Published in final edited form as:

Int J Law Psychiatry. 2009 ; 32(1): 48–55. doi:10.1016/j.ijlp.2008.11.003.

Interpersonal partner violence and women in the United States: An overview of prevalence rates, psychiatric correlates and consequences and barriers to help seeking

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Keywords

Intimate partner violence; Battered females; At risk populations; Mental disorders; Help seeking behavior; Epidemiology

1. Introduction

In 1991, in the United States, Surgeon General Koop declared violence a public health epidemic, ushering in a surge of funding for primary and secondary prevention, as well as research to study the many faces of this social problem. For women, violence may take many forms, violence *against* women being the most common. Defining violence as a public health epidemic recasts problems of violence from a criminal justice framework and allowed an entrée from social science and medical health perspectives. Today, over fifteen years have passed, and we have made substantial advances in our understanding of violence as it affects women. This paper presents an overview of what we know to date on the epidemiology and treatment of intimate partner violence (IPV) in heterosexual relationships. In addition to examining known prevalence rates in the United States of IPV, we will report on gender and ethnic differences in these rates, as well as the correlates and psychiatric consequences of IPV exposure. A discussion of treatments and social and psychological barriers to seeking and receiving help will be offered in the hopes that those in a position to consider public policy may be informed about the current state of science in this field.

2. IPV prevalence rates: gender and ethnic differences

The Center for Disease Control and Prevention (CDC) defines Intimate Partner Violence (IPV), as “actual or threatened physical, sexual, psychological or stalking violence by current or former intimate partners (whether of the same sex or opposite sex).” IPV has received increased attention over the past few decades due to its high prevalence rate and deleterious effects on victims and society. Survey studies reveal that women experience IPV at an alarmingly higher rate than men, and suffer significantly more negative consequences. Tjaden and Thoennes (2000) conducted a national telephone survey (The National Violence Against Women Survey; NVAWS) and found women had higher lifetime rates of being raped, physically abused, and stalked than did men. Specifically, 20.4% of the women reported a lifetime history of physical assault by their current or former partner compared to only 7% of the men surveyed. Likewise, the women reported a greater likelihood of being raped and stalked in their lifetime than the men (4.5% vs. 0.2 and 4.1% vs. 0.5%,

respectively). Similar results were found in the National Crime Victimization Survey (NCVS; Rennison & Welchans, 2000), with women being victimized by their intimate partner at five times the rate of men and were more likely to be injured as a result of their victimization (50% versus 32%). Moreover, the frequency, duration, and consequences of IPV were significantly greater for women than men, with women experiencing more life threats, reporting greater fear of bodily harm, and greater physical and psychological consequences (e.g., injuries requiring medical treatment and the need for mental health services) as a result of their exposure to IPV (Breiding, Black, & Ryan, 2008; Rennison & Welchans, 2000). Indeed, U.S. Department of Justice Bureau of Justice Statistics revealed in 2006 that women were ten times (32.7% versus 3.1%) more likely to be killed by an intimate partner than were men. These surveys clearly indicate that women's experience of intimate partner violence is different than men's.

Among ethnic minority women, the prevalence rates of IPV appear to be even greater when compared to those of white women (Field & Caetano, 2005; Hampton & Gelles, 1994; Rennison & Welchans, 2000; Tjaden & Thoennes, 2000). For instance, Black females had a 35% higher reported rate of IPV than white women between the years 1993 and 1998 (Rennison & Welchans, 2000) and were more than 2.36 times likely to report experiencing severe violence (Hampton & Gelles, 1994). Similar findings have been reported for other ethnic minority groups with Hispanic women reporting a greater frequency of rapes and Native American women experiencing more violent victimization (e.g., Tjaden & Thoennes, 2000) compared to white females. Several researchers argue that the disproportionately greater rate of exposure to IPV among ethnic minority women is related to their overrepresentation among individuals who are of lower socioeconomic status (e.g., being poor, low educational attainment, limited/no access to health insurance and health/mental health services), a consequence of structural inequalities that persist in our society to date (e.g., Hampton, Oliver, & Magarian, 2003; West, 2004). Being from a lower socioeconomic status has been shown to place one at a greater risk of experiencing interpersonal violence (Belle, 1990; Sorenson, Upchurch, & Shen, 1996). The NCVS found that the typical characteristics of intimate partner violence victims between 1993 and 1998 were "being black, young, divorced or separated, earning lower incomes and living in urban areas" (Rennison & Welchans, 2000, p. 3). Moreover, ethnic differences in IPV exposure either disappear (e.g., Coley & Beckett, 1988; Straus & Gelles, 1990; Walton-Moss, Manganello, Frye, & Campbell, 2005) or decrease substantially when socioeconomic status and substance use are controlled for (Field & Caetano, 2005; Schafer, Caetano, & Clark, 1998) suggesting that perceived differences related to race may be more likely due to the effects of additional contextual factors such as poverty, discrimination, or substance abuse history (Bent-Goodley, 2007; Field & Caetano, 2005).

