. . . the following kinds of research ought to be pursued:

- How is the health care system actually used by victims of violence?
- What are the salient characteristics of assault and homicide victims, and what are the circumstances of each incident?
- What kinds of discrepancies are there between hospital and police reports of assault?
- What kind of risks do assault victims run of eventually being killed?
- How effective are current hospital policies and procedures for identifying, coding, treating, and referring victims of assault?

In the area of *Services* we recommend that . . .

. . . organizations representing professionals who provide emergency health care, such as the American College of Emergency Physicians, the National Association of Social Workers, and the American Nursing Association, should review concepts and procedures relative to emergency care for victims of violence, with particular attention to improving victim identification, assessment, treatment, and referral. (S-1)

. . . evaluation and treatment services should be available to both direct and indirect victims of homicide and other violence, including witnesses, care-givers, the victim's family and significant others, and the community. (S-2)

. . . special attention should be paid to the adequacy and sensitivity of the health care given to young minority men in low socio-economic status who are at greatest risk for homicide and repeated assaults. (S-3)

. . . every examination of a direct or indirect victim of violence should include a history of past victimization and/or perpetration of violence, the victim's risk profile, and an assessment of his or her total health needs. (S-4)

. . . a comprehensive, collaborative, community-based approach to victim assistance should be encouraged among health care providers, the criminal justice system, victim service agencies, churches, and other relevant community service organizations. (S-5)

. . . leaders in health and mental health should support the development of victim assistance programs where they don't exist and the improvement of existing programs that are inadequate. (S-6)

. . . health care providers should draw upon the experience of victim service agencies in the course of improving their own case management, advocacy, and referral services for victims of violence. (S-7)

. . . the Public Health Service should help in the review and dissemi-

nation of innovative hospital protocols offering better care for victims of violence. (S-8)

. . . hospital boards and top administrators should clearly articulate their hospital's policy in the following areas affecting the care of victims of violence:

- a commitment to effective identification, treatment, and referral services;
- a commitment to train staff who interact with direct or indirect victims;
- and the use of multi-disciplinary hospital committees to monitor policy implementation and maintenance of quality care for victims. (S-9)

ASSAULT AND HOMICIDE: PREVENTION

CHAIR: John B. Waller, Jr., DrPH
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Robert Ressler
Vicki Weisfeld, MPH

Members of this work group introduced their recommendations with the following statements:

- Our specific recommendations for the health and public sectors are preceded by general policy recommendations that go beyond the health sector.
- The focus on the health sector recognizes the vital contributions health professionals can make without implying that those contributions are any more or any less important than those made by other disciplines.
- We recognize that the Office of the Surgeon General cannot, by itself, carry out all these recommendations, but we nevertheless believe that these policy issues are fundamental to any statement on the prevention of homicide and assaultive behavior.

Therefore, in the area of *Policy* we recommend that . . .

. . . there be a complete and universal federal ban on the manufacture, importation, sale, and possession of handguns (except for authorized police and military personnel) and that the manufacture, distribution, and sale of other lethal weapons, such as martial arts items, knives, and bayonets, be regulated.

. . . criminal penalties be levied for possession of any weapon where alcohol is sold or served.

. . . the public should be made aware that alcohol consumption may also be hazardous to health because of its association with violence.

. . . a full employment policy should be developed and implemented for the nation, with immediate attention given to creating jobs for high-risk youths.

. . . there be an aggressive policy to reduce racial discrimination and sexism.

. . . the cultural acceptance of violence be decreased by discouraging corporal punishment at home, forbidding corporal punishment at school, and abolishing capital punishment by the state — all are models and sanctions of violence.

. . . that there be a decrease in the portrayal of violence and violent role models on television and other media and an increase in the presentation of positive, non-violent role models.

In the area of *Education* we recommend that . . .

. . . the education of health professionals should include training in the identification, treatment, and/or referral of victims, perpetrators, and persons at high risk for interpersonal violence. (E-5)

In the area of *Research* we recommend that . . .

. . . studies should be conducted to examine how current rates of assaultive violence and victimization may be related to the policy of deinstitutionalization of mentally ill persons and the lack of adequate community-based support services for those persons and their families. (R-3)

. . . development should be encouraged of health education demonstration projects for the family, school, and community aimed at decreasing interpersonal violence and that these projects be evaluated to their effectiveness and replicability. (R-4)

In the area of *Services* we recommend that . . .

