# Violence and Victimization:
# Exploring Women's Histories of Survival

***Final Report to the National Institute of Justice***

***(NIJ Research Award #2003-IJ-CX-1037)***

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## Abstract

### Statement of Purpose

This research explored the histories of physical and sexual victimization reported by incarcerated and non-incarcerated women and sought to identify the survival strategies women activated at various points in their lifespan. The goal of this research was to examine the consequences, defined here as the health, mental health, substance use, incarceration, and suicidality, of intimate partner violence, sexual violence, and youth maltreatment and victimization to identify at-risk populations, modifiable risk and essential mediating factors, and optimal times and settings for intervention.

### Research Subjects

The research sample was drawn from five different communities in one Midwestern state. Three urban communities, one rural community, and the only correctional facility for women in the state were selected in an attempt to secure a racially, ethnically and geographically diverse sample of women age 18 and older. Community referrals were generated through recruitment of women seeking assistance from sexual assault and domestic violence programs and from the community at-large. The total survey sample includes 423 women; 157 women incarcerated in the correctional facility, 157 women who had been recipients of services for intimate partner violence and / or sexual assault within the 12 months prior to the research interview, and 109 women from the community at-large who had not received services in the prior 12 months.

### Proposed Research Design & Methodology

In Phase One, all women were interviewed on a variety of topics covering victimization and disclosure experiences and risk and protective factors. In Phase Two, 17 women from the prison and / or the community who had participated in the Phase One interviews were

interviewed in an effort to provide more depth about their experiences of victimization and of the resources, social services and supports they may have received or not, subsequent to the victimization(s).

**Data Analysis**

Descriptive parametric and nonparametric analyses (frequencies, standard deviations, proportional testing, chi-square and phi coefficients, and t-tests as appropriate) were generated to determine the extent to which the three groups of women have been victims of intimate partner violence, sexual violence and child maltreatment. and to allow assessment of endorsement patterns for all measures first as total survey sample, then by the three sub-samples and other breakdowns as appropriate to explicating specific patterns of responses. Internal consistencies of all screening scales and measures were calculated (Cronbach's alpha). A series of linear multiple regression analyses were performed to predict variables identified in the model schematic including victimization and disclosure experiences, mediating factors, service usage, and adult outcomes. A final hierarchical logistic regression analysis was also conducted to test the ability of independent variables in the model to discriminate between incarcerated and non-incarcerated women, based on their characteristics and histories.

Qualitative analyses used basic a priori codes based on the questions asked during the interviews. In-depth analysis of these data for emerging codes was completed after all of the interviews were completed. After analyzing several transcripts, the emergent codes were condensed into four family groups or categories related to the questions asked. The remaining transcripts were then analyzed using those four family groups.

**Results**

Considered as a whole, 98 percent of the women interviewed reported experiencing some type of psychological, physical and / or sexual abuse during their lifetimes. Rates for physical and sexual victimization as children and as adults were high across sample populations but particularly for the incarcerated population. Mediating factors including social support, self-efficacy and use of adaptive and maladaptive coping skills were significant predictors of adult outcomes.

**Conclusions**

Because this research took place in one Midwestern state, additional research is necessary to confirm the applicability of these findings to other populations. Implications for future research indicate that there is much to be studied in the area of physical and sexual victimization the results of which are likely to yield methods of prevention and intervention that will help some women avoid the negative life trajectories that may be in part, the consequences of childhood, youth and adult maltreatment and victimization.

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## Executive Summary

In 2003, in response to a request for proposals under the *Broadening Our Understanding of Violence Against Women from Diverse Communities* Initiative set forth by the National Institute of Justice Office of Research and Evaluation, a unique collaboration between two researchers with different but complimentary areas of expertise resulted in the development of a research agenda which both built on prior research and sought to explore new areas of knowledge in the study of women's victimization. Professors Judy L. Postmus and Margaret Severson combined practice and research interests in violence and abuse against women and children and in mental health and suicide prevention in detention and correctional facilities, respectively, and proposed to study the histories and life trajectories of women victims of violence. As funded, included in this study were women who were, at the time of data collection, incarcerated in a state prison for women and women living in the communities where the sampling occurred, some of whom who were receiving services from domestic violence and / or sexual assault agencies.

The National Institute of Justice provided funding for two years of research into these issues. The results are significant not only for their bearing on the research questions, but also for their implications for future research which is required in the effort to reduce and ultimately eliminate the negative effects of victimization.

The research protocols for each of the two years of this project called for the administration of surveys to three different groups of women and to engage women from two of these groups in more in-depth exploration through an additional qualitatively focused interview.

### *The Relevance of the Data and Findings*

Concerns about the rising female inmate population in state and federal corrections systems in the United States served as a key impetus for conducting this research. As more women enter the criminal justice system, there is a great need to understand their backgrounds and unique needs (Harrison & Beck, 2002; Richie, 2001). Institutional policies and services have not been able to keep up with the unique demands of this growing population (Severson, 2001), particularly because the nature of the corrections industry in the United States has been largely male dominated – by the inmates themselves who are overwhelmingly male and by the management staff as well, where male managers are still the norm. By studying the personal and service-related histories of women victims of violence and also of women who did not have histories of violence, the researchers hoped to identify significant relationships between life events, mediating factors and a series of critical outcomes, including incarceration.

### *Research Aims*

#### *Goals and Objectives*

The focus of the study was to explore certain similarities and differences in life experiences as they occurred between and within several groups of women. Those groups included women who reported having been victims of personal violence who were incarcerated at the time of this study, women living in the community who received services for their victimization experiences sometime in the 12 months prior to the initiation of data collection, and women who may or may not have been victimized and who had not received services in the

12 months prior to the initiation of the interview. The two primary areas of inquiry in this research were to explore women's access and opportunities for various types of social services and their current personal status on various measures of health, mental health, substance use, incarceration, and suicidality. Accordingly, the research findings that point to the common trajectories of victims are important for this study as well.

The overall goal of this research was to compare the life experiences of female victims of intimate partner violence, sexual violence, and youth maltreatment who are living in disparate settings: the state's Women's Correctional Facility (WCF) and in urban and rural communities within this Midwestern state. The specific objectives of this research were: (1) To determine whether victimized women residing in the community were (a) offered and (b) participated in, one or more social service and social support interventions which may have impacted their health, mental health, alcohol or illegal substance use, and incarceration status. Specific attention was directed toward exploring the type and range of involvement of those systems that may have been available to provide assistance to abused and injured women at earlier points in their lives. These systems include schools, sexual assault/domestic violence programs, law enforcement, medical providers, mental health providers, agencies responsible for ensuring the protection and safety of children, religious and faith-based groups, and family or friends. (2) To determine the rate of co-occurrence of sexual assault with intimate partner violence and other forms of familial abuse and youth maltreatment among and between incarcerated and non-incarcerated women. (3) To suggest implications for improving policy and practice strategies within the criminal justice system, both for incarcerated and never-incarcerated victims of intimate partner violence, sexual assault, and youth maltreatment.

***Hypotheses***

The hypotheses supporting this research endeavor included: (1) Prevalence rates of intimate partner violence (IPV), sexual violence, and youth maltreatment are higher among incarcerated women than among those who are not incarcerated. (2) There is a higher degree of co-occurrence of IPV, sexual violence, and youth maltreatment among incarcerated women than among those not incarcerated. (3) Histories of IPV in adulthood will be more common among incarcerated women than will histories of adult sexual violence. (4) Childhood victimization will have more enduring and detrimental outcomes (in health, mental health, substance use, incarceration and suicidality) than will other types of victimization. (5) A woman's positive perception of the supports she has received will be related to better outcomes in health, mental health, substance use, incarceration, and suicide attempts. (6) Statistical analyses will find that women experience poorer adult outcomes when any of the following are true (and these have negative cumulative effects): minority ethnicity; lower education; living in a rural environment; any victimization; multiple victimizations; undisclosed victimization; and limited access to services. (7) Statistical analyses will find that women experience better outcomes when any of the following are true (and these have cumulative positive effects): early disclosure of the violence; social supports; coping skills; self-efficacy and services received and perceived as helpful. (8) The key predictors of poor outcomes will be adult welfare receipt, minority ethnicity, multiple victimizations, and non-disclosure of the victimization.

In sum, this exploratory study was designed to address some of the existing research gaps by investigating the following key questions**:**

(1) What is the prevalence and co-occurrence rate of intimate partner violence, sexual violence and youth maltreatment for three different samples of women in a Midwestern state

(women from urban and rural communities who had not received services for domestic violence and / or sexual assault in the prior 12 months, women actively receiving services for domestic violence and / or sexual assault, and incarcerated women)?

(2) What are the disclosure experiences among women who disclosed their childhood and / or adult victimization?

(3) How does youth or adult victimization relate to outcomes in adulthood, including health, mental health, use of alcohol and drugs, suicide attempts, and incarceration? How does the response to women's disclosure relate to these adult outcomes?

(4) What events and services in adolescence and adulthood, including the kinds of social services, types of coping skills, self-efficacy, social supports, current age, welfare receipt, and adult economic resources, are most predictive of the adult outcomes of health, mental health, use of alcohol and drugs, suicidality, and incarceration?

(5) Which of all these factors (childhood / youth demographics, history of victimization, and the mediating factors itemized in research question #4), are the strongest predictors of adult outcomes?

***Research Methodology***

These key questions were addressed through a research methodology that included a combination of quantitative and qualitative methods. These methods were designed to explore and ultimately to shed light on the types of social support and social services interventions and the timing of those interventions that may have impacted the course of adult female victims' lives.

The collection of data was completed in two distinct phases. In Phase One, all women recruited from the women's correctional facility (WCF) ( and the community venues were asked to participate in face-to-face interviews. The goal was to recruit at least 200 women from the WCF, at least 200 women from domestic violence and sexual assault service providers in the four communities, and at least 100 women from the general population of all four communities. In the end, the final sample fell slightly short of this goal, though achieved the proportionality desired with 157 women recruited from the prison, 157 from domestic violence and sexual assault programs, and 109 from the four communities at large.

The face-to-face interviews of the women incarcerated in the correctional facility were conducted on the prison grounds at regular intervals each month over a twelve-month period. Every interview took place in a private office or meeting room. Interviewing staff were provided with a tour of the women's correctional facility and training on safety and security issues prior to their commencing the data collection. More detail regarding the training of interviewers is provided below.

For women in the community, a similar data collection protocol was implemented. Face-to-face interviews were conducted in a mutually agreed upon location which was determined prior to each actual meeting. The criteria for identifying a safe place to meet included the proximity of the location to the participant, the level of comfort in discussing private concerns, and the safety of the participant and the researcher. Locations included offices within agencies or domestic violence shelters; local restaurants; and local public libraries. Permission from the manager of the selected site was secured prior to interviewing. Interviews were not held in the homes of any of the participants in an effort to protect the safety of the participants as well as the researcher. These community interviews were conducted throughout a 12-month period.

One of the goals of this research endeavor was to obtain an ethnically / culturally diverse sample. Special efforts were made to achieve this goal. Two of the communities from which sampling occurred had significant ethnic minority populations, including persons of the African American and Hispanic heritage. Experienced translators translated the recruitment flyers and the survey instrument into Spanish, ensuring that the language of the survey instrument was culturally appropriate and linguistically accurate. Several of the research interviewers were bilingual and one of the translators reviewed and field tested the final Spanish version of the survey to double check its conformity to the English version.

In *Phase One* of this research, all participants were interviewed on a variety of topics including their physical and emotional health, injuries received from abuse, depression, self-efficacy, alcohol and substance use, suicide attempts, post-traumatic stress, their coping strategies, and the support they received from family, friends, or agencies. Additionally, the respondents were asked about their disclosure experiences, including to whom, when, and how they disclosed their victimization experiences. The interview consisted of closed-ended questions from different scales and measurements, described below (see Appendix F). The average length of time taken to complete an interview was one hour.

In *Phase Two,* if a person met the qualifying criteria, she was asked if she would be interested in participating in an interview with a researcher which was intended to go into more depth about her experiences of victimization and of the resources, social services and supports she may have or have not received subsequent to the victimization(s). Ten women from the prison and seven women who resided and/or received services in one of the urban communities agreed to participate in another face-to-face interview. Given time constraints and an assessment by the Principal Investigators that a certain data saturation level had been reached, once these

seventeen participants were identified and interviewed, recruitment for additional *Phase Two* interviews ceased. In order to accurately capture the narrative data, after providing information about the nature of this in-depth interview, every respondent gave her informed consent for both her participation and the tape-recording of the interview. The taped interviewers were later transcribed using the appropriate privacy safeguards and the data were entered into the computer database, during which time numerical identifiers were substituted for first names and any other identifying information was erased or over-written.

Recognizing that these in-depth interviews might provoke memories of victimization that could result in some emotional discomfort, all of the 17 women participants were warned about this possibility and offered referrals for counseling at the end of the interview. Every woman who initially agreed to participate in the Phase Two interviews and who was subsequently met in person, provided her informed consent and completed the interview.

Participants were interviewed in-depth on several topics related to the quantitative portion of this research (the survey data), in interviews consisting of open-ended questions and probes (see Appendix G). Additionally, the respondents were asked about their disclosure experiences, including to whom, when, and how they disclosed their victimization experiences. The face-to-face interviews of women residing in the WCF took place in a private room provided by the facility. For women in the community, face-to-face interviews were conducted in a mutually agreed upon location determined prior to the actual meeting. The average length of time taken to complete an interview was one and a half hours.

***Data Management & Analyses***

To protect confidentiality, all quantitative data were entered into a computer database using an assigned unique identifier. Paper copies of all of the signed informed consent forms have been stored in a locked file cabinet with only principal investigator and research staff access. The completed survey instruments, with no identifying information, have been stored in a secure room within the School of Social Welfare. SPSS® for Windows Base 10.0 statistical software was used for data input, cleaning, and subsequent analyses. All qualitative data (audiotapes of interviews and notes taken during observations and encounters) were entered into text data using first a word processing program and then downloaded into Atlas[ti] qualitative software. This software facilitated coding, management and retrieval of the test data during analyses.

***Data Analytic Strategy***

***Phase One*.** The initial strategy for all quantitative data included descriptive parametric and nonparametric analyses (frequencies, standard deviations, proportional testing, chi-square and phi coefficients, and t-tests as appropriate) to allow assessment of endorsement patterns for all measures first as total survey sample, then by the three sub-samples and other breakdowns as appropriate to explicating specific patterns of responses. Internal consistencies of all screening scales and measures were calculated (Cronbach's alpha), as discussed in the Method section of this report. A series of linear multiple regression analyses were performed to predict variables identified in the model schematic including victimization and disclosure experiences, mediating factors, service usage, and adult outcomes. A final hierarchical logistic regression analysis was also conducted to test the ability of independent variables in the model to

discriminate between incarcerated and non-incarcerated women, based on their characteristics and histories.

***Phase Two*.** Qualitative analyses used basic a priori codes based on the questions asked during the interviews. In-depth analysis of these data for emerging codes was completed after all of the interviews were completed. After analyzing several transcripts, the emergent codes were condensed into 4 family groups or categories related to the questions asked. The remaining transcripts were then analyzed using those 4 family groups.

The goal of sampling in qualitative methodology is "sample until saturation or redundancy," i.e. sample until no new information is revealed (Strauss & Corbin, 1998). This saturation period came earlier than planned in the second phase of this research, thus negating the need for the full 20 interviews originally proposed.

***Summary of Findings***

Below, in summary outline form are certain *highlighted* findings of this research. This list is not exhaustive.

**Demographics of Samples**

- The sample groups are significantly different in terms of age (community women are older), household composition (agency women have male partners/not husbands), having children (WCF women were most likely to have children), and ages of children (WCF women have older children).
- Women's current economic circumstances are poorest for women receiving agency services and are best in general for community women. The economic circumstances reported by the women in prison were those experienced in the 12 months prior to their incarceration.

- Economic circumstances in childhood did not differ between samples.
- Ethnicity of women did differ by sample. WCF women more likely to be black; community women more likely to be Hispanic, agency women more likely to be white.

**Prevalence and Description of Victimization**

- Rates of victimization in this study are high across all types of victimization, and across all samples.
- In childhood, reports of sexual abuse are higher than those of physical child abuse.
- Of the three types of child abuse reported, the most common was sexual touching (64% of sample); followed by sexual penetration (47%) and physical abuse (46%). Most childhood abuse was within the family.
- Violence between intimates is particularly high in this sample (over 90%). Community women report the lowest rates of IPV, but are still above 75%.
- Sexual assault is reported at 85% in study, and is high across all three samples.
- Experiencing sexually coercive behaviors is most common, followed by rape, followed by attempted rape. This reporting pattern holds across all three samples.
- Co-occurrence of victimization is very common. Physical violence between intimates and rape often co-occur. When only one type of the two victimization experiences occurred, it was most likely to be physical violence between intimates, rather than rape.
- About half of sample experienced victimization both in childhood and in adulthood. Over 56 percent of the total sample report experiencing both childhood sexual abuse and physical IPV.
- Among sexual assault experiences reported, the most common behaviors experienced were pressure by continual arguments, followed by rape. Rape was reported by more

participants than were sexual acts by threats, using physical force in sex, threatening physical force, and feeling useless to stop the person.

- Experience of rape is highest in the WCF sample, followed by the agency sample. Rape occurrence is reported at 50% in the community sample, the lowest rate.
- The experience of violence between intimates differs between samples, in that women who received services from domestic and sexual violence service agencies reported the highest rates of Physical IPV, while the WCF women report the highest rates of Psychological IPV.
- Ethnic groups differ in their experience of victimization in this sample. Experience of physical violence between intimates is most prevalent for women who are White, and lowest for women who are Latina. Sexual assault prevalence also differs across ethnicities: highest rates are reported by Whites; the lowest by Latinas.
- The current age of the participant does not affect her report of victimization, except for violence between intimates. The older the woman, the more likely she is to report having experienced physical or psychological IPV.
- As a result of experiencing sexual assault, the most common physical effects reported by women (reported by more than half the sample) were physical pain lasting more than an hour, and swelling, sprain or bruise. Women in the WCF sample reported more serious injuries from sexual assault than did other women.
- Reported physical effects from intimate partner violence were more common and more severe than those reported for sexual assault. More than half of those women reporting Physical IPV said that it resulted in physical pain lasting more than an hour, swelling, sprain or bruise, bruise, cut or wound on face/neck, bump on wound on head, black eye, bruise/cut

on stomach/chest/back, and that they received medical treatment for their injuries. When there were significant differences between the three samples of women, women in prison reported the highest incidence of injury, followed by women in agencies, followed by women in the community.

**Adult Outcomes in General**

- In general, the sample reports good physical and mental health, with mean scores of 66 and 56 on a 100-point scale, respectively. Women report better physical health than mental health, in general. Women in prison report significantly better physical and mental health than other women. Women in agencies report the poorest current physical and mental health.
- Scores of depression and Post Traumatic Stress Disorder (PTSD) are fairly high in this sample, with women scoring a mean of 55 and 59 on 100-point scales. Women in agencies report the highest levels of both disorders.
- Over a quarter of the women in this study report having a drug problem (28%), while only 19% report having an alcohol problem. Both drug and alcohol problems are reported by significantly more women in prison than in the other samples.
- A small percentage of the sample reported attempting suicide in the past 12 months, with the highest rate among women in prison. Given the low prevalence of suicide attempts in this sample, this variable is not helpful to multivariate analyses.

**Relation of Victimization in Childhood to Adult Outcomes**

- Having experienced physical abuse in childhood was predictive of one's current physical health, mental health, depression, and report of PTSD, in the expected direction. Physical abuse was related to poorer outcomes on all these dimensions.

- Having experienced physical abuse in childhood was not predictive of whether one reported drug or alcohol problems, suicide attempts, or was currently incarcerated.
- The experience of childhood sexual abuse was also predictive of adult outcomes, including physical health, mental health, depression, PTSD, alcohol problems, drug problems and being incarcerated.

**Relation of Victimization in Adulthood to Adult Outcomes**

- Having experienced Physical IPV in adulthood is not predictive of well being in adulthood, in general. There are no significant differences between those so victimized and not in terms of physical health, mental health, depression, having an alcohol or drug problem, and being incarcerated. However, those women reporting any form of Physical IPV did have higher scores on the PTSD scale..
- While having experienced Physical IPV at all was not predictive of adult outcomes, the *degree* to which one experienced Physical IPV was predictive of adult outcomes. One's score on the Physical IPV scale was significantly correlated with one's current physical health, mental health, PTSD score, alcohol or drug problems, and whether one was incarcerated. Physical IPV score was not predictive of depression. However, the correlation between physical IPV scores and alcohol or drug problems ceases to be significant when controlling for the sample group.
- Having experienced rape is highly predictive of adult well being, however. Those women who reported having been raped report significantly poorer physical health, mental health, depression, PTSD, and are more likely to have an alcohol problem. There were no differences in terms of drug problems, suicide attempts or incarceration for rape victims.

- The degree to which one experienced sexual assault, particularly rape behaviors and sexually coercive behaviors, was predictive of adult well being. The greater the number of sexually coercive and rape behaviors one reported, the poorer one's physical health, mental health, depression, PTSD score, the incidence of alcohol or drug problems, suicide attempts, and incarceration. However, the correlation between rape behaviors and suicide attempts ceases to be significant when controlling for the sample group.

**Disclosure of Victimization and Response to Disclosure**

- Women who were victimized were asked a series of questions about whether they disclosed that victimization to anyone and the aftereffects of that disclosure. For each discussion of disclosure, the findings relate only to those women experiencing each specific type of victimization.
- Across all types of victimization, more than half of women experiencing any type of victimization disclosed that experience to someone. The highest disclosure rates were for physical violence between intimates (79%), rape (73%), childhood sexual abuse by touching (71%), childhood sexual abuse by penetration (67%) and childhood physical abuse (67%). Disclosure rates did not differ by sample.
- For childhood victimization, most disclosures were made to family and friends, but disclosures were not made immediately, particularly for sexual abuse. In about two-thirds of cases, nothing happened to the perpetrator.
- Among those women experiencing Physical IPV, many told friends and family, although police and social workers were often told, as well. Those receiving services from agencies were particularly likely to have disclosed to police or social workers. Almost all women said they were believed when they disclosed. Disclosures, particularly to more formal report

agents, were likely to happen within a week of the event. When women were in prison, police and/or doctors were likely to have been notified. In almost three-fourths of cases, the perpetrator was confronted, although less likely for community women. Perpetrators were arrested in over half of the cases.

- Among those women experiencing rape, the disclosure pattern mirrors that for Physical IPV. The most common people told were family and friends, followed by social workers. Almost all women reported that they were believed upon disclosure. Reports were slightly less immediate than those for Physical IPV, except that doctors and police were very likely to be told within the week, at much higher rates than those made for Physical IPV. When the event was rape rather than physical violence between intimates, it was less likely that perpetrators were confronted or arrested.

**Mediating Factors and Adult Outcomes**

Note: Mediating factors in this study included self-efficacy, adaptive coping skills, maladaptive coping skills, social support, current age and difficulty living on income.

- In general, participants report good levels of self-efficacy, adaptive coping and social support, although social support lags behind ratings of self-efficacy and adaptive coping. Maladaptive coping is used to a lesser degree than is adaptive coping in this sample.
- There are significant differences between the three samples in the state of their mediating factors. While self-efficacy did not differ between the three samples, women in agencies reported significantly better adaptive coping skills but significantly poorer levels of social support. Women in agencies also had the most difficulty living on their current income. The use of maladaptive coping skills did not differ between samples.

- One's experience of victimization does indeed predict one's current state of mediating factors. Those women who experienced child physical abuse had lower self-efficacy, higher use of maladaptive coping, lower social support, greater difficulty living on their incomes, and a greater likelihood of having received welfare. The experience of childhood sexual abuse was less predictive of mediating factors. Those experiencing sexual abuse in childhood reported lower self-efficacy and social support, only.
- The experience of physical violence between intimates was not a good predictor of mediating factors. Women experiencing physical IPV had poorer social support and more difficulty living on their income, but did not differ from others on self-efficacy or coping.
- Maladaptive coping scores were significantly higher for women experiencing rape. Experiencing rape also predicted poorer social support, greater difficulty living on their incomes, and a greater likelihood of receiving welfare.
- Mediating factors are indeed predictive of adult outcomes. Among the mediating factors listed above, the best predictor of one's physical health, mental health, or level of depression is the level of social support available. Following social support, one's sense of self-efficacy is a good predictor of the adult outcomes of physical health, mental health, depression, and PTSD.
- One's use of adaptive coping skills is not a good predictor of adult outcomes, but one's use of maladaptive coping skills is a strong predictor of adult outcomes, in the expected direction. The more one uses maladaptive coping skills, the poorer one's physical and/or mental health, depression, and PTSD.
- Difficulty living on one's income is also a good predictor of adult well being, although not a strong as the other mediating factors.

- The mediating factors are not strong predictors of the adult outcomes of alcohol problems, drug problems, suicide attempts or incarceration.

**Service Seeking and Service Usage**

- On average, women in this sample utilized eight of the 24 listed services on the questionnaire. The most commonly used services in response to being victimized were: emotional support, professional counseling, medication, welfare, and support groups. These were used by over half of the sample.
- In general, women in the service agency sample were most likely to report using services. They reported significantly more use of professional counseling, welfare, support groups, legal services, domestic violence shelter, subsidized housing, homeless shelter, and child protective services. Women in prison reported significantly more use of psychotropic medication than women in the other samples.
- Among those using each service, women were asked to rate how helpful the service was. The most useful services were those that were more concrete in nature, including daycare, religious counseling, subsidized housing, welfare, educational services, food bank, and job training (all averaging a score above 4 on a 5-point scale). There were no differences between samples on how helpful women found any particular service, although when added together, women in prison, in the aggregate, found services less helpful than other women.
- Women were asked about the kinds of barriers they perceived or experienced in seeking and using services following victimization. The most commonly perceived barriers were that she thought she could handle the problem herself, she thought the problem would get better on its own, she was unsure about where to go for help, and she didn't think the service would work. These four barriers were named by more than half of the sample. Women receiving

services from agencies were particularly likely to report the following as barriers: concern about cost, transportation problems, unsure about where to go, and could not get an appointment. Women in communities named the fewest barriers to seeking services.

- Service usage is often correlated with mediating factors including a sense of self-efficacy, the use of adaptive and maladaptive coping skills, perceived social support, current age, and the perceived difficulty of living on one's income.
- There were small but significant correlations between service usage and adult outcomes. A woman's physical health was worse when she had received the services of a hospital stay, medication, food bank, homeless shelter, subsidized housing, a medical provider, and so on. Similarly, a women's mental health was reported to be poorer for those women having received services of medication, domestic violence shelter, a hospital stay, rape crisis services, psychotropic medications, food bank, and so on. Generally speaking, physical health was better predicted by service usage than was mental health.
- The best service predictor of current incarceration was *not* using a domestic violence shelter. The best service predictor of current alcohol problems was use of medication. The best service predictor of current drug problems was the use of a food bank, followed by use of psychotropic medications.
- There were many and significant correlations between the barriers a woman named to seeking services, and her adult outcomes.

**Relation of Disclosure to Mediating Factors and Adult Outcomes**

- As to women who experienced physical violence between intimates, when their perpetrators were confronted, their adaptive coping skills were significantly better. This

relationship does not exist for rape. The state of the woman on other mediating factors is not correlated with the response to disclosure.

- No adult outcomes are affected by the confrontation of the perpetrator upon disclosure of the victimization. The sole exception is that women in prison are more likely for their perpetrator to have been confronted and arrested.

***Discussion & Conclusions***

The research sample reflected a significant degree of age and cultural diversity, particularly for a largely rural Midwestern state. There were differences between the three sample groups, in terms of age (community is older), household composition (agency women have male partners/not husbands), having children (prison women were most likely to have children) and in the ages of their children (prison women reported having older children) and ethnicity, with the women in prison being more likely to be African American; the community women more likely to be Hispanic; and the agency women more likely to be White.

The women's economic circumstances at the time they were interviewed were poorest for women receiving agency services and were best in general for the community women. The results suggest that the women in prison enjoyed the best economic circumstances prior to their incarceration, and it is thought that this may be the result of the kinds of behaviors the women engaged in that ultimately lead to their incarceration.

Relative to the economic circumstances these women reported living under during childhood, there was no significant difference between the groups on the measure of their economic circumstances in childhood. Fifty five percent of the entire sample reported that it was "not at all difficult" or "a little difficult" for their childhood families to live on their income. Recent research suggests that poverty and its related social conditions have a direct relationship

on incarceration (Draine *et al.*, 2002). Because of its imprecise nature, we would be unwilling to use these data to challenge the prior research in this area.

In this study sample the rates of victimization are high across all types of victimization, and across all samples. While there were significant differences between all three groups in the experience of childhood sexual abuse, physical IPV, and rape, women in prison reported higher rates of victimization in all of these areas except for physical IPV, which had a reported prevalence among agency women that was significantly higher than in the prison and community samples.

Because we hoped to be able to answer the research questions by differentiating between sub-sample groups, it was decided that for IPV and sexual assault measures and for many of the remaining research questions and hypotheses, the analyses would focus on those women who reported having experienced physical IPV or rape. Excluding from these analyses those women who reported having experienced psychological IPV and "only" sexual coercion or attempted rape allowed for more statistical discrimination. We emphasize that this analytical decision was made in an effort to provide statistically adequate comparative samples; not because of some value judgment about the significance of one's personal experience of physical and sexual victimization.

Overall, we found that co-occurrence of victimization was very common across all groups. Physical violence between intimates and rape often co-occur. When only one type of the two victimization experiences occurred, it was most likely to be physical violence between intimates, rather than rape. About half of the sample experienced victimization both in childhood and in adulthood and sexual abuse in childhood was more highly correlated with adult victimization than was physical abuse in childhood.

In general, the whole sample reports having good physical and mental health, with, in general, better physical health than mental health. The agency women in this study reported having the poorest physical and mental health.

Both drug and alcohol problems were reported by significantly more women in prison than in the other samples. Still, over a quarter of the women in this study reported having a drug problem (28%) and 19 percent reported having an alcohol problem. This suggests that attention must be paid to the aftermath of violence which takes its toll on women's health in other, perhaps less obvious ways than imprisonment.

On every measure except for "suicide attempt in the past year", there was a statistically significant relationship between the experience of *sexual abuse* in childhood and every adult outcome. In general, having experienced physical IPV in adulthood was not predictive of well being in adulthood. The degree to which one experienced sexual assault, particularly rape behaviors, was predictive of adult well being.

One hundred percent of the prison sample reported histories of psychological IPV and over 95 percent reported experiencing physical IPV. In contrast, 72.6 percent of women in prison reported having been raped. Physical IPV was also reported more frequently than any other form of child abuse. Thus, incarcerated women reported histories of adult physical IPV more frequently than histories of sexual violence.

Across all types of victimization, more than half of women who experienced any type of victimization disclosed the experience to someone. The highest disclosure rates were for physical violence between intimates (79%), rape (73%), childhood sexual abuse by touching (71%), childhood sexual abuse by penetration (67%) and childhood physical abuse (67%). Disclosure rates did not differ by sample.

In regard to childhood victimization, in this sample most disclosures were made to family and friends, but for the most part, disclosures were not made immediately after the event. In almost three-fourths of cases, the perpetrator was confronted, although this was less likely for community women. Perpetrators were arrested in over half of the cases. In about two-thirds of these cases, nothing happened to the perpetrator.

Among those women experiencing Physical IPV, many told friends and family, although police and social workers were often told, as well, particularly if the woman was receiving services from the agencies. Almost all women said they were believed when they disclosed.

The disclosure pattern for those women who experienced rape mirrors that for those women who experienced physical IPV. These women most commonly told family and friends, followed by social workers and almost all women reported that they were believed. When a report was made, it was likely to doctors and police and generally within the week - much higher rates than those for physical IPV. When the event was rape rather than physical violence between intimates, it was less likely that perpetrators were confronted or arrested.

Mediating factors in this study included one's sense of self-efficacy, one's use of adaptive coping skills, use of maladaptive coping skills, social support, current age, difficulty living on income, and receipt of welfare. In general, participants reported good levels of self-efficacy, adaptive coping and social support, with social support lagging behind self-efficacy and adaptive coping. Maladaptive coping was used to a lesser degree than was adaptive coping.

The multivariate analyses show that minority ethnicity is not a good predictor of adult outcomes in this sample, when considering all possible predictors. However, ethnicity is highly correlated with childhood economic difficulty as well as lower education, and both of these are much stronger predictors of most adult outcomes, particularly incarceration. These findings are

consistent with prior research (see, Draine *et al*, 2002; U.S. Dept. of Health and Human Services, 2001) but it must be emphasized that these results should be viewed within the context of the long-term effects of institutionalized racism. Both lower levels of educational achievement and disproportionate rates of minority incarceration have been tied to this social / political phenomenon (Pewewardy and Severson, 2003).

Multiple victimizations are not a strong predictor of adult outcomes in this sample. This is an important finding for public policy and service planning efforts, that is, negative adult incomes may be triggered on the basis of "only" one victimization experience.

Disclosure rates can predict adult outcomes, particularly in the case of incarceration, which is predicted by police investigations following disclosure of violence. Taken separately, the best predictors of adult outcomes are childhood physical and sexual abuse, followed by rape in adulthood. The extent to which a woman experiences physical intimate partner violence is not a good predictor of adult outcomes in this sample.

When controlling for all other variables, the mediating factors of self-efficacy, social supports and use of maladaptive coping provided great predictability for adult outcomes. One's level of social support was a good predictor of one's physical health, depression, and levels of PTSD. Not surprisingly, one's use of maladaptive coping strategies was a strong predictor of poorer depression scores, and of PTSD. Self-efficacy was also a strong predictor of adult outcomes, although not as predictive as social support and maladaptive coping. A greater sense of self-efficacy was predictive of better physical health, lower levels of depression, and lower levels of PTSD. Service usage was only predictive of the adult outcome of incarceration; incarcerated women found the services used to be less helpful, and had received fewer crisis intervention services.

So, the best predictors of physical health in the entire sample were age and number of social supports. The best predictors of depression in this sample were use of maladaptive coping strategies, social supports, and one's sense of self-efficacy. The best predictors of one's level of PTSD were one's sense of self-efficacy, use of maladaptive coping strategies, and social supports. The best predictors of incarceration are difficulty in living on the family income in childhood, years of education, proportion of victimization disclosures that were followed by a police investigation, receiving welfare, finding services not helpful, and not using crisis intervention services.

The multivariate analyses revealed that minority ethnicity was not a good predictor of adult outcomes in this sample, when considering all possible predictors. However, ethnicity was highly correlated with childhood economic difficulty as well as lower education, and both of these are much stronger predictors of most adult outcomes, particularly incarceration. Again, the findings with regard to the influence of educational levels and ethnicity are consistent with the existing literature (Draine, *et al*, 2002), as discussed earlier.

Multiple victimizations were not a strong predictor of adult outcomes in this sample. Especially for incarceration, disclosure rates are predictive of police investigations following disclosure of violence. Taken separately, the best predictors of adult outcomes are childhood physical and sexual abuse, followed by rape in adulthood. The extent to which a woman experiences physical intimate partner violence is not a good predictor of adult outcomes in this sample.

At the start of this research initiative we proposed the possibility that *real prevention lies in early intervention*: making sure that critical kinds of social services and social supports are available to the victims of intimate partner violence, sexual violence and youth maltreatment and

injury before they end up incarcerated or in other abusive or injurious relationships. What we have found is that there are indeed certain types of services that could be funneled to those women who present few criminogenic traits but who have turned to alcohol and drugs to self-medicate and / or to be able to support themselves out of a violent situation.

In sum, this research initiative has afforded an opportunity to further refine policy directions and practice strategies in all areas of intervention with victims of intimate partner violence, sexual violence and youth maltreatment. Individual, social service, medical, mental health and criminal justice systems can gain from this exploration of the relationship between women's histories and women's present circumstances.

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***Final Report to the National Institute of Justice***
***(NIJ Research Award #2003-IJ-CX-1037)***

## I. INTRODUCTION

### *The Origin of this Study*

In 2003, in response to a request for proposals under the *Broadening Our Understanding of Violence Against Women from Diverse Communities* Initiative set forth by the National Institute of Justice Office of Research and Evaluation, a unique collaboration between two researchers with different but complimentary areas of expertise resulted in the development of a research agenda which both built on prior research and sought to explore new areas of knowledge in the study of women's victimization. Professors Judy Postmus, PhD and Margaret Severson, J.D., combined practice and research interests in violence and abuse against women and children and in mental health and suicide prevention in detention and correctional facilities, respectively, and proposed to study the histories and life trajectories of women victims of violence. As funded, included in this study were women who were, at the time of data collection, incarcerated in a state prison for women and women living in the communities where the sampling occurred, some of whom who were receiving services from domestic violence and / or sexual assault agencies.

### *Timeliness and Relevance of the Study*

Concerns about the rising female inmate population in state and federal corrections systems in the United States served as a key impetus for conducting this research. As more

women enter the criminal justice system, there is a great need to understand their backgrounds and unique needs (Harrison & Beck, 2002; Richie, 2001). Institutional policies and services have not been able to keep up with the unique demands of this growing population (Severson, 2001), particularly because the nature of the corrections industry in the United States has been largely male dominated – by the inmates themselves who are overwhelmingly male and by the management staff as well, where male managers are still the norm. By studying the personal and service-related histories of women victims of violence and also of women who did not have histories of violence, the researchers hoped to identify significant relationships between life events, mediating factors and a series of critical outcomes, including incarceration.

***Description of the Data Collection Settings***

This study was undertaken principally within a Midwestern state in five disparate communities. The first community wherein sampling occurred was that of the state's only women's correctional facility. This key site was selected in order to learn more about the victimization experiences and related histories of incarcerated women. In the remaining four community settings where sampling occurred, the interviews were conducted at various locations selected by the participant, given that concerns for the safety of the women participants was always at the fore. Collectively, the locales where sampling occurred provided considerable diversity in terms of their offering both rural and urban environments as well as a range of cultural and ethnic representation. Additionally, the prison population is primarily comprised of women from these four communities and, hence, directed our selection of these particular venues for our other samples. The specific venues for the research interviews are discussed in detail below and again later in this report as part of the description of the research methodology.

***The Women's Correctional Facility (WCF).*** According to the state's Department of Corrections' statistical profile for fiscal year 2002, the year during which this study was initiated, over 500 hundred women were incarcerated at the only women's correctional facility (WCF) in the state. As a whole, however, women comprise only six percent of the total inmate population in this Midwestern state, but like elsewhere in the country, when compared to the previous year and to the growth of the male population, female inmates constituted the fastest growing correctional population (Biggs, 2002; Harrison, 2004). Most female inmates, over 41 percent of the population, have fewer than six months to serve in confinement in the CWF. Another 34 percent of the female population remains at the CWF between six months and two years (Biggs, 2002). All of the women have felony convictions and most are confined with minimum (50%) or medium (34%) custody classifications (Biggs, 2002).

In the prison all age groups are represented, though 84 percent of the female population is between age 20 and 44. These women represent different racial and ethnic groups, including White (60%), Black (36%), American Indian (3.2%), and Asian (.4%). Over 62 percent of the women housed in the CWF have either a high school diploma or a G.E.D. Very few women (5.3%) have attended college (Biggs, 2002).

***Urban Communities.*** According to the 2001 U.S. Census Bureau, the estimated population of the first urban community from which the sample was drawn was 157,461 people in 2000. Of that population, approximately 51.6 percent of residents were White, 28.3 percent Black or African American, and 16 percent Hispanic. Seventy-four percent of persons over age 25 were high school graduates, and 12 percent of these persons had earned a Bachelor's degree. Some 16.5 percent of the estimated county population lived below poverty at that time.

The second urban community from which the sample was drawn is the largest community in this Midwestern state. According to the 2001 U.S. Census Bureau, the community's estimated population of 455,516 people included an ethnic make-up of 76.4 percent White, 9.1 percent Black or African American, and 8 percent Hispanic. There were 85.1 percent of persons over age 25 identified as high school graduates, and 25.4 percent of these persons had earned a Bachelor's degree. Persons living below poverty comprised 9.5 percent of the estimated population.

The 2001 U.S. Census Bureau report indicates that the third urban community in this Midwestern state from which the sample was drawn had an estimated population of 170,080 people. Nearly 80 percent were White, 9 percent Black or African American, and 7 percent Hispanic. Over 88 percent of persons age 25 and older were identified as high school graduates, and 26 percent of these persons had earned a bachelors degree. Almost 10 percent of persons in this community lived below the poverty level in 2001.

According to the 2001 U.S. Census Bureau, the one rural community selected for inclusion in this research had an estimated population of 40,082 people. This community, located in a very rural area of the state, is unique for its highly diverse population. The presence of agricultural and meat processing industries and the fact that this community has served as a resettlement area for many Central American and Southeast Asian refugees has resulted in it being an unusually diverse rural community. In 2001, 51.4 percent of inhabitants were White, 1.3 percent were Black or African American, and 43.3 percent were Hispanic. Approximately 67 percent of persons over the age of 25 years were identified as high school graduates, and 14 percent of persons in this same age group had earned a bachelor's degree. Persons living below poverty included 14.2 percent of the estimated population in this rural community.

***Statement of Purpose***

There is a small body of existing research which focuses on girlhood and adult histories of victimization among incarcerated and non-incarcerated women, and which reports their shared histories as revealed through descriptive and demographic data. Indeed, in the last 15 years, research has shed some light on the common and tragic histories of abuse experienced by both incarcerated and "free" women. These women consistently report histories of physical and/or sexual abuse wrought against them and when compared to incarcerated men, are more than three times as likely to report having experienced physical or sexual abuse prior to their incarcerations (ACA, 1990; Greene, Haney & Hurtado, 2000; Greenfeld & Snell, 1999; Harlow, 1998; Snell & Morton, 1994; Veysey, 1998).

Several studies focusing on populations of non-incarcerated women have highlighted the types of emotional and physical abuse and injuries experienced by sexual and / or physical violence (Browne, 1993; Campbell, 1989; Carlson, 1990; Eby, Campbell, Sullivan, & Davidson, 1995; Gelles & Straus, 1990; McNutt, Carlson, Persaud, & Postmus, 2002; Miller & Downs, 1993; Riggs, Kilpatrick, & Resnick, 1992; Tjaden & Thoennes, 1998).

Many incarcerated and non-incarcerated women were victims of youth maltreatment, experiencing immediate injuries and consequences ranging from malnourishment and poor health and developmental delays caused by chronic neglect, to broken bones, brain injuries and physical impairments caused by physical abuse and assault, to trauma to the reproductive system and internal injuries caused by sexual abuse of young children (Cicchetti, 1989; Wolfe, 1999). Beyond this, children who have been maltreated suffer emotional and social injuries as well including a loss of trust in others, a diminished desire to ask for help or to disclose one's problems or the mounting of other vulnerabilities. In adolescence, these vulnerabilities may lead

to self-medication, including the use of painkillers and other substances to diminish the emotional and physical pain from an assault, no matter how distant in time (Bellis, Broussard, Herring, Moritz, & Benitez, 2001; Berry, 2001; Besharov & Laumann, 1997; Briere, 1992; Cowen, 1999; Dore, 1999; Hampton, 1995; Kirby & Fraser, 1997; Kurtz, 1993)

Beyond the existing body of research, however, to date no published research has been located which details these women's opportunities to access various types of social services and social supports after their victimization experiences. Such information seems important to record for its potential use as a foundation for intervention programs after women disclose having been victimized, and for developing preventive strategies that might interrupt the movement into criminal behaviors that ultimately lead some of these women to prison. Consequently, the purpose of this NIJ-funded research was to explore the differential risk and protective factors related to histories of physical and sexual victimization reported by incarcerated and non-incarcerated women and to understand the coping and resilience patterns women activate at various points in their lifespan. The essential goal of this research was to examine the consequences, that is, the health, mental health, substance use, incarceration, and suicidality, of intimate partner violence (IPV), sexual violence, and youth maltreatment and victimization to identify at-risk populations, modifiable risk and protective factors, and optimal times and settings for intervention.

This project called for and succeeded in securing the collaboration of many domestic violence and sexual assault and other service agencies in this Midwestern state, including the state's Department of Corrections and the state's Coalition Against Sexual and Domestic Violence.

## II. RESEARCH QUESTIONS

### *Research Questions*

This exploratory study was designed to address some of the existing research gaps by investigating the following key questions**:**

(1) What is the prevalence and co-occurrence rate of intimate partner violence, sexual violence and youth maltreatment for three different samples of women in one Midwestern state (women from urban and rural communities who had not received services for domestic violence and / or sexual assault in the prior 12 months, women actively receiving services for domestic violence and / or sexual assault, and incarcerated women)?

(2) What are the disclosure experiences among women who disclosed their childhood and / or adult victimization?

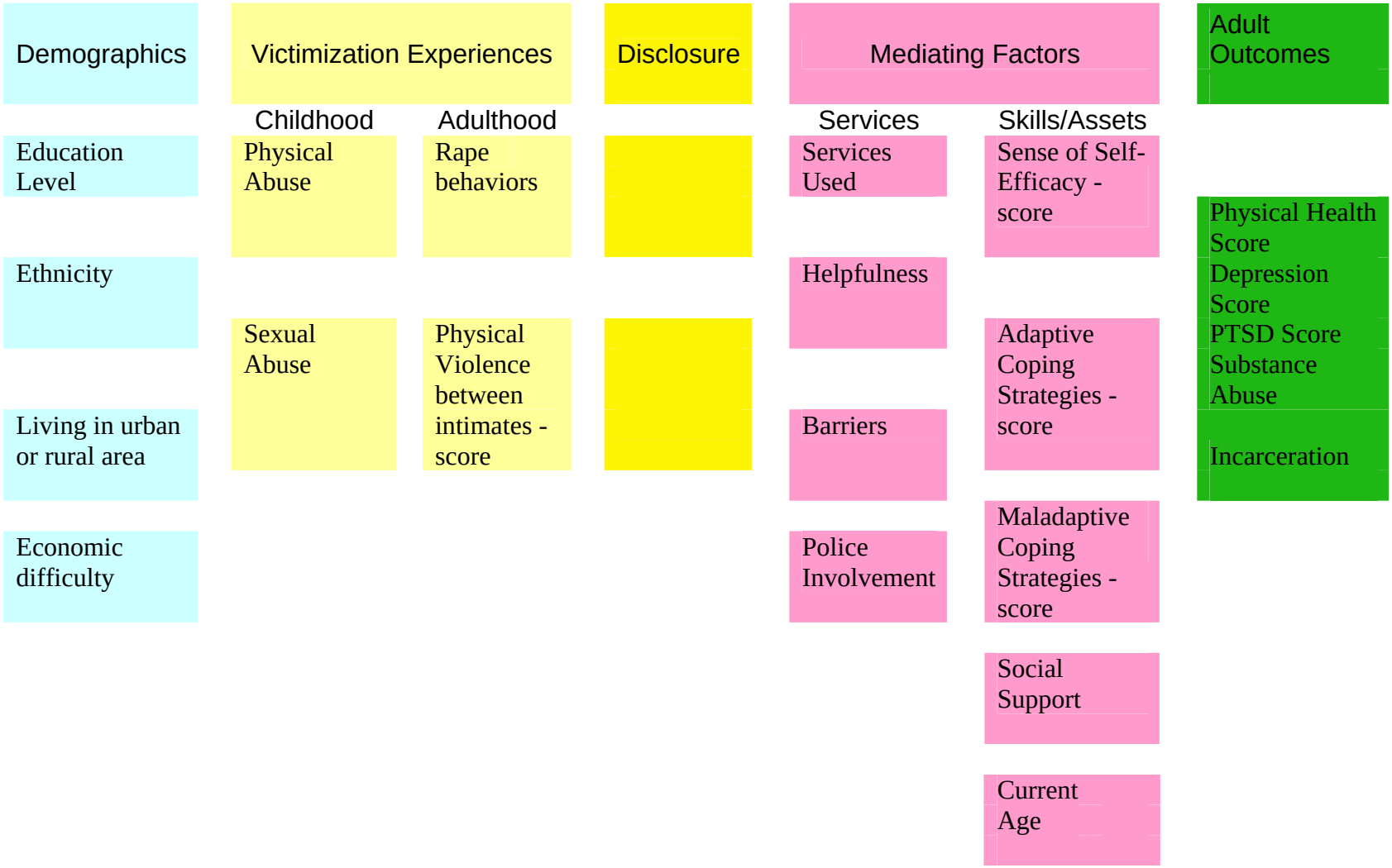
(3) How does youth or adult victimization relate to outcomes in adulthood, including health, mental health, use of alcohol and drugs, suicide attempts, and incarceration? How does the response to women's disclosure relate to these adult outcomes?

(4) What events and services in adolescence and adulthood, including the kinds of social services, types of coping skills, self-efficacy, social supports, current age, welfare receipt, and adult economic resources, are most predictive of the adult outcomes of health, mental health, use of alcohol and drugs, suicidality, and incarceration?

(5) Which of all these factors (childhood / youth demographics, history of victimization, and the mediating factors itemized in research question #4), are the strongest predictors of adult outcomes?

These key questions were addressed through a research methodology that included a combination of quantitative and qualitative methods. These methods were designed to explore and ultimately to shed light on the types of social support and social services interventions and the timing of those interventions that may have impacted the course of adult female victims' lives. The Model of Inquiry graphically illustrates that methodology:

Model of Inquiry




Final Report: NIJ 2003-IJ-CX-1037
Postmus, J.L. & Severson, M. (2005).

***Goals and Objectives***

The focus of the study was to explore certain similarities and differences in life experiences as they occurred between and within several groups of women. Those groups included women who reported having been victims of personal violence who were incarcerated at the time of this study, women living in the community who received services for their victimization experiences sometime in the 12 months prior to the initiation of data collection, and women who may or may not have been victimized and who had not received services in the 12 months prior to the initiation of data collection. The two primary areas of inquiry in this research were to explore women's access and opportunities for various types of social services and their current personal status on various measures of health, mental health, substance use, incarceration, and suicidality. Accordingly, the research findings that point to the common trajectories of victims are important for this study as well.

The overall goal of this research was to explore a specific dimension of personal violence which has yet to be fully developed in the literature; that is, to compare the life experiences of female victims of intimate partner violence, sexual violence, and youth maltreatment who are living in disparate settings: the state's Women's Correctional Facility and in urban and rural communities within the same state. The specific objectives of this research were: (1) To determine whether victimized women residing in the community were (a) offered and (b) participated in, one or more social service and social support interventions which may have impacted their health, mental health, alcohol or illegal substance use, and incarceration status. Specific attention was directed toward exploring the type and range of involvement of those systems that may have been available to provide assistance to abused and injured women at earlier points in their lives. These systems include schools, sexual assault/domestic violence

programs, law enforcement, medical providers, mental health providers, agencies responsible for ensuring the protection and safety of children, religious and faith-based groups, and family or friends. (2) To determine the rate of co-occurrence of sexual assault with intimate partner violence and other forms of familial abuse and youth maltreatment among and between incarcerated and non-incarcerated women. (3) To suggest implications for improving policy and practice strategies within the criminal justice system, both for incarcerated and never-incarcerated victims of intimate partner violence, sexual assault, and youth maltreatment.

***Hypotheses***

The hypotheses supporting this research endeavor included: (1) Prevalence rates of intimate partner violence (IPV), sexual violence, and youth maltreatment are higher among incarcerated women than those who are not incarcerated. (2) There is a higher degree of co-occurrence of IPV, sexual violence, and youth maltreatment among incarcerated women than among those not incarcerated. (3) Histories of IPV in adulthood will be more common among incarcerated women than will histories of adult sexual violence. (4) Childhood victimization will have more enduring and detrimental outcomes (in health, mental health, substance use, incarceration and suicidality) than will other types of victimization. (5) A woman's positive perception of the supports she has received will be related to better outcomes in health, mental health, substance use, incarceration, and suicide attempts. (6) Statistical analyses will find that women experience poorer adult outcomes when any of the following are true (and these have negative cumulative effects): minority ethnicity; lower education; living in a rural environment; any victimization; multiple victimizations; undisclosed victimization; and limited access to services. (7) Statistical analyses will find that women experience better outcomes when any of the following are true (and these have cumulative positive effects): early disclosure of the

violence; social supports; coping skills; self-efficacy and services received and perceived as helpful. (8) The key predictors of poor outcomes will be adult welfare receipt, minority ethnicity, multiple victimization, and non-disclosure.

## III. REVIEW OF THE RELEVANT LITERATURE

### *Incarcerated Women*

Women in prison constitute a small fraction of the total United States prison population but present formidable challenges to correctional and social service managers. Historically, prison-based social service and treatment programs have been designed under policies emphasizing resource efficiency over program efficacy, i.e. programs created in the spirit of reaching the most people with the most readily available resources (Collins & Collins, 1996). By and large, these programs have been geared toward interdicting in the imprisoned *male's* emotional, educational, and criminal symptoms and syndromes. Consequently, male-oriented models of intervention were superimposed on women; and not until the last fifteen years have questions been raised about whether these programs are efficacious as applied to women prisoners (Severson, 2001).

As connections are made between gender and program design and program applicability, so, too, are connections made between gender and gaps in the body of corrections research. With the numbers of imprisoned women rising, many research questions have developed. What histories do incarcerated women share? How can institutional treatment programs address the effects on women of poverty, child and adult abuse, poor health and mental health care? The research undertaken here furthers the relatively new effort to focus on and compare the specific histories and subsequent needs of women who are incarcerated to women who are not

incarcerated but who share similar experiences of victimization and injury by intimate partner violence, sexual violence, and child maltreatment.

***Who and how many women are incarcerated*?** The numbers of women incarcerated throughout the United States are rising at rates considerably faster than those of men. From 1990 through 2003, the number of incarcerated women has more than doubled, increasing by 118 percent (Harrison & Karberg, 2004). Between 1995 and 2003, there was a 48 percent increase in female prisoners compared to a 29 percent increase for males (Harrison & Beck, 2004). This trend continues: In a snapshot of just the one year period between July 1, 2004 and June 30, 2005, there was 2.9 percent increase in the female prison population compared to a 2.0 percent increase in the male prisoner population (Harrison & Beck, 2005). Further, while overall prisoner population increases were due to increases in sentences given for violent crimes, women were more likely than men to have been sentenced on drug and property crimes. Greenfield and Snell (1999) report that since 1990, the number of felony convictions among females in state courts increased at more than two times the rate of their male counterparts. In 1998, 3.2 million women were arrested, and 75,000 women were incarcerated in state prisons, 10,000 women in federal prisons, and 64,000 in local jails (Richie, 2001).

At the same time of rising rates of incarceration and despite or perhaps because of the complex historical and contemporary problems they present to the agencies with which they interface, this population of women offenders is often overlooked in the criminal justice research. Research specifically focused on incarcerated women has yielded some unique findings that undergird theories of why women commit crimes.

***What attributes are common among incarcerated women*?** Recent research which focuses on the incarcerated female population has identified a number of risk factors common to

this discretely defined population and consequently underscores the rationale for including them in a study which explores the risks and resiliencies of women victims of intimate partner violence, sexual violence and youth maltreatment. Statistics from the Bureau of Justice (Greenfeld & Snell, 1999), indicate two out of three incarcerated women are of color while white women represent two out of three women on probation. Researchers have noted that the increased incarceration of African American women is part of a cultural phenomenon that reflects their social exclusion in society (Henriques & Manatu-Rupert, 2001). Most incarcerated women are young and poor. These women are more likely to have never been married than women in the general population. A majority of incarcerated women have at least a high school diploma and have children under the age of 18 (70%).

Alcohol and drug use and abuse are commonly found among incarcerated women (Greenfeld & Snell, 1999). Sixty percent of women reported using drugs one month prior to their arrests with 50 percent of them reporting daily drug usage. Forty percent of women reported being under the influence of drugs at the time of their offense; 33 percent committed the offense to obtain money for their habits. Years ago, Anglin & Hser (1987) reported that drug addiction among women correlated with three types of crime: prostitution, reselling of narcotics or assisting male drug dealers, and property crimes (larceny) (Anglin & Hser, 1987).

Finally, ***most women in prison report having a history of physical and sexual abuse***. The Bureau of Justice Statistics reports 44 percent of women under any correctional authority were physically or sexually assaulted and injured at some time during their lives (Greenfeld & Snell, 1999). In relation to childhood abuse, 23-37 percent of female inmates reported being physically and sexually abused and injured as children compared to 12-17 percent of the general adult population (Harlow, 1999). Browne, Miller, and Maguin (1999) reviewed the research on

the prevalence of sexual and physical abuse, as children or adults, among incarcerated women. Their findings reveal sexual abuse as children reported in as little as 18 percent and as high as 59 percent of the women's prison population. Further, research on childhood physical abuse found rates as low as 29 percent up to 70 percent of the women's prison population. Victimization as adults also had varying ranges with 23-68 percent of incarcerated women reporting sexual assault and 25 percent-80 percent reporting intimate partner violence (Browne, Miller, & Maguin, 1999). The wide variance in reported percentages may be explained by the types of questions asked about victimization; the more details asked about women's experiences, the higher the reports of victimization (Browne et al., 1999).

Clearly, the existing research has produced valuable information about the relationship between childhood and early adulthood sexual and physical abuse and later criminality. Yet to be explored, however, is the question of why some women who have experienced victimization did not turn to or otherwise become involved in criminal activity? What resources, supports, or interventions were available to and for them that may have acted as intervening and interrupting forces in the life paths of victimized women?

One study sought to determine perceived levels of social support and sources of help and found that incarcerated women perceive their social support as low; 41 percent reported that no one helped them cope with traumatic life events. Of the 58 percent who identified people who helped them, the list of supports, in descending order, included family members, friends, acquaintances, strangers, and professionals (Singer, Petchers, & Hussey, 1995). Zweig, Schlichter, and Burt (2002) studied women victims who faced multiple barriers such as substance abuse, mental health and incarceration. The researchers found that problems

encountered by such women included lack of services dealing with multiple barriers, uneducated service providers, and batterers using women's barriers to further control or victimize them.

Roberts (2002) looked at two specifically defined groups of female abuse victims, those who ultimately killed their partners and those who did not, and asked whether certain types of personality characteristics, demographic or psychosocial factors and/or behavior patterns are likely to precipitate homicidal acts. His findings, based on interviews of incarcerated and non-incarcerated women, found that there were eight likely factors at play in battered women who became homicidal. The most important of these factors were the presence of recurring nightmares and flashbacks and a specific death threat having been made by the batterer where the woman's only choice was to kill or be killed (Roberts, 2002).

***Does past victimization as a child or adult lead to criminal behavior?*** Several researchers have recently focused on the relationship between victimization and crime in addition to economic hardship (Marcus-Mendoza, Sargent, & Ho, 1994). Gilfus (1992) interviewed 20 incarcerated women encouraging each of them to tell her own life story within a chronological and developmental framework. Collectively, their stories reveal childhoods filled with injury: sexual and physical abuse, parental violence and substance abuse, disruption by divorce, death, desertion, or suicide, and educational neglect. As these women entered adolescence, their attempts to survive included running away from home, attempting suicide, and committing delinquent acts such as drug use, truancy, and stealing. Their transitions into adulthood included being the victims of battering relationships and involvement with prostitution and addiction. Gilfus indicates that these women experienced an overwhelming amount of violence yet were committed to not harming others through their illegal "work." Additionally, these women formed their identities as caretakers and protectors and viewed their illegal

activities as economic necessities in order to support their partners, their children, and their addictions (Gilfus, 1992).

