Medical Education Systems, Inc.

Course 717

Intimate Partner Violence

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Costs of Intimate Partner Violence against Women in the United States

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Learning Objectives

Upon successful completion of this course, you will be able to:

Describe and discuss the scope of “intimate partner violence” (IPV) in the U.S.

Identify the specific “costs” which can be ascribed to that violence

Demonstrate how to calculate lost productivity and related values

List and discuss the key facts and figures associated with IPV

Describe in some detail the nature and consequences of IPV

Identify some of the major resources available to persons affected by IPV

Executive Summary

Background

Although most people believe intimate partner violence (IPV) is a substantial public health problem in the United States, few agree on its magnitude. Recognizing the need to better measure both the scope of the problem of IPV as well as resulting economic costs—in particular, those related to health care—Congress funded the Centers for Disease Control and Prevention (CDC) to conduct a study to obtain national estimates of the occurrence of IPV-related injuries, to estimate their costs to the health care system, and to recommend strategies to prevent IPV and its consequences.

This report—

- Describes briefly the development of the requested study;
- Presents findings for the estimated incidence, prevalence, and costs of nonfatal and fatal IPV;
- Identifies future research needs;
- Highlights CDC's research priorities for IPV prevention.

Incidence, Prevalence, and Consequences of Intimate Partner Violence Against Women in the United States

Data about nonfatal IPV victimizations and resulting health care service use were collected through the National Violence Against Women Survey (NVAWS), funded by the National Institute of Justice and CDC. Based on NVAWS data, an estimated 5.3 million IPV victimizations occur among U.S. women ages 18 and older each year. This violence results in nearly 2.0 million injuries, more than 550,000 of which require medical attention. In addition, IPV victims also lose a total of nearly 8.0 million days of paid work—the equivalent of more than 32,000 full-time jobs—and nearly 5.6 million days of household productivity as a result of the violence.

Data about IPV homicides were obtained from the Federal Bureau of Investigation's Uniform Crime Reports Supplementary Homicide Reports. According to this source, 1,252 women ages 18 and older were killed by an intimate partner in 1995, the same year as incidence data reported in the NVAWS.

Costs of Intimate Partner Violence in the United States

The costs of intimate partner rape, physical assault, and stalking exceed $5.8 billion each year, nearly $4.1 billion of which is for direct medical and mental health care services. The total costs of IPV also include nearly $0.9 billion in lost productivity from paid work and household chores for victims of nonfatal IPV and $0.9 billion in lifetime earnings lost by victims of IPV homicide. The largest proportion of the costs is derived from physical assault victimization because that type of IPV is the most prevalent. The largest component of IPV-related costs is health care, which accounts for more than two-thirds of the total costs.

Discussion

Due to exclusions of several cost components about which data were unavailable or insufficient (e.g., certain medical services, social services, criminal justice services), the costs presented in this report likely underestimate the problem of IPV in the U.S. Additionally, because of these omissions, the cost figures here are not comprehensive and should not be used for benefit-cost ratios in analyses of interventions to prevent IPV. However, they can be used to calculate the economic cost savings from reducing IPV and associated injuries, to demonstrate the economic magnitude of IPV, and to evaluate the impact of IPV on a specific sub-sector of the economy, such as consumption of medical resources.

More qualitative and quantitative data are needed to better determine the full magnitude of IPV and associated human and economic costs. There is also a need for primary prevention—preventing IPV from occurring in the first place—rather than focusing only on treating victims and rehabilitating perpetrators after abuse has occurred.

CDC, in its *Injury Research Agenda*, has identified several key areas of research for IPV prevention. These areas include learning how to change social norms that accept intimate partner violence; developing programs for perpetrators and potential perpetrators; increasing our understanding of how violent behaviors toward intimate partners develop; improving collection of data about IPV and its health effects; developing and evaluating training programs for health professionals; and disseminating strategies that work to prevent IPV.

