



*A key mission of the Center for Research on Violence Against Women is to ensure that the findings of quality research make it into the hands of advocates. This translation of research to practice ensures that science has an impact on the lives of women and children.*

*In 2010 the Center for Research on Violence Against Women conducted a survey with over 100 rape crisis and domestic violence advocates in Kentucky about what they needed to know from research to help them do their jobs. Advocates identified ten top issues. A series of ten briefs were prepared by the Center to answer the Top Ten Things Advocates Need to Know.*

## TOP TEN THINGS ADVOCATES NEED TO KNOW

1. What services do survivors of rape find most helpful, and what help do they say they need?
2. What type of sex offender is most likely to recommit their crimes? Incest offenders, rapists, or pedophiles?
3. What mental health issues are caused by experiencing intimate partner violence or sexual assault?
4. Do protective orders work? Who violates protective orders the most?
5. What is the impact of mandatory arrest laws on intimate partner violence victims and offenders?
6. What are the most significant long-term health consequences of chronic sexual or physical violence?
7. What percentage of rape cases gets prosecuted? What are the rates of conviction?
8. Does treatment with intimate partner violence offenders work?
9. Does a report of intimate partner violence or sexual assault by a partner put a woman at risk of losing custody of her children?
10. How do women from different racial/ethnic backgrounds experience intimate partner violence (IPV) or sexual assault? Does race and ethnicity matter?

For more information on the Center for Research on Violence Against Women and to find PDFs of the Top Ten Things Advocates Need To Know Series, visit [www.uky.edu/CRVAW](http://www.uky.edu/CRVAW)

## QUESTION 1:

# WHAT SERVICES DO SURVIVORS OF RAPE FIND MOST HELPFUL AND WHAT HELP DO THEY SAY THEY NEED?

### REPORT AT A GLANCE

- 18% of American women have experienced rape in their lifetime.
- Rape survivors may experience physical injury, STDs, unwanted pregnancy, psychological trauma, debilitating fear, PTSD, depression and social isolation.
- Women are least likely to report a rape or sexual assault when they blame themselves, their experience was not a violent rape by a stranger, or they fear retaliation.
- Women fear they will not be believed, will be treated poorly, will be blamed, will have privacy lost, or will be further traumatized.
- Many women experience secondary victimization (an event which adds trauma as a result of an attempt to get help), which can be caused by: judgmental or victim-blaming statements by service providers, invasive medical procedures, pressure by the legal system to press charges, or asking a victim to recount her rape experience to multiple people.
- Immediately following a rape, women need help for health concerns including injuries, STDs and pregnancy.
- Survivors find services the most helpful and least distressing when aided by a Sexual Assault Nurse Examiner.
- The psychological impact of the behavior of service providers makes the difference of whether services are helpful or create additional trauma for the victim.

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### How Big is the Problem?

According to a 2005 national study funded by the National Institute of Justice, at least 18% of American women (or 20 million women) have experienced rape in their lifetimes. Women reported experiencing forcible rape (about 80% of the time), the use of drugs by a perpetrator to facilitate a rape (30% of the time), or a rape committed after a woman was incapacitated due to alcohol consumption (20% of the time) (1). In many cases, women experienced more than one of these; for example, forcible rape while incapacitated due to intoxication.

The consequences of rape can have serious, long-term impacts on survivors. Studies show that rape survivors experience problems including physical injury, sexually transmitted diseases, unwanted pregnancy, psychological trauma, debilitating fear, post-traumatic stress, depression, and social isolation, many of which can actually increase her risk of future victimization (2, 3).

No single rape experience is the same, individual rape survivors often have very different needs and circumstances when seeking help to deal with their victimization.

### Do Survivors Ask for Help?

Many women delay seeking help or do not seek help at all after a sexual assault incident.

Research reveals that women are least likely to report a rape or sexual assault when they feel ashamed or blame themselves, when their experience was not a stereotypical violent rape by a

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*The behaviors and reactions of service providers of all levels - from crisis line operators to nurses - has a psychological impact on rape survivors reaching out for services. See page 4*

stranger (e.g., the so-called "classic" rape case), or when they feared retaliation by their perpetrator if they were to report (4). Under these circumstances, survivors worry that they will not be believed by law enforcement, they will be treated poorly, they will be blamed for their victimization, their privacy will be lost, or that reporting might lead to further psychological or physical trauma. Research shows that rape survivors, particularly those with lower levels of post-traumatic stress, are unlikely to report to police out of concern that reporting will only increase their psychological stress beyond the level at which they are currently able to cope (5). To some extent, research into survivors' experiences with the legal system confirms that the majority of rape survivors who report to police do feel like their involvement with the justice system is more hurtful than helpful. Studies suggest that this is due both to the greater likelihood of experiencing secondary victimization from within the legal system (6,7,8,9), as well as the extremely low likelihood that a rape case will result in a conviction, or even be prosecuted (10, 11, 12). Misgivings about the legal system can in turn discourage women from seeking medical care, mental health treatment, and other services due to concern that these other service professionals will be required to report their rape to the police without the survivor's permission.

One study conducted in Kentucky suggests that there may be different reasons for not reporting a rape or sexual assault for rural versus urban women (13). This research found that rural women most often thought of the rape perpetrator as an intimate partner, while for urban women the perpetrator was usually an acquaintance or a stranger. As a result, rural women were more concerned about experiencing family and community backlash when deciding whether or not to seek help.

Rape survivors who do not report to police or seek other services can experience psychological stress and trauma

long after their rape (3). Research finds that many of these women do not trust that formal services will let the survivor herself determine the extent to which she needs help. For many of these women, research suggests that the greatest barrier to help might be the lack of a safe, trusted, supportive person who will actually listen to and validate her story (14).

Research shows that several factors affect what types of services rape survivor seeks. For example, survivors of stranger rape are more likely to seek legal and medical help than women raped by someone they know (4, 9, 11, 15). Also, many women seek help from religious communities (11). Studies show that when a woman is raped by someone she knows, she is often less likely to immediately identify the incident as rape, and as a result might not immediately seek formal help (13, 16, 17). Further research finds that about 70% of rape survivors do not tell anyone immediately after the assault, but most will eventually tell someone about the rape within days, weeks, or even years of the incident (18, 19). White women are far more likely to seek mental health services or call rape crisis lines than are minority women (11, 20).



Police: One type of outreach by rape survivors is contacting the police. Recent studies estimate that less than one-third of rape cases are reported to police (1, 21). Research indicates that a survivor is most likely to contact police when:

- She feels that her life is in danger;
- Fears the perpetrator would rape her again or would rape another person; or
- When there are serious medical concerns including STDs or physical injuries associated with the rape (1, 4, 9).

Several women interviewed in focus group studies mentioned that the reason their case was reported to police was because another person, for example a family member, encouraged her to report the rape or reported to police without her permission (4, 22). Women in rural areas, in particular, stated in interviews that they did not contact the police because they fear their abuser has political connections which will result in lack of

prosecution, and perhaps retribution against her (13).



**Medical Care:** Another important form of help sought by rape survivors is medical care. Research indicates that a survivor is most likely to seek medical care for one of four reasons (6):

1. Collect forensic evidence (e.g., blood, hair, or semen);
2. Detect and treat physical injuries;
3. Get information and testing for sexually transmitted diseases (STDs); or
4. Get precautionary treatment for unwanted pregnancy

Several studies have found that women treated for sexual assault are not given adequate information from healthcare providers about the health consequences of sexual assault, such as STDs or how to get the morning-after birth control pill (6, 11, 23). One key study, for example, found that while 70% of rape survivors received a forensic medical exam, less than half the women seeking medical help received pregnancy information (49%), the morning-after pill (43%), information on STDs (39%) or information on HIV (32%) (11). Not only did most survivors not receive information about the health consequences of sexual assault, further research suggests survivors who did not receive this type of information felt the services were less helpful, and sometimes even saw their treatment as harmful to their emotional well-being (11, 23, 24).

### *What did Survivors Find Helpful?*

Studies indicate that the risk of a rape survivor experiencing additional trauma while seeking help is a very real concern. A growing body of research indicates that many women experience "secondary victimization" because of service providers, that is, an experience which

adds trauma as a result of her attempt to get help (8, 11, 15, 24, 25, 26). These negative experiences can contribute to long-term mental-health problems, and may discourage rape



*Sexual Assault Nurse Examiners are effective in reducing the secondary victimization of survivors.*

victims from seeking any further treatment or help for their victimization. Secondary victimization most frequently occurs when police, prosecutors, or medical service providers make judgmental or victim-blaming statements to rape survivors while rendering services to them (8, 13, 26). However, additional trauma can also

be unintentionally inflicted when a woman must endure invasive medical procedures, is pressured by the legal system to press charges, or asked to repeatedly recount her rape experience to multiple people (e.g., the doctor, the police, and the prosecutor). Research confirms that victim advocates and Sexual Assault Nurse Examiners (SANE), when utilized, are usually effective in reducing the secondary victimization of survivors (26, 27). One study found that in their sample of rape survivors, legal and medical services were rated as more hurtful than helpful, but mental health professionals, religious counselors, and rape crisis centers were seen as far more healing than hurtful (11).

Some recent research suggests that advocates and service providers' emotional responses while providing help to rape survivors may also be influential. Research finds that many advocates can experience anger or fear as a result of repeated frustrations helping survivors deal with, for example, the legal system or a perpetrator (28). Others

**TO REDUCE DISTRESS AMONG RAPE SURVIVORS (27):**

- DO NOT BLAME OR JUDGE
- PROVIDE A COORDINATED SERVICE DELIVERY SYSTEM/PROGRAM
- PROVIDE ACCESS TO HIV AND STD RISK COUNSELING AND THE MORNING-AFTER BIRTH CONTROL PILL
- GIVE THE INFORMATION AND SUPPORT REQUESTED
- HELP Schedule MEDICAL EXAM WITH A SEXUAL ASSAULT NURSE EXAMINER (SANE)
- HELP NAVIGATE THE LEGAL SYSTEM, SO THEIR CASE MAY BE PROSECUTED

may vicariously share the trauma of their clients. While many advocates can use these experiences to motivate their continued work, these emotions may not be appropriate for all victims. A study on social service providers, for example, found that when service providers believe that victims of crime can "never fully recover" from the experience, this can negatively impact the success of treatment outcomes of their clients (15, 29). Also, research on emergency services reveals that police, doctors, and nurses underestimate the impact their words and attitudes have on the rape survivors they help (25).

When a rape survivor perceives being treated negatively by a service provider, or believes that even the service provider is emotionally distressed by their trauma, they are more likely to have on-going post traumatic stress, depression, and other mental health issues. (11, 19, 28)

### Conclusion

In sum, violence against women researchers have, to date, provided the following answers the question: "What services to survivors of rape find most helpful, and what help do they say they need?" In the immediate aftermath, women need help for health concerns related to the experience of rape. This includes treatment for injuries, potential sexually transmitted diseases, and potential pregnancy. Survivors find these services to be the most helpful (and the least distressing) when paired with the services of a Sexual Assault Nurse Examiner (SANE),

when they are given enough information about STDs and morning-after contraception, and when all medical services are delivered without judgment or victim-blaming. Survivors find all forms of information presented by a supportive service provider helpful; whether that information is provided by a doctor, a police officer, a prosecutor, a rape crisis center, or other advocate. When immediate services are rendered in a supportive way that does not further traumatize a survivor, she is more likely to continue with subsequent treatments such as mental health counseling which serves to better alleviate the long-term impact of rape.

Many of the direct services needed by rape survivors (such as medical treatment, legal referrals, counseling, etc.) are already evident to those working in the field. However, research involving survivors of rape reveals that the manner in which those services are offered to women may often times make the difference of whether the services rendered create additional trauma for survivors, or whether they are indeed helpful. Awareness of the psychological impact of behavior by service providers at all levels, from a police dispatcher to an intake nurse at an emergency room, should be an important point of focus for advocate when attempting to coordinate services for rape victims across multiple agencies. As long as researchers and service providers continue to pay attention to what survivors tell us they need, our ability to better identify and serve their needs will continue to improve.

## A 2002 IN-DEPTH STUDY OF SANE PROGRAMS REPORTED NINE THEMES IDENTIFIED BY SURVIVORS IN DESCRIBING HOW SEXUAL ASSAULT NURSE EXAMINERS HAD BEEN HELPFUL (30)

SURVIVORS FELT:

### RESPECTED AS A WHOLE PERSON

Their needs were met and they were treated with dignity and respect

### INFORMED

Given information but not overwhelmed by too much

### THE PRESENCE OF STAFF

Nursing staff was there for them to provide information and let them know what to expect

### SAFE

Caregivers were women and were sensitive in their care

### CARED FOR

1. By people with expertise (providers knew what they were doing)
2. Beyond the hospital (received the option of follow-up care)

### IN CONTROL

Given options but not pushed toward certain choices

### REASSURED

Felt believed and supported

### APPRECIATIVE

In how they were physically touched (not invasive and nurses held their hands during exam)

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## QUESTION 2:

### WHAT TYPE OF SEX OFFENDER IS MOST LIKELY TO RECOMMIT THEIR CRIMES? INCEST OFFENDERS, RAPISTS OR PEDOPHILES?

#### REPORT AT A GLANCE

- There is little agreement among researchers on how to classify type of offender - by victim, by offender characteristics or other schemes. This report focuses on offender by type of victim.
- Violent, antisocial offenders most often perpetrate rape against adult women, and are the most likely to commit new crimes against a variety of victims.
- These offenders are usually more likely to be re-arrested for a new violent crime than a sex crime.
- Child molesters “fixated” on children have the highest risk of sexual reoffending - this increases with the number of victims they have previously abused.
- Incest-only offenders are the least likely to reoffend, yet incest may be linked to a broader pattern of domestic violence.
- The biggest predictor of reoffending seems to be a history of multiple sexual assaults against multiple victims.
- Mental disorders such as pedophilia, sadism, antisocial personality disorder and a history of violence are linked to repeat sex offending.
- Research is ongoing on how to classify, treat, and understand the risks of future offending associated with different types of sex offenders.

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#### *Background*

Since the 1980s, intense focus has been given to sex crimes committed against women and children. These crimes, by their severity and repetitiveness, have called for increased scrutiny and stronger criminal penalties, tougher policies, and increased public awareness. Today, laws in every state require specific types of sexual offenders to register with state and national sex offender registries.

While a consolidated public policy push has prevailed, the population addressed by these efforts is not homogenous. Criminal offenses committed by individuals grouped together as "sex offenders" include a wide range of activities: pornography, participation in prostitution, statutory rape, indecent exposure, child molestation, forcible rape, sodomy, incest, and online solicitation of sex with minors, to name only a few. Researchers, particularly in the areas of criminal justice, psychology, and psychiatry, have worked for three decades to develop a better understanding of who sexual offenders are, in the process developing and testing several competing classification schemes for grouping and assessing sex offenders. The goal in this scientific work has been to find similarities that can lead to better prevention, risk assessment, or treatment options with this offender population (1).

#### *Who are these offenders?*

The study of sex offenders is still a developing, growing, and ever-changing field of research. At present, there is little agreement between researchers about which characteristics are the most important for understanding types of sex offenders. Some schemes classify offenders by type of victim, others by offender characteristics, and other schemes use the circumstances of the offense itself (for example, planned

versus unplanned assaults) (1). There are even multiple, competing risk-assessment instruments used by mental health and criminal justice practitioners to determine a sex offender's competence for release from treatment, prison, or probation whose predictive strengths and weakness are routinely being tested and re-evaluated (2, 3, 4).

There are, however, several facts about sex offenders that find considerable support across multiple research studies. This research review is intended for advocates who may be providing services to survivors of rape, sexual assault, or family violence which may include the sexual abuse of children. Therefore, this report will focus on research findings which describe sex offenders by the type of victim, specifically focusing on the re-offending characteristics of: incest offenders, adult rapists, and non-family child molesters. Doing so will help to directly connect the experiences of sexual assault survivors whom advocates will assist, with research that can identify the typical risks posed to the survivor or others from the sex offenders they might encounter.

### *Do They Repeat Their Crimes?*

As advocates know, in criminal justice terms recidivism is typically used to discuss a situation where a previously convicted offender is arrested again for a similar offense. Sometimes it is defined broadly (e.g., a new arrest for any reason) and other times recidivism is defined narrowly (e.g., a new arrest for the same offense). Though studies measure recidivism differently, most research on sex offenders makes a distinction between sexual recidivism and non-sexual violent recidivism. This distinction is important because research shows that the motivations for committing different types of sexual crimes are very different.

Studies find that rapists who victimize adult females are more likely to exhibit generally antisocial and violent characteristics, while most non-familial child molesters are non-violent with inappropriate sexual attraction towards children, commonly diagnosed as pedophilia (1, 5). In other words pedophilia, by definition, is about sexual attraction to inappropriately young people, while rape is usually about controlling or hurting others (1, 4, 6).

It is important to note however that many incarcerated offenders, particularly antisocial or violent offenders, admit to having victimized multiple types of targets including related children, non-related children and also adults (7).

In a large study of 4,673 Canadian sex offenders, Hanson (8) found that incest child molesters were the least likely to sexually reoffend. Others studies have found similar recidivism rates within these categories (see Table below).

In a study by Serin et al. (9), rapists are more often re-arrested for committing non-sexual violent offenses, while child molesters were more likely to reoffend with another sexual crime.

In a study tracking 9,691 male sex offenders released from U.S. prisons in 1994, Langan, Schmitt, and Durose (10) found that 5.3% of released sex offenders (517 offenders) were re-arrested for a sex crime within 3 years of release.

