THE MELISSA INSTITUTE HANDOUT FOR THE EIGHTH ANNUAL CONFERENCE FAMILY VIOLENCE: INTERVENTION AND PREVENTION STRATEGIES IN A DIVERSE SOCIETY

FAMILY VIOLENCE: INCIDENCE, ASSESSMENT AND INTERVENTIONS

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TABLE OF CONTENTS

WHAT IS THE INCIDENCE OF DOMESTIC VIOLENCE OR INTIMATE PARTNER VIOLENCE (IPV)?

(Information gleaned from Greenfeld et al., 1998; Koss et al., 1994; Logan et al., 2002; Meichenbaum & Keeley, 2004; Novello, 1992; O'Leary et al., 2000; Pearse, 1994; Schumacher et al., 2001; Slep & Heyman, 2001; Slep & O'Leary, 2001; Straus & Gelles, 1990; Tjaden & Thoennes, 2000; Wathen & MacMillan, 2003)

Domestic or Intimate Partner Violence (IPV)

- In the U.S., an estimated 2 million women annually experience domestic violence from intimate partners. 50% of them have children less than 12 years of age.

- Violence surveys generally place lifetime prevalence of interpersonal violence (IPV) against women at between 20% and 30% and annual prevalence at between approximately 2% and 12%. Men report a lifetime incidence of IVP of 7.5%.

- Partner abuse occurs in both homosexual and heterosexual relationships.

- In the U.S., a woman is battered by her partner every 15 seconds; a woman is raped every 90 seconds.

- Violence against women happens primarily in relationships with an intimate partner (64%) versus 16% in men. Women are significantly more likely to be injured during an assault.

- Among pregnant women in developed countries, the rate of IPV is from 4% to 8%. Women abused during pregnancy are more likely to have pregnancy complications and to give birth to low-birth-weight infants and have a higher than expected level of birth defects. They also delay entry into prenatal care. Women with unintended pregnancy are most vulnerable to abuse.

- It has been estimated that hospital emergency department personnel in the U.S. treated 1.4 million people for injuries from confirmed or suspected intimate violence and about half of female victims of intimate violence were injured.

- Over a 2-year period, half of all women who were victims of an intimate partner homicide had been in the emergency room at least once before their death. Approximately 1/3 of all murders of American women are committed by intimate partners, compared to only 4% of men.

- In one survey, 92% of women who were physically abused by a partner did not discuss these incidents with their doctors (Pearse, 1994). Studies show that the medical community identifies only between 2% and 5% on intimate violence victims. (See Meichenbaum & Keeley, 2004)

- The major barriers offered by physicians for assessing victimization of domestic violence include: lack of adequate training; lack of knowledge regarding prevalence; skepticism about treatment effectiveness; uncertainty about appropriate referrals; patient resistance; physician discomfort with the issues; time constraints; fear of losing patients; financial constraints and fear of safety.

- Brief nurse and physician interventions, or both, have been found to make a difference in the education and referrals for women in violent relationships.

- Men screened for IPV have reported similar rates of partner violence as women. But in many (but not all) instances, men disclosing being abused were abusers as well.

- Dating violence literature revealed that the rates of intimate violence ranged from 9% to 69% among young dating couples. Some 10% to 30% of teens experience violence while dating and surveys of college students indicate that up to 35% report violence during dating.

- Such violence is not limited to the young. 1 out of 20 seniors (65+) are victims of family violence.

In addition to these statistics for the U.S., consider the recent finding offered by a report commissioned by Amnesty International (2004) "It is in our hands: Stop violence against women." (Also see Watts and Zimmerman (2002) for the discussion of the global scope and magnitude of violence against women.)

- As many as 1 billion women worldwide have been beaten, forced to have sex or otherwise abused.

- 1 in every 5 women in the world have been physically or sexually abused at some point.

- Each year, 2 million girls between the ages of 5 and 15 are forced into prostitution.

WHAT IS THE IMPACT OF IPV ON VICTIMS?

(See Meichenbaum, 1997; Wathen & MacMillan, 2003).

Women who experience IPV are at increased risk of physical injury, death and a range of long-term negative health consequences including physical, emotional and social problems. IPV is associated with depression, suicidality, anxiety, PTSD, eating and sleep disorders, substance abuse and personality disorders. The most common location for injury among female IPV victims are the face, neck, upper torso, breast and abdomen. They may experience recurring central nervous system symptoms of headaches, back pain, fainting and seizures. Psychologically, they may evidence chronic fear, posttraumatic stress disorder symptoms, and medically, they may have gastrointestinal disorders, high blood pressure, cardiac and gynecological problems.

Partner abuse has been characterized as a "state of siege" in which discrete battering episodes occur as intermittent events within a cycle of violence. One-third of men who assault women do so in subsequent years. Physical violence perpetrated by the partner is usually accompanied by intimidation, threats, insults, emotional, psychological and sexual abuse and controlling and coercive tactics. As a result victims, may internalize ("take on the voice of the perpetrator") and engage in self-censuring behaviors, altering what they say and do. This not only affects victims, but also their children.

WHAT IS THE INCIDENCE OF CHILDREN EXPOSED TO IPV?

- Estimates range from 3.3. million to 10 million children in the U.S. witness assaults against their mothers annually.
- In 60% of homicides among children 0 – 9 years, the perpetrator was the parent of the child.
- If not a direct victim, children often witness violence. For example, in California, it is estimated that 10% to 20% of all homicides are witnessed by children.
- Locally in the Miami-Dade County, Schaecter (2003) reported that 15% of 2002 homicides were by intimate partners. Moreover, half of the firearm deaths of children under the age of 10 resulted from IPV directed at the mother.

HOW OFTEN DOES IPV AND CHILD MALTREATMENT CO-OCCUR?

- Children who are from homes of domestic violence are 15 times more likely to be maltreated than those children from nonviolent homes.