. . . community health care facilities should offer comprehensive, multidisciplinary programs to detect, assess, and treat victims and perpetrators of all forms of interpersonal violence, as well as to assess and treat family members and individuals at high risk of violence. (S-10)

. . . health care providers, criminal justice agencies, schools, and social service agencies should communicate and cooperate to a greater extent in order to improve the identification and treatment of — and early intervention for — high-risk individuals. (S-11)

CHILD ABUSE: Evaluation and Treatment

Chair:	Howard B. Levy, MD
Advisory Committee Member:	Robert G. McGovern, MD
Recorder:	Lawrence T. McGill
Participants:	Douglas J. Besharov
	Capt. Edgar R. Blount, MD
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	Peter A. Howland, MD, MPH
	Marie Kanne Poulsen, PhD
	Johanna Schuchert
	George G. Sterne, MD

In the area of *Education* we recommend that . . .

. . . professionals who work with children and their families should be offered — and encouraged to take — interdisciplinary continuing education programs. (E-6)

. . . schools that prepare professionals to work with children and families should adopt interdisciplinary curricula for clinical as well as classroom instruction in the prevention and treatment of child abuse; persons from all involved disciplines should share in presenting these curricula to students. (E-7)

In the area of *Research* we recommend that . . .

. . . local, state, and federal agencies should design and fund child abuse research and treatment, utilizing a public health perspective. (R-5)

. . . individual communities should establish their own multi-professional "commissions" to assess both harm and benefit to child abuse victims resulting from criminal prosecution and disposition. (R-6)

. . . a major longitudinal/epidemiological study should be mounted, similar in purpose and scope to the Framingham and Cambridge studies, documenting prospectively at least 30 years' experience in the causes, consequences, and nature of child abuse and responses to it. (R-7)

In the area of *Services* we recommend that . . .

. . . child protection services and other agencies should expand the range of both long-term and intensive short-term treatment alternatives for families in need, using such modalities as medical services, family support, and parent/adult aides. (S-12)

. . . visiting nurses, attending physicians, and other professionals should make their own services more readily available for abused children and their families, allowing Child Protection Service agencies to focus on the more serious incidents of abuse and on the children at highest risk. (S-13)

. . . every hospital should have an interdisciplinary child protection team that can care for all the child's and family's needs at one site and within a minimum number of visits. (S-14)

. . . standards of health care for abused infants and children should include immediate and complete physical and psychological assessments; competent and continuous care should be provided for any problems uncovered in these assessments. (S-15)

CHILD ABUSE: PREVENTION

CHAIR: Douglas A. Sargent, MD, JD
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David M. O'Hara, DASS
Barbara Rawn
Reymundo Rodriguez
Gloria Smith, PhD
Robert L. Stein II

In the area of *Education* we recommend that . . .

. . . public awareness should be dramatically increased regarding the nature and extent of child abuse, with emphasis on the fact that child abuse is not limited to physical and psychological abuse but also includes abusive neglect, poverty, and other social injustice. (E-8)

. . . a major campaign should be carried out, with the help of the media, to reduce the public's acceptance of violence in general and violence against children in particular, including physical punishment (a campaign could use a variety of techniques, such as declaring a "No Hitter Day"). (E-9)

. . . the American people should come to understand and agree that corporal punishment of children should be abolished. (E-10)

. . . planning for pregnancy ought to be seen as the starting point for the prevention of child abuse and other forms of child maltreatment by new and/or young parents. (E-11)

. . . education for parenthood should be more widely promoted and supported so that it may be made available to all prospective and current parents. (E-12)

. . . public health departments and public hospitals and clinics should

provide educational and support services for parents and families, including appropriate cultural and linguistic services for particular ethnic and minority groups. (E-13)

In the area of *Research* we recommend that . . .

. . . studies should be done to identify what makes abusive families different from non-abusive families. (R-8)

. . . we need to learn more about the ways various ethnic and racial groups define "abuse." (R-9)

. . . we learn more about the impact that changes in public policy make upon the family. (R-10)

. . . further development and testing should be done of explanatory and predictive models for maltreatment causality. (R-11)

. . . more multi-disciplinary longitudinal and cross-cultural research be carried out to evaluate the impact of violence prevention programs on individual children, families, communities, and ethnic groups. (R-12)

. . . the Epidemiology of Violence Branch of the PHS Centers for Disease Control ought to focus more attention upon child abuse and maltreatment. (R-13)

In the area of *Services* we recommend that . . .

