

## Intimate Partner Violence

The phrase **intimate partner violence** encompasses a pattern of psychological and emotional abuse, physical abuse, sexual abuse, and stalking between past or present **intimate** romantic **partners**. Scientific and clinical evidence indicates that **intimate partner violence** can result in a plethora of mental health and physical maladies due to ongoing patterns of abuse within relationships, and those most at risk of victimization are women and their children. This entry reviews the incidence and definition of **intimate partner violence**, the risk factors, and the effects of **violence** on both victims and perpetrators. Interventions for such abuse now cut across multiple public and private sectors (criminal/civil justice systems, the health care system, child services, battered women's shelters, etc.), and mental health professionals must know how to negotiate such systems in order to help victims and their children. Various prevention and intervention strategies are described below. Finally, current issues concerning **intimate partner violence** include the controversies surrounding batterer treatment, the unintended consequences of contemporary changes in the law (e.g., mandatory/preferred arrest), and the recent increase in effective yet damaging manipulation of criminal, civil, and family court processes by batterers.

### Incidence of Intimate Partner Violence

According to the latest reports from the United Nations and the World Health Organization, **intimate partner violence** extends across class, culture, ethnicity, and nationality and results in devastating physical and financial costs to individuals, families, and communities across the globe. In the United States, it is estimated that nearly 5.3 million incidents occur each year among women 18 years or older, and 3.2 million occur among men. Fortunately, most **intimate partner violence** assaults within the United States are relatively minor and are limited to pushing, grabbing, or slapping.

Nevertheless, **intimate partner violence** results in nearly 2 million officially reported injuries and 1,300 deaths each year, with the overwhelming majority of perpetrators of such severe **violence** being men and the majority of victims being women. Even so, most **intimate partner violence** incidents are not officially reported to the authorities, and the Centers for Disease Control Injury Center estimates that only about 20% of **intimate partner** sexual assaults/rapes, 25% of physical assaults, and 50% of stalkings against women are reported. Thus, most authorities agree that available data nationwide are gross underestimates of the problem.

### Defining Intimate Partner Violence

Research points to the importance of societal factors that influence individual and collective perceptions of the abuse. For some **intimate partner violence** victims, the abuse is perceived as a normal part of relationships and is not defined as criminal behavior. For many perpetrators, the abuse is perceived as the correct and most effective way to get their needs met within an **intimate** romantic relationship. This should not be surprising, because **intimate partner violence** has only recently been defined as criminal behavior. During the Civil Rights Movement in the United States during the 1960s and 1970s, **intimate partner violence** was named and brought out from behind closed doors. Prior to that time, **violence** between **partners** was viewed as private business and not a place for the state to intervene. Battered women's shelters and rape crisis centers sprang up across the country and are now located within every major metropolitan area in the United States. Due to the

work of women's rights advocates, **intimate partner violence** is now defined as a crime worthy of police intervention and prosecution, similar to assaults that might occur on the street between strangers. Every state in the union now has some form of **intimate partner violence** law on the books (often referred to as “domestic **violence**” in the statutes), and many states now also include stalking within these laws. In addition, most states no longer require **intimate partners** to be married or living together for these laws to apply. Based on variation by state, a complex set of laws protecting **intimate partner violence** victims now exist (ranging from civil protective orders to mandatory/preferred arrest at the scene), and perpetrators can no longer abuse their **partners** with impunity.

Physical abuse is now defined as any act that is physically aggressive or violent against another, from slapping or shoving, up to and including homicide. Unfortunately, some of the best-known and widely used measurement tools (e.g., the Conflict Tactics Scale) do not differentiate between mild forms of such aggression and that which results in intimidation, coercion, and control, not to mention severe injury or death. Sexual abuse is defined as any sexual behavior that is imposed on another without that person's full consent, from sexual imposition or fondling up to and including rape. Psychological or emotional **violence** is defined as behavior meant to intimidate, control, and coerce. This would include things such as threats to harm, put-downs and insults, monitoring of actions, control of the environment, and inducing fear in others. Often, psychological **violence** will overlap with stalking behavior, such as following, tracking down, leaving unwanted phone calls at work or home, contacting coworkers or friends and family, and other unwanted contacts after being told to stop. As noted above, mild **violence** such as pushing, grabbing, or slapping is the most common form of **intimate partner violence** in the United States, leading some to label such actions as “common couple **violence**.” These types of actions are reported about equally by both men and women. However, serious forms of **intimate partner violence** that result in patterns of abuse over time, coercion and control, sexual assault/rape, stalking behavior, injury, and homicide are overwhelmingly perpetrated by men (about 85–95% of all perpetrators). This latter type of **intimate partner violence** has been labeled by some as “**intimate terrorism**” or “battering” and constitutes a severe public health problem. As will be shown below, the primary perpetrators of such battering behavior are overwhelmingly male, while the victims are overwhelmingly female.