- Partner and child physical abuse reliably **co-occur in families in 6%** of all households in the U.S. This estimate increases to 40% in homes where there is evidence of physical abuse. An estimated 37-63% of exposed children are also abused and/or neglected. **Thus, one form of family violence significantly increases the risk of another form of violence**. ***(O'Leary et al., 2000)***

- For husbands, the risk of child abuse escalates from 5% with a single act of partner aggression in a year to nearly 100% when the incidence of partner aggression occurs once a week.

- 2 million cases of child maltreatment (physical abuse and neglect) occur each year in the U.S.

- 1.6 million children are seriously injured or impaired each year as a result of neglect.

For a discussion of ways to assess children who have been exposed to domestic violence and maltreatment see Feindler et al., (2003); Rossman et al., (2004); and Scheeringa et al., (1995). These authors recommend a short history taking, general developmental screening device and parent interviews.

WHAT IMPACT DOES EXPOSURE TO IPV HAVE ON CHILDREN?

(See Barnet et al., 1997; Jaffe et al., 1990; Kerig & Fedorowicz, 1999; Rossman et al., 2000)

The impact varies developmentally. The manual on how teachers can respond to children exposed to IPV ***(See http://www.lfcc.on.ca for a detailed description)*** posits that children may evidence both internalizing difficulties (anxiety, depression, PTSD) and externalizing problems (oppositional and aggressive behaviors, truancy), cognitive and attentional problems. Depending upon the study, some 25% to 75% (median percentage 40%) of children exposed to domestic violence evidence problems severe enough to warrant clinical interventions. This means that approximately 60% of children who witness domestic violence do not evidence behavioral symptoms.

Children exposed to family violence may develop a belief about the acceptability and utility of violence as a means to conflict resolution, may blame themselves for the violence and may feel anxiety and responsibility for protecting their mother and younger siblings. As a result they tend to spend less time with their friends, are less likely to have a best friend, and have lower quality friendships than did children from nonviolent families (Osofsky, 1995, 1997).

Edelson (2004) highlights the marked variability in children's response to exposure to IPV. Consequently, he cautions (Edelson, 2004, p. 20):

1. Children's exposure to adult domestic violence should not automatically be defined as maltreatment under the law.

2. Many children and their families should not be referred for forensic child protection investigations and interventions that carry the possibility of legal action against the parents. Rather, they should be offered voluntary community-based assessments and services.

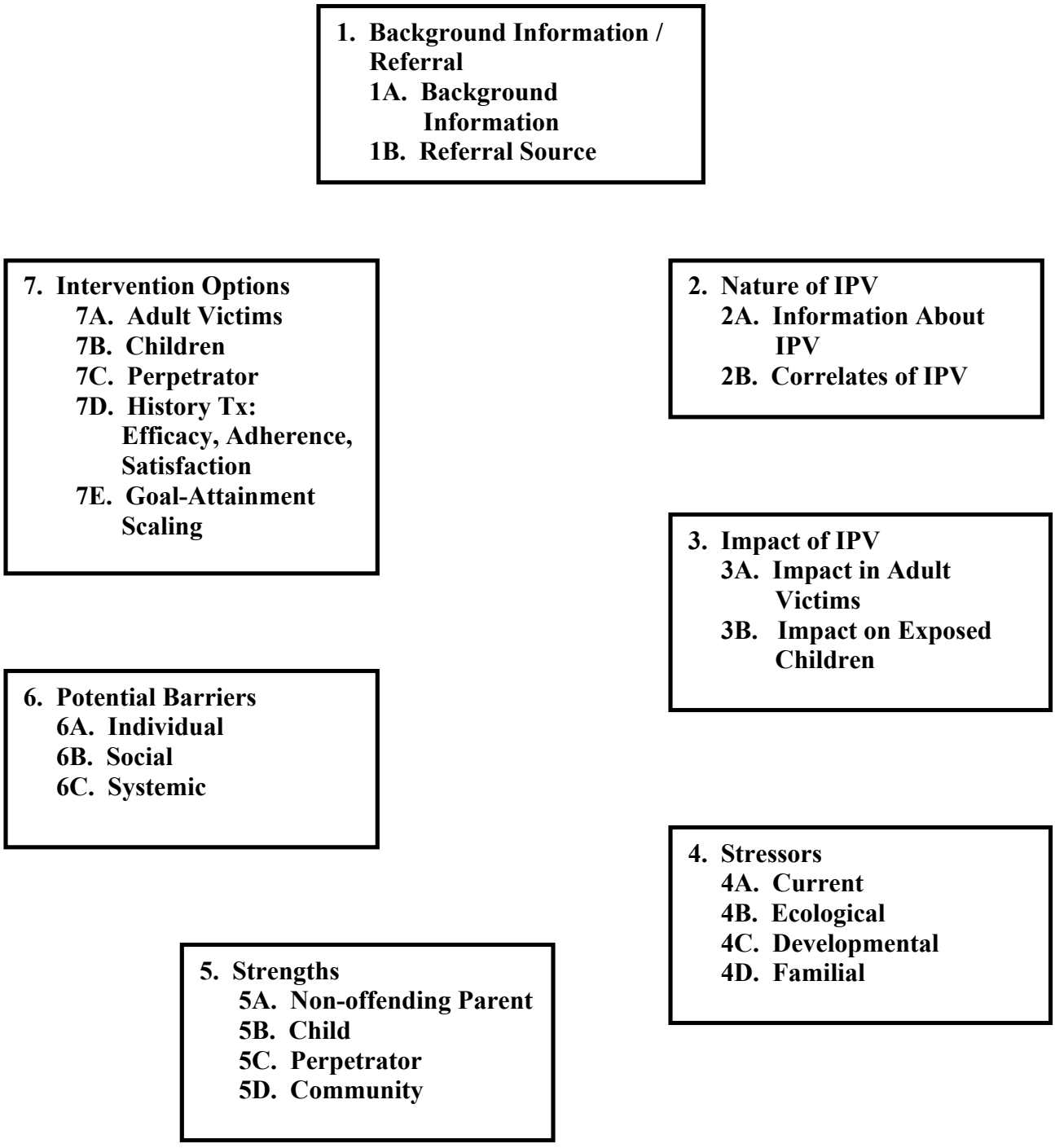
3. Some children exposed to adult domestic violence are at great risk for harm, and should be referred to the child protection system for assessment and intervention with their families.

