Violence Against Women:
Synthesis of Research for Practitioners

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Since the 1970s, society began to define violence against women as a distinct phenomenon rather than a means of grouping offenses by particular victim characteristics. This redefinition has been accompanied by a proliferation of research on the causes and nature of violence against women; the consequences for victims; and the roles of criminal justice, social service, and public health practitioners in preventing, intervening in, and ameliorating the effects of women's victimization.[1]

The purposes of this project are to provide practitioners with information on key findings from scientific research on violence against women, identify knowledge gaps that may be inadvertently filled by unsubstantiated assumptions or beliefs, and increase practitioners' awareness of, access to, and ability to use information across the boundaries of professional domains. The task of communicating research findings to practitioners is challenging on several counts.

- Responding to violence against women is the responsibility of many agents in criminal justice, social services, and public health, and these practitioners occupy independent niches in the public and private sectors.

- These groups tend to think about women's victimization in terms defined by their own professional values, training, and paradigms.

- The fragmentation of service sectors that is reproduced in programmatic responses and in published evaluations of programs and services (Chalk and King, 1998) limits many practitioners' and researchers' understanding of how their practices interact with those of others. This agency-specific and program-specific thinking obscures more constructive recognition of common strategies and goals that might lead to more coordinated and effective responses.

- The channels through which social science findings are disseminated are not readily accessible to most practitioners.

- Many practitioners take pride in the progress that has been made in reforming laws and practices and are optimistic about the effectiveness of those reforms. Research findings that challenge their assumptions, and results that document the limitations of interventions, are occasionally misinterpreted as indictments of their hard-won efforts, rather than practical information that could be incorporated into ongoing innovations.

This report reviews research issues and questions that are common to the work of all audiences for this project.[2] The first section reviews definitions of different forms of violence against women and summarizes what researchers know about their incidence and prevalence. The next section briefly documents the emergence of violence against women as a social, legal, and public health issue. The next section presents a summary of research on risk and contributing factors; it is followed by a review of the consequences associated with violence against women.

Defining Violence Against Women

For the purposes of this project, violence against women is defined as any physical, emotional, sexual, or psychological abuse or violence committed against women by intimate partners or acquaintances, including current or former spouses, cohabiting partners, boyfriends, or dates. Although this definition is broader than ones adopted by many practitioners and narrower than others, it captures the scope of women's victimization at its most fundamental level. Regardless of how it is socially or legally defined, women's experiences of violent victimization are dominated by victimization by people they know (Browne and Williams, 1993; Lentzner and DeBerry, 1980; Mercy and Saltzman, 1989; Tjaden and Thoennes, 1998a). Moreover, although the law distinguishes between sexual assault, domestic violence, and stalking, research shows that these types of victimization often occur simultaneously or sequentially (Browne, 1987; Caputi, 1989; Eby et al., 1995; Frieze, 1983; Shields and Hanneke, 1983; Zillman, 1984).[3]

Researchers and practitioners have yet to develop a complete consensus on what constitutes violence against women, but many include the following:

- Acts carried out with the actual or perceived intention of causing physical pain or injury to another person (Gelles and Harrop, 1989).

- Acts that are, or potentially are, physically and emotionally harmful (O'Leary and Browne, 1992).

- Physical, visual, verbal, or sexual acts that are experienced as threatening, invasive, assaultive, hurtful or degrading, or controlling (American Psychological Association, as cited in Koss et al., 1994). Legally and historically, these behaviors have been distinguished as physical violence, sexual assault, and, most recently, stalking.

Physical violence includes fatal and nonfatal physical assault. Consistent with the definitions most commonly used by researchers, physical violence is defined herein as any act of physical aggression intended to harm one's partner. These acts include pushing, grabbing, and shoving; kicking, biting, and hitting (with fists or objects); beating and choking; and threatening or using a knife or gun.[4]

Legal definitions of rape and sexual assault differ from State to State, although their common element is the lack of victim consent to sexual acts. Many States have ceased to use the term "rape" in their criminal codes, substituting more general definitions of sexual assault and abuse. In general, State laws distinguish between aggravated sexual assault (forcing a victim to engage in a sexual act through actual or threatened death, serious bodily injury, or kidnapping) and sexual abuse (which involves less serious threats and engaging in sexual acts with a person who cannot give consent; see, for example, 18 U.S.C. § 2241–2245). For the purposes of this project, sexual assault includes rape as conventionally defined (forced or coerced vaginal, anal, or oral penetration), as well as other forced or coerced sexual acts that do not involve penetration.

Emotional or psychological abuse includes any act intended to denigrate, isolate, or dominate a partner. Emotional abuse is intended to control victims by limiting resources and social contacts; creating actual and emotional dependence; and reducing victims' sense of self-worth, competence, and value. Emotional maltreatment can include verbal abuse, such as insults, criticism, ridicule, name calling, discounting, and discrediting; isolation of the victim; control of social and family contacts; denial of access to finances or transportation; demonstration of extreme jealousy and possessiveness; the monitoring of behavior; accusations of infidelity; threats of harm to the victim's family, children, or friends; threats of abandonment or infidelity; and damage to or destruction of personal property (Davis and Swan, 1999; Follingstad et al., 1990; Marshall, 1999). Health care, mental health, and legal researchers have not reached full agreement on a definition of emotional abuse, and less is known about this form of abuse than others (O'Leary, 1999).[5]

Stalking has been defined by the National Institute of Justice as "a course of conduct directed at a specific person that involves repeated visual or physical proximity, nonconsensual communication, or verbal, written implied threats, or a combination thereof, that would cause a reasonable person fear" (Tjaden and Thoennes, 1998b, p. 2). Examples include behavior such as following the victim, conducting surveillance, threatening the victim or victim's family, harassing the victim through phone calls or letters, appearing at the victim's home or place of business, or breaking into the victim's home. Although high-profile cases of celebrity stalking have attracted media and public interest, the majority of stalking victims are ordinary people who are pursued or threatened by someone with whom they have had a relationship. Almost 80 percent of stalking cases involve women stalked by persons they know (Tjaden and Thoennes, 1998b). In recognition of this problem, 48 States and the District of Columbia passed antistalking statutes between 1990 and 1994.

