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Violence Against Women: Synthesis of Research for Service Providers

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Survivors of violence against women seek services to address victimization and its effects in a variety of settings. This report addresses providers of those services in community settings. Specifically, the report addresses staff of domestic violence, rape crisis, and victims services programs; mental health providers employed in such settings as family service agencies, mental health centers, and substance abuse treatment settings; staff employed in State and county social services and child protective service programs; and clergy from all denominations to whom victims of violence may turn for support and other assistance. Research indicates that these are the kinds of providers to which victims of violence against women turn most frequently for assistance (Gordon, 1996). The task of synthesizing research on violence against women for this audience is challenging because this group of providers is extremely varied with respect to the centrality of violence against women within their professional roles, the extent of their knowledge about such violence, the extent of formal education and training, especially regarding research, and their values and beliefs about violence against women.

The purpose of this report is to summarize and synthesize the vast and growing body of empirical research on violence against women—intimate partner violence, rape and other sexual assault, and stalking—that is most germane to the service providers described above. An integrated discussion of violence against women is a challenge, because

> In stark contrast to the experiences reported by women, regardless of their ethnicity, research on violence against women has developed categorically. Sexual assault researchers often know little about physical violence and battering, battering experts often fail to acknowledge women's coercive sexual experiences, and, separate from these two groups is a set of researchers who examine psychological and emotional maltreatment. (Sorenson, 1996, p. 138)

The research to be addressed covers the following topics: health and emotional effects of intimate partner violence, sexual assault, and stalking; how victims cope with violence against women, including what is known about their help-seeking behavior; the role of race and ethnicity; effects on children of exposure to intimate partner violence; and intervention and prevention. The report concludes with a discussion of gaps in the research literature and the implications of the research findings reviewed for practice with victims of violence against women and social policy.

Health Effects

Intimate Partner Violence

Because most violence against women consists of less severe forms of violence such as pushing, slapping, grabbing, and shoving, most women who endure these acts do not require medical intervention (Stets and Straus, 1990). Half of the victims of criminal intimate partner violence reported injuries to the National Crime Victimization Survey, but only one in five of those injured sought medical treatment (Greenfeld et al., 1998); 41 percent of women in the National Violence Against Women Survey reported injuries but only 30 percent received medical treatment. Injuries do not appear to be the most common health-related aftereffect of intimate

partner violence. Instead, a wide range of physical health complaints have been found to be associated with physical abuse, including gastrointestinal disorders, chronic pain or fatigue, loss of appetite and eating disorders, and gynecologic and urologic disorders.[1]

Sexual Assault

Rape and other sexual assault are associated with a variety of physical health consequences, including injury, stress-related problems, and chronic health problems (reviewed by Koss and Heslet, 1992). The National Violence Against Women Survey found that 32 percent of rape victims reported injuries and 36 percent sought medical treatment (Tjaden and Thoennes, 1998a). An examination of the health-related effects of sexual assault among patients in a gastrointestinal practice found that overall health status was associated with being raped, even though three-quarters of the reported rapes occurred more than 10 years prior to the study. Serious injury as a result of rape was associated with significantly more reported pain, somatic symptoms, more days in bed due to disability, and more functional disability (Leserman et al., 1997). Thus, it appears that sexual assault is associated not only with injury and short-term physical health problems, but also with more long-term health problems in some women. These health-related problems are associated with a significantly increased use of medical services (Golding et al., 1988; Goodman, Koss, and Russo, 1993a; Leserman et al., 1997).

Emotional and Psychological Effects of Violence Against Women

Intimate Partner Violence

A substantial body of research has investigated the effects of intimate partner violence on emotional well-being. The effects of physical abuse by intimate partners have been studied more extensively than the effects of emotional abuse. A significant limitation of most of this research is that it is based on groups of abused women who seek help rather than the broader group of abused women who do not seek help.[2] The effect of this bias is to overestimate the harmful effects of physical and emotional abuse, because women who seek help due to the effects of abuse tend to have experienced significantly more severe abuse than women who do not seek help (Weaver and Clum, 1995). This is important because the research clearly indicates that the effects of intimate partner violence are closely related to the severity of abuse experienced, as discussed below. In addition, most research studies the effects of abuse at one point in time and therefore cannot determine whether the emotional problems measured are causes of intimate partner violence, are caused by intimate partner violence, or are caused by some other factor.

Overall, physical abuse is associated with depression and suicide attempts, posttraumatic stress disorder (PTSD),[3] other forms of anxiety, and substance abuse. Depression is the most commonly studied correlate of intimate partner violence (Andrews and Brewin, 1990; Arias, Lyons, and Street, 1997; Campbell, Sullivan, and Davidson, 1995; Follingstad et al., 1991; Plichta and Abraham, 1996; Stets and Straus, 1990) and has been found in as many as three-quarters of abused women studied in help-seeking samples (Campbell, Sullivan, and Davidson, 1995; Follingstad et al., 1991). The pervasiveness of depression may be partly explained by the sense of

self-blame some abused women experience (10 to 40 percent, depending on the study) and the sense of powerlessness that develops as abuse escalates in frequency and severity and the victim comes to realize that it is out of her control.

Several studies have reported higher than average rates of suicide attempts or ideation for physically abused women (e.g., Hilbert, Kolia, and VanLeeuwen, 1997; Plichta and Abraham, 1996; Stark, Flitcraft, and Frazier, 1979). This has been said to be particularly problematic for African-American victims of intimate partner violence, whose options to terminate an abusive relationship may be more limited than those of white women due to poverty and the pervasive cultural belief that African-American women are responsible for maintaining the family and preserving the race (Heron et al., 1997, p. 413).

PTSD is also associated with intimate partner violence (Astin et al., 1995; Houskamp and Foy, 1991; Kemp, Rawlings, and Green, 1991; Saunders, 1994; Vitanza, Vogel, and Marshall, 1995; Weaver et al., 1997). There is a growing consensus that if it is necessary to apply mental health diagnoses to victims of violence against women and other trauma, PTSD is the best diagnosis because it views the aftereffects as normal reactions to abnormal circumstances[4] (Goodman, Koss, and Russo, 1993a). PTSD is more prevalent in shelter samples of abused women (84 percent met diagnostic criteria for the disorder in one study) (Kemp et al., 1991) than in groups of abused women who seek help in other settings (Saunders, 1994). Saunders found that intrusive memories of the abuse were the most common symptom. Although the research suggests that more severe and more recent abuse are associated with worse PTSD (a “dose-response effect”; Saunders, 1994), even emotional abuse and minor physical abuse are sufficient to cause PTSD symptoms in some victims (Follingstad et al., 1991; Loring, 1994), and PTSD has been documented in nonclinical as well as clinical samples (Vitanza, Vogel, Marshall, 1995).[5]

Other anxiety symptoms are also well documented as correlates of intimate partner violence (Follingstad et al., 1991; McCauley et al., 1998). This is not surprising in light of the buildup of tension that can be associated with domestic violence and the fear and apprehension associated with trying to prevent outbursts of violence and maintain the safety of oneself and one’s children. Anxiety is also associated with psychosomatic symptoms, such as headaches and gastrointestinal problems (e.g., Follingstad et al., 1991; McCauley et al., 1998; Stets and Straus, 1990).

Elevated rates of alcohol and drug abuse have also been found in survivors of intimate partner violence (Kilpatrick et al., 1997; Koss and Heslet, 1992; McCauley et al., 1998; Miller and Downs, 1993; Plichta and Abraham, 1996). Because many victims of adult intimate partner violence have also experienced childhood victimization (Plichta and Abraham, 1996; Weaver and Clum, 1996; Weaver et al., 1997), the lowered self-esteem that sometimes results may lead them into early use of alcohol as a coping strategy (Miller and Downs, 1993; Weaver and Clum, 1996). Because little research has studied women over time, it is difficult to determine whether substance use contributes to the risk of assault, is a consequence of assault, or both. Kilpatrick et al. (1997) tested these possible explanations in a national study following women for 2 years and concluded that there is a vicious cycle in which violent victimization leads to increased drug and alcohol use, which in turn increases the risk of future violent victimization. Stark, Flitcraft, and

Frazier (1979) also found that alcohol and drug abuse rates increased for abused women over time. Because a subset of victims of intimate partner violence (almost one in four in Plichta and Abraham's [1996] national study, compared with one in eight nonvictims) attempts to cope with the effects of abuse by medicating their feelings with drugs and alcohol, some of these women will develop a problem with substance abuse or addiction.

Effects on parenting in relation to intimate partner violence have also been studied. Given the stress associated with being physically and emotionally abused and the psychological correlates of intimate partner violence, such as depression and PTSD, it would be surprising for a woman's parenting not to be affected in some ways (Levendosky and Graham-Berman, 1998). Levendosky and Graham-Berman found that both physical and psychological partner violence are associated with parenting stress. Another study found that the extent of physical abuse and the number of other stressful life events predicted maternal adjustment (measured in terms of physical problems, anxiety and insomnia, depression, and social dysfunction) of abused women; maternal adjustment was found to be a better predictor of children's behavior problems than the violence to which they had been exposed (Wolfe et al., 1985).

Psychological or emotional abuse, although less well studied, typically precedes physical abuse, which rarely occurs in the absence of psychological abuse (O'Leary, Malone, and Tyree, 1994). Consisting of both overt behavior such as threats and ridicule and more subtle behaviors like undermining, psychological abuse has been shown to have emotional consequences as serious as those of physical abuse, such as depression and diminished self-esteem (Follingstad et al., 1991; O'Leary, 1999; Rollstein and Kern, 1998; Sackett and Saunders, 1999). Women who have experienced both physical and emotional abuse often report that emotional abuse is more harmful (Follingstad et al., 1990). In addition, the research of Jacobson et al. (1996) indicates that psychological abuse is more highly predictive of women ending a relationship than physical abuse.

