America the Violent: Spouse/Partner Abuse

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This is the second in a two-part series on violence in America. It focuses on domestic violence, outlining critical issues in the assessment and intervention of partner abuse for clinicians working with victims as well as perpetrators.

Physical Abuse and Battering

Incidence and Patterns

The incidence of spouse/partner physical abuse is astonishingly high to most professional practitioners. Some surveys have estimated that at least one act of violence occurs from husband to wife in 50 percent of marriages (Straus, Gelles, & Steinmetz, 1980). Other studies gauge the incidence of abuse as closer to a 40 percent lifetime incidence and a 25 percent frequency of abuse within the last year (Hamberger, Saunders & Hovey,1992). As Burge (1989) has noted, there are two main ingredients that lead to the abuse of women. The first involves the inability of abusive men to deal constructively with anger; the second, the prevailing attitudes in the larger society that condone violence toward women. Emotional abuse almost always occurs concurrently with physical abuse, but also can occur in isolation and can be psychologically severely damaging to women. Although these psychological issues are extremely important, this discussion will focus on physical and sexual abuse in adult intimate relationships.

The onset of marital abuse normally occurs within the first year of marriage. Straus and colleagues have reported that 49 percent of battered women saw their husband acting violently with others or were themselves assaulted by him before marriage. By the end of the first year of marriage, an average of 72 percent of women who had seen some evidence of premarital violence had been abused. The majority of these battered women experience multiple assaults each year, with about 40 percent of them experiencing assaults on a weekly basis (Okun, 1986). A high level of regular abuse appears to be related to a number of identifiable factors.

> **Age**--The largest number of assaults on wives occurs where the spouses are under the age of 30 and the wives are younger than their husbands. One possible reason for the shift of abuse toward the younger generation is the changing values among many of the younger women concerning divorce and sex roles (Okun, 1986). In a survey of men and women regarding the presence of family violence, Gin et al (1991) reported an incidence of 44 percent for current violence among respondents under 25 years of age, and an 11 percent incidence for those above 25. Okun (1986) further notes that the age discrepancy between husband and wife is an important one; apparently, the wife being older than her male spouse results in a lower abuse rate. Whereas, when the man is older than his spouse (the average being 3.4 years), the abuse rate is higher than in marriages without this age discrepancy.
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> **Ethnicity**.--Ethnicity is a significant variable in spouse abuse, as groups differ in attitudes and behaviors (Coley & Beckett, 1988). According to Straus (1986) the abuse rate among members of minority groups is over triple that of abuse within Caucasian marriages. In addition, Straus believes that the higher abuse rate in African-American marriages compared to Caucasian marriages has to do with the frustrations encountered by being black in a predominantly white American society. It has also been reported that the rate of abuse is even higher in other

minority groups, such as Asian-Americans, Mexican-Americans, or European immigrants (Lewis, 1987). However, the rate of self-reported abuse was not significantly different in Gin et al's (1991) sample of Spanish-speaking and non-Anglo participants than in English-speaking, Anglo subjects. The results may have been affected by the fact that a number of Spanish-speaking women were excluded from the study because of illiteracy. The authors theorize that illiteracy may be associated with a higher rate of domestic violence and a lower rate may have been found by excluding these women.

Socioeconomic Status.--The lower the income and occupational status of the couple, the higher the rate of partner abuse; the rate of violence in a marriage is double for blue collar workers in contrast to white collar workers (Okun, 1986) Other studies show that the most abusive relationships have a mean income well below the national average (Coleman, Weinman, & Hsi, 1980). Straus reported that families at or below the poverty level have a 500 percent increase in the rate of violence compared to the upper classes (Lewis, 1987). In the Gin et al (1991) study, which included both indigent and affluent subjects, poverty was a significant predictor of domestic violence, as determined by logistic regression analysis.

Gender.--The vast majority of research projects and reports are on man-to-woman violence, and cite an incidence (as noted above) of a 40 to 50% lifetime incidence and a 25 percent frequency of husband-to-wife violence in the last year. James (1996) discusses the idea that men who are the victims of violence from their women partners often conceal this from others and that woman-to-man abuse is a hidden type of domestic violence. As yet, neither the lay press nor the scientific literature has developed adequate information about woman-to-man abuse, or even much about reciprocal abuse, in which both men and women instigate physical attacks on each other. An interesting study by Fiebert (1996) documented that Caucasian students were willing to believe that women are as likely to be assaultive as men in intimate relationships and that there would be acceptance of the importance of looking at men as victims if empirical findings become better known. Yelsma (1996) found that a deficiency of positive emotions and less emotional expressiveness were significant indicators of physical abuse for both men and women who perpetrated violence on intimates. Many of the well publicized accounts of wife-to-husband violence (murder or castration) often are described as connected to the "battered wife syndrome"; that is, a wife will perpetrate violence after purported years of abuse as a victim (e.g., Lorena and John Bobbitt being such a case). Although there is scant empirical exploration of the dynamics of physical aggression by women against their sexually abusive partners, one report (Pollock, 1996) found that women who had committed acts for which they were apprehended found that women psychologically accepted responsibility for their aggression and tended to discount their own previous victimization. In looking at the major 30-year trends in homicide perpetrated against intimate others, Block and Christakos (1995) found that race and gender interacted to affect a person's risk of death by murder. Both long-term (1965 to 1990) and short-term (1991 to 1993) death rates declined for both men and women and for Caucasians; for African-Americans, however, there was a long-term but no short-term decline indicated.

Sexual Orientation.--It is clear that lesbians, gays and bisexuals can also be victims of partner and domestic violence (Klinger and Stein, 1996) and the focus on man-to-woman abuse in the research and the scientific literature so far is clearly one that should be expanded in the future. There are parallels in the strategies that should be employed to address intimate relationship violence among gays, including individual-focused services, but also focusing on the roles

of the criminal justice system and the mental health system in establishing community-focused approaches (Hamberger, 1996). However, it is also important to remember distinguishing characteristics of belonging to a minority group in American culture; a person experiences discrimination or oppression simply by their minority status, in addition to any problems they might encounter when involved in domestic conflict or abuse. As Waldron (1996) points out in regard to lesbians of color who are abusers or survivors of domestic violence, there are distinct issues they have centering around their simultaneous battles with sexism, racism and homophobia. In another study, an extremely high rate of sexual victimization existed for gay men; one-third of them reported being forced into activities (usually anal intercourse) by men with whom they had previously had consensual relations (Hickson, Ford, Davies et al, 1994). For scientists and health care providers, it is crucial to develop a research data base on specific characteristics or dynamics in both abusers and victims of persons with same-gender affiliations; researchers and therapists cannot simply assume that what they have learned over the last two decades about man-to-woman violence will pertain to all situations.

Indicators of Domestic Violence

Realizing that summary statements may not be accurate for all groups, there are numerous studies that have linked certain factors with higher rates of domestic violence, as listed in the table below.