While the results of her qualitative study are limited, Gilfus sheds light on the lives and historical experiences of incarcerated women, with an emphasis on their stories of abusive and injurious experiences as children and adults. Still, it is impossible to conclusively connect past victimization with criminal activity within some cause-effect paradigm.

***Intimate Partner Violence***

Each year in the United States, 1.4 million women are victims of violence at the hands of an intimate partner, defined as a current or former husband, cohabiting partner or date (Tjaden & Thoennes, 1998). Depending on the type, severity, and duration of abuse, the consequences of abuse have varying degrees of impact on the functioning and well being of victims. Physical injuries can leave temporary or permanent scars on victims. Typical injuries include bruises, cuts, black eyes, concussions, broken bones, miscarriages, damage to joints, partial loss of hearing or vision, scars from burns, bites, or knife wounds, and even death (Browne, 1993). Several studies have found that victims also experience non-specific health symptoms that affect their functioning such as chronic fatigue, disturbed eating and sleeping patterns, headaches, and gastrointestinal disorders. Eby et al. (1995) sampled women staying in domestic violence shelters and found a strong correlation between non-specific health problems and sexual and physical violence (Eby et al., 1995). McNutt et al. surveyed women seeking services from two primary care sites of a health maintenance organization and found that recent interpersonal violence was associated with physical symptoms beyond the effects of child abuse, past intimate partner violence, and economic hardship (McNutt et al., 2002). While McNutt's study was

unable to establish a sequential association, Sullivan and Bybee (1999) found that when the abuse ceased, the victim's physical health improved (Sullivan & Bybee, 1999).

Abuse also affects the mental health of victims. Victims often experience feelings of fear, anger, guilt, frustration, depression, anxiety, paranoia, worthlessness, and shame (Browne, 1993; Carlson, 1990). Physical abuse has been found to be associated with several mental health problems including depression and anxiety (Plichta, 1996), PTSD (O'Leary, 1993; Saunders, 1994; Walker, 1993), and suicidal ideation or attempts (Gelles & Straus, 1990; Plichta, 1996). To cope with the violence, victims may turn to alcohol or other mind-altering substances (Miller & Downs, 1993; Plichta, 1996). There is strong agreement in the research on the consequences of intimate partner violence; the more severe, frequent, and long-lasting the abuse, the more likely the deterioration of the physical and emotional health of victims (Follingstad, Brennan, Hause, Polek, & Rutledge, 1991; McCauley, Kern, Kolodner, Derogatis, & Bass, 1998).

How do women cope, then, with physical and emotional abuse? Some studies have found that battered women cope less effectively and use fewer problem-solving strategies and more passive strategies than do nonabused women. One passive coping strategy is the rationalization of the violence and believing that the partner will change as promised (Ferraro & Johnson, 1983). Other studies have described abused women as highly resourceful; having strong coping abilities in light of the types and extent of stress they face (Campbell, Rose, Kub, & Nedd, 1998). Some research suggests that coping strategies change over time – especially if the abuse escalates. Other coping strategies include seeking social and spiritual support, calling the police, or temporarily leaving (Finn, 1985).

Most abused women seek help, usually first from family and friends and then from formal services (Davis & Srinivasan, 1995; Horton & Johnson, 1993). Gordon's (1996) review

of the research on their use of services suggested that the most commonly used social service systems were, in order, the criminal justice system (i.e. law enforcement and lawyers), social service agencies, medical services, crisis counseling, mental health services, clergy, and women's groups. However, while seeking services more often within the various systems, abused women did not necessarily view the services they received as helpful (Gordon, 1996). Humphreys and Thiara (2003) studied the experiences of women victims of domestic violence who reached out to mental health services. Many of the women in this study found their experiences to be negative or unhelpful including, for example, the lack of recognition of trauma or provision of trauma services; making the abuser invisible through focusing on the woman's mental health reified from her experiences of abuse; blaming the victim; offering medication rather than counseling support.

***Sexual Violence***

For all women, rape and sexual assault are associated with several physical consequences, including injury, stress-related problems, and chronic health problems (see review of research by Koss & Heslet, 1992). The psychological and emotional effects of sexual assault most commonly include fear, post-traumatic stress disorder, depression, suicide attempts, reduced self-esteem, and substance abuse (Goodman, Koss, & Russon, 1993). Sexual violence by an intimate partner is no less traumatic than sexual violence by a stranger (Riggs et al., 1992).

How do sexually violated women cope? There is little research on coping with sexual assault; the research that is available focuses on coping as it relates to adjustment. For example, one study found that poorer adjustment is associated with avoidance coping, including social withdrawal, dissociation, or use of drugs or alcohol (Ullman, 1996b). Research has not explained why some survivors seek support in the aftermath of the violence. One explanation

may be the reactions of others to disclosure. Most victims prefer to disclose to family and friends rather than law enforcement, medical staff, or service providers (Neville & Pugh, 1997; Ullman, 1996a, 1996b); however, one study found that only one-third of victims disclosed immediately and another one-third waited a full year or more to tell someone (Ullman, 1996b). Some victims choose not to report the sexual violence to law enforcement due to negative social reactions from police (Ullman, 1996a)

***Child / Adolescent Maltreatment***

Being victimized as a child yields a variety of developmental trajectories through the lifespan. For children for whom child maltreatment is an acute occurrence responded to with appropriate care, there may be few long-lasting effects. For the majority of children suffering child maltreatment in this country however, chronic and/or severe maltreatment is often the norm. Child welfare agencies in most states can provide ameliorative or protective services to only those children and families who have suffered the greatest harm. Therefore, maltreatment can exist for long periods of time until it is severe enough to get the attention of service agencies. In many cases, the protective service provided involves removing the child from his or her family for reasons of safety. This removal and long-term separation can produce injuries and experiences to the child that far outweigh and outlast the initial maltreatment. Longitudinal research has shown that living in multiple homes (often in foster care) is more predictive of poor outcomes in adulthood than is the original maltreatment (McDonald, Allen, Westerfelt, & Piliavin, 1996).

Widom's (1992) prospective study followed the lives of more than 1,500 individuals over a 20-year period. Her study compared a group of 908 substantiated cases of childhood abuse and neglect with 667 children with no abuse or neglect histories. These study groups were matched

on sex, age, race, and family socioeconomic levels. While most members of both groups incurred no juvenile or adult criminal records, being abused or neglected increased the likelihood of arrest as a juvenile by 53 percent and of arrest as an adult by 38 percent. Looking solely at gender, Widom's findings revealed that the abused or neglected females studied had a 77 percent likelihood of arrest when compared to the female study subjects who revealed no childhood histories of victimization (Widom, 1992).

In this study Widom also identified several long-term consequences of abuse and neglect. Those who were abused or neglected scored significantly lower on an IQ scale than the comparison group, irrespective of age, sex, race, and criminal history. Further, the abused and neglected group held more menial and semiskilled jobs and disproportionately experienced unemployment and underemployment than the comparison group. Finally, abused and neglected females were more likely to attempt suicide, abuse alcohol, or suffer from antisocial personality disorder than females in the comparison group (Widom, 2000).

Research by Banyard (1999) showed ties between "childhood maltreatment and mental health problems in the lives of survivors" (p. 161) and between poverty and psychological distress and poverty and adult victimization, too. Additionally, Banyard (1999) found that the experiences of physical and sexual abuse as a child resulted in high-risk levels and traumatic stress and in negative consequences experienced across the woman's lifespan (Banyard, 1999).

Other researchers have combined their results in an attempt to link early victimization with criminal activity. Physical and sexual abuse by male relatives drive young girls to run away from home; to survive, girls turn to prostitution, fraud, and theft (Chesney-Lind, 1989; Gilfus, 1992). Women's involvement in the male-dominated culture of street hustling may expose them to continued violence by intimates who try to control them financially and keep them on the

streets (Romenesko & Miller, 1989). Thus, there appears to be some credibility to the theory that victimization leads to criminal activity.

## IV. METHODOLOGY

Key questions and hypotheses were addressed through a research methodology that included quantitative and qualitative methods used to explore and ultimately understand the social support and social services interventions and the timing of those interventions that may have impacted the course of adult female victims' lives. The methodology is fully described in the following pages.

### *Sample*

Convenience and snowball sampling procedures were used by recruiting women to self-select to participate in the study. While limitations are inherent in self-selection, it was thought to be a more appropriate method for identifying these particular participants given the intensity of the proposed study of sexual and physical violence and related concerns about the protection of human subjects.

Sampling occurred in five (5) distinct communities in one Midwestern state, three (3) in urban settings, one in a unique rural setting, and the fifth in the state's only correctional facility for women. Community referrals were generated through recruitment of women seeking assistance from sexual assault and domestic violence service providers. Women were also recruited from each community from flyers distributed to social service agencies and advertisements in local newspapers (see Appendix A). Flyers were printed and posted in both English and in Spanish. A total of 438 interviews were initiated with 432 completed. Nine of those interviews were excluded from the final sample because of too much missing data. The total study sample included 423 women – 157 from the prison, 157 from domestic violence and sexual assault programs, and 109 from the four communities. Twenty-three women were interviewed in Spanish. Additionally, for the qualitative phase, 17 women from the total study

sample were interviewed, including 10 women from the prison and 7 women from one of the communities.

***Women's Correctional Facility (WCF) Sample.*** All women age 18 and older incarcerated in the WCF for at least one month were eligible to participate in this study. There were no institutional restrictions to recruitment, thus, women housed throughout the prison, including in maximum and minimum security units, were eligible for inclusion. Women were invited to participate after spending at least one month in prison in order to assure their minimum adjustment to prison routines and to give them an opportunity to become involved in ongoing work and program activities. These criteria are established in light of the chaotic and sometime frightening experiences inmates endure during the first few weeks of incarceration (Browne et al., 1999).

***Community Sample.*** Two different sub-samples of community women were recruited. One sample group consisted of women who were currently receiving or had received domestic violence or sexual assault services within the twelve months prior to this research interview. The sexual assault and domestic violence services providers in each of these communities agreed to collaborate with the researchers by posting notices of the research in their agencies and by verbally notifying women of the opportunity to participate in the study.

The other sample group was comprised of women who were otherwise residing in the community and who had not received domestic violence or sexual assault services within the prior twelve months. Along with other recruitment strategies, flyers announcing the study and encouraging women to call for information were posted at various locations in the community and advertised in local newspapers. Altogether, these non-incarcerated women were recruited from four communities in this Midwestern state including three urban and one rural community.

Specifically, recruitment strategies included advertising in local newspapers, distributing flyers and receiving referrals directly from the community service providers or from the health, mental health and classification personnel at the WCF. Flyers, printed in both English and Spanish, were placed in all public locations, were checked periodically and replaced as needed. Researchers and interviewers personally visited local agency staff meetings and support groups to better promote the study. In the latter months of the data collection portion of the study, interviewers scheduled regular times to do interviews at local agencies and shelter programs in order to make interviewing more convenient and accessible for the women.

All women from the community sample received a cash incentive of $25 for their participation in the study. At the behest of prison administrators and in accord with the policies of the State Department of Corrections, the researchers were not allowed to provide the incarcerated women participating in the study with a cash incentive. As an alternative, the researchers contracted with a professional located in the Topeka community to facilitate a series of psycho-educational groups for survivors of sexual and/or physical violence (see Appendix B).

The recruitment flyers contained a cell phone number for a locally-based project interviewer. Thus, women interested in participating had a local number they could call to learn more about the study and, if willing, to make an appointment with the interviewer. The interviewers were provided with and trained in the screening protocols for determining potential participants over the phone as well as the protocols necessary to set up convenient and safe locations to meet and complete the survey interview (see Appendix C).

***Qualitative Sample.*** In *Phase Two* of this research, a small sample of the women who completed the *Phase One* interview and who met the sampling criteria were asked if they would be interested in participating in an additional interview during which they would be asked to

expand on their answers from the first interview through the use of open-ended questions and probes. The sampling criteria included women who identified that they had experienced either adult physical IPV or sexual assault AND childhood physical or sexual abuse. The interviewers received additional protocols relating to how to identify participants from Phase One for possible inclusion in Phase Two of the project (see Appendix D). The women who met the criteria for inclusion received a letter outlining the purpose of the second interview and directing them to supply contact information if they were interested in participating (see Appendix E).

If located in the community, the woman was asked to provide confidential and "safe" information about how she could be contacted for a follow-up interview. If incarcerated in the WCF, the woman was asked to sign a form which indicated her desire to be contacted for a follow up interview. Women in the community who agreed to participate in this *Phase Two* interview received $25.00 at the start of the interview process. If, after the purpose, risk and benefits of this research were presented and discussed, a woman declined to provide her consent to participate, she was free to leave the interview setting. Women in the WCF, consistent with Departmental policy, were not given compensation for their participation, but were also free to refuse to participate and withdraw consent, without consequences, at any time prior to and during the interview.

***Data Collection***

The collection of data was completed in two distinct phases. In Phase One, all women recruited from the prison and the community venues were asked to participate in face-to-face interviews. The goal was to recruit at least 200 women from the WCF, at least 200 women from domestic violence and sexual assault service providers in the four communities, and at least 100 women from the general population of all four communities. In the end, the final sample fell

slightly short of this goal, though achieved the proportionality desired with 157 women recruited from the prison, 157 from domestic violence and sexual assault programs, and 109 from the four communities at large.

The face-to-face interviews of the women incarcerated in the WCF were conducted on the prison grounds at regular intervals each month over a twelve-month period. Every interview took place in a private office or meeting room. Interviewing staff were provided with a tour of the WCF and training on safety and security issues prior to their commencing these data collection. More detail regarding the training of interviewers is provided below.

For women in the community, a similar data collection protocol was implemented. Face-to-face interviews were conducted in a mutually agreed upon location which was determined prior to each actual meeting. The criteria for identifying a safe place to meet included the proximity of the location to the participant, the level of comfort in discussing private concerns, and the safety of the participant and the researcher. Locations included offices within agencies or domestic violence shelters; local restaurants; and local public libraries. Permission from the manager of the selected site was secured prior to interviewing. Interviews were not held in the homes of any of the participants in an effort to protect the safety of the participants as well as the researcher. These community interviews were conducted throughout a 12-month period.

One of the goals of this research endeavor was to obtain an ethnically / culturally diverse sample. Special efforts were made to achieve this goal. Two of the communities from which sampling occurred had significant ethnic minority populations, including persons of the African American and Hispanic heritage. Experienced translators translated the recruitment flyers and the survey instrument into Spanish, ensuring that the language of the survey instrument was culturally appropriate and linguistically accurate. Several of the research interviewers were

bilingual and one of the translators reviewed and field tested the final Spanish version of the survey to double check its conformity to the English version.

In *Phase One* of this research, all participants were interviewed on a variety of topics including their physical and emotional health, injuries received from abuse, depression, self-efficacy, alcohol and substance use, suicide attempts, post-traumatic stress, their coping strategies, and the support they received from family, friends, or agencies. Additionally, the respondents were asked about their disclosure experiences, including to whom, when, and how they disclosed their victimization experiences. The interview consisted of closed-ended questions from different scales and measurements, described below (see Appendix F). The average length of time taken to complete an interview was one hour.

In *Phase Two,* if a person met the qualifying criteria, she was asked if she would be interested in participating in an interview with a researcher which was intended to go into more depth about her experiences of victimization and of the resources, social services and supports she may have or have not received subsequent to the victimization(s). Ten women from the prison and seven women who resided and/or received services in one of the urban communities agreed to participate in another face-to-face interview. Given time constraints and an assessment by the Principal Investigators that a certain data saturation level had been reached, once these seventeen participants were identified and interviewed, recruitment for additional *Phase Two* interviews ceased. In order to accurately capture the narrative data, after providing information about the nature of this in-depth interview, every respondent gave her informed consent for both her participation and the tape-recording of the interview. The taped interviewers were later transcribed using the appropriate privacy safeguards and the data were entered into the computer

database, during which time numerical identifiers were substituted for first names and any other identifying information was erased or over-written.

Recognizing that these in-depth interviews might provoke memories of victimization that could result in some emotional discomfort, all of the 17 women participants were warned about this possibility and offered referrals for counseling at the end of the interview. Every woman who initially agreed to participate in the Phase Two interviews and who was subsequently met in person, provided her informed consent and completed the interview.

Participants were interviewed in-depth on several topics related to the quantitative portion of this research (the survey data), in interviews consisting of open-ended questions and probes (see Appendix G). Additionally, the respondents were asked about their disclosure experiences, including to whom, when, and how they disclosed their victimization experiences. The face-to-face interviews of women residing in the WCF took place in a private room provided by the facility. For women in the community, face-to-face interviews were conducted in a mutually agreed upon location determined prior to the actual meeting. The average length of time taken to complete an interview was one and a half hours.

The interviewers for this portion of the study were the co-principal investigators (Judy Postmus and Margaret Severson) and the Project Coordinator (Loretta Pyles), all of the School of Social Welfare, University of Kansas.

***Informed Consent***

Participation in both *Phase One* and *Phase Two* of this research was entirely voluntary and was only conditioned on the participant being 18 years of age or older and, for the incarcerated women, in prison for a minimum of one month. No survey or intake data were

ultimately linked to any identified participant. For those women living in the community, at the time they entered the interview space they were given $25 cash. Prior to the initiation of each interview, every participant was given information, verbally and in writing, detailing the nature, purpose and procedures of the interview and the research as a whole, the risks and benefits involved in participating in it, the steps taken to ensure confidentiality and privacy, and the availability of local services should she have any emotional reaction after the interview ended. Once this information was relayed, the prospective participant was told she could decline to go any further with the process and could keep the $25, and, if she indicated she was willing to proceed with the interview, was asked to sign the informed consent document. A separate informed consent form was used for Phase One and Two of the research; the central difference between them was that the consent form for the in-depth interviews also contained a provision for tape recording the interview. In addition, the women from the community samples were asked to indicate their receipt of the cash incentive prior to the commencement of the interview(s) (see Appendix H.).

Anyone who refused to provide consent was thanked for their time and the meeting was terminated. Women inmates who refused to provide their consent were returned, without comment or negative consequences, to their housing units.

The entire research protocol was evaluated according to the procedures for full Committee review established by the University of Kansas Human Subjects Committee-Lawrence (HSCL)[1] as well as by the Research Review Board at the state's Department of Corrections.

[1] This is the University of Kansas's IRB process

***Pilot project***

Once the survey instrument was developed (described in detail below), a pilot project was conducted in a mid-sized community for the dual purposes of learning more about the research methodology and making necessary changes in the instrument and interview procedures before moving into the actual study. Eight women participated in the pilot study; four women from the local community and four women incarcerated in the WCF. The women from the community were referred to the researchers by a local domestic violence shelter and a local sexual assault service agency, neither of which were located in the four target communities. Lessons learned from the pilot included issues related to interview scheduling, interview location and logistics, as well as methodological issues such as constructs, measures and instruments and the overall flow of the interview. These findings influenced the development of the final instrument, as well as training points for the research interviewers located across the state.

***Interviewers***

The interviewers for this study were recruited from several sources. Four interviewers were members of the graduate and undergraduate student body enrolled in the School of Social Welfare, University of Kansas and at Wichita State University. Other interviewers were recruited based on recommendations from the service providers in the four communities from which the sample was drawn. Once hired, the interviewers participated in a 40-hour training program, developed and implemented by the research team and key members from the state's Coalition Against Sexual and Domestic Violence (KCSDV) (see Appendix I). Using a combination of didactic and experiential learning strategies, the interviewers learned about the topics of sexual and domestic violence and practiced interviewing techniques as well. Each

interviewer was given a copy of the research protocol which clearly outlined the procedures to be used when talking with prospective participants and completing the interviews.

During the course of data collection, the project coordinator provided on-going consultation and supervision throughout the data collection phase. Additionally, two follow-up meetings were held with the interviewers: at the mid-point and at the conclusion of the data collection phase. The purpose of these follow-up meetings was to answer any questions or challenges raised by the interviewers as well as to address any experience of secondary trauma that might have surfaced as a result of the intensity of the material covered in the interviews. The final meeting provided the opportunity to review some initial and preliminary findings and gave the interviewers the chance to discuss their observations and the lessons learned from their participation in this study.

***Phase One Instrumentation: Quantitative Survey***

***Survey and Interview Measures***. The interview questions were developed from a combination of existing and modified standardized instruments and individual questions which largely sought descriptive information (see Appendix F). Prior to implementation, these questions were reviewed by key staff from Department of Corrections and the Coalition on Sexual and Domestic Violence. Further, the entire draft interview was piloted with eight survivors of interpersonal and / or sexual violence who were recruited from the local community and from the WCF.

The following measures were used, in some cases standardized; in others, scales or items were adapted for these specific research questions.

Demographic and Childhood Characteristics: Respondents were asked a series of questions at the end of the interview concerning their current demographic characteristics (age, ethnicity, income, welfare receipt, household composition, urban or rural community, difficulty

living on income, children and their ages). For women in the prison population, many of these economic and household questions were asked in terms of the 12 months prior to their incarceration. The entire sample was also asked a few questions about their demographic characteristics in childhood (household composition, urban or rural neighborhood, difficulty for family in living on income).

Risk Factor - Child Maltreatment: Sexual, physical, and emotional abuse during childhood and adolescence was measured using the Childhood Maltreatment Interview Schedule developed by Briere (1992). While there are no known studies on overall reliability or validity, the use of this measure in pilot studies suggests predictive and construct validity (Briere, 1992). Given cautions about the use of this instrument in a summary fashion for research purposes (Briere, 1992), this analysis therefore used three summary questions from the Briere instrument, "To the best of your knowledge, before age 17, were you ever sexually assaulted…physically assaulted?" Each of these questions produced a yes or no answer, or a value of 0 (no) or 1 (yes). In addition, participants were asked "How severe would you say the (physical) abuse was?" and answered on a 10-point scale, with 10 indicating the most severity ("an emergency").

Risk Factor - Interpersonal Violence: Interpersonal violence, including physical, sexual, and psychological abuse from an intimate partner, was measured using the Abusive Behavior Inventory (ABI) developed by Shepard and Campbell (1992). This inventory is a reliable measure with alpha coefficients ranging from .7 to .92. Additionally, the inventory has good criterion-related and construct validity (Shepard & Campbell, 1992).

For purposes of this study, three separate scores of intimate partner violence were calculated. Psychological IPV is the mean score of 20 of the 30 items on the ABI having to do with psychological forms of control and humiliation. Physical IPV is the mean score of the

remaining 10 items on the ABI having to do with physical forms of abuse. In addition, a Total IPV score was calculated as the mean of all 30 items. All summary scores were calibrated to range between 0 and 1. The alpha coefficient for the overall IPV scale in this sample is .97; for Physical IPV, the alpha coefficient is .92; for Psychological IPV, the coefficient is .96.

Based on the responses given by the women from all three sample groups, it was decided to use the Physical IPV score in all of the analyses calling for IPV. This decision was statistically based on showing variance between the sample groups and does not reflect the reality that psychological IPV impacts women's lives.

It is important to note that the ABI does not reference a time frame during which women are asked to report their experience of abusive behaviors nor does it ask for the number of intimate partners who demonstrated these behaviors. Instead, women are asked "How often has an intimate partner done the following…?" Thus, the rate of victimization reported may relate to a single partner or multiple intimate partners and may or may not reflect abuse experiences that occurred over any period of time.

Risk Factor - Sexual Assault: Sexual assault in adulthood, by an intimate partner, family member, or stranger was measured using the Sexual Experiences Survey (SES) developed by Koss and Oros (1982). This survey was developed to reflect the large number of unreported incidences of rape and sexual assault; data suggest that rape is often underreported (Koss & Oros, 1982).

For analytical purposes, this study created four summary scores of sexual assault from the Sexual Experiences Survey: sexual coercion, a mean score of four items (#3, 4, 5, and 6); attempted rape, a mean score of 2 items (#8 and 9); rape, a mean score of four items (#10, 11, 12 and 13); and total sexual assault, a mean score of the 10 items above. All summary scores were

calibrated to range between 0 and 1. The alpha coefficient for internal consistency in the current study is .90, indicating high internal consistency in this sample.

Based on the prevalence data which emerged from all three sample groups, in order to maximize the potential of being able to show statistical significance in at least some of the findings, the decision was made to use the rape score in all of the analyses calling for sexual assault data. This strategic decision allowed for the showing of variance between the sample groups, and consequently yielded important information that relates to the original research questions. We emphasize that this decision was not in any way intended to reflect on or diminish the impact of the experience of sexual coercion or attempted rape.

Similar to the ABI, the Sexual Experiences Survey (SES) does not capture the time period during which these experiences occurred nor does it seek information regarding the total number of perpetrators involved. Additionally, the SES queries about women's sexual experiences with anyone, including intimate partners, acquaintances, and strangers. Finally, the SES does not place a time frame around the specific experiences. While the questions about victimization experiences were asked in chronological order, starting with childhood physical and then sexual victimization, moving to adult IPV and sexual assault, the SES asks women, "Have you ever had the following experiences?" Thus, in response, women may have reported sexual victimization experiences from adulthood, adolescence, or childhood.

Mediating Factors – Disclosure and Response to Disclosure: Disclosure about one's victimization was investigated from adapted questions from previous surveys incorporated by the co-principal investigators. There are no known studies on the overall reliability or validity of the questions; however, many of these questions are adapted from a study conducted with adult

women in the community who have experienced several different forms of physical and sexual abuse as children or adults (McNutt et al., 2002).

The Response To Disclosure questions consist of 20 items. The questionnaire asks whether women experienced three different forms of abuse prior to age 17: physical abuse, sexual touching or kissing, and genital sexual abuse and two different forms of assault in adulthood: sexual assault and intimate partner violence. If any of these were answered as yes, participants were asked a series of questions about the disclosure of the experience: Did they tell anyone? Who did they tell? Within what time frame? Did that person believe them? Was the perpetrator confronted? Was the incident investigated? Was the incident reported to one of the following: police, child protective services, or doctor/hospital. Was the perpetrator arrested? Did the perpetrator serve any time?

Three summary variables were created to capture the disclosure experiences and the aftermath of those disclosures. The first variable concerns disclosure. Because a woman could experience or not experience each of the types of victimization (child physical abuse, child sexual abuse, adult physical intimate partner violence, and adult rape), and then disclose or not disclose each of those experiences, there was not one simple answer to the question, "Did you tell anyone?" Instead, a summary variable was computed by counting the number of her disclosures as a percentage of the number of victimizations she experienced. Therefore, the possible values of the summary disclosure variable range from 0% to 100%.

A second variable was created to reflect to what extent the perpetrator(s) of the violence was confronted following the four types of violence listed above. A summary variable of perpetrator confrontation was computed by counting the number of times that she reported that the perpetrator was confronted as a percentage of the number of types of victimization she

experienced. Therefore, the possible values of the summary variable about whether the perpetrator(s) was confronted ranged from 0% to 100%.

Finally, a third summary variable about the aftermath of disclosure concerns whether and how often there was a police investigation following the violence. The summary variable for police investigation was calculated by counting the number of times there was a police investigation as a percentage of the number of victimizations she experienced. Therefore, the possible values of this summary variable range from 0% to 100% of victimizations.

Mediating Factor - Social Support: Perceived support from family and friends was measured with the Social Support Appraisals Scale developed by Vaux and colleagues (1986). This scale has good internal consistency with alpha ranges from .81 to .90. It also has good concurrent, predictive, known-groups, and construct validity; it also correlates in predicted ways with several other measures of social support (Vaux et al., 1986).

For each item on the Social Support Appraisal Scale, the participant indicates on a four-point scale whether she strongly agrees, agrees, disagrees, or strongly disagrees with each relational statement about herself. All items on the Social Support Appraisals Scale were scored or reverse-scored into negative numbers, so that the more negative the number, the less support on each of 23 items. These 23 items were then summed and calibrated to produce a Social Support score that ranged from -100 to 0, with a higher score indicating a greater level of social support. The alpha coefficient for this study sample is .93.

Mediating Factor - Support from Agencies: Support from agencies included any support received from health, mental health, or community agencies. Support from agencies was measured using revised questions from the National Comorbidity Survey, implemented in 1992 as a nationally representative survey that assesses the prevalence and correlates of DSM-IIIR

diagnoses (NCS, 1992). There are no known studies on the overall reliability or validity; however, many of these questions are adapted from a study conducted with adult women in the community who have experienced several different forms of physical and sexual abuse as children or adults (McNutt et al., 2002).

For analysis in this study, each support item was rated as a 0 (no, did not receive this support ) or 1 (did receive this support). There are a total of 24 possible support services; the items were then summed to produce a summary service score between 0 and 24 for each participant. This does not reflect that she may have used one service 24 times; rather it reflects how many different supportive services she may have received in the past for abuse as an adult or as a child.

These 24 services were sorted into three categories of support: <u>therapeutic</u> (6 services), <u>crisis intervention</u> (6 services), and <u>long term tangible support</u> (12 services). The services fitting these categories are itemized in the results section.

Respondents were also asked how helpful they found each service, on a 1 to 5 scale, for each service that they had indeed accessed. To provide an overall measure of service helpfulness, these ratings were summed and divided by the number of services the person used, resulting in a average helpfulness rating of between 1 and 5 for each respondent.

Respondents were also asked to choose from a list of 15 possible barriers to seeking services or support following victimization, and were asked to indicate for each item whether it was true for her. These responses were summed into one variable that is a count of how many barriers she identified.

<u>Mediating Factor - Coping:</u> The *Brief-Cope Scale* is a 28-item theory-based instrument designed to assess a variety of coping reactions/strategies in response to stress. Alpha

reliabilities range from .50 to .90 (Carver, 1997). It is important to caution that this scale was developed and refined with persons living freely, not incarcerated, and has seldom been used in studies of incarcerated women. As a result, behaviors that may be consider maladaptive when one freely can make choices, may actually be adaptive in a prison setting.

For each item on the *Brief-Cope Scale*, the participant rates how often she uses a particular coping strategy on a four-point scale (1=I haven't been doing this at all; 2=I've been doing this a little bit; 3=I've been doing this a medium amount; 4=I've been doing this a lot). The 28 items on the *Brief-Cope Scale* were divided into two groups; adaptive coping behaviors and maladaptive coping behaviors. For the Adaptive Coping score, the participant's responses to 16 items were summed and calibrated, with a final adaptive coping score of between 0 and 100. The higher the score, the higher the adaptive coping.

Similarly, for the Maladaptive Coping score, the participant's answers to 12 items were summed and calibrated, with a final maladaptive coping score of between 0 and 100. The higher the score, the higher the maladaptive coping. The alpha coefficients in this study are .81 for adaptive coping and .68 for maladaptive coping.

Mediating Factor - Self-Efficacy: Self-efficacy was measured using the Self-Efficacy Scale developed by Sherer and colleagues (1982). The scale measures the general levels of belief in one's own competence (Sherer, et al, 1982; p. 525). There are thirty questions. Seven items are filler items and are not scored. Certain items are reverse-scored to avoid a response set. After reverse scoring, 23 items were summed and calibrated to result in a score between 0 and 100, with a higher score indicating high self-efficacy.

The scale has fairly good internal consistency with a reported alpha score of .86. The scale has shown good criterion-related and construct validity (Sherer et al., 1982). The alpha coefficient for self-efficacy in this sample is .87.

Adult Outcome - Health Symptoms: Health symptoms were measured using the Short-Form-36 Health Survey, an abbreviated version of the Rand Medical Outcomes Study. The survey covers physical, social, and mental health functioning as well as pain and health perceptions. Internal consistency coefficients range from .81 to .88 with an alpha reliability of .76 and .67 (Stewart, Hays, & Wate, 1988).

For purposes of this study, the Health Survey was divided into two subscales: Physical Health and Mental Health. The Physical Health scale consists of 25 items on the Health 36 Survey. Certain items were reverse scored so that a higher score indicates better physical health. The resulting score of the 25 items was calibrated to a 100-point scale. The Mental Health scale consists of 19 items from the Health 36 Survey, with reverse scoring of certain items so that a higher score indicated higher mental health. There were eight items that were included in both the physical and mental health scales (general health, feel worn down, tired, sick, full of pep, as healthy as anybody I know, expect my health to get worse, and health is excellent). Finally, a summary score of all 36 items was calculated to indicate a level of general health. All three Health Scores were calibrated to a 100-point scale, with higher scores indicating better reported health. The alpha coefficient for Physical Health in this sample is .93; for mental health, it is .79.

Adult Outcome - Depression: Depression was measured using the Center for Epidemiological Studies Depression Scale (CES-D) developed by the National Institute of Mental Health. This commonly used scale has good internal consistency with alpha scores of .85 for the general population and .90 for psychiatric populations. The scale also has excellent

concurrent validity; it correlates well with a number of other depression and mood scales. Finally, CES-D has good known-groups validity and has fair stability with test-retest correlations (Frazier, 1977).

The scale consists of 20 items answered on a four-point scale. After reverse scoring certain items, items were summed and calibrated to result in respondent scores between 0 and 100, with higher scores indicating higher levels of depression. The alpha coefficient for depression in this sample is .91.

Adult Outcome –Post-Traumatic Stress Disorder: Trauma history was measured using revised questions from the National Comorbidity Survey, implemented in 1992 as a nationally representative survey that assesses the prevalence and correlates of DSM-IIIR diagnoses (NCS, 1992). There were a total of nine questions related to post-traumatic stress, with four answer choices of "never, occasionally, fairly often and very often." Respondents' answers were summed and calibrated to result in a PTSD score between 0 and 100. The alpha coefficient for this scale in this sample is .90.

Adult Outcomes - Suicide Attempts and Substance Abuse: Questions about the range of topics listed were measured using revised questions from the National Comorbidity Survey, implemented in 1992 as a nationally representative survey that assesses the prevalence and correlates of DSM-IIIR diagnoses (NCS, 1992). This Survey produced three primary outcome variables for this study: Have you attempted suicide in the past twelve months/ (yes/no), Do you believe you have an alcohol problem? (yes/no) and Do you believe you have a drug problem (yes/no). Each of these questions was scored as 0=no and 1=yes.

***Phase Two Instrumentation: Qualitative Interview***

For the qualitative portion of this study, plans were made for a total of 20 women to be recruited to participate in these interviews – 10 from the WCF and 10 from the community and from community agencies located in one of the urban communities. In the end, 17 women were interviewed; 10 from the WCF and 7 from the urban community. These women were asked to consent to an in-depth face-to-face interview which focused on further identifying the differential risk and protective factors related to their histories of physical and sexual victimization.

In interviews consisting of open-ended questions and probes, participants were interviewed in-depth on several topics related to the quantitative portion of this research (the survey data) (see Appendix G). Additionally, the respondents were asked about their disclosure experiences, including to whom, when, and how they disclosed their victimization experiences and if they received services as a result of their victimization. Finally, participants were asked about their overall impressions on how their victimization and disclosure experiences impacted their physical and mental health.

***Staff / Research Management Plan***

In addition to the two principal investigators for this research endeavor, both of whom participated in the development of the final quantitative and qualitative instruments, data collection, and data analyses, a project coordinator, Loretta Pyles, a PhD student in the University of Kansas, School of Social Welfare, acting under the direction of the principal investigators, assumed the following responsibilities: (a) served as the liaison between the correctional institution, the agencies offering services for victims of sexual and other forms of violence, and the principal investigators, particularly as initial sampling occurs; (b) coordinated the activities of the personnel assigned to administer the surveys to the research subjects; (c)

participated and managed the administration of the interviews; (d) coordinated and participated in data input activities; (e) participated in the data analysis, and (f) assumed other assigned responsibilities as deemed appropriate to the research endeavor. An additional person, Eliticia Vieyra, a BSW student with bilingual skills, was hired to do the data entry and assist with the validation of the translated materials.

When Ms. Pyles completed her Doctorate in May, 2005, she left the project. At that time Kim Bruns, Staff Project Coordinator (on other projects) for Professor Severson was hired to assist with the development of the final report to the NIJ.

The data management and analysis tasks for this grant were extensive given the volume of data as well as the varying types of data. Dr. Marianne Berry, Ph.D., a well-known researcher in the field of child maltreatment, acted as a consultant on this research. Her involvement and contributions informed the research design and supported, through the completion of the data analysis, the efforts to explore and ultimately explain the life trajectories of victims as they move from childhood into their adult years.

## *V. ANALYSES & RESULTS*

### *Data Management*

To protect confidentiality, all quantitative data were entered into a computer database using an assigned unique identifier. Paper copies of all of the signed informed consent forms have been stored in a locked file cabinet with only principal investigator and research staff access. The completed survey instruments, with no identifying information, have been stored in a secure room within the School of Social Welfare. SPSS® for Windows Base 10.0 statistical software was used for data input, cleaning, and subsequent analyses. All qualitative data (audiotapes of interviews and notes taken during observations and encounters) were entered into text data using first a word processing program and then downloaded into Atlas$^{ti}$ qualitative software. This software facilitated coding, management and retrieval of the test data during analyses.

### *Data Analytic Strategy*

***Phase One.*** The initial strategy for all quantitative data included descriptive parametric and nonparametric analyses (frequencies, standard deviations, proportional testing, chi-square and phi coefficients, and t-tests as appropriate) to allow assessment of endorsement patterns for all measures first as total survey sample, then by the three sub-samples and other breakdowns as appropriate to explicating specific patterns of responses. Internal consistencies of all screening scales and measures were calculated (Cronbach's alpha), as discussed in the Method section of this report. A series of linear multiple regression analyses were performed to predict variables identified in the model schematic including victimization and disclosure experiences, mediating factors, service usage, and adult outcomes. A final hierarchical logistic regression analysis was

also conducted to test the ability of independent variables in the model to discriminate between incarcerated and non-incarcerated women, based on their characteristics and histories.

***Phase Two*.** Qualitative analyses used basic a priori codes based on the questions asked during the interviews. In-depth analysis of these data for emerging codes was completed after all of the interviews were completed. After analyzing several transcripts, the emergent codes were condensed into 4 family groups or categories related to the questions asked. The remaining transcripts were then analyzed using those 4 family groups.

The goal of sampling in qualitative methodology is "sample until saturation or redundancy," i.e. sample until no new information is revealed (Strauss & Corbin, 1998). This saturation period came earlier than planned in the second phase of this research, thus negating the need for the full 20 interviews originally proposed.

***Description of the Samples***

***Total Study Population.*** During *Phase One* of the data collection period, which spanned a total of thirteen months (March 1, 2004 through March 31, 2005), there were 432 women interviewed. Nine of these surveys were excluded from the final study population due to their containing considerable missing information. In total, there were 423 interviews used for analysis.

Table 1 below shows certain demographic characteristics of this sample population. The reader is reminded that, when a particular time period was asked for in the demographic or historical question, the incarcerated women were asked to respond in the context of their lives prior to their incarceration. For example, when asked "In the prior twelve months … who else was living with you?", incarcerated women were directed to consider that question in the context of the 12 months prior to their incarceration. Overall, 87 percent of the study population is

between ages 21 and 50, with the largest cluster of participants in every sample found in the 31-40 age range. There is good representation of women age 51 years and older, particularly from the community sample. A significant number of the participants report living with a "male partner" and / or "parents" in the 12 months prior to the interview or their incarceration, and having teenage children (ages 13-18).

Table 1: **Demographic Characteristics of Sample**

| | **Total (n=423)** | **Communities (n= 109)** | **DV / SA Agencies (n=157** | **Prison (n= 157)** |
|---|---|---|---|---|
| **Age of participant** | | | | |
| 18-20 years of age | 4.0% | 9.3% | 3.8% | .6% |
| 21-30 years of age | 28.3 | 23.2 | 30.7 | 29.3 |
| 31-40 years of age | 36.2 | 27.8 | 34.1 | 44.1 |
| 41-50 years of age | 22.3 | 16.7 | 26.3 | 22.3 |
| 51 years and older ** | 9.2 | 23.0 | 5.1 | 3.7 |
| **Highest grade completed** | | | | |
| Grade School 1-8 | 5.8 | 6.4 | 4.5 | 6.4 |
| High School 9-12 | 52.1 | 38.7 | 47.3 | 66.6 |
| College 13-16 | 39.5 | 51.3 | 43.8 | 27.0 |
| Graduate School | 2.6 | 3.6 | 4.4 | 0 |
| **In the prior 12 months, (a) aside from yourself, who else was living in your home? (mult. response)** | | | | |
| Male Partner ** | 28.6 | 11.9 | 38.9 | 29.9 |
| Husband | 27.0 | 29.4 | 21.7 | 30.6 |
| Own Children | 52.5 | 59.6 | 54.1 | 45.9 |
| Partner's Children | 4.5 | 2.8 | 6.4 | 3.8 |
| Female Partner | 3.5 | 2.8 | 1.9 | 5.7 |
| One or More Roommates | 9.0 | 5.5 | 7.6 | 12.7 |
| Parents * | 11.8 | 7.3 | 8.9 | 17.0 |
| Relatives | 10.9 | 16.5 | 9.6 | 8.3 |
| I lived alone | 9.2 | 11.9 | 10.2 | 6.4 |
| **Do you have any children? *** | | | | |
| Yes | 81.1 | 78.9 | 75.8 | 87.9 |
| No | 18.9 | 21.1 | 24.2 | 12.1 |
| **Have children:** | | | | |
| Less than 5 yrs. old | 26.2 | 29.4 | 30.6 | 19.7 |
| Between 5 and 12 yrs. old | 42.8 | 35.8 | 38.9 | 51.6 |
| Between 13-17 yrs. old ** | 31.0 | 24.8 | 21.0 | 45.2 |
| 18 years of age and older | 30.7 | 32.1 | 25.5 | 35.0 |

(a) For prison population, for the 12 months prior to incarceration
* Difference between the three groups significant at .01 level
**Difference between the three groups significant at .001 level

Table 2 below outlines the economic situation of the women who participated in this research. There are several important findings here. First, significantly more imprisoned women applied for and / or received welfare in the 12 months prior to their incarceration. At the same time, women receiving services in the communities report having the lowest income during the prior 12 month period. It is important to bear in mind that some of the women interviewed at the WCF may have and indeed were likely to have been incarcerated for fewer than 12 months, so that the time frames are not equal between the three sample groups. That more incarcerated women than non-incarcerated women report having the highest incomes in the prior 12 months is not surprising. Many report having been involved in money-making activities that ultimately lead, directly or indirectly, to their incarceration. The data reveal that women receiving services in the community have the most difficulty living on their income.

Table 2: **Current Economic Circumstances of Sample**

| | **Total (n=423)** | **Communities (n= 109)** | **DV / SA Agencies (n=157)** | **Prison (n= 157)** |
|---|---|---|---|---|
| **Have you ever applied for welfare? *Yes* **** | 75.7% | 60.6% | 78.3% | 83.4% |
| **Have you ever received welfare? *Yes* **** | 69.7 | 56 | 68.8 | 80.1 |
| **Average Annual Income (past 12 months) *** | | | | |
| $0-$10,000 | 51.3 | 42.1 | 59.4 | 49.6 |
| $10,001-$15,000 | 13.4 | 10.3 | 17.4 | 11.5 |
| $15,001-$25,000 | 17.6 | 25.2 | 13.5 | 16.6 |
| $25,001-$35,000 | 8.4 | 12.1 | 5.2 | 8.9 |
| Over $35,000 | 9.3 | 10.3 | 4.5 | 13.4 |
| **How difficult was it to live on your household income in the past 12 months? (a) **** | | | | |
| Not at all difficult | 16.1 | 12.0 | 5.1 | 29.9 |
| A little difficult | 16.6 | 23.1 | 12.7 | 15.9 |
| Somewhat difficult | 22.1 | 23.2 | 26.2 | 17.2 |
| Very difficult | 22.7 | 20.4 | 26.1 | 21.1 |
| Extremely difficult | 22.5 | 21.3 | 29.9 | 15.9 |
| **Have you ever owned your own home? *Yes* *** | 35.4 | 46.8 | 28.2 | 34.6 |

(a) For prison population, for the 12 months prior to incarceration
* Difference between the three groups significant at .01 level
**Difference between the three groups significant at .001 level

Participants were asked about their childhood living circumstances, including family composition, family income, perceived socioeconomic status and environment. Table 3 presents these data. As is apparent, a significantly greater number of the WCF sample report spending their childhoods with fewer than both parents, and in more rural areas. In contrast, women receiving services from domestic violence and / or sexual assault agencies are more likely to have spent their childhoods in or near large cities.

Table 3: **Childhood Household and Economic Circumstances of Sample**

| | **Total (n=423)** | **Communities (n= 109)** | **DV / SA Agencies (n=157)** | **Prison (n= 157)** |
|---|---|---|---|---|
| **Lived with both parents **** | 47.8% | 59.6% | 52.2% | 35.0% |
| **How would you describe your childhood community? *** | | | | |
| Country | 9.0 | 6.4 | 9.6 | 10.2 |
| Small Town | 26.5 | 33.9 | 19.1 | 28.7 |
| Medium Sized Town | 23.9 | 19.3 | 20.4 | 30.6 |
| Suburb | 14.4 | 11.0 | 18.5 | 12.7 |
| Large City | 26.2 | 29.4 | 32.4 | 17.8 |
| **How would you describe your family's economic situation while you were growing up?** | | | | |
| Poor | 18.1 | 25.9 | 19.7 | 10.9 |
| Working Class | 26.6 | 27.8 | 25.6 | 26.9 |
| Middle Class | 36.8 | 32.4 | 36.9 | 39.8 |
| Upper-Middle Class | 17.3 | 13.0 | 15.9 | 21.8 |
| Upper Class | 1.2 | .9 | 1.9 | .6 |
| **How difficult was it for your family to live on this income?** | | | | |
| Not at all difficult | 25.4 | 16.7 | 24.4 | 32.3 |
| A little difficult | 29.8 | 31.5 | 28.2 | 30.3 |
| Somewhat difficult | 22.9 | 24.1 | 24.3 | 20.6 |
| Very difficult | 14.3 | 19.4 | 12.8 | 12.3 |
| Extremely difficult | 7.6 | 8.3 | 10.3 | 4.5 |

* Difference between the three groups significant at .01 level
**Difference between the three groups significant at .001 level

Table 4 shows the arrest rates reported by all of the study participants. There are no significant differences between the study sub-samples, even though one of the populations under study was already incarcerated when asked this question. As a whole, almost 68 percent of the

study population report having been arrested sometime in their lives, though they were not asked to differentiate these arrests by type (crime) or category (felony, misdemeanor) of charges. One woman in the prison sample said she had not been arrested, and in the interest of accurately reflecting women's perceptions, her response was not "corrected" in the database.

Table 4: **Arrest Rates of Sample**

| | **Total (n=422)** | **Communities (n= 109)** | **DV / SA Agencies (n=157)** | **Prison (n= 157)** |
|---|---|---|---|---|
| **Been Arrested? *Yes*** | 67.5% | 34.9% | 58.3% | 99.4% |

The researchers sought a diverse study sample and indeed the participants reflect cultural, ethnic and racial diversity. Participants were asked the question "What racial or ethnic group do you consider yourself to be a member of?" and given as response options, the specific categories reflected in Table 5, below, which show ethnic and racial minorities are represented in each sub-sample. Overall, 56 percent of the sample is White; the remaining 44 percent are of another ethnic type. Nearly equal percentages of Black / African American participants are found in each sub-sample. There are a significant number of persons of Hispanic / Latina descent in the community sample.

Table 5: **Ethnicity by Community**

| | **Total (n=423)** | **Communities (n= 109)** | **DV / SA Agencies (n=157)** | **Prison (n= 157)** |
|---|---|---|---|---|
| **Race/Ethnicity **** | | | | |
| White | 55.6% | 39.4% | 64.3% | 58.0% |
| Black/African American | 25.1 | 24.8 | 22.9 | 27.4 |
| Hispanic/Latina | 12.8 | 31.2 | 7.0 | 5.7 |
| American Indian | 2.7 | 2.8 | 1.3 | 4.5 |
| Other | 2.4 | 1.8 | 2.6 | 2.5 |
| Asian/Pacific Islander | 1.4 | 0 | 1.9 | 1.9 |

* Difference between the three groups significant at .01 level
**Difference between the three groups significant at .001 level

***Results of Research Questions***

This study employed multiple levels of data analysis, in order to answer the five (5) research questions. Below, each of the research questions is presented, followed by the results of the research.

(1) *What is the prevalence and co-occurrence rate of intimate partner violence, sexual violence and youth maltreatment for three different samples of women in one Midwestern state? (These samples include (i.) women from urban and rural communities who have not received domestic violence or sexual assault services in the prior 12 months); (ii.) women receiving services or who have received services in the prior 12 months for domestic violence or sexual assault (sometimes referred to in this report as "agency women"); and (iii.) incarcerated women)?*

Descriptive statistics were generated to determine the extent to which the three groups of women in one Midwestern state have been victims of IPV, sexual violence and child maltreatment (See Table 6).

Table 6: **Prevalence of Victimization**

| | **Total (n=423)** | **Communities (n= 109)** | **DV / SA Agencies (n=157)** | **Prison (n= 157)** |
|---|---|---|---|---|
| **Physically Abused as a Child** | 51.6% | 41.5% | 56.1% | 53.9% |
| **Sexually Abused as a Child *** | 59.3 | 47.2 | 58.7 | 68.2 |
| **Physical IPV **** | 91.5 | 78.0 | 96.8 | 95.5 |
| **Rape *** | 67.4 | 55.1 | 70.6 | 72.6 |

* Difference between the three groups significant at .01 level
**Difference between the three groups significant at .001 level

With the exception of childhood physical abuse, for each type of victimization there are significant differences between the three groups of women. Women in prison, followed by

women seeking services, are more likely to have experienced childhood sexual abuse and rape than are women from the community. Women from the agencies are more likely to report having experienced physical IPV than are women in prison and those from the communities.

All three sample groups report high levels of childhood and adult victimization. For example, almost 97 percent of women from the agencies, 96 percent from prison, and 78 percent of women from the communities report experiencing some form of physical Intimate Partner Violence. Physical IPV is also reported more frequently than other forms of victimization for all three sample groups. As with most other studies on violence against adult women, this study used detailed questions that outlined specific forms and types of violence; hence, the more detailed and specific the questions used, the higher rates of victimization (Browne et al., 1999).

Co-occurrence of types of victimization is also common in the three sample groups (see Table 7). Statistical significance levels are not reported, due to multiple responses.

Table 7: **Co-Occurrence of Types of Victimization**

| | **Total (n=423)** | **Communities (n=109)** | **DV/SA Agencies (n=157)** | **Prison (n=157)** |
|---|---|---|---|---|
| **Child Abuse** | | | | |
| No child abuse experienced | 31.8% | 42.5% | 30.3% | 26.0% |
| Physical abuse only | 8.9 | 10.4 | 11.0 | 5.8 |
| Sexual abuse only | 16.6 | 16.0 | 13.5 | 20.1 |
| Both physical and sexual abuse | 42.7 | 31.0 | 45.2 | 48.1 |
| **Physical IPV and Rape** | | | | |
| None | 5.5% | 15.0% | 2.0% | 2.5% |
| Physical IPV only | 27.1 | 29.9 | 27.5 | 24.8 |
| Rape only | 2.9 | 6.5 | 1.3 | 1.9 |
| Both Physical IPV and Rape | 64.5 | 48.6 | 69.3 | 70.7 |
| **Child and Adult Victimization** | | | | |
| (multiple response) | | | | |
| Child sex abuse/Phys IPV | 56.1% | 39.6% | 58.1% | 65.6% |
| Child sex abuse/Rape | 51.3 | 38.5 | 53.6 | 57.8 |
| Child phys. abuse/Phys IPV | 50.4 | 39.6 | 55.5 | 52.6 |
| Child phys. abuse/Rape | 42.8 | 33.7 | 47.7 | 46.8 |

More women in this study have experienced both physical and sexual child abuse than either type of abuse individually. Additionally, 65 percent of women report having experienced both physical IPV and rape; however, women report physical IPV more often than rape alone. When comparing the number of reports of childhood and adult victimization, over 56 percent of the total sample report experiencing both childhood sexual abuse and physical IPV.

Table 8 provides information regarding the number of victimization experiences the women report, by sample group.

Table 8: **Number of Victimization Experiences (a)**

| | **Total (n=423)** | **Communities (n= 109)** | **DV / SA Agencies (n=157)** | **Prison (n= 157)** |
|---|---|---|---|---|
| **Number of Victim Experiences**** | | | | |
| 0 experiences | 4.7% | 12.8% | 1.9% | 1.9% |
| 1 experience | 17.5 | 22.9 | 18.6 | 12.7 |
| 2 experiences | 20.9 | 22.9 | 17.3 | 22.9 |
| 3 experiences | 19.7 | 15.6 | 21.8 | 20.4 |
| 4 experiences | 37.2 | 25.8 | 40.4 | 42.0 |
| **Mean # of Experiences** (0 to 4)** | 2.7 | 2.2 | 2.8 | 2.9 |

(a) Four possible victimization experiences (physical child abuse, sexual child abuse, adult physical IPV, adult rape)
* Difference between the three groups significant at .01 level
**Difference between the three groups significant at .001 level

As the results detail, there are significant differences between the three sample groups on the cumulative number of types of victimizations experienced. Almost 13 percent of the community sample report having no victimization experiences compared to only two percent (2%) of each of the agency and prison samples. Over 37 percent of the total sample report experiencing all four types of victimizations - physical child abuse, sexual child abuse, physical IPV and rape. Additionally, the mean number of experiences is also significantly different between the three sample groups with the women from prison reporting a mean number of 2.9

victimization experiences, followed closely by the agency population with a mean number of 2.8 victimization experiences.

Table 9 describes the prevalence of victimization based on ethnicity. There are no significant differences on reports of physical and or sexual childhood abuse between the ethnic groups. However, there are significant differences between ethnic groups regarding the experience of physical IPV. Over 95 percent of White women in this study report having experienced physical IPV; 91 percent of African-American participants and 74 percent of Latina women do the same. Women from all three ethnic groups report high prevalence rates of rape; there are no significant differences between the groups on this measure.

Table 9: **Prevalence of Victimization by Ethnicity**

| | **Total Population n=423** | **White (n=235)** | **African American (n=106)** | **Latina (n=54)** |
|---|---|---|---|---|
| **Child Physical Abuse** | 51.6% | 54.1% | 45.6% | 43.1% |
| **Child Sexual Abuse** | 59.3 | 60.9 | 56.3 | 45.1 |
| **Physical IPV **** | 91.5 | 95.3 | 90.6 | 74.1 |
| **Rape** | 67.4 | 70.5 | 63.8 | 54.0 |

* Difference between the six groups significant at .01 level
**Difference between the six groups significant at .001 level

***Childhood Victimization – Physical.*** As noted above, there are no significant differences found among the three groups of women regarding their reported experiences of child physical abuse (See Table 6 above), however, over half of the agency (56.1%) and prison samples (53.9%) and over 41 percent of the community sample report experiencing physical abuse as children.

Additional information relating to the experience of childhood physical abuse yields details about the average age when the abuse first occurred, the identities of the perpetrators, and the severity and frequency of the abuse experiences. The frequencies reported in Table 10, indicate that the average age when the physical abuse first occurred was seven. More often than

not, the perpetrator was usually a parent – father or mother, including a biological, adoptive, step, or foster parent. All of the study participants were asked to describe the severity of the physical abuse by rating it on a scale from 1 (not severe) to 10 (emergency room visit). The mean severity score was 6.11 (some more injuries) with the community and agency samples scoring slightly below the mean (5.78 and 5.94, respectively) and the prison sample scoring slightly above the mean at 6.52.

All of the women report relatively high frequencies in the occurrence of physical abuse. The women in the WCF report experiencing physical abuse in childhood at frequencies ranging from every day to a couple of incidences a week. The women from the community and agencies samples report that childhood physical abuse occurred at a rate of either a couple of times a week or a couple of times a month.

Table 10: **Immediate Sequelae of Child Physical Abuse**

| | **Total (n=423)** | **Communities (n= 109)** | **DV / SA Agencies (n=157)** | **Prison (n= 157)** |
|---|---|---|---|---|
| **Before age 17, an adult did something on purpose that made you bleed, have bruises or scratches or broken bones/teeth: Yes** | 45.5% | 37.0% | 52.9% | 43.9% |
| | **Total (n=192)** | **Communities (n= 40)** | **DV / SA Agencies (n=83)** | **Prison (n= 69)** |
| **Mean age when first abused** | 7.03 | 7.24 | 6.87 | 7.09 |
| **Who did this?** | | | | |
| Father/Adoptive/Step/Foster | 37.5% | 37.5% | 30.1% | 46.4% |
| Mother/Adoptive/Step/Foster | 34.9 | 32.5 | 37.3 | 33.3 |
| Both parents | 7.8 | 2.5 | 12.0 | 2.9 |
| Sibling | 5.2 | 10 | 4.8 | 0.0 |
| Unspecified parent | 3.7 | 0.5 | 1.2 | 5.8 |
| Friend of the family | 3.6 | 10 | 7.2 | 1.4 |
| Other relative | 3.1 | 0.3 | 1.2 | 5.8 |
| Uncle | 2.6 | 0.0 | 1.2 | 4.3 |
| Aunt | 1.6 | 0.3 | 2.4 | 0.0 |
| **How severe was the abuse?** | | | | |
| Not severe | 3.6% | 7.5% | 2.4% | 2.9% |
| A little severe | 6.8 | 10.0 | 4.8 | 7.2 |
| Somewhat severe | 7.3 | 5.0 | 10.8 | 4.3 |
| More severe | 10.9 | 12.5 | 13.3 | 7.2 |
| Some injuries | 15.1 | 22.5 | 16.9 | 8.7 |
| Some more injuries | 13.5 | 5.0 | 15.7 | 15.9 |
| Very Severe | 8.3 | 0.0 | 4.8 | 17.4 |
| Many injuries | 12.5 | 12.5 | 12.0 | 13.0 |
| Extremely severe injuries | 5.2 | 7.5 | 4.8 | 4.3 |
| Emergency room visit | 16.7 | 17.5 | 14.5 | 18.8 |
| **Mean Severity Score (0 to 10)** | 6.11 | 5.78 | 5.94 | 6.52 |
| **How often did this happen?** | | | | |
| Everyday | 19.8% | 12.5% | 13.3% | 31.9% |
| Couple of times a week | 31.8 | 25.0 | 37.3 | 29.0 |
| Couple of times a month | 19.3 | 25.0 | 20.5 | 14.5 |
| Couple of times a year | 12.0 | 20.0 | 10.8 | 8.7 |
| Once or twice | 14.6 | 12.5 | 15.7 | 14.5 |
| Other | 2.6 | 5.0 | 2.4 | 1.4 |

* Difference between the three groups significant at .01 level
**Difference between the three groups significant at .001 level

***Childhood Victimization – Sexual Abuse.*** In general, there are significant differences in the reports of childhood sexual abuse experience among the three groups of women (See Table 6) with over two-thirds of the prison sample reporting having experienced childhood sexual abuse

(68.2%) followed by the agency sample (58.7%) and then the community sample (47.2%). Questions about the experience of childhood sexual abuse were later categorized as either "sexual touching" or "sexual penetration". Answers to these questions, similar to those asked and answered regarding childhood physical abuse, provide additional details about the women's experiences as victims of childhood sexual abuse.

In addition to asking the question "To the best of your knowledge, before age 17, were you ever sexually abused?" in this section we are able to report more details on their sexual victimization because, using Briere's (1992) questions as guides, women from this sample were asked two separate questions about their sexual abuse experiences including any sexual molestation – defined here as "sexual touching" (See Table 11) or sexual "penetration" experiences (See Table 12).