There is a strong consensus in the research on health and emotional effects of intimate partner violence that the more severe, frequent, and long-lasting the abuse—physical or psychological—the more likely women are to experience symptoms and the more severe those symptoms are likely to be (Follingstad et al., 1991; McCauley et al., 1998; Stets and Straus, 1990). As abuse escalates, physical and emotional health are likely to deteriorate. This compromised well-being is likely to continue for some even after abuse ends, although the overall picture is one of gradual improvement after abuse ends (Follingstad et al., 1991). Interestingly, the impact of partner violence on its victims' well-being does not appear to be affected by demographic factors such as age, race, or education (Weaver and Clum, 1995). However, a history of childhood physical and sexual abuse, which are experienced by significant numbers of adult partner violence victims, may exacerbate the emotional difficulties associated with abuse (Plichta and Abraham, 1996; Weaver and Clum, 1996).

Sexual Assault

The psychological aftereffects of rape and sexual assault have been extensively studied, although as is the case with physical abuse, studies typically are not based on representative samples. Few

studies follow victims over time, so they are unable to draw conclusions about causality. Short-term emotional reactions to sexual assault include "shock, intense fear, numbness, confusion, extreme helplessness, and/or disbelief . . . [s]elf-blame is common and often severe" (Goodman, Koss, and Russo, 1993b, pp. 82–83). According to a review of research, symptoms begin to subside for most victims at about 2 to 3 months postassault, although little recovery occurs spontaneously after 1 year; a subset of victims experiences chronic problems long term (Resick, 1993).

The most common mental health aftereffects of rape include fear, PTSD, other anxiety such as phobias and obsessive-compulsive disorder, depression and suicide attempts, sexual dysfunction, reduced self-esteem, relationship problems, and substance abuse (Goodman, Koss, and Russo, 1993b; Kilpatrick, Edmunds, and Seymour, 1992; Resick, 1993; Zweig, Barber, and Eccles, 1997). Sorenson and Siegel's (1992) study of Los Angeles adults found that 43 percent of sexual assault victims suffered from depression and 40 percent reported anxiety. The Kilpatrick, Edmunds, and Seymour (1992) national study found that 13 percent of rape victims had attempted suicide, compared with only 1 percent of nonvictims. The predominant group of women with PTSD are said to be sexual assault survivors (Goodman et al., 1993b), and an estimated 4 million U.S. women are said to have experienced rape-related PTSD (Kilpatrick, 1993). Cognitive effects have also been reported following sexual assault, which has been found to alter beliefs such that feelings of personal invulnerability, the view that the world is meaningful, and feelings of personal safety are destroyed (Janoff-Bulman, 1985). Finally, it is common for sexual assault survivors to cope with the distress associated with victimization by medicating themselves with drugs or alcohol (Collins, 1998; Goodman, Koss, and Russo, 1993b; Teets, 1997). The majority of women in some substance abuse treatment programs are said to be survivors of childhood or adult sexual assault (Teets, 1997).

Three kinds of factors have been found to affect rape-related distress and recovery from the effects of sexual assault:

- Preassault variables (prior psychological functioning, history of victimization, coping abilities).

- Assault-related variables (frequency, severity, especially whether force was used, form, and duration of assault; injury).

- Postassault variables (how the assault is perceived, self-blame, concurrent stressors, extent of support, and resources available for recovery) (Gidycz and Koss, 1991; Goodman, Koss, and Russo, 1993b; Resick, 1993).

Sexual assault and rape by an intimate partner are no less traumatic than sexual assault by a stranger (Riggs, Kilpatrick, and Resnick, 1992). Although factors such as education and race do not predict distress or recovery from sexual assault, younger victims have been found to report more distress (Sorenson and Siegel, 1992), perhaps because the assault was more recent.

Survivors who blame themselves (Weaver and Clum, 1995) and survivors of childhood sexual abuse (Cohen and Roth, 1987) have also been found to report more distress.

Because of the extensive impact on health and well-being, survivors of sexual assault use a broader array of both mental health and general health services compared with nonvictims (Sorenson and Siegel, 1992), even when gender, ethnicity, age, and type of insurance are considered. Rape and sexual assault cause virtually universal distress in the short term, with most victims recovering to some extent by about 3 months postassault, although a subset of victims exhibits problems long term. Such problems include fear and anxiety, PTSD, depression and suicide attempts, sexual difficulties, and substance abuse. These postassault aftereffects are associated with substantial increased use of physical and mental health services.

Stalking

The effects of stalking on its victims have been empirically investigated only in the recent National Violence Against Women Survey (Tjaden and Thoennes, 1998b). Significantly more prevalent than previously estimated (8.1 percent lifetime prevalence, an estimated 8.2 million women), stalking disproportionately affects younger women; half of its victims are between ages 18 and 29. Women are most likely to be stalked by a current or former intimate partner, and the majority of those stalked by a partner were also physically abused by that partner; almost one-third were also sexually abused by that partner. Although two-thirds of cases lasted less than 1 year, 10 percent lasted 5 years or more. Typically the stalking ended not because of legal actions but rather because the victim relocated, the perpetrator found a new partner, or the victim persuaded the perpetrator to stop. Interestingly, stalking victims perceived informal law enforcement actions such as the police talking to the perpetrator to be more effective in getting the stalking to stop than more formal actions such as arrest (Tjaden and Thoennes, 1998b).

Coping With Violence Against Women

Intimate Partner Violence

How abused women cope with the ongoing violence in their lives and, in particular, why women remain in abusive relationships for a period of time are important questions. Individual, situational, and societal factors may play a role. The dynamics and characteristic patterns of intimate partner violence may also be a factor. In most cases, intimate partner violence begins with emotional abuse and minor, infrequent acts of physical aggression, such as an occasional slap or shove, accompanied by the abuser's promises that it will not occur again (Cascardi et al., 1995). If abuse escalates and the victim's efforts to make it stop are not successful, economic dependency on the abusive partner and difficulty in obtaining an alternative living situation can serve as barriers to leaving, as can emotional dependency. Fear is another factor that can entrap women in abusive relationships (Strube and Barbour, 1983). The presence of children and concern for their welfare, too, can also serve as a barrier to women leaving a violent relationship. Thus, a combination of internal and external barriers have been found to hinder women from leaving abusive relationships.

Despite the factors discussed above, it appears that many—maybe most—battered women eventually end their abusive relationships (Campbell et al., 1994; Jacobson et al., 1996; Okun, 1986). However, terminating an abusive relationship seems to be more a process than a discrete event (Campbell et al., 1998). That is, as domestic violence program staff are well aware, most women seem to leave and return several times before they leave permanently. Shelter-based studies of women's decisionmaking show that many return to the abusive relationship after leaving a shelter, and some of those who do not return immediately return eventually (Hilbert, Kolia, and VanLeeuwen, 1997; Schutte et al., 1986; Snyder and Scheer, 1981).

How do women cope with physical and emotional abuse while it is occurring? Although some studies have found that battered women cope less effectively than nonabused women because they use fewer active problem-solving strategies and more passive strategies, such as avoidance and denial (Finn, 1985), most researchers and service providers have found that abused women are highly resourceful and cope extremely well considering the types and extent of stress they confront (Campbell et al., 1998; Wolfe et al., 1985). One explanation for the use of passive coping strategies is that people in general tend to cope less effectively when the amount of stress is overwhelming or perceived to be outside their control. Abused women must contend with not only the abuse itself, but typically many other sources of stress, such as poverty and lack of sufficient resources, child-related problems, and so forth. One example of a passive coping strategy used by abused women is rationalization of the violence, such as denying that it will continue, perhaps by believing that their partner will change as promised or by assuming responsibility for the violence, thereby perceiving that they have the ability to control it in the future (Ferraro and Johnson, 1983).

Examples of other coping strategies include seeking social and spiritual support (Finn, 1985). However, research has documented that abused women tend to be socially isolated and have fewer social supports (often because of the abuser) that can be relied on for practical and emotional assistance as compared with nonabused women (Nielsen, Endo, and Ellington, 1992). O'Keefe (1994) found that a quarter of the abused women she studied from Los Angeles shelters reported having no support system at all. One reason for not seeking assistance more often from family and friends may be concerns for their safety. But even when abused women have family and friends, the embarrassment, stigma, or depression associated with abuse may interfere with their willingness or ability to actively seek or receive support (Mitchell and Hodson, 1983). In cases of severe, long-term abuse, others may withdraw from victims (Mitchell and Hodson, 1983). It is not known whether lack of social support contributes to intimate partner violence, is a result of it, or both. Some research suggests that the strategies used by women to cope with abuse change over time. The initial denial that abuse will continue is no longer effective if occasional abuse escalates to recurrent battering, and new strategies to manage the violence must be developed. More active problem-solving strategies may be used to try to avoid the violence or its effects, such as calling the police, trying to soothe the abuser, and leaving temporarily to stay with family, friends, or in a shelter. Anecdotal reports indicate that by the time women have resorted to a domestic violence program or shelter, they usually have tried a range of tactics to cope with and stop the violence, having sought help from family and friends as well as counselors, clergy, lawyers, and other professionals; one study found that women who eventually escape

an abusive relationship had used an average of nine resources (Gondolf and Fisher, 1988; Horton and Johnson, 1993; Wauchope, 1988).

Sexual Assault

It is unfortunate that there is relatively little research on coping with sexual assault, because type of coping is related to postassault adjustment. In particular, poorer adjustment has been found to be associated with avoidance coping, including efforts to avoid dealing with the source of stress or its consequences, such as social withdrawal, dissociation,[6] or use of drugs or alcohol as a means of medicating assault-related distress (Ullman, 1996b). Research has not explained why one survivor may attempt suicide, whereas another actively seeks social support in the aftermath (Sorenson and Siegel, 1992). One explanation may be the reactions of others to disclosure. Ullman (1996a) found that most victims disclosed to someone following a sexual assault, although only one-third did so immediately; more than one-third waited 1 year or more to tell someone. Generally, victims prefer to disclose to family and friends rather than professionals (Neville and Pugh, 1997; Ullman, 1996a). Disclosure may also be related to the relationship with the offender; when the offender is an acquaintance or dating partner, disclosure may be delayed due to confusion about whether what occurred was actually sexual assault. Delayed disclosure is associated with avoidance coping, "suggesting that women delaying disclosure may be attempting to avoid dealing with the assault by drinking, withdrawing from others, or dropping out of school or work" (Ullman, 1996a, p. 567). Ullman (1996b) reported that negative social reactions are associated with poor postassault adjustment.

