Practical Implications of Current Intimate Partner Violence Research for Victim Advocates and Service Providers

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Findings and conclusions of the research reported here are those of the authors and do not necessarily reflect the official position of policies of the U.S. Department of Justice or Health and Human Services.

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Introduction: How to Use this Guide

In 2009, the National Institute of Justice published Andrew Klein's Practical Implications of Current Domestic Violence Research: For Law Enforcement, Prosecutors and Judges. The purpose of that work was to describe to these criminal justice practitioners what the research tells us about domestic violence, including its perpetrators and victims, the impact of current criminal justice and court responses to it, and more particularly, the implications of that research for the day to day, real world responses to domestic violence by law enforcement officers, prosecutors and judges.

Practitioners found that guide helpful, and it was suggested that it be expanded and enhanced to address the practical implications of current domestic violence research for victim advocates and service providers. Reflecting the new focus of this work, in addition to the National Institute of Justice, the guide is also sponsored by the Office of Victims of Crime, the Office on Violence Against Women and the Family Violence Prevention and Services Program.

There are some substantial differences between the earlier work and this guide, although there is also much overlap. Readers will notice immediately that we have dropped "domestic violence," substituting "intimate partner violence (IPV)." We did so first because in 2002 the term IPV became the preferred research terminology recommended by the Centers for Disease Control and Prevention (CDC). The CDC sought to distinguish between violence and abuse by current and former intimate partners from other forms of violence and abuse within the family, including child, sibling, parent and elder abuse [694]. We acknowledge that most advocates and service providers understand that the term "domestic violence" makes this same distinction, while the term "family violence" refers to all violence and abuse within the family.

Second, the earlier work was primarily addressed to criminal justice personnel who are concerned with criminal domestic violence statutes which generally do not differentiate between "intimate partner violence" and "family violence." By using the term "intimate partner violence," we hope to clarify that this guide is dealing with research restricted, as much as possible, to current and former intimate partner violence and abuse as opposed to more general non-intimate partner intra-family abuse. However, as the astute reader will note, occasionally we will still refer to "domestic violence" research. When we do so, it is because we are citing a study that includes data on intimate partner violence.

It is also important to note that the research we review exams IPV utilizing varying definitions. For example, some IPV is incident-based and some is dominance and coercive control-based. As a result, the findings in each study must be understood through the lens of the particular definition of IPV employed. There are also often differences between IPV as studied by researchers and the domestic violence that

advocates and service providers address in practice - differences in the scope of behaviors encompassed, the context of the violence, and the impact thereof on victims.

Some readers may question our use of the term "victim" as opposed to "survivor." We chose the former because many of the services we review are aimed at persons in on-going abusive relationships. In addition, we wanted to be consistent with the nomenclature adopted by those concerned with advocacy, commonly referred to as "victim advocates," not "survivor advocates." We are not intending any editorial comment by the use of this term. We understand that notwithstanding a person's victimization, that person is not defined by the abuse or the abuser!

We must note that the research on IPV victim services and advocacy is less robust than that on IPV criminal legal practice. As a result, some of the implications we draw are based on more limited research, making our analysis more tentative than it would otherwise be and conditional on additional research confirming findings relied upon in this current work. Readers will note that many of the sections pertains specifically to "women" victims. This is because the research reviewed was limited to women victims and is not intended to suggest that the same may or may not be true or apply to men who are IPV victims. In answering questions addressed by only one or two studies, we adopt the terms employed by the researchers so as not to over generalize specific studies' findings.[1]

Further, it is critical to recognize that victim needs for services and advocacy differ among victims and over time. What "works" for one set of victims at a given time may have different impacts on others or different impacts on the same victim in different circumstances. The definition of what "works" may also vary among victims as their goals may vary. Some victims, for example, may decide to remain with their abusers while others may seek to leave them. Many victims who have survived abuse are looking for healing from the adverse impact of past abuse, while victims still in abusive relationships may, necessarily, be concerned primarily with the immediate safety needs of themselves and their children.

As more victims of IPV come into contact with criminal justice agencies than any other set of agencies, we review the role of criminal justice and court agencies in responding to IPV. However, unlike the focus of the first publication, in this guide we focus on the implications of the research on the criminal justice and court response to IPV from the perspective of victim advocates and service providers. We seek to include what it is important for victim advocates and service providers to know about the criminal justice and court response to IPV so that they can guide and assist their clients who must deal with these agencies.

We realize that advocates provide both advocacy to individual victims and systemic advocacy for reform in law, the legal system, health and human services and

[1] It should be noted when researchers refer to "abusers" or "victims" in a specific study, these may be defined by a specific incident examined and not a consistent status. For example, many women labeled as "abusers" in a specific incident, may also be labeled more consistently as "victims" if studied over time.

community institutions. As a consequence, we include analysis of the research that informs what advocates can expect and demand of the legal system and other institutions responding to the needs of IPV victims. To assist advocates in this role, we have reviewed the research to indicate performance standards for various criminal justice and court agencies. While we do not address what standards agencies should obtain, we summarize what agencies have obtained so that advocates can compare the performance of local or state agencies with what other jurisdictions have proven possible. While all jurisdictions vary, we believe, for example, if the research reveals that almost 2,000 law enforcement agencies from 19 states make less than two percent dual IPV arrests, limiting dual arrests to that level is certainly realistic in jurisdictions where dual IPV arrests are substantially higher.

We caution readers that this guide is based on published research. Many promising practices and excellent IPV programs have not been examined or were unavailable to us in completing this research. Omission of these does not imply they are less worthy or effective than programs that have been studied. Also, there are many programs that may serve IPV victims that have not been examined due to limitation of resources and time, especially programs that are not IPV specific. Their omission also does not imply they are less worthy than programs included. The implications drawn from the research are offered as guidance, not rules of practice.

While we tried to be inclusive, examining all research that had implications for victim advocates and service providers, obviously we missed some, probably quite a lot. We did rely heavily on NIJ funded research and research published in peer reviewed journals. However, the inclusion or exclusion of any specific study cannot be assumed to reflect a judgment on its quality or methodology. While some studies' validity may be questionable in regard to some issues, they may be quite revealing in regard to others. Hopefully, we have cited such studies for their relevance to the latter and not the former. We invite readers, in all cases, to read the full studies for themselves. Full citations for all studies covered are footnoted and listed in the references.

And finally, although we tried to be objective, the implications drawn from the research examined cannot help but reflect the experiences, biases and background of the authors. Our bios are attached in the Appendix. In short, Andrew Klein has an extensive background in criminal justice and IPV research while Barbara Hart, a survivor of IPV, has a long and distinguished career in victim services and advocacy.

We hope our readers find this guide useful in their vital work assisting victims of IPV and breaking the crippling cycle of IPV that undermines our society.

Practical Implications of Current Domestic Violence Research for Victim Advocates and Service Providers

I. What is Intimate Partner Violence?

The definition of intimate partner violence (IPV) has been in dispute since activists began organizing the movement to end violence against women and researchers sought to study it. [752, 208] Theoretical explanations of the causes of intimate partner violence shaped the definitions propounded by scholars and practitioners. [421, 853] If theories drive definitions and ultimately measurements, one could reasonably expect that there would be great divergence in the definition of IPV. Although theoretical differences continue to be sharply debated, for the purposes of this work, we join with many others in adopting the following definition of IPV:

Physical, sexual, psychological, economic abuse and stalking are the five multi-faceted methods of violence and abuse that perpetrators utilize to achieve, maintain and regain control of their intimate partners. Coercion or terroristic threats coupled with any of the five methods of abuse is intimate partner violence. [431, 736, 224]

This definition is close to that of the Centers for Disease Control (CDC), although we add "economic abuse" and "stalking" missing from the CDC definition of intimate partner violence. [694]

It should be noted that this definition does not include all violence by intimate partners, including "situational couple violence (isolated violence stemming from conflicts turned violent)," [431, 61] from actions to defend against the coercive violence of an intimate partner, "violent resistance," [431] or from extraordinary trauma, PTSD or other mental illness of the violent partner. Where there is no history of coercion, intimidation, or threats coupled with violence, the behaviors above are not encompassed in the IPV definition. [634]

Much IPV research has focused solely on physical violence and psychological abuse [752], ignoring sexual abuse by intimate partners [270], economic abuse and stalking which all are part of the definition we adopt. Further, much of the research on IPV has focused specifically on violent behaviors that are crimes under state statutes, particularly assault and homicide. [454, 735]

Implications: Victim Advocates and Service Providers focus on the full panoply of coercive and controlling behaviors visited upon IPV victims in developing and implementing policy, practice guides, and research thereon. While more limited definitions of IPV, focusing on criminal violence and threats, may be sufficient for criminal justice practitioners responsible for responding to perpetrators charged and prosecuted for criminal violations, advocates and victim service providers must focus on the more comprehensive definition of IPV.

Why Does IPV Occur?

Early in the DV movement, four competing theories about the causality of IPV gained the most traction among scholars and activists: psychological impairment [348], anger management problems [219, 822], conflict resolution deficits [756], and male dominance over women based in patriarchy and misogyny. [208,709,824]

Over the ensuing decades, more than 20 theories emerged attempting to explain the reasons for IPV, usually referred to as DV [208, 219, 316, 400, 399, 419, 430, 431, 606, 703, 752, 756] Most envisioned offenders, especially repeat offenders, as antisocial, maladaptive, or otherwise psychopathic, a view continued to be implied in much media coverage of DV murders and the like.

However, subsequent research has been unable to find empirical evidence sufficient to support these explanations. For example, a 15-month follow-up analysis of 580 convicted DV offenders in four cities found that only "11 percent of repeat assaulters exhibited primary psychopathic disorders," and more than half did not show indications of secondary psychopathic disorders, a much broader classification. The researchers noted that almost two-thirds (60 percent) of the batterers had "subclinical or low levels of personality dysfunction" and possessed a multitude of personality types, with re-assaulters no more likely to have a psychopathic disorder than others. [197] Other researchers have determined that only about 10 percent of IPV is due to mental disorders. [617, 696, 855]

If psychological theories cannot explain 90 percent of intimate partner abuse, then there must be alternative causal explanations. The National Violence Against Women Survey (NVAWS) attempted to develop predictive models of abusive behavior using logistic regression [791]. The strongest models found significant positive associations between abuse and unmarried, cohabitating couples and abuse of the victim as a child. A negative associated with IPV was found if the victim was white. This model also found significant relationships between abuse and abuser jealousy, abuser isolation of the victim, and verbal abuse of the victim by the partner. The researchers suggest that these relationships offer empirical support to what another researcher refers to a "patriarchal terrorism." [430] In their view, IPV is often "violence perpetrated against women by male partners as part of a systemic pattern of dominance and control." [791]

Some posit that males operate in abuse-supporting peer groups that reinforce social norms allowing males to abuse females. [194] These social supports do not operate in a social vacuum, but rather are bolstered by dominant social patriarchal patterns and coalesce with traditional perceptions of masculinity, privacy, sexual objectification of women, and heavy alcohol use. [196]

As social science data becomes more accurate, researchers are better able to empirically verify (or reject) various theoretical causal assumptions. Evolving research, for example, questions the initial correlation between race and domestic violence by suggesting that social disorganization variables, not race, are associated with increased intimate partner

violence. [57] While previous indicators pointed to a higher incidence of intimate partner abusive behavior among African-Americans, researchers did not consider community contextual factors, i.e., limited informal and formal social controls that influence the collective efficacy of an area. [697] Researchers suggest that "area racial composition and violent crime rates can be explained by other structural correlates of race," [57] including high unemployment, poverty, family fragmentation, economic hardship, and isolation from conventional society; all features that potentially reduce legitimate opportunity structures and weaken informal ties and social control, which are said to foster increased crime and violence. [617, 696, 855] Using data from the National Survey of Families and Households and the 1990 U.S. Census, these researchers suggest that neighborhood disadvantage is responsible for much of the correlation between race and domestic violence, explaining that "the rate of intimate violence is highest in the most disadvantaged communities and lowest in the least disadvantaged communities." [56]

Research utilizing results of California's massive health survey links neighborhood bar concentration with increased IPV emergency room visits. Researchers suggest that bars, likely frequented by men with and without their partners, may encourage heavy drinking linked to increased aggression. Like other such studies, this research goes beyond individual risk factors for IPV and looks at neighborhood, and environmental risk factors. The researchers note that using emergency room visits as their measure of IPV means they were finding much more serious IPV than that found in studies measuring IPV reported in police incident reports or arrests. [518]

Research, thus, sheds important empirical light upon the race-IPV connection by suggesting that varying ecological factors are more powerful predictors.

It is important to note that "correlation" is not the same thing as "causation."

Implications: While further testing of theories of causality will enable enhanced victim services and advocacy, as well as, improved strategies for perpetrator intervention and accountability, Victim Advocates and Service Providers can now draw on ample evidence-based research to support IPV causality based on perpetrator behavior to control, isolate, and dominate intimate partners, as well as, to retaliate, humiliate and punish victims for resistance to IPV.

How Should IPV Be Measured?

Several research instruments have been widely utilized to investigate the incidence and prevalence of intimate partner violence. The Conflict Tactics Scale (CTS) was one of the first. [752] Responding to deficiencies identified by researchers and practitioners, [210, 701] it was subsequently revised as CTS2. [757] However, while some have found that with modifications, the CTS2 is a valuable instrument for measuring the prevalence and frequency of the elements of intimate partner physical and sexual violence and psychological abuse contained in the tool, [193] it still defines IPV as "conflict-based." [767] While CTS measures were used in the NVAWS, the instructions were modified, removing "conflict" as the context/reason for IPV. [794] Other researchers have

supplemented the CTS2 with questions examining the meaning of the violence, its impact on the victim, and the context in which it occurs. [195]

Additional understanding of IPV has been developed from a variety of sources, including researchers [208, 823, 82], journalists and advocates. [8, 531, 597, 644, 709, 824, 859] They recommend that examinations of IPV should include investigation of the sequencing of violence, the intent of perpetrators, the meanings of violent conduct to the victims, injuries, the impact and cost of the violence on victims, and the context of the abuse. Development of the now widely familiar "Power and Control Wheel" provides a shorthand measure of IPV. [633] It affords researchers a more nuanced study of IPV through the lens of the "Wheel" and the tactics of abusers contained therein. While there is not universal acceptance of the "Wheel's" conceptualization of IPV, it shifts the examination of IPV beyond interpersonal conflict.

The CDC provides a compendium of assessment tools for measuring self-reported incidence and prevalence of IPV victimization and perpetration. As of this writing, it contains more than 20 scales. [786]

Criminal justice officials, including law enforcement, prosecutors, judges and probation officers, are concerned with the elements of IPV that constitute violations of specific criminal statutes, often irrespective of the impact on the victim. Historically, most IPV arrests were for various forms of criminal assaults or threats of such assault. However, with the enactment of stalking, strangulation and protection order statutes, abusers can now be arrested for behaviors that have not traditionally been viewed as criminal conduct in the context of IPV but constitute order violations.

Implications: As Victim Advocates and Service Providers attempt to improve the responses of criminal and civil legal systems to IPV, seeking greater accountability from perpetrators and enhanced safety and restoration for victims, the issue of the scope of IPV behaviors is critical. Further, issues of intent and context in IPV cases may be essential in distinguishing between victims and their abusers. The impact of criminal behavior on the victim should also be considered in reforming law and practice.

Are Coercion and Controlling Behaviors Linked to IPV?

It is commonly understood that power and control are "underlying factors" for IPV. [21, 424, 428, 430, 736] Controlling behaviors by men have been associated with both higher likelihood of physical violence [383, 429] and sexual violence. [290, 423] Men who believe they have a right to control and discipline wives are more likely to beat them than those who do not share these beliefs. [760] Other studies suggest that controlling behavior itself can be as, or more, threatening than physical and sexual violence. [98, 160, 192, 711]

A revealing New York study of 600 women, aged 15 to 24, who were patients at a reproductive health center, found two-thirds experienced one or more episodes of controlling behavior. [126] Further, in almost half of the cases, the controlling behavior

overlapped with physical and sexual victimization. Researchers concluded that controlling behavior is a risk factor for physical and sexual intimate partner violence. The younger women, 15 to 18, those who had grown up with domestic violence, those who had been pregnant at least once, those that had suffered recent physical or sexual violence, and those who felt uncomfortable asking their partner to use a condom, were the most likely to experience the most controlling behavior by their partners.

The types of controlling behavior included the male partner: 1) insisting on knowing the woman's location at all times (45.9 percent); 2) being angry if the woman spoke to another man (40.8 percent); 3) being suspicious of infidelity (40.5 percent); 4) attempting to keep the partner from seeing friends (26.5 percent); 5) ignoring or treating his partner indifferently (24.7 percent); 6) restricting contact with her family (6.3 percent); and 7) expecting his partner to ask permission before seeking health care (3.7 percent). [126]

The study also found that young women experiencing these behaviors were more hesitant to answer questions about relationship violence—a fact that presents challenges for healthcare providers and others seeking to assist woman who are at most risk. In the study, information from the women was obtained using anonymous, audio, computer-assisted self-interviews. [126]

A study in Nigeria indicates the New York findings are not unique to this country. The Nigerian study, seeking to determine the role of husband/partner controlling behavior, power relations within intimate relationships and the lifetime risk of physical and sexual violence, was conducted using a cross-sectional, nationally-representative survey, collected by face-to-face interviews from women aged 15 - 49 years in the 2008 Nigeria Demographic and Health Survey. It found husband/partner controlling behavior was associated with three-fold and four-fold higher likelihood of physical and sexual violence, respectively, after adjusting for potential confounders. In contrast, women who had decision-making autonomy had lower likelihood of experiencing physical and sexual violence. [21]

Implications: Victim Advocates and Service Providers can assist victims in identifying coercive and controlling behaviors of perpetrators and help victims design strategies for effective responses to coercive controls.

Are Sexual Abuse and Rape Part of IPV?

Sexual conduct that is illegal (e.g., rape, attempted rape, involuntary deviate sexual acts, sex trafficking) is a limited set of the full range of sexual abuse inflicted by intimate partners. [356] The spectrum of sexual acts that are abusive include: unwanted, nonconsensual or coerced sex acts; forced or denial of contraception and abortion; sex after childbirth or during illness; unwanted intercourse during menstruation; sex during sleep; sexual humiliation and degradation; sexually proprietary behaviors (e.g., jealousy, nagging about sex and accusations of infidelity); "make up" sex following physical assault or perceived infidelity; virginity and vaginal inspections; commercial sexual exploitation of partners; infibulation and other mutilation; sex through trick, fraud or

misrepresentation; sexual abuse by proxy or viewing/acting out pornography; exposure of children to sexual acts; economic support conditioned on sex; nonconsensual sex with 3rd parties, animals, or objects; and more.

Intimate partner sexual assaults often incorporate hurtful dimensions of degradation and humiliation. [498]

There is limited research on "legal" acts of sexual abuse by batterers or its impact on victims. Much of the research on intimate partner sexual assault has focused solely on forced or involuntary sex that is actionable under state criminal statutes. Even the National Crime Victimization Survey (NCVS) and the National Violence Against Women Survey (NVAWS) ask few questions to elicit information beyond coercive sexual behavior and contain extremely low rates of intimate partner sexual assault. [792]

Early research on sexual violence against wives, not just battered wives, suggested that between 10 and 14 percent of married women were raped by their husbands. [270, 687] The NVAWS estimates that 17 percent of women are raped at some time in their lives, but that percentage includes intimate as well as acquaintance and stranger rapes. Women are 86 percent of rape victims. Only 20 percent of women victims report their rape to the police. [792]

Male sexual assault of intimate female partners is more prevalent than stranger and acquaintance sexual violence; 14 to 25 percent of women experience intimate partner sexual assaults. [543] Another study of rural battered women found that half had been raped by their partners. [830]

Between 43 and 55 percent of women experiencing physical assaults by intimate partner also experience sexual assaults by that partner. [110, 111, 552, 856] In turn, psychological and emotional abuse commonly co-occurs with physical and sexual violence. [173, 223, 279, 689] In a recent study of women victims of intimate partner violence who obtained protection orders, 25 to 30 percent reported that their abusers engaged in a wide range of sexual abuse, exploitation and assault. The protection order recipients who were sexually abused were also likely to be stalked. Those stalked were likely to be more severely sexually abused. [494] In a previous protection order study, 68 percent of the physically abused women also reported sexual assault. Of those sexually assaulted, 79 percent reported repeated forced sex. Few made complaints to police or plead the sexual assault in protection orders. [543]

Battered women utilizing emergency shelter and domestic violence services indicate that between one-third and one-half have been sexually assaulted by their partners. [58]

The National Intimate Partner and Sexual Violence Survey (NISVS), involving 18,049 interviews across the country among persons 18 years and older, looked at five types of sexual violence, including rape, being made to penetrate someone else, sexual coercion, unwanted sexual contact and non-contact, and unwanted sexual experiences. NISVS found that 9.4 percent of women experienced rape by an intimate partner at some time

during their life and 0.6 percent during the prior 12 months. The percent of male rape victims was too small to be calculated. The percent of rapes of Black women by intimates (12.2 percent) was higher than White (9.2 percent) and Hispanic women (8.4 percent) over their lifetimes. [68]

Specifically, 6.6 percent of women reported completed, forced penetration by an intimate partner, 2.5 percent reported attempted forced penetration, and 3.4 percent reported alcohol/drug-facilitated rape. In addition, 16.9 percent of women experienced sexual violence other than rape by an intimate partner, including sexual coercion (9.8 percent), unwanted sexual contact (6.4 percent) and non-contact, or unwanted sexual experiences (7.8 percent). In the two months prior to the survey, 2.3 percent of women experienced forms of sexual violence by an intimate partner other than rape. Eight percent of men reported having experienced sexual violence other than rape by an intimate partner, including being made to penetrate an intimate partner (2.2 percent), sexual coercion (4.2 percent), unwanted sexual contacts (2.6 percent) and non-contact or unwanted sexual experiences (2.7 percent). In the twelve months before the survey, 2.5 percent of men experienced sexual violence other than rape by an intimate partner. [68]

NISVS found a tremendous overlap of IPV rape, physical violence, and stalking. Over their lifetime, 12.5 percent of IPV women victims experienced rape, physical violence and stalking, 8.7 percent experienced rape and physical violence, and only 4.4 percent experienced only rape. [68]

In the landmark study of incarcerated battered women, 72 percent reported that their batterers sexually assaulted them. Most were raped and many indicated that their sexual assaults occurred soon after physical assaults - when they were injured and distraught. [664] Fully 45 percent of men incarcerated in state prisons report they have raped or sexually assaulted their partners. [219]

Confirming the high rates of intimate partner sexual assault, a batterer intervention program study found that 53 percent of the men enrolled had sexually assaulted their partners. Most used emotional and physical coercion or threats to compel partners to engage in sex. Fully 33 percent of those who sexually assaulted their female partners did so when the women were asleep. The sexually violent men were also likely to engage in severe acts of physical violence that escalated over time. However, few men in the sample (8 percent) recognized that their acts constituted sexual abuse. [59]

The Georgia Domestic Violence Fatality Review identified sexual violence in 23 percent of the femicide cases examined between 2004 and 2010 and in one attempted homicide in 2007. [300]

Some battered women suggest that the sexual abuse is the most insidious and traumatic of all the abuse suffered. [664]

Implications: Victim Advocates and Service Providers must assess whether they are comfortable discussing sexual abuse/violence with victims. If not, victim assistance

program staff should pursue education about sexual abuse that includes interviewing and supporting IPV victims in exploring any sexual victimization not previously recognized. Risk assessment is incomplete without considering intimate partner sexual assaults. Likewise, restoration and safety strategies for victims must address the sexual violence they have experienced.

Is "Reproductive Coercion" Part of IPV?

Practitioners and researchers have expanded their understanding of the types of abuse visited upon IPV victims. Very recently, researchers have documented that "reproductive coercion" is more common than previously thought, especially among younger women. [555] Reproductive coercion takes different forms including a male partner demanding unprotected sex, sabotaging birth control, threatening murder if his partner has an abortion, and everything else from intimidation to rape. Reproductive coercion may also go a long way in explaining the underlying associations between adolescent partner abuse and pregnancy. [723]

A study of young abused women, 15 to 20 years old in California, for example, found that a quarter reported that their male partners were actively trying to get them pregnant, e.g., manipulating condom use, sabotaging birth control use, and/or making explicit statements about wanting her to become pregnant. [556] Similarly, a study of young abused women in Boston's poorest neighborhood found half reported their partners were "actively trying to get them pregnant by manipulating condom use, sabotaging birth control, or simply sweet-talking them." [651] Another study of 71 women, age 18-49, with a history of being victims of intimate abuse, recruited from a family planning clinic, an abortion clinic and a domestic violence shelter, documented that most experienced "male reproductive control" which encompassed pregnancy-promoting behaviors, as well as control and abuse during pregnancy in an attempt to influence the pregnancy outcome. [573]

A cross sectional study of 717 females at an STD clinic found recently reported IPV was associated with greater sexual risk as measured by more episodes of unprotected sex, both overall and with a steady partner. The study did not examine the specific responsibilities of the parties involved. [678]

A quarter of women who agreed to answer questions after calling the National Domestic Violence Hotline in 2011, more than 3,000 women, said their partners had pressured them to become pregnant, not to use contraceptives, or forced them to have unprotected sex. [649]

The NISVS found that 8.6 percent of women reported having had an intimate partner who tried to get them pregnant by not wanting to or refusing to use a condom. On the other hand, 10.4 percent of the men reported having had an intimate partner who tried to get pregnant when the men did not want to or who tried to stop the men from using birth control. [68]

Implications: Victim Advocates and Service Providers should discuss reproductive coercion with IPV victims. Victims may find it difficult to describe the extent of reproductive coercion, unwanted pregnancies, STDs, and abortions, even with healthcare providers. If referrals are made to health professionals, advocates should assure that they are knowledgeable about reproductive coercion as a significant risk predictor of IPV.

Is Stalking Part of IPV?

Stalking may be discounted by observers because it may not include *immediate* physical assaults against victims. The NVAWS [795] found that 22.1 percent of female and 7.4 percent of male intimates were physically assaulted by their stalkers. The Supplemental Victimization Survey (SVS) found that 21 percent of all stalking victims reported attacks on themselves and 15 percent against third parties or pets. [35] The highest rate of stalking is of intimate partners (28.1%) with former intimates (20%) and current intimates (8.1%) most likely to engage in stalking. [124a]In a large, opportunistic sample, the violence rate was 30 percent against stalking victims, with an additional 16 percent against third parties. [572] Stalking behaviors convey an implicit threat of violence and harm to victims that third parties may not identify as stalking or perceive the potential violence to victims posed by stalkers. In terms of "unwanted contact," the most frequent was the stalker approaching the victim in person (63 percent), followed by telephone contact (52 percent) and then letters, cards, or faxes (30 percent). A little more than a quarter of victims were contacted between once a day and once every two to three days, 36 percent weekly, and 21 percent monthly. [795]

The SVS reported that in addition to receiving unwanted phone calls (62.5 percent) and letters or emails (30.1 percent),-stalking victims experienced high levels of four unwanted behaviors "most commonly associated with stalking÷" - spreading rumors about the victim (29.1 percent), following or spying on the victim (24.5 percent), showing up in places without legitimate reason (22.4 percent), or waiting outside (or inside) places for the victim (20.4 percent). About half of the victims (46 percent) experienced at least one unwanted contact per week.

The SVS, conducted in 2006, also found that a little over a quarter of stalkers specifically engaged in cyberstalking or electronic monitoring of their victims and a little under a quarter (24.4 percent) damaged the victim's property or that of someone in the victim's household. [40] A statewide study suggests, however, that despite the growing threat of cyberstalking, law enforcement has largely failed to identify it in practice. Across the entire state of Rhode Island, police identified only one cyber stalking incident between 2001 and 2005 although the state had enacted a specific cyber stalking law in 2001. [456]

The NISVS found 16.2 percent of women were stalked over their lifetime, 4.3 percent over the year before the survey. For men, the rates were 5.2 percent and 1.3 percent respectively. Two-thirds of the women were stalked by current or former intimate partners, while 41.4 percent of men were stalked by current or former intimate partners. In terms of tactics used by stalkers, more than three quarters of women reported receiving

unwanted phone calls, including voice or text messages or hang ups. More than half were approached and more than a third were watched, followed or tracked. The tactics were similar in cases of male victims however the percent approached was less. [68] Studies of specific population subgroups have documented higher rates of stalking, for example, students on college campuses. [273,587]

Like abuse in general, not all stalking victims report their stalking to authorities. Stalking reported rates were revealed as 41 percent in the SVS and 51.9 percent in the NVAWS. Complicating prevalence surveys, researchers have found that most stalking victims do not use the term "stalking" to describe their victimization. [445,793]. Despite low victim reporting rates, almost all reports of stalking are made by victims, not third parties according to the SVS.

While the literature focuses on the various behaviors involved in stalking, it "may be better characterized by other factors such as duration, intensity, intrusiveness, timing, and implicit and explicit threats." [496] In other words, a focus on the content of stalking may not accurately reveal its seriousness or the full impact on the victim. A meta-analysis of criminal stalking behavior reveals that IPV victims are at risk for repeat violence. [682] Women IPV stalking victims are also at elevated risk for severe violence. [499, 497, 682, 793]

Implications: Victim Advocates and Service Providers should assist IPV victims in identifying stalking behaviors of perpetrators, assessing the risks posed by stalking, and developing strategies to avert those risks. Stalking assessment should be a standard part of IPV risk evaluation and safety planning.

Is Intimate Partner Economic Abuse Part of IPV?

Economic abuse by an intimate partner includes controlling a victim's ability to acquire, use, manage, maintain, and dispose of economic resources. Virtually all perpetrators of IPV impose various tactics of economic abuse on their partners. A shelter study, for example, found that 99 percent of female victims indicated that they were subjected to one or more forms of economic abuse. [5]

Tactics of economic abuse include, but are not limited to: prevention and disruption of education or employment, interference with transportation, failure to provide childcare, compromise of housing, deprivation of food and medicine, interruption of sleep, destruction of work clothes and/or job-related manuals, disposal of assets, theft of income, denial of library or internet access, commercial sexual exploitation, and limitation of communications with economic support networks.

Many women victims of IPV suffer significant material deprivation as a consequence of economic abuse. [5, 796, 799] Most low-income victims seeking domestic violence services report that the material hardships they faced were caused by abusive partners. In one study, three quarters of battered women stated that the abuser was "very much or completely" responsible for the economic hardships they experienced. [5]

Economic abuse can also affect victims in higher income families as well. Perpetrators can limit victim access to assets, e.g., by refusing to include victims as co-owners of real estate, vehicles or businesses, by denying access to cash, checking accounts, savings or investments, by confiscating victim earnings, by depriving access to insurance, by creating debt, or by theft or conversion of assets. [5] Without assets victims cannot achieve financial stability or escape from poverty. [4]

Economic abuse also includes interference in victim participation in education or training programs. [20, 571] Economic abuse involves prohibition or restraint from participation in employment and interruption or termination of employment. Much of the early research on economic abuse related to employment derived from the experiences of victims who were recipients of public welfare. [508, 642] In these studies, perpetrators discouraged, prevented or interfered with victim work significantly; from 16 percent to 59 percent of the victims reported this type of economic abuse. [16, 174, 688] Working victims advised that 35 percent to 56 percent were harassed by abusers at their places of employment; 55 percent to 85 percent reported tardiness, leaving early, or missing work completely as a result of abuse; 44 to 60 percent stated they were reprimanded at work for behaviors stemming from their abuse; and 24 to 52 percent reported loss of employment as a result of the economic abuse of intimate partners. [812] Job interference occurs before, during and after work hours. [774]

Victims stalked by intimate partners are likely to be harassed at the workplace by their partners who engage in work disruption, create attendance and performance problems, and precipitate job loss. [497] Women victims are at 5 times the risk of intimate partner assault at the workplace as are men. [30] Victims have higher levels of job instability than non-abused women. [89, 669, 800] Even when employers institute programs to mitigate abuser interference, victim fear and concerns about safety may be so profound that these services only succeed in short-term retention of employment. [774] The effects of abuser interference in victim employment are complicated, and vary, based on the primacy of this form of economic abuse in the array of perpetrator tactics, the job itself, and the personal circumstances of the victim. [801]

Implications: Victim Advocates and Service Providers should discuss economic abuse with victims and assist them in acquiring essential economic resources and recovering from the economic losses sustained as a result of IPV. If victims are employed, advocates and victims might work with employers, employee assistance programs, coworkers, unions and others to prevent abuse at the workplace.

How Can IPV Economic Abuse be Measured?

Items on economic abuse appear in subscales of several instruments that measure intimate partner victimization. [766, 767, 802] More recently, three standardized instruments have been developed to measure intimate partner economic abuse**:**

(1) The Work/School Abuse Scale (W/SAS) [669] measures a specific component of economic abuse—interfering with women's education and employment. The W/SAS is comprised of 12 questions that assess the frequency of a batterer's use of interference and restraint tactics to keep women from working or going to school, make them miss work or school, get them fired, or make them quit work or school.

(2) The Scale of Economic Abuse (SEA) [5] is an instrument with 28 questions that assess two dimensions of economic abuse: control and exploitation. Questions pertaining to economic control assess abusers' efforts to dictate women's access to and use of money (e.g., interfering with employment, or deciding when and how money is spent), while the exploitation questions assess how an abuser takes advantage of his partner financially (e.g., refuses to work, steals from her, builds debt in her name).

(3) The economic abuse subscale of the Domestic Violence-Related Financial Issues Scale (DV-FI;) [828] consists of five questions that assess the impact of abuse on women's credit ratings, education, employment, access to money, and debt.

Implications: Victim Advocates and Service Providers can utilize various instruments to measure economic abuse suffered by victims. Advocates can advise civil attorneys and prosecutors about methods to identify all of the adverse economic consequences of IPV and facilitate full restitution from abusers for damages, losses and other economic consequences of IPV.

Is Isolation Part of IPV?

Isolation is a common element of IPV, although often overlooked in much IPV research. The research instrument most utilized in investigations of isolation, cited 600 times in the literature [802], contains a subscale on "dominance/isolation" that includes confinement, prohibition against social connections/supports, interruption of employment/education, surveillance, and restriction of access to resources. Isolating victims may not rise to the level of a crime except in cases of kidnapping, hostage-taking, or false imprisonment. As a result, it is not often identified or charged by law enforcement.

Implications: Victim Advocates and Service Providers should support victims as they seek to reconnect with family members, friends, and social networks. It may be difficult for victims to break through abuser-imposed isolation, particularly if a victim's allies are frightened or intimidated by the abuser. Isolation may be overcome if advocates and service providers offer victims' allies education about safety planning and legal options to enhance safety.

Are Men and Women Equally Likely to Be Victims or Perpetrators of IPV?

National surveys supported by the National Institute of Justice, the Centers for Disease Control and the Bureau of Justice Statistics have extensively examined the more serious intimate partner assaults that are most likely to involve courts and criminal justice system responders. They find conclusively that men are much more likely to be perpetrators and women more likely to be victims of IPV. The NVAWS found that women were significantly more likely than men to report being victims of intimate partner violence whether rape, physical assault, or stalking and whether over the lifetime or the previous 12 months. [791] The NCVS has consistently found that female victimization by intimates is more than five times higher than male victimization by intimates. In 2008, for example, the rate of intimate partner victimizations of females was 4.3 per 1,000 females age 12 and older. For males, it was 0.8 per 1,000 males age 12 and older. [125] Further, female victims of IPV sustain more physical and emotional injuries and adverse psychological consequences than do male IPV victims. [747]

The National Intimate Partner and Sexual Violence Survey (NISVS), based on 18,049 interviews of adult women and men across the United States in 2010, found that 35.6 percent of women experienced rape, physical violence, and/or stalking by an intimate partner over their lifetime compared to 28.5 percent of men (67). One in four women (24.3 percent) experienced severe physical violence by an intimate partner over the course of the lifetime, as did one in seven men (13.8 percent). Further, 28.8 percent of women compared to only 9.9 percent of men reported IPV-related impact. IPV-related impact includes fearfulness, concern for safety, symptoms of post-traumatic stress disorder (PTSD), injury, need for healthcare, housing, or victim advocate services, contact with a crisis hotline, missing work or school, or, for rape victims, contracting a sexually transmitted infection or becoming pregnant. [68]

A comprehensive review of the research literature concludes that 90 percent of "systematic, persistent, and injurious" violence is perpetrated by men. [449]

The above data on male and female intimate partner violence is borne out by incident and arrest statistics of law enforcement throughout the country. For example, domestic violence incident files across Rhode Island in 2004 revealed that the state's 38 state and local police departments responded to 7,007 current or former intimate partner violence incidents that year. Of these, 81.7 percent of the victims were female. All but two percent of the female victims were abused by male suspects. By contrast, the male victims were much more likely to be abused by male suspects (12 percent). After investigation, Rhode Island police found probable cause to arrest 4,912 suspects. Of those arrested, 82.6 percent were charged with victimizing female victims and 18.4 percent male victims. [661] The ratios found in Rhode Island are the norm. [451]

A national study of law enforcement in 2,819 jurisdictions from 19 states documents that dual arrests are also relatively rare, averaging less than 2 percent of all incidents of intimate partner violence and intimidation arrests. [391] The only exception appears to

be in same sex IPV, where the research documents that law enforcement is much more likely to arrest both partners; 26.1 percent of the female and 27.3 percent of the male same sex cases resulted in dual arrests. [628]

Implications: Victim Advocates and Service Providers screening applicants for assistance should determine whether intimate partners assert that they are the victim, not perpetrator, of IPV. Intake workers or screeners should evaluate whether an applicant has engaged in patterns of coercive control as well as any of the five methods of IPV. Once a conclusion about victimization is made, acceptance for IPV programming or referrals for appropriate services can be made. Erroneous referrals may endanger the victim and enhance the power and dominance of the abuser.

Is Women's Use of IPV Different from Men's?

Women who engage in violence or use force against their partners are in most aspects very similar to women who are victims of IPV. [770] In fact, the overlap between the two groups has been found to be substantial, with overlap rates ranging from 64 percent [755] to more than 90 percent. [759, 771]

For this reason, it is not surprising that studies of women who use force against male partners reveal different motivations than those of men who perpetrate IPV against female partners. [24, 32, 177, 178, 701, 771, 772] An exploratory, multi-site study of male abusers participating in batterer intervention programs (BIPs) documented the use of force by the female partners against men enrolled in the BIPs. The findings suggest that self-defense (66 percent) or fear (33 percent) were the primary reasons that females used force or violence against male partners in the BIPs. The context of the force used by women partners indicated that they were the "primary victims." In the 3 months prior to BIP intake and in the 15 month follow up period, 20 percent of the female partners reported using a physical tactic enumerated in the CTS against their partners in the BIPs. Women using violence used less severe tactics than enrolled men. The men against whom they used violence were likely to be a subset of men in the BIPs who were more likely to "have antisocial tendencies, be verbally abusive, threaten the women, be repeatedly violent, and cause physical injury during the (15 month) follow-up." The use of physical tactics by women partners decreased as the men reduced their violence. Women who used force against their male partners were more likely to seek public welfare and services from shelters. [309]

At least two dozen studies have found that self-defense and retaliation are the most cited motivations for women assailants. [177, 178, 771, 772] The two motivations may also overlap. [352, 846] Anger has also been found to be a primary or secondary motive of women. A lesser number of studies find "desiring attention" as a motivator for women, suggesting that women use violence as a "last resort" to get their partners' attention. While some inquiries also find "coercive control" to be a motivator for a minority of women using force against their male partners, [349] none have found it to be a primary motivator, unlike studies of males perpetrating IPV. [736] Also, women may use violence

in an attempt to extricate themselves from abuse or to prevent the recurrence of violence by abusers. [97] Battered women with disabilities may recognize that their abusive partners are on the cusp of inflicting violence, and use violence as a preemptive strike to avert the assaults of abusers, a harm reduction strategy or an attempt to gain control over the situation. [350]

A recent study, attempting to create an instrument to measure women's use of force or violence against their intimate partners, did not succeed in constructing a valid measure of women's aggression, but concluded that "the power and control model of IPV may well apply to women's victimization, but not as well as to their perpetration of violence." Finally, the researchers suggest that it is essential "to apply a gendered context to understanding women's aggression" against intimate partners. [773]

Most significantly, research preliminarily reports that the use of advocacy services and community resources by women who use violence against intimate partners reduces the likelihood of them continuing violence against their male partners. Further, women who engage in violence against their partners in self-defense are more likely to seek assistance and services, realizing that violence does not stop their victimization. [97]

Implications: Victim Advocates and Service Providers can be most helpful to victims of IPV when they understand both the violence and the causes/motivators/ social supports of the violence used against victims. It is also critical that providers understand the context and motivations for abused women's use of force against their partners. Women using violence against their intimate partners may be long-term victims of IPV.

II. What Are the Victimization Rates for Intimate Partner Violence?

The NISVS, conducted in 2010, found that 35.6 percent of adult women were raped, physically assaulted and/or stalked by an intimate partner over the lifetime; 5.9 percent experienced IPV within the year before the survey. For men, the rates were 28.5 percent and five percent respectively. In terms of IPV impact, 28.8 percent of women and 9.9 percent of men experienced adverse impacts in their lifetime. Impact included being fearful, concerned for safety, experiencing symptoms of trauma, sustaining injury, missing work or school, becoming pregnant or contracting a sexually transmitted disease, and needing medical care, housing services, victim advocacy, legal services, or crisis hotline assistance. [68]

In terms of physical violence by an intimate partner, NISVS found 30.2 percent of women in the U.S. reported having been slapped, pushed or shoved by an intimate partner at some point during their lives; 3.6 percent in the 12 months before the survey. A little under a quarter of women (24.3 percent) reported severe physical violence by an intimate with 17.2 percent being slammed against something, 14.2 percent being hit with a fist or hard object, and 11.2 percent being beaten by an intimate. Over the year prior to the survey, 2.7 percent of women in the U.S. reported severe intimate partner violence. Among men, 25.7 percent report being slapped, pushed or shoved by an intimate partner over the lifetime and 4.5 percent over the year prior to the survey. For severe violence, the percent over a lifetime for men was 13.8 percent with two percent reporting severe IPV the year prior to the survey. [67, 68]

According to the 2008 NCVS, females age 12 or older experienced about 552,000 nonfatal violent victimizations, including sexual assault/rape, robbery, simple or aggravated assaults by an intimate partner, including a current or former spouse, boyfriend or girlfriend. Men experienced 101,000 such nonfatal violent victimizations by an intimate partner. The rate for females was 0.43 percent and 0.08 percent for males. Females age 18 and older experienced higher rates than younger females (12 to 17), 0.45 percent compared to 0.17 percent. [125]

The perpetrators of IPV differed depending upon the gender of the victim. Ninety-nine percent of the violence against females was committed by a male intimate, while only 83 percent of the intimate partner violence against males was committed by a female intimate. The rate of rape or sexual assault against females was 0.14 percent for females age 12 or older but only 0.03 percent for males. Twenty percent of the rapes or sexual assaults against females were committed by intimate partners. During a 12-month period in 2005 and 2006, 0.02 percent of females age 18 or older were stalked. For males, it was 0.007 percent. Stalking victims reported that 21.5 percent of their stalkers were former intimate partners. [125]

While NCVS includes incidents of victimization not reported to law enforcement (72 percent of the intimate partner violence against males and 49 percent against females in 2008), it is generally understood that NCVS underreports IPV because it asks victims to identify intimate partner violence in the context of what they consider to be a crime.

Individual state health surveys, on the other hand, suggest varying victimization rates for intimates. For example, a 2007 California Health Interview Survey asked adults 18-65 if they had experienced intimate partner violence at any time since turning 18. Nearly 16.7 percent or 3.7 million reported experiencing physical intimate partner violence as adults. Women were twice as likely to be victims (21.1 percent) as men (11 percent) and eight times (8 percent) as likely to report being victims of sexual violence as men (1 percent). A quarter who reported intimate partner violence as adults said it occurred within the last 12 months. [873] Across California 5.75 percent of adult women reported intimate partner violence within the past year [873] compared to 0.43 percent in the NCVS. [125]

An Ohio state health study [742, 743] found less abuse than that reported in California, [873] and less than that reported in the NISVS, [68] but much more than that reported in the NCVS. [125] It found 1.55 percent of Ohio women 18 years and older were physically abused by an intimate over one year (2007-2008) and 0.75 percent of men were abused by a partner. [743, 742] The abuse rate was three times that found in NCVS. [125]

A more recent survey in Alaska conducted in May and June of 2010 found that almost ten percent (9.4 percent) of adult women were victims of intimate partner violence, defined as physical violence (8.6 percent) or threats of physical violence (5.8 percent) in the past year. Almost five percent (4.3 percent) reported they were victims of a sexual assault over the prior year. The sexual assaults were not limited to those by intimates. Together, Alaskan adult women reported that 11.8 percent were either the victim of intimate partner violence or sexual assault over the prior year. Over their lifetime, the rate for women was 47.6 percent for intimate partner violence, 37.1 percent for sexual assault, and 58.5 percent for both. The study only surveyed violence against adult females, and was limited to those living in residences with landline telephones. [695]

A survey of Texans conducted in August 2002, indicated the following abuse rates by a spouse or partner: 26 percent for physical abuse (hit, slapped, pushed or choked), 11 percent forced to have sex, and 19 percent threatened or family threatened. All in all, almost half reported having personally experienced at least one form of domestic violence, either severe abuse, verbal abuse, and/or forced isolation from friends and family at some point in their lifetime. Specifically, 29 percent experienced public humiliation by their partner; 19 percent were intentionally isolated; and 41 percent called names (the only category where male victimization was greater than female victimization). [604]

Implications: Victim Advocates and Service Providers should be aware that the rates of IPV vary. The variance may be due to the instruments used, the sample selected (i.e. urban, rural, isolated rural or reservation), and age, race, class, disability, language capacity, education, income, or sexual identity, etc. and the method by which the data is collected, e.g., whether in person, on line, or by phones (i.e., landline or cell). Although the exact amount of IPV across the country can only be estimated from national and state surveys, the bottom line is that IPV presents a huge challenge to criminal justice personnel, health responders, human services

staff, advocates and other service providers. Research on the rates of IPV suggests that victim advocates and service providers should be responsive to victims of diverse identities and varied service needs or interventions.

Are Certain Populations at Increased Risk for IPV?

Abuse rates are not uniform, but vary based on race, ethnicity, socio-economic status, sexual identity, residence, marital status, disability, immigration status, and age.

In February of 2008, the CDC released one of the more detailed US survey regarding IPV. [118,136] CDC researchers asked adult participants in the 2005 Behavioral Risk Factor Surveillance System survey (BRFSS) if they would answer questions about intimate-partner violence. More than 70,000 Americans -- just over half those asked -- agreed. The survey found abuse rates varied based on household income. While 23.6 percent of women and 11.5 percent of men reported at least one lifetime episode of intimate-partner violence, in households with incomes under $15,000 per year, 35.5 percent of women and 20.7 percent of men suffered violence from an intimate partner. As found in other surveys, rates also varied based on ethnicity and race-- 43 percent of women and 26 percent of men in multiracial non-Hispanic households suffered partner violence, while 26.8 percent of women and 15.5 percent of men in white non-Hispanic households suffered partner violence, 29.2 percent of women and 23.3 percent of men in black non-Hispanic households suffered partner violence, and 20.5 percent of women and 15.5 percent of men in Hispanic households suffered partner violence. [136]

The CDC also found that 39 percent of Native women have experienced intimate partner violence – the highest percentage in the U.S. Native women are also more than five times as likely to die from domestic violence-related injuries than women of any other background. Additionally, one out of every three Native women is sexually assaulted in her lifetime. [136]

Surveys like the NCVS have consistently found higher rates of abuse for African-American women compared to others. Between 1993 and 2005, for example, the nonfatal injury rate for black women was higher than that of white women. In 2005, it was 4.6 per 100,000 black females 12 and older compared to 3.1 per 100,000 white females 12 and older. [123]

In a large California health survey, Indian/Alaskan Natives reported the highest rate of lifetime abuse (33.9 percent), followed by African Americans (24.4 percent), Whites (20.6 percent), Latinos (13.7 percent) and Asians (8.5 percent). Within ethnic groups, rates were higher for persons born in the United States compared to those who immigrated here. For example, the rate was 17.9 percent for US-born Latinos but 10.5 percent for foreign-born Latinos. In terms of marital status, those victims separated, divorced, or previously widowed had the highest rates (41 percent) of IPV compared to adults living with intimate partners (24.6 percent), married (13.3 percent), or single (13.2 percent). Single parents with children had the highest rates (38.3 percent) compared to single adults without children (18.8 percent), married adults without children (14.8

percent), and married adults with children (12.7 percent). In terms of sexuality, bisexuals reported the highest rate (40.6 percent) of IPV compared to gay or lesbian (27.9 percent) and heterosexual adults (16.7 percent). [872]

Implications: Victim Advocates and Service Providers must be aware that the overlap between poverty, geography and race/ethnicity, and the increased rates of IPV suffered by Native American, Black and Latina females may be associated with economics as much as race/ethnicity. Whether poverty, geography or race/ethnicity account for elevated rates of IPV, advocates and service providers must be mindful that poverty exacerbates the challenges faced by IPV victims. Advocates and service providers must be articulate spokespersons for effective and just systemic response to IPV for all victims of whatever class or race/ethnicity.

