Introduction

Take a moment to think about the words “domestic violence.” What images come to mind? Do you think about a submissive, middle aged-woman being beaten by her alcoholic husband? Do you think ‘why doesn’t she just leave?’ or ‘Not in my practice, hospital or agency.’ The reality of domestic violence is that while these stereotypes fit some situations, they do not even begin to touch upon the scope of the problem. Many mental health practitioners are working with clients experiencing current domestic violence, and are unaware that it is occurring because of the shame that is often associated with it.

The National Coalition Against Domestic Violence defines domestic violence as “the willful intimidation, physical assault, battery, sexual assault, and/or other abusive behavior perpetrated by an intimate partner against another.” While there have been studies of domestic violence from a cultural perspective, domestic violence affects individuals in every community, regardless of age, economic status, race, religion, nationality or educational background. Domestic violence is often accompanied by emotionally abusive or controlling behavior, and thus is part of a systematic pattern of dominance and control. There are many consequences associated with domestic violence including physical injury, psychological trauma, and sometimes death.

There are factors that often occur co-morbidly with domestic violence, including family dysfunction, inadequate communication skills, stress and economic hardship. Alcohol abuse is present in about 50 percent of battering relationships. Personality disorders and mental illness may also compound domestic violence. While these issues are associated with the domestic abuse, they are not the cause, nor will the removal of these factors mitigate or stop it.

This course will provide an introduction to domestic violence, including prevalence and impact, cultural factors, same gender abuse dynamics, intervention strategies and community resources. The terms domestic violence, domestic abuse, and intimate partner violence will be used interchangeably throughout the text. The author has chosen to limit use of the word “battering,” which although still prevalent in the popular lexicon may suggest that domestic violence is confined to physical violence only.
Upon completion of this course participants will:

**Educational Objectives:**

1. Define domestic violence and the term “intimate partner.”
2. Discuss common patterns of abusive behavior.
3. Describe some factors associated with domestic violence.
4. Discuss mental health effects of domestic violence, including depression and posttraumatic stress disorder.
5. Discuss prevalence and types of abuse among Gay, Lesbian, Bisexual and Transgendered (GBLT) Relationships.
6. Discuss barriers to treatment and treatment recommendations for GBLT relationships.

**Defining Domestic Violence**

*Case Vignette*

Sarah Ann is consulting with Dr. Jenkins. During the intake Dr. Jenkins is aware of a number of behaviors which draw his attention to the idea that Sarah Ann may be experiencing domestic abuse. When asked about her marital status, she fearfully replies that she is married, and asks whether Dr. Jenkins will be talking to her husband. Similar concerns arise when Dr. Jenkins describes confidentiality. When Dr. Jenkins gently reflects that Sarah Ann seems scared and asks for the source of her fears, Sarah Ann breaks down and reveals that her husband had become increasingly angry and frustrated, that he had pushed her roughly, and that she was fearful that he could become violent.

Domestic violence is often called battering or wife beating, however, domestic violence is not limited to physical abuse, but most often includes other types of violence. The Introduction provided a more comprehensive definition of domestic violence (also called intimate partner violence): “the willful intimidation, physical assault, battery, sexual assault, and/or other abusive behavior perpetrated by an intimate partner against another.”

There is some variability in the use of the term “intimate partner.” This also relates to the varying perspectives of domestic violence (e.g., psychological, legal). The varying perspectives on domestic violence will be detailed in a subsequent section of this material. With regard to the legal definition, states differ on the type of relationship that qualifies under domestic violence laws. Most states require the perpetrator and victim to be current or former spouses, living together, or have a child in common. A significant number of states include current or former dating relationships in domestic violence laws. Delaware, Montana and South Carolina specifically exclude same-sex relationships in their domestic violence laws.
This training material will take a broader view of the definition of intimate partner, defining the term as a particularly close interpersonal relationship that involves physical or emotional intimacy. With this broad definition, intimate partners may be married, unmarried, heterosexual, gay, or lesbian; living together, separated or dating, spouses or ex-spouses, nonmarried co-habiting partners or partners in a romantic relationship. Intimate partners can also be any age, including teens and the elderly.

While the majority of reported domestic violence occurs against women, men are also victims of domestic violence. According to a study by Tjaden and Thoennes (2000) 835,000 men in a national survey reported being victims of domestic violence. Domestic violence against men can take many forms, including emotional, sexual and physical abuse and threats of abuse. It can happen in heterosexual or same sex relationships. As with many forms of abuse, these numbers are likely underreported due to misunderstanding of the definition of domestic violence and the shame that men may feel in identifying themselves as abuse survivors.

Examples of domestic violence include (Berry, 2000):

**Intimidation or emotional abuse.** Emotional abuse (also called psychological abuse or mental abuse) includes behaviors that make the person feel diminished or embarrassed. Emotional abuse can include verbal abuse and is defined as any behavior that threatens, intimidates, undermines the victim’s self-worth or self-esteem, or controls the victim’s freedom (Follingstad, & DeHart, 2000) This can include threatening the victim with injury or harm, telling the victim that they will be killed if they ever leave the relationship, and public humiliation. Abusers will often employ criticism and fault-finding, which may be a precursor to physical violence, but may also accompany it. This may also include withholding money or affection as a means of controlling the other person, threatening abandonment, hurting or threatening children or pets, or isolating the person from friends and family.

**Economic or financial abuse.** Abusive partners may use access to money as a means of control. Economic or financial abuse includes: withholding money or credit cards, withholding basic necessities (food, clothes, medications, shelter), sabotaging the person’s job (such as making them miss work or calling constantly), stealing from you or taking money.

**Physical violence** comprises any behaviors that injure the other person or to cause physical pain. Physical abuse can also include behaviors such as denying the person needed medical care, depriving the person of sleep or other functions necessary to live, or forcing the victim to engage in drug/alcohol use against his/her will.
Sexual abuse is any situation in which force or threat is used to obtain participation in unwanted sexual activity. Sexual abuse may involve a wide range of behaviors. The important component here is that the behavior is non-consensual or makes the other person feel demeaned or violated. It may include rape, forcing someone to perform sexual acts that he/she finds unpleasant, forcing someone to have sex with others or watch others, forcing someone into reproductive decisions.

Stalking can be defined as the willful and repeated following, watching and/or harassing of another person. While stalking does not always occur within an intimate partner relationship, it has become an area of increasing concern in the domestic violence literature.

Case Vignette
Jennifer has recently separated from her husband Jon and plans to file for divorce. She has been subjected to repeated phone calls, text messages, and emails telling her that Jon will “never let her go.” The content infers that he has intimate knowledge of her movements. Jennifer has been told by police that there is nothing they can do since the messages are not “threatening.” Most recently, Jennifer’s has begun to receive “gifts,” of flowers and chocolates, which appear on her apartment doorstep and car windshield. She is certain they are from Jon. Jennifer describes feeling as if she is in a constant state of panic.

Nearly 60 percent of women and 30 percent of men are stalked by a current partner (Tjaden & Thoennes, 1998.) The majority of stalking victims are women (78 percent), and the majority of offenders (87 percent) are men. (Tjaden & Thoennes, 1998).

As in the case vignette, stalking can be seen as "a course of conduct directed at a specific person that involves repeated (two or more occasions) visual or physical proximity, nonconsensual communication, or verbal, written, or implied threats, or a combination thereof, that would cause a reasonable person fear" (Tjaden & Thoennes, 1998). While there is a range of stalking behaviors, they may include leaving or sending the victim unwanted items or presents, damaging the victim’s home, car or other property, following or waiting for the victim, or leaving unwanted messages or other actions intended to control the victim.