#### RECIDIVISM RATES OF VIOLENT OR SEXUAL CRIMES AMONG CONVICTED SEX OFFENDERS

	Hanson (8)	Serin (9)	Langan (10)
Rapists (adult victim)	17.1%	29.4%	18.7%
Child molesters	14.4%	16.2%	14.1%
<i>Incest offenders</i>	8.4%	4.4%	-
<i>Non-family child molesters</i>	19.5%	11.8%	-

### *How Often Do They Reoffend?*

Most research attempting to predict repeat offending among sex offenders is based on small samples of only a few hundred cases, because arrest for sexual recidivism has what is called a "low base rate" of re-offending. This is a statistical problem which, put simply, means that arrest for sexual re-offending among convicted sex offenders occurs so infrequently that it is generally more accurate to predict that no one will re-offend than to try to predict which specific individuals will re-offend (3, 11). Obviously, such a prediction is unacceptable and many research studies have attempted to predict re-offenders despite this substantial hurdle. Research has yet to

definitively identify the best measures to predict who will reoffend, though many possibilities have been explored (2). At present, it appears that the best predictor of sexual recidivism is a history of re-offending: the more sexual crimes an offender has committed, the more likely that offender will continue to do so (12, 13, 14, 15, 16). Most studies of repeat sex offending track only previously convicted sex offenders, recording whether or not they are re-arrested for additional sex offenses. For example, in the Langan, Schmitt, and Durose (10) study of 9,691 convicted sex offenders described above, 71.5% of sex offenders had only one conviction.

Interviews and surveys of convicted sex offenders suggest that sex offenders may commit 2-5 times as many offenses as they are arrested for (11, 17).

Measures of repeat sex offending are almost certainly under-estimates, since recidivism statistics rely on new sex offenses being discovered, resulting in an arrest, and occurring within a limited timeframe (usually 3 years) after release (11). This underestimation is particularly likely among rapists, because research shows that only 14-18% of rapes are even reported to the police, let alone result in an arrest (18).

Several research studies have found that younger age at time of release is predictive of a higher likelihood of re-offending (2, 5, 17). However, this same research also shows that rapists are typically younger than child molesters when released from prison or treatment. Combined with the finding that rapists more often exhibit

general antisocial characteristics (1), and are more likely to be re-arrested for a violent rather than sexual offense (9), it is likely that the effect of older age in lowering recidivism among sex offenders

THE BEST PREDICTOR OF SEXUAL RECIDIVISM IS A HISTORY OF RE-OFFENDING.

THE MORE SEXUAL CRIMES AN OFFENDER HAS COMMITTED, THE MORE LIKELY THAT OFFENDER WILL CONTINUE TO DO SO. (12, 13, 14, 15, 16)

may be due to the fact that criminal offending behavior decreases with age for all criminals, regardless of the type of crime (19). However, Barbaree and colleagues (2) recently found that while aging decreases the ability of antisocial violence measures to predict re-offending, it actually increases the ability of sexual deviance measures to predict re-offending. In effect, they found that all re-offending decreases as a person ages, but that offenders with sexual paraphilias are more likely than antisocial rapists to reoffend at an older age. Woessner (6) also categorizes similar offenders as "socially and mentally unremarkable offenders" who typically commit their offenses under extreme life stressors and have a low risk or recidivism. Research data generally supports that incest-only offenders are the least likely to reoffend after an initial arrest (8, 9).

### *Does Domestic Violence Matter?*

A study of 476 sex offenders by Stalans, Hacker, and Talbot (4) found a direct link between sexual recidivism and an offender's history of partner battering.

Sex offenders with a history of domestic violence were more likely to commit another sex offense than individuals with a history of violence against non-family members, both while on probation (26.4% vs. 15.1%) and after (19.0% vs. 11.2%).

Domestic batterers in this study were also far more likely to be re-arrested for non-sexual crimes than non-batterers (65.5% vs. 44.1%). Interestingly, individuals with no history of violence were the least likely to sexually re-offend (7.9%). Other studies have linked domestic violence to incest sex offending. A study by Wood (20) found that sex offenders without serious mental disorders or violent criminal histories had more instances of domestic violence and incest child abuse.

## *Does Violence Matter?*

Research has found that sex offenders who did commit new violent or sexual offenses were more likely to have certain characteristics than those who did not reoffend.

In addition to being younger, re-offenders were more likely to be violent to their victims and have a history of violent behavior (12, 14), and were less likely to be in a relationship or have stable housing or employment (21, 16, 22, 23). One study found that violent offenders who re-offended were more likely to have reported using alcohol before committing their crimes, but that non-violent offenders who re-offended were more likely to report *not* using alcohol before the crime (4).

Interestingly, a recent study comparing sex offenders who registered with authorities, to those who failed to register as sex offenders found that unregistered sex offenders were no more likely to commit a new sexual offense (24). Much like other research, this study also found that offenders who fail to register are more likely to be young, minority, have more violent charges, and more often have adult rather than child victims.

## *Conclusion*

The study of recidivism among sex offenders is a challenging and controversial area of research. While there are many studies investigating this topic, there is still much debate as to the best ways to screen and predict re-offending by convicted sexual offenders. However, research generally shows that there are many different "types" of sex offender. Violent, antisocial offenders most often perpetrate rape against adult women, and these offenders are the most likely to commit new crimes against a variety of victims. They are usually more likely to commit a new violent crime than a sex crime, but reoffend much sooner after release than child sex offenders. Child molesters who are "fixated" on children (typically diagnosed as pedophiles) have the highest risk of sexual reoffending which increases with the number of victims they have previously abused. Incest-only offenders are the least likely to reoffend, and incest may be linked to a broader pattern of domestic violence.

However, many sex offenders admit to sexually assaulting adults, related children, and non-related children such that any person put in a position of vulnerability around certain types of offenders is at risk regardless of who their previous assaults were against. The most reliable predictor of reoffending for sex offenders seems to be a history of multiple sexual assaults against multiple victims. Some recent research suggests that sex offenders released from custody or treatment at a younger age are more likely to reoffend, and less likely to do so as they get older, but this pattern is true of all criminal offending. Mental disorders such as pedophilia, sadism, antisocial personality disorder, and in particular a history of violence, are all linked to repeat sex offending. Currently, research is still ongoing within prison and treatment settings to classify, treat, and understand the risks of future offending associated with different types of sex offenders.

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## QUESTION 3:

### WHAT MENTAL HEALTH ISSUES ARE CAUSED BY EXPERIENCING INTIMATE PARTNER VIOLENCE OR SEXUAL ASSAULT?

#### REPORT AT A GLANCE

- Rates of diagnosed mental problems are much higher for women who experience intimate partner violence than for the general population of women.
- Studies have found higher levels of depression, eating disorders and anxiety disorders among rape survivors than victims of violent, non-sexual crimes (e.g. robbery).
- If friends, family or service providers react negatively or in a stigmatizing way to rape survivors, they are likely to exhibit more depressive symptoms.
- The most commonly diagnosed mental health consequence of victimization is posttraumatic stress disorder (PTSD).
- PTSD symptoms may include unwanted intrusion of thoughts about the trauma, social withdrawal, debilitating fearfulness, emotional detachment, belief that their situation is hopeless, avoidant behaviors and long-term heightened emotional arousal and fear.
- PTSD has been shown to increase the risk of future victimization among intimate partner violence survivors.
- Current research indicates that IPV and sexual assault must be understood as unique causes of mental illness, with unique consequences, and in turn efforts must be made to address the factors negatively impacting survivors' mental health throughout many parts of our society.

*In 2010 the Center for Research on Violence Against Women conducted a survey with over 100 rape crisis and domestic violence advocates in Kentucky about what they needed to know from research to help them do their jobs. Advocates identified ten top issues. This brief is one in a series of ten prepared by the Center to answer these top ten research questions.*

#### *Introduction*

Intimate partner violence (IPV) and sexual assault can have significant impacts on the mental health of women who are exposed to traumatic experiences. Under certain circumstances, a victimization experience can cause severe, long-term mental health problems which can negatively impact a woman's quality of life, and can increase her likelihood of experiencing more victimization in the future. For this reason, researchers and mental health professionals have sought to understand the ways in which mental health concerns are caused, impacted, and affected by women's experiences of IPV or sexual assault.

#### *Does Victimization Impact Women's Mental Health?*

Rates of diagnosed mental problems in the United States are much higher for women who experience intimate partner victimization than for the general population of women (1, 2, 3). In fact, most of the major non-organic forms of mental distress and disorder have been associated with at least one form of interpersonal victimization in women (4). Golding (1) estimates that the rates of depression, PTSD, alcohol abuse, and drug abuse among women who experienced IPV are anywhere from 2-6 times greater than among national samples of women (see table).

ESTIMATED MENTAL ILLNESS RATES AMONG WOMEN IN THE U.S. (SOURCE 1, 2)

	General Population	IPV Survivors
Depression	21.3%	47.6%
PTSD	10.4%	63.8%
Alcohol Abuse	6.3%	18.5%
Drug Abuse	3.5%	8.9%

## DEPRESSION & VIOLENCE

Women are 3x more likely than men to experience depression after a stressful life event (26)

Women who have experienced IPV report more depression symptoms than other women (27, 28, 29)

Women who have experienced sexual assault have higher depression rates (30, 31, 32)

Research also finds that survivors of physical and sexual victimization:

1. Have more mental health problems than other women, may experience related problems long after the traumatic experience; and
2. Have more severe mental health problems when they experience multiple or repeated victimizations (5, 6, 7).

Survivors of rape are particularly likely to

experience several mental health issues at once following an assault, including anxiety, depression, and substance abuse (7). In one study, for example, a study by Faravelli and colleagues (8) compared rape survivors to victims of non-sexual crimes (e.g., assault or robbery) and found higher levels of depression, eating disorders, and anxiety disorders among women having experienced an assault. Several studies have found that the severity of a sexual assault experience's impact on a survivor's mental health is strongly shaped by what happens *after* the assault (5, 10). For instance, if friends, family, and formal service providers respond in negative or stigmatizing ways to a woman's attempt to seek help, the survivor is likely to exhibit more depressive symptoms (9). Findings such as these emphasize the very practical importance of having advocates available for women following an assault.

### Posttraumatic Stress Disorder

In total, research suggests that the most prevalent mental health problem associated with IPV and sexual assault is post-traumatic stress disorder, or PTSD (1). Posttraumatic stress has been studied in numerous populations, including soldiers returning from combat, rape survivors, survivors of natural disasters, or individuals victimized by crime. Abuse by an intimate partner, however, is unique among the many recognized causes of PTSD.

Unlike many other traumatic stressors, IPV is not

typically a single traumatic event, but rather an *ongoing* pattern of multiple, repeated traumas (10). In a recent research review, Mary Ann Dutton (11) acknowledges that "trauma theorists have not yet adequately addressed the potential implications for ongoing exposure to traumatic experiences that IPV typically illustrates" (p.212).

Posttraumatic stress disorder (PTSD) is diagnosed when "exposure to a traumatic event that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or other that involved intense fear, helplessness, or horror" results in a pattern of symptoms such as recurring distressful recollections or dreams, avoidance of the subject, emotional detachment, or difficulty sleeping following a traumatic experience (33).

Research shows that factors unique to IPV increase the levels of posttraumatic stress experienced by survivors of physical partner violence. For example, studies have found that coercive control by a partner (12), sexual violence by a partner (13), and psychological abuse (14, 15, 16, 17) all have a stronger relationship to PTSD symptoms than physical abuse alone. Likewise, levels of PTSD among survivors of sexual assault are increased by negative experiences during help-seeking, judgmental reactions when disclosing the assault to friends and family, and acceptance of socio-cultural norms which stigmatize sexual assault survivors (5).

Posttraumatic stress disorder has also been shown by researchers to increase the risk of future victimization among IPV survivors. PTSD symptoms may include social withdrawal, debilitating fearfulness, emotional detachment, belief that their situation is hopeless, and avoidant behaviors. A belief that no one can help might be caused by feeling intense fear and helplessness, and in turn this belief can lead survivors to respond in ways that increase rather than decrease their risks. For example, a woman experiencing traumatic fear after an abuser threatens her life might believe that even if she leaves and



reports the abuse, no one will be able to prevent her abuser from finding and killing her. And yet, hiding the abuse because of this fear will not actually protect her, and may instead reinforce or worsen her anxiety, sense of helplessness, and vulnerability to further abuse. Being diagnosed with PTSD as a result of partner violence is a significant predictor of a woman's likelihood of experiencing re-abuse by the same partner within 2 years (18). A recent study following up after 1 year found that re-abuse was predicted by PTSD, even when controlling for the severity of violence, help-seeking, and level of social support (19).

*A study examining psychological abuse found that having a higher level of PTSD symptoms increased the risk of recurring psychological abuse by 1.5 times (21). This important area of research suggests that the symptoms of IPV trauma can have a cumulative impact; without intervention a traumatic experience can leave a woman vulnerable to repeat abuse, and may contribute to additional mental health problems.*

A research review by Briere and Jordan (4) was able to identify several circumstances across studies which increased the severity of mental health symptoms after experiencing victimization. Survivors of traumatic abuse experienced more severe mental health consequences: when the victimization involved continued, multiple forms of violence over time; when survivors had experienced prior childhood or adult abuse which impacted the experience of a new victimization; when survivors had pre-existing mental health disorders such as depression or anxiety which contributed to symptoms after victimization; or when survivors lived in a social environment that was unsupportive or critical of victims of violence.

## *How Do Women Survive the Violence?*

Research also identifies factors which are associated with resiliency among survivors of violence. Studies consistently show that positive social support or support groups are important for improving the well-being of survivors (9, 21, 22) and are especially helpful for African American women who derive strength from identifying with other women of color who share their experiences of victimization within a similar racial context (23). Research into coping strategies finds that women who stay with abusive partners frequently cope by reinterpreting their relationships in positive ways, but are less likely to be able to do so if physical abuse is accompanied by verbal abuse (24). A study by Zink and colleagues (22) examined coping strategies used by older women (55 and up) to live with long-term abuse. Many of these women had survived by developing strategies to limit their partner's abusive behaviors while remaining in the relationship. These coping strategies included building self-worth based on relationships with others such as friends, family, and church members for love and support, while clearly defining behavioral and sometimes spatial boundaries (i.e., staying in a different room) for their abusive partners. Others recognized that their partners didn't love them, so instead found a positive identity within domestic roles such as a parent, caretaker, or homemaker. Because leaving may not be a viable option for dependant older women (25), helping survivors to develop coping strategies that emphasize self-development and emotional well-being may be helpful when typical abuse interventions do not fit a survivor's life.

*In general, research suggests that survivors with positive social support, good psychological adjustment (i.e., self-esteem, optimism, active problem-solving), and an identity based in spirituality or community-belonging were more resilient to the effects of victimization on their mental health.*

## Conclusion

Often, the most enduring consequences of violence against women are the mental health issues that survivors face after experiencing intimate partner violence or sexual assault. The most commonly diagnosed mental health consequence of victimization is posttraumatic stress disorder, caused by a traumatic experience involving threat of serious injury or death where a woman feels intense fear, helplessness, or terror. A survivor with PTSD can experience unwanted intrusion of thoughts about the trauma, emotional numbing or social withdrawal, or experience long-term heightened emotional arousal and fear. Research tells us that IPV and sexual assault are major causes of PTSD, but also that IPV or sexual victimization can cause many other mental health symptoms including depression, anxiety, drug or alcohol abuse, chronic pain syndromes, and eating disorders, to name only a few. Research finds that when women are supported by friends, family, and service providers these effects are lessened, but that even minor negative experiences with help-seeking can substantially increase the trauma and helplessness experienced by a survivor. Survivors, particularly those experiencing sexual assault, face the difficulty of "cumulative victimization" when a woman's own personal experiences with victimization and help-seeking, the socio-cultural norms held by those around her, and the presence of victim-blaming attitudes all contribute to the severity of the mental health impact caused by traumatic violence (5). Practitioners who serve survivors face unique challenges because IPV is typically not a single traumatic event, but instead consists of multiple and diverse forms of traumatic abuse. Researchers are continuing to try to understand and unravel the complex inter-relationships between victimization and mental health in ways that can improve treatment and outreach for women affected by violence. Current research indicates that IPV and sexual assault must be understood as unique causes of mental illness, with unique consequences, and in turn efforts must be made to address the factors negatively impacting survivors' mental health throughout many parts of our society.

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**DO PROTECTIVE ORDERS WORK?  
WHO VIOLATES PROTECTIVE ORDERS THE MOST?**

REPORT AT A GLANCE

- Several studies which interviewed survivors found that the majority of women who received protective orders found them to be effective at preventing violence.
- 2 in 5 women experience a violation of their protective order.
- Even though some abusers violate protective orders and commit additional violent acts, protective orders lead to more felony convictions and harsher penalties for abusers than when there is no protective order.
- The presence of stalking and women staying in the relationship best predicts a protective order violation.
- Stalking may be an indicator for when a woman is most likely to need a protective order, and stalking may also be a critical obstacle in a survivor's decision or ability to leave her abuser.
- A record of prior protective orders, non-participation in court-ordered programs, and multiple criminal arrests after the issuance of a protective order were found to be strong indicators that an abuser might violate a protective order.

*In 2010 the Center for Research on Violence Against Women conducted a survey with over 100 rape crisis and domestic violence advocates in Kentucky about what they needed to know from research to help them do their jobs. Advocates identified ten top issues. This brief is one in a series of ten prepared by the Center to answer these top ten research questions.*

Introduction

Civil court orders of protection are a key resource now available in every state in the United States as a potential legal response to domestic violence. While available in all states, the types of protections offered (e.g., requiring the respondent to cease violence or vacate a residence; required counseling for respondents; child custody), legal requirements (e.g., who is eligible; how long they last), and procedures (e.g., where they are available; how the court hearings are managed) vary from state-to-state (1, 2). For many victims, civil protective orders are an important addition or alternative to criminal justice interventions such as pressing criminal charges, and are unique in that they attend to survivors' worries about future victimization and offer a different legal option for women reluctant to participate in the criminal justice system (3).

This paper provides a review the research literature on protective orders, identifying what is currently known about when protective orders are the most and least effective, the circumstances under which protective order violations most often occur, and what happens when protective orders are violated by abusers.

Do Protective Orders Work?

Research on civil protective orders offers complicated findings about whether these remedies are effective for victims. Some studies suggest that these orders can often be effective in preventing violence. Harrell and Smith (4) interviewed 355 women who received temporary protective orders, and found that only about 40% of the women who received the temporary order returned to court to request a permanent order. Of the women who did not return, 64% reported that the abusive partner had stopped bothering her after the temporary order was issued. In fact, several studies

which interviewed survivors found that the majority of women who received protective orders found them to be effective at preventing violence (5, 6, 7, 8) These estimates are consistent with findings by Spitzberg (9) who combined data from 32 studies and found that on average only around 40% of protective orders were

### KENTUCKY PROTECTIVE ORDER LAWS

In Kentucky, protective orders are governed by the Kentucky Revised Statutes (KRS) chapter on domestic violence and abuse (KRS 403.715 through 403.785).