. . . as a public health priority, families should be provided with vital services, such as home visitor services, for the health and welfare of vulnerable children. (S-16)

. . . priority services — including treatment and rehabilitation — should be provided to children who are at highest risk to be abused, such as developmentally disabled children, runaways, and children of parents who are at highest risk to be abusive, such as prison inmates, teenage mothers, mentally retarded or otherwise mentally impaired parents, substance abusers, homeless parents, and parents who themselves had been abused as children. (S-17)

. . . the kind of quality child care that promotes healthy child development should be available to all families. (S-18)

. . . those services that prevent undesired pregnancies should be generally available. (S-19)

. . . children identified as being at greatest risk for abuse should be afforded linguistically and culturally appropriate services for the prevention of child abuse. (S-20)

. . . alternatives to abusive behavior should be widely offered, such as training in conflict resolution, anger control, and stress management

and other programs in behavioral change like those offered by self-help groups. (S-21)

. . . a national public health resource center ought to be established to train and otherwise assist professionals working on the public health aspects of child maltreatment; this center would also cooperate with social service, legal aid, and other types of resource centers dedicated to child abuse. (S-22)

CHILD SEXUAL ABUSE: EVALUATION AND TREATMENT

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Martin Wasserman, MD, JD
Bruce A. Woodling, MD

In the area of *Education* we recommend that . . .

. . . a core curriculum in child sexual abuse should include strategies for identifying, reporting, assessing, treating, and referring victims and should be a required part of the professional education of all child abuse reporters mandated under state law, such as physicians (especially those in emergency medicine and pediatrics), psychiatrists, psychologists, nurses, mental health workers, dentists, social workers, teachers, law enforcement personnel, and clergy. (E-14)

. . . professional schools and organizations, certifying boards, and institutional accrediting bodies should cooperate in the development and implementation of a core curriculum in child sexual abuse. (E-15)

. . . health, mental health, and criminal justice professionals providing direct service to victims of child sexual abuse need to be trained in (and made sensitive to) normal child development, cross-cultural differences, the special vulnerability of handicapped children, and the many legal and forensic issues in this area; they also need to be trained in the problem of trauma contagion, which can cause staff burnout and victim re-traumatization. (E-16)

In the area of *Research* we recommend that . . .

. . . a national child sexual abuse research and information center should be established to provide computerized data about funding, ongoing research, treatment programs, assessment protocols, and training and educational materials for workers in this field and for families of victims. (R-14)

. . . a centralized information point within the Department of Health and Human Services, preferably the Centers for Disease Control, should be established and made responsible for aggregating, standardizing, and transmitting case report data; for collecting and analyzing violence-related data from the FBI, the National Center for Health Statistics, and the National Institute of Justice; and for conducting surveys of practitioners, institutions, and the public in order to define and report annually on the incidence, prevalence, time trends, and geographic distribution of child sexual abuse. (R-15)

. . . studies should be carried out of the short- and long-term impact of sexual abuse on infant and child victims, with particular attention to children who are physically, emotionally, or developmentally impaired; who are victims of extreme abuse; who have minimal family or other support, particularly children requiring placement; and who have extensive and intrusive legal problems. (R-16)

. . . baseline data need to be gathered — through standardized tests, structured interviews, and genital examinations — to determine genital and psychosexual development among non-abused children for comparison with data from sexually abused children. (R-17)

. . . research should be conducted that leads to the further development of such specialized instruments as symptom checklists, developmental assessments, projective tests, structured interviews using anatomically

correct dolls, coloring books and drawings, and structured family assessments. (R-18)

. . . more studies in treatment outcomes should be conducted, particularly in the following areas:

- What happens when either the perperator or the victim in an intrafamilial case of child sexual abuse is removed from the family?
- How effective are individual, group, and family treatment programs involving sexually abused children?
- What strategies — legal, home care, or patient advocacy, for example — will bring into treatment the families of sexually abused children? (R-19)

In the area of *Services* we recommend that . . .