Some survivors seek professional services to cope with the aftereffects of sexual assault, although apparently not the majority. Sorenson and Siegel (1992) reported that only 21 percent of whites and even fewer Hispanics (9 percent) sought counseling following a sexual assault; Hispanics (7 percent) were more likely than whites (3 percent) to seek help from clergy; and only 3 percent of assault survivors sought assistance from a rape crisis center. Little is known about why some survivors seek counseling and others do not. Some victims choose to report the assault to law enforcement, although estimates of the frequency of police reports are quite variable, up to half in one study (Bachman and Saltzman, 1995) but only 12 percent in another (Kilpatrick, Edmunds, and Seymour, 1992). Resick's (1993) review indicates that following through with criminal justice actions can be very stressful for victims. This factor, along with the negative social reactions from police (as well as physicians) reported by Ullman's (1996a) respondents, may help explain the low levels of reporting to law enforcement.

Victims of marital rape, estimated by some to be the most common form of sexual assault (Russell, 1990), are in an especially difficult position in that they have an ongoing relationship with the abuser. Two large-scale studies suggest that rape occurs in 10 to 14 percent of all marriages (Campbell, 1989b; Russell, 1990). Typically, marital rape occurs in the context of severe, ongoing physical abuse (Campbell, 1989a), and its victims use coping strategies similar to those used by victims of intimate partner violence. In the beginning, the rape tends to be seen as a one-time aberration. But when sexual assault occurs again, victims may devise other strategies to avoid its occurrence, such as active resistance, placating or avoiding their partner, or minimizing the consequences, such as complying with their husband's sexual demands to avoid getting

injured (Bergen, 1998). Other women dissociate, become numb, or try to distract themselves by thinking of more pleasant things (Bergen, 1998). Research has debunked the myth that marital rape is less harmful than stranger rape. Being raped by one's husband involves a greater violation of trust than being raped by a stranger and is associated with injury, suicide attempts, stress, depression, and low self-esteem (Campbell, 1989b; Mahoney and Williams, 1998). Furthermore, women sexually assaulted by their husbands are more likely to experience multiple assaults and less likely to seek medical, police, or other help than women sexually assaulted by acquaintances or strangers (Mahoney, 1999).

Stalking

Little research has investigated how women cope with stalking, but it appears that stalking takes a substantial toll on its victims. In the Tjaden and Thoennes (1998a) study, almost one in three victims sought counseling as a result of the stalking, one in four lost time from work, 22 percent took extra precautions, 18 percent sought help from friends or family members, and 17 percent obtained a gun. Another study found that the most frequent coping strategies reported by college women were ignoring or confronting the stalker, changing her schedule to avoid him, or carrying a spray weapon (Fremouw, Westrup, and Pennypacker, 1997).

Impact of Race, Culture, and Ethnicity

Limited research has examined cultural factors in relation to violence against women, most of it focused on whether there are ethnic differences in the prevalence of violence against women, especially domestic violence. As discussed in Carlson et al. (2000), no consensus has emerged from the results of that research, and thus we cannot say with certainty whether there are ethnic differences in the incidence of physical violence in intimate relationships when other important variables, such as socioeconomic factors, are considered. A recent review concluded that

> In summary, at first glance, partner violence appears to be more prevalent among African Americans, American Indians, and some Latino groups than among Anglos. On closer inspection, these ethnic differences often disappear when age, social class, and husband's employment status are taken into account. When ethnic differences remain, they may be explained by level of acculturation, binge drinking, and normative approval of violence. (West, 1998, p. 201)

Two large-scale studies have found sexual assault rates for whites, blacks, and Hispanics to be in the same range, with the highest rates being reported by American Indian women (Koss and Harvey, 1987; Tjaden and Thoennes, 1998b). In contrast, the Los Angeles study found significantly lower rates of sexual assault for Hispanics (primarily Mexican American) than for whites (Sorenson and Siegel, 1992), and Wingood and DiClemente (1998) cite studies finding higher rates for African-American women. Rather than focus on whether certain ethnic groups have higher rates of violence against women, it may be more valuable to practitioners to understand how cultural factors shape both help-seeking patterns and the ways in which intimate partner violence, sexual assault, and stalking are experienced or interpreted (Coley and Beckett, 1988; West, 1998). For example, Neville and Pugh (1997)—who note that African-American women

have traditionally been even more reluctant to report sexual assault to law enforcement than white women—point out that rape has been viewed in the context of oppression of black women, who have been perceived historically as sexually loose (Asbury, 1987).

Some writers have maintained that African-American women who are physically abused are more prone to suicide than white women (Heron et al., 1997; Koss and Heslet, 1992). Although it is widely believed that black women are more reluctant to call the police in response to domestic violence as a result of the risk of being perceived as disloyal to the race (Brice-Baker, 1994; Sorenson, 1996), national survey data have reported the opposite to be true; 68 percent of African-American women versus 49 percent of white women contacted police (Greenfeld et al., 1998). Neville and Pugh (1997) reported low rates of professional help seeking in their small sample of African-American sexual assault victims; respondents' explanations for not seeking counseling revolved around the need to be strong, historically an adaptive survival strategy for black women that can be a burden if it interferes with victims getting the help they need to recover. Other research has suggested cultural differences in the acceptability of terminating an abusive marriage; for example, Hispanic wives may have greater difficulty than white or black wives in getting family support for ending an abusive marriage (Gondolf and Fisher, 1988).

Immigrant victims of violence against women are especially vulnerable, as discussed in Hagen and Postmus (2000). The immigration experience can disrupt family and community ties and loosen social control mechanisms, thereby increasing the risk of violence against women. Fears about deportation can inhibit victims from seeking police protection or other kinds of assistance (Sorenson, 1996). However, for the most part, studies that have examined race in relation to the effects of intimate partner violence or sexual assault have found few, if any, racial differences (e.g., O'Keefe, 1994; Sorenson and Siegel, 1992; Sullivan and Rumptz, 1994). This suggests that the pervasive effects of violence against women may largely transcend the impact of culture.

Effects on Children of Exposure to Intimate Partner Violence[7]

Wide-ranging estimates suggest that as few as 3.3 million (Carlson, 1984) and as many as 17.8 million (Spaccarelli, Sandler, and Roosa, 1994) children from two-parent homes may be witness to intimate partner violence. Young children are at particular risk for such exposure (Fantuzzo et al., 1997) because rates of intimate partner violence are significantly higher for younger couples (Greenfeld et al., 1998). Researchers began to study the effects of exposure to domestic violence on children in the 1980s. Early studies were based almost exclusively on children who resided with their mothers in domestic violence shelters, although investigators soon realized that such children were not representative of all children exposed to intimate partner violence insofar as women in shelters tend to have experienced the most severe forms of violence. Other studies have surveyed college students and other adults about the effects of exposure to violence between parents.

The results of these two strands of research suggest that young people exposed to intimate partner violence can be affected in diverse ways. There is no single profile of response. Many studies report findings that seem to conflict with other, similar studies. In general, these studies

find that a substantial subgroup of children suffer from "externalizing problems" (e.g., anger, physical aggression, oppositional or destructive behavior) and/or internalizing problems (e.g., depression, fears, anxiety, withdrawal). In addition, children exposed to intimate partner violence can show deficits in social competencies (e.g., lack of empathy, poor peer relationships). As many as half of children in domestic violence shelters may exhibit signs of PTSD (Lehmann, 1997). Younger children may respond with frequent somatic problems, such as fussiness or poor sleeping or eating habits (Jaffe, Wolfe, and Wilson, 1990). There has been a tendency to attribute the problems observed in these children to the effects of witnessing intimate partner violence, but the same kinds of problems are also frequently associated with other sources of stress that are frequently present in the lives of such children. Thus, it is difficult to disentangle the effects of exposure to intimate partner violence from the effects of other stressors such as physical or sexual abuse, poverty, substance abuse, and ineffective parenting (Henning et al., 1996; Holden, Geffner, and Jouriles, 1998). For example, Wolfe et al. (1985) found that maternal adjustment, perception of stressful events, and family crises accounted for as much of children's behavior problems as did exposure to parental violence. Exposure to emotional abuse of their mother, such as threats and insults, can also contribute to children's problems (Jouriles et al., 1996; Levendosky and Graham-Berman, 1998).

Interestingly, not all children exposed to intimate partner violence exhibit problems. Some studies find that even children interviewed in domestic violence shelters are no more likely to have conduct problems than comparison groups of children not exposed to intimate partner violence (Kolbo, Blakely, and Engleman, 1996). Despite a violent home environment, some children are resilient and function quite well because of the presence of protective factors such as social support (Kolbo, Blakely, and Engleman, 1996) and healthy coping skills (O'Brien et al., 1997).

Retrospective studies of adults reporting on their childhood exposure to violence between their parents have found a number of negative outcomes associated with such exposure, including depression, antisocial behavior, dating violence, and trauma symptoms (Maker, Kemmelmeier, and Peterson, 1998; Silvern et al., 1995). Other studies have failed to find that witnessing interparental violence is associated with subsequent dysfunction (Langhinrichsen-Rohling et al., 1998). However, recent studies have found that when the effects of co-existing stressors such as exposure to emotional abuse toward a parent, their own physical or sexual victimization, or parental alcoholism were considered, some or all of the unique effects of exposure to intimate partner violence disappear (Henning et al., 1996; Maker, Kemmelmeier, and Peterson, 1998).

