

Spousal or Partner Abuse: The California Requirement

This course is designed to fulfill the California requirement
for 7 hours of spousal or partner abuse education.

HOW TO RECEIVE CREDIT

- Read the enclosed course.
- Complete the questions at the end of the course.
- Return your completed Answer Sheet to CME Resource by mail or fax, or complete online at www.NetCE.com. Your postmark or facsimile date will be used as your completion date.
- Receive your Certificate(s) of Completion by mail, fax, or email.

Faculty

Alice Yick Flanagan, PhD, MSW, received her Master's in Social Work from Columbia University, School of Social Work. She has clinical experience in mental health in correctional settings, psychiatric hospitals, and community health centers. In 1997, she received her PhD from UCLA, School of Public Policy and Social Research. Dr. Yick Flanagan completed a year-long post-doctoral fellowship at Hunter College, School of Social Work in 1999. In that year she taught the course *Research Methods and Violence Against Women* to Masters degree students, as well as conducting qualitative research studies on death and dying in Chinese American families.

Currently, Dr. Yick Flanagan is a faculty member at Capella University, School of Human Services and Canyon College, Department of Social Work. Her research focus is on the area of racism and mental health consequences in ethnic minority communities. She and her fellow colleagues are currently administering a survey on Asian Americans, Hispanics, and African Americans' experiences with racism and discrimination.

Dee Spring, PhD, MFT, ATR-BC, an international lecturer, specializes in the treatment of individuals who experienced "intimate" trauma with resultant PTSD; she is a consultant and qualified expert witness in several states. She has written professional articles, book chapters, and authored two books. Dr. Spring has taught at many universities and conducted training for professionals in a variety of settings. Additionally, she designed, implemented and directed the first federally funded rape crisis center in the world to utilize visual art in crisis intervention and treatment for victims of sexual assault. She is Past President of the California Society for the Study of Trauma and Dissociation and a past member of the Board of Directors of the American Art Therapy Association, receiving awards from both for clinical and educational achievements, contributions, and innovations related to research and use of visual art in trauma treatment.

Faculty Disclosure

Contributing faculty, Alice Yick Flanagan, PhD, MSW has disclosed no relevant financial relationship with any product manufacturer or service provider mentioned.

Contributing faculty, Dee Spring, PhD, MFT, ATR-BC, has disclosed no relevant financial relationship with any product manufacturer or service provider mentioned.

Audience

This course is designed for all California behavioral health professionals required to complete 7 hours of spousal or partner abuse education.

Accreditation

CME Resource, #1092, is approved as a provider for continuing education by the Association of Social Work Boards 400 South Ridge Parkway, Suite B, Culpeper, VA 22701. www.aswb.org. ASWB Approval Period: 3/13/2010 to 3/13/2013. Social workers should contact their regulatory board to determine course approval.

This program is approved by the National Association of Social Workers (Approval #886531582-9458) for Domestic Violence continuing education contact hours.

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Designation of Credit

Social workers will receive 7 Clinical continuing education clock hours in participating in this intermediate to advanced course.

CME Resource designates this continuing education activity for 3 NBCC clock hours.

This course meets the qualifications for 7 hours of continuing education credit for MFTs and/or LCSWs as required by the California Board of Behavioral Sciences.

This course meets the requirements for 7 Clinical hours as required by the New Jersey Board of Social Work Examiners.

Individual State Behavioral Health Approvals

In addition to states that accept ASWB, CME Resource is approved as a provider of continuing education by the following state boards: California Board of Behavioral Sciences, Provider #PCE 1632; Florida Board of Clinical Social Work, Marriage and Family Therapy and Mental Health, Provider #50-2405; Illinois Division of Professional Regulation for Social Workers, License #159.001094; Illinois Division of Professional Regulation for Licensed Professional and Clinical Counselors, License #197.000185; Illinois Division of Professional Regulation for Marriage and Family Therapists, License #168.000190; Texas State Board of Social Work Examiners, Approval #3011; Texas State Board of Examiners of Professional Counselors, Approval #1121; Texas State Board of Examiners of Marriage and Family Therapists, Approval #425.

Special Approvals

This course is designed to fulfill the California requirement for 7 hours of spousal or partner abuse education.

This course meets the qualifications for 7 hours of continuing education credit for MTFs and/or LCSWs in the area of Spousal or Partner Abuse as required by the California Board of Behavioral Sciences.

About the Sponsor

The purpose of CME Resource is to provide challenging curricula to assist healthcare professionals to raise their levels of expertise while fulfilling their continuing education requirements, thereby improving the quality of healthcare.

Our contributing faculty members have taken care to ensure that the information and recommendations are accurate and compatible with the standards generally accepted at the time of publication. The publisher disclaims any liability, loss or damage incurred as a consequence, directly or indirectly, of the use and application of any of the contents. Participants are cautioned about the potential risk of using limited knowledge when integrating new techniques into practice.

Disclosure Statement

It is the policy of CME Resource not to accept commercial support.

Course Objective

The purpose of this course is to provide California behavioral health specialists information about spousal and partner abuse, while fulfilling their 7 hour state education requirement.

Learning Objectives

Upon completion of this course, you should be able to:

1. Discuss the historical aspects that led to the recognition of domestic violence as a major social problem.
2. Describe the varying definitions of domestic violence and the controversies surrounding these definitions.
3. Identify the dynamics of abuse.
4. List the barriers to leaving an abusive relationship as experienced by a domestic violence victim.
5. Define the characteristics and dynamics experienced by those groups who are at risk for domestic violence, including pregnant women, children, men, and same-sex couples.
6. Identify screening tools for the detection of possible abuse.
7. Describe interventions targeted to victims of domestic violence and components of batterers' programs.
8. List available national, state, and community resources for victims.

INTRODUCTION

Domestic violence is a serious and pervasive problem in the United States today. Because of the number of individuals affected, it is likely those in the helping professions will encounter patients in their practice who are victims. Accordingly, it is essential for mental health professionals to be able to recognize and accurately interpret behaviors associated with domestic violence. It is necessary to establish and implement protocols for early identification of domestic violence victims and their abusers. In order to intervene and promote the well-being of patients, professionals in all settings must take the initiative to properly assess for abuse and offer education, counseling, and referral information to those who are, or may become, victims.

HISTORICAL OVERVIEW OF DOMESTIC VIOLENCE

Domestic violence, or the issue of wife-beating or battered women, became a recognized social problem in the United States in the 1970s. The construction of domestic violence as a major social problem was first aligned with the larger feminist or women's movement that became active in the 1960s. The movement primarily advocated that domestic violence and other forms of violence against women were due to patriarchal ideologies, which were firmly embedded in the social structures [74; 109]. According to Bograd, the concept of male domination is a fundamental construct for understanding domestic violence [7]. Bograd contended the common denominator in all forms of violence against women is gender and power. Feminists argued the plight of women and wife-beating or battering has always existed and is not a new relationship condition. Dobash and Dobash asserted that male patriarchy has been manifested throughout history in legal, political, economic, and ideological structures [38]. They suggested historical records show wife abuse was common in the United States.

The notions of self-determination and egalitarianism espoused by the domestic violence movement at that time led to the implementation of safe havens or shelters for domestic violence victims in the 1970s [109]. The Rainbow Retreat, opened in 1973 in Phoenix, Arizona, is believed to be the first shelter for domestic violence victims [132]. Other shelters, including La Casa de Las Madres in San Francisco and Transition House in Cambridge, Massachusetts, were grass-root feminist safe havens for women [132]. Chiswick Women's Aid was established in 1971 in London [132]. This shelter gained international recognition in 1974 when the founder, Erin Pizzey, published *Scream Quietly or the Neighbors Will Hear* [132]. This book brought additional attention to the plight of domestic violence victims.

Hotlines and support groups for rape victims were also established during this time. In 1972, a hotline was created in St. Paul, Minnesota, and in 1975, the Abused Women's Aid in Crisis was founded in New York City [132]. These services focused on providing crisis counseling by telephone to battered women and referring them to appropriate agencies for assistance [53]. According to a 1979 U.S. News and World Report, a total of 170 shelters opened in the United States between 1975 and 1978 [132]. In 1981, the first "National Day of Unity" was observed, and beginning in 1984, "Domestic Violence Awareness Week" is observed every October [58].

It was not until the 1970s that more empirical attention was given to domestic violence. Prior to the 1970s, scholars and researchers did not study domestic violence, but by the 1980s it was covered in most academic textbooks in the behavioral sciences [79]. Many of the research studies conducted, however, did not include marginalized populations such as ethnic minorities, lesbians, the physically and emotionally disabled, and older adult victims. As a result, the early domestic violence movement was criticized for not capturing the needs of minority and other marginalized women and for being Eurocentric [71]. In part, this was because more white women were involved in the feminist and

domestic violence movements. Those involved in the movement believed gender inequities and power imbalances were the main causes of violence against women of all ethnicities, sexual orientations, socioeconomic statuses, and ages [119]. Other structural and cultural factors, such as racism, ethnocentrism, class, and poverty, were not taken into account in relation to how these factors interacted with gender in influencing domestic violence. For example, lesbian battering was a topic among the early battered women's activists, but there was resistance from both lesbian and heterosexual women in publicizing it. Lesbians were concerned about homophobia, and heterosexual women were concerned the topic would divert funding and hurt the image of the movement. Therefore, lesbian battering was not addressed until 1986 during the National Coalition Against Domestic Violence conference [90].

DEFINING DOMESTIC VIOLENCE

Researchers in the field of domestic violence have not agreed on a uniform definition of what constitutes violence or an abusive relationship. Domestic violence is also referred to as "spouse abuse," "battering," "intimate partner violence," "wife beating," or "wife abuse." These labels are controversial and stem from different theoretical perspectives.

Domestic violence has been defined as "a pattern of assaultive and coercive behaviors including physical, sexual, and psychological attacks, as well as economic coercion that adults or adolescents use against their intimate partners" [111]. Similarly, the California Partnership to End Domestic Violence defines domestic violence as "a deliberate pattern of assaultive and controlling behaviors, including physical, sexual, and psychological attacks, that one intimate partner does to another to gain power and maintain control" [16]. The California Penal Code defines abuse as "intentionally or recklessly causing or attempting to cause bodily injury, or placing another person in reasonable apprehension of imminent, serious bodily injury to himself or herself or another" [19].

The debate over defining domestic violence revolves around the following questions [49]:

- What type of problem is domestic violence?
- What behaviors constitute domestic violence?
- Who are the parties involved?
- What is the relationship between the victim and perpetrator?

What type of problem is domestic violence?

Scholars who espouse feminist theory maintain that the primary cause of domestic violence is rooted in the social inequality between men and women [35; 74]. Feminists argue that domestic violence involves male coercion of women and is but one specific form of violence against women. Other forms of violence include rape, sexual assault, female infanticide, marital rape, and female genital mutilation [36]. Gender and power are the underlying themes in all forms of violence against women [7]. Therefore, feminists maintain that terms such as "family violence," "marital violence," and "spouse abuse" do not accurately reflect the core of the issue, which is deemed to be male coercion. Rather, terms such as "wife assault," "wife beating," and "battered women" are more accurate [35].