The Emergence of Violence Against Women as a Social Problem

Since the 1970s, largely through the efforts of victim advocates, the public and policymakers have become more informed about violence against women. Society has assumed greater responsibility for preventing and ameliorating the effects of violence against women, and it has evolved into a social, community, criminal justice, and public health issue.

The Emergence of Violence Against Women as a Social and Legal Issue

Given the current level of public concern and policy reform surrounding domestic violence, sexual assault, and stalking, it would be easy to overlook the fact that much of what is called violence against women today was classified in the domain of private, interpersonal relationships a few decades ago. Historically, limitations on women's activities, legal protections, and political rights were justified in terms of women's presumed delicacy and emotionalism. Men's presumed role as leader and decisionmaker in both public and private life was another important factor (Dobash and Dobash, 1979; Pleck, 1987).

These assumptions about gender and gender roles underlie legal constructions of violence against women in the form of legislative statutes and common law (Hart, 1991). In the case of sexual assault, the common law addressing rape departed from standard criminal codes in several ways (Estrich, 1987). Early English definitions and subsequent American interpretations of the crime of rape established special circumstances for proving intent, justified by explicit assumptions.

- Truly forced or coercive sexual intercourse is extremely rare.
- Women are socially motivated to lie about consensual encounters.
- Men are often unable to distinguish consensual from nonconsensual sex.

Because the burden of proof in criminal law falls on the prosecution, the effect of such laws is to minimize the probability of conviction when there is any doubt as to the defendant's state of mind about the victim's willingness to have sex, or any doubt about the victim's propensity to misrepresent the incident.[6]

The bias in rape law has had two important effects: It is associated with very low reporting and prosecution rates for sexual assault, and it has created two social categories of rape. The first category includes what one author has termed "real rapes" (Estrich, 1987): allegations of stranger assaults by blameless and helpless victims who suffer severe injuries or die as a result of the attack. The second, and much larger, category includes "simple rapes": assaults committed by acquaintances or friends that typically involve force or coercion but not necessarily weapons or severe injuries and are hence open to the special challenges in rape code.

Domestic violence has a somewhat different legal history, although it is rooted in similar assumptions about relationships between women and men. Although history shows sporadic efforts to criminalize wife-beating (Pleck, 1987), such laws were seldom called into use and many States did not have them. As a result, judges were rarely confronted with assault charges involving spouses, but when they were asked to rule on cases of criminal wife-beating, they often explicitly condoned the behavior as a form of family discipline and male responsibility (Bonsignore et al., 1989; Allison and Wrightsman, 1993). Women's claims were also rebuffed in civil court, where common law rulings declared that if beatings did not cause lasting injury, they were insufficient to constitute the "extreme cruelty" that justified divorce.

Throughout most of history, rape was a difficult accusation to sustain in criminal court because the standards of factual proof were set so high. Assault on a wife was an almost impossible criminal allegation to sustain because physical assault on a wife was not against the law and was at most seen as a matter of civil law. Not surprisingly, rape of one's wife was a legal impossibility: Rape statutes specifically excluded husbands from the charge under almost all circumstances because marriage was assumed to constitute a standing consent to sex, and a husband's physical retribution for a wife's disobedience was accepted (Denno, 1994; Ryan, 1996).

Although these laws may be viewed as relics of the past, some of their core elements remain intact in many States and prosecutors and judges recognize that the beliefs that underlie them are still held by many people, including potential jurors. Research suggests that many people,

including some practitioners, are still reluctant to label violent incidents between partners as crimes (Ellis, 1984; Schmidt and Steury, 1989), even when they strongly disapprove of the behavior (Johnson and Sigler, 1995; Klein et al., 1997; Stalans, 1996). Research also suggests that, regardless of their own attitudes, prosecutors consider this reluctance when deciding whether, and how, to process these cases in court (Schmidt and Steury, 1989; Spohn and Spears, 1996).

The Redefinition of Violence Against Women as a Community Responsibility

The women's movement of the 1960s gave birth to the rape crisis and battered women's movements of the 1970s. Advocacy efforts to ameliorate the effects of violence against women began as two parallel tracks: One focused on sexually victimized women and the other focused on physically assaulted women. Awareness of stalking and its definition as a community responsibility did not emerge until the early 1990s.

Initially, even sexual assault victim advocates assumed that rape and sexual assault were largely committed by strangers. In contrast, battered women's advocates and the public presumed that domestic violence was largely perpetrated in the context of marriage. Over time, sexual assault victim advocates and researchers learned that most sexual assaults were committed by family members, intimate partners, or acquaintances. It also became clear that married men were not the only group that used physical force on their female partners; women in cohabiting and dating relationships beginning as early as adolescence were found to be at equal or higher risk for physical or emotional abuse by their male partners.

The National Organization for Women (NOW) played an active role in the formation of the first task forces on woman abuse, and by the middle 1970s, the first shelters had been formed in Boston, Ann Arbor, San Francisco, and Minneapolis (Okun, 1986). At the same time, NOW was instrumental in some communities in the development of rape crisis centers (Koss and Harvey, 1987). Although not coordinated or integrated, the rape crisis and battered women's movements had several important similarities. Both efforts were social change movements that emerged in the early 1970s. Both were strongly grounded in a feminist awareness and analysis of the problem. (This fundamentally social analysis perceived violence against women as inevitable given the position of women in society and the treatment of women historically.) Both movements believed that the solution was not to change individual women but to change the society that socialized men to believe they were entitled to control and dominate women. Both movements embraced the twin goals of providing support and assistance to victims and community education aimed at preventing violence against women. As social movements, both challenged traditional, male-oriented organizational structures and were committed to forming new organizational structures, such as collectives, that were not patriarchal and were less hierarchically organized (Harvey, 1985; Koss and Harvey, 1987). Both began with few resources and were financed primarily by volunteer contributions. Over time, both movements increased and diversified their funding structures, professionalized their staffs, and in some cases became more conventional and less alternative organizations (Harvey, 1985; Koss and Harvey, 1987; Roberts, 1981, 1998).

