DOMESTIC VIOLENCE: A THEORETICAL OVERVIEW.

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DOMESTIC VIOLENCE:

A Theoretical Overview.

A Research Paper

Presented for the

Master of Science

Degree

Austin Peay State University

Sherry L. Fanara

July 1999

DEDICATION

This research paper is dedicated to all the family members who have suffered at the hands of domestic violence, especially those who have suffered in silence and believed there was no escape.

ACKNOWLEDGMENTS

I would like to thank my major professor, Dr. Stuart Bonnington, for his guidance and patience. I would also like to thank the other committee members, Dr. Garland Blair and Dr. Charles "Buddy" Grah, for their commitment and assistance. I would like to express thanks to my supervisor, and friend, Dr. Jay Gorban, who always supported, encouraged and believed in me. I especially want to thank my best friend, Alicia Birch, who has pushed, pulled and dragged me to the successes I experience in my life now. Without her help I would have never discovered my true worth, and for that I am eternally grateful to her.

ABSTRACT

Domestic abuse can be loosely defined as maltreatment, either physical, psychological or sociological, of an individual within the family structure. It continues to be a much-debated topic among mental health care providers, law enforcement agencies, and social service agencies. Many factors play a role in the undertreatment of domestic violence. Efforts towards eradicating domestic violence have been delayed by a lack of a national definition of what constitutes domestic violence and which relationships should be included. Multiple reporting agencies may impede the fight against domestic violence as well. Agencies may have different goals that may, in some cases, work against each other. Clinicians, health care providers, social workers and law enforcement agencies typically focus on individual symptoms, such as depression and physical injury, and miss the bigger picture of the family at risk. Finally, the clinical myths regarding domestic violence can lead professionals to speculate about effective interventions. These and other problems serve to complicate the primary goal of advocacy groups - the screening and identification of family violence and the subsequent treatment of both the victim and offender.

The purpose of this paper is to research the problems of defining domestic violence, identifying characteristics of an abusive family and the perpetrators, and the psychological costs of abuse. A desired outcome of such an approach would be additional insight into the causes and treatment of abuse, as well as discovering new directions for the 21st century, such as the development and utilization of a simple but effective multidisciplinary approach.

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Chapter I

Introduction

In 1994, Nicole Brown Simpson and friend Ronald Goldman were found brutally stabbed to death on the front walkway of Nicole Simpson's Los Angeles condominium. Within twenty-four hours the police narrowed their investigation's focus to Nicole Simpson's ex-husband, O.J. Simpson. The arrest, and subsequent trial, not only created a media maelstrom involving the rich and famous but also sparked heated debates on domestic violence, an issue of gargantuan proportion that has been viewed by some as a taboo subject. Domestic violence was now in the limelight; a daily media event forcing many observers to take a new look at an old social problem.

Why is it that individuals turn a deaf ear and blind eye to domestic abuse, in particular spousal abuse, while propagating fair treatment of all individuals? Additionally, how do we explain the advancements in gender role expectations while holding on to more traditional views handed down regarding, and the subsequent treatment of, women and men? The answer may lie in part within the very definition of domestic violence. *Domestic abuse* can be loosely defined as maltreatment, either physical, psychological or sociological, of an individual within the family structure. This would include child abuse as well as spousal abuse. A more structured, universal definition is necessary, however. An examination of the empirical data provided by the National Incident-Based Reporting System (NIBRS) (1997) revealed methodological and reporting difficulties with both the Uniform Crime Report (UCR) and the National Crime Victimization Survey (NCVS). The difficulties associated with domestic violence point to fluctuating interpretations within and between law enforcement agencies. For

example, although recent legislation in some states includes both stalking and intimidation as types of domestic abuse, such incidents are rarely reported to the national database because they do not qualify as violent offenses. It appears that another inherent problem with domestic violence is that reports are incident-based as opposed to summary-based. These and other inconsistencies in defining domestic violence result in underreporting creating the illusion that domestic abuse may not be a widespread problem.

Most researchers are not surprised by this indifferent attitude. While child advocacy groups successfully lobbied for changes governing the treatment of minors, spousal abuse has remained a relatively ignored social problem that has received little attention until a notable case was covered by the media. Child abuse and neglect was identified as a social problem long before spousal abuse was (Magen, Conroy, Hess, Panciera & Simon, 1995). The recognition of child abuse as a social and psychological problem emerged in the 1960's while attention to the growing problem of spousal abuse lagged behind nearly a decade (Magen, et al., 1995). Jacobson, Gottman, Gortner, Berns, & Shortt (1990), support this view, asserting that married women have been battered by their husbands throughout the history of civilization and that their plight has only received the attention of social and behavioral researchers in the past few decades. The studies by Jacobson, et al (1990) and Magen, et al, (1995), suggest that society has typically held an apathetic or indifferent viewpoint regarding the plight of abused spouses. The victim is almost always seen as somehow at fault. This phenomenon may account for the lag in recognizing spousal abuse as a social problem. As documented in the Simpson case, even as late as 1994, commentaries surrounding the victim's role in

complicity surfaced. Remarks regarding Nicole Simpson ranged from, "Why didn't she leave if it was so bad?" to, "She probably deserved it." Indeed, there were early efforts to discredit Nicole Simpson by attempting to link her with drugs and sexual indiscretions. Consequently, sympathy ran high for O.J. Simpson and many individuals believed that if O.J. really did kill his ex-wife that he was somehow justified. Even the now well-publicized 911 tapes, which detailed the domestic violence taking place in the Simpson household, could not convince some that domestic violence was a real problem in the Simpson household. In the final analysis neither money nor fame could protect Nicole Simpson from this "indifferent" or apathetic attitude.

It may well be that this apathetic or "indifferent" attitude surrounding spousal abuse can be viewed using a culturally-based model. Different racial, ethnic and cultural groups hold different attitudes towards intimate relationships and the roles of males. In a review of cross-cultural differences in moral thinking, Naire (1997) pointed out that some cultures consider it the husband's moral obligation to "discipline" other family members whenever necessary, and in fact consider it shirking their responsibility if they do not "discipline" their wife and children. Likewise, McClosky and Fraser's (1997) historical treatment of domestic violence referenced the widely held belief that violence was not only the man's right, but that it was also his duty to keep his wife "spiritually" in line. Meloy, Cowett, Parker, Hofland and Frieland (1997), found that differences in attitudes surrounding intimate relationships arise from a dominant patriarchal society. For example, Hispanic males embrace a "machismo" mentality, which clearly outlines what is acceptable male behavior, and what they will tolerate, in a relationship. It is similar to the "real man" mentality seen today's white culture. This may explain why domestic

abuse is tolerated, if not ignored, thus fostering indifference. It may also explain the legacy of domestic abuse, most notably the violence and subsequent indifference, and illustrate its' transmission as it is handed down from one generation to the next (Miller, Veltkamp & Fraus, 1997). It does little to explain, however, why the advancements in the status of women and children have not had a profound impact on these traditionally handed-down views on domestic violence. This is one of many problems that illustrates the paradox of domestic abuse.

Another factor affecting the detection and subsequent treatment of domestic violence is the secrecy that surrounds it. Victims of domestic violence are typically reluctant to openly disclose the violence they endure (Gornter, Berns, Jacobson & Gottman, 1997). This reluctance can be a valid response based on a realistic appraisal of their current situation and the remedies available. In addition to the indifference mentioned previously, victims may blame themselves for the violence, feeling shame and guilt and leading to further secrecy (Gornter, et al., 1997).