3. IPV: risk factors and mental health consequences

The ways that women may become exposed to IPV (i.e., risk factors) and its adverse consequences are multiple and cannot be considered in isolation from one another. Moreover, the type, severity, and level of psychological impairment will differ for each woman depending on the sociocultural context within which the violence occurs (Bent-Goodley, 2007; Briere & Jordan, 2004). Contextual variables such as poverty, exposure to racism and sexism, presence/absence of social supports, community resources and access to treatment may all moderate the consequences of IPV exposure. What follows is an overview of the most common risk factors and psychiatric consequences of IPV.

3.1. Risk factors

3.1.1. History of childhood trauma and adult revictimization—Studies indicate that being a victim of childhood abuse is one of the factors most predictive of

revictimization in adulthood (e.g., Beitchman et al., 1992; Briere & Runtz, 1987; Cloitre, Tardiff, Marzuk, Leon, & Portera, 1996; Coid et al., 2001; Whitfield, Anda, Dube, & Felitti, 2003). Research indicates that women with histories of childhood physical or sexual abuse are two to three times more likely to be exposed to IPV compared to women with no such histories (e.g., Coid et al., 2001; Whitfield et al., 2003).

These observations have led some to characterize revictimized female abuse survivors as having masochistic tendencies or self-defeating personalities, thereby placing further blame on women who have been repeatedly exploited. Cloitre, Cohen, and Scarvalone (2002), however, proposed an alternative and non-pathologizing model for revictimization based on the notion of interpersonal schema theory, an outgrowth of attachment theory. Schemas are models of relationships that guide future expectations and behaviors. The tendency to rely on past experiences to predict the future is not limited to abuse survivors, and can in fact be viewed as an adaptive strategy for negotiating one's interpersonal world. Unfortunately for those who were raised in abusive environments, early negative relationship patterns are those which get applied in adulthood. Specifically, children from abusive homes learned that to be interpersonally connected means to be abused (Cloitre, 1998). Thus aspects of revictimization that come from habitual modes of interpersonal relating are actually based on a healthy impulse to engage. This impulse, however, has been distorted by the influence of abuse and learning, which has taken place in the context of abusive relationships. As a result abuse survivors are often more likely to expect and to accept some degree of victimization in their intimate relationships. These continued experiences serve as "self-fulfilling prophecies" in adulthood and tragically tend to further confirm the idea that women must be willing to settle for some mistreatment in order to maintain connections.

3.1.2. Perpetrator substance misuse and abuse—One of the most documented risk factors for IPV that has consistently been linked to the occurrence, recurrence and severity of IPV as well as homicide, is perpetrator use of alcohol or drugs (Caetano, McGrath, Ramisetty-Mikler, & Field, 2005; Lipsky, Caetano, Field, & Larkin, 2005; Sharps, Campbell, Campbell, Gary, & Webster, 2001; Testa, 2004). IPV has been shown to increase 10-fold for a woman with a substance abusing male partner. Moreover, if both partners are substance abusers, the risk for IPV is 13 times that for a non-using couple (Coker, Smith, McKeown, & King, 2000).

3.1.3. IPV victim's substance misuse and abuse is both a risk factor for and a consequence of IPV—By themselves, female drug or alcohol users are more frequently victims of severe assaults than those who are not alcohol or drug users (Kantor & Straus, 1989; Kilpatrick, Acierno, Resnick, Saunders, & Best, 1997). For example, Goldstein, Belucci, Spunt, and Miller (submitted for publication) reported significant differences between male and female cocaine users in the frequency of IPV, with women significantly more frequently the recipients of violence, suggesting that female cocaine users have a greater risk of being physically abused than male users, and with greater severity than non-drug users.