Reframing Violence Against Women as a Criminal Justice Issue

Advocates from the rape crisis and domestic violence movements who believed the causes of violence against women could be found in a culture that tolerated male violence found ample evidence for that view in laws and legal practices that effectively decriminalized most instances of violence against women. When advocates lobbied for changes in the law and criminal justice practice, they frequently encountered resistance and skepticism. Although reforms in the areas of sexual assault, domestic violence, and stalking have followed different paths, they share a common objective from a sociolegal perspective: removing the burden of proof or prevention from victims and potential victims, thereby chipping away at the exceptions to legal codes that have made these gender-based crimes historically distinct. In the area of domestic violence, reform efforts have also been directed toward placing greater responsibility on the legal system for protecting women from revictimization, largely through greater use and enforcement of protection orders (Worden, 2000a).

Legal changes in the area of sexual assault include elimination of the utmost resistance test, elimination or modification of the corroboration requirement, repeal of the marital exemption, redefinition of the crime from rape to gender-neutral sexual assault, and, in some States, adoption of rape shield laws that bar some forms of defense interrogatories regarding victims' past sexual experiences (Berger, Searles, and Neuman, 1988). These laws were passed by States in various forms and combinations with the intention of alleviating victims' fears of reporting and charging and improving the ability of prosecutors to secure convictions and sentences. The laws were an attempt to reset the balance between defendants' and victims' rights to more closely approximate other criminal adjudications. Research in six States that adopted different packages of reforms during the early 1980s indicates that few changes in these outcomes followed the legal changes, but it concluded that in the most progressive jurisdictions, prosecutors, judges, and defense lawyers had already adopted more victim-sensitive practices (Bachman, 1998; Bachman and Paternoster, 1993; Horney and Spohn, 1991).

Other innovations in the area of sexual assault law are aimed at offenders and include mandatory sentencing and sex offender registries. The aim of such policies is to incapacitate offenders, denying them access to victims and rendering them less likely to recidivate. Despite the political popularity of such innovations, there has been little research on their effectiveness in reducing violent incidents.

Reforms have also occurred in the area of domestic violence. Domestic violence is now criminalized in all States in the sense that exemptions from assault statutes for wives are no longer entertained by appellate court judges, and many States have created code categories for offenses involving family members. The more important target of reform, however, has been enforcement and prosecution practices. Police departments that historically adopted a hands-off approach to domestic incidents or that subscribed to the crisis intervention approach widely promoted in the 1960s (Bard and Zacker, 1971) were encouraged by advocates to arrest offenders. The real impetus for most pro-arrest policies adopted in the 1980s was the threat of civil liability for failing to protect victims, especially victims of repeat violence who were well-known to the police. Some jurisdictions and States have taken an even stronger stand, mandating arrest

in certain circumstances, although the effectiveness of such policies remains a topic of debate (Bachman, 2000; Hirschel and Dawson, 2000; Worden, 2000a).

Just as arrest policies were expected to take the onus off victims, prosecution reforms were intended to clarify victims' roles as victims and witnesses, not disputants, in court. No-drop policies, evidence-based prosecution, and routine issuance of temporary protection orders were aimed at minimizing the need for victims' active participation to secure conviction and improve their own safety (Lerman, 1981; Mickish and Schoen, 1988), but whether they achieved those aims is still in question (Ford, 1991; Ford and Regoli, 1993). Research has addressed only some of these reforms (Ford and Breall, 2000; Worden, 2000a). Sentencing innovations, especially court-mandated counseling, reflect a rehabilitative but controversial approach to offenders (Saunders and Hamill, 2003).

Stalking laws have a distinct legal history. Rape law reforms were adopted to correct the special imbalance between defendants and victims that was historically built into the law, and domestic violence reforms targeted local practices that continued informally to decriminalize spouse assault. Stalking laws, however, were designed to give law enforcement more tools with which to apprehend and prosecute offenders whose behavior in any particular incident was unlikely to rise to the level of a crime (Tjaden and Thoennes, 1998b). Originally conceived as a way to apprehend stalkers whose victims did not know them, stalking laws criminalized patterns of behavior that produced fear in victims. However, it appears likely that these laws will be most often deployed in acquaintance stalking situations.

In summary, the reconstruction of violence against women as a criminal justice issue proceeded along different paths for different forms of violence. However, all criminal justice reforms share a common element: They acknowledge greater responsibility and jurisdiction for criminal justice agents in intervening in and, to a lesser extent, preventing, violence, largely through revoking traditional protections and entitlements afforded to men who are violent.

Violence Against Women as a Public Health Issue

Violence began to be addressed as a public health and medical care issue in the early 1980s (Waller, 1994). In 1985, Surgeon General C. Everett Koop formed the Workshop on Violence and Public Health to focus professionals on the nature and consequences of violence. The three factors that have contributed to the inclusion of violence against women as a public health problem were increased knowledge on the prevalence and effects of partner violence, the efforts of advocacy groups (Hagen and Postmus, 2000), and growing awareness of the impact of violence against women on health care utilization. As a result, the Public Health Service's priority-setting document *Healthy People 2000* includes six objectives directly related to violence against women.

The application of a traditional public health perspective to the problem of violence against women involves identifying its prevalence, pattern variations within a population, and risk factors; developing causal models; and developing and testing preventive intervention strategies at the individual, social, and physical environment levels (see Chalk and King [1998] for further

discussion, as well as Moracco, Runyan, and Dulli, 2003). This research approach is based on public health's considerable success in studying and responding to infectious and chronic disease. However, the usefulness of this approach in understanding and intervening in intimate partner violence has not been proven. The focus on community health promotion has led to the development of largely school-based interventions aimed at preventing partner violence by targeting potential abusers and victims (Foshee et al., 1996; see also Cascardi and Avery-Leaf, 2000).

In the medical care arena, the focus on violence against women is generally limited to screening, identifying, referring, and treating victims of partner violence (Campbell and Boyd, 2000). This reflects the medical care system's historic focus on the diagnosis and treatment of individual patients rather than on the larger social problems and forces that create the problems (Randall 1990). Thus, there has been a proliferation of interventions aimed at improving screening and referral with limited evaluation of and unclear effect on violence against women.

Prevalence of Intimate Partner Violence

Estimates of the prevalence of partner violence vary, in part because researchers use different definitions and data collection strategies and victims report crimes at low rates. Practitioners' estimates of the frequency of victimization vary, depending on whether they work with general or at-risk populations, rely on victim reports or official incident data, and focus on recent incidents or lifetime abuse experiences.