Indicators of Domestic Violence
Female gender[1]
Young age: Less than 25-30[1]
Low Socioeconomic Status[1]
Minority Group Member
Unmarried status[1]
Recently separated or divorced
Woman younger than male partner
Victims or partners abuse alcohol and/or street drugs
Pregnancy

[1]Most significant variables from the Gin et al (1991) study

Abused Partners in the Medical Care System

The medical sequelae of battering are myriad: In the 1990's, almost 100,000 days of hospitalization, 30,000 emergency department visits and 40,000 outpatient visits to physicians were the direct result of physical abuse. The main presentation of physical injuries includes headaches, earaches, bruises, lacerations, orthopedic injuries and more serious head injuries (JAMA, 1992). Recent reports have suggested that a high percentage of emergency room visits by women are for injuries sustained through domestic violence, but that they are not frequently assessed as assault incidents (Morrison, 1988; Raymond, 1989). Another study documented that approximately 30 percent of women visiting internal medical outpatient practices had been victims of partner abuse at some time in their lives, and that 44 percent of young adult patients and 11 percent of older patients were victims of current abuse (Gin, Rucker, Frayne, Gygan, & Hubbell, 1991). If physicians include partner abuse in their differential diagnosis of injuries (including

unexplained abdominal pain), they will detect it. Pregnancy appears to be related to a high level of abuse; approximately 37% of pregnant patients are battered and that the abuser is most likely to strike the abdominal area with resulting sequelae: "placental separation, antepartum hemorrhage, fetal fractures, rupture of the uterus, liver, or spleen and pre-term labor." (JAMA, 1992). Hamberger, Saunders and Hovey (1992) document the rarity of physician inquiry into the problem of physical abuse. In their study of approximately 400 women seeking medical care from a family practice clinic, 22.7 percent had been physically abused by their partners within the last year, with a lifetime rate of physical abuse of 38.8 percent. Yet, only six women in the group had been asked about abuse by their health care providers. In a retrospective chart review of a 100 Caucasian and 100 African-American women seen in a family practice center, Kosch, Burg and Podikuju (1997), reported that not a single patient had had domestic violence noted in their chart by their physicians. These reports underscore the need for psychotherapists to work collaboratively in the same health care settings as physicians. Their presence could focus appropriate attention on these diagnostic issues and provide resources for treatment at a frontline level.

Understanding Why Women Do Not Leave Abusive Relationships

There are several factors related to women staying in abusive situations. Choice and Lamke (1997) contend that the stay/leave decisions center around two pivotal queries: "Will I be better off?" and "Will I be able to do it?" **Realistic Fear of Increased Abuse or Death**.--Many women live in terror for their own health, safety and lives, as well as that of their children. They may well know or perceive that one of the critical "danger points" for increased abuse or attempts at murder occur when a partner leaves a relationship. Some women remain, then, in order to avoid a higher level of danger that would be prompted by their leaving the abuser. The availability of protected shelters where they cannot be found is often pivotal in a woman's being able to leave. The problem arises, of course, when the period of time is completed that a woman can remain in the shelter and she will again live in the community and be able to be found by her abuser. Also, for employed women, even if they are sheltered at night, the husband will harass them at their place of employment and may have the opportunity to physically assault or murder them at the worksite.

> **Economic**.--There are three main reasons why women enter, tolerate, and stay in abusive relationships; these reasons are financial, financial, and financial. In other words, women often answer the question in the affirmative that they and their children are better off financially if they remain in the family home. Economic considerations play the most important role in maintaining relationships; women experience extreme job and pay inequality, and many virtually are not able to support themselves and their children without a man in the household (Straus & Hotaling, 1980). Aguirre (1985) reported that 84 percent of women in a shelter whose spouse was their sole source of income planned on returning to him, while 82 percent of the wives whose husbands did not provide their only means of income planned to separate.
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> **Family and Social Considerations**.--Another major reason that women stay in abusive relationships relates to the preservation of family life and stability for children. In addition, the women experience little societal support for leaving. Society has placed a double bind on battered wives, they are often blamed for not seeking help, but "when they do, they are advised to go home and stop the inappropriate behavior, which causes their men to hurt them" (Okun, 1986). There is also a strong belief among battered women that the husband will be able to change and will cease being abusive (Holtsworth-Munroe, 1988), and that the situation will improve. Additionally, Ferraro and Johnson (1983) point out that women may be prompted to leave when they relinquish hope that the situation will get better. This diminution of hope is associated with a decrease in the partner's remorse and expressed love and an increase in the level of violence.

Also, if the women experience a change in resources, such as a safe place to stay, they may be finally prompted to leave.

Personal.--It is important for the clinician to understand that there are several reasons prompting women to remain in abusive relationships. One factor has to do with the personal sphere: Many women have low self-esteem and a lack of confidence related to their battering by spouses. Most abused women see themselves as relatively powerless and as trapped within their relationships. Since most battered women feel dependent on others (Okun, 1986), their personal initiative and personal assertiveness may not be sufficient to leave the relationship at the point that they are first evaluated. It is essential to emphasize that women do not stay because they have masochistic tendencies, as documented by Kuhl (1984). They may have ambivalent feelings about the abuser, experiencing feelings of love, as well as fear and disdain.

Emotional Disability.--One explanation of why women stay in abusive relationships is because they suffer a form of Post-Traumatic Stress Disorder (PTSD), as described by Janoff-Bulman and Frieze (1983). As noted below, some of the symptoms characterizing abused women include re-experiencing the trauma in nightmares and flashbacks, a numbing of responsiveness to the external world, and a myriad of anxiety-related symptoms. From another perspective, they exhibit symptoms similar to those of kidnap victims or hostages (Hilberman (1980), including a distortion of reality and a pathological transference that often develops between kidnappers and victims. Symonds (1975) uses the analogy of the "Stockholm Syndrome," in which victims describe positive feelings toward their captors and negative feelings toward the rescuers. Women who are repeatedly abused experience threats against their life, damage to their property, and emotional degradation. The male abuser may then follow episodes of abuse with a "honeymoon" period in which he makes amends, promises to reform, and to love and cherish. It is perfectly understandable that the battered woman, like the political hostage, becomes dependent on her tormentor and may, in an ironic distortion of reality, view the assailant as her protector.

Determination of Possible Abuse

First, therapists should have a high index of suspicion of partner abuse, given its high incidence. In addition, it is important to recognize that many of the assaults are severe. Hamberger et al (1992) report that during the past year: (a) about 8 percent of women had been hit by an object or an attempt was made to hit them with an object, (b) 3 percent received multiple blows, (c) more than 5 percent were choked, and (d) 3 percent were threatened or victimized with a knife or gun. The one year injury rate for all women due to domestic assault was 13.3%, while the at-risk women had a rate of 14.8%. During their lifetimes, 38.8 percent of the sample had been physically abused by an intimate partner. Lifetime occurrence of specific threats or actions included 19% were hit or almost hit by an object, 12 to 13% were beaten and/or choked, and 10% were threatened with a knife or gun. The lifetime injury rate was 24.7%.

Clinician Preparation for Handling Abused Patients

Therapists should include partner abuse in their differential diagnosis explaining the symptoms of many women patients, particularly those under 30 years of age or those who are pregnant. Asking some screening questions to all women is an appropriate approach. The clinician should follow inquiries about the patient's level of satisfaction with relationships, with statements and questions about abuse. *"I am aware that women in this society are often victims of verbal or physical abuse by men. Have any events occurred that you consider to be abusive?*" Additional questions are described below. Completing a comprehensive history, including questioning about

some somatic complaints, such as headaches, earaches, and abdominal pain, may uncover an abuse presentation by a woman.