## Risk Markers

While it is well-known that **intimate partner violence** is underreported, those incidents that are severe enough to come to the attention of public and private social service agencies (the police, hospitals, shelters, etc.) suggest that most victims are women, most perpetrators are men, and most are relatively young (15–39 years of age). In terms of ethnicity, some suggest that people of color are more likely to be involved in **intimate partner violence** than Caucasians. However, when socioeconomic status is controlled, these racial patterns tend to disappear. For instance, when one compares police and emergency room patterns with those found in more private services such as battered women's shelters or advocacy centers, public services seem to be used more often by those in poverty, while the more private services seem to be accessed by those who reflect the racial/ethnic proportions found in the general population. Thus, it is safe to say that **intimate partner violence** cuts across all races and ethnicities and is most likely to come to the attention of the criminal justice system within the context of poverty and the risks that are associated with being poor.

Substance use has also been shown to be a risk marker, and some researchers have suggested that intoxication lowers inhibitions and increases impulsivity, thus leading to a higher propensity for **violence** of all kinds (not just **intimate partner violence**); however, research has shown that substance use is correlational and not causal.

The single largest, repeatable risk marker for battering is being a man within our culture, leading many to suggest that the problem is largely one of patriarchal gender socialization concerning **intimate** relationships. Indeed, a recent national survey revealed that cohabiting with a man, whether in a heterosexual or a homosexual **intimate** relationship, was a much stronger risk marker for victimization than cohabiting with a

woman. Others, however, reject this hypothesis because women can also be primary perpetrators. Nevertheless, severe **intimate partner violence** remains overwhelmingly a male problem.

Men who have been abused in childhood or witnessed **violence** in parents or caregivers are at higher risk of becoming a batterer in the teen years and adulthood than those who have not. Conversely, women who have been abused in childhood or witnessed **violence** in the home are at higher risk of being victimized. Thankfully, most individuals with such a history do not become abusive or victimized in the teen years or adulthood, and protective markers are similar to those for other types of **violence** (the presence of non-violent peers and adults in the formative years, etc.). Nevertheless, it has been known for some time that children learn how to negotiate **intimate** relationships from adult caregivers of both genders, and if abusive relationships are the norm, there is a higher chance that such relationships will be repeated in their own lives into adulthood. This is known as the “intergenerational transmission” of **violence**. Disturbingly, estimates suggest that children are present in the home and know about, witness, or are directly involved in up to 75% of all **intimate partner violence** incidents between adults.

### ***Lethality Assessment***

Trying to predict severe injury or death as a result of battering is difficult. Many of the risk markers for severe **violence** never result in death because homicide has an extremely low base rate within the general population. In addition, some **intimate partner** homicides occur “out of the blue,” meaning that others are unaware of problems within the relationship until after homicide has occurred. Nevertheless, there is amassed evidence for highly lethal risk markers from reviews of **intimate partner** homicides, whether or not prior knowledge of the problem was available. Such risk markers include severity of past **violence** (attempts/threats to harm or kill, sexual assault/rape, strangling/choking of **partner**, child and pet abuse, serious injury, etc.), other criminal behaviors (history of prior arrests, threats/harassment of others besides **partner**, etc.), failure of past interventions (others have intervened but **violence** continues, ignoring protective and court orders, numerous police calls, etc.), obsessive stalking behaviors (following, watching, monitoring, isolation, sense of ownership of **partner**, etc.), and psychological risk markers (previous suicide/homicide threats or attempts, military history or weapons training, depression or other mental health disorders, external life stressors such as job loss or death in the family, drug/alcohol use, etc.). *However, the single largest risk marker for severe injury and homicide is when the victim attempts separation from the perpetrator.* It appears that when batterers can no longer control their **partners** or the relationship, their **violence** escalates. Indeed, in the most extreme cases, batterers will kill their **partners**, their children, and then commit suicide rather than allow separation of any kind.