Prevalence of partner violence in national samples. In 1985, the National Family Violence Survey estimated rates of intimate partner violence among married and cohabiting adults. The survey, which measured violence using the Conflict Tactics Scale, found that 11.6 percent of women reported having been physically assaulted by their partners during the preceding year (Straus and Gelles, 1986). The National Crime Victimization Survey, conducted in 1993, estimated that 9.3 out of 1,000 women were victims of partner violence during that year and an additional 12.9 out of 1,000 experienced violence at the hands of friends and acquaintances. Furthermore, this study suggests that 29 percent of victimizations involving single offenders were perpetrated by intimates, 9 percent were perpetrated by other relatives, 40 percent were perpetrated by someone known to the victims but not an intimate or relative, and only 24 percent were perpetrated by strangers (Bachman and Saltzman, 1995). The National Violence Against Women Survey, conducted during 1995 and 1996, examined violence against women rates among adult American women (Tjaden and Thoennes, 2000) and found, consistent with the National Crime Victimization Survey, that 1.3 percent of women had experienced violence by an intimate partner in the previous year. This study also found that 22 percent of women reported physical assaults by an intimate partner at some time in their lives.

Data on sexual assault parallel reports on physical assault. The National Violence Against Women Survey concluded that 25 percent of women experienced sexual or physical assault from an intimate partner at some point in their lives[7] and 77 percent of all sexual assaults on adult women were perpetrated by a current or former intimate partner (Tjaden and Thoennes, 1998a).

Similarly, the National Crime Victimization Survey reported that 80 percent of the 500,000 sexual assaults experienced by women annually are perpetrated by someone known to the victim.

Stalking is the least investigated form of violence against women. The National Violence Against Women Survey, the only community study that assesses the magnitude of stalking, reports that approximately 8.1 percent of women are stalked at some time in their lives (Tjaden and Thoennes, 2000). As with other forms of intimate partner violence, stalking is most commonly perpetrated by current or former partners. About 68 percent of the stalking cases reported to the National Violence Against Women Survey lasted a year or less, but 10 percent lasted 5 years or more.

Prevalence of partner violence in crime reporting systems. Experts agree that despite their accessibility, the two major sources of crime information compiled by the Federal Bureau of Investigation—the Uniform Crime Reports and the National Incident-Based Reporting System—significantly underestimate the prevalence of partner violence. These systems rely on voluntary reports of crimes by local police departments, which include fewer than 50 percent of actual crime victimizations (Reiss and Roth, 1993) and an even lower percentage of partner violence incidents. A recent study concluded that only 20 percent of rapes, 25 percent of physical assaults, and 50 percent of stalking incidents are reported to local authorities, and police do not formally record all incidents reported (Tjaden and Thoennes, 2000). Furthermore, because these records typically do not include complete information on the victim/offender relationship, these statistics are particularly unreliable for cases of sexual assault (Fisher and Cullen, 2000).

Prevalence of partner violence in patient populations (clinical samples). Studies based on clinical samples[8] report that between 5 percent and 35 percent of women presenting complaints in health care settings have been victims of partner violence (Glander et al., 1998; Hamberger, Saunders, and Hovey, 1992; Hayden, Barton, and Hayden, 1997; McCauley et al., 1995; Quillian, 1996; Randall, 1990). These rates exceed those of community samples because victims are more likely than nonvictims to suffer from an array of physical and mental health issues and are thus more likely to seek health care (Bergman and Brismar, 1991; Felitti, 1991; Koss, Woodruff, and Koss, 1991; Sorenson and Siegel, 1992). About 25 percent of women who are identified as victims of intimate partner violence in clinical samples had been severely abused (Abbott et al., 1995; McCauley et al., 1995).

In summary, estimates of the prevalence of violence vary depending on the types of questions asked of the victims and the nature of the samples studied, but at a minimum, 1 percent of women experience violence at the hands of a partner during a year and 25 percent are victimized during their adult lifetime. Women are at higher risk of assault from someone known to them than from strangers (Crowell and Burgess, 1996; Gilbert, 1995). In general, official data reported to government agencies about violence against women is of limited value in estimating the prevalence of the problem because most victims do not make such reports.

Research on Risk and Contributing Factors

Separate areas of research have investigated the risk factors for partner violence, sexual assault, emotional abuse, and stalking. Little is known about risk factors for stalking or emotional abuse. Because there is so much overlap among the risk factors for sexual and physical assault by intimate partners, they are discussed together. There is a strong consensus that there is no single risk factor for violence against women. Rather, researchers have learned that a number of factors may increase the likelihood that a woman will be victimized.

Because there are numerous risk factors, an ecological framework has been adopted for organizing the different factors that are nested within one another. Some explanations for violence look to sociocultural risk factors—characteristics of society that promote social tolerance of violence. In contrast, social structural risk factors include social and economic factors that increase the probability of involvement in violence. Family risk factors include relationship characteristics that are related to violence. The risk markers that have been most studied are those that pertain to individuals—both perpetrators and victims.

Sociocultural Risk Factors

Historically, sociocultural risk factors establish a broad context that has made many forms of violence against women socially acceptable. Sexism in American society and sex-role stereotyping contribute to both physical and sexual victimization of women. A recent review of research attributes social acceptance of violence to "historically male dominated social structure and socialization practices teaching men and women different gender-specific roles" (Kantor and Jasinski, 1998, p. 13). Research comparing rates of marital violence across States has concluded that rates are highest "in those [American] states where structural inequality in economic, educational, political, and legal institutions is greatest," thus supporting patriarchy as a contributing factor (Yllo and Straus, 1990, p. 397). Research on cultural explanations for rape rates across States has reached the same conclusions (Baron and Straus, 1989).

The impact of cultural values has also been examined at the individual level, but findings have been inconclusive. Some studies find that men who sexually assault women are more likely than other men to see sexual violence as acceptable (Burkhart and Stanton, 1988), although other researchers have not consistently reached this conclusion (Neff, Holamon, and Schluter, 1995; Sugarman and Frankel, 1996). Sugarman and Frankel (1996) concluded that assaultive men had more positive attitudes toward violence than nonviolent men, but violent behavior was not associated with the trait of masculinity. In addition, they found that abused women hold more traditional gender role orientations than nonabused women, which may account in part for the difficulty some women experience in extricating themselves from abusive relationships. Thus, research is inconsistent regarding whether traditional sex roles are a risk factor for violence against women (O'Leary and Cascardi, 1998).