Another theoretical perspective is based on a sociological framework purporting that there are several types of family violence, including spousal abuse [48; 74]. Although both feminist and sociological perspectives acknowledge the gravity of the problem and discuss the subordination of women in domestic violence, the key difference between the two perspectives rests on the central unit of analysis. Feminist theorists assert the key unit of analysis is women and their subordinate roles in society, while sociologists assert the key unit of analysis is the family and social structures [74]. Feminists posit that gender inequality stems from social institutions and gender-biased ideologies. Meanwhile, sociologists maintain there are two contributing factors to spouse abuse; one factor is the subordination of women, and the other stems from characteristics of the contemporary family structure [74]. Families are complex and unique, and

the dynamics of the relationships make the system more vulnerable to violence [47; 75]. The family is regarded as a private institution secluded from public scrutiny. Membership roles are ascribed and involuntary, and family members rely on each other for emotional support [47]. These characteristics cloak the secrecy of violence in the home and often make it difficult for women to leave. According to sociological theorists, the terms “family violence,” “spouse abuse,” “conjugal violence,” and “marital violence” more adequately capture the power dynamics within family structures [35].

What behaviors constitute domestic violence? Domestic violence can consist of many behaviors or combination of behaviors, falling under physical, psychological, verbal, sexual, and financial/economic abuse (*Table 1*).

Who are the parties involved? The answer to this question depends on how domestic violence is conceptualized. Although women are most often the victims, abuse can extend to other household members as well, particularly if domestic violence is viewed as one form of family violence. For example, domestic violence can occur when children are abused by their parents, when parents are abused by their children, when the elderly are abused, and when siblings abuse each other [29; 47]. Western society typically assigns victim status to the wife and the husband is seen as the perpetrator, but there

have been studies that discuss husbands being the victims of domestic violence [126]. Finally, when domestic violence is conceptualized as being of an intimate nature, the concept expands into dating violence, which is characterized as an intimate relationship without cohabitation, legal responsibilities, or shared economic burden [130].

What is the relationship between the victim and perpetrator? When domestic violence is defined as an issue of subordination and coercion, a diagram known as the “Power and Control Wheel” has been used to depict the types of behaviors used as tactics to control an individual. Some studies demonstrate that abusive mates are generally possessive, jealous, and suspicious. These characteristics may be so extreme as to border on paranoia [121]. In addition, battered women have frequently reported that abusers are extremely controlling of everyday activities of the family. This domination is generally all encompassing. One battered woman gave the following examples of her controlling husband. He “insisted that no one (including guests and their toddler children) wear shoes in the house, that the furniture be in the same indentations in the carpet, that the vacuum marks in the carpet be parallel, and that any sand spilled from the children’s sandbox during their play be removed from the surrounding grass” [43]. For a copy of the Power and Control Wheel, visit <http://www.leavingabuse.com/powerwheel.html>.

BEHAVIORS AND DOMESTIC VIOLENCE			
Physical Abuse	Psychological/Verbal Abuse	Sexual Abuse	Financial/Economic Abuse
Kicking, punching, biting, slapping, strangling, choking, abandoning in unsafe places, kicking, burning with cigarettes, throwing acid, beating with fists, throwing objects, refusing to help when sick, stabbing, shooting	Intimidation, verbal abuse, humiliation, put-downs, ridiculing, control of victim’s movement, stalking, threats, threatening to hurt victim’s family and children, social isolation, ignoring needs or complaints	Rape, forms of sexual assault such as forced masturbation, fellatio, oral coitus, sexual humiliation, perpetrator refuses to use contraceptives, coerced abortions	Withholding of money, refuse to allow victim to open bank account, all property is in the perpetrator’s name, victim is not allowed to work
Compiled by Author			Table 1

At first glance, it seems the term “domestic violence” is easily definable, but it is not. In fact, it is the definition of the term that is most necessary when studying any social issue. It is the definition or conceptualization of a problem that affects policies, interventions, and even funding.

DOMESTIC VIOLENCE STATISTICS

When examining the statistics, the number of violent acts committed by intimate partners against each other is staggering. This section will only cite general statistics, but in later sections, statistics will be reviewed for specific at-risk groups.

NATIONAL STATISTICS

According to the United States Bureau of Justice Statistics, in 2001 there were 691,710 nonfatal and 1,247 fatal violent assaults committed by intimate partners [117]. Between 1981 and 1998, of the fatal homicides occurring in intimate violence incidents, firearms were listed as the major weapons used [16].

When specifically examining rape and/or physical assaults, approximately 1.5 million women and 834,700 men are raped and/or physically assaulted by an intimate partner each year [133]. The National Crime Survey found the annual national morbidity associated with domestic violence results in 21,000 hospitalizations, 99,800 days of hospitalization, 28,700 emergency department visits, and 39,900 visits to physicians [87]. The National Center for Injury Prevention and Control estimates that the annual cost of intimate partner violence is nearly \$4.1 billion [92]. More than two-thirds of this cost is attributable to health care.

CALIFORNIA STATISTICS

In California, lawmakers consider domestic violence a serious social problem. Each year nearly 6% of adult California women (more than 620,000) experience some form of physical violence by their intimate partners. Approximately 10% of those women seek emergency department care for their injuries. More than 250,000 of those California women are victims of serious, potentially life-threatening violence. California law enforcement receives more than 196,000 calls related to domestic violence per year [18]. In 2002, 153 murders were committed by intimate partners [16]. Of the 153 murders, 128 were women killed by husbands, ex-husbands or boyfriends, and 25 men were killed by wives, ex-wives, or girlfriends [16].

DYNAMICS OF ABUSE

Lenore Walker, who developed the Cycle of Violence model in the 1970s, describes family violence as occurring in phases that include a series of behaviors, moods, and conflicts experienced within intimate relationships [139]. Phase 1 is referred to as the Tension-Building Stage. It encompasses minor forms of battering such as verbal and emotional abuse. The woman becomes more submissive and indulges in placating behavior to reduce tension and avoid antagonizing the batterer. Women describe this phase as “walking on eggshells.” She monitors her actions and words for fear of provoking her partner. The length of this stage can vary from hours to months as tensions build [22].

This cycles into Phase 2, which includes an acute physical battering incident. It is defined as the Explosive Stage. Although this phase can be brief, it often results in serious psychological damage and physical injuries. The battering does not usually occur in public. In the beginning, the victim is shocked that her partner hurt her. Both parties attempt to minimize and rationalize the incident. They talk themselves into believing the violence is a one-time episode. Victims tend to forgive the perpetrators, but trust is broken by the betrayal.

The woman does not usually report the violence to the police or take any legal action.

Phase 3 is the Honeymoon Stage. The batterer begs for forgiveness, maintains he loves her, and promises the abuse will never happen again. If the victim expresses the desire to leave the relationship, the batterer makes the victim feel guilty. He brings gifts and shows tenderness and kindness. As a result, the victim decides to stay in the relationship, hoping this is a single episode. However, the cycle will inevitably begin again with the verbal and emotional abuse of Phase 1, leading to physical violence.

The Cycle of Violence is complicated as it is predicated on the complex dynamics of abuse. The dynamics of abuse exceed the scope of this course but are a major influence on the development of violence in intimate relationships.

Ongoing crisis-making is often the preamble to physical violence and is seldom discussed in the scheme of domestic violence. Crisis-making may be equally initiated by both partners and is not gender-specific. In the most fundamental way, crisis-making can be considered a “distorted search for intimacy” [123; 124]. It is associated with attachment, possession of a love object, and the fear of loss or abandonment on numerous levels. Although the mechanics of sensory interaction between intimate partners is not associated with gender roles, the interactions are attributed to perceptual anomalies. When physical violence occurs, this behavior ordinarily follows the tensions, which build, one upon the other, during crisis-making situations. These tensions are usually entangled with some kind of conflict, confusion, or unidentified psychological trigger linked to past trauma-related experience. Personality disorders or mental illness may be commensurate.

Crisis-making may be a constant pattern in abusive relationships, even if the behavior never reaches the level of physical violence. Nonetheless, there can be serious, ongoing psychological damage that is not quickly or easily reversed. Even though no obvious lethal weapon is used, there is a hidden weapon. The traumatic nature of verbal battering

or perpetual emotional abuse can be described as brutal and viewed as a type of intimate torture that can be difficult to detect. Emotional abuse may be noiseless and invisible to observers. This camouflaged abuse can take place anywhere, at any time. There are no boundaries or established patterns. The motivation is domination and control, which leads to psychological destruction connected to physiological symptomatology. The effects of this defilement may go unnoticed for lack of disclosure or ignored even when disclosure is made. The most observed symptoms are continual anxiety and depression.

BARRIERS TO LEAVING

“Why doesn’t she just leave?” or “Why does she stay?” are common questions asked about domestic violence victims. The better question is: “What are the barriers that prevent her from terminating the abusive relationship?” One simple reason is love. Often, the victim continues to love the perpetrator and retains hope the incident was the only or last one. After all, he is her partner and, in some cases, the father of her children. Violence does not necessarily eradicate love [32].

Financial dependency is also a monumental barrier. If the victim is financially dependent upon the abuser, she may believe she has no option but to stay, seeing herself as helpless. Feelings of helplessness are made worse with the presence of young children. The victim may have no employment history or marketable skills. Consequently, victims are frequently faced with harsh economic realities.

Many victims are not knowledgeable about available support systems such as social services, mental health professionals, and free legal aid. Often, victims are not familiar with the legal system, protective orders, or how child protective services can intervene. In addition, many are not aware of how to enlist the assistance of community resources, such as mental health centers, shelters, county victim services and advocacy programs, and health clinics.

Religious belief systems or cultural values that emphasize the importance of marriage can also prevent women from leaving. Western society still holds to the romantic notions that “marriage is forever” and married couples should “live happily ever after.” These notions are deeply entrenched values espoused by many women. Short et al. addressed focus groups with African American and white women that reinforced this theme [116]. Women in both groups talked about not terminating their relationships because they were committed to their wedding vows and wanted to provide a two-parent home for their children. These idealized values are prevalent and can be further complicated by religious beliefs and cultural perceptions. For example, a devout Catholic woman might be reluctant to leave a marriage due to her religious beliefs about the sanctity of marriage. A traditional Chinese immigrant woman, who is socialized to believe marriage is her ultimate goal in life, will be resistant to leave her marriage [141]. In many cultures, gender roles are influenced by cultural and religious values associated with morality [109]. For example, a woman who leaves her children, regardless of the reasons, may be criticized for being a bad mother. Such judgment inevitably leaves women bearing an emotional burden, low self-esteem, and low self-worth [104].

Fear of retaliation, a potent threat and an ongoing control tactic, is another reason some women stay. Almost one-third of all female homicides are committed by an intimate partner, a spouse, or a boyfriend. Homicides often occur after the victim has left the relationship [22]. Victims are told if they try to leave, the batterer will find and kill them. As a matter of fact, a victim is at the highest risk for homicide when she takes deliberate actions to leave the abusive relationship [22].

The continuous cycle of violence creates a sense of worthlessness in the victim. As this self-perception grows, self-esteem is further damaged. As it is, victims who do not see a way out of abuse grow to believe they are unworthy of any other type of relationship.

