anger and stress management, and substance abuse treatment (many court-referred batterers have substance abuse issues). Therapeutic approaches may include cognitive-behavioral, attachment theory, process-oriented psychodynamic treatment, and self-help. Groups with a justice perspective stress accountability for one's behavior and view their role as an extension of the justice system. Healy, Smith, and O'Sullivan (1998) determined that criminal justice professionals view batterer programs as an extension of probation rather than as treatment. Programs highlighting victim safety are closely associated with battered women's agencies and focus on victim safety checks and justice. A victim advocate may be used for telephone follow-up and referral. The trend has changed from focus on one of these single goals to multi-dimensional models which include aspects of the feminist perspective, cognitive-behavioral skill-building, assessment-based intervention, attention to group process, and emphasis upon both victim safety and batterer accountability (Healy et al., 1998).

Participants usually attend batterer programs as a stipulation of probation, parole, or diversion from prosecution or punishment. Due to domestic violence being a crime in all 50 U.S. states, judges often order batterers to a program as a condition of probation. Infrequently, men volunteer to attend a program, however, these self-referrals are generally thought to be responding to their partner's demand or trying to manipulate partner. Goldolf (1997) found that voluntary participants were more likely to re-assault their partners at 15-month follow-up than court-referred individuals (44% versus 29%).

Contracts are often used in batterer programs and commonly involve (a) number of sessions to be completed (i.e., must attend 22 of 26 group meetings); (b) identification of unacceptable behavior and consequences (e.g., attending group intoxicated; removed from group and probation officer notified); (c) agreement of fee (i.e., $15 per group); and (d) gaining batterer consent to contact victim, probation officer, or other authorities on an as-needed or regular basis. Contracts are tied to victim safety and hold batterer accountable for his behavior.

Many batterer programs use a "time-served" measure to determine program completion (e.g., completion of 26 groups of a 26 week program), however, programs are adding competency-based criteria as well. Competencies may include batterer stated acceptance of responsibility for abuse, completed homework and in-group tasks, compliance with other referrals, and use of sensitive language. Criminal justice professionals seem not to like competency-based criteria because of pressure to move men through the legal system in a timely way. Defense attorneys may object to such criteria on the grounds that it can be politically driven, there is a lack of studies supporting effectiveness, and it requires para-professionals to make subjective evaluations. Program goals may determine usage of competency-based criteria. Specifically, a program with the goal of justice and a batterer program viewed as an extension of probation may view 26 or 52 weeks as sufficient, whereas a program's goal of rehabilitation or victim safety may require behavioral change and competence (being violence-free for a specified time, articulating gender-sensitive ideas, and accepting responsibility for his violent and controlling behavior).

Not many batterer programs have addressed continuing care or relapse prevention. Maintenance programs are in early stages of development (Daniels & Murphy, 1997; Jennings, 1990).

Evaluation of batterer program outcomes reveals, on average, a 40% recidivism rate in the year after the program (Eisikovits & Edelson, 1989; Gondolf, 1991; Rosenfeld, 1992; Tolman & Bennett, 1990; Tolman & Edelson, 1995). Most uncontrolled studies report small but statistically significant effects for batterer programs. The few controlled studies undertaken reveal ambiguous results and methodological concerns, in turn, conclusions regarding batterer program effectiveness remains an open question.

Many women remain with their partner after his arrest and conviction, accordingly, it is vital to identify effective programs producing more permanent behavioral change (Taylor et al., 2001). There is a growing need for standards and guidelines within programs (Goldolf, 1990; Healey et al., 1998). Roberts (2002) recommends consideration of the following modifications to the field of domestic violence:

1. Continue developing coordinated community responses.
2. Develop new programs transcending shelter for women and men's weekly batterer intervention programs.
3. Utilize technological advancements in personal and home security systems allowing battered women and

children to remain in the home.
4. Remove batterer from the home and place him in a residential batterer program.
5. Form batterer programs addressing issues of race, class, and sexual orientation.

Individual or couple therapy may not emphasize formal learning as much as group therapy. One-to-one therapy can assist batterer to process his group experiences and apply this knowledge with his partner. Therapist can connect group treatment with home life while emphasizing responsibility for abuse and exploring family history. It is helpful to continue discussing rage-management behavioral methods, effects of his abuse upon partner, and challenging his denial of responsibility.