Without doubt, domestic violence continues to be a much-debated topic among mental health care providers, law enforcement agencies, and social service agencies. The purpose of this paper is to research the problems of defining domestic violence, identifying characteristics of an abusive family and the perpetrators, and the psychological costs of abuse. A desired outcome of such an approach would be additional insight into the causes and treatment of abuse, as well as discovering new directions for the 21st century, such as the development and utilization of a simple but effective multidisciplinary approach.

Chapter II

Problems With Data Collection

Defining Domestic Violence

The Violence Against Women Act, of the Violent Crime Control and Law Enforcement Act of 1994, mandated the collection of data on the incidences of sexual and domestic violence at both the state and federal level (Campbell, Travis, Chaiken, & Auchter, 1996). In compiling the mandated data, Campbell, et al. (1996) reported wide variations in how each state defines *domestic violence* and how states determine what is counted, measured or reported. For example, the National Crime Victimization Survey (NCVS) cannot identify details for discrete victimization events, such as intimidation, yet intimidation may be a behavior exhibited by an offender, pointing to a potentially serious problem. Additionally, many researchers are beginning to focus on the psychological abuse inflicted by those involved in intimate relationships (Enns, Campbell, & Courtois, 1997). Such data would not be reported to the Uniform Crime Report (UCR) or the NCVS because it does not qualify as a violent event and there is no reporting scheme designed to handle this information. Some reporting agencies globally define family and domestic violence as any offense that occurs within the family structure. By this definition *robbery*, where the relationship of the victim and the offender is identified as within the family, might be reported as domestic violence (NIBRS, 1997).

The National Incident-Based Reporting System (NIBRS) (1997) acknowledges that the definition of domestic violence varies in the types of offenses and types of relationships within the family structure depending on the reporting

agency and recognizes the inherent problems with detecting domestic abuse resulting in inaccurate reporting. Consequently, the NIBRS (1997) outlined ten offenses that are representative of family violence, that included:

1. **Murder and Non-negligent Manslaughter:** The willful (non-negligent) killing of a person.
2. **Negligent Manslaughter:** Killing another person through negligence.
3. **Forcible Rape:** The carnal knowledge of a person, forcibly and/or against their will; or where the person is incapable of giving consent because of their youth or because of their temporary or permanent mental/physical incapacity.
4. **Forcible Sodomy:** Oral or anal intercourse with another person, against their will; or where the person is incapable of giving consent because of their youth or because of their temporary or permanent mental/physical incapacity.
5. **Sexual Assault with an Object:** To use an object or instrument to unlawfully penetrate, however slightly, the genital or anal opening of the body of another person, forcibly or against their will; or where the victim is incapable of giving consent because of their youth or because of their temporary or permanent mental/physical incapacity.
6. **Forcible Fondling:** The touching of the private body parts of another person for the purpose of sexual gratification, forcibly or against that person's will; or where the person is incapable of giving consent because

of their youth or because of their temporary or permanent mental/physical incapacity.

7. **Aggravated Assault:** An unlawful attack by one person upon another wherein the offender uses a weapon or displays it in a threatening manner, or the victim suffers obvious severe or aggravated bodily injury involving apparent broken bones, loss of teeth, possible injury, severe laceration, or loss of consciousness. This also includes assault with disease (as in cases when the offender is aware that they are infected with a deadly disease and deliberately attempts to inflict the disease by biting, spitting, etc.)
8. **Simple Assault:** An unlawful physical attack by one person upon another where neither the offender displays a weapon, nor the victim suffers obvious severe or aggravated bodily injury involving apparent broken bones, loss of teeth, possible internal injury, severe laceration, or loss of consciousness.
9. **Intimidation:** To unlawfully place another person in reasonable fear of bodily harm through the use of threatening words and/or other conduct, but without displaying a weapon or subjecting the victim to actual physical attack.
10. **Kidnapping:** The unlawful seizure, transportation, or detention of a person against their will, or of a minor without the consent of their custodial parents or legal guardian.

Another consideration when defining domestic violence is that abusive situations do not normally constitute a discrete event, rather domestic violence can be

seen as a continuous state of victimization. Campbell, et al. (1996) describe domestic violence as a "continuum of behaviors" which they acknowledge can complicate record keeping. For example, the NCVS has included a designation for "series crime incident" however, behaviors not overtly violent, like intimidation, are typically excluded because they involves judging an offender's motives. Given that there is no standard, accurate reporting is exceedingly difficult for individual states and agencies.

The variability that was found in defining *domestic violence* was also found in defining the relationships between offenders and their victims. Bachman and Saltzman (1995) conducted a study that examined the effectiveness of NCVS's questionnaire. This ten-year study compared NCVS's old questionnaire to a redesigned questionnaire implemented in 1992. A desired goal of redesigning this questionnaire was to produce better accountability in reporting of incidents of domestic violence. Behavior-specific wording replaced criminal justice terminology, making it more understandable and allowing a broad spectrum of incidents. Additionally, Bachman and Saltzman (1995) proposed a more comprehensive definition of different types of relationships which included:

1. **Intimates** – Spouses, ex-spouses, boyfriends, girlfriends, ex-boyfriends, ex-girlfriends.
2. **Other relatives** – Parents, Stepparents, children, stepchildren, brothers, sisters, or some other relative.
3. **Acquaintances/friends** – Friends, former friends, roomates, borders, schoolmates, neighbors, co-worker, or other known nonrelative.

4. **Strangers** – Anyone not known previously by the victim.

Unfortunately, these definitions are not universal. Some reporting agencies continue to make a distinction between family violence and domestic violence. For example, reports on family violence typically include child abuse, while reports on domestic violence are routinely limited to adult victims (Campbell, et al., 1996). Furthermore, other agencies define *family violence* strictly within the bonds of family relationships, such as spouse, common-law spouse, parent, sibling, child, grandparent, grandchild, in-law, stepparent, stepchild, stepbrother or stepsister, or other family member. This can, and usually does, exclude other informal relationships, such as boyfriend, girlfriend, ex-spouse, ex-girlfriend, ex-boyfriend, roommate, cohabitants, and same-sex unions (Campbell, et al., 1996, NIBRS, 1997). Some states will acknowledge an abusive incident as domestic violence if the parties have a child in common (Campbell, et al., 1996).

Clarifying what constitutes domestic violence and who qualifies as a victim is an important issue for several reasons. First, the absence of a national definition can lead to underreporting, which can result in a loss of potential funds to currently available programs. This loss of funds can also slow the development of newer, more effective programs. Second, agencies can be hindered in providing adequate training of personnel in handling cases of domestic violence given that the criteria of what constitutes abuse is unclear. Third, the response to domestic violence may actually be delayed. The failure to provide complete and accurate data that is consistent within and between agencies may result in the possible duplication of records. Agencies may delay involvement believing that another agency will intercede. With multiple

records, multiple service contacts and multiple agencies involved the likelihood that offenders will "slip through the cracks" increases. Additionally, problems in providing services can be compounded by different philosophies and goals between agencies. For example, welfare services may value an outcome that keeps the family together at all costs while law enforcement agencies goal is to incarcerate offenders. Finally, the screening and identification of domestic violence offenders can also be affected since the diversity of the types of intimate relationships can blur the overall issue of abuse.

Statistics

Multiple reporting agencies, definitions and criteria have led to problems in the identification and subsequent treatment of domestic violence. Using the criteria established by the NIBRS (1997), the agency calculated that 27 percent of all violent crimes occur within a family setting. Seventy-one percent of victims are white, with adult females the predominant victims of family violence. Greenfield, Rand, Craven, Klaus, Perkins, Ringle, Warchol, Matson and Fox (1998) dispute these findings. In a study complied for the U.S. Department of Justice, Greenfield and his associates reported that both male and female blacks experienced higher rates of non-lethal intimate violence than their white counterparts. They found that the average annual rate of intimate violence among whites and blacks were 9.6 and 13.8 per thousand respectively.