Protective order violations are defined by KRS 403.763 which stipulates that if a person "intentionally violates the provisions or an order" they are guilty of a Class A misdemeanor, punishable by up to 12 months of imprisonment.

As of July 15, 2010, a "substantial violation" was defined in KRS 403.761 as any violation which might also be classified as a crime against a petitioner, her child, or a family member. If such a violation occurs, this new law allows judges to order a GPS monitoring device be used to track the exact location of potentially dangerous offenders to aid in the protection of survivors.

violated. Carlson, Harris, & Holden (10) found that the number of women reporting physical violence before and after the protective order decreased by nearly two-thirds, from 68% of women to only 23%. Additional research data further supports the assessment that protective orders are generally helpful: women who receive protective orders are less than half as likely to be contacted, threatened, psychologically abused, or physically abused as women who did not obtain a protective order (11). At least one study found that protective orders were a more effective criminal justice intervention than filing assault charges (12), and multiple studies found that over time protective orders further reduced the violence experienced by women who obtained them compared to women who did not obtain protective orders (11, 12). Even though some abusers violate protective orders and commit additional violent acts, research shows that the presence of a protective order leads to more felony convictions and harsher penalties for abusers than when there is no protective order (13).

Though a majority of women are pleased with the outcome, protective orders are far from being completely effective or available. Research reveals several reasons for why women do not receive protective orders. First, the specific requirements in state laws (e.g., experiencing certain types of violence, or having a certain relationship status) have been linked to as many as 27-32% of applying women not being able to qualify for a protective order (12, 14). In Kentucky, research found that during 2003 there were at least 2,205 requests for emergency protective orders denied, representing about 7.3% of all protective order cases handled that year (15). Some studies find that as many as 60-80% of temporary protective orders are not continued in the court system by the women requesting them (4, 16). Interviews with battered women reveal that many women do not follow up on temporary protective orders because they fear retaliation by their partners (4, 17, 18). Other women reported not continuing the process because of pressure or intimidation by the abuser to drop the order, feeling that the protective order had not helped, or giving up after the court had not been able to serve the temporary order (4). Even when women did receive a protective order, it did not always prevent violence and some women still experienced further abuse from a partner.

*A recent study by Logan and Walker (19) involving Kentucky women found that about half experienced a protective order violation within 6 months, but at the same time most women in the study felt that the protective order had reduced the severity of the violence, and made them less fearful of future harm.*

### *Who Violates Protective Orders the Most?*

Only recently have researchers begun to investigate ways to predict whether or not a violent partner is likely to violate a protective order. Logan and Walker (7) specifically note that at present there is a "limited understanding of which factors are most associated with violations" (p.677). However, these and other researchers have begun to investigate this question by examining the context of the relationship from the survivor's perspective, and investigating the background and known characteristics of the abuser.

By interviewing Kentucky survivors about their experiences with protective orders, Logan and Walker (7) found that two factors, stalking and staying in the relationship, best predicted a protective order violation. Around half of the women who were stalked before the protective order were also stalked after it was issued.



*Women who experienced stalking had 4 times the risk of experiencing any physical violence after a protective order was issued compared to women who were not stalked.*

Likewise, women who remained in the relationship after getting a protective order experienced significantly more protective order violations than those who ended the abusive relationship. Along with greater risk of a violation, other research found that women who experience stalking expressed more fear, and felt the protective order was less effective (19). Previous research has found that stalking may be an indicator for when a woman is most likely to need a protective order, and stalking may also be a critical obstacle in a survivor's decision or ability to leave her abuser (20, 21).

Some research also indicates that the abuser's criminal justice status can predict their likelihood of violating a protective order. Several studies have found a connection between an abuser's history of violent crimes and protective orders, noting that between 65% and 80% of abusers had been charged with previous crimes prior to the protective order being issued (3, 6, 22, 23, 24, 25, 26).

*Recent studies have found that multiple criminal arrests for any offense following the issuance of a protective order was associated with a higher likelihood of repeat domestic violence or protective order violations (24, 27).*

In addition, Kindness and her colleagues (27) found that non-compliance with court-ordered domestic violence programs also increased likelihood of re-offending, suggesting that court monitoring could play an important role in further protecting survivors.

Jordan, Pritchard, Duckett, and Charnigo (24), based on their 10-year analysis of 3,445 protective orders in Kentucky, found that the having more prior protective orders and an extensive criminal record were the best predictors of new crimes and the issuance of new protective orders. Specifically, this data revealed that certain criminal charges (felony or misdemeanor sex offense, misdemeanor assault, or misdemeanor stalking) increased the likelihood of a protective order being issued by within the next month by 14% per occurrence (p.1407).

*The study also found a "protective effect" of about 18 months after the issuance of a Kentucky protective order, wherein offenders had decreased odds of being charged with a crime, but after that time the odds of new charges increased again (24).*

Similar to the general criminological research on repeat offending, this study also found that younger, non-white males were more likely to be arrested for additional crimes after a protective order had been issued.

## Conclusion

In general, research has found that protective orders are a useful option for women seeking protection from abuse through the criminal justice system. Research shows that the majority of women who receive protective orders find them to be helpful at stopping abuse, and preventing further violence over time. Some research even suggests that protective orders may be a more effective way to reduce future violence than pressing criminal charges against an abuser, especially over time. If more violence does occur, the presence of a protective order can enhance other criminal justice interventions by allowing prosecutors to enhance a charge to a felony. However, research also shows that protective orders are not universally effective. A sizeable number of women, around 2 in 5, experience a violation of their protective order. Variations in statutory requirements across states or jurisdictions make access to protective orders more difficult for certain women, for example, unmarried women who do not live with the abuser. Other women do not get the protection they need because the court is

unable to serve a protective order, or they fear that seeking protection will only provoke a violent reaction.

Recent research is now beginning to yield clues as to who is most likely to violate a protective order. Studies investigating the experiences of survivors before and after a protective order tell us that stalking behaviors are key predictors of continued violence. Stalking which occurred prior to a protective order, and stalking behaviors after a protective order is issued are the best indicators of risk for future violence. Likewise, women who remain in a relationship with their abuser after seeking a protective order are more likely to experience future abuse. Readily-available criminal justice information about an abuser can also help courts or advocates to predict the likelihood of a protective order violation. The majority of abusers have a history of criminal charges, however a record of prior protective orders, non-participation in court-ordered programs, and multiple criminal arrests after the issuance of a protective order were found to be strong indicators that an abuser might violate a protective order.

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## QUESTION 5:

### WHAT IS THE IMPACT OF MANDATORY ARREST LAWS ON INTIMATE PARTNER VIOLENCE VICTIMS AND OFFENDERS?

#### REPORT AT A GLANCE

- Mandatory arrest refers to any state or local law or police policy which requires a police officer to make an arrest when responding to a domestic violence call if there is probable cause to believe any violence has occurred.
- Mandatory arrest policies have been shown to only slightly lower repeat offending rates, in particular for individuals who are married and employed.
- Arrest may actually increase the risk of retaliation by abusers with a prior history of violence, or among those who are unemployed and have little to lose.
- Mandatory arrest policies may be disempowering for survivors by discouraging them from calling the police. This is particularly true for minority women already weary of the fairness of the criminal justice system.
- Mandatory arrest policies has been shown to result in more women being arrested, often as cases of dual arrest where both offender and survivor are taken into custody.
- No-drop prosecution policies usually mean that the state or city presses assault charges against the domestic violence offender rather than the victim. The survivor's participation is not required.
- Research finds that no-drop policies are costly, not immediately protective, and may even have the opposite effect as intended by discouraging women from reporting future violence.

*In 2010 the Center for Research on Violence Against Women conducted a survey with over 100 rape crisis and domestic violence advocates in Kentucky about what they needed to know from research to help them do their jobs. Advocates identified ten top issues. This brief is one in a series of ten prepared by the Center to answer these top ten research questions.*

#### Introduction

The term "mandatory arrest" refers to any state or local law or police policy which requires a police officer to make an arrest when responding to a domestic violence call if there is probable cause to believe any violence has occurred, regardless of the wishes of the person assaulted. These types of policies are also called pro-arrest policies, or sometimes preferred arrest policies if officers are encouraged but not required to arrest a domestic violence offender. Mandatory arrest laws first appeared in the mid- 1980's immediately following an early domestic violence study called the Minneapolis Domestic Violence Experiment (1). This study found a much lower rate of repeat domestic violence if the police arrested the perpetrator when responding to a domestic violence call, compared to cases where no arrest was made. The Minneapolis study was frequently cited by government reports and national media articles at the time. The study's findings supported the cause of feminist activists who were pressing police departments around the country for not taking domestic violence cases as seriously as other crimes. Importantly, the authors of Minneapolis Experiment study viewed their results as a first look at the effects of arrest, and several new studies in different cities attempting to repeat the results provided strong evidence that arresting a perpetrator did not actually cause a long-term decrease in domestic violence recurrence rates and that the benefits of arrest were modest at best (2, 3). Regardless, there continues to be an on-going debate among policymakers, advocates, and researchers about whether or not mandatory arrest policies can still be helpful to survivors of domestic violence.

This paper reviews some of the scholarship examining the impact of mandatory arrest laws and related policies (i.e., no-drop prosecution policies where victims cannot choose to drop charges).

## *Effects of Mandatory Arrest Policies on Repeat Violence*

The Minneapolis Domestic Violence Experiment (1) was a groundbreaking study which showed a significant reduction in repeat domestic violence after an initial arrest. That study led quickly to development of mandatory arrest policies within police agencies across the country, so much so that within five years, thirteen states had enacted mandatory arrest policies for domestic violence offenders (4, 5). However, later studies building on this research discovered that arrest had different effects in different situations. Several studies found that arrest slightly lowered rates of re-offending, but was not always the best predictor of repeat offending.

An offender with more prior arrests was more likely to engage in repeat violence regardless of whether or not he was arrested (6), but arrest was a better deterrent for individuals who were married or employed, that is, those who had the most to lose by being arrested again (3).

Likewise, individuals with more prior assaults against their partner, and those who were drinking or using drugs at the time of the offense were more likely to re-offend regardless of how police had responded previously (7). Alarming, a few studies found that an arrest actually increased rates of repeat violence if the offender was unemployed or unmarried (8, 3). In sum, while continued evaluation of arrest efficacy is important for victim safety, it has also been noted that the purpose of arrest is, over and above the findings of evaluation research, a societal punishment for criminal conduct (4).

Research also provides evidence that mandatory arrest policies might not be consistently followed across jurisdictions. Across the U.S., the rate of arrest for intimate partner violence reports in places with mandatory arrest policies varied widely from 30%-75% of incidents (9, 10), and one study found that mandatory arrest policies increased the number of reports made to police, but did not significantly change arrest rates or the circumstances under which officers chose to make an arrest (11). In this particular study conducted over a five-year period in a southern city with a 40% African-American population, the survivor's preference was still

the best predictor of whether an arrest was made: if a survivor supported arrest the police arrested the offender 63% of the time, but if the survivor preferred no arrest the offender was only arrested 10% of the time despite the mandatory arrest policy (11).

### WHERE DOES KENTUCKY STAND?(33)

All states in the U.S. permit officers to make a warrantless arrest on domestic violence suspects based on probable cause that an offense occurred. However, Kentucky does not currently have any mandatory arrest laws or no-drop prosecution policies for most offenses. The only exception is that an officer is required by state law to make an arrest when there is probable cause to believe that a violation of a protective order has occurred (KRS 403.760).

- 22 states plus the District of Columbia have mandatory arrest laws requiring an arrest to be made if there is probable cause to believe an assault has occurred, and 33 states have mandatory arrest laws for the violation of a protective order.
- 6 states have preferred arrest laws encouraging officers to make an arrest if there is probable cause to believe an assault has occurred.
- The remaining 22 states have laws which permit officers to make a probable cause arrest at their discretion in domestic violence cases.

One criticism of the police-based mandatory arrest studies is that they do not examine all cases of domestic violence, since many assault cases are not reported to police. Using data from the National Criminal Victimization Survey (NCVS), a survey that asks a random sample of Americans about crimes they have experienced regardless of whether the incidents were reported to police, Felson and colleagues (7) found that arrest had an insignificant effect on reducing repeat assault by an intimate partner. However, reporting to police at all, regardless of whether an arrest was made, did significantly reduce the risk of additional assaults.

Another criticism of mandatory arrest policies has been that mandatory arrest disempowers survivors of abuse by taking away their ability to decide what is best for their own situation. Some scholars argue that mandatory arrest policies can prevent women from calling police for help because an arrest does not seem appropriate for their circumstances (12, 13). This issue is of particular relevance for women of color, since battered African-

American women express concerns about subjecting their partners to a justice system they perceive to be racist and discriminatory (14, 15), and battered immigrant women may fear that calling the police will endanger the immigration status of themselves or their partner (16).

*A study in Kentucky examining barriers to help for rural women finds anecdotal evidence to support the disempowerment caused by women's concerns about mandatory arrest: one woman claimed that "women won't call the police because of the new domestic violence law that mandates automatic arrest of both the husband and wife for domestic violence" despite the reality that no such law exists in the state of Kentucky (17).*

However, not all evidence suggests that mandatory arrest is disempowering. For example, a survey of women in a shelter found that around 85% were supportive of mandatory arrest policies, and the women surveyed were more likely to feel that mandatory arrest policies reduced the burden of responsibility for survivors (77%), rather than disempowering them (18%) (18).

### *An Unintended Consequence: Dual Arrest*

Research consistently shows across multiple studies that an unintended consequence of mandatory arrest policies is that more women are arrested in domestic violence cases in the places where these laws are enacted. This usually involves what is called a "dual arrest" where both domestic partners are arrested by the responding officer, but increases in female single arrest are also associated with the passage of mandatory arrest laws (9, 10, 19). A national study examining arrest practices in jurisdictions across 19 states found that the overall rate of dual arrest for intimate partner cases was low (1.9%), but varied widely by location (9). For example, a study of 4,138 family court cases in Connecticut one year after implementing mandatory arrest laws found that both the survivor and her abuser had been arrested in 33% of the cases (20). A California study found that while only 5% of felony domestic violence arrests were women in 1987 before pro-arrest policies were enacted, the proportion of

female arrests rose to 18% by 2000 (19). Mandatory arrest policies are linked to this increase, since research finds that more women are being arrested in domestic violence cases, while reported rates of intimate victimization of men has not increased (21).

Arresting women who are reaching out for help for domestic violence can be detrimental to survivors' chances of receiving help. Research finds that battered women who have been incarcerated are significantly less likely to utilize the legal system for help with abuse (24), and that these women may be more likely to cope through substance abuse and become further involved with the criminal justice system (24, 25).

### *Mandatory or No-Drop Prosecution Policies*

Some jurisdictions have taken additional steps to strengthen the criminal justice response to domestic violence by implementing mandatory or "no-drop" prosecution policies, again with mixed results. Mandatory prosecution policies usually mean that the state or city presses assault charges against the domestic violence offender rather than the victim, and thus a survivor's participation is not required for prosecution to proceed.

Research evaluating mandatory prosecution policies identifies some positive impacts of this type of policy. Dutton (26) finds that mandatory prosecution "often leads to more effective court-mandated and monitored batterer-treatment programs" (27). One study found that even some survivors who did not want their own cases prosecuted were generally supportive of no-drop prosecution policies, because the survivor would not have to be responsible for bringing charges against her abuser (28). A study comparing a mandatory prosecution policy in Brooklyn, NY to a victim-supported prosecution policy in the Bronx, NY found at least one major benefit of mandatory prosecution for survivors. Most prosecuted cases were accompanied by the issuance of a protective order, and therefore re-arrest for domestic violence in Brooklyn was more likely to lead to a felony conviction and greater sentence for repeat offenders (28).

Scholars have suggested that to avoid liability for *not* arresting a dangerous perpetrator, police officers may be instructed to arrest all parties and let the legal system sort out the conflict (9, 12, 22, 24).

Research also identifies several weaknesses in the mandatory prosecution approach. In critiquing the study in Brooklyn, NY mentioned in the previous paragraph, Buzawa and Buzawa (27) point out that fully prosecuting every domestic violence case is very expensive for prosecutors and not particularly helpful for persons involved in the case.

Despite the mandatory prosecution policy only 5% of Brooklyn cases ultimately led to a conviction (27, 28). One study in Ohio found that domestic violence offenders who were prosecuted were less likely to be re-arrested than offenders that were not (29), but other evidence suggests that mandatory prosecution may simply "increase likelihood that reoffending will not be reported because victim preferences were not followed" (27, 30, 31).

Moreover, there is some concern that prosecution might not be a fast enough response to protect survivors from further abuse, since one study found that 44% of re-offending occurred before the first case had finished the legal process (32).

## Conclusion

In recent decades, the legal and criminal justice system has made significant strides in recognizing the seriousness of domestic violence, and implementing policies and practices which are intended to help women who are survivors of domestic abuse. However, these well-meaning policies have not always been as effective as advocates have hoped, and under certain circumstances may even make a situation worse for a survivor. Mandatory arrest policies have been shown to only slightly lower repeat offending rates, in particular for individuals who are married and employed. However, arrest may actually increase the risk of retaliation by abusers with a prior history of violence, or among those who are unemployed and have little to lose. Mandatory arrest may not be appropriate for all circumstances, and the presence of mandatory arrest policies may be disempowering for survivors by discouraging them from calling the police. This is particularly true for minority women, who may already have reservations about the

fairness of the criminal justice system. Likewise, the implementation of mandatory arrest policies has been shown by researchers to result in more women being arrested, often as cases of dual arrest where both offender and survivor are taken into custody, despite the fact that evidence does not show an increase of violence by women against intimate men.

Similar to mandatory arrest policies, mandatory or "no-drop" prosecution policies have also been implemented to try to improve the criminal justice response for survivors. Again, this approach has been shown by research to bring both benefits and drawbacks. Mandatory prosecution relieves survivors of the responsibility of pressing charges, and may lead to more offenders receiving treatment, the automatic issuance of protective orders, and greater penalties for repeat incidents of domestic violence. However, no-drop prosecution may also violate the wishes of survivors and prevent them from exercising control of their own situations. Research finds that no-drop policies are costly, not immediately protective, and may even have the opposite effect as intended by discouraging women from reporting future violence due to the ordeal of having a case unsuccessfully prosecuted against her will.