In the literature on the relationship between substance use and interpersonal violence, two pathways have been identified that may account for the association of these variables. First, the use of alcohol and drugs may make a woman more vulnerable to being abused by impairing her judgment and interfering with her ability to problem-solve or escape from unsafe circumstances. Studies have indicated, for example, that use of alcohol by the victim increases the likelihood of rape or sexual assault (Marx, Van Wie, & Gross, 1996). Second, there is a growing body of evidence that substance abuse often occurs *after* exposure to IPV, leading some researchers to suggest a "self-medication" model in which substances are used to manage or avoid the distressing PTSD symptoms (see Logan, Walker, Cole, & Leukefeld,

2000 for a review.). Clearly, substance misuse, abuse and dependence can either be considered a risk factor or a mental health outcome related to IPV.

3.2. Mental health consequences

3.2.1. Posttraumatic stress disorder—Posttraumatic stress disorder (PTSD; American Psychiatric Association, 2000) is one of the most common psychiatric consequences of exposure to interpersonal violence in general and intimate partner violence in particular. Studies show significantly higher rates of PTSD (ranging from 33% to 84%) among female survivors of intimate partner violence compared to women in the general public (Astin, Lawrence, & Foy, 1993; Golding, 1999; Jones Hughes, & Unterstaller, 2001; Taft, Murphy, King, Dedeyn, & Musser, 2005). PTSD may be especially severe or long-lasting and it is estimated that on average, a person with PTSD might endure 20 years of active symptoms and will experience almost 1 day per week of work impairment, which speaks to the huge toll that PTSD has on the individual and on society (Kessler, Sonnega, Bromet, Hughes, & Nelson, 1995). Both use of a weapon and sexual victimization by an intimate partner have been shown to predict higher PTSD symptom severity (Dutton, 2003a,b). Notably, one study showed that psychological abuse was a stronger predictor of PTSD than physical abuse among women (Dutton, Goodman, & Bennett, 2001; Street & Arias, 2001).

The characteristic symptoms of PTSD occur in 3 clusters. These clusters include: 1) *reexperiencing* (e.g., intrusive and recurrent thoughts, images, perceptions, flashbacks of the traumatic experience, and nightmares); 2) *avoidance and numbing* (e.g., feelings of detachment, persistent avoidance of memories, feelings, people, places or situations that arouse recollection of the trauma); and 3) *increased arousal* (e.g., difficulty sleeping or concentrating, irritability/anger, exaggerated startle response, hyper alertness not present prior to traumatic exposure). Individuals with PTSD also often report associated features such as intense guilt, decreased awareness of their surroundings, forgetfulness/amnesia, feeling that things are unreal or strange, and feeling detached from their bodies.

3.2.2. Depression—Depression, another common reaction to negative life experiences, has been found to be more prevalent among women with IPV exposure compared to non-exposed women (Campbell, Sullivan, & Davidson, 1995; Danielson, Moffitt, Caspi, & Silva, 1998). In addition to being a consequence of exposure to violence, studies suggest that depression may play some role in increasing the chance of becoming a victim of interpersonal violence and may make it even harder to leave an abusive relationship (Beitchman et al., 1992; Gidycz & Koss, 1991). Individuals with depression are known to make faulty self-attributions of blame (e.g., Coyne & Gotlib, 1983; Peterson & Seligman, 1984) involving internalization and guilt, thus making them vulnerable to maintaining involvements with an abusive partner. Rates of depression and PTSD comorbidity are notably high, with 50% of those with PTSD also meeting criteria for at least one depressive disorder (e.g., Cascardi, O'Leary, & Schlee, 1999; Stein & Kennedy, 2001).

3.2.3. HIV infection and AIDS—In the US, the percentage of females diagnosed with HIV/AIDS has increased to 26% in 2005 (CDC, 2007). HIV infection has also spread disproportionately among ethnic minority women, with African American women accounting for 64% of all women living with HIV/AIDS in 2005. The majority of HIV-infected women now contract HIV through high-risk heterosexual intercourse, which continues to be the fastest growing HIV transmission category, and accounted for 78% of all new infections in women in 2005 (CDC, 2007). More concerning, and relevant to the present review, the research shows a strong relationship between IPV (including coerced sex), substance use and HIV sexual risk behaviors (e.g., Geilen et al., 2007). IPV has been associated with having more than 10 lifetime male partners, trading sex, lower rates of

condom use, being forced to have sex with someone who is HIV positive or having a sexual partner that is at risk for HIV (Cohen et al., 2000; El-Bassel, Witte, Wada, Gilbert, & Wallace, 2001; Gilbert, El-Bassel, Schilling, Wada, & Bennet, 2000).