Significant resources for research are needed to better understand the causes and risk factors for IPV and to develop and disseminate effective primary prevention strategies. Until we reduce the incidence of IPV in the United States, we will not reduce the economic and social burden of this problem.

Intimate Partner Violence

Intimate partner violence—also called domestic violence, battering, or spouse abuse—is violence committed by a spouse, ex-spouse, or current or former boyfriend or girlfriend. It can occur among heterosexual or same-sex couples.

Introduction

Violence against women is a substantial public health problem in the United States. According to data from the criminal justice system, hospital and medical records, mental health records, social services, and surveys, thousands of women are injured or killed each year as a result of violence, many by someone they are involved with or were involved with intimately. Nearly one-third of female homicide victims reported in police records are killed by an intimate partner (Federal Bureau of Investigation 2001).

Intimate partner violence—or IPV— is violence committed by a spouse, ex-spouse, or current or former boyfriend or girlfriend. It occurs among both heterosexual and same-sex couples and is often a repeated offense. Both men and women are victims of IPV, but the literature indicates that women are much more likely than men to suffer physical, and probably psychological, injuries from IPV (Brush 1990; Gelles 1997; Rand and Strom 1997; Rennison and Welchans 2000).

IPV results in physical injury, psychological trauma, and sometimes death (Gelles 1997; Kernic, Wolf and Holt 2000; Rennison and Welchans 2000; Sorenson and Saftlas 1994). The consequences of IPV can last a lifetime. Abused women experience more physical health problems and have a higher

occurrence of depression, drug and alcohol abuse, and suicide attempts than do women who are not abused (Golding 1996; Campbell, Sullivan and Davidson 1995; Kessler et al. 1994; Kaslow et al. 1998; Moscicki 1989). They also use health care services more often (Miller, Cohen and Rossman 1993).

A growing body of evidence demonstrates the health consequences of intimate partner violence against women (Coker, Smith, Bethea, King and McKeown 2000; Kernic, Wolf and Holt 2000). However, the economic costs of IPV remain largely unknown Previous cost estimates range from $1.7 billion to $10 billion annually (Straus 1986; Gelles and Straus 1990; Meyer 1992), but they are believed to underestimate the true economic impact of this type of violence (Institute for Women's Policy Research 1995). Researchers have recommended developing national cost estimates for IPV-related medical care, mental health care, police services, social services, and legal services (Gelles and Straus 1990; Straus 1986; Straus and Gelles 1987). However, a recent literature review (Finlayson, Saltzman, Sheridan and Taylor 1999) found only one U.S. study that derived national cost estimates for violence among intimate partners (Miller, Cohen and Wiersema 1996).

Recognizing the need to better measure the magnitude of IPV and resulting economic costs—in particular, those related to health care—the U.S. Congress funded the Centers for Disease Control and Prevention (CDC) to conduct a study to obtain national estimates of the incidence of injuries resulting from IPV, to estimate the costs of injuries to health care facilities, and to recommend strategies to reduce IPV-related injuries and associated costs. Language related to this funding was included in the Violence Against Women Act provisions of the Violent Crime Control and Law Enforcement Act of 1994 (P.L. 103–322).

Given the greater number of IPV-related injuries that occur among women and the instability of cost estimates based on the small numbers of IPV-related injuries among men, this report focuses only on the costs of IPV against women ages 18 and older. Although Congress called only for costs of IPV-related injuries, it was important to include the costs of lost productivity resulting from IPV and to determine the economic costs of lives lost to IPV homicide. These costs contribute significantly to the economic burden of IPV.

This report describes the development of the requested study; presents findings for the estimated incidence, prevalence, and costs of IPV among U.S. adult women; identifies future research needs; and highlights some of CDC's activities related to IPV prevention.

The Need to Estimate the Costs of Intimate Partner Violence

Cost estimates can serve important purposes. For example, they help demonstrate the impact a problem has on society and can shape the attitudes of people who develop public policy and allocate limited funds (Miller, Cohen and Wiersema 1996; Phillips 1987; Snively 1994). They can also help assess the benefit or effectiveness of violence intervention strategies or programs (Haddix, Teutsch, Shaffer and Dunet 1996; Teutsch 1992), which may, in turn, lead to resource allocation to specific programs (Mercy and O'Carroll 1988).