Mandatory arrest and prosecution policies, while a step in the right direction, are far from being a universally helpful and effective way to respond to domestic violence incidents. This is particularly true when considering the empowerment and protection of the survivor who may be forced against her will to participate in the legal system, much in the same way she has been forced against her will to endure violence in her life. While these policies have been helpful to some women, they have been harmful to others. When considering these types of policies, it is important to understand that not all domestic violence situations are the same and that a general policy may not be effective for everyone. Researchers, advocates, and policymakers should seek to make evidence-based decisions that consider all consequences of a proposed policy, including possible unintended consequences, in order to best act to empower and protect survivors.

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## QUESTION 6:

### WHAT ARE THE MOST SIGNIFICANT LONG-TERM HEALTH CONSEQUENCES OF CHRONIC SEXUAL OR PHYSICAL VIOLENCE?

#### REPORT AT A GLANCE

- Chronic physical, sexual, or psychological abuse can have a long-lasting impact on a woman even after the abuse or the relationship has ended.
- The most direct health consequence of chronic intimate partner violence is the possibility of death.
- Intimate partner violence may directly impact a woman's health through physical attacks and related injuries - chronic pain, broken bones, arthritis, hearing or sight deficits, seizures, or frequent headaches.
- Abuse victims can often suffer repeated "mild" brain injury that can have a lifelong impact which includes: sleep disturbances, headaches, dizziness, depression, irritability, anxiety, changes in social or sexual behavior, speech problems, cognitive impairment, and memory issues.
- Sexual violence often co-occurs with partner violence. Sexual violence can lead to vaginal or anal injuries, high levels of stress linked to sexual dysfunction and immune system problems, depression, and increased risk of bacterial infection.
- Abuse can cause ongoing physical and psychological pain, which over an extended period of time results in physiologic changes to stress-response areas of the body's central nervous system. These stressors can lead to life-long changes in the body's functioning and increases vulnerability to chronic pain syndromes and psychological dysfunction.

*In 2010 the Center for Research on Violence Against Women conducted a survey with over 100 rape crisis and domestic violence advocates in Kentucky about what they needed to know from research to help them do their jobs. Advocates identified ten top issues. This brief is one in a series of ten prepared by the Center to answer these top ten research questions.*

#### Introduction

Any type of intimate partner violence (IPV) negatively affects the health and well-being of the women who experience it. A single incident of physical or sexual violence, for example, can have both immediate and long-term physical health consequences. When a woman experiences chronic physical, sexual, or psychological abuse by a partner, that violence becomes increasingly likely to have long-lasting impact on her health even after the abuse or relationship has ended. Some of the direct, long-term physical health consequences of violence against women may seem obvious (e.g., disability due to traumatic injury, sexually transmitted infections), but many indirect health consequences are less intuitive and have only been recently examined through high-quality research on disparities in women's health. Thanks to years of advocacy and study, more and more health research now controls for intimate partner violence as a major risk factor in women's health.

This article examines and summarizes research findings about significant, long-term health problems which arise from women's experience of chronic violence. We begin by examining the risk of death and the direct consequences of traumatic injury, and then take a closer look at the indirect linkages between IPV, stress, and chronic illness.

#### Direct Health Consequences of Violence

The most significant direct health consequence of chronic intimate partner violence is the possibility of death. Data on national homicide trends from 1976 to 2005 shows that 30% of women murdered in the U.S. were killed by an intimate partner, compared to only 5% of male victims (1). A study which interviewed 311 close friends or family of female homicide victims across 11 U.S. cities found that 66% of victims had been abused by their partner prior to the murder,

and that 41% had utilized the health care system due to the abuse (2). Another study from the same data determined that the presence of sexual violence and escalating severity and frequency of physical violence predicted an increased chance of homicide, while having never lived with the abusive partner was a protective factor (3). This study and many previous studies suggest that chronic and worsening violence is especially dangerous at the point of separation from the abuser.

Injuries are common among survivors of intimate partner violence and can lead to chronic health problems or disability over time, especially if women are exposed to repeated similar traumas. As Coker and colleagues (4) explain: "The mechanism by which IPV affects women's health may be direct through repeated physical assaults and resulting injuries. Examples of health consequences through this direct pathway include chronic pain, broken bones, arthritis, hearing or sight deficits, seizures, or frequent headaches" (p.454). For a variety of reasons including abuser control and low socioeconomic status, many women may not seek health services immediately or openly report IPV to health care providers (5). However, a sizeable proportion of women receiving regular family medicine care or coming to an emergency department for other issues report a recent history of ongoing partner violence when surveyed (4, 6). A longer period of abuse is associated with more adverse health effects and higher utilization of health care services (4, 5, 7, 8, 9).

### Traumatic Brain Injury

One direct health impact of intimate partner violence with severe long-term consequences is traumatic brain injury. A review of previous research studies by Plichta (10) found that facial injuries were sustained by between 81% and 94% of women with abuse injuries. Banks (11) reviews research on the link between traumatic brain injury (e.g., concussions) and partner violence and finds

evidence that abuse victims can often suffer repeated "mild" brain injury that can have a lifelong impact much in the same way sports medicine research is becoming increasingly aware of the risk of repeated mild concussions in athletes. However, unlike athletes who are given protective gear, rest, and rehabilitation, "there are no on-site monitors for victims of intimate partner violence; therefore, similar injuries in victims of interpersonal violence are not assessed and treated, nor are preventions implemented" (11, p. 292). Moreover, she argues, the symptoms of traumatic brain injury are difficult to diagnose because "there is considerable overlap with posttraumatic stress syndrome (PTSD), dissociation, and substance abuse" (p.292). Potential consequences of traumatic brain injury include sleep disturbances, headaches, dizziness, depression, irritability, anxiety, changes in social or sexual behavior, speech problems, cognitive impairment, and memory issues (4, 11, 12).

### Gynecological Problems

Sexual violence by an intimate partner can also lead directly to serious, long-term health problems. According to Campbell (5), "gynecological problems are the most consistent, longest lasting, and largest physical health difference between battered and non-battered women" (p.1332). Sexual violence often co-occurs with partner violence; a study of women in a general practice clinic found that among women who experienced physical violence, 58% also experienced sexual violence (4).

*Sexual violence often co-occurs with partner violence; a study of women in a general practice clinic found that among women who experienced physical violence, 58% also experienced sexual violence (4).*

Sexual violence can include incidents such as controlling verbal sexual degradation, refusal to use condoms, or forced sex. These forms of abuse can lead to external or internal vaginal or anal injuries, high levels of stress linked to sexual dysfunction and immune system problems, depression, increased risk of bacterial infection, and increased exposure to sexually transmitted disease resulting from abusive partners' unprotected sex with others (5, 9, 13).

Moreover, women with a history of childhood or adult sexual abuse are more likely to experience chronic pelvic pain and other gynecological problems than women who were not sexually abused (4, 14), and are at increased risk of developing cervical cancer (15).

### *Indirect Health Consequences of Violence*

Beyond the direct impacts of sexual and physical violence on women's health, research has demonstrated that intimate partner violence is also a significant contributing factor to other chronic health conditions in women. These indirect effects are often difficult for clinicians to recognize and diagnose because they may be unaware of a woman's abuse history and first attempt to rule out other medical causes (8, 16). Groups of symptoms without a known organic cause (i.e., disease or infection) are usually referred to by medical professionals as "syndromes" and many share a common characteristic of increased physical and psychological stress (8). Since long-term intimate partner violence and abuse is a major source of chronic physical and psychological stress, research into these somatic (i.e., bodily) stress syndromes and conditions has discovered an association between a woman's history of violence exposure and lifelong stress-related health and mental health problems.

### *Stress-Related Physical Illness*

Stress-related somatic syndromes include conditions such as fibromyalgia, chronic fatigue syndrome, irritable bowel syndrome, and temporomandibular disorder. A review of research on stress-related somatic syndromes by Crofford (8) finds that patients with these syndromes report higher levels of prior exposure to physical and sexual violence than the general population of women. In addition to stress-related somatic syndromes like those above, exposure to chronic physical and sexual violence has also been linked to chronic pain symptoms (4, 14, 17, 18), chronic inflammation and immune dysfunction (18, 19), migraine headaches, and sleep problems (4, 17). Other research finds that intimate partner violence exposure is linked to physiological and hormonal abnormalities within the nervous system that can lead to heightened pain sensitivity, overactive stress response, aggression, and anxiety (8, 20).

### *Chronic Conditions Worsened by Violence*

Physical and sexual violence has also been shown to worsen the symptoms of more common chronic health problems. A review chapter in *The Sourcebook on Violence Against Women* (21) summarizes: "Violence survivors are also more likely than women who have not experienced violent victimization to have reproductive health problems, such as dysmenorrhea, menorrhagia,

## LARGE, HIGH-QUALITY STUDIES LINKING PARTNER VIOLENCE AND HEALTH (36)

### **Coker, Smith, Bethea, King, & McKeown (4)**

**Sample:** 1,152 families from medical practice clinics.

**Key Findings:** Psychological partner abuse was associated with increased risk of disabilities preventing work; chronic neck or back pain; arthritis; migraines/frequent headaches; problems seeing with glasses; sexually transmitted infection; chronic pelvic pain; stomach ulcers; spastic colon; indigestion/constipation/diarrhea. Ever experiencing physical partner violence was associated with increased risk of hearing loss; angina/heart/circulatory problems; bladder/kidney infections; hysterectomy; gastric reflux.

### **Tolman & Rosen (33)**

**Sample:** 753 women receiving welfare in urban Michigan county.

**Key Findings:** Women who report partner violence had 3 times as many mental health disorders compared to women who had never experienced violence. Even after controlling for demographic differences, recent partner violence was associated with increased

risk of physical health problems.

### **Plichta & Falik (34)**

**Sample:** 1,821 women in nationally-representative sample.

**Key Findings:** Intimate sexual violence, including childhood and adult violence, was associated with poor self-assessed health status, disability, chronic health conditions, depressive symptoms, anxiety/depression diagnosis, and taking medications for depression/anxiety.

### **Kramer, Lorenzon, & Mueller (35)**

**Sample:** 1,268 women from health care setting.

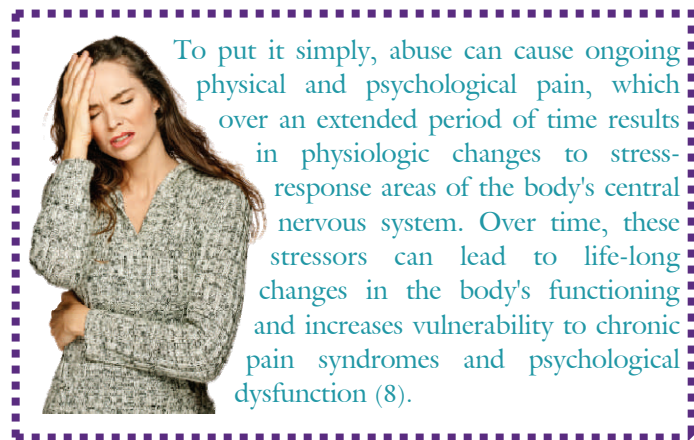
**Key Findings:** Lifetime partner violence increases likelihood of headaches; stomach problems; chronic pain; seizures; broken bones; sexually transmitted diseases; vaginal bleeding; substance abuse; depression; suicidal thoughts.

### **Zink, Fisher, Regan, & Pabst (25)**

**Sample:** 995 participants over 55 years old recruited from primary care services.

**Key Findings:** Participants who report partner violence also report significantly more symptoms of chronic pain, depression/anxiety,

sexual dysfunction, and sexually transmitted diseases. Increased rates of gastrointestinal disorders, including stomach ulcers, spastic colon, gastric reflux, indigestion, and diarrhea, are also found among violence survivors. This research also shows that violence is associated with conditions such as hearing loss and heart disease." (p. 292)



Research suggests that chronic inflammation and depression, both common consequences of violence against women, may be major contributing factors for women's development of cardiovascular disease and metabolic syndrome, the precursor to diabetes (22). Extreme stress and depression over an extended period of time disrupts the body's ability to control inflammation, and thus "the normal feedback loop breaks down and fails to restrain the inflammatory response" (22, p. 119). Preliminary studies suggest that depression in early adulthood and childhood has been linked to early-stage cardiovascular disease and the formation of unstable plaques in the arteries which increases heart attack risk, and these effects appear to be greater for women than men (23, 24). While research is still exploring the scientific and medical reasons for this link, multiple large studies in health care settings clearly demonstrated an association between partner violence and cardiovascular problems (4, 25).

### *Mental Health and Physical Health*

Finally, violence against women can cause mental health problems which can worsen women's physical health problems. In the general population, depression is linked to inflammation and heart disease as described above, and depression is also associated with "premature aging,

impaired immune function, impaired wound healing, and even Alzheimer's disease" (22). Women who experience intimate partner violence not only have significantly higher rates of depression, they are also more likely to experience anxiety, posttraumatic stress disorder (PTSD), and engage in substance abuse (26, 27). An important consequence of many mental health problems is an increase in certain unhealthy coping or risk behaviors. Studies have found links between intimate partner violence and sexual risk behaviors such as low condom usage and unsafe sexual partners (5, 28), increased cigarette smoking which is a risk factor heart disease and cancer (15, 29), and increased drug and alcohol abuse which can contribute to other long-term health problems 28, (30, 31, 32). Over time, experiences of abuse can increase hostility and damage social relationships, cause sleep disturbances, and decrease immune functioning in ways that can also eventually lead to poor health (22).

### *Conclusion*

To put it simply, intimate partner violence can have long-term health consequences for women that are both direct and indirect. The direct consequences of repeated physical, sexual, or psychological abuse are well known. These direct health impacts include the risk of death, physical injuries and resulting disabilities, and long-term gynecological problems. Emerging research suggests that traumatic brain injuries, commonly referred to as concussions, may be an important yet overlooked consequence of long-term physical abuse. Recent public debate and even Congressional hearings on sports injuries finds that repeated mild traumatic brain injuries can have life-altering consequences even with rest and proper treatment, and yet battered women often go undiagnosed and have no protections from further injury. Other research suggests that long-term sexual abuse may increase a woman's risk of developing cervical cancer.

The indirect impacts of chronic abuse on women's health are insidious, often difficult to diagnose but can lead to cumulatively worsening health in a variety of ways that research is only beginning to understand. One of the ways ongoing physical, sexual, and psychological violence can

impact women's health is by creating constant physical and emotional stress on the body. Over time, this stress overwhelms the brain and body's ability to respond appropriately, and can cause patterns of physical symptoms known as stress-related somatic syndromes. In other words, chronic abuse can literally change the survivor's brain chemistry and alter her personality, her ability to cope with pain, and the ability of her body to heal or protect itself from disease. Intimate partner violence also appears to worsen other chronic health conditions, increasing the severity of gastrointestinal disorders and heart disease. Chronic abuse also contributes to mental health problems, which over time can also stress the body, lower immune responses, and increase vulnerability to common health conditions like diabetes. In light of the growing knowledge that violence against women affects women's health in so many ways, many medical professionals and researchers now recognize that solving violence against women should be a priority for improving the health of women in our communities.

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**WHAT PERCENTAGE OF RAPE CASES GETS PROSECUTED?  
WHAT ARE THE RATES OF CONVICTION?**

REPORT AT A GLANCE

- A national study estimates only 37% of reported rapes are prosecuted.
- 18% of prosecuted rape cases end in a conviction.
- Research suggests a survivor's decision to report a rape case and continue within the legal system is one of the most important factors affecting the prosecution of rape cases.
- The criminal justice system can often deter women from continuing their cases due to secondary victimization. Women may be retraumatized by having to repeatedly tell their story and detailed investigations by law enforcement may make survivors feel like they are not believed.
- A Sexual Assault Nurse Examiner, Sexual Assault Response Team or other advocates may be effective in helping rape survivors understand the legal process without feeling further victimized by the process.
- Prosecutors often only take cases they can win, for rape cases many factors may be considered. Often cases are unwittingly approached with rape myths and stereotypes about race, class, gender and the deservingness of rape victims.
- Research shows that even when charges are filed, the legal system often downgrades or drops felony rape charges for guilty pleas on other crimes. This often does not feel like justice for survivors since the offender never has to admit or acknowledge that his actions were rape.
- More effort is needed in understanding and eliminating the gap between the ideals of cultural and legal rape reforms, and the application of these ideals within the realities of the criminal justice system.

*In 2010 the Center for Research on Violence Against Women conducted a survey with over 100 rape crisis and domestic violence advocates in Kentucky about what they needed to know from research to help them do their jobs. Advocates identified ten top issues. This brief is one in a series of ten prepared by the Center to answer these top ten research questions.*

Introduction

The most recent national study examining the prevalence of rape in the United States was reported in 2007 and estimated that 18% of women in this country have been raped in their lifetime (1). Based on their interviews with a representative sample of 5,000 women, the researchers in this study estimated that around 1 million women were raped in 2005, the year of the study. While that Rape in America report spotlighted the plight of 1 million women, however, official data from the Federal Bureau of Investigation indicate that only about 94,000 rapes were reported to law enforcement in the same year (2). Together, these data suggest that fewer than 10% of rapes that occur in the United States are ever reported to police.

When sexual assaults are reported to law enforcement, very few cases end up being prosecuted, with research indicating that only 14-18% of all reported sexual assaults ultimately get prosecuted (3, 4, 5, 6). When limited to rape only (rather than including all forms of sexual assault), prosecution rates are slightly higher. The National Violence Against Women Survey (7) estimated that 37% of reported rapes of adult women were prosecuted.

Not all prosecuted cases end in a conviction. The NVAWS estimated that only 18% of rape cases involving adult women result in a conviction. Since most rapes are not reported to police, the study estimated that only 3.4% of all rapes ultimately lead to a conviction for the offender. Several factors affect if and how a rape is reported and prosecuted, and whether or not the case results in a conviction. This report reviews research on the prosecution of rape, and examines factors which appear to affect the likelihood of prosecution or conviction.