. . . the assessment of a victim of child sexual abuse and his or her family should be done by mental health and other experts as part of a multidisciplinary team, with the primary goal being a treatment and intervention plan for both victim and family to be carried out with community resources. (S-23)

. . . each disclosure of abuse should lead to only one assessment before a treatment plan is created and the clients — victim and family — are referred to community resources. (S-24)

. . . assessments should be done with standardized protocols for four axes (physical health status, mental health status, family and environmental factors, and the investigatory/legal situation), with additional axes of assessment incorporated as they emerge from protocol research. (S-25)

. . . the California protocol for the physical examination of sexually abused children should be considered a model, as it also specifies facility standards, forensic tests, and laboratory tests for the presence of sexually transmitted diseases (and contact testing, when positive). (S-26)

. . . the assessment process should explore the possibility that other members of the victim's household have experienced childhood sexual abuse or other forms of family violence. (S-27)

. . . the assessment process — with the aid of standardized forms, one-way mirrors, a minimum number of designated examiners, video- and/or audiotaped interviews, photographs, and careful scheduling — should keep to a minimum the need to re-interview, re-examine, and re-traumatize the child and the family. (S-28)

. . . consultations and second opinions should be rendered, whenever possible, on the basis of a review of documents and a discussion with

the original interviewing team, rather than on a re-examination and/or a return interview. (S-29)

. . . specialized, comprehensive intervention should help the entire family and/or substitute family understand what happened, acknowledge their feelings, explore their fears, and separate past from present coping mechanisms. (S-30)

. . . the goals of intervention should be to reduce symptoms, to enhance the individual's and family's ability to adapt positively to the situation, and to promote the growth and development of each child. (S-31)

. . . the treatment program for the victim of child sexual abuse should begin immediately and continue according to a plan which is rewritten as the child's needs evolve. (S-32)

. . . regional resource centers should be developed to offer treatment consultation for difficult cases, especially in medically underserved areas, and to guide new self-help groups, to gather data, to coordinate regional, legal and social service providers, to train workers, and to provide other kinds of educational assistance. (S-33)

CHILD SEXUAL ABUSE: PREVENTION

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Suellen Muldoon
Karin Murray
Robin Rushton
James C. Shine

Members of this work group introduced their recommendations with the following set of background assumptions:

- Abuse is everyone's business. The health, mental health, and economic costs associated with abuse affect all Americans now and in the future.
- Prevention is directed both at the *public* and at the *targeted groups at high risk* for sexual abuse.
- *Primary* prevention of child sexual abuse concerns stopping abusive behavior before it occurs; *secondary* prevention concerns early identification and treatment of the victim of abuse.
- Culturally sensitive approaches must be integral to all recommendations.
- American society must realistically confront the phenomenon of child sexual abuse.
- Our first priority must be to protect the child.

In the area of *Education* we recommend that . . .

. . . an aggressive public education campaign, emphasizing sexual abuse as a harmful and criminal act, should be carried out with the objective of stopping the sexual abuse of children. (E-17)

. . . the public should be given the facts about child sexual abuse and the options available for prevention and treatment. (E-18)

. . . core curricula for undergraduate, graduate, and continuing education programs for health and human service professionals should incorporate authoritative, appropriate material on child sexual abuse, including material on prevention and techniques for intervention. (E-19)

. . . educators, parents, and public health officials should provide all children, from elementary school on, with well-evaluated materials on the prevention of child sexual abuse, including (at a minimum) material on sexual abuse, appropriate and inappropriate touching, the right to say no to inappropriate touching, appropriate and accurate sexual terminology, and the importance of telling someone when sexual abuse occurs. (E-20)

. . . educators, parents, and public health officials should design, test, and put into their elementary and secondary schools programs that teach effective parenting skills and child development, in order to foster a new generation of parents better able to prevent — and less likely to perpetuate — the sexual abuse of children. (E-21)

In the area of *Research* we recommend that . . .

. . . a national search should be carried out to identify, evaluate, highlight, and disseminate information about effective primary prevention programs for child sexual abuse. (R-20)

. . . the research agenda should be expanded along the following lines:

- gaining more specific knowledge of the incidence and prevalence of child sexual abuse among specific segments of the population;
- conducting prospective longitudinal studies in order to document and better understand the short- and long-term effects of disclosed and undisclosed child sexual abuse;
- identifying high-risk children and families and delivering preventive educational programs to them;
- evaluating a broad range of preventive educational programs;
- identifying normal sexual development and behavior in order to more accurately identify deviant development and behavior;
- identifying the characteristics of men who are serious, repetitive perpetrators of child sexual abuse;
- examining the role of parenting behaviors and the degree of involvement of fathers in order to provide insight and to reduce their risk of being sexual abusers of children;
- understanding the potential for further harm to a child as a result of the disclosure of having been sexually abused and of the child's subsequent involvement in the criminal justice system. (R-21)

In the area of *Services* we recommend that . . .