Are Separated or Divorced Persons at Increased Risk for IPV?

Rates of IPV for persons separated from intimate partners are higher than for divorced, married or never married persons. [84A, 124, 501] NCVS data reveal that approximately .042 percent of separated women and .013 percent of separated men were victims of IPV compared to .011 percent for divorced women and .003 percent for divorced men, .006 percent for women never married and .002 percent for men never married and .002 percent for married women and .001 percent for married men. [124]

Similarly, an international review of IPV research found that divorced women are nine times more likely than married women to be physically assaulted by intimate partners, and separated women are at 30 times the risk. [92]

Further, women victims of IPV may be at greater risk of sexual violence and rape after separation [191]. In an exploratory rural study of battered women separated from their male partners, the rate of sexual assaults of women upon telling abusers of their intent to leave was 74 percent. At the time of trying to leave, it was 49 percent, and after leaving, it was 33 percent. Formerly married battered women were subjected to sexual assaults at a higher rate than formerly cohabiting battered women. [196]

Although stalking often begins while the IPV perpetrator and victim are living together [499], not surprisingly, victims appear to be at elevated risk of stalking after separation and/or divorce [495, 791].

A recent study in Canada reported that separated and divorced women are at a very high risk for serious forms of violence, including death. [426] Other studies find women victims may be at greater risk of death trying to leave, immediately after leaving, or when their abusive partners are attempting to reconcile with them after separation. [70, 854]

Not all victims are at equal risk after they separate from or divorce their intimate abuser. One study found that in the two-year period after separation a third of abusers assaulted their victims, mostly often severely. The perpetrators most likely to assault their victims

were those who had frequently threatened their partners with violence after separation, who were "sexually suspicious," and who had lived with their victims long before they first assaulted them. Yet, the same study found that for most women, separation proved protective against ongoing abuse. The relocation of the abuser to another city was a significant protective factor. [276] Other research has found that separation may prevent or reduce the likelihood of physical and emotional abuse against women IPV victims. [241, 362]

While some argue that this research proves that marriage is the safest place for women to be, the comparatively lower rate of victimization for married couples may be a function of the fact that married couples tend to have less risk factors for IPV, including being older. In fact, research comparing women IPV victims under and over sixty years of age has found that for the older victims, marriage is the most unsafe marital status. These victims continue to suffer abuse well beyond age sixty. [463]

Implications: Victim Advocates and Service Providers should advise victims that IPV perpetrators may continue or escalate violence and stalking when they believe their intimate partners are thinking of separation and immediately after separation. However, many victims are not targeted for violence or stalking after separation. For this reason, it is important to assist victims in assessing the risk of "separation violence" and to devise safety strategies accordingly. It is also important to advise aging married victims that abuse will not necessary end when they become elderly.

Are Pregnant Women at Increased Risk for IPV?

There is conflicting research about whether pregnancy increases the risk of IPV for a woman. A review of the literature by the General Accounting Office of the U.S. found the research "inconclusive." [813]

Research has found that for most abused women, the violence may not begin with the pregnancy. [574] One study, for example, found only 2 two percent of women reported their abuse began with their pregnancy. [532] A British study of 7,591 pregnant women with due dates between 1991 and 1992 found that fewer women reported domestic violence victimization during pregnancy, (5.1 percent for emotional and/or physical victimization), than they did post-partum (11 percent for any victimization). [77] However, studies agree that if women are abused before becoming pregnant, the abuse is not likely to stop (for at least half of the women) when they become pregnant. [693]

CDC's Pregnancy Risk Assessment Monitoring System (PRAMS) looks at violence, but only for women whose pregnancies resulted in live births. In 1998, PRAMS found the rates of IPV against pregnant women in the 15 participating states ranged from 2.4 percent to 6.6 percent. [488] However, other studies find higher rates ranging from 3.9 percent to 20 percent. [298, 625] A recent study of mostly low-income pregnant Latina women in two Los Angeles clinics found 20.5 percent had experienced IPV within the prior 12 months and 23.2 percent had experienced it in their lifetimes. [815]

Younger women, those most likely to be pregnant, are more likely to be victims of domestic violence than older women. As a result, any increased abuse inflicted upon pregnant women may have as much to do with the victim's age as the fact that they were pregnant. [836]

Pregnancy has also been associated with high rates of hospitalized assaults, but this can be attributed to the fact that the hospital admission threshold for traumatic injuries, including assaults, is lower for pregnant victims compared to non-pregnant women. [835] Data from the CDC National Violent Death Reporting System (NVDRS) of women who died in the perinatal period – while pregnant or up to a year after birth - from 2003-2007 found 94 suicides and 139 homicides, or two suicides and nearly three homicides for every 100,000 live births. The numbers dwarf the rates of what are thought of as "traditional" causes of maternal death, such as hemorrhage and infection. More than 54 percent of the suicides and 45 percent of the homicides involved violent abuse. Older White women were at greatest risk of suicide. Among homicides, younger Black women, 24 years and younger, were most at risk. Many maternal deaths are the result of IPV. [620]

Implications: Victim Advocates and Service Providers should be alert to the possibility of assisting pregnant clients. Pregnant women should be advised that if they were abused before becoming pregnant, the abuse will likely continue through pregnancy. Safety planning must address pregnancy and the specific risks it may pose.

Are Women with Disabilities at Increased Risk for IPV?

Criminal justice-based surveys and health-based surveys produce different estimates about the prevalence of IPV experienced by women with disabilities compared with women without disabilities. The national, multi-state crime surveys conducted by the U.S. Department of Justice suggest that people with disabilities are at no greater risk of IPV than those without, although people with disabilities are at elevated risk of sexual assault.

The NCVS identified six types of disabilities: sensory, physical, cognitive functioning, self-care, go-outside-the-home, and employment. It defines "disabilities" as "a long-lasting (six months or more) sensory, physical, mental, or emotional condition that makes it difficult for a person to perform daily living activities." Women with disabilities are more likely than men with disabilities to be victims of IPV (16 percent vs. 5 percent). [652] The NCVS also found that the risk of IPV for women with and without a disability is basically equivalent (27.3 percent vs. 24.1 percent) [370], and the risk for IPV was comparable for persons with and without disabilities (13 percent vs. 14 percent). [369] Women with disabilities are more likely than men with disabilities to be victims of IPV (16 percent vs. 5 percent). [652] However, the NCVS found that persons with a disability have an age-adjusted rate of rape or sexual assault that is more than twice the rate for persons without a disability. [652]

Yet, in 2000, the NVAWS reported that there is "no empirical evidence that having a disability increases one's risk of intimate partner violence." [791]

On the other hand, the 2006 Behavioral Risk Factor Surveillance System Survey (BRFSS), conducted across seven states, confirmed that women with a disability are more likely to experience IPV than those without a disability. The survey reached 23,154 female respondents of whom 6,309 had a disability. Researchers found that women with a disability were significantly more likely to report experiencing some form of IPV in their lifetime, when compared with women without a disability (37.3 percent vs. 20.6 percent). Women with a disability were more likely to report ever being threatened with violence (28.5 percent vs. 15.4 percent without a disability) and hit, slapped, pushed, kicked or physically hurt (30.6 percent vs. 15.7 percent without a disability) by an intimate partner. Similarly, women with a disability were more likely to report ever experiencing unwanted sex by an intimate partner than those without a disability (19.7 percent vs. 8.2 percent). [25] Other analysis of the 2006 BRFSS data documented that the health problems of women IPV victims with disabilities were greater than those of women with disabilities that did not experience IPV. Women with disabilities who experienced IPV were found to be 35 percent less likely to report their health as good to excellent and 58 percent more likely to report an unmet health care need owing to costs than their disabled counterparts not experiencing IPV. [36]

Data from the General Social Survey of Statistics Canada (GSS), 1999, confirms many other studies in finding that there is no statistical difference in violence inflicted on women with disabilities by their intimate partners as compared to women without disabilities, but only in a one year retrospective. When examining the five years prior to the survey, the prevalence of violence inflicted by intimate partners of women with disabilities was significantly higher and the violence more severe than the IPV against women without disabilities. [92]

Similarly, a meta-analysis of 26 prior studies that included some 21,500 people with a range of physical and mental disabilities from seven countries (Australia, Canada, New Zealand, Taiwan, the United Kingdom, United States and South Africa) found that disabled adults are 1.5 times more likely to be a victim of intimate partner violence, sexual assault or other physical violence than those without a disability. Those with mental illness are nearly four times more likely to be victimized. About three percent of people with physical, mental, emotional or other health problems that restrict activities experienced violence within the past 12 months. About six percent of people with intellectual disabilities were victimized in the past year, while 25 percent of people with mental illnesses were abused. While the studies aggregated all types of violent victimization against victims, three of the studies included, covering 574 individuals with mental illness, found the risks of intimate partner violence at nearly 40 percent.

According to the prime researcher, "Lifetime exposure to violence, and the proportions of individuals with disability who are directly threatened with violence or otherwise live in fear of becoming a victim, are likely to be substantially higher than our estimate." [408]

There are several reasons cited in the social science literature for the paucity of research on and undercounting of IPV against women with disabilities. One important reason for possible undercounting is that the tactics of abuse measured in most survey research do not include additional, and perhaps more salient, tactics of abuse utilized by intimate partners against women with disabilities. [92, 727] Women with disabilities may not be fully included because of the misconception that women with disabilities are asexual and not engaged in intimate relationships. [92, 599] Women with disabilities are devalued, "roleless" and marginalized in multiple, complex ways. [175]

Implications: Victim Advocates and Service Providers must be aware that many disabilities cannot be identified visually. Screening devices used by healthcare providers, victim advocates and service providers should specifically inquire about the disabilities that IPV victims may have, should explicitly determine the accommodations required by victims with disabilities, identify the tactics of control utilized by IPV perpetrators and ascertain the risks posed by any disability. All agencies serving IPV victims should incorporate structures, staff training, procedures and services to accommodate victims with disabilities. Partnerships should be formed with agencies solely assisting persons with disabilities to better serve all IPV victims by designing services according to the expertise of each partner agency.

Are Women Who Are Deaf at Increased Risk for IPV?

There is a dearth of research on the prevalence of IPV against women who are deaf or hard of hearing. Most figures are anecdotal, and estimate that IPV victimization rates are close to equivalent between deaf and hearing women. A domestic violence program specifically serving deaf women estimates that 25 percent of deaf women are victims of IPV annually. [3] A recent study of deaf college women between the ages of 18 and 25 who had been in a dating or intimate relationship the year prior to the study found that twice as many deaf undergraduate women were victimized by a dating or intimate partner as were hearing women students. Although the average number of physical assaults and sexual coercion victimizations of deaf and hearing students was comparable, deaf women reported significantly higher rates of psychological aggression. [19]

Implications: Victim Advocates and Service Providers must be aware that many people who are deaf or hard of hearing cannot be identified visually. Screening should specifically inquire about the hearing deficits that IPV victims may have, determine the accommodations required by victims who are deaf or hard of hearing, identify the tactics of control utilized by IPV perpetrators and ascertain the risks posed by any hearing deficit. All agencies serving IPV victims should incorporate structures, staff training, procedures and services to accommodate victims who are deaf or hard of hearings. Partnerships should be formed with agencies solely assisting persons with hearing deficits to better serve all IPV victims by designing services according to the expertise of each partner agency.

Are Rural Women at Increased Risk for IPV?

Studies have produced mixed results about the risk of IPV for rural, urban and suburban victims. According to the Bureau of Justice Statistics, for example, on average, between 1993 and 2004, residents of urban areas experienced the highest level of nonfatal intimate partner violence. Residents in suburban and rural areas were likely to experience IPV, but at a rate about 20 percent less than those in urban areas. [123]

A secondary analysis of NCVS data, examining figures from 1999 – 2005, found that while the rate of IPV of married women was similar across rural, suburban and urban jurisdictions, separated and divorced rural women (82.6/1000 separated and 18.8/1000 divorced) were victimized by intimate partners at rates exceeding their urban counterparts (46.9/1000 separated and 13.2/1000 divorced). Rural women were more likely to be victimized by boyfriends than spouses or ex-spouses and at a rate equivalent to IPV victims in suburban and urban areas. [657]

A secondary analysis of NCVS 1992-2009 data of separation/divorce sexual assault against females found that rural separated women were victims of intimate partner rape and sexual assault at significantly higher rates than suburban or urban women. [657] A secondary analysis of the National Survey of Families and Households (NSFH) and the 1990 U.S. Census examined the role of social isolation, as opposed or in addition to geographical isolation. Researchers found that social isolation was a significant predictor of IPV in rural counties. However, women in rural counties that receive help from family and friends, including childcare, transportation, housework and advice, were at lower risk of IPV. [481]

Other studies of women in rural areas found a higher incidence of torture and being shot at by abusers than victims in urban areas [832]. A study comparing experiences of rural White women and urban African American women IPV victims found victims in rural areas reported longer duration of abusive relationships, more victimization, and worse economic circumstances than their urban counterparts. They also appeared to suffer more stalking, sexual insistence, and threats of violence to pets, other family members, property, and to the victims themselves compared to urban victims [504].

Research that found rural and urban rates of IPV to be equivalent in Kentucky, nonetheless, found that rural victims may suffer more because of fewer resources, including weaker criminal justice interventions. The study also revealed that half of rural battered women had been forcibly raped. The authors opined that "(g)eographical isolation in rural areas simplifies the subordination and loneliness of many women in the home…and cuts rural battered women off from…potentially beneficial intervention." [504]

A 2011 study in Iowa discovered that rates of IPV were higher for women in isolated, rural communities; physical abuse occurred in greater frequency and severity than against women in urban areas. Researchers surveyed 1,478 Iowa women seeking elective abortions. They found that 61.5 percent of isolated rural women reported four or more

events of physical IPV in the past year compared with 39.3 percent of urban women. The severity of abuse reported was three times higher for the rural women. The researchers hypothesized that the increased IPV among rural women may result from the fact that abusers choose to live in rural areas because the isolation makes it easier for them to control their partners and hide their abuse. The disparity in access to intervention or prevention services in rural areas may also play a role in higher rates of abuse, e.g., the distance to services were an average of 40 miles for rural women, about three times greater than for urban women. [631]

Implications: Victim Advocates and Services Providers should introduce specialized education and outreach to rural women who may not have access to urban media markets or the internet. Overcoming geographical barriers to outreach and service may require 'traveling offices' and/or home visiting. Delivery of services might have to be at public locations, e.g. public libraries, schools, medical facilities, or women's Bible studies, for rural women to participate with the permission of intimate partners or otherwise to disguise that extremely rural women are seeking domestic violence services. Advocates and Service Providers should identify "natural" social networks of rural women and invite network participation in IPV prevention initiatives.

Are Elders at Increased Risk for IPV?

The prevalence of elder IPV is likely greater than reported in the social science literature. [656] There has been little study of IPV perpetrated by persons over 55. [656] That which is available generally finds that persons 60 and older are at decreased risk for IPV, although they may be at increased risk for non-intimate family violence, especially from adult sons and daughters, as well as from other institutional and non-institutional care givers. [463, 777] According to the NCVS, the rate for IPV victimization for women under 50 years is 6.3 to 17 per 1,000 compared to only 1.4 or less per 1,000 for victims 50 and older. [123] In a statewide study of abuse of women over 50, researchers documented that up to age 60, two-thirds of police incidents calls for abuse constituted IPV. However, after 60 years, two-thirds of documented abuse was committed by family members, not intimates. [463]

A statewide examination of IPV police incident reports suggests, however, that if an intimate partner was abused by her husband before reaching age 60, she will continue to be abused by him after that age. [509]

Implications: Victim Advocates and Service Providers should reach out to elders served by traditional elder abuse protection and service agencies which focus on the more prevalent family and institutional care-giver abuse visited on the elderly in order to offer IPV services to those seniors at risk of IPV. Collaboration between agencies addressing IPV and adult protective services is critical to meet the needs of elder IPV victims. Similarly, where special elder abuse prosecutorial units limit their focus to elder financial exploitation and theft, IPV agencies should partner

with them to assure that elder IPV victims are fully protected by the criminal legal process.

Are Lesbian, Gay, Bisexual or Transgender People at Increased Risk for IPV?

Research on the lifetime prevalence of IPV experienced by lesbian, gay, bisexual and transgender (LGBT) victims is limited and the findings are mixed. Many attempts to measure IPV among same sex couples lack scientific rigor; data are gleaned largely from small clinical and convenience samples and the definitions of same sex IPV are often dissimilar. Some suggest standard definitions used for IPV are inadequate to define IPV among LGBT couples. Based on feedback and surveys of 1,000 gay men, researchers, for example, added to the standard definition of IPV to include lying about HIV status or intentionally transmitting HIV. [272a]

As a result, there is a fair amount of difference in the estimates derived from the studies on same sex physical IPV. Some suggest that the prevalence of LGBT IPV is equivalent to that in heterosexual couples [342, 415, 680]. Other estimates vary significantly, finding from between 20 and 50 percent of all LGBT people are victims of IPV [97], between 42 and 70 percent of gay men [335], 11 and 44 percent of gay and bisexual men [805], 23 percent of a convenience sample of gay men and lesbians [97], between 8 and 60 percent of lesbians [805], 40.6 percent of bisexuals, and 27.9 percent of gays and lesbians (contrasted with 16.7 percent of heterosexual adults) [873]. While sample size in studies of transgender people is too low to generalize, there is some evidence that the rate of physical IPV against transgender people in intimate partnerships is similar to that of gay men in same-sex relationships. [805]

The large 2007-2008 California Health Interview Survey found that rates of IPV are higher for bisexual women and gay men. The former were most likely (95%) abused by a male partner. While the researchers also found that binge drinking and a history of psychological distress predicted IPV, these factors could not explain disparities among homosexual, bisexual and heterosexual couples. [305a]

The findings of the NVAWS suggest that IPV is perpetrated primarily by men whether against same-sex or opposite-sex partners. IPV was reported to be more prevalent among gay couples than heterosexual couples. Findings contradicted reports that IPV is more prevalent among lesbian couples than heterosexual couples. [795]

A secondary analysis of the NVAWS preliminarily reveals that males and females in same-sex partnerships are more likely to experience verbal, controlling, physical and sexual IPV than heterosexual partners. The prevalence of IPV among lesbians, gays and bisexuals may be twice that among heterosexual intimate partners. Bisexuals appear to inflict the highest rates of IPV, and an opposite-sex partner is most likely to be the~~ir~~ IPV perpetrator of bisexual victims. [550]

A 2011 survey undertaken by the National Center for Transgender Equality and the National Gay and Lesbian Task Force revealed that 19 percent of the survey participants were victims of "domestic violence" but the survey instrument did not specify whether the IPV was by a partner or another family or household member. However, the survey found that the rate of "domestic abuse" against transgender people of color, immigrants and cultural minorities was greater than for whites. [336] Two studies of violence toward transgender persons found that 56.3 percent and 66 percent of the respondents indicated that the violence inflicted against them had occurred in their homes; but since the research did not differentiate between IPV and violence by others in the home, the question of the prevalence of IPV against transgender people remains largely unanswered. [446]

The most recent report of National Coalition of Anti-Violence Programs (NCAVP), based on a survey of 17 member programs about the prevalence of IPV among their service participants, showed an increase of 38.1 percent in IPV from 2009 - 2010. More than half (55.4 percent) of the IPV victims were physically assaulted in 2010, while slightly more than one-third (36.5 percent) were physically abused in 2009. Almost half of the victims served by member programs were women (45.7 percent), while male victims constituted a third. Most victims served in 2010 were not in current relationships (49.4 percent) with the IPV perpetrators, whereas there had been an increase in clients in current or long-term relationships in 2009. LBGTQ intimate partner homicides (6) reported in 2010 numbered the same as in 2009; two-thirds of the homicide victims were women both years, and the average age of the deceased increased from 30 to 39 years. [590]

A new weighted scale, the IPV-GBM, identifies 23 items to measure intimate personal violence by gay and bisexual men. Five categories are contained in the scale: 1) Physical and sexual violence (33 percent); 2) Monitoring/surveillance and intruding on internet social networking (14 percent); 3) Controlling behaviors (5 percent); 4) HIV-related violence (5 percent); and 5) Emotional violence (5 percent). Most of the categories are contained in other scales of IPV. However, the HIV-related category is new and includes three items: 1) "Lie to you about his status;" 2) "Not tell you he had HIV before you had sex;" and 3) "Intentionally transmitted HIV to you." Two other items were excluded from the HIV-related category after being rejected by the 1,047 gay and bisexual men surveyed: 1) "Refusing to use a condom;" And 2) "Unintentional HIV transmission." The IPV-GBM scale has not yet been validated. [268]

Applying the IPV-GBM scale to the data generated by survey responses, researchers found that 46 percent of the men reported being victims and 32 percent acknowledged being perpetrators. The rate of violence by and against gay men measured by the IPV-GBM scale is sharply higher than the gay violence documented by the CDC (13percent victims and 8percent perpetrators) and the Conflict Tactics Scale (28 percent and 19 percent). Further, gay and bisexual victims of IPV reporting violence in the previous year were twice as likely (compared with men not subjected to IPV in the last year) to report that they had not used a condom the last time they had anal sex. The lack of condom usage was associated with IPV against gay and bisexual men as measured by all

three domestic violence scales, i.e., the IPV-GBM, CDC and CTS scales. [268]

An earlier, more limited sample of gays and lesbians, found lesbians were more likely to push their partners than gay men. Lesbians and gays otherwise were equivalently victims of IPV as measured by the CTS modified. Lesbian perpetrators utilized a broader range of tactics against partners than gays, and lesbians were more likely to report being both victims and perpetrators. [820]

As to same-sex sexual assault, studies involving lesbian partners revealed a wide range of from 5 to 57 percent, and among gay men the figures were between 12 – 55 percent. [805] Transgender people report that 29 percent of their sexual assailants are intimate partners. [753] Another survey inquired about the relative rate of sexual coercion in gay and lesbian IPV, finding that the rate of coercive sex was significantly higher for gay men but that the severity of methods of sexual coercion was equivalent for gay and lesbian perpetrators. [820]

Emotional abuse has been investigated less frequently than physical or sexual violence in intimate partnerships. The amount of emotional abuse in lesbian same-sex couples varies and is preliminarily found to be much higher than physical or sexual IPV; emotional victimization reported by study participants ranging from 65 – 90 percent. [805] Research is not available on emotional abuse by gay men or transgender people in intimate partnerships. [805]

One community survey found that among gay men internalized homophobia was associated with perpetration of physical and psychological IPV. [37]

Data about the brutality of methods employed in more than 50,000 homicides extracted from the U.S. Federal Bureau of Investigation (FBI) Supplementary Homicide Reports (SHRs) for the years 1976 through 2001 revealed that IPV-related homicides by homosexuals were significantly more brutal than by heterosexuals, IPV-related homicides by gay men were more highly brutal than by heterosexual men, and IPV-related homicides by lesbians were more brutal than by gay men. Statistics on the number of gay and lesbian, and male/female heterosexual IPV homicides are not available. [568]

A NISVS Special Report will be issued soon with more survey information on IPV among LGBT people.

Implications: Victim Advocates and Service Providers not specifically serving LGBT people should examine practice protocol, training curricula for agency staff and other professionals, recruitment strategies, community messaging and organizational environments to ensure that advocacy, services and the legal system are welcoming of all LGBT victims of IPV and tailored to meet the diversity of needs of these victims. Comprehensive services should be available to all. Advocates should reach out to organizations specifically providing services and advocacy for LGBT people and collaborate with them to enhance assistance and justice for all LGBT victims of IPV. Strategies for appropriately and effectively

intervening with LGBT perpetrators should be reviewed and upgraded by the courts and community.

Are IPV Rates Higher Among Veterans and Active Duty Military?

Veterans and active duty military personnel are more likely than non-veterans to have experienced IPV. Among women veterans, 39 percent report having experienced IPV at some point in their lives. In active duty women, 30-44 percent report having experienced IPV during their lifetimes.

A study of veterans in VA couples counseling suffering from either PTSD or severe depression found, based on combined veteran and partner reports, approximately 81 percent of veterans suffering PTSD and 81 percent of depressed veterans engaged in at least one act of violence toward their partners in the last year; 45 percent of the former and 42 percent of the latter perpetrated at least one severe violent act in the last year (also based on a combined report from both veteran and partner). These rates were 6 to 14 times higher than were rates from the general population [708, 754] and were higher than the 25 percent severe violence rates found in therapy-seeking couples in university clinics. [610]

Other studies of veterans seeking help for PTSD have found high rates of partner violence in the past year; 42 percent to 63 percent physical violence [102, 671], 92 percent verbal aggression, and 100 percent psychological aggression (based on combined veteran/partner reports of violence). [671] A recent cross-sectional survey of 199 veterans (with a current or separated partner) who had served in Iraq and Afghanistan after 2001 and were referred to treatment in 2005 and 2006 at the Philadelphia VA for a behavioral health evaluation, revealed that many veterans reported "shoving, shouting or pushing their partners" (53.7 percent), and said their partners were afraid of them (27.6 percent). Depression and PTSD were also both associated with higher rates of family re-integration problems. [707]

A forthcoming supplemental NISVS survey, co-sponsored by the CDC and the Department of Defense, will contain more survey information on IPV and veterans.

Implications: Victim Advocates and Service Providers should expand outreach to victims of IPV who are in the military, the National Guard or the Reserves, or who are veterans. IPV victims of military personnel serving in Iraq or Afghanistan may be in greatest need of advocacy and services. Civilian program collaboration with military installation command staff, Family Advocacy Programs in the military, and VA hospital staff should endeavor to enhance both victim safety and perpetrator accountability. Advocates and Service Providers should also collaborate with Veterans Courts to ensure that IPV victim safety and economic needs are recognized.

How Many Children Are Exposed to IPV?

The CDC analyzed information from interviews with 26,229 adults in five states, Arkansas, Louisiana, New Mexico, Tennessee, and Washington, using the 2009 Adverse Childhood Experiences (ACE) module of the Behavioral Risk Factor Surveillance System (BRFSS). [135] Each month, trained interviewers, using a standardized questionnaire, collected data from a probability sample of the non-institutionalized U.S. adult population residing in households with landline telephones. The 2009 ACE module included a question on witnessing domestic violence. Witnessing domestic violence was defined by either a response of "once" or "more than once" to the question: "How often did your parents or adults in your home ever slap, hit, kick, punch, or beat each other up." The survey found 16.3 percent reported witnessing domestic violence, however, the CDC conceded that to be an undercount for reasons enumerated in the study. [135]

Another 48 state survey of those 18 years and older found higher rates of child exposure for households headed by couples, married or unmarried. Based on 2001 U.S. Census data, it found that 21.45 percent of the couple headed households reported partner violence and 59.02 percent of these households had 1.98 children on average. This translated to almost 30 percent of the nation's children living in couple headed households, or 15.5 million children, being exposed to IPV. If only severe violence reported in the prior year was included, the percentage of households with IPV was 8.6 percent of which 62.57 percent had 2.10 children on average. This translated to 13.3 percent of American children living in couple headed households, or 7 million children exposed to severe IPV. Couples with children were more likely to report partner violence than couples without children. The survey did not include children exposed to a parent's partner violence from a non-cohabiting partner. The survey also found more female-to-male partner violence than male-to-female partner violence reported by the couples surveyed, including severe violence. These findings distinguish this investigation from most such surveys that found the opposite. [542]

The National Survey of Children's Exposure to Violence (NatSCEV), a nationally representative telephone survey of the victimization experiences of 4,549 youth, aged 0–17, created by the Office of Juvenile Justice and Delinquency Prevention conducted between January and May 2008, looked at psychological violence between parents (threats and displaced aggression), physical violence, and violence involving other family members. Approximately 6.6 percent of children were exposed to some form of physical assault between their parents in the past year. Almost the same number of children (5.7 percent) were exposed to psychological or emotional violence between parents. If including exposure to other family physical and psychological violence, the percent rose to 11.1 percent of child exposure to IPV. Over their short lifetimes, children's exposure to parental IPV, physical and psychological, was 17.9 to 16 percent, and to family violence, 25.6 percent. Most of the exposure was eye witnessing, accounting for 65 to 86 percent of all exposure. Males were identified as the perpetrators in 78 percent of the IPV incidents with the percent of male perpetrators increasing with the level of violence. Most of the males were fathers, followed by non-cohabiting boyfriends. Of all youth exposure to IPV, more than two-thirds encountered only male IPV perpetrators. Few were exposed

to mutual parental IPV, while 22.6 percent were exposed to female IPV perpetrators. [357]

While the NCVS did not determine the number of children who witness domestic violence, the survey revealed that 38 percent of the households with a female intimate partner victim had at least one child under the age of 12 living in the home. For households with male IPV victims, the percent was less, at 21 percent. [125] Court statistics reveal that children were present in 36 percent of the violent incidents that were charged in state courts in 16 large urban counties in 2002. Of these children, 60 percent specifically witnessed the violence. [728] Other studies put the figure at 40.2 percent of the children of battered women among those mothers reporting IPV. [787]

An earlier review of the research on prevalence estimated that between 10 and 20 percent of American children are exposed to IPV annually and 33 percent are likely to witness IPV during childhood or adolescence. [120]

An investigation of police and victim reports across five cities found that young children, under age six, were more likely than those older to be present during discreet incidents and continuing episodes of IPV. [253]

Research in child welfare systems have found a large proportion of children under protective supervision were exposed to adult domestic violence, although screening by child welfare agencies has been widely found to be inadequate and estimates unreliable. [243, 377]

Studies have found that parents underestimate their children's exposure to domestic violence. In one investigation, even where one or both parents reported their children were not exposed, 21 percent of the children provided detailed descriptions of the domestic violence in their homes. [602, 745]

Implications: Victim Advocates and Service Providers are charged under most state laws with reporting suspected child abuse to police or child welfare agencies. In some states, they are responsible for reporting children's exposure to IPV. Some CPS/Child Welfare agencies are informed about IPV and work with advocates and service providers to find ways that 'exposed children' may remain with abused mothers rather than being placed in foster care. Other agencies may be quick to blame victims and place children exposed to IPV in foster care. Shelters, comprehensive advocacy programs and others providing legal services, resource-acquisition, or counseling may elect to accept voluntary referrals of victims and children from CPS/Child Welfare agencies, inviting referring agencies to provide resources to enable victims to obtain temporary or permanent housing to protect the children from the parent who abuses. Children's programming in shelters and comprehensive IPV advocacy organizations should offer trauma counseling or education to battered parents and children about the violence to which their children have been exposed, about methods of risk assessment and strategies for safety planning.

How Many IPV Victims Are Killed Each Year?

The number of IPV related homicides each year depends how broadly IPV homicides are defined and how accurate the reporting agencies are. Obviously, if the person who committed the homicide is unknown, the relationship to the victim is not determined. Homicide reports made by local police agencies, often do not report prior relationships, even when the known suspect is the victim's former intimate partner. However, reports usually identify divorced spouses. Even if the relationship is subsequently revealed, police infrequently update reports already sent to state or federal authorities. While federal reports of IPV homicides are based on police incident report data, the information garnered by many state and local IPV homicide~~s~~ (or fatality) review panels is more accurate as these are supplemented with investigative police reports, as well as, reports from newspapers, child welfare agencies, family members and other non-law enforcement sources.

Typically, IPV homicide reports include an individual intimate killing his or her partner. Most local police departments identify a killing as an IPV homicide if the intimate killer then commits suicide. However, many IPV fatality reviews go further. The Washington Coalition Against Domestic Violence, for example~~s~~, also includes in its annual IPV fatality report the following: 1) All homicides in which the victim was a current or former intimate partner of the person responsible for the homicide; 2) Homicides of people other than the intimate partner that occur in the context of intimate partner violence~~,~~ or in the midst of a perpetrator's attempt to kill an intimate partner, e.g., homicides in which an abuser kills a current or former partner's friend, family member, new intimate partner, or a law enforcement officer; 3) Homicides that are an extension of or proxy IPV homicides e.g., cases in which an abuser takes revenge on a victim by killing the victim's children; 4) Suicides of abusers that happen in the context of intimate partner violence. [256]

According to the Bureau of Justice Statistics, based on FBI data, in 2010 an estimated 241 men (110 husbands and 131 boyfriends) and 1095 women (603 wives and 492 girlfriends) were victims of IPV homicides. Homicides by former spouses or BF/GF are not reported. [264] The numbers are estimates because only 33 percent of FBI data contain relationship~~s~~ information in the reported homicides. [125]

The Violence Policy Center annually lists murders of women by men based on the most recent Supplementary Homicide Report (SHR) data submitted by the states to the FBI. In 2009, it found 1,818 females were murdered by males in single victim/single offender incidents. This number did not include any cases from Florida and only limited cases from Illinois. For homicides where the victim relationship was known, 93 percent of the victims were killed by a male they knew. Of these 63 percent (989) of the victims were wives or intimate partners of their killers. [819] The Violence Policy Center reports are limited to reported homicides where the relationship is known and does estimate relationships for the cases where the relationship data is not reported.

Returning to the Washington State Coalition fatality reports, from 1997 thru June 2008, most of the fatalities in that state (272) involved a female intimate killed by a current or former husband or boyfriend. However, another 40 friends or family members of female intimates, 26 new partners of female intimates, 32 children of female intimates, two co-workers of female intimates, and four responding police officers were also killed by male abusers. Three male associates of male abusers also killed the female intimates of male abusers. Two females were killed by current or former female intimates and one new intimate female partner was killed by a female abusers. Three children were also killed by female intimate victims.

Three female abusers committed suicide after killing their partners, as did 139 male abusers.

In regard to male victims, 37 were killed by current or former wives/girlfriends and four by a female intimate's associate. Seven males were also killed by a current or former male intimate. Two friends or family members of a male intimate as well as two new intimate partners of male intimates were killed by a female abuser. Friends or family members of female victims killed 14 male abusers, and law enforcement killed 17 male abusers.

The Coalition reported that 22 of the males were killed by their female intimates in self-defense or "probable" self-defense, while seven females killed their male intimates "not in self-defense." [255]

Homicide victims killed by an intimate partner in the U.S. declined from an estimated 3,300 in 1993 to 1,336 in 2010. [264] While the number of women killed by their intimate male partners has declined by 21%, it has not kept pace with a much steeper decline in the number of males killed by their intimates female partners (down 36%), nor the overall decline in all homicides (31%) across the country during the same period. [125]

Implications: Victim Advocates and Service Providers should note that over the last several decades, there has been a smaller decline in female IPV fatalities contrasted with overall homicide fatalities across the United States. The reduction in IPV homicides of males by female intimates may be attributable to female victims accessing advocacy and services, enabling female victims to escape from potentially lethal batterers. Women IPV victims should be alerted to the potential increased risk for severe injury and lethal assault by perpetrators when victims seek to leave their abusers or otherwise engage in help-seeking.

How Many IPV Victims Attempt/Complete Suicide?

The Centers for Disease Control (CDC) is building a National Violent Death Reporting System. As of July 2011, 18 states were participating. In that year, these states reported 573 intimate partner homicides, 386 of which were females. During that same year, these

states reported 2,909 “intimate partner problem” suicides, 439 of which were females. In other words, five times as many people died as a result of “intimate partner problem” suicides as intimate partner homicides. [440]

While the National Violent Death Reporting System does not define “intimate partner problem” as IPV, research suggests a link between IPV specifically and victim suicide. [829] The Washington State Domestic Violence Fatality Review has concluded that far more women died of intimate partner-related suicides than homicides. [740] A study of women admitted to a large Connecticut hospital revealed that 20 percent of battered women had made multiple suicide attempts compared to eight percent of non-battered women. [739] A recent study of mostly poor African American abused women admitted to a large urban public hospital in the South found that 32 percent had attempted suicide in the past, 34 percent once, 19 percent twice, 16.3 percent three times, and 31.4 percent four or more times. [660]

Data from the 2003 – 2007 National Violent Death Reporting System of women who died in the perinatal period - while pregnant or up to a year after birth - found 94 suicides and 139 homicides, or two suicides and nearly three homicides for every 100,000 live births. More than 54 percent of the suicides and 45 percent of the homicides of women involved IPV. Older White women were at greatest risk of suicide. Younger Black women, 24 years and younger, were most at risk for homicide. [620]

Unraveling all of the factors associated with suicide is not easy. A sample of 611 women living in an urban area, half of whom were HIV-positive, found that thoughts of suicide were most prevalent among infected women who also were victims of intimate partner violence. However, HIV-negative women who were abused were also at significantly elevated risk for depression, anxiety, and thoughts of suicide. [303] Another comparative study of women seeking medical treatment in four community-based primary care, internal medicine practices found those who had suffered abuse were more likely to have attempted suicide, but, significantly, did not have more hospitalizations for psychiatric disorders. [548]

Researchers, completing a World Health Association study in Pakistan on violence against women were struck by the strong association found between DV and suicidal thoughts among wives. In cases of physical and sexual violence, they found the risk of suicidal thoughts was elevated four times compared to those not exposed to this violence. In cases of psychological violence, measured as insults, intimidation, threats, and humiliation, it was elevated five times. [15]

Extensive research suggests that separation and divorce may be risk markers for suicide and suicide attempts, just as they are risk markers for lethal IPV. [414]

A study of African American patients in an urban public hospital in the South suggests, not surprisingly, that victims who had better positive coping skills for dealing with their abuse were less likely to attempt suicides than those without these skills. If battered women had good problem-solving skills, strong social supports, and operated from a

stance of greater empowerment, they were less likely to attempt suicide than their peers who accommodated abuser demands and felt themselves helpless to solve problems. [660]

Women are much less likely than men to complete suicides in general. According to the Violent Death Reporting System, women were most likely to use poison (40.8 percent) and firearms (31.9 percent) in their suicide attempts. The most common method used by male suicide decedents was a firearm (56.0 percent) followed by hanging/strangulation/suffocation (24.4 percent). The method of suicide attempt may account for the greater completion rate for male suicides over female suicides. [440]

Implications: Victim Advocates and Service Providers should raise the issue of suicide ideation and attempts with victims they serve. They should be familiar with suicide prevention and interventions strategies and programs. Physicians and other health care providers should be alert to the presence of IPV in responding to attempted suicides. Because the risk factors for IPV-related victim suicides are not fully understood, it cannot be assumed that standard IPV lethality or risk scales will identify the self-harm contemplated by these potential victims.

III. What is the Impact of IPV on Victims?

The impact of IPV is multifaceted and varied. IPV can impact individual victims, their children, third parties, and society as a whole.

Research suggests that the level of IPV, including frequency and severity, influences the impact on the victim with more severe, more frequent IPV increasing the impact. [106]

NISVS reports that lifetime IPV caused 18.8 percent of women to report at least one IPV-related impact (the survey measured) with the highest percent, 25.7 percent, reported being fearful while 10 percent reporting missing at least one day of work or school as a result of IPV. For women specifically, 1.5 percent reported contracting a sexually transmitted disease and 1.7 percent reporting becoming pregnant after being raped by an intimate. For men, the largest percent, 9.9 percent report at least one IPV-related impact, with the highest, 5.2 percent, reported being fearful with 3.9 percent missing at least a day of work or school. [68]

Only 19.2 percent of women who suffered IPV reported they experienced no IPV-related impacts while 65.3 percent of males who suffered IPV reported no IPV-related impacts. [68].

Recent research reveals that despite the expenditure of billions of dollars in the United States on health care every year, the United States ranks only 27 out of the 33 of the most developed countries in life expectancy at birth. According to the research, the dismal statistic is because of high infant mortality associated with pre-term birth and low birth weight, outcomes that may be directly linked to IPV. As the lead researcher concluded: "Women's health simply cannot be disentangled and addressed without consideration of women's freedom from violence and their access to education, employment, finances, decision-making power, health services, and other resources." [71]

Implications: Victim Advocates and Service Providers should be fully cognizant of the trauma and fear, as well as, the health, economic, dislocation, child custody, support community, reputation losses and costs imposed by IPV perpetrators. Almost all IPV victims experience IPV-related impact. IPV may have long-term impacts. In addition to providing immediate safety and emergency housing, the assistance of Advocates and Service Providers may mitigate adverse impacts and facilitate victim resilience.

What are the Costs of IPV?

According to the U.S. Centers for Disease Control and Prevention, the cost of IPV, including rape, physical assault and stalking, exceeds $5.8 billion each year. The survey costs were based on a nationally representative sample of 8,000 men and 8,000 women which suggested that 1.5 percent of women (1.5 million) and 0.9 percent of men (800,000) were raped or physically assaulted by their partner in the twelve months preceding the survey. [589] Nearly $4.1 billion of that amount is for direct medical and

mental health services. IPV incidents result in more than $18.5 million in the costs of mental health care visits each year. Costs also include $0.9 billion in lifetime earnings lost by victims of intimate homicides. The largest proportion of costs recognized is the result of physical victimization, the form of IPV captured in most calculations. The researchers, however, conclude that the above costs do not include all medical, social, and criminal justice services so that the costs presented "likely underestimate the problem of IPV in the U.S." [2]

A later estimate puts the figure higher–$8.3 billion. This cost includes medical care, mental health services, and lost productivity (e.g., time away from work). [537]

A Kentucky study breaks down the costs into two categories, direct and indirect. [504] Direct costs are those that require actual payments by individuals or institutions, generally medical and non-medical costs, e.g. the costs of health, mental health and victim safety services. Indirect costs may include civil or criminal justice system costs. They also include resources and opportunities lost to victims as a result of abuse and violence, e.g. reduced productivity, transportation costs, lost or damaged property. Indirect costs may also include less concrete damages, referred to as "pain and suffering" in civil law suits. The Kentucky study examined the costs incurred by victims as a result of abuse six months before and after a protective order was obtained to compare whether the protective order reduced these costs. [152, 505, 504, 537, 564]

The study examined the costs of health services, mental health services, victim services, legal fees, police and justice system, employment and lost earnings, family and civic responsibilities, transportation and lost property, and quality of life. In regard to the latter, victims were asked to detail the number of days they experienced serious stress, depression or anxiety due to the abuse. The maximum number of days for any one of these conditions was used as an index of the negative impact on quality of life. To create an estimated value for the cost of a day of stress, anxiety, or depression due to abuse, the cost of an outpatient visit to a mental health professional was used. Researchers concede this measure is inexact and conservative as it does not include the cost of medication victims may use to address these states or the long-term impact on health and other areas of life caused by prolonged stress, anxiety or depression. [503]

Not all victims in the study incurred all of these cost categories. In the six months before the issuance of the protective order, most victimizations (81.3 percent) resulted in police and justice system costs, followed by health services (66 percent), lost time from work, family or civil responsibilities (59.8 percent), victim services (36.8 percent), mental health services (30.6 percent), and legal (25.4 percent). In terms of dollar and cents, the cost per victim in Kentucky in 2007 was almost $17,500 per victim in the six months prior to the order and approximately $12,800 after the order for the next six months. The largest costs were associated with quality of life with these costs averaging $13,400 before and $8,500 after per person. Other major costs were health services ($1,613 before and $1,889 after), police and justice system costs ($1,432 before and $1,762). The study found differences in costs between those victims living in rural compared to urban

areas of the state. Costs also varied depending upon the behavior of the abusers including whether they obeyed the order, violated the no contact order or engaged in stalking. [505]

Given that in 2007, researchers estimated there were 9,531 orders issued for women in Kentucky, the total cost just for these female victims for one year totaled almost $300 million, including quality of life costs and $80 million not including quality of life costs. Female victims who seek protective orders represent only a small portion of abused victims in any given year. [505]

The researchers also estimated the savings to the Commonwealth of Kentucky through issuance of protective orders; they estimated cost savings of $85 million in a single year which they deemed to be a moderate estimate of KY's cost savings. [505]

A Canadian study found that IPV cost taxpayers and charities $6.9 billion a year in services for women long after they leave their partners. The annual bill from accessing health, legal, and social services by the women was $13,162 per woman, including doctor visits, legal aid and child protective workers as well as private, third party costs such as food-bank use and counseling. [816]

Implications: Victim Advocates and Service Providers can effectively address the short and long term costs of IPV for victims. IPV victimization has exponential adverse economic impacts on victims and society. The extent of real costs to victims and society is substantially greater than what is currently measured. Recovery of real victim costs requires higher restoration and restitution awards than those currently awarded victims. More than other criminal acts, IPV victimization has substantial adverse personal, social and economic impacts on victims in addition to social and economic costs on society. The full costs incurred by an IPV victim may be realized only after the abuser ceases the violent, controlling and exploiting behavior, which may continue long after the victim leaves the abusers.

What is the Impact of IPV on Victim Health?

Research suggests that victims of IPV make more visits to health care providers over their lifetime, have more and longer hospitalizations, and are more at risk for needing healthcare for a variety of problems than non-IPV victims. [37, 67] IPV impacts health in direct and indirect ways. Physical and sexual violence, for example, may lead to injuries that require treatment. Victims may adopt behaviors that cause adverse health impacts. For example, victims may turn to smoking or alcohol and drugs for self-medication to cope with the trauma of their victimization. [106, 155] The stress of IPV victimization may also result in cellular changes that adversely impact long-term health. [769]

Studies reveal that most IPV assaults do not result in major physical injuries. The NCVS, for example, reported that between 1993 and 2004, about 66 percent of IPV victims reported they were hit, slapped or knocked down. Notwithstanding the IPV, less than 20 percent of victims sought medical treatment for their injuries. [122]

In a community sample of women who had experienced assault by a partner in the previous six months, researchers found that, on average, women sustained three different types of injuries. Ninety two percent reported cuts, scrapes and bruises; 11 percent broken bones and fractures; and 3 percent gunshot or knife wounds. [769]

More than 1,000 women seeking health care were surveyed at 24 suburban, rural and urban emergency departments or primary care clinics. Researchers found that abused women reported significantly lower health status ratings than non-abused women. Emotional abuse was as strongly associated with health problems as physical abuse. The majority (70–93percent) of women with headaches, stomach problems, chronic pain, vaginal bleeding, substance abuse, depression, and suicidal thoughts had experienced lifetime physical/emotional abuse. [471]

IPV is associated with increased use of Emergency Departments and outpatient services. [673] It is estimated that more than 35 percent of all Emergency Department visits by women are the result of domestic violence, although most of the presenting injuries are not acute. Women IPV victims also present to Emergency Departments with somatic complaints (e.g. headaches), obstetric complications and mental health issues, such as depression and substance abuse. [109]

There is mounting evidence of cumulative and long-term adverse health impacts of IPV. [109] In comparison with non-abused women, abused women have been found to have a 50-70 percent increase in gynecological problems (e.g., sexually transmitted diseases, fibroids, pelvic pain, vaginal bleeding or infection and urinary tract infections), central nervous system problems (e.g., headaches, back pain, fainting or seizures) chronic stress related problems (e.g., gastrointestinal disorders, appetite loss) and viral infections (e.g., colds and flu). [109]

Findings from a small study on the impact of IPV on battered women who suffered recurring violence revealed that victims experienced exaggerated responses e.g., racing pulse, cold sweats, depression and PTSD, to negative cognitive stimuli. [480]

Not surprisingly, the adverse health impact of IPV may depend on the amount and severity of the abuse and the length of time the victim suffered the abuse. [158, 769]

Implications: Victim Advocates and Service Providers should assist victims in identifying health problems and obtaining continuing care from primary care providers or clinics. Health screenings should be utilized in all shelter and healthcare settings to determine the immediate, chronic and long-term health needs of IPV victims. Advocates and service providers should partner with healthcare providers to enhance identification of health challenges and the quality of treatment for the variety of health problems that IPV victims encounter. Healthcare providers should introduce victims to safety planning and to the range of victim advocacy and services in the community. The Affordable Care Act provides that new health plans

must include domestic violence screening and counseling along with other preventive services for women.

What Is the Impact of IPV on Victim Mental Health?