It is important for therapists to have completed some planning before an abused woman presents in the therapy setting. For instance, the provider needs to know resources available in the area, such as women and children's shelters and specialized counseling facilities. It is also important to know legal requirements for obtaining restraining orders; if a woman is not able to obtain one on the first documented abuse incident, caution her about returning to her home.

Many different approaches to detecting physical abuse perpetrated against a woman have been suggested. Some clinicians and researchers have used questionnaires, while others have relied on interview techniques. Braham, Furniss, Holtz & Stevens (1986) provide a list of questions for uncovering suspected abuse in women. They suggest that it is crucial to ask direct questions in a nonthreatening, empathetic manner. Examples of statements and questions from their list include:

- *You seem frightened of your partner. Has he ever hurt you?*
- *Many patients tell me they have been hurt by someone close to them. Could this be happening to you?*
- *You mention your spouse loses his temper with the children. Does he ever lose his temper with you? Does he become abusive when he loses his temper?*
- *Have there been times during your relationship when you have had physical fights?*
- *Do your verbal fights ever include physical contact?*

Other statements or questions validate the "normalcy" of abuse or its prevalence, so that the patient is not made to feel inferior or "different" if it is occurring in her family. Another option for assessment would be to use a written scale to assess the possibility of domestic violence, such as Kuhl's (1984) Domestic Violence Assessment Form. Additionally, if a clinician has a patient complete a questionnaire that taps family functioning in several areas, such as the Family Apgar, it is then easy to query about anger and violence. *"So, you state, Mrs. Smith, that you do not feel that your family supports your efforts outside the home. Tell me a little about what happens in your family when people are angry. For instance, are you a 'loud anger' or a 'quiet anger' family? Do people lose their temper often or infrequently? Does the anger ever escalate to the point that one person might throw something or hit someone else?"* If the physician sees the children in a family, they are the perfect family members to ask about anger, especially if the physician claims past experience with really noisy, "loud anger" families. Children often do not see the harm in describing the events to an empathetic, concerned clinician; whereas, adults may be embarrassed or worried about the consequences of such a disclosure.

One intriguing study completed by Feldhaus, Koziol-McLain, Amsbury, Norton, Lowenstein, & Abbot (1997) found that one query, when asked in emergency departments when women presented there, had greater sensitivity and specificity for detecting partner violence than longer screening protocols. So, clinicians may be able to reduce the time required to identify abuse; the one inquiry is: "Have you been hit, kicked, punched, or otherwise hurt by someone within the past year? If so, by whom?"

Characteristics of Abused Women

Common Symptoms of Partner Abuse

Physical Symptoms/Findings:

- physical injuries of all kinds, especially injuries to the head (headaches, earaches)
- except in pregnancy, blows to the abdomen resulting in injury
- psychosomatic complaints
- vague pain reports
- exaggerated startle reflex
- Panic disorder symptoms:
  choking
  palpitations
  dizziness
  numbness and/or tingling of extremities

Psychosocial Symptoms:

- emotional blunting
- elevated feelings of guilt
- increased irritability
- sleep disturbance
- anxiety, panic disorder, or phobias
- depression
- terror
- nightmares, flashbacks, intrusive thoughts
- inability to handle anger
- intense feelings of vulnerability
- helplessness-hopelessness syndrome
- lowered self-esteem
- withdrawal from the external world
- isolation from peers
- shyness
- reduced coping skills
- avoidance of confrontation
- suicidal thoughts or attempts
- homicidal thoughts or attempts

Cognitive Symptoms:

- a numbing of responsiveness to the external world
- avoidance of any stimuli associated with the trauma
- diminished decision-making and problem-solving
- distortion of reality - the "Stockholm Syndrome"
- denial and rationalization of injuries or partner responsibility

Presentation and Patterns

The previous table includes symptoms commonly occurring in physical abuse. They are categorized into different diagnostic groups, including physical, psychosocial, and cognitive. A review of the research on victims of violent crime by Symonds (1979) described a three-stage reaction pattern: (1) an initial phase of shock, disbelief and denial; (2) a second phase of acknowledging the reality wherein a state of terror sets in and the victim feels dependent, and (3) a period of depression with intermittent inner-directed rage and outbursts of anger. In all of these phases the woman's emotional responses may profoundly influence her problem-solving ability and judgment. The "Stockholm Syndrome" consists of behavioral changes exhibited by kidnap victims and hostages. It is often characterized by a pathological transference that develops between abuser and victim; due to terror, development of a regressed dependence and gratitude. A woman may develop negative attitudes toward potential helpers and the distorted notion that her persecutor is her protector. There is not a psychological prototype of an abused woman. According to Follingstad, et al (1988) "the population of battered women is a heterogeneous one that will react and cope in a vast range of ways with their experiences" (p. 387). Additionally, there is no empirical proof that abused women contribute to their own abuse by being aggressive, efficient, masculine, sexually frigid, controlling or castrating, nor by having a masochistic personality (Kuhl, 1984). On the other hand, Kuhl reports that these women do exhibit characteristics that appear to be a result of abuse: cautiousness, shyness, emotional blunting or low emotional expressivity, difficulty in coping with stress or trauma, and avoidance of confrontations.

The long-term psychological effects of constant victimization include: a profound betrayal of trust; chronic tension; low ego strength and an impaired level of self-esteem; difficulty coping with aggression; feelings of guilt, shame, and inferiority, especially if verbal and emotional abuse are present along with the physical; and a gradual replacement of love with loneliness and pessimism. As noted previously, posttraumatic stress disorder is a frequent result of partner

abuse. Watson, Barnett, Nikunen et al (1997) found that PTSD was reported as present in 78% of abused women, so it is clear that this is indeed a dominant and common development. Depression was found to have a 65% occurrence rate in this same sample, followed by lower numbers with alcohol abuse or dependence, avoidant personality disorder, and panic disorder. It is crucial to remember that in addition to the severe depression that often occurs, an increased risk of suicidality may also be present. Stark, Flitcraft and Frazier (1979) reported on studies that found a 25 percent suicide attempt rate after chronic abuse, whereas only 6 percent of these women had any attempts before an initial assault. Other reports of data collected in the 1970's indicated that about 40% of women who had been battered had attempted suicide and over two-thirds had been prescribed hypnotics, tranquilizers or antidepressants. Stark et al (1979) found that victims of abuse are more likely to leave emergency rooms with some sort of prescription than other patients, including tranquilizers or pain medications. It appeared that physicians at first "medicated" the abuse by trying to control or reduce symptoms, and may have inadvertently given the woman the impression that she herself was responsible for her victimization. Physicians prescribed medications whether or not patients acknowledged family conflict or abuse. Stark et al emphasize that this approach to treatment may stabilize an abusive family situation and increase the likelihood that the woman will be injured again. Hilberman and Munson (1977-78) found that most abused women had been treated periodically or consistently with sedative-hypnotics, tranquilizers and/or antidepressants. The greatest needs of abused women are safe living situations and adequate income for themselves and their children, not medication that can, at best, only blunt the pain of abuse. Self-destructive acts by the abused victims encourage health care providers to view the women as pathological; clinicians may then focus on the battered partner as the problem rather than the abusive partner who may be absent from the professional's office.