The Need for National Estimates of Intimate Partner Violence

To estimate the costs of IPV, one must first estimate its incidence. While most people acknowledge IPV as a substantial public health problem, few seem to agree on its magnitude (Crowell and Burgess 1996). Several surveys (e.g., Bachman and Saltzman 1995; Rennison and Welchans 2000; Straus and

Gelles 1990) have attempted to determine the extent of violence against women, but methods and findings vary considerably, arousing some debate. Many people contend that the magnitude of violence against women—including violence by intimate partners—is underestimated, while others believe it is exaggerated. Why has the scope of intimate partner violence been so difficult to measure?

Lack of consensus about terminology. Researchers have been unable to agree on a definition of intimate partner violence. In some studies, IPV includes only acts that may cause pain or injury, while ignoring behaviors designed to control or intimidate, such as stalking, humiliation, verbal abuse, imprisonment, and denial of access to money, shelter, or services. Much of the debate about the number of women affected by intimate partner violence results from this lack of consensus. For example, a researcher who defines IPV more broadly—including stalking and other forms of psychological abuse, as well as physical and sexual violence—will produce a larger estimate than a researcher who uses a more narrow definition that includes physical and sexual violence only (DeKeseredy 2000). A definition that separately measures component types of violence—physical, sexual, and emotional—will also likely produce different measurements than one that combines all types of violence (Gordon 2000).

Variations in survey methodology. Sampling strategies and how the purpose of a survey is explained may affect how participants answer survey questions. For example, a respondent on the National Crime Victimization Survey may not acknowledge being the victim of IPV if he or she does not believe IPV is a crime. However, the same respondent might disclose IPV victimization on a survey about family conflict.

Gaps in data collection. Because no national system exists for ongoing collection of data about IPV against women, estimates are often drawn from data gathered for other purposes. For example, hospitals collect information about victims to provide patient care and for billing purposes; they may record few details about the violence itself or about the perpetrator and his or her relationship to the victim. In contrast, police collect data that will aid in apprehending the perpetrator, and thus may collect little information about the victim.

Different time frames. Studies of IPV have used different time frames to study victimization. Some measure lifetime victimization, while others measure annual victimization. These differences are not always well understood and have sometimes resulted in inappropriate comparisons being drawn between studies that are not in fact comparable.

Reluctance to report victimization. Many victims do not want to report IPV because they may fear, love, depend on, or wish to protect the perpetrator. When medical care is required, women may attribute their injuries to other causes.

Repetitive nature of IPV. Often, IPV involves repetitive behavior, rather than a single incident. However, reports about IPV do not always clearly indicate whether data refer to the number of IPV incidents or the number of victims.

Limited populations. Previous studies have focused either on married or cohabiting couples or on dating relationships. Although a few studies have looked at violence among same-sex couples, most research has examined only heterosexual relationships. Few studies have examined IPV among the population overall.

Survey limitations. Many data about IPV have been collected through surveys, which rely on self-reports by victims. These self-reports may not accurately reflect the magnitude of the problem, if respondents do not answer questions truthfully or do not accurately recall events. Additionally, despite

carefully worded questions and efforts to ensure that participants understand what is being asked, respondents may interpret terms differently.

Because methodological differences such as those described here can affect the findings of a survey or study, researchers must explain the choice of a particular methodology, define terms used, and clearly explain how information was gathered (CDC 2000). This information allows others to examine findings in the context in which data were collected and can help readers understand how the findings compare with those of other surveys or studies. In keeping with this practice, this report specifies the methodology employed and the definitions used.

The National Violence Against Women Survey

When Congress requested a study about the costs of IPV, no existing survey or study had a large enough sample to reliably estimate the occurrence of IPV-related injuries in the U.S. population. Nor did any existing survey or study include enough information about the nature and extent of injuries and their treatment to make the national projections Congress had requested. A new study was needed to fill gaps in knowledge about the magnitude of IPV.