It is widely agreed that IPV can create serious and long-lasting psychological and emotional injuries for many victims [407], although not all victims are equally affected. Many symptoms, such as depression, may resolve when social support and safety increases for victims. [111, 776] For other women, however, being abused over a period of time may result in significant mental distress. For example, in a study with a large sample of randomly selected women, 48 percent of those who had been battered reported they had needed help with mental health issues in the past 12 months. [834]

NISVS asked IPV victims to rate their mental health. Both female and male victims reported higher rates of "poor" mental health than non-victims, although 3.4 percent of female victims reported "poor" mental health compared to 2.7 percent of male victims. Compared to non-victims, female victims were three times more likely to report poor mental health and male victims were only a little more than twice as like to report poor mental health. [68]

Victims may suffer low self-esteem, depression, hopelessness, anger, distrust, and anxiety. [278, 468, 670, 690, 306] IPV victims are more likely to suffer from depression than the general population [448, 837]. Many may contemplate or attempt suicide. [639, 737] An analysis of 16 published longitudinal studies involving more than 36,000 participants found IPV increased the likelihood of suicide attempts as well as doubling depression among women. The study also found the reverse, depressed women were more likely to experience IPV. Men who experienced IPV also experienced increased depression but no increase in suicide attempts and the depressed men were no more likely to experience IPV. [201a]

Studies consistently reveal that a large proportion of battered women suffer from posttraumatic stress disorder (PTSD). A meta-analysis across multiple samples of battered women, including those in settings other than domestic violence agencies (e.g., hospital emergency rooms, psychiatric settings), found a weighted mean prevalence of 48 percent for depression and 64 percent for PTSD. [306] Studies have found that half of the women who experienced PTSD remained symptomatic even after they had been out of a violent relationship for 6 to 9 years. [860]

Studies find that women victims of IPV can suffer the same PTSD symptoms as any other trauma survivor. They may become overly sensitive to situations that bring up the traumatic event causing a cognitive bias and developing physiological symptons such as a racing pulse or cold sweats that can impair their self-efficacy and coping strategies. In short, the study found that the women survivors were at increased risk for a cycle of self-defeating behaviors due to bias. [480]

One of the largest health surveys, conducted in 2009, for almost 50,000 households across California found that women were more than twice as likely as men to have been IPV victims. More than half of adult IPV victims experienced recent symptoms of serious

psychological distress such as anxiety and depression. Both male and female IPV victims were three times more likely than non-victims to report acute psychological distress in the past year. They were also far more likely to seek mental health care. Although women were more than twice as likely as men to have been IPV victims, both male and female IPV victims were more likely than non-victims to report serious psychological distress during the past year. One in three of IPV victims reported they needed help for a mental, emotional, or substance abuse problem. As a result, IPV victims were 2.5 times (23.9 percent) more likely than non-victims (9.5 percent) to report seeing their primary care physician, a psychiatrist, a social worker, or a counselor in the past year. [872]

NISVS found 22.3 percent of IPV victimized women reported PTSD symptoms over their lifetime as did 4.7 percent of IPV victimized men. [68]A significant correlate of PTSD is that many sufferers may self-medicate to reduce symptoms of arousal, to block out intrusive thoughts, to calm themselves, or to create numbness. [149, 386, 483] Binge drinking is also associated with IPV victimization. The large California survey, for example, found that more than half of the victims subjected to recent violence reported engaging in binge drinking over the prior year, significantly higher rates than non-victims. [872]

A study conducted in Israel compared battered women with other women who had also suffered traumatic events, but not from intimate partners. The battered women exhibited significantly higher levels of psychiatric symptoms and risk for suicide than the control group; 51.6 percent of the battered women suffered from PTSD. The findings emphasize the toll and severity of IPV trauma, even compared to other trauma experienced. [716]

Implications: Victim Advocates and Service Providers should have a rudimentary understanding of and ability to identify symptoms of psychiatric distress, including trauma, and the impact of such distress and trauma on victim participation in risk assessment, safety planning, shelter utilization and other counseling services, as well as, legal proceedings. Victim service programs should establish close working relationships with mental health providers and develop protocols for collaborative assistance to victims experiencing mental health problems.

Is the Health Impact of IPV Different for Women than Men?

Not surprisingly, because the level and context of abuse differs, so do the health impacts of IPV on females and males. Both NVAWS and NISVS data have disclosed the differences. IPV women (7.9 percent) reported needing more medical care than IPV men (1.6 percent). [67] Women IPV victims, for example, were injured twice as often as male victims during their most recent assault; 41.5 percent women compared to 19.5 percent men. Female victims (7.2 percent) were more likely than males (4.4 percent) to seek treatment in hospitals. [155, 122]

NISVS looked at victim reports of maladies and health conditions over their lifetime and found that with the exception of high blood pressure, the prevalence of adverse physical health outcomes was significantly higher for IPV women victims of rape, stalking (by any perpetrator), or physical violence by an intimate partner. The adverse health impacts identified included asthma, irritable bowel syndrome, diabetes, frequent headaches,

chronic pain, difficulty sleeping, and activity limitations. IPV female victims reported their overall health to be "poor" at a rate three times higher than non-victimized women. In comparison, there were no significant differences between men who had been raped, stalked or a victim of IPV and those who had not; measured by the prevalence of asthma, irritable bowel syndrome, diabetes, or high blood pressure. Victimized males, however, were more likely to suffer from frequent headaches, chronic pain, difficulty sleeping, and activity limitations than non-victimized males. Also, victimized males were twice as likely to report "poor" health than non-victimized males. [67] NISVS documented that 22.3 percent of IPV victimized women identified PTSD symptoms over their lifetime compared with 4.7 percent of IPV victimized men. [68]

NISVS also found that 14.8 percent of women victims reported injuries as a result of IPV over their lifetime compared to 4.0 percent of male victims. In addition, 7.9 percent of victimized women needed medical care, compared with only 1.6 percent of victimized males. [68]

Implications: Victim Advocates and Service Providers should assist victims in identifying acute and chronic health problems resulting from IPV. Parity in treatment and service provision between men and women victims of IPV is not indicated based on the differential impacts of types and prevalence of abuse suffered by men and women.

Why May the Adverse Mental and Physical Health Effects of IPV Remain Long after the Abuse Has Ended?

Breakthroughs in genetic research reveal that IPV can cause molecular changes in victims. A recent study found that IPV is linked to cellular damage in victims, perhaps explaining why the detrimental health impacts of IPV may last years after the abuse ends. The exploratory study of 112 women ages 18 and older, 66 of who had experienced IPV in the past, and 46 of whom had not, found the former had cellular damage. The longer they experienced the abuse, the more the damage by a factor of five to 10 times as much. The abused women also had higher unhealthy body mass index (BMI) findings. [410]

The abused women reported an average length of time in the abusive relationship of a little less than five years. All of the abused women had experienced psychological aggression; 80 percent reported severe physical assaults, 58 percent suffered severe physical injuries; and 50 percent experienced severe sexual coercion inflicted by their abusers. Despite the passage, on average, of five years since the last abuse, tests revealed that the abused women had shortened telomeres when compared with those who had not been abused. Telomeres are a region of repetitive DNA sequences at the end of chromosomes which protect people from deterioration or from fusion with neighboring chromosomes. The lead researcher explained, "Until now, no one has been able to figure out how someone can have all these problems years after the trauma or stress occurred." [410]

Initial research linking chronic stress with cellular damage studied women who experienced chronic stress from caring for their chronically ill and disabled children. This recent study adds to a growing body of literature that finds exposure to life stresses endanger not just the mind, but also the body, with actual damage on the molecular or cellular level. [410]

Implications: Victim Advocates and Service Providers should advise IPV victims of the long-term damage that may be caused by the stress precipitated by IPV. The association between stress and cellular damage suggests potential strategies that might, at least, limit or interrupt the damage that stress inflicts on victims' bodies.

What Are the Special Risks of IPV for Pregnant Women?

Domestic violence significantly increases the risk of pregnancy trauma and placental abruption which account for more than ten percent of perinatal deaths. If women suffer domestic violence during the prenatal period, they are 30 times at risk for clinical pregnancy trauma and 5 times higher risk for experiencing placental abruption compared with women who did not report domestic violence. Researchers looked at medical records for more than 2,873 diverse women who gave birth in 2000 to 2002 in Syracuse, New York. They found that 3.7 percent reported domestic violence during the prenatal period. Even after controlling for other risk factors and social demographic variables associated with pregnancy trauma and placental abruption, IPV was found to be an independent and significant risk for pregnancy trauma and placental abruption. [484]

IPV during pregnancy is associated with additional adverse pregnancy outcomes, including preterm birth and having a low birth weight baby [9], as well as increased risk of cesarean delivery, uterine rupture, hemorrhage and antenatal hospitalization. It is also linked with higher rates of maternal morbidity, including low weight gain, anemia, kidney infections, and first- and second-trimester bleeding. IPV is also a cause of depression and other psychological problems. [18, 583, 156] Women who are abused during pregnancy are more likely to delay entry into prenatal care. [622]

In fact, despite the expenditure of billions of dollars on health care in the United States, the US ranks 27th out of 33 developed countries for life expectancy at birth because a significant cause of infant mortality is complications related to pre-term birth and/or low birth rate outcomes linked to IPV. [71]

Implications: Victim Advocates and Service Providers must fully understand that violence during pregnancy is a 'quintessential threat' to maternal and child health. Pregnant victims should be encouraged to obtain prenatal care. Health care providers should screen all women patients for IPV, particularly pregnant women. Advocates and Service Providers should educate health care providers about the economic and social resources available to women subjected to IPV. Partnerships should be formed between health care providers and shelters to encourage health screening, as well as, primary and pre-natal care.

What is the Relationship Between Abuse During Pregnancy and Post-Partum Depression?

Studies, in Los Angeles, Brazil, Australia and the United Kingdom, have all documented a significant association between intimate partner violence and post-natal depression. They first looked at 210 low income Latina women from two clinics in Los Angeles, finding that those who endured violence at the hands of a partner during or within a year of pregnancy were more than five times (5.4) more likely to suffer postpartum depression than women who had not experienced such violence. In fact, intimate partner violence turned out to be a much stronger prenatal predictor of postpartum depression than even prenatal depression, generally considered the most significant predictor. In addition, the intimate partner violence had a stronger effect on postpartum depression than prior episodes of trauma from either partners or non-partners. [815]

The Brazilian study found the association between intimate partner violence and postnatal depression, but also found that intimate-partner psychological violence during pregnancy was strongly associated with the development of postnatal depression, independent of accompanying physical or sexual abuse. The study involved 1,045 pregnant Brazilian women. It also found that psychological violence was the most common form of intimate partner violence in the study. [506]

The Australian study found that 40 percent of first-time mothers reporting depression post-partum also reported IPV. The risk of post-partum depression was found to be three times higher for women suffering emotional abuse and four times higher for those suffering physical abuse. Most of the reports of depression occurred more than six months after delivery. [864]

The UK research assessed 13,617 women and found that those who suffered emotional or physical abuse during pregnancy were 2.5 times more likely to have depressive symptoms when their child was eight weeks old (25 percent) compared to those who had not (10 percent). The study also found that while seven percent of the women reported emotional and/or physical violence at 18 weeks gestation, at 33 months after the child was born, rates increased to 14 percent of the women experiencing domestic violence. Almost three-quarters of women who experienced antenatal domestic violence pregnancy also experienced post-natal violence. [275]

Implications: Victim Advocates and Service Providers should inquire of women recipients of IPV service whether they experienced prenatal depression. Providers should share information about interventions that may prevent the onset of postnatal depression and its adverse consequences for mother, infant and family.

Can Prenatal Exposure to IPV Adversely Affect the Health of the Child?

Prenatal exposure to maternal stress caused by IPV can have lifelong implications for the child, including behavioral problems and even mental illness. A recent small study of 25 children, teens and their mothers found that children, even teenage children, whose mothers had been abuse victims during pregnancy, had altered expression of a gene linked to stress response and behavioral problems. The research suggests that the genetic alteration associated with their mother's abuse while pregnant could impair their ability to cope with stress and the altered gene expression in the womb can persist into adulthood. [650]

Another study looked at the specific behavior of children of women who had experienced antenatal violence. It documented the children were more likely to have behavioral problems. The behavioral problems of these children, recorded at 42 months of age, included hyperactivity, emotion, and conduct problems. Antenatal violence was more commonly reported in the mothers of children with behavioral problems at 42 months (11 percent) compared with mothers with children with no problems (7 percent).[275]

Further, a large study of more than 5 million pregnant women in California over a 10-year period (1991-2002) found an association between IPV assaults and low birth weight babies. [9] Infants born to women who were hospitalized for injuries received from an assault during their pregnancies weighed, on average, one-third pound less than did infants born to women who were not hospitalized. Assaults in the first trimester were associated with the largest decrease in birth weight. Low birth weight babies have an increased risk of death or of developing several health and developmental disorders, including greater risk for sudden infant death syndrome (SIDS), breathing problems, cerebral palsy, heart disorders and learning disabilities.

Implications: Victim Advocates and Service Providers should collaborate with pregnancy, post-natal and early childhood programs to prevent and reduce IPV to reduce the number of low birth weight infants and improve the prospects for these babies' lives over time.

Is There a Link Between Abortions and IPV?

Numerous studies here and abroad link abortions with domestic violence. The link ranges from 20 percent in Canada for physical abuse and 27 percent for sexual abuse [274], to 33 percent in New Zealand [849], and 35.1 percent in England. [442]

Research in the United States found that of the women having abortions in North Carolina up to 31.4 percent had experienced physical or sexual abuse at some time in their lives and, of these, more than half had witnessed domestic violence as children. Almost 22 percent had experienced abuse over the past year. [246]

A more recent study of 986 women seeking abortions in Iowa found nearly 14 percent had experienced intimate partner violence in the previous 12 months. [691] Interestingly, however, the abuse was mostly (74 percent) not by the current partner. One researcher surmised that the women may seek an abortion after leaving an abusive relationship for

fear of the former partner harming the child, especially when the former partner is the biological father.

A study in Quebec compared women seeking abortions with those who did not. It found significant differences in demographics between pregnant women experiencing IPV and those not. Those seeking abortions were younger, single or in a relationship "that was in difficulty or breaking down," less educated, had lower incomes, had a prior abortion, and their pregnancies were more likely unplanned. They were also significantly at greater risk for being victims of abuse, including abuse over their lifetime, as well as physical, psychological, and sexual abuse in the past year. The risk of physical and or sexual IPV in the past year was almost four times higher for the women seeking an abortion than those continuing their pregnancies. Although women with planned pregnancies were less likely to seek abortions, the majority of women with planned pregnancies seeking abortions had suffered abuse. Researchers concluded the IPV victims changed their minds and sought abortions so as "not to bring a child into the world under conditions of violence." [76]

Implications: Victim Advocates and Service Providers who encounter abused women seeking abortions should be as supportive of a woman's choice as they are of other decision-making of victims and be prepared to make referrals to appropriate health services. The high prevalence rates of IPV among women seeking elective abortions calls for routine assessment for IPV during health visits related to abortion. Advocates and Service Providers should assist medical personnel in responding to the service and safety needs of abused women both before and after abortions.

Are Abused Women at Special Risk for HIV Infection?

The association between IPV and increased risk for HIV has been identified in multiple studies here and abroad. [154, 615, 700, 867] For example, among adolescent girls diagnosed with HIV or another sexually transmitted infection, more than half suffered physical or sexual intimate partner violence. Compared to their non-abused peers, abused teens were 2.5 times more likely to be infected. [190] More than, 55.3 percent of American women with HIV/AIDS suffer IPV, more than twice the national rate [814]. Almost 12 percent of HIV infected women were infected by their abusive partner. Women in abusive relationships have been found to be more than three times as likely to have HIV infection as women who are not suffering abuse. [512, 513, 522, 700] In 2010, women received 25 percent of the new AIDS diagnoses, up from 8 percent of the newly diagnosed in 1985; and women were 25 percent of the population living with AIDS in the U.S. [140] AIDS is now the leading cause of death among African-American women age 25 to 34. Adolescent and young women, particularly those of racial and ethnic minority groups, are disproportionately affected by STIs and herpes simplex virus. [137] Having a STI or herpes is proven to increase a woman's susceptibility to contracting HIV if exposed to it. [291]

For abused girls and women, the growing number of those infected is not because of their high risk behavior, but because of the high risk behavior of their abusive partners. One study, for example, documented that many young men who perpetrate IPV (physical or sexual) are more likely to have HIV or other STIs, than non-abusers. Further, they are more likely to coerce partners into nonuse of condoms, to have other partners, and to engage in transactional sex. [189, 404, 474, 665, 676, 722, 723, 781, 783, 782, 857]

Implications: Victim Advocates and Service providers should be knowledgeable about HIV/AIDS and be informed of the heightened risk for battered women. The standard chapter of any *sexual abuse curriculum* for staff of victim services should include a section on "reproductive coercion" as well as the risks for HIV/AIDS and other STIs posed by male perpetrators of IPV. "Condom coercion" should be emphasized as an important factor contributing to risk of HIV/AIDS/STI.

What Are the Effects of Economic Abuse?

At its worst, economic abuse by intimate partners can propel victims into poverty. IPV is associated with an elevated likelihood of welfare receipt, welfare dependency and cycling on and off of welfare. [796] More than half of women receiving public assistance have been or are currently victims of IPV. The loss of economic support from abusers and the barriers to economic independence erected by abusers frequently compel victims to seek public welfare and other government benefits. [508]

Economic abuse of intimate partners frequently results in homelessness for victims fleeing from abusers. Of the adults sheltered in facilities for homeless people across the nation in 2010, 12.3 percent were victims of domestic violence. This does not include the thousands of victims housed in specialized domestic violence shelters. [810, 882] According to the National Network to End Domestic Violence's Census, on September 15, 2011, 36,322 women and children were temporarily housed in domestic violence shelters and transitional housing programs, and 31,007 were provided non-residential services that included numerous economic supports. [592]

Economic abuse coupled with physical and sexual violence often pushes battered women into poverty. [508]

Even if not impoverished, studies find that victims of IPV also experience psychological trauma derived from the economic abuse. [796] Adults economically abused by their intimate partners have been found to be 5 times more likely to be physically assaulted than those who are not economically abused. [618] Economic abuse by the father of an abused woman's children is more predictive of depression over time than other forms of abuse. [643] Financial difficulties lead to depression, make trauma worse, and decrease self-efficacy. [5] Further, women victims have been found to be at heightened risk of abuse as they seek economic self-sufficiency. [801]

The Scale of Economic Abuse (28 items) was developed to measure the numerous ways and the extent to which IPV perpetrators interfere with victims' acquisition of assets,

retention of employment, expenditure or savings of their own incomes, matriculation through post-secondary education, creditworthiness, maintenance of transportation, stability of child care enrollment, and even sufficient food, clothing, shelter and healthcare. Participants in a study on economic abuse of IPV women victims, ranging from 18 – 85 years of age, suffered physical abuse in the previous 6 months of their relationships with abusers (98 percent), sexual assault (57 percent) and strangulation (65 percent). Virtually all of the abusers also imposed economic control or exploitation at some point in 8-year average of their relationships with the IPV victims (99 percent). Economic abuse was a successful strategy to keep abused women in relationship, most often on the edge of poverty, for long periods of time. [5]

Although, advocates, legal system professionals, healthcare providers and policymakers began to address the economic challenges confronted by victims of IPV twenty years ago, research confirms that concerted initiatives to create economic opportunity and to remediate the effects of economic abuse are relatively recent endeavors. [641, 698]

Implications: Victim Advocates and Service Providers are vital actors in the collaborative community efforts to broker economic resources for IPV victims, create opportunities for asset development, expand educational and job-related knowledge and skills, establish affordable, safe temporary and permanent housing, and gain restitution to fully compensate for economic losses sustained as a result of the violence of the IPV perpetrator. Coordinated community responses for economic capability and stability are nascent endeavors in most communities. Development of these networks for economic opportunity and restoration will build systems for economic empowerment and security for victims of intimate partner violence.

Does IPV Contribute to Homelessness?

Many women and children seek domestic violence shelters for the safety and support these specialized shelters offer. Others do so because they have no resources to find alternative housing. For this reason, many victims also rely on emergency shelter in non-domestic violence shelters as well as domestic violence shelters.

Across the country as a whole, more than 80 percent of homeless mothers with children experienced domestic violence in their lifetime. Intimate partner violence is a significant precursor to homelessness. [447, 686, 734, 809, 805] A 2010 Connecticut examination of its homeless population utilizing state supported emergency housing, for example, found that more than half (56 percent) of adults with children said they had been in a family or intimate relationship in which they had been physically injured or threatened and 41 percent reported that domestic violence had directly contributed to their current homelessness. These homeless did not include those who obtained shelter in Connecticut's separately administered domestic violence shelters. In addition to the state's 24 emergency shelters, there are another 18 state funded domestic violence shelters. At the same time the emergency shelters housed 11,700 individuals in 2010,

including 1,500 children, the domestic violence shelters served another 1,100 women and almost as many children. [80]

Almost half of the homeless families in the Connecticut emergency shelters were newly homeless, never having had to stay in shelters before. A little less than 40 percent in shelter were newly homeless in 2010. Asked why they left their last permanent residence, among the newly homeless families with children, 20 percent said it was because of domestic violence. Among those who had been previously homeless it was 14 percent. Fewer shelter residents were without children, seven percent for childless households among the newly homeless and five percent for the previously homeless. [80]

Intimate violence was also among the top three reasons that Connecticut youth were homeless. [80]

An earlier Rhode Island study found that although most "sheltered" victims of domestic violence were housed in domestic violence shelters, some victims utilized the state's emergency shelters even though there were beds available in the domestic violence shelters most nights. [458] Among women utilizing non-domestic violence emergency shelters, 22.4 percent of single women and 39.6 percent of women with children reported domestic violence to be the primary reason for their seeking shelter in 2002 and 2003. [389]

Homeless victims of intimate partner violence are more frequently and severely assaulted and injured than "housed" battered partners. [844] In a recent study of homeless people in four cities in Florida, homeless women reported rates of physical and sexual violence, stalking, and injury that were much higher than those reported by women in the NVAWS. [422] Sixty-one percent of homeless women in a study in a northern city stated that their male intimate partners had severely abused them. The rate of IPV among "housed" poor women in the same northern city was substantially lower. [91]

Homeless victims are vulnerable to violent victimization beyond IPV because of the circumstances in which they live (e.g., panhandling, selling drugs, exchanging sex for money/shelter, sleeping in the streets and in mixed gender homeless shelters). [784] Homelessness exposes them to violent perpetrators but does not provide them with the allies and bystander interveners that many "housed" battered women have. Homeless women may be victimized as many times in one year as the average woman in the U.S. is victimized in her entire lifetime. [843]

One study of homeless shelters and DV shelters in upstate New York found that the women in both types of emergency housing had similar problems and required similar assistance to return to safe and affordable housing. Both groups of women had experienced IPV within the last 3 months (21 percent for homeless and 73 percent for DV shelter); lacked sufficient food (48 percent for homeless and 33 percent for DV shelter); income inadequate to pay rent (34 percent for homeless and 22 percent for DV shelter); no funds to pay utilities (both shelters 33 percent); unable to purchase necessities such as diapers or prescriptions (both shelters 33 percent); problems accessing childcare,

transportation (equivalent); difficulties in making scheduled appointments and meetings (equivalent). As there is considerable overlap in the problems of women in both types of shelters, the researchers suggest that the homeless and the DV programs in each community should work together to meet the similar needs of their respective constituencies. [392]

Implications: Victim Advocates and Service Providers should collaborate with non-domestic violence emergency shelters to offer assistance to the significant number of IPV victims who seek refuge in these shelters. Domestic violence CCRs (Coordinated Community Response initiatives), already existing in many communities, should consider establishing programs that provide victims of IPV both permanent housing and the social, education and economic resources essential to sustaining economic capacity and stability.

What is the Impact on Children Who Are Exposed to IPV?

Child exposure to adult domestic violence may be associated with significantly greater behavioral, emotional, and cognitive functioning problems among children, as well as continuing difficulties into adulthood. [23, 229, 235, 253, 482, 526, 602, 609, 683, 244]Two meta-analyses find that children exposed to domestic violence exhibit significantly worse problems than children not exposed. [450, 858] Short-term impacts include aggression and delinquency; emotional and mood disorders; posttraumatic stress symptoms, health-related problems, social, academic and cognitive problems. Long-term impacts include an increased likelihood that a child will become either a victim or perpetrator of aggression later in life. [232] The impacts on children exposed to domestic violence often were similar to the impacts on those children who were physically abused. [450]

Another study finds that exposure to IPV increases a child's sensitivity to detect potential threats by actually altering the brain similar to brain changes experienced by soldiers exposed to military combat. The study used functional brain imagining and found the enhanced reactivity to a biologically salient threat cue such as anger may represent an adaptive response for these children. The adaptive response may help keep them out of danger in the short run. However, it may also constitute an underlying neurobiological risk factor increasing their vulnerability to later mental health problems, particularly anxiety. For example, when presented with angry faces, children with a history of abuse or abuse exposure, show heightened activity in the brain's anterior insula and amygdala, regions involved in detecting threat and anticipating pain, the same pattern of heightened activation in these two areas of the brain experienced by soldiers. The research suggests that both exposed children and soldiers may adapt to becoming "hyper-aware" of danger in their environment, the brain's way of adapting to a challenging or dangerous environments. Those shifts may come at the cost of increased vulnerability to later stress. [541]

A most recent study finds that childhood exposure to IPV, especially before two years of age, is associated with a seven point drop in a child's IQ. [244] Another study of children

exposed to IPV before age three suffered no behavior problems at first but by the time they entered school at age five they became overly aggressive. The researcher labeled this a “sleeper effect” of IPV. [

Not surprisingly, found that children ages eight through 16 years old witnessing IPV was associated with sleep problems. The more IPV witnessed, the greater the sleep was adversely impacted. The study followed the children for three months. [733a]

Assessment of the impact of exposure on children varies among children and is complicated because there is a close association between exposure to IPV and child physical and sexual abuse. The National Survey of Children’s Exposure to Violence (NatSCEV) revealed that children exposed to IPV may suffer more severe maltreatment than children living without IPV. [271] Physically maltreated children exposed to IPV experienced more injuries, sought more medical care for injuries, and were more likely to have maltreatment incidents reported to police. These children felt greater fear during episodes of child maltreatment than abused children not exposed to IPV. Neglected youth reporting exposure to IPV were more likely to report illness deriving from the neglect. [358] Prior research has found more severe behavioral problems in children who were both maltreated and exposed to IPV. [121, 407, 745]

A study of the impact of domestic violence on the children of battered women in Latin America offers preliminary findings that children whose mothers suffered IPV are likely to have lower weight and height, a lesser likelihood of vaccinations, and more reported diarrhea compared to children whose mothers were not so victimized. [9]

A small, preliminary investigation revealed that the prevalence of victimization of children (ages 12 – 15) of battered women through teen dating violence and bullying is significantly higher than the figures found in national studies. Half of the teen children of battered mothers experienced dating violence that involved psychological abuse, 28 percent physical abuse, 36 percent sexual abuse, and 36 percent cyber-abuse (i.e., electronic methods of harassment and psychological abuse). [286] Prior national studies, the Youth Risk Behavior Survey (YRBS) [134] and the National Longitudinal Study of Teen Health (Add Health) [348], had shown much lower rates of physical victimization by teen partners, 9.4 percent and 12 percent, respectively. The sample in the investigation was teens whose mothers had been abused and were separated from their batterers. On average, the teens had been exposed to IPV for 6.9 years, and 80 percent witnessed IPV by their biological fathers The national samples did not measure exposure to IPV.

Research suggests a different impact on boys than girls. In a review of the literature on children exposed to IPV, one scholar suggests that in general, boys exposed to IPV may experience more frequent problems and may be more likely to “externalize” or “act out,” e.g. act with hostility and aggression. Girls may be more likely to “internalize” problems, e.g. experience depression and somatic problems. [121, 733] There is some evidence that as girls get older, they may demonstrate more aggressive behaviors. [733] A minority of research that reveals that girls exposed to IPV externalize their problems more than boys.

[177]

One study of 550 undergraduate students revealed that exposure to IPV as a child was associated with reports of depression, trauma-related symptoms and low self-esteem in women students but only trauma-related symptoms in male students. The researchers found that exposure to IPV, notwithstanding being abused as children and independent of parental alcoholism and divorce, accounted for a significant amount of their adult problems. [723]

Impact may vary with the age of a child's exposure. Exposure to IPV can have notable impact on very young children. A study of 116 mother-child dyads found that preschoolers, 4 to 6 years old, are able to meaningfully respond to statements about parental IPV. Both mothers' and children's reports of violence were significantly associated with children's appraisals of threat, but not with appraisals of self-blame. Girls reported significantly higher levels of self-blame than did boys. [558] Another pre-schooler study revealed that children exposed to IPV often exhibit significant behavioral problems. They experienced more negative affect, responded less appropriately, were more aggressive with peers, and were more ambivalent with teachers than children not exposed to IPV. [484] Yet, even very young children (between 1 and – 2.5 years) may attempt to actively intervene in conflicts and IPV. [173]

Impact may vary based on the child's relationship with the abuser. Little research has been undertaken on the impact on the child of his/her relationship with the mother's abuser. The findings of a clinical study of 80 mothers and 80 children from two DV shelters in a mid-sized city reveal that the impacts of exposure to IPV are complex and varied. Most child participants in the study were functioning at average and above levels of self-competency and self-worth with minimal evidence of behavior problems. Their mothers had suffered extensive abuse in the months prior to the study. Biological fathers were significantly more abusive to mothers than stepfathers or non-father figure partners. The children suffered a comparable amount of physical abuse themselves from the three groups of abusers. However, children were more fearful of and more often targeted with psychological abuse by stepfathers. Biological fathers were the most emotionally available to the children. The levels of competency evidenced by the children whose mothers' abusers were biological or stepfathers were lower than children whose mothers were beaten by non-father figures. Overall, it appears that compromise of the children's well-being was greater when abusers were biological and stepfathers. [761]

The impact of exposure to IPV may vary based on the child's relationship with the mother. Although one study demonstrated that IPV may have a positive effect on victim-mother parenting and child-mother attachment, it, nonetheless, found that IPV may negatively affect the interaction of children with battered mothers, while not adversely affecting their general behavior. [484] When mothers exhibit stress, some research shows that children have increased behavioral problems [392, 484, 484], while other investigations reveal that a mother's poor mental health did not affect children's behavior. [541, 761]

In another investigation, linking childhood exposure to IPV and other family abuse with their adult IPV, researchers analyzed 453 individuals who were in committed relationships where IPV occurred and evaluated the levels of interparental aggression, mother-to-child aggression, father-to-child aggression, and other forms of family violence that the participants had experienced during childhood. The most common type the participants had survived was interparental violence, followed by mother-to-child aggression. When both partners came from homes with interparental aggression or mother-to-child aggression, their risk for IPV was much higher. Individuals who were exposed to multiple types of family-of-origin~~al~~ violence were more vulnerable to IPV. [288]

Impact may vary based on the amount of adverse experiences a child suffers or is exposed to during childhood. Childhood exposure to IPV against their mothers may increase the rate of health problems experienced by the children in adulthood. The more exposure a child has to an array of dysfunctional parental behaviors and child maltreatment or victimization, the greater the risk of health problems in adulthood, particularly severe obesity, alcoholism or use/injection of illicit drugs, depressed moods, smoking (lung cancer), physical inactivity, sexually transmitted diseases, suicide attempts [262] and premature mortality. [87] Living in poverty may be associated with increased behavior problems in children exposed. [535]

Some studies have found children who showed no adverse impact. [341, 407] Other studies found that exposed children maintained "positive adaptation" when they were characterized as having "easy temperaments" as compared to their peers who were non-resilient. Generally research suggests resilient children are less affected by witnessing IPV when they have a positive and supportive caregiver-child relationship, competent parenting (structured and warm), and positive caregiver mental health, or the child had an easy/engaging temperament~~,~~ and higher cognitive ability. [341, 407, 533, 535, 790, 868]

The NatSCEV reported that most children are not passive observers of violence, including IPV. Almost half yelled to try to stop IPV (49.9 percent) or tried to get away from it (43.9 percent). Another quarter (23.6 percent) called for help. [354, 355] These findings parallel those found in clinical reports. [7A, 232, 234]

Implication: Victim Advocates and Service Providers, recognizing the potential adverse impacts of IPV on children exposed and the potential resilience of these children when they have supportive caregiver-child relationships, as well as recognizing the great variance among children exposed, should develop curricula for both the children exposed and the battered parent to mitigate adverse outcomes for children to IPV exposure and to facilitate the strengths of both the child and battered parent. Beyond educational venues, providers should engage abused parents and children in on-going conversations about methods of mitigating adverse impacts and strategies for enhancing child resilience.

Does Exposure to IPV Increase Likelihood that a Child Will Become Involved in IPV as an Adult?

Not surprisingly, research suggests that IPV may start a chain reaction of anti-social behavior in the following generation [526, 527] Exposure to IPV has been found, for example, to adversely affect children's ability to regulate their emotional responses to conflict, laying the groundwork for the child's election to engage in violent relationships. One long-term, 25 year study, involving 678 parents and 396 of their offspring over three generations found that IPV influences the replication of antisocial behaviors for the subsequent generations. In particular, in the second generation, children exposed to IPV showed significant risks for conduct disorder in adolescence as well as adult anti-social behaviors. The experiences of the second generation, both as children exposed to IPV and as adults engaging in IPV, predicted behavior problems in their children, the third generation. IPV predicted higher levels of emotional expressivity, aggression, hostile reactivity, and depressive mood in offspring. [235]

The researchers concluded that IPV resulted from the fact that IPV by adults exposed as youngsters resulted because IPV increased the risk for children's difficulties with "impulsive emotionality and aggressive personality styles in adolescence." These traits are in place long before their own adult intimate relationships begin, increasing the likelihood that the adult exposed in childhood may use violence when conflict arises in adult relationships. [235].

One of the numerous reports from the California health study found that witnessing IPV as a child doubled the risk of adult victimization in females and doubled the risk of adult perpetration in males. Men who were physically and sexually abused and exposed to IPV as children were 3.8 times more likely than other men to perpetrate IPV as adults. [848]

Unfortunately, research that investigates the specific experiences (e.g., relationships, peer supports, positive decision-making and critical thinking development) of those children exposed to IPV who elect to be non-violent, respectful of partners, committed to mutuality and equality in relationships, and perhaps engaged in violence prevention either formally or informally, is not yet a robust field of investigation for IPV researchers.

Implications: Victim Advocates and Service Providers should reassure parent-victims of IPV and adults who were exposed to IPV as children that their destinies and that of children exposed to IPV are not predetermined.

Are Children Exposed to IPV More Likely to Suffer Child Abuse?

The overlap between children witnessing intimate partner violence and being abused themselves is widely documented. [23, 377, 437, 486] Over 30 studies show a 41 percent median co-occurrence of child maltreatment and adult domestic violence in families. [230]

Data from NatSCEV found witnessing partner violence is very closely associated with several forms of maltreatment as well as exposure to other forms of victimization. [271, 358] More than 1/3 (33.9 percent) of youth who witnessed partner violence had also been

maltreated in the past year (56.8 percent over their young life), compared with just 8.6 percent of non-witnesses. Neglect and custodial interference were most closely associated with child witnessing. In fact, custodial interference was found to be rare among youth with no history of witnessing partner violence (1.5 percent) compared to youth witnesses (20.1 percent). Almost 3/4 (72.3 percent) of the youth who had experienced custodial interference had also witnessed partner violence. More than 70 percent of the youth who had been sexually abused by a known adult also had witnessed partner violence. Fully, 90 percent of children exposed to IPV saw the violence rather than indirectly experiencing it, such as overhearing it, or observing injuries after the fact.

The differences are also substantial for more common forms of maltreatment. Physical abuse was reported by 4.8 percent of non-witnessing youth but nearly 31.1 percent of witnessing youth. The findings for psychological abuse were similar. Witnessing youth are 3–9 times more likely to be maltreated as non-witnessing youth.

A study conducted by a large HMO in California revealed that when mothers were subjected to IPV, their children were at elevated risk for physical (31 percent), psychological (34 percent), and sexual (41 percent) abuse, as well as mental illness (38 percent) and substance abuse (59 percent). [872, 873]

Implications: Victim Advocates and Service Providers should share information from the NatSCEV and related research about the elevated risk of maltreatment and neglect of their children in the context of IPV and explore strategies to avert such maltreatment. However, victim parents must be advised that close, nurturing relationships of children with the non-abusing parent (and other family and friends who do not interfere with the custodial relationship of the child with the non-abusing parent) can avert or mitigate the adverse impacts of IPV on children. Opportunities for children to gain support and connection with children's violence prevention programs should be explored with the battered parent.

Is Abnormal Sexual Behavior by Children Linked to Exposure to IPV?

It is widely held that the aggressive, abusive and abnormal sexual behaviors in children between two and six years are typically the result of the children having been sexually abused themselves. Research, however, also links such behavior to children witnessing IPV in their homes. [445] Among children who exhibit abnormal sexual behavior, a majority report living with an adult batterer. [321, 721] Abnormal child sexual behavior includes sexual behavior with children who are four years or more apart in age, sexual behavior displayed on a daily basis, sexual behavior that results in emotional distress or physical pain, and sexual behaviors that are persistent.

Implication: Victim Advocates and Service Providers should alert abused parents to the possibility of abnormal sexual behavior by children exposed to IPV. Abused parents should, likewise, be informed about sexual behaviors that are normal and abnormal for children of various ages. Options for treatment should be explored if abnormal behaviors become apparent. Professionals who assess and treat child

sexual behavior problems should be carefully screened by IPV programs related to their understanding of IPV and the vulnerability and strengths of abused parents.

How Can The Impact of Child IPV Exposure Be Measured?

A number of different scales have been developed to measure children's exposure to abuse. Researchers have found them largely wanting. [231] Some scholars, advocates and clinicians suggest that in order to understand the impact of child exposure to domestic violence, one must look at the nature of the exposure, the manner in which the child was exposed to it, the child's reaction to it, specific risk and protective factors present in the individual child's life, including the co-occurrence of maltreatment, the efficacy of the child's coping skills, the support and nurturing available from significant adults, as well as how the child specifically processes his/her experiences [232].

Researchers have created a 42-item Child Exposure to Domestic Violence Scale (CEDV) that is designed to be self-administered by children from the ages of 10 - 16. The CEDV was reviewed by an international panel of experts to establish face validity. Subsequent tests had found that the CEDV appears to be a valid and reliable measure of the level of exposure to domestic violence from a child's perspective. [232]

Domestic violence programs have developed numerous tools to assist abused mothers and children to talk about the violence inflicted on mothers that the child has seen, ~~or~~ heard or apprehended. The tools invite the child and mother to talk about the various consequences of the violence. Guides also suggest ways that mothers and advocates can talk with children about the violence they have experienced in their lives (within the family and beyond), their feelings about the violence, the perpetrator, bystanders and themselves, the risks posed by the violence to them, and the effects of the violence on them. The tools and guides also are designed to engage advocates, children and mothers to talk about safety planning, risk avoidance, and employing allies to assist them when violence occurs. No research is known as to the validity of any of these "conversational guides."

Implications: Victim Advocates and Service Providers may elect to evaluate the utility of the CEDV in helping older children reflect on the violence in their lives and consider the potential benefits of child and teen programs at DV shelters, school programs, faith communities and child treatment programs. A number of online resources to support the use of the CEDV are available.

IV. Who Abuses?

Although some sociological research [756] based on self-reporting finds equal rates of male and female partner **conflict** (including mostly minor physical assaults), behavior that is likely to violate most state and federal criminal and civil (protective order) statutes is typically perpetrated by males. [452, 515] For example, 86 percent of abusers brought to court for restraining orders in Massachusetts were male, [7] as were those arrested for domestic violence in California [866] and Charlotte, N.C. (as much as 97.4 percent for the most serious cases). [287] In Rhode Island, 92 percent of abusers placed on probation for domestic violence were male. [287, 4] A Cincinnati court study found 86.5 percent of 2,670 misdemeanor domestic violence court defendants to be male. [46] The overwhelming majority of their victims were women: 84 percent in both Charlotte, N.C., [287] and Berkeley, Calif. [866] A large 2000 NIBRS-based multistate study found that 81 percent of the IPV suspects were male and their victims were female. [391]

Jurisdictions with higher numbers of female suspects and male victims typical include non-intimate family violence cases. [463, 726] The latter can include, for example, adult daughters who abuse elderly parents. A Rhode Island study documented that two-thirds of elder female victims were abused by family members, not intimate partners. Unlike intimate abusers, these abusers included large numbers of adult daughters [463].

The NatSCEV identified males as perpetrators in 78 percent of IPV incidents, ranging from 72 to 88 percent depending upon the type of abuse, physical, psychological or emotional. The most severe violence, which included kicking, strangling, or beating, had the highest percent of male perpetrators at 88 percent. Most of the males were fathers, followed by the mothers' non-cohabiting boyfriends. [357, 358]

See the earlier section, "Are Men and Women Equally Likely to be Victims or Perpetrators of IPV?" for more studies documenting that males are more likely to be abusers than females.

Implications: Victim Advocates and Service Providers should recognize that the gender of IPV perpetrators is readily revealed by criminal justice, court, DV programs, and other service provider data and research. Further, if sexual abuse is part of IPV, the gender of the victim is almost exclusively female. Claims of gender parity in IPV are generally derived from research based on more minor, situational and isolated conflict.

What Age are Abusers?

Studies find most perpetrators are between 18 and 35 years old, with a median age of about 33 years, although abusers range in age from 13 to 81. [46, 100, 287, 866] A large U.S. west coast study of abusers subject to police incident reports or protective orders found that 33 percent were between 20 and 29 years old, and slightly more (33.4 percent) were between 30 and 39 years old. [397]

Implications: Victim Advocates and Service Providers should deliberate with legal system professionals to devise interventions that will specifically address the young adult perpetrator. Perhaps greater resources should be directed at this cohort of abusers who may require more and varied interventions to cease IPV.

Are Abusers Likely to be Known to Law Enforcement?

Most studies agree that the majority of domestic violence perpetrators that come to the attention of criminal justice or court authorities have a prior criminal history for a variety of nonviolent and violent offenses against males as well as females. For example, a study of intimate partner arrests in Connecticut, Idaho and Virginia of more than 1,000 abusers found that almost 70 percent (69.2 percent) had a prior record and that 41.8 percent of those with records had been convicted of a violent crime, including robbery and rape. [391]

The percentage of officially identified perpetrators with criminal histories ranges from a low of 49 percent for prior arrest within five years in an arrest study in Portland, Ore. [432], to 89 percent for at least one prior nonviolent misdemeanor arrest for domestic violence defendants arraigned in a Toledo, Ohio, Municipal Court. [265] Not only did most of the abusers brought to the Toledo Court for domestic violence have a prior arrest history but the average number of prior arrests was 14. Similarly, 84.4 percent of men arrested for domestic violence in Massachusetts had prior criminal records, averaging a little more than 13 prior charges (resulting from five to six arrests) — including four for property offenses, three for offenses against persons, three for major motor vehicle offenses, two for alcohol/drug offenses, one for public order violations, and 0.14 for sex offenses. [100] A study of the Cook County (Chicago) misdemeanor domestic violence court found that 57 percent of the men charged with misdemeanor domestic violence had prior records for drug offenses, 52.3 percent for theft, 68.2 percent for public order offenses, and 61.2 percent for property crimes. On average, they had 13 prior arrests. [371]

Even if abusers have no prior arrest records, they may be known to local police. In North Carolina, for example, researchers found from police files that 67.7 percent of the domestic violence arrestees had prior contact with the local criminal justice system, 64.5 percent were officially known by local police, and 48.3 percent had prior domestic violence incident reports. [287]

Similarly, studies of abusers brought to court for protective orders find similarly high rates of criminal histories, ranging from slightly more than 70 percent in Texas [121] to 80 percent in Massachusetts. [455]

Implications: Victim Advocates and Service Providers should impress upon criminal justice officials that criminal justice intervention to protect victims of domestic violence is consistent with and frequently involves the same suspects as those responsible for non-domestic violence crime in the community. Further, given

the criminal history of most abusers, police, bail commissioners, prosecutors and judges should review abuser criminal histories to inform decision-making about bail, sentencing, and related issues.

Are Abusers Likely to be Drug and/or Alcohol Abusers?

The majority of the research examining substance use and partner violence has suggested a positive, reliable association between perpetrator substance use with the severity and frequency of partner violence. [250, 103, 318, 710, 847, 851, 164] Alcohol abuse has also been linked to high levels of verbal abuse and psychological aggression with partners. [439]

As with criminality in general, there is a high correlation between alcohol and substance abuse and IPV for abusers. This is not to say that substance abuse causes domestic violence. The Memphis night arrest study found that 92 percent of assailants used drugs or alcohol on the day of the assault, and nearly half were described by families as daily substance abusers for the prior month. [87] Other studies found a lower but still substantial incidence of substance use. For example, a California arrest study found alcohol or drugs, or both, were involved in 38 percent of the domestic violence incident arrests. [866]

A large Seattle arrest and protective order study found that alcohol/drug use was reported in 24.1 percent of incidents of IPV reported to police. [398, 397] It was higher in North Carolina, where 45 percent of suspects were identified as being intoxicated. [287]

A domestic violence fatality review study in New Mexico documented that alcohol and drugs were present in 65 percent of 46 domestic violence homicides between 1993 and 1996: 43 percent abused alcohol and 22 percent abused drugs. [611] Two surveys, one of state correctional facilities in 1991 and the other of jails in 1995, found more than half of those jailed or imprisoned for domestic violence admitted drinking and/or using drugs at the time of the incident. [335] Self-reports from batterers in Chicago revealed that 15 to 19 percent admitted to having a drug problem, and 26 to 31 percent scored more than one on the CAGE (Cut down drinking, drinking Annoyed others, felt Guilt over drinking, and needed a morning Eye-opener drink) test indicating alcohol abuse. [53] Among defendants prosecuted in Chicago's domestic violence misdemeanor court, 60.7 percent were found to have "ever had an alcohol or drug problem." [371]

Interviews with more than 400 North Carolina female victims who called police for misdemeanor domestic assaults found that abuser drunkenness was the most consistent predictor of a call to police. According to the victims, almost a quarter (23 percent) of the abusers "very often" or "almost always" got drunk when they drank, more than half (55 percent) were binge drinkers, 29.3 percent used cocaine at least once a month, and more than a third (39 percent) smoked marijuana. Furthermore, almost two-thirds of abusers were drinking at the scene of the incident, having consumed an average of almost seven drinks, resulting in more than half of them (58 percent) being drunk. [412]

The NCVS found substantial, but lesser rates of substance abuse. Between 1993 and 2004, victims reported that 43 percent of all nonfatal intimate partner violence involved the presence of alcohol or drugs, another seven percent involved both alcohol and drugs, and six percent involved drugs alone. [124]

A 2009 California health survey, the largest of its kind in the nation, found almost half of all IPV victims (47.6 percent) said that their partner appeared to be drinking alcohol or using drugs during the most recent violent incident. [872]

Both a batterer and an alcohol treatment study similarly reveal a consistent, high correlation between alcohol abuse and domestic violence. In one study of 272 males entering treatment for battering or alcoholism, the odds of any male-to-female aggression were 8 to 11 times higher on days they drank than on days they did not. [249] A New Zealand general population study found that binge drinking increased intimate partner violence severity and frequency for both victims and abusers, although women were much more likely to report that their partner had been drinking when physically aggressive towards them. Binge drinking was associated with the highest levels of severity, anger and fear-induction. [164]

A study of poor women found that, if the partner had a drug problem, poor women had nearly five times the odds of being victimized. A partner's poor work history also predicted increased risk for partner violence. [696]

A related study utilizing data from California's massive health survey links neighborhood bar concentration with increased IPV emergency room visits. [518]

Implications: Victim Advocates and Service Providers should advise victims that an abusive intimate's IPV and controlling behaviors are not likely to stop unless and until his substance abuse behavior also stops. Victims should evaluate the association of drug or alcohol consumption with abuser patterns of IPV. Examining the frequency, amount, and episodes of consumption can inform safety planning and relevant victim services.

Are Abusers likely to be Mentally Ill or Have Certain Personality Traits?

Batterers are no more likely to be mentally ill than the general population. [324] Although various researchers have attempted to classify abusers, ranging from agitated "pit bulls" and silent "cobras" [443] to "dysphoric/borderline" and "generally violent and anti-social" [400], attempts to use these classifications to predict risk of reabuse have proven unhelpful. [380] After reviewing the literature for the U.S. Military, one researcher summarized, "There has not yet been a classification (typology) model that has demonstrated a clear clinical or research benefit for improved batter identification and treatment. [540]

However, researchers agree that batterers may differ markedly from each other. [142, 399, 703] Although some batterers may appear to be emotionally overwrought to responding police officers, other batterers may appear calm and collected. [443] Other research suggests that batterers can be classified as low-, moderate- and high-level abusers and that, contrary to common belief, batterers remain within these categories. [130]

Although the multistate study of four batterer intervention programs consistently found that approximately a quarter of court-referred batterers are high-level abusers, unlikely to respond to treatment, there was no evidence that mental illness or pronounced personality disorders were related to recidivism. [321, 312, 322]

At least one national study found that male intimate partner perpetrators are significantly more likely than male non-perpetrators to utilize hospital emergency rooms, even controlling for those behaviors that make it more likely males will utilize emergency rooms, including substance abuse, transportation-related risk-taking (e.g., excessive speeding, nonuse of seat belts), and serious mental illness. [489] The investigators suggests that intimate partner perpetrators may have poor impulse control and/or be risk takers. In the study the men were asked questions like, "Do you like to test yourself doing risky things? Do you get a real kick out of doing dangerous things? Have you ridden with a drunk driver, or walked alone after dark through a dangerous neighborhood, or ridden a bike without a helmet or swum outdoors during a lightning storm?"

Implications: Victim Advocates and Service Providers should advise victims that mental illness and personality disorders are not causal factors in IPV. However, victims might consider abusers' mental health challenges in making plans for their own safety. Typically, mental health counseling does not deter abusers and while abusers may be in need of such treatment, it is not predictive of abuse cessation.

Are Veterans/Military Personnel More Likely to Abuse?

Estimates of IPV committed by veterans and active duty servicemen range between 13.5 percent and 58 percent, and these rates are three times higher than that generally seen among civilians. IPV rates among active-duty military men, [385] and historically Vietnam veterans, have been found to be higher than those from the general population [434].