Edelson's cautions about involving child protection investigations raise critical questions about assessment and the need for a Case Conceptualization Model.

WHAT ARE THE ASSESSMENT CONCERNS IN THE AREA OF IPV?

What information do we need in formulating an intervention plan? The following Case **Conceptualization Model** offered in the form of a Flow Chart helps to organize the needed information.

CASE CONCEPTUALIZATION MODEL OF INTIMATE PARTNER VIOLENCE



INFORMATION NEEDED IN FORMULATING A CASE CONCEPTUALIZATION OF INTIMATE PARTNER VIOLENCE

1. BACKGROUND INFORMATION / REFERRAL

1A. Background Information

Name, age of child, gender, ethnicity of all family members, level of education, number and ages of all children

Living conditions (present and past) – who is present in the home, homelessness, dislocation, family constellation (marital status). Relationship between perpetrator and victims (adults, child e.g., step-father)

Evidence of poverty and exposure to social ills

Custody and legal issues pending. Batterer fails to comply with restraining order, noncompliant with terms of probation.

Parental information – ethnicity, immigration status, education, income, employment status, lack of resources, marketable vocational skills

1B. Referral Source

How did the case come to be brought to attention? By whom? When? How? Legal and other actions?

Police involvement, referral by medical services, court-initiated, self-referral

Consideration of potential barriers to self-disclosure of IPV (e.g., the victim of abuse may choose not to report abuse because of a desire to keep the family together; distrust of authorities who they perceive as oppressive and corrupt; and feelings of fear, shame, guilt, embarrassment, denial, stigma, language and cultural barriers) ***(See list of Potential Barriers – BOX 6)***

2. NATURE OF IPV

2A. Information About IPV

Various forms, severity, frequency and chronicity of violence (physical, sexual, psychological, financial). How documented?

Level of marital distress, psychological abuse. How documented?

Nature of threats and intimidation used: Use children as a control tactic against adult victim

Was the child also a recipient of abuse or other forms of maltreatment (e.g., neglect, harsh discipline)?

Children's understanding of violence in home (What was the child told, by whom? How were events explained to the child? Who is blamed?) Health and psycho-social impact.

Impact of violence on victims. Level of adjustment. ***(See list below.)***

Present assessment of "risk" or dangerousness to both adult and child victims. Risk of reabuse. How documented? (Note, presence and availability of weapons, and role of jealousy, stalking behaviors, patriarchal beliefs.) ***(See list below of ways to assess dangerousness.)***

Consideration of legal consequences to mother, such as charges of "failure to protect children". Consider legal ramifications for the mother.

Address heightened risks associated with custody issues.

2B. Correlates of IPV

Comment on factors that exacerbate IPV – unemployment, underemployment, substance abuse, especially binge drinking, poverty, overall level of marital distress, stress-related factors, status inconsistencies in partners, differences in race, religion

Comment on type of battering and related forms of violence --spouse-specific, general violence, accompanied by comorbid disorders such as personality disorders ***(See Holtzworth-Munroe et al., 2000; Meichenbaum 2001)***

History of aggressive behaviors and related psychiatric problems (e.g., substance abuse, antisocial personality disorder, borderline personality disorder, level of depression, risk of homicide, risk of suicide)

Child-rearing practices and parenting style – abusive,, neglectful, hostile, coercive, family interactions, low family cohesion

Comment of how children attempt to cope with domestic violence (e.g., attempted to intervene, distance oneself, withdrawal, use distraction, called on someone to help)

How successful was each child's strategy?

Ecological (neighborhood, community) and cultural norms and attitudes toward the use of violence

Developmental history of exposure to violence. Evidence of intergenerational violence. ***(See list of risk factors below.)***.

3. IMPACT OF IPV

3A. Impact on Adult Victim

Documentation of physical signs of violence

Health-related problems

Psycho-social sequelae (PTSD, depression, anxiety, anger, substance abuse)

Note the developmental history of these problems prior to present victimization

3B. Impact on Exposed Child

Remember that children of different ages appear to exhibit differing responses to witnessing violence; 40%-60% of children witnessing violence are also exposed to maltreatment.

Presence of internalizing and externalizing problems - PTSD and health-related problems

Level of adjustment at school, peers, siblings

Note how assessed and time period since end of abuse

Ongoing perceived threats and their impact, as well as coping efforts. Do children evidence ambivalence toward parents, including the perpetrator?

4. STRESSORS

4A. Current Stressors

Other stressors victim and children are exposed to – racism, health, financial, legal, daily hassles, break-up of family, special risks associated with custody issues

4B. Ecological Stressors

Exposure to community violence and social ills, accompanying poverty (e.g., homelessness, marginalization., presence of social anomie)

4C. Developmental Stressors

Prior experience and exposure to victimization; family history of violence

4D. Familial Stressors

Prior and current levels of psychopathology in family members

Exposure of adults to ongoing and developmental stressors

5. STRENGTHS

5A. Characteristic of Non-offending Parent (Mother)

Quality of mothering

> ***"The emotional recovery of children who have been exposed to domestic violence appears to depend on the quality of their relationship with the nonabusive parent more than on any other single factor, and thus perpetrators who create tensions between mothers and their children can sabotage the healing process." (Bancroft & Silverman, 2004, pp. 102)***

Kinship and other social supports

Mother's efforts to protect child

Level of acculturation, language and cultural competencies

Role of faith (religion)

5B. Characteristic of the Child

Self-esteem, intelligence, coping skills, particular talents, personality characteristics

Child positive relationships with other adults

Sibling and peer relationships

5C. Characteristics of Perpetrator

Degree to which perpetrator evidence change ***(See list below gleaned from Bancroft & Silverman, 2004)***

Work ethic

Presence of positive kinship and peer supports

5D. Characteristic of the Community

Active Community involvement ***(See Aldarondo & Mederos, 2002, article on The Melissa Institute Website for examples.)***