GROUPS AT RISK

PREGNANT WOMEN

Domestic violence among pregnant women is a public health concern. The woman’s physical well-being is at risk, as well as the health of her child. It is difficult to believe, but violence during pregnancy affects more women than hypertension, gestational diabetes, or other complications related to pregnancy [8]. Each year, as many as 324,000 women experience some form of domestic violence during pregnancy [45]. This represents approximately 8% of all pregnant women in the United States. As with all domestic violence statistics, this number is presumed to be lower than the actual incidence as a result of under-reporting and lack of data on women whose pregnancies ended in fetal or maternal death. This makes inactivated poliovirus vaccine more prevalent among pregnant women than some of the health conditions included in prenatal screenings [45]. Because 96% of pregnant women receive prenatal care, this is an optimal time to screen for domestic violence and develop trusting relationships with the women. Possible factors that may predispose pregnant women to inactivated poliovirus vaccine include young maternal age, unintended pregnancy, delayed prenatal care, lack of social support, and use of tobacco, alcohol, or illegal drugs [45].

The dynamics of abuse during pregnancy are complex. It is not clear whether the pregnancy actually instigates the abuse, whether the violence existed prior to pregnancy and continues, or whether pregnancy serves as a buffer from further abuse [8]. Jasinski notes studies that use hospital or clinic-based samples show there is a relationship between pregnancy and violence; that is, pregnancy increases the risk of domestic violence. However, probability-based studies conducted nationwide do not find this association [68].

Abused pregnant women are at three times greater risk for homicide when compared to women who are abused but not pregnant [84]. Other studies found that 11% to 23% of pregnant women reported histories of abuse before pregnancy [60]. Some women who were abused prior to pregnancy found that violence decreased or stopped during pregnancy [8]. Additional evidence points to pregnancy as an outcome of domestic violence; some victims experience violence when they suggest the use of condoms. Another example is when the perpetrator discovers the use of covert contraceptives and makes the assumption the woman is being unfaithful [5; 39]. Empirical evidence exists that indicates women who experience domestic violence during pregnancy are more likely to disclose that the pregnancy was unplanned, closely spaced, or that they are unhappy about the pregnancy when compared to nonabused women [125]. The Centers for Disease Control and Prevention (CDC) found that women with unintentional pregnancies had 2.5 times the risk of experiencing physical abuse compared to those whose pregnancies were planned [107]. In addition, rates of abortion are higher among abused women when compared to their nonabused counterparts, demonstrating a relationship between abuse and abortion [98].

The psychological health effects for pregnant victims of domestic violence can be long-term and complicated. Physical complications can be aggravated by delayed access to health services [68]. For example, abused women are twice as likely to seek prenatal care for the first time well into their third trimester [86]. Physical abuse can affect intrauterine growth of the fetus, causing low birth weight, premature labor, fetal trauma, and even fetal death [68; 98]. Studies also reveal violence during pregnancy leads to unhealthy maternal behaviors, which can affect the physical health of the fetus and ultimately the infant [68]. Abused pregnant women also suffer from depression, are more likely to experience bleeding during the first two trimesters, have difficulty putting on weight, experience anemia, and have kidney infections [68].

CHILDREN

Children who are raised in violent homes are in danger. Research studies have increased over the years to examine how domestic violence affects children. Yet, despite the proliferation of research, many concepts remain ambiguous. The term “exposure to domestic violence” actually entails different types of experiences. What is the impact if a child can hear the abuse but not actually witness it first hand? This type of exposure is very different from children who attempt to intervene when their mother is being abused and are physically assaulted as a result [62]. Types of children’s exposure to domestic violence may be classified as [62]:

- Exposed prenatally – Effects of domestic violence on the fetus.
- Child intervenes – The child intervenes on behalf of the mother to help stop the abuse. For example, the child defends the mother or asks the perpetrator to stop.
- Victimized – The child is physically or psychologically harmed during the abuse.
- Participation in the abuse – The child is forced by the perpetrator to participate in the abuse (e.g., the child is used as a spy or forced to help in denigrating the mother).
- Witness – The child directly witnesses the abuse.
- Overhears – The child hears the abuse but does not directly see the abuse.
- Observes the initial effects – The child sees the injuries caused by the abuse.
- Experiences the aftermath – The child experiences the different social consequences of the abuse (e.g., maternal depression, the father leaving, relocation, etc.).
- Hears about it – The child learns about the abuse through a third party (e.g., neighbor, relative, sibling, etc.).
- Unaware – The child is unaware of the occurrence of the abuse (e.g., the child was sleeping during the abuse).

It is crucial that service providers encourage the child to disclose his or her experience of violence, as each may have a different psychosocial outcome. Children who are 12 years of age or younger are present in more than half of homes where domestic violence occurs [77]. In California, approximately 916,000 children are exposed to intimate partner violence at home every year [16]. Studies show when children witness family violence, they are more likely to become either an abuser or a victim than a child who was not abused. For example, male adolescents who witness domestic violence are many times more likely to batter their mates later in life than those who did not witness abuse. Moreover, victims of abuse will often turn on their own children. Statistics demonstrate 85% of domestic violence victims abuse or neglect their children [76]. Children who reside in homes where violence occurs are 15 times more likely to be physically abused and neglected than the national average [97].

The discussion of children who are exposed to family violence raises legal implications. Domestic violence has been considered a crime for the past 25 years. One side of the legal debate has been whether or not the exposure of children to domestic violence should be viewed as a separate criminal offense, holding perpetrators accountable for these outcomes of their crime. In California, judges will take into account children's exposure to domestic violence when determining sentences [67]. The positive side to viewing children's exposure to family violence as a separate criminal act is it avoids retraumatizing the mother or nonoffending caregiver with allegations of "failure to protect" [67]. However, there are adverse consequences, such as charges of contempt of court or perjury, when victims do not want to testify against the abuser or change their stories [67].

The other side of the controversy is whether or not children's exposure to family violence should be viewed as child abuse or neglect as a separate allegation. In other words, if there are negative psychological, behavioral, and social consequences for children exposed to domestic violence, perhaps these children should be protected by the state [67]. Some states have taken a broad perspective and classified the need for state protection for any child exposed to domestic violence. Other states take a more limited approach, requiring the establishment of a clear relationship between exposure to domestic violence and extreme negative mental or emotional consequences. One of the major drawbacks is the creation of another barrier for domestic violence victims who, when seeking help, fear the loss of their children [67].

ELDERLY WOMEN

As previously mentioned, the domestic violence movement emerged during the late 1960s and early 1970s. The issue of elder abuse did not come to light nationally until the early 1980s, when testimonies at Congress were given about the plight of elders experiencing abuse at the hands of family members [44]. As a result, gerontologists began to focus on elder abuse. Although battering or victimization by a spouse can occur in all age groups, the advocacy activities of the domestic violence movement and the emerging scholarship did not focus on elderly female victims who were battered by their spouses [44]. To this day, our society does not typically envision an elderly woman as a "battered woman" [138]. Researchers and helping professionals have dichotomized the terms "battered women" and "elder abuse victims." Consequently, elders are conceptualized as being abused by caregivers, who are taxed by the daily stressors of providing ongoing caregiving activities [138]. The news media and pamphlets distributed on domestic violence typically depict victims as young mothers with children [10]. Domestic violence experienced by older women is often shrouded in secrecy, thus society remains uninformed. The idea that abuse

is a private matter to be confined within the family is also a barrier. Therefore, many older female victims find it difficult to ask for help. When help is finally sought, the availability of services targeted to this population is limited [88].

Data does indicate that intimate partner violence is more common among younger females. The National Crime Victimization Survey (NCVS) used data from 1993 to 2001 to compare estimates of intimate violence for females in three age cohorts: 55 years of age and older, 25 to 49 years of age, and 12 to 24 years of age [91; 101]. The NCVS found that of all intimate violence acts, 62% of the acts were committed against the 25 to 49 years of age group; 36% of the acts were committed against the 12 to 24 years of age group, and only 2% for the 55 years of age and older group. This means an estimated 118,000 acts of intimate violence were perpetrated against the elder group. Findings revealed that 62% of the violent acts against elder females were by spouses [101].

Many of the dynamics in domestic violence among older females are similar to the experiences of younger women in abusive relationships. In a qualitative study examining the healthcare needs of older women in domestic violence relationships, researchers found that 20 of the 38 women 55 years of age and older did not disclose the abuse because they were embarrassed and ashamed. They were still committed to their spouse and did not classify the behaviors as abusive. Furthermore, many discussed their belief that marriage was a lifetime commitment, reflecting a traditional perspective about marriage [46]. In addition, these women perceived time constraints of a healthcare provider as another barrier. They believed healthcare providers were too busy to listen to personal problems. Some women mentioned that they and their spouses often shared the same healthcare provider. As a result, there was rarely a time to talk to their healthcare provider privately. Those who did disclose the abuse described the providers' discomfort; others described the provider as ignoring the signs [46].

GAYS/LESBIANS

Although public education about domestic violence has increased over the past decade, there is still much silence surrounding domestic violence in the gay and lesbian communities. For example, one rarely sees two women or two men depicted in domestic violence literature. However, estimates of the prevalence of domestic violence in the gay community are similar to, or greater than, in the heterosexual community [102].

Domestic violence is considered to be the third largest health problem facing gay men in the United States [66]. Prevalence estimates of intimate partner violence among gay men vary from 12% to 36% [55]. As with research in the general population, domestic violence prevalence estimates are difficult to obtain and to compare with other studies because of inconsistencies in definitions and methodology. Furthermore, many studies do not address sexual orientation. A large-scale probability telephone survey was conducted with 2,881 gay men in four different U.S. cities between 1996 and 1998 [55]. The authors found that 34% of the sample reported psychological abuse, 22% reported physical battering, and 5% reported sexual battering. In a study conducted in Puerto Rico, a total of 199 gay Puerto Rican men were recruited [134]. Almost half of the participants disclosed violence in their intimate relationships. Forty percent of these domestic violence cases involved emotional abuse, yet few participants perceived this as abuse [134]. A study conducted by Loulan with 1,566 lesbians found that 17% had been involved in violent relationships [80]. In another survey, researchers found victimization rates of 31% among 284 lesbian respondents [78].

Domestic violence for the heterosexual couple and the same-sex couple expose similar patterns and dynamics. However, while the types of physical, emotional, psychological, verbal, and sexual abuse are similar, there are unique characteristics associated with violence in same-sex relationships. For example, the batterer might threaten to reveal his or her partner's sexual orientation to family members, friends, or even employers if the knowledge is still

confidential. This is referred to as “homophobic control” [90]. Again, the barriers to disclosing abuse are similar to the barriers experienced by domestic violence victims in heterosexual relationships. However, in gay or lesbian relationships, disclosure and help-seeking are further complicated by societal homophobic responses, which heighten gay and lesbian victims’ fears of reporting the abuse to law enforcement agencies, medical facilities, and social service institutions [134]. Moreover, the gay and lesbian communities have denied the problem of domestic violence for fear of fueling homophobic responses by the heterosexual community. Another concern is about detracting attention and funds away from medical and social problems such as human immunodeficiency virus/acquired immune deficiency syndrome (HIV/AIDS) [134].