With increasing use of technology, cyberstalking has become more prevalent. Some examples of cyberstalking are: researching the victim using public records or on-line search services, monitoring phone calls or computer use, and using technology, like hidden cameras or global positioning systems (GPS), to track the victim’s movements.
Like other forms of domestic violence, stalking usually escalates. It is a behavior that should be taken seriously and mental health clinicians may benefit from being aware of specific laws in their states of practice.
Prevalence of Domestic Violence

How widespread is domestic violence? Domestic violence is one of the most chronically underreported crimes (U.S. Department of Justice, Bureau of Justice Statistics, 2003). There is a great deal of stigma associated with intimate partner violence. While there are many reasons for stigma, Mitchell and Anglin (2009) believe that victims of domestic violence feel that the abuse is a result of a personal flaw and do not disclose the abuse due to shame. There are other reasons as well including family loyalty, fears of breaking up a family, and distrust of authority and the efficacy of authority figures.

It is believed that only one-quarter of all physical assaults, one-fifth of all rapes, and one-half of all stalkings perpetuated against females by intimate partners are reported to the police (Tjaden, & Thoennes, 2000).

Research on intimate partner violence against women has exploded in the past 20 years, but despite this increase in research, many gaps exist in our understanding of domestic violence. To further understanding of domestic violence against women, the National Institute of Justice and the Centers for Disease Control and Prevention conducted a national survey entitled *The National Violence Against Women (NVAW) Survey* (Tjaden, & Thoennes, 2000). The researchers sampled both women and men.

Some of the key findings are:

- Physical assault is widespread among adults: An estimated 1.9 million women and 3.2 million men are physically assaulted annually in the United States.

- Approximately 1.3 million women and 835,000 men are physically assaulted by an intimate partner annually in the United States.

- Violence against women is primarily intimate partner violence: 64.0 percent of the women who reported being raped, physically assaulted, and/or stalked since age 18 were victimized by a current or former husband, cohabiting partner, boyfriend, or date. 16.2 percent of the men who reported being raped and/or physically assaulted since age 18 were victimized by such a perpetrator.

- Stalking is more prevalent than previously thought: 8.1 percent of surveyed women and 2.2 percent of surveyed men reported being stalked at some time in their life; 1.0 percent of women surveyed and 0.4 percent of men surveyed reported being stalked in the 12 months preceding the survey. Approximately 1 million women and 371,000 men are stalked annually in the United States.
• Almost one-third of female homicide victims that are reported in police records are killed by an intimate partner. In 70-80% of intimate partner homicides, no matter which partner was killed, the man physically abused the woman before the murder (Campbell et. al., 2003).

• For both men and women, divorced or separated persons were subjected to highest rates of intimate partner victimization, followed by never-married persons (Rennison, & Welchans, 2000).

While these numbers are eye-opening, domestic violence impacts other areas as well. Intimate partner violence results in more than 18.5 million mental health care visits each year; the cost of intimate partner violence exceeds $5.8 billion each year, $4.1 billion of which is for direct medical and mental health services (CDC, 2003).

With prevalence ratings this significant, it is likely that most mental health professionals will work with a current or past victim of intimate partner violence.

Theories on Domestic Violence

While have been many efforts to explain why domestic violence occurs, there is no one explanation. While a common understanding of the causes of domestic violence can help practitioners develop more effective responses to domestic violence, this is not an easy task with the many perspectives regarding intimate partner violence. Mitchell and Anglin (2009) summarize this in the chart below. Several of these perspectives will be detailed further.

<table>
<thead>
<tr>
<th>Group</th>
<th>Population studied</th>
<th>Conceptualization</th>
</tr>
</thead>
<tbody>
<tr>
<td>Psychological/Medical</td>
<td>Patients seeking care</td>
<td>Violence as a result of frustration; as a cause of presenting symptoms; trauma response</td>
</tr>
<tr>
<td>“Family Violence” Researchers</td>
<td>College students, general population</td>
<td>Violence as a response to intermittent conflict</td>
</tr>
<tr>
<td>Domestic Violence Movement, Feminist</td>
<td>Women seeking services; men in “batterer” programs</td>
<td>Violence is part of a coercive pattern of behavior meant to establish power and control</td>
</tr>
<tr>
<td>Legal System</td>
<td>Crime victims and perpetrators</td>
<td>Violence as a criminal act</td>
</tr>
</tbody>
</table>

Although many of these systems may seem to offer contradictory views of domestic abuse, another perspective is that they can all provide information that increases understanding of domestic violence.
Psychological Framework

Frustration-Aggression Theory

Dollard (1939) was one of the first writers to identify a theory that was applied to intimate partner violence: the frustration-aggression theory. Simply put, the theory states that when people perceive that they are being prevented from achieving a goal, their frustration is likely to turn to aggression. Aggression, then, is seen as an instinctual response to frustration. When applied to intimate partner violence, marital/dating relationships can trigger anger (justified frustration) or aggression (unjustified frustration).

Social Learning Theory

The Social Learning Theory is a popular way to explain violent behavior. Social learning theorists reject the idea of instinct, and instead believe that “human aggression is learned conduct that, like other forms of social behavior, is under stimulus, reinforcement, and cognitive control.”

According to social learning theory, family violence arises due to many contextual and situational factors. Examples of contextual factors include individual/couple characteristics, stress, or an aggressive personality. Situational factors include substance abuse and financial difficulties. Social learning theory also extends these factors onto the influence of children growing up in families in which these external forces exist (Domestic Violence Group Action Project).

Although the relationship is not entirely straightforward, there does seem to be some support for the learned behavior theory of violence. The strongest risk factor for males who become perpetrators of domestic violence is witnessing violence between one’s parents or caretakers (Break the Cycle, 2006). Boys who witness domestic violence are twice as likely to abuse their own partners and children when they become adults (Strauss, Gelles & Smith, 1990) 30% to 60% of perpetrators of intimate partner violence also abuse children in the household (Edelson, 1999). Witnessing violence in the home seems to provide these young men with lessons that validate that it’s appropriate to control women and that physically acting out is one way to do so.

The relationship between witnessing domestic violence and acting out or entering an abusive relationship is not as clear-cut for women. There have been virtually no studies of women who become domestic abusers. Research does show that women who witness domestic violence are not any more likely to be battered as adults. Women who were physically or sexually abused as children, however, may be more likely to be abused as adults (Family Violence Prevention Fund).

Cognitive-Behavioral Theories
Cognitive-Behavioral theorists look at how a person perceives, interprets, and processes the events in any given situation (Todd & Bohart, 1994). Aggressive behaviors are influenced by what a person perceives and interprets prior to the aggression. Changing these thought patterns, then, will contribute to a change in behavior.

CBT also emphasizes that violence and aggression are choices. People cannot be ‘forced’ to act abusively, a cognitive-behavioral approach encourages the individual to acknowledge that they chose to behave in the way that they do.

A common CBT intervention is an anger log. This log encourages individuals to monitor and record the thoughts and behaviors which immediately preceded violent outbursts (Koonin, Cabarcas, & Geffner, 2002). This anger log is like other cognitive-behavioral thought logs but also includes awareness of the person’s physiology prior to aggression.

**Feminist/Domestic Violence Movement Framework**

Emphasis on the importance of addressing domestic violence dates to the 1970s, which also coincides with a boom in feminist approaches to psychology. The feminist/domestic violence movement explains domestic violence as a result of “historically created gender hierarchy and sexual division of labor in the home, in which men dominate and control women” (Messerschmidt, 1986). In addition to looking at power/gender inequalities, an important part of the feminist approach is in educating society about the problem of intimate partner violence.

Many authors have written about the link between domestic violence and power and control dynamics in the relationship. One commonly used paradigm is The *Power and Control Wheel* (Domestic Intervention Programs, Duluth, Minnesota). It was developed based on focus groups of women who had been victims of domestic abuse.

The *Power and Control Wheel* describes the different tactics that are used by abusive individuals to maintain power and control over a partner. The Wheel is depicted below.
What is significant about this depiction is that it looks at domestic violence as part of a larger pattern of behavior rather than a single (although repeated) loss of control.