IPV is particularly associated with military personnel and veterans suffering from PTSD. And among veterans, IPV is two to three times higher among male veterans suffering PTSD than other returning veterans from combat areas. [385, 434, 610, 720] A Bristish study on 13,000 returning soldiers from Iraq and Afghanistan also found a link between combat, trauma and IPV. Researchers found 12.5 percent of the returning soldiers assaulted someone upon return, a third of the victims being their partners. [549a]

A study of veterans in VA couples counseling suffering from either PTSD or severe depression found, based on combined veteran and partner reports, approximately 81

percent of PTSD and 81 percent of depressed veterans engaged in at least one act of violence toward their partners in the last year; 45 percent of the former and 42 percent of the latter perpetrated at least one severe violent act in the last year. These rates were 6 to 14 times higher than were rates from the general population [708, 754] and were higher than the 25 percent severe violence rates found in therapy-seeking couples in university clinics. [610]

Other studies of veterans seeking help for PTSD have found high rates of partner violence from 42 percent to 63 percent in the past year [102, 671], as well as 92 percent for verbally aggression, and 100 percent for psychological aggression (based on combined veteran/partner reports of violence). [671] A recent cross sectional survey of veterans referred to treatment in 2005 and 2006 at the Philadelphia VA found among 199 veterans who served in Iraq or Afghanistan after 2001 and were referred for a behavioral health evaluation, of those with a current or separated partner, 53.7 percent reported "shoving, shouting or pushing their partner," and 27.6 percent said their partner was afraid of them. Also, depression and PTSD were both associated with higher rates of family re-integration problems. [707]

Another study of vets from the current conflicts in Iraq and Afghanistan, who had recent partners and were afflicted with PTSD, found that 60 percent reported mild-to-moderate IPV within the previous six months. Of the veterans and active duty military personnel attending a batterers' intervention program, those with PTSD were found to have a greater frequency and intensity of IPV perpetration than those without PTSD. Close to half (53 percent) of the veterans returning from Iraq and Afghanistan who were receiving care at a VA clinic engaged in at least one act of physical aggression in the prior four months. [301]

Implications: Victim Advocates and Service Providers should ask victims if their abusers are in the military, National Guard and Reserves or are veterans and explore the possibility that the abuser may suffer from PTSD or depression and the ramifications thereof in terms of risk factors for further abuse. Victims should be informed of the opportunities for PTSD treatment provided by the VA and other non-VA agencies.

Are Veterans/Military Personnel Who Abuse Different from Civilian Abusers?

Veterans and military personnel suffering PTSD as a result of combat or other trauma who were not abusive before the trauma differ from other abusers. Combat veterans with PTSD display higher levels of anger than do non-PTSD combat veterans. In fact, the anger may be related to the PTSD, not the military combat experience. [600] This anger can be manifested in hostile behavior, including interpersonal interaction. A study of Vietnam vets, for example, found those with PTSD evidenced more hostile interpersonal interactions than non-PTSD veterans or civilians. [42] PTSD also results in hyper-arousal. Hyper-arousal has been found to be correlated significantly with perpetration of

domestic violence among veterans. [604] A complex interplay of anger, hostility, and hyper-arousal places the veteran with PTSD at increased risk of perpetrating domestic violence. [720]

The increased risk for domestic violence evident in the literature is not surprising, given the high comorbidities between PTSD and other risk factors for IPV including depression, substance abuse, relationship distress, impaired problem-solving skills and prior assaults. For example, a large military personnel study found that among both male and female vets, those who were diagnoses with PTSD after returning from war were more likely to have suffered prior assaults and, for females, sexual assaults, before enter the military. New-onset PTSD symptoms or diagnosis among deployers reporting combat exposures occurred in 22 percent of women who reported prior assault and 10 percent not reporting prior assault. Among men reporting prior assault, rates were 12 percent and six percent, respectively. Adjusting for baseline factors, the odds of new-onset PTSD symptoms was more than 2-fold higher in both women and men who reported assault prior to deployment. [731] However, research suggests that PTSD contributes to IPV, controlling for related risk factors. Data from the National Comorbidity Study [448] found that although combat exposure was associated with current physical abuse of spouses or partners in combat-exposed men, the abuse was principally an indirect consequence of combat that was mediated through the experience of PTSD. Further, research confirms the more severe the PTSD symptoms, the higher the risk for perpetrating partner violence. [614]

On the other hand, a study comparing severely depressed veterans and those suffering PTSD found both were equally likely to abuse their partners compared to veterans who suffered neither condition. [720]

Confirming research suggests that veterans suffering from PTSD who abuse their partners differ from other abusers in that, concerned with their behavior, veterans who assault their partners are more likely to voluntarily seek treatment. Preliminary studies indicate that while non-PTSD abusers abuse on purpose, traumatized vets are more likely to recognize the horror of their behavior and seek treatment. [624] According to the Journal of Disabled American Veterans, veteran IPV typically involves "only one or two extremely violent and frightening abusive episodes that quickly precipitate treatment seeking." [31]

Despite these findings, it is important to note that just because a person has experienced a traumatic event or has PTSD does not mean that they will exhibit violent behavior. There are many factors that contribute to aggressive behavior and much more research is needed to identify the specific risk factors for aggressive behavior among people exposed to traumatic events or who have PTSD.

Implications: Victim Advocates and Service Providers should communicate the findings of this relatively new research on IPV by service members and veterans to victims and other professionals serving battered women. Whether suffering from PTSD and/or depression, the risk to victims posed by traumatized veterans must be

taken very seriously. Treatment for the service member or veterans' PTSD and depression should be considered a vital element for safeguarding their partners.

Are Adolescents with Attention Deficit/Hyperactivity Disorder and/or Conduct Disorder More Likely to Become Abusers?

The research is limited. However, at least one study suggests that adolescents with conduct disorder (CD), alone or with attention-deficit/hyperactivity disorder (ADHD), may be at increased risk for perpetrating intimate partner violence as young adults. In addition, childhood ADHD without CD has been found to be a significant predictor of later intimate partner violence resulting in injury. Specifically, hyperactivity/impulsivity (HI) symptoms significantly predicted IPV resulting in injury. Adolescents with both ADHD and CD "were at the very highest risk" for IPV. [252]

Implications: Victim Advocates and Service Providers should be aware that it is important to provide a strong foundation for children and teens suffering from childhood trauma to enable them to understand how to resolve conflict, to pursue respectful and non-violent relationships, to develop strong coping skills, and to be able to identify the risks for difficulties in relationships with intimates.

Do Abusers Stick with One Victim?

Deprived of one victim, many abusers will go on to abuse another intimate partner or family member. Some may abuse multiple intimate partners and family members simultaneously. [150] The Rhode Island probation study, for example, found that in a one-year period, more than a quarter (28 percent) of those probationers who were rearrested for a new crime of domestic violence abused a different partner or family member. [461] The Massachusetts study of persons arrested for violating a civil restraining order found that almost half (43 percent) had abused two or more victims over six years. [72] This confirms an earlier state study finding that 25 percent of individuals who had protective orders issued against them in 1992 had up to eight new orders taken out against them by as many different victims over the subsequent six years. [7]

Studies have generally found that abusers who go on to abuse new partners are not substantially different from those who reabuse the same partner, with the caveat that they tend to be younger and are not married to their partners. [7, 461]

Implications: Victim Advocates and Service Providers should alert victims that their battering partners may be abusing or abuse in the future others in the family. Similarly, victims should be alerted that men who have battered previous partners may be prone to continue that behavior with new partners, notwithstanding the claim that the previous partner "caused" them to be abusive.

How Many Abusers are Likely to Reabuse?

Depending on how reabuse is measured, over what period of time, and what countermeasures either the victim (e.g., getting a protective order or going into hiding) or the criminal justice system takes (arresting or locking up the abuser), a hard core of approximately one-third of abusers typically reabuse in the short run (a year or two), and still more in the longer run.

In Rhode Island, for example, 38.4 percent of abusers were arrested for a new domestic violence offense within two years of being placed on probation supervision for a misdemeanor domestic violence offense. [461] A half-dozen batterer program studies published between 1988 and 2001 and conducted across the United States documented reabuse, as reported by victims, ranging from 26 to 41 percent within five to 30 months. [14, 209, 233, 321, 312, 322, 324, 353] Five studies published between 1985 and 1999 of court-restrained abusers in multiple states found reabuse rates, as measured by arrest and victim reports for the period of four months to two years after their last abuse offense, to range from 24 to 60 percent. [14, 121, 365, 444, 455]

Where studies have found substantially lower rearrest rates for abuse, it appears the lower rate is a result of police behavior, not abuser behavior. In these jurisdictions, victims report equivalent reabuse, notwithstanding low rearrest rates. For example, studies of more than 1,000 female victims in Florida, New York City and Los Angeles found that, whereas only four to six percent of their abusers were arrested for reabuse within one year, 31 percent of the victims reported being physically abused during the following year (one-half of those reporting being burned, strangled, beaten up or seriously injured) and 16 percent reported being stalked or threatened. [261, 679] Similarly, in a Bronx domestic court study, whereas only 14 to 15 percent of defendants convicted of domestic violence misdemeanors or violations were rearrested after one year, victims reported reabuse rates of 48 percent during that year. [655]

Reabuse has found to be substantially higher in longer term studies. A Massachusetts study tracked 350 male abusers arrested for abusing their female intimate partners over a decade, 1995 to 2005. The study determined that eventually 60 percent were rearrested for a new domestic assault or had a protective order taken out against them.

Implications: Victim Advocates and Service Providers should advise victims that the likelihood for batterer cessation, notwithstanding criminal justice and/or court civil intervention, is often not good. Victims cannot rely on the criminal legal system to stop the violence and protect victims; victims, themselves, must engage in various strategies for protection.

When Are Abusers Likely to Reabuse?

Studies agree that for those abusers who reoffend, a majority do so relatively quickly. In states where no-contact orders are automatically imposed after an arrest for domestic violence, rearrests for order violations begin to occur immediately upon the defendant's release from the police station or court. For example, in both a Massachusetts misdemeanor arrest study and a Brooklyn, N.Y., felony arrest study, the majority of

defendants rearrested for new abuse were arrested while their initial abuse cases were still pending in court. [100, 596] The arrest rate for violation of no-contact orders was 16 percent with a 14 percent arrest rate for ~~a~~ new felony offenses. [596]

Similarly, a little more than one-third of the domestic violence probationers in Rhode Island who were rearrested for domestic violence were rearrested within two months of being placed under probation supervision. More than half (60 percent) were arrested within six months. [461] A multistate study of abusers referred to batterer programs found that almost half of the men (44 percent) who reassaulted their partners did so within three months of batterer program intake, and two-thirds within six months. The men who reassaulted within the first three months were more likely to repeatedly reassault their partners than the men who committed the first reassault after the first three months. [315, 317, 321] In the Bronx, similarly, reoffending happened early among those convicted for misdemeanor or domestic violence violations. Of those rearrested for domestic violence, approximately two-thirds reoffended within the first six months. [655]

Implications: Victim-Advocates and Service Providers should advise victims that they may be particularly subject to reabuse after criminal justice intervention. Advocates should encourage criminal justice officials to take appropriate counter measures in this heightened period of victim risk.

Which Abusers are Likely to Reabuse?

The research consistently finds that basic actuarial information, readily available, provides as accurate a prediction of abuser risk to the victim as do more extensive and time-consuming investigations involving more sources, including clinical assessments. [379, 332, 381, 678] As a Bronx study on batterer treatment concluded, intensive individual assessments of attitudes or personality are not required to make reasonable judgments regarding abusers' risk of reabuse. [648]

First, these factors include abuser gender. Males are more likely to reabuse than females. [648] Second, younger defendants are more likely to reabuse and recidivate than older defendants. [100, 461, 648, 655, 817, 866] This has been found to be true in studies of arrested abusers and batterers in treatment programs as well as court-restrained abusers. [379, 332, 455, 515, 866] Third, if the abuser has even **one** prior arrest on his criminal record for **any** crime (not just domestic violence), he is more likely to reabuse than if he has no prior arrest. [100, 184, 312, 613, 655] A multistate study of more than 3,000 police arrests found that IPV offenders with a prior arrest record for any offense were more than **seven** times more likely to be rearrested than those without prior records. [391]

The length of prior record is also predictive of reabuse as well as general recidivism. [584] In looking at all restrained male abusers over two years, Massachusetts research documented that if the restrained abuser had just one prior arrest for any offense on his criminal record, his reabuse rate of the same victim rose from 15 to 25 percent; if he had five to six prior arrests, it rose to 50 percent. [455] In the Rhode Island abuser probation study, abusers with one prior arrest for any crime were almost twice as likely to reabuse

within one year, compared to those with no prior arrest (40 percent vs. 22.6 percent). If abusers had more than one prior arrest, reabuse increased to 73.3 percent. [461] Prior civil or criminal records specifically for abuse also increased the likelihood for reabuse. [100, 287, 817, 866]

Related to the correlation between prior arrest history and reabuse, research also finds similar increased risk for reabuse if suspects are on warrants. In the Berkeley study, researchers documented that having a pending warrant at the time of an IPV incident for a prior nondomestic violence offense was a better predictor of reabuse than a prior domestic violence record alone. [866] Similarly, one large statewide study found that if the suspect before the court for domestic violence was already on probation for anything else, or if another domestic violence case was also pending at the time of a subsequent arrest for domestic violence, that defendant was more likely to be arrested again for domestic violence within one year. [461] In the one study that addressed this issue, suspects who were gone when police arrived were twice as likely to reabuse as those found on the scene by police. [100]

Although research has generally failed to find a specific personality profile associated with risk for reabuse, a study of more than 800 middle-aged adults with borderline and antisocial personalities found that continued aggression was associated with the former, not the latter. This suggests that adults with borderline personalities may be less likely to see reductions in IPV as they age. [834a]

Implications: Victim Advocates and Service Providers should inform victims that a criminal record related to IPV and other offenses is correlated with offender recidivism. Victims should not ignore an intimate abuser's criminal conduct outside the relationship in evaluating risks posed by the offender.

Are IPV Stalkers Likely to Reabuse?

Studies generally concur that intimate stalkers are the most dangerous of all stalkers and are highly likely to continue both their surveillance and violence. [363, 550, 712, 881] For many IPV victims (12 to 80 percent), the stalking began before the IPV victims separated from their abusers. [84, 227, 499, 496, 572, 794] Research also suggests that intimate partners who stalk are the most likely to commit violence and stranger stalkers are the least likely. [580] The NVAWS found that the majority of women stalked by husbands or ex-husbands report prior physical abuse, with almost a third reporting sexual assaults. [793, 794]

Intimate stalkers are the most likely to engage in frequent stalking. [572, 598] They may be more likely to employ proxy stalkers to assist them [503, 580] Intimate stalkers may also be the least deterred by criminal justice intervention. [572, 681]

A study of slightly more than 1,000 stalkers drawn from police, prosecutor, and Hollywood security files compared intimate and non-intimate stalkers. The intimate stalkers were the most likely to reoffend (92 percent vs. 56 percent), to be male (94

percent vs. 77 percent), have violent criminal histories (50 percent vs. 17 percent), and least likely to be psychotic at the time of the offense (11 percent vs 25 percent). The researchers concluded that intimate stalkers were "by far the most malignant" of all stalkers studied. [572]

Not only have studies found that intimate stalkers are more likely to threaten harm to their victims [452, 572, 619, 681, 719] but some suggest that stalkers who make threats are more likely to carry out violence than those that do not make threats. [73, 675]

It appears that women who are stalked after obtaining a protective order are at particularly high risk for violence, notwithstanding other variables including minor children, prior abuse, and length of relationship. A KY study found, for example, that women who were stalked after the orders were issued were four to five times more likely to experience physical abuse, severe physical violence, and injury as well as almost ten times more likely to experience sexual assault that other women with orders. [502]

The NVAWS found that more than two-thirds of the protective orders obtained by female intimate stalking victims and 90 percent of orders obtained by male intimate stalking victims were violated. The violation rates were substantially higher than the 50 percent violation rate reported for the victims of physical assaults who had secured protection orders. [793, 794] These findings mirror earlier reports that half of stalking victims secured orders and 81 percent of these were violated. [347, 346] As illustrated by these high violation rates, intimate stalkers are persistent, more likely to recidivate than non-intimate stalkers. [496, 681]

Further, by time the time most victims report stalking to police, the stalking behavior has been well established and it is likely that victim-initiated countermeasures have already failed to stop the stalker. Research demonstrates that **v**ictims take many actions to protect themselves from their stalkers before contacting police. [81, 82] The victims in the SVS survey, for example, reported taking a number of countermeasures, including asking friends for assistance (42.6 percent), changing their day-to-day activities (21.6 percent), installing caller ID/call blocking (18.1 percent), getting pepper spray (6.3 percent), or getting a gun (2.9 percent). Only 39.7 percent reported that they did NOT change their behaviors. In addition, a little more than a third of female intimates (36.6 percent) and 17 percent of male intimates reported obtaining a protective order in the NVAWS survey. A little over fifteen percent of all stalking victims reported having obtained a protective order in the SVS survey.

Implications: Victim Advocates and Service Providers may find that IPV victims do not recognize the stalking of their abusers or they may have experienced skepticism about stalking from law enforcement or other helping professionals. Intimate partner stalking should be taken extremely seriously. IPV stalking victims may require heightened victim service provision, safety planning, and criminal justice response to safeguard victims from the recurring, severe violence of IPV stalkers.

Is Substance Abuse a Significant Risk Factor for Reabuse?

Acute and chronic alcohol and drug use are well-established risk factors for reabuse. [393, 842] Prior arrests for drug and alcohol offenses also correlate with higher rates of reabuse. [307] Just one prior arrest for any alcohol or drug offense (e.g., drunk driving or possession of a controlled substance), for example, doubled the reabuse rate from 20 percent (no prior drug/alcohol arrest) to 40 percent (at least one arrest for drugs/alcohol) in a restraining order study over two years. [455] Similarly, a national arrest study found that If an offender used alcohol or drugs in the initial arrest incident, he was about 25 percent more likely to be arrested again. [390]

A study of men in treatment for alcohol abuse found that at baseline nearly all reported using verbal or psychological aggression with their partner. That number decreased to 88 percent after 12 months of follow-up. [439]

Defendant alcohol and substance abuse, similarly, are predictive of reabuse and recidivism. [100, 455, 461, 866] A study of impoverished women victims, for example, found that women were at nearly five times more likely to be victims of IPV if their partners had substance abuse problems. [692]

The multistate batterer program referral study found heavy drinking to be a significant predictor for reabuse. It found that abuser participation in drug treatment predicted repeated reassaults. [381] Batterers who complete batterer intervention are three times more likely to reabuse if they are found to be intoxicated when tested at three-month intervals. [317, 321, 312, 322] Many [265, 391, 613], but not all, studies [100] have found abuser or victim abuse of drugs or alcohol at the time of the incident to be a consistent risk marker for continued abuse.

Implications: Victim Advocates and Service Providers should apprise victims that continued substance abuse, including abusive drinking, represent continued risk for IPV.

Are There Other Common Risk Factors Associated with Reabuse?

Several studies have found that poverty and other factors consistent with poverty are risk markers for reabuse. These include increased risk associated with abusers who flee the scene of domestic violence [100]; abusers who are unemployed [56, 115, 470, 520, 613]; have poor work histories, [692, 696]; are economically disadvantaged and living in disadvantaged neighborhoods [515]; living in a household with firearms [115, 470]; or abusers who are not the fathers of children in the household. [115, 470] Such associations may explain the particularly high rates of abuse suffered by impoverished women. A study of 436 homeless and poor housed mothers, for example, documented that 61 percent reported severe violence by a male partner. [91]

Sexual abuse by IPV perpetrators is a significant risk marker for reabuse. [874]

IPV victims with children appear to be at elevated risk compared to victims who are not parenting. [874]

Implications: Victim Advocates, Service Providers and criminal justice officials should be aware of these risk factors and encourage victims to undertake careful assessment of abuser risk and to take appropriate measures to mitigate heightened risk. Advocates might collaborate with local police agencies in regard to policy and procedures for pursuit of abusers who leave the scene before police respond to a "domestic." Collaboratives might consider whether patrols or special domestic violence law enforcement and prosecution units might design practices that specifically focus on poorer neighborhoods, while guarding against discriminating against people based on race or economic status. Similarly, Advocates and law enforcement should undertake specialized outreach to victims in poorer neighborhoods.

What Factors Are Not Associated with Reabuse?

Generally, the seriousness of the presenting incident does not predict reabuse, whether felony or misdemeanor, including whether there were injuries or not. [100, 184, 455, 461, 479, 613] Abuser personality types have not been found to be associated with increased risk of reabuse. [381] Actuarial data offer improvement over clinical data. [678]

Victim characteristics, including relationship with abuser, marital status, and whether the parties are living together or separated, have not been found to predict reabuse. [100] At least one study has found that victim cooperation with the criminal justice system does not predict recidivism. [479]

Implications: Victim Advocates and Service Providers should assure victims that they are not responsible for the abuse. The research on factors not associated with abuse is limited in scope and of little utility in assessing the risk of reabuse. These factors should never be utilized in establishing eligibility guidelines for victim services. Further, criteria for filing criminal charges or protection orders should not be confused with criteria for determining abuser risk

Are Victims Accurate Predictors of Reabuse?

Victim assessment of risk has been found to significantly improve the accuracy of prediction of reabuse over other risk factors [188].

Risk has been conceptualized as "batterer-generated" and "life-generated"; batterer-generated risks are dangers arising from the batterer's controls, intimidation, surveillance and violence, and life-generated risks are factors in a victim's life that may impede her capacity to assess risk, access services, manage her environment, obtain essential resources, or to utilize legal and human service options. Life-generated risks may include mental illness, literacy, limited English proficiency, immigration status, financial limitations, or locale of residence. Victim assessment of risk takes both types of risk into consideration in identifying the danger posed by abusers. Assessment by victims goes far

beyond the factors contained in instruments developed by professionals to identify the likelihood and severity of reabuse. [179]

Research has only begun to address the complexity of the assessment process anticipated by the conceptualization above. From a recent meta-analysis of risk assessment, a team of researchers concluded that victim related variables of risk fall into three groups – the victim's level of resources, the victim's experience in the system, and the victim's capacity to appraise the risk of future violence. [127]

Research on risk assessment by victims has largely utilized the "Danger Assessment" instrument (a 20 item measure of future risk) developed initially to enable nurses to assist battered women in identifying the dangers of severe violence and homicide posed by abusers. [103, 95]

In the multi-state study of BIPs, victim assessment of risk at intake significantly predicted reabuse in the 15 months that followed. The proportion of true positives for reabuse identified by victims ranged from 55 to 70 percent. Victim assessment was as good as that produced through two of three risk assessment instruments. The "Danger Assessment" was slightly more accurate in predicting future abuse. [332] However, the same researchers found that accuracy of women's assessments varied. Women who felt very safe were less likely to be repeatedly reassaulted than those that felt somewhat safe. However, women who were uncertain or felt somewhat unsafe were more likely to be reassaulted repeatedly than those who felt they were in great danger. The reason for this apparent contradiction is that women who felt in greatest danger took effective countermeasures during the study. The findings suggest that if women are not certain they will be reabused, they err by giving the benefit of the doubt to abusers. The researchers concluded that the best predictions of repeated reassaults were obtained by using independent risk markers coupled with women's assessments. [188, 332]

A subsequent study utilizing a community sample of battered women over a 9 month period also found that the accuracy of victim assessments and four risk instruments were moderately high; again, only the "Danger Assessment" predictions were better. [113] A study of battered women whose abusers were court-involved found similar comparability in the accuracy of risk predictions. [50] A study of help-seeking, low-income African American women likewise demonstrated that 66 percent of the victims accurately predicted both reabuse and no recidivism (true positives/true negatives). Of the batterer women who did not accurately predict, victims were equally likely to overestimate as to underestimate (false positives/negatives). [129] A meta-analysis of IPV risk assessment confirms that victim assessments contain similar levels of predictive accuracy to clinical and actuarial risk assessments. [361]

Victim assessment of risk also affects their evaluation of criminal justice interventions. Arrest research finds that victims who were not revictimized for more than two years were twice as likely to have opposed arrest, compared to those who were revictimized. Those victims who thought police and court intervention did not go far enough were also accurate. Those who said police actions were too weak were three times more likely to experience revictimization, and those victims who said courts failed them were seven times more likely to experience revictimization. [100]

Nonetheless, victim risk assessment is not failsafe. In a study of more than 1,000 women who sought protective orders or shelter, or whose abusers were arrested in Los Angeles or New York City, almost a quarter of the victims who thought their risk of reassault was low were reassaulted within one year. [679]

Implications: Victim Advocates and Service Providers should advise victims and professionals assisting them that victim assessment of risk and fear of reabuse should never be dismissed. Victim assessment is likely to be accurate. Where incorrect, preliminary research indicates victims are as likely to underestimate as overestimate abuser danger. Advocates can assist victims in realistically reflecting on the batterer-generated and life-generated risks. Risks are not stagnant; risks posed by abusers change and may become more acute and life-threatening. If victims indicate uncertainty or doubt about risks of reabuse, dialogue with advocates may enhance victim assessments.

Which Abusers Are Most Likely to Try to Kill their Intimate Victims?

Predicting lethality is much more difficult than predicting reabuse and recidivism because, fortunately, it is much rarer. Also, the risk of lethality may increase because of situational circumstances and not because of static abuser characteristics. Possession, access to, and use of firearms are prime risk factors that increase the likelihood of IPV homicide or severe injuries. According to a CDC study, more female intimate partners are killed by firearms than by all other means combined. [629]

Firearms in the household increase the odds of lethal versus nonlethal violence by a factor of 6.1 to 1. Women who were previously threatened or assaulted with a firearm or other weapon are 20 times more likely to be murdered by their abuser than are other women. [115, 470] Prior firearm use includes threats to shoot the victim; cleaning, holding, or loading a gun during an argument; threatening to shoot a pet or a person the victim cares about; and firing a gun during an argument. [70, 684]

A Massachusetts study of 31 men imprisoned for murdering their female partners (and willing to talk to researchers) found that almost two-thirds of the guns used by men were illegally possessed because the suspect had a prior abuse assault conviction or a protective order was in effect at the time of the killing. [6]

A fatality review report of the 28 persons killed as a result of IPV across Minnesota in 2010 illustrates that firearms possession is a significant risk factor~~s~~ for IPV-related homicide. Almost two-thirds (60 percent) of the 15 female victims died as a result of firearms. One of the two male victims was killed by a firearm. The report also identifies other common risk factors. [565]

Implications: Victim Advocates and Service Providers should make it a priority to advise law enforcement and the courts about the importance of enforcing firearm prohibitions and the risks to victims in returning firearms to perpetrators without

affording victims the opportunity to show why a return is dangerous and/or unlawful. Advocates should monitor the willingness and competency of law enforcement and the courts to enforce firearm prohibitions. Advocates should advise victims that one of the most crucial steps to prevent lethal violence is to disarm abusers and keep them disarmed. Victims may know of both legal and illegal firearms possessed by abusers and may wish to communicate this information to officials or surrender firearms, when safe to do so.

What Are Other Lethality Risk Markers?

In a national study, other lethality markers that multiply the odds of homicide five times or more over nonfatal abuse have been found to include: (a) threats to kill, 14.9 times more likely; (b) prior attempts to strangle, 9.9 times; (c) forced sex, 7.6 times; (d) escalating physical violence severity over time, 5.2 times; and (e) partner control over the victim's daily activities, 5.1 times more likely. [115, 470] Research has also found that male abusers are more likely to kill if they are not the fathers of the children in the household. [70, 115, 470]

A Chicago study similarly found that death was more likely if the abuser threatened his partner with or used a knife or gun, strangled his partner or grabbed her around her neck, or both partners were drunk. [70]

A series of interviews with 31 men imprisoned in MA for partner murders revealed how quickly abusers turned lethal. Relationships with short courtships were much more likely to end in murder or attempted murder; these relationships were also likelier to end much sooner than those with longer-term courtships. Half of the murderers had relationships of no more than three months with the partners they murdered, and almost a third had been involved for only one month. The researcher also interviewed 39 women whose partners had attempted to kill them. Of these, only 5 used firearms and 40 beat their partners viciously. [6]

Intimate stalkers have also generally been found to be among the most dangerous of all stalkers. [363,550,580, 712,881] And the research also suggests a close association between stalking a femicide. A national domestic violence homicide study, for example, documented that three-quarters (76 percent) of intimate femicide victims had been stalked by their partners and more than half of their victims had reported stalking to police prior to their murders. [545]

In terms of female murders of male partners, the research suggests that abused women who killed their partners had experienced more severe and increasing violence over the prior year. They tended to have fewer resources, such as employment or high school education, and were in long-term relationships with their partners at the time. [70]

Implications: Victim Advocates and Service Providers should encourage victims to chart perpetrator abuse over the year prior to advocacy and services. Victims should be advised of the heightened risks of lethal violence if the abuse included

threats to kill, strangulation (often incorrectly minimized as "choking), sexual abuse, stalking or escalating severity of violence. Charting may enable victims to more clearly apprehend lethal risks.

Can Police Accurately Assess the Risk of Victims for Lethality?

Several risk assessment tools have been devised for use by police officers in assessing the risk of recidivism of IPV perpetrators. None measure the risk for lethality. The Ontario Domestic Assault Risk Assessment (ODARA) tool, an actuarial assessment tool used by many police agencies in Canada and the US, is an instrument containing 13 yes/no questions that rank IPV perpetrators on risk for future domestic assault by men against wives, former spouses, common law partners and teen dating violence victims. A high score on the ODARA indicates that an offender is likely to commit more assaults, commit them sooner, and cause more injury. The ODARA includes a victim's assessment of recidivism risk as one of the factors in the tool completed by police. Research on the ODARA demonstrates the validity, reliability and generalizability of the tool. [387, 388]

The Lethality Assessment Protocol (LAP), based on extensive review of domestic violence homicides, was crafted by the Maryland DV coalition and law enforcement. The LAP is a "multi-pronged intervention program that consists of a research-based lethality screening tool, an accompanying referral protocol that provides direction for the screener based on the results of the screening process, and follow-up contact." [534]

The LAP tool consists of 11 questions designed to elicit information from victims when law enforcement officers respond to IPV incidents; LAP enables officers to quickly assess risk for highly dangerous/lethal recidivism. If the victim answers yes to any of the first three questions, they are deemed to be in "high-danger." 1) Has he ever used a weapon against you or threatened you with a weapon? 2) Has he threatened to kill you or your children? 3) Do you think he might try to kill you? Another eight questions follow. Even in the absence of any positive answers to the first three, positive answers to four of the remaining questions, triggers a conclusion that victims are in "high danger" of lethal assault. 4) Does he have a gun or can he get one easily? 5) Has he ever tried to choke you? 6) Is he violently or constantly jealous or does he control most of your daily activities? 7) Have you left him or separated after living together or being married? 8) Is he unemployed? 9) Has he ever tried to kill himself? 10) Do you have a child that he knows is not his? 11) Does he follow or spy on you or leave threatening messages? If the victim's responses fall into the "high danger" category, law enforcement immediately connect the victim with a local DV advocate in order to apprise her of the advocacy, legal options and services available. After this preliminary phone consultation, an advocate from the DV program reaches out for a second connection with the victim. While there is no research on the effectiveness of the LAP Protocol, the Kansas City Star reports that there has been a 300 percent increase in victims seeking the services of DV programs since LAP was instituted in 2009, [672] and in Maryland, of the victims identified as "high danger" in a five year period, 59 percent spoke on the phone to a hotline worker and 19 percent sought additional DV program assistance. [453]

The LAP tool is a refinement of the "Danger Assessment" instrument (DA) previously used and validated in clinical and shelter settings. [114, 116, 115]

There are other risk and lethality scales utilized by law enforcement that are also based on victim input. The DV MOSAIC, developed by de Becker [188], has been found to be the best scale for predicting subsequent stalking and threats. [113]

Implications: Victim Advocates and Service Providers should encourage law enforcement agencies to establish protocols for risk screening, on-scene referrals to advocacy and services, and follow-up contacts with IPV victims. The risk faced by women most likely to be severely injured or murdered by their current or former intimate partners may be clearer to them (as well as third parties) through use of a validated instrument like the ODARA. Interventions that follow screening should be tailored to address heightened risks.

What Are the Risk Markers for Severe Injury?

Sexual abuse of IPV victims is associated with more frequent and severe abuse and heightened homicide risk. [222]

Medical researchers have looked at severe injuries, those causing victims to seek hospital emergency room treatment. They have found that alcohol abuse, drug use, intermittent employment or recent unemployment, and less than a high school education distinguish partners of women seeking medical treatment for IPV injuries from partners of women seeking treatment for non-IPV injuries. In one study, researchers found that 63.7 percent of the abusive partners were alcohol abusers, 36.7 percent abused drugs, a slight majority (51.6 percent) was drinking at the time of the assault, and 14.8 percent were using drugs use at the time of the assault. [478] A similar hospital study found that cocaine use and prior arrests distinguished the violent partners from the nonviolent partners of women admitted to hospitals for treatment of injuries. [338]

It is important to note that the above risk markers are associated with abusers that cause severe injury. The research does not attempt to identify the role that drugs and alcohol may play in causing abusers to act.

Implications: Victim Advocates and Service Providers should alert medical treatment providers, especially emergency medical responders, to the probability that severe injuries may be caused by abusive partners. Sensitively probing the circumstances of the injuries may reveal that injuries may either be inflicted by abusers or result from victim attempts to resist violence. Healthcare professionals should coordinate with victim service providers where appropriate to promote healing and avert future injuries.

V. Do Victim Demographics Predict IPV Victimization?

Victims come in all shapes, sizes, ages and relationships, but these differences are largely irrelevant in terms of their victimization. Victim characteristics — other than gender and age — have generally not been found to be associated with the likelihood of abuse. [100]

Prior victimization, especially sexual abuse, may increase the risk for future victimization. [848] NISVS researchers concluded that although no demographic group is immune to IPV, "consistent patterns" emerge with respect to the subpopulations in the United States that are most heavily affected. Many forms of IPV are first experienced during childhood and remain prevalent among young adults aged 18 to 24. These data provide further evidence that "when victimization occurs, particularly, when it occurs in childhood, it is often repeated in adult hood. [689] Several other studies found that the onset of relationship violence begins in early adolescence and tends to persist into adulthood. [181, 467, 519,680, 730, 791, 845]

Having children appears also to be a risk marker for future victimization. [874]

Those victims who leave their abusers are as likely to be reabused as those who remain with them. [461] Those victims who obtain civil restraining orders or criminal no-contact orders against their abusers are as likely to be reabused as those who drop the orders. The one study, comparing women with orders and those without, found that women with permanent as opposed to temporary orders were less likely to have new police-reported domestic violence. However, the data excluded violations of the orders not brought to the attention of the police, as well asviolations of no-contact or stay-away orders. [398] (Note, a more detailed discussion of civil protective orders can be found in sections IX and XI.)

Nonetheless, some victim circumstances may make specific groups of victims more vulnerable for abuse by intimates. For example, there is general agreement that women who report experiencing IPV during pregnancy are more likely to be unmarried, to have had their first child at a young age, to be poorly educated, have financial difficulties and are in relationships in which substance use and crime were common. [803, 239, 748, 131, 77]

Implications: Victim Advocates and Service Providers should educate the community that IPV victimizations is under the control of the abuser, not the victim. However, IPV prevention may begin with the elimination of child physical and sexual abuse. Further, Advocates and Service Providers, cognizant of the heightened risks for IPV in certain populations, should engage in specialized outreach to and service for potential victims of those demographics or life experiences. However, advocacy and services should be readily available to all potential IPV victims.

Are IPV Victims also Perpetrators?

Research on IPV victims utilizing force or violence against male IPV perpetrators find that male victims differ substantially from female victims. [349. 352, 350, 515] First and foremost, male victims of any specific IPV incident are more likely than female victims to be **future suspects** for IPV. In one of the only studies to track abusers and victims over time, the Charlotte, N.C., law enforcement study found that 41 percent of males who were identified as **victims** and who were involved in new incidents of domestic violence within two years were subsequently identified by police as **suspects**. This compares with only 26.3 percent of females victims later identified as suspects. On the other hand, males identified as suspects were much less likely to be identified later as victims than were female suspects (26 percent vs. 44.4 percent). [287]

Similarly, male victims of domestic violence homicides are much more likely than female victims to have been identified as abusers of the partners who kill them. [438, 741, 832]

Implications: Victim Advocates and Service Providers should assess the history of abuse and coercive/controlling behavior by accused persons, not just the conduct in the most recent immediate incident of IPV. Similarly, the evidence of prior victimization should be examined, particularly in cases where women have been identified as the IPV perpetrator.

Does Victim Substance and Alcohol Abuse Increase the Likelihood of Intimate Partner Victimization?

While there is a well-established association between being a victim of intimate partner violence and abusing alcohol and drugs, the association is complex. Some research indicates that substance use/abuse and alcohol abuse by women can increase the risk of being victimized by one's domestic partner as well as reduce a victim's capacity to protect herself, increasing frequency of abuse over time. [79, 162, 164, 478, 715, 784]

A study of a random sample of 416 women on methadone over one year, for example, examined the relationship between IPV and substance use disorder in both directions, i.e., whether or not substance use disorders increased the likelihood of IPV and/or whether IPV increased the likelihood the victim would have a substance use disorder. Women who reported frequent cocaine use (crack) during the 6 months after initially assessment were 4.4 times more likely than non-drug using women to report intimate partner violence after 12 months from initial assessment. Frequent marijuana users at six months were 4.5 times more likely than non-drug users to report IPV after 12 months. In addition, women who reported IPV at 6 months were almost three times (2.7) more likely than women who did not report intimate partner violence to indicate heavy heroin use at 12 months. The researchers concluded that the relationship between frequent drug use and IPV is bidirectional, but varies by type of drug. [237]

There is consensus in the literature that binge drinking and abusive drinking among women is more problematic than for men. Women become intoxicated after drinking half as much, metabolize alcohol differently, and have greater risk of dying from alcohol-

related accidents and higher risk of being victims of violence and suffering from depression. [336]

A study of 700 Kentucky women with protective orders found they all experienced high levels of violence by their intimate partners overall. However, women's substance use, independent of their partner's reported substance use, had significant associations with the violence experienced from their partner in the last year of the relationship. Multivariate analyses indicated that women's substance use was associated with perpetrator psychological abuse tactics and the severity of physical and sexual victimization in the last year of the relationship. Women's alcohol use was associated with the severity of physical violence within the last year of the relationship, whereas illegal drug use had associations with the number of verbal abuse, degradation and jealousy/control tactics. There was also a significant positive interaction of women's alcohol and drug use with the severity of sexual assault. [715]

A general population study across New Zealand found that binge drinking by men and women, drinking five or more drinks on an occasion at least once a month, made them twice as likely to be an aggressor and three times as likely to be a victim of partner aggression, compared with people who did not binge. The binge drinkers did not appear to be more aggressive in general, but were more likely to be involved in aggressive acts when they were drinking. Although both female and male aggression increased with binge drinking, women were much more likely to report that their partner had been drinking when physically violent towards them, and this situation was associated with the highest levels of severity, anger and fear. [164]

Among drug abusers, at least one study found that the drug used may make a difference. Data from a random sample of 416 women attending methadone programs were analyzed to elucidate the differential associations between intimate partner violence and use of the following: marijuana only, cocaine only, heroin only, or cocaine and heroin. Prevalence of intimate partner violence among this sample far exceeded estimates from the general population. After adjusting for socio-demographic variables, use of cocaine or cocaine and heroin were significantly associated with an increased likelihood of experiencing IPV compared with no drug use. [237]

Implications: Victim Advocates and Service Providers not clinically trained may not be skilled in providing treatment for drug and alcohol-involved women. Nor may they be effective educators about the potential additional risks that substance use by victims may pose in relationships in which they are abused. Providing a peer mentor who has suffered both IPV and substance abuse should be encouraged.

Do Alcohol and Substance Abuse Impede Victim Ability to Protect Themselves and Family?

Abused women who use illicit drugs or abuse alcohol are less likely to call police for protective against abusive partners or support prosecution on their abusers [663] and are less likely to able to leave their abusers and support themselves and children. [692]

Failure to address the substance abuse problems of female domestic violence victims may increase their risk of further victimization after they leave drug or alcohol treatment. [133, 257] Unfortunately, intimate partner violence is associated with poorer outcomes in terms of substance abuse treatment. [269, 666, 667] On the other hand, there is research that suggests victims may be especially motivated to remain drug free and sober once they realize it compromises their ability to protect themselves and children. [472]

The detrimental effects of victim substance abuse are most striking among impoverished victims. A study found significant negative effects of substance abuse among women IPV victims related to work. For women unable to hold jobs over time, escaping poverty through work becomes challenging. Low-wage entry-level employment can be transformed into work that produces true economic independence only when workers are able to invest enough time in the workplace to secure promotions or to move progressively to new and higher paying jobs. Women addicted to drugs or alcohol may not be able to sustain consistent employment. As a result, these women were more likely to remain financially dependent upon their abusers. [692]

Implications: Victim Advocates and Service Providers should develop specialized assistance or services to enable IPV victims who suffer substance abuse disorders to deal successfully with problematic use of alcohol and/or drugs. Victims should be advised that an EAP at the workplace may assist victim employees in sustaining employment while addressing both drug/alcohol problems and any continued abuse by partners.

Are There Specific Risk Factors for Women Veterans and Military Personnel?

Military sexual trauma survivors are at increased risk of having experienced other forms of violence, such as IPV, and are at increased risk of future violence. [811] The sexual trauma combined with combat trauma makes women service members and veterans far more likely to experience PTSD than male veterans. [869]

Implications: Advocates and Service Providers should ask victims about current or former service in the military and be sensitive to the fact that women in military service and female veterans may suffer from trauma as a result of military service that may also make it more difficult to cope with IPV. Advocacy with the command on military installations or the VA may be essential to prevent future IPV and to promote recovery from adverse outcomes.

Are There Specific Risk Factors for IPV for Pregnant Women?

Women who were abused before becoming pregnant are likely to continue to be abused while pregnant. [693] Less than half of abuse victims, 41 percent, report their abuse did not continue when they became pregnant. [532] Younger pregnant women are more

likely to be abused than older pregnant women. [168, 331, 835] A study in the District of Columbia, for example, documents that pregnant adolescents, ages 13 to 17, are much more likely to be abused than women who are 18 years and older when they become pregnant. [475] Those with unintended pregnancies are more two to four times more likely to be abused than those with planned pregnancies. [297] Other risk factors found include lower socioeconomic status and abuse of alcohol and drugs by both victims and abusers. [168, 331]

A large hospital study of women who were assaulted found, for example, that Black women were much more likely to suffer assaults than Whites, both pregnant or not. [835] A large study using data from 27 states and New York City from 2004 through 2007 found that prevalence of abuse by a former partner was consistently higher than that of a current partner. The same study found the three strongest predictors of domestic violence during pregnancy were the woman's partner not wanting the pregnancy, having had a recent divorce or separation, and being close to someone having a drug or alcohol problem. Maternal characteristics were less important predictors. [147]

Implications: Victim Advocates and Service Providers should counsel victims in regard to the risks of IPV during pregnancy, unintended or planned. Women victims should also be alerted to the risks from current and ex-partners during pregnancy.

What is the Link Between Social Supports and IPV Victimization?

Women victims with higher levels of social support are less likely to be reabused. However, social support appears not to be a protective factor for the most severely abused women. [330] Two aspects of women's social support networks in adulthood are significantly associated with decreased risk of partner violence. Studies indicate that women who are not abused by their partners have significantly higher levels of emotional support from nonprofessional network members and significantly less conflict in their nonprofessional networks than women who report partner violence. [696]

Social support may be particularly important for African American women who often choose informal networks to avert or escape violence. In one study of African American victims, those with the highest levels of social support had a 20 percent risk of reabuse and those with the lowest levels had a 65 percent risk of reabuse in the year following the research. Friends and family (principal sources of social support) provide resources and emotional support critical to implementing victim safety planning. [330, 328]

Victims with strong social supports are also less likely to develop mental health problems than battered women without social support. [466]

Perpetrators of IPV use many tactics of control and manipulation to interrupt and undermine the social supports of their battered partners. [802]

Implications: Victim Advocates and Service Providers should seek to assist IPV victims in efforts to regain social support networks that may have been compromised by perpetrators and to identify other supportive communities for IPV victims.

VI. Do IPV Victims Seek Assistance and Services?

The research on help-seeking by IPV victims is rich and extensive, albeit largely based in small sample studies. Studies reveal that victims of IPV engage in help-seeking from family, other social support networks, the legal system, community-based DV shelters and comprehensive programs, healthcare providers, faith leaders, colleagues in school and employment, among others. [211, 323, 413, 570] Victims may seek help through informal networks before engaging community institutions. [578] Victims often seek assistance from a variety of sources and numerous times. [413, 570, 323, 211] One study reported that 98.7 percent of abused women sought help from eleven options enumerated in the study. [413] A large representative sample of over 3,500 battered women found that two-thirds had sought help from friends, relatives, or agencies within their communities. [827]

Help-seeking may involve a single or multiple strategies to obtain assistance to resist coercive controls, to break out of isolation, to minimize, manage or stop the violence, to expand coping and risk management skills, to engage the legal system in protection and/or accountability action(s), to obtain medical and mental health care, to repair or develop support networks, to transform the relationship with the partner, or to heal physically and emotionally from the IPV. [413, 319, 578]

Help-seeking may occur in circumstances of grave emergency or after calm deliberation. Help-seeking is not necessarily or even typically focused on leaving the violent intimate partner. [44, 218, 203] Help-seekers may not disclose their victimization. [570]

A study of over 6,000 women from 50 different shelters documented that the women had made an average of half a dozen prior help-seeking efforts before entering shelters. [318] A large representative sample of over 3,500 battered women found 67 percent had previously sought help at least once from friends, relatives or agencies within their communities. [827] In another study, researchers reported that 98.7 percent of abused women sought help from among eleven options enumerated in the study. [413]

One researcher found that most victims whose partners are court-ordered participants in batterer programs are “active” help seekers and often have previously sought assistance from the criminal legal system. These victims may also obtain counseling, related to intimate partner violence, drug and alcohol problems, or otherwise. A few have utilized shelter services of domestic violence organizations. Half had accessed other assistance (e.g. housing, job training, emergency food, parenting programs, family planning, legal advice). Others received cash welfare assistance, and welfare recipients often acquired multiple forms of assistance. Some used childcare services. [319]

However, until victims believe that IPV is illegitimate and dangerous, they may not seek assistance. Beliefs related to gender roles may shape perceptions about IPV. A victim who believes that her partner is entitled to assert power over her, constrict her decision-making, and use violence to enforce his demands may be less likely to recognize abusive or violent behavior as such. The more entrenched the perceived legitimacy of men’s

violence toward intimate partners, the less likely victims may be to identify IPV early in its onset. Culture, race, ethnicity and socioeconomic status may also influence victim perceptions about the violence they are experiencing and identification of the violence as illegitimate. Membership in or experience with violence-promoting or tolerating organizational or institutional structures may delay identification of IPV. Occupational and religious cultures can also support violence-tolerating attitudes. Abuse in early years, either witnessed or experienced, may have an impact on identification of IPV in adulthood. Media, including social media, may shape victim perceptions about IPV. Thus, victims may identify IPV quickly or slowly based on the **gender** and **cultural** environments in which they live. [277]

Additionally, victims may not pursue help-seeking if barriers to assistance seem insurmountable or too costly. A study of older adult victims found that barriers to help-seeking include: abuser jealousy, intimidation or threats, and victim isolation, self-blame, powerlessness, hopelessness, privacy or secrecy concerns, anticipated adverse responses of religious communities, desire to protect the abuser, and fear for family members. [218] Women using hospital services reported a broad array of barriers to help-seeking, e.g., lack of knowledge of services or their eligibility for services needed, prevention of help-seeing by abusers or fear of abuser retaliation, logistical barriers (e.g., no money, insurance, transportation, childcare, or time), shame or embarrassment about the abuse, desire to protect the abuser from criminal or social consequences, uncertainty about the confidentiality of assistance, strong values about privacy or secrecy, apprehensions about loss of housing, immigration status and/or child custody, desire to preserve the relationship with the abuser, and fear that help-seeking might result in greater risk to safety or intrusion on self-determination. [289] Other research confirmed barriers based in lack (or potential loss) of resources [323] or compromise of immigration status. [218]

The "helping" institution's outreach practices, messaging in service delivery, and responses offered can be barriers to initiation or continuation of help-seeking. If victims believe that they must end their relationships with abusers to be eligible for services, or that they must cooperate with criminal justice system interventions against the abuser, or participate in religious services, or place their children in foster or kinship care, or leave their homes and reside in agency shelters, or have no contact with abusers for the duration of services or court orders, they may not pursue "help-seeking" from institutions that make any of these a condition of receipt of service. [218]

There may be structural barriers to help-seeking. Victims of IPV may be ineligible for the assistance they seek. [570] If victims are homeless, they may not be able to acquire TANF, SNAP, public housing or housing subsidies or obtain civil protection orders. If a victim has a criminal record, even ~~a~~ one non-violent conviction, she may be excluded from TANF or public housing and sometimes from domestic violence shelters. [388, 571] If a survivor has mental health or drug and alcohol problems, is a person with disabilities~~,~~ or cognitive challenges, helping institutions may screen the victim out, provide services that are inadequate to her needs, or undercut her other efforts to obtain services or escape the violence. [791] If helping institutions do not provide translation services, IPV victims cannot be served well, if at all. Some institutions deny services to undocumented

victims. If victims have sought help and failed to acquire assistance or not followed through on the assistance offered, the failure may raise a negative interference against eligibility for future assistance by the same or other institutions. [570]

Many victims may not seek services because they do not know such services or legal remedies exist. Research reveals, for example, that many victims learn of the availability of civil protective orders and related services only after police respond to a 911 call from the victim or a third party. A study of shelter residents found a quarter did not know about the shelter until the day or two before entering it. Another 26 percent did not learn about it until the month before entering. [512] In short, social isolation coupled with poor community responses to IPV, may impede victim accessing IPV services.