Coping Strategies

Major coping strategies of abused women include substance abuse, denial, and a constant stance of learned helplessness. The findings delineated above about the prevalence of psychotropic drug prescriptions given to abused women are illuminating considering the risk of prescription drug abuse in battered women. In addition, abused women are often abusers of alcohol and illegal drugs, as are their partners. Denial is pervasive and injurious to the woman and her responsiveness to help from the medical profession. She may: (a) deny the injury (It really did not hurt very much."), (b) rationalize the motives of the partner ("His job is very stressful."), (c) deny victimization ("It was really my fault for spending too much money."), and (d) deny alternative options ("I really can't leave, the children would be devastated.") Another form of denial has to do with belief that it is her job to stay and help the abuser; here the woman usually appeals to traditional or religious values. She may also believe that violence is normal, justified and controllable; these beliefs are more common in women who grew up in abusive homes.

The victim may also have a cognitive defense style of learned helplessness, as originally described by Seligman (1975) to explain depression. When a person has experienced trauma she cannot control, her motivation to respond in the face of later trauma is diminished. In spouse abuse, a learned helplessness stance is developed partially due to the attacks being unprovoked, without cues, and of a degree not corresponding to the external events (Symonds, 1976). In addition, when women do act to help themselves, their efforts may not be rewarded in the external world. For instance, some data suggest that physicians do not ask women about possible abuse and the legal system does not respond by issuing assault charges when women request them (only 3% of women were successful in this). Then, the women may be punished when their attempts to protect themselves threaten the husband and she may be subjected to additional abuse (Follingstad, 1980)

Another negative coping mechanism important to mention involves the displacement of anger; some battered women abuse their children physically. Inquiry into this dynamic is crucial, as the physician is often able to convince a woman that treatment is imperative if her children are at risk,

either due to her bouts of anger or the abuse of her partner.

Characteristics of Men Who Are Physical Abusers

A series of articles by Hamberger and Hastings have detailed important findings about personality characteristics of spouse abusers and their responses to treatment. For instance, these researchers have found no differences between abusers and nonabusers on the variables of ethnic background or religion (Hastings and Hamberger, 1988). On the other hand, they report that abusers are more likely to: (a) be unemployed, (b) be in intact relationships, (c) have a lower educational level, (d) be alcohol abusers, and (e) have witnessed or experienced physical abuse in their childhood homes. Hamberger and Hastings (1985) completed a factor analysis of the Millon Clinical Multiaxial Inventory (MCMI) responses of abusive men and concluded that there were three major personality factors most characteristic of abusers: (a) asocial/borderline, (b) narcissistic/antisocial and (c) dependent/compulsive. They cite that there is no one characteristic personality pattern, but abusers demonstrate more marked psychopathology when compared to nonabusers. Most often abusers have personality disorders and evidence dysphoria, anger proneness, and a nonconforming personality style. Holtzworth-Munroe and Stuart (1994) have noted that there are three main clusters in terms of personality types among batterers and that the frequency and severity of violence may be related to the personality of abusers. Their findings indicate that men without significant psychopathology have the lowest levels of frequency and severity. Interestingly, men with antisocial personality characteristics were the most violent in general, both within and outside the home, but passive aggressive-dependent men had the highest frequency level.

An intriguing study by Brookoff, O'Brien, Cook, Thompson and Williams (1997), in which victims and alleged perpetrators of domestic violence were interviewed and examined at the scene when police were called, found that 92% of the perpetrators allegedly used alcohol or other drugs prior to the time of the assault. The assailants readily reported that they had used alcohol the day of the event (86%) and 14% acknowledged cocaine use. Of 26 perpetrators who denied using cocaine but agreed to confidential urine testing, 67% tested positive. In terms of the victims, 42% reported themselves or family members reported that they had used alcohol or drugs on the day of the assault and 17% of the victims tested positive for cocaine use. This study again underscores the close association between substance abuse and family violence and indicates that one major direction of treatment needs to be focused on drug use.

Assessment and Management of Physical Abusers

Hamberger (1992) describes an assessment strategy called a funneling technique. He advises that the practitioner begin with general, nonthreatening questions about the relationship that normalize conflict within families and focus on nonabusive forms of conflict resolution. Recommended questions include the following: *In general, how do you and your partner get along? When you and your partner have a conflict, how do you settle it? Do you try to persuade with logic? Do you ever use a third party to mediate a conflict?* Next, the practitioner focuses on the use of nonviolent, but psychologically abusive acts, such as insults, put downs, and name calling, and threats of physical violence or property destruction. The next stage of inquiry covers the use of force, starting with questions about grabbing, restraining, pushing, etc., and gradually progressing to more severe violence. Discussions of more severe violence include slapping, punching, kicking, or throwing objects at them. The final questions comprise what he calls the spout of the funnel and include questions about forced sexual acts, clubbing, beating, choking and the use of lethal weapons such as knives or guns. The value of this technique is that it allows assessment of the full range of potential violent actions and permits an estimate of lethality.

Initial interventions recommended by Hamberger (1992) include confronting the violence and

challenging the perpetrator to stop perpetrating acts of violence. One important confrontation deals with the cost of the violence to the man, including ongoing family distress and disruption, legal consequences, health consequences, and financial costs. Following confrontation, the abuser should be informed of counseling programs for treatment of family violence in the community. It is important for practitioners to follow up on their referrals by checking that a patient actually presents himself for treatment at a center. General counseling strategies for working with a male batterer include the following: use empathic confrontation, support the emotions but not the actions, assign responsibility without blaming, provide information and work collaboratively rather than as an accuser. Because of the high association of alcohol and drug abuse and battering, concomitant substance abuse treatment is imperative for abusers with such problems.

Other work by Hamberger and Hastings (1989; 1990) showed that abusers who drop out of treatment versus those who complete treatment are younger, have lower employment levels, have a greater number of alcohol and drug offenses before abuse, have greater borderline and schizoid tendencies, and higher levels of psychopathology. Interestingly, they show no differences in pretreatment violent offenses. It was also found that court-mandated participants have lower drop out rates. In terms of recidivism after treatment, the treated abusers who were most likely to re-abuse had higher levels of abuse initially and higher narcissism scores on the MCMI (Hamberger & Hastings, 1990).

Assessment and Management of Abused Women

After providers have determined that a woman patient is a victim of abuse, they should: (a) assess the level of current danger; (b) develop an atmosphere of empathy and understanding in regard to her experiences; (c) validate her fears and negative emotions; (d) discuss immediate and long-range alternatives to living with violence; and (e) develop an appropriate intervention plan with the patient. "The battered woman should not be blamed for staying with the abusive partner, rather she must be understood as a victim/survivor. Yet, after the understanding must come the interventions to help her understand and confront the ties that bind" (Follingstad, et al, 1988, p 387). The feelings of the victims require empathy on the part of the health care provider and skilled counseling can prompt the woman to develop priorities that are self-protective.