Developing and Implementing the National Violence Against Women Survey

CDC learned that the National Institute of Justice (NIJ), the research arm of the U.S. Department of Justice, had funded Patricia Tjaden and Nancy Thoennes of the Center for Policy Research in Denver to develop the National Violence Against Women Survey—or NVAWS. The NVAWS was to generate information about the incidence, prevalence, characteristics, and consequences of physical assault, rape, and stalking perpetrated against U.S. women ages 18 and older by all types of perpetrators, including intimate partners.

Rather than duplicating efforts, CDC approached NIJ about supplementing its grant to Tjaden and Thoennes to broaden the size and scope of the survey by increasing the sample size, conducting a companion survey of male respondents, and adding questions about violence in same-sex intimate relationships. The broader survey could then be used as the basis for calculating more reliable cost estimates of IPV and other forms of violence. Both NIJ and the Center for Policy Research agreed to delay the survey to accommodate a supplemental award and make CDC's proposed changes.

The supplemental funds expanded the survey population to a number large enough to provide reliable national estimates of the incidence and prevalence of forcible rapes, physical assault, and stalking; related injuries and health care costs, including those for mental health care services; and indirect costs due to lost productivity of paid work and household chores.

CDC and the office of the Assistant Secretary for Planning and Evaluation, another component of HHS, contracted with Wendy Max, Dorothy Rice, Jacqueline Golding, and Howard Pinderhughes at the University of California, San Francisco, to use the methodology they had developed earlier (Rice et al. 1996) to review draft survey questions and to recommend changes that would enable cost data to be collected with the NVAWS. The survey questions sought to detail the type of violence; the circumstances surrounding the violence; the relationship between victim and perpetrator; and consequences to the victim, including injuries sustained, use of medical and mental health care services, contact with the criminal justice system, and time lost from usual activities.

From November 1995 to May 1996, a national probability sample of 8,000 women and 8,000 men ages 18 and older were surveyed via telephone using a computer-assisted interviewing system. Female

interviewers surveyed female respondents. A Spanish language version of the survey was used with Spanish-speaking respondents.

In addition to the 8,000 completed interviews, the women's survey contacts included 4,829 ineligible households; 4,608 eligible households that refused to participate; and 351 interviews that were terminated before completion. The women's response rate was 71.0%.

Analyzing NVAWS Data and Estimating the Costs of Intimate Partner Violence

Tjaden and Thoennes (1999) used the NVAWS data and U.S. Census figures for the population of women ages 18 and older to generate national estimates of the incidence and prevalence of IPV-related injuries among women.1 Cost estimates were to be derived from these estimates. Max and colleagues (1999) applied their previously developed methodology for estimating the costs of intimate partner violence to the NVAWS incidence data and data from other sources (Rice, Max, Golding and Pinderhughes 1996).

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[1]This report used only the data about violence committed against women by intimate partners. However, NVAWS data have also provided insight into other areas of violence, including a comparison of women's and men's experiences as victims of rape, physical assault, and stalking by all types of perpetrators.

CDC funded Research Triangle Institute International (RTI) to derive measures of reliability for the incidence, prevalence, and cost estimates. Additionally, Max and colleagues and RTI developed estimates of the present value of lifetime earnings for fatal IPV by combining economic data with IPV homicide data from the Federal Bureau of Investigation.

The report that follows reflects CDC's integration of the work by Tjaden and Thoennes, Max and colleagues, and RTI.

Definitions Used in the NVAWS and this Report

Throughout this report, one will read about intimate partner violence (IPV) and specific types of violent behaviors, as well as about incidence, prevalence, and victimization rates of IPV. As stated earlier, there is a lack of consensus about IPV-related terminology. Therefore, it is important to define those terms as they were used in the NVAWS to ensure that readers have a consistent understanding of what they mean and to allow readers to compare findings presented in this report with those of other studies.