Intervention With Victims of Violence Against Women

Intimate Partner Violence

Initially, concerns about intervention focused on victims but quickly turned to offenders; as a result, in recent years, less research has focused on interventions for victims. In contrast to the common stereotype of abused women as helpless, two large-scale studies have shown that most abused women seek help repeatedly before seeking shelter (Gondolf and Fisher, 1988; Wauchope, 1988), which for many survivors may be a last resort. Most abused women who seek

help go first to family and friends and are quite satisfied with the substantial assistance they receive from such supporters (Bowker, 1984; Davis and Srinivasan, 1995; Horton and Johnson, 1993; Pakieser, Lenaghan, and Muelleman, 1998). Regarding formal sources of help, a recent review noted:

> Services for victims have not changed dramatically in the last 20 years; they still tend to be organized around community-based shelters that emphasize ensuring the immediate safety of victims. . . . [E]valuating the psychological status of victims, even for the purpose of evaluating outcome or facilitating recovery, is still controversial. (Hamby, 1998, p. 221)

Underlying this controversy is the belief of many practitioners within the battered women's community that mental health approaches pathologize victims.

Gordon's (1996) review of research on use of services by abused women concluded that the most commonly used formal services (starting with the most frequent) were criminal justice (law enforcement, lawyers), social service agencies, medical services, crisis counseling, mental health services, clergy, support, and women's groups. However, the most frequently contacted services were not necessarily viewed as the most valuable. Most helpful were "crisis counselors, psychologists and/or counselors, physicians, social workers and lawyers" (Gordon, 1996, p. 319), although there was wide variability in the perceived helpfulness of mental health and social service professionals, crisis counselors, and doctors. More than three-quarters of Horton and Johnson's (1993) sample of women who had escaped abuse recommended counseling to other victims. Counselors who were knowledgeable about abuse and understood the situation in which abused women find themselves were perceived as most helpful. A Canadian study found that women reported helpful responses to include listening and taking the woman seriously, believing her story, and helping her to see her strengths (Hamilton and Coates, 1993). A U.S. national study of 1,000 abused women concluded that women's groups were rated higher than traditional social services, "with clergy a distant third" (Bowker and Maurer, 1986, p. 73). Women's programs have generally received high marks, despite being used less frequently than many other services (Davis and Srinivasan, 1995; Gordon, 1996; Horton and Johnson, 1993).

Although much has been written about intervention with victims of intimate partner violence, limited empirical research has evaluated the effectiveness of recommended interventions. Two broad types of interventions are described in the literature: services of domestic violence programs and group, couple, and individual counseling. Evaluating shelter-based services is extremely important because shelters and related domestic violence programming have spread rapidly and are generally seen as the most appropriate intervention for abused women. More than 2,000 domestic violence programs exist nationally; 1,200 of them are shelters (Sullivan and Rumptz, 1994). At a minimum, these programs provide emergency respite for abused women and their children (up to 90 days); advocacy; safety planning information about domestic violence, victims' rights, and service options; and peer support. Many also provide transportation, support groups, longer term counseling, children's services, and parenting education

(Hamby, 1998). In addition, many provide such prevention services as community education and consultation to schools.

An early review noted that three kinds of outcomes of shelter-based programs have been studied: decisions to leave the abusive relationship, recurrence of violence, and women's reports of helpfulness. Although several studies have evaluated the number of women who intend to end the relationship with the abuser upon shelter exit, this is viewed as a poor measure of shelter effectiveness for several reasons. First, not all those who enter a domestic violence shelter do so with the intention of ending the relationship with their partner; some use it as respite from the violence or as a coping strategy (Okun, 1986). Other women use a shelter stay to pressure their partners to change, returning home with the hope that they will refrain from future violence. Such public disclosure of intimate violence "is one of the most common and most effective strategies used by women to stop their partners' violence" (Aldarondo and Sugarman, 1996, p. 1,017). Thus, shelters may be part of the "progressive process in which women exert increasing leverage upon their violent mates to change, while the women simultaneously become more familiar and more competent with living separately from their mates" (Okun, 1986, p. 230). However, many continue to be abused despite ending the relationship, as discussed below. The few studies that have evaluated the number of women who remain violence free after shelter exit have found that many continue to be at risk (e.g., Berk, Newton, and Berk, 1986; Dutton-Douglas and Dionne, 1991; Sullivan and Rumptz, 1994). One small study found that, ironically, women who returned to their partners reported more severe violence and longer relationships; in contrast, those who ended the relationship were older, had experienced more frequent abuse, had an independent source of income, and had stayed at the shelter longer (Hilbert and Hilbert, 1984).

Sullivan and her colleagues evaluated a postshelter intervention using a control group that did not receive the intervention for comparison purposes. The intervention consisted of 10 weeks of postshelter advocacy services provided by trained undergraduate students. The goals of the intervention were to increase social support and mobilize community resources to meet needs for goods and services, education, transportation, financial assistance, health and employment services, housing, and child-related services. Half of the 141 women were randomly assigned to the intervention group; the remainder did not receive the intervention and served as the control group. A wide array of outcomes were measured to evaluate the intervention's effect at five points in time (intake, immediately following the intervention [10 weeks postshelter], and 6, 18, and 24 months later) on depression, fear and anxiety, attachment to the abuser, social support, and well-being. At 6 months, 43 percent were still being abused, women were overwhelmingly satisfied with the services provided, and the intervention was effective in the short run at increasing social support. No differences were found in postshelter involvement with the abuser or in the percent being abused between the intervention and control groups. Across both groups, those who relied on the abuser for half or more of their income were more likely to still be involved with him (Sullivan et al., 1994; Sullivan et al., 1992; Tan et al., 1995).

However, at 24 months a very different picture emerged: Most of the original 75 percent of the sample who said they wanted to end the relationship at shelter exit had done so; those who had worked with an advocate were significantly more likely to have ended the relationship (96 versus

87 percent). Three-quarters were involved in new relationships; quality of life had improved for both groups, but significantly more so for those who had received the advocacy intervention. No long-term group differences in depression or social support were found. However, at the 24-month point, 89 percent of the control group and 76 percent of the intervention group had been reabused, although not necessarily by the original partner (Sullivan and Bybee, 1999).

Several studies have evaluated counseling interventions for abused women, including an intervention to increase safety behaviors. One study tested an intervention during pregnancy designed to increase women's safety behaviors, such as hiding money, extra clothes, or an extra set of car keys (McFarlane et al., 1998). Significant increases in all 15 safety behaviors were found. Attending a nurse-delivered, 30-minute "empowerment protocol" covering how to access legal services, information about violence, and other resources in addition to safety behaviors was associated with a greater drop in physical and emotional abuse than just receiving a wallet card with resource phone numbers (Parker et al., 1999). Another study without a control group found that 2 to 3 months of individual counseling following termination of abuse did not seem to make a difference in psychological functioning (Rollstein and Kern, 1998). Mancoske, Standifer, and Cauley (1994) compared a feminist-based group intervention with a grief-based one. All women received crisis intervention, information, and referral. Women in the grief-based group had significantly improved scores on self-esteem and self-efficacy. Another evaluation of an unstructured group intervention was based on only six women from whom data were available both before and after treatment. The author concluded that the "data do not provide substantial grounds for optimism about the effectiveness of [this] counseling and support group intervention" (Rubin, 1991, p. 351). In contrast, a Canadian evaluation of a social worker-facilitated support group for abused women found improvement in those who attended in the areas of self-esteem, marital functioning, and perceived stress (Tutty, 1996). Although there were reductions in both physical and nonphysical abuse and significant improvements in marital satisfaction, abuse did not totally cease (Tutty, Bidgood, and Rothery, 1993). McNamara and colleagues (1997) compared the effects of one to three sessions of individual counseling with case management and found that counseling clients reported more improvement in coping and reduced abuse, but clients who were higher functioning and had experienced less severe abuse benefited most. Those evaluating interventions for abused women have reported many challenges such as significant dropout (McNamara et al., 1997) and poor attendance or participation in the actual intervention (Rubin, 1991).

Interventions for couples that have experienced violence have been controversial. Many believe they should never be used because of the danger they pose to victims, the message they convey about who is responsible for the violence (both parties), the potential for coercing the victim to continue the relationship against her will, and so forth. Others, however, maintain that couples interventions can be appropriate if certain conditions are met, including no history of severe violence, successful completion of a group intervention for batterers by the male partner, and the desire by both parties to preserve the relationship and participate in counseling together. Brannen and Rubin (1996) compared a couples group intervention with gender-specific group interventions for batterers and domestic violence victims. The goals were to reduce violence, increase conflict resolution skills, and enhance communication and problem solving. A sample of men

referred from probation and their partners were randomly assigned to either condition. Two-thirds of the men had a history of minor violence; the remainder had used severe violence toward their partners. Extensive safety procedures were put in place to reduce the likelihood that women would continue to be abused during treatment. In the couples group, a 12-week cognitive-behavioral intervention program was used that focused on abusers taking responsibility for their violence and learning techniques to avoid future violence. Victims reported that the majority of men in both groups (92 to 93 percent) were violence free at 6 months postintervention. Considering the differential levels of alcohol problems across the two groups, no differences in psychological abuse were reported across interventions. Men with alcohol problems did better in the couples group, which they attended with their partners, where their tendencies to deny and minimize could be more effectively confronted. Two couples from each group (out of a total of 42 participating couples) experienced incidents of ongoing physical or emotional abuse, challenging the commonly held notion that couples treatment is more dangerous to victims' safety than individual men's treatment (Brannen and Rubin, 1996). A major limitation of this study was the small sample size.

In conclusion, although most abused women do seek help from both informal and formal sources, few interventions for victims of intimate partner violence have been evaluated. There is only mixed support for the effectiveness of these interventions in helping women reduce the violence in their lives or improve their well-being, perhaps because such interventions have not been sufficiently potent or are too short term to have the desired effects, or because women have little control over their partners' violence. However, there is evidence of the potential effectiveness of advocacy and group interventions. There are no evaluations of shelter interventions per se and no agreement on what outcomes should be evaluated following shelter stays.