The issues of power and control appear to be a common theme in both heterosexual and same-sex domestic violence cases. Feminist theories have traditionally been utilized to explain the role of power, domination, and coercion etiology of violence against women. Feminist theories contend patriarchy and male domination found in social institutions that oppress women is one factor that contributes to violence against women [7]. However, this construct does not work when explaining violence in lesbian relationships, unless one argues that lesbian relationships are immune to domestic violence because they are not influenced by patriarchal forces [103]. In order to understand the power dynamics of violence in lesbian relationships, Ristock conducted a series of focus groups in which 80 lesbians participated [103]. Several interesting themes emerged. First, almost half of the participants described their first relationship as abusive. Frequently, the abusing partner was older and had been “out” longer. Given the heterosexist climate of our society, the less experienced lesbian victim is dependent upon her offending partner for information about the lesbian culture and community. This stressor places a lesbian victim at risk for violence much like an immigrant woman who moves to a new country [103].

Second, the power dynamics in lesbian relationships shift and fluctuate, unlike in heterosexual domestic violence where the power dynamics are more consistent, usually residing with the male perpetrator. For example, one of the focus group participants described how she was abused one time, and then decided she was not going to take it. She then became the aggressor [103]. This finding is consistent with the phenomenon of mutual battering. Mutual battering is the idea that each partner is both an abuser and a victim [102]. In heterosexual violence, female victims may employ abusive tactics against the males for self-defense as a last resort or when under extreme duress. However, in lesbian relationships, research indicates that the victim fights back more frequently [99]. Some have offered possible reasons for this trend. One reason might be more equality in size and strength between the female partners. In addition, lesbians are more likely to take self-defense courses [99].

Much more investigation is needed in this area [103]. Already, research on same-sex relationships is showing gender is not the absolute factor in all incidents once theorized. The expressed need for power, dominance, and control remains a stable factor.

MUTUAL BATTERING

Mutual battering is present in both heterosexual and same-sex relationships. Abuser and victim roles often shift back and forth between partners. The cause can be linked to untreated or unresolved past traumatic experience causing difficulty in the present. This problem is not limited to a single gender. Rather, the pattern is frequently associated with trauma triggers and re-enactment behavior [11; 120; 123; 124].

Mutual battering, as it relates to violence in relationships, seems to have numerous causes. Gender roles, as the primary theoretical base for the conceptual framework of feminist perception, is one contributing factor based on history. In the postmodern world, other influential factors are significant to consider because the roles of women are changing. As previously mentioned, the dynamics of abuse are complex and are primarily sensory and percep-

tually driven, culturally sensitive, and transmitted across generations as learned behavior. The need and drive for control and power in relationships, as well as aggressive behavior, is not limited to males in a changing society. The dynamic remains a historical factor not to be denied or ignored. Aggression, however, has many forms and shapes. To fully understand domestic violence, it is essential to investigate all aspects, not just strict adherence to gender, but also the relationship between perpetrator and victim.

ETHNIC MINORITY AND IMMIGRANT WOMEN

The United States is becoming increasingly diverse in terms of ethnic composition. During the 1990s, the combined population of African Americans, Native Americans, Asians, Pacific Islanders, and Hispanics/Latinos in the United States grew at 13 times the rate of the non-Hispanic white population [100]. As a result, it is inevitable that race, culture, and ethnicity will have a profound effect on American culture. Race, culture, and ethnicity become the lens through which individuals view the world and all aspects of human life, and mental health professionals must become more aware of, and sensitive to, the cultural norms, belief systems, and needs of culturally diverse patients in order to provide relevant services and interventions [96].

Ethnicity and culture influence the labeling or perception of social problems. Understanding general views about gender roles and beliefs pertaining to family authority will help professionals appreciate the intersection of culture, race, ethnicity, and family norms related to abuse. Diller believes individuals relate to their world through cognitive worldviews or paradigms [37]. These worldviews and paradigms provide individuals with rules and assumptions about how the world works. Culture and ethnicity provide the content for worldviews [37]. Consequently, how a group labels or constructs perception of abuse or maltreatment is influenced by cultural beliefs and values. This perception affects how domestic violence is viewed, managed, exhibited, and reported [2].

Results from the National Violence Against Women Survey indicate all racial minorities experience more intimate partner violence than whites [133]. Certain ethnic minority groups are more vulnerable to violence because of environmental risk factors such as poverty, racism, oppression, and discrimination. For example, the sociocultural backdrop of slavery, oppression, and economic deprivation may have contributed to violent behavior in the African American community [56]. One study suggests that nearly one-third of African American women experience intimate partner violence in their lifetimes, compared to one-fourth of white women [133].

Domestic violence is a major social problem in other ethnic minority groups as well. One study with 1,234 Mexican American adults found that 20% of the sample reported physical violence against a spouse. Those born in the United States reported a 2.4 times higher rate of violence than those born in Mexico (12.8% for those born in Mexico and 30.9% born in the U.S.) [122]. In another health clinic-based study with 155 Latina women in rural Texas, 19% of the Latina women disclosed experiencing abuse within the last year [137].

In the Asian American community, the mistaken notion that Asian Americans have achieved success often cloaks the issue of domestic violence. Hicks and Li conducted telephone interviews with a sample of 181 Chinese women in Boston; 14% of these women reported partner violence during their lifetimes [61]. In another telephone interview with 262 Chinese American men and women in Los Angeles County, 81% reported verbal abuse within the past 12 months, and 85% for a lifetime. Furthermore, 6.8% reported physical spousal abuse in the last 12 months, and 18% for a lifetime [17]. In the Korean American community, Kim and Sung interviewed 256 Korean American couples over the telephone to find that 19% of these Korean Americans experienced at least one incident of minor physical assaults by a spouse during the year [72].

Culture, race, and ethnicity also influence help-seeking patterns. Researchers from the National Violence Against Women Survey found that American Indian/Alaska Native women and men were most likely to report domestic violence and Asian/Pacific Islander women and men were least likely to report [133]. A host of factors influence ethnic minority families and elders in seeking outside professional assistance. Factors might include financial limitations, suspiciousness or wariness of professionals, and inconvenience in locating and traveling to agencies [54]. Help-seeking behavior is in part influenced by an individual's definition and understanding of abuse, which is ultimately influenced by culture. For example, an ethnic minority woman who is being abused by her husband may not seek help because she does not label the "event" as a problem. Instead, she believes the event is something to be persevered. In other words, the victim has a "cognitive map" or explanatory model about the expectations regarding illness, symptoms, or other events like violence [54].

WOMEN WITH PHYSICAL DISABILITIES

Minimal research has been conducted about women with physical disabilities and their experiences of domestic violence. What is known is that this particular population is marginalized on two levels, by gender and by disability. These women represent a highly vulnerable group due to physical disability, which limits their ability to protect themselves [28]. Similar to nondisabled women, women with physical disabilities experience abuse by spouses or intimate partners in their places of residence, which may include a variety of settings [34]. Some research indicates the rates of intimate partner victimizations are comparable in disabled and nondisabled populations. In a study of disabled women and a comparison sample of nondisabled women, almost two-thirds of each group reported experiencing some sort of physical, emotional, or sexual abuse during their lifetime, and the abusers were primarily intimate partners [41]. Interestingly, the data also indicate that the length of abuse for disabled women might be longer than for nondisabled women [41].

Like other vulnerable populations, women with physical disabilities confront unique barriers in disclosing abuse. They may tolerate the abuse longer and/or be slower in terminating abusive relationships. Because of physical limitations, female domestic violence victims with physical disabilities may be more reliant on their partner for their daily living activities [27]. They also have difficulty accessing services due to factors related to their physical disability, as well as the limited number of domestic violence services that specifically target their needs. Furthermore, Western society promotes cultural values emphasizing independence and individualism, thus individuals with physical disabilities experience societal assumptions about their powerlessness. They are devalued to some degree, and their abilities are questioned [27]. All of these aspects increase feelings of helplessness and isolation [27]. These feelings of helplessness and powerlessness are then reinforced on a daily basis when other individuals, although well intentioned, are making decisions for them [28]. Not only does Western culture value independence, but physical beauty is also highly emphasized. Therefore, their sense of self may be compromised due to the perception that their body is less than ideal. For example, women with physical disabilities are less likely to be employed or married, further reinforcing a negative sense of self. Psychological and emotional abuse, such as put-downs and denigrating remarks, compound existing feelings of negative self-worth, contributing to low self-esteem.

Although there are similarities in the types of abuse encountered by nondisabled and disabled women, there are also unique types of abuse experienced by women with physical disabilities, which service providers may not perceive. Abusers can harm disabled victims in various forms, such as removing a battery from a wheelchair, withholding medication, or touching a victim during personal care activities, indicating the perpetrator's need for power and control [34]. Given the unique types of abuse women with disabilities experience, experts recommend specific routine assessments for women with disabilities, using a 4-question screening instrument [85]. Two questions address

standard physical and sexual abuse questions, and two questions are focused on disability. This screening instrument detected a 9.8% prevalence of domestic violence within a sample of 511 women. The first two traditional questions about physical and sexual abuse detected a rate of 7.8%, while the last two questions focused on disability and found an additional 2% prevalence rate in the sample. The questions are:

- Within the last year, have you been hit, slapped, kicked, pushed, shoved, or otherwise physically hurt by someone?
- Within the last year, has anyone forced you to have sexual activities?
- Within the last year, has anyone prevented you from using a wheelchair, cane, respirator, or other assistive devices?
- Within the last year, has anyone you depend on refused to help you with an important personal need, such as taking your medicine, getting to the bathroom, getting out of bed, bathing, getting dressed, or getting food or drink?

If a woman provides an affirmative response to any of the above, then the interviewer asks if the act was perpetrated by an intimate partner, care provider, health professional, family member, or other individual [85].

MEN AS VICTIMS OF DOMESTIC VIOLENCE

The issue of women being perpetrators of domestic violence against men is seldom discussed as research on the topic is sparse. Men as victims of spousal abuse is a controversial topic because most domestic violence advocates and feminists are concerned the topic will detract attention away from the abuse of women. In no way is this section of the course meant to minimize the injury and pain of female domestic violence victims. It is important to recognize that domestic violence by male intimates is a historical construct that far outweighs female-perpetrated violence in terms of prevalence and physical costs to society. Yet, it is also important to acknowledge the seriousness of husband or male intimate abuse.

Due to bias, lack of reporting by males, and denial about females who abuse, an adequate analysis of the scope of this type of domestic violence is difficult to determine. Steinmetz argued this abuse is a social problem and coined the term “battered husband syndrome” [129].

Some studies, like the National Family Violence Surveys, found the rate of wife-to-husband assault was comparable to husband-to-wife assault [48; 128]. However, investigators propose these figures stem from the instruments utilized to measure violence. The Conflict Tactics Scale, for example, is a common instrument used in domestic violence research. It evaluates the broad range of strategies used by family members to resolve conflicts [127]. The instrument has been criticized for examining violence without taking into account the context in which the violence occurs and the power dynamics involved [14]. For example, it does not take into account women who employed physical aggression as self-defense. Yet, there are those who maintain the self-defense argument is not a legitimate explanation for data that shows comparable use of violence by men and women. Sarantakos conducted a qualitative study involving 68 families with purportedly violent wives in order to explore if self-defense was a reason for abuse [106]. The study found wives did not use violence as a form of self-defense (e.g., when they were fearful for their lives and/or the lives of their children). Rather, the women in the study primarily used violence as a means to resolve a conflict or punish their husbands. In addition, the occlusion of statistics related to women who kill their partners is a factor.