. . . key community, government, public health, and media and advertising professionals should work together to establish policies and to encourage public and private initiatives for setting limits on the sexualization of children in the media and advertising. (S-34)

. . . better coordination should be accomplished among federal, state, and local programs, policies, and activities in law enforcement, prosecution, defense, social service, criminal and juvenile justice, and public health in order to improve the identification and prevention of child sexual abuse. (S-35)

. . . programs should be strengthened and expanded serving runaway and homeless youth, since they are at high risk for sexual exploitation.

. . . public/private partnerships and community-level cooperation ("networking") among family and youth services should be increased. (S-37)

. . . federal, state, local, and private financial resources should be in-

creased to support programs that might effectively reduce the incidence of child sexual abuse. (S-38)

ELDER ABUSE: Evaluation and Treatment Of Victims and Prevention

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Richardson White, Jr.

Members of the work group on elder abuse said the following assumptions are basic to their recommendations:

- Competent older persons have the right to self-determination.
- No group is immune to elder abuse; the problem cuts across all social classes and all racial, ethnic, and religious groups.
- Most older people live independently, while others live happily and safely in the care of or in the homes of others; many American families are heroic in the care they provide elderly relatives.
- Elder abuse is, in many instances, a result of the ageism prevalent in our society.
- Elder abuse is part of the larger social problem of violence in contemporary American life.

In the area of *Education* we recommend that . . .

. . . health care providers, social service agencies, and criminal justice professionals should receive education and/or training in the detection, assessment, and treatment of elder abuse. (E-22)

. . . educational programs should be developed to increase public understanding of elder abuse. (E-23)

. . . community educational and outreach programs should be developed to help older people protect and take better care of themselves and to make use of community resources. (E-24)

. . . educational programs should be developed to illustrate the potential for family violence throughout the life cycle and for the prevention of such violence. (E-25)

In the area of *Research* we recommend that . . .

. . . national studies should be carried out on the incidence, prevalence, dynamics, and outcomes of elder abuse. (R-22)

. . . studies should be conducted to determine the effectiveness of programs to prevent, detect, treat, and control elder abuse. (R-23)

. . . items regarding elder abuse should be added to existing public health surveys, such as the National Health Interview Survey and the National Health and Nutrition Examination Survey. (R-24)

. . . there be a national elder abuse clearinghouse for coordinating research, training, and program development in the public and private sectors. (R-25)

In the area of *Services* we recommend that . . .

. . . services to elder abuse victims should include legal assistance, victim advocacy, emergency and long-term housing, and other services that help ensure the rights of older people to be independent and live free from abuse. (S-38)

. . . additional services, such as respite care and adult day-care, should be made available to help families care for members who are elderly and vulnerable. (S-39)

. . . the criminal justice system should be better equipped to respond, in cooperation with other agencies, to the problem of elder abuse. (S-40)

. . . such community coordinating mechanisms as case identification, case management, crisis intervention, and communication linkages should be developed and expanded to address the problem of elder abuse. (S-41)

RAPE AND SEXUAL ASSAULT: EVALUATION AND TREATMENT

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Maj. Henry F. Vader, USAF

Members of this work group introduced their recommendations by listing these background issues:

- The general public, families of victims, and providers of human services will only further victimize rape victims if they continue acting on the basis of commonly held but mistaken myths and biases concerning rape, or bringing insufficient knowledge and skill to the task of caring for rape victims, or failing to accept a more responsible role in the evaluation and treatment of victims. Rather, the community and its service providers must respond on the basis of the facts of rape and sexual assault.
- Rape is a crime of violence. It is not primarily a sexual act, whether it occurs between strangers, acquaintances, or intimates. However, a rape victim may have difficulty later experiencing normal sexual and other interpersonal relations.
- Rape is rarely the act of a psychotic person. Rape is a criminal expression of power and domination inflicted primarily by men upon women, although some victims are also men.
- Sexual violence is behavior learned from various sources, such as the mass media, pornography, childbearing experiences, and family violence.
- Sex role stereotyping supports the unequal power relationships between women and men. Traditional male socialization limits men's ability to express tenderness and encourages their use of violence to resolve conflicts rather than the use of communication and negotiation.

- Women have the right to say no and to have their refusal respected.
- Violence must be eliminated as a means of resolving conflict.