Research also suggests that shelter rules and facilities may discourage victims from entering the shelters or participating in the services offered by the shelter agencies. [394] A Rhode Island study found that many single abused women preferred the state's shelter facilities with less restrictive rules rather than IPV shelters. [458] To make IPV shelters more accommodating, the Washington State Coalition Against Domestic Violence engaged an architectural firm to design shelter facilities that address the space preferences of residents and staff. [825]

Victims may feel entrapped in abusive relationships when informal and formal support and assistance systems fail to respond adequately. [570]

Implications: Victim Advocates and Service Providers should continuously educate gate-keepers and first responders, including police, emergency room personnel, welfare workers, clergy, and school teachers, about available IPV-specific services. Advocates should advise other helping professionals that victims of IPV seek help from numerous informal and formal sources. Informed IPV victims can make the best selection of helpful assistance and services. Assistance needed may differ as circumstances change. Advocates should examine the barriers to help-seeking created by building and program structures and shelter rules and address the barriers in the design of emergency shelters and their operations.

When Do IPV Victims Seek Assistance?

Many victims do not seek assistance until the abuse is frequent and serious. [323, 413] As the abuse worsened, victims choose a wider range of helping institutions to avert or escape the violence. [323] Others wait to approach formal helping institutions until they are seeking to end the violence or preparing to leave the relationship. Often, victims with children seek assistance when they perceive their children are threatened. [877]

Limited research suggests that pregnant victims may be more likely to leave their abusers than those who are not pregnant. Research, for example, involving poor, rural pregnant IPV victims found that the need to protect unborn or newborn babies was the seminal factor in decisions to leave abusive relationships. These findings contrast with those of non-pregnant rural women, the majority of whom choose appeasement or bargaining with

their abuser over terminating the relationship. According to the researchers, the pregnant and recently birthing women saw their babies as a ray of hope for a new beginning. [64]

Some scholars, advocates and researchers have adapted the Transtheoretical Model of Change (TM) [645], initially developed to explain how smokers give up tobacco, for describing the process victims go through in deciding to seek assistance and/or to take action to leave their abuser [203]. They developed the Domestic Violence Survivor Assessment (DVSA) tool to help counselors determine the readiness of women experiencing IPV to attempt to change their situations. The DVSA suggests that victims may go through the following change stages: 1) Committed to Continuing Relationship; 2) Questioning Relationship with Abuser; 3) Considering Change; 4) Examining Abuse and Options; and 5) Breaking Away or Partner Curtails Abusiveness. For example, if a victim excuses her abuser or minimizes injuries received, she may be at the first stage. On the other hand, if she makes the decision not to tolerate the abuse and either leaves the relationship or takes actions to stop the abuse, she has reached the level of change, itself.

It should be noted that the ability of a victim to change or act effectively is not necessarily under her control. Although the DVSA may suggest a victim's readiness to change, it does not address her partner's coercive interventions to prevent that change.

Implications: Victim Advocates and Service Providers must recognize that all victims do not seek assistance at the same time or in the same way or under the same circumstances. Nor do victims have the same capacity to seek and utilize assistance. Advocates and Service Providers should engage in various methods of outreach to inform survivors about service and assistance options. It is imperative that victims are able to identify which services are offered on a voluntary, confidential, and no-cost basis. If a victim risks losing her/his decision-making authority in pursuing any service, he/she should be notified about potential encroachments on her/his autonomy and privacy in accepting services.

VII. What Protective Factors and Coping Skills Mitigate the Adverse Impact of IPV?

Scholars early defined coping strategies employed by IPV victims as behaviors characterized by active and engaging approaches to problem-solving as contrasted with avoidance and disengagement. Active coping involves efforts to change a particular problematic or dangerous situation, while disengagement coping involves behaviors that avoid addressing the problem or danger. [413]

Other scholars devised a construct of coping strategies used in the "private," "informal network" and the "public" realms. Public coping strategies entail outreach to human service agencies, social networks and the legal system, and private strategies involve various attempts to respond to violence and emotional abuse through accommodation and resistance. The Intimate Partner Violence Strategies Index (IPVSI) tool was created to measure private, informal network and public realm coping strategies. The six strategies contained in the IPVSI are safety planning, legal, formal network, informal network, placating, and resisting. Research demonstrated that the most helpful of coping strategies were the external safety planning, legal options, formal networks and informal networks. Strategies engaging the victim's informal social networks were particularly helpful. Placating and resisting were the least helpful. [329]

The same scholars expanded the theoretical framework for IPV victim coping by producing an "ecological" model of coping. The model posits that IPV victims devise complex coping strategies based on the context of their personal, historical, social, political, economic and cultural world. Included in the elements that shape coping are the tangible resources of the victim, her social supports, life stressors and the specific factors of the relationship with the abuser. [221, 226]

A recent longitudinal study of African American women seeking civil protection orders after the arrest of an intimate male partner for IPV showed that the greater the history of physical, sexual, and psychological abuse and stalking, as well as the greater the limitations on victim resources, the more coping strategies, private and public, were utilized by IPV victims. [874]

A survey of women health services examined the role of protective factors in mitigating adverse mental health symptoms linked to IPV. Protective factors included social support, education, employment, self-esteem, good health and absence of economic hardship. The study found that the more such protective factors are present, the more victims are shielded against anxiety and depression. However, severely abused women may suffer adverse mental health symptoms regardless of the presence of such protective factors. [120]

A study of African American battered women in a large urban public hospital in the South found the difference between those women who attempt suicide from those who did not was the absence or presence of coping skills. [660] Positive coping skills included help-seeking skills, adaptive living skills, ability to access and use material

resources, viability and use of social support systems, as well as efficacy in dealing with the partner violence. Negative coping skills included alcohol and substance abuse. Victims who accommodated the demands of their abuser and approached problems from a stance of helplessness were at greater risk for suicide attempts. Those with good problem-solving skills, strong social supports and operating from a stance of greater empowerment were less likely to attempt suicide. Interviews with the two sets of battered women found that those utilizing "positive" coping skills were more likely to engage in safety planning, self-preservation, or development of separation strategies to leave their batterers. It should be noted, however, that those who attempted suicide also reported using some positive coping strategies, particularly through engagement in therapy and nurturing their children. [660]

A cross-sectional survey of 1,152 women, ages 18-65, recruited from family practice clinics from 1997 through 1999, similarly found higher social support scores were associated with a significantly reduced risk of poor mental and physical health, anxiety, current depression, PTSD symptoms, and suicide attempts among women experiencing IPV. [159] Among impoverished women, a study found IPV victimization was associated with low levels of emotional support from nonprofessional networks and significantly more conflict in their nonprofessional networks. [692]

Social support also plays an important role as a predictor of resource utilization by battered women. [329, 788, 567, 787, 415]

Not all coping strategies work equally as well. Victims may rely on avoidance coping to deal with their victimization. Some research suggests that avoidance coping results in poorer outcomes, including increased depression and decreased likelihood of seeking counseling assistance [820], although other studies have found avoidance coping to be an effective immediate response to IPV. [355, 871] Hitting abusers back has also been found to be counter-productive, with victims reporting that such responses may increase the severity of attacks by abusers. [100]

Research on coping strategies that enhance victims' emotional and mental health and healing does not generally evaluate the efficacy, if any, of coping strategies in terms of future victim safety or the likelihood of reabuse.

Implications: Victim Advocates and Service Providers might encourage victims to identify the history, range and effectiveness of their coping skills, offering victims opportunities for learning techniques that will enhance existing and develop new coping skills.

VIII. What Services Are Typically Available to Victims of Domestic Violence?

Since the 1970's, safe home and shelter services (e.g. crisis hotlines, emergency housing, peer counseling, safety planning, advocacy and referrals to other community services) have been provided to victims of IPV and their children by DV programs affiliated with the battered women's movement. [511, 709] Over the course of the ensuing 40 years, many DV programs have expanded advocacy and services to include transportation assistance, medical, mental and emotional health services, TANF and SNAP (welfare and food stamp), advocacy, "limited English proficiency" and interpreter services, immigration advocacy, specialized services for children, transitional housing, assistance to victims who are elderly and those with physical and other disabilities and who are deaf or hard of hearing, community education, organizing and outreach, support services for allies of victims (friends and extended family), economic advocacy, education and employment assistance, and legal advocacy and representation. [511, 512, 620]

The National Network to End Domestic Violence (NNEDV) completes an annual 24-hour census of DV shelters and advocacy programs. On September 15, 2011 89 percent of all 1,944 programs provided the following data. On that day, 67,399 victims received services. More than half (36,332) obtained emergency shelter or transitional housing. Adult victims and children (31,007) also received non-residential services, e.g., individual counseling, legal advocacy and children's support groups. [592]

The Census report also revealed that over the course of the entire year, all of the DV programs provided victims individual and group support and advocacy; 92 percent offered children's support and advocacy; 92 percent provided court/legal accompaniment and advocacy; more than 88 percent provided emergency shelter, including hotels and safe houses; 86 percent provided advocacy related to government benefits; 85 percent provided transportation; 82 percent offered landlord-tenant advocacy; 81 percent advocated for victims in mental health services; 75 percent offered advocacy for victims with disabilities; 73 percent provided financial skills and budgeting training; 70 percent provided culturally or linguistically-specific services; 70 percent provided accompaniment to medical services; more than 62 percent offered bilingual advocacy; 55 percent offered job training/employment assistance; and 41 percent provided transitional housing. In addition, that same day DV programs answered 23,522 hotline calls and sponsored training and education programs reaching 30,134 individuals. [592]

A recent study involving 215 DV shelters in eight states reported offering the following services: support groups (97 percent); crisis counseling (97 percent); individual counseling (92 percent); parenting classes (55 percent); counseling for children (54 percent); and childcare [586]. DV programs also provided advocacy for residents: housing (95 percent); civil court (82 percent); criminal court (81 percent); healthcare (81 percent); and TANF (80 percent). [512]

A Rhode Island state study documented that the state's six shelters provided almost all of the comprehensive DV services available to victims across that state. In 2003, 8,489 adult

females over the age of 18 years received services from these agencies. In addition, 22,000 calls were made to the shelter agencies' hotlines. The same year, 2,778 victims received individual advocacy services, including 200 impoverished victims receiving special TANF services offered by one of the shelter agencies; 3,500 victims obtained temporary protective orders, assisted by court advocates provided by the shelter agencies; and 314 women with 377 children were offered emergency housing for various lengths in the state's six shelters. All of the shelters offered at least weekly group counseling for residents. One of the shelters transported residents each week to a drop-in center where it offered a psycho-educational group meeting dealing with stress reduction, depression, DV education, child discipline and related topics. Another contracted out weekly individual and group counseling to a Center that provided psycho-therapy groups dealing with depression, anxiety, medication and related issues. [458]

One of the most common services provided both by DV shelters and mental health or family services agencies is counseling. Either individually or in groups at DV shelters, counseling programs have been characterized by researchers as "empowerment counseling," designed to help a victim gain or regain a sense of personal power and enhance her capacity in risk assessment, coping, and strategic safety planning. [511, 592]

Not all DV programs provide a full range of services. With the expansion of criminal justice response to IPV and the establishment of local task forces or coordinating councils starting in the 1980's, many unmet needs of victims were identified and a wide swath of human service, child welfare, family services, public health, hospital-based, legal assistance, and higher education institutions, as well as, local business leaders, began delivery and coordination of specialized services for victims, their children and perpetrators of IPV. [372] Although development of specialized DV services in traditional human service organizations was spurred on by the demand for IPV services and resources [33, 212, 884], focus groups of battered women across Ohio as recently as 2003 reported "incredibly inconsistency" in response to IPV victims among "helping professionals." located in traditional social service agencies [187]

In efforts to tailor the work of human service organizations to meet the unique needs of IPV victims and their families, Congress enacted several pieces of legislation to provide financial support for development of specialized DV services. The Family Violence Prevention and Services Act (FVPSA) grant program provides funding for emergency shelter and supportive/core services for victims of IPV across the country, in the Commonwealth of Puerto Rico, U.S. territories and for 200 tribes. [207] In 2011, FVPSA funded 1,600 DV shelters and 1,100 non-residential service programs. Of these funded programs, 31 were tribal shelters and 160 were tribal non-residential services. [206] DV programs provided 8,572,392 shelter nights (i.e., # of victims multiplied by the # of nights). Shelter capacity precluded service for more than 165,000 IPV victims. Hotlines for crisis counseling, advocacy, shelter or other services served 2.8 million callers in 2011. [207] Another example of specialized services made available to IPV victims through the Office on Violence Against Women (OVW) since 2001 are the "Legal Assistance to Victims" (LAV) and the "Safe Havens - Supervised Visitation Program" grant programs. LAV grantees provide comprehensive civil legal representation for

victims of IPV, sexual and dating violence and stalking. The 2010 OVW "Report to Congress" stated that LAV grantees offered legal services to an average of 71,000 victims annually in the U.S. About 22 percent of the victim clients were provided assistance on more than one legal issue. Every six months LAV programs typically dealt with divorce (11,558), protection orders (11,006), child custody and visitation (9,938), and child support (6,326). The "Safe Havens - Supervised Visitation Program" grantees provide protected visitation environments for approximately 6,000 families and 10,000 children annually. The unmet needs of victim clients in all of the OVW grant programs are significant. [605]

Data are not available as to the variety, numbers and quality of services provided to victims by all community agencies.

Implications: Victim Advocates and Service Providers should meet with local task forces and survivors to assess the essential services for victims and the remaining unmet needs. Priorities should be developed for expansion of services and resources based on the most pressing needs and available resources. Communities should engage in periodic "360 degree" performance reviews to ensure the quality and fair distribution of services and resources to survivors of IPV and their families.

Are Intimate Partner Victim Services Reaching Those in Need of Them?

Notwithstanding the exponential increase in services in the last 40 years provided both by DV programs and community agencies, many advocacy and service needs remain unmet. For example, the NNEDV Census reported that DV programs were unable to meet 10,581 (or 14 percent of the) requests for assistance on Census Day 2011; of these 64 percent were seeking emergency shelter or transitional housing (6772). Further, on that day, only 26 percent of the programs provided outreach to rural victims, just 35 percent offered transitional housing, and, surprisingly, only 48 percent offered counseling or advocacy services to victims. [592]

The 2011 Census also revealed that with the economic recession in the last four years, and the concomitant reduction in government and private sector funding, DV and service agencies have had to reduce coverage and services even though the demand for services has significantly increased. Across the country, 43 percent of the DV programs reported that they were understaffed. [592]

An earlier NNEDV Census found that programs in rural, poor, and predominantly black or Native American communities were most unable to meet the range and number of requests by victims. [416]

The Rhode Island domestic violence shelter study reported that although most female IPV adult victims seeking services were able to access them, services were consistently not available or accessible to specific groups of victims, including abused women who

suffered from mental illness or substance abuse disorders, linguistic minorities, abused men, elderly and the many children across the state exposed to domestic violence. [458]

A recent survey involving 17 anti-violence programs that serve lesbians, gay, bisexual, transgender, queer (LGBTQ) and HIV-affected victims in 14 states across the country, including Arizona, California, Colorado, Georgia, Illinois, Massachusetts, Michigan, Minnesota, Missouri, Ohio, New York, Texas, Vermont and Wisconsin, documented an increase in the severity of violence experienced by victims, coupled with data revealing that 44.6 percent of victims being turned away from shelters in 2010, up from 34.8 percent in 2000. In addition, the survey reported that 54.4 percent of LGBTQ victims who sought protective orders were unable to secure them. [590]

Generally, the needs identified by male victims were found to be similar to those of women victims. The sample in the 2008 multi-state survey of DV shelter residents included only 13 males (of the 3,410 victims). One reason for the low rate of male participation in the study is that most male victims receive services other than emergency shelter from DV programs or are provided housing assistance through motel vouchers or safe homes. [511] While research is not available otherwise on available services to heterosexual men, research confirms that there are few comprehensive DV service programs or social supports for gay, bisexual and transgender persons. [173, 540, 541]

Although IPV may be less prevalent in immigrant communities [871], immigrant victims of IPV are underserved by DV programs as well as the criminal justice system. [871] Besides the challenges of limited English proficiency, immigrants may have service needs that are particular to their respective cultures of origin and that arise as a consequence of immigration or immigration status. [591, 686] For example, South Asian Indian women victims report that physical and emotional violence inflicted by in-laws, sometimes as proxies for and almost always associated with IPV by male partners, poses a significant problem that traditional DV programs are not prepared to address. [650]

The **demand** for IPV services may not be the same as the **need** for them. Many victims may need services but be unaware that they are available or unable to access them. Studies suggest, for example, that the vast majority of IPV fatalities involve victims who did not receive any IPV services prior to their deaths. A recent report revealed that the majority of Connecticut IPV homicide victims was not served by any of the state's 18 local domestic violence agencies that provide a full range of comprehensive services including but not limited to a 24 hour hotline, counseling, educational and support groups, advocacy in court and with area providers, children's programs, emergency shelter, training and community education. Family interviews conducted indicated that these homicide victims were not aware that these domestic violence services existed. [163]

Similarly, a fatality review report in Georgia only 18 percent of IPV homicides victims had been in contact with a domestic violence shelter or safe house in the five years prior to their murder. The only agency that had reached most of these victims within five years of their murder was law enforcement (78 percent). Only 17 percent had ever been

involved with community-based advocacy, defined as non-residential domestic violence services. [146]

Further, a Florida county study found of the 96 IPV homicide cases reviewed over 11 years, only four victims had contact with a domestic violence center although in 65 of the cases, friends, family or neighbors knew about the abuse prior to the homicide. [254]

Implications: Victim Advocates and Service Providers should engage in robust outreach to inform victims of services available to them. The most vulnerable victims may be the most difficult to reach and to serve. It is critical that communities identify the unmet needs of IPV victims and their families. In times of economic crisis, it behooves all agencies in every community to effectively organize to sustain current programming and to grow programs to address unmet needs.

What Services Do Victims Typically Seek?

Not surprisingly, studies suggest that informal social support networks are the resources most frequently used by victims. [329, 788] Most abused women seek help first from family and friends before reaching out, if ever, to IPV services. In terms of formal assistance, research suggests that the most commonly used specific IPV services are those offered by the criminal justice system, followed by social service agencies, medical services, crisis counseling, mental health services, clergy, and women's groups. [158, 180, 329, 401, 413, 516] The preeminent role played by criminal justice agencies is not surprising as studies have found, for example, that 25 percent of the women who reported assaults to police said it was the police who referred them to domestic violence services. [792, 793] The NCVS found that about half of women victimized since age 12 reported police involvement. [125] Half or more of women in shelters report police involvement at some point prior to entry into the shelter. [276, 427, 636] Another study found that 77 percent of women seeking IPV services had called police for assistance. [20] Finally, studies indicate that from 30 to 82 percent of women who obtain protective orders utilized police services before or after obtaining the orders. [366, 444, 647]

The 2008 multi-state survey of IPV victims utilizing DV shelters found that at the time of entry, victims identified their service needs in the following 8 categories: parenting/child, support, economic, criminal justice, health/disability/government benefits, child welfare/protection, legal, and safety needs. At the time of exiting the shelter, victims reported the need for ongoing assistance related to their children, financial viability, healthcare, support, housing, benefits, transportation, criminal and civil justice systems interventions, and safety. [512]

In a study of 423 women, almost all of whom suffered physical abuse and two-thirds sexual abuse, victims were asked to identify the services they used from a list of 24 possible services. The top ten identified were**:** 1) emotional support from friends/family (76 percent); 2) professional counseling (64 percent); 3) medication for emotional problems (53 percent); 4) welfare (51 percent); 5) support/self-help (50 percent); 6)

medical providers (48 percent); 7) civil legal services for divorce and restraining orders (46 percent); 8) psychotropic medication (44 percent); 9) food banks (41 percent) and 10) religious/spiritual counseling (40 percent). [640]

A smaller study of a little over 100 women victims who used violence against their male partners, but were found to use the same services as other IPV victims, found the following service utilization. Almost all, 87 percent, talked to someone about the violence, with 62 percent relying on the support of people in their social networks, and 60 percent stayed with family or friends to keep themselves safe. Second, the most used resource was police, although 41 percent reported that **someone else** called police. Following police, resources used by victims using force against male intimate partners included Section 8 (subsidized) housing (50 percent), talking to a court-appointed family counselor (44 percent), substance abuse treatment (42 percent), obtaining orders of protection (42 percent), and individual counseling (41 percent). Relatively few used specific domestic violence services: 14 percent called a domestic violence hotline, nine percent used a domestic violence shelter, and five percent attended a domestic violence counseling/support group. [770]

Most of the women in the above study had children and reported being involved with child protective services, as well as child counseling (54 percent), receiving home visits (39 percent), and receiving parenting training (21 percent). Although the sample in the study involved very poor women, most utilized an average of five different services/resources. It should be noted the study incidentally found that those who used the most services were the least likely to resort to violence against their abusive partners. [770]

It should be noted, however, that the reasons services were utilized by victims the most is because they were most known and available, not necessarily the most needed.

Implications: Victim Advocates and Service Providers should build collaboratives with other social, legal, health, government benefits, education, child welfare, business and economic resource agencies in local communities to enhance referrals and to establish complementary protocols among these service providers on how best to respond to the diverse needs of IPV victims.

Do Victims Seeking Shelter Differ from Those Seeking Non-Shelter Services?

Studies suggest significant differences between those victims who seek residential shelter and those that seek non-residential, community-based domestic violence program services. A statewide survey of victims receiving IPV services found that while both those in residential shelters and those receiving non-residential domestic violence services suffered equivalent abuse, the two populations were significantly different. The shelter population was significantly younger, most were between 20 and 30 years,

compared to the non-residential victims, most of whom were between 30 and 50 years. Most of the former only went through high school while more than a third of the non-shelter victimswere college graduates. Most shelter residents were unemployed while two thirds of the latter were employed full or part time. Most residents had lower incomes, were half as likely to be White, as opposed to African American or Hispanics and only 18 percent of the shelter residents owned a car as opposed to 90 percent of the non-residents receiving domestic violence program services. [458]

It should be noted that two-thirds of the shelter directors in the study reported that most of the women in their shelters needed shelter services, but did not necessarily need to be hidden from their abusers. In other words, they needed housing and other supports more than they needed a place to hide out from their abusers. [458]

Implications: Victim Advocates and Service Providers might assess whether the lack of resources, as opposed to need for safety, may be the primary difference between victims seeking residential and non-residential domestic violence programming. DV programs should offer economic services to shelter residents, including employment skills training, asset development, permanent housing, TANF enrollment, and other services essential to establishing safe and stable homes, independent from abusers.

Are the Needs of Women and Their Children in Homeless Shelters Different from Those of Women and Children in Domestic Violence Shelters?

Research has found the needs of women with children in homeless shelters to be similar to their counterparts in domestic violence shelters. One of the reasons for this may be that the majority of women in non-domestic violence shelters also have experienced domestic violence The two groups have been found to have similar rates of mental health issues, substance abuse problems and lifetime rates of victimization and trauma. [734, 686]

One study, for example, compared women in three domestic violence shelters and three non-domestic violence family shelters across upstate New York. The study looked at demographic factors, history of homelessness, mental health symptoms, drug and alcohol problems, IPV and other victimization, PTSD symptoms, availability of social support and problems in the month prior to admission into the shelters. The proportion of Black women was higher in the non-domestic violence shelters, comprising 2/3rds of the population, as compared to only half of the population in the domestic violence shelters. For about half of the women in both groups, it was their first use of a shelter. Levels of social support were equivalent between the two groups. Both groups experienced the same financial difficulties. While most women in the domestic violence shelters said they became homeless as a result of domestic violence, these women also attributed the cause to eviction or financial problems, housing issues, and building or neighborhood problems. In turn, 13 to 18 percent of the women in non-domestic violence shelters said domestic violence was the reason for their residency. [734]

In terms of needs, the majority in both samples met the clinical threshold for mental health problems, although at low levels, thus indicating "little distress." Both had the same histories for drug and alcohol treatment. The lifetime rate of trauma and trauma experiences was high for both groups, ranging from 92 percent for residents of DV shelters to 73 percent for those in homeless shelters. However, for trauma experienced within 3 months of admission to the shelter, it was significantly higher for the women in domestic violence shelters, 62 to 72 percent for residents in domestic violence shelters and 16 to 33 percent for non-domestic violence shelter residents. A little more than half of the domestic violence shelter residents had PTSD symptoms compared to a little over a third of the women in the non-domestic violence shelters. While domestic violence was not as prevalent among the residents of the non-domestic violence shelters (75 percent), researchers concluded that domestic violence constituted a significant part of their lifetime trauma history even though they were not in domestic violence shelters. [734]

Implications: Victim Advocates and Service Providers should recognize that the needs of most women and children in non-domestic violence shelters parallel those of women and children in domestic violence shelters, especially in regard to the need for economic resources. Victim Advocates and Service Providers working in domestic violence shelters should collaborate with homeless shelter programs to share in services and advocacy ~~by~~ for women in their respective programs.

What are Common Barriers to Services?

The most specific study surveying victims on the factors that prevented them from accessing services identified the two most common barriers to services, out of 15 choices, were desire to handle abuse on their own (82 percent) and thinking the problem would resolve itself in time (70 percent). However, the majority also reported they did not know where to go for services (59 percent), and others said they did not seek treatment services because they did not think treatment would work (54 percent). [640]

The study testing the Domestic Violence Survivor Assessment instrument (DVSAI) found the following factors were associated with barriers to change: 1) severity of physical abuse; 2) frequency of physical abuse; 3) survivor and perpetrator substance abuse; 4) survivor economic dependence on the perpetrator; 5) survivor citizenship dependence on the perpetrator; and 6) children under 18 at home. [203]

Implications: Victim Advocates and Service Providers should use multiple methods of community education to inform victims and their allies about welcoming shelter environments, the safeguards available, the legal services provided, the range of economic resources, and the childcare/child programming offered.

Do Services Sought Differ by Victim Race?

A study of several hundred victims, either seeking services from a DV center, an outpatient mental health center, or a metropolitan police department, found that even when African Americans opted for the law enforcement intervention initially, the service finally selected was frequently advocacy in obtaining court protective orders. Euro-

American victims, by contrast, most often used outpatient counseling services as a source of support, using court advocacy less frequently. [396]

Another study of 376 African American and Caucasian victims of IPV found that compared to the latter, the African American women were significantly more likely to report using prayer as a coping strategy and significantly less likely to seek help from mental health counselors. However, the two groups did not differ in terms of seeking help from clergy or medical professionals. [238]

Implications: Victim Advocates and Service Providers recognize that while these studies do not tell us whether victims needs differ by race or the suitability of services offered differed by race, they highlight that services must be culturally sensitive.

Are Rural Intimate Partner Victims Receiving Domestic Violence Services/Advocacy?

Research suggests a particular need for services for victims of domestic violence in rural and frontier America. [141, 496, 503, 831] Analyzing the distribution of programs listed by the National Coalition Against Domestic Violence as of 2000, researchers found less than a third of rural counties had domestic violence victim service programs, including shelter, hotline, legal services, or counseling programs. [789] By comparison, 71 percent of urban counties had such programs. Discrepancies were also greater in terms of specific services available to victims of domestic violence. For example, only 25 percent of rural counties had battered women shelters compared to 66 percent of urban counties. Even if a rural county had a shelter that shelter may have been inaccessible to most of the county residents. Specific rural regions had even less resources. Mississippi and Kentucky, for example, had domestic violence programs in only 15 percent of their counties.

The same research also documented the difficulty grant-makers have had reaching underserved areas. Existing funding processes favor ongoing organizations. As a result, existing agencies tend to expand, but new programs that may target underserved women are often excluded. Many rural counties simply do not have domestic violence advocates or personnel available to even apply for these funds.

An Oregon study documents the disparities in services available to victims in rural and urban areas. The study examined the availability for managing IPV at rural hospitals compared to urban hospitals. It found that a smaller proportion of rural emergency departments had IPV screening policies, standardized screening instruments, clinical education, or on-site IPV advocacy. [145]

In addition to lack of services for victims in rural areas, existing services are harder to access. An Iowa study found that IPV victims living in rural and isolated areas, not surprisingly, live the farthest from IPV services. The average distance to the closest resources was three times farther for women in small or isolated areas than for women in urban or large rural towns. More than 25 percent of women in the former areas live more

than 40 miles from the closest services, compares to less than one percent of urban women.[631]

Specialized domestic violence services in traditional social service agencies are relatively recent offerings. Their development was spurred on by the absence of effective services for IPV victims seeking assistance from generic social services. [33, 212, 884] Focus groups of battered women across Ohio as recently as 2003 reported "incredibly inconsistent" response to IPV victims among "helping professionals" located in traditional social service agencies [187]

An evaluation of an Office on Violence Against Women rural faith and community-based grant initiative found that in many rural communities, faith-based organizations were the only agencies available to offer victim services. [462]

Implications: Victim Advocates and Service Providers must devise new methods of service to meet the needs of rural victims. Outreach though branch offices, itinerant services and on-line supports should be incorporated in services offered to rural IPV victims. Grant-makers should construct new approaches to funding rural IPV advocacy and services.

What Role does Spirituality Play in Victim Services?

It is well understood that spirituality plays a role in helping many people cope with life problems, including mental illness, [240] death of a loved one, [289, 554, 612] deadly illnesses, [41, 724] racial discrimination, and substance abuse. [86, 165, 713] Spiritual expression can play a similar role for domestic violence victims. Social support from religious institutions has been found to be a key factor for many women rebuilding their lives after suffering abuse. [304, 305] Other researchers have found that abuse, especially from a loved one, can cause spiritual distress. Spiritual healing can restore life's meaning and empower some victims. [215, 536, 733] The role of spirituality may be of particular importance among African American women as religion plays a larger role in their lives than among Caucasians. [143, 485, 780] A comparison study between African Americans and Caucasians IPV victims, for example, found that the former found prayer to be more helpful than the White victims. African American victims relied on it as a coping strategy while were more likely to rely on mental health counseling. [238]

A study of 151 recently physically abused women recruited from courts, local domestic violence service agencies, and legal services looked at the abuse and its impact on victim depression, quality of life, social support, and self-esteem. It also measured spirituality, the degree to which they viewed spirituality or God as a source of strength, and their involvement in organized religion. The study found that almost all of the women noted that spirituality or God was a source of strength or comfort to them, even though 31 percent said they had not attended a religious service during the prior year. The research found that the more women attended religious institutions and viewed them as a source of strength or comfort, the less depressed they were and the higher their quality of life. Greater religious involvement significantly increased social support for women of color,

but not Whites, although religious involvement did not predict self-esteem. Further, religious involvement appears to promote greater well-being for victims, decrease depression and increase quality of life. [305]

The same research found that having children was also associated with increased well-being, greater self-esteem and lower depression. [305]

According to the researchers, spirituality and religious involvement are significant aspects of many survivors' identities. [73, 304, 473]

Another study of 65 African American women who experienced IPV in the past year similarly found that women who evinced higher levels of spirituality and greater religious involvement reported fewer depression symptoms. Religious involvement was also found to be negatively associated with posttraumatic stress symptoms. The women who reported higher levels of religious involvement reported higher levels of social support. [826] On the other hand, a study of African American women utilizing a large urban public hospital in the South found that both those who attempted suicide - and those that did not - both coped with their victimization through their religious beliefs. [660]

A national survey found religious involvement was protective against IPV. Among 4,662 Catholics and Protestants surveyed, higher levels of church attendance were predictive of lower levels of reported cases of domestic violence. The exception to this pattern was fundamentalist Protestants who held strong beliefs about the inerrancy of the Bible and religious authority. [242]

A Georgia study of IPV homicide victims found that while only 17 percent had ever accessed IPV services, 30 percent had been actively involved in a religious community. [146] Another survey found that 40 of battered women reported they had been involved in religious/spiritual counseling for their IPV. [640]

Implications: Victim Advocates and Service Providers should welcome the spiritual aspect of victims' lives and identities. Staff should support the spiritual healing appropriate and necessary for many abused women. At the same time, Victim Advocates and Service Providers should collaborate with religious institutions to discuss the important role that spiritual expression can play in assisting victims of domestic violence seeking safety and agency.

IX. Do Victim Services Work?

Research shows that IPV programs "work" that enhance victims' internal resources and improve their social support. Specific programs that accomplish these include counseling, support groups, advocacy and shelter services. [60, 524, 763, 806] Participation in community-based advocacy services were found to result in higher quality of life and greater social support and less difficulty obtaining community resources compared to battered women who did not have such services. [101, 763, 766]

One study demonstrated that the most effective service components for IPV victims include domestic violence emergency shelters, support groups, information sessions, resource referral and participation in individual counseling. As to the efficacy of counseling, 60 percent of the women who received individual counseling for three or more months found them to be helpful. However, participation in psycho-educational group counseling did not play a significant role. The researchers also found that group counseling focusing on empowerment and information about domestic violence was the weakest service. Based on these findings, and reinforced by the revelation that a large percent of victims in the sample suffered PTSD, trauma recovery was substituted for empowerment in the group counseling program. [203]

Research suggests that the needs of IPV victims who suffer both physical and sexual assaults are different from those who suffer only non-sexual assaults by intimates. One study compared community-based counseling outcomes of battered women with outcomes of women who were both raped and battered by their partners. Over time, both groups improved in wellbeing and coping. While those both battered and raped benefited more from counseling, they had lower scores before and after counseling compared to women who were battered only. [350]

Other research finds that just disclosing abuse decreases victim distress. [788]

Studies have found that resources including hotlines, shelters, and legal advocacy programs are associated with lower rates of IPV homicides, net of other influences. [90, 214] These "exposure-reducing" options and corresponding public policy, generally appear to decrease the likelihood of recurring abuse and violence. [214] However, the findings of a study of IPV homicides in 48 of the largest cities in the U.S. from 1976 – 1996 suggest that "exposure-reducing" resources may not benefit all victims. When legal advocacy resources were more robust (at least by design), the fewer the number of white women killed by their husbands. However, the strength of legal advocacy resources was associated with increased killing of black, unmarried women. The study did not examine the strength of implementation of legal advocacy, e.g., enforcement of protection orders by police, prosecutors, courts and probation. Implementation may be influenced by bias related to marital status and race, thus increasing the vulnerability of unmarried, African American IPV victims. "Evidence of increased lethality… could reflect failures within the criminal justice and social service systems to adequately protect victims once they access their services… . [The] unmet promises of "exposure reduction" in severely violent relationships can be worse than the status quo." [213]

A large study of more than 5,000 cases where state officials investigated reports of child maltreatment found that when child protective services referred the mothers who were themselves abused by their partners to domestic violence services, their physical abuse declined from 54% to just 6%. In addition, maternal depression decreased, a risk factor for child maltreatment. The same study found, unfortunately, that authorities failed to refer or offer services in a third of the cases. [117a]

Not only is there very limited research on the efficacy of IPV victim services, but what works for one victim at one specific time may not work for other victims, or the same victim at different times. A victim's needs may differ over time and needs among victims may differ at all times. Also, the definition of "works" may vary from victim to victim depending upon each victim's individual circumstances and goals. Some victims may be primarily concerned with their very survival, while others may seek emotional healing from past trauma.

Implications: Victim Advocates and Service Providers recognize that not every program and service may be helpful or safeguard every victim. Advocates and providers should offer *core services* (i.e., hotlines, safety planning, advocacy, emergency shelter, information and referral, and resource-brokering). Similarly, advocates should collaborate with other social service providers and the civil and criminal legal systems to ensure robust implementation of exposure-reducing strategies and legal safeguards.

Are Victims Satisfied with the Services They Receive?

Research finds that most victims are satisfied with the services they receive, but they do not always find all of the services they receive to be adequate. [33, 212, 332, 884]

A multi-state survey of 1467 victims served by non-residential DV programs and 10 focus groups of victims from specific diverse populations found that respondents reported that more than 75 percent found each of the 4 types of services offered, i.e., support services, counseling, group counseling, and legal advocacy, very helpful. The vast majority of the respondents stated that they received some or all of the help needed from the 54 sub-categories of assistance provided. Respondents advising that they received all of the help they wanted were affiliated with the program for longer periods of time. Those who reported at least one unmet or inadequately met need in the year prior to the survey (28 percent of the respondents) primarily identified needs of a financial nature (e.g., acquiring a job, transportation, rent, and other cash assistance); many of these needs were beyond the scope of assistance offered by the non-residential DV programs. Respondents recommended expanding culturally-specific programming, immigration-related assistance, interpreter services, resources to meet economic needs, support to meet the mental health needs for victims and their children. [510]

In other research in the Midwest, 423 IPV women victims of childhood physical abuse, childhood sexual assault, adult sexual assault (67 percent), and IPV (92 percent) were

asked to identify the rate of use and the helpfulness of services or resources they received in the aftermath of violence. Note, the sample included women in prison (1/3), those receiving DV or SA program services (1/3), and women not receiving DV program services in the year prior to the study (1/3); 40 percent had experienced at least two types of victimization. The 3 cohorts of victims were consolidated for analysis. They identified the following as most used: 1) Emotional support from friends/family (76 percent); 2) professional counseling (64 percent); 3) medication for emotional problems (53 percent); 4) welfare (51 percent); 5) Support/self-help (50 percent); 6) medical providers (48 percent); 7) civil legal services for divorce, restraining orders (46 percent); 8) psychotropic medication (44 percent); 9) food banks and 10) religious/spiritual counseling (40 percent). When asked to rate the most helpful of the services received, they listed as most helpful (on an ascending scale of 1 to 5: 1) subsidized welfare (4.6); religious/spiritual counseling (4.3); 3) subsidized housing (4.3); 4) welfare (4.3); 5) education services (GED, vocational) (4.3); 6) food banks (4.2); 7) job training (4.2); 8) unemployment comp (4); 9) rape crisis or sexual assault services (3.9); 10) domestic violence shelters (3.9). Overall, financial and economic assistance were the services/resources deemed most helpful in the aftermath of violence. [640]

Other studies found that just because victims use services does not mean they are found to be the most helpful. For example, those seeking mental health treatment complain that some providers fail to focus on the abuse, are quick to provide medication, but not support, and do not appreciate or understand the trauma victims experienced. [409, 883] Further, a study of battered women in Ohio found the majority had received individual counseling services. Individual counseling offered by DV programs were reported to be helpful. The verdict, however, was much more mixed for individual counseling obtained outside of DV programs. While some found it helpful, others did not. Those who found the counseling unhelpful reported therapists urged them to reconcile with their abusers or attend couple counseling. [187]

Implications: Victim Advocates and Service Providers, recognizing that IPV programs cannot address all the service, resource and advocacy needs of the victims they serve, should evaluate whether IPV programs might expand to more comprehensively and effectively meet the needs of victims. IPV programs should cross train and collaborate with state and local human agencies and advocacy organizations to identify the matrix of services currently available to IPV victims throughout their communities and to devise a plan for improvements and/or expansion in services and delivery systems. Victim Advocates and Service Providers should cooperate with, even encourage researchers to evaluate services to promote evidence-based services.

How Do Victims Rate Shelter Services?

Shelter programs have been found to be among the most supportive, effective resources for abused women, this according to the women who obtain shelter in them.[55, 768, 807, 511] Interviews reveal that residents feel shelters increase their knowledge of their

rights and options, resources, safety strategies, and make them feel more hopeful about the future.[765, 764, 768]

A multi-state study, surveying 3,410 shelter residents in 215 DV shelters in eight geographically diverse states measured the impact of shelter on IPV victims. The sample of victims included: more women of color than in the populations of each state; more than half without children or not accompanying mothers to shelter; and only 13 male victims. Exit surveys related to the impact of shelter services showed that residents were better able to achieve their goals (93 percent), more hopeful about the future (92 percent), more able to act without assistance (92 percent), engage in more nuanced safety planning (91 percent), better informed about options (90 percent), more confident in their decision-making (90 percent), more comfortable about requesting assistance (89 percent), more comfortable talking about problems (86 percent), and more knowledgeable about community resources (85 percent). The longer the residence of a victim, the more likely the victim rated shelter benefits as above. [511]

Survey respondents also reported that they experienced problems while in shelter. The most frequent was conflict with other residents (32 percent), followed by difficulty with transportation (24 percent), shelter rules in terms of time limits and curfews (15 percent), child disciplining (13 percent), and chores (13 percent). The lack of interpreter services was an issue also identified by residents. More than half of the identified problems were resolved during shelter stay. Over 90 percent of LGBTQ victims, women of color, and victims over 50 said they were respected by shelter staff. The assistance received was rated as helpful (18 percent) to very helpful (74 percent). Respondents who answered surveys in Spanish rated the assistance received most highly. Ninety-seven percent of respondents would recommend the shelter to a friend. Male victims stated they received help on 8 of the 10 needs they identified at intake. [511]

A survey of women residing in Rhode Island's six domestic violence shelters found, for example, that all rated as most helpful just knowing they had a secure, safe place to stay. This was followed by the group support they received from other residents, domestic violence education received from shelter staff, as well as information on finance, employment, housing and planning for the future. Only a minority noted counseling to be what they found most helpful. [451] A similar survey on Ohio found the majority reported their experiences in shelters were "very helpful" and "supportive."[187]

An evaluation of the services offered by one DV program in the Midwest found that the four types of services offered (hotline, shelter, advocacy and counseling) were deemed helpful by victims. The overall effect of receipt of DV services was small. However, outcome measures from shelter stay showed that residents experienced improvements in self-efficacy, coping skills, goal-setting, and understanding abuse. Respondents also reported that they were comfortable while in shelter and experienced the staff as respectful. Although respondents were diverse, there was an under-representation of Whites and Latinas respondents and an over-representation of African American victims in the sample. Shelter staff from around the state participated in the development of the instrument and in the evaluation process. [55]

While some victims may not seek or require shelter, battered women shelters may not be available to all victims, including those denied entrance for substance abuse, mental or physical health issues or disabilities. Other victims may not feel comfortable in shelters or shelters may not be able to provide for them. This may be particularly true if they differ from shelter staff or the majority of shelter residents based on sexual orientation, language, culture, religion, ethnicity or race. For example, one survey found Asian/Pacific islanders were the least likely to say shelter staff made them feel welcome or that the shelter seemed like a place for people like them. [511] Another found Black women felt isolated in shelters because there was an absence of ethnic staff. [266]

Studies also reveal that two groups are generally underserved by shelters, abused women under age 20 and older women. The former may be excluded by law because they are not legally emancipated. The latter may not find facilities suited to them, e.g. limited mobility access, programs designed for young to middle-aged victims, and shared living facilities with other residents' minor children.[765]

On the other hand, a Rhode Island study found that even among abused homeless women, some prefer shelter in non-domestic violence shelters. Among women entering the state's non-domestic violence shelters in 2002-2003, 22.4 percent of the single women and 39.6 percent of the women with children admitted to shelter said domestic violence was the primary reason for their homelessness. About 17 percent of single abused women and 14 percent of abused women with children in shelters sought refuge in non-domestic violence shelters, although the domestic violence shelters generally had beds available for them.[389]

An evaluation of one homeless shelter in the Midwest found through 20 interviews and field observations with women residents that it operated as a "total institution," inhibiting resident empowerment and autonomy. Residents were, in effect, cut off from the wider society for an appreciable period of time. [202] One scholar suggests that some DV shelters may operate similarly. [569] In a small, qualitative study of the experience of victims in a DV shelter in the Southwest, the researcher found that the shelter "was driven by concerns about its rules and policies." Rules covered most aspects of the lives of residents. Breaches of rules were sometimes harshly penalized. Shelter schedules were largely inflexible. Five mandatory counseling sessions were required weekly. "Staff controlled access to various privileges, resources, and material goods." One minor example of the power exerted over residents was the padlocking of refrigerators. Some residents analogized the overarching power wielded by staff as akin to that of their abusive partners. The constraints arising from the "privacy" of shelter services isolated victims from their support networks. On the other hand, residents praised advocacy services and reported that the shelter was a safe and comfortable environment. [569]

Many state DV coalitions and local shelters, recognizing the contradictions between "total institutions" and the philosophies embraced by the shelter movement, have sought to revise shelter operations to facilitate the agency and empowerment of residents. [395, 566, 616]

Implications: Victim Advocates and Service Providers can be pleased that women who utilize DV shelters generally rate them as very helpful. While the *core services*, sheltering, advocacy, hotline, and counseling, are highly valued by shelter residents, economic or financial services/resources are of comparable importance to residents. Advocates and providers should examine the feasibility of expanding resident access to economic resources and financial services, either through shelter or allied agencies in the community.

Have Programs Proven Effective in Responding to Reproductive Coercion?

A study at family planning clinics in California investigated the effectiveness of a brief intervention program for female patients experiencing reproductive coercion. Results showed a 70 percent reduction in the likelihood that female patients would continue to experience pregnancy coercion. The brief intervention consisted of family planner counselors asking a series of questions of women related to their partners' attempts to force them to become pregnant. With those revealing reproductive coercion, counselors discussed harm reduction strategies, such as injectable birth control and other safety measures. As a result of the interviews, coercion was reduced by 70 percent over a comparison group of patients who, while screened for intimate partner abuse, were not questioned specifically about reproductive coercion. In addition, the abused patients who were interviewed were also 60 percent more likely to end their relationships with abusive partners. The study was conducted in four Northern California family-planning clinics between May 2008 and October 2009. The brief intervention was offered in two sites and two other sites were used as controls. The two control sites provided standard domestic violence and sexual assault screening. Participants included approximately 900 English- and Spanish-speaking women between 16 and 29 years old, with the vast majority of the women, 76 percent, aged 24 or younger. [557]

Implications: Victim Advocates and Service Providers might screen at intake (or after first delivery of services) for reproductive coercion of female victims. It appears that identifying women experiencing reproductive coercion and offering harm reduction advice may significantly reduce further abuse.

Are Battered Women Shelters Responding to the Heightened HIV Infection Risk of Victims?

A regional study suggests that many domestic violence shelters find the challenge of responding to the heightened risk of HIV infection among victims seeking refuge beyond their capacity. [685, 751] Researchers surveyed 21 domestic violence shelters in the southwest, located in rural, suburban and urban locations. Most of the shelters lacked sufficient HIV/AIDS policies and programs to respond to their clients' heightened risk of infection. While almost all of the shelter intakes asked about their clients' sexual abuse histories, there was no link between what was disclosed and provision of HIV/AIDS

services such as referral for testing or treatment. While HIV/AIDS awareness was high among shelter staff, prevention and education programs concerning HIV/AIDS were nonexistent. [685]

Although most of the shelters felt they should provide HIV/AIDS programming, only three shelters reported their staffs were trained about a woman's risk of acquiring STIs, only five reported staff counseled clients about methods to prevent and treat STIs, and four specifically talked about HIV/AIDS. Only one reported that HIV/AIDS prevention was part of the safety planning process completed with shelter clients. All shelters made referrals to appropriate HIV/AIDS agencies if clients requested them.

Successfully treating abused women for HIV may prove as challenging as it is necessary. Research suggests that women with HIV are more than twice as likely to have been victims of IPV and five times more likely to have PTSD compared to a national sample of American women. Women with HIV who report recent trauma are over four times more likely to fail their HIV treatment and almost four times more likely to engage in risky sexual behavior. [512, 513] As a consequence, effectively addressing trauma in STD/HIV/AIDS treatment has the potential to enhance both recruitment and retention of battered women therein.

Implications: Victim Advocates and Service Providers should inform victims about their heightened risk for STDs and HIV/AIDS. Education about sexual coercion and the risk of STIs and HIV/AIDS will enable victims to make informed decisions about their health and wellbeing. DV programs should develop referrals for treatment with healthcare agencies that recognize the power of abusive partners, not only to coerce unprotected sex, but also to interrupt treatment for HIV/AIDS. Treatment for victims with STIs/HIV/AIDS should address trauma-recovery.

Do Services Reduce Abuse of Pregnant Women and New Mothers?

Even limited counseling of pregnant abused women has been found to reduce reabuse rates. In a study, 132 pregnant women received three counseling sessions that were designed to reduce further abuse. A comparison group of 67 abused women were offered wallet-sized cards listing community resources for abuse. Women in both groups were followed at 6 months and 12 months post-delivery. Researchers found significantly less violence reported by women in the intervention group than by women in the comparison group. [623, 546, 543]

A meta-analysis of more than 128 articles on home visitation program for pregnant or postpartum women suffering intimate partner violence found that although the programs were not designed to specifically address intimate partner violence, they "likely" improved pregnancy and infant outcomes. [717]

Similarly, a Hawaiian study of more than 600 **new mothers** found those who received in-home visits from counselors after giving birth were less likely to report being physically

abused by current or former intimates compared to mothers who did not have home visits. The trained counselors visited weekly, teaching about child development, demonstrating positive parenting and problem-solving, and offering emotional support as well as connecting families to community services including IPV shelters, advocacy groups, and mental health treatment. By the third year, most of the families were no longer receiving visitation. The abuse was measured during the first three years after the birth of the children and then again when they were 7 to 9 years old. While physical abuse decreased significantly for victims receiving visitation, verbal abuse did not. Researchers suggest that the program encouraged self-efficacy which may have contributed to the decrease in IPV. The mothers trusted the counselors and the relationship provided social support and decreased isolation. [32]

Implications: Victim Advocates and Service Providers should investigate the range of social service and health agencies provided to pregnant women and new mothers in their communities. Collaboration with these agencies (and others that offer educational, recreational and faith-based programming for young children) to employ even brief support and information modules for mothers about IPV, including safety planning, legal options and other strategies to intervention, may ~~result in~~ reduce~~d~~ reabuse during pregnancy and new motherhood. Home visitation programs for pregnant and postpartum mothers should specifically address intimate partner violence.