There are few studies about the motivations of female perpetrators of domestic violence. Those that have been conducted found control, anger expression, and coercive communication to be motivating factors for both genders. Specifically, retaliation by women using self-defense as a means to escape from aggression was a commonly cited reason. Men talked about using physical aggression as punishment [4]. In an interesting study, Babcock and Siard examined if there were different motivations for women who use violence only against intimate partners versus women who use violence

in other general situations and also against their intimate partners [4]. Women who used violence in general situations and against their intimate partner were more likely to use psychological and emotional tactics for control; to blame their violence on external factors; to have witnessed their mothers being aggressive toward their fathers; and to believe violence is justified compared to women who used violence solely on their intimate partners. Both groups equally cited self-defense as the reason. Considering all these factors, further research is needed to understand the dynamics of why women use violence against their intimate partners.

ADOLESCENTS AND DATING PARTNERS

The domestic violence agenda did not initially focus on intimate violence among adolescents. In the late 1950s, Kanin examined aggression in dating relationships and found 30% of adolescent girls had been sexually assaulted (attempted or completed forced sexual intercourse) while on a high school date [70]. In the early 1980s, a study by Makepeace found 20% of female college students experienced dating violence [81]. This study was considered a landmark, and “dating violence” was publicly acknowledged as a serious social problem. The acknowledgment launched many empirical studies in this area. *Against Our Will: Men, Women, and Rape*, a book by Susan Brownmiller, first used the term “date rape” [13]. Brownmiller’s book is a historical account of violence against women, set against the backdrop of the 1970s. At this time, the women’s movement was gaining strength related to an emphasis on the serious social problems of domestic violence and sexual assault [42].

The period between 14 and 18 years of age is a particularly risky time for dating violence [118]. It is estimated that one in three high school students have been or will be involved in an abusive relationship [89]. In a national study on adolescent health, 32% of the adolescents studied reported experiencing violence in the preceding 18 months. Physical violence was disclosed by 12% of the adolescents [57]. Psychological abuse is also prevalent. One

study found that more than 75% of college women had experienced some form of psychological abuse during a 6-month period, and 91% over their dating lifetime [93]. In the context of dating, sexual assault is also common. A national study with college-age females found 54% had experienced some form of sexual aggression by a dating partner at least once since the age of 14 [73].

Like other population groups, dating violence shares similarities to violence in committed relationships. In both areas, the dynamics of power and control are present [130]. Victims in both dating and committed relationships may be afraid to end the relationship, as they are usually at increased risk for physical injury at that time [130]. However, there are differences among the groups, which supports the need for research specific to dating violence. More often than not, there are no economic ties in a dating relationship that bind the couple together [25; 130]. Usually, in adolescent dating relationships, children are not involved, unlike partners in married relationships, which is often cited as a reason victims do not terminate abusive relationships [25].

Risk factors for dating violence overlap with other factors that are characteristic of the adolescent developmental years, such as substance abuse, relationship conflicts, reluctance to involve adults in decision making, and proclivity to risk-taking behaviors [140]. Furthermore, immature development of prosocial problem-solving strategies and conflict resolution skills heighten adolescents’ risk towards dating violence. One study found that teenage girls who were victims of dating violence were more likely to report suicidal ideations or be engaged in risky sexual behaviors and abused drugs or alcohol more often than nonabused girls [64].

Dating violence as a social problem has been argued to be distinctly different from domestic violence. Because of important developmental milestones, prevention efforts should focus on teaching adolescents and young adults about conflict management and resolution, prosocial communication skills, health issues, and problem-solving strategies.

MILITARY FAMILIES

It has been argued that because the military culture legitimizes violence, it places military family members at risk for various forms of violence [82]. Furthermore, the stressors associated with military lifestyle, such as the lack of social support systems, adjustments to a new region, or encountering different cultures, can heighten risk factors for domestic violence [33]. Often, military needs take priority over family issues. These factors contribute to stress, which can lead to domestic violence [50]. One study suggested that combat produces stress and antisocial behaviors among veterans, and these antisocial behaviors then affect marriage [51]. However, overall there has been minimal research about domestic violence in military families.

Because state laws for mandatory reporting vary, in the 1980s the U.S. Army established its own definitions and policies for domestic violence [83]. When an incident of abuse (child abuse or spouse abuse) is reported, the Case Review Committee, which falls under the purview of the commander of the medical treatment facility, reviews the case to determine if it is substantiated or unsubstantiated. When the review is complete, the information is forwarded to the Army Family Advocacy Program [95]. The Army Family Advocacy Program is mandated to focus on identification, reporting, prevention, and treatment of child abuse and domestic violence. As part of the Army Family Advocacy Program's mission, the U.S. Army has a central registry that collects and maintains all cases of reported child abuse and domestic violence. Child abuse information has been collected since 1975, and domestic violence cases since 1983 [83].

In terms of prevention and intervention, the Family Advocacy Program provides a range of prevention strategies, including support groups for new parents, education programs for married couples to learn how to deal with stress, parenting classes, communicating and coping instruction, and anger management courses [136]. Training is also targeted to professionals such as law enforcement agents and social workers. Interventions range from crisis intervention, marital counseling, emergency medical care, safety plan development, drug and alcohol

treatment, support groups, case management, and anger control management groups.

As with domestic violence in the civilian population, military victims face a host of barriers in disclosing abuse. In addition to shame and embarrassment, fear of reprisals, feelings of isolation, and lack of available services, many military victims found when they did report abuse, military personnel were not sensitive to their needs [40].

Given the barriers to disclosure, it is difficult to assess the prevalence of domestic violence among military families. However, a few studies provide a glimpse of the scope of this problem. McCarroll et al. used the Army's central registry to examine domestic violence cases from 1989 to 1997 [83]. They reported a total of 61,827 initial substantiated cases, 5,772 subsequent incidents, and 3,921 reopened cases. Victim rates varied between 8 and 10.5 per 1,000 married persons. More than two-thirds of the victims were female, and almost half of the referrals were from law enforcement agencies. The majority (93%) involved physical violence resulting in minor injuries. According to the U.S. Department of Defense, since inception of the Army Central Registry, the Army itself has recorded 57,421 confirmed cases of domestic violence. The majority (94%) consisted of minor physical violence, 3% were severe abuse, and 3% were emotional abuse [136]. According to Brannen et al., some Department of Defense data indicates that 19 out of 1,000 wives of Navy and Air Force personnel and 21 out of 1,000 wives of Army personnel were abused in the last year [9].

Risk factors are complex and multifaceted. Brewster conducted a study of 2,991 abusers who used physical domestic violence that received treatment at the Air Force Family Advocacy Program and agreed to participate in the study. As with the general population, the physical violence sustained was more severe when the offender was male. Previously reported domestic violence cases were higher than the base rate for the general population—one in four had been reported for spouse abuse, and one in eight offenders had been substantiated for spouse abuse [12].

In another study, a total of 716 married military service men, stationed in a U.S. Army post in Alaska, participated in a survey study. Almost one-third of the men (31.6%) reported engaging in some act of aggression against their partner in the last 12 months. Nine percent disclosed having engaged in at least one moderate-to-severe act of aggression [105].

Race is another factor. When researchers examined white and African American spouse abuse cases documented in the Army Central Registry, rates were higher among all age brackets for African Americans. It is not clear what specific factors are influencing these different rates. The authors postulated that a systematic bias exists in the referral process [95]. It is also possible that referrals are made to the Family Advocacy Program due to stereotypical perceptions that African American families are more violent. The authors recommended further longitudinal studies to examine cultural specific factors that contribute to these rates.

It has also been speculated that exposure to the trauma of combat and the development of post-traumatic stress symptoms provokes military veterans to be violent at home [50]. Furthermore, when these veterans do obtain treatment, either voluntarily or as mandated, many do not complete their treatment regimens. A sample of 62 male perpetrators from a domestic violence rehabilitation program participated in a study. Forty-eight men were veterans, while the remaining 14 were active duty. In general, findings showed that there was a relationship between the severity of post-traumatic stress disorder (PTSD) and the severity of domestic violence. Furthermore, there was a relationship between the severity of PTSD and the witnessing of parental domestic violence during childhood. Findings also indicated that those who did not complete treatment were usually older than 35 years of age, had higher levels of post-traumatic stress, experienced higher levels of stress in their daily lives, and reported less mutuality in their relationships [50].

In a similar vein, a study examined the extent by which recent military deployment predicted domestic violence against wives whose husbands were deployed and wives whose husbands were not deployed [94]. A survey was mailed, and a total of 368 wives of deployed soldiers and 528 wives of non-deployed soldiers responded to the survey. Wives who reported post-deployment domestic violence tended to be younger. The authors found that military deployment was not related to domestic violence during the first 10 months of the post-deployment period. However, when there was a history of pre-deployment domestic violence, the risk of post-deployment domestic violence was greater. Thus, age and previous history of domestic violence are important indicators to consider when developing prevention efforts [94].

The risk factors for domestic violence in military families are multi-faceted. The role of stress emanating from family, military life, culture, and environment and combat stress must be further researched to understand its influence on domestic violence.

BIOPSYCHOSOCIAL IMPLICATIONS OF DOMESTIC VIOLENCE

Domestic violence is a significant direct and indirect risk factor for various physical health problems. Schollenberger et al. found African American female victims of intimate violence had significantly more health problems per medical visits and emergency room visits than African American women who were not victims [112]. The link between physical abuse and health problems can be traced as studies show that when physical violence escalates, health problems and depression intensify. Conversely, for women whose experiences with violence subside, their experiences with health problems diminish [21].

Many of the health problems experienced by domestic violence victims are treated in healthcare facilities, such as emergency rooms. Because they frequently present in healthcare facilities, professionals should be aware of the different health effects of domestic violence.

Physical injury, including bruises, fractures, and on the more severe continuum, head trauma, are the evidence of the aftermath of violence [20]. These are the more tangible, visible symptoms; other less visible consequences include chronic pain, hypertension, chest pains, gastrointestinal problems, headaches, migraines, sleep disorders, and colds due to suppressed immune systems [20]. The exact mechanisms that cause these symptoms are not known because there are a number of complex factors correlated with these symptoms.

Gynecological problems, such as sexually transmitted diseases, vaginal bleeding and infections, pelvic pain, and urinary tract infections, are common in this population [20]. Forced sex from sexual abuse increases the likelihood of these symptoms, but because many victims do not seek treatment immediately or on a consistent basis, symptoms are further exacerbated. Cause and effect is difficult to determine without objective health records.

In addition to physical symptoms, battered women also exhibit psychological cues that resemble agitated depression. Depression is four times higher and suicidal ideation is 5.5 times higher for victims of intimate violence compared to nonabused women [48]. In addition, past unresolved trauma can exhibit similar symptomology, or compound acute stress. Hicks and Li conducted interviews with 181 Chinese American women in the Boston area [61]. Women who had a history of partner violence were at a four times higher risk for depression.

Stress, an invisible force, impacts both physical and mental health. Battered victims experience more current stress than non-battered women, and stress levels adversely affect their physical and mental health. As a result of prolonged stress, victims often manifest various psychosomatic symptoms

generally lacking an organic basis. The extensive literature and research on traumatic stress is applicable to domestic violence. Review of effects of trauma reveals the following symptoms: backaches, headaches, digestive problems, fatigue, restlessness, insomnia, or loss of appetite. Great amounts of anxiety, guilt, and depression or dysphoria are also typical [31; 110]. In many women, this constellation of symptoms is also associated with “battered woman’s syndrome” [139].