Table 11: **Immediate Sequelae of Child Sexual Abuse (sexual touching)**

| | **Total (n=423)** | **Communities (n= 109)** | **DV / SA Agencies (n=157)** | **Prison (n= 157)** |
|---|---|---|---|---|
| **Before age 17, did anyone ever kiss you in a sexual way, or touch your body in a sexual way, or make you touch their sexual parts without your consent: *Yes*** | 63.7% | 55.6% | 63.1% | 70.1% |
| | **Total (n=269)** | **Communities (n=60)** | **DV / SA Agencies (n=99)** | **Prison (n=110)** |
| **Mean age when first abused** | 8.0 | 9.0 | 7.7 | 7.8 |
| **Who did this?** | | | | |
| Family Member | 69.9% | 59.0% | 72.4% | 73.6% |
| Friend | 13.1 | 14.8 | 12.9 | 12.4 |
| Stranger | 11.4 | 5.6 | 14.1 | 12.4 |
| Teacher or Professional | 3.8 | 1.9 | 5.9 | 3.1 |
| Babysitter or Nanny | 5.1 | 3.7 | 3.5 | 7.2 |
| **Abuser more than 5 yrs older? *Yes*** | 86.6% | 85.2% | 87.6% | 86.4% |
| **Did anyone use physical force on any of these occasions? *Yes*** | 58.1% | 54.1% | 61.9% | 57.0% |
| **How often did this happen?** | | | | |
| Everyday | 11.5% | 5.1% | 12.9% | 13.6% |
| Couple of times a week | 24.0 | 15.3 | 22.6 | 30.0 |
| Couple of times a month | 13.0 | 8.5 | 18.3 | 10.9 |
| Couple of times a year | 8.0 | 13.6 | 6.5 | 6.4 |
| Once or twice | 34.4 | 47.5 | 31.2 | 30.0 |
| Other | 6.9 | 8.5 | 5.4 | 7.3 |
| Don't know | 2.3 | 1.7 | 3.2 | 1.8 |

* Difference between the three groups significant at .01 level
**Difference between the three groups significant at .001 level

While no significant differences in the experiences of sexual abuse – sexual touching – are found between the sample groups, the results indicate that over 70 percent of women from prison, over 63 percent of women from the agencies, and almost 56 percent of women from the four communities report being sexually molested, usually by a family member. The mean age when the sexual molestation began was eight years old. A majority of the women from all three groups who report being molested also report experiencing the perpetrator's use of physical force.

There are significant differences found between the groups with regard to the experience of sexual penetration as a child. When women were asked about sexual penetration as a child, more than 57 percent of the women in prison answer "yes" compared to 45 percent of the women from the agencies and 36 percent of women from the communities (See Table 12 below). Similar to patterns of sexual molestation, the perpetrator was usually a family member who used physical force during the abuse. The mean age when penetration first occurred for the agency women was 8 years old; for others, it was 9 years old.

Table 12: **Immediate Sequelae of Child Sexual Abuse (sexual penetration)**

| | **Total (n=423)** | **Communities (n= 109)** | **DV / SA Agencies (n=157)** | **Prison (n= 157)** |
|---|---|---|---|---|
| **Before age 17, did anyone ever have oral, anal, or vaginal intercourse with you, or insert a finger or object in your anus or vagina without your consent: *Yes* *** | 47.0% | 35.5% | 44.5% | 57.3% |
| | **Total (n=126)** | **Communities (n=39)** | **DV / SA Agencies (n=70)** | **Prison (n=90)** |
| **Mean age when first abused** | 9.0 | 9.5 | 8.0 | 9.5 |
| **Who did this?** | | | | |
| Family Member | 63.8% | 51.3% | 65.2% | 68.2% |
| Stranger | 14.6 | 9.1 | 16.1 | 15.9 |
| Friend | 13.5 | 18.2 | 10.7 | 13.4 |
| Babysitter or nanny | 2.9 | 6.1 | 3.6 | 1.2 |
| Teacher or professional | 1.8 | 0.0 | 3.6 | 1.2 |
| **Abuser more than 5 yrs older? *Yes*** | 87.6 | 84.6 | 82.4 | 93.1 |
| **Did anyone ever use physical force on any of these occasions? *Yes*** | 73.8% | 71.8% | 72.1% | 76.1% |
| **How often did this happen?** | | | | |
| Everyday | 12.4% | 5.3% | 11.9% | 15.9% |
| Couple of times a week | 24.9 | 13.2 | 25.4 | 29.5 |
| Couple of times a month | 16.1 | 13.2 | 20.9 | 13.6 |
| Couple of times a year | 2.6 | 7.9 | 0.0 | 2.3 |
| Once or twice | 34.2 | 47.4 | 31.3 | 30.7 |
| Other | 7.3 | 10.5 | 9.0 | 4.5 |
| Don't know | 2.6 | 2.6 | 1.5 | 3.4 |

* Difference between the three groups significant at .01 level
**Difference between the three groups significant at .001 level

***Adult Victimization – Intimate Partner Violence***. A further examination of the specific questions asked on intimate partner violence and sexual assault, provides greater understanding of women's reported victimization in this study. As to intimate partner violence, of the thirty questions on the Abuse Behavior Inventory (ABI), twenty items identify psychological abuse and ten items identify physical abuse. Table 13 below outlines the percentage of women from the three sample groups who have experienced overall Intimate Partner Violence, psychological IPV, and physical IPV. Additionally, the means of their scores (range of 1 to 5) are also included in Table 13.

Table 13: **Intimate Partner Violence Experiences**

| | **Total (n=423)** | **Communities (n= 109)** | **DV / SA Agencies (n=157)** | **Prison (n= 157)** |
|---|---|---|---|---|
| **Any IPV **** | 97.4% | 91.7% | 98.7% | 100% |
| **- IPV Mean (a)** | 2.95 | 2.47 | 3.13 | 3.11 |
| | | | | |
| **Psychological IPV **** | 97.4% | 91.7% | 98.7% | 100% |
| **- Psychological IPV Mean (a)** | 3.17 | 2.65 | 3.41 | 3.30 |
| | | | | |
| **Physical IPV **** | 91.5% | 78.0% | 96.8% | 95.5% |
| **- Physical IPV Mean (a)** | 2.51 | 2.09 | 2.56 | 2.74 |

** Differences between those answering "ever" across samples are sign. at .001 level.
(a) Mean scores based on scale of 1-5 with 1=Never, 2=Rarely, 3=Sometimes; 4=Often; 5=Very Often

The means of the IPV, psychological IPV, and physical IPV scale responses are not significantly different between the three sample groups. However, there are significant differences between the groups on the overall numbers of women who report having experienced at least one form of IPV. Thus, women in prison are most likely to report having experienced any IPV (100%) and psychological IPV (100%), followed by women from the agencies (98.7% and 98.7%, respectively) and then women from the communities (91.7% and 91.7%,

respectively). Women from the agencies (96.8%) are those most likely to report having experienced physical IPV.

A further examination of the ten items describing physical assault on the ABI reveals that, on six of the items, there are significant differences between the groups. Again, the women from the community sample are most likely to report "never" on the separate items detailing the method or type of physically assaultive behaviors used, and the agency and prison samples are more likely to report "very often" on these same measures when compared to the community sample (see Appendix J).

It is important to note that the ABI does not reference a time frame during which women are asked to report their experience of abusive behaviors nor does it ask for the number of intimate partners who demonstrated these behaviors. Instead, women are asked "How often has an intimate partner done the following…?" Thus, the rate of victimization reported may relate to a single partner or multiple intimate partners and may or may not reflect abuse experiences that occurred over any period of time.

Women were asked to provide information that would yield a measure from which to view the severity injury sequelae of IPV for the three different populations. The women were asked "As a result of the physically or emotionally violent behaviors, how often would you say you experienced the following." Their answers range from 1 (never) to 2 (rarely) to 3 (sometimes) to 4 (often) to 5 (very often). The results, outlined in Table 14 below, demonstrate that incarcerated women have significantly more frequent reports of injuries and other effects of violence in almost all of the categories, followed by women from the agencies.

Table 14: **Immediate Sequelae of Adult Intimate Partner Violence Among Victims of Physical IPV**

| As a result of the physically or emotionally violent behaviors… | Total (n=386) | Communities (n=85) | DV/SA Agencies (n=151) | Prison (n= 150) |
|---|---|---|---|---|
| **Had physical pain lasting more than one hour **** | 83.9% | 68.2% | 84.1% | 92.7% |
| **Did you have swelling, sprain, or bruise on your arm/leg? *** | 75.9 | 65.9 | 76.2 | 81.3 |
| **Did you have a bruise, cut, or wound on your face/neck? **** | 75.6 | 64.7 | 70.2 | 87.3 |
| **Did you have bump or wound on your head? **** | 69.4 | 50.6 | 63.5 | 86.0 |
| **Did you have a black eye? **** | 60.4 | 50.6 | 51.0 | 75.3 |
| **Did you have to get medical treatment for stress?** | 55.7 | 50.6 | 57.6 | 56.7 |
| **Did you have a bruise/cut on your stomach/chest/back? **** | 53.9 | 34.1 | 53.0 | 66.0 |
| **Received medical treatment for injuries *** | 52.5 | 37.6 | 48.0 | 65.3 |
| **Did you have a fractured or broken bone?** | 29.5 | 23.5 | 21.9 | 40.7 |

* Difference between the three groups significant at .01 level
**Difference between the three groups significant at .001 level

The incarcerated women report experiencing a range of physical injuries related to Intimate Partner Violence including bruises, cuts, or wounds on their faces or necks (87.3%), on their heads (86.0%), on their arms or legs (81.3%), and on their torsos (66.0%). Additionally, over three-fourths of the incarcerated women have received black eyes as a result of the IPV (75.3%).

Women were also asked about their injuries resulting from their experiences of physical *or* emotional abuse. Consequently, the women's reports about the injuries they received cannot be linked to any specific type of physical or psychological victimization or to any specific IPV score.

***Adult Victimization – Sexual Assault.*** As noted earlier, women from all three samples report a high incidence of rape. The Sexual Experiences Survey (SES) also included ten different questions relating to other sexual assault experiences. Based on the responses to these ten

questions, three subscales were generated, including sexual coercion, attempted rape, and rape (See Table 15).

Table 15: **Sexual Assault Experiences**

| | **Total (n=423)** | **Communities (n= 109)** | **DV / SA Agencies (n=157)** | **Prison (n= 157)** |
|---|---|---|---|---|
| **Any Sexual Assault *** | 85.0% | 75.7% | 87.1% | 89.1% |
| **- Mean # of Sexual Assault Items ** (up to 10 items)** | 5.1 | 4.0 | 5.4 | 5.7 |
| | | | | |
| **Sexual Coercion** | 77.6% | 70.1% | 79.4% | 80.9% |
| **- Mean # of Sexual Coercion Items * (up to 4 items)** | 2.1 | 1.7 | 2.2 | 2.4 |
| | | | | |
| **Attempted Rape** | 50.6% | 42.1% | 53.6% | 53.5% |
| **- Mean # of Attempted Rape Items (up to 2 items)** | 0.9 | 0.7 | 0.9 | 0.9 |
| | | | | |
| **Rape *** | 67.4% | 55.1% | 70.6% | 72.6% |
| **- Mean # of Rape Items * (up to 4 items)** | 2.2 | 1.6 | 2.3 | 2.4 |

* Difference between the three groups significant at .01 level
**Difference between the three groups significant at .001 level

Women from the three samples report experiencing high rates of any sexual assault and significant differences exist between the groups. The WCF women report the highest rate of having experienced any sexual assault (89.1%), followed closely by women from the agencies (87.1%) and from the community ( 75.7%). A detailed examination of the three subscales in the SES reveals significant differences in the mean scores of overall sexual assault with women from prison answering "yes" to an average of 5.7 items on a ten-item scale, followed closely by women from the agencies (5.4). Women from the community answer "yes" to an average of 4.0 items. The mean number of coercion subscale items (4 items) was also significant as well as the mean number of rape items (4 items). In each case, the WCF sample reported significantly more sexual assault experiences (89.1%) followed closely by the women from the agencies (87.1%). Regardless of the inherent problems with the scale discussed earlier in the Method section of this

report, the women in this study report high levels of sexual assault experiences with significant differences found between the groups on half of the SES items.

Finally, women were also asked if they ever received medical treatments for any injuries that resulted from their sexual experiences. The results indicate that there are significant differences between the three sample groups with 51 percent of the prison sample reporting "yes" followed by 26 percent of the agency sample and 25 percent of the community sample also reporting "yes".

In sum, the research findings on the prevalence and co-occurrence rates of child physical abuse, child sexual abuse, physical IPV, and rape partially support Hypothesis (1), which states:

> *Prevalence rates of intimate partner violence (IPV), sexual violence, and youth maltreatment are higher among incarcerated women than those not incarcerated.*

The prison sample is more likely to experience childhood sexual abuse and rape than the other sample members. However, the agency sample reports higher rates of physical IPV than the prison sample. There are no significant differences between the three sample groups regarding the experience of childhood physical violence.

The research findings support Hypothesis (2), which states:

> *There is a higher degree of co-occurrence of IPV, sexual violence, and youth maltreatment among incarcerated women that those not incarcerated.*

Forty-two percent of the prison sample experienced all four victimizations including physical and sexual child abuse, physical IPV, and rape – a number that is slightly higher than the agency sample (40.4%). Additionally, the prison sample report the highest mean number of victimization experiences at 2.9, again, slightly higher than the agency sample of 2.8.

Finally, the findings from this study support Hypothesis (3), which states:

> *Histories of IPV in adulthood will be more common among incarcerated women than will histories of adult sexual violence.*

Over 95 percent of the prison sample report having experienced some form of physical IPV compared to 73 percent reporting rape. The experience of physical IPV is reported more frequently than the experience of any form of child abuse. The same is true of the agency and community samples: the experience of physical IPV is more commonly reported by these women, compared to their reports of rape or childhood physical or sexual abuse.

*(2) What are the disclosure experiences among women who disclosed their childhood and / or adult victimization?*

The following tables present certain findings related to the full sample of women who report having disclosed their victimization experiences. The responses to these disclosures by type of victimization are also presented in table form. The same set of questions about disclosure experiences was asked of each participant who experienced (1) physical child abuse, (2) child sexual molestation - touching, (3) child sexual abuse - penetration, (4) adult physical IPV, and / or (5) adult rape. If a participant indicated that she told someone about her experience(s), she was asked whom she told, whether she was believed, and how soon after the victimization she disclosed the violence. Participants were also asked who was notified as the result of their disclosure(s), what happened to the perpetrator, and if any investigation ensued. Cross-tabulations were conducted to note any significant differences between the sample groups. Tables 16 through 20 provide the frequencies (percentages) of disclosures in these samples and any significant differences between the groups.

Table 16: **Response to Disclosure of Child Physical Abuse**

| | Total | Communities | DV / SA Agencies | Prison |
|---|---|---|---|---|
| **Among those physically abused** | (n=192) | (n=40) | (n=83) | (n=69) |
| **Did you tell anyone? *Yes*** | 67.1% | 57.5% | 65.1% | 75.4% |
| | | | | |
| **Among disclosers…told:** | (n=129) | (n=23) | (n=54) | (n=52) |
| Parent | 42.6% | 52.2% | 51.9% | 28.8% |
| Family Member | 42.6 | 56.5 | 44.4 | 34.6 |
| Friend | 33.3 | 43.5 | 42.6 | 19.2 |
| Social Worker/Counselor | 45.7 | 30.4 | 42.6 | 55.8 |
| Minister/Priest | 7.0 | 8.7 | 9.3 | 3.8 |
| Teacher | 5.3 | 4.0 | 2.5 | 7.6 |
| **Did they believe you?** | | | | |
| Parent (n=42) | 76.4 | 75.0 | 75.0 | 80.0 |
| Family Member (n=55) | 83.6 | 69.2 | 87.5 | 88.9 |
| Teacher (n=27) | 84.4 | 80.0 | 75.0 | 100.0 |
| Friend (n=43) | 100.0 | 100.0 | 100.0 | 100.0 |
| Social Worker (n=59) | 83.1 | 85.7 | 78.3 | 86.2 |
| Minister/Priest (n=9) | 77.8 | 50.0 | 100.0 | 50.0 |
| **Did you tell within one week?** | | | | |
| Parent (n=42) | 81.5 | 83.3 | 74.1 | 93.3 |
| Family Member (n=55) | 52.7 | 76.9 | 45.8 | 44.4 |
| Teacher (n=27) | 65.6 | 80.0 | 56.3 | 72.7 |
| Friend (n=43) | 73.8 | 77.8 | 69.6 | 80.0 |
| Social Worker (n=59) | 25.9 | 28.6 | 17.4 | 32.1 |
| Minister/Priest (n=9) | 11.1 | 0.0 | 0.0 | 50.0 |
| **What happened after you told someone?** | | | | |
| Police were called | 20.3 | 13.6 | 20.4 | 23.1 |
| Investigated by Child Protective Services | 27.3 | 18.2 | 29.6 | 18.2 |
| Went to the Doctor/Hospital | 21.9 | 36.4 | 18.5 | 19.2 |
| Nothing happened | 67.2 | 59.1 | 63.0 | 59.1 |
| **Was the perpetrator confronted? *Yes*** | 63.3 | 54.5 | 63.0 | 67.3 |
| | | | | |
| **If yes, what happened?** | (n=81) | (n=12) | (n=34) | (n=35) |
| Investigated by Police? | 24.7% | 0.0% | 26.5% | 31.4% |
| Investigated by Child Protective Services? | 32.1 | 0.0 | 35.3 | 40.0 |
| Perpetrator arrested? | 14.8 | 16.7 | 11.8 | 17.1 |
| Perpetrator served time? | 6.2 | 0.0 | 8.3 | 11.4 |
| Nothing happened to perpetrator | 69.1 | 83.3 | 61.8 | 71.4 |

* Difference between the three groups significant at .01 level
**Difference between the three groups significant at .001 level

On the measure of disclosure of child physical abuse, there are no significant differences found between the three sample groups. The frequencies for the total sample of women who report having been physically abused as children (n=192) reveal that over 67 percent of them reported their childhood physical victimization to someone, most commonly a parent, family member, friend, or social worker. Teachers were told least frequently but, when told, were thought to have been likely to believe the victim. In fact, a majority of the women who report childhood physical abuse and who disclosed the abuse indicate that those they told had believed them and that additionally, they had disclosed the abuse to someone within one week of the victimization. When asked what happened after they told someone, most of the women who report experiencing childhood physical abuse (67.2%) report that nothing happened after the disclosure was made. When something did happen after the disclosure was made, in more than 63 percent of the cases the perpetrator was confronted about the abuse. The most common response to that confrontation is that nothing happened (69.1%).

Table 17 below reports the frequencies and the significant differences between the sample groups regarding their victimization experiences involving sexual touching or molestation as a child.

Table 17: **Response to Disclosure of Child Sexual Abuse - Sexual Touching**

| | Total | Communities | DV / SA Agencies | Prison |
|---|---|---|---|---|
| **Among those abused** | (n=269) | (n=60) | (n=99) | (n=110) |
| **Did you tell anyone? *Yes*** | 70.9% | 60.0% | 70.5% | 77.3% |
| | | | | |
| **Among disclosers…told:** | (n=188) | (n=36) | (n=67) | (n=85) |
| Parent | 70.6% | 65.7% | 80.6% | 64.7% |
| Family Member | 43.9 | 51.4 | 31.3 | 50.6 |
| Social Worker/Counselor | 43.3 | 34.3 | 37.3 | 51.8 |
| Friend | 26.7 | 22.9 | 26.9 | 28.2 |
| Minister/Priest | 8.6 | 5.7 | 11.9 | 7.1 |
| Teacher | 4.8 | 2.9 | 6.1 | 4.7 |
| **Did they believe you?** | | | | |
| Parent (n=131) | 69.5 | 63.6 | 64.8 | 76.4 |
| Family Member (n=83) | 86.7 | 100.0 | 81.8 | 83.7 |
| Teacher (n=9) | 77.8 | 100.0 | 75.0 | 75.0 |
| Friend (n=50) | 100.0 | 100.0 | 100.0 | 100.0 |
| Social Worker (n=81) | 93.8 | 100.0 | 96.0 | 90.9 |
| Minister/Priest (n=30) | 100.0 | 100.0 | 100.0 | 100.0 |
| **Did you tell within one week?** | | | | |
| Parent (n=131) | 37.4 | 52.2 | 32.1 | 36.4 |
| Family Member (n=83) | 34.1 | 33.3 | 23.8 | 39.5 |
| Teacher (n=9) | 40.0 | 100.0 | 40.0 | 25.0 |
| Friend (n=50) ** | 24.0 | 0.0 | 5.6 | 45.8 |
| Social Worker (n=81) | 6.2 | 8.3 | 4.0 | 6.8 |
| Minister/Priest (n=30) | 6.3 | 0.0 | 12.5 | 0.0 |
| **What happened after you told someone?** | | | | |
| Police were called | 19.6 | 14.3 | 12.5 | 27.1 |
| Investigated by Child Protective Services | 12.5 | 8.6 | 12.5 | 14.1 |
| Went to the Doctor/Hospital | 15.8 | 20.0 | 10.9 | 17.6 |
| Nothing happened | 72.1 | 74.3 | 73.4 | 70.2 |
| **Was the perpetrator confronted? *Yes*** | 48.9 | 42.9 | 46.0 | 53.6 |
| | | | | |
| **If yes, what happened?** | (n=93) | (n=15) | (n=31) | (n=47) |
| Investigated by Police? | 30.1% | 26.7% | 19.4% | 38.3% |
| Investigated by Child Protective Services? | 19.4 | 13.3 | 9.7 | 27.7 |
| Perpetrator arrested? * | 24.7 | 33.3 | 3.2 | 36.2 |
| Perpetrator served time? | 17.2 | 26.7 | 3.2 | 17.2 |
| Nothing happened to perpetrator | 69.9 | 66.7 | 77.4 | 66.0 |

* Difference between the three groups significant at .01 level
**Difference between the three groups significant at .001 level

Most of the women who report sexual molestation also report that they told someone (70.9%), usually a parent, family member, social worker, or friend, and that the person(s) told believed them. Of the types of persons who were told, parents were the least likely to be

perceived to believe the victim. When friends were told of the victimization, the prison women are significantly more likely to have told them within one week of the abuse. When asked what happened after they disclosed the sexual molestation, over 72 percent of the sample report that nothing happened.

Fewer than 49 percent of those experiencing sexual molestation report that the perpetrator was confronted, in contrast to the 63 percent of the total sample who report that the perpetrator was confronted when physical child abuse occurred. As a result of the confrontation for sexual molestation, the agency women are significantly more likely to report that the perpetrator was not arrested. Finally, similar as that reported for physical child abuse, most of the women in this sample (69.9%) indicate that nothing further happened after the perpetrator was confronted.

Table 18 below reports the frequencies and the significant differences between the sample groups regarding their child sexual abuse victimization with penetration.

Table 18: **Response to Disclosure of Child Sexual Abuse- Sexual Penetration**

| | Total | Communities | DV / SA Agencies | Prison |
|---|---|---|---|---|
| **Among those abused** | (n=197) | (n=38) | (n=69) | (n=90) |
| **Did you tell anyone? *Yes*** | 67.0% | 68.4% | 60.0% | 73.3% |
| | | | | |
| **Among disclosers…told:** | (n=132) | (n=26) | (n=40) | (n=66) |
| Parent | 63.4% | 60.0% | 77.5% | 56.1% |
| Family Member | 35.1 | 40.0 | 22.5 | 40.9 |
| Social Worker/Counselor | 45.8 | 36.0 | 45.0 | 50.0 |
| Friend | 33.6 | 36.0 | 30.0 | 34.8 |
| Minister/Priest | 9.9 | 16.0 | 12.5 | 6.1 |
| Teacher | 5.3 | 4.0 | 2.5 | 7.6 |
| **Did they believe you?** | | | | |
| Parent (n=82) | 67.1 | 66.7 | 64.5 | 69.4 |
| Family Member (n=46) | 80.4 | 90.0 | 77.8 | 77.8 |
| Teacher (n=6) | 83.3 | 100.0 | 100.0 | 75.0 |
| Friend (n=44) | 97.7 | 100.0 | 100.0 | 95.7 |
| Social Worker (n=60) | 90.0 | 100.0 | 88.9 | 87.9 |
| Minister/Priest (n=12) | 100.0 | 100.0 | 100.0 | 100.0 |
| **Did you tell within one week?** | | | | |
| Parent (n=82) | 39.0 | 46.7 | 35.5 | 38.9 |
| Family Member (n=46) | 39.1 | 40.0 | 33.3 | 40.7 |
| Teacher (n=6) | 33.3 | 100.0 | 0.0 | 25.0 |
| Friend (n=44) | 34.1 | 11.1 | 0.0 | 60.9 |
| Social Worker (n=60) | 10.3 | 11.1 | 11.8 | 9.4 |
| Minister/Priest (n=12) | 15.4 | 25.0 | 20.0 | 0.0 |
| **What happened after you told someone?** | | | | |
| Police were called | 21.7 | 20.8 | 7.7 | 30.3 |
| Investigated by Child Protective Services | 12.4 | 12.5 | 7.7 | 15.2 |
| Went to the Doctor/Hospital | 20.2 | 20.8 | 12.8 | 24.2 |
| Nothing happened | 74.2 | 73.9 | 76.9 | 72.7 |
| **Was the perpetrator confronted? *Yes*** | 52.3 | 52.2 | 51.3 | 53.0 |
| | | | | |
| **If yes, what happened?** | (n=70) | (n=12) | (n=22) | (n=36) |
| Investigated by Police? * | 34.3% | 16.7% | 13.6% | 52.8% |
| Investigated by Child Protective Services? | 18.6 | 8.3 | 9.1 | 27.8 |
| Perpetrator arrested? | 28.6 | 25.0 | 9.1 | 41.7 |
| Perpetrator served time? | 20.0 | 33.3 | 4.5 | 25.0 |
| Nothing happened to perpetrator | 68.6 | 58.3 | 72.7 | 69.4 |

* Difference between the three groups significant at .01 level
**Difference between the three groups significant at .001 level

As with the findings on sexual molestation, most of the women who report the experience of child sexual abuse with penetration also report that they told someone, usually a parent, family member, social worker, or friend. Most of those told were reported to have believed the women

about the abuse. In contrast to the timing of disclosure with other forms of childhood victimization, the timing of when women reported the sexual abuse with penetration indicates that women waited longer, on average, to tell someone about the experience. When asked what happened after they disclosed, 74 percent of those who experienced sexual penetration report that nothing happened.

When disclosure of the abuse was made, in more than half of the cases (52.3%) the perpetrator was confronted. Most of the women (68.6%) report that nothing happened when the perpetrator was confronted. The only significant difference between the sample groups is whether the police investigated the sexual abuse; the prison sample report police involvement (52.8%) more often than do the other two sample groups.

Table 19 below reports the frequencies and the significant differences among the sample groups regarding their victimization experiences with physical IPV as an adult.

Table 19: **Response to Disclosure of Intimate Partner Violence (Physical IPV only)**

| | Total | Communities | DV / SA Agencies | Prison |
|---|---|---|---|---|
| **Among those physically victimized** | (n=387) | (n=85) | (n=152) | (n=150) |
| **Did you tell anyone? *Yes*** | 79.3% | 76.5% | 81.5% | 78.7% |
| | | | | |
| **Among disclosers…told:** | (n=306) | (n=65) | (n=123) | (n=118) |
| Family Member | 69.9% | 63.6% | 65.3% | 78.2% |
| Friend | 68.9 | 74.2 | 59.7 | 75.6 |
| Police * | 59.5 | 42.4 | 62.1 | 66.4 |
| Social Worker/Counselor ** | 50.5 | 39.4 | 64.5 | 42.0 |
| Doctor | 37.5 | 28.8 | 36.3 | 43.7 |
| Minister/Priest | 15.5 | 18.2 | 16.9 | 12.6 |
| **Did they believe you?** | | | | |
| Family Member (n=216) | 96.3 | 95.2 | 96.3 | 96.8 |
| Friend (n=213) | 98.6 | 95.9 | 100 | 98.9 |
| Police (n=184) * | 94.6 | 82.1 | 94.8 | 98.7 |
| Social Worker (n=156) | 98.1 | 96.2 | 98.7 | 98.0 |
| Doctor (n=116) | 99.1 | 94.7 | 100 | 100 |
| Minister/Priest (n=48) | 93.8 | 91.7 | 90.5 | 100 |
| **Did you tell within one week?** | | | | |
| Family Member (n=216) | 60.0 | 51.2 | 56.8 | 66.7 |
| Friend (n=213) | 61.5 | 51.0 | 58.1 | 70.0 |
| Police (n=184) | 75.4 | 63.0 | 66.2 | 88.6 |
| Social Worker (n=156) | 27.1 | 20.0 | 30.0 | 26.0 |
| Doctor (n=116) | 67.0 | 77.8 | 55.6 | 73.1 |
| Minister/Priest (n=48) | 14.9 | 18.2 | 19.0 | 6.7 |
| **What happened after you told someone?** | | | | |
| Police were called ** | 56.2 | 30.8 | 57.7 | 68.6 |
| Went to the Doctor/Hospital * | 30.7 | 20.0 | 26.0 | 41.5 |
| Investigated by Child Protective Services | 8.5 | 7.7 | 5.7 | 11.5 |
| Nothing happened ** | 47.1 | 72.3 | 37.4 | 43.2 |
| **Was the perpetrator confronted? * *Yes*** | 71.6 | 56.9 | 73.2 | 78.0 |
| | | | | |
| **If yes, what happened?** | (n=219) | (n=38) | (n=88) | (n=93) |
| Investigated by Police? | 52.7% | 31.6% | 53.9% | 60.2% |
| Investigated by Child Protective Services? | 8.7 | 10.5 | 8.0 | 8.6 |
| Perpetrator arrested? | 54.8 | 39.5 | 51.1 | 64.5 |
| Perpetrator served time? | 30.1 | 18.4 | 29.5 | 35.5 |
| Nothing happened to perpetrator * | 38.4 | 50.0 | 26.1 | 45.2 |

* Difference between the three groups significant at .01 level
**Difference between the three groups significant at .001 level

Of the 387 women who report having experienced physical Intimate Partner Violence, more than 79 percent told someone about their abuse, the highest rate of disclosure for all types of victimizations. The majority of the women in the entire sample also report having been

believed by those they told. Significant differences are found between the sample groups regarding who was told of the victimization. More than 66 percent of the prison sample and 62 percent of the agency sample disclosed their abuse experiences to the police; only 42% of the community sample did so. Further, more than 64 percent of the agency sample disclosed their physical IPV to a social worker or counselor whereas 42 percent of the prison sample and 39 percent of the community sample did the same. A significant difference is also found between the samples on the measure of whether the woman was believed when police were told. As noted above, the community sample report disclosing to the police less frequently than did the other two groups and 82 percent of the community sample report being believed by the police less frequently than did the agency (94.8%) or prison samples (98.7%).

Additionally, there are significant differences between the sample groups regarding what happened after they told someone. The prison sample (68.6%) and the agency sample (57.7%) are significantly more likely to have had the police called than is the community sample (30.8%). The prison sample (41.5%) is also more likely to have seen a doctor or go to a hospital than is the agency (26.0%) or the community sample (20%). Finally, 72 percent of the community sample report that nothing happened as a result of telling someone while a lesser percentage of those in the prison (43.2%) and agency samples (37.4%) report that nothing happened.

More than 71 percent of those who report experiencing IPV indicate that the perpetrator was confronted about the IPV. Both the prison sample (78%) and the agency sample (73.2%) indicate that the abuser was confronted at rates significantly higher than that reported by the community sample (56.9%). Additionally, slightly over half of the sample (54.8%) report that the perpetrator was arrested after being confronted. Finally, 38 percent of the sample report that nothing happened to the perpetrator after the confrontation, and in this regard significant

differences are found between the prison sample (45.2%), the community sample (50%) and the agency sample (26.1%) relative to this measure.

Finally, with regard to the disclosure of sexual assault, Table 20 provides the findings related to women's experiences of rape. We focus our discussion and analysis on rape rather than sexual coercion and attempted rape, due to the relative frequency of all forms of violence in this sample and our intent to illuminate the prevalence and consequences of the most severe form of assault.

Table 20: **Response to Disclosure of Sexual Assault (Rape Victims Only)**

| | Total | Communities | DV / SA Agencies | Prison |
|---|---|---|---|---|
| **Among those assaulted** | (n=281) | (n=59) | (n=108) | (n=114) |
| **Did you tell anyone? *Yes*** | 73.3% | 71.2% | 66.7% | 80.7% |
| | | | | |
| **Among disclosers…told:** | (n=206) | (n=42) | (n=72) | (n=92) |
| Friend | 59.3% | 61.9% | 58.3% | 58.9% |
| Family Member | 55.1 | 57.1 | 44.4 | 62.6 |
| Social Worker/Counselor * | 50.5 | 35.7 | 65.3 | 45.6 |
| Doctor | 38.2 | 31.0 | 37.5 | 42.2 |
| Police | 37.7 | 31.0 | 41.7 | 37.8 |
| Minister/Priest | 13.7 | 23.8 | 15.3 | 7.8 |
| **Did they believe you?** | | | | |
| Friend (n=121) | 97.5 | 100 | 100 | 94.3 |
| Family Member (n=112) | 88.5 | 91.7 | 87.5 | 87.7 |
| Social Worker (n=103) | 100 | 100 | 100 | 100 |
| Doctor (n=78) | 98.7 | 100 | 100 | 97.4 |
| Police (n=76) | 94.8 | 100 | 93.3 | 94.1 |
| Minister/Priest (n=26) | 96.3 | 100 | 90.0 | 100 |
| **Did you tell within one week?** | | | | |
| Friend (n=121) | 52.9 | 46.2 | 52.4 | 56.6 |
| Family Member (n=112) | 46.4 | 45.8 | 48.4 | 45.6 |
| Social Worker (n=103) | 20.4 | 20.0 | 21.3 | 19.5 |
| Doctor (n=78) | 64.1 | 61.5 | 55.6 | 71.1 |
| Police (n=76) | 73.7 | 83.3 | 56.7 | 85.3 |
| Minister/Priest (n=26) | 34.6 | 33.3 | 30.0 | 42.9 |
| **What happened after you told someone?** | | | | |
| Police were called | 36.8 | 29.3 | 40.3 | 37.5 |
| Investigated by Child Protective Services | 33.5 | 29.3 | 31.0 | 37.5 |
| Went to the Doctor/Hospital | 3.5 | 4.9 | 2.8 | 3.4 |
| Nothing happened | 61.7 | 70.7 | 56.9 | 61.4 |
| **Was the perpetrator confronted? *Yes*** | 48.0 | 54.8 | 50.0 | 43.3 |
| | | | | |
| **If yes, what happened?** | (n=101) | (n=24) | (n=37) | (n=40) |
| Investigated by Police? | 46.5% | 29.2% | 54.1% | 50.0% |
| Investigated by Child Protective Services? | 6.9 | 8.3 | 5.4 | 7.5 |
| Perpetrator arrested? | 36.6 | 33.3 | 32.4 | 42.5 |
| Perpetrator served time? | 30.7 | 29.2 | 29.7 | 32.5 |
| Nothing happened to perpetrator | 48.5 | 54.2 | 37.8 | 55.0 |

* Difference between the three groups significant at .01 level
**Difference between the three groups significant at .001 level

Of the 281 women who report having been raped, 73 percent indicate that they told someone. Most of the women (88% or more) in this rape sub-sample report that they were believed by those they told. Over 65 percent of agency women told a social worker or

counselor, a rate that is significantly higher than women from prison (45.6%) or from the communities (35.7%). However, when a social worker was told, 100% of the women in this rape sub-sample indicated that they were believed by the social worker. When police were told, the women in this sample (73.7%) often told the police within a week of the rape. When asked what happened after they disclosed their rape, 62 percent of the rape sample report that nothing happened.

Less than half of the sample (48%) reports that the perpetrator was confronted and more than 48 percent of the total sample reports that nothing happened to the perpetrator. Though not statistically significantly different between samples, slightly more than 36 percent of the perpetrators were arrested and 31 percent of the perpetrators subsequently served time.

A summary view of the women in the three sample groups who experienced victimization and then disclosed the victimization yields some significant findings (See Table 21). For example, women in prison and agency women who experienced any form of child abuse (physical, molestation, penetration) and disclosed their abuse experiences within one week report higher rates of abuse than do women from the communities, and the difference between the three samples is statistically significant. Additionally, there are significant differences between the three sample groups on the experience and disclosure of rape, with the prison sample reporting the highest rate of victimization followed by disclosure (58.6%); then the agency sample (45.9%) and the community sample (38.5%). While almost 74 percent of the entire sample experienced and disclosed their IPV victimization, no statistically significant difference exists between the three groups on this measure.

Table 21: **Disclosure and Response Summary Table**

| | **Total (n=423)** | **Communities (n=109)** | **DV/SA Agencies (n=157)** | **Prison (n=157)** |
|---|---|---|---|---|
| Experienced and Disclosed Child Abuse (including physical & sexual abuse) * | 51.5% | 39.4% | 51.6% | 59.9% |
| Experienced and Disclosed Physical IPV | 73.8 | 63.3 | 79.0 | 75.8 |
| Experienced and Disclosed Rape * | 48.7 | 38.5 | 45.9 | 58.6 |
| | | | | |
| Perp. (Physical IPV) Confronted (n=312) * | 29.2 | 43.5 | 27.4 | 22.7 |
| Perp. (Physical IPV) Arrested (n=221) | 45.7 | 62.5 | 48.9 | 35.5 |
| | | | | |
| Rape Perp. Confronted (n=217) | 53.5 | 50.0 | 51.3 | 57.1 |
| Rape Perp. Arrested (n=105) | 64.8 | 70.4 | 68.4 | 57.5 |

* Difference between sample groups is significant at .01 level.
** Difference between sample groups is significant at .001 level.

A further look at the women who experienced physical IPV or rape and whose perpetrator was confronted and arrested reveals that the only significant difference between all three sample groups exists when women report experiencing physical IPV and their perpetrators were confronted. In this regard, the community sample reported the highest rate (43.5%) of confrontation followed by the agency sample (27.4%) and then the prison sample (22.7%).

Among women experiencing victimization, on average, the woman disclosed 73% of her victimization experiences. On average, she confronted her perpetrator in a smaller proportion of the victimization experiences (50%) and police investigated only one quarter of her experiences. The only significant difference between the sample groups is found on the mean percentage where the police investigated. Both the prison sample (31%) and the agency sample (30%) were more likely to have police investigate their victimization when compared to the community sample (15%).

Table 22: **Proportion of Incidents Where Victims Disclosed**

| | **Total (n=423)** | **Communities (n=109)** | **DV/SA Agencies (n=157)** | **Prison (n=157)** |
|---|---|---|---|---|
| Mean % of disclosures | 73% | 68% | 73% | 76% |
| Mean % where perpetrator was confronted | 50 | 44 | 52 | 50 |
| Mean % where police investigated * | 27 | 15 | 30 | 31 |

* Difference between sample groups is significant at .01 level.

(3) *How does youth or adult victimization relate to outcomes in adulthood, including health, mental health, use of alcohol and drugs, suicide attempts, and incarceration? How does the response to women's disclosure relate to these adult outcomes?*

Table 23 details the adult outcomes compared across the three samples. As a reminder, higher scores on the health and mental health measures (Rand Health Survey) indicate better physical and mental health; conversely, higher scores on the depression (CES-D) and Post Traumatic Stress Disorder (National CoMorbidity Study) scales indicate poorer levels of depression and PTSD.

Table 23: **Current Outcomes in Adulthood**

| Adult Outcome | Instrument | Total (n=423) | Communities (n= 109) | DV / SA Agencies (n=157) | Prison (n= 157) |
|---|---|---|---|---|---|
| **Health** | **Mean Physical Health Score (a)*** | 66.4 | 66.4 | 62.1 | 70.7 |
| **Mental Health** | **Mean Mental Health Score (a)**** | 56.2 | 57.9 | 49.2 | 62.2 |
| | **Mean Depression Score (a)**** | 55.0 | 51.2 | 60.2 | 52.5 |
| | **Mean PTSD Score (a)**** | 58.9 | 53.4 | 64.3 | 57.3 |
| **Alcohol** | **Alcohol Problems? *Yes* *** | 18.5% | 9.3% | 17.2% | 26.1% |
| **Drug** | **Drug Problems? *Yes* **** | 27.7% | 4.6% | 15.9% | 55.4% |
| **Suicide** | **Suicide Attempt in past 12 months? *Yes*** | 7.1% | 2.8% | 7.0% | 10.2% |

(a) Score of 0-100
* Difference between the three groups significant at .01 level
**Difference between the three groups significant at .001 level

There are significant differences between the three sample groups relating to their health, mental health, and alcohol or drug use. Women from the domestic violence and sexual assault agencies report poorer physical health and mental health (mean scores of 62.1 and 49.2, respectively) than do women in the community group (mean scores of 66.4 and 57.9, respectively). The women from prison have better health (70.7) and mental health scores (62.2)

scores than do the other two groups, on average; however, these same women in prison are more likely to respond that they believe they have a significant alcohol and/or drug problem than do the women in the other groups. Though there appears to be a substantial difference between the groups in regard to the incidence of suicide attempts in the prior 12 months, due to the low overall incidence of suicide behaviors, these differences are not statistically significant.

***Childhood Victimization.*** Looking at the relationship between child physical abuse and current adult outcomes, the results indicate that women who were physically abused in childhood report significantly poorer physical and mental health than do women who were not abused (See Table 24 below).

Table 24: **Association of Child Physical Abuse with Adult Outcomes**

| **Outcome** | **Instrument** | **Total (n=416)** | **Physically Abused in Childhood?** | |
|---|---|---|---|---|
| | | | **Yes (n=214)** | **No (n=202)** |
| **Health** | **Mean Physical Health Score (a)**** | 66.4 | 61.1 | 72.1 |
| **Mental Health** | **Mean Mental Health Score (a)**** | 56.2 | 50.5 | 62.3 |
| | **Mean Depression Score (a)**** | 55.0 | 59.9 | 49.8 |
| | **Mean PTSD Score (a)**** | 58.9 | 65.2 | 52.2 |
| **Alcohol** | **Alcohol Problems? *Yes*** | 18.6% | 22.9% | 13.9% |
| **Drug** | **Drug Problems? *Yes*** | 28.2% | 30.4% | 25.9% |
| **Suicide** | **Suicide Attempt in past 12 months? *Yes*** | 7.2% | 10.3% | 4.0% |
| **Incarceration** | **Incarcerated at time of Interview** | 37.1% | 38.8% | 35.3% |

(a) Score of 0-100

* Difference between the three groups significant at .01 level
**Difference between the three groups significant at .001 level

On every outcome measure, except that of suicide attempts, there are significant differences in adult well being between the groups of women who were and were not victims of childhood sexual abuse (see Table 25). Thus, women in this study who were sexually abused as children report poorer levels of physical health, mental health, depression, and Post Traumatic Stress Disorder than do those women who were not abused. Similarly, more women who

experienced childhood sexual abuse also report having problems with alcohol and drug use and are more likely to be incarcerated.

Table 25: **Association of Child Sexual Abuse with Adult Outcomes**

| Outcome | Instrument | Total (n=416) | Sexually Abused in Childhood | |
|---|---|---|---|---|
| | | | Yes (n=247) | No (n=169) |
| **Health** | **Mean Physical Health Score (a)**** | 66.4 | 63.1 | 71.4 |
| **Mental Health** | **Mean Mental Health Score (a)**** | 59.2 | 52.4 | 61.8 |
| | **Mean Depression Score (a)**** | 55.0 | 58.6 | 49.8 |
| | **Mean PTSD Score (a) **** | 58.9 | 63.0 | 52.9 |
| **Alcohol** | **Alcohol Problems? *Yes* *** | 18.6% | 23.2% | 11.8% |
| **Drug** | **Drug Problems? *Yes* **** | 28.2 | 34.6 | 18.9 |
| **Suicide** | **Suicide Attempt in past 12 months? *Yes*** | 7.2 | 9.8 | 3.6 |
| **Incarceration** | **Incarcerated at time of Interview *** | 37.1 | 42.7 | 29.0 |

(a) Score of 0-100

* Difference between the three groups significant at .01 level
**Difference between the three groups significant at .001 level

***Adult Victimization.*** Looking at the relationship between the experience of physical IPV and current adult outcomes for the sample, one significant finding emerges. Women who have experienced physical IPV report higher levels of PTSD than do those who do not report having been victims of physical IPV (See Table 26 below).

Table 26: **Association of Physical IPV with Adult Outcomes**

| Outcome | Instrument | Total (n=423) | Physical IPV in Adulthood | |
|---|---|---|---|---|
| | | | Yes (n=386) | No (n=37) |
| **Health** | **Mean Physical Health Score (a)** | 66.4 | 65.9 | 72.7 |
| **Mental Health** | **Mean Mental Health Score (a)** | 56.2 | 55.6 | 64.4 |
| | **Mean Depression Score (a)** | 55.0 | 55.4 | 50.0 |
| | **Mean PTSD Score (a) **** | 58.9 | 59.9 | 47.1 |
| **Alcohol** | **Alcohol Problems? *Yes*** | 18.6% | 19.0% | 11.1% |
| **Drug** | **Drug Problems? *Yes*** | 28.2% | 28.6% | 19.4% |
| **Suicide** | **Suicide Attempt in past 12 months? *Yes*** | 7.2% | 7.5% | 2.8% |
| **Incarceration** | **Incarcerated at time of Interview** | 37.1% | 38.9% | 19.4% |

(b) Score of 0-100

* Difference between the three groups significant at .01 level
**Difference between the three groups significant at .001 level

There are several statistically significant relationships between having experienced rape in adulthood and certain adult outcomes (see Table 27). Women who were raped report poorer levels of physical health, mental health, depression, and PTSD than do those women who were not raped. There is no relationship between adult rape and the adult outcomes of drug problems and suicide attempts, but those who have been raped have higher rates of self-reported alcohol problems (see Table 27 below).

Table 27: **Association of Rape Victimization with Adult Outcomes**

| **Outcome** | **Instrument** | **Total** | **Rape in Adulthood** | |
|---|---|---|---|---|
| | | | **Yes (n=281)** | **No (n=142)** |
| **Health** | **Mean Physical Health Score (a)*** | 66.4 | 64.5 | 70.6 |
| **Mental Health** | **Mean Mental Health Score (a)**** | 56.2 | 53.5 | 61.7 |
| | **Mean Depression Score (a)**** | 55.0 | 57.5 | 49.8 |
| | **Mean PTSD Score (a)**** | 58.9 | 62.1 | 52.5 |
| **Alcohol** | **Alcohol Problem **** | 18.6% | 23.2% | 8.1% |
| **Drug** | **Drug Problem** | 28.2 | 31.4 | 20.6 |
| **Suicide** | **Suicide Attempt in past 12 months? *Yes*** | 7.2 | 8.9 | 3.7 |
| **Incarceration** | **Incarceration** | 37.1 | 40.6 | 31.6 |

(c) Score of 0-100

* Difference between the three groups significant at .01 level
**Difference between the three groups significant at .001 level

When exploring the relationship between disclosure and response experiences and adult outcomes, the few significant relationships found between victimization and adult outcomes exist for childhood victimization, rather than victimization in adulthood (See Table 28 below). Those who experienced and disclosed the child abuse have poorer well being in adulthood, including physical and mental health outcomes, depression and Post Traumatic Stress Disorder; in addition, these women are more likely to be incarcerated.

Table 28: **Association of Disclosure and Response Experiences with Adult Outcomes**

| | **Physical Health** | **Mental Health** | **Depression** | **PTSD** | **Incarceration** | **Alcohol Problem** | **Drug Problem** | **Suicide Attempt** |
|---|---|---|---|---|---|---|---|---|
| Experienced and Disclosed Child Abuse (including physical & sexual abuse) | -.186** | -.189** | .218** | .206** | .128** | | | |
| Experienced and Disclosed Physical IPV | | | | | | | | |
| Experienced and Disclosed Rape | | | | | .152** | .160** | | |
| | | | | | | | | |
| Phys IPV Perp Confronted | | | | | | | | |
| Phys IPV Perp Arrested | | | | | .175* | | | |
| | | | | | | | | |
| Rape Perp. Confronted | | | | | | | | |
| Rape Perp. Arrested | | | | | | | | |

* Correlation is significant at .01 level.
** Correlation is significant at .001 level.

Table 28 also shows a positive correlation between the experience and disclosure of rape and the outcomes of incarceration and reporting an alcohol problem. Finally, if the perpetrator of physical IPV was arrested, the victim herself is more likely to be incarcerated.

Correlation coefficients indicate the significant relationships that exist between physical IPV and rape scores and adult outcomes (See Table 29.). The reader is reminded that a woman's rape score indicates how many of four different rape behaviors she has experienced.

Table 29: **Associations of Intimate Partner Violence with Adult Outcomes**

| | **Physical IPV Score** | **Number of Rape Behaviors** |
|---|---|---|
| **Mean Physical Health Score (a)** | -.169** | -.171** |
| **Mean Mental Health Score (a)** | -.188** | -.200** |
| **Mean Depression Score (a)** | | .253** |
| **Mean PTSD Score (a)** | .289** | .265** |
| **Alcohol Problem** | (.133**) | .186** |
| **Drug Problem** | (.111*) | .133** |
| **Suicide Attempt in past 12 months? *Yes*** | | (.098*) |
| **Incarceration** | .162** | .116* |

(a) Score of 0-100
Only significant correlations are reported.
* Association between variables is significant at .01 level.
**Association between variables is significant at .001 level.
( ) Correlation ceases to be significant when controlling for sample group (community, agency or prison)

The results show a correlation between adult victimization and well being in adulthood. For example, there are inverse relationships between physical IPV scores and physical and mental health scores; thus, the higher the IPV score, the poorer the physical and mental health of the woman. Additionally, there are statistically significant and positive correlations between physical IPV scores and a woman's severity of Post Traumatic Stress Disorder, having drug and/or alcohol problems, and incarceration. However, the correlation between physical IPV scores and alcohol or drug problems ceases to be significant when controlling for the sample group; in other words, it is incarceration that is more strongly correlated with alcohol and/or drug problems than is physical IPV.

When correlating the number of rape behaviors a woman has experienced with her well being in adulthood, all relationships with adult outcomes are statistically significant. Thus, as the number of rape behaviors increases, so do the levels of depression and PTSD, the reporting of alcohol and drug problems, suicide attempts in the past year, and the likelihood of current incarceration. Additionally, as the number of rape behaviors experienced increase, the status of one's physical health and mental health decreases. When controlling for sample groups, the only

correlation that ceases to exist is that between number of rape behaviors and suicide attempts, which may be a function of the low base rate of suicide attempts.

The findings relating childhood and adult victimization with current adult outcomes are outlined in Table 30 below.

Table 30: **Correlation of Victimization Experiences to Adult Outcomes**

| | Physical Health | Mental Health | Depres-sion | PTSD | Incarcer-ation | Alcohol Problem | Drug Problem | Suicide Attempt |
|---|---|---|---|---|---|---|---|---|
| Any child physical abuse | -.255** | -.279** | .305** | .340** | | | | |
| Any child sexual abuse | -.189** | -.219** | .262** | .259** | .139* | .143* | .171** | |
| Any physical IPV | | | | .188** | | | | |
| Any rape | -.134* | -.181** | .219** | .235** | | .184** | | |

* Correlation is significant at .01 level.
** Correlation is significant at .001 level.

These findings reveal that the experience of childhood sexual abuse is correlated with more adult outcomes than any other type of victimization, related to a poorer status on physical health, mental health, depression, PTSD, incarceration, or alcohol and drug problems. However, physical child abuse is a stronger predictor than child sexual abuse of physical health, mental health, depression, and PTSD. The experience of physical IPV has the fewest relationships to adult outcomes. Thus, the results support Hypothesis (4), which states:

> *Childhood victimization will have more enduring and detrimental outcomes (in health, mental health, substance use, incarceration and suicide attempts) than will other types of victimization.*

(4) *What events and services in adulthood, including social services, types of coping, maladaptive coping, self-efficacy, social supports, current age, and adult economic resources, are most predictive of the adult outcomes of health, mental health, problems with alcohol and drugs, suicide attempts, and incarceration?*

This section begins with a review of the mediating factors across the three sample groups. The first set of mediating factors presented includes the use of adaptive coping strategies, the use of maladaptive coping strategies, one's sense of self-efficacy, the number of social supports, adult economic resources, and current age. Following the findings on these mediating factors, the next set of tables provides information on the type of social services used, the women's appraisal of the helpfulness of those services, and any barriers she encountered in accessing these services. The final set of tables demonstrates correlations between the mediating factors, service usage, and adult well being.

***Mediating Factors: Adaptive Coping, Maladaptive Coping, Self-Efficacy, Social Supports, Current Age, & Adult Economic Resources.*** Table 31 below provides an overview of the scores on each of the mediating factors across the three sample groups. These mediating factors include adaptive coping, maladaptive coping, self-efficacy, social supports, and adult economic resources. The two coping scales, adaptive and maladaptive coping, were scored on a 100 point scale; the higher the score, the more the adaptive or maladaptive coping skills were reportedly used. Similarly, the higher the self-efficacy score, the greater the sense of self-efficacy reported; the higher the social support score (because these are negative numbers, the closest to zero), the greater the level of perceived social support reported. The final mediating factors include the woman's age, the woman's perception of the difficulty living on her household income during

the prior year (i.e., the 12 months prior to their incarceration for the women in the prison sample), and receipt of welfare.

When compared across sample groups, there are significant differences between the groups in their use of adaptive coping strategies, their level of social support, their perceived difficulty living on their household income, and whether they had received welfare. On most of these measures, the women from the domestic violence and sexual assault agencies report better adaptive coping skills, less perceived social support, and more difficulty living on their household income. Almost 30 percent of the prison sample report that it was "not at all difficult" to live on their household income, though this response may be related to the illegal activities that preceded and ultimately led to their incarceration. However, the prison sample was more likely to have received welfare (80.1%) than was the agency sample (68.8%) or the community sample (56%).

Table 31: **Level of Mediating Factors**

| | **Total (n=423)** | **Communities (n= 109)** | **DV / SA Agencies (n=157)** | **Prison (n= 157)** |
|---|---|---|---|---|
| **Self Efficacy Score (a)** | 70.4 | 71.6 | 69.7 | 70.3 |
| **Adaptive Coping Score(a) **** | 71.7 | 66.7 | 75.9 | 71.0 |
| **Maladaptive Coping Score (a)** | 51.0 | 50.7 | 52.1 | 50.2 |
| **Social Support Score(b)**** | -51.7 | -47.5 | -54.2 | -52.1 |
| **Mean Age of participant** | 35.8 | 38.1 | 35.0 | 35.1 |
| **How difficult was it to live on your household income in the past 12 months? **** | | | | |
| Not at all difficult | 16.1% | 12.0% | 5.1% | 29.9% |
| A little difficult | 16.6 | 23.1 | 12.7 | 15.9 |
| Somewhat difficult | 22.1 | 23.2 | 26.2 | 17.2 |
| Very difficult | 22.7 | 20.4 | 26.1 | 21.1 |
| Extremely difficult | 22.5 | 21.3 | 29.9 | 15.9 |
| **Have you ever received welfare? *Yes* **** | 69.7 | 56 | 68.8 | 80.1 |

(a) 0 to 100 point scale; mean score.
(b) -100 to 0 point scale; mean score
* Difference between the three groups significant at .01 level
**Difference between the three groups significant at .001 level

A woman's victimization experiences are highly correlated with her status on a variety of mediating factors (See Table 32 below.)

Table 32: **Correlation of Victimization Experiences and Mediating Factors**

| | **Self Efficacy** | **Adaptive Coping** | **Maladaptive Coping** | **Social Support** | **Current Age** | **Difficulty on Income** | **Received Welfare** |
|---|---|---|---|---|---|---|---|
| Any child physical abuse | -.208** | | .200** | -.327** | | .150* | .133* |
| Any child sexual abuse | -.212** | | | -.264** | | | |
| Any physical IPV | | | | -.139* | | .127* | |
| Any rape | | | .196** | -.235** | | .159** | .136* |

* Correlation is significant at .01 level.
** Correlation is significant at .001 level.

Women who report experiencing physical child abuse also report a lower sense of self-efficacy, use of more maladaptive coping skills, a lower level of social support, a greater degree of difficulty managing on their income, and a greater likelihood of having received welfare. The experience of child sexual abuse is correlated only with a woman's low sense of self-efficacy and poor social support. The experience of physical IPV only predicted lower social support and a greater difficulty living on one's income. Women who experienced rape are more likely to use maladaptive coping skills, have fewer social supports, a greater difficulty living on their income, and a greater likelihood of having received welfare. Except for childhood sexual abuse, victimization is associated with women experiencing more difficulty living on their income. Finally, neither childhood nor adult victimization is predictive of one's use of adaptive coping strategies.

Knowing whether or not a woman disclosed her victimization is not a good predictor of her use of mediating factors in adulthood (See Table 33 below).

Table 33: **Association of Disclosure and Response Experiences with Mediating Factors**

| | Self Efficacy Score | Adaptive Coping | Maladaptive Coping | Social Support | Difficulty Living on Income | Received Welfare | Current Age |
|---|---|---|---|---|---|---|---|
| Experienced and Disclosed Child Abuse (including physical & sexual abuse) | -.161** | | | -.229** | | .143* | |
| Experienced and Disclosed Physical IPV | | .161** | | | | .195** | |
| Experienced and Disclosed Rape | | | | | | | .125* |
| | | | | | | | |
| Phys IPV Perp Confronted | | .196** | | | | | |
| Phys IPV Perp Arrested | | | | | | | |
| | | | | | | | |
| Rape Perp. Confronted | | | | | | | |
| Rape Perp. Arrested | | | | | | | |

* Correlation is significant at .01 level.
** Correlation is significant at .001 level.

The experience and disclosure of child physical and/or sexual abuse is negatively correlated with one's sense of self efficacy and with one's perception of having social support and is positively correlated with the receipt of welfare. For adult victims, a positive correlation exists between the experience and disclosure of physical IPV and the use of adaptive coping skills and receipt of welfare. Additionally, for rape victims, a positive correlation exists between the experience and disclosure of rape and a woman's age; thus, women in this sample who are raped and who disclose the rape are more likely to be older. Finally, women who experienced physical IPV where the perpetrator was confronted were more likely to use adaptive coping skills. It is important to note that, for each of these correlations in the table above, it may be the experience of victimization, and not the disclosure that is affecting the strength of the correlation, so caution in the interpretation of this table is recommended.

***Mediating Factors: Use of Social Services.*** Cross-tabulations were used to compare the three sample groups with the social services and supports they utilized (Table 34), the helpfulness of

these services (Table 35), and any barriers they encountered to using these services (Table 36). Services were categorized post-hoc as therapeutic in nature (noted in the tables with a "t"), crisis intervention ("c"), and long-term tangible ("l"). Women were asked to indicate which services they received at any time in the past for any of their abuse experiences, and to give an indication of the helpfulness of the services received. Because all of the women in the three samples experienced some form of abuse, the answers for the total sample are included in the following three tables.

As indicated by Table 34, there are 24 different types of services or supports that women could have sought after their victimization, presented here by decreasing frequency of use. Thus, the most common services used included emotional support (76.0%), professional counseling (64.4%), medication (53.0%), welfare (50.8%), support groups (50.2%), and visits to medical providers (48.2%).