On the most basic level, being in a violent relationship significantly limits a woman's ability to negotiate condom use (Cohen et al., 2000; Grella, Anglin, & Annon, 2000; Wyatt et al., 2002). Wingood and DiClemente (1997) found that African-American women in physically abusive relationships, despite being *more* concerned than their counterparts in non-abusive relationships about becoming infected with HIV, were in fact *less likely* to use condoms. Difficulty in convincing their partners to use condoms resulted in part from threats of physical abuse that women experienced when attempting to discuss condom use with their sexual partners. Power differentials and male sexual ownership/control in abusive relationships may have prevented women from negotiating safe sex. Indeed women reported being too poor, lonely, terrorized or addicted to leave their partners despite knowledge of their partners HIV status (Lichtenstein, 2005).

3.2.4. Other trauma responses—As we have reviewed above, women exposed to IPV often have to endure frequent and severe abuse. As a result, they present with a more complex clinical picture than those who have experienced a single traumatic event. Often these women not only present with PTSD but also co-morbid depression, anxiety, and substance abuse, among other problems. “Complex PTSD” or “Disorders of Extreme Stress Not Otherwise Specified (DESNOS),” (e.g., Herman, 1992, van der Kolk, ref) include alterations in self-regulatory systems: regulation of affective impulses (e.g., difficulty modulating anger), cognitive processes (e.g., disruptions in attention, memory and consciousness), and relationship to others (e.g., problems with intimacy and trust). An individual with Complex PTSD will often exhibit affect and impulse dysregulation, dissociation, somatization and altered beliefs about identity and relationships to others. Most (92%) of those who meet criteria for DESNOS meet criteria for PTSD, however DESNOS may occur independently of PTSD (van der Kolk, Roth, Pelcovitz, & Mandel, 1993). Studies comparing individuals with childhood trauma-only and individuals with childhood trauma and subsequent victimization in adulthood show that the revictimized individuals are consistently more troubled, particularly in the domains of affect modulation, anger management and interpersonal relationships (Cloitre, Scarvalone, & Difede, 1997; van der Kolk et al., 1993 and Zlotnick, Najavits, & Rohsenow, 2003).

Another term that is frequently used when considering consequences of IPV in particular is *Battered Woman Syndrome* (BWS, Walker, 1984, 1991). Rather than diagnosing the victim of abuse with a psychiatric label, some believe that consequences of IPV are more appropriately described such that the context and content of the battered woman's response (e.g., the cycle of violence and the learned helplessness that occurs in response to unpredictable and repetitive violence) is evident. In this way, less blame is placed upon the victim and more accountability on the stressor (i.e., battering).

4. Barriers to help-seeking

Despite the many negative psychological and psychiatric consequences of IPV that we have discussed above, the majority of women in abusive relationships reveal significant difficulty with seeking help. The contextual factors that present obstacles for intervening with IPV among women are reviewed for policymakers and clinicians considering approaches to reach this challenging population.

4.1. Personal and family safety

Many women who experience IPV often find it difficult to seek help or leave an abusive relationship. Often these women live with intense shame and fear that prevents them from taking action to protect themselves. They fear for their lives as well as their children's in addition to worrying about retaliation if they go outside of the relationship for support (Mears, Carlson, Holden, & Harris, 2001; Zoellner et al., 2000). As noted earlier, women exposed to IPV experience more life threats and fears of bodily injury than men and are exposed to frequent and long lasting violence. A significant proportion (47%–72%) of these women do not report their abuse experiences to the police (Rennison & Welchans, 2000; Tjaden & Thoennes, 2000). In addition to fear, many of these women suffer from psychiatric disorders as a consequence of their exposure to violence (e.g., depression, PTSD, substance abuse), which may make it even harder to mobilize their psychological and social resources and take action.