## *Reported Rape Cases in the Criminal Justice System*

The likelihood and outcome of rape case prosecution is dependent on a number of factors, as noted below:

1. First, as mentioned above, most rapes are never reported to police. Research suggests, however, that the sooner a rape is reported, the more likely it will be prosecuted. When a rape is reported early, there is a greater likelihood that medical forensic evidence can be collected (5, 8), and that law enforcement, prosecutors, and jurors will find the survivor's story credible (9, 10).
2. Women raped by strangers on average report the incident much sooner than those raped by a known person, even though the typical rape perpetrator is likely to be an intimate partner or acquaintance (4, 7). Research suggests that cases are more likely to be reported and prosecuted if they involve strangers, multiple offenders, and other crimes which co-occur with the rape (12).
3. More severe cases are also more likely to be prosecuted (9). One study conducted 102 in-depth interviews with women in Chicago, and found that only 25% of reported rape cases were prosecuted (4). In this particular study, 70% of the prosecuted cases had white victims, and 80% of the prosecuted cases closely fit the profile of a "classic rape case" involving a stranger offender, injuries, and/or weapon use (4).

Once a rape has been reported, the criminal justice process involves several gatekeeping steps from the initial report to prosecution. Much of the research on barriers to prosecuting rape cases focuses on two critical stages of the criminal justice system: the police investigation stage, and the prosecutor stage.

### *Police Investigation Stage*

Contact with a law enforcement officer or detective is usually the first step towards prosecuting a rape case. The goal of police officers and detectives is to build a strong case of evidence and recommend to prosecutors that charges be filed (2).

Some research has suggested that police detectives, by whether they encourage or discourage a woman's decision to press charges, may be the biggest influence whether or not a legal case is pursued (13).

The survivor herself must play an important role in the investigation process, and many cases only go forward if the survivor participates (5, 14). This often means that a survivor must re-tell the story of her rape to many different people, over and over again, which can be traumatic and difficult. However, fulfilling detectives' requests for information during the investigation must take place before prosecutors will commit time and resources to prosecuting a rape case (14). Often these necessary steps for the investigation must be done at times and locations (for example, coming to the police station to identify a suspect in a line-up at whatever time the police can bring him into custody) which may continue to disrupt a survivor's day-to-day life activities (14).

Some survivors report that the detailed investigation by law enforcement can make them feel further violated and not believed, a situation researchers have termed the "second rape" or "secondary victimization" (15, 16, 17). Studies surveying rape survivors found that in the past police have doubted women's stories, were unsupportive or threatened to charge the women with crimes for not cooperating, or asked intrusive questions about the woman's sexual history or how they were dressed (18, 19, 20). A study by Patterson (21) suggests that survivors' perceptions of secondary victimization by detectives depended on the outcomes of cases:

"Victims whose cases had many factors of credibility and were ultimately prosecuted described their detectives as compassionate. On the other hand, victims whose cases had many factors typically viewed as lacking credibility indicated their detectives as engaging in secondary victimization." (p.342)

A large survey of 891 police officers in the southeastern U.S. found that officers who accepted more rape myths were less likely to believe rape victims without "classic rape case" circumstances (22).

However, research also finds that the assistance of an advocate improved survivors' experiences with police. Survivors with victim advocates were more likely to file a police report, were less likely to be treated negatively by police, and reported less distress from participating in the legal system (23). Other research suggests that a Sexual Assault Nurse Examiner (SANE) provides important support and confidence to women when they are first choosing to report a rape to law enforcement and seek prosecution (5).

### *Prosecutor Stage*

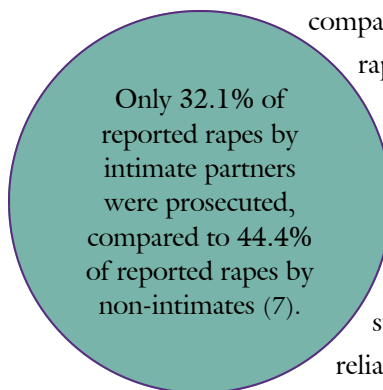
Once a police report has been filed and evidence is gathered, a prosecutor usually makes the decision of which, if any, criminal charges to bring against an offender (12). A research review by Miller, Iovanni, and Kelley (24) concludes that "prosecutors often only take cases they are reasonably sure they can win" (p. 278). For those survivors whose case doesn't meet those standards; is less clear with respect to evidence, their case may not seem winnable for prosecutors. In these instances, this often means that the needs of the rape survivor are lost among the practical concerns of meeting the legal requirements of the criminal justice system. Because they focus on successful prosecution if a case goes to trial, prosecutors may almost immediately press survivors on issues that might arise in trial, for example, her ability to withstand cross-examination by a defense attorney.

Research shows that a Sexual Assault Nurse Examiner (SANE), Sexual Assault Response Team (SART), or other advocates may be effective in helping rape survivors understand the legal process without feeling further victimized by the prosecution process (5, 24).

Unfortunately but important to report from the literature, at least one study reported that some women reported to researchers that they felt pressured by advocates who

worked together with prosecutors to convince her to accept certain legal decisions made against her wishes (14).

Other problems can arise for prosecutors when considering the likelihood of a successful prosecution. Evaluating the viability of a case can sometimes mean that prosecutors approach rape survivors with rape myths in mind, thereby unwittingly reproducing stereotypes about race, class, gender, and the deservingness of "real" rape victims (25). Data from the National Violence Against Women Survey demonstrate the consequences of these myths. In the nationally-representative study, only 32.1% of reported rapes by intimate partners were prosecuted,



Only 32.1% of reported rapes by intimate partners were prosecuted, compared to 44.4% of reported rapes by non-intimates (7).

compared to 44.4% of reported rapes by non-intimates (7).

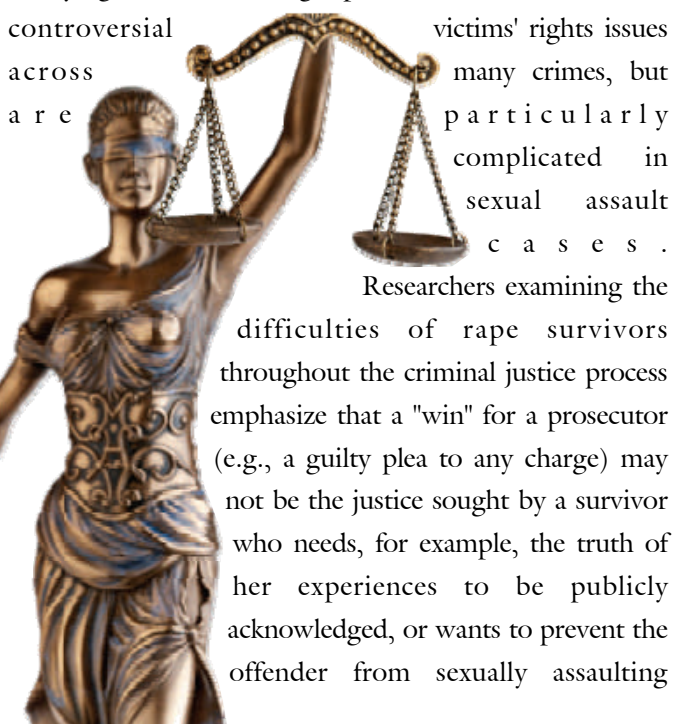
Conviction rates for intimate rapists were also significantly lower (36.4% to 61.9% of prosecuted cases), suggesting that prosecutors' reliance on rape myths when considering prosecution may be at least partially based on experiences in trying real cases (7). Likewise, interviews with rape survivors also show that white victims with stranger offenders fitting a "classic rape case" profile are most likely to have their cases prosecuted, and yet fewer than half of these offenders were convicted at trial (4).

Establishing the credibility of a survivor is an important part of both investigation and prosecution, but having her story repeatedly questioned at each stage of the legal process can be extremely difficult and discouraging to survivors and can ultimately affect the woman's decision on whether or not to pursue or continue participation in a prosecution (14, 21, 26). Prosecutors must walk a fine line between building a strong and credible case, and making the survivor feel like she is being accused of lying by the people who are there to help her.

## *Plea Bargains by Prosecutors*

Reaching a plea deal can be favorable in some rape cases because it prevents the rape survivor from having to testify at trial and expedites the prosecution process. It may also be the only way to secure an omission of guilt from the offender. However the amount of influence a survivor has in the plea process affects whether or not she feels justice has been served (14, 27). In interviews with approximately 50 rape survivors about their cases, Konradi (14) found that women were most satisfied with plea negotiations when their level of actual participation most closely fit the level of involvement they desired. Some women felt angry, depressed, badgered, or dissatisfied when they had offered to testify but prosecutors went forward with a plea deal anyway, and other women who did not want to testify appreciated "the prosecutor's efforts to resolve the case short of trial as an extension of other efforts not to burden her" (p147). Research into plea deals in sexual assault cases finds that most plea bargains downgrade felony rapes to misdemeanor non-rape sex crimes, and at other times dropped sexual charges altogether in exchange for guilty pleas to other crimes like burglary, assault, or kidnapping (14, 28).

Participation in prosecution, plea negotiations, and testifying in sentencing phases are difficult and controversial across victims' rights issues many crimes, but are particularly complicated in sexual assault cases.



Researchers examining the difficulties of rape survivors throughout the criminal justice process emphasize that a "win" for a prosecutor (e.g., a guilty plea to any charge) may not be the justice sought by a survivor who needs, for example, the truth of her experiences to be publicly acknowledged, or wants to prevent the offender from sexually assaulting

others (5, 14, 29). A plea deal to a lesser charge or a conviction on a non-sexual crime may not feel like justice since the offender is never required to actually admit or acknowledge that he raped the survivor.

Research continues to identify the need for more sensitivity towards survivors' perspectives in order to prevent secondary victimization by the services attempting to help rape survivors to get justice.

## *Conclusion*

Overall, research on rape prosecution reflects the highly personal and sensitive nature of sexual offenses and the ways in which these realities shape prosecution of rape cases. A major national study estimates that only 37% of reported rapes are prosecuted (7), and other research studies estimate that only 14-18% of reported sexual assaults of any kind lead to prosecution (5). Moreover, the estimated conviction rate among reported rape cases is only 18%, and if the total number of rapes based on victimization surveys instead of only those reported to police are considered, only 3.4% of rape incidents lead to a conviction (7). Research conducted to date suggests that a survivor's decision to report a rape and continue within the legal system is one of the most important factors affecting the prosecution of rape cases, and yet the criminal justice system in many ways can discourage or disappoint women seeking justice. Quick reporting of rape incidents (more often done by women raped by strangers) affects the potential to collect evidence and build a case, and is associated more sympathy from police. This fact, however, is related to the stereotypes and myths about rape held by police officers and detectives, many of whom base their judgments of a survivor's credibility on elements of a "classic rape case" involving a stranger offender, physical injuries from a survivor fighting back, or the use of a weapon by the rapist. The way in which police officers and detectives initially respond to a woman's report seems to be critical in whether a woman chooses to participate in further legal action, or feels she has experienced "secondary victimization" and harsh

treatment by the criminal justice system (13, 21). When a rape case is sent to a prosecutor, a survivor must endure more questioning and scrutiny from prosecutors who are attempting to build a strong case. Just like police officers and detectives, prosecutors also employ rape myths when examining the credibility of a survivor's potential testimony. The pressures put on the survivor in the prosecution stage may lead her to withdrawal her complaint or participation, and may affect whether or not her rapist is charged at all. Even when charges are filed, research shows that the legal system often downgrades or drops felony rape charges for guilty pleas on other crimes, which means that justice for survivors may not be as simple or fair as she expects (14, 27, 28). In all, research on the prosecution of rape reveals that more effort is needed in understanding and eliminating the gap between the ideals of cultural and legal rape reforms, and the application of these ideals within the realities of the criminal justice system.

## MUST-READ RESOURCE

### *Taking the Stand: Rape Survivors and the Prosecution of Rapists*

By Amanda Konradi. Praeger Publishers, 2007  
ISBN 0-27599-718-9. \$49.95 Hardcover.

*"While I knew that other women had gone through rape trials before me, no book existed that could tell me what it was like to testify in court, what it was like to talk to and work with detectives and attorneys, what choices I could make, what I could refuse to do, and what feelings I might have about my whole experience. Sometimes not knowing was in itself frightening." (p.2)*

This empowering book provides detailed information for rape survivors going through the legal process based on interviews with approximately 50 rape survivors about their experiences before, during, and after their legal cases. While also providing critical insights and suggestions for reform, the book uses the stories of real women to guide rape survivors through the legal process so that they can better understand what to expect, and what they can do to guide or aid prosecutors in their efforts to get justice.

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**DOES TREATMENT WITH INTIMATE PARTNER  
VIOLENCE OFFENDERS WORK?**

**REPORT AT A GLANCE**

- Batterer treatment and intervention programs are often used as a way for the criminal justice system to respond to domestic violence offenders.
- In 2008, 45 states had legislative statues mandating the use of batterer interventions with specific standards.
- Most programs follow either the Duluth power and control model or utilize elements of unstructured group psychotherapy.
- Research finds a minimal benefit from attending batterer interventions, estimating treatment prevents future violence only about 5% more than arrest alone.
- Dropout rates vary by program, but research has found that about half of all men assigned to attend interventions do not finish the program.
- Researchers are exploring factors which affect drop-out rates and have investigated ways to improve participation and success rates for racial minorities, individuals with substance abuse problems, and batterers with differing psychological problems and needs.
- Some researchers suggest re-examination of what "success" in intervention means, suggesting that preventing some violence or reducing the severity of violence should be viewed as a positive effect of intervention, even if treatments do not accomplish the ideal outcome of ending violence completely.

*In 2010 the Center for Research on Violence Against Women conducted a survey with over 100 rape crisis and domestic violence advocates in Kentucky about what they needed to know from research to help them do their jobs. Advocates identified ten top issues. This brief is one in a series of ten prepared by the Center to answer these top ten research questions.*

*Introduction*

Clinical treatments and batterer intervention programs for intimate partner violence offenders have been in existence since the 1970's. Many of these programs started locally and grew over time, eventually resulting in partnerships between the mental health system and the legal system, frequently with help from state legislatures who mandated treatment for domestic violence offenders. As of 2008, only five states did not have legislative standards in place mandating batterer treatment (1). Since their inception, two major treatment approaches to intervening with men who abuse their partners have emerged: the feminist "Duluth" power and control model developed by advocates (2), and the unstructured group psychotherapy model based on cognitive-behavioral therapy (CBT) techniques developed by clinical psychologists (3). Research finds that both of these men's group therapy approaches have strengths and weaknesses, and limited research has also been conducted on a limited range of other interventions.

Over the past several decades, the prevailing question in the area of batterer treatment programs has been deceptively simple: "do they work?" Interventions for men who batter are a part of a larger system dealing with domestic violence which includes police, criminal courts, civil courts, victim's advocates, children's advocates, and mental health professionals. Because these organizations have different goals and perspectives, the "success" of intervention programs for men has been contested and difficult to measure (4). To date, researchers have conducted, compared, and reviewed numerous studies which can give us a more informed picture of the strengths, weaknesses, shortcomings, and opportunities these batterer intervention programs offer as one small part of addressing the common problem of ending domestic violence.

## *Types of Batterer Treatment Programs*

Treatment programs for men who batter have been broadly categorized into two types depending on the philosophical orientation of the people responsible for developing the interventions.

1. Feminist approaches following the "Duluth model" (named for the city in which it was first developed) see domestic violence as a consequence of men using their power in society to exert control over their female partners (2). These approaches seek to educate men about connections between patriarchy and violence using tools like the well-known *Power and Control Wheel*.
2. Clinical psychology techniques are grouped together as the "unstructured group psychotherapy" approach using cognitive-behavioral therapy (CBT) techniques, which view violence as a learned behavior of individual men. Group psychotherapy approaches examine the pros and cons of violence and teach abusive men to utilize communication skills, anger management techniques, and alternatives to violence (3, 5).

Research has extensively debated the strengths and weaknesses of each of these two major approaches to batterer intervention. The Duluth approach confronts men with the idea that violence is a voluntary control strategy made possible by patriarchy and gender-based power in society, yet critics argue that "focusing on the political context and ignoring the individual context seems dehumanizing and dismissive of men's experience, which often includes histories of abuse and or neglect" (6, p. 179). On the other hand, psychotherapy approaches are criticized by feminists as dismissive of women's experience, by ignoring how patriarchy permits men to get away with abusing women within the home. Employing techniques like anger management "downplays the fact that most batterers selectively confine their violence to their partners, rarely striking friends or coworkers" which feminists claim demonstrates that men can, in fact, control their behavior in the parts of society where they are more likely to be held accountable (6, p. 171). Through 2008, 43 states had mandated that a

power and control perspective be included in batterer treatment programs (1). In all, 12 states require treatment programs to exclusively use a power and control model, and 31 require programs to discuss both power and control, and social psychology principles (1).

About half of batterer treatment programs nationwide identified their primary approach as "Duluth" (53%) and half as cognitive-behavioral (49%, according to Price & Rosenbaum, 2007, as cited by Saunders. (7, p. 157).

Despite the basic philosophical differences between the two major approaches and legislative mandates, in practice most intervention strategies for batterers utilize elements of both strategies: men's group cognitive-behavioral therapy, and confrontation of oppressive social attitudes towards women (5, 6, 7, 8). Some researchers have raised concerns which might apply to any batterer intervention program, regardless of the basic approach. For example when the criminal justice system forces men to attend treatment programs, or when group facilitators use their position of authority to confront men, these actions may inadvertently reinforce the effectiveness of using power and control to get your way, which the programs are trying to teach men to avoid using in their own homes (4, 6). Others point out that court-ordered interventions are "one size fits all" (1, 4, 9, 10) and that criminal justice driven programs detrimentally blur the lines between legal punishments and mental health treatments (6, 11).

Some researchers argue that if intervention programs are not clearly shown to be effective, they will give a false sense of security to the partners of abusers (12).