One logical question would be: Why is there such a discrepancy between two federal agencies that seemingly have the same goal, to report on incidents of domestic violence? The difference could be accounted for by examining the purpose of each

agency. Some reporting agencies use data complied from the NCVS. The NCVS is a survey of individuals which focuses on non-lethal victimization. It does not gather data on homicides. Other reporting agencies, however, use data from the UCR, provided by the Federal Bureau of Investigation (FBI). The UCR includes the number of homicides known. When domestic violence was categorized into lethal and non-lethal incidents, Greenfield, et al. (1998) found that while blacks experienced higher rates of non-lethal intimate violence, they also experienced a rapid rate drop for intimate murders over the past two decades. Cases of lethal domestic violence decreased an average of six percent for blacks, while white only experienced a decline of two percent over the same period of time.

Despite the inherent problems found in defining and reporting intimate violence between agencies, the Department of Justice has been able to evaluate and monitor the incidence and prevalence of domestic violence. Other important information has been complied by federal agencies. For example, three in four victims of intimate violence are between 20 and 39 years of age. Eighty percent of intimate violence incidents occur in the home, forty percent happen during the weekend. The highest percent of incidents, 30 percent, occurs between 9 p.m. and midnight (Greenfield, et al., 1998). These and other alarming statistics underlie the necessity for a uniform reporting system. If a common pattern could be established, intervention and prevention strategies could be successfully developed and implemented.

Chapter III

Profile of an Offender

During the past few decades offenders of domestic violence have been characterized as needy, fragile individuals who are terrified by their dependency needs and enraged at their spouses or significant others for any signs of autonomy. They are reported to have poor self-esteem, intense jealousy of their partners, and a need to dominate or control their partner (Reade, 1998).

Exactly what are the identifying characteristics of an offender? This question has been asked repeatedly over the past two decades by researchers and policy makers in an attempt to deal with the problem of domestic violence. An answer is important for several reasons. First, the ability to answer key questions may lead to the identification of behavioral patterns and characteristics shared by offenders thus making intervention more likely. If behavioral patterns can be identified agencies might be able to intervene with appropriate strategies before domestic violence erupts. Likewise, agencies might be able to stop the domestic violence that is occurring within a family unit. Second, by identifying behavioral patterns agencies might be able to divide the larger, global population of offenders into identifiable sub-populations (i.e., alcoholics, addicts, etc.), simplifying treatment options and reducing stressors that may lead to domestic violence. Finally, if researchers could find a correlation between domestic violence and certain behavioral patterns, it is possible a comprehensive screening tool could be developed to detect potential offenders.

Type 1 and Type 2 Batterers

Interestingly, a study by Jacobson, et al. (1995) has suggested that offenders

may fall into two types of categories, Type 1 and Type 2 Batterers. They employed tests that measured physiological reactivity of self-reported offenders and found differences in vagal reactions (i.e., heart rate, respiration rate). At certain critical moments of conflict, the Type 1 Batterer's heart rate decreases, while as the Type 2 Batterer's heart rate increases. The best guess is that Type 1 Batterers focus their attention on maximizing the impact of their verbal aggression. Whether or not the reduction of heart rate is voluntary or involuntary it is probably learned and is very functional if the aggression is effective in controlling the behavior of the victim. Heart rate in Type 2 Batterers accelerated as a response to stress. Type 2 offenders may have been overwhelmed by their emotional discomfort. These offenders may resort to battering when withdrawal is not possible.

Correlations based on these differences provided the framework for predicting differences in the type of violence perpetrated by offenders. Type 1 Batterers were more emotionally abusive, more belligerent and contemptuous, more antisocial and drug dependent, and likely to have reported violence outside of the relationship. Type 2 Batterers were more likely to have witnessed unilateral violence (father-to mother or mother-to-father). Their violent behavior was seen as lacking the severity of Type 1 Batterers. These studies have not been replicated, however, and need to be the focus of more research.

Demographic Characteristics

Offenders are a demographically heterogeneous group; however, researchers have noted some characteristics consistent of offenders. Offenders are typically male (Greenfield, et al., 1998; Koss, Ingram & Pepper, 1997; NIBRS, 1997). The

overrepresentation of males is not surprising. Meloy, et al. (1997) point to biological differences as a possible reason, stating that males are more aggressive than females, thus have higher rates of criminality and violent behavior.

Domestic violence also occurs more frequently in low-income households, with intimate violence decreasing as household income levels increase (Greenfield, et al., 1998). There appears to be a slightly higher rate of domestic violence in urban households, as opposed to suburban and rural households (Greenfield, et. al, 1998). The data compiled from Greenfield's report to the Bureau of Justice Statistics (BJS) illustrate the differences in abusive incidents involving female and male victims of domestic violence and supports the general consensus that males are more likely to be the offender in cases of intimate violence.

There is little information regarding the relationship between educational attainment and offenders; much of the information available addresses the education levels of victims. Given that greater earning power and income levels are correlated with higher educational levels, it could be hypothesized that offenders do not typically have high educational levels.

Caution must be used in the interpretation of data provided by agencies. As noted in chapter two, agencies lack uniform reporting systems between and within states. Additionally, the use of demographic characteristics such as income level and education can lead to stereotyping. Agencies may target "suspicious", innocent males while overlooking actual offenders, simply because they do not "meet the criteria". Finally, other social issues, such as unemployment and social class, can confound differences. The fact that domestic violence rates are higher in low-income families

may be due to the stressors surrounding a lack of employment rather than being employed in a low-income job. It should also be noted that none of these factors suggest a causal relationship to intimate violence. Perhaps the greatest value of such demographic data is that it enhances how agencies can identify potential areas of concern and offers new avenues of intervention to explore.

Childhood History

A popular poster of the 70's and 80's, "Abused, Abuser, Abuse", reflects the public's perception of how domestic violence is perpetuated. Von Steen (1997), and Oriel and Fleming (1998) refer to this trend as the "Transmission of Abuse" hypothesis, which states that violence is passed down through generations of abuse and violence. It appears to be derived in part from social learning theory. Other researchers agree with the transmission of violence hypothesis, generally accepting that most offenders were abused as children (Magen, et al., 1995; Reade, 1998). Oriel and Fleming (1998) conducted a survey that questioned 375 men about partner violence. Men who admitted to intimate violence also reported increased alcohol consumption, depression and a history of enduring early abuse in their families of origin. It may be, however, that there is a more powerful predictor of intimate violence. Reid (1998) believes that a history of child abuse is a poor predictor of domestic violence and that a history of having witnessed violence in the home as a child increases the probability of violent behavior. Miller, et al. (1997) agree, pointing to the multigenerational transmission of abuse as a key element in domestic violence.

Children's and adolescent's responses to domestic violence do appear to have far-reaching consequences (Oriel & Fleming, 1998; Magen, et al., 1995). Despite the growing evidence of psychological dysfunction and violent behavior among children witnessing intimate violence, the experiences of adults exposed to domestic violence during childhood has not been widely researched. Von Steen (1997) has labeled adults who witnessed violence as children the "forgotten victims". Her study summarized the psychological effects of witnessing intimate violence in children, adolescents and adults while identifying several responses across these three groups. These responses included, but were not limited to, depression, anxiety, low self-esteem, impaired social competence, school and work related problems, somatic complaints, post-traumatic symptoms, dissociation, impaired interpersonal relationships, anger and aggression.