The relationship between stress and psychophysiology is complicated. In a study conducted by Sutherland, Bybee, and Sullivan, they took it one step further and asked what relationships existed among the factors of intimate violence, injuries, stress, depression, income, and physical health [131]. In other words, do injuries from the violence account for the range of physical health problems? Using a series of convenience sampling strategies, a total of 397 women participated in face-to-face interviews. Findings showed intimate violence affected physical health through the injuries experienced, stress, and the combined effects of stress and depression. Stress accounted for 80% of the psychophysiological effects on physical health.

Abuser motive and the effect committing violence has on the perpetrator have not been thoroughly studied. Some past studies suggest a correlation between the occurrence of abuse and the consumption of alcohol. It is not clear whether abuse is a direct consequence of alcohol consumption, or if batterers who use alcohol are more likely to use violence because of decreased inhibition levels. Some studies found that men who abuse alcohol are also likely to abuse their mates, although abusers are not necessarily inebriated at the time the abuse is inflicted [114]. Another study found that male partners’ unemployment along with drug or alcohol use were associated with increased risk for physical, sexual, and/or emotional abuse [30]. When treating families with a history of domestic violence, practitioners should ask questions that explore social drinking habits of both partners.

Additionally, a high proportion of abusers report higher depression levels, lower self-esteem, and more aggressive tendencies than intimate partners who are not abusive. Evidence indicates violent partners are more likely to have schizoid or borderline personality disorders, antisocial or narcissistic behaviors, and dependency or attachment problems [65].

ASSESSMENT OF ABUSE

A major difficulty in assessing domestic violence is specifically defining the type of abuse because each involves different dynamics and consequences. Physical violence is characteristically different from the sole experience of unrelenting emotional abuse and persistent verbal attacks. Physical violence cannot occur without psychological abuse, but psychological abuse can occur without physical violence. Because the focus of research within domestic violence primarily addresses physical violence with psychological abuse as its companion, more investigation is required to clarify the impact of prolonged psychological abuse on intimate partners' cognitive function, emotional health, stability of personality, and whether this type of torment leads to more suicides than is currently known.

SIGNS AND SYMPTOMS

The following is a list of possible indicators or warning signs that point to abusive behavior [23; 59]:

- Injuries that are not medically consistent with the explanation of how they occurred
- Chronic and vague complaints with no obvious physical cause
- Frequent trips to the emergency room or to a healthcare provider
- No consistent or regular healthcare provider
- Physical symptoms, including joint pain, burns, clumps of missing hair, bruises, welts, or scars on breast, upper arm, or thighs

- Physical injuries during pregnancy
- Frequent fractures and trauma injuries
- Urinary tract infections or chronic pelvic region pain
- A history of suicidal thoughts or attempts
- Late access to prenatal care services
- Unexplained delays between an injury and medical attention
- Vague information about the reasons or causes of an injury
- Minimizing serious injuries
- A partner who seems overly attentive, controlling, reluctant to leave the room while the healthcare provider is examining the patient, or exhibits inappropriate reactions to examinations
- Low self-esteem, anxiety, depression, fear, or hyperarousal

SCREENING

Screening is vital to the detection of domestic violence. When practitioners inquire about the occurrence of domestic violence, patients are more likely to disclose abusive incidents. Screening helps patients to evaluate their situation and make decisions about their safety. It also assists practitioners in implementing interventions and making appropriate referrals. In addition, screening reduces and/or prevents the possibility of homicide or further child abuse. In one study, 44% of all domestic violence homicide victims had visited an emergency room or clinic with injuries less than two years prior to their deaths [135]. These victims made a total of 48 visits during this time period, and there was clear documentation in 8 of the women's records showing they were specifically victims of domestic violence. However, no referrals to any victim resources were made.

The language and terminology utilized by the helping professional is crucial. The terms “domestic violence,” “abuse,” “intimate violence,” and “spouse abuse” are technical jargon used within the helping professions. However, many domestic violence victims do not identify with these terms. It is frequently more effective to identify patterns of behaviors that are considered to be abusive [10]. For example, questions should be specific and behaviorally oriented. Such questions might include: “Does someone put you down and call you stupid?” or “Does someone not allow you to leave the house whenever you want?” or “Does your spouse or anyone ever slap, hit, or punch you?” [10]

Screening instruments or tools are available to detect domestic violence in mental health and healthcare settings. In a large pediatric clinic, a formal screening process was implemented using an instrument called the Partner Violence Screen [63]. Three questions are asked: “Have you been hit, kicked, punched, threatened, or otherwise hurt by someone in the past year?” If the patient responds affirmatively, then the practitioner inquires who did this. This is followed by: “Do you feel safe in your current relationship?” and “Is there a partner from a previous relationship who is making you feel unsafe now?”

HITS, an acronym for Hurt, Insult, Threaten, and Scream, is a four-item screening tool for partner abuse [115]. A practitioner asks the patient how often in the last year did his/her partner: **H**urt him/her physically? **I**nsult or talk down to him/her? **T**hreaten him/her with physical harm? Or **S**cream or curse at him/her?

Jory describes the development of a 15-item instrument called the Intimate Justice Scale (IJS) [69]. The instrument is designed to detect physical and psychological abuse in a clinical setting when used by practitioners such as social workers, marriage and family therapists, and counselors. It is different from other instruments in that the IJS is based on intimate justice theory, which is focused on fairness in family relationships. It taps into individuals’ perceptions of “equality, fairness, and ethics of care, and relates these concepts to gender, including problems of male entitlement” [69].

Jacqueline Campbell developed the Danger Assessment to help practitioners and victims evaluate their level of danger or safety in an abusive relationship [24]. A victim is given a calendar and asked to mark the days when violence occurred, then rank the severity of the incident. This assessment provides a tangible record for the victim to evaluate her level of danger.

Despite the fact that merely asking patients questions about domestic violence actually increases the disclosure rate by patients, many helping professionals simply do not inquire. Barriers to screening include a variety of reasons, such as lack of education in this area, lack of time in busy schedules in clinics and social service settings, reluctance to intrude on private family matters, and mandated reporting laws [135]. Professionals may also be uncomfortable asking for fear of insulting the patient.

Screening should be done in a manner that does not place the patient in further danger or leave the patient in a vulnerable position. Screenings of patients should be conducted in private without the presence of family members or children [135]. When the patient cannot speak English, an interpreter should be used; however, children should not be used as interpreters.

INTERVENTIONS FOR DOMESTIC VIOLENCE

SAFETY PLANNING

All practitioners should periodically review safety planning with domestic violence victims. Homicide is a high risk for victims, thus safety planning is crucial.

- Advise victims to be aware of weapons in the house.
- Instruct victims to make an escape or survival plan in the case that violence escalates.
- If children are old enough, they should be instructed about the safety plan and assigned roles.
- When possible, women should save or hide money to prepare for the need to leave suddenly. However, victims should be cautioned that this may precipitate violence if the abuser finds out.
- A bag should be packed with necessities and stored in a safe place in the event leaving must be immediate.
- Advise victims to work out a code or system with the children to more easily and discretely facilitate an escape plan.
- Encourage victims to keep a list of important contact information in their packed bag. Memorizing important numbers provides more safety.
- Copies of important documents and necessary items should be available. These include:
 - Identification and legal documents
 - Financial documentation and money

- Prescription medications
- Children's necessities and records
- Address book
- Sentimental or valuable photos or jewelry

Although safety planning may be advocated, it does not necessarily mean victims will employ safety planning guidelines. A study conducted by Goodkind, Sullivan and Bybee asked about strategies women used to keep themselves and their children safe [52]. They developed a survey to determine if the women had used the various forms of strategies. Women were then queried about what the consequences were when utilizing the strategies. Findings showed that out of the 28 strategies recommended, the average number used was 16. The most frequently used strategies were: trying to talk to the perpetrator; calling the police; and avoiding the perpetrator at certain times. About 73% of the women talked to family and friends, and 67% stayed with family and friends to escape the abuse. However, less than 25% sought professional help. Less than 25% also developed codes to communicate with children. Only 29% developed safety plans, and only 25% secretly removed weapons from the home. Unfortunately, according to the women in the survey, no one strategy was helpful in protecting them. Those who used shelters provided by a domestic violence program found this strategy was the most effective in managing the situation. Interestingly, those who tended to use placating or mollifying the batterer (e.g., keeping children quiet, not resisting, and doing whatever the batterer wanted) were effective in keeping themselves safe. However, those women who used these strategies were more likely to experience higher levels of depression and a lower quality of life [52].

LEGAL INTERVENTIONS

California Mandatory Reporting Law

****Please note, the California's Mandatory Reporting Law does not pertain to behavioral health professionals, but only to healthcare practitioners who provide medical services. This information has been included for background and informational purposes only.**

There are six states with mandatory reporting laws to address domestic violence [64]. California requires healthcare providers to report injuries resulting from firearm or assaultive violence, including injuries from intimate violence. Reports to law enforcement agencies are required even if the patient opposes the report [6; 104]. In addition, healthcare providers are mandated to document and record the injuries in the patient's medical records and provide referrals to appropriate agencies [6]. Those healthcare providers who do not comply can face fines up to \$1000 and/or jail sentences up to 6 months [104].

There is a great amount of controversy among helping professionals about mandatory reporting laws. Those in favor of mandatory reporting for adult domestic violence maintain these laws improve the safety of the victim and will assist law enforcement to effectively intervene. Those who oppose the mandatory reporting laws also consider mandatory reporting creates a safety issue. They argue mandatory reporting can place the victims at risk for more violence because abusers can retaliate. Professionals who oppose mandatory reporting believe the laws violate victims' rights of autonomy. By taking these rights away, victims are disempowered, which is contrary to many of the interventions that emphasize empowering these victims [3]. The necessity of mandatory reporting can retraumatize the victim [6].

Rodriguez et al. conducted a study on the attitudes of females toward California's mandatory reporting law when they sought medical attention in emergency facilities [104]. The study involved 1,218 women in 12 emergency departments in California and Pennsylvania. (Pennsylvania does not have a mandatory reporting law.) Of the sample,

12% reported they had been physically or sexually abused within the past year by a current or former partner. Of the abused women, 55.7% supported mandatory reporting, and 44.3% opposed mandatory reporting. Of the nonabused women, 70.7% supported reporting and 29.3% opposed reporting. There were no differences in attitudes by state. The abused women who opposed mandatory reporting feared retaliation by the abuser, feared family separation, did not trust the legal system, and preferred patient-physician confidentiality and autonomy. Many women in the study supported a policy that would honor the patient's preference about what she wanted to do. The study also found that many women who did not speak English were opposed to mandatory reporting. The final outcome of the report revealed further research is needed to address the preferences of those involved in abusive relationships and policymakers should consider patient preferences when enacting laws [104].