### **Negative Effects of Intimate Partner Violence**

Similar to any other form of trauma, once the abuse stops, most victims will recover to the emotional and functional levels that were present before the abuse started. Indeed, most battered women will not enter into another abusive relationship in their lifetime. On the other hand, batterers often go from one violent relationship to the next and, without intervention, will often abuse a string of **intimate partners**. Not surprisingly, data have shown that among **intimate** couples reporting **violence**, women report significantly more fear of their **partner** and fear for their safety than do men.

Victimized women can present with cognitive disturbances due to repeated head banging or beatings, hyperarousal and anxiety disturbances, attentional deficits, seclusion, denial, minimization, somatization, depression, and classic posttraumatic stress disorder symptoms such as dissociation, nightmares, and flashbacks. These symptoms can unfortunately result in misdiagnosis if the effects of **intimate partner violence** are not taken into account. Such victimization can also cause changes in personality that usually remit on cessation of abuse and establishment of safety but that can also be easily misdiagnosed if the context of **intimate partner violence** is not taken into account. This is not to say that victimized women never have prior

comorbid health issues, only that misdiagnosis is likely to occur if the abuse is not identified. Perpetrators, on the other hand, often cannot be distinguished from other men in terms of personality disorders, depression, anxiety, or any other mental health issue. They are more likely, however, to hold more traditional views concerning men's and women's roles than those who are not abusive.

The effects on children in a home where battering is present are quite negative. As mentioned above, children in such families are at higher risk of becoming future perpetrators or victims themselves. Children from such homes can also experience anxiety and depression, become withdrawn and secretive, struggle in school, have trouble with attention and memory, or begin to act out aggressively. If they attempt to intervene during an **intimate partner violence** incident, they can suffer mild to severe physical injuries. Perhaps most disturbingly, it has been estimated that in up to 60% of all homes where battering is present, child abuse in some form also occurs.

## **Types of Interventions**

Similar to other types of public health problems, there are three classes of interventions that are currently being applied for the problem of **intimate partner violence**: (a) primary prevention strategies, (b) secondary prevention strategies, and (c) tertiary intervention strategies.

### ***Primary Prevention***

Primary prevention refers to public access educational efforts that attempt to reach most or all members of a population. Such efforts include educational material presented through the media (television, radio, newspapers, the Internet, etc.) that defines the problem of **intimate partner violence** and provides information about services available and how to access them and what to do if you or someone you know is a victim or a perpetrator.

### ***Secondary Prevention***

Secondary prevention refers to efforts that are tailored to those groups most at risk for perpetration (young males) and victimization (young females). Such interventions are usually presented within educational institutions, religious institutions, and other community organizations such as hospitals and include information similar to that found in primary prevention efforts.

### ***Tertiary Intervention***

Tertiary intervention refers to "after the fact" interventions directly targeting known victims and perpetrators. Such services include police intervention and prosecution of the batterer, probation and parole monitoring, civil and criminal protective orders issued by the courts, family divorce courts, legal advocacy centers, battered women's shelters and rape crisis hotlines, child protective services after abuse or threats of abuse, emergency room visits after injury, and access to private or public physicians and mental health workers after the abuse has occurred.

There is evidence that some medical and mental health professionals overlook **intimate partner violence** victimization in terms of information gathering and diagnosis, even though females nationwide access such health services in larger numbers than males. As noted earlier, misdiagnosis can result from a lack of professional knowledge about **intimate partner violence**, not to mention ineffective interventions and perhaps even an increase in risk to clients. Nevertheless, more and more health workers are dealing with the unique problems that **intimate partner violence** can pose in clients' lives, and there has been a call to increase the amount of training concerning such issues across health professions. In addition, the treatment of perpetrators has become a widespread concern, especially since many court jurisdictions now use batterer treatment as an adjunct to or instead of incarceration.