As an outgrowth of other research, domestic violence professionals have attempted to look at individual and familial variables in domestic violence. Crowell (1996) was one of the first researchers to conduct a study of family violence in the United States. She correlated domestic violence with households below the poverty line, racial minority households, and heads of household being 18-30 years old. These characteristic produced high degrees of stress. Straus et al. (1990) found that in middle or upper class households, family violence was much more sheltered.

There is also a body of research and antidotal information on individual factors that may heighten the risk of potential abuse (Alabama Coalition of Domestic Violence). Males who abuse may display the following:

- Jealousy
- Controlling behavior
- Quick involvement
- Unrealistic expectations
- Isolation of victim
- Blames others for his problems
- Blames others for his feelings
- Hypersensitivity
- Cruelty to animals or children
- History of past battering
- Threats of violence
- Breaking or striking objects
- Any force during an argument
- Objectification of women
- Tight control over finances
- Minimization of the violence
- Manipulation through guilt
- Extreme highs and lows
• "Playful" use of force during sex
• Verbal abuse
• Rigid sex roles
• “Jekyll and Hyde” personality
• Expects her to follow his orders
• Frightening rage
• Use of physical force
• Closed mindedness

In addition to identifying the characteristics of abusive men, domestic violence researchers have also developed a schema for what they term the “cycle of abuse. This classic conceptualization was developed by Lenore Walker in the 1970s (Walker, 1979).

**Tension Building Phase**
Characterized by poor communication, tension, fear of causing outbursts. During this stage the victims try to calm the abuser down, to avoid any major violent confrontations.

**Violent Episode**
Characterized by outbursts of violent, abusive incidents. During this stage the abuser attempts to dominate his/her partner(victim), with the use of domestic violence.

**Honeymoon Phase**
Characterized by affection, apology, and apparent end of violence. During this stage the abuser feels overwhelming feelings of remorse and sadness. Some abusers walk away from the situation, while others shower their victims with love and affection.

**Calm phase**
During this phase (which is often considered an element of the honeymoon/reconciliation phase), the relationship is relatively calm and peaceable. However, interpersonal difficulties will inevitably arise, leading again to the tension building phase.

**Case Vignette**
Anna has been attending therapy sessions, a bold move considering how fearful she is that her physically abusive husband will discover it. Following a particularly brutal encounter, she tells her therapist that she feels that her husband has “finally made a change.” He appears attentive, and has even brought her flowers, something that has not occurred since their earliest years together. Although her therapist cautions that abusive situations are very difficult to change without therapy and support, Anna is shocked when he again hurts her after an argument.
Integrative Models

The Socio-Ecological Model

The Socio-Ecological Model (Heise, 1998) attempts to integrate many of these approaches as a means of creating change. As depicted in the graphic below, this model places individual characteristics within the family/relationship, the individual and family within the community, and the individual, family and community within society.

When applied to domestic violence prevention, this framework allows for development of specific interventions. For example, an individual factor may include use of power and control, and an appropriate strategy may be coaching. This must be viewed, however, within the larger societal context. For example, domestic violence may be associated with historical patterns that glorify violence against women and a strategy may include public education campaigns.

Warning Signs of Abuse

The following warning signs may alert practitioners to the possibility of abuse.

Psychological warning signs of abuse

- Depression, anxiety, or suicidality or post traumatic stress symptoms.
- Clients that display outbursts of anger or poor impulse control.
- Clients that display extreme hypervigilance.
- Clients that have very low self-esteem, or report that they used to be confident.
- Clients that demonstrate major personality changes (e.g. an outgoing person becomes withdrawn).
General warning signs of domestic abuse
- Secrecy about entering therapy, in particular keeping the decision from a partner or spouse.
- Clients that seem overly afraid or anxious to please their partner, or who go along with everything their partner says and does.
- Clients that check in often with their partner to report where they are and what they’re doing.
- Clients that receive frequent, harassing phone calls from their partner or who are constantly checking the cell phones for messages from a partner.
- Client who talk about their partner’s temper, jealousy, or possessiveness.

Warning signs of physical abuse
- Clients that have frequent injuries, with the excuse of “accidents.”
- Frequently missing appointments without explanation.
- Clients that dress in clothing designed to hide bruises or scars (e.g., wearing long sleeves in the summer or sunglasses indoors).

Warning signs of isolation
- Clients who report being restricted from seeing family and friends.
- Clients that rarely go out in public without their partner.
- Clients that have limited access to money, credit cards, or the car.

The Impact of Abuse

Case Vignette
Dr. Katz has been working with Kelly, a 46-year-old client for a month. The primary focus of counseling to this point in time has been Kelly’s anxiety. As a nurse at a local hospital, she has talked about the stresses that job entails. Dr. Katz is surprised, however, to learn that Kelly has been fired from her position. As she breaks down in Dr. Katz’s office, Kelly reveals that the termination resulted from the numerous and relentless phone calls her husband had been making to her while she was at work. Her supervisor was concerned that she was unable to focus on her patients and when she did make a relatively minor mistake with some medication, Kelly was terminated. As Dr. Katz probes, he realizes that Kelly has been dealing with domestic violence.

As the case vignette illustrates, domestic violence has many potential effects on its victims. Like Kelly, many men and women who are subjected to intimate partner violence do not disclose it, due to shame or fear. The reach of domestic violence is far: stress, economic hardship, psychological illness, and addiction. Like other forms of trauma, intimate partner violence has a number of effects on its victims. However, the impact of domestic violence varies enormously between individuals. Clinicians working with victims of domestic violence should not assume that they are one homogeneous group. In addition to individual differences, it is also important to consider whether the person who has experienced domestic violence has any prior history of trauma. There are also differences in terms of the type and severity of abuse.
While these differences are important, research indicates that there are a number of long-term effects of domestic violence. These may include (Newton, 2001):

- anxiety
- chronic depression
- chronic pain
- drug and alcohol dependence
- eating disorders
- hyper vigilance
- emotional numbing
- chronic health problems
- panic attacks
- post traumatic stress symptoms
- self-injury and self-neglect
- inconsistent parenting

While domestic violence adversely affects its victims, it is important to recognize that domestic violence is a family matter in that it also affects the children in the family. These reactions can vary depending on the child's gender and age. Children exposed to family violence are more likely to develop social, emotional, psychological and or behavioral problems than those who are not. Recent studies indicates that children who witness domestic violence show more anxiety, low self esteem, depression, anger and temperament problems than children who grow up in homes where there is no trauma. The effects of family violence can continue into adulthood.

The National Coalition Against Domestic Violence defines domestic violence as “the willful intimidation, physical assault, battery, sexual assault, and/or other abusive behavior perpetrated by an intimate partner against another.” Domestic violence is displayed across a broad spectrum of cultural, economic, religious and racial groups. While this is not an exhaustive list, Kurst-Swanger and Petocsky (2003), have identified some behaviors indicative of intimate partner violence which include:

- Denying a person autonomy
- Isolating victims from family and friends
- Instilling fear through intimidation, threats and violence
- Manipulating behavior
- Punishing victims for challenging an abuser’s authority
- Unjustified jealousy
- Controlling financial resources
- Using children as a way to hurt, control or manipulate

**Common Patterns of Intimate Partner Violence**
Prior to discussing the effects of domestic partner abuse, it is helpful to understand common patterns of abuse. There is also variability in the degree of chronicity with which abusive behaviors occur. Johnson and Ferraro (2000) describe these patterns of violence:

**Common Couple Violence** - within the context of a single issue, there is one or at most two incidents of violence, and it is not used as part of a pattern of behavior to control the partner. This is similar to the “family-only” batterer, or someone who is not violent outside the home and is the least likely to be sexually and emotionally abusive. Johnson and Ferraro report this kind of batterer is about evenly split between males (56%) and females (44%), and some studies showing that in younger samples women may use more aggression than men. However, women still tend to suffer more serious injuries compared to men.

**Intimate Terrorism** – this pattern of relationship violence is centered on the abuser’s need to control his/her victim. This form of violence is likely to increase over time, to involve a higher frequency of incidents, and more serious injuries.