How Can the Detrimental Effects of Child Exposure to Domestic Violence Be Mitigated?

One recent study suggests that children who are traumatized as a result of witnessing intimate partner violence and show signs of PTSD can benefit from a relatively brief community-based trauma-focused cognitive behavior therapy (TF-CBT). Both intimate partner violence-related PTSD and anxiety symptoms were significantly reduced after children, ages 7 to 14 years, received eight 45-minute individual therapy sessions. Two of the sessions were with their mothers. Key components of TF-CBT included: 1) resiliency skills for child and parent (trauma education, relaxation, feeling and behavioral modulation skills); 2) changing unhelpful thoughts such as self-blame; 3) creating a narrative about the domestic violence; 4) helping the mother to understand the affects of IPV on the child; 5) developing optimal ways of staying safe; and 6) focusing on how children could feel safer in the face on ongoing danger. [151]

The study found that 8 weeks of TF-CBT was superior to 8 weeks of child-centered therapy, the most commonly applied therapy. The PTSD remission rate was significantly higher in TF-CBT completers relative to CCT completers (75 percent v. 44 percent). The treatment was provided in a domestic violence shelter. Although dropout rates were high, almost 40 percent, the rate was lower than that commonly found in community mental health centers. According to researchers, the sessions helped children gain skills and talk directly about their trauma experiences in order to gain mastery over these experiences. [151]

A longitudinal study comparing 100 children, ages two through four years old, who witnessed intimate violence against their mothers and compared them with 70 who had not, also suggested the importance of working with nonabusive parent of children witnessing IPV. As expected, the children witnesses were four times more likely to suffer emotional and behavioral problems, with those as young as one year exhibiting trauma symptoms. However, a little more than half of the exposed children did as well as the children not exposed. Two resilience-promoting factors were found: 1) healthy, supportive mothers and 2) easy-going natures of the children. Support for battered mothers that may mitigate the adverse mental and emotional impact of IPV may also help to mitigate traumatic and other adverse effects for children witnesses. [533]

Implications: Victim Advocates and Service Providers should explore educational and therapy programs for children exposed to IPV. Many such programs have been developed. Few have been evaluated. Costs may be prohibitive for many battered mothers. Yet, children exposed to IPV who evidence emotional and behavioral problems may benefit from specialized IPV-informed services to foster emotional and behavioral well-being. Advocates and providers should inform victims about the importance of healthy, supportive mothering in fostering the resilience of their children. An array of parent-support services should be offered to battered mothers.

What Works for Victims Experiencing PTSD?

The greatest number of studies of PTSD treatments haves focused on exposure-based treatments and cognitive interventions. (The former involves having survivors repeatedly re-experience their traumatic events. The latter's primary focus is challenging and modifying maladaptive beliefs related to the trauma, but also includes a written exposure component. Cognitive behavioral treatment includes psycho-education, anxiety management, exposure, and cognitive restructuring.) Both exposure and cognitive behavioral therapies have been found to benefit female trauma victims. [96, 659, 658]

Research on treatments for PTSD experienced by battered women is nascent. Cognitive Processing Therapy (CPT) has been found to be effective specifically for women who have experienced frequent IPV. [659] In a small clinical study of ethnically diverse battered women in Hawai'i, preliminary findings revealed that three months after completion of the cognitive trauma therapy, 94 percent of the victims no longer suffered from PTSD symptoms and experienced reduced depression, guilt and shame with a corresponding improvement in self-esteem. [476] The first evaluation of a cognitive behavioral treatment model (HOPE) designed for battered women in DV shelters suffering PTSD or sub-threshold PTSD revealed that the treatment effect 6 months afterwards was minimal (and did not reach statistical significance) related to PTSD symptoms. However, participants in HOPE, as compared to the control group, were less likely to experience reabuse at follow-up. [426]

There are evidence-based treatment programs for women suffering from PTSD and substance use disorders, including Seeking Safety. [166,198,878, 879]

Implications: Victim Advocates and Service Providers recognize that the trauma experienced by IPV victims may cause some to suffer PTSD. While the research on PTSD treatment of IPV victims is not yet sufficient to show compelling treatment effect, clinicians are exploring various trauma-informed treatments for PTSD and other psychological distress experienced by IPV victims. Services offered victims should be trauma informed.

X. What Role Do Health Care Providers Play in Responding to Intimate Partner Violence?

Many victims regularly come into contact with medical and health care providers although the providers may not identify their patients as victims of IPV. In fact, early help-seeking by battered women is often with healthcare providers. [78] Health care providers are in the position to assess victim health needs (related to abuser violence and victim isolation, depression or suicidality), to assist in safety planning, to provide preventive healthcare, follow-up consultations, and information-sharing about legal options and supportive community resources.

Research suggests, however, that women victims of IPV may not seek health care when they encounter providers who appear "uninterested, uncaring, or uncomfortable" about domestic violence.[117] In addition, screening and risk assessment by healthcare providers makes little sense if they have no idea what to do once IPV is assessed. [603]

Recognizing the importance of effective screening, risk assessment, continuing health care and informed referrals to community agencies, researchers undertook a quasi-experimental study of emergency departments, primary care facilities, and pediatric clinics in a Midwest, university city to determine if explicit changes in healthcare practice (i.e., screening; improvements in confidential care; internal advocacy by nursing staff; enhanced capacity of doctors and nurses to discuss sensitive and complex issues related to violence against women; upgraded referral practice; and routine communication with victim service staff) would improve healthcare delivery to battered women. The study anticipated improved health and safety outcomes for those DV patients in the "intervention" group rather than those in the "as usual" group.

The design of the study - "Healthcare Can Change From Within" (HCCW) – was change generated within the health sector. It was posited that institutionalizing a change model within the healthcare system could better produce change that would be effective, sustained and modified through on-going evaluation. The model created an internal network of professionals within each participating health sector who would advocate for essential reforms. The methods of change employed were: saturated training of all staff, adoption of parallel policies and procedures, development of relationships with community victim services personnel, continuous evaluation of changes, and primary prevention. [351]

Researchers reported that prior efforts at significant change of the healthcare system had generally been initiated by victim advocates and services providers. As a result, adoption of methods of change was uneven. Outcomes for providers and victims were unsatisfactory. Attrition was high. The health of victims appeared compromised over the lifespan, even after the abuse terminated, due to the lack of continuing access to healthcare, among other factors. [351]

As to benefits for victims in the "intervention" as contrasted with the "as usual" group, the results were not as strong as expected. However, the "intervention" and the "as

usual" battered women experienced significantly lower rates of violence during the study. The two groups engaged in similar, but modest, increased rates of help-seeking, safety-planning, cultivation of relationships and connections within the community, improvement of health, or satisfaction with healthcare services. The researchers suggest that participation in research interviews may have created an unintentional positive intervention related to help-seeking and community connection for the "as usual" group. [351]

Implications: Victim Advocates and Service Providers should collaborate with medical and health care providers to assist them in identifying IPV victims and responding once identified. Response should include acute and continuing health care and referrals to appropriate community agencies and resources.

Do IPV Victims Utilize ERs?

Studies indicate that IPV victim trips to ERs are frequent. Most ER visits of battered women may be for medical complaints other than physical injuries. [579] The high utilization of ERs by battered women is the result of the negative physical and emotional health consequences of the abuse, and is not limited to injuries sustained from a specific assault. [1, 579]

In one study a little more than 20 percent of the visits involved mental health or substance abuse issues. However, based on limited screening, the study documented that 5.8 percent of the visits were the result of IPV assaults, involving 23 percent of the study victims over the three years. Those victims with the most visits were the most likely to have been identified as IPV victims. [699]

Another study looked at the ER utilization by battered women in a southwestern Michigan county served by two trauma centers and six ERs.[469] It found that among women identified by the police as victims of IPV, almost all utilized ERs, most multiple times over the three year study period. Researchers found that nearly 67 percent of the victims used ERs in 2000, the same year they were identified by local prosecutors as IPV victims. Over three years, going back to 1999 and forward to 2001, their ER usage rose to 81.7 percent. The IPV victims who visited ERs visited them 4,456 times, with a median of 4 four visits each. [662]

The Michigan study also found that not all of the identified victims in the study went to ERs. Those victims who used ERs were more likely than those who did not to be Black, younger, and victims of boyfriends rather than husbands. This may reflect in overall differential uses of ERs based on access to private physicians and health insurance. It should be noted that researchers found that most of the more chronic ER users went to different ERs over the three years, making it more problematic for ERs to identify chronicity of victimization. [662]

While the negative health consequences of IPV are well documented, [158, 153, 553] many ERs are still struggling with identifying IPV victims and attending to more than the immediate medical conditions that bring them to the hospitals. [469, 662]

Implications: Victim Advocates and Service Providers should collaborate with ERs and emergency care facilities in identifying and serving IPV victims. To fully address the needs of IPV victims, the scope of medical services must go beyond identification and emergency treatment to include prevention, risk assessment, safety planning, follow-up medical care and referral to appropriate community services. Since ERs may be the "gatekeepers" of the health care system (and provide many referrals to DV programs and beyond), it is critical that all staff of these facilities have broad knowledge of the resources available to IPV victims in the community. ERs should develop modules of information and referral for IPV victims to be shared both orally and in writing with abuse victims. Since many poor women live in communities with few medical practices and virtually no urgent care facilities, ERs are often the only medical care available. To deliver these essential medical and human services, collaboration between hospitals, DV programs and community agencies is essential.

Do Hospital ERs Successfully Identify IPV Victims Seeking Emergency Medical Treatment?

The most recent study of use of ERs by IPV victims found 993 female victims generated 3,246 police incident reports over a four-year period and 80 percent of these victims ended up in ERs, almost all with medical complaints. Yet, ERs identified only 28 percent as IPV victims, even though, on average, these women visited ERs seven times over the four year study period. Researchers found that ERs tended to identify patients as IPV victims only if the patients self-disclosed, had filed an IPV complaint that day, were brought to the ER by police, or had mental health or substance abuse problems. [662]

Implications: Victim Advocates and Service Providers should reach out to hospital ER staff to assist them in developing methods of identifying IPV victims, including those victims with no visible injuries.

Does Universal Medical Screening Help IPV Victims?

While previous research failed to find that health provider screening for IPV promoted increased safety or other benefits for IPV victims, more recently, the research indicates there are benefits of universal medical screening for IPV.

A 2012 review of 15 studies undertaken by the U. S. Preventive Series Task Force that evaluated the accuracy of screening for IPV found that: 1. IPV screening instruments designed for health care settings can accurately identify women victims of IPV.
2. Screening women for IPV can reduce IPV and improve health outcomes (noting that

there are important limitations in “effectiveness” studies. 3. Screening had minimal adverse effects on women, although some women experienced “discomfort, loss of privacy, emotional distress, and concerns about further abuse.” [593]

A review of all major studies conducted on the topic between 1990 and 2010 concluded that while universal screening is not always accurate, if the screening program has the support of the institution and senior administrators where it is performed, and meets minimum standards, it is “very effective and more patients can be helped.” However, the study also found that not all screening programs are equal. To be successful, the questions must be standardized, patients must be questioned privately, and, most importantly, immediate services and referrals must be made if IPV is revealed. Successful screening programs had support services in place for individuals who disclosed IPV, including, but not limited to, mental health services, safe shelters or transitional housing, health care, employment assistance and legal services. The review challenges the measures used in some prior studies that looked primarily at whether the screening resulted in less abuse because so many other factors are involved in reabuse. The researchers posit that one measure of the utility of screening is whether it results in the immediate provision of support services and/or referrals to community agencies. [603]

Another study of multiple ERs found that when screening was conducted, it made a difference. When the ERs did identify a IPV victim, researchers found that ER staff ~~they~~ acted to help. Almost all ER staff provided legally useful documentation of injuries. Half contacted police and a social worker for follow-up. However, only a third assessed whether or not the victim had a safe place to return to after leaving the hospital and only a quarter referred victims to domestic violence service providers. [662]

In addition, screening may prevent IPV victim suicides. While tradition suicide screening looks for depression, research suggests that IPV should be added to the suicide screening protocol. For this reason, Kaiser Permanente of Northern California, an HMO with over 3 million members and 20 medical centers, has instituted a program of primary care suicide prevention that seeks to reach patients who are not involved in mental health clinics. As a result, Kaiser Permanente screens for depression, anxiety, substance abuse, <u>and</u> now intimate partner violence.[490]

A recent study among women seeking healthcare in UK primary care surgeries who had experienced physical and sexual abuse from a partner or ex-partner in the previous year found they wanted their doctors to ask them about IPV, refer them to help, but not demand they leave their abusers before they are ready. [521]

IPV screening is recommended by most every major professional medical organization including the American Medical Association (AMA), American Academy of Family Physicians (AAFP), American College of Physicians (ACP), American College of Obstetricians and Gynecologist (ACOG), American Academy of Pediatrics (AAP) and the American Psychiatric Association (APA).

Implications: Victim Advocates and Service Providers should encourage healthcare providers to adopt IPV screening for all patients and collaborate with them to establish protocol for triage, risk assessment, safety planning and referral to appropriate community agencies for support and resources.

How Should Medical Screening Be Administered?

There has been limited study of which medical screening programs and protocols are best. One such study employed a randomized trial, conducted from May 2004 to January 2005 at two emergency departments, two family practices, and two women's health clinics across Ontario, Canada. [514] The study involved English-speaking women, aged 18 to 64 years, who were well enough to participate and could be seen individually. Almost all of the 2,602 women eligible for the study (95 percent) agreed to participate. Three screening approaches were tried, a face-to-face interview with a health care provider (physician or nurse), a written self-completed questionnaire, and a computer-based self-completed questionnaire. The various instruments identified 4.1 percent to 17.7 percent IPV. Although there were no significant differences in determination of prevalence depending on the screening method, instrument, and health care setting, the face-to-face approach was least preferred by participants. Women preferred self-completed approaches over face-to-face questioning.

Another study involving multiple data bases examined what IPV victims expect when they encounter health care professionals. The researchers reviewed 29 articles reporting 25 studies involving English-speaking females 15 years or older with experience of intimate partner violence. They found the women desired responses from health care professionals to be nonjudgmental, nondirective, and individually tailored, with an appreciation of the complexity of partner violence. However, women's perceptions of appropriate and inappropriate responses partly depended on the context of the consultation, their own readiness to address the issue, and the nature of the relationship between the woman and the health care professional. For example, repeated inquiries about partner violence was seen as appropriate by women who were seriously concerned about the risks posed by the IPV perpetrator and were contemplating separation or termination of the relationship. [259]

Implications: Victim Advocates and Service Providers should review screening instruments and methods utilized in healthcare settings throughout their service area to determine if screening is accurately identifying IPV victims. Any review should assess the administrative support for IPV screening available in each healthcare agency, especially among women who are repeatedly utilizing ERs. If identified, responses should be nonjudgmental, nondirective, and individually tailored, with an appreciation of the complexity of partner violence. Heath care providers not engaged in IPV screening should be encouraged to do so.

XI. What Do Victim Advocates and Service Providers Need to Know About the Legal System?

There are two sides of the legal system, civil and criminal. For IPV victims, they may most likely be involved in the former to request civil orders of protection, divorce and/or custody of children and related issues although this review will be limited to research on civil orders of protection. Victim involvement in the criminal system may typically involve being witnesses if their abusers are arrested and prosecuted. Distressingly, too, victims may be charged as defendants as a result of a dual arrest by police or failure to determine the primary/predominant aggressor.

A. What Do Victim Advocates and Service Providers Need to Know About the Civil Legal System, Specifically Civil Orders of Protection?

Every state, U.S. territory, and the District of Columbia provide civil protective orders (CPOs) enabling victims of intimate partner violence to obtain court injunctions barring their current or former partners from abusing and/or contacting them, as well as other provisions authorized by state statute or judicial order. Other provisions may include: vacate and stay away from the victim's home, school, place of employment or other specified locale; temporary custody orders that may limit access of the abuser to the children of the couple; payment of child support or maintenance orders; compensation to victims for loss of wages, damaged or stolen property, counseling fees, purchase of security devices, and/or health costs orders; payment of attorney's fees; orders for exclusive use of property by victims, such as vehicles, computers, or medical equipment; directives as to payment of taxes or other debts; and orders enjoining surveillance or stalking by abusers, whether in person or through 3rd parties or by electronic means, including phone, email, texting, and social networking sites. Orders can also direct abusers to surrender and not possess any firearms, ammunition and weapons permits. Most statutes allow judges to award other relief that they believe will facilitate the safety of adult and child victims of IPV. CPOs are a legal tool that is unequaled both in constraint of IPV perpetrators and the provision of a broad scope of protective relief for victims [371, 452].

But civil protection orders may constitute more than the sum total of such provisions for some victims. They may, if obeyed, serve to interrupt the dominance and power of the abuser over the victim; enabling victims to create stable, violence free homes and reclaim their authority to make and execute decisions without interference or coercive control by abusers [11].

In many jurisdictions, victims may obtain emergency orders, usually with the assistance of local law enforcement, followed by temporary ex parte orders. These are obtained based solely on the affidavit of law enforcement or the petition of the victim. The respondent (the alleged abuser) then receives notice for a hearing on a "final" order and may contest the order at that hearing before the "final" order is issued by the court. The

duration of the "final" order is contingent on state law and the discretion of the judge; typically statutes provide for durations of one year up to life.

Courts may issue similar orders concurrent with an abuser's arrest for IPV. These orders are not necessarily requested by the victim and may even be opposed by the victim. They usually run until the arrest is resolved in court and then the criminal protection order may be incorporated into the sentence if the abusers admit guilty or are found guilty and the judges so order.

Similarly, every state and the District of Columbia have amended their criminal statutes since the 1970's to allow for warrantless arrests, based on probably cause, of at least some IPV perpetrators. Most states have extended the warrantless arrest authority of law enforcement to arrest for explicit violations of provisions of CPOs.

Federal law requires states, territories, and tribal nation courts to enforce CPOs issued by other jurisdictions. Military-issued protective orders are only enforceable within the military. However, military command staff are obliged to enforce civilian CPOs on military installations. [452]

Implications: Victim Advocates and Service Providers should be acquainted with the protection order law and practice in their own and contiguous jurisdictions. Protection orders are not self-implementing. Advocates should ~~to~~ be able to accurately inform victims of IPV about their eligibility for CPOs, the relief available, application processes, court procedures and enforcement of CPOs.

Are Arrested Perpetrators of IPV Different from Court-Restrained Abusers against Whom Victims Have Obtained Protective Orders?

Research suggests that abusers who are respondents in civil protective order~~s~~ cases differ little from their peers arrested by police for domestic abuse. Studies have found that each have equivalent criminal histories [245], ranging from 65 percent in a study of respondents in Denver, Delaware and the District of Columbia [444], to a little more than 70 percent in a Texas study [121], and 80 percent in a Massachusetts study. [455] Another Massachusetts study of protective order violators found 80 percent had a prior record, 69 percent for a non-domestic, but violent offense. [7] One of the reasons for the substantial overlap between abusers brought to court for civil protection orders and those arrested for abuse by police is that many petitioners come to civil court as a result of police encouragement following an abuse incident involving police. In a multi-court study, 43 percent of victims who obtained civil protective orders said they either learned of the orders or were encouraged to apply for them from police responding to a domestic violence incident. [647] Another hospital-based study documented that 70 percent of women who received police assistance for abuse obtained protective orders against their abuser. [748]

A study of 400 male IPV stalkers in KY revealed significant criminal histories prior to the index stalking crime. Of those with one or more prior CPOs, 31.5 percent had prior

protection orders; 64 percent had prior misdemeanor violent threatening charges and 24 percent felony; 36 percent had drug/alcohol misdemeanor charges and 14 percent felony; 21.6 percent had misdemeanor property offenses and 34 percent felony. [501]

Implications: Victim Advocates and Service Providers should be aware that respondents in CPO cases may have criminal histories, as well as pending charges for IPV and other crimes. The civil court may run a criminal records check, but victims may choose to advise courts about criminal histories related to IPV, child abuse and other crimes of violence or stalking. Courts can best craft comprehensive CPOs when they understand the full spectrum of respondent criminal history and the understand that victims seeking CPOs may be at elevated risk for reabuse.

Which Victims Seek Civil Protective Orders?

Most persons seeking protective orders do not seek CPOs the first time they are abused. Most suffer multiple incidents over several years before petitioning. [435] However, only a small minority of IPV victims seek orders. Several studies based on samples of women who reported abuse to police found only 12 to 22 percent secured protective orders. [397, 841] According to the NVAWS, only 16.4 percent of rape victims and 17.1 percent of physical assault victims, and 36.6 percent of stalking victims seek orders. [791]

One reason victims do not seek orders is because they do not know about them. While there is little research directly on point, at least some research suggests that knowledge of CPOs may be extremely limited at least among certain populations of victims. For example, researchers found that among a sample of immigrant women who sought services for domestic violence from among 14 agencies offering advocacy services to battered immigrant women, 61 percent had no prior knowledge of protective orders. [225] Among the general population of victims, the large correlation between police intervention and petitions for CPOs suggests police either inform victims about orders or motivate them to access orders. [647, 373]

Research suggests that victims who seek orders may be different from those who do not. The former tend to be White~~r~~, older, better educated and with higher incomes. [444] Victims who are economically dependent upon their abusers may be less likely to seek or maintain orders. [586] However, many residents of DV shelters seek CPOs; a survey of victims in battered women shelters found that had 40 percent obtained orders prior to entering the shelter. [636]

Victims who know about orders may not seek them because of reluctance to reveal intimate details in open court, the time-consuming steps that may be needed to secure orders, or their perceptions about the hostility of court personnel, including judges. [549, 267, 647]

A Kentucky study asked victims about barriers to seeking orders. The biggest barrier reported was the limitation of the law's reach, e.g., failing to include dating relationships.

In addition to statutory deficiencies, other barriers included expectations that victims would not be believed, that they lacked evidence of abuse, or that they would present poorly in court. Victims said they would not pursue orders out of fear of retaliation from the abuser or his family, or wish that the abuse would just go away. Others expressed lack of support or resources to follow through, combined with embarrassment, fear of being blamed, and fear of child protective services involvement. Barriers related to the court included inconvenience, bureaucracy, lack of knowledge about how to navigate courts, as well as perceived bias or prejudice of judges. [504]

Implications: Victim Advocates and Service Providers should conduct community education and outreach about civil protective orders to victims and the general population. Outreach might especially target victims and their allies who are immigrants or non-English speaking, elders, LGBT, those with disabilities, and those who are isolated, rural or not recipients of police services.

When Do Victims Seek Protective Orders?

The research agrees that most victims do not request civil orders after the first abuse incident or assault. According to NVAW survey, only 16.4 percent of rape victims, 17.1 percent of assault victims and 36.6 percent of stalking victims sought orders following an abuse incident. [791] A survey of women in battered women shelters found only 40 percent has obtained orders prior to entry. [636] Several studies of women who reported their abuse to police found no more than 22 percent secured protective orders. [397, 841]

The research agrees that most victims who do request civil orders do not do so after the first abuse incident or assault. Generally, victims petition courts for orders after failing to stem the abuse through other means. In a multi-court study involving both an inner city minority jurisdiction and a suburban non-minority city south of Boston, prior to petitioning court for an order, female victims had tried to protect themselves in a variety of other ways first. Perhaps most significantly, more than two-thirds, 68 percent, had left their abuser at least once and 15 percent had kicked their abuser out at least once before petitioning the courts for orders. In addition, three-quarters, 78 percent, had called police at least once before, 30 percent had obtained counseling, 25 percent had called a hotline or gone to a shelter. [647] A study of stalking victims similarly found that most victims initially attempted to handle the situation themselves before seeking legal assistance. [83]

Most victims who petition courts for CPOs have suffered several years of abuse with the same abuser before coming to court for the first time. In a multi-state and District of Columbia study, researchers found 10 percent sought protection orders after only a week of abuse, 15 percent experienced abuse for one to two years and nearly a quarter had endured abuse for more than five years. [444] In a Colorado study, the average female petitioner suffered a dozen abusive behaviors in the year prior to requesting their orders; the abuse ranged from being sworn at to rape. A fifth of the victims reported the prior abuse included severe violence, including strangulation, forced sex and beating. The duration ranged from once to 31 years with a median of 2.4 years. [365] A Texas

protective order study found that 68 percent of the victims taking out orders had been physically abused by their partners in the two years before they took out orders. [121]

Implications: Victim Advocates and Service Providers assisting battered women petitioning for CPOs recognize that while court forms typically focus on the most recent, discreet violence, the triggering incident rarely reveals the full spectrum and severity of the abuse suffered by the petitioner nor the risk faced for future abuse. Petitions can succinctly apprise the court of the history of the violence as well as the significance of the danger apprehended that caused the victim to seek protection. Advocates accompanying victims to court to obtain orders or to police to enforce orders should make sure that legal system personnel understand that the violence that was the basis for the order, and even the violence involved in violation of a CPO, is likely to represent but a small fraction of the abuse history and therefore constitutes a very limited indicator of the risk of future harm.

Why Do Victims Seek Protective Orders?

Although statutes allow victims to obtain protective orders for an array of abusive behaviors, the specific incident that prompts victims to petition for protective orders generally involves physical abuse or threat of serious bodily injury or death. [674] In a multi-state and District of Columbia study, more than a third of petitioners had been threatened or injured with a weapon (36.8 percent), more than half (54.4 percent) had experienced severe physical abuse, 83.9 percent experienced mild physical abuse and almost all, 98.9 percent, had been intimidated through threats, stalking and harassment. [444] In a Quincy, Massachusetts study, 64.4 percent of the victims were physically assaulted, and another third had been threatened with harm or death to victims, their children or a relative. [455] In two other courts studied in Massachusetts, one located in a minority neighborhood of Boston and the other a south shore mid-sized city, 92 percent of the petitions filed by female victims described incidents that constituted criminal acts, 70 percent assault and batteries. Breaking down the affidavits further, the researcher found 48 percent described separation violence, 22 percent punishment, coercion, and retaliation concerning children, and 12 percent retaliation for calling police. Two-thirds of the female petitioners (65 percent) told the researcher that the abuser had threatened them with death, 35 percent had visited hospitals as a result of prior violence in past, 30 percent suffered sexual abuse, and of those who were mothers, 51 percent reported threats to take children from them or report them as unfit to child protective services. [647] Similarly, in a Colorado study, 56 percent of the female petitioners had sustained physical injuries during the incident that led to the CPO requests. [365]

On the other hand, the violence that prompts victims to seek orders may not be the most serious they experienced at the hand of their abusers. Research finds that the incident on which the CPO petition is based is not necessarily predictive of risk of reabuse. [100, 184, 455, 461, 479, 613]

Implications: Victim Advocates and Service Providers should inform the public, law enforcement and responders that the violence upon which CPOs are granted is

often more extensive and severe than that contained in criminal complaints filed by law enforcement.

Why do Victims Not Return to Court for Final Orders or "Drop" Orders?

Up to half of victims who obtain emergency or temporary orders do not return to court for final orders. [880] A review of disparate jurisdictions reveals that the rates of pursuit of final orders varied from a low of just 16 percent in Omaha, Nebraska in 2003 [452], a high of 80 percent in East Norfolk, Massachusetts in 1995 [455], and in between at 69 percent in the District of Columbia in 2000. [492]

The research indicates several different reasons that victims do not pursue final CPOs or seek to vacate orders. The reason may be based on a victim's assessment of risk of future abuse, grounded in the relationship with the abuser, or influenced by court practice in the jurisdiction in which the CPO is sought. Victims who perceived a threat to safety, especially to their children, were likely to persist in seeking final orders. Women who indicated an attachment to their abusers, not surprisingly, were less likely to seek final orders. [880] Comparing two courts in MA, one deemed to be especially user-friendly to victims seeking orders and the other not, research found that the victims were more likely to pursue orders to their conclusion in the user-friendly court, 80 percent compared to only 20 percent in the non-user-friendly court. [362]

Even when victims do secure final orders, some petition the court to drop the orders before their expiration dates. For example, although "final orders" in Massachusetts are for one year, in a study of one court, almost half of the victims subsequently returned to court to drop their orders before the year ended. [455]

A Pennsylvania study found that the most common reason women give for dropping orders was they were no longer afraid (35 percent), the abuser was receiving counseling (29 percent), the abuser promised to change (26 percent), the children missed the abuser (15 percent), or the victim needed the abuser's financial support (13 percent). [674]

Another multi-site study in Massachusetts found that judges issuing orders fell into three categories: 1) those with "good natured demeanors," who were supportive and informative with victims and firm with abusers; 2) those with "bureaucratic demeanors," who were firm and formal with all parties; and 3) those with "condescending, harsh and demeaning demeanors," but who were often good natured with abusers. The research found that victims felt more empowered, listened to, and were more likely to retain orders issued by the former than the two other groups of judges. They were also more likely to cooperate with prosecutors on concurrent criminal charges against their abusers. [647]

Similarly, and perhaps for the same reason, specialized domestic violence courts have also been found to increase CPO retention rates. A study of the District of Columbia Domestic Violence Court, for example, found it increased retention from 40 percent to 55 percent after adoption of the specialized domestic violence calendar~~s~~. [744]

Implications: Victim Advocates and Service Providers should investigate both the reasons that victims decide not to pursue final CPOs and the reasons they seek to have orders modified or vacated. Formal research may not be feasible; however, a "Court Watch" initiative may be an effective method of preliminary investigation. All systemic barriers should be eliminated. Victims should be assured that advocates and courts will not make negative judgments about victim decisions not to pursue or to vacate CPOS. Assurances should include statements from the bench that courts will not be disinclined to issue future orders as a consequences of victim decision-making about pursuit or retention of CPOS.

Do Orders Prevent Further Victimization by the Court Restrained Abusers?

There is substantial evidence obtained from victim interviews that civil protection orders may reduce both the level and number of reabuse incidents. [121, 444, 493, 496, 434]

Studies suggest CPOs may deter some abusers from future violence. In a study of 150 women seeking CPOs, victims reported significantly lower levels of IPV in the 18 months following their applications whether or not an order was granted. [547] In Travis County, Texas, for example, in the period two years before and after order issuance, physical abuse dropped from 68 percent prior to issuance to 23 percent after the orders issuance for victims who maintained the orders. [121]

Seattle investigations compared women who obtained orders compared to women who were abused (as indicated by a police incident reports) but did not obtain orders. One study found that women with "final" orders were less likely to be physically abused than women without them. However, victims who only obtained temporary orders (of two weeks duration) were more likely to be psychologically abused than women who did not obtain any orders. However, the study was unable to control for demographic and other differences between the women who obtained orders and those that did not. [398] The second study found that the CPOs were more effective nine months after issuance than during the first five months after issuance. CPOs significantly reduced the likelihood of contact, threats with weapons, injuries, and medical care. [397] In other words, while orders may not stop immediate reabuse, abusers may desist from violence several months later.

At least one study suggests that the specific provisions contained in CPOs may make a difference. Specifically, victims are more likely to be reabused if their orders merely bar abusive contact but not all contact. Compared to women whose orders barred all contact, those that barred only abusive contact were significantly more likely to suffer psychological violence, physical violence, sexual insistence, and injuries within a year. [500]

Research varies but CPO violation rates have been found to range from 25 percent within five weeks [493] to 60 percent within twelve months. [365] Other studies have found violation rates of 35 percent to 50 percent within six months [444, 495] and 23 percent to 48.8 percent over two years. [121, 455] The rates are higher depending upon whether reabuse is measured only by new domestic violence arrests or victim self-reports.

A Kentucky study found that even when orders were violated, there were significant reductions in the abuse and violence after issuance of CPOs. [495]

By state statute, CPO violations are not limited to acts of violence. Violations may stem from stalking, surveillance, impermissible phone or internet contact, failure to surrender weapons. Any non-compliance with the explicit provisions of a CPO may be charged as a violation; some non-compliance claims are considered in civil court and others only in criminal court. It should also be noted, however, that violations in explicit contempt of or contradiction to a court order, even if non-violent, may terrorize victims fearful for their safety or that of their children.

Several other studies compared women who maintained orders and those who did not return for final orders or who dropped them. [365, 455] One found that order retention made no different in reabuse rates. [455] A Rhode Island study involving criminal no contact orders (issued by statute in conjunction with a domestic violence arrest), similarly found that whether the orders continued for the length of the criminal case and probationary sentences that followed (usually one year) or not, the reabuse rates did not vary. [461]

Implications: Victim Advocates and Service Providers should assist victims in considering whether CPOs may be useful tools in the multiple strategies that victims may employ to safeguard against recurring abuse by their intimate partners. Part of a victim's decision-making about seeking a CPO should be the knowledge that the issuance of protective orders does not guarantee abuser compliance or victim safety; while a majority of abusers may comply with the no-violence mandates of CPOs, many may continue nonviolent tactics of harassment and coercion. As with all protective strategies, victims should assess the potential limitations as well as benefits of CPOs. Victims should also be informed that CPOs are not self-implementing and that enforcement may necessitate further court appearances at compliance reviews, contempt proceedings or criminal court.

Are Victims Satisfied with Civil Protection Orders?

Research consistently finds that most victims express satisfaction with civil protection orders, **even if the orders are violated by their abusers**! For example, in the multiple-site study in Massachusetts, 86 percent of the women who obtained a "final" order said the order either stopped or reduced the abuse notwithstanding the fact that 59 percent called police to report an order violation. Upon further questioning, the women expressed the feeling that the order demonstrated to the abuser that the "law was on her side." [647] In Kentucky, victims reported being less fearful of future harm and most felt

the order was "fairly to extremely" effective despite a 50 percent violation rate. [504] Victims who obtained orders in the multi-state CPO study reported that in most cases CPOs deterred repeat acts of violence and the orders improved their overall "well-being," especially if the abuser had a prior criminal history and were more likely to reabuse. [444] It may be that victims express satisfaction with orders because CPOs enhance victim autonomy and agency through the no-contact, eviction, support, and custody provisions or limit the power of abusers to coercively control, as much as reduce the frequency or severity of the reabuse and/or make victims feel respected, vindicated and empowered.

While not studied directly, it appears to be significantly easier for law enforcement to monitor and enforce protective and no contact orders than abuse in general. Officers may more readily conclude that there is probable cause to believe that an abuser has been violent when a court has previously found that the suspect committed violence or conduct giving rise to a CPO. This may explain why abusers are significantly more likely to be arrested for protective order violations than other domestic violence offenses. For example, in one study the rearrest rate across an entire state for abusers initially arrested for violation of protection or no contact orders was 45.6 percent over one year compared to 37.6 percent for domestic assaults, disorderly or vandalism. [461] Of course, it may also be that abusers with orders are generally higher risk for reabuse than abusers without orders, giving police more cause to arrest them for reabuse.

Implications: Victim Advocates and Service Providers should share or aware of the experience of victims who have sought and obtained civil protection orders. Many batterers adhere to some, if not most, of the provisions of CPOs. Victims should be aware that an order is not an impenetrable shield against violence, but it appears that for many victims the orders provide significant relief both in terms of deterring violence and enhancing autonomy and agency. Victims should be apprised of local police practice related to enforcement of CPOs.

Should Victims Pursue Both Civil and Criminal Intervention against their Abusers?

Preliminary research suggests that civil and criminal responses combined against abusers may improve outcomes by reducing reassault and rearrests. In a Pittsburgh, Pennsylvania study, 236 women involved in civil and/or criminal abuse cases were examined for six months. The outcomes in the overlap cases were significantly better than in either the criminal or civil-only cases." [313] In Travis County, Texas, two years before and after order issuance, physical abuse dropped by a third. If the abusers were also arrested at the time of the order issuance, the physical abuse dropped even further. [121] Similarly, studies of coordinated community responses have found that lower criminal recidivism is associated with the cumulative effects of civil and criminal interventions, notwithstanding the more extensive abuse histories of batterers. [584]

Victims seek civil protection orders, rather than pursuing criminal charges, for several reasons: broad relief available, ability to tailor requests for relief, limited time involved in application and court appearance(s), immediacy of issuance of CPOs, and preference not to engage the criminal legal system. However, if IPV perpetrators are not deterred by CPOs, victims may decide to pursue criminal legal intervention.

Implications: Victim Advocates and Service Providers should assist victims in critical thinking about pursuit of both civil and criminal interventions. Part of the assessment should be a review of the policy and practices of the civil and criminal legal systems in the jurisdiction.

Which Abusers are More Likely to Violate Orders?

Research has found certain subgroups of abusers are significantly more likely to violate orders than others. One significant risk factor is whether the abuser engaged in stalking. Stalkers have been found to be more likely to violate orders than other category of abusers. Their violations also appear to be more violent than other violators. [375]

Risk predictors for order violations otherwise parallel those for reabuse in general, except that having an order of protection, itself, is a risk factor for reabuse. [77, 245, 255] This does not mean that having an order increases victim risk. The fact that the IPV perpetrator inflicted prior abuse is a risk factor for further violence and coercive controls. [26] Almost all research agrees that prior domestic violence arrests are also a risk factor for reabuse [100, 287, 817, 866].

Implications: Victim Advocates and Service Providers should warn IPV victims that some abusers are more likely to ignore orders than others, particularly abusers who have engaged in stalking behavior or have been arrested previously for crimes inflicted on intimate partners.

What Consistent Flaws Have Been Found in Protective Orders Practice?

Two serious problems with the civil legal system have consistently been found to undermine protective order efficacy - service of CPOs and firearm prohibition enforcement. Many jurisdictions have trouble serving CPOs on respondent abusers. In 2009, 19 percent of the protection orders issued were not served across the state of Illinois according to state police records reported in the local press. [588] A study across Kentucky documented a rural/urban divide finding “structural barriers to order service in rural counties. [850] A Houston, Texas study found that 12 percent of the women seeking protection orders were denied based on lack of service of the petition and temporary order on their assailants. [547]

It is federal law (18 U.S. C. § 922(g)(8)) that most CPO respondents may not possess or purchase firearms or ammunition. Many, but not all, states have similar legal mandates.

However, studies consistently find that these prohibitions are not applied or enforced. In North Carolina, court restrained abusers are required to turn in all firearms and ammunition to the county sheriff within 24 hours of order issuance. The judge is supposed to ask the victim about firearms when a victim first applies for an order. However, less than half of victims applying for orders reported being asked by the judge about their abusers' firearms. Further, even though the study found more judges checked the box on the form prohibiting firearms after the state firearm prohibition was enacted, here was no change in the actual number of court-restrained respondents who surrendered their firearms. [577] A study of victims in New York and Los Angeles found only a minority of judges ordered court restrained abusers with firearms to turn them in. Researchers concluded that the states' laws designed to disarm abusers were either poorly implemented or courts failed to inform victims when the firearm prohibitions were put into effect. [833]

The Violence Against Women Act (VAWA) requires judges to notify IPV offenders of the federal firearms prohibition in 18 USC §922(g)(8)&(9). Failure of court policies to articulate policies and procedures for the removal of firearms from CPO respondents and lack of judicial notice about the prohibitions renders states ineligible for funding under VAWA. (42 USC §3796(g). Implementation of the notice requirement has been uneven. Firearm prohibition enforcement has been found to be absolutely essential in preventing homicides. [115, 116, 818, 819]

Another problem with CPO practice is that judges may refuse to grant orders even when state statutes explicitly include marginalized victims as eligible petitioners. It should also be noted that reports from programs across much of the country that serve lesbian, gay, transgender, queer and HIV-affected IPV victims report that the majority of their clients, 55.4 percent, seeking protective orders were denied them. [590]

Implications: Victim Advocates and Service Providers should investigate the procedures and practices of CPO courts to evaluate whether systems for service of CPOs and docketing of proofs of service promote swift and effective service. Likewise, enforcement of federal and state firearm prohibitions requires diligence by courts and law enforcement. Advocates should examine law enforcement policies and court rules related to firearms prohibitions and confiscation to determine the compliance of legal professionals therewith. Advocates should be receptive to complaints that judicial bias prevents victims of marginalized communities from obtaining and enforcing CPOs. The failure of the legal system to remedy any problems identified should be addressed through seeking reforms and establishing oversight mechanisms to sustain the changes effected. Advocates should alert IPV victims about existing system failures and work with them to remedy problems encountered.

B. What Do Victim Advocates and Service Providers Need to Know About the Criminal Legal System?

Through the 1990's, studies suggested that beyond arrest, IPV offenders were rarely prosecuted. More recent research reveals a large proportion of IPV arrests are prosecuted. [538] However, the results of prosecution vary. State statutes vary. For example, while a Connecticut statute promotes diversion of IPV cases for first and second offenders [2], California repealed its domestic violence diversion statute and imposed a presumptive three-year probationary sentence that includes a 52 week mandatory batterer program for first offenders. [4] Other states mandate incarceration for repeat abuse.

A sampling of studies documents the variation. A Brooklyn Misdemeanor Domestic Violence Court study of 9,157 cases in 2002 found that of those pleading or found guilty, 51 percent received a conditional discharge, 35 percent received jail, seven percent received probation, five percent were ordered to complete community service, and one percent were fined. [148] In Chicago, a little less than a third of the IPV misdemeanants were given conditional discharges, 24 percent received probation or court supervision, and 23 percent were sent to jail (including time served pending trial). [371] While in Massachusetts, where three-quarters of the suspects (74.1 percent) were charged with some form of assault and/or battery, a quarter of the defendants were diverted, a quarter placed on probation and 13.5 percent imprisoned. [100] In Ohio, of those found guilty, almost 70 percent were incarcerated, with the largest number incarcerated between 30 and 45 days, although 18.8 percent were incarcerated 150 to 180 days. [46] The number of domestic violence offenders sent to Ohio prisons increased nine-fold between 1991 and 2005. [861] In three different states with specialized prosecution programs, 52 percent to 76 percent of convicted abusers were incarcerated. [726]

Many states require abusers to complete batterer intervention programs (BIP), required or authorized by statute, or as a condition of sentence imposed by the judge. Completion of a batterer program of some type is the most common outcome of IPV prosecution across the country for diverted or convicted abusers. A study of over a thousand domestic violence arrests across three states, Connecticut, Idaho and Virginia, found that, of those convicted, almost half (46.7 percent) were ordered into either BIPs or anger management. [391] (Note, Section XI.B discusses the appropriateness of anger management for batterers.)

A number of states, like California, mandate batterer program participation for sentenced abusers by statute. By statute (CA Penal Code §1203.097), California batterers must be sentenced to three years probation; criminal protective orders must be incorporated to protect victims from further violence, threats, stalking, sexual abuse and harassment; the defendant must complete a batterer program of no less than a year, make a minimum $200 payment, and perform a specified amount of community service as well as attending substance abuse treatment as needed, pay restitution and, in lieu of a fine, pay up to $5,000 to a battered women's shelter. However, a 2005 study revealed widespread variance between the law and practice, with judges allowing defendants to plead guilty to nondomestic violence crimes. [492]

In addition to arrest, prosecution and sentencing abusers, the criminal justice system, including law enforcement, criminal courts, and probation, is probably the most likely

first responder that IPV victims come into contact with or rely on to get assistance for IPV. Studies indicate, for example, that many victims learn of protective orders and other victim related services from law enforcement. In addition, many domestic violence service agencies as well as law enforcement, prosecutor and/or court agencies provide victim advocates that may refer victims to services. [452]

Implications: Victim Advocates and Service Providers should recognize that the criminal justice system constitutes a primary service provider and referral source for a large proportion of IPV victims. For this reason, advocates should monitor local and state criminal justice agencies to ensure they are meeting the needs of IPV victims as well as holding perpetrators accountable. Community audits may be methods for identifying problems and crafting solutions to better safeguard IPV victims.

Do Batterer Intervention Programs Prevent Reabuse?

Commonly, whether diverted, placed on probation or jailed, many domestic violence offenders are required to attend batterer intervention programs. These programs have increased dramatically over the past several decades. [378] There have been more than 35 evaluations of batterer intervention programs, but they have yielded inconsistent results.

The largest multistate study of four batterer programs concluded that approximately a quarter of batterers appeared unresponsive and resistant to batterer intervention regardless of batterer treatment programs. In this long-term study, based on victim and/or abuser interviews and/or police arrests, approximately half of the batterers reassaulted their initial or new partners sometime during the study's 30-month follow-up. Most of the reassaults occurred within the first six months of program intake. Nearly a quarter of the batterers repeatedly assaulted their partners during the follow-up, and these offenders accounted for nearly all of the severe assaults and injuries. [308, 312, 320, 321, 322] The leading researcher suggests that "the system matters." [320] BIPs that incorporate enhanced "support and notification to partners, program orientation sessions, open-ended enrollments, curricula that are designed for open-ended enrollments, 'voluntary' post-program sessions, and on-going risk management that identifies and responds to problematic cases and dropout" may achieve better outcomes. [310]

Several meta-analyses of the more rigorous batterer program studies find the programs have, at best, a "modest" treatment effect, producing a minimal reduction in re-arrests for domestic violence. [29, 228a, 262] In one of the meta-analyses, the treatment effect translated to a five percent improvement rate in cessation of reassaults due to the treatment. [29] In the other, it ranged from none to 0.26, roughly representing a reduction in recidivism from 13 to 20 percent. [262]

A randomized, experimental evaluation of an "early intervention" BIP with male IPV suspects who had minimal DV criminal history and were detained in a county jail pending trial found that a one week intervention appeared to reduce controlling behavior

and alcohol and drug use in the 6 months after the program. However, the BIP did not have an effect on physical, sexual, and psychological abuse, threats and the injuries inflicted on victims. Victim partners reported that the intervention did *not* create problems for them. Participant and victim follow-up data were collected 6 months after the BIP, and police reports were tracked from 6 – 12 months thereafter. The "system" in which the BIP program was delivered included a daily, 3 hour, Duluth Model-based educational workshop for 5 days, mandatory detention in a special DV jail unit, supervision by correction officers who had specialized DV training, daily Twelve-Step Drug/Alcohol addiction support groups, and strict regulations on TV watching (special non-violent education programs were the only available programs). [778]

The rate of recidivism 8 years following the last class of the DAIP Men's program attended by 353 men in Duluth revealed that men enrolling in the DAIP Men's program recidivate at a rate of 28%, with non-completers reoffending at 31% and completers at 25%. There is a significant difference in the number of re-offenses; non-completers commit 63% more re-offenses than men who complete the program. Recidivism was measured by arrests, citations for DV, and protection orders issued against program participants by intimate partners or former partners. The DAIP is embedded in the Duluth CCR such that the deterrence must be viewed as a result of the entire criminal justice process rather than just of the DAIP Men's program. [35a]

On the other hand, a few studies have found that batterer intervention programs are associated with higher rates of reabuse [333, 364] or have found no reduction in abuse at all. [185, 261] A meta-analysis of four randomized trials involving more than 2,300 batterers comparing those who received Cognitive Behavioral Therapy (CBT) and those who had no intervention found the positive difference obtained by the CBT participants in terms of reabuse to be so slight that researchers could not conclude there was any clear evidence for an effect. Another single study compared CBT with process psychodynamic group treatment and found equivocal differences, although the process-psychodynamic treatment proved marginally better. [725]

Implications: Victim Advocates and Service Providers should advise victims of the limitations and potential benefits of batterer education and treatment programs. Advocates should regularly monitor batterer programs (by whatever name or method). It is critical that BIPs eliminate practices that compromise the privacy, safety and well-being of victims and their children.

Does the Type or Length of Batterer Intervention Programs Make a Difference?

Several studies have found that the type of batterer intervention program, whether feminist, psycho-educational, or cognitive-behavioral, does not affect reabuse. [29, 217, 322] One study also found that a "culturally focused" program specifically designed for black male abusers did no better than the program offered to all abusers. In fact, those assigned to a conventional, racially mixed group were half as likely to be arrested for

reassaults compared to those assigned to a black culturally focused counseling group or a conventional group of all blacks. [314]

As to duration of the BIP program, in the 4 state, multisite study, similar reassault rates were found for the participants in the shorter BIP (13 sessions over 3 months) as for those in longer ones (9 month), except that the reported reassaults were less severe in the 9 month program that included some alcohol treatments. The shorter BIP outcomes appeared to be related to the swift and certain actions of the court (judicial reviews) and the higher completion rates. [308, 312, 321, 322]

However, a rigorous study based in New York City found the length of the program (26 weeks compared to 8 weeks) may make a difference, with the longer program proving more effective at deterring reabuse. The researchers suggest that the longer program's increased effectiveness was due to its longer "suppression effect" while abusers were mandated to attend, whether or not they actually attended. In other words, whether or not they actually attended the program, while they were under court supervision they were more likely to be on their best behavior. [185]

Implications: Victim Advocates and Service Providers should obtain outcome data on the BIPS (by whatever name or method) operating in their communities. It may not be sufficient if the batterer intervention program is focused solely on preventing reabuse and does not address coercive and controlling behaviors or sexual abuse in their program. In such cases, advocates should seek an expansion of the curriculum and referrals or mandates to that program should be suspended until revisions in program content address controlling behaviors and sexual abuse. Longer batterer programs may produce better outcomes than shorter programs. While some criminal justice officials may want shorter programs, advocates should resist shorter duration programs unless they are embedded in a robust coordinated system of accountability.