Community support networks that are employed in a culturally sensitive manner

Stable community

Ongoing services – for example, men's groups that focus on skills-building and follow-through

6. POTENTIAL BARRIERS

6A. Individual Barriers

Fearfulness (justified), shame, guilt, distrust of police and courts, fear of deportation – concerns about confidentiality

6B. Social Barriers

Cultural beliefs such as the home is a private domain; strangers have no right to interfere; violence is acceptable; If marriage fails, then the woman fails as a wife and as a mother; mother and family will be ostracized by community for reporting abuse – social stigma

6C. Systemic Barriers

Unavailability of services, waiting list, distance – transportation, no child care, costs (lack of access to health insurance), legal impediments. (Not know how to negotiate the legal system)

Cultural divide between therapists and patients

Less contact with doctors and other social services agencies

Not have "helpers" from own cultural community

7. INTERVENTION OPTIONS ***(See list below of Treatment Options)***

7A. Treatment for Adult Victims

Safety-focused parenting plan

Treatment alternatives ***(See list below)***

7B. Treatment of Children

(See list of individual and group interventions)

7C. Treatment of Perpetrator

(See list of culturally-sensitive batterer's treatment programs)

7D. History of Treatment in Terms of Efficacy, Adherence, Satisfaction

7E. Goal-Attainment Scaling: Evidence of Efficacy of Interventions and Plans for Relapse Prevention and Avoidance of Revictimization

ISSUES OF SCREENING FOR IPV

by Meichenbaum & Keeley, 2004

The enclosed article, **Domestic Violence And Doctor's Response**, ***(also on the www.melissainstitute.org website)*** summarizes ways that doctor's can screen for IPV in victims and their children. See Ammerman and Hersen, 1999 and Feindler et al., 2003 for ways to assess for family violence.

ISSUES IN ASSESSING THE ONGOING LEVEL OF DANGEROUSNESS TO VICTIMS AND CHILDREN

(See the article by Aldarondo and Mederos, 2002, on The Melissa Institute Website for a summary of risk assessment measures.)

There is a need to use multiple sources of information combining both actuarial and clinical data. The sources include police and probation officer's records, and reports from abuse victims, families and batterers. Some of the actuarial measures include:

- Spousal Assault Risk Assessment (Kropp & Hart, 2000)
- Kingston Screening Instrument for Domestic Violence (Gelles, 1988)
- MSAIC-20 (Trone, 1999)
- Danger Assessment Scale (Campbell, 1986, 1995; Campbell et al., 2001 and Campbell, 2004, p. 92)

Campbell (2004) begins assessment with a calendar of the past year with the dates and severity of each abuse incident. If there is indication of a moderate or a high risk of danger, then mediation or face-to-face negotiations between the batterer and the victim should be avoided.

Aldarondo and Mederos (2002) highlight the following risk factors:

1) Prior history of domestic violence
2) Access to handguns
3) Estrangement from the abuse victim
4) History of depression in the batterer
5) Stalking behavior
6) Abusive behavior during female's pregnancy

In addition, consider the following of risk factors:

- In abusive relationships, there is a high level of marital discord and dissatisfaction (high frequency and intensity of conflicts with accompanying high rates of verbal aggression followed by physical aggression)
- Major sources of marital conflict are often arguments over children or parenting issues (e.g., not being a good mother, not keeping the children quiet, spending too much time with the children and not enough time with partner). Other major areas of conflict are finances, role responsibilities and sexual issues.

- Perpetrators' prior experience with violence (experienced or witnessed violence in family of origin; aggression toward peers while growing up and in earlier relationships; trouble with the law because of violence)

- Perpetrators' attitude about aggression (violence is a justifiable way to resolve conflicts). Use threats of control of spouse's daily activities. Perceived challenge to patriarchal views.

- Perpetrators have attributions of intentionality (blaming behaviors) accompanied by physiological arousal and reactivity, plus aggression-specific attitudes and expectations

- Perpetrators have a history of attachment disruptions and react aggressively when they perceive their relationships to be threatened (Spouse violence is highest when partner tries to leave)

- Perpetrators may feel threatened, jealous, possessive and fearful, and thus, respond to perceived threats with high levels of anger and controlling behaviors. (Spouse has another intimate partner.)

- Abusive males have a sense of entitlement, reflecting issues concerning power, control and domination. Aggressive men tend to make household decisions unilaterally, resulting in an imbalance of power.

- Spouse abusers constitute a heterogeneous group consisting of (1) family-only violence; (2) violence that is part of a generalized aggressive antisocial pattern (i.e., antisocial abusers may be an important subgroup of partner violent men); (3) aggressiveness may be accompanied by a psychopathology such as borderline personality disorder (See Aldarondo & Mederos, 2002 and Holtzworth-Munroe et al., 2000 for a discussion of this typology)

Other Risk Factors for IPV

(Note: Spouse abuse is multidetermined and is influenced by a variety of risk factors that can fluctuate over time.)

- Unmarried cohabitation

- Having a child prior to marriage

- Occupational status of abuser (unemployed, underemployed). There is a higher incidence of marital violence where there are high levels of stress, unemployment, couple differences in religion, and educational levels. Status inconsistency is more frequent in violent homes than in nonviolent homes (that is, where the

husband is less educated, makes less money than the wife, or has failed to achieve his desired occupational level).