4.2. Economic dependence

Economic dependence is frequently cited as one of the most significant barriers to seeking help or leaving an abusive relationship. Several studies have found that women who remain in abusive relationships are more likely to be unemployed, have low educational status and have more children at home (see Barnett, 2000 for a review). A majority of these women remain in abusive relationships because they lack economic resources and perceive little to no alternative to their distressing situation (Rusbult & Martz, 1995). When they do decide to press charges against their abusive partners, worries about child support and economic survival will influence whether or not they follow-through with the process (Bennett, Goodman, & Dutton, 1999). Finally, their low socioeconomic status places them at even greater risk for revictimization (Carlson, Harris, & Holden, 1999; Mears et al., 2001). Barnett (2000) maintains that “the American political and legal system continues to allow sexist practices that sabotage women's attempts to become economically independent in areas of income, employment, and child support” (p. 347) and as a result victimized women are left with little choice but to tolerate their abusive relationships.

4.3. Psychological factors

Psychological theories that have been proposed to account for the difficulties these women face in seeking help or extricating themselves from their abusive relationships include learned helplessness (Strube, 1988, Walker, 1991), attachment and commitment to the relationship (e.g., Strube & Barbour, 1983, 1984; Zoellner et al., 2000) and economic dependence on the abuser (see Bornstein, 2006 for a review). Learned helplessness is assumed to occur as a consequence of a “perceived noncontingency between responses and outcomes that gives rise to the expectation that future responses and outcomes will also be independent” (Strube, 1988, p. 243). Initially, an abused woman may put forth efforts to leave an abusive relationship or try to stop the violence in the relationship, however, when these efforts fail to produce any significant change in the violence experienced in the relationship (i.e., the violence continues to occur in an unpredictable and repetitive way), she may feel helpless and incompetent and withdraw into a state of passivity (see Barnett, 2001 for a detailed reviews of this concept).

Attachment and commitment to the abuser and the relationship often make it difficult to take the necessary steps towards leaving or seeking help (Strube & Barbour, 1983, 1984; Zoellner et al., 2000). Zoellner et al. (2000) found that the women who expressed love for their partner and a willingness to take him back if he could change were less likely to follow through and obtain a restraining order. Strube and Barbour (1983, 1984) found that love and length of time in the relationship (both considered measures of commitment) were negatively related to victimized women's decisions to leave.

4.4. Sociocultural factors

Along these same lines, many theorists argue that the patriarchal and sexist attitudes and practices that exist in American society today, particularly gender role socialization (Birns, Cascardi, & Meyer, 1994) and the normative acceptability of violence perpetrated against women (Geen, 1998) both create significant barriers for abused women to seek or receive help. Violence is an embedded part of our society and social norms dictate the circumstances under which aggression is acceptable and even condoned. It has historically been socially acceptable for males to use aggression against their wives to resolve interpersonal conflicts. The socially sanctioned use of violence in combination with the power inequality evident in many parts of our society today, help to create a system of male domination and female submission (Barnett, 2000; Geen, 1998).

Cultural proscriptions against seeking help outside of the family or the immediate cultural milieu, as well as exposure to negative experiences secondary to being an ethnic minority in the United States (Hampton et al., 2003), may make it harder for certain subgroups of women to seek help. For instance, it is often theorized that given African American women's past negative experiences in the United States (e.g., being negatively stereotyped and their credibility questioned), they may be less likely to disclose their experience of victimization out of fear that they will not be believed and/or will not receive the support that they desire. Moreover, they may be conflicted about reporting African American male perpetrators to the legal system because they suspect they may be treated harshly. Hence, African American female victims face a "double bind" when they are making the difficult decision to seek help and protect themselves versus report their violent African American partners and "betray" their community (Abney & Priest, 1995; Hampton et al., 2003; Wyatt, 1992).

4.5. Legal factors

A wide range of legal measures have been instituted to assist victims of IPV. Some of these interventions include arrest, prosecution, and protective orders. Several general overviews of the literature on the effectiveness of the criminal justice system responses to IPV have been conducted with conclusions ranging from completely ineffective (e.g., Barnett, 2000) to moderately effective (e.g., Jordan, 2004). Some argue that the criminal justice system's ineffectiveness stems from it being a time-consuming and confusing process as well as their failure to implement interventions appropriately, which both present significant obstacles for abused women when they attempt to leave their partners (Barnett, 2000). Despite these difficulties and the disparate findings in the literature, studies do indicate that, of all the available interventions, arrest and protective orders are moderately effective in reducing revictimization of abused women (Jordan, 2004). We will provide a general overview of the most common findings of various legal interventions along with some of the significant challenges that abused women experience once they enter the legal system.