## *Do Batterer Treatments Stop Recidivism?*

Over the past several decades, dozens of studies have documented the outcomes of batterer intervention programs, attempting to address the question of whether or not batterer treatment can prevent repeat acts of violence. Each of these outcome studies is limited to specific treatment programs, study populations, and research methodologies. In order to draw conclusions across decades of similar studies of varying quality and

## A COMPARISON OF THE TWO MAJOR MODELS FOR BATTERERS INTERVENTION (6)

	<u>Unstructured Group Psychotherapy</u>	<u>Feminist Power &amp; Control Model</u>
Practitioners	<ul style="list-style-type: none"> <li>Developed and supported mainly by mental health practitioners</li> </ul>	<ul style="list-style-type: none"> <li>Developed and supported mainly by feminists, victim's advocates</li> </ul>
Program Length & Conditions of Completion	<ul style="list-style-type: none"> <li>Groups typically last between 3 months and 18 months, depending on the program and conditions of court mandate</li> </ul>	<ul style="list-style-type: none"> <li>Groups typically last 6 months, but can vary depending on state standards and conditions of court mandate</li> </ul>
Group Structure	<ul style="list-style-type: none"> <li>Men in the groups are at different stages in the program—modeling is expected</li> </ul>	<ul style="list-style-type: none"> <li>Men in the groups are at different stages in the program—modeling is expected</li> </ul>
Group Content	<ul style="list-style-type: none"> <li>Themes emerge, but the topics and activities of each week are not extensively preplanned</li> <li>Men are encouraged to share experiences of victimization and vulnerability</li> </ul>	<ul style="list-style-type: none"> <li>Focus on eight preplanned themes, each presented in a similar fashion with similar activities over a 3-week period</li> <li>Men typically discouraged from sharing experiences of victimization, but instead are required to take responsibility and be accountable</li> </ul>
Group Facilitation	<ul style="list-style-type: none"> <li>Meetings are facilitated by a trained leader, often a clinician</li> <li>Facilitator encourages the group to be self-directed, often taking a back seat in discussions</li> </ul>	<ul style="list-style-type: none"> <li>Meetings are co-facilitated by trained male and female activists</li> <li>Facilitators are vigilant for and routinely confront the men's sexist and controlling attitudes</li> </ul>
Additional Program Components	<ul style="list-style-type: none"> <li>Men often expected to continue emotional work related to program outside the group</li> </ul>	<ul style="list-style-type: none"> <li>Men have homework assignments that include journals and reading</li> </ul>

design, researchers have utilized two common research techniques: traditional review articles (i.e., grouping many previous studies by key characteristics and looking for noteworthy similarities) and a technique called *meta-analysis* (i.e., gathering all known quantitative studies of a certain methodological quality which measure the same variables, then using advanced statistical techniques to combine the results for a measurable "overall" effect). While individual study results vary, both of these research techniques find that batterer treatment programs generally have only a small overall effect on stopping repeat domestic violence.

Stover, Meadows & Kaufman (8) reviewed the research on batterer treatment programs and conclude that "group treatment for batterers have meager effects on the cycle of violence, with most studies demonstrating no or minimal impact above that of mandatory arrest alone" and that recidivism rates are similar "regardless of intervention strategy" (p.225).

Comparing studies on the effectiveness of mandatory arrest, batterer interventions, and victim advocacy

interventions, Stover, Meadows & Kaufman (8) conclude that repeat offending occurs at a rate of "20-30% within 6 months, regardless of the intervention strategy" (p.231).

A meta-analysis by Babcock, Green, and Robie (5) combined data from 22 research studies that measured recidivism using either police records or victim reports, were based on experimental (i.e., a treatment group compared to a control group with no treatment) or quasi-experimental design (i.e., no true control group, but instead comparing program drop-outs to completers), and recorded whether the intervention was based on the Duluth model, CBT, or another approach. There was no significant difference between the Duluth and CBT approaches in their analysis.

Regardless of intervention program, they found that "based on a partner report, treated batterers have a 40% chance of being successfully nonviolent, and without treatment, men have a 35% chance of maintaining nonviolence. Thus, there is a 5% increase in success rate attributable to treatment" (p.1044).

Based on this 5% success rate, they calculate that if batterer interventions for every reported domestic violence case in the U.S. might protect as many as 42,000 women per year, but they also caution that "whether this success rate is cause for celebration or despair depends on a cost-benefit analysis" taking into account both costs and potential "side effect" dangers to some families for whom mandatory interventions might do more harm than good (p.1044).

Using different inclusion criteria than Babock, et al. (5), Feder and Wilson (11) conducted a more limited meta-analysis of 10 studies from 1986-2003 which had stricter rules about experimental design, post-arrest court-mandated programs designed to reduce battering, and followed offenders for at least 6 months post-treatment using third-party recidivism data. Like the previous meta-analysis, this analysis across multiple studies found only a small, if any, positive effect of treatment on recidivism.

Another approach to measuring the effectiveness of a batterer's treatment program is by gathering the input from the partners of men in treatment. In fact, Carol Gregory and Edna Erez (13) criticize studies that measure the success of batterer intervention programs by simply whether or not there is any future violence, claiming that this narrow definition of "success" ignores the input of the women these programs are designed to help. Interviews with 33 women whose partners entered a batterer intervention program in Ohio found that even though most of the women continued to experience abuse, about half of the women felt the program had improved their relationship, 81% reported a decrease in violence and threats, and 70% said the program reduced the severity of the violence and threats they did experience (pp. 214-215). While the interventions may not have ended the violence, the majority of women felt they had benefitted from their partner's treatment. Still, about one-fifth of the women in their sample reported that the program made their partner angry or taught the men new strategies for abuse. Most women in the study, even those reporting benefits, reported an increase or no

About one-fifth of the women in Gregory and Erez's sample reported that the program made their partner angry or taught the men new strategies for abuse (13).

change in verbal abusive tactics after batterer interventions (13).

### *Batterer Program Limitations*

After examining the above review of existing research, one may be tempted to conclude that batterer treatment programs have limited, if any, effect on preventing future abuse. However, a number of critical limitations to the reviewed studies exist. First and foremost, batterer treatment programs have very high drop-out rates of around 46% on average, and in individual studies have attrition rates as high as 78% (8).

Researchers have investigated the reasons that men drop out of batterer treatment programs, and find that stable demographic characteristics (e.g., employment, older age, higher income, stable housing, married, higher education) predict which individuals complete the treatment (14, 15). On the other hand, abusers with previous domestic violence, other criminal histories, and with substance abuse problems are more likely to drop out of treatment (14).

Research also finds that white participants are more likely than minorities to remain in treatment (14), however culturally-specific batterer programs, all-minority groups, or groups with minority counselors have been shown to improve treatment completion rates (1, 10). At least one study improved batterer participation significantly by employing motivational enhancement techniques like phone call reminders and follow-ups for missed session (16).

The second limitation of existing studies is the "one size fits all" approach to batterer treatment. While attrition rates and recidivism rates are high in most studies, there are studies which show promise by acknowledging differences between offenders. Jewell and Wormith (14) found that "men who were more educated and court mandated were more likely to complete feminist psychoeducational programs than were men who were not as educated or court mandated, whereas

batterers who were older completed cognitive-behavioral programs more readily than younger men" (p.1107).

Mankowski and colleagues (6) remind us that patriarchy might not explain all abuse, since "not all men become batterers and not all batterers are violent for the same reasons" (p.177). In fact, other domestic violence research has discovered strong evidence supporting different "types" of batterers based on clusters of psychological characteristics (17, 18, 19). Matching batterers to certain types of treatments based on their psychological traits, abilities, and motivations has been shown to improve program completion and success rates (7, 14, 20, 21).

A third limitation of the current knowledge is that most research on batterer treatment outcomes focuses on the court-mandated Duluth power and control group programs which predominate the treatment landscape, arguably to the detriment of other treatment alternatives. The Duluth model is favored by feminist political activists, who have accomplished the widespread acceptance of this model through state law in 95% of states with laws regarding batterer treatment (1). However, as reviewed above, research has repeatedly shown only minor improvements from these treatments. Some scholars now argue that while these laws have raised awareness of domestic violence as a serious political and social issue, the restrictions within the framework of the legal and criminal justice system which allow only one treatment model may inhibit the testing of new, potentially more effective intervention strategies (1, 4, 11, 9). Feder and Wilson (11) argue that "alternative programs cannot be implemented and tested even as evidence builds indicating that batterer intervention programs, at least as designed and implemented today, may not be effective" (p.258). Evidence from state statutes highlights these types of restrictions; 68% of states with batterer treatment laws forbid couples therapy for batterers, 2 states forbid individual therapy, and 35% of states with batterer treatment laws explicitly forbid any treatments based on mental health disorder models or approaches such as anger management, based on the reasoning that these approaches might allow the abuser to deny responsibility or blame the victim in some way (1,

pp. 136-137). A separate, but related issue, may also be the lack of qualified personnel to serve as group facilitators for these state-mandated programs, either due to limited resources in smaller rural communities (9), or tension between professionally licensed psychologists and experienced advocate facilitators over minimum qualifications to lead groups (6).

### *Treatment Possibilities and Controversies*

Despite legal restrictions in many states on the types of interventions the court can mandate for abusers, there is growing evidence that incorporating a more holistic approach to batterer treatment may produce more favorable results for some batterers. One of the most promising areas of research for improving batterer treatment addresses the second limitation described above; that is, improving treatment by assessing the batterer's other needs and thereby avoiding the "one size fits all" approach. Research indicates that many abusers also have substance abuse and addictions problems, which can lead to program attrition (14) as well as lead to increases in domestic violence perpetration (22). A few research studies exist which find that alcohol treatment on its own (23), or in combination with batterer treatment may help to prevent partner violence (9, 24, 25).

Currently, only 40% of states (up from 20% in 2001) require a bachelor's degree for treatment facilitators, and 15% (including Kentucky) require professional licensure at a master's level or better (1, p. 145).

Along with substance abuse, researchers suggest that treatments for men who batterer might also be improved by addressing issues of racial prejudice, economic stress, detrimental community or family culture, mental illness, and the men's own histories of childhood abuse (4, 6). Saunders (7) describes this multi-faceted approach as a "coordinated community response" such that no single intervention is expected to solve the complex problem of domestic violence (p.165). Such a response may, for example, involve prosecution, probation, counseling, drug courts, and danger assessments in coordination with victim services.



Finally, some controversial research challenges many traditional assumptions about batterer intervention groups and

has discovered some noteworthy results when examining outcomes from couples' therapy or individual counseling involving abusive men. Most state laws now expressly forbid mandatory couples counseling for batterers (since this is equivalent to forcing abuse victims to attend treatment or to stay with their abusers, and could also endanger victims as a direct result of their disclosures in couples' therapy), and a few prohibit individual counseling (1, 26). Unfortunately, research also shows that many battered women initially choose to stay with their abuser after one or more incidents of violence (27), so some researchers argue that working with couples could still be a last-resort alternative in some cases, since a few research studies suggest that batterers may be less likely to drop out of couples' treatment than from men's groups (8). Critics have argued that couples therapy or individual therapy unfairly diffuses responsibility for the abuse, and may even prevent reporting of repeat violence by victims (4, 6). Nevertheless, abusers may already be in couples' therapy since many couples who voluntarily seek counseling report a history of domestic violence. Also, some women may seek a more active role in their abusive partner's treatment, evidence by one qualitative study in which some battered women suggested that there "should be an option to include both partners" in order to improve interventions (13). Emerging new research within couples' therapy that includes working on intimate partner violence issues suggests that, under certain restrictive qualifications and circumstances, these approaches might reduce violence and improve therapy outcomes (28, 29). One study found that couples therapy in combination with substance abuse treatment significantly reduced reported male violence better than substance abuse treatment alone (30), and several research reviews cited couples' therapy studies which had lower drop-out rates and slightly better success rates among batterers (5, 11, 8). Still, these results should be viewed with caution since couples therapy is certainly not

appropriate in most cases, and the participants in these handful of studies "differ substantially from the prevailing court-referred population" (9). Individual treatment has largely been ignored or outright banned as a possible batterer intervention, but research on case-tailored therapy suggests that it may be beneficial for men with underlying psychological issues either by itself, or alongside traditional group therapy (31).

Researching controversial alternatives to Duluth model such as individual or couples' therapy seems to violate the feminist principles on which much of the domestic violence movement is based, however other feminists argue that scholars and advocates should listen to battered women's voices in order to best understand needs of women living with abusive men. The study cited above (13) that reviewed the experiences of women whose partners were in batterer's treatment is a good example of this approach. Their qualitative results, like the results of other research, reinforces the fact that each domestic violence case is a unique, multifaceted, and ongoing problem that cannot be solved with a one-time, "one size fits all" intervention.

### Conclusion

Batterer treatment and intervention programs have been in existence in the United States for decades, and have become a widely used option for the criminal justice system to respond to domestic violence offenders. In the most recent national review of states' batterer intervention laws in 2008, 45 states had legislative statutes in place mandating the use of batterer interventions with specific standards (1). Most batterer intervention programs are men's groups which focus on the Duluth power and control model, a feminist educational approach aimed at confronting men with the knowledge that patriarchal social attitudes are a misguided justification for sexism and abuse. In practice, many intervention groups also utilize elements of unstructured group psychotherapy, also known as cognitive-behavioral therapy (CBT) which attempts to help men learn non-abusive behavioral responses to stress and conflict in their lives. Research that compiles and analyzes outcome studies from dozens of

these mandated batterer intervention programs, however, finds at best a very minimal benefit from attending batterer treatment, estimating treatment to prevent future violence only about 5% more than arrest alone (5, 8, 11).

Despite these somewhat discouraging findings, the results of these research reviews should be viewed with caution. Treatment or education can only work if batterers actually attend and complete the programs, and research finds that almost half of all men who are assigned to attend batterers interventions do not finish the program (8). Some researchers are now exploring factors which affect drop-out rates (14), and others have investigated ways to improve participation and success rates for racial minorities (10), individuals with substance abuse problems (24, 25), and batterers with differing psychological problems and needs (6, 7, 20). An emerging area of research is examining controversial alternatives to the traditional batterer intervention models, including the use of individual counseling (31), couple's therapy approaches (29), or a combination of treatment strategies (25, 30). Some researchers even go as far as to suggest re-examination of what "success" in intervention means, suggesting that preventing some violence or reducing the severity of violence should be viewed as a positive effect of intervention, even if treatments do not accomplish the ideal outcome of ending violence completely (4, 13).

Ultimately, research on batterer interventions demonstrates that current intervention approaches, sometimes criticized as a "one size fits all" approach, are not as successful as victims, advocates, researchers, or criminal justice personnel would like them to be. Despite political and legislative successes, there are still many tensions, controversies, and opportunities to improve the way both the criminal justice system and the broader community intervene and attempt to address domestic violence through the treatment of men who abuse their intimate partners.

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**DOES A REPORT OF INTIMATE PARTNER VIOLENCE OR SEXUAL ASSAULT BY A PARTNER PUT A WOMAN AT RISK OF LOSING CUSTODY OF HER CHILDREN?**

REPORT AT A GLANCE

- A recent national study found that 25.6% of children were exposed to physical or psychological violence between parents or caretakers in their lifetimes.
- Exposure to violence may involve seeing violence, overhearing a confrontation, seeing the aftermath such as bruises or broken furniture, or being told about the violence.
- Children exposed to domestic violence may suffer from significant emotional and behavioral problems related to this traumatic experience.
- Witnessing parental violence may be the single strongest factor for involvement in intimate partner violence as an adult.
- Though all 50 U.S. states explicitly require judges to consider exposure to domestic violence when evaluating welfare and custody options for children, the significance of the issue is often overlooked by family courts, lawyers, and court-related services.
- Intended to protect children's well being, "failure to protect" laws may unduly punish victims of domestic violence and not the offender.
- There may be many mitigating circumstances as to why a victim may not have taken any formal action to protect herself or her children from exposure to domestic violence. This perceived lack of action can be used against women in child custody cases.
- As professionals work to improve the systemic responses to domestic violence and child maltreatment, the ultimate goal must be to intervene in ways that balance the needs of the both children and mothers affected by intimate partner violence, so that no battered woman has to choose between getting help and losing custody of her children.

*In 2010 the Center for Research on Violence Against Women conducted a survey with over 100 rape crisis and domestic violence advocates in Kentucky about what they needed to know from research to help them do their jobs. Advocates identified ten top issues. This brief is one in a series of ten prepared by the Center to answer these top ten research questions.*

Introduction

The problem of domestic violence is most often seen as a conflict between two adults where the victim, most often a woman, is the person harmed through physical, sexual, and psychological aggression by her partner. To fully understand the breadth of domestic violence, however, a broader perspective on how "victim" is defined is crucial. In the majority of homes where there is violence between the adult partners, there are children there to witness the assault and to live through its aftermath. Studies find that children living in violent homes are at greater risk of being abused, maltreated, or neglected in homes where domestic violence occurs (1; 2, 3). Even if a child is not physically harmed, witnessing or being aware of parental violence might be emotionally, psychologically, or developmentally harmful (3, 4, 5).

This article discusses recent research literature on child custody issues facing women who experience domestic violence. Research in recent decades has been helpful to raise awareness of the impact of domestic violence on child well-being and to create better protections for children, but in some ways this awareness has also created a more precarious situation for battered mothers. This is a controversial and challenging problem in which experts and practitioners must weigh the ethical concerns of protecting children *and* the needs of adult victims of abuse, a balancing act that becomes challenging when those needs appear to be in conflict. The first section of this article defines and describes children's exposure to parental domestic violence. This research provides important background for understanding controversial "failure to protect" laws, which hold caretakers legally accountable for exposing their children to dangers such as violence in the home. Supporters of "failure to protect laws" believe they compel women to report abuse sooner for fear of losing their children, however other research suggests

that there are good reasons why a woman might not immediately report domestic violence, especially when she has children. The final section looks at challenges and possibilities suggested by experts for improving the legal response to domestic violence and child welfare, with the goal of protecting children without discouraging battered mothers from reporting abuse.