Perhaps the most important finding in studying the effects of exposure to early domestic violence is an impaired level of interpersonal functioning. Von Steen (1997) characterized the relationships of the adults who had witnessed intimate violence as significant for mistrust, low self-esteem, fear of abandonment and anger, all of which impede establishing and maintaining intimate relationships. These adults tend to employ non-constructive strategies to resolve conflicts in relationships, thus supporting the transmission of violence hypothesis. Von Steen believes that the long-term psychological effects of witnessing intimate violence as a child can be used in identifying at-risk offenders and assist in formulating better therapeutic interventions. For example, clients being seen by clinicians for anger control could be screened for past family-of-origin abuse and possible ongoing, or future, partner violence.

Consequently, the formulation of therapeutic interventions could address more effective strategies in dealing with anger while exploring old issues of fear and abandonment. Oriel and Fleming's (1998) data seems to support the idea that such criteria can be used as a defining characteristic in the identification of potential offenders.

Alcohol and Drug Abuse

The data collected by national agencies indicate that nearly half of all victims of intimate violence report that the offender was drinking or using an illegal drug at the time of the abuse (Greenfield, et al., 1998). These estimates may be conservative. Brookoff, O'Brien, Cook, Thompson, and Williams (1997) evaluated the characteristics of both victims and offenders and found that 92 percent of the offenders questioned reported using alcohol or other drugs on the day of the assault. Despite the differences in these percentages it is clear that alcohol and drug use play a major role in domestic violence.

A study by Meloy, et al. (1997) compared the issuance of mutual and nonmutual protection orders. Their research revealed that alcohol and/or drug use was an important factor in post-issue arrests. Mutual protection orders were operationally defined as orders issued at the same time to both parties. This study looked for variables that would predict the occurrence of a violent, victim-related arrest and a violent, victim-related arrest following the issuance of a protective order. Prior drug and alcohol arrests emerged as a key factor. In situations of non-mutual protection orders, alcohol and drugs dramatically increased the risk of violent, victim-related offenses by a factor of two; that is, a prior history of alcohol and drug arrests

increased the risk of domestic violence in cases of nonmutual protection orders from ten percent to twenty-eight percent.

The report prepared by the NIBRS (1997) was more aggressive in identifying the prevalence of alcohol and/or drug use in incidents of domestic violence. The researchers undertook the daunting task of reporting the involvement of substance abuse in each of the categories of domestic violence outlined in chapter two. Significant differences were found in the composition of overall violent acts and the different categories of domestic violence relative to substance abuse. For example, with respect to family murders, substance abuse was involved more often in cases of domestic murders (22%), than in general cases of murder (17%). One interesting finding involved the category of "other offenses" which included forcible sodomy, sexual assault with an object, forcible fondling, and kidnapping/abduction. This category accounts for four percent of all violent offenses and five percent of domestic violence. The "other offenses" category reported less substance abuse on the part of the offender as compared to other categories. In reviewing the data provided by the NIBRS, alcohol would appear to be involved more frequently in cases of domestic violence than the use of illegal drugs. Bachman and Salzman (1995) support this finding, reporting that nearly 25 percent of all intimate violence involves evidence of offender drinking.

History of Violence

Another factor in profiling offenders that has generated interest among researchers is whether or not they had a history of convictions for violence. Greenfield, et al. (1998) has reported some compelling statistics that supports in part

the use of such criteria in screening for potential intimate violence. Their report offered the following data maintained by the BJS and the FBI:

- Nearly 25 percent of convicted offenders in local jails admitted they had committed intimate violence.
- Nearly 40 percent of convicted offenders in local jails who committed intimate violence had some type of criminal justice status at the time of the offense (i.e., probation, parole, restraining order, etc.).
- Half of all offenders of intimate violence incarcerated in local jails had a history of having been placed under a restraining or protection order.
- Seventy-five percent of local jail inmates convicted of intimate violence had prior convictions, most for violent acts.
- Among state prisoners serving a sentence for intimate violence, two-thirds had a prior conviction history.

Another very interesting factor found in this report was that twenty-one percent of female in State prisons had been convicted of intimate violence as opposed to nearly seven percent of males. This means that women convicted and incarcerated of violent offenses were about three times more likely to have committed intimate violence than men were. An explanation of this conflicting data is possible, however. The discussion in chapter two identified several problems with uniform reporting at the federal level, including variations in defining what constitutes *intimate violence*. It may be that incidents of child abuse were used in compiling the data. If so it would explain the higher proportion of females in prison for intimate violence. An examination of institutional problems by Magen, et al. (1995) points to a perceived

division of responsibility. Women are traditionally viewed as responsible for child abuse and neglect. Despite the fact that there is clear evidence that a significant proportion of males are abusive or neglectful parents, females are often treated as complicit in allowing the abuse or neglect to take place and are held accountable more often. This view is exacerbated when the mother herself is a victim of abuse. Being a victim of abuse is not seen as an excuse for failing to protect one's child; therefore, it may be that women are proportionally convicted in higher numbers than males.

It is apparent that there are double standards. Taken a step further, this sentiment of victim complicity can explain, in part, the apathetic or indifferent attitude Jacobson, et al. (1990) and Magen, et al. (1995) address regarding how domestic violence is viewed. As noted in the first chapter, the case of Nicole Brown Simpson illustrates how victims are viewed sometimes as being at fault. In order to dispel this belief, it is all the more important to identify the characteristics of a victim, and assess what role these characteristics play in cases of domestic violence.

Chapter IV

The Profile of a Victim

Greenfield, et al. (1998) have reported that only 52 percent of women who are victimized by intimate violence report it to law enforcement agencies. Although it is estimated that approximately one in six women will be abused each year, only an annual average of 160,000 victims solicited assistance from appropriate agencies (Hamberger & Ambuel, 1997, Greenfield, et al., 1998). Clearly it is difficult for victims of intimate violence to disclose incidents of abuse and this leads to another important question: Can victims be successfully detected by screening for demographic information or characteristic symptoms? Given that the identification of offenders is complicated due to the lack of definitive profile characteristics, and that there has been substantial research on the costs and consequences of intimate violence over the past two decades, it would be reasonable to examine current data in order to discover the symptoms and patterns common to victims. The identification of common characteristics that would facilitate the detection and subsequent intervention of intimate violence is beneficial for several reasons. First, such an approach would lead to improve screening protocols. Second, the identification of common characteristics would serve to promote a uniform reporting system. As screening tools are modified the information could be shared within and between agencies. Finally, since intimate violence is underreported, the proper identification of victims would lead to an increase in funds to programs and service agencies designed to assist individuals in crisis.

Demographic Characteristics

As was the case with offenders, victims come from a demographically heterogeneous group. They drawn from all ages, social classes, income levels, ethnic groups, and relationship status (i.e. spouse, ex-spouse, significant other, etc.). Like offenders, victims share some consistent characteristics. Women are approximately five to eight times more likely to be victims of intimate violence (Greenfield, et al., 1998; Koss, et al., 1997; McCloskey & Fraser, 1997). Women with an annual income under $10,000 were more likely to report having experienced intimate violence than women with incomes over $10,000 (Bachman & Saltzman, 1995). In general, victims were more likely to reside in urban locations (Bachman & Saltzman, 1995).