When cross-tabulations are created, identifying the services that were used by each of the three sample groups, there are significant differences in service usage between the groups for fewer than half of the services. A significantly larger proportion of the women from the agency sample used all but one of the services (psychotropic medication) more than the other two sample groups. Finally, the agency sample used more services overall, with an average use of 9.1 services, followed by the prison sample (mean = 7.5) and the community sample (mean = 5.8). This pattern across groups was true when examining the use of therapeutic services, the use of crisis intervention services, and the use of long-term tangible supports. The services most used by each sample were the long-term tangible services (see Table 34).

Table 34: **Social Services and Supports Used After Victimization**

| | **Total (n=423)** | **Communities (n= 109)** | **DV / SA Agencies (n=157)** | **Prison (n= 157)** |
|---|---|---|---|---|
| **Service / Support Used** | | | | |
| Emotional Support (t) | 76.0% | 67.0% | 81.4% | 76.9% |
| Professional Counseling (t) ** | 64.4 | 51.9 | 76.3 | 61.1 |
| Medication (l) | 53.0 | 45.4 | 51.9 | 59.2 |
| Welfare (l) * | 50.8 | 38.9 | 58.3 | 51.6 |
| Support Group (t) ** | 50.2 | 34.9 | 67.3 | 43.9 |
| Medical Provider (c) | 48.2 | 37.0 | 52.6 | 51.6 |
| Legal Services (l) * | 45.8 | 32.4 | 55.1 | 45.9 |
| Psychotropic Medication (l) * | 43.9 | 32.4 | 42.9 | 52.9 |
| Food Bank (l) | 40.7 | 29.9 | 43.6 | 45.2 |
| Religious Counseling (t) | 40.1 | 31.5 | 48.7 | 37.6 |
| Domestic Violence Shelter (c) ** | 39.2 | 15.7 | 65.4 | 29.3 |
| Hospital Stay for Emot. Prob. (t) | 29.7 | 21.3 | 34.0 | 31.2 |
| Educational (l) | 27.1 | 21.3 | 25.6 | 32.5 |
| Job Training (l) | 25.4 | 19.4 | 33.3 | 21.7 |
| Subsidized Housing (l) * | 20.2 | 16.7 | 28.2 | 14.6 |
| Homeless Shelter (c) * | 18.8 | 12.0 | 26.3 | 15.9 |
| Rape Crisis (c) | 18.5 | 13.0 | 25.0 | 15.9 |
| Child Protection (c) * | 16.9 | 5.6 | 22.4 | 19.1 |
| Daycare (l) | 15.9 | 13.9 | 21.2 | 12.1 |
| Unemployment (l) | 15.7 | 16.7 | 18.6 | 12.1 |
| Vocational Rehabilitation (l) | 8.8 | 5.6 | 11.5 | 8.3 |
| Reproductive Services (l) | 7.8 | 7.4 | 8.3 | 7.6 |
| Worker's Compensation (l) | 6.7 | 7.4 | 6.4 | 6.4 |
| Internet Support (t) | 4.0 | 2.6 | 6.4 | 2.5 |
| | | | | |
| **Mean Number of Service / Supports Used ** ** | 7.7 | 5.8 | 9.1 | 7.5 |
| **Mean # of Therapeutic Services (t) **** | 2.6 | 2.1 | 3.1 | 2.5 |
| **Mean # of Crisis Interventions (c) **** | 1.8 | 1.1 | 2.4 | 1.8 |
| **Mean # of Long-term Services (l) *** | 3.2 | 2.6 | 3.6 | 3.2 |

* Difference between the three groups significant at .01 level
**Difference between the three groups significant at .001 level

Service usage is sometimes correlated with mediating factors including a sense of self-efficacy, the use of adaptive and maladaptive coping skills, perceived social support, current age, and the perceived difficulty living on one's income (See Table 35 below).

Table 35: **Correlations of Services Used and Mediating Factors**

| Service Used | Self Efficacy | Adaptive Coping | Maladaptive Coping | Social Support | Current Age | Difficulty on Income | Received Welfare |
|---|---|---|---|---|---|---|---|
| Emotional support (t) | .111* | .211** | | .182** | -.124* | | |
| Support group (t) | | .118* | | -148* | | .107* | |
| Professional counseling (t) | | .128* | | -.145* | .116* | .141* | |
| Hospital stay (t) | -.131* | | .146* | -.205** | .118* | .096* | |
| DV shelter (c) | | .156** | | -.216** | | .187** | .201** |
| Homeless shelter (c) | -.103* | | | -.170** | | | .144* |
| Medical provider (t) | | .148* | .108* | -.113* | .145* | | .146* |
| Psychotropic medication (l) | -.201** | | .144* | -.191** | .126* | .112* | |
| Subsidized housing (l) | -.100* | .113* | | -.127* | | .124* | .203** |
| Food bank (c) | -.140** | .098* | | -.193** | .129* | .194** | .315** |
| Welfare (l) | | .164** | | | | .209** | .578** |
| Job training (l) | | .113* | | | | | .230** |
| Education support (l) | | | | | -.123* | | .192** |
| Unemployment (l) | | | | | .120* | .135* | .156* |
| Workers compensation (l) | | | | | .148* | .102* | |
| Vocational Rehab (l) | | | | | | | |
| Daycare support (l) | | | | | | | .259** |
| Reproductive services (l) | | .130* | .099* | | | | |
| Medication (l) | -.245** | | .225** | -.258** | .131** | .124* | |
| Rape crisis services (c) | | | .117* | -.164** | | .143* | |
| Legal services (l) | | | | -.133* | .113* | .165** | |
| Child protective services (c) | | .109* | | | -.125* | | .186** |
| Religious counseling (t) | | .302** | .157** | | .181** | | |
| Internet support group (t) | | | | | | | |

* Correlation is significant at .01 level.
** Correlation is significant at .001 level.

The table above illustrates many correlations between the use of a particular service and a woman's use or level of a particular mediating factor. The correlations are too numerous to be itemized here. However, a general pattern is evident for the mediating factors of social support, difficulty living on one's income, and receipt of welfare. Women who use services report lower levels of social support, having greater difficulty living on their income, and a greater likelihood of receiving welfare. Women who report staying in a hospital for psychiatric reasons, visiting

medical providers, using psychotropic medication or other types of medication, or using rape crisis services or religious counseling show a greater use of maladaptive coping skills. In general, having a greater sense of social support is associated with a lower likelihood of using many of the services listed. Difficulty in living on one's income and receiving welfare is associated with greater use of many of the services listed, particularly those categorized as long-term tangible supports. One's use of adaptive coping strategies is associated with higher use of many services, while maladaptive coping is not very predictive, overall. It is important to note that these correlations do not indicate the direction of influence. We cannot ascertain from this study whether the use of services leads to better mediating strategies, or whether women with better mediating strategies are more likely to seek help.

For each service or support received, women were also asked to rank its helpfulness on a scale of 1 (not helpful) to 5 (extremely helpful). The mean helpfulness rating was then compared across the three samples. In addition, helpfulness ratings were calculated for the three types of services used: therapeutic, crisis-intervention, and long-term tangible.

The top quarter of services perceived as being the most helpful include daycare, religious counseling, subsidized housing, welfare, educational services, and food banks. When compared to the top quarter of services received, only welfare remains as being both received and helpful; the other services received (emotional support, professional counseling, medication, support groups, and medical providers) are ranked in the bottom half of services listed in the order of their perceived helpfulness. When perceived helpfulness of any one service is viewed across the three sample groups, no significant differences emerge between the groups.

When viewed in the aggregate, there is a small but statistically significant difference between the three samples in how they rate the helpfulness of the post-victimization services

they have received. In the aggregate, the community sample rates services as a 3.9 on a five-point scale (5 is the most helpful); those recruited from domestic violence and sexual assault agencies also rate services on average as a 3.9; women currently in prison rate the helpfulness of services as a 3.6 on a five-point scale. For women in prison and/or receiving services from agencies, long-term tangible services receive the highest ratings of helpfulness, on average.

Table 36: **Helpfulness of Social Services and Supports after Victimization (a)**

| Mean Scores | **Total (n=423)** | **Communities (n= 109)** | **DV / SA Agencies (n=157)** | **Prison (n= 157)** |
|---|---|---|---|---|
| **How helpful was this service? (b)** | | | | |
| Daycare (l) | 4.60 | 4.60 | 4.70 | 4.42 |
| Religious Counseling (t) | 4.31 | 4.21 | 4.32 | 4.36 |
| Subsidized Housing (l) | 4.29 | 4.28 | 4.25 | 4.39 |
| Welfare (l) | 4.27 | 4.29 | 4.20 | 4.35 |
| Educational (l) | 4.25 | 4.13 | 4.15 | 4.38 |
| Food Bank (c) | 4.17 | 4.16 | 4.19 | 4.16 |
| Job Training (l) | 4.15 | 4.05 | 4.08 | 4.32 |
| Unemployment (l) | 3.97 | 3.78 | 4.14 | 3.89 |
| Rape Crisis (c) | 3.92 | 3.62 | 4.18 | 3.67 |
| Domestic Violence Shelter (c) | 3.89 | 3.76 | 4.29 | 3.07 |
| Reproductive Services (l) | 3.85 | 3.50 | 3.69 | 4.25 |
| Emotional Support (t) | 3.82 | 4.01 | 3.95 | 3.57 |
| Professional Counseling (t) | 3.71 | 3.64 | 3.93 | 3.47 |
| Vocational Rehabilitation (l) | 3.70 | 3.17 | 4.00 | 3.54 |
| Medication (l) | 3.65 | 3.67 | 3.73 | 3.58 |
| Support Group (t) | 3.63 | 3.65 | 3.78 | 3.39 |
| Medical Provider (c) | 3.62 | 3.45 | 3.82 | 3.51 |
| Psychotropic Medication (l) | 3.54 | 3.54 | 3.61 | 3.48 |
| Worker's Compensation (l) | 3.43 | 3.75 | 3.00 | 3.60 |
| Homeless Shelter (c) | 3.35 | 3.46 | 3.22 | 3.50 |
| Hospital Stay (t) | 3.33 | 3.13 | 3.77 | 2.94 |
| Legal Services (l) | 3.33 | 3.12 | 3.54 | 3.18 |
| Internet Support (t) | 3.18 | 2.67 | 3.30 | 3.25 |
| Child Protection (c) | 3.03 | 3.33 | 3.09 | 2.90 |
| | | | | |
| **Mean Helpfulness Rating *** | 3.8 | 3.9 | 3.9 | 3.6 |
| **Mean Helpfulness - Tangible** | 3.9 | 3.5 | 3.9 | 3.9 |
| **Mean Helpfulness - Therapeutic** | 3.7 | 3.6 | 3.8 | 3.5 |
| **Mean Helpfulness – Crisis Int.** | 3.7 | 3.6 | 3.8 | 3.5 |

(a) Ratings among those using each service.
(b) Scale from 1 (not helpful) to 5 (very helpful).
* Difference between three groups is significant at .01 level.

Women in this study were also asked whether or not a number of barriers or challenges prevented them from getting help after their abuse experiences. The barriers are listed below (Table 37) in descending order as indicated by the total sample.

Table 37: **Barriers to Using Services and Supports**

| **Barrier (a)** | **Total (n=423)** | **Communities (n= 109)** | **DV / SA Agencies (n=157)** | **Prison (n= 157)** |
|---|---|---|---|---|
| I wanted to handle the problem on my own | 82.1% | 73.8% | 83.3% | 86.5% |
| I thought problem would get better by itself | 69.9 | 60.7 | 71.8 | 74.4 |
| I was unsure about where to go or who to see * | 59.4 | 48.6 | 70.5 | 55.8 |
| I didn't think treatment would work | 53.5 | 47.7 | 50.6 | 60.3 |
| I was concerned about how much money it would cost * | 48.2 | 45.8 | 59.6 | 38.5 |
| I had problems with things like transportation or scheduling that made it hard to get to the services ** | 46.1 | 29.9 | 57.1 | 46.2 |
| The problem didn't bother me very much at first | 45.0 | 40.2 | 48.4 | 45.0 |
| I was concerned about what people would think if they found out I was in treatment | 44.2 | 39.3 | 50.0 | 41.7 |
| I thought it would take too much time or would be inconvenient | 38.0 | 27.4 | 40.4 | 42.9 |
| I was scared about being put in hospital against my will | 34.2 | 30.2 | 34.0 | 37.21 |
| My health insurance would not cover services | 31.6 | 24.3 | 37.4 | 30.8 |
| I received services before and it didn't work | 30.5 | 26.2 | 28.2 | 35.9 |
| My parents did not take me to get help * | 25.4 | 14.2 | 34.8 | 23.7 |
| I was not satisfied with available services | 21.3 | 19.8 | 21.9 | 21.8 |
| I could not get an appointment * | 10.3 | 4.7 | 17.3 | 7.1 |
| | | | | |
| **Mean Number of Barriers Named *** | 6.2 | 5.3 | 6.7 | 6.2 |

(a) Percent answering yes, it was a barrier.
* Difference between the three groups significant at .01 level
**Difference between the three groups significant at .001 level

Of the fifteen possible barriers, two barriers stand out as common to each of the three groups of women. The first is the desire of the women to handle the problem on their own, reported by 82 percent of the total sample. The second barrier, thinking that the problem would get better by itself, is reported by 70 percent of the sample. These are the most commonly reported barriers, and there are no significant differences between groups on these items.

When cross-tabulations and phi coefficients are calculated comparing the three sample groups, five barriers emerge as being differently experienced. In each case, the agency sample is more likely to report having experienced the barriers than are the prison or community samples. Additionally, a significant difference in the mean number of barriers named by each group is found, with the agency sample reporting a mean of 6.7 barriers (out of 15 possible barriers), the prison women reporting a mean 6.2 barriers and the community sample identifying 5.3 barriers to services, on average (although community women also seek services significantly less often than the other samples).

Correlation coefficients were calculated to determine the relationship between the types of barriers to services experienced and one's status on mediating factors (self efficacy, use of adaptive and maladaptive coping strategies, perceived social support, current age, and perceived difficulty living on one's income) (See Table 38 below).

Identifying any but one of the barriers to services is positively correlated with the use of maladaptive coping skills whereas identifying most of the barriers is negatively correlated with one's sense of self-efficacy and social support. Again, this study methodology cannot determine whether having experienced the barrier leads to lower level of self-efficacy, for example, or whether those women who do not feel self-efficacious are more likely to see barriers where others do not. A few of the barriers identified are positively correlated to a greater use of adaptive coping skills. Finally, being unsure of where to go or who to see is positively correlated with adaptive coping strategies, maladaptive coping strategies, current age, and difficulty living on one's income, while being negatively correlated with sense of self-efficacy and social supports.

Table 38: **Correlations of Barriers to Seeking Services and Mediating Factors**

| Barrier | Self Efficacy | Adaptive Coping | Maladaptive Coping | Social Support | Age | Difficulty on Income | Received Welfare |
|---|---|---|---|---|---|---|---|
| I wanted to handle the problem on my own | | .166** | .153* | | | | |
| I thought problem would get better by itself | -.123* | | .182** | -.117* | | | |
| I was unsure about where to go or who to see | -.255** | .107* | .171** | -.202** | .144* | .204** | |
| I didn't think treatment would work | -.186** | | .181** | -.181** | | | |
| I was concerned about how much money it would cost | -.143* | | .239** | -.204** | .120* | .167** | |
| I had problems with things like transportation or scheduling that made it hard to get to the services | -.228** | | .240** | -.226** | | .232** | .144* |
| The problem didn't bother me very much at first | | .105* | | | | | |
| I was concerned about what people would think if they found out I was in treatment | | .148* | .224** | -.112* | | | |
| I thought it would take too much time or would be inconvenient | -.185** | | .180** | -.181** | | .121* | |
| I was scared about being put in hospital against my will | -.176** | | .265** | -.272** | .101* | .183** | |
| My health insurance would not cover services | -.098* | | .252** | -.155** | | | |
| I received services before and it didn't work | -.107* | | .211** | -.219** | | | |
| I was not satisfied with available services | -.168** | | .141* | -.259** | .160** | | |
| I could not get an appointment | | .109* | .136* | -.174** | | .140* | |

* Correlation is significant at .01 level.
** Correlation is significant at .001 level.

***Mediating Factors and Adult Outcomes.*** When correlating a woman's status on the mediating factors with the measures of her well being in adulthood, many significant relationships emerge. Table 39 displays the correlations between the mediating factors (self-efficacy, coping, social

support, current age, and difficulty living on income) and adult outcomes (health, mental health, depression, PTSD, incarceration, alcohol and drug problems, and suicide attempts).

Table 39: **Correlations of Mediating Factors with Adult Outcomes**

| | Physical Health | Mental Health | Depres-sion | PTSD | Incarcer-ation | Alcohol Problem | Drug Problem | Suicide Attempt |
|---|---|---|---|---|---|---|---|---|
| **Self Efficacy** | .286** | .480** | -.497** | -.417** | | | -.111* | |
| **Adaptive Coping** | | | -.112* | | | .157** | | |
| **Maladaptive Coping** | -.272** | -.463** | .511** | .525** | | | | |
| **Social Support** | .360** | .492** | -.555** | -.471** | | -.112* | -.105* | -.118* |
| **Current Age** | -.265 ** | -.110* | | | | .107* | | -.117* |
| **Difficulty living on income** | -.279** | -.298** | .200** | .256** | -.234** | | | |
| **Received Welfare** | | | | | .174** | | .191** | |

* Correlation is significant at .01 level.
** Correlation is significant at .001 level.

This table indicates that the strongest correlations exist between levels of physical health, mental health, depression, and PTSD and a woman's perception of social support, followed by her sense of self-efficacy. As social support increases, so do women's physical health and mental health improve; in addition, stronger social support is related to decreases in depression and PTSD. Having a greater sense of self-efficacy is also associated with better physical health and mental health as well as with lower levels of depression and PTSD. While social support is also correlated with a lower likelihood of alcohol problems, drug problems, and suicide attempts, the association is weak.

Adaptive coping skills show poor correlations with adult outcomes with only a weak relationship seen between the use of adaptive coping and lower levels of depression. However, maladaptive coping skills have stronger correlations with several adult outcomes. The more a

woman relies on maladaptive coping skills, the poorer her physical health and mental health and the greater her depression and experience of post-traumatic stress disorder.

Difficulty living on one's income is also moderately correlated with several outcomes. Having a greater difficulty managing on one's income is associated with poorer physical and mental health scores and higher depression and PTSD scores. When examined in relation to incarceration, there is a negative relationship between difficulty living on one's income and incarceration. As noted earlier in the findings, this finding may be related to the type of illegal activity engaged in (that increases one's income) that preceded the woman's incarceration. Also noteworthy is the positive correlation found between having received welfare and incarceration as well as between having received welfare and reporting a drug problem.

In general, the mediating factors are much better predictors of physical health, mental health, depression and post-traumatic stress disorder, than they are of incarceration, drug and / or alcohol problems, and attempting suicide.

Use of services and potential barriers encountered to seeking or securing services were also tested as mediating factors. Table J-2 (see Appendix J) provides a view of the correlations between each of the 24 services women used and their adult well being. Women's physical health scores are poorer for those women who use support groups, professional counseling, a hospital stay, a domestic violence shelter, homeless shelter, medication, subsidized housing, a food bank, welfare, religious counseling, and other services. Similarly, women's mental health is poorer among those using many of these same services. On the other hand, women's levels of depression and PTSD were better among those using rape crisis services and domestic violence shelters, as well as hospital stays, psychotropic medications, subsidized housing, and legal services.

Other adult outcomes showed some weak relationships with services used. Women who use support groups, domestic violence shelters, and subsidized housing are less likely to be incarcerated; however, use of psychotropic or other medications is positively correlated with incarceration. Several services are positively although weakly correlated with reporting one's self as having alcohol problems. Medication, support groups, professional counseling, food banks, and a few other services are more commonly used among those reporting having alcohol problems (see Table J-2; Appendix J).

When correlation coefficients were calculated between the barriers to service usage identified and a woman's well being as an adult, several relationships emerge (see Table J-3; Appendix J). For example, naming one of many of the barriers is associated with higher levels of PTSD and depression and poorer levels of physical health and mental health. There are a few barriers more likely to be named by those women reporting an alcohol problem. Being incarcerated, having a drug problem, and having attempted suicide shows little to no correlation with naming barriers to seeking services.

In conclusion, these results support Hypothesis (5), which states:

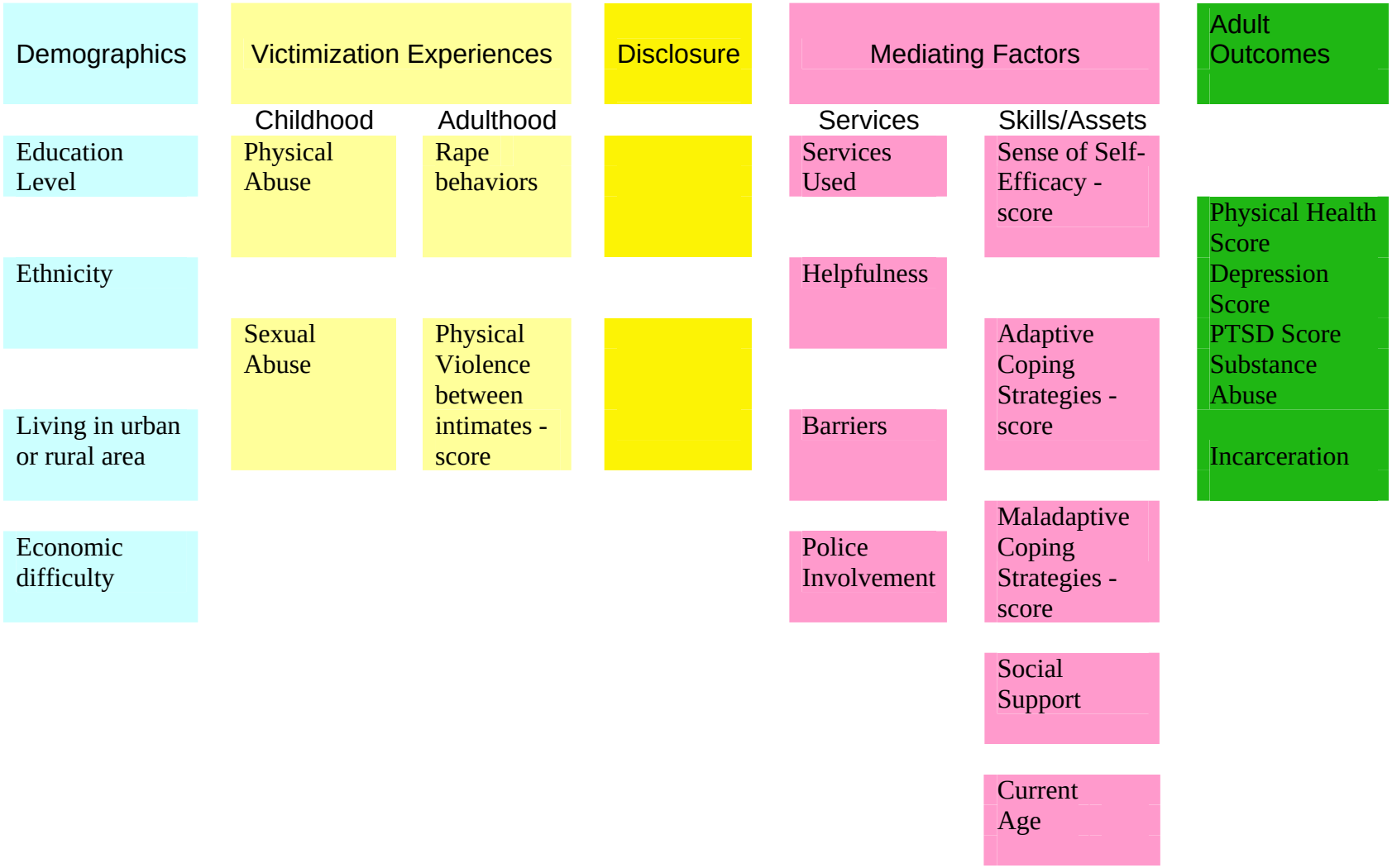
*A woman's positive perception of the supports she has received will be related to better outcomes in health, mental health, substance use, incarceration, and suicide attempts.*

Women's reports of perceived social support and their sense of self-efficacy are associated with better adult outcomes than are other mediating factors. Additionally, reports of using services are also associated with better outcomes in health, mental health, substance use, incarceration, and suicide attempts. Finally, women who identify encountering barriers when seeking services have poorer adult outcomes.

(5) *Which of all these factors (childhood demographics, history of victimization, and the mediating factors itemized in research question #4, are the strongest predictors of adult outcomes?*

A schematic of the analytic model is presented in Figure 1. The model used to predict the adult outcomes of study participants consists of six groupings of factors: demographic characteristics, victimization experiences, disclosure experiences, mediating factors, service usage and experiences, and adult outcomes. In the multiple regression analyses used to answer the question above, these groupings of characteristics and experiences were entered as blocks of variables, to determine the distinct utility of each block of factors in predicting one's experiences and outcomes. Once again, the Model of Inquiry graphically illustrates that methodology.

Model of Inquiry




Final Report: NIJ 2003-IJ-CX-1037
Postmus, J.L. & Severson, M. (2005).

***Predicting Victimization.*** Four separate multiple regression analyses were performed, using demographic characteristics to predict the four distinct experiences of victimization. The four experiences were entered differently: child physical abuse and child sexual abuse are dichotomous variables, where the respondent answered either yes or no on either variable. For Physical Intimate Partner Violence and Rape, the variable was the score of the number of behaviors experienced by the woman, thus allowing greater variability in the predictor. The demographic characteristics included in each of these models were: age, African American ethnicity, living in an urban area in childhood, family's difficulty in living on income in childhood, highest grade of school completed, and did not live with both parents in childhood.

This model is poor at predicting victimization, based on demographic characteristics. Each model has an $R^2$ of between .04 and .05, explaining very little of the variance in victimization experience. For the childhood experiences of either physical or sexual abuse, the only significant predictor is childhood poverty. For the adult experiences of Physical IPV or rape, the significant predictors are age and years of education, with victimization more likely with older age, and less likely with more education.

A final multiple regression analysis was performed to predict the number of different types of victimization a woman could experience (between zero and four). This model produces an $R^2$ of .06, slightly better than the individual victimization models. The only significant predictor variables in this model are childhood poverty and not living with both parents.

***Predicting Disclosure and Response.*** Given the high multicollinearity (high co-occurrence rates) of the four types of victimization, subsequent analyses used the number of different types of victimization experienced (childhood physical abuse, childhood sexual abuse, physical intimate partner violence, and adult rape) rather than each type of victimization. The

demographic characteristics discussed above and the number of types of victimization experienced were tested as to their ability to predict the frequency with which (1) a woman disclosed her victimization, (2) her perpetrator was confronted, and (3) a police investigation ensued. Each of these disclosure and aftermath variables was measured as a percentage of her victimization experiences. For example, if she experienced childhood physical abuse and childhood sexual abuse, but only disclosed the physical abuse, her score on disclosure would be 50% (see Method for more complete explanation of these disclosure and response measures and variables).

The first model was tested to predict the percentage to which women had disclosed their victimization. This is a very poor model, with an $R^2$ of .01. No demographic or victimization experiences predict whether or how often a woman discloses her victimization.

The second model was tested to predict the percentage to which the perpetrator was confronted following disclosure. This model performs better, with an $R^2$ of .09. A woman's older age reduces the likelihood of confrontation, as does a higher number of the types of victimization she has experienced.

Finally, a third model was tested to predict the percentage of times that a police investigation followed disclosure. This model produces an $R^2$ of .10. Again, older age reduces the likelihood of police investigation, as does the number of victimizations she has experienced.

***Predicting Current Levels of Mediating Factors.*** Building on prior analyses, the woman's childhood demographic characteristics, the number of victimization experiences and disclosure experiences were regressed on her difficulty in living on her current income. The reader is reminded that the incarcerated women were asked about economic difficulties for the 12 months prior to their incarceration, and generally were less distressed than the other samples. This is a

very poor predictive model, with an $R^2$ of .02. The only predictor of current economic difficulty is childhood economic difficulty.

Given the problematic nature of the variable measuring difficulty living on current income, these variables were regressed on a woman's receipt of welfare, instead of current economic difficulty. This model produces an $R^2$ of .05, better than that of the model above. The key predictors of whether a woman was a welfare recipient in adulthood are years of education, with an inverse relationship. Childhood economic difficulty is not a predictor of welfare receipt in adulthood in this sample.

The same set of variables was tested to predict a woman's level of social support. This model is better, producing an $R^2$ of .18. The significant predictors of a woman's level of social support are her education level, and the number of victimization experiences (negative effect on social support).

The same set of variables was tested to predict the use of adaptive coping strategies, and then the use of maladaptive coping strategies. These are poor models. The model to predict use of adaptive coping strategies has an $R^2$ of .04, while the model to predict use of maladaptive coping strategies has an $R^2$ of .05. The only predictor of the use of adaptive coping strategies is the percentage of violence occasions in which the perpetrator(s) had been confronted, with greater confrontation predicting higher use of adaptive coping. The one key predictor of maladaptive coping is a higher number of victimization experiences.

A final regression of the mediating factors was run to predict one's sense of self-efficacy. This model produces an $R^2$ of .11. The only significant predictor of one's level of self-efficacy is years of education, evidenced by a positive correlation.

***Predicting Service Usage Following Victimization.*** The next set of regression analyses used the variables in prior tests to predict service usage. Services were categorized into three groups: therapeutic/counseling, crisis services, and tangible services. In this set of regressions, the predictor variables included demographic and childhood characteristics, number of victimization experiences, disclosure experiences, and the mediating factors discussed above. The first model was performed to predict the amount of a woman's use of therapeutic services following victimization. This model produces an $R^2$ of .15, and the only significant predictors of the use of therapeutic services are years of education, number of victimization experiences, proportion of events where she disclosed the victimization, and her use of adaptive coping strategies. Each of these predicts a higher use of therapeutic services following victimization.

A second model was performed to predict a woman's use of crisis-oriented services following victimization. This model produces an $R^2$ of .20. The significant variables in this model are being a welfare recipient, the number of victimizations, the proportion of incidents where police investigated the incident, and social support. Number of victimizations, police involvement, and welfare receipt increase the likelihood of use of crisis services, while more social supports decrease the likelihood of using crisis interventions.

A third model was performed to predict a woman's use of long-term tangible services. This model produces an $R^2$ of .19. The best variables to predict a woman's use of tangible services are the number of victimizations and receipt of welfare.

Women were asked to rate the helpfulness of each service they received. These ratings were averaged for each woman into an overall rating of the helpfulness of services received. A fourth model was performed to predict how helpful a woman found post-victimization services overall. This model produces an $R^2$ of .17. The significant predictors of how helpful a woman

finds post-victimization services are childhood poverty, social support, and adaptive coping level. Higher levels of each of these predicts that a woman will find services more helpful.

Women were also asked to indicate how many of a number of barriers they perceived as limiting their use of services post-victimization. The model to predict the number of barriers perceived produces an $R^2$ of .21. Perceiving a number of barriers is best predicted by the number of victimizations experienced, poor social support, and the use of maladaptive coping strategies.

***Predicting Adult Outcomes***

A series of linear multiple regression analyses were performed to predict the four adult outcomes that were measured in terms of continuous scores: physical health, depression, post-traumatic stress disorder, and a self-identified problem with alcohol, drugs, or both. A fifth multivariate analysis, a hierarchical logistic regression analysis, was also conducted to test the ability of independent variables in the model to discriminate between incarcerated and non-incarcerated women, based on their characteristics and histories. All of the variables identified in the model schematic (Figure 1) and tested above were included in each of these models. These five multivariate analyses will be discussed separately.

***Predicting Physical Health Score.*** The first multivariate model is only fair in predicting the physical health of the study participant, with an overall $R^2$ of .20. Thus, the variables in the model explain 20% of the variance in physical health scores in this study sample. The variables were entered in four blocks, to determine the relative contribution of each block to the utility of the model. As seen in Table 40, age is a significant predictor of one's physical health. It is the only demographic characteristic associated with physical health status, and the demographic model produces an $R^2$ of .11.

The number of victimization experiences was entered into the analysis next. When these victimization experiences are added to the model in a second block, the $R^2$ increases from .11 to .13. However, the number of victimization experiences is not a significant predictor of one's physical health score.

Disclosure experiences were added to the model next, and cause no change in the $R^2$.

The fourth block of variables to be entered into the analysis concerned mediating factors. These included: self-efficacy score, use of adaptive coping strategies, use of maladaptive coping strategies, number of social supports and the receipt of welfare. This block of variables increases the $R^2$ of the model to .20. The best predictor of physical health in this block of variables is the number of social supports named by the participant, with a higher number of supports predicting better physical health.

The final block of variables to be entered focused on service usage, and included five variables: how helpful the participant rated the victimization services she used, and the number of barriers she named to seeking/receiving services, and her use of therapeutic services, and use of crisis intervention services, and use of long-term tangible services. Entering this final block of variables does not change the $R^2$; no service usage variable is a significant predictor of physical health.

Therefore, in the overall multivariate model to predict one's current physical health score, the two significant predictors are the woman's age and her level of social support. The amount of victimization she has experienced is not predictive of her current physical health, when all factors are considered.

Table 40: **Multivariate Model to Predict Physical Health Score**

| | B | Beta | sign. | $R^2$ |
|---|---|---|---|---|
| **Block 1 - Demographics** | | | | |
| Age | -0.621 | -0.262 | .000 | |
| African American ethnicity | -4.643 | -0.090 | .116 | |
| Urban | 1.038 | 0.020 | .714 | |
| Difficulty living on family income | -1.733 | -0.099 | .084 | |
| Years of education | 0.183 | 0.020 | .736 | |
| Didn't live with 2 parents | -0.800 | -0.018 | .755 | |
| | | | | .11 |
| **Block 2 - Victimization** | | | | |
| Number of victimizations | -1.099 | -0.050 | .486 | |
| | | | | .13 |
| **Block 3 - Disclosure** | | | | |
| % of events disclosed | 8.020 | 0.084 | .210 | |
| % of events confronted | -8.038 | -0.101 | .182 | |
| % of events invest. police | 2.280 | 0.034 | .591 | |
| | | | | .13 |
| **Block 4 – Personal Mediators** | | | | |
| Sense of self-efficacy | 0.100 | 0.052 | .435 | |
| Use of adaptive coping | 0.132 | 0.077 | .212 | |
| Use of maladaptive coping | -0.179 | -0.095 | .109 | |
| Social supports | 0.302 | 0.189 | .010 | |
| Welfare receipt | -1.041 | -0.020 | .737 | |
| | | | | .20 |
| **Block 5 – Service Usage** | | | | |
| Helpfulness rating | -0.001 | 0.000 | .999 | |
| Number of barriers named | -0.729 | -0.098 | .119 | |
| Number of therapeutics | -1.131 | -0.069 | .293 | |
| Number of crisis intervention | -0.190 | -0.013 | .856 | |
| Number of long-term tangible | 0.071 | 0.008 | .910 | |
| | | | | .20 |

***Predicting Depression Score.*** This multivariate model is very accurate in predicting the depression score of the study participant, with an overall $R^2$ of .53. Thus, the variables in the model explain 53% of the variance in depression scores in this study sample. This is by far the most predictive of the five models. The variables were entered in five blocks, to determine the relative contribution of each block to the utility of the model. As seen in Table 41, demographic characteristics are not good predictors of one's level of depression, and account for only 4% of the variance in depression level.

Victimization experiences were entered into the analysis next. When the number of victimization experiences is added to the model, the $R^2$ increases from .05 to .13.

The next block of variables concerned disclosure experiences. This did not improve the model in predicting depression; no disclosure variable is a significant predictor of depression.

The fourth block of variables to be entered into the analysis concerned mediating factors. These included: self-efficacy score, use of adaptive coping strategies, use of maladaptive coping strategies, number of social supports, and receipt of welfare. This block of variables increases the $R^2$ of the model a great deal, from .13 to .53. There are three highly significant predictors of one's level of depression in this block of variables: use of maladaptive coping strategies, followed by number of social supports, followed by one's sense of self-efficacy. Use of maladaptive coping strategies increases one's depression level, while social support and self-efficacy are related to decreased depression. The use of adaptive coping strategies is a weaker predictor of depression level in this model.

The final block of variables to be entered focused on service usage, and included five variables: how helpful the participant rated the victimization services she used, the number of barriers she named to seeking/securing services, and her use of therapeutic services, crisis intervention services, and long-term tangible services. Entering this final block of variables does not change the $R^2$ at all; no service variable is a significant predictor of one's level of depression.

Therefore, in the overall multivariate model to predict one's current level of depression, the three significant predictors are the mediating factors of use of maladaptive coping strategies, social supports, and sense of self-efficacy. One's status on these three factors is highly predictive of one's level of depression. The number of victimization experiences is not predictive of one's current level of depression when all factors are considered.

Table 41: **Multivariate Model to Predict Depression Score**

| | B | Beta | sign. | $R^2$ |
|---|---|---|---|---|
| **Block 1 - Demographics** | | | | |
| Age | -0.076 | -0.044 | .324 | |
| African American ethnicity | 2.429 | 0.064 | .146 | |
| Urban | 0.024 | 0.001 | .988 | |
| Difficulty living on family income | 0.416 | 0.032 | .463 | |
| Years of education | -0.316 | -0.048 | .302 | |
| Didn't live with 2 parents | -0.982 | -0.030 | .498 | |
| | | | | .04 |
| **Block 2 - Victimization** | | | | |
| Number of victimizations | 1.652 | .111 | .045 | |
| | | | | .13 |
| **Block 3 - Disclosure** | | | | |
| % of events disclosed | 1.873 | 0.027 | .604 | |
| % of events confronted | 1.019 | 0.018 | .765 | |
| % of events invest. police | -0.491 | -0.010 | .838 | |
| | | | | .13 |
| **Block 4 – Personal Mediators** | | | | |
| Sense of self-efficacy | -0.274 | -0.195 | .000 | |
| Use of adaptive coping | -0.123 | -0.098 | .040 | |
| Use of maladaptive coping | 0.551 | 0.398 | .000 | |
| Social supports | -0.326 | -0.278 | .000 | |
| Welfare receipt | -2.705 | -0.071 | .123 | |
| | | | | .53 |
| **Block 5 – Service Usage** | | | | |
| Helpfulness rating | 0.254 | 0.012 | .789 | |
| Number of barriers named | 0.227 | 0.042 | .391 | |
| Number of therapeutics | 0.266 | 0.022 | .661 | |
| Number of crisis intervention | 0.538 | 0.049 | .366 | |
| Number of long-term tangible | -0.339 | -0.051 | .341 | |
| | | | | .53 |

***Predicting Post-Traumatic Stress Disorder Score.*** This multivariate model is fairly accurate in predicting the degree to which the study participant has post-traumatic stress disorder; the variables in the model explain 41% of the variance in PTSD scores in this study sample. This is one of the more predictive of the five models. The variables were entered in five blocks, to determine the relative contribution of each block to the utility of the model. As seen in Table 42, demographic and childhood factors, including the family's difficulty living on their income in childhood, are not significant predictors of one's level of post-traumatic stress, and account for only 4% of the variance in PTSD level.

Victimization experiences were entered into the analysis next. When the number of victimization experiences is added to the model, the $R^2$ increases from .04 to .13.

When disclosure variables are added to the model, the $R^2$ does not change. Disclosure experiences are not associated with one's level of post-traumatic stress.

The fourth block of variables to be entered into the analysis concerned mediating factors. These included: self-efficacy score, use of adaptive coping strategies, use of maladaptive coping strategies, number of social supports, and receipt of welfare. This block of variables increases the $R^2$ of the model a great deal, from .13 to .40. There are three highly significant predictors of one's level of PTSD in this block of variables: use of maladaptive coping strategies, followed by sense of self-efficacy, followed by number of social supports. Use of maladaptive coping strategies increases one's PTSD level, while social support and self-efficacy are related to a decreased level of PTSD. The use of adaptive coping strategies does not predict one's PTSD level in this model.

The final block of variables to be entered focused on service usage, and included five variables: how helpful the participant rated the victimization services she used, the number of barriers she named to seeking/receiving services, and her use of therapeutic services, crisis intervention services and long-term tangible services. Entering this final block of variables barely improves the accuracy of the model.

Therefore, in the overall multivariate model to predict one's current level of PTSD, the three significant predictors are the mediating factors of use of maladaptive coping strategies, sense of self-efficacy, and social supports. One's status on these three factors is fairly predictive of one's level of PTSD. Victimization experiences are not predictive of one's current level of PTSD when all factors are considered.

Table 42: **Multivariate Model to Predict Post Traumatic Stress Disorder Score**

| | B | Beta | sign. | $R^2$ |
|---|---|---|---|---|
| **Block 1 - Demographics** | | | | |
| Age | -0.044 | -0.022 | .659 | |
| African American ethnicity | -0.185 | -0.004 | .932 | |
| Urban | 2.796 | 0.065 | .177 | |
| Difficulty living on family income | 0.613 | 0.041 | .401 | |
| Years of education | 0.253 | 0.033 | .522 | |
| Didn't live with 2 parents | 0.059 | 0.002 | .975 | |
| | | | | .04 |
| **Block 2 - Victimization** | | | | |
| Number of victimizations | 1.931 | 0.112 | .068 | |
| | | | | .13 |
| **Block 3 - Disclosure** | | | | |
| % of events disclosed | -5.084 | -0.063 | .276 | |
| % of events confronted | 2.047 | 0.030 | .641 | |
| % of events invest. police | 0.797 | 0.014 | .797 | |
| | | | | .13 |
| **Block 4 – Personal Mediators** | | | | |
| Sense of self-efficacy | -0.319 | -0.196 | .001 | |
| Use of adaptive coping | -0.038 | -0.026 | .622 | |
| Use of maladaptive coping | 0.515 | 0.322 | .000 | |
| Social supports | -0.266 | -0.196 | .002 | |
| Welfare receipt | -1.519 | -0.035 | .501 | |
| | | | | .40 |
| **Block 5 – Service Usage** | | | | |
| Helpfulness rating | 0.447 | 0.019 | .715 | |
| Number of barriers named | 0.670 | 0.106 | .050 | |
| Number of therapeutics | 0.95 | 0.007 | .904 | |
| Number of crisis intervention | 1.668 | 0.132 | .030 | |
| Number of long-term tangible | -0.714 | -0.092 | .119 | |
| | | | | .41 |

***Predicting Problems with Substance Use.*** Participants were asked to self-report whether they thought they had an alcohol problem, and whether they thought they had a drug problem. These two questions were combined into a summary outcome variable of problems with substance use, which could vary from 0 (no problems) to 1 (a problem with either alcohol or drugs) to 2 (self-report of having both problems). The multivariate model is poor in predicting the degree to which the study participant reports drug or alcohol problems, with an overall $R^2$ of .07. Thus, the variables in the model explain only 7% of the variance in substance abuse in this study sample. This is the least predictive of the five models. The variables were entered in four

blocks, to determine the relative contribution of each block to the utility of the model. As seen in Table 43, difficulty living on the family income in childhood is not a significant predictor of one's reported substance problems, and demographic characteristics explain only 6% of the variance in drug and alcohol problems.

The remaining blocks of variables did not improve the accuracy of the model in predicting drug or alcohol problems. Therefore, in the overall multivariate model to predict one's current report of problems with drugs and/or alcohol, no one variable is predictive, nor is the entire model, including one's status on other adult outcomes.

Table 43: **Multivariate Model to Predict Alcohol and/or Drug Problems**

| | B | Beta | sign. | $R^2$ |
|---|---|---|---|---|
| **Block 1 - Demographics** | | | | |
| Age | 0.009 | 0.1109 | .078 | |
| African American ethnicity | -0.048 | -0.027 | .660 | |
| Urban | 0.242 | 0.140 | .021 | |
| Difficulty living on family income | -0.085 | -0.142 | .021 | |
| Years of education | -0.004 | -0.012 | .851 | |
| Didn't live with 2 parents | 0.216 | 0.143 | .022 | |
| | | | | .06 |
| **Block 2 - Victimization** | | | | |
| Number of victimizations | 0.064 | 0.093 | .229 | |
| | | | | .07 |
| **Block 3 - Disclosure** | | | | |
| % of events disclosed | 0.069 | 0.021 | .769 | |
| % of events confronted | -0.146 | -0.054 | .507 | |
| % of events invest. police | 0.151 | 0.066 | .332 | |
| | | | | .06 |
| **Block 4 – Personal Mediators** | | | | |
| Sense of self-efficacy | -0.007 | -0.103 | .152 | |
| Use of adaptive coping | 0.006 | 0.098 | .143 | |
| Use of maladaptive coping | -0.004 | -0.061 | .337 | |
| Social supports | 0.002 | 0.039 | .623 | |
| Welfare receipt | 0.149 | 0.085 | .189 | |
| | | | | .08 |
| **Block 5 – Service Usage** | | | | |
| Helpfulness rating | -0.019 | -0.020 | .761 | |
| Number of barriers named | 0.016 | 0.063 | .355 | |
| Number of therapeutics | -0.016 | -0.029 | .684 | |
| Number of crisis intervention | 0.016 | 0.031 | .679 | |
| Number of long-term tangible | 0.024 | 0.077 | .300 | |
| | | | | .07 |

***Predicting Incarceration.*** The same model of blocks of variables was tested for it ability to predict the incarceration status of the women in the sample. This model accounts for 21% of the variance in this outcome. In the first block of demographic characteristics, childhood poverty and not living with both parents as a child are highly predictive of incarceration. This first block of variables produces an $R^2$ of .12.

The second block of variables, concerning victimization, does not change the accuracy of the model. Number of victimization experiences does not predict incarceration.

The third block of variables, disclosure experiences, also does not improve the $R^2$ for the model. However, a higher percentage of victimization experiences where police investigate is predictive of incarceration.

The fourth block of variables includes the mediating factors of social support, adaptive coping, maladaptive coping, self-efficacy and receipt of welfare. This block increases the $R^2$ from .12 to .16. Welfare receipt is highly predictive of being incarcerated.

The last block of variables, concerning service usage, increases the overall $R^2$ to .23. In this block, a lower use of crisis intervention services is predictive of incarceration, as is a lower perception of services as being helpful. Therefore, as seen in Table 44, in the overall model to predict incarceration, the most significant predictors of incarceration are not living with both parents as a child, childhood economic difficulty, police investigations following victimization, welfare receipt, a lower use of crisis intervention services, and a perception of services as less helpful.

Table 44: **Multivariate Model to Predict Incarceration**

| | B | Beta | sign. | $R^2$ |
|---|---|---|---|---|
| **Block 1 - Demographics** | | | | |
| Age | 0.006 | 0.104 | .071 | |
| African American ethnicity | 0.033 | 0.029 | .613 | |
| Urban | 0.114 | 0.100 | .074 | |
| Difficulty living on family income | -0.058 | -0.146 | .010 | |
| Years of education | -0.031 | -0.151 | .012 | |
| Didn't live with 2 parents | 0.177 | 0.177 | .002 | |
| | | | | .12 |
| **Block 2 - Victimization** | | | | |
| Number of victimizations | 0.067 | 0.148 | .038 | |
| | | | | .12 |
| **Block 3 - Disclosure** | | | | |
| % of events disclosed | 0.151 | 0.070 | .290 | |
| % of events confronted | -0.157 | -0.088 | .243 | |
| % of events invest. police | 0.259 | 0.170 | .007 | |
| | | | | .12 |
| **Block 4 – Personal Mediators** | | | | |
| Sense of self-efficacy | -0.002 | -0.038 | .566 | |
| Use of adaptive coping | -0.004 | -0.108 | .081 | |
| Use of maladaptive coping | -0.004 | -0.097 | .099 | |
| Social supports | 0.005 | 0.130 | .075 | |
| Welfare receipt | 0.220 | 0.189 | .002 | |
| | | | | .16 |
| **Block 5 – Service Usage** | | | | |
| Helpfulness rating | --0.099 | -0.158 | .009 | |
| Number of barriers named | 0.014 | 0.082 | .189 | |
| Number of therapeutics | -0.025 | -0.069 | .290 | |
| Number of crisis intervention | -0.061 | -0.182 | .010 | |
| Number of long term tangible | -0.003 | -0.015 | .822 | |
| | | | | .21 |

In conclusion, the multivariate analyses, above, show that minority ethnicity is not a good predictor of adult outcomes in this sample, when considering all possible predictors. However, ethnicity is highly correlated with childhood economic difficulty as well as lower education, and both of these are much stronger predictors of most adult outcomes, particularly incarceration. Multiple victimizations are not a strong predictor of adult outcomes in this sample. Disclosure rates can predict adult outcomes, particularly in the case of incarceration, which is predicted by police investigations following disclosure of violence. Taken separately, the best predictors of adult outcomes are childhood physical and sexual abuse, followed by rape

in adulthood. The extent to which a woman experiences physical intimate partner violence is not a good predictor of adult outcomes in this sample. Thus, the results partially support Hypothesis (6), which states:

> *Statistical analyses will find that women experience poorer adult outcomes when any of the following are true (and these have negative cumulative effects): minority ethnicity; lower education; living in a rural environment; any victimization; multiple victimizations; undisclosed victimization; limited access to services.*

When controlling for all other variables, the mediating factors of self-efficacy, social supports and use of maladaptive coping provide great predictability for adult outcomes. One's level of social support is a good predictor of one's physical health, depression, and levels of PTSD. One's use of maladaptive coping strategies is a strong predictor of poorer outcomes on measures of depression and PTSD. Self-efficacy is also a strong predictor of adult outcomes, although not as predictive as social support and maladaptive coping. A higher sense of self-efficacy is predictive of better physical health, a lower level of depression, and decreased levels of PTSD. Service usage was only predictive of the adult outcome of incarceration, in that incarcerated women had found services less helpful, and had received fewer crisis intervention services. Thus, the results partially support Hypotheses (7) and (8), which states:

> *Statistical analyses will find that women experience better outcomes when any of the following are true (and these have cumulative positive effects): disclosure of the violence; social supports; coping skills; and services received and perceived as helpful.*
>
> *The key predictors of poor outcomes will be adult poverty, minority ethnicity, multiple victimization, and non-disclosure.*

To summarize, the best predictors of physical health in this sample are age and number of social supports. The best predictors of depression in this sample are the use of maladaptive coping strategies, social supports, and one's sense of self-efficacy. The best predictors of one's level of PTSD are one's sense of self-efficacy, use of maladaptive coping strategies, and social supports. The best predictors of incarceration are difficulty in living on the family income in childhood, years of education, proportion of victimization disclosures that were followed by a police investigation, receiving welfare, finding services not helpful, and not using crisis intervention services.

***Qualitative Results***

Seventeen women agreed to participate in the qualitative phase of this study; 10 women from the women's correctional facility (WCF) and 7 women from one of the communities (see Table 45). The average age of the 17 women is 34 with a range of 21 to 47. Most of the women are White (11) followed by African American (3), Native-American (2), and Hispanic (1).

**Table 45: Demographic Data on Qualitative Interviews**

| | **Total (n=17)** | **Community (n=7)** | **Prison (n=10)** |
|---|---|---|---|
| **Age** | 34.47 | 36.86 | 32.8 |
| **Ethnicity** | | | |
| White | 11 | 5 | 6 |
| African American | 3 | 1 | 2 |
| Latina | 1 | 0 | 1 |
| Native American | 2 | 1 | 1 |
| **# of Victimization Experiences** | | | |
| 0 experiences | 0 | 0 | 0 |
| 1 experience | 1 | 1 | 0 |
| 2 experiences | 4 | 1 | 3 |
| 3 experiences | 3 | 1 | 2 |
| 4 experiences | 9 | 4 | 5 |
| **Mean # of Experiences** (0 to 4) | 3.18 | 3.14 | 3.2 |

In order to qualify for participation in this qualitative phase of the study, each woman must have reported experiencing at least one form of physical or sexual abuse as a child and either physical intimate partner violence (IPV) or rape as an adult. After providing their written consent to participate in the qualitative interview and to have the interview taped (see Appendix H), a series of questions with corresponding probes were asked. Each of the individual interviews lasted approximately one hour.

The following pages provide the analysis of these 17 qualitative interviews. The names and identifying information of the women interviewed have been changed to protect their privacy and to assure them of the confidentiality of the research process. Finally, the women's

quotes have been edited for grammar and content but the integrity of their comments has been maintained.

Consistent with the research protocol, of the 17 women presented here, about one-third (5) reported having experienced two forms of victimization; though most (12) reported having experienced either three or all four types of victimization. Their experiences with victimization and disclosure and with the interventions received vary and yet have many similarities. The results presented here begin with a description of their victimization and disclosure experiences, and then are linked to the interventions they report having received. This section ends with the women reflecting back on the ways their experiences shaped their lives and with advice offered to other women who survive victimization.

***Victimization Experiences – Childhood Physical Abuse***

Thirteen of the seventeen women talk about their childhood and adolescent experiences with physical abuse. The abusers usually include their mothers or fathers, whether biological or step-parents. Rachel describes the abuse from her mother:

> *I remember when I was [a young child], I wanted a drink of milk, and I wanted my blue glass, my favorite glass. And it was dirty and I guess I was throwing a fit about it. My mother took a gallon of milk and dumped it over my head. And it just shocked me and then she spanked and made me clean up the kitchen. She became angry with me one time because I hadn't done my chore the way that she wanted it done and she hit me in the face with a hairbrush. [The abuse] pretty much [happened] every day. It seemed worse in the summer because I was home all day.*

Anne describes both of her parents as being physically abusive:

> *They punched me a couple of times but it was never just one quick smack across the face; it was multiple [punches] to where I would be down on the floor or I would be across the room and trying to get up. It was more frequent and it was a little bit more intense because I got older, I got bigger and where as it used to just take one hit to stop me now and they were having to used more.*

Rebecca describes how her stepfather was violent with her as a way to manipulate her mother into having sex with him:

> *I had guns put up to my head, knives put up to my throat, stuck down my throat. He [stepfather] just did it to try to get his way with my mom. Because if she wouldn't have sex with him, he'd grab me.*

Delores was also abused by her stepfather. Delores reports that he chose her as his victim but that he did not abuse his own male children. Delores describes her daily routine which included being abused:

> *It seemed every day we'd get home from off the bus, the minute we walked through the door we usually got a whack on the head, just automatically. We got a backhand because he [her stepfather] just knew that we'd done something wrong. And then I would have to come in and do the chores. Mom worked evenings so he pretty much had total control from 3:30 on. And I'd have to do the dishes, I would have to clean the house, the bathrooms, every part of the house had to be spic and span. His boys pretty much got to go outside. They got punished but I don't know why he picked on me the most. But I was chosen to do all the dirty work. And then when I was done we had to sit down and do our homework and he'd sit over the top of us and watch us. If we wrote something down wrong we got the thump in the head or in the mouth. And then I was sent to my room for the rest of the evening till supper.*

The women were asked to reveal their experiences around disclosing their childhood physical abuse. Not all of them told others about the abuse; for example, Rachel recalled that no one knew about her victimization until she was a teenager. Even then, she did not disclose her victimization but rather, the bruises were noticed by a teacher.

> *I didn't realize that it was not normal that everybody's parents treated them that way until I was older -- about 14. She [mother] hit me with the belt and I had to go to school the next day and dress up for gym and I didn't want to dress up because my legs were bruised up and my teacher made me anyway and I think somebody called [reported the abuse] because the DFS worker came after that. I was brought up in a home where you didn't talk about things outside the home. So, even though I knew it was hurting me, it didn't feel right to talk about it.*

It was not until middle school that Anne first told someone about the physical abuse she endured at home. Later, she told a school official in high school. The reactions to her disclosures were not favorable.

> *I told someone when I was in middle school. I had been seeing one of the counselors there privately letting him know what's going on and everything. And he finally brought my dad in to talk to him about [the abuse] but nothing ever came of it. I ended up getting grounded. And then, when I was a sophomore in high school and my mom split my lip, I told my school counselor and he had the nurse look at my lip and then they brought in the student resource officer and he said after talking to my mom he felt like she was defending herself. So nothing was ever done and I ended up running away that night.*

Rebecca describes the challenges she faced, living in a small town.

> *They pretty much knew in my school, too. My best friend and her family knew. But it was a small town. They hid things back then. They don't do things like they do now. When that abuse was going on, they don't put people in jail like they do now. Everybody knew.*

Finally, Delores talks about how she struggled with her feelings of anger and how she hit her brothers in frustration. Whether due to her experience in counseling or her relationship with her parents or both, Delores reports not being able to trust anyone and as a result, her being forced to "bottle" up her feelings.

> I felt worthless, really. I didn't feel like I needed to live. I always had a lot of anger. And because he would punish me, I would attack his boys, so I got in a lot of trouble.
>
> I went to counseling and they told me to write a journal, and I did. He [stepfather] found my journal and I got a whipping that never ended, it seemed like. So I stopped writing feelings down. I never expressed feelings. I didn't trust counselors from that day on, because they always tell your parents eventually, when you're under age, it seems like. So I didn't have anybody to trust. And my mom didn't believe me. Because I tried telling her and she told him, and, the minute she left, I got it again for telling. So I always had to bottle it up. I was always frustrated and confused and very angry.

### *Victimization Experiences – Childhood Sexual Abuse*

Thirteen of the 17 women report being sexually abused as children and their disclosure experiences. Beth describes her sexually abusive relationship with her father. While her words are edited for clarity, Beth struggled with talking about her experiences as evidenced by her coughing, clearing her throat, and repeating herself during the interview.

> *From what I can recall, it [sexual abuse] started when I was like probably about three. And it went on until I was sixteen or seventeen. When I was little, it was almost every night. [As I got older], it didn't happen near as often [because] I had my period. He would touch me and then he raped me [when I was] about nine.*

Beth went on to describe her rationale for not telling her mother about her father's abuse. When asked, "Did you tell anyone?" Beth said, "No, [because] I felt too ashamed." Later in the interview, Beth talks of how she told her mother years later and her mother's response:

> *She [her mother] just said she was sorry and that she stayed with him, and she hadn't helped me and stuff like that. But then she tried to act like she didn't know that it had happened but I thought that's crap because she always used to ask me if it happened and I used to say no but she had an idea so why is she acting like she doesn't know now. I think she feels guilty.*

Teresa describes experiencing sexual abuse at the hands of her mother and then also at the hands of one of her dad's friends. She provides her rationale for not telling her father about his friend.

> *I only recently started having memories of sexual abuse from my mother. And I think I was about 4. When I was [a pre-teen], one of my dad's friends put his finger in me. He actually touched me under the blanket and then my dad walked in while he was doing it and I tried to pretend like nothing was happening. So I felt like if I didn't say anything at that time, why say anything later? He never said not to tell. But I knew if I told my dad [it] would break that friendship and then, if it broke the friendship I would feel guilty but then if it didn't break the friendship I would feel like my father didn't care about me so there is no win situation. I didn't see anything good coming out of telling so I didn't. He never touched me again.*

Denise describes her sexual abuse at the hands of her brothers and an uncle. She also talks about her mother's disbelief when she disclosed the abuse by the uncle. As a result of her mother's disbelief, Denise did not say anything further to her mother, but reports that other family members told her mother about the abuse at the time her mother was dying.