Race and ethnicity have been widely researched as possible risk factors for violence against women, but the results have been inconclusive.[9] Some studies show that black women experience higher rates of physical violence than white women (Neff, Holamon, and Schluter, 1995;

Sorenson, Upchurch, and Shen, 1996). Other research reports higher rates for whites than for Hispanic women (Neff, Holamon, and Schluter, 1995; Sorenson and Telles, 1991) or no racial or ethnic differences (Bachman and Saltzman, 1995; Tjaden and Thoennes, 1998a). Many of these studies have not considered the effects of socioeconomic status, which is correlated with race and ethnicity, so they may overestimate the effect of race on violent victimization. For example, when Straus and Smith (1990) controlled for age, income, and urban residence, the apparently higher rate of spouse abuse for Hispanic families disappeared.

The research on sexual assault indicates that

> Except for college students, sexual assault is slightly more prevalent among African-American women compared to White women. . . . The prevalence rate of sexual assault among non-Hispanic Whites has been reported to be 2.5 times higher than that of Hispanics. . . . [P]revalence varies by acculturation [based on the work of Sorenson and Siegel, 1992]. (Koss, 1993, p. 215)

Among college students, the highest rates of sexual victimization were reported by Native American women, followed by white, black, and Latino women (Koss, Gidycz, and Wisniewski, 1987). Tjaden and Thoennes (1998a) also found the highest rates of rape among Native American women and the lowest among Hispanic women. As is the case with domestic violence, however, most research on race and sexual assault has not controlled for the effects of socioeconomic factors, such as income, that may help to explain ethnic differences in sexual assault rates.

The findings on race or ethnic differences in stalking from the National Violence Against Women Survey indicate the highest rates for American Indian women and the lowest rates for Asians, with no differences between Hispanic and non-Hispanic women (Tjaden and Thoennes, 1998b).

Social Structural Risk Factors

Two kinds of social structural risk factors have been investigated: economic status and community factors. Domestic violence occurs in households of all income levels, but researchers agree that low income is a risk factor for partner violence (Bachman and Saltzman, 1995; Greenfeld et al., 1998; Plichta, 1996). It is not only severe poverty and its associated stressors that increase the risk for partner violence. Higher income correlates with lower reported intimate violence rates. For example, in a large national sample, Sorenson, Upchurch, and Shen (1996) found that families with incomes below $40,000 were at higher risk. Several studies have also found unemployment of the male partner to be a risk factor (Straus and Gelles, 1986). Low income has also been found to predict the continuation of violence over time (Aldarondo and Sugarman, 1996), with higher income a predictor of cessation (Aldarondo and Kantor, 1997).

Economic status may increase the risk of violence in two ways. First, insufficient income can affect the perpetrator. Second, researchers have documented that poverty or economic dependency on the abuser can also be a barrier to the victim's ability to terminate an abusive relation-

ship (Horton and Johnson, 1993; Strube and Barbour, 1983; Sullivan et al., 1994; Woffordt, Mihalic, and Menard, 1994).[10]

The most compelling finding regarding community-level risk factors is that rates of intimate partner violence are highest in urban areas (Greenfeld et al., 1998; Plichta, 1996; Sorenson, Upchurch, and Shen, 1996). Little has been written about how urban life may increase the risk for violence, but associations between urban residence and poverty may account for the relationship. This finding has significant implications for prevention and intervention efforts.

A second community-level risk factor relates to the availability and quality of prevention and intervention services. A lack of services increases the risk that a victim will stay in an abusive relationship or be unable to address the consequences of physical or sexual abuse. In the past, the lack of services was a major barrier that prevented women from addressing the consequences of violence against women, and abused women were often "frustrated in their efforts to obtain help from traditional institutions such as the criminal justice, legal, and mental health systems" (Mitchell and Hodson, 1983, p. 633). Since the 1970s, services, especially domestic violence programs and rape crisis centers, have grown dramatically (Chalk and King, 1998); however, victims were often dissatisfied with the help they received from community agencies through the middle 1980s (Gondolf and Fisher, 1988). Although not well researched, many community services for partner violence and sexual assault were reported to be culturally insensitive and "in large part inappropriate and inadequate" (Heron et al., 1997). Thus, they were underused by certain racial and ethnic groups (Neville and Pugh, 1997). The stigma associated with violent victimization also interfered with women's willingness to access those services, especially in the case of rape. Few women utilized rape crisis centers, although those who did reported satisfaction with the services they received.

Family Risk Factors

Risk factors pertaining to the family or couple unit have not been well researched, although mental health professionals assume such factors play a contributing role in partner violence. There is a consensus that relationship status is a risk factor. Among intimates, separated and cohabiting couples are at a higher risk for partner violence than are married or dating couples (Bachman and Saltzman, 1995; Capaldi and Crosby, 1997; Plichta, 1996), even when important risk factors such as age and education are taken into account (Stets and Straus, 1989). Rates of violence by cohabiting men in this study were almost triple those of married males (Yllo and Straus, 1981).

Although it is often assumed that factors such as poor problem-solving and communication skills and unilateral power and decisionmaking are significant risks for partner violence, there is little research comparing violent and nonviolent couples on these dimensions. Based on data from the 1975 National Family Violence Survey, Kalmuss (1979) concluded that highly dependent wives were significantly more likely to experience marital violence because "wives who are highly dependent on marriage are less able to discourage, avoid, or put an end to abuse" than wives in more egalitarian relationships (p. 379). Victim substance abuse and serious mental health

problems can increase dependency and interfere with a woman's ability to prevent violence or leave an abusive relationship once it has developed (Hilbert, Kolia, and VanLeeuwen, 1997).

Research also suggests that conflict is an important risk factor for partner violence. An early study showed that both male and female dominance were associated with marital conflict, which was in turn predictive of violence unless the wife believed that the husband should be dominant (Coleman and Straus, 1990).