### *How Many Children Experience Abuse and/or DV Exposure?*

The U.S. Department of Health & Human Services found that in FY 2009, there were 3.3 million reported incidents of child maltreatment (6). These national statistics record that a maltreated child's primary caregiver was either a perpetrator or victim of domestic violence in 18.3% of cases where evidence of child maltreatment could be substantiated, but this report does not go into detail about the parental violence (6). It is likely that most statistics underestimate both child maltreatment and co-occurrence of domestic violence, because not all incidents of domestic violence or child maltreatment are reported or are able to be substantiated by authorities. Appel and Holden (7) analyzed the results of 17 studies of battered mothers and estimate that approximately 40% of children whose mothers are battered are also physically abused, though individual study estimates vary widely. This variability is because measuring exact rates of co-occurrence between domestic violence and child maltreatment is very difficult due to people's reluctance to report one or both types of violence, the sensitivity of the subject matter, the challenge of clearly defining the many different types of possible violence, and inconsistencies when a child, mother, and father are each surveyed about violence in a home (8).



Even if they are not directly maltreated, many children are exposed to intimate partner violence between their parents or caretakers. The phrase "exposure to domestic violence" can describe a variety of different experiences for children.

Researchers do not agree on which types of partner violence impact children the most, or what exactly constitutes exposure to violence. Researchers use the term "exposure" because studies have found that violence in a home impacts children even if not directly witnessed (4, 9, 10).

*Exposure to violence may involve seeing violence, overhearing a physical confrontation, seeing the aftermath of an incident such as bruises or damaged furniture, or being told about violence by siblings or parents (8).*

In October 2011, the U.S. Department of Justice released the first national study designed to estimate children's exposure to intimate partner violence between caretakers (11). The National Survey of Children's Exposure to Violence (NatSCEV) estimated that approximately 17.9% of children were exposed to parental intimate partner physical violence over their lifetime, and about 6.6% were exposed in the past year. The study also measured exposure to psychological and emotional abuse between parents and/or caretakers (16.0% lifetime exposure, 5.7% within the past year). If both physical and psychological violence between parents or caretakers is considered, 25.6% of children were exposed to IPV in their lifetimes, and 11.1% in the past year. These findings are similar to prior estimates, which had placed children's annual intimate partner violence exposure rates between 10-20% of all children in the U.S. (8, 12). Prior to this study, most research in this area was focused more on the impact of children's exposure to domestic violence rather than its prevalence.

25.6% of children were exposed to physical or psychological violence between parents or caretakers in their lifetimes (11).

Several research studies find that domestic violence in a household has a detrimental impact on children. Even if children are unaware that violence is taking place, some theories suggest that domestic violence may temporarily "spillover" into how the victimized parent treats a child (7,

13). Multiple research studies that interviewed battered mothers provide evidence of spillover effects; many women described how the emotional toll of domestic violence affects how much energy and empathy they could put into parenting (14, 15, 16). One interview-based study found that some battered women "create unhelpful silences" about their own abuse when trying to shield their children from the violence (16). Other research has found that maternal victimization may undermine women's parental authority in ways that have been linked to child-to-parent aggression and other child behavioral problems (3, 17). However, at least one study found that the effects of domestic violence on women's parenting was temporary; the quality of parenting by battered women in their study improved significantly within 6 months of separation from their abusers (13).

A study that followed a group of 500 children over 20 years found that witnessing parental violence was the single strongest factor for involvement in intimate partner violence as an adult (23).

Research is inconclusive as to whether or not exposure to domestic violence makes women more likely to engage in child abuse. A small study by Coohy (18) found that previous child abuse by a woman's mother—and importantly not battering by a partner—predicted the likelihood that battered women in the study had engaged in child abuse. Holden, Stein, Ritchie, Harris, and Jouriles (13) conducted two studies comparing child abuse among women in shelter to women in the community with contradicting results. Several studies have utilized data from the 1975 and 1985 National Family Violence Survey data, and have generally concluded that domestic violence is at least associated with child abuse. One of the most recent analyses of this data found husband-to-wife domestic violence was a significant predictor of a mother's violence towards her child even when controlling for several demographic factors (19). However, using the same data to analyze child abuse by either parent, Ross (20) calculated that the father was three times as likely to abuse a child as the mother whenever domestic violence was present. Though

there is still much debate among researchers about the extent to which battered mothers are involved in child abuse, most research clearly shows that any domestic violence "increases the risk that the child has been or will be subject to violence" (21, p. 7).

Exposure to intimate partner violence may cause psychological trauma or distress in children, or may teach children to use violence and aggression to solve their problems (3, 4, 12, 22). Kitzmann, Gaylord, Holt, and Kinney (5) analyzed 118 studies on children exposed to violence and concluded that children who witnessed violence were just as likely as children who were directly abused to have negative outcomes in terms of psychosocial functioning, emotional development, adjustment problems, levels of distress, and the likelihood of using violence themselves. There is also evidence that childhood exposure to domestic violence leads to domestic violence later in life. A study by Ehrensaft et al. (23) followed a group of 500 children over 20 years and found that witnessing parental violence was the single strongest factor for involvement in intimate partner violence as an adult. Research suggests that this intergenerational transmission of violence occurs because many children learn to tolerate or use violence as they grow older, and is especially common among children who develop behavioral problems as a result of violence they have experienced or witnessed (3, 18, 23). Still, not every child exposed to child maltreatment or domestic violence has problems later in life.

Children with more stability, social support from friends or caregivers, a strong mother-child relationship, and a feeling of control of their own lives appear to more readily escape the cycle of violence (3, 22).



## *Reporting IPV, Children and the Law*

Today, laws in all 50 U.S. state explicitly require judges to consider exposure to domestic violence when evaluating welfare and custody options for children (24, 25). Statutes in 28 states (including Kentucky) require courts to consider evidence of domestic violence in custody cases, and the other 22 state have stronger statutes that directly presume that it is against a child's best interest for the perpetrator of domestic violence to have sole or joint custody (24). A legal presumption against a domestic violence perpetrator usually means a non-abusive parent will receive sole custody (24, 26, 27), except in states that also have a contradictory "friendly parent" provision which encourages joint custody (28). Kentucky currently has neither a presumption against abusers nor a "friendly parent" provision, but specifies that domestic violence be considered as a factor in custody cases (see Table 1).

The general trend in domestic violence laws and services has been to increase protections for women and their children. For example, many domestic violence shelters provide programs for the children of battered women

who seek shelter services (8, 12). Recently, child custody evaluations have been highlighted by researchers as an area which needs improvement, because there is no uniform procedure for dealing with child custody evaluations when domestic violence is alleged between parents (4, 26, 27, 29, 30, 31, 32, 33, 34).

Despite the increased attention to domestic violence issues in child custody, there are practical challenges for carrying out these protections. One major difficulty has been the ability of the court system to integrate research and new information into practice (35). For example, a 2002 exploratory study conducted by University of Kentucky researchers found that over half of their sample of child custody evaluations "reported interviewing parents together regardless of domestic violence" (36). Such practices most often will prevent the full disclosure of abuse because women fear retaliation from the ex-partner, since research shows that women do remain at risk for future violence by a former partner when the abuser has continued contact with her through joint custody arrangements (34, 37).

### TABLE 1. EXCERPTS FROM KENTUCKY LAWS ON CHILDREN AND DOMESTIC VIOLENCE

#### KRS 403.270

(2) The court shall determine custody in accordance with the best interests of the child and equal consideration shall be given to each parent and to any de facto custodian. The court shall consider all relevant factors including:

- (f) Information, records, and evidence of domestic violence as defined in KRS 403.720;
- (i) The circumstances under which the child was placed or allowed to remain in the custody of a de facto custodian, including whether the parent now seeking custody was previously prevented from doing so as a result of domestic violence as defined in KRS 403.720 and whether the child was placed with a de facto custodian to allow the parent now seeking custody to seek employment, work, or attend school.

#### KRS 620.023

(1) Evidence of the following circumstances if relevant shall be considered by the court in all proceedings conducted pursuant to KRS Chapter 620 in which the court is required to render decisions in the best interest of the child:

- (b) Acts of abuse or neglect as defined in KRS 600.020 toward any child;
- (d) A finding of domestic violence and abuse as defined in KRS 403.720, whether or not committed in the presence of the child;

#### KRS 600.020

(1) "Abused or neglected child" means a child whose health or welfare is harmed or threatened with harm when his parent, guardian, or other person exercising custodial control or supervision of the child:

- (b) Creates or allows to be created a risk of physical or emotional injury as defined in this section to the child by other than accidental means;

A major misconception is that parental divorce and separation ends a child's exposure to domestic violence. A national survey in Canada found that 28% of women reported some type of violence by a former partner, and over half of those reporting violence by an ex-partner said the violence got worse or began after separation (38). Other research shows that separated mothers already experience increased stress because of financial strain and day-to-day responsibilities after separation (39), and that abusive men use child visitation or custody challenges to further stress, intimidate, threaten, control, or abuse these women (40, 41, 42, 43). Interviews with divorced battered mothers suggest that women struggle to negotiate fear, continuing partner abuse, and child-welfare concerns when a joint custody agreement requires continued contact with an abuser (14).

Finally, there is research to suggest that women who report domestic violence feel like they receive contradictory messages from the systems designed to help them. For example, Stark (44) conducted interviews in which many battered women said they felt pressured into participating in the prosecution of domestic violence cases by the worry or implication that child protective services might investigate them if they did not cooperate. In some jurisdictions, women may have legitimate child custody concerns when reporting domestic violence because of "dual arrest" policies in which both parties are automatically arrested when police respond to a domestic violence call (45, 46, 47). Fear or apprehension about getting themselves, their children, or their partner involved in the legal system may discourage women from reporting abuse occurring prior to separation, which in turn can undermine her credibility when she only later reports a history of intimate partner violence during a divorce case or child custody hearing (27, 48, 49). As Jaffe, Johnston, Crooks, and Bala (27) explain:

Some victims may hesitate to report violence in an attempt to reduce conflict, while others may not initially recognize what they have experienced as abuse until they have some distance and counseling. For example, a woman may not recognize that sexual abuse can even happen in the context of a marriage, but may later come

to understand her experience as a violation of her rights. Unfortunately, in these cases, she might be subjected to an unjustifiable extent of suspicion by justice system professionals when she discloses sexual abuse for the first time after separation. Reports of abuse first made in the context of litigation should never be dismissed solely because of the timing of disclosure. (p. 507)

### SEVEN MISCONCEPTIONS ABOUT DOMESTIC VIOLENCE AND CHILD CUSTODY (49)

1. **Domestic violence is rarely a problem for divorcing couples involved in a child custody dispute.**  
*Reality:* The majority of parents in "high-conflict divorces" involving child custody disputes report a history of domestic violence.
2. **Domestic violence ends with separation for abused women.**  
*Reality:* Abused women often face continuing risks from their partner after separation.
3. **As long as children are not abused directly, they are not harmed by exposure to domestic violence.**  
*Reality:* Children exposed to domestic violence may suffer from significant emotional and behavioral problems related to this traumatic experience.
4. **Since domestic violence is behavior between adults, it is not relevant for the determination of custody.**  
*Reality:* Domestic violence is highly relevant to the determination of child custody by courts and court-related services.
5. **Family courts, lawyers, and court-related services, such as mediation and custody evaluation, can assess the needs of abused women and their children as well as the impact of the batterer.**  
*Reality:* The significance of domestic violence is often overlooked by family courts, lawyers, and court-related services.
6. **Legal and mental health services for abused women and their children separating from batterers are readily accessible and well coordinated.**  
*Reality:* Abused women often experience difficulty accessing appropriate legal and mental health counseling services for themselves and their children.
7. **There are no apparent solutions and community strategies to the complex dilemmas posed by abused women and children separating from batterers.**  
*Reality:* There are many emerging community and court innovations in responding to women and children separating from an abusive parent.

Delays in reporting abuse also contribute to the incorrect perception that false allegations of domestic violence are common legal tactics to be disregarded in family court decisions (32, 27, 50). Based on their review of research, Jaffe and his colleagues (27) recommend that parents' abuse claims should be evaluated by verification from multiple sources, like police and medical reports, eyewitnesses, or corroboration by neutral third parties (e.g., teachers, neighbors), and also by taking into consideration the psychological state of the parties involved.

### *"Failure to Protect" Laws and IPV*

Of significant relevance to a battered woman's custody of her children may be the so-called "failure to protect" laws. The purpose of these laws is to hold caretakers accountable for any harm done to the children for whom they are responsible, or for not taking action to protect children from known dangers. Because the court system now recognizes that domestic violence or sexual assault against a child's mother can be detrimental to child welfare, domestic violence in a home has been used by courts or social services to challenge child custody or even criminally charge mothers for being unable to protect a child from exposure to domestic violence (51, 24, 52). A well-known challenge to "failure to protect" laws occurred in 2002 in the case of *Nicholson v. Williams* (53). This was a class-action against New York City's Administration for Children's Services (ACS) that overturned a policy of removing children from mothers who experienced domestic violence. In the *Nicholson* case a woman was severely attacked for attempting to leave her abuser, and made arrangements for a babysitter to care for her children before going to the emergency room, however ACS policy still required social services to remove the children from the babysitter's home because the mother allegedly could not protect them due to domestic violence.

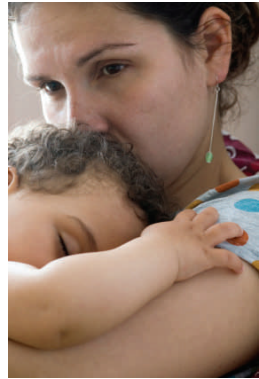
The U.S. District Court eventually ruled that children could not be removed from their mothers solely because of exposure to domestic violence. The *Nicholson* case is important because "for the first time, and in an incredibly powerful opinion, a federal court had found that battered mothers could not constitutionally be held responsible for the acts of their abusers" (53).

However, Goodmark (53) also reports that several states such as New Jersey, Florida, and Pennsylvania continue to carry out these types of policies despite the *Nicholson* ruling. Kentucky laws related to domestic violence and child custody do include in some language on "failure to protect" as a form of child neglect (see Table 1).

Supporters of "failure to protect" laws argue that the first responsibility of the family court system should be to protect children from exposure to domestic violence, even if protective actions are against the interests of the direct victim of partner abuse. Some scholars argue that these laws will reduce violence in homes because they "hold victims of domestic violence liable for not protecting their children [in] an attempt to compel these victims to take affirmative action to prevent harm to their children" (52, p. 288). In this view, reporting domestic violence is considered a way of protecting children, and ideally as long as women immediately report abuse they should not be charged under "failure to protect" statutes. Evidence from case law and research studies suggests that, in practice, these laws are most often cited by courts and social services to incriminate domestic violence victims (as in the above example of the New York City ACS) or cited by abusers and their attorneys to undermine battered mothers in child custody disputes (3, 24, 25, 51, 53). Scholars have also raised issues with the fairness of "failure to protect" laws, arguing that in practice they are usually only charged against mothers (3, 51, 52). Some scholars pointedly ask: why aren't abusive men charged with exposing their children to domestic violence when they harm the child's mother? (51, 54).

As "failure to protect" laws are usually only charged against mothers, some scholars pointedly ask: why aren't abusive men charged with exposing their children to violence when they harm the child's mother? (51, 54)

Several scholarly law articles cite cases in which a battered mother's status as a survivor of domestic violence made



her vulnerable to child custody challenges related to "failure to protect" claims (24, 25, 51, 53).

For example, Harris (24) describes a 2009 case in New York where a woman named Charlotte separated from her abusive partner, Gary, and took her child to live with her new partner, David. When

Charlotte separated from David due to domestic violence, she and her son temporarily moved back in with Gary. Soon after, Charlotte was arrested on outstanding traffic warrants and went to jail. Upon her release, Charlotte returned to David and filed for custody of her child, but Gary argued that Charlotte should not have custody due to ongoing domestic violence between her and her new partner. The court awarded custody to Gary, even though he had assaulted Charlotte when they were in a relationship years earlier, because, the court ruled, that by returning to her new partner Charlotte was failing to protect her son from exposure to current domestic violence. This case is a good example of the complex circumstances under which a battered woman may lose custody of her children after reporting the domestic violence she has experienced.

A battered mother might not report domestic violence to the police or other service providers for many of the same reasons that women in general do not report domestic violence or sexual assault. In her review of domestic violence and sexual assault in the justice system, Jordan (55) describes the "numerous factors" affecting any woman's decision to report violence, including "fear of reprisal from the offender, a victim's perception of social stigma attached to a victimization, and a belief that nothing may be accomplished in doing so" (p.1415). Regardless of whether or not she has children, representative national studies show that only around 17% of rape survivors and 27% of women physically assaulted report violent victimization to police (56).

Women may choose not to report violence for reasons such as:

- Perceptions of racial bias in the justice system (57, 58)
- Fear of being arrested themselves (59)
- For immigrant women, fear that reporting will lead to themselves or their partner being deported (60)
- Simply not believing that the police are an appropriate solution for their situation (61)
- Because they have employed different strategies to protect their children (25, 44)

Taking the steps to separate from an intimate partner can also be extremely disruptive, especially if a woman and her children are dependent on the abuser for housing, income, and child-care responsibilities (39, 55). This research suggests that holding battered women responsible for "failure to protect" their children may not be appropriate, given the "many mitigating circumstances as to why a victim may not have taken any formal action to protect herself or her children from exposure to domestic violence" (52).

### Controversies

There are many controversies surrounding the question of how to protect children from exposure to domestic violence. Recent scholarship in domestic violence and child custody criticizes the "behind closed doors" approach to custody settlements (29). Other researchers suggest that child custody evaluations should improve and standardize their techniques for investigating domestic violence and abuse claims (26, 27, 32, 33). One proposed solution is to refer allegations of domestic violence in custody cases to the juvenile court system, which has the ability and resources to investigate the home and work with a parent to improve conditions for child welfare, rather than simply transferring custody to the other parent (24). Some scholars challenge the gendered assumptions about mothers and fathers which may place children with unsafe custodians, for example, assuming that a son will benefit from having a relationship with his father

regardless of how violent he may be (30, 32). Because of the success of laws which deny custody to domestic abusers, a number of father's rights organizations have emerged to challenge the validity of domestic violence and child abuse claims in court (25). Some of these legal strategies have been successful, with some fathers arguing "parental alienation syndrome" (the claim that after separation women brainwash children to believe that their fathers were abusive) despite the fact that this diagnosis is based on biased, poor-quality, non-scholarly claims (50). All of these controversies challenge us to re-think our assumptions and common practices with the goal of improving outcomes for both child and adult survivors of domestic violence.