Are Court-Referred Batterers Likely to Complete Batterer Programs?

Multiple studies of disparate programs around the country have found high non-completion rates ranging from 25 percent to 89 percent, with most at around 50 percent. [176, 312, 314, 648] Rates vary because different programs have different standards for monitoring attendance as well as different policies regarding re-enrollment, missed meetings, and so on. A study in California found that, of 10 counties examined, only one maintained a database to track offender participation in the mandated batterer intervention program; it reported that 89 percent did not complete the program. [492] Not surprisingly, requiring additional treatment programs increases non-completion. For example, although 42 percent of the referred batterers in the Bronx court study failed to complete the batterer intervention program, that number increased to 67 percent for those also required to complete drug treatment. For those required to complete drug treatment alone, the non-completion rate was lower at 60 percent. [648]

High rates of technical violations are common for probationers sentenced for IPV, including violations of no-contact orders, drug abstinence, and failure to attend batterer intervention programs. Various probation studies have found technical violation (non-crime) rates ranging from 34 percent of those sentenced in the Brooklyn felony domestic violence court [596], 41 percent in Colorado [411], to 61 percent in Champaign County, Ill. [376] Rates of technical violations may vary based on the practices of the probation officers or others charged with monitoring the probationers. For example, technical violations were found to be 25% in Rhode Island for those abusers supervised in regular mixed caseloads, but 44% in specialized IPV only caseloads. [461]

Implications: Victim Advocates and Service Providers should be reluctant to support court-ordered batterer intervention programs unless the abusers are closely monitored. Prompt enrollment and completion should be enforced, and noncompliant abusers appropriately sanctioned. Programs should be monitored to determine completion rates.

Do Those Who Complete Batterer Programs Do Better Than Those Who Fail?

Abusers who complete batterer programs are less likely to reabuse than those who fail to attend, are noncompliant, or drop out. [28, 144, 209, 233, 314, 333, 648] The differences have been found to be significant.

A Chicago study of more than 500 court-referred batterers referred to 30 different programs found that recidivism after an average of 2.4 years was 14.3 percent for those who completed the program, whereas recidivism for those who did not complete the programs was more than twice that (34.6 percent). [53] Those who did not complete their program mandate in the Bronx court study were four times more likely to recidivate than those who completed their program. [648]

A multistate study of four programs found that abusers who completed the programs reduced their risk of reassault in a range of 46 to 66 percent. [320] A Florida study found that the odds that abusers who completed the program would be rearrested were half those of a control group not assigned to the program, whereas the odds of rearrest for those who failed to attend were two and one-half times higher than the control group. [263] A Massachusetts study found that, over a six-year period, those who completed a certified batterer intervention program were significantly less likely to be rearraigned for any type of offense, a violent offense, or a protection order violation. The rate differences for these offenses, between those who completed a program and those who did not, was as follows: 47.7 vs. 83.6 percent for any crime, 33.7 vs. 64.2 percent for a violent crime, and 17.4 vs. 41.8 percent for violation of a protective order. [72] A Dallas study found that twice as many program dropouts as program completers were rearrested within 13 months: 39.7 vs. 17.9 percent for any charge, and 8.1 vs. 2.8 percent for assault arrests. [228] An Alexandria, Va., study of almost 2,000 domestic violence defendants found that noncompliance with court-ordered treatment was associated significantly with being a repeat offender. [613]

A few studies have found less dramatic reductions, for example, in Broward County, the difference was only four percent vs. five percent [261], and in Brooklyn, it was 16 percent vs. 26 percent for completers compared to non-completers. [779]

Implications: Victim Advocates and Service Providers should advise victims that while program completion does not mean the abuse will stop, program non-completion is a strong indicator that abuse will continue. For this reason, advocates should monitor courts to ensure that noncompliance is sanctioned timely and appropriately and victims informed of abuser attrition and the failure of probation in securing compliance with the court order to the BIP.

Which Batterers Are Likely to Fail to Attend Mandated Batterer Intervention Treatment?

Researchers generally agree that there are a number of variables associated with failure to complete programs. They include being younger, having less education, having greater criminal histories and violence in their family of origin, being less often employed and less motivated to change, having substance abuse problems, having children, and lacking court sanctions for noncompliance. [63, 191, 197, 261, 320, 340, 353, 638, 705]

A number of studies emphasize the positive correlation between program completion and "stakes in conformity," including the variables of age (being older), marital status (being married) and employment (being employed). [53, 261]

Studies also find that many of the same variables that predict non-completion also predict reabuse or general recidivism. In the Florida probation study, an examination of court-referred batterers found that the same characteristics that predicted rearrest (including prior criminal history and stakes in conformity) also predicted missing at least one court-mandated program session. [261] Other studies, including a study of two Brooklyn batterer intervention programs, also found that employment correlated both positively with completion and negatively with rearrest. [148]

However, prior criminal history remains the strongest and most consistent predictor of both non-completion and new arrests. In the Brooklyn study, defendants with a prior arrest history were found to be four times more likely to fail to complete programs than defendants without prior arrests. [148] The Bronx court study similarly found that prior arrests as well as a history of drug abuse predicted both non-completion and recidivism and found background demographics to be less important. [648]

Implications: Victim Advocates and Service Providers should oppose BIPs as the default probation condition to an IPV plea or conviction. BIP referrals by probation should be screened based on the common variables found to correlate with successful completion — age, prior criminal history and substance abuse. In any case, higher risk abusers should not be referred without alternative or supplemental

conditions that will enhance victim safety, as well as assure consistent program participation.

When are Noncompliant Abusers Likely to Drop Out of Batterer Programs?

Several studies have found that batterers who do not complete batterer intervention programs are likely to be noncompliant from the start. Furthermore, these studies found that noncompliance at the first court monitoring predicted both program failure and recidivism. In the Brooklyn study, the strongest predictor of program failure was early noncompliance. Defendants who had not enrolled in a program by the time of their first compliance hearing were significantly less likely to complete the program than those enrolled by the first hearing. [148] These findings are similar to those found in the Bronx study. Defendants who were not in compliance at their first monitoring appearance were six times more likely to fail to complete the program than those in compliance at that time. [648] Attrition may even occur before enrollment in BIPS. In a study of the use of polygraphs in BIP programs, researchers reported that 46 percent of the "high-risk" abusers did not report to probation or enroll in the BIP. [852]

These findings are consistent with extensive research indicating that the largest proportion of court-identified abusers who reabuse are likely to reabuse sooner rather than later.

Implications: To safeguard victims and/or new partners, Victim Advocates and Service Providers should press prosecutors and courts to respond immediately to an abuser's first failure to enroll in or attend a court-mandated BIP. Re-enrollment should be conditioned on victim safety and additional constraints imposed on the non-compliant abuser, if not incarceration.

What Should the Court's Response be if Court-referred Abusers are Noncompliant with Programs?

The Rhode Island probation study that compared probationers in specialized probation supervision caseloads with those in less stringent general caseloads found that the former committed significantly less reabuse over one year. The difference, however, applied only to what researchers called "lower risk" probationers, those without prior arrest histories. Although there were several differences in how the two caseloads were supervised, enforcement of batterer intervention program attendance was one of the major differences. The specialized group's program was more rigidly enforced, as measured by significantly more probation sanctions for nonattendance. As a result of the court violation hearings, most of the noncompliant probationers were required to attend weekly compliance court sessions until they completed the program. [461]

An evaluation of two OVW demonstration domestic violence courts found that abusers who participated in the specialized DV court with considerably more probation

revocations for noncompliance (12 percent vs. only 1 percent in the other court) were significantly less likely to reabuse than those in the comparison court. In the court with more revocations, victims reported a lower frequency of physical assaults for up to 11 months after the study incident. The offenders in the court with the higher revocation rates had a significantly higher number of prior arrests than the defendants in the comparison court (8.3 vs. 3.7 percent). Researchers posited that lower rates of recidivism were obtained primarily through early detection and incarceration of probationers who either continued to reabuse or failed to comply with conditions. [367]

Broward County probation study researchers concluded that if abusers are not afraid of violating their court orders, they are also not afraid of the consequences of committing new offenses. [263]

Implications: Victim Advocates and Service Providers should insist that courts sanction non-compliant abusers. Sanctions might include significantly increasing court reviews, probation monitoring and/or jail time.

Are Victims Satisfied with Batterer Intervention Program Referrals?

Studies find that most victims are satisfied with their abuser's referral to a batterer intervention program. In the Bronx study, 77 percent of victims were satisfied with the sentence imposed by the court if the abuser was ordered to attend a BIP, compared to only 55 percent of victims who were satisfied when the abuser was not required to attend a program. [479] A survey of victims of men attending batterer intervention programs throughout Rhode Island found most female victims enthusiastic about the batterer programs. Some victims were enthusiastic and felt that the program improved their situation even though they were reassaulted. [457]

Victims may be more likely to remain with their abusers if their abusers are in treatment programs and are hopeful that the abusers will "get better." [258, 315] For some victims, the failure of abusers to attend and complete mandated BIPs is a key component in their decisions to terminate relationships with violent partners. [315]

Many IPV victims want help for their intimate partners. Victims consider BIP participation by abusers an important opportunity to learn and to choose to stop abuse. Listening sessions with African American and Latina women revealed that participants strongly support programming that will assist their abusive partners in stopping IPV. Participants added that services should be offered in community settings apart from traditional DV services and that community engagement should address the economic fragility of the environments in which they live to build safeguards against IPV. [74]

Implications: Victim Advocates and Service Providers should caution victims that batterer programs are not cures for abusers and that relying upon the participation of abusers in BIPs in victim decision-making about remaining with abusers is ill-advised. Advocates should advise both victims and courts that the imposition of

BIPs for high risk abusers is likely to fail unless enrollment and participation is tightly monitored.

Do Couples Counseling or Anger Management Treatment Programs Prevent Reabuse?

There has been little recent research on the application of couples counseling involving batterers and their victims [749, 750] as most batterer treatment standards prohibit couples counseling. [27] An overview of evaluation studies on couples counseling (not IPV specific) reports that couples counseling is not generally effective with couples who are severely distressed, emotional disengaged or where emotional affection is poor, and where the couple is polarized with respect to gender role preferences. [418]

An early study in 1985 found couples counseling for IPV to be ineffective, with half of the couples reporting new violence within six weeks of couples counseling [487]. However, a small study in 1986 with a sample of only 15 couples found lower reabuse rates 8 months after treatment. [201] Another small study suggests that couples counseling **after** separate counseling for batterers and victims may be safe and beneficial for couples who want to remain together. [425]

Battered women may not be interested in participating in couples counseling. A survey in Pittsburgh of battered women partners of abusers prosecuted in a specialized DV court) revealed that 20 percent of the victims had some interest in a couples education program. Yet out of over 1,000 women contacted about the option after the criminal case was resolved, only a handful pursued it, and none attended for more than a few sessions. [311] In the experimental San Diego naval study only two out of ten partners attended any one session of a randomly assigned couples group. [217]

Extensive screening of couples in which IPV has occurred should precede any referral or mandate for counseling. Guidelines for assessing the propriety of IPV couples counseling have been developed based on research and practice. [12]

Most state batterer treatment standards prohibit generic anger management programs as well as couples counseling as alternative forms of treatment on their own. [27] In one of the largest studies to date, the Office of the Commissioner of Probation in Massachusetts studied a sample of 945 defendants arraigned for violating a protective order. As part of the abusers' subsequent disposition, they were ordered into a certified batterer intervention program, anger management program, and/or a mental health treatment or substance abuse treatment program. The study found that those referred to 12- to 20-week anger management programs had a higher completion rate than those referred to the much longer 40-week batterer intervention programs. Higher completion rates notwithstanding, there was no difference in rearrest rates for those who completed anger management programs and those who failed to complete. Furthermore, those who completed anger management programs recidivated at higher rates than those who completed batterer intervention programs, even though those referred to batterer intervention programs had significantly more criminal histories, including more past

order violations, more long-standing substance abuse histories, and less education than those referred to anger management programs. [72]

An early study of a program in Pittsburgh found that abusers who relied on anger management control techniques were more likely to reabuse their partners than those who relied on increased empathy, a redefinition of their manhood, and more cooperative decision making as a means to ending their abuse. [316]

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Implications: Victim Advocates and Service Providers should alert victims that there is no evidence that couples counseling or anger management programs effectively prevent court-referred batterers from reabusing or committing new offenses after treatment. While many victims may be interested in couples counseling, advocates should advise victims that couples counseling should not be considered until their abusive partner has completed BIPs and remained violence-free for a substantial period of time. Even then, couples counseling should only be considered with therapists who have demonstrated expertise in IPV treatment. Advocates should offer specialized safety planning assistance for victims pursuing couples counseling. While courts are increasingly directing batterers into 'anger management' treatment, victims should be apprised that the treatment effect of anger management has been found to be minimal, and the techniques learned therein may actually undermine the safety strategies of battered women.

Does Alcohol and Drug Treatment Prevent Reabuse?

The correlation between IPV reduction and alcohol and/or drug treatment has been confirmed in numerous studies cited previously. Multiple studies find substance abuse treatment can be effective in reducing domestic violence. [603a; 759a] In one such study, for example, researchers found that among 301 alcoholic male partner abusers, of whom 56 percent had physically abused their partners the year before treatment, partner violence significantly decreased for half a year after alcohol treatments but still was not as low as the nonalcoholic control group. Among those patients who remained sober, reabuse dropped to 15 percent, the same as the nonalcoholic control group; half that of treated alcoholics who failed to maintain sobriety. [758] As this study suggests, however, alcohol and drug treatment, in and of itself, may not be sufficient for all abusers. Supporting this is a Massachusetts treatment study of 945 defendants convicted of violating protective orders and subsequently ordered into a drug treatment program. The study found that those who completed a variety of alcohol and drug treatment programs had higher rates of re-arraignment for a new criminal offense over six years, for any crime or for violations of protective orders, than those who completed batterer intervention programs (57.9 vs. 47.7 percent for any crime, and 21.1 vs. 17.4 percent for violation of protective orders). Furthermore, there was no significant difference in re-arraignment rates between those who completed the substance abuse treatment and those who did not. [72]

On the other hand, studies suggest alcohol and drug treatment may be a necessary component of successful intervention to prevent reabuse. [52] A meta-analysis of interventions with abusers who are alcoholic or drug addicted suggests: 1. Singular drug and alcohol treatment may reduce the risk of IPV is some batterers. 2. Screening for addiction should occur periodically throughout BIP program participation. 3. Serial interventions are counter-indicated. Integration or coordination of drug and alcohol treatment with BIP programming may result in the greatest reduction of risk for future violence. [52] The multistate study of four batterer programs found that, among those who completed the program, those who became intoxicated within a three-month period were three times more likely to reassault their partners than those who did not. [312, 321, 322]

Implications: Victim Advocates and Service Providers should inform IPV victims that alcohol and drug treatment should not be a "stand alone," primary response to IPV. BIPs that incorporate alcohol and/or drug treatment as a standard component of their programs for abusers who are addicted to or engaged in problem use of alcohol and/or other drugs offer the preferred method of intervention.

C. What Do Victim Advocates and Service Providers Need to Know About IPV Law Enforcement?

Do Victims Call Police?

Both the older NVAWS [791] and the more contemporary NCVS [125] reports agree that victims do not report all cases of their victimization to police. According to the NVAWS, only 27 percent of women and 13.5 percent of men who were physically assaulted by an intimate partner reported their assault to law enforcement. Less than 20 percent of women victims reported intimate partner rapes to police. Reporting rates for stalking were higher, with 52 percent of women and 36 percent of men reporting stalking incidents to law enforcement. However, a succession of NCVS surveys over the past several decades have found much higher reporting rates (but for far fewer victimizations). According to these surveys, reporting to police of nonfatal partner victimization has increased for all victims (male and female) to more than 62 percent, with no gap between male and female victim reporting rates. The highest reporting rate is for black females (70.2 percent) and the lowest is for black males (46.5 percent). [124]

Comparing hundreds of police IPV incident reports with victim statements at four sites in three different states, researchers found that a proportion of victims deny abuse documented by police. Researchers found 29 percent of victims reported "no assault," contradicting police findings. Ironically, their alleged assailants were more likely to admit to the assaults, with only 19 percent reporting "no assault." However, suspects were more likely than victims to minimize the severity of the assaults. Researchers also found that some victims do not report repeated incidents of abuse to police. A review of NCVS data from 1992 through 2002 found that, although 60 percent of the victims had been assaulted by their intimate partners before, only half of the latest assaults were

reported to police, and these included reports made by persons other than the victim. Prior unreported domestic violence may be more serious than the incident actually reported. [265]

Reasons given in the 2012 NCVS for not reporting abuse incidents included a belief that the abuse was a private or personal matter (32 percent for females, 36 percent for males), fear of reprisal (20 percent for females, 8 percent for males), a belief that police would not do anything (15 percent for females and 16 percent for males), and a conclusion that the abuse was not enough to report (14 percent for females and 22 percent for males. These data were the average of unreported IPV incidents between 2006 and 2010. [480a]

Implications: Victim Advocates and Service Providers, recognizing that the incidence of IPV is significantly higher than its reporting to law enforcement by victims, should collaborate with law enforcement and community agencies to reduce barriers to reporting and enhance law enforcement responses to victims who report.

At What Point Do Victims Report IPV?

Victims do not generally report their initial intimate partner victimization but typically suffer multiple assaults or related victimizations before they contact authorities or apply for protective orders. [265, 365, 444] A Massachusetts arrest study, for example, found that a majority (55 percent) of sampled intimate partner victims who called police reported that either the frequency or the severity of ongoing abuse was increasing in the period before the call. Another 11 percent reported no increases in either frequency or severity but increased controlling behaviors such as restrictions on freedom of movement, access to money, medical or counseling services, or social support. [100] The NCVS found that victims were more likely to report reassaults than initial assaults. [265]

Implications: Victim Advocates and Service Providers should encourage law enforcement to investigate the history of abuse prior to the reported incident in order to understand the level of abuse and the risks faced by the victim, as well as to inform police assessment of the crimes committed by IPV suspects.

Which Victims are Likely to Report IPV?

Some victims are more likely to report their victimization or re-victimization than others. Research indicates that women who have more experience with the criminal justice system — especially those with protective orders or who have experienced more severe abuse histories — are more likely to call police. [100, 124, 398, 461]

The seriousness of injury may not increase victim reporting, however, because of incapacity, the increased likelihood that a third party will call in these cases, or the fact that seriously injured victims are less likely to have protective orders. [100]

Younger women, those in dating relationships, and those with little prior contact with the criminal justice system are less likely to call police. [100, 124]

Implications: Victim Advocates and Service Providers should not assume that reporting IPV to law enforcement is always a course of action that victims normally or should pursue. Nor should shelters and community agencies condition their assistance and advocacy on victim reporting to the police. Advocates should assist victims who choose to report in initial contacts with the police to ensure that law enforcement response provides protection to those victims who report.

Does the Quality of the Law Enforcement Response Influence IPV Reporting?

Research indicates that actions of law enforcement, such as follow-up home visits after violent incidents, can encourage victim reports of IPV. [183] It appears that victim confidence in police response leads to more reports of new violence. [182, 287] A study of a specialized DV police unit that documented law enforcement follow-up contacts with victims found that this practice significantly increases the likelihood of victim reports of re-victimization. [432] On the other hand, research also shows that victims who reported prior victimization and thought the criminal justice response was insufficient or endangered them are less likely to report subsequent victimizations. [100] However, even when victims oppose the arrest of abusers, they are generally just as likely to report re-victimizations as are victims who did not oppose the initial arrest. [100, 432]

Implications: Victim Advocates and Service Providers should determine how IPV victims evaluate law enforcement response to IPV and encourage law enforcement to engage in outreach and assistance to victims independent of pending criminal cases.

What Kinds of IPV are Reported to Law Enforcement and are Prosecuted?

Notwithstanding varying numbers and types of crimes that constitute IPV in state codes and the U.S. Code, almost two-thirds to three-quarters of all IPV cited in law enforcement incident reports are for assaults. [100, 287, 398, 726, 866] According to the NVCS, 33 percent of IPV victims annually experienced physical assault and 66 percent were threatened or assaults were attempted; these figures are an average of the annual percentages from 2001 – 2005. [124] The same generally holds true for IPV prosecutions. Although prosecutors screen cases, a study of domestic violence prosecutions in California, Oregon, Nebraska and Washington found that assaults constituted 59 to 81 percent of all prosecuted domestic violence cases, although some IPV assault charges are dropped to disorderly conduct charges. [726]

The percentage of felony assaults varies widely, largely reflecting specific state felony enhancement statutes. The highest percentage of felony assault domestic violence charges documented (41 percent) is in California, where injurious domestic assaults are classified as felonies. [866] However, most studies find much smaller percentages of felony assault

charges — for instance, 13.7 percent in Charlotte, N.C. [287], and only 5.5 percent in Massachusetts [100] — as most physical injuries are minor and most cases do not involve the use of weapons. Also, research suggests that prosecutors routinely fail to charge abusers as repeaters that make such offenses felonies in order to promote pleas and avoid trails. [455a]

These studies accord with the findings of the NCVS, based on victim self-reports, not police characterizations, which found simple assaults against female intimate partners to be more than four times more numerous (4.4) than aggravated assaults in 2005. Most assaults (80.5 percent) did not involve weapons. [124]

A review of 35 English language studies revealed that about 1/3 of the reported incidents of IPV and more than 3/5 of IPV arrests result in the filing of charges. More than half of all IPV prosecutions result in criminal convictions. However, among jurisdictions, there is great variability in the reported rates of prosecution and conviction for IPV. [294]

Police "exceptionally clear" (i.e., do not arrest DV offenders even though there is probable cause to support arrest and prosecution and the reason for failure to arrest is outside of the control of law enforcement) IPV cases at a rate of 16.1% of reported incidents. Incidents involving male offenders, minority offenders, older offenders, and/or more serious assaults/injury were less likely to be exceptionally cleared. IPV incidents were more likely to be exceptionally cleared in the south (3 times as likely), if the victim "refused to cooperate" (54.9%), or prosecution was declined (42.5%), or if the alleged offender was female. Cases of IPV violence were less likely to be exceptionally cleared than other family (20.8%), acquaintance (30%) or stranger crimes (19.7%). [389a]

Research indicates that while many IPV incidents reported to police are for stalking [38], neither the victims nor police officers identify the incidents as stalking and generally arrest and charge abusers for lesser offenses such as disorderly conduct. [456, 793]

Implications: Victim Advocates and Service Providers should investigate the rates of IPV arrests, charges and pleas or convictism in their jurisdictions. In assessing police response to IPV, advocates should review the proportion of incidents coded as assault. If lesser charges and non-domestic violence charges, like disorderly conduct or breach of the peace, are disproportionately identified, in lieu of assault, stalking or other crimes related to IPV, advocates should work with law enforcement agencies to improve their response to IPV.

What is Law Enforcement's Response to Stalking?

While there has been limited research on the criminal justice response to stalking [347, 462, 499], the studies agree with the data from the few states that collect stalking statistics. Stalking is woefully under-identified by law enforcement. The variance between the (SVS) estimated rates of stalking, for example, and stalking incident reports filed by police is stark. [456] In 2004, for example, according to SVS there were 119,284 persons stalked in Ohio yet police filed only 1,390 stalking reports across the entire state.

In 2005, 205,454 persons were stalked according to SVS estimates in Florida, yet law enforcement reported only 1,094 stalking incidents across the entire state. [456] Similarly, the New Mexico stalking study found that while 17,177 victims were stalked annually, yet local and state law enforcement identified only 116 stalking victims in 2006. [119]

The rarity of police incident reports for stalking is explained by seminal research conducted in Colorado Springs, Colorado [793] and replicated in 2009 in Rhode Island. [456] In Colorado Springs, only one suspect out of 1,785 domestic violence incidents reported by the Colorado Springs Police Domestic Violence Unit was charged with stalking. However, researchers found that stalking was evident in 16.5 percent of the IPV incidents reports, where either the victim or police officer described that the suspect had stalked the victim or had engaged in stalking behaviors. Nonetheless, the suspects were generally charged with lesser misdemeanor offenses of harassment or violation of a restraining order, but not stalking, a felony in Colorado. [793] In the Rhode Island study, researchers found almost 7 percent of the 33,000 domestic violence incident reports filed between 2001 and 2005, inclusive, described stalking, yet police cited only 108 suspects for stalking during that period. [456] Both sets of research reveal that police are most likely to misidentify stalking when protective or no contact orders are violated, identifying the single violation incident and missing the continuing stalking conduct of which that violation is part.

According to both NVAWS and SVS surveys, the primary police response to reported stalking was to write up reports, not to arrest suspects. Intimate victims in the NVAWS reported that the police responded by writing up reports in 67.4 percent of cases involving female victims and 64.7 percent of male intimates victims. [791] Similarly, victims reported in the SVS survey that police responded by taking reports in 55.3 percent of cases. [40] Arrests rates were 28 percent in cases involving female intimates in NVAWS and 7.7 percent for all stalking cases in SVS. Victims in both SVS and NVAWS reported that police did "nothing" between 18.5 percent and 18.8 percent of the time. [40, 791] Given the low number of stalking incidents identified by police, stalking arrests are rare. However statewide Kentucky study documented a 37 percent arrest rate for all cases where women reported stalking. [436]

A statewide study comparing outcomes in cases were police correctly identified stalking and cases where they did not, charging the abuser with another domestic violence offenses, found that the correct identification of stalking mattered. Where police correctly identified stalking, they were more likely to arrest. Prosecutors were more likely to prosecute alleged stalkers, even though such prosecution required more resources. Stalking was a felony in the study site. Further, among the lower risk stalkers, those without prior criminal histories, there were significantly reduced incidents of reabuse of the stalking victim after arrest and successful prosecution. [456]

Implications: Victim Advocates and Service Providers should monitor law enforcement statistics on stalking and press departments to correctly identify

stalking incidents in order to respond appropriately and accurately to the elevated risk that stalking poses to victims. It is important that law enforcement recognize that a court issuing a CPO has previously found that the restrained person has committed abuse, that a large proportion of violations of CPOs may involve stalking, and that the risk of continuing and more severe IPV posed by stalkers requires robust law enforcement response.

Do Arrest Rates Correspond to Actual Rates of IPV based on Victim Surveys of Abuse?

IPV arrest rates as a percentage of written police incident reports vary greatly because incident report writing practices vary across jurisdictions. A better, more consistent measure is the **arrests per capita** over the course of a year. At least one study documents that actual per capita arrests for IPV across an entire (albeit small) state actually exceeded the national estimates of IPV as predicted by the NCVS. A Rhode Island study found in 2004 that per capita IPV arrests were 10.5 per 1,000 females (including both male and female suspects of female victims) and were 2.9 per 1,000 males (including both male and female suspects of male victims), higher than the national estimated incidence rates of 8.6 per 1,000 females and 2.5 per 1,000 males. [459] Other jurisdictions similarly demonstrated high per capita arrest rates: Wichita, Kan. 12.1/1,000 (2000); Chicago, 6.9/1,000 (1997); and Nevada, 5.4/1,000 (2001). [452]

Implications: Victim Advocates and Service Providers should urge law enforcement agencies to thoroughly investigate IPV offenses, as broadly defined, and to arrest IPV suspects upon a finding of probable cause. Advocates should determine appropriate benchmarks to assess local law enforcement arrest responses to all crimes related to IPV. It is not unrealistic to expect arrest rates to at least approach victimization rates as determined by national or state surveys.

Is Arrest an Effective Criminal Justice Response to Reported IPV?

An analysis of arrest studies in five urban jurisdictions found that arrest deters repeat reabuse. In none of the sites was arrest associated with increased reabuse against intimate partners. Approximately 50 percent of the abusers did not commit further IPV during the follow-up period. [539]

A major study, based on 2,564 partner assaults reported in the NCVS (1992-2002), found that whether police arrested the suspect or not, their involvement had a strong deterrent effect. The positive effects of police involvement and arrest did not depend on whether the victim or a third party reported the incident to law enforcement. Neither did they depend on the seriousness of the incident assault, whether a misdemeanor or a felony. [265] A Berkeley arrest study found similarly that all actions taken by responding officers, including arrest, providing victims with information pamphlets, taking down witness statements, and helping victims secure protective orders, were associated with reduced reabuse. By contrast, the highest reabuse rates were found where the responding

officers left it to the victim to make a "citizen arrest," swearing out a complaint herself. [866]

Research has shown that police response also significantly increases the likelihood that victims will secure protective orders. [432]

Research also reveals that, by and large, the vast majority of victims report satisfaction with the arrest of their abuser when interviewed after the fact. In Massachusetts, 82 percent of victims were either very or somewhat satisfied with police arrest response, and 85.4 percent said they would call police again for a similar incident. [100]

A study of courts in California, Oregon, Nebraska and Washington found that 76 percent of the victims said they wanted their abusers arrested. [726] Also, important to note is that police arrests in spite of victims' objections do not reduce the likelihood of victims reporting new abuse to police. [23]

Victims may want police to arrest their violent partners, not necessarily for the purpose of prosecution or incarceration, but rather to remove abusers from the home temporarily or permanently. [100]

Implications: Victim Advocates and Service Providers should encourage police and victims to consider the deterrent effects of arrest and urge law enforcement to arrest abusers absent compelling reasons not to.

What Should Law Enforcement's Response Be If the Suspect Is Gone When Officers Arrive?

A large percentage of alleged abusers leave the crime scene before law enforcement arrives. Where noted, absence rates range from 42 to 66 percent. [100, 216, 391, 726, 865, 866] Pursuing alleged abusers, including the issuance of warrants, is associated with reduced re-victimization. [216] Pursuing absent suspects may be of particular utility because limited research finds that suspects who flee the scene before police arrive are significantly more likely to have prior criminal histories and to reabuse than those arrested at the scene. [100] Similarly, another study finds higher reabuse **if the victim is gone** when officers arrive. [866]

According to a national survey, 68 percent of police departments have specific policies that cover procedures for responding law enforcement officers if the alleged perpetrator is gone when they arrive. [804] In a study of the south shore communities of Massachusetts, researchers documented that police arrested 100 percent of abusers present at the scene and arrested or issued warrants for a majority (54 percent) who left the scene, for a total arrest or warrant rate of about 75 percent. [100] Similarly, a statewide New York study found that half of the domestic violence suspects fled the scene, but local police ultimately arrested 60 percent of those who fled. [594]

State laws vary, with some limiting police arrest powers for misdemeanor IPV after passage of time.

Implications: Victim Advocates and Service Providers should press law enforcement agencies to establish policies and procedures for officer response to abusers who flee the scene. Procedures should address pursuit, immediate and continuing, related to the presenting abuse, seeking warrants for all appropriate charges, executing outstanding warrants, and notifying victims of progress in these endeavors. Pursuit of absconding abusers should be a priority.

What Role Can Law Enforcement Play in Linking IPV Victims to Services?

Research reveals a consistent association between victim involvement with law enforcement and involvement in IPV services. Half or more of the women in shelters report police involvement at some point during the time they were with their abuser. [170, 276, 427,636] Another study of women seeking victim services for IPV found 77 percent had called police in response to the violence. [20] Many victims who secure protective orders first learned of them from police. [366]

Victim outreach initiatives promote law enforcement's role in linking victims to IPV services. A study of a police program in Denver, Colorado, for example, has found that early victim-focused, risk management contact by a "Triage Team," sponsored by law enforcement in collaboration with other criminal justice and community-based agencies, is perceived as a very positive action by victims, indicating to them that the community does care. Research found that such victim-focused outreach has a positive impact on women's wellbeing. Those who received outreach from system-based and community advocate (compared to women who received referrals) reported greater decreases in distress one year later, including PTSD symptoms, depression, & fear. Additionally, women who had early, victim-focused contact with system-based advocates were more likely to have contact with community-based agencies providing IPV services than women who declined to talk with or were never reached by system-based advocates. The victim-focused outreach to women living with their abusers, provided about a month after the incident, was found to help improve criminal case outcomes, compared to victims who only received referrals. [198]

These figures suggest that the referral role played by police agencies can be instrumental in connecting victims with advocacy and services. Although just beginning to be examined, more and more police agencies are conducting lethality reviews with IPV victims and then referring and urging victims to seek services or actually calling domestic violence service agencies for the victim at the incident scene. These efforts are generally reported to result in a high percentage of victims connecting with services. [453]

Implications: Victim Advocates and Service Providers should commend police agencies for outreach, information and referral for victims. Police can play an important role connecting victims with vital services and advocacy. Police

contributions to victim safety and well-being should extend well beyond diligent investigation of crimes and arrests of IPV suspects. Advocates and service providers should work with law enforcement to develop this role.

Are Specialized Law Enforcement Units Effective in Responding to IPV?

A total of 11 percent of police departments in the US have specialized domestic violence units, according to a national survey of a representative sample of 14,000 law enforcement agencies. Most specialized domestic violence units work within investigative units and are common in larger departments. A majority of departments (56 percent) with 100 or more officers have specialized domestic violence units. [804]

Specialized domestic violence units, emphasizing repeat victim contact and evidence gathering, have been shown to significantly increase the likelihood of prosecution, conviction and sentencing. [432] Specialized domestic violence units are generally associated with more extensive inquiries by police department call takers — asking if weapons are involved, advising callers to stay on the line until police arrive, asking if children are present, whether the suspect uses drugs/alcohol, whether restraining orders are in effect, and whether the suspect is on probation or parole. [804] Domestic violence units are also more likely to amass evidence to turn over to prosecutors. The specialized unit in Mecklenburg County, Charlotte, N.C., collected evidence in 61.8 percent of its cases, compared to only 12.5 percent of cases collected by patrol officers. In addition, whereas victims "declined to prosecute" in 30 percent of the cases handled by regular patrols declined to prosecute, only eight percent "declined prosecution" in cases handled by the specialized DV unit. [287]

Specialized police response is more likely to be associated with victims leaving their abusers sooner — within four months, compared to an average of 14 months for victims not receiving specialized police response. Specialized police response also results in higher victim reporting of reabuse, although this does not indicate higher reabuse rates, just higher reporting rates. Finally, victims handled by specialized police response are more likely to secure protective orders against their abusers. [432] Specialized police services such as serving protective orders and assisting in safety planning also influence victim behavior. By contrast, victim services alone have not been found to be associated with victims leaving abusers. [613, 838]

Specialized units have been found to be more effective: Victims self-report significantly less reabuse, but are more likely to report the reabuse they do suffer. [432] Another study found that specialized responses reduce "personal harm" but not non-personal harm, such as property damage. The positive effect may be tied to the safety planning offered to victims. [287] Research in New York City among victims in public housing suggests that specific crime prevention training by staff, as opposed to general victim counseling, may be associated more closely with reduced subsequent victimization. [183]

In North Carolina, 29 percent of the abusers handled by the specialized domestic violence unit had at least one subsequent domestic violence offense during a two-year follow-up period, compared to 37 percent of abusers handled solely by patrol units. This reduced rate was obtained even though the specialized unit handled more serious cases and offenders with more prior offenses. The odds ratio on reoffending for suspects handled by domestic violence units was nearly half that for suspects not handled by these units. Domestic violence suspects who reabused also reabused less often, averaging 0.46 new assaults compared to 0.62 in the two years following the incident crime. The difference is statistically significant but, because fewer of the unit's abusers reabused, the actual difference in the number of new incidents for just those abusers who reabused was less (1.59 vs. 1.67), not reaching statistical significance. [287]

An early study of a specialized detective unit in Dade County, Florida found that the unit did not affect reabuse rates. [627]

Implications: Victim Advocates and Service Providers should assist larger police departments in developing specialized IPV units, emulating successful models organized by other departments.

Are Victims Satisfied with Law Enforcement Response?

Research suggests that victims express satisfaction with law enforcement is associated with police doing their job, including arresting suspects as desired by victims, issuing warrants if the suspect is absent, and providing assistance to victims in obtaining protective orders. [393] The NVAWS found, for example, that stalking victims whose stalkers were arrested were significantly more likely to be satisfied with the police response than those in situations where no arrest was made (76 percent vs. 42 percent). [795] Not surprisingly, victims are most satisfied with law enforcement when they do what victims ask them to do. [99]

In a study of a large Midwest city, for example, victim expressed satisfaction with serious and sympathetic responses of law enforcement and system-based advocates. Victims were particularly satisfied when police stopped the violence and removed the abuser. However, victims reported that the efforts of police and advocates did not increase their safety. Rather, the research found that the multiple needs of victims facing serious economic challenges, neighborhood crime, and the long-term effects of racism are such that law enforcement intervention is insufficient as a stand-alone response to IPV. [838]

Another study involving police in several Northeastern cities found general satisfaction (82 percent) with police response to reported IPV victimization by victims with an even higher proportion declaring they would call police again for a similar IPV incident. Unlike the Midwest city study, almost three-quarters of the victims (73.7 percent) also reported feeling safer as a result of the police presence. Two actions taken by police were associated with a minority of victims being dissatisfaction. Victims were significantly more likely to report dissatisfaction when their requests that their abusers <u>not</u> be arrested were ignored by police, although most, 60 percent of victims, who said they were

satisfied with police also had opposed their abusers' arrests. The second police action was whether or not they informed victims of their rights and advised them about obtaining protective orders. Those not so advised were significantly more likely to be dissatisfied with the police. [100]

Implications: The most appreciated service that officers can deliver to the greatest number of victims is doing what the victim requests – be it stopping the violence, arresting the abusers, removal of the abuser from the home or facilitating no-contact orders. While victim preferences are not binding on law enforcement, responding to the requests of victims may promote victim engagement in the criminal justice process, enhance the likelihood of successful prosecution and increase victim satisfaction and safety.

Should Law Enforcement Agencies Participate in Coordinated Community Responses?

A total of 65 percent of police departments have established partnerships with community-based victim advocacy groups, according to a national survey of 14,000 police departments. [804]

A number of jurisdictions have endeavored to create what have been called **coordinated community responses**, composed of multiple criminal justice and social service agencies that respond to domestic violence. This approach may exert a positive impact on both case processing and reducing the rate of reabuse, according to initial research. [393, 798] For example, both arrests and successful prosecutions increased in several Minnesota jurisdictions with the creation of coordinated community responses involving law enforcement. [292] The Denver, Colorado "Triage" initiative is a recent example of effective coordinated community response involving police, system-advocates, community advocates and prosecutors. [198] Other studies have found similar promising results [393], although more is required than participation in multidisciplinary task forces for communities to create effective coordinated responses. [865]

Coordinated community initiatives require buy-in and support from the executives of public and private agencies involved, as well as from the professionals engaged in the collaborative. [632a] Personnel of relatively autonomous organizations (both public and private) cannot be assumed to have the organizational capacity or the willingness to truly collaborate. Practical and philosophical problems may undermine interagency collaborative efforts. Leadership dominance by the founding agency (law enforcement) may undermine the necessary conditions of power sharing and a sense of ownership in the work. Collaboratives may suffer from 'turfism'—"partners who consciously or unconsciously strive to remain in control, protecting their own interests." [302]

Implications: Victim Advocates and Service Providers should invite law enforcement agencies to actively participate in coordinated community responses to IPV, not simply send representatives to periodic IPV task force meetings to discuss IPV. Effective collaboratives require leadership, time commitment, critical

discourse, compromise, and problem-solving. Dominance by one sector of the collaborative is likely to compromise full engagement by all essential partners. Relationship among executives and practitioners in collaboratives is a key to success.

Does IPV Training Improve Law Enforcement Responses to Victims?

A survey of law enforcement departments across the nation finds that three-quarters have written domestic violence policies in place. Most policies have been in place for six years or longer. A large majority of departments (88 percent) require officers to complete incident reports for all domestic violence calls to which they are dispatched, regardless of outcome. Almost two-thirds of departments (63 percent) require officers to fill out a supplemental form for domestic violence, and most require written justification when no arrest is made (68 percent) or when there is a dual arrest (86 percent). [804]

Several studies suggest that general domestic violence training for law enforcement officers does not necessarily change attitudes toward IPV or, more importantly, change police behavior in terms of arrests of abusers or responses to IPV incidents. Although knowing a department's policy regarding "preferred" arrest for IPV increases the likelihood that officers will arrest alleged IPV suspects, the amount of IPV training received does not. [260, 272, 732] Research suggests that IPV arrest decisions are influenced more by an officer's assessment of the legal variables or prosecutor perspectives involved than by the officer's attitudes. [391] At least one study found that failure of police managers to hold police officers accountable for failure to arrest in contravention of statutory requirements is responsible for their poor performance, not their lack of training. [668]

Implications: Victim Advocates and Service Providers should look for clear policy pronouncements and enforcement of those policies from top law enforcement administrators. Executive commitment to diligent response to IPV incidents is more likely to change officer responses to IPV than IPV training alone.

D. What Do Victim Advocates and Service Providers Need to Know About IPV Prosecution?

Does IPV Prosecution Increase Victim Safety?

The research on the effectiveness of prosecution of domestic violence has found mixed results in terms of stopping abusers from reabusing their victims.

Regardless of the victim's wishes to proceed with prosecution or not, research has found that contact with the prosecutor may be protective against future IPV-related police calls or emergency room use. [663] A large, longitudinal, mixed-methods study examining to what extent female IPV victim participation in prosecution is associated with their future

safety, found that victim communication with a prosecutor appears to be protective against future IPV. This finding holds across both the pre- and post-disposition periods. Specifically, researchers found that direct victim contact with the prosecutor's office (in person or by phone) was associated with a victim being 37 percent less likely to have a subsequent police-reported IPV incident, without any increase in the risk of emergency room visits for IPV or injury. If prosecutors dropped cases against victim wishes, those victims were twice as likely as those who had their case prosecuted to return to the prosecutor's office for a subsequent event. Victims were also more likely to apply for a protective order in the civil court system for a future IPV event. Victims who wanted to drop the case - and the case was dropped - were more likely to go to the emergency room for a subsequent IPV event compared to women who wanted and secured prosecution of their cases. [663]

Other researchers suggest that direct contact or communication with the prosecutor's office may provide victims a type of legal leverage necessary to "rebalance" power in relationships. [281, 282, 283] "Actual prosecution of the criminal act is probably less important to (some) victims than the power they gain (in the relationship with the batterer) through bargaining with significant threats of prosecution and punishment." [281]

A 2008 reexamination of a large Ohio prosecution data set [862] found the prosecution of domestic violence arrestees was associated with less repeat offending, as was conviction and sentencing to probation. However, sentencing to a treatment program or sentencing to jail was not. [296] In fact, the researchers found that among convicted offenders, being sentenced to jail was associated with **more** repeat offending. The same researchers recently completed a review of 31 prosecution studies and found **no** consistent evidence that prosecution had a deterrent effect over arrest without prosecution; prosecution without conviction, or conviction regardless of sentence severity. [538]

The Indianapolis experiment assessing the efficacy of prosecution of IPV perpetrators found that in victim-initiated complaints of IPV where suspects were subsequently arrested on warrants were least likely to suffer future abuse. [284, 287] One researcher suggests that "coercive (prosecution) policies may be less effective (against recidivism) than efforts to empower a victim by informing and supporting her choices with respect to prosecution and her need for safety." [282]

Victim participation in prosecution does not appear to lead to retaliatory violence. [281, 282, 663]

More recent research has re-examined IPV prosecutions in the broader context of how abusers' non-IPV cases are prosecuted compared to their IPV cases. As most repeat abusers also commit many non-IPV crimes, the researchers wanted to see if differential prosecution and sentencing severity between IPV and non-IPV cases impacted on likelihood of repeat IPV arrests. The researchers found that if the IPV cases during the first several years of an abuser's criminal career were prosecuted and sentenced more severely than non-IPV cases, the abusers were significantly less likely to continue to

commit new IPV cases (or committed fewer IPV cases) over the rest of their criminal careers than if their IPV cases were prosecuted less severely than the non-IPV cases. On the other hand, if the IPV cases were prosecuted less severely than the non-IPV cases, reabuse rates were unaffected. [455a]

Implications: Victim Advocates and Service Providers should encourage prosecutors to establish policies that invite victim input in decision-making about prosecuting IPV offenders. Especially if the victim specifically wants the case prosecuted, prosecutors should be encouraged to do so. Victim Advocates should closely monitor prosecution to make sure that IPV cases are not routinely treated less seriously than non-IPV cases.

Do Victims Want Their Intimate Abusers Prosecuted?

Although many prosecutors routinely blame lack of "victim cooperation" for non-prosecution of domestic violence cases, at least one major study finds that much of what prosecutors label as victim "failures to cooperate" is, in fact, prosecutor failure to send notices to victims to appear in court to testify. [46]

In a small study in DC, "victim cooperation" with prosecution of IPV perpetrators was found to be positively associated with the severity of injuries, material assistance from friends and family, and perpetrators who are fathers of the children of victims. Victims who are drug or alcohol dependent may be less likely to "cooperate" than other victims. There was no evidence that emotional support from family and friends or institutional support from police or advocates facilitated victim cooperation with prosecution. [327]

However, studies consistently reveal strong support by victims for case prosecution. For example in recent analysis of a little less than 1,000 domestic violence prosecutions over four years in the Midwest, researchers found that the majority of IPV victims had direct contact with the prosecutor's office (65 percent). Despite some victim vacillation between prosecution and dropping the case, the large majority (65 percent) ultimately supported prosecution. Among this group, while white and black women were equally likely to call police, white women were more likely to have direct contact with the prosecutor's office and to participate in the prosecution and less likely to want the charges dropped. Victims whose abusers used alcohol or drugs were more likely to have a documented wish for prosecution, but victims who themselves used alcohol or drugs were much less inclined to press for prosecution. [662] In a Detroit study of mostly African American women, 64.9 percent wanted their partners prosecuted.[839]

In a Massachusetts study, 60.7 percent of female victims talked with prosecutors after the arrest of their partner, and only a third (34.7 percent) wanted the charges dropped. [100] Research on four jurisdictions with no drop prosecution in California, Washington, Oregon and Nebraska found 55 percent of victims wanted their abuser prosecuted, while 34 percent told prosecutors or police they did not want the case prosecuted. Most, 87 percent, reported talking to prosecutors. After the case was prosecuted, 73 percent reported they were satisfied or somewhat satisfied. [726] In a Cook County, Illinois

study, two thirds (67.6 percent) of victims wanted their abusers prosecuted **and** jailed! [371]

Implications: Victim Advocates and Service Providers, recognizing that some victims of IPV want their abusive partners prosecuted and others do not, should develop practice guidelines that assist victims in examining the benefits and limitations of prosecution; in identifying barriers to prosecution that are system-generated or that are based in victim needs for practical and material support during the pendency of criminal cases; and in developing strategies for participating in prosecution or declining cooperation with prosecution. If prosecutors assert that their failure to prosecution domestic violence is a result of lack of victim cooperation, advocates should invite elected prosecutors and DV specialists to examine and, as appropriate, to upgrade policy and practice guidelines for notifying victims and engaging them in identifying their preferences related to prosecution, implementing safeguards essential during a criminal case, and defining outcomes that meet the safety and restitution needs of victims.

Why Do a Minority of Victims Oppose Prosecution?

Studies have found multiple reasons for victim opposition to prosecution. Fear of abuser retaliation is among the most stated reasons expressed by victims, followed by fear of testifying in court. A study of five jurisdictions in three states found that victims across all sites reported that fear of defendant retaliation was the most common barrier to participation with prosecutors. [367] An Ohio study, on the other hand, found that victims were actually more afraid of testifying in court than they were of the defendant or compromising their relationship with the defendant. Specifically, victims expressed fear that the prosecutors would not prepare them adequately to testify. They were also concerned that the defendant might not be found guilty. [46]

In a Cook County, Illinois study, victims reported 13 reasons for wanting prosecutors to drop the charges against their abusers. Some victims (31.5 percent) opposed prosecution because they did not want their partners to have criminal records. Other victims opposed prosecution because they didn't want their abusers to lose their jobs (57.8 percent) or depended upon their abusers for financial support (20.5 percent). [371]

Implications: Victim Advocates and Service Providers should work with victims to understand the reasons that they may oppose prosecution of their abusive partners. For at least some of the reasons, action by prosecutors may eliminate reluctance and persuade victims to cooperate with prosecution. Advocates should assist prosecutors in devising remedies that may address victim concerns Measures to counter victim fear, for example, may require appropriate pretrial restrictions on defendants, and meeting with victims to inform and prepare them for trial.

Is Victim Fear Well Founded?

Victim apprehension of abusers is well founded. Multiple prosecution and arrest studies broadly concur that a high proportion of abusers who come to the attention of the criminal justice system reabuse and are likely to do so sooner rather than later.

In a Massachusetts court study, about 40 percent of the arrested abusers reabused their victims within one year. Forty-four percent did so **before** the IPV arrest was prosecuted in court. The average case took about six months from arraignment to prosecution. [100] Similarly, in a Cook County study, 30 percent of the defendants were rearrested within six months of their study arrest, and half of the arrests were for a new domestic violence offense. The average rearrest time was only 29 days after initial arrest. Moreover, 29.1 percent of these defendants stalked their victims before the trial, and 8.7 percent specifically threatened them. In addition, in almost half of the cases (45.9 percent), the defendants tried to talk the female victims out of testifying. [371]

An Indianapolis prosecution study found that almost a quarter of the defendants reabused their victims before the pending trial. [283] In the Brooklyn Specialized Felony Domestic Violence Court where cases took 6.5 to 7.0 months, on average, to disposition, 51 percent of defendants charged with domestic felonies (other than violation of protective orders) were rearrested before disposition; 14 percent were arrested for a crime of violence; and 16 percent were arrested for violation of a protection order. Among those charged with order violations, a felony in New York, the rearrest rate was 47 percent, including 37 percent for violating the protective order again. [596]

In short, it is evident that pending prosecution and sentencing do not deter recidivist abusers.