**Violent Resistance** - This kind of violence occurs in response to a perceived threat, and is not part of a pattern of control and manipulation.

**Mutual Violent Control** - this kind of violence occurs when two parties use violence to control each other. Johnson and Ferraro note that even in these cases some gender differences remain. In 31% of these couples, the male initiated more violence, as opposed to 8% for the female.

**Effects on Victims**

*Unexplained Physical Symptoms/Somatization*

Emotional pain is often expressed through physical pain. Studies confirm an association between domestic violence and poor physical health (Hagion-Rzepka (2000; Mitchell & Anglin, 2009). While it may seem to follow that these symptoms are a result of the person having been physically assaulted, this does not appear to be the case. Often the problems appear unrelated to physical injury.

Those who have been victims of domestic violence may exhibit a wide range of physical symptoms, a greater number of symptoms, and more severe symptoms. According to Hagion-Rzepka (2000) “The stress of being in an abusive relationship often has a physiological impact, as well as the obvious physical and psychological impact: it often increases one’s vulnerability to illness.” The following case study provides an example.
Case Vignette
Natalie, a 48-year-old woman, who has been in an emotionally abusive and controlling relationship is presenting for therapy. She states that she is there reluctantly, and knows that “the doctor just hasn’t found what is wrong.” Symptoms include diffuse pain, periods in which her fatigue is so great that she cannot get out of bed, shortness of breath, and blinding headaches. Natalie has consulted with several doctors, including her PCP, a neurologist and a cardiologist. Natalie believes that she must have a rare physical problem, but that it has not yet been found. She is upset that the doctor has referred her for therapy.

Patients with unexplained physical ailments generally first seek treatment in primary care settings, but may be even more common in neurologic settings. In addition to “unexplained” physical problems, such as chronic pain or migraine headaches, a number of symptom-based syndromes are also related to domestic violence. These include fibromyalgia, chronic fatigue syndrome, multiple chemical sensitivity, temporomandibular disorder, irritable bowel syndrome, and tinnitus (Richardson & Engel, 2004). These disorders share some important features, such as fatigue or pain, disability that is out of proportion to physical findings and stress or psychosocial factors. They also tend to effect women more than men.

The impact of abuse seems to be in large part biological. Abuse appears to activate the body’s stress responses, and the release of cortisol. While small increases in cortisol are not problematic, chronic stress has negative effects.

In addition to biology, chronic stress has psychological effects. Somatization is the idea that emotional pain and stress are expressed through bodily symptoms. While some victims of intimate partner violence may meet DSM criteria for Somatization Disorder, many do not meet the full criteria. It is helpful to recognize that trauma may underlie unexplained physical symptoms.
**DSM Criteria: Somatization Disorder**

A history of many physical complaints beginning before age 30 years that occur over a period of several years and result in treatment being sought or significant impairment of functioning.

Each of the following criteria must have been met, with individual symptoms occurring at any time during the course of the disturbance.

- 4 pain symptoms: a history of pain related to at least 4 different sites or functions
- 2 gastrointestinal symptoms: a history of at least 2 gastrointestinal symptoms other than pain
- 1 sexual symptom: a history of at least 1 sexual or reproductive symptom other than pain
- 1 pseudoneurological symptom: a history of at least 1 symptom or deficit suggesting a neurological condition not limited to pain

Either:

After appropriate investigation, each of the symptoms cannot be fully explained by a known general medical condition or the direct effects of a substance OR

When there is a related general medical condition, the physical complaints or resulting social or occupational impairment are in excess of what would be expected from the history, physical examination, or laboratory findings

The symptoms are not intentionally produced or feigned.

It is important for clinicians to be aware of the possibility that clients with chronic pain or unexplained physical symptoms (but especially with multiple symptoms) may have a history of abuse, and explore this sensitively. It is important that clinicians not express doubt as to the symptoms or imply that they are “imagined,” but rather to state that traumatic experiences can worsen the experience of pain or make physical symptoms more severe or difficult to handle.

**Other Mental Health Consequences of Domestic Violence**

Domestic abuse and other forms of violence are associated with increased risk for developing a range of psychiatric conditions — including depression, anxiety and posttraumatic stress disorder — or of exacerbating existing mental health concerns. Substance abuse, somatoform disorders, eating disorders, sexual difficulties and psychotic episodes have also been linked to adult and childhood abuse (Briere et al, 1997; McCauley et al, 1995; Poirier, 2000). Partner abuse is
also a significant risk factor for suicidality (Plichta & Weisman, 1995). What is also concerning is that living with a serious mental illness may increase a woman’s vulnerability to abuse.

Some of these prevalence statistics are as follows:

- Of 140 women attending an outpatient psychiatric clinic, 64% had a lifetime history of physical and/or sexual abuse (Surrey et al, 1990). On average, half of all women seen in a range of mental health settings have been abused by an intimate partner (Friedman & Lou, 2007).

- Among 153 women seen in a range of psychiatric settings, half had been sexually abused and 16% had been physically assaulted as children (Mueser et al, 1998). As adults, 64% had been sexually assaulted, 36% had been physically attacked, and 24% had witnessed severe violence.

- Out of 303 depressed women culled from a large random sample, 63% had experienced abuse at some point in their life (Scholle et al, 2008). 55% reported having been abused in adulthood by “a family member or someone they knew well, such as a boyfriend.”

Experiences of abuse and violence are especially high for women diagnosed with serious mental illness.

- 64% of female inpatients that had been physically assaulted as adults, 56% shared a home with the perpetrator (Jacobson and Richardson 2007).

- In one study with 66 female psychiatric inpatients, 44% had experienced physical assault as an adult (Bryer et al 1987). Of those, 59% had been assaulted by an intimate partner.

- Out of 93 women seen in a psychiatric emergency room 42% had been abused by a partner (Briere et al, 1997).

Case Vignette
Anna has been married to Mark, and has been a victim of intimate partner violence. She has been able to seek help from Dr. Frank, an outpatient psychologist. Dr. Frank has diagnosed Anna with depression, and she has begun taking medication. Anna was tearful in the last session, stating that Mark now had “more ammunition against me.” Whenever he becomes upset with her, he asks if she has taken her medication and frequently calls he “crazy.” He has also shared the fact that she is in therapy with members of her church, and is seen as a “saint” for sticking by her.
While the statistics verify the scope of mental health consequences and domestic violence, what is not reflected in the statistics is that mental illness and intimate partner violence have a circular effect. Mental illness is often cited as the impetus for incidents of family violence, particularly among those with severe mental illnesses. Additionally abuse results in more acute symptoms of these disorders, or can be a stressor underlying the mental health concern.

**Depressive Disorders**

Chief among the mental health effects of domestic violence is depression. Prevalence rates of women who have been abused by a partner range from 37.7% to 63% (Bonomi et al., 2006). One factor that increases a victim’s risk for depression is perpetrator behavior. Perpetrators often exert control, manipulate and degrade their victims, and isolate them from friends and family. When sexual abuse or assault is added to the mix, the result is even higher levels of depression.

Several studies of depression and intimate partner violence suggest that the strongest predictors of depression among abuse victims are the frequency and severity of family violence, emotional or psychological abuse, sexual violence, and lack of social support (Koopman, Ismailji & Palesh, 2007, Pico-Alfonso, 2005, Pico-Alfonso, Garcia-Linares & Celda-Navaro, 2006). These appear to be stronger predictors than cultural/demographic factors or preexisting mental illness.

The research also confirms that the incidence of depression is higher among women who reported more frequent sexual abuse by partners. Among those surveyed in the National Violence Against Women Study, twenty-five percent of women and 8 percent of men, said they were raped and/or physically assaulted by a current or former spouse, cohabiting partner, or date at some time in their life; 1.5 percent of women and 0.9 percent of all men said they were raped by a partner (Thaden & Thonnes, 1998). Although symptoms of anxiety more often predominate immediately following a sexual assault, depression quickly develops and can persist over time. Survivors of childhood abuse who are then assaulted by adult partners are at significant risk of depression (Dickinson et al., 1999).