*My younger brother did it more to me than the oldest brother who only did it a few times but the younger, the younger brother did it all the time … at least three times a week …he would have intercourse with me and make me do things to him like suck him or whatever and he'd want to fondle me and put his finger up me and things like that. Which I knew nothing being in kindergarten.*

*I had an uncle that I met one time and I was in my bunk bed and I was like probably 7 years old and when he met me the first thing he did was grab my boob and rub my boob and go "Oooh nice." And I did tell my mom about that and my mom didn't believe me, my mom didn't believe me. So I never told my mom anything else after that.*

*My mom was dying before any of them ever told her anything about it. She was crushed cause she said she never knew. We were always kind of thought she knew but I guess not you know?*

***Victimization Experiences – Adult Physical IPV and Rape***

Almost all of the women (16) talk about their physical IPV experiences in the qualitative interview. As part of their disclosure experiences, most describe their involvement with law enforcement or the courts. The women portray their victimization in somewhat graphic detail, and yet at the same time, express uncertainty as to whether their experiences constituted physical abuse or minimize the frequency or severity of the attacks.

***Teresa**: One day, I was mad at him [for not letting me go out with him] and I locked him out, so he smashed the door in. And a he punched me in my kidney and it ripped open and he wouldn't take me to the hospital. [After] I was bleeding internally for two days, I called his grandma and she took me to the hospital. Another time, I was screaming help out the door and he grabbed me and put his whole entire fist in mouth until it split my lip and that was a big fist. One time he drug me down the stairs by my hair, he hit me open handed in my ear and broke my ear drum, and bruised my cheek. He'd strangled me a lot. He liked to choke me. This is physical abuse, right?*

***Kris**: He wasn't physically abusive very often. He only broke my nose and my chin and bruises here and there. [It] only happened four times. That's not true either. He threw things at me and pushed me. One time I tried to run away and all he did was he grabbed my hair and drug me across the parking lot and there was a person there that saved me. I was scared he was going to beat the crap out of me. I just couldn't believe he was doing it because he's a sweet person sometimes and then he's got two personalities.*

***Mavis**: He would punch me in the face, I mean, there were times when I couldn't see, my face was so black and blue. Most of the time, he wouldn't hit me in the face so much; he didn't want it to show I guess.*

While describing the violence inflicted by her husband, Jennifer also talks about her decision to get married and to stay with her abusive husband for the sake of their child.

*My first husband was very physically abusive. I got married when I was [young]. I didn't have any children. I had my son when I was [in my teens]. He was physically abusive from the start, even before we got married. The day before we got married he had, I call it, kicked my ass, smacked me around quite a bit, you know, took me out, verbally abused me but I still married him anyhow because I thought I was in love. [At the time,] we lived at my grandparents' house and one of the reasons why I married was because my grandparents' had a rule you couldn't sleep together unless you were married. He was physically abusive all this time; at least once a week I would be slapped, punched, restrained, verbally abused on a daily basis. I was going to divorce him right after I found out I was pregnant with my son and he said no, you can't do that. You can't let a child be without both parents and coming from the background I did with my grandparents' old morals and values I thought OK I can't do that to my child. I've got to have both parents. I didn't have a mom. My children's going to have both parents no matter what. So I stayed with him many years and endured a lot.*

Jennifer went on to describe what happened when she became "fed up" with the abuse.

*I was so fed up with him that I stabbed him. I stabbed him once because I just couldn't take him no more. I just couldn't take the beatings. Every day of my life he was abusing me. I had had my daughter by that point. I had no self esteem. I couldn't even get a job no less than hold a job. I stabbed him once. He stabbed me six times and I went to court. I went to jail for stabbing him but he didn't get any charges and he didn't go to jail for stabbing me six times.*

Susana also talks about her abuse and what happened when she fought back.

> *The first time he just choked me, and slammed me up against the wall. I remember that was the very first time; you remember the first, and you remember the worst. And then the worst time [which began with a beating that left me with black eyes and bruises all over – and this was the last time he ever abused me – he had me down and was choking me. I was about ready to lose consciousness. …. And I just remember, "I've gotta do something. He's gonna kill me, I'm gonna die." I had a [young] baby …, and a five-year-old [child] and I'm gonna die, they're not gonna have a mother. This all rolled through my head. And I just reached with everything I could and grabbed the lamp and I hit him over the head with it and got him off of me. And the neighbors had long since called the police, so here they are, they see what I've done to him, and they take us both to jail. They see my face is beaten so bad you can't even tell who I am, and we both go to jail.*

Several other women describe their experiences of physical IPV and sexual assault by an intimate partner:

> ***Rachel**: He's what I call a rageaholic. You could wrap chicken in foil in the refrigerator and set him off or you could not come home when you were supposed to be at home -- you just never knew what would set him off. I can remember we were having an argument and I was in the shower downstairs. I said something under my breath and apparently he heard it and the next thing I know I was picking myself up off the shower room floor. The last incident, he had been hitting on me and then made me get into a truck and took me off. When we came back, I thought if I just tell him I'm not leaving you and go to sleep everything will be okay. The next thing I know, he was on top of me and I was trying to fight him off and he choked me and I passed out. I woke up and I knew I didn't have any clothes on and I knew what had happened.*
>
> ***Joyce**: He took a knife to me one night and cut my clothes off, and that's how the sexual abuse came about. The last time he ever put his hands on me he put me in the hospital. That was in [date]. He hit me in the back of the head with a big metal pot and it split my head wide open and they had to put 15 staples in the back of my head.*
>
> ***Lorraine**: He had ripped off my clothes, put my bra around my neck, and pinned me up against the door on this nail that we had above the peephole. I lost consciousness and woke up on the floor in front of the door. That was my first marriage. My second marriage ended up being even worse, because the drugs were involved then. There were times where I had to lock me and the boys up in our room because he was enraged and hitting me. He broke my jaw, two of my ribs. I'd be curled up on the ground in a ball and he would kick me and keep continuing to hit me. He'd actually raped me [because] we were making too much noise in the morning. I was cooking breakfast and he slammed my head up against the refrigerator and ripped my nightgown and yanked my panties off and he raped me in the ass.*

### *Seeking Help*

After describing their victimization experiences, the women also discuss where they turned for help and if the assistance they received was helpful or not. Almost all of the women (16) contacted someone in the law enforcement – actions usually taken because of IPV or sexual

assault. A few women talk about how the police were helpful, such as Tory who describes how the police helped her:

> *He had never put his hands on me so there was nothing tangible for me to say until he pulled the gun and I called the police and the police officer advised me to just go ahead and just come into the shelter. They were all a big help.*

Anne describes her ordeal with the hospital and the police as a result of rape, describing how one officer was helpful whereas another one was not.

> *I said that I thought I had been sexually assaulted and they took me to the back room, they told me to undress, and I couldn't do it. I was just crying so hard and I called a friend and said that I was there. She met me there and helped me get out of clothes and called another mutual friend and she came down and so they helped me get out of my clothes and get into the gown and we just waited for the hospital people to come in and they asked if I wanted to press charges, I didn't want to press charges I just wanted to get checked out like for STDs and everything and they told me they wouldn't give me an exam like an STD exam unless I press charges so I flipped out because I didn't want to press charges, I wanted it to be done I didn't want to get any diseases either. So I finally agreed to press charges and they called the police and a police officer showed up, he was real nice. It was only when the lady detective showed up that it was really bad like she started saying that I was acting like a victim and that all victims act the same. That I was just making up for attention and actually asked me if I was trying to get back together with my boyfriend and questioned both my friends about whether or not I had a history of lying and stuff like that. It was not good and I was so traumatized that I couldn't cry anymore. The hospital staff was great though. They were really supportive. One of the doctors told the police officer she was being totally inappropriate. [Later,] he [boyfriend] said it was consensual and the detective that I talked to a couple of days after it happened told me that in his professional opinion I didn't have a case and the DA would never take it up. So I would save myself a lot of headache and heartache if I just dropped it. So I did.*

Seven of the 16 women who report being victims of IPV and who also report police involvement, describe how <u>they</u> were arrested – usually along with the abuser. Joyce and Lorraine provide two examples of being arrested:

> ***Joyce:*** *I got tired of calling the cops because every time I did we both went to jail. I've gotten domestic violence charges on my record now. There have been times they've come out and arrested me and seen that I was so beat up I couldn't see out of either one of my eyes, but I still got charged with domestic violence. So I pretty much refuse to call the cops for any reason.*
>
> ***Lorraine:*** *[One time I called the police], and they took him to jail, but they took me to jail [too] because he had a cut on his hand. Everything was dropped against me and then I had to go to court. I had to bail out, and hurting at the same time. And the screwed up thing about it was they said you should have called 911. Well, I had called 911 several times before this, and we didn't have a phone. So I couldn't call 911. I had these papers of the judge and everything and even the officer, there was two of them, and one officer said this is part of my job that I don't agree with. And there's not a thing I can do. And I don't think this is right to take you to jail. But the other one had no compassion at all. I was very pissed.*

Mavis succinctly sums up her experiences with the police:

> *I got double violated… triple violated. [Interviewer: And you mean by that?] There was two men and then law enforcement.*

The women also report relying on the domestic violence shelter or sexual assault providers as well as other social services or therapists. Kris and Rachel talk about their positive experiences with the shelters.

> ***Kris**: Women's shelters have this icky picture painted to society and I guess that's what I thought. But it's not like that, it's like a home. This place [shelter] has helped me to see that there are other things out there.*
>
> ***Rachel**: After [my] relationship ended, I ended up in a domestic violence shelter. And I went to the complete program which was 12 weeks long and then when I got out of shelter, I continued with counseling for almost two years.*

While Rachel portrays her experience with the shelter as a helpful experience, she and others talk about some of the barriers or challenges they encountered when turning to the shelter for help.

> ***Rachel**: I tried to call the shelter once and they were full. So then my kids and I slept in the park [The shelter] didn't seem to be available to me or I didn't know about them.*
>
> ***Teresa**: They wouldn't let me drink alcohol and that was the only way I had to deal with the issues going on in my life. So I ended up leaving there after 3 days. But I did continue some outpatient counseling.*
>
> ***Tanya**: It was hard being in a shelter with [my kids], though, because they couldn't do what they wanted to. You had to be with your kid every place they went. So if one wanted to go outside and one wanted to watch TV, we had to decide what are we going to do?*
>
> ***Lorraine**: I'm just scared of reaching out to a shelter [because of] the rules, and being told what to do.*
>
> ***Rebecca**: They didn't have, well, I'm hearing now that they do have domestic abuse shelters for women there. That was in [a small rural community]. But they didn't [back then]. There was no where to go for women with domestic abuse.*

Jennifer, who was arrested for IPV after hitting her partner with a lamp, talks about the helpfulness of the batterer's intervention program:

> *I'm real grateful for the battered women's shelter for holding those classes [batterer's intervention] there. And I'm grateful that the judge court ordered that because I did get a lot out of it; a lot of information. After I went through alternatives to battering [class], I decided that I was going to leave my first husband. I didn't want to be abused.*

The women also talk of their use of therapeutic services and their opinions of and thoughts about social workers, therapists, clinics, or psychiatric hospitals. Most often, the women describe the interventions as being helpful.

> ***Tanya**: I went to mental health and guidance [clinic] and they talked to me, [and] let me know the abuse wasn't my fault. They had a lot of programs [that] helped me. I was torn between loving him and having his kids and not being with him because he was abusing me. That's why I'm a big advocate for social workers … because we don't do what we're supposed to do. I've had very many social workers try to get me in different groups, programs. It's just whether or not I utilize it or not. It wasn't the system who took my kids. It was the system who stepped in and intervened, but it was me that decided to continue to do drugs and run with the boys. Of course you may get some social workers who are mean, but for the most part what I've looked in myself is because I didn't do what I was supposed to do.*
>
> ***Lorraine:** I loved it. In fact, I remember one of my doctors, his wife would call. I'd actually have him crying sometimes. He was a really good doctor and he listened and he just let me talk and talk. And he'd even be late to get home. But yeah, it helped to talk. I liked that.*
>
> ***Rebecca:** And we were working on more of it[the abuse], trying to figure out things, yes. I was pretty satisfied with [counseling].*
>
> ***Jennifer:** It was an outpatient and the counselor did make a difference in my life because even though it was a male person and I was really totally shut off from this person because it was a male, he pointed things out to me about myself that made me open up my eyes … and I'm grateful to him.*

However, some of the women discuss how the therapeutic interventions were not helpful. For example, Anne did not find therapy helpful in part because she was not ready to make a change or deal with the aftermath of her abusive victimization and in part because she perceived the therapist to be focused on a different concern than the abuse itself.

> ***Anne**: I don't think [therapy] was helpful at all. I didn't want to deal with it [the abuse], I didn't want to talk about it and my therapist was more concerned about how I was making my parents feel than anything else.*

Delores describes how she experienced further abuse after the therapist told her parents what she had said in her individual session:

> *I was in counseling when I was in foster care, and then when I got put back with my parents they would make me, and my whole family go [to counseling]. I would go in first and the counselor would ask a bunch of questions, how I felt and all that stuff, and I would tell her. And after I would come out she'd call my stepdad in and she would tell him everything I said, so the minute I got in the car it [the abuse] began. And then I got home it was ten times worse. I hated counselors. It got to the point where I would literally just throw fits if I had to talk to them, because I knew they were going to get me more in trouble. To me, they weren't helping me. They were just making it really worse.*

A common intervention mentioned by the women had to do with their involvement with the child welfare system, including the juvenile justice system, either as a child or as an adult. Elizabeth tells how social workers from the child protective system removed her from her home and what happened to her in foster care:

> *I've had a bitterness towards Social Workers because they came just like the police to our house and just treated us like we were criminals and just yanked us out of our house and stuck us in the back of this car. Just took us off, and stuck me in a children's home. … And the man in that foster home sexually molested me and when I told the women the next day, I came home from school and our bags were packed. Cause she was afraid I was going to report it or whatever.*

Delores describes how she became involved with the child welfare system and her frustrations with the system:

> *In … grade [school] when I got whipped and had welts, I went to school and my friend had grabbed me by my back and I jerked forward saying don't do that and she pulled my shirt up and saw that I had bruises, and I kept telling her don't you say nothing. And then she went to the counselor, or it could have been the principal, I'm not really for sure, went to one of them, and before the day was over I had the welfare office, the police department, everybody was at the school talking to me. They wanted to take me out of the home then, but I knew that my stepdad wouldn't have. So they waited and they followed the bus home and he stood there and he waited and I went in the house and he asked me if I had told anybody, and I replied no, because I knew they were going to come to the door any minute. And within 15 minutes he screamed my name and I knew they were there. And he got a good lashing in before they got to the door. He hit me upside my face pretty good, called me some names, and they came in. But it was like the early 90s. They didn't do much. They took me out of the home for a couple of weeks and that was it. It was maybe a month tops I was gone. Because they were going to remove him out of the home and my mom had came back there and started yelling at me, they're going to take him away, and started calling me a bunch of names. And I was trying to tell her and show her what he had done and she didn't even want to look at it. I think she was disappointed that he did do it, but she couldn't let him get the punishment for him. And she started yelling at me and the social worker heard her and she came back there and grabbed me up, grabbed my clothes, and said you're going with us, but I wasn't gone long. They didn't do nothing to him. They didn't file no papers against him.*

Rachel reports that because she was running away from home to escape the abuse, she became involved with the juvenile justice system. She describes her reactions:

> *I at this time too I was running away from home and the focus of everything sort of shifted on my behavior and not what was going on in the house and basically their recommendation was for my parents to take me to a juvenile officer and talk about my truancy and my parents ended up signing me over to the ward of the state when I was 14. The juvenile system wasn't much of a help at all. No counseling was ever offered. I was really angry because I felt like my parents threw me away like nobody tried to understand me.*

Several of the women also describe their adult involvement with the child welfare system. Some report that their children were removed from the home because of having witnessed the IPV. One woman describes her experiences with losing her children and how she would have made different choices had she only known what would happen:

> *I took off running and then I called on one of those cop phones. And the cops came and arrested him and took the kids from me for child endangerment. So that's how the system ended up with my kids to begin with. [Later,] they gave my children to my mother-in-law. Then my husband ended up getting out of prison and because he took a 2 hour parenting class that I didn't take, he got my kids, and ended up with full custody in [date]. I went over to see them and my daughter had called me in the bathroom and she was scared to death to talk to me. She said she had something to tell me and she didn't want to get in trouble. I ensured her that she would never get in trouble for telling me something that was going on. And she told me that her dad's girlfriend was duct taping them to chairs and abusing them. And I didn't know what else to do besides do it legally, so I went and called the cops. And then I made a report to the SRS on that Saturday. They took my kids that Wednesday out of his home and now they won't even give me a chance to try to get out of prison in 12 months and get my kids back like they gave him 4 years and whatever. Anyways, they're trying to terminate my rights. And I was just trying to protect my children. If I'd have known this was going to happen, I would have taken matters in my own hands and I would have kidnapped them.*

Finally, the women report receiving other types of interventions but not as often as those reported above. These interventions include visits to a medical provider or emergency room, participating with drug or alcohol providers, psychiatric hospitalizations, utilizing welfare, and relying on their spirituality or religion.

***Looking Back***

Finally, the women reflect on the lessons they learned as they look back on their lives and consider the impact of their victimization experiences on their present lives. They also provide some advice for other women grappling with their own victimization experiences. Some of the women muse about how they might have made different choices regarding disclosing their victimization or seeking help.

> ***Tanya****: I'd have utilized the services more, and I would have been a responsible adult and raised my kids, been the mother that I know I could have been. If I'd have told sooner it probably didn't have to get as bad as it was. If I could have told somebody, they maybe could have helped the next family. Because I have found out that it happens more often than we think.*
>
> ***Anne****: I would have maybe tried to be a better victim, as sick as that sounds. Maybe not laughed as much, so maybe they would have believed me. Sometimes I think that I would have fought back because then maybe I would have had some kind of like external injury that showed I was telling the truth. Because it sickens me to think he might still be out there doing this to people. Taking advantage of people [like] he took advantage of me. And I get upset because I feel like if I had done something right then he would be in jail and nobody else would get hurt.*

Delores is ambivalent about whether, if she had it all to do over, she would have disclosed her abuse or not:

> *I could have probably tried harder. I could have told more people. I could have made a really big deal out of it. I would probably have gone to social services. I could have thrown myself down and made a big fit, but instead I sucked it up a lot and made it look like I could deal with it, and it would get better. [But] still, I am not too keen on telling. I would have just packed up and moved without contact. I don't trust. I can tell, but I'm not going to turn him in to nobody because to me it backfires.*

Other women view their past victimization experiences as necessary evils to help shape who they are today. They portray themselves as survivors, understanding that their struggles with their abuse experiences have strengthened them, leading them to better, more compassionate lives.

***Anne**: On the one side I think dealing with the stuff with my family has made me the person that I am today. And I come from an area where people don't really have a lot of issues; they're more concerned with buying brand new cars and having the trendiest clothes. They're shallow and they're superficial and I'm not and maybe I have my family to thank for that. I wouldn't trade my identity for anything in the world.*

***Rachel**: I think I'm a totally different person today than I used to be, and even though they were bad, difficult situations, I've tried to at least look at some good experiences that have come out of it like I've gotten counseling. I've changed my life, I know about healthy boundaries today, [and] I have some self respect. I have a sense of purpose and a sense of person. I certainly know what some of my strengths are because of it.*

***Rebecca**: I've survived. I am a survivor. A lot of people can't believe I do as well as I do for all I've been through, but I don't dwell on that. I learn from it and go on. Yeah, it bothers me and stuff. And I don't want to forget it, because it helps me to lead a better life, but yeah, I'm a survivor because I'm strong willed.*

***Mavis**: I've grown a lot. I'm a good person through all this. I have more compassion for people, and I'm able to forgive people. I learned that I had to do that in order to be comfortable with myself. Because, I can be angry and pissed off at somebody forever, but it's not hurting anybody but me.*

***Jennifer:** Counseling will help me cope and deal with it because all my life I'm going to have scars and memories but I think it's made me a stronger person, made me see I can make healthy choices. I don't have to make those mistakes again. I don't have to live like I lived before. I can be independent. I don't have to be so reliant upon other people.*

The women close their comments by offering advice to other women who struggle with childhood or adulthood physical and sexual victimization . These comments range from encouraging other victims to trust others and to disclose their experience(s), to understanding that their lives will change. They often conclude with reassurances to other victims that it is right and just to refuse to accept fault for the abuse wrought against them.

***Teresa**: Reach out, trust somebody. [It] has to be more than one person; I could never have done it alone. And life can be good, you know, life after sexual, physical abuse.*

***Rebecca**: I think they need to talk more to people. If I had been more persistent and talked to the teachers; nowadays, they will listen. And they might have back then, too. I think I might have been just too scared to tell, but talking I think is the most important. Not putting up with the abuse. If it happens once, it's going to happen again, and it's going to progressively get worse.*

***Anne**: For the kids, tell someone, keep telling until somebody listens. Because I think that was my biggest mistake after not having anyone listen to me I was afraid I just let it go on because I didn't think anyone would [help]. But there are people out there that would listen, they'll try and help. For other survivors of rape I think the important thing for them to know is that their life is going to change. They can have most supportive friends and family and there are still going to be people who are going to turn on them. And they're not going to believe that this happened to them. I lost some of the best friends I've ever had after I was raped because they didn't believe me.*

***Rachel**: You don't have to be a victim. There's support and counseling and help out there that's available. And it may seem the hard thing to do but in the long run it will save your life.*

***Mabel**: Just get out as soon as you can. And understand that if someone loves you, they don't do those things to you.*

***Beth**: Just to have belief in themselves that it's not their fault. You can't control what an adult does to you especially when it is your caregiver, your parent, the one that's supposed to nurture you. And just not feel shameful [or] guilty, because it's not their fault. Just know that there is better out there. There's a lot of people and you don't have to be with one that will abuse you. Cause abuse does not equal love.*

***Mavis**: Realize something bad happened, [but] it doesn't make you a bad person. It's not your fault. And share your thoughts with other people.*

***Denise**: Be strong, stay with the domestic violent advocate and the groups. Talk to people about it. Just stay strong, stay away from it, if you can, just you know. It's a hard thing to walk away from and stay away from. It's not hard to walk away from but it's hard to stay away from. It's easy to walk away from it. The hard part is staying away from it.*

***Jennifer**: No matter how ashamed you feel and how bad that you think that things were or could be or is, that there's always something happening to somebody that's worse than what's happening to you and so you don't have to be ashamed. You don't have to be embarrassed if you just talk out. It all works out, you know? You can get it out. Just talk about it I guess, you know? And don't put it off another day. Talk to someone, even if it's just a stranger … Somebody that you don't have to face tomorrow.*

## VI. DISCUSSION and SIGNIFICANCE OF FINDINGS; CONCLUSIONS

This research was designed to provide descriptions, using certain attributes, and comparisons of the life experiences of female victims of intimate partner violence, sexual violence, and youth maltreatment who live in environmentally disparate settings: in a women's prison and in urban and rural communities within one Midwestern state. Two primary areas of inquiry were pursued. First, an exploration of these women's access to and opportunities for various types of social services was undertaken and second, their status in regard to certain health, mental health, substance use, incarceration, and suicidality markers was recorded. In essence, it was hoped that the research findings would provide clearer understanding of the life trajectories of women victims of violence.

Our objectives were clear. We sought to determine the singular and co-occurrence rates of sexual assault, intimate partner violence and other forms of familial abuse and youth maltreatment for both the incarcerated and non-incarcerated women in this sample. We also sought to determine whether women victims of childhood and adult physical and sexual violence were (a) offered and (b) participated in, one or more social service and social support interventions which may have impacted their health, mental health (depression and PTSD), their use of alcohol and/or illegal substances, and possible incarceration. It was hoped that the findings on these questions would lead naturally to implications for improving policy and practice strategies within the criminal justice system, a system with which, in one way or another, every victim must contend. With some modifications, these objectives were largely realized.

In this section, the important findings which relate to the research questions and objectives will be discussed in some detail. Initially however, a discussion of the limitations of

the research methodology will help set the context within which a more critical examination of these findings can be realized.

***Methodological Limitations***

This exploratory study is the first known study to identify differences in service usage between women found in various geographical and agency milieus. As such, these results only pertain to the women interviewed for this study. Future research which pursues a similar inquiry using refined protocols will serve to confirm or refute the findings set out here. In the same vein, the sample for the research presented here was generated in one Midwestern state. While there is no reason to believe that life in that particular state would itself have an extraordinary affect on the women living within its borders, undertaking this research in other states in the Midwest and across the country will lend support for the findings presented here. In the interim, all of these findings should be narrowly interpreted as applying only to the women in this sample.

***Sampling***. Clearly, the convenience sampling relied upon to generate the entire sample limits the interpretation of these results. The flyers used to recruit the agency women and the women from the correctional institution were worded in such a way that the women who volunteered to participate were women who more likely than not, had histories of victimization. While the flyer that was posted in the various locations in the communities (e.g. grocery stores) was not as explicit in detailing the purpose of the study as those posted in the agencies and the prison, admittedly, a similar sampling bias may have occurred even in that portion of the sample. Consequently, the high percentages of women who experienced some form of abuse and / or assault in their lifetimes is in part a reflection of the bias in sampling.

The convenience sampling used is also a reminder of the burdens associated with sampling strategies when undertaking research in areas involving victimization. In designing

this research protocol and in seeking the approval of our institutional research committee, we were particularly sensitive to the extent of disclosure we were asking of women and worked very hard to avoid any interviewing procedures that could be perceived as being coercive, manipulative, gratuitous or in some way dangerous. We paid the community women the $25 compensation up front and they were clearly told the interview would end if they wished it to end with no questions asked or penalties imposed. As it was, very few women withdrew from the interview once it began. Every woman was given a copy of the consent form which contained the names and contact information of the researchers. We were contacted, indirectly, on behalf of only one of the women who participated in the study. In that case, the woman's therapist contacted one of the researchers asking for a blank copy of the interview instrument so that it could be used to generate discussion in the therapy that was underway. We complied with this request.

***Participant Incentives.*** The disparity in opportunity to provide remuneration between the "free" women and the women in the prison was disconcerting. While it is unlikely that the responses to the questions were influenced by the fee paid to one and not the other, the commitment to in some way honor these women participants by providing them payment for their time and effort was unable to be fulfilled equally between them. Other state prison systems may not have the same rules regarding payment for participation in research and future researchers in this area may want to clarify such rules and negotiate, if necessary and possible, some more equitable form of remuneration prior to starting data collection.

It is also possible that the monetary incentive given for participation in the study resulted in a certain socioeconomically based sample bias. In turn, the relationship between current socioeconomic status and histories of victimization was not the subject of this research nor to our

knowledge has it been the subject of definitive research elsewhere. Consequently, the extent of the sample bias that may have been unavoidably introduced because of the monetary incentive cannot be adequately addressed here but should be seen as a possible limitation.

***Survey Instrument.*** Finally, as indicated throughout this report, the survey instrument itself had inherent limitations. Some of the scales had not been validated with incarcerated populations. Others, while good in detail, provided no reasonable means of determining, for example, the severity of the injuries which resulted from the victimization and the duration of each experience. While in an overall sense, we consider the survey instrument to be adequate in terms of the specificity of questions posed, that specificity probably also had something to do with the high prevalence rate of victimization reported, a research challenge identified by other scholars (Browne *et al.*, 1999).

Because we asked the research participants to identify the racial / ethnic group to which they belonged and provided them with answers framed within the broad and commonly accepted categories of race / ethnicity (as well as an "other" category), we are unable to tease out more definitive information about the influence of specific cultural norms and mores on their experiences and responses. While we are pleased with the diversity of our sample, we know that in a rural state such as this one, it is a limitation to be unable to relate the similarities and differences, by culture, in the experiences of those, for example, raised in the isolated areas of the western part of the state from those raised in or near its large cities to the east. There is no question that the rich cultural context of women's experiences should be explored in future research.

In essence, the convenience sampling, the recruitment strategies employed, the sole-state site for data collection and instrument inadequacies are all limitations to this research. Readers

are reminded that the findings here relate solely to the sample studied. That being said, there is no doubt that the findings, interpreted with these limitations in mind, are important from both the policy and practice perspectives. And, these findings tell us a lot about the need for more targeted research. At the end of this report, implications for future research along similar lines of inquiry are presented.

***Discussion and Significance of Findings***

The discussion that follows is organized, in part, by the hypotheses set forth in the early stages of writing the proposal for this National Institute of Justice funding. Though in the end some of these hypotheses could not be fully supported, they provide a good structural scheme for a healthy discussion of both the analytic strategies chosen and the findings made.

***Demographics of Samples.*** The entire research sample reflected a significant degree of age and cultural diversity, particularly for a largely rural Midwestern state. While these personal differences did not always in the end lead to statistically significant findings, the healthy representation of different ethnic, socioeconomic and age groups strengthens the findings with regard to their application to a diverse population.

There were differences between the three sample groups, in their descriptive characteristics. The sample groups were significantly different in terms of age (community is older), household composition (agency women have male partners/not husbands), having children (prison women were most likely to have children) and in the ages of their children (prison women reported having older children) and ethnicity, with the women in prison being more likely to be African American; the community women more likely to be Hispanic; and the agency women more likely to be White.

The women's economic circumstances at the time they were interviewed were poorest for women receiving agency services and were best in general for the community women. It is important to recall the women in prison were asked to report their economic circumstances for the 12 months prior to their incarceration and thus this economic measure lacks precision. The results suggest that the women in prison enjoyed the best economic circumstances prior to their incarceration, and it is thought that this may be the result of the kinds of behaviors the women engaged in that ultimately lead to their incarceration. The literature provides some support for the idea that women who ultimately end in prison may participate in what is referred to as the "informal economy" in order to make ends meet (Gilfus, 1992) (see also, Danesh, 1991; Edin & Lein, 1997).

Relative to the economic circumstances these women reported living under during childhood, one additional finding is worth pointing out here. There was no significant difference between the groups on the measure of their economic circumstances in childhood. Fifty five percent of the entire sample reported that it was "not at all difficult" or "a little difficult" for their childhood families to live on their income. Recent research suggests that poverty and its related social conditions have a direct relationship on incarceration (Draine *et al.*, 2002). Because of its imprecise nature, we would be unwilling to use these data to challenge the prior research in this area.

***Prevalence Rates.*** The first hypothesis proposed: "*Prevalence rates of intimate partner violence (IPV), sexual violence, and youth maltreatment are higher among incarcerated women than those not incarcerated."* As noted earlier, perhaps because of the sampling strategies used, in this study sample the rates of victimization are high across all types of victimization, and across all samples. However, while there were significant differences between all three groups in the

experience of childhood sexual abuse, physical IPV, and rape, women in prison reported higher rates of victimization in all of these areas except for physical IPV, which had a reported prevalence among agency women that was significantly higher than in the prison and community samples.

Child Victimization. In childhood, reports of sexual abuse were higher than those of physical child abuse. Of the three types of child abuse reported, the most common was sexual touching (64% of sample); followed by sexual penetration (47%) and physical abuse (46%). Most childhood abuse occurred within the family.

Adult Victimization. When one's total IPV experience, including physical and psychological IPV, was included, almost the entire sample, 97 percent, reported having been victimized in one or both ways. Because we hoped to be able to answer the research questions by differentiating between sub-sample groups, it was decided that for many of the remaining research questions and hypotheses, the analyses would be focused on those women who reported having experienced physical IPV. Excluding from these analyses those women who reported having experienced "only" psychological IPV allowed for more statistical discrimination. While this response rate may in part be attributed to sampling bias and to the extent of detail sought in the interview, the overwhelming perception of victimization cannot be ignored and begs further exploration. We also want to emphasize that this analytical decision was made in an effort to produce findings; not because of some value judgment about the significance of one's personal experience of victimization by psychological abuse.

The experience of sexual assault is reported at 85 percent in study, and is high across all three samples. Experiencing sexually coercive behaviors is most common, followed by rape, followed by attempted rape. Sixty seven percent of the sample reported having been raped;

ranging from 55 percent of the community women to 71 percent of the agency women to nearly 73 percent of the prison women. Again, in part, detailed interview questions may have encouraged these specific disclosures and the effect of sampling bias is thought to be reflected in these percentages as well. Still, the recruitment methods used did not specify that we were seeking rape victims. Our recruitment efforts were in the communities at large and in domestic violence as well as sexual assault agencies. Consequently, the high percentage of women reporting having been raped is at best disconcerting and begs additional study.

Similar to IPV, because we hoped to be able to answer the research questions by differentiating between sub-sample groups, it was decided that for many of the remaining research questions and hypotheses, the analyses would be focused on those women who reported having experienced rape. Excluding from these analyses those women who reported having experienced "only" sexual coercion or attempted rape allowed for more statistical discrimination. Again, we want to emphasize that this analytical decision was made in an effort to produce findings; not because of some value judgment about the significance of one's personal experience of sexual victimization.

***Ethnicity and Victimization.*** Ethnic groups differed in their experiences of victimization in this sample. Experience of physical violence between intimates is most prevalent for women who are White, and lowest for women who are Latina. In terms of sexual assault, prevalence rates also differ across ethnicities, with the highest rates reported by Whites; the lowest by Latinas. We would caution the reader to consider the impact of cultural experience and personal perception of victimization when interpreting this finding. It may be that the women's interpretations of their different experiences of physical and sexual victimization vary because of particular cultural definitions and mores. Every woman was asked to make her own judgment

about her experience: was a certain type of behavior abusive; was a certain sexual violation rape; was maltreatment as a child, abuse?

***Co-Occurrence Rates.*** We hypothesized that "*there would be a higher degree of co-occurrence of IPV, sexual violence and youth maltreatment among the incarcerated women than the other samples."*

Overall, we found that co-occurrence of victimization was very common across all groups. Physical violence between intimates and rape often co-occur. When only one type of the two victimization experiences occurred, it was most likely to be physical violence between intimates, rather than rape. About half of the sample experienced victimization both in childhood and in adulthood and sexual abuse in childhood was more highly correlated with adult victimization than was physical abuse in childhood.

***Victimization and Adult Outcomes.*** We hypothesized that "*childhood victimization would have more enduring and detrimental outcomes, on measures of health, mental health, substance use, incarceration and suicidality, than would other types of victimization.*" Before discussing the relation of victimization to outcomes in adulthood, it is important to review the general level of well being in adulthood for the study participants. In general, the whole sample reports having good physical and mental health, with, in general, better physical health than mental health.

Health and Mental Health. At first glance, the finding that women in prison report significantly better physical and mental health than do the other groups of women may seem counterintuitive. However, this health status may well be due to the availability and relative ease of access to health and mental health care when incarcerated. Since the late 1960s, the courts have consistently found an obligation on the part of each state to care for its incarcerated population. While such obligation does not necessarily translate into an individual right to one

or more specific types of treatment, it does require prison authorities to provide for the care of those in custody at least at a level that protects their Fourteenth Amendment rights to "life and liberty" and their Eighth Amendment right to freedom from "cruel and unusual punishment" (Collins, 1998). Thus, women with significant mental health needs who are incarcerated find that their access to psychotropic medications is much easier simply because they are incarcerated and because their total physical and mental health care is a matter of constitutional obligation on the part of prison administrators. No such constitutional parallel exists in the community for women victims of violence.

Also, given the structure and routine of the prison environment – that largely defined by rules and order – women may actually experience "better" mental health because they are removed from the immediate environment of (old) abusive relationships and from the environmental cues that trigger discomforting memories.

The agency women in this study reported having the poorest physical and mental health. This finding echoes those recorded by other researchers who have reported finding strong correlations between complaints of non-specific health problems that affect their functioning such as chronic fatigue, disturbed eating and sleeping patterns, headaches, and gastrointestinal disorders, and sexual and physical violence (Eby et al. 1995; McNutt et al., 2002). Sullivan and Bybee's (1999) findings that when the abuse ceased, the victim's physical health improved lends support for our different health status findings when looking at the agency and prison women.

When viewed along with the economic data that shows the agency women are the poorest of the sample groups, there is some logic to thinking that their economic status may serve as a barrier to accessing adequate health and mental health care. With regard to mental health conditions, scores on depression and Post Traumatic Stress Disorder (PTSD) are fairly

high in the overall sample, with women scoring a mean of 55 and 59 on 100-point scales. Again, the agency women report the highest levels of both of these disorders. It is conceivable that these women were temporally closer to the abusive experience and thus expressed the more emotional effects of the victimization because of the recency of its occurrence.

Drug and Alcohol. As one might expect, both drug and alcohol problems were reported by significantly more women in prison than in the other samples. Still, over a quarter of the women in this study reported having a drug problem (28%) and 19 percent reported having an alcohol problem. This suggests that attention must be paid to the aftermath of violence which takes its toll on women's health in other, perhaps less obvious ways than imprisonment.

Suicide. While we planned to use suicide behavior as one adult outcome, a very small percentage of the sample reported attempting suicide in the prior 12 months, with the highest rate of suicide behavior occurring among women in prison. Given the low prevalence of suicide attempts in this sample, this variable was not helpful to the multivariate analyses and thus was dropped in that analysis.

Child Victimization and Adult Outcomes. As to their physical and mental health scores, women who were *physically* abused in childhood fared worse on these measures than did women who were not abused. Women who had experienced childhood physical abuse had significantly poorer physical health, mental health, more depression and greater levels of PTSD. On every measure except for "suicide attempt in the past year", there was a statistically significant relationship between the experience of *sexual abuse* in childhood and every adult outcome. As to the relationship between childhood physical abuse and incarceration as an adult, contrary to previous research (Browne et al., 1999; Harlow, 1999), in this sample there was no finding of a significant relationship between these two conditions. Alternately, a significant relationship

exists between sexual victimization as a child and adult incarceration, a finding consistent with the hypotheses and findings of Browne, et al (1999), Chesney-Lind, 1989; and Gilfus, (1992). When controlling for sample of origin, the relationship between childhood sexual abuse and adult outcomes did not hold for women from the communities.

IPV and adult outcomes. In general, having experienced physical IPV in adulthood was not predictive of well being in adulthood. There were no significant differences between those so victimized when compared to adult outcomes of physical health, mental health, depression, having an alcohol or drug problem, and being incarcerated. These findings stand in contrast to those reported by Gelles & Straus (1990), Miller and Downs (1993), O'Leary (1993), Plichta (1996), and Saunders (1994) – all of whom reported physical abuse being associated with mental health problems including depression and anxiety and suicide attempts as well as the use of alcohol or other mind-altering substances. The only significant difference found was with PTSD; women who experienced physical IPV reported higher PTSD scores than those who were not abused – a finding similar to that found by Walker (1993).

While having experienced physical IPV at all was not predictive of adult outcomes, the *degree* to which one experienced physical IPV was predictive of adult outcomes. One's score on the physical IPV scale was significantly correlated with one's current physical health, mental health, PTSD score, alcohol or drug problems, and whether one was incarcerated. Physical IPV score was not predictive of depression. However, the correlation between physical IPV scores and alcohol or drug problems ceases to be significant when controlling for the sample group.

Rape and adult outcomes. The degree to which one experienced sexual assault, particularly rape behaviors, was predictive of adult well being. Consistent with prior research findings (Koss & Heslet, 1992; Goodman, Koss, & Russon, 1993) the higher the number of rape

behaviors one reported, the poorer one's physical health, mental health, depression, PTSD score, and the incidence of alcohol problems. Correlations were just as strong between the number of rape behaviors and these adult outcomes. There were no significant differences in terms of the extent or incidence of drug problems, suicide attempts or incarceration for rape victims.

We also hypothesized that *histories of IPV in adulthood would be more common among the incarcerated women than would histories of adult sexual violence.* In fact, 100 percent of the prison sample reported histories of psychological IPV and over 95 percent reported experiencing physical IPV. In contrast, 72.6 percent of women in prison reported having been raped. Physical IPV was also reported more frequently than any other form of child abuse. Thus, incarcerated women reported histories of adult physical IPV more frequently than histories of sexual violence.

***Disclosure Experiences.*** Women who were victimized were asked a series of questions about whether they disclosed that victimization to anyone and the aftereffects of that disclosure. For each discussion of disclosure, the findings relate only to those women who had experienced each specific type of victimization.

Across all types of victimization, more than half of women who experienced any type of victimization disclosed the experience to someone. The highest disclosure rates were for physical violence between intimates (79%), rape (73%), childhood sexual abuse by touching (71%), childhood sexual abuse by penetration (67%) and childhood physical abuse (67%). Disclosure rates did not differ by sample.

Research suggests that most victims prefer to disclose to family and friends rather than to law enforcement, medical staff, or service providers (Neville & Pugh, 1997; Ullman, 1996a, 1996b); though studies have evidence of non-immediate disclosure among a majority of victims

(Ullman, 1996b). Some victims choose not to report the sexual violence to law enforcement due to negative social reactions from police (Ullman, 1996a)

Childhood Victimization and Disclosure. In regard to childhood victimization, in this sample most disclosures were made to family and friends, but for the most part, disclosures were not made immediately after the event. In almost three-fourths of cases, the perpetrator was confronted, although this was less likely for community women. Perpetrators were arrested in over half of the cases. In about two-thirds of these cases, nothing happened to the perpetrator.

Adult Victimization and Disclosure. Among those women experiencing Physical IPV, many told friends and family, although police and social workers were often told, as well, particularly if the woman was receiving services from the agencies. Almost all women said they were believed when they disclosed.

The disclosure pattern for those women who experienced rape mirrors that for those women who experienced physical IPV. These women most commonly told family and friends, followed by social workers and almost all women reported that they were believed. When a report was made, it was likely to doctors and police and generally within the week - much higher rates than those for physical IPV. When the event was rape rather than physical violence between intimates, it was less likely that perpetrators were confronted or arrested.

***Mediating Factors and Adult Outcomes.*** Mediating factors in this study included one's sense of self-efficacy, one's use of adaptive coping skills, use of maladaptive coping skills, social support, current age, difficulty living on income, and receipt of welfare.

In general, participants reported good levels of self-efficacy, adaptive coping and social support, with social support lagging behind self-efficacy and adaptive coping. Maladaptive coping was used to a lesser degree than was adaptive coping.

Some significant differences between the three samples were found in terms of these mediating factors. Levels of self-efficacy did not differ between the three samples but women in agencies reported significantly better adaptive coping skills. They also reported having significantly poorer levels of social support. These agency women also had the most difficulty living on their current income; however, the women in prison were more likely to have received welfare when compared to the other samples. The use of maladaptive coping skills did not differ between samples.

One's experience of victimization predicted one's current status vis-à-vis the mediating factors. Those women who experienced child physical abuse had a lower sense of self-efficacy, higher maladaptive coping scores, lower social support levels, greater difficulty living on their incomes, and a greater likelihood of receiving welfare. The experience of childhood sexual abuse was less predictive of mediating factors. Those experiencing sexual abuse in childhood reported lower levels of self-efficacy and social support, only.

The women who experienced rape, similar to those experiencing childhood physical abuse, had greater use of maladaptive coping skills, lower levels of social support, greater difficulty living on their income, and greater likelihood of receiving welfare. The experience of physical IPV, similar to childhood sexual abuse, was less predictive of mediating factors; those experiencing physical IPV reported lower social support and greater difficulty living on their income.

Relation of Disclosure to Mediating Factors and Adult Outcomes. The adaptive coping skills of women who experienced physical violence between intimates were significantly better when their perpetrators were confronted. However, this statistical relationship was not sustained when the victimization involved rape, perhaps a reflection of the intensity of that experience.

None of the adult outcomes were affected by the confrontation of the perpetrator upon disclosure of the rape.

Social Supports and Adult Outcomes. We hypothesized that *"a woman's positive perception of the supports she received after the victimization would be related to better outcomes in health, mental health, substance use, incarceration, and suicidality."* Overall, our findings indicate that, with the exception of welfare, the supports perceived as being most helpful were those that were the least received. In other words, emotional support, professional counseling, medication, support groups, and medical providers were perceived as being less helpful than the supports which were more frequently reported as having been received.

Women who reported using each service were asked to rate how helpful the service was. We reported that the most useful services were those that were more concrete or tangible in nature, including daycare, religious counseling, subsidized housing, welfare, educational services, food bank, and job training. There were no differences between samples on how helpful women found any particular service, although when added together, women in prison, in the aggregate, found the services they used less helpful than other women.

Most abused women seek help, usually first from family and friends and then from formal services (Davis & Srinivasan, 1995; Horton & Johnson, 1993). Gordon's (1996) review of the research on their use of services suggested that the most commonly used social service systems were, in order, the criminal justice system (i.e. law enforcement and lawyers), social service agencies, medical services, crisis counseling, mental health services, clergy, and women's groups. However, while seeking services more often within the various systems, abused women did not necessarily view the services they received as helpful (Gordon, 1996). Humphreys and Thiara (2003) studied the experiences of women victims of domestic violence

who reached out to mental health services. Many of the women in this study found their experiences to be negative or unhelpful including, for example, the lack of recognition of trauma or provision of trauma services; making the abuser invisible through focusing on the woman's mental health reified from her experiences of abuse; blaming the victim; offering medication rather than counseling support.

Service Seeking and Service Usage. As we reported, on average, women in this sample utilized eight of the twenty-four services listed on the questionnaire. The most commonly used services in response to being victimized were: emotional support, professional counseling, medication, welfare, and support groups. These were used by over half of the sample.

Service usage is often correlated with mediating factors including a sense of self-efficacy, the use of adaptive and maladaptive coping skills, perceived social support, current age, and the perceived difficulty of living on one's income. Women who reported staying in a hospital for psychiatric reasons, visiting medical providers, using psychotropic medication or other types of medication, or using rape crisis services or religious counseling showed higher usage of maladaptive coping skills.

One of the best predictors of service usage was the difficulty a woman experienced living on her current income: the higher the difficulty, the more likely the woman was to use welfare, food banks, a domestic violence shelter, legal services, rape crisis services, professional counseling, and so on.

Agency women also reported using these supports more commonly than did the other women in the sample. This is not surprising as it is reasonable to expect that receipt of one social support service in a community, e.g., at a domestic or sexual violence agency, would lead to referrals to other support agencies in the community.

The words “used” and “received” in the study question are somewhat inaccurate as they imply availability of the support. In fact, some of these supports – daycare, subsidized housing, food, job training and educational supports – were no doubt not offered, let alone “used”. In some cases not receiving a particular type of support might be due to structural barriers such as incarceration; in other cases it may be that the support was not received because some of the women may not have met the eligibility criteria for it, e.g., job training and subsidized housing.

There were small but significant correlations between service usage and adult outcomes and it is important to note that these findings are probably a reflection of aftermath of the victimization. A woman’s physical health, for example, was worse when she had received certain services, including a hospital stay, medication, food bank, homeless shelter, subsidized housing, and a medical provider. Similarly, a women’s mental health was reported to be poorer for those women having received services of medication, domestic violence shelter, a hospital stay, rape crisis services, psychotropic medications, food bank, and so on. If we believe that physical and mental health are impacted by victimization, then the services sought and received by these women are related to their overall health because their health concerns drove them to seek these services, not because of the quality of the services.

In general, those women recruited from service agencies were most likely to report using services. They reported significantly higher use of professional counseling, welfare, support groups, legal services, domestic violence shelter, subsidized housing, homeless shelter, and child protective services. Women in prison reported significantly greater use of psychotropic medication than women in the other samples. This may again be a reflection of access, with prison women having more expedient and low or no cost access to medications than do women living in the community.

Barriers to Services**.** *S*ignificant differences were found between groups in five categories. The agency women reported experiencing the most barriers and most of these had to do with access issues: money, familiarity, transportation (on own or through others) and securing an appointment time. Women in communities named the fewest barriers to seeking services.

The more striking finding in looking at barriers is that where no significant differences were found between the groups. Indeed, over 82 percent of the women reported wanting to take care of the problem themselves and almost 70 percent thought that the problem would resolve itself without intervention. These may well be related to the difficulty disclosing one's experience of victimization and the stigma associated with receiving support services in the aftermath of that victimization.

Coping. We used the *Brief-Cope Scale* to assess a variety of coping reactions/strategies in response to stress. We want to caution that this scale was developed and refined with persons who were not incarcerated, and the extent of its use in studies of incarcerated women is unknown. It is highly probable that behaviors that are considered maladaptive for a "free" person, may actually be adaptive for an imprisoned person. For example, avoidant behavior may actually better serve women prisoners, i.e., these may be adaptive in nature.

In this study, the agency women used more adaptive coping skills than did their study counterparts. This is consistent with the findings of some studies that suggest that abused women are highly resourceful; having strong coping abilities in light of the types and extent of stress they face (Campbell, Rose, Kub, & Nedd, 1998). In contrast, other studies have found that battered women cope less effectively and use fewer problem-solving strategies and more passive strategies than do nonabused women. In the present research, because of our very high prevalence rates of the various types and combinations of victimization experiences, it is

impossible to compare abused women to nonabused women. It is worth noting again that there is little published research on women's ability to cope with sexual assault.

***Mediating Factors Associated with Poor Adult Outcomes.*** We hypothesized that "*women would have experienced poorer adult outcomes if (and these have negative cumulative effects) an ethnic minority; had achieved a lower level of education; were living in a rural environments as adults* (a measure not captured in the data)*; had experienced any type of victimization and multiple victimizations; had undisclosed victimization(s); encountered barriers to seeking services; and had experienced multiple trauma in addition to IPV, sexual violence, and child maltreatment."*

The multivariate analyses show that minority ethnicity is not a good predictor of adult outcomes in this sample, when considering all possible predictors. However, ethnicity is highly correlated with childhood economic difficulty as well as lower education, and both of these are much stronger predictors of most adult outcomes, particularly incarceration. These findings are consistent with prior research (see, Draine *et al*, 2002; U.S. Dept. of Health and Human Services, 2001) but it must be emphasized that these results should be viewed within the context of the long-term effects of institutionalized racism. Both lower levels of educational achievement and disproportionate rates of minority incarceration have been tied to this social / political phenomenon (Pewewardy and Severson, 2003).

Multiple victimizations are not a strong predictor of adult outcomes in this sample. This is an important finding for public policy and service planning efforts, that is, negative adult outcomes may be triggered on the basis of "only" one victimization experience.

Disclosure rates can predict adult outcomes, particularly in the case of incarceration, which is predicted by police investigations following disclosure of violence. Taken separately,

the best predictors of adult outcomes are childhood physical and sexual abuse, followed by rape in adulthood. The extent to which a woman experiences physical intimate partner violence is not a good predictor of adult outcomes in this sample.

***Mediating Factors Associated with Positive Adult Outcomes.*** We hypothesized we would find that "*women experience better outcomes if (and these have cumulative positive effects): if they disclosed the victimization early; if they had social supports and used coping skills; and if they received services and these services were perceived as helpful.*"

When controlling for all other variables, the mediating factors of self-efficacy, social supports and use of maladaptive coping provided great predictability for adult outcomes. One's level of social support was a good predictor of one's physical health, depression, and levels of PTSD. Not surprisingly, one's use of maladaptive coping strategies was a strong predictor of poorer depression scores, and of PTSD. Self-efficacy was also a strong predictor of adult outcomes, although not as predictive as social support and maladaptive coping. A greater sense of self-efficacy was predictive of better physical health, lower levels of depression, and lower levels of PTSD. Service usage was only predictive of the adult outcome of incarceration; incarcerated women found the services used to be less helpful, and had received fewer crisis intervention services.

So, the best predictors of physical health in the entire sample were age and number of social supports. The best predictors of depression in this sample were use of maladaptive coping strategies, social supports, and one's sense of self-efficacy. The best predictors of one's level of PTSD were one's sense of self-efficacy, use of maladaptive coping strategies, and social supports. The best predictors of incarceration are difficulty in living on the family income in childhood, years of education, proportion of victimization disclosures that were followed by a

police investigation, receiving welfare, finding services not helpful, and not using crisis intervention services.

***Key Predictors of Poor Adult Outcomes.*** We hypothesized that *the key predictors of poor outcomes would be adult poverty, minority ethnicity, the experience of multiple victimizations, and non-disclosure(s) about the violence.* The multivariate analyses revealed that minority ethnicity was not a good predictor of adult outcomes in this sample, when considering all possible predictors. However, ethnicity was highly correlated with childhood economic difficulty as well as lower education, and both of these are much stronger predictors of most adult outcomes, particularly incarceration. Again, the findings with regard to the influence of educational levels and ethnicity are consistent with the existing literature (Draine, *et al*, 2002), as discussed earlier.

Multiple victimizations were not a strong predictor of adult outcomes in this sample. Especially for incarceration, disclosure rates are predictive by police investigations following disclosure of violence. Taken separately, the best predictors of adult outcomes are childhood physical and sexual abuse, followed by rape in adulthood. The extent to which a woman experiences physical intimate partner violence is not a good predictor of adult outcomes in this sample.

***Information Dissemination.***

This final comprehensive technical report which contains the findings of the study has been provided to the sexual violence and domestic violence agencies from which the samples were derived, the state Department of Corrections, the Coalition on Sexual and Domestic Violence and the National Institute of Justice. This report includes a discussion of the research questions, a thorough review of the relevant literature, a description of the research methodology,

a presentation of the project findings, a discussion about these findings and their significance for this Midwestern state and, where possible, for other national and international community based and adult justice systems struggling to create social services programs that will effectively reach out to physically and sexually victimized women during their childhood, adolescence and adulthood.

A summary of the various research findings and the policy issues implicated by those findings will be posted on the project website that has been created at the University of Kansas (www.kussw.edu). Additionally, Dr. Postmus and Prof. Severson expect to cite findings and detail the research process in the appropriate peer-reviewed journal publications (e.g. Social Work; Affilia; Journal of Families and Society; Criminology; Criminal Justice and Behavior; Journal of Sociology and Social Welfare; International Journal of Prisoner Health; Violence Against Women). Already, certain findings have been presented at one international conference (Severson, Postmus & Berry, (June 2005): *What Works with Women Offenders*, Prato, Italy). Two additional presentations are scheduled for delivery at the *Council on Social Work Education* (Chicago; February, 2006) and the *Academy of Criminal Justice Sciences* (Baltimore; February - March, 2006). We anticipate preparing relevant materials for many national and international conference presentations, geared toward informing practitioners, researchers, as well as policy makers in the field (e.g. National Institute of Justice Annual Research Conference; National Council on Crime and Delinquency; The National GAINS Center's National Conference on People with Co-Occurring Disorders in the Justice System, American Correctional Association, Trapped by Poverty, Trapped by Abuse Bi-annual Conference, Society for Social Work and Research, etc.).

***Implications for Research, Policy, and Practice***

In every state, victims of one or more forms of violence live in distinct communities – urban, rural and institutional – and they are members of every stratified socioeconomic, racial and occupational group. Certainly, prior research has explored the relationship between a variety of risk and resiliency factors and these personal, descriptive characteristics. This research advances this knowledge by lending to it an understanding of the factors that contribute to the perpetuation or the diminution of status or severity on certain outcome measures, that is, that clarify the interaction between youth and adult victimization, certain defined mediators (risks and protective factors) and current adult status in regard to health, mental health, substance use and incarceration.

The conceptualization of the implications for research, policy, and practice identified below springs from our knowledge of the complexities of actually planning, engaging in and completing this kind of research. We trust the reader will, as we do, consider these ideas as important but tentative formulations given the systemic and methodological limitations to the research presented in this report.

While much was learned from this study, it is humbling to have developed from this research an idea of how much remains *unknown* about women's experiences of victimization, their experiences of interventions that did occur, did not occur, should have occurred and should have been different in some way(s) in order to be more helpful. Further, much remains that is unknown and indeed invisible for women victims when they end up incarcerated. In the prison setting, no matter how progressive the institution, women (and men as well) lose their individual voices and faces and instead for the period of their incarcerations, become "prisoners". The

experiences had in their lifetimes that may have moved them toward that prisoner status seem critical to identify. The research reported here furthers existing efforts to do just that.

From the process and the findings of this research, we have identified specific and important areas of inquiry that remain unsatisfied. First, a larger and more broadly and randomly selected sample would help answer questions critical to a full understanding of the different experiences and impacts of various forms of abuse. Whether the result of sampling bias or geographical bias, the fact is that overall, 97 percent of the study participants reported having experienced some form of IPV and 85 percent reported one or more sexual assault experiences. A larger sample may provide the opportunity to explore in greater detail the separate kinds of victimization experiences which here required grouping in order to facilitate comparative analyses. So, further exploration of the experience and meaning of psychological abuse is needed as is additional study into the impact of separate behaviors which constitute sexual touching and sexual penetration.

The subjects of this research were all adult women, age 18 and older. The questions asked of them called for historical information, information dependent on their memories of certain events. While implementation of the necessary research protections regarding human subjects would be formidable, a similar exploration of adolescent girls in comparable situational / environmental milieus could be useful for planning both policy and practice interventions. So, adolescent girls in juvenile detention, in the custody of the state's child welfare agency and in the community at large would constitute an informative sample for future research. Both the recency of events and the potential for more timely and appropriate service interventions could constitute an effective three pronged (research, temporal proximity to the victimization and timely interventions) approach to the exploring the early outcomes of victimization.

Certainly future research could seek the same information with a similar population but focus on particular facets of the experience that were not the subject of study here. For example, more exploration into the role of culture, ethnicity and race and their relationship to the experience of victimization is needed. Further, while we have data from each participant about who the abusers were with regard to their childhood victimization, because our interest was in understanding the correlates to and outcomes of these women's victimization experiences, we did not seek specific information about the perpetrators of adult victimization, e.g. whether a married partner, same-sex perpetrator, significant but non-cohabitating other, a partner from whom the victim was divorced or separated, etc. Other research indicates that women are not infrequently victimized at the hands of these "related" partners and it is important that future research build in a method of identifying the kind of relatedness the perpetrator and victim may have had.

It will be important that future research which looks at outcomes of victimizations and service utilization and appraisal be designed to measure the severity of single and multiple incidents of victimization. In the study method and findings presented here, we are unable to ascertain the severity of the violence. A woman who experienced one episode of violence could have suffered equal or greater harm than another woman who experienced multiple episodes over longer periods of her lifespan. The relationship between abuse types and severity and frequency may well inform service planning and interventions. In the same vein, as noted in the report, the ABI and the SES do not ask women for the number of intimate partners who demonstrated these behaviors. Consequently, the rate of victimization reported may relate to a single partner or multiple intimate partners and may or may not reflect abuse experiences that

occurred over any period of time. Future research should seek to reveal this kind of discrete information.

While there are other research implications to be generated from this research protocol and the findings, we will mention only two others here. First, information around disclosure behaviors and the victims' perceptions of the consequences of disclosure, i.e., "nothing happened" requires further investigation. Indeed, in this study, across all types of victimization from physical abuse as a child to adult rape, and across all populations, the majority of the women who reported the victimization experience report that "nothing happened" as a result. Further detail is needed in this regard. What was expected to happen? Did something other than what was expected in fact happen? When "nothing happened", how is "nothing" defined? Second, the not surprising but somewhat worrisome finding that women in prison more frequently reported their victimization suggests this finding needs to be explored against the various law enforcement policies which may end in their incarceration. For example, if women victims are arrested on the basis of evidence of a crime being found incidental to an assault investigation, changes in public policies and law enforcement protocols and options for officer discretion may be implicated.

Finally, and perhaps related to women's perceptions of "nothing" happening after the disclosure of their victimization, there must be research methods used which allow for the voices of all of these women to be heard. Two of the incarcerated women indicated in their interviews that the interview itself was the first opportunity they had had to tell the whole story of their victimization experiences. Another incarcerated woman spoke of the informal group of women in her housing unit, each of whom participated in this research, who began to share their victimization experiences and in doing so, found they were not alone. Carefully designed and

implemented qualitative studies can serve to humanize the experience of what turns out to often be marginalized adult women – invisible women – and can also serve as educational tools for law enforcement responders and clinical and agency social service providers.