Individual Risk Factors—Perpetrators

Individual risk factors affecting perpetrators have been studied extensively. Age is among the best documented individual risk factors for physical and sexual violence for both victims and perpetrators, with younger age being at greater risk (Bachman and Saltzman, 1995; Koss, Gidycz, and Wisniewski, 1987; Pan, Neidig, and O'Leary, 1994; Plichta, 1996; Sorenson et al., 1987; Tjaden and Thoennes, 1998a). Substance abuse, especially alcohol use and abuse, has also been found to be associated with both partner violence (Aldarondo and Kantor, 1997; Kantor and Jasinski, 1998; Leonard and Senchak, 1996; Pan, Neidig, and O'Leary, 1994; Woffordt, Mihalic, and Menard, 1994) and sexual assault (Ullman, Karabatsos, and Koss, 1999). Between 33 and 66 percent of sexual assaults are reported to be alcohol related (Ullman, Karabatsos, and Koss, 1999).

Numerous perpetrator personality characteristics or traits have been studied as antecedents of physical or sexual abuse, although findings have been inconclusive. It is clear that there is no single male personality type that is prone to sexual or physical violence. Kantor and Jasinski's (1998) review of research concluded that the following are personality risk markers for male partner abuse:

- Emotional dependence and insecurity.
- Low self-esteem, empathy, and impulse control.
- Poor communication and social skills.
- Aggressive, narcissistic, and antisocial personality types.
- Anxiety and depression.

Some research has attempted to identify different types of batterers (Holtzworth-Munroe and Stuart, 1994). These studies have concluded that there may be several different types of abusive men. At least two types—one that is violent only toward intimates and another that more generally is violent toward others—may require different types of interventions. Because emotional or psychological abuse typically precedes and accompanies physical abuse (O'Leary, Malone, and Tyree, 1994), emotional abuse should also be considered a risk factor.

A history of violence in the family of origin has been extensively researched, with most researchers concluding that exposure to violence between parents and being the recipient of violent punishment are risk factors for violence toward intimates as an adult (Aldarondo and Kantor, 1997; Barnett and Fagan, 1993; Leonard and Senchak, 1996), but not all studies have supported this conclusion (MacEwen and Barling, 1988; Riggs and O'Leary, 1996).

Although stress is assumed to be a risk factor for violence against women, there is limited research support for this assertion. One study found that men who were violent toward intimate partners reported more stressors (Barnett and Fagan, 1993), but another found that work and marital stressors were not predictive of partner violence (Pan, Neidig, and O'Leary, 1994). The relationship between stress and intimate partner violence is complex and may be affected by other important factors, such as social isolation, the husband's belief that he should be dominant or his approval of violence, and his exposure to violence as a child (Straus, 1990).

Individual Risk Factors—Victims

It is difficult to study risk factors for victimization because most studies do not identify victims until after abuse has occurred. Consequently, what appears to be a risk factor might actually be a consequence of victimization. This is especially true for social isolation and substance abuse. There is strong research support for the assertion that earlier victimization, especially childhood physical and sexual abuse, and witnessing violence between parents increases the risk of sexual assault and partner violence in adulthood (Collins, 1998; Gidycz and Koss, 1991; Maker, Kemmelmeier, and Peterson, 1998; Miller and Downs, 1993; Weaver et al., 1997).

Substance abuse has also been studied as a risk factor for victimization, especially sexual assault. Several studies have documented the association between alcohol or drug abuse and physical (Hilbert, Kolia, and VanLeeuwen, 1997; Plichta, 1996) and sexual victimization (Collins, 1998; Miller and Downs, 1993; Teets, 1997). Kilpatrick and colleagues (1997) attempted to disentangle substance abuse as a cause or effect of violent victimization in a 2-year longitudinal study that concluded that substance abuse, especially drug use, is both a predictor *and* an effect of violent victimization, affecting young women and minority women in particular. Abuse of alcohol or drugs, which may have origins in childhood victimization and the ongoing distress it causes, appears to be associated with the kind of lifestyle and male relationships that increase women's risks for victimization and makes it more difficult for women to terminate abusive relationships (Hilbert, Kolia, and VanLeeuwen, 1997; Kilpatrick et al., 1997; Weaver et al., 1997).

Social isolation of abused women has been documented by researchers. Although it can be a consequence of abuse, it may also serve as a risk factor. It is plausible that women with greater social support are less likely to be physically or sexually assaulted, and thus social support may be protective. The research of Nielsen, Endo, and Ellington (1992, p. 381) suggests that social isolation both precedes and follows partner violence. Research suggests that abusive men often attempt to control their partners by cutting them off from meaningful social contact. In addition, isolated women and families may be less closely monitored by others, allowing abuse to occur more easily (Nielsen, Endo, and Ellington, 1992). Although social isolation has not been widely studied as a risk factor for sexual assault, Zweig, Barber, and Eccles (1997) found that it was one predictor of sexual coercion in young adults.

Risk Factors for Stalking

Little is known about the risk factors for stalking. One study concluded that batterers who also stalk their victims are different from nonstalking abusive men. They are more likely to have

stalked previous victims and have a history of assault, alcohol abuse, and noncohabitation (Burgess et al., 1997). Women surveyed in the National Violence Against Women Survey perceived motivations to be the stalker's desire to control the victim, continue the relationship, or instill fear (Tjaden and Thoennes, 1998b). A history of physical or sexual assault by an intimate partner can also be considered a risk factor for stalking (Tjaden and Thoennes, 1998b).

Conclusions

Neither physical nor sexual assault are caused by one factor. Usually several factors, often interconnected, interact with one another to increase risk. The following risk factors for violence against women have the strongest research support:

- Low income.
- Urban residence.
- Relationship status (unmarried or separated).
- Relationship conflict.
- Emotional abuse.
- Young age.
- Substance abuse.
- Childhood abuse.

Although little is known about risk factors for stalking, a history of domestic violence, sexual assault, stalking behavior, and alcohol abuse can be considered risk factors.

Consequences of Violence Against Women

Because consequences of partner abuse are discussed in detail in the reviews for nurses, physicians, and service providers, only a brief summary is provided here. Violence against women has significant consequences in terms of injury, physical complaints and symptoms, and mental illness. Physical violence has been demonstrated to have a direct effect on trauma-related injuries, numerous health conditions, and stress-related psychological outcomes and is implicated as a risk factor for a range of physical and emotional disorders.