Depression appears to be significantly associated with domestic violence. Clinicians should be aware that this may a consequence of intimate partner violence and screen for such symptoms when working with survivors.

**Case Vignette**

Anna Louise, a 28-year-old married woman has a history of psychiatric illness. In her most recent hospitalization for a failed suicide attempt, Anna Louise disclosed that she was a victim of sexual abuse in childhood. When she initially met her husband Ken, she thought that he was “different,” but that has not proven to be the case. She states that he is verbally abusive and controlling. Her hospitalization was precipitated by an incident in which she felt that Ken “forced”
her to have sexual intercourse despite her indications that she did not wish to. Anna Louise is despondent and hopeless that her situation will change.

**Posttraumatic Stress Disorder**

Like depression, posttraumatic stress disorder (at clinical or subclinical levels) is frequently a consequence of intimate partner violence. Rates of PTSD among survivors of domestic violence are estimated to be between 33% and 84% (Kemp, Rawlings & Green, 1994; Woods & Wineman, 2004). In the *National Violence Against Women Study* (Thaden & Thonnes, 1998), 24% of those who had experienced partner violence in the past year met full clinical criteria for PTSD.

Diagnostic criteria for PTSD include *exposure* to a severe stressor (such as threats to the physical integrity of oneself), a response that involved intense fear, helplessness, or horror. For a diagnosis of PTSD, the person must also have experienced symptoms of *intrusive recollection*, such as recurrent and intrusive distressing recollections of the event, dreams, or flashbacks; *avoidant/numbing reactions*, such as efforts to avoid things that arouse recollections of the trauma, diminished interest or participation in significant activities or restricted range of affect; *hyperarousal*, such as irritability or exaggerated startle response. Responses of men and women who have been victims of domestic violence are similar to those of other types of traumatic exposure.

Using a PTSD framework is helpful as it places symptoms squarely within the context of it being a consequence of the abuse.

As with depression, PTSD in domestic violence victims has been associated with severity of the abuse, history of repeated abuse, sexual abuse and/or assault, and psychological abuse. Stalking is also associated with the development of PTSD. The more kinds of abuse someone experiences (physical, emotional, sexual) the greater his or her risk becomes for developing PTSD (Coker, Davis & Arias, 2002).

**Case Vignette**

Marybeth is a 29-year-old woman presenting for an initial consultation with Dr. Arian. She states that she has been feeling overwhelmed and exhausted. She has been more irritable than normal, is having sleep problems and nightmares, and has a feeling of “dread.” Due to her current symptoms, Marybeth is increasingly isolating herself and has missed several days of work. She reports that she is separated from her husband Charlie, who is an alcoholic and often violent and unpredictable.
Social Constructs and Subcultures

Although racial background reasonably persists in being the social construct that captures our attention the most, myriad other factors infuse what we generally accept as culture. These subcultures include:

- Generation and age.
- Region or locale of residence.
- Socioeconomic status.
- Gender and sexual orientation.
- Occupation or profession.
- Developmental and chronic disabilities.
- Language.
- Politics.
- Nationality.

All of these areas, and others, directly affect our lives and influence our response to personal and societal challenges. We tend, for example, to coalesce with others according to familiarity and commonality. Recent immigrants and refugees often cluster for mutual support and develop their own living, business, and social communities. The existence of a Little Saigon, Koreatown, Chinatown, or Islamic neighborhood is highly visible in cities where these groups have settled. Recent arrivals, however, may have tenuous relationships with those of their same racial/ethnic background who have been Americans for generations because of differences in acculturation, facility in native languages, and adherence to ancestral customs. Mexicanos and their Chicano predecessors, for example, may have noteworthy differences that victim assistance providers must respect. Although there is usually some cultural stream through generations, not all Mexican Americans are fluent in Spanish or live in barrios.

The age of the victim/survivor may or may not be helpful in sorting out these variations. There are nuances based upon immigration/citizenship standing and generational place and role that trump other attributes. It is thus helpful to listen to how people refer to themselves.
Regions in the United States also seemingly have cultural markings. For example, we speak matter-of-factly about Southern hospitality. We may wholly accept this description of Alabamans, Georgians, and Mississippians while at the same time recognize that living in Atlanta is unlike living in Savannah. Where we live helps mold how we live. Residents of farming communities on the Midwestern prairie may seem like extraterrestrials to retirees in resorts on the Florida peninsula. Transplants to Las Vegas may have only minimal resemblance to diehard Milwaukeean.

Culture, moreover, is linked to a person’s socioeconomic position and occupation or profession. The cultural divide may be more determined by poverty and wealth than other conditions and identifiers. How does victim assistance take into account a victim’s situation of “concentrated disadvantage” (Sampson and Raudenbush, 2001)—poverty, absence of social resources, high unemployment—in providing services? Are outreach and transportation, for example, key to being culturally competent for this population?

**Same Gender Abuse Dynamics**

*Case Vignettes*

**Andrew** is a 45-year-old man, who has been in a 5-year relationship with David, an emergency room physician. Andrew’s work as an artist allows him to stay home and raise Chloe, the couple’s 5-year-old daughter. David routinely holds back funds that Andrew needs to run the household, and on several occasions David has punched Andrew, the most recent time in front of Chloe.

**Robert and Beatrice** are 70 and 68. They have been married for 45 years. They have recently been experiencing some financial stress, and Robert has been drinking. When he drinks, he becomes very angry, and often screams at Beatrice and calls her names.

**Lauren and Brent**, juniors in high school, have been dating since freshman year. Brent is very jealous of Lauren, and expects her to see him every day. He keeps close tabs on her. She has lost friendships as a result of defending Brent’s actions. When Lauren and Brent fight, it often becomes physical.

While on the surface there are differences between Andrew, Beatrice and Laura, they share that they are victims of domestic or intimate partner violence. Domestic violence is “the willful intimidation, physical assault, battery, sexual assault, and/or other abusive behavior perpetrated by an intimate partner against
another” (The National Coalition Against Domestic Violence). Domestic violence affects individuals from every walk of life, whether gay or straight, young or old, married or unmarried. As these cases illustrate, domestic violence is often accompanied by emotionally abusive or controlling behavior, and thus is part of a systematic pattern of dominance and control. The terms “domestic violence,” and “intimate partner violence,” are synonymous, although the later is more inclusive.

While this is not an exhaustive list, Kurst-Swanger and Petocsky (2003), have identified some behaviors indicative of intimate partner violence. These include:

- Denying a person autonomy
- Isolating victims from family and friends
- Instilling fear through intimidation, threats and violence
- Manipulating behavior
- Unjustified jealousy
- Controlling financial resources

While domestic violence researchers have focused primarily on “traditional” marriages in which there is abuse, this does a disservice to many victims. It is important to recognize that intimate partner violence occurs in all types of partnerships.

**Domestic Violence in Gay, Lesbian, Bisexual and Transgendered (GBLT) Relationships**

*Prevalence*

Intimate partner violence is a serious issue in the GLBT community. How serious? Island and Letellier (1990, 1991) suggest that intimate partner violence occurs in about 15-20% of gay male relationships. They describe intimate partner violence as “the third most severe health problem facing gay men today,” behind HIV/AIDS and substance abuse.