## Conclusion

Current research literature suggests that battered mothers' worries that they may lose custody of their children because they report domestic violence or sexual assault can, in certain circumstances, be a valid concern. Research finds that children do not have to be abused or directly witness parental violence to be affected by violence in their homes, but rather that exposure to domestic violence can involve a wide range of experiences which affect children in many different ways. As courts and social services come to better understand how intimate partner violence impacts children, all 50 U.S. states have included domestic violence as an important factor to be considered in child custody cases. Some people have claimed that the "failure to protect" children from exposure to intimate violence is the legal responsibility of the mother as caretaker, even when she is the one who has been victimized. These continuing challenges highlight the need to continue to critically examine the ways in which domestic violence is understood and addressed within our legal system, especially with regard to mothers and their children. As scholars, legislators, advocates, and other professionals work to improve the systemic responses to domestic violence and child maltreatment, the ultimate goal must be to intervene in ways that balance the needs of the both children and mothers affected by intimate partner violence, so that no battered woman has to choose between getting help and losing custody of her children.

## Resources

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## QUESTION 10:

### HOW DO WOMEN FROM DIFFERENT RACIAL/ETHNIC BACKGROUNDS EXPERIENCE INTIMATE PARTNER VIOLENCE OR SEXUAL ASSAULT? DOES RACE AND ETHNICITY MATTER?

#### REPORT AT A GLANCE

- Studies have found significant differences in rates and types of victimization experiences by women from different racial backgrounds.
- A national survey found that American Indian and African American women experience the most violence, Latinas and White women experience violence at similar rates, and Asian women report the lowest rates of violence.
- Most differences between racial categories can be accounted for by socioeconomic status and demographic factors like a woman's age, income, marital status and education.
- While racial and ethnic differences may not cause violence against women, research does show that race and ethnicity impact the experience of IPV or sexual assault.
- Women may be harassed or abused in ways that are uniquely demeaning in their own culture, which may not be easily understood by outsiders.
- Women may have specific cultural practices or attitudes which make them more or less likely to report violence, or may impact the ways in which they choose to seek help.
- The development of culturally competent services is extremely important for increasing the ability of professionals to help women from different backgrounds.

*In 2010 the Center for Research on Violence Against Women conducted a survey with over 100 rape crisis and domestic violence advocates in Kentucky about what they needed to know from research to help them do their jobs. Advocates identified ten top issues. This brief is one in a series of ten prepared by the Center to answer these top ten research questions.*

#### Introduction

Women from all racial and ethnic groups experience violence, and women from any particular group may experience or understand violence differently from women in other racial or ethnic groups. This report discusses the research literature on how a woman's experience of intimate partner violence or sexual assault is shaped by her racial and ethnic background.

#### Overall Racial/Ethnic Rates of Violence Against Women

Over the years, national studies measuring the extent of violence against women have reported similar findings about race and ethnicity. For example, the National Violence Against Women Survey (NVAWS), and the recent Collaborative Psychiatric Epidemiology Surveys (CPES) found significant differences in rates and types of victimization experienced by women from different racial backgrounds over their lifetimes (1, 2). These studies show that American Indian and African American women experience the most violence, Latinas and White women experience violence at similar rates, and Asian women report the lowest rates of violence (see table 1 on page 3). Overall, around 1 in 4 White women reported experiencing rape, physical assault, or stalking, while almost 1 in 3 non-White women reported these types of victimization.

Importantly, the fact that there are differences do not necessarily mean that belonging to a certain race or ethnic group makes women more vulnerable to abuse, or makes men more likely to commit acts of violence. In fact, research shows that socioeconomic characteristics (e.g., poverty) appear to be far more important than race or ethnicity as a risk factor for education, marital status, or place of residence. Many sociodemographic characteristics are strong predictors of rates of violence, and most racial differences disappear when these other factors are accounted for.

However, understanding what violence *means* to women from different cultures, or what unique barriers minority women face when seeking help for victimization does depend on understanding the relationships between race, ethnicity, and the experiences of physical and/or sexual violence.

### *Distinguishing Race/Ethnicity from Other Factors*

Studies have generally found that racial differences in rates of intimate partner violence and sexual assault can be almost completely explained by socioeconomic variables. This is because social problems like violence and substance abuse tends to be more prevalent in poor communities where there are also disproportionately large numbers of minority women (3, pp. 76-77). The fact that many minority groups experience higher rates of violence simply reflects the number of minority women living in poverty.

Most large, national studies on violence against women or victimization find that sociodemographic and relationship variables almost completely account for the differences between racial groups (1, 2, 4, 5). These studies identify several key variables which increase any woman's likelihood of experiencing intimate partner violence, regardless of race. These variables include: younger age, unmarried, lower income, lower educational attainment, unemployment and less

**Race** refers to a group of people recognized by others through a set of common physical traits (e.g., skin color, appearance). **Ethnicity** refers to a group of people who share a similar historical and cultural background (e.g., shared attitudes, beliefs, values, or practice). Usually members of an ethnic group share a common race, but not always.

**Racism** refers to stereotypical (usually negative) attitudes a person may hold about other people based on their perceived racial or ethnic background.

**Discrimination** refers to the act of treating people differently on the basis of these attitudes.

financially security.

Socioeconomic status is also a predictor of sexual victimization that cuts across race.

For example, a study from a Southern community sample of 836 low-income Black, White, and Mexican-American women found that significantly more low-income White women had experienced sexual assault (78.8%) than

Black (67.0%) or Mexican-American (63.1%) women in their lifetimes, but that there were no significant differences in the rates of current intimate partner violence (around 67-69%) these low-income women were experiencing (6). These generally high rates of victimization for low-income women, regardless of race, underscore that sociodemographic variables are usually more important predictors of victimization risk than race.

Neighborhood or community characteristics are also critical for understanding sexual assault and intimate partner violence. Historically, criminology research on violent crime has found that race is a poor predictor of crime and victimization rates when community-level variables are considered. Hampton, Carillo, and Kim (7) reviewed family violence research from the 1970's through the 1990's and concluded that differences between African Americans and Whites with regard to violent crime victimization or family violence have been largely explained by:

- Extreme poverty or lack of resources (i.e., income, social support networks);
- Family disruption (i.e., divorce, single-parent households); and
- Social stability (i.e., living in one place over time, being married, having children).

Research comparing the domestic violence service needs of Black and White women from rural and urban areas has also found that region also has a stronger effect on service needs than race, with rural women needing more help regardless of race (8). Sometimes race and community interact to create additional risks; for example, one study found that 42% of the African-American women they surveyed in a low-income housing community had experienced rape, and that these sexually victimized women were at greater risk for substance abuse and HIV exposure (9). This and other research on low-income communities suggests that poverty and social instability may help contribute to women's vulnerability within poor communities, which impacts a large number of minority women who are concentrated in these communities.

TABLE 1. NATIONAL LIFETIME PREVALENCE RATES OF VIOLENCE BY RACE

Survey		White	Black/ African American	Asian/ Pacific Islander	Hispanic/ Latina <sup>b</sup>	American Indian
National Violence Against Women Survey (NVAWS) <i>Data collected: 1995-1996</i>	<i>women</i>	n=6,45	n=780	n=133	n=628	n=88
	<i>rape</i>	7.7%	7.4%	3.8%	7.9%	15.9%
	<i>physical</i>	21.3%	26.3%	12.8%	21.2%	30.7%
	<i>stalking</i>	4.7%	4.2%	--	4.8%	10.2%
	<b><i>overall</i></b>	<b>24.8%</b>	<b>29.1%</b>	<b>15.0%</b>	<b>23.4%</b>	<b>37.5%</b>
Collaborative Psychiatric Epidemiology Surveys (CPES) <i>Data collected: 2001-2003</i>	<i>women</i>	n=644	n=62	n=746	n=864	
	<i>physical</i>	15.2%	17.3%	10.3%	15.2%	

CPES only examines physical violence, while NVAWS includes physical, sexual, and stalking victimization by an intimate. In the NVAWS, Hispanic women may be of any race.

### *Specific Effects of Race/Ethnicity*

Even though sociodemographic and community-level variables explain most racial or ethnic differences, this does not mean that women from all racial or ethnic groups experience the same types of violence or react in the same way. There are many ways in which race or ethnicity has a direct effect on the experience of intimate partner violence or sexual assault, which can be very important for understanding and helping women from diverse backgrounds. This section describes four ways in which race and ethnicity impacts the experience of violence against women.

#### *The types of violence experienced may differ for women from certain racial and ethnic groups.*

Sometimes, the same issues can have an opposite impact on members of two different ethnicities. For example, many immigrant women face the unique threat of deportation by abusers who control their immigration status (10, 11, 12). For South Asian

Cultural norms may shape violence and may affect how much violence is reported to outsiders. (14, 16, 17)

immigrant women, abuse within the United States is often made worse by extreme social isolation due to the distance from family overseas (11), while for Mexican immigrant women, sending

a woman back to Mexico is a tactic used by abusive men to control a woman's ability to work and become independent (13).

In another example of how cultural norms may shape violence, Latina women who contribute more to family finances are at higher risk for victimization because women's earnings may challenge gender norms about Latino men's ability to provide for their families (14), while higher women's earnings do not increase violence for Vietnamese women who are traditionally expected to contribute financially to the household (10). Unique cultural norms can also be particularly challenging when women are trying to explain their victimization to others, for example, testifying in a family court. As Jaffe, Johnston, Crooks & Bala (15) explain:

Particular behaviors may be deemed especially insulting and offensive in some minority ethnic families in ways that may not be understood by most others (e.g., slapping with shoes in an Islamic culture). Moreover, a victim might have multiple abusers (e.g., her spouse and mother-in-law in some Indian families).

Culture may also affect how much violence is reported to outsiders. As noted above, Asian women report less physical and sexual violence than other racial groups, but some scholars believe this is because many traditional Asian cultures view women's help-seeking as shaming the family name, losing face, challenging male-dominated



traditions, or disrupting family harmony (16, 17). Unless service providers or legal system personnel understand the cultural significance of certain types of actions and attitudes, it may be difficult for women from some ethnic groups to access the help they need.

Race and ethnicity may influence the way a woman responds to intimate partner violence or sexual assault.

Research finds that women's response to violence may differ based on their race or ethnicity. For example, Hispanic women who experience violence were found to be more likely to use emergency room services, and less likely to use other victim services compared to Black or White women, suggesting that cultural, legal, or linguistic barriers may affect Hispanic women's decisions about where to seek help for violence (18, 19). A recent national study found that two-thirds of Latinas in a national sample sought help from informal rather than formal sources (20).

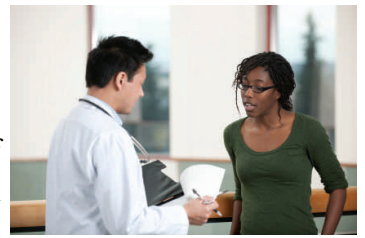
When African American women experience sexual or intimate partner violence, research shows that they are less likely to use formal counseling, but are more likely than White women to cope by using prayer (21) or by engaging in substance abuse following an experience of violence (22, 23). Intimate partner violence has also been shown to increase suicidal behavior among low-income African American women (24, 25, 26). Many Asian cultures value harmony in family life, and some Asian women have described attempting to cope with violence through "tolerance" and "endurance" to avoid feelings of shame (16). Research like these studies on help-seeking behaviors by Latinas and coping behaviors by African American or Asian women has obvious and critical implications for understanding and effectively helping these diverse survivors.

A lack of cultural competence by service providers may discourage minority women from disclosing abuse or seeking services that may help them.

Issues of racial or ethnic inequality may impact the help that minority women seek or receive.

Many racial or ethnic minorities may perceive that official helping systems like the justice system, medical care, or shelters are mainly operated by and for White people (e.g., 11, 27, 28, 29). Language can be an obvious barrier for some women, but other cultural differences can also affect a woman's experience with helping agencies. A lack of cultural competence by service providers may discourage minority women from disclosing abuse or seeking services that may help them.

Reviews of research literature note that depression symptoms are different among African American women, who often strive to maintain an appearance of strength in public. The unique symptoms of depression in African American women have been understudied, and this lack of knowledge has been shown to result in inadequate treatment and missed diagnoses of depression among this group (28, 30).



The lack of culturally competent services can also discourage African American women from seeking or continuing formal victim services (31, 32, 33, 34), while the history of racial discrimination in the criminal justice system towards Black men may limit the ways in which Black battered women use law enforcement for help (27, 35, 36). Research finds that experiences and perceptions of racism by White health care providers is common among African American women who have sought help for sexual assault or intimate partner violence (28, 32, 37). This research highlights the importance of culturally competent services that are careful to avoid discrimination and avoid subjecting minority women to additional stress.

Lack of cultural awareness by service providers is also a barrier for women of other racial or ethnic groups. For

example, Horsburgh (38) notes that strict dietary and lifestyle rules (e.g., eating only kosher foods, bans on television viewing) may prevent Orthodox Jewish women from being able to flee to a secular shelter with their children.

Some minority women may even avoid reporting violence to formal agencies out of fear that they or their culture will be criticized based on racial/ethnic stereotypes, or that they will bring shame and scrutiny to their families or cultural communities (11, 12, 16).

*Certain cultural characteristics among members of specific racial or ethnic groups may shape the impact of victimization.*

It is important not to assume that minority cultures cause or promote violence against women, and instead look at the ways in which culture and violence interacts.

Dasgupta (11) points out that "many white Americans presume that 'other' cultures, especially minority ones, are far more accepting of woman abuse than the U.S. culture" (p.61). This inaccurate assumption leads to discriminatory treatment of minority women and can have detrimental impacts on victims.

For example, many victimized African American women try to live up to the "strong Black woman" stereotype, burying their trauma and emotional pain in culturally prescribed ways (27, 29, 36). As a result, Black women may not exhibit traditional PTSD or "rape crisis syndrome" symptoms (which are based on studies of mostly white battered women) and thus may not receive the care, respect, and attention they need (36). Some African American women may even perceive the terminology used by White service providers as racist, since they are being made to conform to White women's cultural notions of trauma and relationship conflict (27, 28, 36). These studies do not mean that battered Black women do not benefit from empowerment, which has in fact been shown to increase Black women's resilience to IPV (34), but instead highlight the ways in which the history of racial injustice in the U.S. may impact Black women's openness to certain forms of outside help if

available services are not competently aware of cultural differences.

Helping systems that encourage women to divorce or leave violent relationships have also been identified as a barrier to many immigrant ethnic groups, including many Asians and Latinos, who are strongly patriarchal or family



-centered, or rely on keeping their marriage intact to remain in the U.S. with their children (11, 16, 38). Battered women in these groups may hold

values which encourage self-sacrifice or putting the community or family first (11, 12), and research suggests that couple therapy or other family-involved approaches can be effective at stopping marital violence for many Asian couples (16). When Asian women choose to leave a violent relationship, shelters with Asian staff can help women to overcome cultural and language barriers (16). Mothers in most cultures frequently place the needs of their children first; however, for women with strong religious traditions, tight cultural communities, or vulnerable immigration status the best outcome for their children may be linked to the entire family's reputation in the community (11, 38). Such cultural norms may prohibit women from accepting services, treatments, legal options, or other forms of help from outside of their community.

### *Implications of Race/Ethnicity for Intervention*

This report has described some specific effects of race and ethnicity on experiences of intimate partner violence and sexual assault. The research literature also includes many community-based studies relating to specific racial/ethnic groups, cultures, or social circumstances. Many studies have specific implications for intervening on behalf of women from different racial and ethnic backgrounds.

Here are a few examples:

- Many African American women benefit from informal social support or other organized means of "self-help" within the Black community (27, 39, 40).

- Culturally-sensitive forms of empowerment for African American women have a positive impact on reducing PTSD and depression symptoms (34).
- Asian women may benefit from services that recognize the dilemma of culturally-based shame when seeking help and recognize that silence does not mean Asian women are resistant to help. Many Asian cultures interpret tangible assistance as "a way to demonstrate the professional's willingness to help and his or her competence" (16, p. 478, 17, 41).
- Language difficulties are one of the most commonly identified barriers for Latina and Asian immigrant women seeking help for domestic violence (12, 16).
- Sexual assault interventions that are culturally-specific (e.g., addressing race-specific rape myths) have been found to be more meaningful to African American participants than "colorblind" examples (42).

Any approach to understanding how race, ethnicity, and culture affects women's experience of sexual assault or intimate partner violence must at the very least take into account the complexities of race, ethnicity, gender, and socioeconomic status. However, Kasturirangan, Krishnan, and Riger (43) provide an important warning that "incomplete comprehension of cultural scripts only reinforces stereotypical notions of the lives of minority people" (p. 322). Scholars and practitioners must be careful to ensure that knowledge of other cultures does not "become a new set of stereotypes" but instead helps to facilitate cross-cultural dialogues which can be "transformed into culturally sensitive policies, practices, and programs" (29, p. 5).

## *Conclusion*

Research finds that race and ethnicity matter when a woman experiences intimate partner violence or sexual assault. National prevalence data reveal that women from different racial categories experience different rates of physical violence, sexual assault, and stalking. However, most differences between racial categories can be accounted for by other factors, such as socioeconomic status. Important demographic factors which explain higher rates of victimization regardless of race include a woman's younger age, lower income, less financial stability, unmarried status, limited education, and unemployment. Other criminology research suggests that rates of violence against women, like most other forms of crime, are affected by community characteristics such as poverty, family disruption, and social instability. Therefore, most researchers conclude that race and ethnicity are not really the cause of different rates of violence against women, but that sociodemographic inequalities which are more or less prominent among certain racial/ethnic groups determine a woman's risk of experiencing violence. While racial and ethnic differences may not cause violence against women, research does show that race and ethnicity impact the experience of IPV or sexual assault. Women from certain ethnic groups experience unique threats related to their culture or immigration status. Women may be harassed or abused in ways that are uniquely demeaning in their own culture, which may not be easily understood by outsiders. Other women may have specific cultural practices or attitudes which make them more or less likely to report violence, or may impact the ways in which they choose to seek help. Race and ethnicity may also shape the types of trauma women experience and the ways they attempt to cope. For all of these reasons, the development of culturally competent services is extremely important for increasing the ability of professionals to help women from different backgrounds.

## Resources

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