Injuries

Because the majority of violence against women cases consists of less severe forms, most women who are the recipients of these acts are not physically injured and do not require medical intervention (Stets and Straus, 1990). The National Violence Against Women Survey found that 36 percent of rape victims and 42 percent of physical assault victims reported injuries and between 28 and 31 percent of them received medical care. The most common injuries are scratches, bruises, and welts (about 72 percent of rape victims and 76 percent of physical assault victims who are injured); lacerations and knife wounds (9 to 15 percent); and broken bones and dislocated joints (6 to 11 percent). Perpetrator substance abuse is a significant predictor of injury (Tjaden and Thoennes, 2000). However, injuries do not appear to be the most common health-related aftereffect of violence against women.

Physical Complaints and Symptoms

Abused women have generally poorer health and more symptoms than nonabused women (Attala, 1994; McCauley et al., 1995). Among the symptoms commonly associated with physical violence[11] are gastrointestinal disorders, chronic pain, fatigue or low energy, dizziness, loss of appetite and eating disorders, and gynecologic and urologic disorders. Alcohol and drug abuse and other risky health behaviors are also aftereffects of physical violence.[12] Both abused pregnant women and their fetuses are at risk for a number of negative outcomes, including miscarriage, preterm labor, and neonatal death (Webster, Chadler, and Battistutta, 1996). In addition, violence against women may influence pregnancy outcomes through its effect on health behaviors, such as smoking and substance abuse (Martin et al., 1996).

Like victims of physical abuse, victims of sexual assault have higher rates of both medically explained and unexplained symptoms compared with nonvictims (Kimerling and Calhoun, 1994; Golding, Cooper, and George, 1997). In general, victims of sexual assault are at higher risk for all the symptoms and health outcomes associated with physical violence. Gynecological symptoms may be even more prevalent among victims of sexual abuse, including increased risk of sexually transmitted disease infections (e.g., Murphy, 1990), pregnancy (e.g., Koss, Woodruff, and Koss, 1990), and sexual problems and dysfunction (Campbell, 1989; Eby et al., 1995). Women assaulted by someone known to them are more likely to have sexual problems than those assaulted by strangers (Becker et al., 1984). Although many sexual assault survivors recover within 6 months, at least 20 percent (Resick, 1993) and as many as 70 percent have reported long-term problems (Burgess and Holmstrom, 1974).

Mental Health Effects

Physical abuse has consistently been found to be associated with several adverse mental health outcomes, such as depression (Campbell, Sullivan, and Davidson, 1995; Plichta, 1996; Stets and Straus, 1990), suicide and suicide attempts (Gelles and Straus, 1990), posttraumatic stress disorder (PTSD) (Astin, Lawrence, and Foy, 1993; Saunders, 1994), other forms of anxiety (Follingstad et al., 1991; McCauley et al., 1998), and alcohol and drug abuse and dependency (Kilpatrick et al., 1997; Miller and Downs, 1993; Plichta, 1996).

The negative mental health effects of sexual assault and rape have been extensively documented and substantially overlap with the effects of physical violence. Short-term emotional reactions to sexual assault include "shock, intense fear, numbness, confusion, extreme helplessness, and/or disbelief, in addition to self-blame" (Goodman, Koss, and Russo, 1993, p. 82). Mental health effects associated with sexual assault include fear, PTSD, anxiety disorders (including phobias and obsessive-compulsive disorder), depression, suicide attempts, sexual dysfunction, reduced self-esteem, relationship problems, and substance abuse (Collins, 1998; Goodman, Koss, and Russo, 1993; Kilpatrick, Edmunds, and Seymour, 1992; Resick, 1993; Teets, 1997; Zweig, Barber, and Eccles, 1997). One research review found that symptoms begin to subside for most victims after 3 months, but little spontaneous recovery occurs after 1 year. Thus, a subset of victims experience problems such as fear, anxiety, PTSD, depression, suicide attempts, sexual difficulties, and substance abuse on a chronic level (Resick, 1993).

Although it has not been thoroughly researched, emotional abuse also appears to be associated with compromised psychological well-being. Both overt and subtle psychological abuse have been found to influence a range of mental health and well-being outcomes, even when the effects of physical and sexual abuse are considered (Marshall, 1999). Psychological abuse is regarded by many women and researchers as more distressing and harmful than physical abuse (Follingstad et al., 1990; Marshall, 1994). Emotional abuse is associated with lower self-esteem (Aguilar and Nightingale, 1994; O'Leary and Jouriles, 1994; Orava, McLeod, and Sharpe, 1996), depression (Rollstein and Kern, 1998), somatic problems (such as headaches), and posttraumatic effects (Arias and Pape, 1999; Loring, 1994).

Results from the National Violence Against Women Survey suggest that victims of stalking experience considerable distress, and stalking typically activates a protective or help-seeking response. Almost 33 percent of self-reported stalking victims sought counseling, 25 percent lost time from work, 22 percent took extra precautions, 18 percent sought help from friends or family members, and 17 percent acquired a gun (Tjaden and Thoennes, 1998b).

The more severe, frequent, and long-lasting the abuse is, the more likely it is that the victim will experience symptoms and the more severe those symptoms are likely to be (Follingstad et al., 1991; McCauley et al., 1998; Stets and Straus, 1990). The harmful effects of abuse may linger significantly beyond the end of the abuse. For example, a rape that occurred 10 or more years ago can be associated with current overall health status (Leserman et al., 1997). In addition, a history of childhood physical and sexual abuse, common in women abused as adults (McCauley et al., 1997), exacerbates the effects of current physical violence (Plichta, 1996; Weaver and Clum, 1996) and has especially deleterious effects on adult victims of sexual assault (Becker et al., 1984).

Economic Impact

Partner abuse has a significant economic impact on victims and families, as well as on society as a whole. This is due in part to its impact on the health care, mental health, and criminal justice systems. Data from the National Crime Victimization Survey between 1992 and 1996 indicate that costs to women who are victims of nonfatal partner violence can be conservatively estimated to be $150 million per year. These costs included medical expenses (40 percent), property losses (44 percent), and lost pay. In addition to victim impact, partner violence creates an enormous burden on and cost to the health care system (Bachman and Saltzman, 1995).