The clinician must help women to develop realistic expectations about leaving an abusive relationship. It is especially important for the physician to account for the factors that prompt women to stay and realize that expecting the patient to move immediately to a shelter and extricate herself from a dangerous situation is often not realistic. She should be sensitively counseled about the reasons that she has chosen not to leave before now, have the reasons validated as understandable and urged to develop a plan that will eventually be successful. In the meanwhile, she should be given emergency numbers (police, domestic crisis lines, women and children's shelters) and brought back for regular visits. In addition to leaving the relationship, intensive individual and conjoint counseling can be utilized in selected couples to overcome the cycle of violence in which they both live.

Various protocols have been proposed to deal with the presentation of abused women in the medical system (McLeer & Anwar, 1987). The plan that the physician develops depends partially on the level of risk to the patient's health/life that the situation encompasses. For a situation deemed to present a high level risk, the physician should arrange for a shelter representative to meet the patient at the office or emergency room. Ask the patient to at least talk to the representative, even if she appears intent on going home. If there has been a clear assault on an adult only, ask the woman for permission to call police or inform her of your plan to do so.

Immediate intervention is required if children have also been abused. In that case, the practitioner must notify the child protection team or another HRS agency of abuse. Inform the woman that this

is mandatory and have her take steps to protect herself and the children during the investigation. If a careful assessment indicates that the patient or others are at a low level of present risk: (a) provide her with the number of a local women and children's shelter; (b) provide her with the number and address of family counseling services and encourage participation by the woman and her partner; (c) clarify her "point of contact" within the legal system, both police or sheriff's office and an attorney who could help her with a restraining order; (d) tell the patient that you are not only concerned for her safety, but that of the children (women may be motivated to seek help "for the sake of the children"); (e) provide her with a referral to vocational counseling or job information if she is unemployed or underemployed; and (f) have the patient return within two weeks for a re-check to re-assess the level of danger and her coping strategies.

Informing Patients About Specialized Treatment for Partner Abuse

Group, individual and conjoint therapy modalities have all been employed to treat men and women involved in domestic violence. There is considerable debate about the most appropriate therapeutic modality for spouse abuse and different interpretations of empirical data available on treatment outcomes. Different approaches stress the importance of individual counseling, group counseling, or conjoint or family work; often the focus of treatment emanates from theoretical underpinnings about the dynamics of violent interactions. For many treatment strategies, group and individual treatment of male abusers is an essential part of treatment. Strategies may include confrontation by both therapists and other male abusers about the client's responsibility in perpetrating and continuing violent acts, controlling abusive anger and using alternative expressions, using time outs and other anger-diffusing techniques. For men who are childhood victims of physical abuse, an important treatment focus needs to be on dealing with family of origin issues, including working through feelings of inadequacy, powerlessness, and rage about one's own victimization.

The Duluth model (Pence & Paymar, 1993) strongly emphasizes counseling that is not conjoint, at least for the initial phases of therapy, due to important safety and control issues. The model believes that perpetrators of violence need to be in group therapy with other perpetrators and be separated from the partner against whom violence occurred. The approach is founded on the premise that violence is used by a man to control a woman's behavior and does not emanate from problems with anger control. Exploring the basis of each perpetrator's violence and his intent with his partner(s) is an important ingredient of the therapeutic work, as is exploration of other types of relationships with women intimates. Another group approach for male perpetrators known as Relating Without Violence (Wolfus & Bierman,1997) was shown to improve scores for abusers who completed the program on aggression and defensiveness scales and on conflict tactics, compared with untreated controls. There are also some programs that have been directed specifically toward gay male perpetrators that describe a multilevel coordinated approach to treatment (Hamberger, 1996).

Counseling approaches developed for couples involved in domestic violence which utilize psychoeducational and behavioral models have several key ingredients: (1) emphasizing the role of anger control, (2) teaching constructive problem-solving skills, (3) using behaviorally-oriented communication skills, (4) clarifying assumptions each party makes about the other's behaviors, (5) educating clients about the cycle of violence and asking for acceptance of appropriate responsibility around the violence, (6) educating clients in the use of time-outs and other anger-defusing techniques, (7) encouraging independence from the destructive parts of the relationship, and (8) teaching appropriate assertiveness skills. For the conjoint therapy, co-therapy with opposite gender therapists is seen as the most effective therapeutic modality. "This technique diffuses anger, increases clarification, and helps reduce tensions or resentments that build into violence later." (Harris, 1986) During the initial stages of therapy, the couple should be separated and living apart, as this de-escalates the conflict and increases the motivation for the batterer to work on the relationship.

In terms of outcome studies of treatment of couples in which the male has battered, Jacobson,

Gottman, Gortner, et al (1996) noted that there were several variables that predicted later divorce, including severity of husband to wife emotional abuse, the wife's dissatisfaction with the relationship, the husband's physiological arousal during marital discussions, the wife's assertiveness during interactions. Of intact couples, they found, at two year follow-up, that men who continued with severe levels of violent behavior were initially higher on measures of being domineering, globally negative and psychologically abusive. Overall, 54% of the abusive husbands decreased the frequency of physical abuse over the 2 years, but only 7% had no recurrences of violent acts.

Individual and group treatment of abused women focuses on self-esteem, on the cultural determinants of violence, on appropriate assertiveness, and on direct treatment of depression and PTSD symptoms. As Hattendorf and Tollerud (1997) point out, it is crucial to avoid "secondary victimization" of women in treatment of family violence by emphasizing that violence is the product of a troubled relationship rather than part of the oppression of women. These authors believe that individual psychotherapy for women can underscore women's empowerment and overcoming their own feelings of helplessness. Another crucial dynamic to address in the treatment of women is their tendency to make the abuse invisible to outsiders to save face or protect the stability of their families (Lempert, 1996); women must be assisted with changing their beliefs about containing the violence and made comfortable confronting it publicly.

Historical Overview of Family Systems Perspective on Violence

Family therapy theories and techniques during the1970's through the mid-1980's assumed a "pure systemic stance." This included the following features: violence was seen as a regulatory mechanism that restores homeostasis in as relationship/system; violence was seen as a symptom of systemic dysfunction that was caused equally by both parties to the violence; and violence was seen as victimizing men and women equally.

As the prevalence and danger of violence toward women has been more widely understood and as the feminist critique of family systems therapy (see below) has emerged, family systems thinking has changed in regard to many of these earlier features. Newer systemic approaches include: explicitly addressing safety issues, making violence the primary focus of treatment, holding abusers responsible for their actions, and concern for the rights of the victim. Recent family systems approaches attempt to do conjoint treatment and still insure safety through means such as contracts, time outs, and explicit agreements that partners will leave the situation should violence occur (Bograd, 1986; Krugman, 1986 and Shapiro, 1986).