Sexual Assault

Rape crisis centers have been the cornerstone of intervention efforts on behalf of survivors of sexual assault. Although many adult survivors of sexual assault are served in these settings, rape crisis centers also serve significant numbers of survivors of child sexual abuse. The most commonly used interventions in such centers are crisis intervention and psychotherapy/support groups (Foa, Rothbaum, and Steketee, 1993). For the most part, these interventions have not been subject to rigorous evaluation. The typical short-term interventions offered by rape crisis centers are not sufficient for the subset of victims that exhibit long-term problems. The most carefully evaluated treatments for rape and sexual assault victims have been cognitive and behavioral interventions. Foa, Rothbaum, and Steketee (1993) critically review these studies. A variety of cognitive and behavioral intervention strategies have been found to be effective in reducing the aftereffects of sexual assault, such as fear and anxiety, PTSD, cognitive distortions, depression, and sexual dysfunction. Examples of such techniques are systematic desensitization, relaxation training, and stress inoculation (coping skills) training. Some of these techniques address the original trauma directly, such as systematic desensitization, whereas others address the resulting distress only, such as Kilpatrick and Veronen's (1983) composite model, which uses a variety of techniques and has been shown to be effective in reducing "rape-related fear, anxiety, phobic anxiety, tension, and depression" (Foa, Rothbaum, and Steketee, 1993, p. 267). Other studies have compared the effectiveness of different types of cognitive and behavioral interven-

tions and have generally concluded that all are associated with improved postassault functioning compared with no treatment (e.g., Foa et al., 1991; Resick, 1993). Foa, Rothbaum, and Steketee, (1993) conclude their review by noting that "several cognitive/behavioral treatment programs have been developed or adapted for rape victims. These programs have been found to be successful in treating rape-related distress, but no one intervention has proved superior" (p. 271).

Intervention With Offenders

It is widely believed by practitioners that once partner violence occurs, it will inevitably not only continue but escalate. The research does not bear out that assumption, however. Several longitudinal studies challenge the assumption that intimate partner violence inevitably continues or escalates. Using the National Youth Survey data, Woffordt, Mihalic, and Menard (1994) found that half of the victims at the first point in time were still victims at the second point in time. Several factors predicted continuance, including severity and poverty. Quigley and Leonard (1996) found that about one in four newlywed men desisted, with severity again predicting continuation. Another study followed couples from early marriage to 30 months later and found that the likelihood of those who used aggression initially continuing to do so at 18 months and 30 months varied considerably (O'Leary et al., 1989). The conclusion from this research is that although there is substantial stability in marital aggression, a minority of men do cease their violence, even without intervention, especially those whose violence is not severe initially. Emotional abuse has not been evaluated over time.

Fagan's (1989) review of research concluded that desistance is typically a lengthy process that involves reduction in frequency and severity over time rather than an abrupt cessation all at once. It occurs frequently in response to actions taken by the female partner as well as a range of other negative social sanctions and consequences, such as run-ins with the law and threats from family members. The first stage of the process involves developing the motivation to stop, which occurs when the rewards for using violence are outweighed by the costs. This process can be lengthy and has implications for working with victims who prefer to remain with their partners if the violence stops. Providers might consider discussing with victims ways to increase the negative sanctions for battering to increase its costs, thereby enhancing their partner's motivation to stop.

Although many authors describe a single pattern of violence, research indicates that intimate partner violence is "not a homogeneous phenomenon" (Fagan, 1989, p. 416). Johnson (1995) has identified two patterns of violence, which he terms "common couple violence" and "patriarchal terrorism." "Patriarchal terrorism, a product of patriarchal traditions of men's right to control 'their' women, is a form of terroristic control of wives by their husbands that involves the systematic use of not only violence, but economic subordination, threats, isolation, and other control tactics" (Johnson, 1995, p. 284). In contrast, common couple violence, the most common type of violence observed in large-scale, random surveys, is used by both men and women, has different causes, consists largely of acts of minor violence, occurs with low frequency in a relationship, and is less likely to escalate into a serious or life-threatening problem (Johnson, 1995).

In light of this research, it is important to consider formal interventions with abusive men and their effectiveness. These interventions have been a source of considerable controversy, especially among advocates for battered women, and are discussed in detail in Saunders and Hamill (2003). Research on batterer intervention programs proliferated in the 1990s, resulting in a better understanding of what types of interventions work most effectively with different kinds of abusive men. Although such interventions show promise in helping men who have been violent toward their partners to reduce their abusive behavior, it would be premature at this time to suggest that all such men can be effectively helped.

Much was written in the 1990s about treatment of sex offenders, and there is empirical research showing that the cognitive-behavioral programs commonly in use are effective with at least some offenders (Marshall and Serran, 2000). Current issues in treatment of sex offenders are length of treatment (longer not necessarily better), addressing pre-offense planning, selection of targets of treatment (e.g., denial, lack of empathy), relapse prevention strategies, and appropriate therapist stance or style (Marshall and Serran, 2000).

Gaps in the Research Literature

Despite the considerable research on violence against women conducted since the early 1980s, numerous gaps remain regarding both the nature and dynamics of abuse as well as how society should address violence against women and its effects. For example, little is known about how survivors of this type of violence cope and factors that might protect them from the harmful effects of abuse, such as social support. Why do some survivors become depressed, while others abuse substances or develop PTSD? More empirical research on all aspects of stalking, as well as the effects of emotional abuse and marital rape, is needed. To better understand the cultural aspects of violence against women, research is also needed on special populations of victims, such as women with disabilities, lesbians, immigrants, and Native Americans. Longitudinal studies that follow women over time, especially survivors of intimate partner violence, are necessary to better understand the process of symptom development and recovery from the effects of abuse after it has stopped. Many women appear to be resilient in the face of the harmful effects of abuse, and this needs to be better understood.

Research is needed on effective interventions for survivors of intimate partner violence, using larger samples and focusing especially on what is most effective in shelter settings and group and individual counseling models. Shelter-based programs targeted to children and maternal parenting interventions also need to be evaluated. More up-to-date evaluations of rape crisis centers are also needed to determine whether the interventions they offer shorten recovery time. Comparisons of individual versus group interventions for survivors of both sexual and physical assault, and professional versus peer interventions would also provide valuable information.

Implications for Practice

An important reality in thinking about practice recommendations for victims of violence against women is that many service providers have not undertaken professional education and have

limited training to support their work with victims (Hamby, 1998). This is unfortunate in light of the pervasive, complex, and sometimes severe aftereffects of violence against women. Working with survivors of sexual assault, partner violence, and stalking requires a high level of skill because of the complexity of their needs and problems as well as their emotional ties to the perpetrator. Facilitating self-determination by allowing women to make their own decisions after they have been informed about options and choices is often challenging.

Several effective intervention approaches to working with rape and sexual assault survivors exist, as discussed above. Practitioners in rape crisis and other service settings who see sexual assault victims should be familiar with and use these cognitive and behavioral approaches. It is more difficult to make recommendations for service providers who work on behalf of victims of partner violence because of the dearth of research supporting specific types of interventions. Because so many effects of intimate partner violence are similar to the effects of sexual assault, the same types of counseling interventions should also prove effective. Hamby (1998) recommends that, at a minimum, providers should receive training in basic screening and assessment skills that will facilitate asking directly about the existence of partner violence, whether injuries have occurred, any risk to children, assessing level of danger (e.g., Does the perpetrator have access to weapons? What is the most serious act of violence he has committed in the past? Has he made direct threats?), and suicide risk to victim or perpetrator. A standard recommendation of most who write about interventions with victims of intimate partner violence pertains to the importance of safety planning (Davies, Lyon, and Monti-Catania, 1998), and the research of McFarlane et al. (1998) supports the effectiveness of an intervention to increase safety behaviors.

Davies, Lyon, and Monti-Catania (1998) provide detailed (although not empirically evaluated) suggestions for safety planning focused on helping survivors evaluate the potential risks and benefits of staying with the abuser versus leaving him, a process that most survivors engage in continually. Negative outcomes associated with abuse, such as injury, depression, PTSD, substance abuse, and harm to or loss of children resulting from child protective action are potential risks of remaining in the abusive relationship. On the other hand, abuse may escalate if the woman tries to leave, and she might lose her housing or her children in a custody battle (Davies, Lyon, and Monti-Catania, 1998). Helping a woman evaluate the potential risks and benefits of leaving versus staying can be a valuable intervention offered by service providers in different settings, such as mental health, domestic violence programs, and social service agencies.

Because violence against women can be associated with significant emotional problems, a substantial subset of victims will need more intensive and longer term interventions than the crisis intervention and short-term support and advocacy offered in typical rape crisis and domestic violence programs. It is important that practitioners providing mental health services do so in a manner that avoids pathologizing or labeling abuse survivors. In the sexual assault arena, this problem seems to have been largely avoided, and many rape crisis programs have professional mental health staff trained to assess for emotional problems and provide appropriate services (Harvey, 1985). Domestic violence programs that lack mental health staff should train staff to conduct well-being assessments (or contract for professional services) and thorough

assessments of children and make referrals as necessary. For example, several methods for assessing depression levels and PTSD are available that are easy to score[8] and would be helpful in making referrals. Ideally, domestic violence programs can develop referral relationships with knowledgeable mental health providers or find resources to contract with providers who can perform assessments and provide treatment on site.

Implications for Social Policy

Although many communities are moving toward enhanced coordination of the systems used by abused women, services for abused women continue to be fragmented in the "absence of a coherent system of family violence interventions" (Chalk and King, 1998, p. 52). A more comprehensive and accessible system of services should be developed in the hopes of attracting victims of violence against women who have not traditionally used formal services. It is important to determine why so few survivors of sexual and physical violence seek services from specialized programs despite the high satisfaction ratings of these programs. Ways of reducing the stigma associated with receiving services should be explored.

Funders of domestic violence programs that lack professional mental health staff should strongly consider funding these services for clients so that problems such as depression, PTSD, and substance abuse—all of which can be barriers to women taking constructive action to end abuse—can be effectively addressed. Ensuring women's safety should be a primary goal, as it is a prerequisite to beginning to address the aftereffects of abuse. One alternative would be for domestic violence programs to develop partnerships with rape crisis centers that have mental health services and share the domestic violence community's feminist vision and victim-centered approach.