Batterer can be sensitized to his abuse by exploring his family-of-origin experience with violence and possibly including his family members within session. He must discontinue using past family violence as excuse for present perpetration. Connecting batterer's feelings about having been abused to partner's feelings utilizing family-of-origin work can be positive. Investigation into benefits attained from perpetrating abuse is worthy as Ellis (1970) and Novaco (1975) observe that it is harder for men to continue abuse when it is seen as deliberate.

Analyzing non-violent and non-abusive substitute behavior, contracting for legal consequences if violence resumes, and presenting homework whereby batterer tracks abusive and controlling behavior and attitudes and expectations leading to such in a control log are beneficial. Therapist may address times in which batterer maintained self-control and withheld violence illuminating that he can choose to be non-violent and his violence is willful and is not out of control.

As violence is eliminated, therapy and group treatment can work through batterer's sexist and oppressive attitudes and beliefs toward women and his partner. Treatment may be near conclusion upon batterer accepting his lack of control over partner's feelings, attitudes, and thoughts.

CASE STUDY

As the safety of spouse and children is mandatory, conjoint therapy is not recommended if husband refuses or is unable to demonstrate non-violence. Couple therapy may be indicated upon: violence having stopped, the man has accepted responsibility for abuse and his future behavior, the woman is asserting her rights, has re-gained self-esteem, and does not fear husband, and both agree to conjoint therapy (Pressman, 1989). Therapist may need to rely on his/her intuitive sense gauging client honesty because batterer or victim may lie, in fact, many couples do not disclose abuse as the presenting issue (Mack, 1989).

Neidig and Friedman (1984, p.9) suggest the following treatment goals from a cognitive-behavioral view: accept self-responsibility for the violence; contract for change; utilize time-out and other security methods; understand the violent episode; use anger-control abilities; and control interpersonal conflict through problem-solving.

The main goals of conjoint therapy are to facilitate batterer control over violence and help family recover. The following couple therapy case study (Busby, 1996), including commentary, used a feminist-informed systems model. Following discovery of violence, each spouse was seen individually while husband (Mike) attended a batterer's group and wife (Mary) focused on self-esteem and support systems.

Session 1. Couple expressed communication concerns as primary reason for therapy and secondly, Mike's lying. Each completed a demographic questionnaire and several general couple functioning instruments and whether substance abuse is an issue. They did not check physical abuse under "concerns for therapy" nor indicate battering as the main problem during the first session. They were in their mid-thirties without children. Mike was self-employed and Mary worked part-time.

Commentary: Therapist is recommended to see each partner separately for a portion of session thus facilitating victim disclosure of possible abuse. If abuse is discovered, during any session, assessment of the extent of violence and danger follows, including questions of how couple fights (specific description of a typical sequence or the most extreme fight), and frequency of abuse.

Session 2. Therapist explored the marriage for underlying issues. Mary answered a question with, "He gets angry," and in that state she said, "He yells, that's all." When asked what happens if Mike gets angrier, Mary said, "He gets violent." The therapy goal now became ending the violence. Mike agreed but Mary emphasized that his lying was the real problem. Therapist tried to reframe Mike's lying as an attempt to avoid his anger, and indicated that communication issues could be better addressed once she and Mike knew that he would not hurt her.

Commentary: Occasionally, wife may be more hesitant than husband to prioritize the violence due to feelings of shame, responsibility for the violence, hopelessness that violence will stop, fear, and accepting the historical pattern of violence as norm. Rather than therapist deciding therapeutic goals for client, comfortably-paced exploration into ways fear and violence affect the woman's experience in the marriage can put matters into focus. A non-violence contract is recommended though may be challenged by husband's downplaying extent and importance of the violence. Therapist can confront such denial by expressing the degree to which violence pervades the relationship, discussing known effects of battering on all concerned, and introducing benefits of a violence-free bond.

Therapist takes an active stance upon discovering battering by prioritizing the violence and recommending group treatment for the abuser. Couple therapy would have been terminated if Mike disagreed with the goal of non-violence and Mary would have received supportive services. Mike agreed, in turn, each person was seen individually with separate goals. Mary worked on

empowerment, pursuing safety for herself, and eliminating substance-abuse for coping while Mike targeted eliminating violence and lying. Neither wished to end the relationship which therapist supported while informing Mary that abuse could continue.

Session 3. A safety plan with Mary was created. Discussion and offering of resources ensued in case couple discontinued services. A genogram tracing history with violence was completed with Mike. He disclosed physical and emotional abuse from father and feelings of helplessness, fear, and anger.
Commentary: Therapist implementing safety-plan with Mary offers a potentially life-saving tool. Encouraging Mike to open-up regarding past abuse can be instrumental in effecting change for each partner.