While study of violence in GBLT relationships is not widespread, an important source of compiling data is the National Coalition of Antiviolence Programs. Their reported prevalence data for 2010 underscores the need for clinicians to be aware of and responsive to intimate partner violence in GBLT couples. The following are some key findings:

- In 2010, NCAVP programs received 5,052 reports of intimate partner violence. While this represents an increase of 38.1% from 2009 (3,658 reports this was mainly due increased funding at the Los Angeles Gay & Lesbian Center (LAGLC) for their intimate partner violence programming.
• NCAVP documented six IPV murders/homicides in 2010 equal to the six documented murders/homicides in 2009. The majority of victims were women.
• The average age of murder/homicide victims increased. In 2009 the average age of the victims was 30, while in 2010 the average age was 39.
• Females accounted for nearly half (45.7%) of victims who reported to NCAVP member programs in 2010, while males accounted for more than a third (37%).
• 50.6% of survivors indicated they experienced intimate partner violence with a boyfriend/girlfriend or long-term partner, a decrease from 2009 (61.3%).
• More victims in 2010 (44.6%) were turned away from shelter than in 2009 (34.8%)
• More than half of victims (55.4%) experienced physical violence from their abusive partners, a substantial increase from 2009 (36.5%). Less victims called the police. In 2010 7.1% of victims called the police for support, a decrease from 2009 where 21.7% of victims called the police.

What makes these figures even more alarming is that LGBT domestic violence is vastly underreported, unacknowledged, and often reported as something other than domestic violence (National Coalition of Anti-Violence Programs, 2006). Gay men and women who are abused by a partner frequently report being afraid of revealing their sexual orientation or the nature of their relationship. Delaware, Montana and South Carolina explicitly exclude same-sex survivors of domestic violence from protection under criminal laws. Eighteen states have domestic violence laws that are gender neutral but apply to household members only. There are a number of additional barriers to reporting such abuse, and these will be discussed later in this material.

Nature of Abuse

In many ways, domestic violence in lesbian, bisexual and gay relationships is the same as in heterosexually-paired relationships. Some of these behaviors that are similar in heterosexual and GLBT relationships include (National Coalition of Antiviolence Programs, 2000):

• Verbal abuse, such as calling a partner names or belittling them in some way.
• Isolating a partner from their family or friends.
• Withholding money, shelter, food, clothing and/or medication from a partner as a means of controlling them.
• Interfering with a partner's ability to obtain or keep employment, housing or any other benefit or service.
• Harming or attempting to harm a partner physically, or threatening to do so. Threats of harm may also extend to a partner's family, friends, children and/or pets.
• Sexually assaulting or raping a partner.
• Threatening a partner with suicide or harm to self, if a partner tries to end a relationship or does not comply with an abuser’s demands.
• Stalking or otherwise harassing a partner.

While these types of abuse may be found in gay or straight relationships, there are some very specific forms of abuse that may be found in GBLT relationships. Some examples include (National Coalition of Antiviolence Programs, 2000):

• “Outing” or threatening to out a partner to friends, family, or employers.
• Reinforcing fears that no one will help a partner because he or she is lesbian, gay, bisexual or transgender, or that for this reason, the partner “deserves” the abuse.
• Justifying abuse with the notion that a partner is not “really” lesbian, gay, bisexual or transgender.
• Telling the partner that abusive behavior is a normal part of GBLT relationships, or that it cannot be domestic violence because it is occurring between same gender individuals.
• Portraying the violence as mutual or consensual.

According to the National Coalition of Anti-Violence Programs (2006), specific forms of abuse occur in relationships where one partner is transgendered, including:

• Using offensive pronouns such as “it” to refer to the transgender partner
• Ridiculing the transgender partner’s body and/or appearance
• Telling the transgender partner that he or she is not a real man or woman
• Denying the transgender partner’s access to medical treatment or hormones

Case Vignette
Keliana and Jeanette have been in an exclusive relationship for the past two years. In the past three months, Jeanette’s behaviors have become increasingly erratic. Keliana would like to leave the relationship, but is fearful to do so because Jeanette has threatened to kill herself if Keliana leaves. She also says that if Keliana leaves her she will call members of Keliana’s very religious family and let them know that the two have been lovers.

There is a domestic abuse power wheel specific to GBLT couples experiencing intimate partner violence:
Barriers to Seeking Services

While it is undeniable that there is a need for GBLT men and women to seek services, there are barriers to doing so. Some of these barriers include:

- The belief that domestic violence does not occur in GBLT relationships
- Societal anti-GBLT bias (homophobia, biphobia and transphobia)
- Lack of funding for research into GBLT relationship abuse
- Fear that airing of the problems among the GLBT population will detract from progress toward equality or fuel bias.
- Lack of appropriate training regarding GBLT domestic violence for service providers
- Domestic violence shelters are typically female only, thus transgender people may not be allowed entrance into shelters or emergency facilities.

Factors that Increase Vulnerability in GBLT Relationships

Some of the factors that increase vulnerability to domestic violence in GBLT
Relationships:

- Isolation of some GBLT individuals from families of origin
- Acceptance of violence in LGBT relationships from general population
- The “double closet,” need to hide sexual orientation status and need to hide the relationship abuse
- Co-Existential situations, such as low self-esteem and substance abuse
- Dismissal by police and some social service providers
- Impact of HIV in keeping couples together
- Lack of support from peers who would rather keep quiet

Recommendations for Providers

While there are a number of important issues in working with GBLT individuals who have been affected by domestic violence, the following recommendations are a few helpful ones (many excerpted from American Psychological Association recommendations):

- Increase their knowledge and understanding of homosexuality and bisexuality through continuing education, training, supervision, and consultation.
- Recognize the scope of the problem, and know that domestic violence is a “real” issue among same gender partners.
- Understand the effects of stigma (i.e., prejudice, discrimination, and violence) and its various contextual manifestations in the lives of lesbian, gay, and bisexual people.
- Understand that same-sex attractions, feelings, and behavior are normal variants of human sexuality.
- Be knowledgeable about and respect the importance of lesbian, gay, and bisexual relationships. Recognize that domestic violence should not be an acceptable part of these relationships.

Intervention Strategies

There are a number of different descriptions of the phases of crisis intervention and several different approaches to the intervention itself. No single approach has been shown to be better than another. It is important for victim service providers to find an approach that feels comfortable to them. The National Center for Victims of Crime (2004) has identified three phases of crisis intervention: immediate crisis intervention, needs assessment, and recovery intervention. Immediate crisis intervention focuses on ensuring that the victim’s immediate medical, mental health, and personal needs are met. The needs assessment includes identifying the victim’s needs for emotional support, identifying how the
crisis has affected the victim, and developing a plan for the future. The third phase, recovery intervention, represents the victim’s movement toward regaining psychological equilibrium and moving forward with his or her life. The victim service provider’s role may include helping victims to avoid secondary trauma through their interaction with the criminal justice system or other agencies and professionals.

Dixon (1987) has described a nine-step crisis intervention model that can be used with families in any type of crisis:

1. Rapidly establish a constructive relationship.
2. Elicit and encourage expression of painful feelings and emotions.
3. Discuss the precipitating event.
4. Assess strengths and needs.
5. Formulate a dynamic explanation.
6. Restore cognitive functioning.
8. Terminate.
9. Follow up.

Victim service providers often provide services beyond the initial crisis intervention stage, so Step 8 may not be relevant for them. However, Step 4 is an important aspect of crisis intervention. Both victims and their family members (including extended family and clan members) have strengths, but it can be difficult for them to focus on these strengths when they are in the middle of a crisis.

Another approach to crisis intervention focuses on three phases: safety/security, vent/validate, and prepare/predict (Young, 1993). This method has gained wide acceptance in the victim services field and will be discussed in greater detail.

Phase 1: Safety/Security. The first phase focuses on ensuring that victims feel they are safe from additional harm. The victim service provider can aid victims by having them identify their need for safety and security and providing options and resources that may fill these needs. For example, a domestic violence victim in a small tribal community may not feel safe staying at the tribal shelter because her
abuser knows the shelter's location. The victim service provider may be able to provide information about other domestic violence programs and arrange for transportation to the alternate shelter.

The need for safety is one of the most basic human needs. It is very difficult to focus on any other issue until a person feels safe. In many situations, the victim service provider’s first role is to help a crime victim feel safe and secure. Some victims may need little to feel safe, while others may not be able to feel secure no matter how many resources are provided. The victim service provider should explore with the victim as many options as possible to help the victim feel safe, both physically and psychologically.