Mental health and social service professionals across a variety of settings should receive education regarding the pervasiveness of intimate partner violence, sexual assault, and stalking and their aftereffects, as well as specific training in the use of the most effective practice modalities in working with survivors of violence against women. From a social policy standpoint, one of the most important efforts should be to fund evaluations so that effective intervention models for working with survivors of intimate partner violence can be developed and disseminated to shelters and other organizations.

Notes

1. For a more detailed discussion of the research on the health-related effects of intimate partner violence and sexual assault, see Campbell and Boyd, 2000.

2. A noteworthy exception is the Gelles and Harrop (1989) report based on the 1985 Second National Family Violence Survey.

3. PTSD is an anxiety disorder characterized by three kinds of responses to a traumatic event: persistent re-experiencing of the event (e.g., through nightmares or flashbacks; avoidance of

things that remind the person of the event; and symptoms of arousal, such as difficulty concentrating or sleeping).

4. On the other hand, an equal number of victims may be suffering from clinical levels of depression and if so should receive that diagnosis to obtain appropriate intervention.

5. At least one study found that the intermittency and unpredictability of abuse were more highly associated with PTSD than its severity or frequency (Dutton and Painter, 1993).

6. Dissociation can be considered an avoidance coping strategy that occurs in response to stress. It consists of going away in one's mind, a kind of involuntary daydreaming that can last from minutes to hours and about which the person can recall little.

7. A more extensive review of this topic can be found in Carlson (2000) and Edleson (1999).

8. For example, the Beck Depression Inventory (Beck et al., 1979) and Impact of Event Scale (Horowitz, Wilner, and Alvarez, 1979).

References

Aldarondo, Etiony, and David B. Sugarman. "Risk marker analysis of the cessation and persistence of wife assault." *Journal of Consulting and Clinical Psychology*, 64 (1996): 1010–1019.

Andrews, Bernice, and Chris R. Brewin. "Attributions of blame for marital violence: A study of antecedents and consequences." *Journal of Marriage and the Family*, 52 (1990): 757–767.

Arias, Iliana, Carolyn M. Lyons, and Amy E. Street. "Individual and marital consequences of victimization: Moderating effects of relationship efficacy and spouse support." *Journal of Family Violence*, 12 (1997): 193–210.

Asbury, Jo-Ellen. "African-American women in violent relationships: An exploration of cultural differences." In *Violence in the black family: Correlates and consequences*, Robert Hampton (ed.). Lexington, MA: Lexington Books, 1987: 89–105.

Astin, Millie C., Suzann M. Ogland-Hand, Esther M. Coleman, and David W. Foy. "Posttraumatic stress disorder and childhood abuse in battered women: Comparisons with maritally distressed women." *Journal of Consulting and Clinical Psychology*, 63 (1995): 308–312.

Bachman, Ronet, and Linda E. Saltzman. *Violence against women: Estimates from the redesigned survey.* Special Report. Washington, DC: U.S. Department of Justice, Bureau of Justice Statistics, 1995. NCJ 154348.

Beck, A.T., A.J. Rush, B.F. Shaw, and G. Emery. *Cognitive therapy of depression.* New York: Guilford, 1979.

Bergen, Rachel K. “The reality of wife rape: Women’s experiences of sexual violence in marriage.” In *Issues in intimate violence*, R.K. Bergen (ed.). Thousand Oaks, CA: Sage, 1998: 237–250.

Berk, R.A., P.J. Newton, and S.F. Berk. “What a difference a day makes: An empirical study of the impact of shelters for battered women.” *Journal of Marriage and the Family*, 48 (1986): 418–490.

Bowker, Lee H. “Personal and social networks.” In *Battered women and their children*, Albert R. Roberts (ed.). New York: Springer, 1984: 168–191.

Bowker, Lee H., and L. Maurer. “The effectiveness of counseling services utilized by battered women.” *Women & Therapy*, 5 (1986): 65–82.

Brannen, Stephen J., and Allen Rubin. “Comparing the effectiveness of gender-specific and couple groups in a court-mandated spouse abuse treatment program.” *Research on Social Work Practice*, 6 (1996): 405–424.

Brice-Baker, Janice R. “Domestic violence in African-American and African-Caribbean families.” *Journal of Social Distress and the Homeless,* 3 (1994): 23–38.

Campbell, Jacquelyn C. “A test of two explanatory models of women’s responses to battering.” *Nursing Research*, 38 (1989a): 18–24.

Campbell, Jacquelyn C. “Women’s responses to sexual abuse in intimate relationships.” *Health Care for Women International*, 10 (1989b): 335–346.

Campbell, Jacquelyn C., and David Boyd. “Violence against women: Synthesis of research for health care professionals.” Final Report submitted to the National Institute of Justice, grant number 98–WT–VX–K011. Washington, DC: U.S. Department of Justice, National Institute of Justice, 2000. NCJ 199761.

Campbell, Jacquelyn C., Mary Jo Pliska, Wendy Taylor, and Daniel Sheridan. “Battered women’s experiences in the emergency department.” *Journal of Emergency Nursing*, 20 (1994): 280–288.

Campbell, Jacquelyn, Linda Rose, Joan Kub, and Daphne Nedd. “Voices of strength and resistance: A contextual and longitudinal analysis of women’s responses to battering.” *Journal of Interpersonal Violence*, 13 (1998): 743–762.

Campbell, Rebecca, Cris M. Sullivan, and William S. Davidson. “Women who use domestic violence shelters: Changes in depression over time.” *Psychology of Women Quarterly*, 19 (1995): 237–255.

Carlson, Bonnie E. "Children exposed to intimate partner violence: Research findings and implications for intervention." *Trauma, Violence and Abuse*, 1 (2000): 321–342.

Carlson, Bonnie E. "Children's observations of interparental violence." In *Battered women and their families*, A.R. Roberts (ed.). New York: Springer, 1984: 147–167.

Carlson, Bonnie, E., Alissa Pollitz Worden, Michelle van Ryn, and Ronet Bachman. "Violence against women: Synthesis of research for practitioners." Final Report submitted to the National Institute of Justice, grant number 98–WT–VX–K011. Washington, DC: U.S. Department of Justice, National Institute of Justice, 2000. NCJ 199577.

Cascardi, Michele, K. Daniel O'Leary, Erika E. Lawrence, and Karin A. Schlee. "Characteristics of women physically abused by their spouses who seek treatment regarding marital conflict." *Journal of Consulting and Clinical Psychology*, 63 (1995): 616–623.

Chalk, R., and P.A. King. *Violence in families: Assessing prevention and treatment programs.* Washington, DC: National Academy Press, 1998.

Cohen, Lawrence J., and Susan Roth. "The psychological aftermath of rape: Long-term effects and individual differences in recovery." *Journal of Social and Clinical Psychology*, 5 (1987): 525–534.

Coley, Soraya M., and Joyce O. Beckett. "Black battered women: A review of empirical literature." *Journal of Counseling and Development*, 66 (1988): 266–270.

Collins, Mary E. "Factors influencing sexual victimization and revictimization in a sample of adolescent mothers." *Journal of Interpersonal Violence*, 13 (1998): 13–24.

Davies, J., E. Lyon, and D. Monti-Catania. *Safety planning with battered women: Complex lives/difficult choices.* Thousand Oaks, CA: Sage, 1998.

Davis, Liane V., and M. Srinivasan. "Listening to the voices of battered women: What helps them escape violence." *Affilia*, 10 (1995): 49–69.

Dutton, Don, and Susan Painter. "The battered woman's syndrome: Effects of severity and intermittency of abuse." *American Journal of Orthopsychiatry*, 63 (1993): 614–622.

Dutton-Douglas, Mary Ann, and Dorothy Dionne. "Counseling and shelter services for battered women." In *Woman battering: Policy responses*, A. Kuhl (ed.). Cincinnati, OH: Anderson Publishing Co., 1991: 113–130.

Edleson, Jeffrey L. "Children's witnessing of adult domestic violence." *Journal of Interpersonal Violence*, 14 (1999): 839–870.

Fagan, J. "Cessation of family violence: Deterrence and dissuasion." In *Family violence*, L. Ohlin and M. Tonry (eds.). Chicago: University of Chicago Press, 1989: 377–425.

Fantuzzo, John, Robert Boruch, Abdullahi Beriama, Marc Atkins, and Susan Marcus. "Domestic violence and children: Prevalence and risk in five major U.S. cities." *Journal of the American Academy of Child and Adolescent Psychiatry*, 36 (1997): 116–122.

Ferraro, Kathleen, and John M. Johnson. "How women experience battering: The process of victimization." *Social Problems*, 30 (1983): 325–339.

Finn, Jerry. "The stresses and coping behavior of battered women." *Social Casework*, 66 (1985): 341–349.

Foa, Edna B., Barbara O. Rothbaum, David Riggs, and T. Murdock. "Treatment of PTSD in rape victims: A comparison between cognitive-behavioral procedures and counseling." *Journal of Counseling and Clinical Psychology*, 59 (1991): 715–723.

Foa, Edna B., Barbara O. Rothbaum, and Gail S. Steketee. "Treatment of rape victims." *Journal of Interpersonal Violence*, 8 (1993): 256–276.

Follingstad, Diane R., Anne F. Brennan, Elizabeth S. Hause, Darlene S. Polek, and Larry L. Rutledge. "Factors moderating physical and psychological symptoms of battered women." *Journal of Family Violence*, 6 (1991): 81–95.

Follingstad, Diane R., Larry L. Rutledge, Barbara J. Berg, Elizabeth S. Hause, and Darlene S. Polek. "The role of emotional abuse in physically abusive relationships." *Journal of Family Violence*, 5 (1990): 107–120.

Fremouw, William J., Darah Westrup, and Jennifer Pennypacker. "Stalking on campus: The prevalence and strategies for coping with stalking." *Journal of Forensic Science*, 42 (1997): 666–669.

Gelles, Richard J., and John W. Harrop. "Violence, battering, and psychological distress among women." *Journal of Interpersonal Violence*, 4 (1989): 400–420.

Gidycz, Christine A., and Mary P. Koss. "Predictors of long-term sexual assault trauma among a national sample of victimized college women." *Violence and Victims*, 6 (1991): 176–190.