Session 4. Empowerment and sporadic drug-use were focal issues with Mary. Mike's becoming a batterer was confronted and he was sensitized to Mary's experience of receiving such abuse through usage of video playback from previous session's disclosure of his father's abuse. He was asked to "pretend you are listening to your wife, and she is talking about you and your battering." The videotape was intermittently stopped allowing Mike to express feelings and thoughts. Therapist matched Mike's personal abuse with abuse he perpetrates on wife which initiated Mike accepting responsibility for his violence.
Commentary: At this point, a session with Mike and his mother, if possible, and/or brothers and sisters to work through family-of-origin abuse and support non-violence with Mary could be a catalyst. Without family member availability, therapist can pursue inter-generational effects of violence in Mike's life and Mary's reactions to his anger.

Session 5. Mary worked on recognizing and expressing her pain, relationship ambivalence, strengthening sense of self, family-of-origin issues and support systems. She shared that the couple had a fight and Mike broke down rather than being violent. Therapist continued to confront Mike to take self-responsibility for the abuse by accepting the label of "wife beater." The area batterers' group was incorporated into treatment.
Commentary: Mike is showing more self-control but has not taken full responsibility and feels as a victim of his father and now of Mary. Accepting the label of "wife beater" may expedite taking responsibility for the abuse and informs Mike that his recovery process may be long with need of maintenance similar to recovery from addiction.

Ideally, batterer's positive movement corresponds to wife's personal growth. Abuser progresses from seeing self as a powerless victim without self-control to a responsible adult with decision-making ability to avoid violence and victim evolves from the victim role to sensing self-responsibility for her life.

Therapist could have considered having Mary invite supportive family and others to a future session at this time of therapeutic movement.

Future Sessions: After a number of sessions, Mike accepted responsibility for the violence, consistently substituted other behavior for violence, and continued attending the batterers' group. Mary revealed no fear for Mike's potential for violence and she was asserting herself with him. Each requested return to conjoint rather than individual sessions. Remaining sessions focused upon the couple's patterns of interaction accommodating to their individual work, communication, Mike's lying, Mary's ambivalence about the relationship, and her testing of Mike's potential for violence. As risk of violence decreased, each partner suggested additional treatment goals. Therapist can broaden potential assistance to such families by including family members and friends for each spouse, women's shelters for group support, and other professionals in the field.

CONCLUSION

The past few decades have seen intimate violence penetrate public awareness as a significant social problem leading to victim services in every U.S. state. As recently as twelve years ago, most prevention efforts targeted assault by strangers - now we know that women are more likely to be assaulted and sexually abused by someone they know and trust. Research and program development have led to interventions addressing men's responsibility to prevent such abuse. Promising interventions include honest dialogue about intimate violence within a safe environment coupled with strict sanctions. Publicizing intimate violence as a social issue allows perpetrator and victim to accept it as problem behavior capable of modification.

Mental health professionals, the medical community, law enforcement officers, judges, and others receive intimate violence education and training, however, this knowledge seems limited against a culture which condones and perpetuates violence within relationships. Victims continue to experience disbelief, minimization, shame, and accusations from formal and informal sources of support. Senator Joseph Biden (1993) stated, "If the leading newspapers were to announce tomorrow a new disease that, over the past year, had afflicted from 3 to 4 million citizens, few would fail to appreciate the seriousness of the illness. Yet, when it comes to the 3 to 4 million women who are victimized by violence each year, the alarms ring softly" (p. 1059).

Domestic violence is a startling epidemic with many physical and emotional consequences. Violent behavior may be learned and reinforced from many sources, including the media, television, movies, the justice system, and world relations. Accordingly, this pattern of behavior is difficult to change, but it also implies that numerous

points of intervention exist for breaking the cycle of violence. Multi-faceted approaches have been suggested to counter the multiple contributing factors, for example, Hage (2000) recommends prevention programs stop violence before it occurs, and offer early intervention for people at risk, treatment for perpetrators and victims, and institutional, community, and governmental programs and policies which "promote healthy relationships." A timely New York Times newspaper article dated January 13, 2004, entitled, "Bush Plans $1.5 Billion Drive for Promotion of Marriage" indicates a federal proposal to train couples to develop interpersonal skills which sustain "healthy marriages." One goal is to help couples, especially low-income couples, "manage conflict in healthy ways."