One of the best articulated family systems approaches to date incorporates feminist and family systems positions, as well as psychodynamic and social learning theory. Goldner, Penn, Sheinberg and Walker (1990) argue that conjoint treatment can occur when: violence is not pervasive or severe, the woman still has some agency and power within the relationship, and the man shows some capacity to take responsibility for being violent. The Ackerman group accepts the feminist concept that violence is a societal phenomenon in which men try to exert power over women by using their physical force and intimidation. In addition, however, they contend that systemic concepts such as complementarity can help clarify the cycle of violence in which couples find themselves caught. They also view male violence as both a method of social control and an expression of dependency and helplessness on the abuser's part. Therapeutic strategies include: "deconstructing the violent moment" (intensively tracking the moment of escalation of violence and identifying internal and external triggers), fully exploring " the bond" that appears to hold these couples together using family of origin work, and explaining the woman's "stuckness" in relationships using recent feminist theories. Extensions of this general feminist critique have been offered by Hare-Mustin (1978) and others, who similarly question the core assumptions of a traditional systemic perspectives and raise concerns regarding this approach to treatment for particular families. Bograd (1984) offers a succinct critique of systemic formulations by stating that they: dehumanize the reality of violence, ignore physical size differences between men and women, attenuate the man's responsibility for his violence, and minimize violence by viewing it as

only a sign of underlying systemic dysfunction rather than a primary problem.

Partner Sexual Abuse and Rape

There is sparse literature on marital rape, especially given the probable frequency of its occurrence. For instance, in a study of 930 women in San Francisco completed during the 1980's (Russell, 1990), "one in every seven women who had ever been married…disclosed an experience of sexual assault by their husbands." Rape in marriage continues to be an avoided topic of discussion and even an area of great skepticism on the part of many men and some women, including health care providers. Our historical traditions have emphasized that primacy of the husband's role as the "head of the family" and a belief that wives should attempt to fulfill the needs of the husband, including sexual ones. Laws pertaining to rape in the United States, as in most of the world, have contained an aspect known as the "marital rape exemption." The laws define rape as "the forcible penetration of the body of a woman who is not the wife of the perpetrator." By statute, then, marital rape could not occur. The rationale was related to the idea that, in promising to obey, the wife had given her husband the right to intercourse on all occasions and reflected the notion that the wife was the property of her husband.

The high prevalence of marital or partner rape reflects many aspects of male-female relationships in many societies and the confluence of male physical power with sexual expression. As Jones (1994) points out, male aggressiveness and sexuality are seen as linked in our culture, and some "fighting," both sexual and physical, is thought to be natural or even desirable in marriage. Often, then, marital violence is thought to occur with the woman's consent, much as rape used to be thought to be provoked, "asked for," or secretly desired by victims. There are still many men, indeed, many professionals, including psychotherapists, who subscribe to the notion that women secretly want men to take them in some "caveman-like" scenario and that the average woman will ultimately enjoy such a display of power in sexual interactions. This belief is simply untrue for the vast majority of women. Notwithstanding that some men and some women like activities that include games of dominance and submission with trusted partners; they like them when they are just that-games-that can be ended if fear occurs or if unusual discomfort or pain occurs. The idea of masochistic women who derive great pleasure from being actually tortured physically or sexually is a psychoanalytic myth; to the contrary, the research on women's sexual responsiveness is quite clear: the vast majority of women do not derive sexual pleasure from captivity, torture or pain. Moreover, battered women cannot be distinguished by personality variables from other women in terms of premorbid characteristics; the only distinguishing features are the sequelae of abuse--PTSD symptoms, low self-esteem, substance use and suicidality that follows repeated battering.

In addressing the area of men assaulting women physically, a psychologist-researcher, Dr. Hamberger, contends that men abuse women for three reasons: they want power or control over the woman, they can (meaning that they often suffer no consequences for it in this culture), and it works - - that is, it is effective in getting them what they want. In terms of husbands perpetrating sexual violence on their wives, the awareness of problems in this area has lagged behind a focus on both child abuse and wife-battering. By 1997, all states in the United States have marital rape laws on the books, but this is a very recent state of affairs. As recently as July 1, 1980, only Oregon, Nebraska and New Jersey had completely excluded the exemption for marital rape and several other states had limited the scope of the exemption: California, Delaware, Hawaii, Minnesota and Iowa. All states now have provisions in laws that define marital rape as a crime; however, the reporting, response to, and prosecution of sexual assault of a husband or partner toward his wife / partner is highly variable. Interestingly, Russell (1990) reports a conviction rate of 88% for prosecuted cases from 1978-1985, a strikingly high rate. She notes that this may be because the wives who choose to charge their husbands have been raped in especially brutal ways, with the use of "tire irons, dogs, strangulation, or death threats," whereas thousands of

women raped in more "ordinary ways" may simply not report the incidents. A significant area of risk for women is the link identified by the National Center for Disease Control between woman battering and the spread of HIV and AIDS among women. If husband or male partners are perpetrators of spousal rape, their concern about not transmitting HIV if they are positive or at risk for the disease is also likely to be low or nonexistent.

Marital Rape, Physical Assault and their Overlap

Men who physically batter their wives may also commit marital rape (JAMA, 1992); rape is reported by 33-46% of women who have been physically assaulted by their partners and is responsible for many injuries (including serious lacerations and damage to bodily orifices and internal organs). In fact, research has shown that fully one half of all rapes of women over 30 years of age are committed by domestic partners (Injury Prevention Network Newsletter, 1988). To help us "paint the picture" of marital rape and its close tie to assault and battery, some case examples from the book "Next Time She'll Be Dead" by Jones (1994) are described:

> In the state of Nebraska in 1979, Lynn Ditter charged her husband with sexual assault and battery in what was to have been the state's first trial for marital rape. In January, 1979, she asked the court to revoke his bond and lock him up; he was stalking and threatening. The court cited a Nebraska Mental Health Clinic psychiatrist's report that said that Mr. David Ditter "presents every evidence of good emotional and physical self-control" and should not be "considered assaultive or dangerous to be at large at this time. So bond was continued. Mr. Ditter shot and killed Lynn Ditter just as she said he would.
>
> In 1979 in Alaska, Jeanette Tedesco reported that her boyfriend Charlie Walton had kidnapped, assaulted and raped her. Police failed to investigate and the Assistant DA refused to prosecute unless Tedesco passed psychiatric and lie detector tests. Before she completed these examinations, Walton killed her.
>
> In California in 1981 Victor Burnham was convicted of marital rape after three of his wives testified to rape, battery and torture at his hands, dating back to 1964.

The last example points out the situation that the courts have often treated allegations of marital rape as a "he said, she said" situation, much like allegations of stranger rape or sexual harassment. It is almost as if one must have corroborating witnesses; and in the case of marital rape, that is often difficult to produce. In the Burnham case, however, it was quite easy because he had two former spouses who had also experienced rape and repeated torture and they were willing to testify. It should be noted that Mr. Burnham, after his release from a moderate prison sentence, went on to torture and sexually assault a live-in girlfriend at a later date.

According to Russell (1990), collapsing situations where women are raped by their husbands into a category with women who are beaten by their husbands is not accurate, because the relative frequency of being beaten or raped may vary greatly and the psychological impact and the interpretation of the marital dynamic on the women may be quite different. She and co-researchers studied 644 women who had ever been married and found that of these marriages, 63 (10 percent) had included both wife rape and beating, 24 (4 percent) had included wife rape only, and 75 (12 percent) had included beating only. An estimated prevalence of wife rape then, would be 14 percent and wife beating would be 21 percent in this sample of ever-married women. It is important to note that women who had not experienced husband-violence outside of sexual activities and had been subjected to lower levels of force during coerced marital sex (being pushed, pinned, held down or struggled with but not hit, slapped or beaten) rarely answered yes to a query of: "Was your husband or ex-husband ever physically violent with you?" Again, it appears that there is a societal acceptance of a certain level of force in marital sexual relationships and women tend to have a greater tolerance of low levels of force.