In the area of *Education* we recommend that . . .

. . . a nationwide public education campaign should be carried out giving the facts about violence, sexual assault, and rape, including information describing the type and extent of service a victim should expect to receive. (E-26)

. . . professionals involved across a wide spectrum of health, human service, and criminal justice activities — persons most likely to have contact with rape victims — should be given information concerning the evaluation and treatment of rape victims in basic professional preparation and continuing education programs. (E-27)

. . . mental health professionals should take the lead in assuring the relevance of their own education concerning sexual violence before offering consultation services to police, educators, and others. (E-28)

. . . the planning for public education programs to correct the myths and biases concerning rape ought to be carried out with an understanding that the information will also be reaching and influencing health and human service professionals as well. (E-29)

In the area of *Research* we recommend that . . .

. . . there be training programs specifically to prepare professionals to conduct research in the area of rape and sexual assault. (R-26)

. . . the following research areas ought to be pursued:

- the epidemiology of rape;
- the social environment of rape and sexual assault;
- the types and effects of various intervention strategies;
- the longitudinal pattern of recovery by victims and significant others from sexual assault, including thoughts, feelings, behavior, and general health status;
- the behavior of sexual assailants, factors associated with assaultive behavior, and the effectiveness of deterrents upon potential assailants;
- strategies and programs to change basic attitudes about rape;
- analyses of social and health costs and benefits from early intervention and treatment following rape, compared with no action at all. (R-27)

In the area of *Services* we recommend that . . .

. . . the groups that accredit, certify, and license agencies and individuals who provide emergency/crisis, mental health, criminal justice, and other

human services should incorporate standards for the evaluation and treatment of sexual assault victims. (S-42)

. . . clear guidelines and protocols, such as exist in many rape crisis centers and hospital-based programs, should be sensitive to the experiences and needs of rape victims of both sexes and be developed by every community health facility. (S-43)

. . . institutions should provide a caring ombudsperson/expediter to assist each victim through the evaluation and treatment process. (S-44)

. . . programs serving rape victims should conform to national standards of various accrediting bodies in order to insure that they provide all the recommended elements of coordinated, effective victim services. (S-45)

. . . technical assistance — such as program design, clinical protocols, training curricula, and research results — should be readily available from a central clearinghouse (e.g., SHARE) to communities that want to develop their own service programs for victims of rape and sexual assault. (S-46)

. . . there be adequate public and private funding for programs serving victims of rape and sexual assault. (S-47)

RAPE AND SEXUAL ASSAULT: PREVENTION

CHAIR: Eddie Bernice Johnson, RN, MPH
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Henry W. Foster, Jr., MD
Philip A. Harding
Ann Maney, PhD
William Oltman
Murray A. Straus, PhD
Marvin E. Wolfgang, PhD
Laura X

Members of this work group introduced their recommendations with the following preamble:

- As part of their basic right to personal safety, all people — male and

female alike — have the right to control access to their bodies. Rape and sexual assault violate this basic right.

• Rape and sexual assault are brutal crimes with potentially life-shattering consequences for victims and with disruptive effects for society. The following recommendations are offered, therefore, to help society reduce and ultimately eliminate these crimes.

• "Sexual assault" is here defined as "nonconsensual sexual behavior, including stranger, acquaintance, and spousal assaults against either male or female victims."

• We recognize that substantial financial outlays will be required to carry out these recommendations. In view of the significance of rape and sexual assault as devastating public health problems, we urge that adequate funding for these recommendations be made available from both public and private sources.

In the area of *Education* we recommend that . . .

. . . increased public education should be carried out to bring about equality between women and men, since it has been shown that the rate of rape is low where the status of women is high. (E-30)

. . . public awareness should be heightened regarding 1) the legal, statistical, and human service definitions of rape and sexual assault; 2) the myths and facts surrounding each; 3) the impact of these crimes on victims and families; 4) the need for crisis services; and 5) the harm that comes to individuals and society from our nation's high tolerance of violence and aggressive behavior. (E-31)

. . . specific educational programs need to be designed for potential victims (especially high-risk populations), potential assailants (especially pre-adolescents and adolescents), and such professional persons as those in health care, law, religion, education, and human services. (E-32)

In the area of *Research* we recommend that . . .