Implications: Victim Advocates and Service Providers should work to ensure that prosecutors, bail commissioners, and courts understand the very real likelihood of recidivism of IPV offenders immediately after an IPV arrest, while the case is pending in court, as well as after case disposition.

Can Cases be Successfully Prosecuted without Victims?

Despite the fact that most prosecutors see the lack of victim cooperation as the reason why domestic violence prosecutions cannot proceed, both individual jurisdiction and comparative studies clearly suggest that either lack of victim cooperation is exaggerated or victims are not the key variable in successful prosecution programs.

A study of almost 100 domestic violence trials in San Diego found that uniformly high conviction rates were obtained independent of victim or defendant statements, witness testimony and corroborating evidence. In fact, outcomes were also independent of whether the victim testified for the prosecution or for the defense! [726]

Other comparative studies consistently have found that the determination of prosecutors rather than the availability of victims or other evidence accounted for varying rates of prosecution. For example, in the three statewide examinations of tens of thousands of

domestic violence prosecutions, researchers documented widely varying rates of prosecution across equivalent counties. In Massachusetts, county prosecution rates ranged from 82 percent to 25 percent. [39] In South Carolina, prosecution rates varied from 69 percent to 22 percent from one prosecution district to another. [95] After the study was published in the newspaper and the state's Attorney General ordered prosecutors to prosecute all cases, the statewide dismissal rate dropped by 29 percent the next month. [94] In North Carolina, domestic violence prosecution rates ranged from 57 percent to 21 percent in specific prosecution districts. [65] In all three statewide studies, although some of the counties or prosecutorial districts differed in terms of demographics and population density, even among those that did not, prosecution rates varied greatly.

Studies confirm that jurisdictions with specialized domestic violence prosecution programs generally support the highest rates of successful prosecution. [726] These specialized programs apparently create their own momentum. For example, they either help create or are associated with courts with expedited domestic violence dockets. For example, as a result of the specialized prosecution in San Diego, processing time for domestic violence cases decreased to 32 days, with almost half of the defendants (46 percent) pleading guilty at arraignment. In Everett, Washington, prosecutors reduced time to trial to 80 days, and in Omaha, Neb., it was reduced to 43 days. Shortened trial times proved to reduce both victim vulnerability to threats and rates of reconciling with the abuser pending trial. In both San Diego and Everett, bail was regularly set at $10,000 per domestic violence charge (with no cash alternative in the latter location). As a result, for defendants unable to raise bail, there was an incentive to plead guilty to get ***out*** of jail. [726]

In these jurisdictions, researchers found that evidence (eyewitnesses, photos, admissions, excited utterances, medical evidence and physical evidence) was ***not*** uniformly the most powerful predictor of prosecutors'decisions to proceed without victims and was not significantly associated with the decision to prosecute at all in Klamath Falls, OR. [726]

Supporting the contention that prosecutorial determination is a powerful predictor of prosecutorial success, the Ohio court study found that increased time the prosecutor spent with victims while preparing the case was positively associated with successful prosecution, and large prosecution caseloads were negatively associated with successful outcomes. The availability of evidence (911 tapes, photographs, medical records and police testimony) was **not** associated with the likelihood of a conviction. [46]

Surprisingly, a New York Study found that video taping defendant statements can provide essential evidence to increase successful prosecutions. Conviction rates with video were 37.1% for almost 2,000 DV misdemeanor prosecutions compared to 31.5% for more than 10,000 cases prosecuted without use of videos. Controlling for other factors that predicted prosecution success, including victim injuries, jailing the defendant pre-trial, crimes against children, reseachers concluded the video program accounted for a 3.1 to 8 percent higher conviction rate depending upon which court the prosecution was conducted. The rates would have been higher but 20% of the defendants refused to

speak. The rates were highest (46%) when defendants admitted on camera that they knew of the protective orders they were accused of violating. [636a]

Implications: Victim Advocates and Service Providers should ascertain whether a lack of prosecution of IPV cases is based on any reluctance of prosecutors to pursue IPV cases or on lack of evidence. Lack of evidence may be more likely to deter prosecutors from going forward than deterring defendants from pleading guilty. Advocates should encourage prosecutors and police to create protocols for collecting evidence in IPV cases that remove as much as feasible the onus on victims to testify in court.

Can Prosecutors Increase Victim Cooperation?

The seeds for victim engagement in prosecution may be planted before the case even reaches prosecutors. A Portland, Oregon police study found that the following police activities significantly correlated with increased prosecution: (1) Police contacted victims. (2) Victim accepted services. (3) Police provided victims with prosecution information. (4) Police helped set up victim appointments with prosecutors. (5) Police helped victims obtain restraining orders and served the orders. [432]

Although victims commonly report fear of retaliation as a barrier to their participation in prosecution, a three-state study found that the fear was reduced at sites with specialized prosecution programs, increased victim advocacy and specialized domestic violence courts. [367] These specialized response programs generally include fast-track scheduling, reducing victim vulnerability pending trial, increased victim contact pending trial, and victim-friendly proceedings that remove, as much as possible, victim testimony in the trial. These measures contrast with those used in some jurisdictions, in which studies indicate some prosecutors treat victims like civil claimants. In a large 45-county study of upstate New York domestic violence prosecutions, researchers found that half of the prosecutors required victims to sign complaints in order to file charges. Further, they provided affidavits to victims to confirm their interest in having charges withdrawn. Not surprisingly, prosecution rates were not high. [865]

There is more research on what not to do than on what works. Specific studies suggest that the more prosecution-related burdens are placed on victims, the less likely victims are to participate in the prosecution. In Milwaukee, a study found the majority of cases were dismissed when victims were required to attend a charging conference within days of the arrest of their abusers. However, when victims were absolved of this responsibility, Milwaukee prosecution rates increased from 20 percent to 60 percent. [181] In a similar vein, a comparison of protective order violation prosecutions across Massachusetts found a 66 percent dismissal rate when prosecutors routinely provided and encouraged victims to sign waivers of prosecution forms (often asked to signed them in front of defendants), compared to a 33 percent dismissal rate in adjacent counties in which victims were not provided such waivers. [39]

Some prosecutors are better at maintaining contact with victims than others. In the Ohio court study, the strongest predictor of a guilty verdict in domestic violence misdemeanor cases was how many times the prosecutors met with the victim before trial. However, the study found that the majority of victims never received rudimentary information from prosecutors before trial, including court dates. In almost 90 percent of the court cases, prosecutors never spoke with the victim on the phone and, in more than half of the cases (52 percent), never met with them before the trial date. When they did meet, it typically was for no more than a few minutes. [46] The importance of prosecutor-victim contact is underscored by a Toronto study that found if the victim met with a victim/witness representative, victim cooperation increased by a factor of 3.3. [186]

A limited number of studies suggest that victim engagement with court-based victim advocates may facilitate victim cooperation in criminal cases. The studies found that victims appreciated contact with victim advocates/liaisons and reported a high degree of satisfaction with their services. In a Massachusetts study, for example, 81 percent of the victims reported satisfaction with the time they spent with victim advocates, and three-quarters (77 percent) said they would talk to the advocate again if a similar incident recurred. [100] Cook County domestic violence victims who had contact with victim advocates reported more satisfaction with the proceedings than those who had no contact. However, the same study reported that advocate contact with victims was not associated with victim participation in the court phase of criminal cases. [371]

Implications: Victim Advocates and Service Providers should closely monitor prosecutors and the number of IPV cases dismissed attributed to lack of victim cooperation. If this is indicated in more than a minority of cases, Victim Advocates and Service Providers should work with police and prosecutors to reduce barriers to victim participation.

Are Most Victims Ultimately Satisfied with Prosecution?

The same research that documents that most victims want their abusers prosecuted, also found that even a greater number are satisfied after their abusers are prosecuted. In the Massachusetts study, after the prosecution, almost two-thirds, 64.5 percent, reported being "somewhat or very" satisfied with the prosecution. The majority of victims were satisfied even if they initially had wanted the charges dropped, remained unchanged, or increased. Further, 60.7 percent of the victims reported the prosecution "greatly or somewhat" increased their safety. Only 9.4 percent reported that prosecution "greatly or somewhat" decreased safety with the remainder saying it had no effect. Surprisingly, even among those who felt the prosecution decreased their safety, the majority reported being satisfied with the prosecution. Satisfaction levels were equally high if the case was ultimately dismissed (65.5 percent) or the abuser was sentenced to probation (62.1 percent) or jail (66.7 percent). [100]

Similarly, in a four state study, in the end, 64 percent of victims reported satisfaction with the prosecutor, while only 27 percent reported dissatisfaction. The satisfaction rates for

case outcomes (dispositions) were a bit lower at 59 percent and dissatisfaction with the prosecutor slightly higher. However, 85 percent of the victims concluded that it was good that the case had been prosecuted. [726]

Implications: Victim Advocates and Service Providers might advise victims involved in criminal cases that research suggests that the majority of victims, even those initially opposed to case prosecution, report satisfaction after disposition. Victim satisfaction and victim safety are independent outcomes. Advocates, however, can promote safety and satisfaction with criminal case outcomes by working with prosecutors andvictims safety throughout criminal cases to implement safety plans and related activities

E. What Do Victim Advocates and Service Providers Need to Know About Judges/Sentencing of IPV?

Does Sentencing Deter Reabuse?

The research is fairly consistent. Simply sentencing offenders without regard to the specific risk they pose, unlike arresting IPV defendants, does not deter further criminal abuse. [46, 184, 339, 538] Without the imposition of significant sanctions at disposition, including incarceration, the majority of "high risk" IPV offenders will reabuse regardless of prosecution — many before the case against them is reached in court. Similarly, many offenders who are "low risk" are also likely to reabuse in the short run, during the case, and after disposition.

A study of a large number of arrests in three states (Connecticut, Idaho and Virginia) found that those who were prosecuted and convicted for domestic violence were **more** likely to be rearrested than offenders who were not convicted. However, in this study, those prosecuted and convicted were significantly more likely to be higher risk offenders as measured by prior criminal history. [391] This is not to say that prosecution *causes* continued abuse, but that IPV offenders typically continue to use violence regardless of sanctions imposed in criminal cases.

Research in Kentucky on recidivism of 400 IPV stalkers charged with first and second degree stalking found that during the same year and subsequent to the felony charges 38 percent of the offenders had final CPOs entered against them, 55 percent were convicted of other misdemeanors, 12 percent were convicted of other felonies, 15 percent were again charged with stalking offenses, 81 percent with misdemeanors and 34 percent with felonies. [501]

However, a number of studies have found that prosecution can reduce subsequent arrests and violence. [284, 334, 432, 798, 861, 863] The key to reducing reabuse may not depend on whether or not the case is prosecuted, but on the dispositions imposed. For example, a Toledo, Ohio, misdemeanor court study found that conviction was significantly associated with reduced rearrests for domestic violence one year following court disposition, even when controlling for batterers' prior history of IPV arrests, age, gender,

education, employment and marital status. However, the details of the specific disposition mattered. The more intrusive sentences — including jail, work release, electronic monitoring and/or probation — significantly reduced rearrest for domestic violence as compared to the less intrusive sentences of fines or suspended sentences without probation. The difference was statistically significant: rearrests were 23.3 percent for defendants with more intrusive dispositions and 66 percent for those with less intrusive dispositions. [817]

Another study of 683 defendants in Hamilton County (Cincinnati), Ohio who were arrested for misdemeanor domestic violence also confirmed that sentence severity was significantly associated with reduced recidivism, especially for unmarried defendants, although in this study the actual sentence length (number of days in jail) was not found to be significant. [785] Similar research looking at the cumulative effects of arrest followed by prosecution and court dispositions (including those receiving batterer treatment) has found modest reductions in reabuse associated with greater post-arrest criminal justice involvement. [584, 775] Research of almost 2,000 domestic violence defendants in Alexandria, Va., found that, over a period of three and one-half years, repeat offenders were those who had a prior criminal history and were **not** sentenced to incarceration for the index arrest during that period. This led researchers to recommend jail sentences for domestic violence defendants with any prior criminal history. [613]

The Ohio felony study, however, found mixed results between jail sentences and prison sentences. Although jail sentences were significantly related to lower odds of subsequent misdemeanor or felony intimate-partner assaults after two years, prison sentences were not significantly related. The likelihood of new charges was nine percent less for those jailed (compared to those sentenced to probation), but the likelihood was only two percent lower for those imprisoned, compared to those placed on probation. [861] This may simply reflect that the sample size in the study was too small to produce a statistically significant effect, but it could suggest that those sent to prison, presumably those convicted of more serious felonies, were more likely to continue IPV upon release.

Finally, diversion of abusers has been found to endanger a significant proportion of victims. The few studies that have examined reabuse among diverted or discharged abusers have consistently found that a steady minority continued to reabuse, notwithstanding no prior or minimal prior records. In the Quincy arrest study, for example, a quarter of the arrested defendants were continued, without a finding and charges to be dismissed, if they remained arrest free for six months to a year, a disposition reserved for first or lesser defendants. A quarter was arrested or had new protective orders taken out against them within two years of their study arrest. Although this reabuse rate was still half that of defendants with more substantial prior criminal histories, it was substantially higher than prosecutors and judges had anticipated. [459] Similarly, a little over a quarter of the abusers (27.5 percent) given a conditional discharge in Cook County violated the conditional discharge. [371] While in Rhode Island the rearrest rate for those placed on probation with guilty findings was higher than those placed on probation without guilty findings, the rearrest rate for domestic violence over one year was still 35 percent. [461]

Research suggests that the severity of a specific IPV sentence must be contrasted with how the same abuser is sentenced for non-IPV offenses. As most chronic abusers are prosecuted for a wide array of offenses during their criminal careers, to evaluate the severity of a specific IPV sentence, it is necessary to compare any differential severity between IPV and non-IPV prosecution and sentencing. Research conducted across an entire state and over abusers' criminal careers found that if the abusers were prosecuted and sentenced more severely for IPV offenses compared to non-IPV offenses over the first six years from their first criminal case, they were significantly less likely to commit subsequent IPV offenses thereafter. Sentencing patterns may be more important in deterring reabuse as opposed to any sentence imposed on a specific IPV case. [455a]

Implications: Victim Advocates and Service Providers might encourage judges to impose sentences commensurate with both the risk abusers present to their victims and the seriousness of abusers conduct. Abusers with prior criminal histories for IPV or any other crime should not be treated as "first" offenders or as posing little threat of reabuse.

Should Judges Follow Victim Preferences When Sentencing Abusers?

Victim assessments of the dangerousness of suspects have been found to be good predictors of subsequent violence [48,50,127, 128,129], although victim preferences on case disposition may not speak to risk of recidivism. The victims in the Quincy, Massachusetts study who wanted the charges dropped were no more likely to be reassaulted (51 percent vs. 48 percent after one year) than those who did not want the charges dropped. [100] Similarly, studies in New York found that victim cooperation with prosecutors did not predict recidivism. In other words, when judges imposed sentences to which victims objected, these victims were no more or less likely to be re-victimized than victims who wanted their abusers to be prosecuted and sentenced.[479]

The desire to drop criminal charges, or not, is a crude measure, at the very least, of victim preferences. No research to date measures offender recidivism or victim satisfaction when judges tailor criminal sanctions to the specific requests of victims regarding incarceration, restitution, protective conditions, monitoring or treatment programs, or blanket terms of probation. However, the research suggests that if victims express fear of their abusers or even if they say they are unsure, judges should pay attention. [100, 179, 188, 332, 647]

Implications: Victim Advocates and Service Providers should confer with victims about the sanctions or sentencing conditions imposed by judges after guilty pleas or convictions. Victims may want to testify or provide victim impact/input statements to the court in which they inform the court about dangers they fear are posed by offenders going forward, about restitution requests, about treatment or BIP mandates, about compliance reviews, about GPS monitoring, about protective conditions desired and about incarceration. Although advocates may be asked to

represent victim wishes in court, this is not the purview of advocates. When advocates disagree with the requests made by victims, they should not speak against victim preferences without victim permission.

How Should Courts Proceed Against Abusers Who Fail to Show for Court Hearings?

Just as research suggests that abusers who are gone when police arrive on the scene are more likely to reabuse their victims [100], research suggests the same for abusers who fail to show for scheduled court appearances. A Cook County study found that no-show defendants had a significantly greater number of new arrests than those who appeared in court as ordered, 78% compared to 46%. Measures taken to increase defendant appearance rates were associated with reduced reabuse. [371]

In related research, the study of the Judicial Oversight Demonstration Initiative in Milwaukee revealed that when technical and criminal non-compliance with the pre-trial conditions imposed by judges were monitored closely by probation and sanctioned by courts, resulting in early detection and pre-trial detention, significantly fewer IPV probationers were arrested for IPV and other crimes in the two years following case disposition. [368]

Implications: Victim Advocates and Service Providers should work with courts and prosecutors to immediately and seriously sanction abuser noncompliance with conditions of release before trial and/or sentencing.

What Accounts for Abuser Sentencing?

IPV dispositions do not always follow standard sentencing patterns. Dispositions often fail to reflect defendants' prior criminal histories and appear to disregard prior records that are not related to IPV charges. In a large Ohio court study, for example, researchers found no correlation between offenders' prior criminal histories and sentence severity. [46] Similarly, and surprisingly, the Toledo, Ohio, study found defendants with prior **felony** convictions were the least likely to be prosecuted and sentenced. [817] In contrast, in both Quincy, Massachusetts, and Rhode Island, prior criminal history was significantly associated with the severity of sentences. [100, 461]

Also, it appears that victim preferences are not a significant factor either. Victim preference was not found to be a significant factor in sentencing in Quincy, Massachusetts, Everett, Washington, Klamath Falls, Oregon, Omaha, Nebraska, San Diego, California, or Ohio. [46, 100, 726] In these jurisdictions, factors associated with more severe sentences varied considerably and included whether there was strangulation, the gender of the defendant, whether the defendant and victim were living together, and the size of the prosecutor's caseload. No consistent patterns were noted from study to study**.**

Implications: Victim Advocates and Service Providers should examine sentencing patterns of IPV offenders to determine if they reflect prior criminal history of IPV defendants, any history of use or threatened use of weapons against victims, reoffending during the pendency of the criminal case, noncompliance with pre-trial conditions, particularly continued stalking or surveillance by the offender, and the severity of violence and injuries to victims. Safeguards and sentencing preferences requested by victims also should be addressed in sentencing. Where sentencing practices fail to account for any of the above, advocates should seek sentencing reform, perhaps including specific guidelines for IPV sentencing.

XII. What is IPV Victim Advocacy and its Impact?

As one researcher described, victim advocacy, at its most basic level, may be defined as helping "survivors of domestic violence navigate the systems involved in the community… as they attempt to acquire needed resources." The researcher adds that many victims have a constellation of needs that can only be addressed by a broad variety of social institutions. [17] Advocacy may include speaking on behalf of a victim or assisting a victim in advocating for herself.

Although national surveys reveal that almost all domestic violence program service providers report providing victim advocacy, definitions of what that means vary widely. A 2011 national survey of DV programs revealed that 92 percent provided legal advocacy/court accompaniment, 86 percent provided advocacy related to public benefits, 83 percent offered advocacy related to child protective services, 82 percent housing advocacy, 81 percent mental health advocacy, 77 percent immigration advocacy, 75 percent advocacy on disability issues, 73 percent financial or economic advocacy, 73 percent advocacy related to addiction/alcoholism, 70 percent medical advocacy, 66 percent advocacy related to technology/cyberstalking, and 23 percent legal representation to victims. [592] An early 1990's survey found domestic violence programs describing their advocacy work as including providing direct services to victims, representing victims, acting as a liaison for victims, and engaging in community education and policy work. [632] Notwithstanding the variety of advocacy provided by DV programs, many victims require advocacy beyond that which is often available. [74, 640, 761]

There are generally two types of advocacy, individual and system-based advocacy. The former involves, for example, assisting an individual victim in moving her belongings out of an abuser's home or accompanying her through the court process or providing her information on domestic violence, medical assistance, and emergency shelter or transportation. [17, 75, 510, 632, 763, 764, 839] System-based advocacy targets the criminal and civil justice systems, health care, and welfare systems as well as other relevant institutions. [764] System advocacy seeks to reform institutional responses to intimate partner victims collectively so that the totality of their needs and experiences are taken into account to increase victim safety and abuser accountability. [477]

A study of domestic violence programs receiving VAWA funding in 12 urban jurisdictions across Ohio provides examples of victim advocacy services offered by federally funded domestic violence programs in 1999-2000. The 13 programs served approximately 65,000 victims collectively per year. Reportedly, 86 percent of the clients received victim advocacy, representing half (51 percent) of the programs' collective budgets. The programs provided legal assistance for victims dealing with law enforcement and prosecutors (91 percent), information on the legal process (82 percent), escorts to court to obtain protective orders (73 percent), and assistance to victims for obtaining victim compensation from a state fund (55 percent). The survey did not include any information on system-based advocacy by the domestic violence programs. [75]

Victims receiving intensive, comprehensive advocacy services during and after shelter residence are more likely to achieve the goals they develop for safety, well-being and legal process than those not. [766]

Legal advocacy can be both individual and system-based, although most typically the former. Advocacy for victims in criminal and civil legal systems provides victims with the information, supportive relationships, safety planning, intervention with legal system professionals, evidence gathering, accompaniment to court, etc. needed to successfully participate in legal process against batterers. [837a] A quasi-experimental evaluation of a law school-based legal advocacy program found that victims who worked with law student advocates reported decreased physical and psychological abuse and marginally higher emotional well-being six weeks after assistance by non-lawyer advocates. [47] An evaluation of an outreach and legal advocacy program involving community-based advocates, system-based victim specialists, and law enforcement demonstrated that victim participants obtain significantly better criminal justice and safety outcomes than those victims in the control group. [198] Both of these advocacy programs required significant system advocacy to effect change in the medical and legal systems, respectively, in which they were embedded. Another study of legal advocacy for battered women revealed that those receiving advocacy were more likely to call the police, and their assailants were more likely to be arrested, prosecuted and convicted. [841] Further, a longitudinal study in 29 large US cities found that legal advocacy services were associated with reduced domestic violence-related fatalities for married men, to a lesser degree married women, but not for unmarried African American women. [214]

Litigation on behalf of victims can be both individual and system advocacy. A lawsuit, such as *Thurman vs. Torrington*,[2] against a police department and City for failure to enforce a court protective order and safeguard an individual victim, might constitute both individual and system-based advocacy. In this example, as a result of the lawsuit, the state of Connecticut enacted mandatory domestic violence arrest legislation and training of law enforcement.

Implications: Victim Advocates and Service Providers should map the individual and system advocacy undertaken by their respective organizations in the last decade and examine the outstanding needs of victims for individual and system advocacy. Advocates should, similarly, identify individual and system advocacy initiatives related to IPV in the broader community. Through collaboration within communities, plans should be developed to fill the gaps for essential advocacy for victims.

Should Advocates Encourage IPV Victims who Suffer Intimate Partner Sex Assaults to Participate in SANE programs?

In light of the fact that there are now over 475 Sexual Assault Nurse Examiner programs (SANE) in the United States and its territories, and they are quickly becoming "the"

[2] 595 F. Supp. (DC Conn. 1997).

model of care for sexual assault victims, the importance of research linking elements of practice to case outcomes cannot be overstated.

Although the U.S. Department of Justice has provided funding and encouraged the establishment of SANE programs to enhance prosecution of sexual assaults, SANE is a victim-focused program to provide psychological, medical, as well as forensic services for patients following a sexual assault. [528] SANE program services strive to be independent and objective, with priorities defined by the needs of the individual patient, rather than the criminal justice investigation of reported sexual assaults. SANE programs generally maintain a philosophy that patient care—not supporting law enforcement or building legal cases—is their primary goal. SANE programs do not pressure their patients to report to law enforcement. Instead, they emphasize that it is the survivors' choice, and, either way, the SANE nurses will be there to care for them. Nurses and advocates work together as a team to attend to survivors emotional needs, link them to advocacy and counseling, and provide information about criminal justice system process. This care facilitates survivors' emotional and physical health, and also gives them hope and confidence for their court cases. [285]

Studies have found, however, that SANE programs that best serve victim health and psychological needs, also facilitate prosecution of assailants. One study, for example, found that patients who had SANE exams were more likely to respond to related criminal justice system needs and participate in that process. In other words, the focus on patient care and service, rather than a specific criminal justice focus, actually increased positive criminal justice outcomes.[118]

Successful sexual assault case prosecution requires the continued involvement of survivors, and SANEs play an important *indirect* role in supporting that link as well. When victim trauma is addressed and victims are well-informed, they are in a better position to participate in the criminal justice system. The combination of stronger forensic cases, coupled with increased victim participation, appears to result in increased case progression through the criminal justice system. [118]

Implications: Victim Advocates and Service Providers should collaborate with SANE programs. Victims of intimate partner sexual assault should be referred to SANE programs, particularly in the immediate aftermath of sexual assault. Advocates should seek to establish SANE programs where none exist.

Do Police and Prosecution Advocates Help Victims?

It is difficult to unravel the effect of institutional advocates embedded in police and prosecutors' offices from the offices in which they work. A Detroit study that compared outcomes from police precincts with institutional advocates and those without found no differences in police performance in regard to arrests or issuance of warrants against alleged abusers. Advocates embedded in the prosecutor's office, however, were associated with greater number of warrants filed. The role of institutional advocates was to provide information about the legal system, make referrals and conduct safety

planning, including helping women obtain protective orders. Court outcomes and reabuse rates were unaffected by the involvement of system-based advocates, but overall between 60 and 100 percent of the women rated these advocates as "very or somewhat helpful" because the women received information and emotional support, and were otherwise helped. [838]

A Massachusetts court study revealed that 80 percent of IPV victims talked to advocates in the prosecutor's office located in the courthouse. While 20 percent had only cursory communication, 15 minutes or less, the rest spent from 15 to 45 minutes or more with advocates. Satisfaction with the victim advocates was high at 81 percent reporting being very or somewhat satisfied. While some victims opposed the prosecutor's office pro-prosecution policy, over three-quarters of victims (77.1 percent) said they would want to talk to the victim advocates again if a similar abuse incident re-occurred. [100]

Implications: Victim Advocates and Service Providers should develop cordial, collaborative relationships with system-based advocates. Victims generally find institutionally-embedded advocates to be helpful, and such advocacy should be encouraged as it can facilitate legal and social service outcomes preferred by victims.

XIII. What Performance Measures Should Advocates Adopt to Evaluate the Criminal Justice Response to IPV?

The administration of criminal justice is not uniform across states, much less the entire country. However, there are enough studies of varying criminal justice responses to IPV across disparate jurisdictions to reveal parameters of current practice, suggesting what can (and should) reasonably be expected of key criminal justice responders to IPV by Victim Advocates and Service Providers. [454]

A. What Performance Measures Should Advocates Require of Law Enforcement in Terms of Arresting Suspect Abusers?

Arrest rates depend, among other things, on reporting rates which may vary. A better measure of police arrest performance is to look at arrests per capita in any jurisdiction.

The largest study of police arrest practices was completed using 2000 NIBRS data from 2,819 jurisdictions across 19 states. Researchers examined 577,862 incidents of aggravated assault, simple assault, and intimidation, with 235,690 arrests resulting. They found that 49 percent of the offenses involving intimate partners (spouses, ex-spouses and boy or girlfriends but not ex-boy/girlfriends) resulted in an arrest. This compared to 44 percent for non-intimates including family members, 28 percent for acquaintances and 31 percent for strangers. In addition to an intimate partner arrest rate of 49 percent, in an additional 15.7 percent of the incidents, an arrest was not made due to factors beyond the control of law enforcement, including prosecution was declined, victim refused to cooperate, or the suspect died. In other words, based on this 19 state study, on average,

almost 2/3rds (64.7 percent) of IPV incidents constituted probable cause for an arrest or issuance or an arrest warrant. [390, 391]

The same 19 state study found that dual arrests, where both parties were arrested, were higher for intimate partner incidents than the others, but still were less than two percent. However, the same research finds that police are much more likely to arrest both parties when the incident involves same sex couples. The 19 state study also found mutual arrests rates of a little more than a quarter for same sex couples, male or female compared to less than one percent for cases with male offenders and female victims or three for cases of female offenders and male victims. [390, 391]

However, in terms of arrest rates, the latest NCVS found an intimate partner violence rate slightly higher for male victims than female victims with 56 percent for the former and 57 percent for the latter. [125]

Implications: Victim Advocates and Service Providers should be concerned if a jurisdiction's intimate partner arrest or warrant issuance rates for reported incidents of assault and intimidation are less than 64 percent and/or dual arrests are more than 2 percent.

What Percent of Arrests Should be for Female Perpetrators of Intimate Partner Violence?

The 19 state study documented that 80.9 percent of intimate partner violence cases involved male perpetrators and female victims. [390, 391] A Berkeley, California police study documented male intimate partner violence suspect rates at 84 percent [866] and even more, 97.4 percent, was found in Charlotte, North Carolina for the most serious IPV charges. [287] It should be noted that these arrest rates are for IPV, not family violence (often conflated with IPV as "domestic violence"), as family violence includes girls against parents, parents against female children, sister and against sister, and other relationships that inflate female arrests.

In at least some jurisdictions, unusually high IPV female arrest rates are associated with unusually high dual IPV arrest rates. [172]

Implications: Victim Advocates and Service Providers should review intimate partner arrest rates to make sure that primary and predominate aggressors are being arrested, not victims. While second guessing each arrest may be problematic, aggregate arrest statistics that reveal less than 80% of the arrests involve female victims indicate a need for further police training.

For What Should Abusers be Arrested?

Despite varying numbers and types of crimes codes that constitute IPV as defined by specific state statutes, almost two-thirds to three-quarters of intimate partner violence arrests are for assaults, simple assaults for those without injury and aggravated for those

with injury or use of a weapon. [100, 287, 398, 726, 866] About half of the states enhance repeat simple assaults to felonies. As a result, the rate of felony compared to misdemeanor arrests vary based on state statute. In California, approximately 41 percent of intimate partner arrests are for felonies. [866]

In at least one state where the majority of IPV arrests are **not** for assaults, they are for public order violations, disorderly conduct and breach of the peace, because almost a third of the states DV arrests are dual arrests. [172]

There is little research comparing police arrests and the specific criminal behaviors of arrested abusers. In two stalking studies where researchers specifically analyzed police arresting and charging behavior and the specific conduct for which the abusers were arrested and charged, they found great variance. Specifically, police in the two jurisdictions, Colorado Springs and the state of Rhode Island (with 38 separate police departments) rarely arrested abusers for stalking notwithstanding that the police incident reports clearly described stalking behavior that met each jurisdiction's legal definition of stalking. According to the researchers, police should have arrested and charged in 16.5 percent of the IPV incidents in Colorado and seven percent in Rhode Island. [793,456]

Implications: Victim Advocates and Service Providers should review IPV offender arrests to determine if police are accurately arresting and/or charging abusers for assaults and the panoply of other crimes against victims, including stalking as opposed to public order crimes such as disorderly conduct or breach of the peace. If the state has a felony enhancement law for repeat offenses, advocates should determine if police and/or prosecutors are checking prior records in order to charge abusers appropriately.

What Has Been Shown to Increase Arrest Rates?

The research has consistently found that mandatory and preferred arrest laws and/or implemented law enforcement department polices are associated with the increased likelihood of IPV arrests from 97 percent to 177 percent compared to jurisdictions without such laws or law enforcement policies. Further, the research finds that these laws do not result in more female victims being arrested. States without mandatory or preferred arrest laws or policies had more than four times higher dual arrest rates than those with mandatory or preferred arrest laws or law enforcement policies. [390]

Increased arrests may also be obtained by going after abusers who leave the scene of a domestic before police arrive. The arrest rate in the 19 state police study, for example, found for those abusers gone when police arrive, the arrest rate was eventually 42.2 percent while those arrested at the scene was 74.4 percent. [390]

Implications: Victim Advocates and Service Providers should determine if arrests rates reflect IPV victimization rates based on NCVS, NVAWS, NISVS or other victimization surveys. If not, advocates should review state laws and/or individual law enforcement policies to promote mandatory or preferred arrest policies, as well

as policies for responding to abusers who are gone when law enforcement respond to an IPV incident. In addition, advocates should review what charges abusers are arrested for to ensure they reflect the seriousness of the abuse. Two thirds of the charges should be for assaults or aggravated assaults or equivalent charges.

B. What Performance Measures Should Advocates Require of Prosecutors and Courts?

Like arrests, intimate partner prosecution rates vary across the country. However, recent research suggests prosecution rates are higher than many may perceive. In a study following up on more than 1,500 intimate partner arrests in Connecticut, Idaho and Virginia, researchers found that prosecutors brought court cases against the abusers in 90.3 percent of the cases, higher than prosecution for family, acquaintance or stranger violence cases. The conviction rate, however, was 44.1 percent, with most of the cases being dismissed. As with prosecution, the conviction rates were higher for the intimate partner cases than the other non-intimate cases. Most of the prosecutions were for misdemeanor assaults. In a little more than a quarter of the cases, the initial charges were amended before conviction. More than 70 percent of the defendants were sentenced to probation and three quarters on partially or fully suspended sentences. Almost half of the defendants were ordered to participate in treatment or batterer programs. The likelihood forsuccessful prosecution was five times greater if the case began with an arrest or warrant. Defendants initially summonsed to court on a citation were less likely to be convicted, notwithstanding the fact that generally citations are used in less serious cases. [391, 393, 392]

A review of 120 studies of intimate partner prosecutions between 1973 and 2006 found that more than three-fifths of arrests resulted in prosecution and nearly one half of the prosecutions resulted in criminal convictions. Prosecution rates were found to range from a low of 4.6 percent in Milwaukee in 1989 to a high of 95 percent in Cincinnati in 1996, and convictions ranged from a low of 50.4 percent in Detroit to a high of 90.1 percent in Brooklyn. While some of the studies examined were old, the researchers found rates did not significantly change over time. [296]

Implications: Victim Advocates and Service Providers should assess prosecution and conviction rates in their jurisdictions. If most IPV cases are not prosecuted and if at least half charged do not result in convictions, prosecutors should be pressed to do significantly better, especially if prosecutors blame low rates on lack of victim cooperation.

Can Successful Prosecutions be Increased?

There have been multiple studies of specific prosecution efforts that significantly increase prosecution by adopting no-drop policies. A study of specialized prosecution programs in Oregon and Washington that instituted no-drop policies, for example, found that increased use of evidence-based prosecution dramatically increased conviction rates,

reduced processing time, and only initially increasing the number of trials. Dismissal rates more than halved in Everett, Washington, from 79 to 29 , and guilty findings increased from 10 to 53 percent (although diversion increased from 2 to 22 percent), whereas processing time declined from 109 days to 80 days. Trials increased from one percent to 10 percent. Conviction rates at trial were 80 percent. In Klamath Falls, Oregon, only 10 to 20 percent of cases were screened out by prosecutors. Dismissals dropped from 47 to 14 percent, and convictions rose from 47 to 86 percent after introduction of evidence-based prosecution. Unlike Everett, diverted cases dropped from six percent to none. Trials rose from one percent to 13 percent but prosecutors won 63 percent of them. [726]

Although the concept of a no-drop policy has proven elastic, the success of these programs in significantly increasing prosecution has been demonstrated in multiple jurisdictions. In the Queens Borough of New York City, prosecutors increased convictions from 24 to 60 percent. Research suggests that much of the increase was the result of increased follow-up with victims, and prosecutor's improved linkage with police (e.g., monitoring the same case log and asking whether each of eight evidentiary items were covered in police incident reports, including photos and victim, witness, and suspect statements). [560]

Implications: Victim Advocates and Service Providers should encourage law enforcement, prosecutors and the courts to attempt robust evidence-based no drop prosecution. While initially there may be increased time required from police and investigators, as evidence gathering becomes more routine, the loss of time at the front end may produce better outcomes at trial and increase pleas at arraignment. When victims request that charges be dropped, prosecutors and their staff should communicate with victims about their reasoning for terminating cases, devise victim-specific safeguards, and offer material aids to enable victim participation in criminal cases. No-drop policies should be flexible enough to accommodate exigent victim requests for diversion or termination.

Do Specialized Prosecution Units Work?

There are a limited number of studies specifically devoted to evaluation of specialized domestic violence prosecution programs. Because specific programs vary, including the resources expended, it is difficult to pinpoint or generalize what works and what does not. Also, in many instances, these programs coexist with specialized domestic violence courts and other programs that may affect outcomes independent of the prosecution programs. However, in general, the research suggests that these programs work well on a number of levels.

First, research indicates that victims generally report satisfaction with domestic violence prosecutions conducted by specialized prosecution teams. Increased satisfaction may translate into increased victim cooperation. For example, in Alexandria, Virginia, a study revealed that 90.2 percent of victims found prosecutors either very or somewhat helpful, a higher rating than that given to the police or a victim support service agency. The 90.2

percent satisfaction rate reported by Alexandria victims compares to only 67.3 percent for victims in Virginia Beach, a jurisdiction that did not have a specialized domestic violence response program by police, prosecutors or victim advocates. [613]

Similarly, in Cook County, Illinois, victims reported higher satisfaction with the specialized domestic violence prosecution unit than with the prosecutors who handled domestic violence outside the unit. The unit featured specially trained prosecutors and vertical prosecution, where one prosecutor handled the case from arraignment through final disposition. This unit also had prosecution-based victim advocates. The victims were also more likely to appear in court: 75 percent compared to 25 percent in domestic violence cases in jurisdictions with no specialized domestic violence unit. [371] The latter finding was not unique.

A three-state study found that victims' fear of court participation was reduced in sites with specialized domestic violence courts that also contained specialized prosecution programs and increased victim advocacy. The same study found equal satisfaction with prosecutors in both demonstration sites and comparison sites that had no specialized court domestic violence programs. [367]

Second, specialized prosecution programs have significantly increased prosecution and conviction rates. The specialized prosecution unit in Cook County obtained a conviction rate in IPV cases of 71 percent compared to 50 percent obtained by prosecutors in general units. [371] In Milwaukee, the specialized domestic violence prosecution unit increased felony convictions five times over. [368] Implementation of a specialized domestic violence prosecution unit in Champaign County, IL increased prosecutions by 18 percent, and overall domestic violence case dismissals decreased by 54 percent. Convictions increased by 22 percent. [376]

However, other studies suggest that specialized prosecution units must be adequately staffed to make a difference. The specialized prosecution unit in Mecklenburg County (Charlotte), North Carolina obtained a much lower conviction rate (38 percent), akin to that obtained without specialized units. However, researchers noted that the unit was significantly understaffed, with only two prosecutors assigned to hundreds of cases annually. [86] In contrast, Brooklyn's specialized felony prosecution program within the Borough's special felony domestic violence court increased convictions from 87 percent to 94 percent for felonies other than protection order violations and to 93 percent for violations. Although the rate was higher than before, the difference was not statistically significant. [596]

Third, specialized prosecution programs appear to be associated with more robust dispositions that also appear to be better monitored and enforced. A study of three domestic violence courts with specialized prosecutors in three different states found more augmented probation conditions as compared to jurisdictions without domestic violence specialization. Augmented conditions included drug and alcohol abstinence and testing, batterer intervention programs that lasted longer and were more expensive, more no-contact protective orders, attendance at fatherhood programs or women's groups for

female offenders, more mental health evaluations, mandatory employment and restrictions on weapons. [367]

Implications: Victim Advocates and Service Providers should encourage prosecutors to develop specialized IPV prosecution units with the requisite resources and staff to do the job.

What Characterizes Specialized Prosecution Units?

An analysis of dozens of responses of prosecutors' offices to domestic violence found that the following dimensions characterized their responses: (1) responsiveness to victims (treating them as if they were petitioners for civil protective orders or treating them dispassionately as witnesses to a crime), (2) treatment of suspects, (3) expectations for victim participation in prosecution, (4) specialization, and (5) information utilization. [865] The specialized units in upstate New York, unlike in other prosecutors' offices, were more likely to track: (1) cases for specialized prosecution, (2) data to inform the pressing of charges for recidivists, (3) data to inform sentencing recommendations, and (4) police incident reports as well as police arrest reports. In addition, specialized domestic violence units were more likely to participate in task forces or coalitions involving other criminal justice and community agencies involved in responding to domestic violence. [865]

Most large prosecutors' offices have special domestic violence units, allowing for innovations such as vertical prosecution for misdemeanors, improved case preparation, greater contact with victims, reduced caseloads and more malleable court scheduling. [561] One-third of prosecutors in small and medium-sized cities across upstate New York also had specialized domestic violence prosecution programs, half of which made advocates available to victims. [865]

Implications: Victim Advocates and Service Providers are acutely aware that new initiatives are likely to fail or produce marginal results unless adequately funded and staffed. Specialized domestic violence prosecution units, especially if associated with specialized domestic violence law enforcement units and courts, should increase domestic violence prosecutions and convictions, victim cooperation and satisfaction and, if dispositions are geared to defendant risk for reabuse, more victim safety.

Do Specialized Domestic Violence Courts Work?

Some specialized domestic violence courts have been found to reduce reabuse; other not. [575] Reductions may be due to reforms of court processes or a corresponding specialization of domestic violence prosecution and/or probation supervision, or all three.

A study of Milwaukee's federally funded model domestic violence court, for example, found that the number of arrests was halved for domestic violence defendants sentenced to probation, compared to those sentenced to probation before court reform. The rearrest rate dropped from 8 percent to 4.2 percent. The average number of new arrests also dropped significantly. Researchers posited that one of the prime explanations for the drop was a corresponding rise in the use of incarceration as a sentence. As a result of tight judicial monitoring and enforcement of release conditions, the post-reform probationers spent 13,902 days confined, compared to the 1,059 days probationers spent jailed in the days before court reform. The researchers speculate that the reabuse rate in those cases heard by the special domestic violence court was due to offenders having less time on the streets to reabuse and reoffend. However, there was also evidence that early detection of continuing reabuse and detention pre-trial were associated with lower recidivism rates in the two years following the index arrest. [367, 368]

Another study of a federally funded model domestic violence court in Dorchester, Massachusetts found reductions in reabuse. However, a third federally funded model domestic violence court examined in Michigan found no reduction over a comparison court. Although reabuse declined in two of the courts, overall new arrests for any offense were not statistically different, although they were in the expected direction: 22 percent for the domestic violence courts, and 28 percent for the nondomestic violence courts. [367]

Three other studies of specialized domestic violence courts have found small but significant reductions in reoffending [307,334], including a study of the San Diego superior court, in which rearrests dropped from 21 to 14 percent in one year. [637] An evaluation of Cook County's four domestic violence courts, on the other hand, found no differences in rearrest rates over six months. [260]

A literature review of domestic violence courts released in 2009 indicated that specialized domestic violence courts are successful in promoting expedited case processing and tend to be associated with increased victim satisfaction and access to services. These courts also appear to increase the use of mechanisms that promote offender accountability such as program mandates, probation monitoring, and judicial monitoring. In fact, research indicates that domestic violence courts are more likely than are non-specialized courts to enforce court orders through the imposition of sanctions for noncompliance, including probation revocation and incarceration." [575]

Implications: Victim Advocates and Service Providers should evaluate the feasibility and potential efficacy of specialized domestic violence courts (or specialized dockets in smaller jurisdictions) that promote expedited case processing, increase victim access to services, and hold abusers accountable through imposition of sanctions for noncompliance, including, but not limited to, probation revocation and incarceration.

C. Do IPV Laws Make a Difference?

Even before the National Council of Juvenile and Family Court Judges promulgated its model state code on domestic violence in 1994, advocates championed IPV criminal and civil code reform and successfully pressed the U.S. Congress, as well as state legislatures, to reform criminal and civil laws relating to IPV. Promulgation of the model code, however, ostensibly accelerated such reforms. According to one study, between 1997 and 2003, state legislatures enacted over 700 domestic violence related laws. [559] In 2010 and 2011, just about every state in the nation whose legislatures met continued to enact still more IPV related laws addressing bail and retrial release, custody, extended protective orders, firearm prohibitions, stalking, strangulation, dating violence, and more. [78a, 551]

It is difficult to assess the impact of these laws in general. It is one thing to enact a new law, it is another to actually implement it. One measure of impact may be reduction in IPV homicide rates. A study seeking to determine if state legal reforms influenced the overall rate of IPV homicides found that these laws in general did not account for variance in state rates except for specific legal reforms that removed firearms from court-restrained abusers. These exceptions were moderate but significant. [85] This research is consistent with at least one other study that found that firearm prohibition laws in states with centralized registries, enabling officials to track protective orders significantly reduced IPV homicides. [818]

Another impact measure is the cost savings realized from civil protection order issuance. A KY study of protection orders calculated that the state saved $85 million in one year related to protection order issuance and enforcement. Even when one measure, the "quality-of-life" index was factored out, victims benefited from protection orders at small cost to the state. Cost savings were not achieved and violations of protection orders were significantly more likely in those cases where the batterer had stalked the victim in the 6 months prior to application for the order. [504, 505]

Not surprisingly, some IPV related laws have been found to have different impacts on different sets of victims. There is evidence that warrantless arrest laws may be associated with a decrease in IPV homicides with fewer killings of white women and black unmarried men. The same study found that protection order laws were associated with decreases in victimization of black married women, but contrariwise with increased homicides for black women killed by their unmarried partners. [213]

Research agrees that the enactment of mandatory arrest and preferred arrest laws increase IPV arrests, with 97 percent higher arrest rates in states with mandatory arrest laws compared to states with discretionary arrest laws, and 177 percent higher in states with preferred arrest laws, compared to states with discretionary arrest laws. Primary or predominate aggressor provisions, whether through statutory reform or promulgation of policy, appear to result in reduced dual IPV arrests from nine to two percent on average. [390]

Other studies have found specific laws to have significant impacts in specific jurisdictions at specific times. For example, in 2011, New York State enacted three new strangulation offenses. Before enactment, strangulation cases were prosecuted for harassment, generally a lesser offense. In the first 15 weeks after the effective date of New York's new strangulation laws, 2,003 people were charged with strangulation, almost all of the suspects (94.3 percent) were male, the greatest percent being in their twenties. [43]

On the other hand, some popular IPV laws have proven to have little effect. For example, Kentucky enacted a new law authorizing courts to require select abusers to wear GPS monitors. A year after enactment, according to advocates, the new law was not implemented for lack of funding, lack of technology, and lack of political will by officials charged with its implementation. [69]

Implications: Victim Advocates and Service Providers recognize that no law is self-implementing. Advocacy does not end with passage of IPV legal reforms. Advocates should monitor implementation, identify possible unintended consequences, and develop strategies to improve legal system adherence to legal reforms.

Appendix

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2. Author Bios

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Andrew Klein, Ph.D., Senior Research Analyst at Advocates for Human Potential, Inc., has served as a principal investigator for a diverse range of domestic violence studies, including use of civil protective orders, a longitudinal study of abusers, elder abuse, stalking, and specialized programs of probation supervision of abusers. He is author of The Criminal Justice Response to Domestic Violence (Thomson/Wadsworth). His Practical Implications of Current Domestic Violence Research for Law Enforcement, Prosecutors and Judges was released as a Special Report by the National Institute of Justice. Previously, he served as Chief Probation Officer of a Massachusetts District Court, helping to establish the country's first dedicated domestic violence court. He has a BA from Harvard and a PhD in Law, Policy and Society from Northeastern University

Barbara Hart

Barbara J. Hart, J. D. is the Director of Violence Against Women Initiatives and Director of Strategic Justice Initiatives in the Justice Policy Program of the Cutler Institute on Health and Social Policy of the Muskie School of Public Service of the University of Southern Maine. Her work includes public policy development, training, and technical assistance on a broad range of issues such as: advocacy; economic justice and security for survivors; systems to monitor batterer intervention programs; implementation of coordinated community intervention systems; development and critique of legislation; construction of court procedures and standards; consultation on impact litigation; development of fatality review processes; and design of training curricula. She has served as a leader in the national efforts to implement the Violence Against Women Act.

Ms. Hart hosts a series of national/international webinars designed to create discourse between prominent researchers and expert practitioners. Web libraries and MP3s are produced for the webinars. The series introduce in 2011 is Ethics for Lawyers. She also writes monthly columns for the *National Bulletin on Domestic Violence Prevention* and has authored and co-authored many articles on domestic violence, including: State Codes on Domestic Violence: Analysis, Commentary and Recommendations; Model Code on Domestic and Family Violence; Safety and Accountability: The Underpinnings of a Just Justice System; Confronting Domestic Violence: Effective Police Response; Seeking Justice: Coordinated Justice System Intervention Against Domestic Violence; Safety for Women: Monitoring Batterers' Programs; and Accountability: Program Standards for Batterer Intervention Services.

Several treatises suggest that the abuse experienced by male victims of female intimates is contextually different than that experienced by women victims of male intimates. [549, 643] Just as male victims differ, so do females convicted of abusing male partners. [563]