Physical safety may include locating a safe place for a victim to stay or arranging for a medical examination to ensure there are no bodily injuries. Psychological security can be provided by supplying favorite items, such as a child’s favorite stuffed animal, or contacting a support person to come and stay with the victim. It is critical to remember, however, that the victim must define what safety and security means. **Never make assumptions about what a victim wants, and always ask and clarify to ensure that you understand the victim’s needs.** Some people, for example, might want a family member to stay with them following a traumatic event. Other people may not be close to members of their family, or might prefer to be alone. Sexual assault victims, for example, often fear that family members will find out about their assault (Kilpatrick, 2000), so contacting a family member may further traumatize the victim.

Victims may also make choices that the victim service provider feels will not provide adequate safety or security. In most cases, the victim service provider has no right or ability to force the victim to seek safety. An elder physical abuse victim who desires to stay in her own home alone, even though the perpetrator has not been apprehended, might be making a choice that seems unsafe. However, the trauma of leaving the familiarity of her home may cause more psychological distress than remaining in the home. A victim service provider may be able to help get additional police patrols or arrange to provide the victim with a cellular phone to make it easier for the victim to call for help in an emergency.

Phase 2: Ventilation and Validation. Ventilation refers to victims being able to tell their story, in their own time and in their own way. It is important for victims to talk
through their experiences, no matter how long it takes and how disconnected or unimportant the information seems. Child victims may want to tell stories or draw pictures. Victim service providers who work with child victims may want to have a kit on hand that includes Play-Doh, crayons, paper, markers, and other art items. If the victim service provider will be traveling to meet the child victim onsite, he or she should have a mobile kit to take on calls. Remember that adults, as well as children, may benefit from having art supplies available. Having something to do with their hands, such as kneading play dough or squeezing a stress ball, may help victims alleviate stress.

Victim service providers should also be aware of how members of different cultural and ethnic groups express themselves. Native Americans, for example, may begin a story and go off on what sounds like many tangents to the non-Native person. The story may sound circuitous, often going off target. However, this is a common way of describing events, through interlacing related activities over a period of time. The victim service provider needs to be patient and allow victims to complete their stories without trying to get them back on topic. Since victims are telling the story in their own terms, they may use words or concepts with which the victim service provider is unfamiliar. It is appropriate to ask for clarification of such terms or concepts to avoid misunderstandings. By becoming familiar with a victim’s style of communicating, the victim service provider may be able to explain unfamiliar terms and concepts to investigators and prosecuting attorneys.

Even when the victim and the victim service provider share a common language, it is important to clarify the language the victim uses. In sexual assault cases, for example, victims may use various words to describe what they have experienced (e.g., using “attacked” as a way of describing being raped). Various communities have words that they commonly use and that are easily understood within their peer group but have a different meaning outside that group. Lesbian, gay, bisexual, and transgender (LGBT) people, for example, may refer to “the community.” Often they are referring to the LGBT community, rather than the area that they live in. People with disabilities, ethnic minorities, members of religious minorities, or other groups all tend to have their own language and unique terminology.
Both children and adults may need to work through their trauma through re-telling the experience. Often, victims will remember additional details as they go through their experience (Young, 1993). Victims gain control or mastery over their experience by reliving the details through the process of talking about what happened. This process can also improve their capacity as witnesses in criminal cases.

Validation is the process of helping victims understand that their reactions are part of a normal process, if this is true. Victims who experience reactions that are life-threatening or are well beyond the “normal” range should be referred for psychological assessment. While each victim’s reactions are individual, victim service providers should be cautious when a victim appears to be experiencing physical, psychological, and/or spiritual problems outside the usual reactions. In these cases, the victim service provider should make the appropriate referrals. Victims may develop mental health issues as a result of their victimization (e.g., clinical depression, anxiety, or posttraumatic stress disorder). These reactions develop over time. A diagnosis of PTSD requires that symptoms have persisted more than 4 weeks. However, for people with pre-existing mental health conditions, their victimization may exacerbate symptoms that may require professional treatment. Any victims’ statements or actions suggesting suicide ideation must be taken seriously and appropriate interventions undertaken.

The goal of validation is to help people realize that the physical, psychological, cognitive, behavioral, and spiritual reactions they are having are often typical of the reactions experienced by crime victims, even when those reactions are very intense and uncomfortable. Many crime victims may experience intense anger. This may be a frightening experience for the person who has never had such an intense feeling. Victims can benefit from understanding that crime victims can experience feelings that they have never had before or experience these feelings more intensely than ever before.

It is important to remember that every victim’s experience is unique and that each person will want to have his or her experience regarded in that manner. Rather than telling victims that their reactions are normal, Young (1993) suggests telling them that their responses are not uncommon. Nothing about the victimization experience is normal.
Phase 3: Predict and Prepare. Following a criminal victimization, a victim often enters a whole new world—a world filled with unfamiliar people who are talking an unfamiliar language and often want something that the victim may not be able to provide. Victims of violent crime may be subjected to uncomfortable physical examinations by unfamiliar medical personnel. Law enforcement officers are focused on identifying and apprehending the suspect(s), and the legal jargon they often use may be confusing or intimidating to victims. Investigators may appear to demand that victims provide more and more detailed information about their victimization, forcing them to relive the worst event of their lives over and over. Victims may feel that they have entered an alien environment, and the victim service provider is their guide through this environment.

The victim service provider can provide a road map, explaining to the victim what is going on and what is likely to happen in the future. For example, victim service providers can prepare a victim for a sexual assault examination by explaining the procedures to be performed and the purpose for each procedure. They can also explain what will happen to the evidence collected, how long it will take to get test results, and what will happen if there is or is not any evidence that can be used to identify the perpetrator.

A child who has been removed from home due to physical abuse will be confused about why he or she is being taken away from the family and will have many questions, such as the following: Am I going to jail? Where will I live? What will happen to my pets? Where will I go to school? What will happen to my parents? Have I done something wrong? Why are the police here? The victim service provider can help to answer these questions by talking to the child in language that is commensurate with his or her age and cognitive development, explaining who the people at the scene are and their jobs, as well as what will happen in the short term and the long term.

**Psychological First Aid**

The National Child Traumatic Stress Network (NCTSN) and National Center for PTSD have developed a guide to offering psychological first aid to victims of disasters (Ruzek, Brymer, Jacobs, Layne, Vernberg, and Watson, 2006). While psychological first aid is aimed at mental health providers, there are many useful concepts that can be applied by all first responders, including victim assistance.
providers, particularly those responding to terrorism or mass victimization situations. The following paragraphs include excerpts from this guide. Participants are encouraged to read the entire guide for additional information. The guide can be found at www.nctsn.org.

The NCTSN and National Center for PTSD (2005) describe psychological first aid as follows:

Psychological First Aid is designed to reduce the initial distress caused by traumatic events, and to foster short- and long-term adaptive functioning. Principles and techniques of Psychological First Aid meet four basic standards. They are: (1) consistent with research evidence on risk and resilience following trauma; (2) applicable and practical in field settings; (3) appropriate to developmental level across the lifespan; and (4) culturally informed and adaptable.

The basic objectives of psychological first aid are similar to the objectives for any type of crisis intervention or first response. The NCTSN and National Center for PTSD describe these objectives as follows:

- Establish a human connection in a nonintrusive, compassionate manner.
- Enhance immediate and ongoing safety, and provide physical and emotional comfort.
- Calm and orient emotionally overwhelmed or distraught survivors.
- Help survivors to articulate immediate needs and concerns, and gather additional information as appropriate.
- Offer practical assistance and information to help survivors address their immediate needs and concerns.
- Connect survivors as soon as possible to social support networks, including family members, friends, neighbors, and community helping resources.
- Support positive coping, acknowledge coping efforts and strengths, and empower survivors; encourage adults, children, and families to take an active role in their recovery.
- Provide information that may help survivors to cope effectively with the psychological impact.
- Facilitate continuity in response efforts by clarifying how long the psychological first aid provider will be available, and (when appropriate) linking the survivor to another member of a disaster response team or to
indigenous recovery systems, mental health services, public-sector services, and organizations.