In identifying and creating a research plan designed to address some of the gaps in the existing research regarding intimate partner violence, sexual violence, and youth maltreatment, it was apparent that the determination of *who* would be queried would be of equal importance as the query itself. Practice strategies for preventing and intervening in intimate partner violence and sexual violence must be built on knowledge of the antecedents to victimization and the outcomes of victimization and on a study of the outcomes which may be population related as well. We anticipate that the information yielded in this report will be useful to human service providers who serve diverse populations of victimized women who are living and coping in diverse geographic environments. Specifically, human service providers must examine their own assessment and intervention protocols and to modify them in order to capture information about the different types of victimization women experience. The findings of this study indicate that not infrequently, women experienced multiple types of victimization. More efforts to identify those experiences and to use appropriate and specific interventions are needed.

Notably, one of these environments is the only correctional facility for women in the state. While replications of this research are important prior to the implementation of major policy revisions, we believe these and future like findings can be expected to influence prevention and intervention strategies that may decrease the effects of intimate partner violence, sexual violence and youth maltreatment in women's lives as well as decrease the impact of those effects on women victims' potential for involvement with the criminal justice system. "Strategically and specifically designed … services" for women offenders are important

particularly given the recent alarming increase in the incarcerated female population (Severson, 2001). The captive nature of the prisoner population along with institutional service mandates based on Constitutional rights to health care may mean that victimized women can be assured of being offered services only after their incarceration. What was revealed here is what is being found in other areas of correctional practice: there are certain services that are perceived by women prisoners as being more helpful to them than others, and these services could be offered to women *before* they ever become entrenched in the criminal justice system or in place of services more commonly offered to women victims but which are perceived by them to be less beneficial. For example, of the five most commonly used services the women participants identified receiving after their victimization experiences, only one remained in the top five of the services perceived as being most helpful. Indeed, these women told us that what we call long-term tangible services – daycare, housing, welfare and educational supports – were the services most helpful to them in the aftermath of violence. This does not mean that the therapeutic services available such as counseling, mediation, support groups, etc. are not useful; only that there may be a temporal sequence of service receipt that proves more helpful to victims of violence. Practitioners should build this knowledge into their service delivery plans.

In the same vein, when asked about barriers to service receipt, these women indicated that they did not make use of available services either because they thought they could handle the problem on their own or they believed the violence would stop without intervention. These constructed barriers – probably related to stigma and perhaps also to the perception that "nothing happens" when disclosures are made – serve only to keep women in violent situations. From a practice perspective, effectively countering these attitudes so that victimized women actually are psychologically free to make use of the services available, may require a more aggressive public

education campaign about girlhood and adult woman violence. Agencies which provide individual and small group therapeutic services to all women victims, incarcerated and free, should carefully train their staff in methods of interviewing and intervening which work to overcome attitudes formed by stigma, by historical gender-based behavior prescriptions and by actual system barriers which make disclosure and asking for help risky propositions for victims of violence.

Finally, the multiple regression analyses on these data also point to ways targeted interventions may make a difference, i.e. where interventions used to enhance the mediating factors of one's sense of self-efficacy and social support stand to enhance positive outcomes for women victims. Recall that a woman's level of social support is a good predictor of her physical health, depression, and levels of PTSD and her sense of self-efficacy is also a strong predictor of adult outcomes, predictive of better physical health, a lower level of depression, and decreased levels of PTSD. Practice interventions such as participation in women's support groups and opportunities to enhance personal competence – through educational forums including life skills programs which include topics such as problem-solving and budgeting methods – may serve to strengthen these potential mediators.

Additionally, it is important to find out whether the "clients" being served by an agency actually find the services they receive to be helpful. This research suggests that a woman's perception of whether services are helpful or not may have some relationship to her later incarceration, that is, if a woman does not find a service to be helpful, the lack of benefits from that service may have some bearing on her later incarceration. Consequently, an ongoing process of program evaluation – relying on input from clients to gage the helpfulness of the

services provided – is critical to providing appropriate and helpful and perhaps successful preventive interventions.

In sum, the implementation of the preventive-interventive measures identified above and others which will emerge from additional research has implications for public safety in a number of ways. Such interventions may prevent the initiation of a spiral of negative outcomes for girlhood and adult victims of violence, including depression, post-traumatic stress, poor physical and mental health and incarceration. It is conceivable that evidence-based interventions will work to prevent a woman from entering prison who might otherwise be at high risk for criminal and substance-using behaviors. This prevention and intervention knowledge can also benefit women who have already been incarcerated by providing effective interventions that may decrease the likelihood of recidivism.

At the start of this research initiative we proposed the possibility that *real prevention lies in early intervention*: making sure that critical kinds of social services and social supports are available to the victims of intimate partner violence, sexual violence and youth maltreatment and injury before they end up incarcerated or in other abusive or injurious relationships. What we have found is that there are indeed certain types of services that could be funneled to those women who present few criminogenic traits but who have turned to alcohol and drugs to self-medicate and / or to be able to support themselves out of a violent situation.

In sum, this research initiative has afforded an opportunity to further refine policy directions and practice strategies in all areas of intervention with victims of intimate partner violence, sexual violence and youth maltreatment. Individual, social service, medical, mental health and criminal justice systems can gain from this exploration of the relationship between women's histories and women's present circumstances.

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# Appendix A

# Recruitment Flyer

# Appendix B

# Psychoeducational Groups at the Women's Correctional Facility

# Appendix C

# Screening Protocols

# Appendix D

# Qualitative Protocols

# Appendix E

# Qualitative Recruitment

# Appendix F

# Survey

# Appendix G

# Qualitative Interview Questions

# Appendix H

# Consent Forms

# Appendix I

# Training Protocols

# Appendix J

# Tables
# (J-1, J-2, J-3)

# *EARN $25*

## To be interviewed for the Women's Histories of Survival Project

If you are interested in participating in this project, please call the Women's Histories of Survival Project at

**620-640-0191**

for more details

**All information you provide will be confidential.**

**If you are a female 18 or older, you are eligible to participate.**

The interview will last approximately one hour, be scheduled at a time and place convenient for you, and will cover topics such as:

- Your coping abilities & your confidence in managing your life
- Your mental health and well-being
- The types of supports and services you have received

**A research project of the KU School of Social Welfare and funded by the National Institute of Justice**

Women's Histories of Survival **620-640-0191**

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**VIOLENCE AGAINST WOMEN GROUP AT TOPEKA CORRECTIONAL FACILITY**
**April 2005**
**Tuesday, April 19, 2005 *J Dorm* 12:30pm**
**Friday, April 22, 2005 *Central Access* Educational Room 5:30pm**
**Sunday, April 24, 2005 *Central Access* Educational Room 5:30pm**
**Monday, April 25, 2005 *Central Access* Educational Room 5:30pm**

1. **Intro – *5 min***

Introduce myself. Explain that this group is completely confidential and that whatever someone says in the group needs to stay in that room. We will be talking about primarily violence against women (i.e. sexual assault and domestic violence). Explain that this group is for people who completed the history of violence interview. Explain that we will not be using anyone's name in our research and that I will ask people to introduce themselves but they can just use a first name or even a nickname if they want. Have folks introduce themselves.

2. **Explain the agenda for the day – *5 min***

We will be talking about what is domestic violence, sexual assault, and child abuse. Additionally, we will talk about some safety planning, and resources for help. While this group will be primarily a chance for them to get information, I want them to ask questions as they have them.

3. **Domestic Violence, Sexual Assault, and Child Abuse Basic Information – *30 min***
    a. Domestic Violence
        i. Go through Myths and Facts
        ii. Define: What do they think it is?
            1. Domestic violence is a pattern of abusive and coercive behavior to gain power and control over an intimate partner
        iii. What types of behavior/abuse?
            1. Physical Violence
            2. Sexual Violence
            3. Emotional/Verbal Abuse
            4. Intimidation and Threats
            5. Isolation
            6. Controlling Money or Financial Resources
            7. Threatening Children or other loved ones
            8. Minimization, Denial, Crazy-Making
        iv. How often does it occur and who does it happen to?
            1. Domestic Violence crosses all class, race, lifestyle, religious, etc… lines
            2. 95% of all people who perpetrate domestic violence are men
            3. 25% of women will be the victim of domestic violence

4. Children whose mother's are abused are also more likely to be abused by the perpetrator

v. Why not just leave??
   1. Barriers to Leaving
   2. Dangers of Leaving

vi. Questions

b. Sexual Assault
   i. Go through Myths and Facts
   ii. Different types of sexual assault
      1. Rape – Define It
      2. Sexual molestation
      3. Sexual Harrasment
      4. Other forms?
   iii. How often does it happen and who does it happen to?
      1. 1 in 3 women will be sexually assaulted during her lifetime
      2. 1 in 6 men will be sexually assaulted
      3. Sexual assault crosses all race, lifestyle, religion, color, class, and other social lines
   iv. Who perpetrates rape and why?
      1. Men perpetrate sexual assault 95-98% of the time
      2. Sexual assault is not motivated out of lust or desire, but rather sex or sexual acts are used as a weapon against someone in an attempt to hurt them and have power over them
      3. Not the stranger in the bushes, but typically someone you love and trust (i.e. family member, neighbor, friend, intimate partner, etc…)
   v. Why don't people talk about it?
      1. Rape is the most dramatically underreported crime, with as much as 84% of sexual assaults going unreported

c. Child Abuse in the Context of Sexual Assault or Domestic Violence
   i. Different forms
      1. Physical Abuse
      2. Sexual Abuse
      3. Emotional/Verbal Abuse

4. **Power and Control Wheel – *15 min***
   a. Go through power and control wheel quickly
   b. Ask women to give examples of different tactics used under each one
   c. Use Power and Control Worksheet
   d. Hand out both Power and Control Wheel and Worksheet

5. **Emotional Reponses – *10 min***
   a. Have the women name off some of the feelings that they have had
   b. Hand out the two sheets that talk about emotional responses
   c. How to get help?

6. **Safety Planning - *10 min***
    a. Talk briefly about the importance of safety planning
    b. Talk about that safety planning and other resources won't necessarily keep you safe
    c. Hand out safety plans
    d. Go through them briefly
    e. Explain that they might want to have someone go through it with them

7. **Red Flags – *5 min***
    a. Hand out and go through chart for dangerous behavior
    b. Explain that while this is for domestic violence it would describe potential things to look for
    c. Ask them to add things to it

8. **Resources for Help and What to Expect – *5 min***
    a. Hand out KCSDV brochure and show them where the resources section is at
    b. Resources available:
        i. Shelter
        ii. Support Group
        iii. Counseling
        iv. 24/hr crisis line
        v. Children's crisis counseling
        vi. Help with getting housing or jobs
        vii. Ongoing support
        viii. Educational Information

9. **Wrap up and Questions – *5 min***

# AGENDA

I. Introductions and what the group is about — *10 min*

II. General Information — *20 min*
- a. Domestic Violence
  - i. What is it?
  - ii. How Often Does it Happen?
- b. Sexual Assault
  - i. Definitions
  - ii. How Often Does it Happen?
- c. Child Abuse
  - i. Different types
  - ii. How Often Does it Happen?

III. Power and Control Wheel — *10 min*
- a. Go through each part briefly
- b. Ask participants to give examples

IV. Emotional Responses — *15 min*
- a. Typical reactions
- b. What you can you do
- c. "Why" this happened to you

V. Safety Planning — *10 min*
- a. Safety Planning for DV
- b. Safety Planning for Sexual Assault
- c. Safety Planning for Children

VI. Red flags — *10 min*

VII. Resources for Help and what to expect — *10 min*

VIII. Questions — *5 min*

# Safety Plan for Survivors of Sexual Assault

***This safety plan will be most effective when filled out with an advocate, trusted friend, or family member who also has some knowledge regarding sexual assault issues. This safety plan can be helpful at differing points during the healing process, but will be most helpful only after some of the initial crisis and emotions have calmed. Some of it may not apply to you, and while attempting to give concrete suggestions, it is impossible to cover every possible scenario.***

Sexual violence affects a person's emotional and physical safety. The following steps will help me identify ways to increase my safety.

**Step 1: Emotional Safety:** The experience of being sexually assaulted is very emotionally draining and traumatic. The process of overcoming these traumatic effects takes courage and energy. To get through some of the hard emotional times, I can:

1) Expand my support network through talking with an advocate, joining a support group, making new friends, etc…

2) If I feel down or frightened, I can
_____
_____.

3) I can tell myself "_____" if I feel others are trying to control my life.

4) I can attend workshops, support groups, or _____ to gain support and strengthen my relationships with other people.

   a. Local group info: _____
      Contact person: _____

5) I can begin to identify my triggers by journaling, especially after feeling particularly anxious or fearful. I can then discuss this with someone I trust and who has an understanding of sexual assault issues, such as _____.

6) I can begin to recognize that triggers are a natural part of healing, but that when I am triggered I can do the following things to calm myself down:
   a. _____
   b. _____
   c. _____

7) I can ask that people in my life who love and support me, also get support. They may be able to get support from the local sexual assault center or from _____.

**Step 2: Safety within my house**: To increase my feelings of safety at my house, I can do some or all of the following:

1) I will make sure that all the doors and windows lock. If the offender was someone who used to live at the house I will have my locks changed. If I have a sliding glass door, I can put a wooden rod in the track to make sure it can't be slid open. Other structural changes to increase safety include _____.

2) Increase lighting in my house, and have outside lights as well. Maybe even put a nightlight in a hall, bedroom, or bathroom.

3) Other things that I can do within my house to increase my feelings of safety include _____.

4) I can change my telephone number and/or get my address unlisted.

**Step 3: Flashbacks and Intrusive Memories:** I can implement the following strategies when memories of the assault are effecting my day-to-day living:

1) I can do deep breathing and mental imagery to help reorient my body and lower the level of adrenaline in my body. I choose to use a picture of _____ as my mental imagery.

2) I can call _____, _____, _____ or the local sexual assault crisis center at (____) ____-_____ if I need to talk to someone to help overcome some of my fears.

3) I can attempt to reorient myself to the current place and time through the following grounding techniques:
   a. Ice
   b. Stomping Feet
   c. Saying the day and/or time
   d. Other _____

4) I can ask _____ or _____ to help me with some of my responsibilities if I need more time to relax or rest.

5) I can choose to talk with someone who is knowledgeable about sexual assault such as _____.

**Step 4: Safety if there is still contact with the offender.** Since sexual assault is often perpetrated by someone that is known or trusted it is not always feasible to not have contact with the offender. In order to help ensure my safety, I can use some or all of the following strategies:

1) I can tell _____ and _____ to have them stay near me when the offender is around so that I don't have to be alone with him.

2) I will choose _____ as a code word, and tell _____ and _____ so that if I am feeling unsafe they can help me get to a previously agreed upon place where I may feel more safe.

3) In case the offender attempts to be violent again, I can know the possible exits. I will keep an extra set of keys and some money _____ in case I have to leave quickly, and I will practice exiting quickly several times.

4) If I feel unsafe in my current place of residence, I can go stay with _____ or _____. I can also call the local sexual assault program at (____) _____-_____.

5) If I have to leave quickly or need to change residences, I know that the following will be important for me to have. These items can be gathered up beforehand and given to a friend or relative or placed somewhere where they can be grabbed quickly.

   a. Driver's license and registration
   b. Social security cards
   c. Money, checkbook, ATM card
   d. Keys
   e. Welfare records
   f. Birth certificates
   g. School and vaccination records
   h. Credit cards
   i. Medications/medical records
   j. Other _____
   k. Other _____

6 ) I know that the offender may try to maintain control over me while in his presence. Therefore, I have asked _____ to look for these specific things (triggers)_____ and to accompany me out of the offender's presence if those things are taking place. Also, if unable to immediately leave or to be accompanied by someone, I can call _____ afterward to help process what I am feeling.

7) I may run into the offender at places unexpectedly and where there is less chance of having someone pre-planned to be with me. At those times, some safety considerations would include:

   a. Carrying a cell phone (even if it only has access to 911, which can be gotten for free through the local domestic violence/sexual assault program)
   b. Being aware of exits
   c. Trying to have someone with me
   d. Immediately calling one of my previously identified support people

**Step 5: Safety Within the Criminal Justice System:** If I am involved with the criminal justice system, I may want to look at some strategies to make myself feel more safe and more in control throughout that process. Additionally, it is important to make sure that my voice is heard in the process.

1) I can ask the following people to attend hearings, trial, or sentencing with me _____, _____, or _____. I can also ask an advocate from the local sexual assault program.

2) I may be eligible for a protection order. I can talk with an advocate at the local program about the eligibility guidelines for protection orders, how I would apply for a protection order, and the possibly benefits or consequences of getting a protection order. I can reach an advocate at this number (___) _____ - _____.

3) I have the right to speak at the sentencing, to be informed of the dates and times of any hearings associated with this case, and to be informed about parole or probation. I can talk with the local victim/witness coordinator regarding this information and to make sure that my voice is heard. The local victim/witness coordinator who I would need to contact is _____ at (_____)___ -_____.

4) I can apply for victim's compensation to help with costs associated with being sexually assaulted, including therapy, cost of any treatment at the hospital, lost wages, etc... I can get a victim's crime compensation application through the Attorney General's Office, through my local program, or through the local prosecutor's office.

**Helpful telephone numbers:**

| | |
|---|---|
| Local Sexual Assault Program | _____ |
| Police/Sheriff | _____ |
| Prosecutor | _____ |
| Victim/Witness Coordinator | _____ |
| Kansas Legal Services | _____ |
| Therapist | _____ |
| Doctor | _____ |
| Statewide Crisis Number | 1-800-End-Abuse |

# *Safety Planning*

Name: _____
Date: _____
Review Dates: _____
_____

The following steps represent my plan for increasing my safety and preparing in advance for the possibility for further violence. Although I do not have control over my partner's violence, I do have a choice about how to respond to him/her and how to best get myself and my children to safety.

**Step 1: Safety during a violent incident.** Women cannot always avoid violent incidents. In order to increase safety, battered women may use a variety of strategies.

I can use some or all of the following strategies:

A. If I decide to leave, I will _____. (Practice how to get out safely. What doors, windows, elevators, stairwells, or fire escapes would you use?)

B. I can keep my purse and car keys ready and put them (place) _____ in order to leave quickly.

C. I can tell _____ about the violence and request they call the police if they hear suspicious noises coming from my house.

D. I can teach my children how to use the telephone to contact the police and the fire department.

E. I will use _____ as my code word with my children or my friends so they can call for help.

F. If I have to leave my home, I will go _____. (Decide this even if you don't think there will be a next time.)

G. I can also teach some of these strategies to some/all of my children.

H. When I expect we are going to have an argument, I will try to move to a space that is lowest risk, such as _____. (Try to avoid arguments in the bathroom, garage, kitchens, near weapons or in rooms without access to an outside door.)

# *Safety Planning, cont.*

I. I will use my judgment and intuition. If the situation is very serious, I can give my partner what he/she wants to calm him/her down. I have to protect myself until I/we are out of danger.

J.

**Step 2: Safety when preparing to leave.** Battered women frequently leave the residence they share with the battering partner. Leaving must be done with a careful plan in order to increase safety. Batterers often strike back when they believe that a battered woman is leaving a relationship.

I can use some or all of the following safety strategies:

A. I will leave money and an extra set of keys with _____ so I can leave quickly.

B. I will keep copies of important documents or keys at _____.

C. Other things I can do to increase my independence:

_____

_____

_____

_____

D. The domestic violence program's hotline number is _____. I can seek shelter by calling this hotline.

E. I can keep change for phone calls on me at all times. To keep my telephone communications confidential, I must either use coins or I might get a friend to permit to use their telephone credit card for a limited time when I first leave.

F. I will check with _____ and _____ to see who would be able to let me stay with them or lend me some money.

G. I can leave extra clothes with _____.

H. I will sit down and review my safety plan every _____ in order to plan the safest way to leave the residence. _____ (domestic violence advocate or friend) has agreed to help me review this plan.

# *Safety Planning, cont.*

I. I will rehearse my escape plan and, as appropriate, practice it with my children.

**Step 3: Safety in my own residence.** There are many things that a woman can do to increase her safety in her own residence. It may be impossible to do everything at once, but safety measures can be added step by step.

A. I can change the locks on my doors and windows as soon as possible.

B. I can replace wooden doors with steel/metal doors.

C. I can install security systems including additional locks, window bars, poles to wedge against doors, an electronic system, etc.

D. I can purchase rope ladders to be used for escape from second floor windows.

E. I can install smoke detectors and purchase fire extinguishers for each floor in my house/apartment.

F. I can install a motion detector light that lights up when a person is coming close to my house.

G. I will teach my children how to use the telephone to make a collect call to me and to (friend/minister/other) in the event that my partner takes the children.

H. I will tell people who take care of my children which people have permission to pick up my children and that my partner is not permitted to do so. The people I will inform about pick-up permission include

_____.

I. I can inform _____ (neighbor), _____ and _____ (friend) that my partner no longer resides with me and they should call the police if he is observed near my residence.

**Step 4: Safety with a protection order.** Many batterers obey protection orders, but one can never be sure which violent partner will obey and which will violate protection orders. I recognize that I may need to ask the police and the courts to enforce my protection order.

# *Safety Planning, cont.*

The following are some steps that I can take to help the enforcement of my protection order:

A. I will keep my protection order _____ (location). (Always keep it on or near your person. If you change purses, that's the first thing that should go in.)

B. I will give my protection order to police departments in the community where I work, in those communities where I usually visit family or friends, and in the community where I live.

C. There should be a county registry of protection orders that all police departments can call to confirm a protection order. I can check to make sure that my order is in the registry. The telephone number for the county registry of protection orders is _____.

D. For further safety, if I often visit other counties in my state, I might take a certified copy of my PFA to the law enforcement agency (ies) in the following counties: _____.

E. I can call the local domestic violence program if I am not sure about B, C, or D above or if I have some problem with my protection order.

F. I will inform my employer, my minister, my closest friend and _____ and _____ that I have a protection order in effect.

G. If my partner destroys my protection order, I can get another copy from the courthouse by going [the office] located at _____

H. If my partner violates the protection order, I can call the police and report a violation, contact my attorney, call my advocate, and/or advise the court of the violation.

I. If the police do not help, I can contact my advocate or attorney and will file a complaint with the chief of the police department.

J. I can also file a private criminal complaint with the district justice in the jurisdic-

tion where the violation occurred or with the district attorney. I can charge my battering partner with a violation of the protection order and all the crimes that he commits in violating the order. I can call the domestic violence advocate to help me with this.

**Step 5: Safety on the job and in public.** Each battered woman must decide if and when she will tell others that her partner has battered her and that she may be at continued risk. Friends, family and coworkers can help to protect women. Each woman should consider carefully which people to invite to help secure her safety.

I might do any or all of the following:

A. I can inform my boss, the security supervisor and _____ at work of my situation.

B. I can ask _____ to help screen my telephone calls at work.

C. When leaving work, I can _____.

D. When driving home if problems occur, I can _____.

E. If I use public transit, I can _____.

F. I can use different grocery stores and shopping malls to conduct my business and shop at hours that are different than those when residing with my battering partner.

G. I can also _____.

**Step 6: Safety and drug or alcohol use.** Most people in this culture use alcohol. Many use mood-altering drugs. Much of this use is legal and some is not. The legal outcomes of using illegal drugs can be very hard on a battered woman, may hurt her relationship with her children and put her at a disadvantage in other legal actions with her battering partner. Therefore, women should carefully consider the potential cost of the use of illegal drugs. But beyond this, the use of any alcohol or other drugs can reduce a woman's awareness and ability to act quickly to protect herself from her battering partner, I can enhance my safety by some or all of the following:

# *Safety Planning, cont.*

A. If I am going to use, I can do so in a safe place and with people who understand the risk of violence and are committed to my safety.

B. I can also _____.

C. If my partner is using, I can _____.

D. To safeguard my children, I might _____ and _____.

**Step 7: Safety and emotional health.** The experience of being battered and verbally degraded by partners is usually exhausting and emotionally draining. The process of building a new life for myself takes much courage and incredible energy.

To conserve my emotional energy and resources and to avoid hard emotional times, I can do some of the following:

A. If I feel down and ready to return to a potentially abusive situation, I can _____.

B. When I have to communicate with my partner in person or by telephone, I can _____.

C. I can try to use "I can..." statements with myself and to be assertive with others.

D. I can tell myself, "_____" whenever I feel others are trying to control or abuse me.

E. I can read _____ to help me feel stronger.

F. I can call _____, _____ and _____ as other resources to be of support to me.

G. Other things I can do to help me feel stronger are _____, _____, and _____.

# *Safety Planning, cont.*

H. I can attend workshops and support groups at the domestic violence program or _____, _____, or _____ to gain support and strengthen my relationships with other people.

**Step 8: Items to take when leaving.** When women leave partners, it is important to take certain items with them. Beyond this, women sometimes give an extra copy of papers and an extra set of clothing to a friend just in case they have to leave quickly.

Items with asterisks on the following list are the most important to take. If there is time, the other items might be taken, or stored outside the home.

These items might best be placed in one location, so that if we have to leave in a hurry, I can grab them quickly.

**********

When I leave, I should take:

- Identification for myself
- Children's birth certificates
- My birth certificate
- Social Security cards
- School and vaccination records
- Money
- Vision Card
- Keys – house/car
- Driver's license and registration
- Medications
- Green card, work permits
- Passport
- Divorce papers
- Medical records –for all family members
- Lease/rental agreement, house deed
- Insurance papers
- Small saleable objects

# *Safety Planning, cont.*

- Address book
- Pictures
- Jewelry
- Children's favorite toys and/or blankets
- Items of special sentimental value

## Telephone Numbers I Need to Know:

Police department (home) _____
Police department (school) _____
Police department (work) _____
Battered women's program _____
Minister _____
Other _____

# A Safety Plan For Kids

**Domestic Violence is when a grownup in your family hits, kicks, pushes or throws things at someone else in your family.**

- It might make you feel scared, confused or mad.
- It can make you feel like crying or yelling.
- It might make you feel embarrassed or guilty, but it's not your fault.

**When the Fighting Starts**

- Stay out of the room where the fighting is
- Stay out of small rooms where you might get trapped, like a closet or bathroom.
- Stay out of the kitchen and garage, where it's easy to get hurt during a fight.

**Get Help!**

- Go to a safe place, like a neighbor's or friend's house.
- If you need help RIGHT NOW, try to call 911 from a room away from the fighting.

**Things to Think About**

- Which doors, windows or stairs are the safest way to get out of your house during a fight?
- Which grownups could you talk to about getting help?

**Remember: It's not your fault!**

It's okay to love both of your parents, even if one parent is hurting the other.
But it's not okay for that parent to hurt you, your other parent or anyone else.

**My Safety Plan**

When I get scared I can think about _____

When I get scared I can go to _____

When I am feeling down or afraid I can talk to _____

These are the exits from my house _____

In an emergency I can _____

My important Numbers _____

My Phone Number _____

The Police _____

A neighbor, relative or friend's number _____

*Adapted from handouts by the American Bar Association and the Alabama Coalition Against Domestic Violence*

# *Barriers to Leaving*

The following are common barriers survivor's face to leaving an abusive relationship:

- Threats to severely injure or kill her or her children if she leaves
- No place to go/lack of emergency shelter and housing
- Loss of home
- Loss of resources
- Cultural, societal or religious beliefs about marriage, families, children
- Stigma of divorce
- Survivor does not believe she can make it on her own
- Lack of economic resources
- Hope for and belief in change
- Ambivalence about the relationships- still caring about the partner
- Being told by many that it is important to stay or go back
- Lack of community demand for accountability of perpetrator

# *Definitions of Domestic Violence*

Domestic violence is a pattern of behavior, both personal and social, whose goal is to gain power and control over an intimate partner. It includes a behaviors that undermine the survivor's sense of self, free will and safety. Domestic violence forces survivors to make choices based on how their partner may harm them, physically, spiritually, and/or emotionally. Batterers utilize physical violence and threats of violence to "enforce" the control they establish. The vast majority of batterers are physically and emotionally controlling of their intimate partners only and do not assault other adults. Battering is a chosen behavior, committed away from the sight of others to avoid detection. It is not a mental illness, behavior disorder, or anger management problem. It does not stem from an inability to be nonviolent but from an unwillingness to be so.

**Types of abuse include:**

- Physical Violence
- Sexual Violence
- Emotional/Verbal Abuse
- Intimidation and Threats

**Additional abusive behavior includes:**

- Exploitation of Privilege
- Isolation
- Economic Control
- Threatening Children and Loved Ones
- Minimization, Denial and Blame

Domestic Violence crosses all class, race, lifestyle and religious lines. The only clear distinction is gender, more than 95% of the victims of domestic violence are women, perpetrated against by their male partners. Although, when women are battered by their female intimate partners or men battered by their male or female intimate partner, the goal remains the same....one partner controlling the other through abuse. What may change are specific behaviors related to the power dynamics of the relationship and the relationship within the context of our social environment.

# *Myths and Facts*

**MYTH**—Women who are abused have low self-esteem. Otherwise, they wouldn't allow someone to treat them that way.
**FACT**—Many battered women do suffer from low self-esteem. However, the self-esteem is a result of the systematic abuse they have survived, not the cause of it.

**MYTH**—Domestic violence occurs mostly in poor, undereducated, dysfunctional, or minority families.
**FACT**—Domestic violence crosses all age, ethnic, socioeconomic, religious and educational boundaries. There is no typical violent family. There are doctors, ministers, psychologists, police, attorneys, judges, social workers and other professionals who abuse their partners. At least one-third of all married women have been physically abused by their husbands or ex-husbands.

**MYTH**— Women are just as violent as men.
**FACT**— In approximately 95 percent of domestic assaults, the man is the perpetrator. Women are 13 times more likely to be the victim in cases of spousal abuse. Sixty percent of men who were killed by their wives were killed as they were assaulting or threatening to injure or kill the woman.

**MYTH**— When there is violence in a relationship, both members are at fault to a certain extent and therefore must both do some changing for the violence to stop.
**FACT**— Only the batterer has the ability to stop the violence. Battering in an attitude and chosen behavior. Many battered women try to change their own behavior and their children's hoping that this will stop the abuse. This does not work. Changes in family members' behavior will not cause or influence the batterer to not be violent.

**MYTH**— Domestic violence is usually a one-time or infrequent occurrence where the abuser simply lost control and hit.
**FACT**— Battering is a pattern, a reign of force and terror. Once violence begins in a relationship, it gets worse and more frequent over a period of time. Battering is not just physical attacks, but a number of tactics, like intimidation, threats, economic deprivation, psychological and sexual abuse, used repeatedly.

**MYTH**—Battered women always go back to their abuser.
**FACT**—Many battered women leave their batterers permanently, and despite many

# *Myths and Facts, cont.*

obstacles, succeed in building a life free of violence. The batterer often dramatically increases his violence when a woman leaves (or tries to), because it is necessary for him to reassert his control and ownership. Battered women are often very active on their own behalf. Their efforts often fail because the batterer continues to assault, and society refuses to provide protection and resources. Consequently, the average battered woman leaves seven times before she is able to leave for good.

**MYTH**— Substance abuse and/or stress cause domestic violence.
**FACT**—One of the most widely held beliefs is that substance abuse, unemployment, financial problems, or other stresses of daily living cause domestic violence. Although these are often factors, they can more accurately be called triggers, rather than causes. Many people dealing with these problems do not batter. However, a batterer will list lots of reasons to excuse or justify their decision to be abusive, from addiction and stress to their partner provoking them or not making the bed right.

**MYTH**— Batterers are abusive because they cannot control themselves or because they have anger management problems.
**FACT**— Batterers are usually not violent toward anyone but their partners and/or children. They can control themselves sufficiently enough to pick a "safe" target. Batterers often beat their partner on areas of the body that don't show, indicating a high level of anger management and control.

**MYTH**— Women are just as violence as men.
**FACT**— In approximately 95 percent of domestic assaults, the man is the perpetrator. Women are 13 times more likely to be the victim in cases of spousal abuse. Sixty percent of men who were killed by their wives were killed as they were assaulting or threatening to injure or kill the woman.

**MYTH**— Batterers suffer from low self-esteem. They abuse and put down their partner to make themselves feel better.
**FACT**— Batterers tend to have very high self esteem. They express shame or low self-esteem in the aftermath of an abusive incident or when they get caught, but overall tend to have high self-esteem and an entitled attitude.

# *Power and Control Wheel Worksheet*

The power and control wheel was written based on the statements of battered women. It is a tool used to describe the pattern of behaviors that batterers use to gain control in an intimate relationship. The wheel's center is power & control, women describe that their abusive partners clearly want to control every aspect of their life and are willing to use many tactics to accomplish this. Physical and sexual violence surround the circle, they are the "enforcer" of all of the other controlling behaviors; fear of physical and sexual violence are an undercurrent to all aspects of a battering relationship. The remaining spokes of the wheel include behaviors, that when combined with the intent to control another person, are devastating. The following is a list of definitions and behaviors identified by survivors of domestic violence. This list isn't complete, but can be a starting place in naming what is happening.

**Physical Abuse**

Physical abuse includes unwanted physical contact, which may or may not cause an injury. Physical abuse can be directed at you, your children, household pets or others. Has your partner ever:

_____ pushed, shoved or kicked you
_____ held you down to keep you from leaving
_____ slapped, hit or punched you
_____ bit, stabbed, burned or choked you
_____ thrown objects at you
_____ locked you out of the house
_____ abandoned you in dangerous places
_____ refused to help when you were sick, injured or pregnant
_____ tried to hit or force you off the road with a car
_____ threatened or hurt you with a weapon

**Sexual Abuse**

Degrading treatment based on your sex or sexual orientation; using force or coercion to obtain sex or perform sexual acts. Has your partner ever:

_____ made jokes or crude remarks about you or other women
_____ treated women as sex objects
_____ jealousy; accusing you of affairs
_____ forced you to dress a particular way
_____ put down your feelings about sex
_____ criticized you sexually
_____ insisted on sexual contact or touching
_____ withheld sex and affection
_____ called you sexual names, like "whore" or "frigid"
_____ forced you to strip
_____ shown sexual interest in others
_____ had affairs with others while agreeing to monogamy
_____ demands monogamy from you, while insisting on freedom for self
_____ forced sex with him/her or others
_____ forced sex after beating or threatening beating

# *Worksheet, cont.*

**Emotional Abuse**

Emotional abuse is mistreating and controlling another person. The emotional abuser makes their partner feel afraid, helpless and/or worthless. Has or does your partner ever:

_____ ignored your feelings
_____ ridiculed or insulted your valued beliefs, religion, race etc.
_____ withhold appreciation, approval or affection as punishment
_____ continually criticize, calling you names or shouting at you
_____ insult or drive away friends/family
_____ humiliate you in public or private
_____ lied or withheld important information
_____ always checks up on you
_____ treat you like a child or servant
_____ threaten to leave you continually
_____ abused pets to hurt or scare you
_____ made you feel worthless, never good enough
_____ dislike your friends/family or how you do just about anything

**Intimidation and Threats**

The primary function of intimidation and threats is to instill fear and insure compliance. Has or does your partner:

_____ put you in fear through looks, gestures or actions
_____ smashed things
_____ destroyed things of value to you
_____ injured or killed pets to frighten you
_____ threatened to hurt/kill someone you love
_____ displayed weapons in a threatening way
_____ cleaned weapons immediately after or during a threatening argument
_____ threatened to leave you or commit suicide
_____ made you commit illegal acts
_____ threatened to report illegal acts or report you to welfare or child abuse investigators
_____ said he'll/she'll never let you leave him

**Isolation**

Isolation can be devastating. It prevents battered women from accessing support or resources. In addition, batterers through abusive tactics will turn family and friends against their partner. Has your partner ever:

_____ started fights whenever you want to go out or spend time with friends
_____ put your family/friends down
_____ made you feel guilty when you spend time away from him/her
_____ although it is not said directly, you always feel like you must ask before going out
_____ refused to care for the children as you are preparing to leave
_____ made you account for every moment of the time you are gone – who you are with,

# *Worksheet, cont.*

where you went, who you saw, what you did, etc.
_____ made you late for work so many times, you lose your job
_____ accused you of having affairs
_____ monitors your use of the car
_____ taken the phone or car keys when he/she leaves
_____ locked you in a room when he/she leaves

**Using the Children**
Threatening or hurting someone we love is a tactic to insure compliance. Batterers know that many survivors are willing to suffer much to protect their loved ones. Has or does your partner:
_____ threaten to kidnap or kill the children
_____ punished or deprive the children when mad at you
_____ call you a bad parent
_____ use visitation to harass you
_____ tell the children "I'm going to jail because Mommy is mad at me"
_____ refuse to participate in the care of the children
_____ use the children to make you feel guilty
_____ threaten to sexually abuse the children if you won't have sex

**Economic Abuse**
Controlling a battered woman's access to financial resources can directly affect her ability to be independent of the batterer. Has or does your partner:
_____ control access to household money, you don't know how much or where it is
_____ make all the financial decisions
_____ if you are responsible for the household budget you have to account for every dime and are punished if there isn't "enough"
_____ take your paycheck or sell your belongings to get extra money
_____ prevent you from getting or keeping a job

**Minimization, Denial and Blame**
Minimization, denial and blame undermines the credibility and reality of battered women. By making light of, denying responsibility for, or blaming the survivor for their actions, the batterer creates an environment in which the survivors feelings, thoughts or needs are ignored and devalued. Has or does your partner:
_____ say he/she wouldn't hit you if you hadn't made him/ her angry
_____ say the abuse never happened or that it was no big deal
_____ say you deserve it

**Control through Overprotection and "Caring"**
Some batterers will use concepts like caring for or protecting as a means to control another.

# *Worksheet, cont.*

The emphasis here is on the intention of the action - will there be consequences if you don't go along with his "kindness"

_____ he/she doesn't like it if you are away from home, he/she worries and wants to know where you are all the time

_____ he/she phones or unexpectedly shows up where you work to see if you're "ok"

_____ he/she shops or runs errands so you don't have to go out

_____ he/she drives you to and from places so no one will get "ideas"

**Using Societal Privilege**

In our society, many of us carry value based on our status. Some examples include being male, wealthy, heterosexual or white-skinned.

Has your male partner ever:

_____ treated you like a servant

_____ made all the "big" decisions, telling you what to do

_____ acted like the "master of the castle", using that to justify abusive behaviors

Has your female partner ever:

_____ used heterosexism or homophobia to put you in fear

_____ threatened to "out" you to family or coworkers

_____ say you aren't a "real" lesbian

_____ threatened to tell your children or former male partner that you are in a relationship with a woman

*Adapted from materials written by Ginny NiCarthy. Used with permission from the Iowa Coalition Against Domestic Violence*

## Chart of Dangerous Behavior

| | Abuse | Emotional / Psychological | Social / Environmental | Sexual Abuse |
|---|---|---|---|---|
| **Potentially Dangerous** | Pinch - squeeze, push - shove, restrain, jerk, pull, shake, slap, bite, pull hair. | Ignores feelings, withholding approval as punishment<br><br>humiliation, public and private<br><br>blames victim for all faults<br><br>labelling or name calling: crazy, bitch, whore, etc. | jokes about role of women<br><br>denies victim her history, heritage | looks at and makes jokes about women as sex objects<br><br>extreme jealousy<br><br>minimizes feelings and needs regarding sex<br><br>sexual criticism |
| **Dangerous** | Shaking that leaves bruises<br><br>hitting, punching, kicking<br><br>choking, throwing objects<br><br>targeted or repeated hitting for punishment | threats of violence, retaliation<br><br>puts down abilities as worker, mother, lover<br><br>threaten victim with abusing children or getting custody of | isolates victim by not allowing friends, frequent moves<br><br>economic dependency<br><br>threatens victim's family<br><br>perpetrator stays isolated and demands control of environment | forces victim to touch or look at genitalia<br><br>withholds sex and affection<br>forces victim to strip in front of others-perhaps children<br><br>forces victim to watch sex with others<br><br>manipulates victim into having sex |
| **Highly Dangerous** | Household objects as weapons, restraining and hitting<br><br>broken bones, internal injuries medical treatment needed<br><br>use of knives, guns, poisons for disabling or disfiguring | provokes following reactions in victim:<br><br>- powerlessness,<br>- unpredictable consequences of actions<br>- nervous breakdown, depression, mental illness | Hits, punches or kicks wall, not victim.<br><br>deprives victim of food, sleep, etc.<br><br>destroys pets<br><br>incest or child abuse<br><br>threatens suicide | demands sex with threats<br><br>forces sex after a beating<br><br>sadism, sex for purpose of hurting, uses objects and weapons. |
| **Lethal** | Homicide | Suicide | Death | Murder |

## Myths & Facts

There are many myths surrounding rape. Believing the myths reinforces them.

MYTH: Rape is committed by crazed strangers.
FACT: Most people are raped by someone they know.

MYTH: A person who is raped deserves it, especially if the victim agreed to go to the person's house or ride in their car.
FACT: No one deserves to be raped. Being in a person's house or car does not mean you agree to have sex with them.

MYTH: People who don't fight back have not been raped.
FACT: You have been raped when you are forced to have sex against your will, whether you fight back or not. Fighting back does not solely include physical fighting. All rape victims fight emotionally during the attack. It is their decision what is safest for them at that time and how to react.

MYTH: If there's no gun or knife involved, you haven't been raped.
FACT: It's rape whether the rapist uses a weapon, physical or verbal threats, drugs or alcohol, physical isolation, your own diminished physical or mental state, or physical dominance to overcome you.

MYTH: It's not really rape if the victim isn't a virgin.
FACT: Rape is rape, even if the person has had sex before.

MYTH: If you let a person buy you drinks, take you to dinner or a movie, you owe that person sex.
FACT: No one owes sex as a payment to anyone, no matter how expensive the date.

MYTH: Agreeing to kiss, neck or pet with someone means that you agree to have intercourse with that person.
FACT: Everyone has the right to say "no" to sexual activity, regardless of what has preceded it, and to have that "no" respected.

MYTH: Women lie about being raped, especially when they accuse men they date or know as acquaintances.
FACT: Rape really happens - to people you know, by people you know. Rape is no more falsely reported than any other felony crime.

**Concern for the Assailant:**
If a sexual assault is reported and/or prosecuted, some victims may express concern about what will happeu to the person that assaulted them. Others may express concern that the assailant is "sick" or ueeds psychiatric care more than prison. It is human to show concern for others, especially those who are believed to be troubled, destructive, or confused. It is also common for victims to show interest and concern for the assailant's well being, when they are someone known to them (i.e. spouse, partner, family member, friend of the family, etc.). In some cases, showing concern may be a result of the victim attempting to understand or make sense of the assault or they may be blaming themselves for the attack, believing that somehow they could have prevented the assault. If the victim feels sorry for the assailant, they might find it difficult to express their anger and indignation for what they have suffered as a result of the sexual assault.

**Guilt, Shame, Self-Blame:**
Victims often feel guilty about the assault. They question that they somehow "provoked" or "asked for" the attack. They may believe that they should have known what was going to happen to them or feel guilty for trusting the assailant. Victims may also question their own actions thinking they could have prevented the assault. Some of these feelings result from society's long-standing perpetuation of myths about rape and sexuality. Victims know what society believes and worry about what others might think of them now. Sometimes blaming oneself for the assault helps a victim to feel less helpless.

**Anger:**
Anger is an appropriate, healthy response to sexual assault. It usually means the victim is healing and has begun to recognize that the assault is not their fault. They begin to see that the assailant is responsible for the attack. Victims may vary greatly in how readily they feel and express anger. It may be especially difficult for a victim to express anger if they have been taught that being angry is never appropriate. Anger can be healthy if vented in an appropriate and helpful way. If anger is turned inward or "stuffed", it may result in sadness, pain, and/or depression.

Source: Wichita Area Sexual Assault Center

# COMMON FEELINGS OF VICTIMS WHO HAVE BEEN SEXUALLY ASSAULTED

**Fear of People; Sense of Vulnerability:**
Victims of sexual assault frequently fear people and feel vulnerable even when going through the regular activities of life. They may be afraid to be alone or afraid of being with lots of people. It is common for victims to feel a loss of their sense of safety in their own environment and in the world around them. This can make them feel vulnerable. They may fear they will be assaulted again and may be particularly aware of sexual innuendoes, stray looks, pats, whistles, etc.

**Loss of Control; Fear of the Assailant:**
The assailant stepped into the victim's life and took control. The victim did not have a choice and did what was necessary to survive the assault. As a result, victims may feel unsure about themselves and temporarily lack their usual amount of self-confidence. Decisions about their life that once felt routine, now feel monumental. Victims may also feel that the assailant has taken away the positive feelings they had about their own body, leaving them to feel "used", "dirty", "unhealthy", or "bad".

**Anxiety, Shaking, Nightmares:**
Victims may experience shaking, anxiety, flashbacks, and nightmares after an assault. This can begin shortly after the assault and continue for a long period of time. During nightmares the assault may be replayed or the victim's dreams become filled with actions such as being chased, etc. Over time, victims often feel as if they are "losing it" because they do not feel any "better" and they may truly believe that they should be "over it by now".

**Talking about the Assault vs. Keeping the Secret:**
Some victims of sexual assault may feel compelled to tell others about the assault after it happens, other victims believe it must be hidden away from everyone around them and/or especially from certain people. They may fear that some people will not be supportive and understanding, and/or may not even believe that the assault happened. Such risks are very real and not believing the victim, blaming them, and/or not providing support can be very damaging to their healing process. It is extremely important for victims to be able to talk about the assault, their feelings about what happened, and how it has changed their life.

Trusting Yourself. The best guide for healing is your own inner voice. Learning to trust your own perceptions, feelings, and intuitions forms a new basis for action in the world.

Grieving and Mourning. As children being abused, and later as adults struggling to survive, most survivors haven't felt their losses. Grieving is a way to honor your pain, let go, and move into the present.

Anger -- The Backbone of Healing. Anger is a powerful and liberating force. Whether you need to get in touch with it or have always had plenty to spare, directing your rage squarely at your abuser, and at those who didn't protect you, is pivotal to healing.

Disclosures and Confrontations. Directly confronting your abuser and/or your family is not for every survivor, but it can be a dramatic, cleansing tool.

Forgiveness? Forgiveness of the abuser is not an essential part of the healing process, although it tends to be the one most recommended. The only essential forgiveness is for yourself.

Spirituality. Having a sense of a power greater than yourself can be a real asset in the healing process. Spirituality is a uniquely personal experience. You might find it through traditional religion, meditation, nature, or your support group.

Resolution and Moving On. As you move through these stages again and again, you will reach a point of integration. Your feelings and perspectives will stabilize. You will come to terms with your abuser and other family members. While you won't erase your history, you will make deep and lasting changes in your life. Having gained awareness, compassion, and power through healing, you will have the opportunity to work toward a better world. (pgs 64-65)

Notes from The Courage to Heal, 3rd Ed.
(Ellen Bass & Laura Davis, 1994)

# THE STAGES

Although most of these stages are necessary for every survivor, a few of them -- the emergency stage, remembering the abuse, confronting your family, and forgiveness -- are not applicable for every woman.

The Decision to Heal. Once your recognize the effects of sexual abuse in your life, you need to make an active commitment to heal. Deep healing happens only when you choose it and are willing to change yourself.

The Emergency Stage. Beginning to deal with memories and suppressed feelings can throw your life into utter turmoil. Remember, this is only a stage. It won't last forever.

Remembering. Many survivors suppress all memories of what happened to them as children. Those who do not forget the actual incidents often forget how it felt at the time. Remembering is the process of getting back both memory and feeling.

Believing It Happened. Survivors often doubt their own perceptions. Coming to believe that the abuse really happened and that it really hurt you, is a vital part of the healing process.

Breaking Silence. Most adult survivors kept the abuse a secret in childhood. Telling another human being about what happened to you is a powerful healing force that can dispel the shame of being a victim.

Understanding That It Wasn't Your Fault. Children usually believe the abuse is their fault. Adult survivors must place the blame where it belongs — directly on the shoulders of the abusers.

Making Contact With the Child Within. Many survivors have lost touch with their own vulnerability. Getting in touch with the child within can help you feel compassion for yourself, more anger at your abuser, and greater intimacy with others.

**RECRUITMENT SCRIPT**

Hello. My name is _____, and I am conducting a research project for the KU School of Social Welfare. I am asking women to share their experiences with violence and about the assistance they received from human service agencies.

Let me tell you about this study. The research will include questions on your mental health and well being, your coping abilities, the confidence you feel about managing your life, and the types of support or services you have received. The information you provide will be confidential. Your responses will help us and community agencies to develop better ways in which to reach out to women who are victims of violence – in other words, to make plans to better respond to the needs of these women.

Are you interested in participating in this study?
(If no), Thank you for your time.
(If yes) Are you at least 18 years old?
(If no), unfortunately, you do not qualify for this study. Thank you for your interest.
(If yes) The face-to-face interview will take approximately one hour and will be scheduled for a time that is convenient for you. The results from the interview will be kept confidential.

Your participation in this research is completely voluntary. You can withdraw from the study at any time without penalty. You may also refuse to answer any question that you do not want to answer. You will receive $25 for your time spent in the interview.

Do you have any questions about the study?
Are you willing to participate in the interview? Yes_____ No_____
(If no) Thank you for your time.
(If yes) Great! As stated earlier, the face-to-face interview will last approximately one hour. I would like to schedule a time that is good for you and in a convenient location. When would be a good time for me to interview you? Where would be a good place for us to talk? (Some suggestions include the local domestic violence shelter, the public library, coffee shop or an office.)

Date:_____ Time:_____ Place:_____

My name is _____. I am _____ (physical description) and/or will be wearing _____ for you to find me at the interview. Would you mind telling me your first name?

First Name: _____

That's all for now. Do you have any questions or comments at this time? Should you have any questions about this study, please feel free to contact me by phone at (785) 760-3739.
Once again, thank you for agreeing to participate in this study. I will be chatting further with you on – (repeat date, time, and location to ensure accuracy).

**NIJ Research Protocol Addendum**
**Follow-up Interview Recruitment Procedure**

The researchers are interested in conducting follow-up interviews with a small number of women who have participated in the survey interviews. We are asking interviewers to assist us in recruiting for these follow-up interviews. One of the researchers will actually conduct these follow-up interviews. Please do the following:

Step One: Determine who to ask for a follow-up interview

After the interview is completed, the following women are eligible to be asked to participate in a follow-up interview:

- Women who experienced some form of childhood abuse by answering "Yes" to G1 (p. 11), G2 (p. 12), or G3 (p. 14).

AND

- Women who experienced some form of adult violence by scoring 3-5 at least once on questions H25-30 (pp. 17-18) or answering "Yes" at least once on questions I10-13 (p. 20).

Step Two: Ask for a follow-up interview

Once the interviewer has decided to ask a woman for a follow-up interview, explain to her that we are doing a very small number of follow-up interviews that consist of open-ended questions and that are more in-depth than the survey they just completed.

Step Three: Fill out the Follow-Up Interview Form

Hand the women the form to read and complete. Answer any questions that the women might have. They can respond either yes or no as to whether they want to be contacted for a follow-up interview. If they answer yes, they need to fill in their contact information. Reiterate to them that they should give contact information that will not jeopardize their safety. Collect the form from the women and put the form in the envelope with their interview.

Some additional notes that might help you in your interactions with the women:

- The follow-up interviews will focus on the women's "stories" about some of the items they answered in the first interview, particularly issues of intimate partner violence and child abuse.

- The interviews will take approximately one and half hours.

- The women will be compensated $25 for their time.

- Please keep in mind and emphasize to the women that they should only provide contact information if they feel it is safe to do so.

- It is very important that we let women know that there is only a small chance that they would be contacted for an interview, because the study can only interview a very small group. We don't want women to get their hopes up or feel slighted if they do not get chosen for a follow-up interview.

Dear Research Participant,

In order to learn more about women's histories of survival, a different interviewer will be conducting a small number of follow-up interviews. Though the researcher is only able to interview a few women, the researcher would like to determine your interest in participating in an in-depth, open-ended interview about some of the topics you have been asked you about today. If you agree to participate in this interview, it will be held at a place of your convenience and will last approximately an hour and a half.

If you are interested in being contacted for a possible follow-up interview, please indicate below by providing your contact information. Please be sure that the contact information that you provide will be a safe place for you to be reached, i.e. that anyone with access to the mail, e-mail or phone service you provide understands your interest in participating in this study. The researcher will contact you in the next 30 days to tell you more about the follow-up interview and to answer any questions you might have. You will have an opportunity at that time to accept or decline the interview.

Please understand that the researcher can only select a few of the women who express interest. We apologize for not being able to accommodate everyone who is interested in follow-up interviews.

**********

____ Yes, I am interested in a possible follow-up interview. Below is a safe place where I can be contacted within the next 90 days:

Name _____ Phone_____

Street Address _____

E-Mail_____ Cell Phone_____

____ No, I do not want to be contacted for a follow-up interview.

**RECRUITMENT SCRIPT**

Hello. Is this a good time to talk? If not, is there a better time or a better number where I could reach you?

My name is _____, and I am conducting follow-up research on the survey you recently completed for the KU School of Social Welfare. I am asking women to share their experiences about violence and about the assistance they received from human service agencies.

Let me tell you about this study. The research questions are open-ended, so the emphasis on this research is to give you an opportunity to fully describe your victimization experiences including your disclosure experiences, the types of support or services you received, and the overall impact on your mental health and well-being.

Are you interested in participating in this study?
(If no), Thank you for your time.
(If yes) The face-to-face interview will take approximately one hour to an hour and a half and will be scheduled for a time that is convenient for you. The results from the interview will be kept confidential.

Your participation in this research is completely voluntary. You can withdraw from the study at any time without penalty. You may also refuse to answer any question that you do not want to answer. You will receive $25 for your time spent in the interview.

Do you have any questions about the study?
Are you willing to participate in the interview? Yes_____ No_____
(If no) Thank you for your time.
(If yes) Great! As stated earlier, the face-to-face interview will last approximately one hour. I would like to schedule a time that is good for you and in a convenient location. When would be a good time for me to interview you? Where would be a good place for us to talk? (Some suggestions include the local domestic violence shelter, the public library, coffee shop or an office.)

Date:_____ Time:_____ Place:_____
_____

I will call you the day before to confirm our meeting time and place. Is the number I called today the one I should use? If no, which phone number should I use?
_____

[On the day of the interview] My name is _____. I am _____ (physical description) and/or will be wearing _____ for you to find me at the interview.

That's all for now.  Do you have any questions or comments at this time?  Should you have any questions about this study, please feel free to contact me by phone at (785) 864-2647.
Once again, thank you for agreeing to participate in this study.  I will be chatting further with you on – (repeat date, time, and location to ensure accuracy).

Respondent ID Number:_____ Beginning Time: _____

## A. PERSONAL ATTITUDES

This first section includes questions about your personal attitudes and traits. There are no right or wrong answers. Please be very truthful and describe yourself as you really are, not as you would like to be.

| **The answers range from:** | | **Disagree strongly** | **Disagree moderately** | **No opinion** | **Agree moderately** | **Agree strongly** |
|---|---|---|---|---|---|---|
| 1. | I like to grow house plants. | 1 | 2 | 3 | 4 | 5 |
| 2. | When I make plans, I am certain I can make them work. | 1 | 2 | 3 | 4 | 5 |
| 3. | One of my problems is that I cannot get down to work when I should. | 1 | 2 | 3 | 4 | 5 |
| 4. | If I can't do a job the first time, I keep trying until I can. | 1 | 2 | 3 | 4 | 5 |
| 5. | Heredity plays the major role in determining one's personality. | 1 | 2 | 3 | 4 | 5 |
| 6. | It is difficult for me to make new friends. | 1 | 2 | 3 | 4 | 5 |
| 7. | When I set important goals for myself, I rarely achieve them. | 1 | 2 | 3 | 4 | 5 |
| 8. | I give up on things before completing them. | 1 | 2 | 3 | 4 | 5 |
| 9. | I like to cook. | 1 | 2 | 3 | 4 | 5 |
| 10. | If I see someone I would like to meet, I go to that person instead of waiting for him or her to come to me. | 1 | 2 | 3 | 4 | 5 |
| 11. | I avoid facing difficulties. | 1 | 2 | 3 | 4 | 5 |
| 12. | If something looks too complicated, I will not even bother to try it. | 1 | 2 | 3 | 4 | 5 |
| 13. | There is some good in everybody. | 1 | 2 | 3 | 4 | 5 |
| 14. | If I meet someone interesting who is very hard to make friends with, I'll soon stop trying to make friends with that person. | 1 | 2 | 3 | 4 | 5 |
| 15. | When I have something unpleasant to do, I stick to it until I finish it. | 1 | 2 | 3 | 4 | 5 |
| 16. | When I decide to do something, I go right to work on it. | 1 | 2 | 3 | 4 | 5 |
| 17. | I like science. | 1 | 2 | 3 | 4 | 5 |

| The answers range from: | | Disagree strongly | Disagree moderately | No opinion | Agree moderately | Agree strongly |
|---|---|---|---|---|---|---|
| 18. | When trying to learn something new, I soon give up if I am not initially successful. | 1 | 2 | 3 | 4 | 5 |
| 19. | When I'm trying to become friends with someone who seems uninterested at first, I don't give up very easily. | 1 | 2 | 3 | 4 | 5 |
| 20. | When unexpected problems occur, I don't handle them well. | 1 | 2 | 3 | 4 | 5 |
| 21. | If I were an artist, I would like to draw children. | 1 | 2 | 3 | 4 | 5 |
| 22. | I avoid trying to learn new things when they look too difficult for me. | 1 | 2 | 3 | 4 | 5 |
| 23. | Failure just makes me try harder. | 1 | 2 | 3 | 4 | 5 |
| 24. | I do not handle myself well in social gatherings. | 1 | 2 | 3 | 4 | 5 |
| 25. | I very much like to ride horses. | 1 | 2 | 3 | 4 | 5 |
| 26. | I feel insecure about my ability to do things. | 1 | 2 | 3 | 4 | 5 |
| 27. | I am a self-reliant person. | 1 | 2 | 3 | 4 | 5 |
| 28. | I have acquired my friends through my personal abilities at making friends. | 1 | 2 | 3 | 4 | 5 |
| 29. | I give up easily. | 1 | 2 | 3 | 4 | 5 |
| 30. | I do not seem capable of dealing with most problems that come up in my life. | 1 | 2 | 3 | 4 | 5 |

## B. HEALTH AND WELL-BEING

**These next few questions ask for your views about your health.**

1. In general, would you say your health is (choose one):
___ Excellent ___ Very Good ___ Good ___ Fair ___ Poor

2. Compared to one week ago, how would you rate your health in general now?
___ Excellent ___ Very Good ___ Good ___ Fair ___ Poor

3. The following items are about activities you might do during a typical day.

| **Does your health now limit you in these activities?** | | **Yes, limited a lot** | **Yes, limited a little** | **No, not limited at all** |
|---|---|---|---|---|
| a. | Vigorous activities, such as running, lifting heavy objects, participating in strenuous sports | 1 | 2 | 3 |
| b. | Moderate activities, such as moving a table, pushing a vacuum cleaner | 1 | 2 | 3 |
| c. | Lifting or carrying groceries | 1 | 2 | 3 |
| d. | Climbing several flights of stairs | 1 | 2 | 3 |
| e. | Climbing one flight of stairs | 1 | 2 | 3 |
| f. | Bending, kneeling, or stooping | 1 | 2 | 3 |
| g. | Walking more than a mile | 1 | 2 | 3 |
| h. | Walking several blocks | 1 | 2 | 3 |
| i. | Walking one block | 1 | 2 | 3 |
| j. | Bathing or dressing yourself | 1 | 2 | 3 |

4. During the past week, have you had any of the following problems with your work or other regular daily activities as a result of your physical health?

| | | |
|---|---|---|
| a. Cut down on the amount of time you spent on work or other activities | ___ Yes | ___No |
| b. Accomplished less than you would like | ___ Yes | ___ No |
| c. Were limited in the kind of work or other activities | ___ Yes | ___ No |
| d. Had difficulty performing the work or other activities (for example, it took extra effort) | ___ Yes | ___ No |

5. During the past week, have you had any of the following problems with your work or other regular daily activities as a result of any emotional problems (such as feeling depressed or anxious)?

| | | |
|---|---|---|
| a. Cut down on the amount of time you spent on work or other activities | ___ Yes | ___ No |
| b. Accomplished less than you would like | ___ Yes | ___ No |
| c. Didn't do work or other activities as carefully as usual | ___ Yes | ___ No |

6. During the past week, to what extent has your physical health or emotional problems interfered with your normal social activities with family, friends, neighbors, or groups?