Victimized women's first exposure to the criminal justice system often comes through their contact with the police. However, many incidents of IPV go undetected and unreported. African American women tend to report and file charges against their violent partners at higher rates than white women (McFarlane, Willson, Lemmey, & Malecha, 2000; Tjaden & Thoennes, 2000). Likewise, Hispanic women reported their victimization at a higher rate than non-Hispanic women in the NCVS (Rennison & Welchans, 2000). The finding of higher rates of reporting among African American women might appear inconsistent with cultural expectations against reporting African American men. However, one reconciliation of these two findings is that women are more likely to contact the police when the abuse is frequent and severe (Gelles, 1976, McFarlane et al., 2000) and African American women tend to be exposed to more severe abuse than white women (Hampton & Gelles, 1994), which may account for their greater frequency in reporting the abuse (see Hampton et al.,

2003 for a similar argument regarding the higher rate of African American women who murder their violent partners).

Many abused women often experience and report strong ambivalence about contacting and involving the police in their relationships difficulties (e.g., Bennett et al., 1999). Moreover, it is argued that certain criminal justice system practices (e.g., mandatory arrest and no-drop policies) further contribute to a victimized woman's sense of powerless and offer her little control over the outcome of the arrest (Bennett et al., 1999). Finally, the efficacy of arrest in deterring future violence against women has been questioned. Some studies find deterrent effects and others find an increase in female re-victimization after arresting the abusive partner (e.g., Buzawa & Buzawa, 2003; Dugan, Nagin, & Rosenfeld, 2001). Jordan (2004), in her review of several outcome studies, found that arrest is positively associated with a decrease in recidivism, although the levels of reduction were not always significant. Moreover, it was found that perpetrators who had "something to lose" as a result of arrest were less likely to re-abuse their partner (Jordan, 2004).

Once a victimized woman decides to press charges against her violent partner, the process is one that is often fraught with difficulties. McFarlane et al. (2000) conducted interviews with 90 women at the time they filed assault charges against an intimate partner and followed them for 6 months to determine the outcomes of their cases. An alarming finding was that 48% of the women who filed charges had insufficient evidence for filing even though they experienced similar levels of violence to those women whose charges were accepted. Moreover, three months later, these same women had significantly higher scores on a measure designed to determine their risk of being killed by their partner. Finally, among all 90 women, there was no greater reduction in revictimization whether the violent partner was arrested or not, which highlights the question of whether or not criminal justice system interventions are effective deterrents (McFarlane et al., 2000). Bennett et al. (1999) gathered qualitative data on primarily African American women's experience of the criminal justice system and found that they experienced a wide range of difficulties including 1) feeling frustrated about the length of the procedure and confusion about the process, 2) living in fear throughout the procedure, and 3) feeling conflicted about the incarceration of their violent partner. Their ambivalence was often related to worries about economic survival or child support and betrayal of their cultural community. Hare (2006) measured abused women's opinions regarding prosecution of their violent partner and asked whether or not they wanted charges to be filed. Several themes emerged among those who were opposed to prosecution, which included emotional commitment and financial dependence on the perpetrator.

Once the case makes it to the prosecution level, evidence suggests that it is often an adversarial and stressful experience for many victims of IPV because their credibility and truthfulness are often called into question, there is a tendency to try to blame and discredit the victim (Jordan, 2004; Walker, 1991), and the attitudes and behaviors of court personnel (e.g., lawyers, judges etc.) often result in negative biases and rulings that work against the victims (Barnett, 2000).

The specific term "battered woman's syndrome" is often utilized during legal cases as a self-defense argument for women who may have used lethal force against her batterer. Some maintain that the definition and diagnostic criteria of BWS are not clearly defined and do little to explain a battered woman's post-victimization responses including her perception of threat or her decision to remain in or terminate the abusive relationship (Dutton, 2004). Others argue that the label BWS portrays abused women as psychologically unstable and calls into question the reasonableness of the actions taken after being battered (see Schuller, Wells, Rzepa, & Klippenstine, 2004 for review). Moreover, it has been argued that BWS is not unique to battered women's experiences and significantly overlaps with other assault

groups' post-victimization responses (e.g., childhood abuse and rape victims). Having a diagnosis of BWS is not predictive of exposure to IPV because many victims of IPV do not present with such reactions (Briere & Jordan, 2004). Nonetheless, the label BWS was an important step towards highlighting the social contexts in which abused women are living (e.g., fear, domination, few alternative options to the abusive relationships etc.) and offered a less stigmatizing approach to understanding these women's experiences.