- Low SES (perceived economic status). There is a higher incidence of marital violence in lower SES, but marital violence occurs across all socioeconomic and educational levels.
- Dense family size
- Social isolation
- Lack of religion
- Perceived stress
- High levels of anger
- High levels of depression and anxiety
- Low self-esteem
- Have problems with drugs or alcohol or both. There is a strong relationship between alcohol use and marital violence. It is estimated that alcohol abuse is involved in half of all wife-beating incidents. Note, binge drinking is more related to spouse abuse than are severe forms of alcohol abuse.
- Communication deficits and intimacy problems
- Impulsive and less skilled at problem-solving
- Personality style – borderline, passive-aggressive, narcissistic, antisocial and defended
- Availability of weapons

Assessing Risk To Mother and Children From Contact With Abusers
(See Aldarondo & Mederos, 2002; Bancroft & Silverman, 2004; Koziol et al., 2001; Schumacher et al., 2001)

- Level of physical danger to the mother (chronicity of violence in the relationship)
- Men's youthfulness
- Level of violence outside of the home
- History of physical abuse toward the children
- History of sexual abuse or boundary violations toward the children
- Level of psychological cruelty to mother or the children
- Level of coercive or manipulative control exercised during the relationship
- Level of entitlement and self-centeredness
- History of using the children as weapons and of undermining the mother's parenting
- History of placing children at physical or emotional risk while abusing their mother
- History of neglectful or severely underinvolved parenting
- Refusal to accept the end of the relationship or to accept the mother's decision to begin a new relationship
- Level of risk for abduction of the children
- Substance abuse history
- Mental health history (Presence of personality disorders such as Antisocial Personality Disorder and Borderline Personality Disorder)
- Noncompliance with court orders and batterer intervention programs

Assessing Change in the Abusers
(Bancroft & Silverman, 2004; Scott & Wolfe, 2000)

- Has he made full disclosure of his history of physical and psychological abuse?
- Has he recognized that abusive behavior is unacceptable?
- Has he recognized that abusive behavior is a choice?
- Does he show empathy for the effects of his actions on his partner and children?
- Can he identify his pattern of controlling behaviors and entitled attitudes?
- Has he replaced abuse with respectful behaviors and attitudes?
- Is he willing to make amends in a meaningful way?
- Does he accept the consequences of his actions?

ISSUES OF ASSESSING VICTIMS – SHORT-TERM AND LONG-TERM

(See Logan et al., 2002; Straus et al., 1996; Tolman, 1999; Wathen & MacMillan 2003 for examples of assessment measures.)

It is important not only to assess for possible negative health affects, but also to assess for signs of possible strengths and resilience. Do not view women who have been victimized by IPV as "helpless". Instead, these women are often making numerous decisions and plans to protect their children and themselves. Surely, they need assistance as noted below, but any assessment and feedback should highlight the rest of the story of "strengths".

Things to Keep In Mind

- Women tend to **underreport** IPV.
- Less than 10% of women who experienced IPV ever told a physician; less than 50% have told anyone.
- Surveys have indicated that only 10% - 15% of physicians reported ever asking about victimization and none reported always asking about victimization.
- Only one in five women who were asked reported that their doctor raised the subject of abuse and of these who discussed their abuse with the doctor, less than half were referred to a support service and less than one quarter were referred to the police.
- See Meichenbaum & Keeley (2004) for a discussion of what doctor's can do differently (Also on Melissa Institute Website.).

Assessment

- Examples of questions that can be asked, as suggested by Koziol et al. (2001) and Rhodes and Levison (2003):

  "Has your partner ever hit you, or otherwise physically hurt you?"
  "Are you in a relationship with anyone who has hurt or threatened you?"
  (If the answer to either questions is "yes", then ask about the nature of the injuries.)

- Also probe about the nature of the relationship.

  "Is your partner (husband) very jealous or controlling?"
  "Does your partner keep you away from family and friends?"
  "Can you come and go as you please?"
  "Has your partner ever made you have sex when you didn't want to?"

- These questions can be supplemented by a variety of self-report scales such as the Revised Conflict Tactics Scale (Straus et al., 1996), the Psychological Maltreatment of Women Inventory (Tolman, 1999), Abusive Behavior Observation Checklist (ABOC) (Dutton, 1992) and Specific Affect Coding System (Gottman, 1994). See Wathem and MacMillan (2003) for a list of possible additional screening scales for intimate partner violence.

- In addition, the assessment should cover the following areas:

  - Severity and history of various forms of abuse
  - Level of adjustment and quality of life indicators
  - Presence of psychopathology (depression, anxiety, suicidality, PTSD, substance abuse, physical health issues, such as presence of HIV and sexually transmitted diseases [STD])
  - Level of social supports
  - Signs of resilience and "strengths"

- There is also a need to assess for risk factors for reabuse in order to determine the likelihood of revictimization.

Since adult IPV is often accompanied by child maltreatment, it is worth noting factors that contribute to child abuse.

ISSUES IN ASSESSMENT OF CHILD MALTREATMENT

(See Bancroft & Silverman, 2004; Black et al., 2001l Kerig & Fedorwicz, 1999; Magen et al., 2000; Martin, 2002; Rossman et al., 2004; Scheeringa & Zeanah, 1995))

- Abusive parents have unrealistic and rigid expectations for children which lead them to define a broad range of child behavior as misbehaviors

- Abusive parents have misinformed norms of when children should engage in various behaviors

- Abusive parents attribute hostile intent to their children's behaviors ***("Doing it on purpose."***) and easily become angry by child misbehaviors. Such emotional arousal interferes with problem-solving abilities.

- Abusive parents hold beliefs that physical discipline is normative and desirable (approve and accept physical discipline)

- Abusive parents tend to use coercive parenting styles that lead to abuse. They have high rates of negative interactions with their children.

- Abusive parents have poor parenting and disciplining skills

- Child abuse is more likely to occur in lower SES families (role of poverty with accompanying stress, exposure to violence, exposure of children to deviant peers and low levels of social supports, social isolation)

- Being an unmarried mother is associated with an increased rate of child abuse

Other Risk Factors For Child Abuse

Parent Indicators

- Depressive symptomatology in the parent
- Marital discord
- Being a victim of partner violence
- Family history of aggression
- Use of alcohol and drugs
- Impulsivity
- Parent-child dissatisfaction
- Absence of father's biological relatedness to the child

Child Indicators

- Prematurity
- Low birth weight
- Mental retardation
- Physical and sensory handicaps
- Difficult to mange children
- Oppositional defiant children

Algorithm For Family Violence

- Hold belief that aggression is justifiable
- Attributions of intentionality – ***"On purpose"***
- Emotional and physiological arousal in response to conflicts (anger intensity)
- Coercive conflictual and negative interactions that escalate ("become entrapped" and use verbal aggression that contributes to the use of physical aggression)
- Lack of communication skills and parenting skills
- Social isolation, little social supports and culturally normative beliefs that aggression is an appropriate and desirable means of resolving interpersonal conflict

ISSUES IN ASSESSING PERPETRATORS OF IPV

(See article by Aldarondo & Mederos, 2002 on The Melissa Institute Website)

There is a need to asses for the history of violent behavior, nature and type of present IPV, as described by Amy Holtzworth and her colleagues, presence of psychopathology (e.g., see Spitzer et al., 1994) and presence of "strengths". See the Section above on predicting dangerousness and "risk" factors.