Additional California Domestic Violence Legislation

Over the past two decades, California has enacted numerous laws to combat domestic violence. To summarize every law relating to the prevention of domestic violence and prosecution of perpetrators is beyond the scope of this activity. Instead, the following is an abbreviated list of some of the more important legislation that has been passed [15]:

- Senate Bill 1472 (Watson, 1984), enacted January 1, 1986, requires (1) law enforcement to enforce domestic violence as criminal conduct, (2) Peace Officers Standards and Training to create new guidelines for law enforcement response to domestic violence cases, (3) peace officers to complete supplementary training, and (4) law enforcement agencies to adjust reporting procedures to collect domestic violence data and submit it monthly to the Attorney General, Department of Justice.
- Assembly Bill 1588 (Speier, 1987), enacted July 1, 1988, gave peace officers the ability to receive Emergency Protective Orders against domestic violence.

- Penal Code 12028.5, amended in 1987, authorized peace officers to seize and take temporary custody of firearms at specified domestic violence scenes.
- Senate Bill 132 (Watson, 1995) required law enforcement officers who normally respond to domestic violence calls to complete an updated course of instruction on domestic violence every two years.
- Penal Code 13701, amended in 1995, mandated law enforcement agencies to develop and implement written policies that encourage the arrest of domestic violence offenders if there is probable cause that an offense has been committed, and it discourages but does not prohibit dual arrests.
- Assembly Bill 1139 requires a death certificate to include whether the woman was pregnant at the time of death.
- Assembly Bill 2084 allocates funds from marriage license fees to domestic violence shelters.
- Senate Bill 585 allows law enforcement to immediately confiscate firearms from individuals served with protective orders.

The task force will periodically hold regional hearings throughout the state to study local policies and practices, identify those that work well, and determine those that may harm or threaten the safety of domestic violence victims.

Other Legal Interventions

Domestic violence victims can obtain protective orders through a civil proceeding [26]. Until the enactment of Pennsylvania's Protection of Abuse Act in 1976, only two states had protective order legislation [26]. Protective orders prohibit the abuser from communicating with the victim and/or other family members in a threatening manner. The order also prohibits the abuser from going to the home or place of employment of the victim or family members. Violations of protective orders can result in fines, imprisonment, or a combination of both [26].

Victims can file for a temporary or permanent protective order. A temporary protective order does not require the abuser to be present. These orders last about 30 days or until a court date is scheduled. A permanent protective order requires both the victim and abuser to be present in court. Permanent protective orders last for about 12 months [113].

Laws for dating violence are different. All 50 states and the District of Columbia have state laws related to dating violence. However, the term "dating violence" is not used. Instead, the following terms are used: "sexual assault," "domestic violence," and "stalking" [91]. Only 39 states and the District of Columbia offer the option of protective orders for dating violence victims. The National Center for Victims of Crime is a resource to obtain additional information about state laws.

For more information about legal interventions, state coalitions for domestic violence can be contacted. The American Bar Association has compiled a list of domestic violence state coalitions. Although, the American Bar Association Commission on Domestic Violence suggests victims do Internet searches for local domestic violence resources, they caution them to use a local library or go to a friend's home where they can access a computer without the abuser being able to track Internet and email activities [1].

CASE MANAGEMENT

Because abused women often suffer physical injuries, they will likely seek care from a healthcare professional who can make referrals to counseling services. Some women seek counseling on their own. After identifying victims and their abusers, mental health professionals should immediately implement a plan of action that includes providing referrals for available community services and safe havens to assist the victim and the victim's family.

Most abused women are in ongoing danger when seeking help. If they decide to leave, the risk factors increase significantly [23]. Accordingly, if the victim consents, acute situations should be referred immediately to local law enforcement officials. Other resources include crisis hotlines and rape relief centers. After victims are in the system, counseling and follow-up is generally available through victims of crime programs. A list of approved services is provided and include social workers, marriage and family therapists, psychologists, psychiatrists, other mental health workers, and community mental health services. The goals are to make resources accessible and safe and to enhance support for crime victims who are unsure of their options [59].

Assisting crime victims is essential. Coordinating and accessing an array of social service benefits, which include mental health counseling, health-care, legal and advocacy services, and other public benefits, is crucial. Consequently, it is vital for professionals to establish relationships with community organizations and be acquainted with appropriate contact persons. When working with diverse cultural and ethnic groups, it is also important to develop relationships with culturally sensitive and bilingual professionals who can provide appropriate interventions.

SUPPORT GROUPS

Support groups for crime victims can be beneficial. Often, victims think they are the only ones who have experienced the abuse. Victims may express shame and guilt, assume responsibility for the incident, and question what they did wrong to provoke the abuse. Support groups offer the opportunity for victims to meet others who are going through similar experiences and have similar feelings and concerns. Because batterers often utilize psychological tactics such as isolation to keep the victim

away from interacting and talking with family, friends, and other individuals, the victim's primary source of information, companionship, and support comes from the batterer [10]. Support groups diminish victims' sense of isolation and provide education. Victims can learn about the dynamics of abuse and learn from other group members and their experiences. Furthermore, support groups can assist members to help each other with problem-solving various conflicts, including child custody issues, employment opportunities, and parenting concerns [10].

BATTERER PROGRAMS

Programs and interventions for batterers are controversial in terms of effectiveness. It is beyond the scope of this course to analyze the strengths and limitations of these programs. There are several different types of interventions for batterers. Some interventions focus on skills training. These programs are based on behavioral theory related to negative, destructive, and aggressive behaviors, which can be altered through modeling of positive behaviors and subsequent rehearsal. Other interventions are based on cognitive theory and assume that batterers have distorted, inaccurate thinking patterns, which trigger negative emotions that lead to aggressive behaviors. Belief systems, such as gender role precepts, are challenged. Other interventions include awareness and education about what behaviors constitute different types of abuse. The goal is to educate batterers about the impact of different forms of abuse while increasing their empathy for victims. Finally, interventions presume abusers have a history of family violence. Often, batterers were victims of child abuse or witnesses to parental violence during childhood and their own traumas have not been resolved. Therefore, the cycle of violence continues without interruption [108].

SHELTERS

Shelters provide a haven for domestic violence victims and their children. They provide temporary emergency housing and a range of services to help victims “get back on their feet.” Services vary but may include job training, support groups, skills development groups, and counseling.

To access shelter information by geographic region, there is a valuable website sponsored by the Office for Victims of Crime Resources Center. The Directory of Crime Victim Services is available at <http://ovc.ncjrs.org/findvictimservices>. This is a search engine that allows resources and services to be located by state.

CONCLUSION

To lump all behavior in chaotic relationships under the category of violence can be misleading to the public. The common image of violence for the majority of people is physical harm, attack, and observable injury. Differentiating types of behavior in intimate relationships is necessary to define consequences and outcomes and to form an evidence base for treatment. The development of accurate definitions is instrumental in designing methodology to compare differences. More accurate and sensitive instruments to measure the depth of the social problem are needed to reveal differences in violence, mutual battering, and effects of intimate violence on men, women, and children.

The long-term focus on domestic violence is responsible for major reforms on multiple levels within systems related to criminal prosecution, legislative views and actions, and healthcare protocols. Given the pervasive nature of abuse in relationships, histories of partners, including mental, psychological, and behavioral documentation, is vital when determining the causes and effects of abuse. Understanding how historical and cultural belief systems are connected to domestic violence is essential in determining an accurate measurement of intimate violence.

RESOURCES FOR DOMESTIC VIOLENCE

Those in the mental health professions can be of great service to individuals suffering from traumatic domestic violence. Victims may present with anxiety, depression, suicidal thoughts, headaches, or other signs of chronic post-traumatic stress. Many of these symptoms are alleviated if the victim has support. Family support is of primary importance. One aspect of support is the referral of abusers to treatment and referral of victims to appropriate community services. It is also important to note that referrals may be entangled with investigations and court decisions, and referrals by professionals are not necessarily enough when abuse is recurrent. Therefore, evaluation is on a case-by-case basis.

CALIFORNIA RESOURCES

California Partnership to End Domestic Violence

1-800-524-4765

<http://www.cpedv.org>

California Victim Compensation

1-800-777-9229

California Family Violence Referral Directory

<http://www.safenetwork.net/agencylist.aspx>

GENERAL NATIONAL RESOURCES

American Bar Association on Domestic Violence

Provides valuable information about a wide-range of domestic violence issues and extensive links to other resources and organizations.

<http://www.abanet.org/domviol/home.html>

**Communities Against
Violence Network (CAVNET)**

CAVNET is a nonprofit organization and has developed an international network of professionals addressing domestic violence, sexual assault, rape, incest, stalking, and crime victims with disabilities, bringing together a diverse community which includes law enforcement, judges, clergy, lawyers, social workers, domestic violence shelters, rape crisis centers, disability advocates, and hundreds of others.

<http://www.cavnet2.org>

DV Survival Kit

<http://www.domesticviolence.com/content.html>

Family Violence Prevention Fund

Works in the area of preventing family violence. Provides information on public policy, violence in different population groups, and general information on resources.

<http://endabuse.org>

**Minnesota Center Against
Violence and Abuse (MINCAVA)**

The mission is to support research, education, and access to violence related resources.

<http://www.mincava.umn.edu>

National Clearinghouse on Family Violence

Canada's resource center for information on family violence.

<http://www.phac-aspc.gc.ca/ncfv-cnivf/index-eng.php>

National Coalition Against Domestic Violence

Serves as a national information and referral center for the general public, practitioners, organizations, and victims of domestic violence.

<http://www.ncadv.org>

National Center for Victims of Crime

The National Center for Victims of Crime is recognized as the nation's leading advocate for crime victims.

<http://www.ncvc.org>

National Organization for Victim Assistance

Private, non-profit organization committed to the recognition and implementation of victim rights and services.

<http://www.trynova.org>

Office on Violence Against Women

Handles the U.S. Department of Justice's legal and policy issues regarding violence against women, provides national and international leadership, and responds to requests for information regarding violence against women.

<http://www.ojp.usdoj.gov/vawo>

Violence Against Women Online Resources

Provides law, criminal justice, advocacy, and social service professionals with up-to-date information on interventions to stop violence against women.

<http://www.vaw.umn.edu>

**RESOURCES FOR ETHNIC MINORITY
AND IMMIGRANT WOMEN**

Asian and Pacific Islander

Institute on Domestic Violence

A network of professionals from various disciplines to serve as a forum and clearinghouse to provide information on domestic violence in the Asian and Pacific Islander communities.

<http://www.apiahf.org/index.php/programs/domestic-violence.html>

**Institute on Domestic Violence in
the African American Community**

An interdisciplinary forum by which scholars and practitioners can disseminate information about domestic violence in the African American community.

<http://www.dvinstitute.org>

**The National Latino Alliance for the
Elimination of Domestic Violence (Alianza)**

Part of a national effort to address the domestic violence needs and concerns of under-served populations. It represents a growing network of Latina and Latino advocates, practitioners, researchers, community activists, and survivors of domestic violence.