Russell and her co-researchers then studied 175 women who had suffered abuse to determine prevalence rates for five types of situations involving marriages with violence toward women: (a) Wife rape only (14 percent incidence), (b) wife beating only (49 percent), (c) both rape and beatings with a predominance of rapes (9 percent), (d) both beating and rapes with a predominance of beating (5 percent) and (e) approximately equal significance of beating and rapes (22 percent).

Some Women Stay in Sexually Abusive Relationships, Many Leave

Spouse abuse and marital rape are violent acts of power and control perpetrated by men against women without women's consent or tacit approval. As Jones (1994) points out, the question "Why do women stay?" in and of itself put the focus on the victim and appears to blame the victim by suggesting that she could easily leave. It is clear, then, that the better question would be "Why do men batter, rape or torture their wives?" There are many pressures on women in this society to preserve marriages and families and as violence is such a real threat to many of them, women often remain in relationships even though violence is persistent. "Trying to save a marriage, or save her life or save her children, a battered woman may submit to violence, just as a rape victim may submit to rape for fear of being killed. But submission is not consent." (Jones, 1994, p. 126-127).

There are some clear answers for those therapists or scientists who still query: "Why women stay with rapist-husbands, why they do not leave?" The first important answer is that the premise that women **do** stay, in general, may be false; most, in fact, may leave. Again, as this issue has not been addressed by other researchers, it is important to focus on Russell's findings: the majority of raped wives in this study were not married at the time they were interviewed; wives who were battered or raped had a divorce rate of 40%, compared to 22% for women who had not been physically or sexually abused. In examining the statistics by looking at rape alone, however, 51% of the women who had been wife-raped were divorced, compared to 18% of women who had not been raped by their husbands. The divorce rate for battered-only women and nonbattered women showed no difference (22%). There appeared to be no differences in background or attitudes toward marriage between raped and nonraped wives, however "The more traditional wife does handle wife rape differently from the less traditional wife, and is more likely to blame herself and stay in the marriage" (Russell, 1990, p. 189). This may reflect only a difference in attitude or the constraints of more traditional views had fewer financial resources than less traditional women, who may have had more education or held higher paying jobs. As noted previously in the case of physical abuse, the literature shows that 80% of women in abuse shelters with their own means of financial support were likely to leave the relationships, whereas 80% of women without financial support planned to stay.

Men Who Perpetrate Rape Upon their Wives

There are, to date, no controlled studies of husbands who have perpetrated wife rape in terms of a broad sample of such men compared to controls in the general population. According to Russell, the data of Groth (Groth, Longo, & McFadin, 1983; Longo & Groth, 1984) based on rapists who were convicted and imprisoned for sexual assaults on unrelated victims and were also were found to have raped their wives, is not a sample of usual perpetrators. Groth notes that the husbands who were convicted rapists regarded their wives as "possessions or even opponents to be used, controlled or dominated." These men want to be clearly seen as the boss, set the rules and have orders followed and do not have relationships characterized by "equality, reciprocity, mutuality, and sharing." "Sex is seen as the solution to all marital problems, as well as the source of validation for their masculine identities" (Russell, 1990).

Frieze (1980) and Frieze and Browne (1989) reported on studies that compared battered women with matched-controls from the same neighborhood. If women who were recipients of partner assault were asked about marital rape, 34% said that they had also experienced it. Frieze contended, according to the analysis of the data from interviews with the women, "the more

violent the men were in general, the more likely they were to rape their wives." Other aspects were noticed that distinguished the violence from men who raped their wives than those who battered alone: (a) the violence started earlier in the relationship; (b) the violence was higher in severity, (c) the violence was higher in frequency; (d) the violence was more likely to be associated with alcohol use, (e) beatings during pregnancy were more likely; (f) the men were significantly more likely to want sex after beatings; (g) the men were more likely to associate sex and physical force in other ways, such as desiring sadomasochistic activities; (h) the men got into more fights with people outside the home; (i) the husband had higher levels of dominance in the marital relationship; (j) had higher levels of jealousy (even though wives were less likely to be involved in extramarital affairs than battered-only wives) and (k) were more likely to use coercive techniques of emotional withdrawal and abandonment (disappearing and staying away overnight) and were more likely to restrict their wives' freedom. The family backgrounds of the marital-rape perpetrators were more likely to have emotional distance and violence between the parents, but not necessarily toward the children.

As Russell (1990) summarizes: "The portrait of the husband-rapist that emerges from Frieze's research is of a tyrannical, violent man, who uses violence as well as other techniques to get what he wants, both with his wife and with others. Since he associates sex and violence, this means he also rapes his wife…[this is] the portrait also of a patriarch-of a man who sees himself as the master in his own home, and who does…have a great deal of power over his wife." And for Groth's description of "men who rape," Russell summarizes these as men for whom "sexual domination is their desperate attempt to establish control in the face of overwhelming powerlessness."

Alcohol Use, Gender Roles and the "Normalcy of Rape"

Estimates are that about 50% of rapes are associated with alcohol use by either the assailant or the victim or both. The juxtaposition of these features in college campus sexual assaults is well documented, for example, where both parties may have been involved with consuming alcohol in dating contexts. In the case of marital rape and assault, however, the situation may be quite different. "For married women, a violent assault is usually preceded by only her spouse's drinking behavior…" (Beckman and Ackerman).

Morgan theorized that men who hold stronger beliefs in traditional gender roles are more likely to commit sexual assault, a thesis borne out by several studies, as also noted in the work of Frieze noted above. Studies of college student men at universities have demonstrated that many men acknowledge in an anonymous questionnaire that they would commit rape if the opportunity arose and they knew they would not be caught. Again, these findings underscore societal attitudes toward hard-drinking, swashbuckling, "real men" overpowering "real" feminine, submissive women being part of the natural order of things.

Who Should Be Screened for Marital Sexual Assault?

"The data on the social characteristics of victims of wife rape reveal that wife rape occurs to married women in all social classes, in all racial or ethnic groups…in all religious groups, and in a great range of age groups" (Russell, 1990). This is in contrast to spousal battering victims, who are more likely to be from the lower social classes. The extent of the injuries varies from minimal, such as bruises from being hit, choked, or held down (58% in Russell's study) to severe. In 16%, it involved hitting, kicking or slapping; in 19% it was an extreme level of beating and slugging; in 7% threats of force, drugging the woman, or her being unable to consent due to being drunk or asleep. Russell estimates that in about 30% of cases the force was more excessive than what would have been required to complete the rape. One of the most important reasons for therapists and legal personnel to intervene aggressively when a married woman presents to a provider after an incidence of sexual trauma is "to reduce mortality" by preventing her potential future murder. As has been seen, men who rape their wives may be more violent in general, the most badly battering husbands have a marital-rape rate of about 30% (Frieze, 1980). It is thus also likely that

women who are at high risk of being murdered by their husbands are women who are raped by their husbands.