Aldarondo and Mederos (2002) observe that 50% of batterers engage in family only violence and that this group is least likely to engage in psychological and sexual abuse and evidence fewer legal problems. In contrast, 25% of batterers fit the Dysphoric/Borderline category and are more likely to evidence comorbid problems of substance abuse, depression, as well as moderate to severe domestic violence. The last 25% of batterers fit the generalized violence subgroup and evidence the most severe form of violence and other forms of abuse. This group is more likely to evidence antisocial personality disorder and substance abuse. Most of the men who are in court-mandated treatment programs tend to belong to this latter group.

WHAT ROLE DO CULTURAL AND RACIAL FACTORS PLAY IN THE ASSESSMENT AND TREATMENT OF VICTIMS AND PERPETRATORS OF IPV?

(See article by Fernando Mederos, and Julie Perillo, 2004 on The Melissa Institute Website for a discussion of ways to develop culturally sensitive community connections.)

An examination of the literature suggests that cultural and racial factors have played a limited role in the past, but there is an increasing recognition that assessment and treatment need to be culturally and racially sensitive. For example, Williams and Becker (1994) conducted a survey of batterer's programs and found that they did not adequately consider race nor culture.

There is an increasing recognition, as the following references indicate, of the need to make our assessment and intervention tools more sensitive. For example, See et al. (2002) have offered a domestic violence program for African American families, while Ferrer (2002) has offered a program for the Hispanic population.

Other examples of treatment intervention programs have been offered by Aldorando & Mederos (2002); Bancroft (2002); Davis & Taylor (1999); and Donnelly et al. (2000).

Racial and Cultural Influences

1. The incidence of domestic violence varies across races and ethnic groups. For example, the incidence of battering is significantly higher in African American populations, but such race estimates are confounded by SES differences.

2. Varied expression of symptoms.

3. How exposed children of different races and gender respond.

4. Unique risk and protective factors vary by race and culture.

5. Barriers to treatment. Need to match clients and therapists and use translators of both language and culture.

6. Inclusion of culturally specific rituals in treatment.

7. Nature of strengths. (Use the individual's cultural background as a source in developing culturally-sensitive interventions). See examples, offered on treatment programs for Latino and African American populations offered by Aldarondo and Mederos (2002). For instance, consider how to build strong kinship bonds, strong religious orientation, active community involvement.

Issues of the format and type of intervention need to be considered from a contextual cultural perspective. For example, what has been the batterer's experience with racism and oppression and how does this influence his relationship with his family members? See American Psychological Association (2002); Poterotto et al. (1995); Sue (1998) and Williams & Donnelly (1997) for a discussion of cross-cultural counseling techniques. They describe how various culturally specific rituals such as libation, circularity, reflection, vicarious mentoring and various manhood development projects can be incorporated into treatment.

WHAT WOULD AN INTEGRATED MULTIFACETED PROGRAM FOR REDUCING IPV LOOK LIKE?

Any comprehensive intervention program needs to consider the treatment of victims of abuse, children exposed to domestic violence, perpetrators and what can be done on a preventative basis. As noted below, professionals from various areas of expertise need to combine their efforts, if the incidence of family is to be reduced. As Mederos and Perillo (2004) describe, **Coordinated Community Response Initiatives (CCRI)** programs have been developed that include:

- Implementation of pro-arrest policies by police
- Proactive prosecution that is focused on victim safety
- Effective judicial oversight of convicted offenders
- Ongoing monitoring of abusers by probations officers
- Batterer intervention programs, that focus on behavior change
- Imprisonment for abusers who violate probation or who re-assault or harrass victims
- Ongoing coordination with battered women's services
- Oversight of the process by battered women's advocates

There are, however, two **important caveats** that have to be recognized when considering such Coordinated Community Research Initiatives (CCRI). First, as Aldarondo and Mederos (2002) observe, the treatment elements apply only when the perpetrators of IPV are brought under the auspices of authorities or social service agencies. In fact, 75% of intimate partner assaults are not reported to authorities and the majority of women whose partners are arrested for assault do not pursue charges for a variety of reasons that may include fear and mistrust of the criminal system,. An alternative to the CCRI approach is to engage in **outreach programs** to high risk populations described by Mederos and his colleagues. ***(See Website Building Partnerships Initiatives www.endabuse.org/bpi).*** A related problems is the very high drop out rate and noncompliance with court orders and intervention programs.

The second major caveat to various intervention programs is the limited demonstration of the effectiveness of various interventions in the area of family violence. A recent report by the National Research Council and The Institute of Medicine (2004) provides a major warning. They conclude:

> ***"The Nation spends billions of dollars each year to curb family violence, but most of the money supports an array of treatments and intervention efforts that have not been evaluated for their impact or effectiveness."***

They go on to observe that:

> ***"Heath care law enforcement and social service interventions for family violence commonly exist side by side within a community, in an uncoordinated system that is largely undocumented."***

The national Research Council Report edited by R. Chalk and P. King is worth examining. ***To see the full Report, go to http://www4.nationalacademies.org/news.nsf/isbn/0309054966?OpenDocument or call 1-800-621-6242 and ask for the report Violence in families: Assessing prevention and treatment programs.***

With these important warnings in mind, we can now consider the variety of interventions that have been tried and note those that are most promising.