<http://www.dvalianza.org>

**U.S. Citizenship and Immigration Services
Guidelines Concerning Battered Immigrant
Women, Children and Parents**

<http://www.uscis.gov>

**Asian Pacific American Legal
Center of Southern California**

1145 Wilshire Blvd., 2nd Floor,
Los Angeles, CA, 90017

Tel: (213) 977-7500

Fax: (213) 977-7595

<http://www.apalc.org>

Asian Pacific Women's Center

1145 Wilshire Blvd., Suite 102

Los Angeles, CA 90017

Tel: (213) 250-2977

Fax: (213) 250-2949

<http://www.apwcla.org>

Asian Women's Shelter

3543 18th Street, #19

San Francisco, CA 94110

Tel: (415) 751-7110

Crisis: (877) 751-0880

Fax: (415) 751-0806

<http://www.sfaws.org>

Donaldina Cameron House

920 Sacramento Street

San Francisco, CA 94108

Tel: (415) 781-0401

Fax: (415) 781-0605

<http://www.cameronhouse.org>

Maitri

P.O. Box 60111

Sunnyvale, CA 94086

<http://www.maitri.org>

**RESOURCES FOR WOMEN
WITH DISABILITIES**

**The National Women's Health
Information Center**

Provides information about women's health.

There is specific information about women
with disabilities and domestic violence.

<http://www.womenshealth.gov/violence>

**Center for Research on
Women with Disabilities**

<http://www.bcm.edu/crowd>

**RESOURCES FOR
THE GAY COMMUNITY**

Gay Men's Domestic Violence Project

Provides community education and direct
services to gay, bisexual, and transgendered
male victims and survivors of domestic violence.

<http://www.gmdvp.org>

National Gay and Lesbian Taskforce

<http://www.thetaskforce.org>

**Annual Report on Lesbian, Gay,
Bisexual, Transgender Domestic Violence**

[http://www.mincava.umn.edu/documents/glbtdv/
glbtdv.html](http://www.mincava.umn.edu/documents/glbtdv/glbtdv.html)

California Domestic Violence Crisis and Support Resources

The following information was verified at the time of publication.

This is not a stated or implied endorsement.

Statewide Domestic Violence Hotline

1-800-524-4765

Domestic Violence Centers Listed by County

Alameda

A Safe Place	Oakland	510-536-7233
Building Futures with Women/Children	San Leandro	1-866-A-Way-Out (1-866-292-9688)
DeafHope	San Leandro	TTY 510-733-3133 Hotline@Deaf-Hope.org
Emergency Shelter Program, Inc.	Hayward	510-786-1246 1-888-339-SAFE
SAVE Shelter Against Violent Environment to Safe Alternatives to Violent Environments.....	Fremont	510- 794-6055
Tri Valley Haven.....	Livermore	925-449-5842 1-800-884-8119

Amador

Operation Care	Jackson	209-223-2600 209-223-2897
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Alpine

South Lake Tahoe Women's Center	Markleeville	1-888-750-6444
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Butte

Catalyst Domestic Violence Services	Chico	1-800-895-8476
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Calaveras

Calaveras Women's Crisis Center	San Andreas.....	209-736-4011
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Contra Costa

STAND! Against Domestic Violence	Concord	1-888-215-5555 925-676-2845
Del Norte Rural Human Services	Crescent City.....	707-465-3013

El Dorado

El Dorado Women's Center	Placerville.....	530-626-1131
South Lake Tahoe Women's Center	South Lake Tahoe	530-544-4444 1-888-750-6444

Fresno

Marjaree Mason Center	Fresno	559-233-HELP
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Humboldt

Humboldt Women for Shelter	Eureka	1-866-668-6543 707-443-6042
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Imperial

Center for Family Solutions/Women Haven	El Centro	760-353-8530
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Kern

Women's Center High Desert, Inc.	Ridgecrest	760-375-7525
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Kings

Kings Community Action Organization	Hanford	1-877-727-3225
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Lake

Sutter Lakeside Community Services	Lakeport	1-888-485-7733
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Lassen

Lassen Family Services, Inc.	Susanville	530-257-5004 1-888-289-5004
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Los Angeles

1736 Family Crisis Center	Los Angeles	213-745-6434
1736 Family Crisis Center	Long Beach	562-388-7652 1-877-367-7752
1736 Family Crisis Center	Redondo Beach	310-370-5902
Angel Step Inn	Downey	323-780-HELP 1-800-655-2226
Antelope Valley DV Council.....	Lancaster	661-945-6736 1-800-282-4808
Center for the Pacific-Asian Family (CPAF)	Los Angeles	1-800-339-3940
CSAC Chicana Service Action Center.....	Los Angeles	1-800-843-9675 1-800-548-2722

Domestic Violence Center

of Santa Clarita Valley	Santa Clarita	661-259-HELP
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Family Violence Project/

Jewish Family Services	Sherman Oaks	1-818-505-0900
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Good Shepard Shelter.....	Los Angeles.....	323-737-6111
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Haven Hills	San Fernando Valley.....	818-887-6589 1-800-978-3600
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Haven House.....	Pasadena	323-681-2626
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House of Ruth.....	Claremont	909-988-5559
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Interval House	Long Beach	562-594-4555
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Jenesse Center, Inc.	Los Angeles	323-731-6500 1-800-479-7328
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Peace & Joy Care Center	Carson	310-898-3117
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Rainbow Services, Ltd.....	San Pedro	310-547-934
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Sojourn Services	Santa Monica	310-264-6644
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Su Casa ~ Ending Domestic Violence.....	Artesia	562-402-4888
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Women's & Children's Crisis Center.....	Whittier	562-945-3939
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WomenShelter of Long Beach.....	Long Beach	562-437-4663
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YWCA of Glendale, DV Project	Glendale	1-818-242-1106
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YWCA Wings, Domestic Violence	West Covina	626-967-0658
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Marin

Marin Abused Women's Services.....	San Rafael	415-924-6616 415-924-3456
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Mariposa

Mountain Crisis Services.....	Mariposa	209-966-2350 1-888-966-2350
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Mendocino

Project Sanctuary, Inc.	Ukiah	707-463-HELP 707-462-9196
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Merced

Valley Crisis Center	Merced	209-722-4357
A Woman's Place of Merced County	Merced	209-722-4357 1-800-799-SAFE

Domestic Violence Centers Listed by County (Continued)

Modoc			
Modoc Crisis Center (T.E.A.C.H.)	Alturas	530-233-4575 1-800-291-2156	
Mono			
Wild Iris	Mammoth Lakes.....	1-877-873-7384	
Monterey			
Shelter Outreach Plus	Marina	831-422-2201 1-800-339-8228	
YWCA of Monterey County	Seaside	831-372-6300 1-800-YWCA-151	
Napa			
Napa Emergency Women's Services (NEWS) ..	Napa.....	707-255-6397	
Orange			
Human Options, Inc	Irvine	949-854-3554 1-877-854-3594	
Interval House	Seal Beach.....	714-891-8121	
Laura's House	San Clemente	949-498-1511	
Women's Transitional Living Center (WTLC) ...	Orange	714-992-1931	
Placer			
P.E.A.C.E. for Families	Auburn.....	1-800-575-5352	
Tahoe Women's Services	Kings Beach.....	1-800-736-1060	
Plumas			
Plumas Rural Services, Inc.	Quincy.....	1-800-485-8099	
Riverside			
Alternatives to Domestic Violence	Riverside	951-683-0829 1-800-339-SAFE	
Shelter From the Storm, Inc.	Palm Desert	760-328-7233 1-800-775-6055	
Sacramento			
My Sister's House	Sacramento, Davis.....	916-428-3271	
WEAVE.....	Sacramento.....	916-920-2952 1-866-920-2952	
San Bernardino			
Desert Sanctuary, Inc.	Barstow	760-256-3441 1-800-982-2221	
DOVES of Big Bear Valley, Inc.	Big Bear Lake.....	1-800-851-7601	
High Desert Domestic Violence Program	Victorville.....	760-949-4357 1-866-770-7867	
Morongo Basin Unity Home	Joshua Tree	760-366-9663	
Option House	San Bernardino	909-386-1647	
Victor Valley Domestic Violence Center	Victorville.....	760-955-8723	
San Diego			
Center for Community Solutions	San Diego	1-888-385-4657 1-888-272-1767	
Community Resource Center	Encinitas.....	1-877-633-1112	
South Bay Community Services	Chula Vista.....	1-800-640-2933	
Women's Resource Center	Oceanside	760-757-3500	
YWCA of San Diego County	San Diego	619-234-3164	
Community Resource Center ~ Libre!	Encinitas.....	1-877-633-1112	
San Francisco			
Asian Women's Shelter	San Francisco	415-751-0880 1-877-751-0880	
Community United Against Violence	San Francisco	415-333-HELP	
La Casa de les Madres	San Francisco	877-503-1850 1-877-923-0700	
Riley Center/St. Vincent de Paul	San Francisco	415-255-0165	
W.O.M.A.N., Inc.....	San Francisco	415-864-4722 1-877-384-3578	
San Joaquin			
Women's Center of San Joaquin County	Stockton	209-465-4878	
San Luis Obispo			
North Co. Women's Resource Center/Shelter...	Atascadero	805-461-1338 1-800-549-8989	
Women's Shelter Program.....	San Luis Obispo.....	805-781-6400 1-800-549-8989	
San Mateo			
Community Overcoming Relationship Abuse	San Mateo.....	650-312-8515 1-800-300-1080	
Santa Barbara			
Domestic Violence Solutions	Lompoc	805-736-0965	
Domestic Violence Solutions	Santa Barbara	805-964-5245	
Domestic Violence Solutions	Santa Maria	805-925-2160	
Domestic Violence Solutions	Santa Ynez	805-686-4390	
Santa Clara			
Asian Women's Home (AACI)	San Jose	408-975-2739	
Community Solutions	Morgan Hill	408-683-4118	
Next Door Solutions to Domestic Violence.....	San Jose	408-279-2962	
Support Network for Battered Women	Sunnyvale	1-800-572-2782 408-541-6100	
Santa Cruz			
Defensa de Mujeres	Watsonville	831-MUJERES	
Walnut Avenue Women's Center	Santa Cruz	1-866-2MYALLY	
Women's Crisis Support	Santa Cruz	831-685-3737	
Shasta			
Shasta County Women's Refuge, Inc.	Redding	530-244-0117	
Siskiyou			
Siskiyou Domestic Violence & Crisis Center	Yreka	1-877-842-4068	
Solano			
SafeQuest Solano	Fairfield	707-425-73422	
Sonoma			
YWCA of Sonoma County	Santa Rosa	707-546-1234	
Stanislaus			
Haven Women's Center of Stanislaus.....	Modesto	209-577-5980 1-800-834-1990	
Sutter			
Casa de Esperanza, Inc.	Yuba City	530-674-2040	
Tehama			
Alternatives to Violence	Red Bluff	530-528-0226 1-800-324-6473	
Trinity			
Human Response Network	Weaverville	530-623-4357	
Tulare			
Central California Family Crisis Center, Inc.	Porterville	559-784-0192	
Family Services of Tulare County.....	Visalia	559-732-5941 1-800-448-2044	
Tuolumne			
Kene Me-Wu Family Healing Center, Inc.	Sonora	1-800-792-7776	
Mountain Women's Resource Center.....	Sonora	209-533-3401	
Ventura			
Coalition to End Domestic & Sexual Violence... Oxnard		805-656-1111 1-800-300-2181	
Interface Children Family Services.....	Camarillo	1-800-339-9597	
Yolo			
Sexual Assault & Domestic Violence Center	Woodland	530-662-1133 916-371-1907	
Statewide			
Domestic Violence & Employment Project of The Legal Aid Society ~ Employment Law Center	All Cities	1-888-864-8335 (toll-free in CA)	

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