Although there were no significantly statistical differences in overall intimate violence rates between white, blacks, and Hispanics, blacks experienced higher rates of non-lethal intimate violence while whites experienced higher rates of intimate murder (Bachman & Saltzman, 1995; Greenfield, et al., 1998.). Compared to all other age groups, young adults (ages 19-29) were more likely to experience intimate violence (Bachman & Saltzman, 1995; Greenfield, et al., 1998; Koss, et al., 1997). Victimization rates for women separated from their husbands was about three times higher than those of divorced women and twenty-five times higher than those of married women. Caution must be exercised, however, in the interpretation of the data. As in the case of age and marital status, there may be inherent reporting problems. For example, the marital status of a victim may reflect the status at the time of the data collection as opposed to their status at the time of the victimization.

The Special Case of Battered Men

The literature overwhelmingly depicts women as victims of intimate violence. There is a small body of literature, however, that has investigated males as victims of abuse. The rates of reported intimate violence against males is still well below that of females. Greenfield, et al. (1998) report that the male rates of non-lethal intimate violence is about one-fifth of the rate for women and that only six percent of all male murders were committed by an intimate. They found no difference in the rate of non-lethal intimate violence between white and black males and, as in the case of females, found that incidents of violence occurred most frequently at home between the hours of 6:00 p.m. and midnight.

Cook (1997) has argued that women strike males first at about the same rate as males who strike women first. Additionally, he states that only half of all incidents of intimate violence are one-sided. Mutual combat makes up the other half of all such incidents. These rates are not in agreement with the data provided by federal reporting agencies. Cook clarifies this discrepancy by explaining that male victims are rarely taken seriously given that agencies and healthcare providers are reluctant to view females as abusive. Male victims are often ridiculed and this may lead to isolation. Consequently, males may be more likely to rationalize, deny or disguise incidents of domestic violence.

Childhood History

Von Steen's (1997) study on witnessing histories not only addressed the impact of witnessing intimate violence as a child on adult offenders, but also addressed its impact on adult victims. As discussed previously, children who witness

intimate violence are more likely to display anger and aggression and are also more likely to have problems in establishing interpersonal relationships. Von Steen, also noted that some subjects reported a tendency to be passive in relationships in order to assure their psychological safety.

McCauley, Keen, Kolodner, Dill, Schroeder, DeChant, Rayden, Derogeits and Bass (1997) surveyed 1,931 women to identify current physical and psychological problems and compared those women, who had existing incidents of violence, with women who had previous childhood abuse. They found that half of the women who reported being abused as adults were also abused as children. Additionally, women who experienced child abuse, but not intimate violence, had levels of physical and psychological symptoms as severe as those experiencing current intimate violence. Subjects who had a history of childhood abuse and either past or current intimate violence had the highest rates of physical and/or psychological symptoms. Both Von Steen's and McCauley, et al's. studies are helpful in understanding the cycle of abuse. Victims who stood helplessly as children witnessing, or experiencing, intimate violence run a higher risk of passivity in violent relationships. The subsequent depression and low self-esteem can result in a feeling of hopelessness and detachment from others, extracting a great psychological cost from victims.

Psychological Symptoms and Characteristics.

Because intimate violence can produce an array of psychological effects that are less common in the general population, it would be logical to identify the behavioral indicators consistent in victims in order to facilitate the detection of possible domestic violence. Victims of domestic violence typically experience

prolonged stress that can result in a number of identifiable mental health problems (Miller, Veltkamp & Kraus, 1997; Briere & Elliot, 1997). Responses to intimate violence include, but are not limited to: depression, anxiety, somatic complaints, poor concentration, substance abuse, and suicide (Miller, et al., 1997; Briere & Elliot, 1997). Measuring individual symptoms, however, can hamper the identification of victims of intimate violence. Such procedures produce an incomplete picture, and in some cases, suggest that no abusive situation exist simply because of the absence of "key" symptoms that agencies typically regard as red flags. It is generally accepted that victims are reluctant to report intimate violence (Briere & Elliot, 1997; Hamberger & Ambuel, 1997). While strategies such as denial and passivity are superficially adaptive, they interfere with accurate evaluations.

Given the need to identify the many different responses to domestic violence, researchers have begun focusing on the presence of Post-traumatic Stress Disorder (PTSD) as a means of evaluating victimization. PTSD includes a variety of symptoms, most of which have been identified as responses to intimate violence. The Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV) (1994), outlines the diagnostic features of PTSD as:

A. The person has been exposed to a traumatic event in which the person either experienced, or witnessed, an event that involved actual or threatened death, serious injury, physical integrity of self or others, and the person's response involved intense fear, helplessness, or horror.

B. The traumatic event is persistently re-experienced through recurrent and intrusive distressing recollections of the event, either through dreams or

feeling as if the traumatic event were recurring, intense psychological distress at exposure to cues that symbolize or resemble the event, or through physical reactions to exposure to such cues.

C. The person persistently avoids cues and experiences a numbing of responses, as indicated by at least three of the following: 1) efforts to avoid thoughts, feelings, or conversations associated with the trauma, 2) efforts to avoid actives, places, or people that arouse recollections of the trauma, 3) inability to recall important aspect of the trauma, 4) markedly diminished interest or participation of significant actives, 5) feelings of detachment or estrangement of others, 6) restricted range of affect (e.g., unable to have loving feelings), and 7) sense of foreshortened future (e.g., does not expect to have a career, marriage, children, or normal life span).

Clearly, screening for a diagnosis of PSTD is useful in evaluating and detecting domestic violence since many of the symptoms reported by victims of intimate violence are found in PTSD. The list of symptoms and criteria provided by the DSM-IV (1994) include:

1. difficulty falling or staying asleep.
2. irritability or outburst of anger.
3. difficulty concentrating.
4. hypervigilence.
5. exaggerated startled response.

Associated features of PTSD include: Major Depressive Disorder, Panic Disorder, Social Phobia, Somatization Disorder, Obsessive-Compulsive Disorder, and Substance-Related Disorders.

Victims of domestic violence experience a more complex picture of psychopathology. Because many victims of intimate violence suffer from PTSD symptoms, some researchers have begun using psychological assessment tools associated with PTSD to identify victimization. Briere and Elliot (1997) have had success in using victimization-relevant instruments. They found that one protocol, the Post-traumatic Stress Diagnostic Scale (PDS), was a good predictor of PTSD in the general population and that it also demonstrated positive results when administered to sample of 376 women with histories of intimate violence. Enns, et al. (1997) also conceptualized the symptoms of intimate violence as a collection of posttraumatic reactions. Because intimate violence may not be the stated reason for seeking treatment, detection becomes all the more important. Enns, and her associates, found that as many as 89 percent of women who are victims of intimate violence meet the criteria of PTSD.

Women who present with symptoms positive for PTSD should undergo further screening for signs of potential domestic violence. There are still several unanswered questions that need to be addressed. Do both victims and offenders perpetuate the cycle of abuse common in domestic violence? Who bears the responsibility for ending the cycle of abuse? Are agencies and healthcare providers hampered by a lack of clearly defined boundaries typical of at-risk families? Clearly an in-depth view of how victims and offenders interact is necessary.

Chapter V

Relationships:

Ground Zero for Offenders and Victims.

Jacobson, et al. (1996) have suggested that intimate violence tends to increase in severity and frequency over time. Why do couples stay together? What factors are involved in the perpetuation of domestic violence? Can the identification of these factors aid in decreasing the incidence of domestic violence? Answers to these and other questions could be valuable in shedding light on what sustains the cycle of violence seen in intimate relationships.

In assessing at-risk families, Miller, et al. (1997) created a composite of constellation factors they termed the *Victim-Victimization Spectrum*. When these factors are viewed as ingredients by appropriate agencies and healthcare providers, they become powerful predictors of intimate violence.