Golding, Jacqueline M., Judith A. Stein, Judith M. Siegel, M. Audrey Burnam, and Susan B. Sorenson. "Sexual assault history and use of health and mental health services." *American Journal of Community Psychology*, 16 (1988): 625–644.

Gondolf, Edward W., and Ellen R. Fisher. *Battered women as survivors.* Lexington, MA: Lexington Books, 1988.

Goodman, Lisa A., Mary P. Koss, and Nancy F. Russo. "Violence against women: Mental health effects. Part II. Conceptualizations of posttraumatic stress." *Applied & Preventive Psychology*, 2 (1993a): 123–130.

Goodman, Lisa A., Mary P. Koss, and Nancy F. Russo. "Violence against women: Physical and mental health effects. Part I: Research findings." *Applied & Preventive Psychology*, 2 (1993b): 79–89.

Gordon, Judith S. "Community services for abused women: A review of perceived usefulness and efficacy." *Journal of Family Violence*, 11 (1996): 315–329.

Greenfeld, L.A., M.R. Rand, D. Craven, P.A. Klaus, C.A. Perkins, C. Ringel, G. Warchol, C. Maston, and J.F. Fox. *Violence by intimates: Analysis of data on crimes by current or former spouses, boyfriends, and girlfriends.* Washington, DC: U.S. Department of Justice, Bureau of Justice Statistics, 1998. NCJ 167237.

Hagen, Jan L., and Judy L. Postmus. "Violence against women: Synthesis of research for advocacy organizations." Final Report submitted to the National Institute of Justice, grant number 98–WT–VX–K011. Washington, DC: U.S. Department of Justice, National Institute of Justice, 2000. NCJ 199760.

Hamby, Sherry L. "Partner violence: Prevention and intervention." In *Partner violence: A comprehensive review of 20 years of research*, J.L. Jasinski and L.M. Williams (eds.). Thousand Oaks, CA: Sage, 1998: 210–258.

Hamilton, Bonita, and John Coates. "Perceived helpfulness and use of professional services by abused women." *Journal of Family Violence*, 8 (1993): 313–324.

Harvey, Mary. *Exemplary rape crisis programs: A cross-site analysis and case studies.* Rockville, MD: U.S. Department of Health and Human Services, 1985.

Henning, Kris, Harold Leitenberg, Patricia Coffey, Tonia Turner, and Robert T. Bennett. "Long-term psychological and social impact of witnessing physical conflict between parents." *Journal of Interpersonal Violence*, 11 (1996): 35–51.

Heron, Reva L., Heather B. Twomey, Diane P. Jacobs, and Nadine J. Kaslow. "Culturally competent interventions for abused and African American suicidal women." *Psychotherapy*, 34 (1997): 410–424.

Hilbert, Judith C., and Harvey C. Hilbert. "Battered women leaving shelter: Which way do they go? A discriminant function analysis." *Journal of Applied Social Sciences*, 8 (1984): 291–297.

Hilbert, Judith C., Raiza Kolia, and Dawn M. VanLeeuwen. "Abused women in New Mexico shelters: Factors that influence independence on discharge." *Affilia*, 12 (1997): 391–407.

Holden, George W., Robert A. Geffner, and Ernest N. Jouriles. "Introduction: The development of research into another consequence of family violence." In *Children exposed to marital violence: Theory, research and applied issues*, G.W. Holden, R.A. Geffner, and E.N. Jouriles (eds.). Washington, DC: American Psychological Association, 1998: 1–18.

Horowitz, Mardi, Nancy Wilner, and William Alvarez. "Impact of event scale: A measure of subjective stress." *Psychosomatic Medicine*, 41 (1979): 209–218.

Horton, Anne L., and Barry L. Johnson. "Profile and strategies of women who have ended abuse." *Families in Society*, 74 (1993): 481–492.

Houskamp, Beth M., and David W. Foy. "The assessment of posttraumatic stress disorder in battered women." *Journal of Interpersonal Violence*, 6 (1991): 367–375.

Jacobson, Neil S., John M. Gottman, Eric Gortner, Sara Berns, and Joann W. Shortt. "Psychological factors in the longitudinal course of battering: When do couples split up? When does the abuse decrease?" *Violence and Victims*, 11 (1996): 371–392.

Jaffe, Peter, David Wolfe, and Susan Wilson. *Children of battered women*. Newbury Park, CA: Sage, 1990.

Janoff-Bulman, Ronnie. "Criminal versus noncriminal victimization: Victims' reactions." *Victimology*, 10 (1985): 498–511.

Johnson, M.P. "Patriarchal terrorism and common couple violence: Two forms of violence against women." *Journal of Marriage and the Family*, 57 (1995): 283–294.

Jouriles, Ernest, William D. Norwood, Renee McDonald, John P. Vincent, and Annette Mahoney. "Physical violence and other forms of marital aggression: Links with children's behavior problems." *Journal of Family Psychology*, 10 (1996): 223–234.

Kemp, Anita, Edna I. Rawlings, and Bonnie L. Green. "Post-traumatic stress disorder (PTSD) in battered women: A shelter sample." *Journal of Traumatic Stress*, 4 (1991): 137–148.

Kilpatrick, Dean G. "Introduction." *Journal of Interpersonal Violence*, 8 (1993): 193–197.

Kilpatrick, Dean G., Ron Acierno, Heidi S. Resnick, Benjamin E. Saunders, and Connie L. Best. "A 2-year longitudinal analysis of the relationships between violent assault and substance use in women." *Journal of Consulting and Clinical Psychology*, 65 (1997): 834–847.

Kilpatrick, Dean G., C.N. Edmunds, and A.K. Seymour. *Rape in America: A report to the nation.* Arlington, VA: National Victim Center, 1992.

Kilpatrick, Dean G., and N.J. Veronen. "Treatment for rape-related problems: Crisis intervention is not enough." In *Crisis intervention*, L.H. Cohen, W.L. Claiborn, and C.A. Spector (eds.). New York: Human Sciences Press, 1983: 165–185.

Kolbo, Jerome R., Eleanor H. Blakely, and David Engleman. "Children who witness domestic violence: A review of empirical literature." *Journal of Interpersonal Violence*, 11 (1996): 281–293.

Koss, Mary, and Mary Harvey. *The rape victim: Clinical and community approaches to treatment.* Lexington, MA: Stephen Green Press, 1987.

Koss, Mary, and Lynette Heslet. "Somatic consequences of violence against women." *Archives of Family Medicine*, 1 (1992): 53–59.

Langhinrichsen-Rohling, Jennifer, Candice M. Monson, Kathryn A. Meyer, J. Jeffrey Caster, and Audrey Sanders. "The associations among family-of-origin violence and young adults' current depressed, hopeless, suicidal, and life-threatening behavior." *Journal of Family Violence*, 13 (1998): 243–261.

Lehmann, Peter. "The development of posttraumatic stress disorder (PTSD) in a sample of child witnesses to mother assault." *Journal of Family Violence*, 12 (1997): 241–257.

Leserman, J., Z. Li, D.A. Drossman, T.C. Toomey, G. Nachman, and L. Glogau. "Impact of sexual and physical abuse dimensions on health status: Development of an abuse severity measure." *Psychosomatic Medicine*, 59 (1997): 152–160.

Levendosky, Alytia A., and Sandra A. Graham-Berman. "The moderating effects of parenting stress on children's adjustment in wife-abusing families." *Journal of Interpersonal Violence*, 13 (1998): 383–397.

Loring, Marti T. *Emotional abuse.* New York: Lexington Books, 1994.

Mahoney, Patricia. "High rape chronicity and low rates of help-seeking among wife-rape survivors in a nonclinical sample: Implications for research and practice." *Violence Against Women*, 5 (1999): 992–1016.

Mahoney, Patricia, and Linda M. Williams. "Sexual assault in marriage: Prevalence, consequences, and treatment of wife rape." In *Partner violence: A comprehensive review of 20 years of research*, J. Jasinski and L.M. Williams (eds.). Thousand Oaks, CA: Sage, 1998: 113–162.

Maker, Azmaira H., Marcus Kemmelmeier, and Christopher Peterson. "Long-term psychological consequences in women of witnessing parental physical conflict and experiencing abuse in childhood." *Journal of Interpersonal Violence*, 13 (1998): 574–589.

Mancoske, R.J., D. Standifer, and C. Cauley. “The effectiveness of brief counseling services for battered women.” *Research on Social Work Practice*, 4 (1994): 53–63.

Marshall, William L., and Geris A. Serran. “Improving the effectiveness of sexual offender treatment.” *Trauma, Violence and Abuse*, 1 (2000): 203–222.

McCauley, Jeanne, David E. Kern, Ken Kolodner, Leonard R. Derogatis, and Eric B. Bass. “Relation of low-severity violence to women’s health.” *Journal of General Internal Medicine*, 13 (1998): 687–691.

McFarlane, J., B. Parker, K. Soeken, C. Silva, and S. Reel. “Safety behaviors of abused women after an intervention during pregnancy.” *Journal of Obstetrical, Gynecological, and Neonatal Nursing*, 27 (1998): 64–69.

McNamara, John R., Melissa A. Ertl, Sue Marsh, and Suzanne Walker. “Short-term response to counseling and case management intervention in a domestic violence shelter.” *Psychological Reports*, 81 (1997): 1243–1251.

Miller, Brenda A., and William R. Downs. “The impact of family violence on the use of alcohol by women.” *Alcohol Health and Research World*, 17 (1993): 137–143.

Mitchell, Roger E., and Christine A. Hodson. “Coping with domestic violence: Social support and psychological health among battered women.” *American Journal of Community Psychology*, 11 (1983): 629–654.

Neville, Helen A., and Aalece O. Pugh. “General and cultural-specific factors influencing African American women’s reporting patterns and perceived social support following sexual assault.” *Violence Against Women*, 3 (1997): 361–381.

Nielsen, Joyce M., Russell K. Endo, and Barbara L. Ellington. “Social isolation and wife abuse: A research report.” In *Intimate Violence: Interdisciplinary Perspectives*, E.C. Viano (ed.). Washington, DC: Hemisphere, 1992: 73–81.