___ Not at all ___ Slightly ___ Moderately ___ Quite a bit ___ Extremely

7. How much bodily pain have you had during the past week?

___ None ___ Very Mild ___ Mild ___ Moderate ___ Severe ___ Very severe

8. During the past week, how much did pain interfere with your normal work (including both work outside the home and housework)?

___ Not at all ___ A little bit ___ Moderately ___ Quite a bit ___ Extremely

9. These next questions are about how you feel and how things have been with you during the past week. For each question, please give the one answer that comes closest to the way you have been feeling.

| **How much of the time during the past week…** | | **All of the time** | **Most of the time** | **A good bit of the time** | **Some of the time** | **A little bit of the time** | **None of the time** |
|---|---|---|---|---|---|---|---|
| a. | Did you feel full of pep? | 1 | 2 | 3 | 4 | 5 | 6 |
| b. | Have you been a very nervous person? | 1 | 2 | 3 | 4 | 5 | 6 |
| c. | Have you felt so down in the dumps that nothing could cheer you up? | 1 | 2 | 3 | 4 | 5 | 6 |
| d. | Have you felt calm and peaceful? | 1 | 2 | 3 | 4 | 5 | 6 |
| e. | Did you have a lot of energy? | 1 | 2 | 3 | 4 | 5 | 6 |
| f. | Have you felt downhearted and blue? | 1 | 2 | 3 | 4 | 5 | 6 |
| g. | Did you feel worn out? | 1 | 2 | 3 | 4 | 5 | 6 |
| h. | Have you been a happy person? | 1 | 2 | 3 | 4 | 5 | 6 |
| i. | Did you feel tired? | 1 | 2 | 3 | 4 | 5 | 6 |

10. During the past week, how much of the time has your physical health or emotional problems interfered with your social activities (like visiting with friends, relatives, etc.)?

___ All of the time ___ Most of the time ___ Some of the time ___ A little of the time ___ None of the time

11. How TRUE or FALSE is each of the following statements for you?

| | | Definitely true | Mostly true | Don't know | Mostly false | Definitely false |
|---|---|---|---|---|---|---|
| a. | I seem to get sick a little easier than other people. | 1 | 2 | 3 | 4 | 5 |
| b. | I am as healthy as anybody I know. | 1 | 2 | 3 | 4 | 5 |
| c. | I expect my health to get worse. | 1 | 2 | 3 | 4 | 5 |
| d. | My health is excellent. | 1 | 2 | 3 | 4 | 5 |

12. Do you have any chronic medical condition? Yes ____ No ____

13. If yes, please check all that apply (As a reminder, you do not have to answer any question you don't want to answer):

Asthma ____ Diabetes ____ Heart Disease ____ Tuberculosis ____

COPD ____ (Cardio Obstructive Pulmonary Disease)
PID ____ (Pelvic Inflammatory Disease)
HIV/AIDS ____
STDs ____ (Gonorrhea, syphilis, chlamydia, herpes)

Other: _____

## C. RELATIONSHIP WITH FAMILY AND FRIENDS

The next questions are about your relationships with family and friends. Please indicate how much you agree or disagree with each statement as being true.

| How much do you strongly agree, agree, disagree, or strongly disagree with the statement… | | Strongly agree | Agree | Disagree | Strongly disagree |
|---|---|---|---|---|---|
| 1. | My friends respect me. | 1 | 2 | 3 | 4 |
| 2. | My family cares for me very much. | 1 | 2 | 3 | 4 |
| 3. | I am not important to others. | 1 | 2 | 3 | 4 |
| 4. | My family holds me in high esteem. | 1 | 2 | 3 | 4 |
| 5. | I am well liked. | 1 | 2 | 3 | 4 |
| 6. | I can rely on my friends. | 1 | 2 | 3 | 4 |
| 7. | I am really admired by my family. | 1 | 2 | 3 | 4 |

| How much do you strongly agree, agree, disagree, or strongly disagree with the statement… | | Strongly agree | Agree | Disagree | Strongly disagree |
|---|---|---|---|---|---|
| 8. | I am respected by other people. | 1 | 2 | 3 | 4 |
| 9. | I am loved dearly by my family. | 1 | 2 | 3 | 4 |
| 10. | My friends don't care about my welfare. | 1 | 2 | 3 | 4 |
| 11. | Members of my family rely on me. | 1 | 2 | 3 | 4 |
| 12. | I am held in high esteem. | 1 | 2 | 3 | 4 |
| 13. | I can't rely on my family for support. | 1 | 2 | 3 | 4 |
| 14. | People admire me. | 1 | 2 | 3 | 4 |
| 15. | I feel a strong bond with my friends. | 1 | 2 | 3 | 4 |
| 16. | My friends look out for me. | 1 | 2 | 3 | 4 |
| 17. | I feel valued by other people. | 1 | 2 | 3 | 4 |
| 18. | My family really respects me. | 1 | 2 | 3 | 4 |
| 19. | My friends and I are really important to each other. | 1 | 2 | 3 | 4 |
| 20. | I feel like I belong. | 1 | 2 | 3 | 4 |
| 21. | If I died tomorrow, very few people would miss me. | 1 | 2 | 3 | 4 |
| 22. | I don't feel close to members of my family. | 1 | 2 | 3 | 4 |
| 23. | My friends and I have done a lot for one another. | 1 | 2 | 3 | 4 |

## D. COPING WITH STRESS

The next questions ask about ways you've been coping with stress. There are many ways to try to deal with problems. These items ask what you've been doing to cope. Don't answer on the basis of whether it seems to be working or not – just whether or not you're doing it.

| To what extent have you used the following as a way to cope? | | I haven't been doing this at all. | I've been doing this a little bit. | I've been doing this a medium amount. | I've been doing this a lot. |
|---|---|---|---|---|---|
| 1. | I've been turning to work or other activities to take my mind off things. | 1 | 2 | 3 | 4 |
| 2. | I've been concentrating my efforts on doing something about the situation I'm in. | 1 | 2 | 3 | 4 |
| 3. | I've been saying to myself "This isn't real." | 1 | 2 | 3 | 4 |

| **To what extent have you used the following as a way to cope?** | | **I haven't been doing this at all.** | **I've been doing this a little bit.** | **I've been doing this a medium amount.** | **I've been doing this a lot.** |
|---|---|---|---|---|---|
| 4. | I've been using alcohol or other drugs to make myself feel better. | 1 | 2 | 3 | 4 |
| 5. | I've been getting emotional support from others. | 1 | 2 | 3 | 4 |
| 6. | I've been giving up trying to deal with it. | 1 | 2 | 3 | 4 |
| 7. | I've been taking action to try to make the situation better. | 1 | 2 | 3 | 4 |
| 8. | I've been refusing to believe that it has happened. | 1 | 2 | 3 | 4 |
| 9. | I've been saying things to let my unpleasant feelings escape. | 1 | 2 | 3 | 4 |
| 10. | I've been getting help and advice from other people. | 1 | 2 | 3 | 4 |
| 11. | I've been using alcohol or other drugs to help me get through it. | 1 | 2 | 3 | 4 |
| 12. | I've been trying to see it in a different light, to make it seem more positive. | 1 | 2 | 3 | 4 |
| 13. | I've been criticizing myself. | 1 | 2 | 3 | 4 |
| 14. | I've been trying to come up with a strategy about what to do. | 1 | 2 | 3 | 4 |
| 15. | I've been getting comfort and understanding from someone. | 1 | 2 | 3 | 4 |
| 16. | I've been giving up the attempt to cope. | 1 | 2 | 3 | 4 |
| 17. | I've been looking for something good in what is happening. | 1 | 2 | 3 | 4 |
| 18. | I've been making jokes about it. | 1 | 2 | 3 | 4 |
| 19. | I've been doing something to think about it less, such as going to the movies, watching TV, reading, daydreaming, sleeping, or shopping. | 1 | 2 | 3 | 4 |
| 20. | I've been accepting the reality of the fact that it has happened. | 1 | 2 | 3 | 4 |
| 21. | I've been expressing my negative feelings. | 1 | 2 | 3 | 4 |
| 22. | I've been trying to find comfort in my religion or spiritual beliefs. | 1 | 2 | 3 | 4 |
| 23. | I've been trying to get advice or help from other people about what to do. | 1 | 2 | 3 | 4 |

| **To what extent have you used the following as a way to cope?** | | **I haven't been doing this at all.** | **I've been doing this a little bit.** | **I've been doing this a medium amount.** | **I've been doing this a lot.** |
|---|---|---|---|---|---|
| 24. | I've been learning to live with it. | 1 | 2 | 3 | 4 |
| 25. | I've been thinking hard about what steps to take. | 1 | 2 | 3 | 4 |
| 26. | I've been blaming myself for things that happened. | 1 | 2 | 3 | 4 |
| 27. | I've been praying or meditating. | 1 | 2 | 3 | 4 |
| 28. | I've been making fun of situations. | 1 | 2 | 3 | 4 |

## E. EMOTIONAL HEALTH

The next set of questions deal with your emotional health during the past week.

| Please indicate how often you felt or behaved in this way **DURING THE PAST WEEK…** | | Less than 1 day | 1-2 days | 3-4 days | 5-7 days |
|---|---|---|---|---|---|
| 1. | I was bothered by things that usually don't bother me | 0 | 1 | 2 | 3 |
| 2. | I did not feel like eating; my appetite was poor. | 0 | 1 | 2 | 3 |
| 3. | I felt that I could not shake off the blues even with help from my family or friends. | 0 | 1 | 2 | 3 |
| 4. | I felt that I was just as good as other people. | 0 | 1 | 2 | 3 |
| 5. | I had trouble keeping my mind on what I was doing. | 0 | 1 | 2 | 3 |
| 6. | I felt depressed. | 0 | 1 | 2 | 3 |
| 7. | I felt that everything I did was an effort. | 0 | 1 | 2 | 3 |
| 8. | I felt hopeful about the future. | 0 | 1 | 2 | 3 |
| 9. | I thought my life had been a failure. | 0 | 1 | 2 | 3 |
| 10. | I felt fearful. | 0 | 1 | 2 | 3 |
| 11. | My sleep was restless. | 0 | 1 | 2 | 3 |
| 12. | I was happy. | 0 | 1 | 2 | 3 |
| 13. | I talked less than usual. | 0 | 1 | 2 | 3 |
| 14. | I felt lonely. | 0 | 1 | 2 | 3 |

| Please indicate how often you felt or behaved in this way **DURING THE PAST WEEK…** | | Less than 1 day | 1-2 days | 3-4 days | 5-7 days |
|---|---|---|---|---|---|
| 15. | People were unfriendly. | 0 | 1 | 2 | 3 |
| 16. | I enjoyed life. | 0 | 1 | 2 | 3 |
| 17. | I had crying spells. | 0 | 1 | 2 | 3 |
| 18. | I felt sad. | 0 | 1 | 2 | 3 |
| 19. | I felt that people disliked me. | 0 | 1 | 2 | 3 |
| 20. | I could not get "going." | 0 | 1 | 2 | 3 |

## F. ALCOHOL & DRUG USE

The next set of questions deal with your alcohol or drug use during the past 12 months.

***The word "drink" in the next set of questions refers to a glass of wine, a can or bottle of beer, or a shot or jigger of liquor either alone or in a mixed drink.***

1. During the past 12 months, about how many drinks did you usually have:
   ___ Average number of drinks per day
   ___ Average number of drinks per week?
   ___ I don't drink alcoholic beverages

2. During the past 12 months, how often did you have someone complain about your drinking?
   ___ Not at all
   ___ A little bit
   ___ Somewhat
   ___ A lot

3. During the past 12 months, how often did you feel guilty or upset about your drinking?
   ___ Not at all
   ___ A little bit
   ___ Somewhat
   ___ A lot

4. Do you believe you have an alcohol problem? ___ Yes ___ No

5. Which of the following substances have you used in the past 12 months? (Check all that apply)

| | # of times/day? | # of times/ week? |
|---|---|---|
| ___ Marijuana or hashish | ____ | ____ |
| ___ Cocaine (powder, crack, free base, coca leaves, paste) | ____ | ____ |
| ___ Heroin | ____ | ____ |
| ___ LSD | ____ | ____ |
| ___Tranquilizers, stimulants, pain killers, or other prescription drugs | ____ | ____ |
| ___ Meth | ____ | ____ |
| ___ Opium, peyote, glue, or any other drugs | ____ | ____ |

7. During the past 12 months, how often have you had someone complain about your use of drugs?
___ Not at all ___ A little bit ___ Somewhat ___ A lot

8. During the past 12 months, how often did you feel guilty or upset about your using drugs?
___ Not at all ___ A little bit ___ Somewhat ___ A lot

9. Do you believe you have a drug problem? ___ Yes ___ No

10. Do you believe you have ever had a drug problem? ___ Yes ___ No

| **Did you ever receive the following services for either alcohol abuse or drug abuse?** | **Yes** | **No** | **How helpful was this service?** 1=No Benefit 5=Maximum Benefit |
|---|---|---|---|
| 11. Support group or self-help group | ___ | ___ | 1 2 3 4 5 |
| 12. Substance abuse treatment | ___ | ___ | 1 2 3 4 5 |
| 13. Hospital stay for substance abuse | ___ | ___ | 1 2 3 4 5 |

## G. CHILD MALTREATMENT

In the next few sections, I will ask about your experiences as a child and as an adult. We will start with any experiences as a child.

**1. Before age 17, did a parent, step-parent, foster-parent, or other adult in charge of you as a child ever do something to you on purpose (for example, hit or punch or cut you, or push you down) that made you bleed or gave you bruises or scratches, or that broke bones or teeth?** Yes ___ No ___

**IF NO, SKIP TO QUESTION #2**

a. Who did this? _____ (Relationship to you?)

b. How severe would you say the abuse was?

| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
|---|---|---|---|---|---|---|---|---|---|
| Not severe | | | | Some injuries | | | | | Emergency Room Visit |

c. How often did the physical violence occur before age 17?
___ Everyday
___ Couple times a week
___ Couple times a month
___ Couple times a year
___ Once or twice
___ Other _____

d. How old were you the first time it happened? _____ years

e. During any time, were you hurt so badly that you had to see a doctor or go to the hospital? Yes ___ No ___

f. Did you tell anyone? ___ Yes ___ No

**IF NO, SKIP TO QUESTION #2**

| | **Who did you tell?** | **When did you first tell this person?** | **Did he/she believe you?** |
|---|---|---|---|
| 1. | ___ Parent | ___ 1-6 days after<br>___ 1-4 weeks after<br>___ 1-12 months after<br>___ 1-5 years after<br>___ Greater than 5 years | ___ Yes ___ No |
| 2. | ___ Family member | ___ 1-6 days after<br>___ 1-4 weeks after<br>___ 1-12 months after<br>___ 1-5 years after<br>___ Greater than 5 years | ___ Yes ___ No |

| | Who did you tell? | When did you first tell this person? | Did he/she believe you? |
|---|---|---|---|
| 3. | ___ Teacher/school personnel | ___ 1-6 days after<br>___ 1-4 weeks after<br>___ 1-12 months after<br>___ 1-5 years after<br>___ Greater than 5 years | ___ Yes ___ No |
| 4. | ___ Friend | ___ 1-6 days after<br>___ 1-4 weeks after<br>___ 1-12 months after<br>___ 1-5 years after<br>___ Greater than 5 years | ___ Yes ___ No |
| 5. | ___ Social worker/counselor | ___ 1-6 days after<br>___ 1-4 weeks after<br>___ 1-12 months after<br>___ 1-5 years after<br>___ Greater than 5 years | ___ Yes ___ No |
| 6. | ___ Minister/Priest/Relig. Advisor | ___ 1-6 days after<br>___ 1-4 weeks after<br>___ 1-12 months after<br>___ 1-5 years after<br>___ Greater than 5 years | ___ Yes ___ No |
| 7. | ___ Other _____ | ___ 1-6 days after<br>___ 1-4 weeks after<br>___ 1-12 months after<br>___ 1-5 years after<br>___ Greater than 5 years | ___ Yes ___ No |

g. What happened after you told someone? Check all that apply.
___ Police were called
___ Child protective services called
___ Went to doctor or hospital
___ Nothing happened

h. Was the perpetrator ever confronted about the abuse? Yes___ No___

i. If yes, what was the result? (If no, skip to question 2) Check all that apply.
___ Investigated by the police
___ Investigated by Child Protective Services
___ Arrested
___ Served time
___ Nothing

**2. Before age 17, did anyone ever kiss you in a sexual way, or touch your body in a sexual way, or make you touch their sexual parts without your consent?** Yes ___ No ___

**IF NO, SKIP TO QUESTION #3**

a. Did this ever happen with a family member? Yes ___ No ___
If yes, who did this? _____ (Relationship to you?)

b. Did this ever happen with someone 5 or more years older than you? Yes ___ No ___

If yes, with who (check all that apply):
___ A friend
___ A stranger
___ A teacher, doctor, or other professional
___ A babysitter or nanny
___ Someone not mentioned above (who? _____)

c. Did anyone ever use physical force on any of these occasions? Yes ___ No ___

d. How often did the molesting occur before age 17?
___ Everyday
___ Couple times a week
___ Couple times a month
___ Couple times a year
___ Once or twice
___ Other _____

e. How old were you the first time it happened? _____ years

f. Did you tell anyone? ___ Yes ___ No

**IF NO, SKIP TO QUESTION #3**

| | **Who did you tell?** | **When did you first tell this person?** | **Did he/she believe you?** |
|---|---|---|---|
| 1. | ___ Parent | ___ 1-6 days after<br>___ 1-4 weeks after<br>___ 1-12 months after<br>___ 1-5 years after<br>___ Greater than 5 years | ___ Yes ___ No |
| 2. | ___ Family member | ___ 1-6 days after<br>___ 1-4 weeks after<br>___ 1-12 months after<br>___ 1-5 years after<br>___ Greater than 5 years | ___ Yes ___ No |
| 3. | ___ Teacher/school personnel | ___ 1-6 days after<br>___ 1-4 weeks after<br>___ 1-12 months after<br>___ 1-5 years after<br>___ Greater than 5 years | ___ Yes ___ No |
| 4. | ___ Friend | ___ 1-6 days after<br>___ 1-4 weeks after<br>___ 1-12 months after<br>___ 1-5 years after<br>___ Greater than 5 years | ___ Yes ___ No |
| 5. | ___ Social worker/counselor | ___ 1-6 days after<br>___ 1-4 weeks after<br>___ 1-12 months after<br>___ 1-5 years after<br>___ Greater than 5 years | ___ Yes ___ No |

| | Who did you tell? | When did you first tell this person? | Did he/she believe you? |
|---|---|---|---|
| 6. | ___ Minister/Priest/Relig. Advisor | ___ 1-6 days after<br>___ 1-4 weeks after<br>___ 1-12 months after<br>___ 1-5 years after<br>___ Greater than 5 years | ___ Yes ___ No |
| 7. | ___ Other _____ | ___ 1-6 days after<br>___ 1-4 weeks after<br>___ 1-12 months after<br>___ 1-5 years after<br>___ Greater than 5 years | ___ Yes ___ No |

g. What happened after you told someone? Check all that apply.
___ Police were called ___ Went to doctor or hospital
___ Child protective services called ___ Nothing happened

h. Was the perpetrator ever confronted about the abuse? Yes___ No___

i. If yes, what was the result? Check all that apply.
___ Investigated by the police ___ Investigated by Child Protective Services
___ Arrested ___ Served time ___ Nothing

**3. Before age 17, did anyone ever have oral, anal, or vaginal intercourse with you, or insert a finger or object in your anus or vagina without your consent?** Yes ___ No ___

**IF NO, SKIP TO QUESTION #4**

a. Did this ever happen with a family member? Yes ___ No ___
If yes, who did this? _____ (Relationship to you?)

b. Did this ever happen with someone 5 or more years older than you were?
Yes ___ No ___
If yes, with who (check all that apply):
___ A friend
___ A stranger
___ A teacher, doctor, or other professional
___ A babysitter or nanny
___ Someone not mentioned above (who? _____)

c. Did anyone ever use physical force on any of these occasions? Yes ___ No ___

d. How often did the sexual violence occur before age 17?
___ Everyday
___ Couple times a week
___ Couple times a month
___ Couple times a year
___ Once or twice
___ Other _____

e. How old were you the first time it happened? _____ years

f. Did you tell anyone? ___ Yes ___ No

**IF NO, SKIP TO QUESTION #4**

| | **Who did you tell?** | **When did you first tell this person?** | **Did he/she believe you?** |
|---|---|---|---|
| 1. | ___ Parent | ___ 1-6 days after<br>___ 1-4 weeks after<br>___ 1-12 months after<br>___ 1-5 years after<br>___ Greater than 5 years | ___ Yes ___ No |
| 2. | ___ Family member | ___ 1-6 days after<br>___ 1-4 weeks after<br>___ 1-12 months after<br>___ 1-5 years after<br>___ Greater than 5 years | ___ Yes ___ No |
| 3. | ___ Teacher/school personnel | ___ 1-6 days after<br>___ 1-4 weeks after<br>___ 1-12 months after<br>___ 1-5 years after<br>___ Greater than 5 years | ___ Yes ___ No |
| 4. | ___ Friend | ___ 1-6 days after<br>___ 1-4 weeks after<br>___ 1-12 months after<br>___ 1-5 years after<br>___ Greater than 5 years | ___ Yes ___ No |
| 5. | ___ Social worker/counselor | ___ 1-6 days after<br>___ 1-4 weeks after<br>___ 1-12 months after<br>___ 1-5 years after<br>___ Greater than 5 years | ___ Yes ___ No |
| 6. | ___ Minister/Priest/Relig. Advisor | ___ 1-6 days after<br>___ 1-4 weeks after<br>___ 1-12 months after<br>___ 1-5 years after<br>___ Greater than 5 years | ___ Yes ___ No |
| 7. | ___ Other _____ | ___ 1-6 days after<br>___ 1-4 weeks after<br>___ 1-12 months after<br>___ 1-5 years after<br>___ Greater than 5 years | ___ Yes ___ No |

g. What happened after you told someone? Check all that apply.

___ Police were called
___ Child protective services called
___ Went to doctor or hospital
___ Nothing happened

h. Was the perpetrator ever confronted about the abuse? Yes___ No___

i. If yes, what was the result? Check all that apply.
___ Investigated by the police
___ Investigated by Child Protective Services
___ Arrested
___ Served time
___ Nothing

j. During any time, were you hurt so badly that you had to see a doctor or go to the hospital? Yes ___ No ___

**4. To the best of your knowledge, before age 17, were you ever…**
Sexually abused? Yes ___ No ___
Physically abused? Yes ___ No ___

## H. INTIMATE PARTNER VIOLENCE

Listed below are behaviors that many women report have been used by their intimate partners or former partners. Please indicate your closest estimate of how often it happened in your relationship with your partner or former partner.

| **How often has an intimate partner done the following?** | | **Never** | **Rarely** | **Sometimes** | **Often** | **Very Often** |
|---|---|---|---|---|---|---|
| 1. | Called you a name and/or criticized you. | 1 | 2 | 3 | 4 | 5 |
| 2. | Tried to keep you from doing something you wanted to do (example: going out with friends, going to meetings) | 1 | 2 | 3 | 4 | 5 |
| 3. | Gave you angry stares or looks | 1 | 2 | 3 | 4 | 5 |
| 4. | Prevented you from having money for your own use. | 1 | 2 | 3 | 4 | 5 |
| 5. | Ended a discussion with you and made the decision him/herself. | 1 | 2 | 3 | 4 | 5 |
| 6. | Threatened to hit or throw something at you. | 1 | 2 | 3 | 4 | 5 |
| 7. | Pushed, grabbed, or shoved you. | 1 | 2 | 3 | 4 | 5 |
| 8. | Put down your family and friends. | 1 | 2 | 3 | 4 | 5 |
| 9. | Accused you of paying too much attention to someone or something else | 1 | 2 | 3 | 4 | 5 |
| 10. | Put you on an allowance. | 1 | 2 | 3 | 4 | 5 |

| **How often has an intimate partner done the following?** | | **Never** | **Rarely** | **Sometimes** | **Often** | **Very Often** |
|---|---|---|---|---|---|---|
| 11. | Used your children to threaten you (example: told you that you would lose custody, said he/she would leave town with the children). | 1 | 2 | 3 | 4 | 5 |
| 12. | Became very upset with you because dinner, housework, or laundry was not ready when he/she wanted it or done the way he/she thought it should be. | 1 | 2 | 3 | 4 | 5 |
| 13. | Said things to scare you (examples: told you something “bad” would happen, threatened to commit suicide). | 1 | 2 | 3 | 4 | 5 |
| 14. | Slapped, hit, or punched you. | 1 | 2 | 3 | 4 | 5 |
| 15. | Made you do something humiliating or degrading (examples: begging for forgiveness, having to ask permission to use the car or do something). | 1 | 2 | 3 | 4 | 5 |
| 16. | Checked up on you (examples: listened to your phone calls, checked the mileage on your car, called you repeatedly at work). | 1 | 2 | 3 | 4 | 5 |
| 17. | Drove recklessly when you were in the car. | 1 | 2 | 3 | 4 | 5 |
| 18. | Pressured you to have sex in a way that you didn’t like or want. | 1 | 2 | 3 | 4 | 5 |
| 19. | Refused to do housework or childcare. | 1 | 2 | 3 | 4 | 5 |
| 20. | Threatened you with a knife, gun, or other weapon. | 1 | 2 | 3 | 4 | 5 |
| 21. | Spanked you. | 1 | 2 | 3 | 4 | 5 |
| 22. | Told you that you were a bad person. | 1 | 2 | 3 | 4 | 5 |
| 23. | Stopped you or tried to stop you from going to work or school. | 1 | 2 | 3 | 4 | 5 |
| 24. | Threw, hit, kicked, or smashed something. | 1 | 2 | 3 | 4 | 5 |
| 25. | Kicked you. | 1 | 2 | 3 | 4 | 5 |
| 26. | Physically forced you to have sex. | 1 | 2 | 3 | 4 | 5 |
| 27. | Threw you around. | 1 | 2 | 3 | 4 | 5 |
| 28. | Physically attacked the sexual parts of your body. | 1 | 2 | 3 | 4 | 5 |
| 29. | Choked or strangled you. | 1 | 2 | 3 | 4 | 5 |

| How often has an intimate partner done the following? | | Never | Rarely | Sometimes | Often | Very Often |
|---|---|---|---|---|---|---|
| 30. | Used a knife, gun, or other weapon against you. | 1 | 2 | 3 | 4 | 5 |

As a result of the physically or emotionally violent behaviors listed above, how often would you say you experienced the following?

| | | Never | Rarely | Sometimes | Often | Very Often |
|---|---|---|---|---|---|---|
| 31. | Received medical treatment for injuries. | 1 | 2 | 3 | 4 | 5 |
| 32. | Had physical pain lasting more than an hour | 1 | 2 | 3 | 4 | 5 |
| 33. | Had a bruise, cut, or wound on your face or neck. | 1 | 2 | 3 | 4 | 5 |
| 34. | Had a bump or wound on your head. | 1 | 2 | 3 | 4 | 5 |
| 35. | Had a swelling, sprain, or bruise on your arm or leg. | 1 | 2 | 3 | 4 | 5 |
| 36. | Had a bruise or cut on your stomach, chest, or back. | 1 | 2 | 3 | 4 | 5 |
| 37. | Had a fractured or broken bone. | 1 | 2 | 3 | 4 | 5 |
| 38. | Had a black eye. | 1 | 2 | 3 | 4 | 5 |
| 39. | Had to get medical treatment for stress. | 1 | 2 | 3 | 4 | 5 |

40. Did you ever tell anyone about your experiences? ___ Yes ___ No

**IF NO, SKIP TO NEXT SECTION**

| | Who did you tell? | When did you first tell this person? | Did he/she believe you? |
|---|---|---|---|
| a. | ___ Family member | ___ 1-6 days after<br>___ 1-4 weeks after<br>___ 1-12 months after<br>___ 1-5 years after<br>___ Greater than 5 years | ___ Yes ___ No |
| b. | ___ Friend | ___ 1-6 days after<br>___ 1-4 weeks after<br>___ 1-12 months after<br>___ 1-5 years after<br>___ Greater than 5 years | ___ Yes ___ No |
| c. | ___ Police, attorney, or other legal professional | ___ 1-6 days after<br>___ 1-4 weeks after<br>___ 1-12 months after<br>___ 1-5 years after<br>___ Greater than 5 years | ___ Yes ___ No |

| | Who did you tell? | When did you first tell this person? | Did he/she believe you? |
|---|---|---|---|
| d. | ___ Social worker or counselor | ___ 1-6 days after<br>___ 1-4 weeks after<br>___ 1-12 months after<br>___ 1-5 years after<br>___ Greater than 5 years | ___ Yes ___ No |
| e. | ___ Doctor, nurse, or other medical professional | ___ 1-6 days after<br>___ 1-4 weeks after<br>___ 1-12 months after<br>___ 1-5 years after<br>___ Greater than 5 years | ___ Yes ___ No |
| f. | ___ Minister/Priest/Relig. Advisor | ___ 1-6 days after<br>___ 1-4 weeks after<br>___ 1-12 months after<br>___ 1-5 years after<br>___ Greater than 5 years | ___ Yes ___ No |
| g. | ___ Other<br>(Who?)_____ | ___ 1-6 days after<br>___ 1-4 weeks after<br>___ 1-12 months after<br>___ 1-5 years after<br>___ Greater than 5 years | ___ Yes ___ No |

41. What happened after you told someone? Check all that apply.

___ Police were called
___ Child protective services called
___ Went to doctor or hospital
___ Nothing happened

42. Was the perpetrator ever confronted about the abuse? Yes___ No___

43. If yes, what was the result? Check all that apply.
___ Investigated by the police
___ Investigated by Child Protective Services
___ Arrested
___ Served time
___ Nothing

44. Were you ever hurt so badly that you had to see a doctor or go to the hospital?
Yes ___ No ___

## I. SEXUAL EXPERIENCES

The following questions ask about your sexual experiences. Please note that you don't have to answer any question you don't want to answer.

| Have you ever had the following experiences? | | Yes | No |
|---|---|---|---|
| 1. | Had sexual intercourse when you both wanted to? | | |

| **Have you ever had the following experiences?** | | **Yes** | **No** |
|---|---|---|---|
| 2. | Had someone misinterpret the level of sexual intimacy you desired? | | |
| 3. | Been in a situation where someone became so sexually aroused that you felt it was useless to stop the person even though you did not want to have sexual intercourse? | | |
| 4. | Had sexual intercourse with someone even though you didn't really want to because the person threatened to end your relationship otherwise? | | |
| 5. | Had sexual intercourse with someone when you didn't really want to because you felt pressured by the person's continual arguments? | | |
| 6. | Found out that someone had obtained sexual intercourse with you by saying things the person didn't really mean? | | |
| 7. | Been in a situation where someone used some degree of physical force (twisting your arm, holding you down, etc.) to try to make you engage in kissing or petting when you didn't want to? | | |
| 8. | Been in a situation where someone tried to get sexual intercourse with you when you didn't want to by **threatening** to use physical force (twisting your arm, holding you down, etc.) if you didn't cooperate, but for various reasons **sexual intercourse did not occur**? | | |
| 9. | Been in a situation where someone **used some degree of physical force** (twisting your arm, holding you down, etc.) to try to get you to have sexual intercourse when you didn't want to, but for various reasons **sexual intercourse did not occur**? | | |
| 10. | **Had sexual intercourse** with someone when you didn't want to because the person **threatened** to use physical force (twisting your arm, holding you down, etc.) if you didn't cooperate? | | |
| 11. | **Had sexual intercourse** with someone when you didn't want to because the person **used some degree of physical force** (twisting your arm, holding you down, etc.)? | | |
| 12. | Been in a situation where someone obtained sexual acts with you (i.e. anal or oral intercourse) by using threats or physical force when you didn't want to? | | |
| 13. | Have you ever been raped? | | |

| As a result of the sexual experiences listed above, how often did you experience the following? | | **Never** | **Rarely** | **Sometimes** | **Often** | **Very Often** |
|---|---|---|---|---|---|---|
| 14. | Received medical treatment for injuries. | 1 | 2 | 3 | 4 | 5 |
| 15. | Had physical pain lasting more than an hour | 1 | 2 | 3 | 4 | 5 |
| 16. | Had a bruise, cut, or wound on your face or neck. | 1 | 2 | 3 | 4 | 5 |

| As a result of the sexual experiences listed above, how often did you experience the following? | | Never | Rarely | Sometimes | Often | Very Often |
|---|---|---|---|---|---|---|
| 17. | Had a bump or wound on your head. | 1 | 2 | 3 | 4 | 5 |
| 18. | Had a swelling, sprain, or bruise on your arm or leg. | 1 | 2 | 3 | 4 | 5 |
| 19. | Had a bruise or cut on your stomach, chest, or back. | 1 | 2 | 3 | 4 | 5 |
| 20. | Had a fractured or broken bone. | 1 | 2 | 3 | 4 | 5 |
| 21. | Had a black eye. | 1 | 2 | 3 | 4 | 5 |
| 22. | Had to get medical treatment for stress. | 1 | 2 | 3 | 4 | 5 |

23. Did you ever tell anyone about your experiences? ___ Yes ___ No

**IF NO, SKIP TO NEXT SECTION**

| | Who did you tell? | When did you first tell this person? | Did he/she believe you? |
|---|---|---|---|
| a. | ___ Family member | ___ 1-6 days after<br>___ 1-4 weeks after<br>___ 1-12 months after<br>___ 1-5 years after<br>___ Greater than 5 years | ___ Yes ___ No |
| b. | ___ Friend | ___ 1-6 days after<br>___ 1-4 weeks after<br>___ 1-12 months after<br>___ 1-5 years after<br>___ Greater than 5 years | ___ Yes ___ No |
| c. | ___ Police, attorney, or other legal professional | ___ 1-6 days after<br>___ 1-4 weeks after<br>___ 1-12 months after<br>___ 1-5 years after<br>___ Greater than 5 years | ___ Yes ___ No |
| d. | ___ Social worker or counselor | ___ 1-6 days after<br>___ 1-4 weeks after<br>___ 1-12 months after<br>___ 1-5 years after<br>___ Greater than 5 years | ___ Yes ___ No |
| e. | ___ Doctor, nurse, or other medical professional | ___ 1-6 days after<br>___ 1-4 weeks after<br>___ 1-12 months after<br>___ 1-5 years after<br>___ Greater than 5 years | ___ Yes ___ No |
| f. | ___ Minister/Priest/Relig. Advisor | ___ 1-6 days after<br>___ 1-4 weeks after<br>___ 1-12 months after<br>___ 1-5 years after<br>___ Greater than 5 years | ___ Yes ___ No |

| | Who did you tell? | When did you first tell this person? | Did he/she believe you? |
|---|---|---|---|
| g. | ___ Other<br>(Who?)_____ | ___ 1-6 days after<br>___ 1-4 weeks after<br>___ 1-12 months after<br>___ 1-5 years after<br>___ Greater than 5 years | ___ Yes ___ No |

24. What happened after you told someone? Check all that apply.

___ Police were called
___ Child protective services called
___ Went to doctor or hospital
___ Nothing happened

25. Was the perpetrator ever confronted about the abuse? Yes___ No___

26. If yes, what was the result? Check all that apply.
___ Investigated by the police
___ Investigated by Child Protective Services
___ Arrested
___ Served time
___ Nothing

27. Were you ever hurt so badly that you had to see a doctor or go to the hospital?
Yes ___ No ___

## J. SERVICES

I will now read a list of services or resources you may have received in the past for the abuse experiences you had as an adult or child. Please indicate which ones you received and whether they were helpful or not.

| | | Yes | No | How helpful was this service? (1=Not helpful at all, 5=Extremely helpful) |
|---|---|---|---|---|
| 1. | Emotional support from friends or family | ___ | ___ | 1 2 3 4 5 |
| 2. | Support group or self-help group | ___ | ___ | 1 2 3 4 5 |
| 3. | Professional counseling | ___ | ___ | 1 2 3 4 5 |
| 4. | Hospital stay for emotional problems | ___ | ___ | 1 2 3 4 5 |
| 5. | Domestic violence shelter | ___ | ___ | 1 2 3 4 5 |
| 6. | Homeless shelter | ___ | ___ | 1 2 3 4 5 |
| 7. | Visit to a medical provider | ___ | ___ | 1 2 3 4 5 |

| | | Yes | No | How helpful was this service? (1=Not helpful at all, 5=Extremely helpful) |
|---|---|---|---|---|
| 8. | Prescribed psychotropic medication | ___ | ___ | 1 2 3 4 5 |
| 9. | Subsidized housing | ___ | ___ | 1 2 3 4 5 |
| 10. | Food bank | ___ | ___ | 1 2 3 4 5 |
| 11. | Welfare | ___ | ___ | 1 2 3 4 5 |
| 12. | Job training/employment counseling | ___ | ___ | 1 2 3 4 5 |
| 13. | Educational Support (GED, Vocational) | ___ | ___ | 1 2 3 4 5 |
| 14. | Unemployment compensation | ___ | ___ | 1 2 3 4 5 |
| 15. | Workers compensation | ___ | ___ | 1 2 3 4 5 |
| 16. | Vocational Rehabilitation | ___ | ___ | 1 2 3 4 5 |
| 17. | Subsidized daycare support | ___ | ___ | 1 2 3 4 5 |
| 18. | Reproductive services | ___ | ___ | 1 2 3 4 5 |
| 19. | Medication for emotional problems | ___ | ___ | 1 2 3 4 5 |
| 20. | Rape crisis or other sexual assault services | ___ | ___ | 1 2 3 4 5 |
| 21. | Legal services for divorce/restraining order | ___ | ___ | 1 2 3 4 5 |
| 22. | Child Protective Services | ___ | ___ | 1 2 3 4 5 |
| 23. | Religious or spiritual counseling | ___ | ___ | 1 2 3 4 5 |
| 24. | Internet support group or chat room | ___ | ___ | 1 2 3 4 5 |

Next, I will ask about possible barriers or challenges that prevented you from getting help for your abuse experiences.

| | | Yes | No |
|---|---|---|---|
| 25. | My health insurance would not cover services. | ___ | ___ |
| 26. | I thought the problem would get better by itself. | ___ | ___ |
| 27. | The problem didn't bother me very much at first. | ___ | ___ |
| 28. | I wanted to handle the problem on my own. | ___ | ___ |
| 29. | I didn't think treatment would work. | ___ | ___ |
| 30. | I received services before and it didn't work. | ___ | ___ |
| 31. | I was concerned about how much money it would cost. | ___ | ___ |

| | | Yes | No |
|---|---|---|---|
| 32. | I was concerned about what people would think if they found out I was in treatment. | ___ | ___ |
| 33. | I had problems with things like transportation or scheduling that made it hard to get to the services. | ___ | ___ |
| 34. | I was unsure about where to go or who to see. | ___ | ___ |
| 35. | I thought it would take too much time or be inconvenient. | ___ | ___ |
| 36. | I could not get an appointment. | ___ | ___ |
| 37. | I was scared about being put in a hospital against my will. | ___ | ___ |
| 37. | I was not satisfied with available services. | ___ | ___ |
| 38. | My parents did not take me to get help. | ___ | ___ |

## K. OTHER TRAUMATIC EXPERIENCES

The following is a series of questions about other stress or traumatic life events. These types of events actually happen a lot and they affect how people feel about, react to, and/or think about things afterwards. For each event, please indicate whether this ever happened to you at any time during your life.

1. Have you ever had a life-threatening illness?
___ Yes ___ No

2. Were you ever in a life-threatening accident?
___ Yes ___ No

3. Was physical force or a weapon ever used against you in a robbery or mugging?
___ Yes ___ No

4. Has an immediate family member, romantic partner or very close friend died as a result of an accident or sudden death?
___ Yes ___ No

5. Other than the experiences already covered, has anyone ever threatened you with a weapon such as a knife or gun?
___ Yes ___ No

6. Have you ever been present when another person was killed, seriously injured, or sexually or physically assaulted?
___ Yes ___ No

7. Have you ever been in any other situation where you were seriously injured or your life was in danger (e.g. involved in military combat, living in a war zone, held at gun point)?
___ Yes ___ No

8. Were you ever involved in a major natural disaster, like a devastating flood, hurricane, tornado, or earthquake?
___ Yes ___ No

9. Were you ever in a man-made disaster, like a fire started by a cigarette, or a bomb explosion?
___ Yes ___ No

10. Were you ever kidnapped or held hostage?
___ Yes ___ No

11. Have you ever been in any other situation that was extremely frightening that has not been covered above?
___ Yes ___ No If yes, please explain_____

Some people experience problems as a result of being hurt by their loved ones or by other traumatic events.

| **During the past month, how often have you experienced…** | | **Never** | **Occasionally** | **Fairly Often** | **Very Often** |
|---|---|---|---|---|---|
| 12. | A loss of interest in doing things you used to enjoy? | 0 | 1 | 2 | 3 |
| 13. | Feeling emotionally distant or cut-off from other people? | 0 | 1 | 2 | 3 |
| 14. | Having trouble feeling normal feelings like love, happiness, or warmth toward other people? | 0 | 1 | 2 | 3 |
| 15. | Flashbacks or sudden, vivid distracting memories? | 0 | 1 | 2 | 3 |
| 16. | Spacing out or going away in your mind? | 0 | 1 | 2 | 3 |
| 17. | Feeling like things are unreal? | 0 | 1 | 2 | 3 |
| 18. | Feeling numb or unable to have feelings for others? | 0 | 1 | 2 | 3 |
| 19. | Having trouble sleeping or concentrating? | 0 | 1 | 2 | 3 |
| 20. | Feeling jumpy or easily startled? | 0 | 1 | 2 | 3 |

## L. HISTORY OF SELF INJURY

1. Have you ever thought about committing suicide? ___ Yes ___ No

2. If yes, have you ever made a plan for committing suicide? ___ Yes ___ No

3. Have you ever attempted suicide? ___ Yes ___ No

**If no, go to the next section**

4. How many times have you attempted suicide in your lifetime? ___ Number of times

5. Have you attempted suicide during the past 12 months? ___ Yes ___ No

6. Which of these statements listed below best describe your situation when you attempted suicide the first time?

a. I made a serious attempt to kill myself and it was only luck that I did not succeed.
b. I tried to kill myself but knew that the method was not fool-proof.
c. My attempt was a cry for help. I did not intend to die.
d. Don't know or don't remember.

7. Which of these statements listed below best describe your situation when you attempted suicide the last time?

a. I made a serious attempt to kill myself and it was only luck that I did not succeed.
b. I tried to kill myself but knew that the method was not fool-proof.
c. My attempt was a cry for help. I did not intend to die.
d. Don't know or don't remember.

8. Did any of your suicide attempts require the following?

Medical attention ___ Yes ___ No
Overnight hospitalization ___ Yes ___ No

## M. RESOURCE GENERATING STRATEGIES

People do different things to get by. We are interested in learning the different strategies you have used to financially survive. Remember, all answers are confidential.

| **How often have you engaged in the following activities to generate income?** | | **Never** | **Once** | **Some-times** | **Often** | **Very Often** |
|---|---|---|---|---|---|---|
| 1. | Worked *part-time* (less than 40 hours per week) | 1 | 2 | 3 | 4 | 5 |
| 2. | Worked *full-time* (40 hours per week) | 1 | 2 | 3 | 4 | 5 |

| How often have you engaged in the following activities to generate income? | | Never | Once | Some-times | Often | Very Often |
|---|---|---|---|---|---|---|
| 3. | Worked *more than 40 hours per week* | 1 | 2 | 3 | 4 | 5 |
| 4. | Got a *second* or *third* job | 1 | 2 | 3 | 4 | 5 |

5. Types of wage or salary paying jobs held in the past 12 months (check all that apply)

___ Retail ___ Factory or warehouse

___ Food Service ___ Nursing or other health professional

___ Clerical/Data Entry ___ Child care or teacher's aide

___ Customer Service or Telemarketing ___ Professional such as management, teacher or lawyer

___ Maid or cleaning service ___ Other (Please Describe) _____

| How often have you engaged in the following activities to generate income? | | Never | Once | Some-times | Often | Very Often |
|---|---|---|---|---|---|---|
| 6. | Sold something hand-made by yourself to family, friends or neighbors | 1 | 2 | 3 | 4 | 5 |
| 7. | Sold something you purchased to family, friends or neighbors | 1 | 2 | 3 | 4 | 5 |
| 8. | Provided a service to family, friends or neighbors for a fee | 1 | 2 | 3 | 4 | 5 |
| 9. | Started your own small business or home-based business such as a daycare | 1 | 2 | 3 | 4 | 5 |
| 10. | Sold recyclable items such as clothing or aluminum | 1 | 2 | 3 | 4 | 5 |
| 11. | Swapped or exchanged goods or services with family, friends or neighbor | 1 | 2 | 3 | 4 | 5 |
| 12. | Used or sold items found in dumpsters and trash cans | 1 | 2 | 3 | 4 | 5 |
| 13. | Sold plasma or blood | 1 | 2 | 3 | 4 | 5 |
| 14. | Begged or panhandled | 1 | 2 | 3 | 4 | 5 |
| 15. | Sold illegal or prescription drugs | 1 | 2 | 3 | 4 | 5 |
| 16. | Wrote bad checks | 1 | 2 | 3 | 4 | 5 |
| 17. | Stole or burglarized money or goods | 1 | 2 | 3 | 4 | 5 |
| 18. | Provided sex or sexual acts for money or goods | 1 | 2 | 3 | 4 | 5 |

| How often have you engaged in the following activities to generate income? | | Never | Once | Some-times | Often | Very Often |
|---|---|---|---|---|---|---|
| 19. | Used payday loan service | 1 | 2 | 3 | 4 | 5 |
| 20. | Took out a second mortgage | 1 | 2 | 3 | 4 | 5 |
| 21. | Used credit cards to obtain goods | 1 | 2 | 3 | 4 | 5 |
| 22. | Used credit cards for a cash advance | 1 | 2 | 3 | 4 | 5 |
| 23. | Pawned personal or family items at a pawn shop | 1 | 2 | 3 | 4 | 5 |
| 24. | Received money or goods from family, friend or neighbor as a gift | 1 | 2 | 3 | 4 | 5 |
| 25. | Received money or goods from family, friend or neighbor with expectations of some form of repayment | 1 | 2 | 3 | 4 | 5 |
| 26. | Received money or goods from husband, boyfriend or intimate partner as a gift | 1 | 2 | 3 | 4 | 5 |
| 27. | Received money or goods from husband, boyfriend or partner with expectations of some form of repayment | 1 | 2 | 3 | 4 | 5 |

## N. LEGAL

1. Have you ever run away from home? ___ Yes ___ No

2. Have you ever been arrested? ___ Yes ___ No

**IF NO, SKIP TO NEXT SECTION O**

3. At any time in your past, were you arrested for soliciting or for acts of prostitution?
   _____ Yes _____ No

   a. If yes, how old were you the first time? ____ years of age
   b. How many times? ____ Number of times

4. At any time in your past, were you arrested for selling illegal or prescription drugs?
   _____ Yes _____ No

   a. If yes, how old were you the first time? ____ years of age
   b. How many times? ____ Number of times

5. At any time in your past, were you arrested for shoplifting or misdemeanor theft?
   _____ Yes _____ No

   a. If yes, how old were you the first time? ____ years of age
   b. How many times? ____ Number of times

6. Have you been arrested for other crimes? ___ Yes ___ No

**IF NO, SKIP TO SECTION O**

| What were you arrested for? | How old were you at the time of the arrest? | If convicted, what were you convicted for? | What was your sentence? (Check all that apply.) | How long was your sentence? |
|---|---|---|---|---|
| 7. | | | __ Fined<br>__ Diversion<br>__ Probation<br>__ Jail<br>__ Prison | |
| 8. | | | __ Fined<br>__ Diversion<br>__ Probation<br>__ Jail<br>__ Prison | |
| 9. | | | __ Fined<br>__ Diversion<br>__ Probation<br>__ Jail<br>__ Prison | |
| 10. | | | __ Fined<br>__ Diversion<br>__ Probation<br>__ Jail<br>__ Prison | |
| 11. | | | __ Fined<br>__ Diversion<br>__ Probation<br>__ Jail<br>__ Prison | |

12. Do you believe that any of these arrests were the direct result of you being victimized?
___ Yes ___ No

13. (For residents of TCF) What was the month and year you entered TCF?
____ Month ____ Year

## O. DEMOGRAPHICS

For this LAST section of the interview, I will be asking you some information about your background.

1. What is the year you were born? _____

2. What racial or ethnic group do you consider yourself to be a member of?

___ White ___ Asian/Pacific Islander
___ African-American or Black ___ American Indian
___ Latina or Hispanic ___ Other: _____

3. Do you have any children? ___ Yes ___ No

If yes, number and ages of children:

___ Less than 5 years old ___ Between 13 and 17 years old
___ Between 5 and 12 years old ___ Over 18 years of age

4. What is the highest grade or year of school that you have completed?

| Grade School | High School | College | Graduate School |
|---|---|---|---|
| 1 2 3 4 5 6 7 8 | 9 10 11 12 | 13 14 15 16 | 17 18 19 20 21+ |

5. In the prior 12 months prior, aside from yourself, who else was living in your home? (Check all that apply.)

___ A male partner
___ Husband
___ Own children
___ Partner's children
___ A female partner
___ One or more roommates
___ Parent(s)
___ Relative(s) (Who? _____)
___ Someone else (Who? _____)
___ I lived alone

6. Have you ever **applied** for welfare? ___ Yes ___ No

7. Have you ever **received** welfare? ___ Yes ___ No

8. In the past 12 months, what has been your average annual income?

___ 0-$10,000
___ $10,001-$15,000
___ $15,001-$25,000
___ $25,001-$35,000
___ More than $35,000

9. In the past 12 months, how difficult was it to live on your total household income?

___ Not at all difficult
___ A little difficult
___ Somewhat difficult
___ Very difficult
___ Extremely difficult

10. Have you ever owned your own home? ___ Yes ___ No

11. How would you describe the community you spent most of your childhood in?
    ___ Country
    ___ Small town
    ___ Medium-sized town
    ___ Suburb
    ___ Large City

12. Who lived in your home for most of your childhood? (check all that apply).
    ___ Both biological parents
    ___ Biological mother
    ___ Biological father
    ___ Divorced or widowed mother
    ___ Divorced or widowed father
    ___ Stepmother
    ___ Stepfather
    ___ Mother's boyfriend(s)
    ___ Father's girlfriend(s)
    ___ Natural siblings (Number of sisters ___; Number of brothers ___)
    ___ Step siblings (Number of stepsisters ___; Number of stepbrothers ___)
    ___ Half siblings (Number of half sisters ___; Number of half brothers ___)
    ___ Other (Please describe: _____)

13. While you were growing up, how would you describe your family's economic situation?
    ___ Poor
    ___ Working class
    ___ Middle class
    ___ Upper-middle class
    ___ Upper class

14. While you were growing up, how difficult was it for your family to live on their total household income?
    ___ Not at all difficult
    ___ A little difficult
    ___ Somewhat difficult
    ___ Very difficult
    ___ Extremely difficult

15. Did your family own their own home? ___ Yes ___ No

16. How did you find out about this study?

___ Domestic violence or sexual assault program
___ Flyer. Where was it posted? _____
___ Word of mouth. Who told you about it? _____
___ Other_____

17. Have you received domestic violence or sexual assault services in the last 12 months?

___ Yes ___ No

18. If in TCF, which unit are you in? ___ (A-J)

This concludes the interview. Thank you very much for taking the time to answer our questions. The information you provided will help us to develop better ways in which to reach out to women who are victims of violence. I have a packet of information on domestic violence and sexual assault services in your area. If you wish to speak to someone regarding your domestic violence or sexual assault experiences, please use this list to get help.

Time at completion of interview: _____

**STUDY ID #: _____** **Beginning Time:_____**

## A. CHILDHOOD EXPERIENCES

To qualify for this study, you stated that you experienced physical or sexual abuse as a child and as an adult. Let's first talk about your childhood.

1. Describe your family composition. Who was part of your family growing up?
   (Probes: Parents, siblings, step-family members, boyfriends, girlfriends, extended family members)

2. Describe the interactions between family members.
   (Probes: Between adults. Between siblings. Between adults and children).

3. Were you physically abused? If so, describe your abuse experiences.
   (Probes: Who, frequency, severity, thoughts, feelings)

4. Were you sexually abused? If so, describe your abuse experiences.
   (Probes: Who, frequency, severity, thoughts, feelings)

5. Did you tell anyone? If so, who? When? Were you believed?
   (Probes: explore disclosure with all types of abuse)

6. What happened after you told someone?
   (Probes: Police called; CPS involved; other action taken)

7. What help or services did you receive as a result of the abuse?
   (Probes: Give some examples of services available)

8. Were they helpful? If so, how?

9. Thinking about the responses you received, were any of them not helpful to you? If so, how?

10. What else would have been helpful for you?

11. If you could go back in time, what, if anything, would you do differently?
    (Probes: About telling someone, getting help)

12. What advice would you give to someone (child or adult) who had similar abuse experiences?

13. Is there anything else that you think would be important that I haven't asked about?

## B. ADULT EXPERIENCES

We will now move from your childhood into adulthood.

1. Describe your current family composition. Who do you consider as part of your family?
   (Probes: Children, significant others, spouse, parents, siblings, step-family members, boyfriends, girlfriends, extended family members)

2. Describe the interactions between family members.
   (Probes: Between adults. Between adults and children).

3. Were you physically abused? If so, describe your abuse experiences.
   (Probes: Who, frequency, severity, thoughts, feelings)

4. Were you sexually assaulted? If so, describe your abuse experiences.
   (Probes: Who, frequency, severity, thoughts, feelings)

5. Did you tell anyone? If so, who? When? Were you believed?
   (Probes: explore disclosure with all types of abuse)

6. What happened after you told someone?
   (Probes: Police called; CPS involved; other action taken)

7. What help or services did you receive as a result of the abuse?
   (Probes: Give some examples of services available)

8. Were they helpful? If so, how?

9. Thinking about the responses you received, were any of them not helpful to you? If so, how?

10. What else would have been helpful for you?

11. If you could go back in time, what, if anything, would you do differently?
   (Probes: About telling someone, getting help)

12. What advice would you give to someone else who had similar abuse experiences?

13. Is there anything else that you think would be important that I haven't asked about?

## C. OVERALL IMPRESSIONS

Now that we finished discussing your life as a child and adult, let's talk about your life today.

1. How do you believe these experiences shaped who and where you are today?
   (Probes: interactions with family members, work or career, survival, employment status, housing, involvement with criminal justice system)

2. How do you believe these experiences impacted your physical health?

3. How do you believe these experiences impacted your emotional health?
   (Probes: depression? PTSD? Mood disorders? Outlook on life?)

## D. DEMOGRAPHICS

For this LAST section of the interview, I will be asking you some information about your background.

1. What is the year you were born? _____

2. What racial or ethnic group do you consider yourself to be a member of?
   ___ White
   ___ African-American or Black
   ___ Latina or Hispanic
   ___ Asian/Pacific Islander
   ___ American Indian
   ___ Other: _____

3. Do you have any children? ___ Yes ___ No
   If yes, number and ages of children:
   ___ Less than 5 years old
   ___ Between 5 and 12 years old
   ___ Between 13 and 17 years old
   ___ Over 18 years of age

4. What is the highest grade or year of school that you have completed?

| Grade School | High School | College | Graduate School |
|---|---|---|---|
| 1 2 3 4 5 6 7 8 | 9 10 11 12 | 13 14 15 16 | 17 18 19 20 21+ |

5. In the prior 12 months prior, aside from yourself, who else was living in your home? (Check all that apply.)

___ A male partner
___ Husband
___ Own children
___ Partner's children
___ A female partner
___ One or more roommates
___ Parent(s)
___ Relative(s) (Who? _____)
___ Someone else (Who? _____)
___ I lived alone

6. In the past 12 months, how difficult was it to live on your total household income?

___ Not at all difficult
___ A little difficult
___ Somewhat difficult
___ Very difficult
___ Extremely difficult

7. Have you received domestic violence or sexual assault services in the last 12 months?
___ Yes ___ No

This concludes the interview. Thank you very much for taking the time to answer our questions. The information you provided will help us to develop better ways in which to reach out to women who are victims of violence. I have a packet of information on domestic violence and sexual assault services in your area. If you wish to speak to someone regarding your domestic violence or sexual assault experiences, please use this list to get help.

Time at completion of interview: _____

Respondent ID Number:_____

***Violence & Victimization: Exploring Women's Histories of Survival***
***Consent Form for Women in the Topeka Correctional Facility***

The School of Social Welfare at the University of Kansas supports the protection of participants in research. This information is provided for you to decide whether you wish to participate in a study about women who have been victims of domestic violence, sexual violence, or other kinds of violence. You may refuse to sign this form and not participate in this study. If you agree to participate, you are free to withdraw from the study at any time, without penalty. If you do withdraw from this study, it will not affect your relationship with the agency where you learned about this study, the services they may provide to you, or the University of Kansas.

***Purpose & Procedures:*** We want to learn more about women's past experiences with violence and about the assistance they received from human service agencies. We would like for you to participate in a face-to-face interview in which you will be asked to identify any physical or sexual violence you experienced as an adult or child as well as any exposure you had to traumatic events. We anticipate that the interview will take no more than an hour to complete.

The interview will include questions on your mental health and well being (for example depression), your coping abilities, the confidence you feel about managing your life, and the types of support or services you have received. You will also be asked questions about alcohol and drug usage. The information you provide will be confidential.

***Risks:*** There is a chance that you might feel uncomfortable with some of the questions we ask. For this reason, we will provide you with information about available support services in your community prior to your completing the interview.

***Benefits:*** Your responses will help us, the correctional institution for women, and community agencies to develop better ways in which to reach out to women who are victims of violence – in other words, to make plans to better respond to the needs of these women.

***Confidentiality:*** Once you have completed the interview, a unique identification number will be assigned to the information you provided and, using only that number, the information will be entered into a database. Consequently, your name will be removed from all records. What you answer will not be reported back to either the agency from which you received notice of this study or to any other agency in individual form. Instead, our findings will be reported on a group summary basis (i.e., "the majority of participants answered…."). Your participation is strictly your choice, thus it is voluntary. We will use the information you and other women provide to make a report to the community agencies and the correctional facility supporting the study about ways they might improve services offered to victims of violence.