Other than prosecuting her perpetrating partner, protective orders are alternative legal interventions that victimized women can request. One of the main functions of a protective order is to prevent the perpetrator from having direct contact or communication with the victim, and hence a cessation of the violence. However, the process and outcome of obtaining a protective order may be no less demoralizing than other legal options. For example, Zoellner et al. (2000) found that less than 50% of the women completed the process to obtain an order of protection. Two of the most significant obstacles included fear of retaliation and threats to their children. The women were more likely to complete the process when their own lives were threatened. It was hypothesized that the fear some victimized women experience may be curvilinear; a certain degree of fear or threat may drive a woman to obtain an order whereas paralyzing fear, a possible consequence of threat to one's children, may hinder her from following through with the process (Zoellner et al., 2000). Several studies indicate that the fear that victimized women experience is often validated given their experiences after seeking help. A significant proportion of women are re-victimized after seeking legal intervention (Carlson et al., 1999; Keilitz, Davis, Efkenan, Flango, & Hannaford, 1998). Mears et al. (2001) examined the differential impact of various types of legal interventions (e.g., arrest, protective order, or arrest plus protective order) and found that no single intervention was more effective than the others in reducing the prevalence of or length of time to revictimization. They also found that poor, black women benefited the least from any of the interventions and were more likely to be revictimized after an intervention was implemented. They theorized that the increased risk for black women may be related to the unresponsiveness of the police to their needs. Moreover, the confluence of ethnic minority status and living in low-income communities heightens African American women's risk for revictimization.

Logan, Shannon, Walker, and Faragher (2006) conducted a comprehensive review of the effectiveness of protective orders and organized the barriers to achievement and implementation of protective orders into two main categories: accessibility and acceptability. Obstacles to accessibility included: 1) costly and time-consuming process; 2) stringent eligibility criteria; and 3) inadequacy in the provision and enforcement of the protective orders by the justice system. The main barriers to acceptability included: 1) fear of retaliation; 2) perceived ineffectiveness of the protective order and negative attitudes toward the justice system; and 3) economic difficulties (lack of employment and housing). The overarching conclusion from this review was that, although women reported general satisfaction with the protective orders, violations of the orders were commonplace and frequently did not result in any negative sanctions (e.g., arrest) against the perpetrators (Logan et al., 2006). Since the effectiveness of legal interventions are mixed and not one intervention appears to be more effective than others, many scholars are now advocating for a Coordinated Community Response (CCR), which incorporates several systems including social services, advocacy services, and the criminal justice system. Preliminary results indicate that men who participate in a CCR program evidenced lower recidivism rate than men who did not (Jordan, 2004; Shepard, Falk, & Elliot, 2002).

5. Implications for providers and policy makers

In summary, the literature to date reveals the significant challenges victimized women face on their road to recovery and freedom from violence. The psychiatric consequences of victimization have been well-established and inflict a significant toll on abused women and society. Confounding the problems are the significant psychological, sociocultural, and legal barriers to seeking and receiving help, as well as terminating an abusive relationship. This section will provide an overview of frequently suggested guidelines for the assessment and treatment of victims of IPV and implications for legal and research policies and practices.

5.1. Screening/assessment

The United States Preventive Services Task Force (USPSTF, 2004) has given an “inconclusive” recommendation regarding the effectiveness of screening for IPV. However, several health professional organizations have endorsed the practice and more recent studies indicate that IPV screening can have beneficial outcomes (e.g., McFarlane, Groff, O'Brien, & Watson, 2006; Phelan, 2007). Screening and assessment of the frequency and severity of IPV exposure as well as the risk for homicide by IPV may be conducted using several well-known screening tools such as the Abuse Assessment Scale (McFarlane, Parker, Soeken, & Bullok, 1992), Partner Violence Screening (Feldhaus et al., 1997), or the Danger Assessment Scale (Campbell, 1986). Victimized women may evidence significant difficulty trusting others and as a result have trouble revealing a history of victimization or current experiences with violence. Clinicians can play an important role in eliciting this type of information and providing the much needed support and treatment that these women require. McCloskey and Grigsby (2005) highlight the significance of screening for IPV exposure in the first session of meeting with a client. If the screening is positive, the clinician can then move into a full-scale assessment where he/she gathers a full history to determine past and present experiences with violence, determines whether the client is the primary victim and/or batterer, and then conducts a lethality assessment. Depending on the assessment of lethality, the clinician can then move into safety planning (see Briere & Jordan, 2004 and Walker, 1991 for similar recommendations).