O’Brien, Mary, Mudita A. Bahadur, Christina Gee, Kathy Balto, and Stephanie Erber. “Child exposure to marital conflict and child coping responses as predictors of child adjustment.” *Cognitive Therapy and Research*, 21 (1997): 39–59.

O’Keefe, Maura. “Racial/ethnic differences among battered women and their children.” *Journal of Child and Family Studies*, 3 (1994): 283–305.

Okun, Lewis. *Woman abuse: Facts replacing myths.* Albany, New York: State University of New York Press, 1986.

O'Leary, K. Daniel. "Psychological abuse: A variable deserving critical attention in domestic violence." *Violence and Victims*, 14 (1999): 3–32.

O'Leary, K.D., J. Barling, I. Arias, A. Rosenbaum, J. Malone, and A. Tyree. "Prevalence and stability of physical aggression between spouses: A longitudinal analysis." *Journal of Consulting and Clinical Psychology*, 57 (1989): 263–268.

O'Leary, K.D., J. Malone, and A. Tyree. "Physical aggression in early marriage: Prerelationship and relationship effects." *Journal of Consulting and Clinical Psychology*, 62 (1994): 594–602.

Pakieser, Ruth A., Patricia A. Lenaghan, and Robert L. Muelleman. "Battered women: Where do they go for help?" *Journal of Emergency Nursing*, 24 (1998): 16–19.

Parker, Barbara, Judith McFarlane, Karen Soeken, Conception Silva, and Sally Reel. "Testing an intervention to prevent further abuse to pregnant women." *Research in Nursing & Health*, 22 (1999): 59–66.

Plichta, Stacy B., and C. Abraham. "Violence and gynecologic health in women, 50 years old." *American Journal of Obstetrics and Gynecology*, 174 (1996): 903–907.

Quigley, Brian M., and Kenneth E. Leonard. "Desistance of husband aggression in the early years of marriage." *Violence and Victims*, 11 (1996): 355–370.

Resick, Patricia A. "The psychological impact of rape." *Journal of Interpersonal Violence*, 8 (1993): 223–255.

Riggs, David S., Dean G. Kilpatrick, and Heidi S. Resnick. "Long-term psychological distress associated with marital rape and aggravated assault: A comparison to other crime victims." *Journal of Family Violence*, 7 (1992): 283–296.

Rollstein, Amber, and Jeffrey M. Kern. "Correlates of battered women's psychological distress: Severity of abuse and duration of the postabuse period." *Psychological Reports*, 82 (1998): 387–394.

Rubin, Allen. "The effectiveness of outreach counseling and support groups for battered women: A preliminary evaluation." *Research on Social Work Practice*, 1 (1991): 332–357.

Russell, D.E.H. *Rape in marriage.* Indianapolis: Indianapolis University Press, 1990.

Sackett, Leslie A., and Daniel G. Saunders. "The impact of different forms of psychological abuse on battered women." *Violence and Victims*, 14 (1999): 105–117.

Saunders, Daniel G. "Posttraumatic stress symptom profiles of battered women: A comparison of survivors in two settings." *Violence and Victims*, 9 (1994): 31–44.

Saunders, Daniel G., and Richard Hamill. "Violence against women: Synthesis of research on offender interventions." Final Report submitted to the National Institute of Justice, grant number 98–WT–VX–K011. Washington, DC: U.S. Department of Justice, National Institute of Justice, 2003. NCJ 201222.

Schutte, Nicola S., Linda Bouleige, Justine L. Fix, and John M. Malouff. "Returning to partner after leaving a crisis shelter: A decision faced by battered women." *Journal of Social Behavior and Personality*, 1 (1986): 295–298.

Silvern, Louise, Jane Karyl, Lynn Waelde, William F. Hodges, Joanna Starek, Elizabeth Heidt, and Kyung Min. "Retrospective reports of parental partner abuse: Relationships to depression, trauma symptoms and self-esteem among college students." *Journal of Family Violence*, 10 (1995): 177–203.

Snyder, Douglas K., and Nancy S. Scheer. "Predicting disposition following brief residence in a shelter for battered women." *American Journal of Community Psychology*, 9 (1981): 559–566.

Sorenson, Susan B. "Violence against women: Examining ethnic differences and commonalities." *Evaluation Review*, 20 (1996): 123–145.

Sorenson, Susan B., and Judith M. Siegel. "Gender, ethnicity, and sexual assault: Findings from a Los Angeles study." *Journal of Social Issues*, 48 (1992): 93–104.

Spaccarelli, Steve, Irwin N. Sandler, and Mark Roosa. "History of spouse violence against the mother: Correlated risks and unique effects in child mental health." *Journal of Family Violence*, 9 (1994): 79–98.

Stark, Evan, Ann Flitcraft, and W. Frazier. "Medicine and patriarchal violence: The social construction of a 'private' event." *International Journal of Health Services*, 9 (1979): 461–493.

Stets, Jan E., and Murray A. Straus. "Gender differences in reporting marital violence and its medical and psychological consequences." In *Physical violence in American families: Risk factors and adaptations to violence in 8,145 families*, M.A. Straus and R.J. Gelles (eds.). New Brunswick, NJ: Transaction Publishers, 1990: 151–165.

Strube, Michael J., and Linda S. Barbour. "The decision to leave an abusive relationship: Economic dependence and psychological commitment." *Journal of Marriage and the Family*, 45 (1983): 785–793.

Sullivan, Cris M., and Deborah I. Bybee. "Reducing violence using community-based advocacy for women with abusive partners." *Journal of Consulting and Clinical Psychology*, 67 (1999): 43–53.

Sullivan, Cris M., Rebecca Campbell, Holly Angelique, Kimberly K. Eby, and William S. Davidson. "An advocacy intervention program for women with abusive partners: Six-month follow-up." *American Journal of Community Psychology*, 22 (1994): 101–122.

Sullivan, Cris M., and Maureen H. Rumptz. "Adjustment and needs of African-American women who utilized a domestic violence shelter." *Violence and Victims*, 9 (1994): 275–286.

Sullivan, C.M., C. Tan, J. Basta, M. Rumptz, and W.S. Davidson. "An advocacy intervention program for women with abusive partners: Initial evaluation." *American Journal of Community Psychology*, 20 (1992): 309–332.

Tan, C., J. Basta, C.M. Sullivan, and W.S. Davidson. "The role of social support in the lives of women exiting domestic violence shelters." *Journal of Interpersonal Violence*, 10 (1995): 437–451.

Teets, Janet M. "The incidence and experience of rape among chemically dependent women." *Journal of Psychoactive Drugs*, 29 (1997): 331–336.

Tjaden, Patricia, and Nancy Thoennes. *Prevalence, incidence, and consequences of violence against women: Findings from the National Violence Against Women Survey.* Research in Brief. Washington, DC: U.S. Department of Justice, National Institute of Justice, and U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, 1998a. NCJ 172837.

Tjaden, Patricia, and Nancy Thoennes. *Stalking in America: Findings from the National Violence Against Women Survey.* Research in Brief. Washington, DC: U.S. Department of Justice, National Institute of Justice, and U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, 1998b. NCJ 169592.

Tutty, Leslie M. "Post-shelter services: The efficacy of follow-up programs for abused women." *Research on Social Work Practice*, 6 (1996): 425–441.

Tutty, Leslie M., Bruce A. Bidgood, and Michael A. Rothery. "Support groups for battered women: Research on their efficacy." *Journal of Family Violence,* 8 (1993): 325–343.

Ullman, Sarah E. "Correlates and consequences of adult sexual assault disclosure." *Journal of Interpersonal Violence*, 11 (1996a): 554–571.

Ullman, Sarah E. "Social reactions, coping strategies, and self-blame attributions in adjustment to sexual assault." *Psychology of Women Quarterly*, 20 (1996b): 505–526.

Vitanza, Stephanie, Laura C.M. Vogel, and Linda L. Marshall. "Distress and symptoms of posttraumatic stress disorder in abused women." *Violence and Victims*, 10 (1995): 23–34.

Wauchope, Barbara. (1988). Help-seeking decisions of battered women: A test of learned helplessness and two stress theories. Paper presented at the Eastern Sociological Society, Durham, NH.

Weaver, Terri L., and George A. Clum. "Interpersonal violence: Expanding the search for long-term sequelae within a sample of battered women." *Journal of Traumatic Stress*, 9 (1996): 783–803.

Weaver, Terri L., and George A. Clum. "Psychological distress associated with interpersonal violence: A meta-analysis." *Clinical Psychology Review*, 15 (1995): 115–140.

Weaver, Terri L., Dean G. Kilpatrick, Heidi S. Resnick, Connie L. Best, and Benjamin E. Saunders. "An examination of physical assault and childhood victimization histories within a national probability sample of women." In *Out of darkness: Contemporary perspectives on family violence*, G.K. Kantor and J.L. Jasinski (eds.). Thousand Oaks, CA: Sage, 1997: 35–46.

West, Carolyn M. "Lifting the 'political gag order': Breaking the silence around partner violence in ethnic minority families." In *Partner violence: A comprehensive review of 20 years of research*, Jana L. Jasinski and Linda M. Williams (eds.). Thousand Oaks, CA: Sage, 1998: 184–209.

Wingood, Gina M., and Ralph J. DiClemente. "Rape among African American women: Sexual, psychological, and social correlates predisposing survivors to risk of STD/HIV." *Journal of Women's Health*, 7 (1998): 77–84.

Woffordt, Sharon, Delbert E. Mihalic, and Scott Menard. "Continuities in marital violence." *Journal of Family Violence*, (1994): 195–225.

Wolfe, David A., Peter Jaffe, Susan K. Wilson, and Lydia Zak. "Children of battered women: The relation of child behavior to family violence and maternal stress." *Journal of Consulting and Clinical Psychology*, 53 (1985): 657–665.

Zweig, Janine M., Bonnie L. Barber, and Jacquelynne S. Eccles. "Sexual coercion and well-being in young adulthood." *Journal of Interpersonal Violence*, 12 (1997): 291–308.