ILLUSTRATIVE INTERVENTIONS TO REDUCE FAMILY VIOLENCE

Interventions for Victims of Abuse *(See attached list)*

- Mandatory Reporting – There is much controversy about reporting rules. If the victim objects and if protective services are not available, and if the victim is able to gain access to therapeutic treatment or support services and the risk of reabuse is low, then mandatory reporting should be reconsidered
- Safety Planning -- planned course of action (Where to go, people to inform, clothing, documents, financial resources, etc.)
- Community Advocacy Programs and community initiatives
- Parent Training Programs
- Treatment for the Aftermath of IPV. See enclosed article by Mary Ann Dutton on Posttraumatic Theory with Domestic Violence Survivors. ***(See Dutton, 1992; Zust, 2000)***

A valuable summary of the interventions for women who have been victimized has been offered by Wathen and MacMillan (2003) which is available at ***http://jama.ama-assn.org/***. It provides a detailed review of empirical studies. They conclude that:

> ***"There is a lack of evidence regarding the effectiveness of interventions for women experiencing abuse and the potential harm of identifying and treating abused women has <u>not</u> been well evaluated. (Wathen & MacMillan, 2003, p. 589)***

While the data-base is limited, there is some promising evidence for the need for <u>multifaceted interventions</u>. As Logan at al. (2002) observe:

> ***The Intervention outcome literature also highlights the importance of providing a <u>comprehensive array of programs</u> for women in addition to specific interventions for victimization, substance abuse, and mental health problems.***
> ***(Logan et al., 2002, p. 356)***

<u>Possible Interventions For Abused Women</u>
(See Abel, 2000; Bryant, 2000; Campbell et al., 2002; Koss et al., 1994; Meichenbaum, 1997,; Najavits, 2002)

The following list provides examples of some of these comprehensive programs.

- Residential shelter stays
- Advocacy counseling in shelters focused on legal representation, support, victimization, ways to negotiate the legal system and ways to access social services. (Use of police, negotiating judicial system, victim assistance programs, child protective service and health system. Note that mothers in abusive relationships have been prosecuted for failing to protect a child from the abuse or from witnessing violence.)
- Accessing community resources – need agency linkages and cross referrals with follow-up
- Employing social support groups
- Outreach programs
- Community-based advocacy programs with a post-shelter interventions
- Personal and vocational counseling

- Receive treatment for comorbid disorders such as depression, Substance abuse, PTSD, and physical problems

- Treatment Features ***Note that women only substance abuse treatment programs have had more positive treatment outcomes than mixed-gender groups.*** The more services provided, the longer the treatment retention. Use "one-stop" shopping to meet the multiple needs of victims of violence. Include flexible treatment programming, child care and parenting classes. **Assertive outreach** and active **case management** are key treatment ingredients. Ongoing safety assessments are also critical.

- Address possible risk of revictimization that may be an outcome of custody proceedings. (Devise a safety plan) (See Hardesty & Campbell, 2004)

- Child custody interventions (Jaffe & Geffner, 1998)

- Home visitation programs

- Couples therapy where indicated (See Aldarondo & Mederos, 2002 – Perpetrator has mace progress and risk of reabuse has significantly decreased.)

Interventions for Children Exposed to Domestic Violence
(See Bancroft & Silverman, 2002; Geffner et al. 2000; Graham-Bermann, 2001; Graham et al., 2001; Groves et al., 1993; Holden et al., 1998; Jaffe et al., 2004; Osofsky, 1997; Pearce & Pezzot-Pearce, 1997)

- Individual and group interventions
  (e.g., Storybook Club – Tutty & Wagar, 1994; Preschool Kids Club – Graham-Bermann, 2001; Group-based work – Peled & Edelson, 1992; Program for shelter abused children – Hughes, 1982; Tutty & Wagar, 1994)
- Treatment of sheltered children with behavioral problems –(Jouriles et al., 2001)
- Osofsky (1997) has described the elements of the treatment of children and adolescents who have witnessed domestic violence. These treatment programs usually include having young children:

    - Talk about feelings or play their feelings out symbolically (depending on the age of the child)
    - Drawing about their family feelings and events
    - Puppet and doll house play
    - Role-play
    - Cognitive-behavioral play therapy that nurtures coping skills
    - Have children draw pictures of what goes on in their neighborhood and ways to be safe and different ways to cope

- Group treatment of <u>older children</u> who have witnessed domestic violence may include:

    - Education about violence and consideration about feelings and reactions
    - Work on emotional regulation and addressing fears
    - Relationship building within and outside of the group
    - Nurturing coping skills

- Programs also involve police and the combined treatment with nonoffending parent. Osofsky (1997) has extended the child treatment program to involve police, parents and the community-at-large. Her community-based program includes

:

    - The education for police officers at all levels in the effect of violence on children
    - 2-hour hotline for consultation by police or families by a mental health profession
    - Raise awareness of perceptions of violence in the community
    - Work with parents on ways that they can protect their children
    - Osofsky (1997) has developed a Police Education Manual, a Children's Safety Booklet and a Quarterly Newsletter about activities of the project (Dr. Osofsky is at the School of Medicine, Louisiana State University Medical Center)

<u>Interventions for Batterers</u>
(See Aldarondo & Mederos, 2002)

- Batterer Intervention Programs – EMERGE (Adams & Cayouette, 2002); DULUTH (Pence & Paymer, 1990, 1993; Pence, 2002); MANALIVE (Sinclair, 1989, 2002) and COMPASSION Workshops (Stosny, 1995, 2002; Wexler, 2000; Wexler & Welland, 2002 – Hispanic version)

- <u>Arrest</u> had a stronger deterrent effect on employed than for unemployed men.

- <u>Civil protection orders</u> – Permanent (12 month) were more effective than temporary (2 week) protective orders. In fact, the temporary orders were associated with a significant increase in psychological abuse, but no change in physical abuse.

- Court-mandated treatment with ongoing supervision. There is a need to develop a system that detects early failure to comply with court orders and treatment.