The foundation upon which the field of domestic violence rests has grown since its inception. Legislation, resources, experience, awareness of institutional effects on our lives, and arrest-treatment combinations represent a growing arsenal in combating intimate violence. Remaining goals include: need to determine the effectiveness of preventive and treatment programs, make further improvements, and offer these services to greater numbers of people. The hope is for significant decline, if not elimination, in the devastation which domestic violence imparts upon couples and families.

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TEST – DOMESTIC VIOLENCE

8.4 contact hours
Record your answers on the Answer Sheet (click the "California Nurse Answer Sheet" link on Home Page and either click, pencil or pen your answers).
Passing is 70% or better.
For True/False questions: A = True and B = False.

Provider approved by the California Board of Registered Nursing, Provider # CEP 14008, for 8.4 Contact Hours. In accordance with the California Code of Regulations, Section 2540.2(b) for licensed vocational nurses and 2592.2(b) for psychiatric technicians, this course is accepted by the Board of Vocational Nursing and Psychiatric Technicians for 8.4 contact hours of continuing education credit.

TRUE/FALSE

1. **At least one million women in the United States are victims of intimate violence annually.**
   A) True B) False

2. **Intimate violence causes more physical injury to women than violence by strangers.**
   A) True B) False

3. **Many battered women evaluate emotional abuse effects as worse than physical abuse effects.**
   A) True B) False

4. **Psychological abuse rarely occurs in battering relationships.**
   A) True B) False

5. **Most researchers agree that the major components of violence against women are emotional, sexual, physical and verbal violence.**
   A) True B) False

6. **Men experiencing violence in their family-of-origin are more likely to perpetrate domestic violence.**
   A) True B) False

7. **The Coordinated Community Response is a comprehensive intervention model augmented by police action and court systems.**
   A) True B) False

8. **The Violence Against Women Act of 1994 addresses domestic violence, sexual assault, and stalking.**
   A) True B) False

9. **Intimate violence victims rarely feel ambivalence toward their relationship with batterer.**
   A) True B) False

10. **Evaluation of batterer intervention programs reveals a 40% recidivism rate in the year after the program.**
    A) True B) False

11. **Risk factors associated with partner violence include _____.**
    A) alcohol abuse
    B) witnessing parental violence
    C) experiencing child abuse
    D) all of the above

12. **Marital violence is highest among those aged _____.**
    A) 35 to 45 years
    B) 45 to 55 years
    C) 18 to 29 years
    D) 55 to 65 years

13. **The essential goal of therapy for batterers and their families is to _____.**
    A) address sexual issues
    B) end the violence
    C) resolve financial difficulties
    D) acknowledge no one is to blame

14. **One of the first treatment goals in working with an abused spouse is to _____.**
    A) implement a safety plan
    B) promote self-actualizing tendencies
    C) increase leisure activities
    D) address childhood issues

15. **The typical assessment process may not detect intimate violence because client _____.**
    A) may be in denial
    B) may fear partner retaliation through additional violence
    C) may fear partner will end relationship
    D) all of the above

16. **Relationship symptoms, including male pathological jealousy, history of family abuse, high anxiety, shame and guilt, and alcohol use, may suggest _____.**
    A) husband infidelity
    B) wife infidelity
    C) need for couple counseling addressing vocational issues
    D) physical or sexual violence

17. **Given heightened national awareness, improved arrest and prosecution, and civil remedies, domestic violence _____.**
    A) has been resolved
    B) occurs quite infrequently
    C) remains a significant and unresolved issue
    D) exists only in isolated geographical areas

18. **The prevalence of intimate violence against women in dating relationships compared to married women reveals _____.**
    A) significantly more married violence
    B) comparable occurrence
    C) significantly more dating violence
    D) the absence of any dating violence

19. **Multi-dimensional theories of violence against women _____.**
    A) have evolved from singular theoretical models and utilize social, individual, and relationship factors
    B) are proven to be ineffective
    C) lack comprehensive orientation
    D) do not address marital violence

20. **Battering is described as _____.**
    A) ongoing abuse of a woman by her intimate partner
    B) ongoing control of a woman by her intimate partner
    C) assaultive and non-assaultive methods designed to dominate relationship partner
    D) all of the above

Please transfer your answers to the Answer Sheet (click the “California Nurse Answer Sheet” link on Home Page and either click, pen or pencil your answers, then fax, mail or e-mail the Answer Sheet to us). Do not send the test pages to Continuing Psychology Education; you may keep the test pages for your records.

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