Summary

Psychotherapists can assist women in stopping partner-initiated violence by: (a) having a high index of suspicion regarding partner violence and partner rape, (b) providing counseling or referring patients for counseling when domestic violence is uncovered, (c) involving law officers and agencies when assault has occurred and documenting the assault to assist in prosecution, and (d) supporting the establishment of effective substance abuse treatment and family violence treatment programs to help curb the continuation of abuse against women and children. These efforts will result in better clinical outcomes for many of our clients (lowered morbidity and mortality) and will ultimately reduce health care costs. As in most areas, an ounce of prevention is worth pounds of cure. In better protecting women who are mothers, we can also extend a helping hand to children who are traumatized by the sight of violence, as well as likely to be the next victims of abusers.

Resources

California

The California Alliance Against Domestic Violence
926 J Street, Suiite 210
Sacramento, CA 95814
Phone: 916-444-7163
Toll Free: 800-524-4765
Fax: 916-444-7165
Web site: http://www.caadv.org/

SafeState
California Attorney General's Office
Crime and Violence Prevention Center
1300 I Street, Suite 1120
Sacramento, CA 95814
Phone: 916-324-7863
Fax: 916-327-2384
Web site: http://safestate.org/

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

Support Network for Battered Women
1975 W. El Camino Real, Suite 205
Mountain View, CA 94040

Phone: 650-940-7850
TDD: 650-940-7857
24-hour Crisis Line (English and Spanish): 800-572-2782
Web site: http://www.snbw.org

Family Violence Prevention Fund
383 Rhode Island St. Suite #304
San Francisco, CA 94103-5133
Phone: 415-252-8900
Fax: 415-252-8991
Web site: http://endabuse.org/

Center for Domestic Violence Prevention - Bay Area
P.O. Box 5090
San Mateo, CA 94402
24-Hour Phone Line Support: 650-312-8515
National Domestic Violence Hot Line: 800-799-SAFE
Web site: http://www.cdvp.org/main.html

Florida

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

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

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

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

Betty Griffin House
Serving St. Johns County
24-Hour Crisis Hotline: 904-824-1555
E-mail: shelter@aug.com
Web site: http://www.bettygriffinhouse.org/

Refuge House

Serving 8 Counties: Franklin, Gadsen, Jefferson, Leon, Liberty, Madison, Taylor, Wakulla
24 Hour Crisis Line: 850-681-2111 (Collect calls accepted)
Phone: 850-922-6062
Web site: http://www.refugehouse.com/main.htm

General Resources

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

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

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

Asian & Pacific Islander Institute on Domestic Violence
http://www.apiahf.org/apidvinstitute/default.htm

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

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

Community Insights on Domestic Violence Among African Americans
http://www.hawaii.edu/hivandaids/Community%20Insights%20on%20Domestic%20Violence%20among%20African%20Americans.pdf

Additional State Resources

- Alabama Domestic Violence Crisis and Support Resources
  http://www.aardvarc.org/dv/states/aldv.shtml
- Alabama Coalition Against Domestic Violence
  http://www.acadv.org
- Alaska Network on Domestic Violence and Sexual Assault
  http://www.andvsa.org
- Arizona Domestic Violence Safety
  http://www.supreme.state.az.us/dr/dv/dv.htm
- Arkansas Coalition Against Domestic Violence
  http://www.domesticpeace.com
- Colorado Domestic Violence Coalition
  http://www.ccadv.org
- Connecticut Coalition Against Domestic Violence
  http://www.ctcadv.org

- Delaware Domestic Violence Coordinating Council
  http://www.dvcc.state.de.us/index2.html
- District of Columbia
  http://www.dccadv.org
- Florida Coalition Against Domestic Violence
  http://www.fcadv.org
- Georgia Coalition Against Domestic Violence
  http://www.gcadv.org
- Hawaii State Coalition Against Domestic Violence
  http://www.hscadv.org
- Illinois Coalition Against Domestic Violence
  http://www.ilcadv.org
- Indiana Domestic Violence Crisis & Support Services
  http://www.aardvarc.org/dv/states/inddv.shtml
- Iowa Coalition Against Domestic Violence
  http://www.icadv.org
- Kansas Coalition Against Sexual and Domestic Violence
  http://www.kcsdv.org
- Kentucky Domestic Violence Association
  http://www.kdva.org
- Louisiana Coalition Against Domestic Violence
  http://www.lcadv.org
- Maine Coalition to End Domestic Violence
  http://www.mcedv.org
- Maryland Network Against Domestic Violence
  http://www.mnadv.org
- Massachusetts Coalition Against Domestic and Sexual Violence
  http://www.janedoe.org
- Michigan Coalition Against Domestic and Sexual Violence
  http://www.mcadsv.org
- Minnesota Coalition for Battered Women Projects
  http://www.mcbw.org
- Mississippi Coalition Against Domestic Violence
  http://www.mcadv.org
- Missouri Coalition Against Domestic Violence
  http://mova.missouri.org
- Montana Coalition Against Domestic and Sexual Violence
  http://www.mcadsv.com/
- Nebraska Domestic Violence Sexual Assault Coalition
  http://www.ndvsac.org/
- Nevada Network Against Domestic Violence
  http://www.nnadv.org/
- New Hampshire Coalition Against Domestic and Sexual Violence
  http://www.nhcadsv.org
- New Jersey Coalition For Battered Women
  http://www.njcbw.org
- New Mexico Coalition Against Domestic Violence
  http://www.nmcadv.org
- New York State Coalition Against Domestic Violence
  http://www.nyscadv.org/
- North Carolina Coalition Against Domestic Violence
  http://www.nccadv.org
- North Dakota Council on Abused Women's Services
  http://www.ndcaws.org/

- Ohio Domestic Violence Network
  http://www.odvn.org/
- Oklahoma Coalition Against Domestic Violence and Sexual Assault
  http://www.ocadvsa.org
- Oregon Coalition Against Domestic and Sexual Violence
  http://www.ocadsv.com/home.htm
- Pennsylvania Coalition Against Domestic Violence
  http://www.pcadv.org
- Rhode Island Domestic Violence
  http://www.courts.state.ri.us/domesticnew/default.htm
- South Carolina Coalition Against Domestic Violence and Sexual Assault
  http://www.sccadvasa.org
- South Dakota Coalition Against Domestic Violence and Sexual Assault
  http://www.southdakotacoalition.org
- Tennessee Coalition Against Domestic and Sexual Violence
  http://www.tcadsv.org
- Texas Council on Family Violence
  http://www.tcfv.org
- Utah Domestic Violence Advisory Council
  http://www.udvac.org/
- Vermont Network Against Domestic Violence and Sexual Assault
  http://www.vtnetwork.org
- Virginia Against Domestic Violence
  http://www.vadv.org
- Washington State Coalition Against Domestic Violence
  http://www.wscadv.org
- West Virginia Coalition Against Domestic Violence
  http://www.wvcadv.org
- Wisconsin Coalition Against Domestic Violence
  http://www.wcadv.org/
- Wyoming Coalition Against Domestic Violence and Sexual Assault
  http://www.users.qwest.net/%7Ewyomingcoalition/index.htm

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