Briere and Jordan (2004) note that given the complexity and variability of a victimized women's response to IPV exposure, it is imperative that clinicians utilize an individualized approach to assessment and treatment. They encourage the use of general, structured assessment tools such as the Symptom Checklist-90-R (Derogatis, 1983), in addition to trauma specific measures such as the Posttraumatic Stress Diagnostic Scale (Foa, 1995) to aid in the understanding of the specific trauma-related symptoms these women are experiencing as well as important diagnostic correlates (e.g., depression, anxiety, substance abuse etc.) that may complicate abused women's overall diagnostic picture. Walker (1991) encourages clinicians to be mindful of the typical coping strategies employed by victimized women when recounting their trauma experiences including denial, minimization, and dissociation and notes that attentiveness to non-verbal communications (e.g., facial expressions, speech content and process, eye contact) can provide important information that aids in the validation of one's initial diagnostic impressions.

5.2. Treatment

Given the multifaceted nature of women's response to IPV, treatment will necessarily require a multimodal approach which targets a wide range of psychiatric symptoms (Briere & Jordan, 2004). A strong emphasis is placed on helping victimized women re-establish a sense of safety and empowerment to regain control of their lives in the context of a safe, therapeutic relationship (Herman, 1992; Walker, 1991). Moreover, given the multiple levels on which women may need help, clinicians may find themselves in the position of

coordinating a wide range of services for these women including social support and legal advocacy. Also of importance is increased awareness of the various legal options and responses available to each client and the necessity of protecting client's psychotherapy records during legal trials (McCloskey & Grigsby, 2005; Walker 1991). Clinicians are encouraged to be mindful of the socio-cultural barriers to seeking or receiving help including gender and ethnic/racial proscriptions against help-seeking as well as the economic factors that prevent women from leaving an abusive relationship (Barnett, 2000; Hampton et al., 2003; McCloskey & Grigsby, 2005).

5.3. Legal implications

Several specific suggestions and alternative approaches have been offered by scholars to counteract and reduce the negative impact of the criminal justice and legal systems as they exist today. Barnett (2000) calls for increased funding, education, and training for the criminal justice system (i.e., police response) as well as improvements in legislation as it applies to the protection of victimized women and their children through prosecution of offenders. Jordan (2004) recommends an increased recognition of the importance of contextual factors as well as offender characteristics in understanding prevalence rates of recidivism for offenders. Likewise, in order to improve our understanding of the positive effects as well as the limitations of the criminal justice system response, future empirical studies with solid research methodologies must be conducted with a nuanced understanding of the many contextual and psychological factors and barriers that we have discussed above that prevent an abused woman from turning to the criminal justice system for help. Suggestions for research include the utilization of more comprehensive outcome measures, increase in follow-up periods, and clarity on the operational definitions utilized to determine positive or negative outcomes (Jordan, 2004). Finally, with respect to the prosecution of offenders, a "therapeutic jurisprudence" approach is recommended that utilizes a more client-centered perspective to support and empower a women throughout the trial process with her intimate offending partner. In order to encourage women to follow through with legal actions against offenders with an ultimate goal being a more positive and therapeutic experience within the legal system, the tendency to discredit and blame the victims must be minimized (Hartley, 2003). Finally, coordinated community responses which incorporate law enforcement, prosecution, civil remedies, legal advocacy, and clinical treatment may lead to improvements in the justice system's effectiveness with IPV.

6. Summary

This review has highlighted the degree to which IPV for women in the United States is a significant and growing public health concern with sequelae that span psychological, sociocultural and legal domains. Since medical, psychiatric and legal response systems are typically organized in such a way as to be independently functioning, cross-communication efforts must be directed and intentional. Consequently, we face great challenges in future efforts to integrate prevention and intervention of IPV for women across interdisciplinary lines. It is our hope that this paper will promote dialogue towards these ends.

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