Conclusions

Since the 1970s, violence against women has been redefined as a social and legal problem, so communities, criminal justice agencies, and public health organizations have been encouraged to take greater responsibility for intervening in and preventing its occurrence. Contemporary discussions about how to respond to violence most effectively are characterized by differences of opinion on the gravity and urgency of the problem as well as what to do and how to do it. Across diverse fields, practitioners disagree about the causes of violence, the goals of interventions, and the potential for effecting positive change. Even people in the same professions hold different

views about effective practices and strategies. Because emerging strategies for intervention and prevention call for collaboration across these groups, there is a compelling need to understand and respect these differences in perspective and to recognize that effective solutions will require transcending these differences and reaching common understandings.

In part, these different points of view stem from the fact that most practitioners encounter violence against women as only a part of their work. Often, the protocols, practices, and assumptions built into their work are of limited applicability to situations involving violence against women. This begins with the issue of defining, recognizing, and counting victimizations. Whereas health workers may define violence victims as patients who seek attention for injuries, police define them as a subset of 911 calls. Victim advocates attend to shelter residents and women who seek services, educators concern themselves with teens who prefer not to discuss it, and mental health professionals work with clients in distress. Probation officers are most likely to encounter victims as partners of men they are supervising on other criminal charges. Most practitioners generalize from their own experiences, which are often based on different subsets of the victim and offender populations.

Furthermore, practitioners often must choose between adapting their responses to violence against women to their agencies' general structure and devising new strategies that may challenge the assumptions built into those structures. For example, an adversarial criminal process that assumes victims will be proactive, cooperative, and retributive (and therefore make good witnesses for the prosecution) may have to be modified to accommodate the ambivalence experienced by many female victims who are in close relationships with offenders. Criminal justice practitioners' frustration with reluctant victims is matched by advocates' frustration with an unwieldy, often hostile criminal process.

Practitioners also differ over priorities, especially when resources are scarce. Resources invested in batterer treatment may be seen by some as resources lost to victim services or prevention. These differences of opinion reflect not only competition for resources, but also more basic disagreement about what causes violence and what might be effective in reducing, ending, or preventing it. For example, policies aimed at deterring violence through arrest or punishment may not look promising to practitioners who attribute violence to mental health problems or deeply entrenched socialization patterns.

As practitioners and policymakers experiment with collaborative responses to violence against women, they face the dual challenges of coming to terms with these differences in perspective and increasing their knowledge about the causes, consequences, and effectiveness of interventions. Practitioners and policymakers seem to agree that coordinating efforts across agency lines will prove more effective than traditional responses to violence, but researchers have only begun the challenging task of evaluating the impacts of these coordination efforts (Chalk and King, 1998; see also Worden, 2000b). Increasingly, practitioners will be obliged to learn what does and does not work, not only in their own domains, but also in those of others with whom they share responsibility for victims and offenders. Their knowledge is often based more on their own experiences than on an understanding of the broader picture that research can provide. It is

obvious that there are potential benefits to acquiring more knowledge about other fields—for instance, victim advocates' opinions of batterers' programs would ideally be influenced by information on what kinds of programs have been found effective and ineffective and with what populations; accessing research-based knowledge is time-consuming, however. Furthermore, most reports of research are not written with practitioners in mind. This project represents an attempt to remedy that deficiency toward the dual objectives of increasing practitioners' understandings of each others' work and contributing to a more informed dialogue about responding to violence against women.

Notes

1. The focus of this report is on violent victimization of women. Much research has documented that women are also sometimes violent toward their male or female partners (e.g., Straus and Gelles, 1986). There is debate over the prevalence, reasons for, and effects of women's intimate violence. However, researchers are generally agreed that female victims of violence are more likely than male victims to be injured and harmed in other ways (Tjaden and Thoennes, 2000).

2. Studies reviewed here were U.S. empirical research studies published through 1999, obtained via CD–ROM searches of Criminal Justice Abstracts, Medline, PsycINFO, and Sociofile databases as well as other research of which participating authors were aware.

3. Sexual harassment is not included here, despite its overlap with emotional abuse in particular, and despite its deleterious impact on women, because it typically occurs outside of intimate and romantic relationships (U.S. Equal Opportunity Commission, 1997).

4. These acts are included in the Conflict Tactics Scales inventory of physical aggression acts (Straus et al., 1996). "Severe" physical violence includes acts very likely to cause physical injury, such as hitting, beating, choking, or using a knife or gun.

5. For example, the Psychological Maltreatment of Women Inventory differentiates psychological abuse into two categories, dominance/isolation and emotional/verbal abuse (Tolman, 1999, 1989), and the revised Conflict Tactics Scales (Straus et al., 1996) includes measures that reflect a definition of abuse that involves both overt emotional abuse and intent on the part of the abuser. In contrast, Marshall (1999) argues for the importance of recognizing more subtle emotional abuse, irrespective of the abuser's intent to harm, which can also affect well-being.

6. As a result, the law of rape, unlike most criminal law, historically has required that the prosecution prove that victims did not consent, and in fact resisted to the point of being seriously injured or incapacitated (known to lawyers as the "utmost resistance" test). Corroboration, either from physical evidence of the act (e.g., semen, injuries), or less likely, a witness, was a required element for conviction. Victims' sexual biographies were fair game for defense attorneys, in that women who had been unchaste once were perceived as likely to be willing parties. However, even women with no sexual experience were suspect, since presumably a virgin might be both

desperate and duplicitous enough to preserve her social reputation by lying about a sexual encounter prior to marriage.

7. Rates of sexual assault may be even higher in some population groups; for example, based on a large national sample of female college students, Koss, Gidycz, and Wisniewski (1987) found that more than half had been sexually victimized, most commonly experiencing unwanted sexual contact.

8. Clinical populations are groups of people who present for services at an organization such as an agency or hospital and are not randomly selected from the community.

9. Only research based on large, representative community samples is discussed here.

10. Low income also is associated with higher sexual assault rates (Koss, Gidycz, and Wisniewski, 1987).

11. For reviews, see Bodden-Heidrich et al. (1999); Drossman et al. (1990); Drossman et al. (1995); Eby et al. (1995); Hendricks-Matthews (1993); Hourani et al. (1999); McCauley et al. (1995); and Rapkin et al. (1990).

12. Although clearly significantly associated, the causal direction between intimate partner violence and substance abuse among victims has not yet been clearly established. However, there are indications that intimate partner violence victims, like other people, self-medicate as a means of coping with the stress and pain caused by abuse (Martin et al., 1996; Stark et al., 1981).

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