. . . studies be carried out to determine which educational campaigns are most effective for preventing rape and sexual assault. (R-28)

. . . a clearinghouse on rape and sexual assault should be established to gather baseline data, provide technical assistance, and circulate information drawn from research, education, community action, and health and human services. (R-29)

. . . the human service, statistical, and legal communities and the general public need to re-examine their definitions of rape and sexual assault. (R-30)

. . . the way sexual aggression is portrayed in the mass media ought to be studied and evaluated for its effects upon the public health. (R-31)

. . . researchers should give additional attention to the following areas:

- victim and bystander strategies that do or do not stop rapes in progress;
- how the mass media do or do not encourage sexual assault;
- treatments that do or do not change assailant behavior;
- behavioral antecedents of assaultive behavior;
- the role of incarceration in prevention;
- situations and conditions in which rape occurs;
- and the constraining effects of a person's fear of rape. (R-32)

. . . qualified researchers should be called together to set an agenda of the research that needs to be done in rape and sexual assault. (R-33)

In the area of *Services* we recommend that . . .

. . . all sexual offenders, especially adolescents and pre-adolescents showing sexually deviant behavior, should be identified, evaluated, and treated as early in life as possible. (S-48)

. . . the criminal justice system should clearly recognize sexual assault as a serious violent crime; that sanctions, including incarceration, should be imposed upon assailants commensurate with the devastating impact of the crime upon their victims; and that treatment to prevent future criminal behavior be part of sentencing wherever possible. (S-49)

. . . all remaining states and territories should remove the husband's exemption from prosecution for the rape of a wife, as is now the case in 28 states. (S-50)

. . . designers of cities, buildings, and transportation systems should pay more attention to the problem of reducing the risk of sexual assault in their projects. (S-51)

SPOUSE ABUSE: EVALUATION AND TREATMENT

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Members of this work group on spouse abuse introduced their recommendations with the following preamble:

- The phenomenon of "spouse abuse" includes physical, sexual, and psychological abuse and is found in all social, economic, ethnic, and racial groups.
- Spouse abuse is a crime perpetrated primarily against women, often causing them serious injury and premature death and affecting the psychological development of their children and of other family members.
- Spouse abuse is not a private matter; it has ramifications beyond the immediate family.
- Spouse abuse is rooted in a sexist social structure that produces profound inequities in roles and relationships and in the way resources and power are shared by men and women in families.
- All public policies that encourage or support spouse abuse and other forms of interpersonal violence are wrong; they should be reviewed and changed.
- Interventions that "blame the victim" and do not hold the abuser accountable are ineffective and inappropriate.

In the area of *Education* we recommend that . . .

. . . information on interpersonal violence, including spouse abuse, should

be a part of the basic education and training curriculum for all health professionals (physicians, psychologists, nurses, social workers, counselors, health educators, etc.), as well as for teachers, lawyers, police, and others who serve the public. (E-33)

. . . information on interpersonal violence, including spouse abuse, should be part of post-graduate and continuing education for health professionals and faculty. (E-34)

. . . certification, licensing, credentialing, and board examinations should include questions on interpersonal violence and spouse abuse so that health professionals and faculty have at least minimum knowledge of these phenomena. (E-35)

. . . the identification of victims and abusers and some knowledge of appropriate interventions and intervention strategies should be part of standards of practice and recommended standards of care for such various health disciplines as nursing, psychology, social work, health education, and medicine (pediatrics, psychiatry, family practice, obstetrics-gynecology, orthopedic surgery, and emergency medicine). (E-36)

. . . the Surgeon General should develop a public information and education campaign identifying spouse abuse as a major public health problem. (E-37)

. . . realistic standards need to be developed to help reduce the level of violence in all mass media, since — despite occasional and excellent examples of self-regulation — violence is still over-represented in the media. (E-38)

In the area of *Research* we recommend that . . .

. . . federal agencies should identify and coordinate their spouse abuse research and make sure that the results are widely disseminated. (R-34)

. . . the resources available for research on the prevention, causality, treatment, and intervention of spouse abuse and family violence ought to be proportionate to the high priority of this problem, when compared with other public health problems. (R-35)

. . . a number of research opportunities in violence ought to be pursued, such as . . .