Victims	Victimizer
Isolation from others	Likely history multigenerational abusive behavior.
Feelings of helplessness	Learned violent behavior as a way of coping.
Vulnerable	Unstable emotions.
Maintains secrecy	Low self-esteem.
Indecision/uncertainty	Impulsive behavior patterns.
Poor self-confidence	Impaired judgment.
Low self-esteem	Narcissistic qualities.
Fear, anxiety, depression	Alcohol or substance abuse
Impaired ability to judge trustworthiness in others	Control and power seeking over victims.
Accommodates to the victimizer	Lacking or limited communication skills.

Miller and his associates identified several other at-risk factors found in families embroiled in domestic violence. These factors include:

1. One extremely passive, dependent parent/partner who is reluctant to assert his/her self for fear of destroying the family unit.
2. Lack of social contacts outside of the family.
3. Financial problems.
4. Frequent moves
5. Isolation from friends and family support systems.

These findings are not surprising given the body of research available on the profiles of victims and offenders, yet agencies and health care professionals still admit there are problems in identifying intimate violence. Miller, and his associates, suggest that agencies may view specific behaviors as the problem, rather than the symptom of the greater problem of domestic violence. This is due, in part, to the silence surrounding intimate violence.

Family Silence Surrounding Domestic Violence

Researchers have recognized that if the victim is not in crisis then domestic violence may not be the stated reason for seeking assistance. Victims may hope to maintain their silence about abusive behaviors (Enns, et al., 1997; Johnson, 1997; Koss, et al., 1997). Several psychological and sociocultural forces can influence victims to remain silent (McCloskey & Fraser, 1997). As mentioned previously, a lack of universal definitions and reporting systems can affect the response of law enforcement agencies and the legal system, rendering victims helpless in a sea of administrative red tape. The problems found within and between agencies can create a lack of funds, which may affect the availability of shelters and advocacy group. Other factors influencing the silence of victims include a loss of potential income

(either the offender's due to incarceration or the victim's due to relocation), brainwashing (you are at fault for this), and religious or cultural beliefs (it is your duty). Bradshaw, (1988) illustrated how these forces can combine to create the condition of *learned helplessness*, a theory developed by Martin Seligman. Bradshaw explains the paradoxical bonding of victims to their offender by pointing out that victims typically come to believe that their situation is hopeless. Bounding with an offender not only decreases feeling of helplessness and hopelessness, but also serves as survival tool. Reporting intimate violence is not only dangerous in the eyes of the victim, but also useless.

In order to give symptoms a voice of their own in communicating the violence that is taking place, Miller, et al. (1997) have divided indicators of family violence into two categories: Physical Indicators and Behavioral Indicators.

Physical Indicators	Behavioral Indicators
Unexplained bruises , welts or burns	Emotional constriction and blunted affect
Rope burns on wrists, legs, neck or torso	Fear of contact with others
Unexplained fractures to skull, nose facial structure, arms or legs	Extreme withdrawal or aggressiveness
Sprains	Extreme rejection or dependency
Unexplained cuts or abrasions to mouth, gums, eyes or other areas	Apprehension or fearfulness
Wounds in various stages of healing	Reluctance to go home
Difficulty in walking or sitting	Depression, phobias or anxiety
Torn or bloody clothing	Sleep disturbances
Poor hygiene or inappropriate dress	Inhibited behavior
Unattended physical problems or medical needs	Obsessive-Compulsive behavior
	Poor interpersonal skills
	Anorexia
	Constant fatigue
	Children experiencing delinquency problems

Johnson's (1997) work views domestic violence as a pattern of behavior that unfolds in three stages. Stage 1 is characteristic of the stress and tension that precede

outburst of violence and exemplify minor incidents of battering such as intimidation or pushing. Stage 1 behavior may continue for long periods of time and victims typically use denial as a coping strategy. Stage 2 occurs when the offender explodes and physical abuse occurs. The offender's behavior is made all the more dangerous because it lacks predictability and control. During Stage 2 the victim usually seeks shelter or involves law enforcement agencies. In addition to using denial as a coping strategy, victims may be in shock, keeping them in a victim role and unable to identify faulty belief systems and adopt healthy alternatives. Stage 3 is the honeymoon stage. Offenders are typically remorseful and promise to change their behavior. Once again, the victim responds with denial and the cycle of victimization repeats itself. Johnson provides a simplified list in assessing the potential for domestic violence, which include: obvious injuries at various stages of healing, erroneous explanation for their injuries, repeated bruises and other injuries, chronic depression, insomnia, nightmares, and anxiety fear and hypervigilance, reluctance to offer information, vague somatic complaints, overdependence on spouse, complaints of marital problems, history of alcohol/substance abuse of the offender, and personal decision making by the spouse as to what the victim may wear, who they may see, and what they may do.

Although not as comprehensive as other lists, Johnson provides a practical guide that could easily be used by health care practitioners, clinicians, social workers, and law enforcement agencies. As discussed in the previous chapters, one inherent problem with addressing domestic violence has been defining violence within and

between agencies. Some of the criteria are lengthy and cumbersome. The adoption of simpler assessment tools could be beneficial in addressing this problem.

The Myths Behind Domestic Violence

There is ample research and documentation on how agencies miss key symptoms of domestic violence and why victims remain silent. Cases such as that of Nicole Brown Simpson, however, blur the important issues. The media, and public, seemed to ask, "What did she stay if the abuse was so bad?" instead of, "Why was her case overlooked?" Gortner, et al. (1997) believe that many of our perceptions on domestic violence are shaped by clinical lore. Specifically, Gortner, and his associates, believe that domestic violence is neglected in clinical settings because of poor therapeutic guidance. They contend that despite the abundance of literature on spousal abuse, much of the information available on the course and treatment of domestic violence is based on myths (i.e., "battered women stay," or "leaving stops the abuse").

Gortner, et al. (1997) conducted a longitudinal study designed to examine three pieces of clinical lore: (1) Victims of abuse are unlikely to leave their husbands, (2) Victims of domestic violence are passive and self-defeating, and (3) Physical violence is the most important factor in women's decision to leave. Sixty couples, who participated in a study of domestic violence two years previously, were selected as subjects and administered the Locke and Wallace Marital Adjustment Scale and the Conflict Tactics Scale to assess levels of domestic violence. Fifty percent of the violence reported by the couples was bi-directional. Six couples did not complete the

study and of the fifty-six couples available, thirty-four were still together (61%) and twenty-two (39%) were either divorced or separated.

In addressing the myth that victims of domestic violence are unlikely to leave their abusers, Gortner, and his associates, found that the relationship of violent couples was unstable and that victims of abuse were likely to leave their abusive partners within two years. Women had initiated the separation in every instance and none of these women returned during the course of the study. Over 50 percent of the victims who separated eventually divorced. Given that the prevalence of divorce for the general population is approximately 50 percent, Gortner, et al. asserted that most victims do leave offenders and that once they leave they do not return.

Gortner, and his associates, also found evidence that victims of domestic violence are not passive or self-defeating. The victims who separated or divorced in this study reportedly were more likely to defend themselves against offenders and were more dissatisfied with the relationship. Offenders reported that the victims were more likely to be emotionally abusive themselves. Care must be taken in interpreting the data, however, given the offenders capacity for minimization, denial, and distortion. It may be that what offenders claim is aggressive behavior by victims is actually assertive behavior.

Interestingly, while offenders in this study reported that victims were more likely to be emotionally abusive, Gortner, et al. found that the strongest predictor of victims leaving offenders was that the offenders were emotional abusive. This dispels the myth that physical violence is the most important factor in women's decision to leave abusive spouses. Marital satisfaction was strongly negatively

correlated with emotional abuse ($r = -.62$) but not with physical abuse ($r = -.21$), suggesting that emotional abuse may be a more important factor in separation and/or divorce.