The NCTSN and National Center for PTSD guidelines also offer useful suggestions for behaviors to avoid, including the following:

- Do not make assumptions about what the person is experiencing or what he or she has been through.
- Do not assume that everyone exposed to a disaster will be traumatized.
- Do not pathologize. Most acute reactions are understandable given what people exposed to the disaster have personally experienced.
- Do not label reactions as “symptoms” or speak in terms of “diagnoses,” “conditions,” “pathologies,” or “disorders.”
- Do not talk down to or patronize the survivor, or focus on his or her helplessness, weaknesses, mistakes, or disability. Focus instead on what the person has done that is effective or may have contributed to help others in need, both during the disaster and in the present setting.
- Do not assume that all survivors want to talk or need to talk to you. Often, being physically present in a supportive and calm way helps affected people to feel safer and more able to cope.
- Do not debrief by asking for details of what happened.
- Do not speculate or offer erroneous or unsubstantiated information. If you don’t know something that you are asked, do your best to learn the correct facts.
- Do not suggest fad interventions or present uninformed opinion as fact. (NCTSN and National Center for PTSD, 2005, p. 7)

It is important to be aware of the needs of at-risk populations. Individuals who are at special risk after a terrorism attack or mass victimization include the following:

- Children (especially children whose parents have died or are missing).
- Those who have had multiple relocations and displacements.
- Medically frail adults.
- The elderly.
- Those with serious mental illness.
- Those with physical disabilities or illnesses.
- Adolescents who may be risk-takers.
- Adolescents and adults with substance abuse problems.
- Pregnant women.
- Mothers with babies and small children.
- Professionals or volunteers who participated in response and recovery efforts.
- Those who have experienced significant loss.

Those exposed firsthand to grotesque scenes or extreme life threat. (NCTSN and In some instances crime victims may need mental health interventions. People who are victims of crime may have pre-existing mental health issues or may develop psychological or psychiatric problems as a result of their victimization. It is appropriate to refer victims to professional therapists if their level of psychological distress is beyond what the victim service provider is capable of handling. It is also appropriate to develop a network of mental health professionals who have special training or skills in the trauma of victimization. As a victim service provider, it is vital to recognize one’s own limitations. Victims who are seriously depressed and/or suicidal need professional assistance that is beyond the capability of the victim service provider to provide.

**Common Pitfalls To Avoid**

It is important to avoid common pitfalls when providing crisis intervention. Many victim service providers enter the field because they are natural helpers; they take great satisfaction in helping other people. However, there is a danger that in trying to help others, victim service providers will make the situation worse instead of better. Here are some things to avoid (Young, 1993).

Avoid:

- Giving advice ("If I were you, I would…").
- Being judgmental ("That is the worst thing I've ever heard...").
• Trying to change someone’s values or beliefs (“If you would only accept that…”).

• Telling the person that you know how he or she feels.

• Telling the person that he or she will “get over it.”

• Making promises you can’t keep (“He will never hurt you again.”).

• Getting in over your head.

Avoid Saying:

• “I understand.”

• “I’m glad you can share those feelings.”

• “You’re lucky that. . .”

• “It’ll take some time but you’ll get over it.”

• “I can imagine how you feel.”

• “Don’t worry; it’s going to be all right.”

• “Try to be strong for your children.”

• “I know how you feel.”

• “Calm down and try to relax.”

**Identify Community Resources**

The majority of victim assistance programs are administered locally. Victims can access services through a variety of agencies, including private nonprofit organizations, faith-based organizations or churches, tribal governments, local criminal justice agencies, and public agencies (such as hospitals and mental health agencies). A significant portion of funding for these programs comes from VOCA funds administered by OVC.

Other offices within the Office of Justice Programs, U.S. Department of Justice provide funding for a number of programs related to crime victims.
• The Violence Against Women Office provides funding for federal, state, tribal, and local programs that assist victims of family violence and sexual assault.

• The Bureau of Justice Statistics (BJS) provides funding to improve the collection of data on crime and victimization, as well as statistics on crime.

• The National Institute of Justice (NIJ) is the "research arm" of the U.S. Department of Justice. NIJ has funded evaluation projects to assess the efficacy of victim assistance programs.

In addition to the provision of funding for services related to crime victimization, many federal agencies have developed resources for victims of crime during the past decade. Victims of crime that occur on federal lands or where there is federal jurisdiction (such as Indian country, federal parks, federal offices, and military installations) may be able to access services from federal law enforcement and criminal justice agencies. The Federal Bureau of Investigation has victim assistance coordinators. United States citizens who are victimized overseas can use services available through the U.S. State Department. The Department of Homeland Security (DHS), Customs and Border Patrol (CBP) also has services for victims of crime. The idea of providing services to victims of crime is relatively new for some of these agencies, with programs slowly being developed as a result of increased awareness of the need for services.

Each U.S. Attorney’s Office has a victim/witness coordinator, who works with victims and witnesses. Victim service providers who work with victims of federal crime will find these federal victim/witness coordinators to be an invaluable asset. Similarly, victim service providers or victim coordinators based in the State Attorney’s or District Attorney’s Office can provide important services for crime victims.

Assist With Compensation and Restitution Programs

One of the most common types of assistance offered to victims of violent crime is help with applying for compensation, which is available to victims of crime in all 50 states, the District of Columbia, tribal communities, Puerto Rico, Guam, and the U.S. Virgin Islands. The purpose of these programs is to reimburse victims of crime for expenses that they incur because they have been the victim of a crime.

State Compensation Programs
Each state establishes its own guidelines for crime victim compensation. The programs have many common elements, however. To be eligible for compensation crime victims MUST:

- Report the crime to law enforcement in a timely manner.
- Cooperate with the law enforcement investigation of the crime.
- File a timely application.
- Not be involved in illegal activity at the time of the crime.
- Have an expense that is not covered by another source, such as insurance, Indian Health Service, or the Veterans Administration.

The key aspects of victim compensation are described in Chapter 3, “Basic Victims’ Rights.” However, there are a few important considerations for victim service providers to understand relevant to helping victims apply for compensation:

- Violent crime victims should be advised that they “have the right to apply for victim compensation.” Victim service providers should not offer any assurances or guarantees about “the right to compensation” or that victims “will” receive an award.
- Any agency that receives VOCA funding is required by statute to help violent crime victims apply for victim compensation.
- It is important for victim service providers to be familiar with the crime victim compensation application procedures and forms in their respective states. Most states now have online applications, and many offer compensation information and forms in Spanish and other dominant languages in the jurisdiction.
- Not all applications for crime victim compensation will be approved. Each jurisdiction has an appeals process. Victim service providers can be helpful in finding out why an application was denied and helping victims file an appeal.
- All state compensation programs offer free training and technical assistance to victim service providers and allied professionals to improve their capacity to help victims complete the application process.
- Generally, crime victim compensation cannot pay for property damage. The exceptions to this prohibition on payment for property are medical devices (e.g., eye glasses and hearing aids) and property that is necessary for security (e.g. locks and windows).
- Many states also reimburse for culturally appropriate services, such as use of a traditional healer. As new needs are identified, states have begun to include services such as crime scene clean up as allowable reimbursable expenses.

- States will reduce the amount of the payment to a victim if the victim was found to be involved in “contributory conduct” that resulted in his or her victimization. The state compensation program may determine that a victim was 50 percent responsible for his or her victimization and reduce the reward by that percentage.

For obvious reasons, if the victim was involved in illegal conduct at the time of the crime, he or she is not eligible for compensation. Even if the illegal activity is not directly related to the crime, the victim is still not eligible for compensation.
REFERENCES


Centers for Disease Control and Prevention, National Centers for Injury Prevention and Control (2003).*Costs of Intimate Partner Violence Against Women in the United States.* Atlanta, GA.