- longitudinal studies of victim/survivors of spouse abuse;
- research among different vulnerable populations at high-risk for spouse abuse, such as racial and ethnic minorities and persons with low socioeconomic status;
- evaluation of models of intervention and prevention in spouse abuse and of models of the processes by which abusers stop abusing;

- the kinds of state and local policies that effectively reduce violence and protect victims;
- risk factors that may predict homicide in violent relationships;
- the relationship between an abuser's intake of alcohol and drugs and the frequency, severity, and lethality of the abuse of his spouse;
- how personal and environmental factors interact and escalate spouse abuse;
- the relationship between violence in mass media and spouse abuse;
- the way psychological assessment tools may be adapted to measure the psychological impact and other post-traumatic stress disorders upon the victims of spouse abuse;
- relationships between stress-related disorders and spouse abuse;
- the long-term effects upon health and social service providers who work in the area of spouse abuse;
- the characteristics and coping skills of women who have left violent relationships;
- characteristics of batterers in order to determine causation of male aggression against women;
- the long-term impact on children who witness spouse (parent) abuse. (R-36)

In the area of *Services* we recommend that . . .

. . . the first priority for intervention in spouse abuse must be to provide shelters, safe homes, and other protective environments for victims and their children. (S-52)

. . . every community should have available a full range of fully funded and fully coordinated health, mental health, legal, and social services for victims, abusers, and their children. (S-53)

. . . spouse abuse services should include the kind of innovative and creative treatments that address the specific economic, social, and cultural needs of vulnerable populations. (S-54)

. . . intervention strategies must hold abusers accountable for their violent behavior. (S-55)

. . . protocols for spouse abuse identification and intervention should be developed and used by health care professionals in all settings, such as emergency rooms, trauma centers, primary care sites, mental health centers, psychiatric hospitals, and physicians' offices. (S-56)

. . . all existing and proposed typologies should be examined to eliminate victim-blaming. (Consistent with this recommendation, we oppose the proposed new DSM III-R psychiatric diagnosis 301.89, Masochistic Per-

sonality Disorder, which may be applied to victims of spouse abuse. This diagnosis is victim-blaming, pejorative, and sexist. It would be harmful and counterproductive to identification, intervention, and prevention strategies.) (S-57)

. . . the Surgeon General should vigorously pursue adequate federal funding for spouse abuse programs, particularly the funding to carry out the Family Violence Prevention and Services Act. (S-58)

. . . questions concerning possible spouse abuse should be included on prenatal history forms and be routinely asked during medical, nursing, and social work assessments of pregnant women. A physically or sexually abused pregnant woman should be identified as having a high-risk pregnancy and be eligible for high-risk prenatal care. (S-59)

SPOUSE ABUSE: PREVENTION

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The members of this work group agreed that the following issues and problems need to be addressed by the recommendations:

- The acceptance of violence as a means of responding to and resolving interpersonal and marital problems is widespread in our culture.
- Women have historically been the most likely target of family violence;

hence, health care professionals must take the lead in guaranteeing the physical integrity of women.

- Spouse abuse and woman battering each has an incremental/developmental sequence, which, if unchecked, will result in increased physical, psychological, and social morbidity of the victims.
- The link between child abuse and spouse abuse is well-documented; therefore, efforts to prevent spouse abuse and woman battering are also major factors in the prevention of child abuse.
- The major objectives of a prevention program in spouse abuse and woman battering are to identify the problem, to protect the victim, to stop the violence, to expand the options, and to empower women.

In the area of *Education* we recommend that . . .

. . . programs to prevent domestic violence should be developed by federal, state, and local educational agencies and carried out in institutions at all levels. These prevention programs should focus on the following:

- the causes, dimensions, consequences of, and responsibility for interpersonal violence;
- the relationships between violence and power, control, gender stereotypes, and sex roles; and
- the nonviolent resolution of interpersonal conflict. (E-39)

. . . national leaders in health care, politics, business, labor, religion, culture, and the professions should declare their opposition to spouse abuse and woman battering and should develop and distribute appropriate educational materials to their constituents. (E-40)

. . . the Surgeon General should initiate a major media campaign designed to prevent spouse abuse and woman battering. The campaign should highlight the following points:

- spouse abuse and woman battering are against the law;
- the physical integrity of *all* family members is a basic health right;
- spouse abuse and woman battering have serious health consequences;
- battering is not limited to any group, gender, racial minority, geographic area, or social class;
- normative male behavior is itself a potential health hazard;
- shared decision-making and nonviolent conflict resolution are preferable to male dominance and the use of force; and
- services are available for abusive adults and their victims. (E-41)

. . . curriculum materials on spouse abuse and woman battering should be introduced into the education, training, and continuing education of