The data is compelling, nevertheless, care must be take in its interpretation. For example, if the women in this study were more likely to leave abusive husbands, then why did the findings show that the most important factor in separation and/or divorce was emotional abuse? Gortner, et al. explain that emotional abuse is powerful precisely because it has been associated in the past with physical abuse; however, this explanation fails to illustrate why it would be more effective at driving women out of their relationships. Perhaps the most important value of this study is in it's strategical use by agencies and clinicians working with families at risk. The ambiguity encountered by victims of domestic violence is not limited to the problems in defining abuse within and between agencies, but also affects treatment planning and prognostic evaluations by clinicians and therapist.

Chapter VI

Conclusions

Intervention in cases of domestic violence has not been as successful as many agencies and professionals had hoped. Many factors play a role in the undertreatment of domestic violence. In reviewing the available literature, several problems have emerged. First, efforts towards eradicating domestic violence have been delayed by a lack of a national definition of what constitutes domestic violence and which relationships should be included. Second, multiple reporting agencies may actually impede the fight against domestic violence. Agencies may have different goals that may, in some cases, work against each other, placing the victim in a quagmire of bureaucracy and red tape, and leaving them feeling even more helpless. Third, cultural and racial attitudes regarding intimate relationships and gender roles continue to foster an indifferent attitude towards domestic violence, facilitating it transmission from one generation to the next. Fourth, the psychopathology accompanying intimate violence is rarely viewed as a constellation of symptoms. Clinicians, health care providers, social workers, and law enforcement agencies typically focus on individual symptoms (i.e., depression, injury, loss of income, removal of offenders, etc.) and miss the bigger picture of the family-at-risk, and the impaired level of interpersonal functioning that plague these relationships. Fifth, patient stigmatization and the lack of diagnostic skills among providers play a major role in the level of care victims of domestic violence receive. Finally, the clinical myths regarding domestic violence can lead professionals to speculate about effective interventions. For example, because it is widely believed that victims are unlikely to leave their abusers, agencies

may be more concerned in encouraging victims to fight back and this could place them at an increased risk for abuse. Additionally, clinicians may not acknowledge that the victim's reluctance to seek assistance is often based on a realistic appraisal of their life situation, choosing to focus on fixing the victim instead of assisting family members in finding a solution. These and other problems serve to complicate the primary goal of advocacy groups - the screening and identification of family violence and the subsequent treatment of both the victim and offender.

Alternative avenues are necessary but have been slow to develop. There have been a few innovative approaches to this growing problem. McCloskey and Fraser (1997) have developed an approach using a feminist model. Using Mental Research Institute (MRI) brief therapy as a platform, McCloskey and Fraser modified the MRI in order to take a more feminist view. This study supports the work of Gortner, et al. (1997), which observed that advocates of domestic violence reform, and other professionals, typically fit the woman to the services instead of fitting the services to the woman. They hypothesize this occurs because of widely held assumptions over the beliefs of domestic violence (i.e., women who stay really don't want help). Services and options are typically available for women who leave, and not for women who chose to stay. The implications are that women are categorized into two groups, *ready to leave* and *not ready to leave*, with victims who fall into the latter group seen as impaired, unenlightened or weak. It is difficult for victims of domestic violence to overcome these negative beliefs. As mentioned previously, leaving an abusive situation may be that last option for a victim. Women may refuse to view themselves as victims due to cultural and/or social beliefs. Additionally, the victim's choices may

be based on a realistic appraisal of the situation. Consequently, the silent categorization of victims into groups comes dangerously close to placing the blame of domestic violence on their shoulders, revictimizing women and making them more reluctant to disclose abuse. The feminist MRI approach focuses on eliciting the victim's point of view on the problem after rapport has been established. Four key questions are asked: (1) Why now?, (2) How do you see the problem?, (3) What have others said about the problem?, and (4) What has been done about this problem in the past? These questions convey that the professional takes this problem seriously and provides a collaborative problem-solving atmosphere whereby the victim engages in brainstorming activities to identify goals and possible actions.

The second approach, suggested by Heron, Twomey, Jacobs and Kaslow (1997) proposes that interventions should be culturally sensitive. They assert that existing services do not adequately detect, prevent, and treat domestic violence in part because of the unique socioeconomic and cultural factors that forms a victim's evaluation of, and response to, abusive situations and its associated stressors. Heron, and her associates, focused on African-American women as a means of addressing problems encountered by minorities. Three key concepts are combined to form a proposed integrated theoretical model: (1) the appraisal of stressors, (2) coping strategies, and (3) stages of change. Each of these concepts is designed to be culturally sensitive. For example, Heron, et al. emphasize that abuse originates in, and is perpetuated by, inequality due to traditional gender roles. African-American women are victims of both traditional and cultural views. As such, they report that the decisions made by African-American women who are in abusive situations are

influenced by such cultural factors as racial preservation, loyalty to one's family, and a sense of community, as well as being subjected to the traditional factors previously discussed. In assessing stressors unique to minorities, clinicians can come to understand how they are interwoven and begin to assess other resources available. Efforts should focus on mobilizing new coping strategies in order to facilitate change. Thus, a cultural intervention model emphasizes the importance of understanding domestic violence in the context of the victim's own beliefs and commitments, allowing access to necessary resources given the victim's disenfranchised position within the community and the family unit.

These are but two of a handful of new approaches on the treatment horizon. Unfortunately, these and other models address only one dimension of treating domestic violence, namely, therapeutic intervention designed to bring about the metamorphosis of the victim. Additionally, these models do not include detection, an equally important issue in domestic violence cases. Clearly, a broader approach is necessary given that one-dimensional programs, meaning those that focus on intervention only, have been unsuccessful in addressing domestic violence in the past 20 years. It would appear then that a more practical approach in the prevention of domestic violence would be to divide domestic violence into two major tasks – detection and intervention.

Detection:

The American Medical Association (AMA) has encourage physicians to play a major role in the detection of domestic violence, since patients usually look up to their physicians as advisors, educators, and confidants, (Marwick,1998; AMA, 1995).

Caralis and Musialowski (1997) reported that victims believe doctors should routinely screen for incidents of domestic violence. In a study of 406 adults, 40 percent of which reported past physical or emotional abuse, subjects were surveyed about their personal experiences with domestic violence. Eighty-five percent of the total number of subjects believed that routine screening for domestic violence should be incorporated into all physicians' medical practice. Despite the high percentage of women who expressed what they felt should happen during routine visits to their doctors, only 49 percent reported that their physicians actually inquired about possible domestic violence. Twenty-three percent of the women who reported experiencing domestic violence also reported their doctor never questioning them about possible abuse.

More current research appears to confirm that patients want their physicians to ask about family conflict. Burge (1999) conducted a study that collected survey data on partner violence from 220 subjects (142 females and 78 males) located at six family practice centers. Nine percent of the women surveyed reported being stuck of hurt by their partners in the past 12 months. Thirty-two percent reported they had been abused by their partners in their lifetime. Eight percent of males reported having hit or abused their partner in the past year, with fifteen percent admitting to violent behavior toward an intimate in their lifetime. Although all of the subjects who reported a history of victimization or abusive behavior (72) believed that physicians should ask about family conflicts, only 66 of the 220 subject reported that their doctors engaged in a line of questioning to detect domestic violence. Only seven percent felt that physicians should not get involved.