## ***Victim Intervention***

In terms of victim intervention, the single largest issue is safety. Mental health providers cannot assist victims and their children in overcoming the effects of trauma if the abuse is continuing or they continue to live in fear of their batterers. Thus, providers must know how to design and monitor client safety plans, be aware of local resources for victims and how to access them, be well versed in lethality factors (especially recent separation), and be willing to call in outside resources such as the police if victims or their children report especially lethal behavior on the part of the batterer. While there are no mandated reporting requirements on the books because victims are enfranchised adults, standard lethality assessment requirements nevertheless apply. Of course, for child victims, mandated reporting is required. Once victim safety is established, mental health providers often serve in the triple roles of therapist, advocate, and case manager. This is because, as noted above, the tertiary interventions for **intimate partner violence** victimization now cut across multiple public and private systems. In addition to helping victims and their children cope with the psychological aftermath of abuse within an ongoing lethality analysis, therapists often find themselves assisting victims to access services such as shelters, crisis lines, and advocacy centers; helping victims navigate within the criminal, civil, and family courts and child protective services; and testifying in court.

## ***Batterer Intervention***

In terms of batterer intervention, many criminal jurisdictions require batterers to attend and successfully complete treatment in lieu of sentencing or jail time or as part of probation/parole requirements. Studies show that batterer treatment is relatively unsuccessful due to high drop-out rates nationwide. Unfortunately, courts are inconsistent and vary by jurisdiction concerning the penalties for such treatment failures on the part of batterers. Still, when court-ordered batterers do complete treatment, studies suggest that recidivism is reduced when measured as future arrests for **intimate partner violence**. However, batterer treatment remains controversial because of the high drop-out rates, the problems inherent in court-ordered treatment in general (similar to court-ordered drug/alcohol treatment), and the finding that following treatment, some batterers have learned to become more savvy in their abuse in order to avoid future detection by the authorities. Overall, studies suggest that if perpetrators are not personally ready to change their behavior at the time of treatment, at best treatment is ineffective and at worst it creates more savvy batterers. Nevertheless, for those ready to change, treatment is quite helpful as long as it is conducted within an ongoing lethality analysis. Once again, mental health providers who deal with batterers often find themselves in multiple roles. Therapists are not only expected to deliver antiviolenence treatment to batterers, they are also usually required to interact with probation and parole officers, judges, child protective services, and victims to ensure that the **violence** has stopped. Not only are therapists required to play multiple roles, they must also be quite clear in identifying the "client" when providing batterer treatment. This means that, often, the client is the court and the goal is victim safety, not necessarily the "best interests" of the batterer.

## ***Contemporary Issues***

Sadly, with the advent of mandatory arrest policies, there has been an unintended increase in victim arrests at **intimate partner violence** scenes across the United States, and therefore an increase in victims being mandated for batterer treatment. Nationwide, the best estimates suggest that only about 2% to 3% of all **intimate partner violence** arrests are of actual primary female perpetrators, and the remainder of these women have been erroneously arrested. Therapists need to be cognizant that erroneous victim arrest can result in job loss, loss of aid and access to other services, charges of unfit parenthood, and future threats by batterers to have them arrested again. Furthermore, those therapists providing batterer treatment should provide thorough assessments of all referrals to ensure that primary perpetrators are identified and separated from their victims regardless of gender and that treatment is then tailored accordingly.

Yet another contemporary issue of which therapists should be aware is that harassing and manipulative

behaviors on the part of batterers are becoming more and more commonplace within the criminal, civil, and family court systems. This can be seen not only in the recent increase in victim arrests as noted above but also in the increase in the number of batterers obtaining criminal and civil protection orders against their victims as well as the number of batterers using invalid “parental alienation” arguments in custody battles in the family courts. Even though many states and local communities forbid the issuing of dual protective orders, batterers are nevertheless obtaining them because of the lack of communication across most jurisdictions resulting in inadequate tracking of such cases. Similarly, batterers are using the family courts during highly conflictual custody proceedings to make unjustified claims against their victims concerning unfit parenthood, with the children caught squarely in the middle. Mental health professionals need to be cognizant of such manipulative batterer behavior in the treatment of victims, perpetrators, and their children.

—Kathy McCloskey

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## Further Readings

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