Some persons or groups that receive your information may not be required to comply with the Health Insurance Portability and Accountability Act's privacy regulations, and your information may lose this federal protection if those persons or groups disclose it. The researchers will not share information about you with anyone not specified below unless required by law or unless you give written permission. Permission granted on this date to use and disclose your information remains in effect indefinitely. By signing this form you give permission for the use and disclosure of your information for purposes of this study at any time in the future.

All of the completed interview forms will be kept in a locked file cabinet at the University of Kansas. Only the researchers listed below and their assistants will have access to these surveys. Again, once a numerical identifier is issued on your survey, your name will be removed from the paper copy of the interview instrument.

***Refusal to Sign Consent and Authorization:*** Your services provided by the agency from which you learned of this study will not be affected by whether you participate or not. You may decline to answer any questions you choose, and you may stop taking part in this study at any time, without penalty.

***Canceling the Consent and Authorization:*** You also have the right to cancel your permission to use and disclose information collected about you, in writing, at any time, by sending your written request to the researchers listed below. If you cancel permission to use your information, the researchers will stop collecting additional information about you. However, the research team may use and disclose information that was gathered before they received your cancellation, as described above.

---

**PARTICIPANT CERTIFICATION:** I have read this Consent and Authorization form. I have had the opportunity to ask, and I have received answers to, any questions I had regarding the study and the use and disclosure of information about me for the study. I understand that if I have any additional questions about my rights as a research participant, I may call (785) 864-7429 or write the Human Subjects Committee Lawrence Campus (HSCL), University of Kansas, 2385 Irving Hill Road, Lawrence, Kansas 66045-7563, email dhann@ku.edu.

I agree to take part in this study as a research participant. I further agree to the uses and disclosures of my information as described above. By my signature I affirm that I am at least 18 years old, and that I have received a copy of this Consent and Authorization form.

**PRINT NAME:_____**

**SIGNATURE:_____DATE: _____**

**FORM EXPLAINED & WITNESSED BY _____DATE_____**

**Researcher Contact Information:**

Judy Postmus, Co-Investigator
School of Social Welfare University of Kansas
Lawrence, KS 66044
(785) 864-2647

Margaret Severson, Co-Investigator
School of Social Welfare, University of Kansas
Lawrence, KS 66044
(785) 864-8952

Respondent ID Number:_____

***Violence & Victimization: Exploring Women's Histories of Survival***
***Consent Form for Women in the Community***

The School of Social Welfare at the University of Kansas supports the protection of participants in research. This information is provided for you to decide whether you wish to participate in a study about women who have been victims of domestic violence, sexual violence, or other kinds of violence. You may refuse to sign this form and not participate in this study. If you agree to participate, you are free to withdraw from the study at any time, without penalty. If you do withdraw from this study, it will not affect your relationship with the agency where you learned about this study, the services they may provide to you, or the University of Kansas.

***Purpose & Procedures:*** We want to learn more about women's past experiences with violence and about the assistance they received from human service agencies. We would like for you to participate in a face-to-face interview in which you will be asked to identify any physical or sexual violence you experienced as an adult or child as well as any exposure you had to traumatic events. We anticipate that the interview will take no more than an hour to complete. We will also be asking a group of incarcerated women to participate in the same study.

The interview will include questions on your mental health and well being (for example depression), your coping abilities, the confidence you feel about managing your life, and the types of support or services you have received. You will also be asked questions about alcohol and drug usage. The information you provide will be confidential.

***Risks:*** There is a chance that you might feel uncomfortable with some of the questions we ask. For this reason, we will provide you with information about available support services in your community prior to your completing the interview.

***Benefits:*** Your responses will help us, the correctional institution for women, and community agencies to develop better ways in which to reach out to women who are victims of violence – in other words, to make plans to better respond to the needs of these women.

***Payment:*** You will receive $25 for your willingness to participate in this study.

***Confidentiality:*** Once you have completed the interview, a unique identification number will be assigned to the information you provided and, using only that number, the information will be entered into a database. Consequently, your name will be removed from all records. What you answer will not be reported back to either the agency from which you received notice of this study or to any other agency in individual form. Instead, our findings will be reported on a group summary basis (i.e., "the majority of participants answered…."). Your participation is strictly your choice, thus it is voluntary. We will use the information you and other women provide to make a report to the community agencies and the correctional facility supporting the study about ways they might improve services offered to victims of violence.

Some persons or groups that receive your information may not be required to comply with the Health Insurance Portability and Accountability Act's privacy regulations, and your information may lose this federal protection if those persons or groups disclose it. The researchers will not share information about you with anyone not specified below unless required by law or unless you give written permission. Permission granted on this date to use and disclose your information

remains in effect indefinitely. By signing this form you give permission for the use and disclosure of your information for purposes of this study at any time in the future.

All of the completed interview forms will be kept in a locked file cabinet at the University of Kansas. Only the researchers listed below and their assistants will have access to these surveys. Again, once a numerical identifier is issued on your survey, your name will be removed from the paper copy of the interview instrument.

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***Canceling the Consent and Authorization:*** You also have the right to cancel your permission to use and disclose information collected about you, in writing, at any time, by sending your written request to the researchers listed below. If you cancel permission to use your information, the researchers will stop collecting additional information about you. However, the research team may use and disclose information that was gathered before they received your cancellation, as described above.

---

**PARTICIPANT CERTIFICATION:** I have read this Consent and Authorization form. I have had the opportunity to ask, and I have received answers to, any questions I had regarding the study and the use and disclosure of information about me for the study. I understand that if I have any additional questions about my rights as a research participant, I may call (785) 864-7429 or write the Human Subjects Committee Lawrence Campus (HSCL), University of Kansas, 2385 Irving Hill Road, Lawrence, Kansas 66045-7563, email dhann@ku.edu.

I agree to take part in this study as a research participant. I further agree to the uses and disclosures of my information as described above. By my signature I affirm that I am at least 18 years old, that I have received the $25 for my participation, and that I have received a copy of this Consent and Authorization form.

**PRINT NAME:**_____

**ADDRESS:**_____ **SSN:**_____

**SIGNATURE:**_____**DATE:** _____

**FORM EXPLAINED & WITNESSED BY** _____**DATE**_____

**Researcher Contact Information:**

Judy Postmus, Co-Investigator
School of Social Welfare University of Kansas
Lawrence, KS 66044
(785) 864-2647

Margaret Severson, Co-Investigator
School of Social Welfare, University of Kansas
Lawrence, KS 66044
(785) 864-8952

***Violence & Victimization: Exploring Women's Histories of Survival***
***Consent Form for Women at the Topeka Correctional Facility, Kansas Department of Corrections***
*Qualitative Interview*

The School of Social Welfare at the University of Kansas supports the protection of participants in research. You were one of many women who recently participated in a survey where the interviewer asked you about your experiences of physical and / or sexual violence as a child, adolescent and adult. At the time of that interview, you indicated that you might be willing to participate in a follow-up interview with a different researcher. Today, this information is provided for you to decide whether you wish to participate in that follow up interview, which is part of our study about women who have been victims of violence. You may refuse to sign this form and not participate in this interview. If you agree to participate, you are free to withdraw from the study at any time, without penalty. If you do withdraw from this study, it will not affect your relationship with the Topeka Correctional Facility or with the University of Kansas.

***Purpose & Procedures:*** I want to learn more about women's past experiences with violence. I would like for you to participate in a face-to-face interview in which you will be asked to provide more information about your experiences with violence and about the services and supports you may or may not have received after that violence. I anticipate that the interview will take an hour to an hour and a half to complete.

The interview will include questions that will allow you to fully describe your victimization experiences including your disclosure experiences, the types of support or services you received, and the overall impact on your mental health and well-being. The information you provide will be confidential.

***Risks:*** There is a chance that you might feel slightly uncomfortable with some of the questions I ask. For this reason, I will provide you with information about available support services in your community prior to your completing the interview.

***Benefits:*** Your responses will help us, the correctional institution for women, and community agencies to develop better ways in which to understand and reach out to women who are victims of violence – in other words, to make plans to better respond to the needs of these women.

***Confidentiality:*** To make sure I gather all of your comments, I will audiotape the interview. Please do not use any last names while being taped. Any notes and audiotape labels will not include your name but instead will have letter and number identifiers. Audiotapes and notes from the interview will be kept in a locked cabinet in my office. Only the researchers listed below and their assistants will have access to these tapes and notes.

Once you have completed the interview, a pseudonym will be assigned to the information you provided and, using only that pseudonym, the information will be entered into a database. Consequently, your name will be removed from all records. What you answer will not be reported back to either the agency from which you received notice of this study or to any other agency in individual form. Instead, our findings will be reported on a group summary basis (i.e., "the majority of participants answered…."). Your participation is strictly your choice, thus it is voluntary. We will use the information you and other women provide to make a report to the community agencies and the correctional facility supporting the study about ways they might improve services offered to victims of violence.

***Refusal to Sign Consent and Authorization:*** Your release date, your parole status, and your general living conditions in the correctional facility will not be affected by whether you participate or not. You may decline to answer any questions you choose, and you may stop taking part in this study at any time, without penalty.

***Canceling the Consent and Authorization:*** You also have the right to cancel your permission to use and disclose information collected about you, in writing, at any time, by sending your written request to the researchers listed below. If you cancel permission to use your information, the researchers will stop collecting additional information about you. However, the research team may use and disclose information that was gathered before they received your cancellation, as described above.

---

**PARTICIPANT CERTIFICATION:** I have read this Consent and Authorization form. I have had the opportunity to ask, and I have received answers to, any questions I had regarding the study and the use and disclosure of information about me for the study. I understand that if I have any additional questions about my rights as a research participant, I may call (785) 864-7429 or write the Human Subjects Committee Lawrence Campus (HSCL), University of Kansas, 2385 Irving Hill Road, Lawrence, Kansas 66045-7563, email dhann@ku.edu.

I agree to take part in this study as a research participant. I further agree to the uses and disclosures of my information as described above. My decision to take part or not will not affect the care I receive at the facility, my release date, or parole status. My name will not be used in any report. By my signature I affirm that I am at least 18 years old, and that I have received a copy of this Consent and Authorization form.

**(PRINT NAME)_____**

**SIGNATURE:_____DATE: _____**

**FORM EXPLAINED & WITNESSED BY _____DATE_____**

**Researcher Contact Information:**

Judy Postmus
School of Social Welfare,
University of Kansas
1545 Lilac Lane
Lawrence, KS 66044-3184
785-864-2647

Margaret Severson
School of Social Welfare
University of Kansas
1545 Lilac Lane
Lawrence, KS 66044-3184
785-864-8952

Respondent ID Number:_____

***Violence & Victimization: Exploring Women's Histories of Survival***
***Consent Form for Women in the Community***
*Qualitative Interview*

The School of Social Welfare at the University of Kansas supports the protection of participants in research. You were one of many women who recently participated in a survey where the interviewer asked you about your experiences of physical and / or sexual violence as a child, adolescent and adult. At the time of that interview, you indicated that you might be willing to participate in a follow-up interview with a different researcher. Today, this information is provided for you to decide whether you wish to participate in that follow up interview, which is part of our study about women who have been victims of violence. You may refuse to sign this form and not participate in this interview. If you agree to participate, you are free to withdraw from the study at any time, without penalty. If you do withdraw from this study, it will not affect your relationship with any community service agency or with the University of Kansas.

***Purpose & Procedures:*** I want to learn more about women's past experiences with violence. I would like for you to participate in a face-to-face interview in which you will be asked to provide more information about your experiences with violence and about the services and supports you may or may not have received after that violence. I anticipate that the interview will take an hour to an hour and a half to complete.

The interview will include questions that will allow you to fully describe your victimization experiences including your disclosure experiences, the types of support or services you received, and the overall impact on your mental health and well-being. The information you provide will be confidential.

***Risks:*** There is a chance that you might feel slightly uncomfortable with some of the questions I ask. For this reason, I will provide you with information about available support services in your community prior to your completing the interview.

***Benefits:*** Your responses will help us, the correctional institution for women, and community agencies to develop better ways in which to understand and reach out to women who are victims of violence – in other words, to make plans to better respond to the needs of these women.

***Payment:*** You will receive $25 for your willingness to participate in this study. I may ask for your social security or other identification number in order to comply with state and federal accounting regulations.

***Confidentiality:*** To make sure I gather all of your comments, I will audiotape the interview. Please do not use any last names while being taped. Any notes and audiotape labels will not include your name but instead will have letter and number identifiers. Audiotapes and notes from the interview will be kept in a locked cabinet in my office. Only the researchers listed below and their assistants will have access to these tapes and notes.

Once you have completed the interview, a pseudonym will be assigned to the information you provided and, using only that pseudonym, the information will be entered into a database. Consequently, your name will be removed from all records. What you answer will not be reported back to either the agency from which you received notice of this study or to any other agency in individual form. Instead, our findings will be reported on a group summary basis (i.e., "the majority of participants answered…."). Your participation is strictly your choice, thus it is voluntary. We will use the information you and other women provide to make a report to the community agencies and the correctional facility supporting the study about ways they might improve services offered to victims of violence.

Some persons or groups that receive your information may not be required to comply with the Health Insurance Portability and Accountability Act's privacy regulations, and your information may lose this federal protection if those persons or groups disclose it. The researchers will not share information about

you with anyone not specified below unless required by law or unless you give written permission. Permission granted on this date to use and disclose your information remains in effect indefinitely. By signing this form you give permission for the use and disclosure of your information for purposes of this study at any time in the future.

***Refusal to Sign Consent and Authorization***: Your services provided by the agency from which you learned of this study will not be affected by whether you participate or not. You may decline to answer any questions you choose, and you may stop taking part in this study at any time, without penalty.

***Canceling the Consent and Authorization:*** You also have the right to cancel your permission to use and disclose information collected about you, in writing, at any time, by sending your written request to the researchers listed below. If you cancel permission to use your information, the researchers will stop collecting additional information about you. However, the research team may use and disclose information that was gathered before they received your cancellation, as described above.

---

**PARTICIPANT CERTIFICATION:** I have read this Consent and Authorization form. I have had the opportunity to ask, and I have received answers to, any questions I had regarding the study and the use and disclosure of information about me for the study. I understand that if I have any additional questions about my rights as a research participant, I may call (785) 864-7429 or write the Human Subjects Committee Lawrence Campus (HSCL), University of Kansas, 2385 Irving Hill Road, Lawrence, Kansas 66045-7563, email dhann@ku.edu.

I agree to take part in this study as a research participant. I further agree to the uses and disclosures of my information as described above and agree to be audio-taped. By my signature I affirm that I am at least 18 years old, that I have received the $25 for my participation, and that I have received a copy of this Consent and Authorization form.

**PRINT NAME:_____**

**ADDRESS:_____ SSN:_____**

**SIGNATURE:_____DATE: _____**

**FORM EXPLAINED & WITNESSED BY _____DATE_____**

**Researcher Contact Information:**

Judy Postmus
School of Social Welfare,
University of Kansas
1545 Lilac Lane
Lawrence, KS 66044-3184
785-864-2647

Margaret Severson
School of Social Welfare
University of Kansas
1545 Lilac Lane
Lawrence, KS 66044-3184
785-864-8952

The University of Kansas
Center for Research, Inc.
COORDINATING RESEARCH FOR THE UNIVERSITY OF KANSAS

Contract Negotiations and Research Compliance

11/10/2003
HSCL #14163

Judy Postmus
SOC WEL
120 Twente Hall

The Human Subjects Committee Lawrence has received your response to its full IRB review of your research project,

14163 Postmus/Severson (SOC WEL) Violence and Victimization: Exploring Women's Histories of Survival

and found that it complied with policies established by the University for protection of human subjects in research. The subjects will be at minimal risk. Unless renewed, approval lapses one year after approval date.

1. At designated intervals until the project is completed, a Project Status Report must be returned to the HSCL office.
2. Any significant change in the experimental procedure as described should be reviewed by this Committee prior to altering the project.
3. Notify HSCL about any new investigators not named in original application. Note that new investigators must take the online tutorial at www.research.ukans.edu/tutor.
4. Any injury to a subject because of the research procedure must be reported to the Committee immediately.
5. When signed consent documents are required, the primary investigator must retain the signed consent documents for at least three years past completion of the research activity. If you use a signed consent form, provide a copy of the consent form to subjects at the time of consent.
6. If this is a funded project, keep a copy of this approval letter with your proposal/grant file.

Please inform HSCL when this project is terminated. You must also provide HSCL with an annual status report to maintain HSCL approval. Unless renewed, approval lapses one year after approval date. If your project receives funding which requests an annual update approval, you must request this from HSCL one month prior to the annual update. Thanks for your cooperation. If you have any questions, please contact me.

Sincerely,

David Hann
Coordinator
Human Subjects Committee - Lawrence

Youngberg Hall • 2385 Irving Hill Road • Lawrence, KS 66045-7563 • (785) 864-7431 • Fax: (785) 864-5049
www.research.ku.edu

KANSAS DEPARTMENT OF CORRECTIONS
ROGER WERHOLTZ, SECRETARY

KATHLEEN SEBELIUS, GOVERNOR

January 5, 2004

Judy Postmus, Ph.D.
Margaret Severson, J.D.
University of Kansas
School of Social Welfare
1545 Lilac Lane
Lawrence, KS 66044

Dear Dr. Postmus and Ms. Severson:

This is to inform you that Secretary of Corrections Roger Werholtz has approved your research proposal titled "Violence and Victimization: Exploring Women's Histories of Survival."

Feel free to contact Deputy Warden Pellant at Topeka Correctional Facility [ (785) 296-7287 or by email at kevenp@kdoc.dc.state.ks.us ] to make arrangements to begin data collection. The Department is very interested in the results of your study. As stated in IMPP 06-101, each researcher is required to submit to the Department of Corrections a copy of the final report on the project. Please review this IMPP for details on this requirement and for the procedure for obtaining permission to submit any research results for publication.

Also, at the conclusion of your work and if it is feasible, we would like you to come to the KDOC Central Office in Topeka to make a brief presentation (one hour maximum) in which you would describe your findings to interested staff. Arrangements for this can be made later. Good luck with the project.

Sincerely,

Kenneth W. Shirley

Kenneth W. Shirley
Research and Planning Unit
KWS:kws
cc Secretary Werholtz, Deputy Secretary Haden, Deputy Secretary Sanders, Deputy Secretary Simmons, Warden Richard Koerner

900 SW Jackson-4th Floor, Topeka, KS 66612-1284
Voice 785-296-3310 Fax 785-296-0014 http://www.dc.state.ks.us

# The University of Kansas

Office of the Vice Provost for Research
Contract Negotiations and Research Compliance

2/19/2004

Judy Postmus
SOC WEL
120 Twente Hall

The Human Subjects Committee Lawrence Campus reviewed your research update application for project

14163 Postmus (SOC WEL) Violence and Victimization: Exploring Women's Histories of Survival

and approved this project update through an expedited review process according to 45 CFR 46.110 (b)(2) minor changes (or no changes) in a previously approved project. Your project has continued approval to 11/10/2004. Approximately one month prior to 11/10/2004, HSCL will send to you a Status Report request, which will be necessary for you to complete in order to obtain continued approval for the next twelve months. Please note that you must stop data gathering if you do not receive continued HSCL approval.

HSCL approves your revisions and added questions as described in your request and as provided in the copy of your survey instrument sent to HSCL with your request. HSCL notes that questions about illness and drug use have already been approved by the full committee.

If you complete your project before the renewal date, please notify HSCL. Thank you for providing HSCL with update information.

Sincerely,

David Hann
HSCL Coordinator
University of Kansas

# The University of Kansas

Office of the Vice Provost for Research
Contract Negotiations and Research Compliance

9/9/2004
HSCL #14163

Judy Postmus
SOC WEL
120 Twente Hall

The Human Subjects Committee Lawrence Campus reviewed your research update application for project

14163 Postmus/Severson/Pyles (SOC WEL) Violence and Victimization: Exploring Women's Histories of Survival

and approved this project update through an expedited review process according to 45 CFR 46.110 (b)(2) minor changes (or no changes) in a previously approved project. Your project has continued approval to 11/10/2004. Approximately one month prior to 11/10/2004, HSCL will send to you a Status Report request, which will be necessary for you to complete in order to obtain continued approval for the next twelve months. Please note that you must stop data gathering if you do not receive continued HSCL approval.

HSCL approves your revised consent forms, your qualitative interview letters, and your qualitative interview questions. HSCL understands that the questions provided by you represent the core around which the qualitative interviews will be conducted.

Please use the HSCL "approval stamp" on your consent forms.

If you complete your project before the renewal date, please notify HSCL. Thank you for providing HSCL with update information.

Sincerely,

David Hann
HSCL Coordinator
University of Kansas

# The University of Kansas

Office of the Vice Provost for Research
Contract Negotiations and Research Compliance

10/27/2004
HSCL #14163

Judy Postmus
SOC WEL
120 Twente Hall

The Human Subjects Committee Lawrence Campus reviewed your research update application for project

14163 Postmus/Margaret Severson/Loretta Pyles (SOC WEL) Violence and Victimization: Exploring Women's Histories of Survival

and approved this project update through an expedited review process according to 45 CFR 46.110 (b)(2) minor changes (or no changes) in a previously approved project. Your project has continued approval to 11/10/2005. Approximately one month prior to 11/10/2005, HSCL will send to you a Status Report request, which will be necessary for you to complete in order to obtain continued approval for the next twelve months. Please note that you must stop data gathering if you do not receive continued HSCL approval.

Please use the HSCL "approval stamp" on your consent forms. Just cut and paste. You may resize and reshape the text to fit your documents.

**Approved by the Human Subjects Committee University of Kansas, Lawrence Campus (HSCL). Approval expires one year from 10/27/2004**

If you complete your project before the renewal date, please notify HSCL. Thank you for providing HSCL with update information.

Sincerely,

David Hann
HSCL Coordinator
University of Kansas

Youngberg Hall • 2385 Irving Hill Road • Lawrence, KS 66045-7563 • (785) 864-7431 • Fax: (785) 864-5049
www.research.ku.edu

# The University of Kansas

Office of the Vice Provost for Research
Contract Negotiations and Research Compliance

11/9/2005
HSCL #14163

Judy Postmus
SOC WEL
120 Twente Hall

The Human Subjects Committee Lawrence Campus reviewed your research update application for project

14163 Postmus/Severson/Pyles (SOC WEL) Violence and Victimization: Exploring Women's Histories of Survival

and approved this project update through an expedited review process according to 45 CFR 46.110 (b)(2) minor changes (or no changes) in a previously approved project. Your project has continued approval to 11/10/2006. Approximately one month prior to 11/10/2006, HSCL will send to you a Status Report request, which will be necessary for you to complete in order to obtain continued approval for the next twelve months. Please note that you must stop data gathering if you do not receive continued HSCL approval.

Please use the HSCL "approval stamp" on your consent forms. Just cut and paste. You may resize and reshape the text to fit your documents.

**Approved by the Human Subjects Committee University of Kansas, Lawrence Campus (HSCL). Approval expires one year from 11/10/2005.**

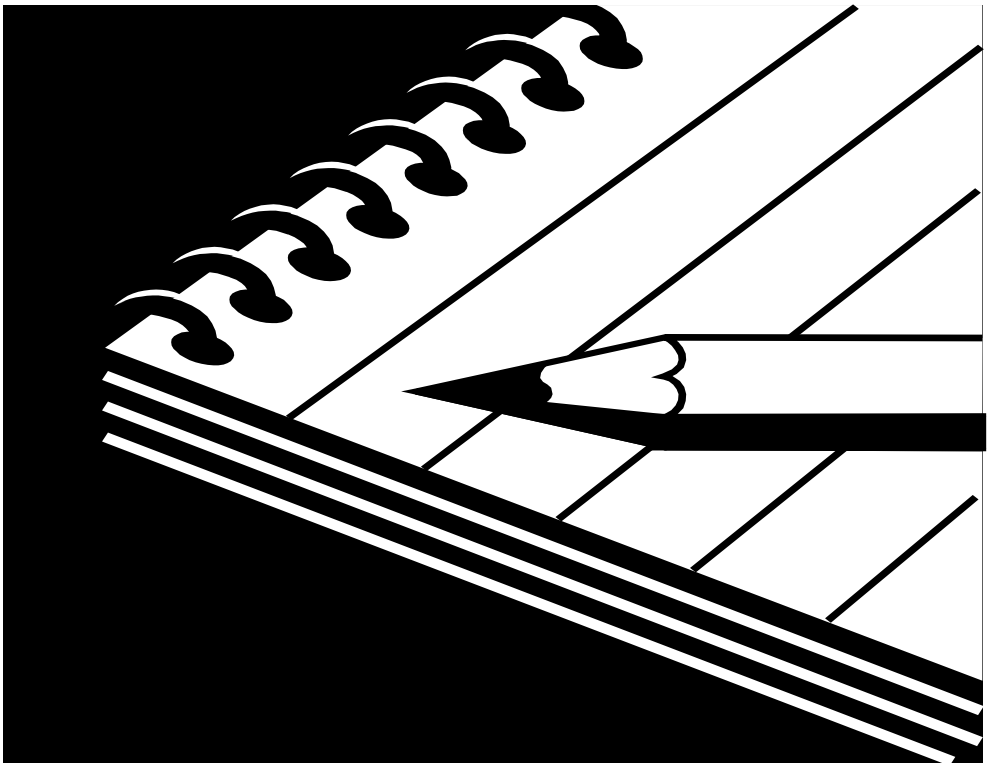
If you complete your project before the renewal date, please notify HSCL. Thank you for providing HSCL with update information.

Sincerely,

David Hann
HSCL Coordinator
University of Kansas

# *Violence and Victimization: Exploring Women's Histories of Survival*

***A Research Project Funded by:***
***The National Institute of Justice***



**University of Kansas School of Social Welfare**

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# I. BACKGROUND INFORMATION

## A. History of the Project

The **Violence and Victimization: Exploring Women's Histories of Survival** Project of the University of Kansas School of Social Welfare is a one-of-its-kind research endeavor designed to learn more about the differential risk and protective factors related to histories of physical and sexual victimization reported by incarcerated and non-incarcerated women and to understand the coping and resilience patterns women activate at various points in their lifespan. The first year of this project focuses on gaining information about such things as women's sense of well-being, their histories of victimization, criminal history, coping behaviors and service utilization. It is anticipated that the results will address the current gap in knowledge around the pathways women victims of violence have taken.

Drs. Judy Postmus and Margaret Severson, the co-principal investigators of the project have combined their respective backgrounds studying violence against women and women's criminality, mental health and incarceration to address the current gaps in knowledge. Other studies point to differences in cultural norms, psychological stress, individual coping skills, and institutional and interpersonal factors, which carry serious life saving implications for the identification, care, and management of incarcerated persons of varying ethnic backgrounds. There have been no evaluation efforts of women's victimization histories, service utilization patterns and outcomes.

The agencies who have partnered with KU to complete this study are the Kansas Department of Corrections and the Kansas Coalition Against Sexual and Domestic Violence. With input from these partners, Drs. Severson and Postmus submitted a proposal to the National Institute of Justice which was subsequently funded.

This study addresses the following questions:

(1) What is the prevalence and co-occurrence rate of intimate partner violence, sexual violence and youth maltreatment for three different samples of women in Kansas (women from urban and rural communities, women receiving services for domestic violence or sexual assault, and incarcerated women)?

(2) How does youth victimization relate to outcomes in adulthood, including health, mental health, use of alcohol and drugs, suicidality, and incarceration?

(3) How does adult victimization relate to outcomes in adulthood, including health, mental health, use of alcohol and drugs, suicidality, and incarceration?

(4) What events and services in adolescence and adulthood, including kinds of social services, types of coping skills, social supports, adult economic resources, and the

response to the disclosure of violence, are most predictive of the adult outcomes of health, mental health, use of alcohol and drugs, suicidality, and incarceration?

(5) Which of all these factors (childhood / youth demographics, history of victimization, and the mediating factors itemized in research question #4), are the strongest predictors of adult outcomes?

The study utilizes mixed research methods. In the first year, we will survey women living in one or four Kansas communities or in the Topeka Correctional Institute for Women (TCF) who have self-identified as having histories of violence. Interviews will occur within a 12 month period of time during which these women will be asked about their victimization, depression, health, substance abuse, coping skills, etc. This is the quantitative part of the study – collecting survey data that we can then analyze in a quantitative manner. The second part includes conducting interviews with a small sample of women victims of violence. These interviews (qualitative data) will give us context as well as insight into why current practices are working or not working, and methods for improvement in violence response protocols. Because of the diverse nature of the study population, both the quantitative and qualitative inquiry will help us answer the research questions

The specific objectives to be accomplished are:

(1) To determine whether victimized women residing in the community were (a) offered and (b) participated in, one or more social service and social support interventions which may have impacted their health, mental health (depression, suicide attempts, PTSD), their self-efficacy, alcohol or illegal substance use, and possible incarceration. Specific attention will be directed toward investigating the extent of involvement of those systems that may have been available to provide assistance to abused and injured women at earlier points in their lives. These systems include schools, sexual assault/domestic violence programs, law enforcement, medical providers, mental health providers, agencies responsible for ensuring the protection and safety of children, religious and faith-based groups, and family or friends.

(2) To determine the rate of co-occurrence of sexual assault with intimate partner violence and other forms of familial abuse and youth maltreatment among incarcerated and non-incarcerated women.

(3) To suggest implications for improving policy and practice strategies within the criminal justice system, both for incarcerated and never-incarcerated victims of intimate partner violence, sexual assault, and youth maltreatment.

A summary of the research findings and the implicated policy issues will be presented to the community domestic and sexual violence agencies who have partnered with us in this research endeavor, the Kansas Department of Corrections, and the National Institute of Justice for publication in a *NIJ Research in Brief*. Nationally distributed publications of the findings and recommendations will help inform community and prison facilities serving the population of women who have been victims of physical and other forms of violence.

## B. The Principal Investigators & Staff

The principal investigators and their staff (a research name for those responsible for the study) are:

***Judy L. Postmus, Ph.D., ACSW*** is an Assistant Professor, School of Social Welfare, University of Kansas. Her practice background includes work in various social work capacities with children and families. As executive director of a nonprofit domestic violence shelter, Dr. Postmus was actively involved in the education and training of health and human service professionals regarding practice and policy issues affecting victims of domestic violence. Her current research is on victimization experiences of women and their interactions with welfare, child welfare, and criminal justice systems. She is Co-Principal Investigator on a research grant from the National Institute of Justice that explores women's histories of survival from victimization experiences as adult and children. Dr. Postmus also teaches in the areas of social welfare policy, family violence, and personnel management.

***Margaret Severson, JD, MSW*** is an Associate Professor, School of Social Welfare, University of Kansas. She has extensive experience in the interface of mental health and criminal justice systems as evidenced by numerous publications. Dr. Severson's research and teaching interests are correctional mental health program development and implementation; mental health policy and practice with pre-trial detainees and sentenced prisoners; suicide prevention and crisis intervention in pre-trial detention and state correctional facilities, expert consultation in jail suicide and mental health-related litigation; legal issues impacting on professional mental health administration and practice; and mental health policy and procedure development and delivery of clinical services.

**Loretta Pyles**, a social welfare doctoral student at the University of Kansas, is the Project Coordinator and will assist Drs. Postmus and Severson in this project.

**Sarah Potter**, grants staff at the School of Social Welfare will be responsible for administrative issues such as issues of payment, reimbursement and cell phones.

## C. Confidentiality Policy

The Principal Investigators through the University of Kansas Committee on the Protection of Human Subjects and the Kansas Department of Corrections have established the following policies to assure that the confidentiality of all research participants is respected and that the identity of individual participants is protected.

### Computer Data Sources

Information collected and maintained by the University of Kansas will have a numeric identifier. No names will be attached to any surveys or computer listings. After data are recorded, all paper copies of survey instruments will be stored in locked file cabinets, with access limited only to the Principal Investigators and the Project Coordinator during the time of the study. After the completion of the project, two clean copies of the databases will be made available for archiving with the National Institute of Justice as required by the grant award. Any other external access to the data will be prohibited.

### Data Management

Once the surveys are completed, each questionnaire is marked with an identification number. Data entry personnel will not have access to any identifying information such as names. Interviews completed during the second phase of this project will be transcribed; the transcriptionist will leave blank any inadvertent mention of a person's full name. The transcriptionist will receive only the numerical identifier when the transcript is delivered.

### Survey Administrators

Survey administrators will follow routine confidentiality policy and procedures of the agency or correctional facility. Any breaches of confidentiality (except as provided under Emergency Procedures) are grounds for review.

### Reported Analyses of Data

Research results will be reported in several formats. A final report is required by the NIJ. Articles for journals (i.e., *NIJ Research in Brief*) and conference presentations will be prepared to share the results to improve both scientific investigation and service provision. In all cases, unless otherwise agreed upon, the University and will not identify the individual participants. The identification of the correctional facility will be decided by an agreement with the Kansas Department of Corrections.

## D. RIGHTS OF RESEARCH PARTICIPANTS:

Even though we want as many women victims of physical and other forms of violence to participate as possible, there are ethical guidelines to keep in mind. All research conducted must follow strict ethical guidelines to protect the rights of the research participants. The following guidelines must be followed ***by all*** to insure that the participants are not harmed by their participation in this study.

1) Respondents have the right to refuse to participate in the study.

2) Respondents have the right to withdraw from the study at any time.

3) Respondents have the right to refuse to answer any specific questions.

4) Refusing to participate or withdrawing from the study will not affect any woman's treatment, or case disposition and, in the case of a participant located in the Topeka Correctional Institute for Women, her length of stay in the prison facility.

5) Respondents must be informed about the general purpose of the study.

"This study involves asking questions about your experiences of victimization and also about your present health status. In addition, we will ask you about the supports and services you have accessed in your life. Your answers will help us better understand women's unique histories and ultimately will help create more effective policy, procedures and programs to help those who have had experiences like yours."

6) Respondents must be informed about what they will be asked to do if they agree to participate in this study.

"This study asks respondents to answer questions about their experiences of victimization, their service histories, their health and mental health statuses and about the various traumas that they been exposed to during their lives."

7) Respondents must be informed of the potential risks associated with participation in the study.

"The risks may include psychological discomfort related to discussion of topics which may be painful or bring back unpleasant memories."

8) Respondents must be informed of potential benefits with participation.

"The respondents will not benefit directly from participation in the study. However, they might be comforted to know that they took part in a study that

could help this and other organizations respond more appropriately to those with similar histories and similar service and support needs."

9) Respondents must be informed about confidentiality.

"All information that the respondents give will be kept confidential, with the exception of reports of intention to do harm to themselves or others, which we are required to report by law. Confidentiality means that all information the respondent shares will remain private. Respondents will remain anonymous, which means that code numbers will be on the materials instead of names. The project staff will take precautions for safe-guarding all materials."

10) Respondents must be informed about whom they can call if they have questions.

"This information is included on the SUBJECT CONSENT FORM."

11) Respondents must sign and receive a copy of the SUBJECT CONSENT FORM to indicate that they have been informed of their rights as research participants.

# II. THE SURVEY DEVELOPMENT

## A. Development of the Survey

The self-report survey includes many published and validated "scales" or measurements of concepts that the researchers were interested in learning more about. In research, it is imperative that the precise questions asked in the survey and the resulting answers adequately and accurately capture the concepts that we want to measure. Are we measuring what we really want to measure (validity)? Also, will this hold across all participants during all times (reliability)? The process of translating ideas or concepts into questions to be asked in a survey is very complicated, time consuming, and expensive. Thus, using scales developed by other researchers saves money and time. As pilot tested, the mean time to complete the survey was approximately 60 minutes.

## B. Areas of Questioning

This violence and victimization survey is composed of the following instruments:

Child Maltreatment: Sexual, physical, and emotional abuse during childhood and adolescence will be measured using the Childhood Maltreatment Interview Schedule developed by Briere (1992). While there are no known studies on overall reliability or validity, the use of this measure in pilot studies suggests predictive and construct validity (Briere, 1992).

Sexual Assault (Sexual Experiences): Sexual assault, by an intimate partner, family member, or stranger will be measured using the Sexual Experiences Survey developed by Koss and Oros (1982). This survey was developed to reflect the large number of unreported incidences of rape and sexual assault; data suggest that rape is often underreported (Koss & Oros, 1982).

Intimate Partner Violence: Intimate partner violence, including physical, sexual, and psychological abuse from an intimate partner, will be measured using the Abusive Behavior Inventory developed by Shepard and Campbell (1992). This inventory is a reliable measure with alpha coefficients ranging from .7 to .92. Additionally, the inventory has good criterion-related and construct validity (Shepard & Campbell, 1992).

Social Support (Relationship with Family and Friends): Perceived support from family and friends will be measured with the Social Support Appraisals Scale developed by Vaux and colleagues (1986). This scale has good internal consistency with alpha ranges from .81 to .90. It also has good concurrent, predictive, known-

groups, and construct validity; it also correlates in predicted ways with several other measures of social support (Vaux et al., 1986).

Disclosure: Disclosure will be measured from adapted questions from previous surveys incorporated by the co-principal investigators. There are no known studies on the overall reliability or validity; however, many of these questions are adapted from a study conducted with adult women in the community who have experienced several different forms of physical and sexual abuse as children or adults (McNutt et al., 2002).

Support from Agencies (Services): Support from Agencies will include any support received from health, mental health, or community agencies. Questions about support from agencies will be measured using revised questions from the National Comorbidity Survey, implemented in 1992 as a nationally representative survey that assesses the prevalence and correlates of DSM-IIIR diagnoses (NCS, 1992). Support from agencies will be measured from adapted questions from previous surveys. There are no known studies on the overall reliability or validity; however, many of these questions are adapted from a study conducted with adult women in the community who have experienced several different forms of physical and sexual abuse as children or adults (McNutt et al., 2002).

Coping (Coping with Stress): The *Brief-Cope Scale* is a 28-item theory-based instrument designed to assess a variety of coping reactions/strategies in response to stress. Alpha reliabilities range from .50 to .90. This instrument consists of 14 subscales (Carver, 1997).

Trauma History (Other Traumatic Experiences): Trauma history will be measured using revised questions from the National Comorbidity Survey, implemented in 1992 as a nationally representative survey that assesses the prevalence and correlates of DSM-IIIR diagnoses (NCS, 1992).

Health Symptoms (Health and Well-Being) Health symptoms will be measured using the Short-Form-20 Health Survey, an abbreviated version of the Rand Medical Outcomes Study. The survey covers physical, social, and mental health functioning as well as pain and health perceptions. Internal consistency coefficients range from .81 to .88 with an alpha reliability of .76 and .67 (Stewart, Hays, & Wate, 1988).

Suicide Attempts (History of Self-Injury), PTSD, and Substance Abuse: Questions about the range of topics listed will be measured using revised questions from the National Comorbidity Survey, implemented in 1992 as a nationally representative survey that assesses the prevalence and correlates of DSM-IIIR diagnoses (NCS, 1992).

Self-Efficacy (Personal Attitudes): Self-efficacy will be measured using the Self-Efficacy Scale developed by Sherer and colleagues (1982). The scale has fairly good

internal consistency with an alpha score of .86. The scale has shown good criterion-related and construct validity (Sherer et al., 1982).

Depression (Emotional Health): Depression will be measured using the Center for Epidemiological Studies Depression Scale (CES-D) developed by the National Institute of Mental Health. This commonly used scale has good internal consistency with alpha scores of .85 for the general population and .90 for psychiatric populations. The scale also has excellent concurrent validity; it correlates well with a number of other depression and mood scales. Finally, CES-D has good known-groups validity and has fair stability with test-retest correlations (Frazier, 1977).

Help Seeking asks if the respondent has received help from resources other than family or friends during the past 6 months for specific problems (i.e., emotional support, alcohol use or abuse, drug use or abuse, domestic violence, anger control, health problems, or housing).

Stress & Trauma History section is the Stressful Life Events Questionnaire. This scale is a 13-item scale that asks if particular traumatic event ever happened to the respondent.

# II. SURVEY ADMINISTRATION

## A. Sample

You will be asking ***all*** persons age 18 and older who contact you and agree to meet with you if they would be willing to participate in the survey. We will continue this procedure until we have sufficient number of positive consents and completed surveys. We anticipate that we need approximately 500 positive consents which yields 500 surveys. We need this number to provide us with enough statistical "power" for us to make appropriate statistical conclusions. Please continue the survey process until you hear from one of the Principal Investigators or the Project Coordinator that you can stop.

It is very important to document if the person answered "no" or "yes to giving their consent to participate. If applicable, write across the consent "refused" or the other reason why the woman is not participating by taking the survey. We will be keeping track of all contacts and whether they participate or not.

## B. Your Role

Because the survey is lengthy and contains sensitive areas of questioning, this survey will be administered face-to-face with an interviewer. A survey booklet is provided for each interview.

Women who call in on a project provided cellular phone may have seen a flyer advertising this study and eliciting their participation. Ask her if she is at least 18 years old. Then, explain to her the essence of the project. After explaining the study, ask her if she wants to participate in a study that the University of Kansas is doing to further understand the life histories of women victims.

When you set up a location and time for the interview there are a couple of important things to keep in mind. First, identify a time that is convenient for the woman, taking into account times when she is not working or otherwise engaged, as well as times when her children are in daycare or school. Because the interviews involve extremely sensitive topics, it is important that women try not to bring their children. Second, identify a place that is accessible to the woman, taking into account what her transportation options are. This may include a local social service agency, a coffee shop or restaurant. It is important that she will feel that the location is confidential.

Your role "in a nutshell" for the survey process is as follows: 1) put the unique identifier number on the consent form, 2) explain the purpose of the study and the participant's rights and obtain her consent or refusal, 3) (if yes) put the identifier number on the survey, 4) when you have completed administering the survey, write in the time of completion of the survey, on the survey, 5) place the survey and consent

form in the legal envelope provided and write the unique identifier number on the outside of the envelope, and 7) mail the envelope to the Project Coordinator.

***WE WILL NEED A CONSENT/REFUSAL FORM FOR ALL WOMEN WHO AGREE TO MEET WITH THE SURVEY ADMINISTRATOR!!!! PLEASE REMEMBER TO PUT THE PERSON'S UNIQUE IDENTIFIER NUMBER ON THE CONSENT FORM, THE SURVEY, AND ON THE ENVELOPE!!!***

# THE SURVEY PROCESS

**FOLLOW ROUTINE CALLING PROCEDURES**

**CONSENT PROCEDURE AT TIME THE MEETING OCCURS**

1. PUT **IDENTIFIER NUMBER** ON THE CONSENT FORM (See page 14 for instructions)
2. EXPLAIN THE CONTENTS OF THE CONSENT FORM
3. ASK IF THEY WANT TO PARTICIPATE
4. HAVE THEM SIGN THE CONSENT FORM
5. WITNESS FORM

***IF YES***,

1. PUT THE IDENTIFIER NUMBER AND THE DATE & TIME THE SURVEY BEGINS ON SURVEY
2. GIVE A COPY OF THE SURVEY TO THE PARTICIPANT TO FOLLOW AS YOU ADMINISTER THE SURVEY
3. BE SURE YOU ARE LOCATED IN A PRIVATE OR SEMI-PRIVATE AREA
4. WHEN COMPLETED HAVE THE PARTICIPATE WRITE TIME OF COMPLETION ON SURVEY, PLACE THE SURVEY AND CONSENT FORM IN MANILA ENVELOPE AND SEAL
5. PLACE THE IDENTIFIER NUMBER ON ENVELOPE
6. SAFEGUARD THE ENVELOPE UNTIL DELIVERED TO THE PROJECT COORDINATOR

***IF NO,***

1. MARK "REFUSED" ON THE CONSENT FORM ALONG WITH THE IDENTIFIER NUMBER.
2. PLACE THE CONSENT FORM IN ENVELOPE AND DELIVER TO THE PROJECT COORDINATOR

***AT LEAST ONCE A WEEK,***

ARRANGE FOR COMPLETED CONSENT FORMS AND SURVEYS TO BE DELIVERED TO THE PROJECT COORDINATOR

**Respondent Identification Number Procedure**

The identification number consists of three parts:

**Part I. Location Code**

| Location | Code |
|---|---|
| Kansas City | KC |
| Topeka | T |
| Wichita | W |
| Garden City | GC |
| Topeka Correctional Facility | TCF + A through J (Cell house number) |

**Part II. Date**

| Date | Code |
|---|---|
| February 20 | 0220 |
| November 5 | 1105 |

**Part III. First Letter of First Name**

**Examples of Respondent Identification Numbers:**

1. Interviewing Maria in Garden City on March 15

   Respondent ID Number GC0315M

2. Interviewing Susan in Kansas City on June 1

   Respondent ID Number KC0601S

3. Interviewing Becky at TCF from Cell house E on October 31

   Respondent ID Number TCFE1031B

## C. Techniques for Obtaining Consent

A consent form must be obtained from each participant ***before*** they are interviewed.

Explaining the Consent:

The following items should be ***emphasized*** when obtaining the consent:

1) Explain the project and purpose.

   "The University of Kansas is … . The results will help us better design early screening and intervention tools and policy and procedures to …. I'd like to explain this consent form, and then you will have the option to participate in the study."

2) All women who contact us and identify as being victims of physical and possibly other forms of violence are being asked to participate in this study.

3) There are several benefits to participation in this study. First, the women in the community will be getting paid for their time and the women in the correctional facility will have an opportunity to attend a support group. Second, there may be a therapeutic or empowering effect of having told their story. Third, telling their story may make lives better in the future for women who have experiences similar to theirs through improved service delivery.

4) If during or after the survey, they feel any emotional discomfort from the survey, you will provide them with helpful resources in the community and, if applicable, in the facility, that they can contact.

5) All information provided will be kept confidential with the exception of reports to harm oneself or others, which by law the study personnel are required to report. Information that the researchers receive will only have unique identifier numbers, ***no names.***

6) Their participation will not affect their case disposition or care that they receive within the facility or in the community.

7) Participation is ***strictly*** voluntary. Even after signing the consent, the person can terminate her participation at any time, without penalty.

8) A participant may choose not to answer certain questions.

9) There are two parts to the consent for women incarcerated in the Topeka Correctional Institute for Women: the consent to participate and the consent for release of information in the records by booking number.

Techniques for Obtaining Consent

Your relationship with the person when you first talk with her is very important. In the crucial first minutes of your phone contact you must convince the person that the routine screening information that you gather is to determine whether they can be considered for an important study that will help describe how women victims of violence have managed their lives.

If the woman meets the criteria for survey administration, you must arrange a meeting time and place. Encourage the woman to name a public place where she will feel comfortable talking with you and answering the survey questions.

When you meet with the woman, you must explain to her the nature and objectives of this research project.

You want to convince them that this is an important and worthwhile project, and their participation is vital to the research success. You and your words must convey your credibility. You should be serious, pleasant, and self-confident, that you, yourself, believe this is important.

You should be prepared to answer in a calm, professional manner, any questions the participant might ask. In order to do this you must learn as much about the study as you can and write out your explanations in your own words. This serves to focus your thoughts and reinforce your confidence. You should have several different explanations and approaches ready so as to adjust your introduction to suit the person you are talking to. Approach each person as if s/he were friendly and interested. You should assume that if they aren't, it is because they are not yet informed about what we are doing. Listen carefully to what she has to say, the tone of their voice, any background noises, and respond accordingly. Some subjects will be quite willing to participate with only a brief explanation of purpose; for others you will need to go into some detail. It is best to begin with a brief explanation and save your more detailed explanation to use as needed. Don't overwhelm the person with more information than they want or need. Talk to them, not at them. If they believe you are really interested in what they have to say, they are more likely to participate.

Your state of mind is often reflected in your respondent's reaction. If your approach is uncertain or uneasy, this feeling will be communicated to the respondent who will react accordingly. If you have a pleasant, positive, and well-informed approach, this again will be reflected in the respondent's attitude. Your effectiveness will be increased by the knowledge that survey research is legitimate and important.

Rights and Responsibilities/Confidentiality

***Confidentiality*** means that information is not shared outside the setting where it was obtained; it is kept secret or private. There are several types of confidentiality involved with this study.

1) Employee/Researcher confidentiality means that personal information will not be shared outside the project staff.

2) Respondent confidentiality means that we will not reveal the names of the women who participated in the study. Actually the researchers will have only the unique numerical identifiers and thus will not have names available to them. When they share the results of the study with others, no individual's responses can be identified. It also means that the researchers at the University of Kansas will not discuss any personal information that they learn during the course of any survey with anyone including agency staff except where they might be required by law if plans to hurt others are revealed. Please see the section "Confidentiality Policy" for other ways that we will protect the information we collect.

3) Community confidentiality means that we safeguard the identity of the specific setting in which this research takes place unless agreed upon with appropriate persons when talking or writing about the results in public forums. When referencing the setting, research staff can say five distinct communities located in the "Midwest".

4) Exceptions to confidentiality occur when someone may be dangerous to himself/herself or others. However, research staff will not receive the surveys until almost a week after the survey is completed and then not analyzed for months later. There will be weekly mailings of the survey to the University. Thus, this process can prolong any reporting.

5) Survey Confidentiality means that the survey materials that we will be using are not to be shared with anyone except research staff. It is important to let respondents in the study know what the study is about and the nature of the questions we will be asking (see Rights of Research Participants). However, we will not show individual survey materials to people outside of the study. These materials are tools for research that are only to be used by people who have been trained to administer them. Always keep the completed surveys in a safe place.

## C. When to Delay the Survey

This issue is pretty simple***. Delay the survey process anytime that you would delay any interview*** – if the person becomes emotionally distraught, if their children are being disruptive or need attention, in combative situations or when the person appears to be intoxicated, or mentally or physically impaired. You should indicate to the person that their consent is only valid if they provide it having their full intellectual and emotional facilities and that you are forbidden by the Principal Investigators from administering the survey if these personal conditions are not met.

**There are only two times when not to ask women to participate: 1) If they are under the age of 18. Please mark the consent form of this, and 2) If you are unable to obtain a signed consent. Again, in the latter case please mark the consent form "refused."**

## D. When to Make A Referral

During the survey, some questions may bring back painful memories or stir up emotions. We do not expect this to happen very often. However, we need to be aware that this is a possibility. If the situation arises, use your normal mental health referral policy and procedure. If a respondent becomes emotional, you should ask if they need a break. You may also indicate that you will provide them with resources to assist them at the end of the survey administration. The respondent can then decide if they would like to receive this information. Since we also need to be made aware of this, please document that a break was needed, that a referral was made, and / or that a list of area or appropriate state resources was provided.

If a women incarcerated at the Topeka Correctional Institute for Women requests a mental health referral, notify the institution's mental health staff. If an incarcerated woman does not request or refuses mental health intervention but seems upset, ask her to take a brochure or other written referral information in case she changes her mind and wishes to seek emergency assistance.

***For any situation that makes you uncomfortable or seems out of the ordinary, please contact the Project Coordinator.***

# IV. ADMINISTRATION

## A. Mailing the surveys to the University of Kansas

After you complete each survey, please put the survey and consent form in the envelope provided as soon as possible. The envelope will be pre-stamped and pre-addressed.

Remember that the information contained in these documents is **confidential**. Be sure these documents are not accessible to anyone.

## B. Questions & Contact Information

Please do not hesitate to contact the Project Coordinator, Loretta Pyles, if you need anything:

Loretta Pyles
University of Kansas School of Social Welfare
118 Twente Hall
Lawrence, KS 66044
785-864-1047 (W)
785-760-3739 (Cell)
lpyles@ku.edu (E-mail)

For questions about payment or reimbursement, contact:

Sarah Potter
Grants Administrator
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Table J.1: **Physical Intimate Partner Violence - Individual Items**

| How often has an intimate partner done the following? | **Total (n=423)** | **Communities (n= 109)** | **DV /SA Agencies (n=157)** | **Prison (n= 157)** |
|---|---|---|---|---|
| **Pushed, grabbed, or shoved you** ** | | | | |
| Never | 12.3 | 28.4 | 7.7 | 5.7 |
| Rarely | 12.3 | 17.4 | 12.8 | 8.3 |
| Sometimes | 17.5 | 16.5 | 21.8 | 14.0 |
| Often | 19.4 | 8.3 | 17.3 | 29.3 |
| Very Often | 38.4 | 29.4 | 40.4 | 42.7 |
| **Slapped, hit, or punched you** ** | | | | |
| Never | 19.2 | 38.5 | 15.4 | 9.6 |
| Rarely | 15.4 | 19.3 | 17.9 | 10.2 |
| Sometimes | 15.4 | 8.3 | 18.6 | 17.2 |
| Often | 18.5 | 13.8 | 15.4 | 24.8 |
| Very Often | 31.5 | 20.2 | 32.7 | 38.2 |
| **Pressured you to have sex in a way that you didn't like or want** ** | | | | |
| Never | 34.4 | 50.9 | 25.0 | 32.5 |
| Rarely | 14.0 | 11.1 | 15.4 | 14.6 |
| Sometimes | 20.0 | 10.2 | 23.7 | 22.9 |
| Often | 10.7 | 10.2 | 8.3 | 13.4 |
| Very Often | 20.9 | 17.6 | 27.6 | 16.6 |
| **Spanked you** | | | | |
| Never | 71.0 | 76.1 | 74.2 | 64.3 |
| Rarely | 9.7 | 6.4 | 7.1 | 14.6 |
| Sometimes | 10.7 | 11.0 | 8.4 | 12.7 |
| Often | 2.9 | 1.8 | 3.9 | 2.5 |
| Very Often | 5.7 | 4.6 | 6.5 | 5.7 |
| **Kicked you** ** | | | | |
| Never | 43.0% | 60.2% | 46.8% | 27.4% |
| Rarely | 11.9 | 12.0 | 9.0 | 14.6 |
| Sometimes | 17.6 | 14.8 | 15.4 | 21.7 |
| Often | 9.3 | 2.8 | 7.1 | 15.9 |
| Very Often | 18.3 | 10.2 | 21.8 | 20.4 |
| **Physically forced you to have sex** | | | | |
| Never | 48.6 | 57.8 | 48.7 | 42.0 |
| Rarely | 13.3 | 14.7 | 10.9 | 14.6 |
| Sometimes | 15.6 | 7.3 | 16.7 | 20.4 |
| Often | 9.0 | 7.3 | 8.3 | 10.8 |
| Very Often | 13.5 | 12.8 | 15.4 | 12.1 |
| **Threw you around** ** | | | | |
| Never | 29.6 | 55.0 | 23.7 | 17.8 |
| Rarely | 11.8 | 6.4 | 17.3 | 10.2 |
| Sometimes | 20.9 | 12.8 | 21.8 | 25.5 |
| Often | 18.5 | 13.8 | 15.4 | 24.8 |
| Very Often | 19.2 | 11.9 | 21.8 | 21.7 |
| **Physically attacked the sexual parts of your body** | | | | |
| Never | 59.7 | 72.5 | 57.7 | 52.9 |
| Rarely | 15.4 | 10.1 | 13.5 | 21.0 |
| Sometimes | 9.2 | 6.4 | 8.3 | 12.1 |
| Often | 6.9 | 5.5 | 9.6 | 5.1 |
| Very Often | 8.8 | 5.5 | 10.9 | 8.9 |

| How often has an intimate partner done the following? | **Total (n=423)** | **Communities (n= 109)** | **DV /SA Agencies (n=157)** | **Prison (n= 157)** |
|---|---|---|---|---|
| **Choked or strangled you** ** | | | | |
| Never | 39.1 | 56.0 | 37.8 | 28.7 |
| Rarely | 16.8 | 11.9 | 22.4 | 14.6 |
| Sometimes | 20.1 | 11.9 | 17.9 | 28.0 |
| Often | 9.0 | 8.3 | 7.1 | 11.5 |
| Very Often | 14.9 | 11.9 | 14.7 | 17.2 |
| **Used a knife, gun, or other weapon against you** | | | | |
| Never | 55.7 | 67.0 | 59.6 | 43.9 |
| Rarely | 17.5 | 12.8 | 15.4 | 22.9 |
| Sometimes | 11.4 | 6.4 | 10.9 | 15.3 |
| Often | 6.2 | 7.3 | 5.1 | 6.4 |
| Very Often | 9.2 | 6.4 | 9.0 | 11.5 |

* Difference between the three groups significant at .01 level

**Difference between the three groups significant at .001 level

Table J.2: **Correlations of Services Used and Adult Outcomes**

| | Physical Health | Mental Health | Depres-sion | PTSD | Incarcera-tion | Alcohol Problem | Drug Problem | Suicide Attempt |
|---|---|---|---|---|---|---|---|---|
| Emotional support | | | | | | | | |
| Support group | -.105* | -.138* | | -.140* | -.097* | .168** | | |
| Professional counseling | -.147* | -.130* | | | | .162** | | |
| Hospital stay | -.227** | -.209** | -.170** | -.142* | | .104* | | .190* |
| DV shelter | -.064 | -.226** | -.237** | -.220** | -.156** | .130* | | |
| Homeless shelter | -.183** | -.136* | | | | | .125* | |
| Medical provider | -.166** | -.132* | | | | .126* | | .141* |
| Psychotropic medication | -.180** | -.177** | -.185** | -.192** | .139* | .156** | .224** | .238** |
| Subsidized housing | -.170** | -.156** | -.136* | -.137* | -.106* | | | |
| Food bank | -.203** | -.174** | | | | .164** | .246** | |
| Welfare | -.097* | -.135* | | -.146* | | .126* | .191** | |
| Job training | | | | | | | | |
| Education support | | | | | | | .102* | |
| Unemployment | | | | | | | | |
| Workers comp. | -.156** | | | | | | | |
| Vocational Rehab | -.126* | | | | | | | |
| Daycare support | | | | | | | | |
| Reproductive services | -.098* | | | | | | | |
| Medication | -.264** | -.333** | | | .097* | .228** | .186** | .183* |
| Rape crisis services | | -.179** | -.288** | -.334** | | | | |
| Legal services | | | -.178** | -.201** | | | | .130* |
| Child protective services | | | | | | | | |
| Religious counseling | -.104* | -.114* | | | | | | |
| Internet support group | | | | | | | | |

*Correlation is significant at the 0.01 level

**Correlation is significant at the 0.001 level

Table J.3: **Correlations of Barriers to Seeking Services and Adult Outcomes**

| Barrier | Physical Health | Mental Health | Depres-sion | PTSD | Incarcer-ation | Alcohol Problem | Drug Problem | Suicide Attempt |
|---|---|---|---|---|---|---|---|---|
| I wanted to handle the problem on my own | | | | .131* | | .110* | | |
| I thought problem would get better by itself | | | .131* | .177** | | .112* | | |
| I was unsure about where to go or who to see | -.207** | -.286** | .272** | .328** | | | | |
| I didn't think treatment would work | | -.125* | .177** | .173** | .105* | | | |
| I was concerned about how much money it would cost | -.201** | -.266** | .238** | .252** | -.150* | .102* | | |
| I had problems with things like transportation or scheduling that made it hard to get to the services | -.238** | -.309** | .282** | .319** | | .135* | .155* | |
| The problem didn't bother me very much at first | | | | | | | | |
| I was concerned about what people would think if they found out I was in treatment | | -.164** | .156* | .225** | | | | |
| I thought it would take too much time or would be inconvenient | -.153* | -.170** | .175** | .211** | | | | |
| I was scared about being put in hospital against my will | -.249** | -.303** | .313** | .328** | | | | |
| My health insurance would not cover services | -.097* | -.177** | .194** | .170** | | | | |
| I received services before and it didn't work | -.112* | -.158** | .169* | .173** | | .188** | .121* | .205** |
| I was not satisfied with available services | -.198** | -.241** | .180** | .176** | | | | |
| I could not get an appointment | -.109* | -.110* | .178** | .145* | | | | |

* Correlation is significant at .01 level.

** Correlation is significant at .001 level.