- Couple behavior therapy for alcoholism has been found to reduce IPV (O'Farrell & Fals-Stewart, 2000)

- Cognitive-behavioral treatment (See Meichenbaum, 2001)
- Interventions need to be culturally sensitive (See et al., 2002; Ferrer, 2002)
- Community-based interventions – See descriptions of the following programs as offered by Aldarondo & Mederos (2002)
    - Boston/Dorchester Initiative
    - Atlanta -- Caminar Latino, Tapestri and Men Stopping Violence Program
    - Men's Nonviolence Project of the Texas Council on Family Violence

These program have community resource specialists who conduct active outreach programs, psychoeducational treatment and actively build in procedures to enhance treatment generalization and maintenance. **Aldarondo and Mederos (2002) observe that approximately two-thirds of batterers who go through such interventions will remain nonviolent. 10% to 20% continue to be severely violent.** ***(See Meichenbaum, 2001 for a discussion of ways to intervene more effectively with aggressive individuals.)***

Illustrative Preventative Programs

In order to have a major impact on family violence, there needs to be a focus not only on treatment, but also on prevention. The following list illustrates the variety of prevention programs that have been developed.

Ethnic Media Outreach Program	Komateros, 2004
School-based Programs	Committee for Children, 1990; Jaffe et al., 1999, 2004; Stavrou-Peterson & Gamoche, 1988; Sudermann et al., 1996
Preventing Dating Violence Programs	Neufeld et al., 1999; Wolfe et al., 1998
Court-involvement Programs	Dunford-Jackson, 2004; Jaffe & Geffner, 1998; Shaffer & Bala, 2004
Home-visiting Program	Olds et al., 1997
Doctors and Nurses Screening	Meichenbaum & Keeley, 2004
Police-mental Health Liaison Programs	Berkman et al., 2004; Osofsky, 1997; Websdale & Johnson, 1997
Policing Rural Settings	Gorton & Hightower, 1999; Monsey et al., 1998
Family Preservation Practitioners	Schechter & Ganley, 1995

HOW CAN I OBTAIN MORE INFORMATION ABOUT IPV?

We have put on The Melissa Institute Website ***(www.melissainstitute.org)*** Handout Materials from the presenters of the Eighth Annual Conference of The Melissa Institute on Family Violence. Please see the Website. For example, Aldarondo and Mederos (2002) have addressed the following questions:

1. When should a person be considered an "abuser" or a "batterer"? Can you "diagnose" battering?

2. Is domestic violence a problem primarily among the poor?

3. Are men of color more violent against their female partners than white European American men?

4. Isn't it true that most men who batter their female partners were raised in violent homes?

5. Do men who have poor social and problem solving skills batter more?

6. Are men who batter mentally disordered?

7. Does alcohol and drug abuse lead to domestic violence?

8. Is domestic violence also a problem in gay and bisexual relationships?

9. Assessment Issues:

    a) How can I tell if he will try to beat her again?
    b) When should psychological evaluations of abusive men be used?

10. Interventions with Abusive Men

    a) Do different types of men who batter require different interventions or treatments?
    b) What is the best treatment for abusive men?
    c) Is couples' counseling an effective and safe way to work with men who batter?
    d) Under what conditions is psychotherapy an appropriate intervention for abusive men?

11. Do abusive men stop the use of violent behavior and change the way they relate to their partners?

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INTERNET RESOURCES

American Academy of Family Physicians
http://www.aafp.org/

American Academy of Pediatrics
http://www.aap.org/

American College of Emergency Physicians
http://www.acep.org/

American College of Obstetricians and Gynecologists
http://www.acog.org/

Centers for Disease Control and Prevention (domestic violence information)
http://www.cdc.gov/ncipc/dvp/fivp/ipvlinks.htm

Domestic Violence: A Practical Approach for Clinicians
http://www.sfms.org/

Family Violence Prevention Fund
http://endabuse.org/

Kids Club Program
www.sandragb.com

References on Children Exposed to Domestic Violence
http://www.lfcc.on.ca/CEFV_bib.html

Safety planning for children: Strategizing for unsupervised visits with batterers. (Hart, B. J., 2001)
www.mincava.umn.edu/documents/hart/safetyp.shtml

Stop Abuse of Everyone
http://www.safe4all.org/

State Reporting Requirements
http://endabuse.org/statereport/list.php3

U.S. Department of Justice
http://www.ojp.usdoj.gov/vawo/

NATIONAL DOMESTIC VIOLENCE ORGANIZATIONS

(Also see Websites listed at the end of the article Domestic Violence and Doctor's Response on www.melissainstitute.org)

Battered Women's Justice Office, Minneapolis, MN
http://www.bwjp.org/

Center for Prevention of Sexual and Domestic Violence, Seattle, WA
http://www.cpsdv.org/

Family Violence Prevention Fund, San Francisco. CA
http://endabuse.org/

Minnesota Center Against Violence and Abuse, Minneapolis, MN
http://www.mincava.umn.edu/

National Academy Press Violence in Families Assessing, prevention and treatment approaches (2004)
http://www4.nationalacademies.org/news.nsf/isbn/0309054966?OpenDocument

National Center for Children Exposed to Violence (NCCEV), New Haven, CT (1-877-496-2238)
http://www.nccev.org/

National Coalition, Denver, CO (303-839-1852)
http://www.ncadv.org/

National Coalition Against Domestic Violence, Denver, CO
http://www.ncadv.org/

National Coalition of Anti-Violence Programs (2001) Lesbian, gay and transgender domestic violence
http://www.avp.org/publications/reports/reports.htm /

National Council of Juvenile and Family Court Judges, Resource Center on Domestic Violence, Child Protection and Custody, Reno, NV
http://www.ncjfcj.org/dept/fvd/res_center/

National Domestic Violence Hotline (1-800-799-SAFE [7233])
http://www.ndvh.org/

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

National Network to End Domestic Violence, Washington, DC
http://www.nnedv.org/

National Resource Center on Domestic Violence, Pennsylvania Collation Harrisburg, PA (800-537-2238)
http://www.pcadv.org/

Physicians for a Violence-free Society, San Francisco, CA
http://www.pvs.org/

Violence Against Women Office (VAWO)
http://www.ojp.usdoj.gov/vawo/