These and other data suggest that victims want physicians to provide meaningful intervention with regards to domestic violence. The expectation is that doctors recognize and refer patients at risk for victimization, as well as potential offenders, by asking routine questions about violence in the home, detecting the physical signs of abuse, and recognizing the vegetative signs of depression and post-traumatic stress disorder. Physicians are also expected to educate patients about domestic violence. Many physicians and health care providers, however, still view involvement as problematic and ineffective. Rodriguez, Craig, Mooney and Bauer (1998) conducted a study that investigated the attitudes and experiences of physicians and patients. This study was the result of a 1994 California statute mandating health care providers report all cases of actual and suspected domestic violence. Physicians and health care providers identified several barriers that affected the ability to address domestic violence in a primary care setting, which included: 1) confidentiality, 2) time constraints, 3) a lack of training or protocols, 4) discomfort with the subject material, fear of offending patients, and 5) feeling of powerlessness. Patients typically cited embarrassment, fear of retaliation, low self-esteem, and family loyalty as barriers to open dialog with their physicians.

Rodriguez, et al's. (1998) study is unique in that it found a number of unintentional consequences to mandatory reporting. Patients in this study felt that mandatory reporting compromised their confidentiality and autonomy, and that it only served to deter them from seeking medical services, jeopardizing their safety. Subjects reported that they preferred their physicians to keep their confidentiality and allow them the final decision about when to involve law enforcement agencies.

Physicians, and other health care professionals, shared these views. In another study, Rodriguez, McLaughlin, Bauer, Paredes and Grumbach (1999) surveyed primary care providers and emergency room physicians subjected to California's new mandate, and 59 percent of these subjects felt they might not comply with mandatory reporting laws if the patient objected. Rodriguez, and his associates, also found that the rate of compliance was lower for primary care providers than emergency room personnel.

In both his 1998 and 1999 studies, Rodriguez, and his associates, provide ample data that show that both physicians and victims have clearly defined views of the type and level of involvement needed from the medical community. Health care professionals are in a unique position to detect and assist potential or actual victims of domestic violence, and typically such intervention is welcomed. Both patients and health care professionals, however, agree that lawmakers' response with mandatory legislation crosses the line of helpful to hurtful. It is for this reason that a comprehensive, multidisciplinary approach is necessary.

The Need for a Comprehensive Approach.

Of greatest interest has been the suggestion of a multidisciplinary approach. The characteristics and psychopathology of families embroiled in domestic violence can be understood from several different perspectives. Despite the various agencies available to address domestic violence, victims can, and often do, maintain an outward appearance of normalcy and adjustment. For this reason it is important for service providers to understand that domestic violence presents a broad spectrum of symptoms. A multidisciplinary approach recognizes that indicators of abuse can be

biomedical (bruises, scars, etc.), psychological (anxiety, depression, etc.) or sociological (history of arrest, cultural values, etc.), and therefore necessitate multidimensional detection and interventions. As noted in the introduction, domestic violence is an issue of gargantuan proportion. In addition to the psychological, biomedical, and sociological considerations that serve as both source and the symptoms of domestic violence, there is a lack of coordination between and within agencies.

Multidisciplinary approaches are not new ideas. Magen, et al. (1995) reviewed a protocol implemented by New York City's Child Welfare Administration that provided special training to caseworkers, supervisors, and administrators. Although some client services improved, there were no significant changes in domestic violence rates and many victims continued to fall through the cracks.

Although other programs have emerged across the country in the past two decades, it appears that few have been successful in coordinating efforts with all of the agencies involved in cases of domestic violence. For example, Violence Against Women, a domestic violence unit within the U.S. Department of Justice, established a grant program aptly named STOP in 1995 (Travis, 1995). Established to address the growing problem of intimate violence, STOP funded grass root efforts to coordinate services to domestic violence victims. Grantees were required to devote a third of awarded funds to the prosecution of offenders. Another third was earmarked for the allocation of services such as community safe houses. Many communities took advantage of federal STOP grants and established a domestic violence unit within their judicial system, however, the focus of these grant programs has been equivalent

to community policing. While community policing has been successful in lowering the crime rate in communities nationwide, the needs of the victim are often subjugated to the needs of the community. These grants, which were for an average of five years, are only entering their fourth year of funding, therefore, much of the data has not been made available. The statistics available from the Department of Justice and other studies, however, paint another picture. STOP programs do not appear to have made a significant difference in the detection of domestic violence. STOP personnel typically become involved with families who are referred by law enforcement agencies after an altercation and not before. As noted earlier, victims may be forced to press charges against offenders before they are prepared to deal with the psychological trauma and financial burden that accompanies such action.

A Gatekeeper Program: New Directions for the 21st Century.

Given the available data and research, this study proposes that a comprehensive program that utilizes both federal and state agencies is possible. Simply outlined, a Gatekeeper program would train key personnel in existing agencies and coordinates all activities at the federal level. Such a program could be both cost-effective and efficient. Because the Department of Justice has a domestic violence unit in place, coordination of services would begin within the Violence Against Women program. There are several advantages in using Violence Against Women as the parent agency. First, funding for this program has already been allocated. Second, personnel within this program have already been trained on issues of domestic violence. Finally, its association with the Department of Justice would allow for the adoption of national definitions (i.e., expanding domestic violence to

include intimate violence in all states) and facilitate access to, and the delivery of, important statistical information. The data gathered would not be subjected to the variations found in the sampling done by the NCVS and the UCR, reducing the margin of error.

The Violence Against Women unit would require minor changes in its structure. Modest changes would need to occur in other federal agencies as well. Ancillary duties could be assigned to key personnel within the Department of Human Services covering social services, law enforcement services, and medical services at the federal level. Liaisons would report directly to the parent Gatekeeper agency while coordinating services at the state level using federal guidelines. Each state would then appoint a liaison responsible for comprehensive services (i.e., state social services, law enforcement and medical services). State liaisons would responsible for establishing a Community Gatekeeper program. The key line of defense in domestic violence would then become a Community Gatekeeper program geared to: 1) training key community health care providers and other appropriate personnel in the detection of intimate violence, 2) coordinating intervention services with appropriate agencies, and 3) reporting all incidents of intimate violence to the state liaison.

Currently, millions of federal dollars are available to fund domestic violence programs, yet some programs have proved ineffective given the high rates of domestic violence (NIBRS, 1997). Additionally, some areas have not taken advantage of grant money because they lack the personnel able to write successful grants. The same federal money available for grant programs could be channeled into establishing programs that provide uniform services within and between agencies and

states. Federal dollars could also be used for additional research. It is apparent that further research is needed to investigate interactions between intimates, therapeutic interventions and the efficient utilization of grant dollars. Longitudinal studies could be utilized in investigating the relationship between therapy, the decrease in domestic violence and marital status, to understand what role, if any, therapy plays. Future research should include such information to provide a more complete picture of what processes victims use to get out of abusive relationships. Other areas of investigation should focus on matching offenders to specific psychotherapies. If psychotherapy is to be successful in the treatment of domestic violence, it will have to be integrated with a community-wide response so that there is coordination between therapists, law enforcement agencies, judicial agencies, and other advocates. Finally, research needs to focus on developing streamlined reporting strategies. By developing standardized reporting schemes, agencies can obtain a more accurate picture of the scope of domestic violence and more effectively focus their time, and energy, in the eradication of abuse.

Appendix 1

Acronyms

AMA	American Medical Association
BJS	Bureau of Justice Statistics
FBI	Federal Bureau of Investigation
NCVS	National Crime Victimization Survey
NIBRS	National Incident-Based Reporting System
NIJ	National Institute of Justice
PTSD	Post-traumatic Stress Disorder
PDS	Post-traumatic Stress Disorder Scale
UCR	Uniform Crime Reports

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