Intimate partner violence (IPV) against women includes rape, physical assault, and stalking perpetrated by a current or former date, boyfriend, husband, or cohabiting partner, with cohabiting meaning living together as a couple. Both same-sex and opposite-sex cohabitants are included in the definition. This definition of IPV resembles the one developed by CDC (Saltzman et al. 1999); however, it also includes stalking because of the high level of fear that stalking generally provokes in women and the associated costs that may result.

Rape is the use of force, without the victim's consent, or threat of force to penetrate the victim's vagina or anus by penis, tongue, fingers, or object, or the victim's mouth by penis. The definition

includes both attempted and completed acts. This definition is similar to that used in the National Women's Study (National Victim Center and Crime Victims Research and Treatment Center 1992) and is roughly equivalent to what the justice system refers to as rape or attempted rape.

Physical assault is any behavior that inflicts physical harm or threatens or attempts to do so. Specific behaviors include throwing something at the victim; pushing, grabbing, or shoving; pulling hair; slapping, hitting, kicking, or biting; choking or trying to drown; hitting with an object; beating up the victim; threatening with a gun or knife; and shooting or stabbing the victim. This definition is similar to that used in the National Family Violence Survey (Straus and Gelles 1986) and the Canadian Violence Against Women Survey (Johnson 1996), and it is roughly equivalent to what the justice system refers to as simple and aggravated assault.

Stalking is repeated visual or physical proximity, non-consensual communication, and/or verbal, written, or implied threats directed at a specific individual that would arouse fear in a reasonable person. The stalker need not make a credible threat of violence against the victim, but the victim must experience a high level of fear or feel that they or someone close to them will be harmed or killed by the stalker. This definition is similar to that used in the model anti-stalking legislation developed for states by NIJ (National Criminal Justice Association 1993).

Prevalence is the number of U.S. women ages 18 and older who have been victimized by an intimate partner at some point during their lifetimes (lifetime prevalence) or during the 12 months preceding the NVAWS (past 12 months prevalence). In this report, prevalence refers to past 12 months prevalence unless otherwise specified.

Incidence is the number of separate episodes of IPV that occurred among U.S. women ages 18 and older during the 12 months preceding the survey. For IPV, incidence frequently exceeds prevalence because IPV is often repeated. In other words, one victim (who is counted once under the prevalence definition) may experience several victimizations over the course of 12 months (each of which contributes to the incidence count).

Victimization rate is the number of IPV victimizations involving U.S. women ages 18 and older per 1,000 women in that population. The population estimate used in this report is the U.S. Census Bureau's projection of 100,697,000 women ages 18 and older in 1995.

A Note About Annual Estimates

This report presents annual data about IPV and its costs, generalized from data about the incidence of intimate partner violence in a given year (1995) and the costs associated with those victimizations. CDC acknowledges that the health care costs, value of lost productivity, and present value of lifetime earnings among IPV murder victims may be different today than in 1995. However, this report reflects the most appropriate, reliable data currently available about the costs associated with IPV.

Incidence, Prevalence, and Consequences of Intimate Partner Violence Against Women in the United States

Before estimating the costs of intimate partner violence, one needs to know how many women were injured nonfatally as a result of IPV; how many women used medical and mental health care services after IPV victimization; and how many women lost time from paid work and household chores after IPV. The National Violence Against Women Survey (NVAWS) provided that information. One also needs to know how many women died as a result of IPV. This information was obtained from the FBI's Uniform Crime Reports Supplementary Homicide Reports (Fox 2000).

This chapter describes the findings of the NVAWS, along with the national estimates calculated from those findings. It also presents estimates of the number of IPV homicides. The data presented reflect the incidence of IPV and related health care service use in 1995; these data are the most appropriate, reliable data currently available about the health care costs associated with IPV.

Incidence and Prevalence of Nonfatal Intimate Partner Rape, Physical Assault, and Stalking

The NVAWS asked the 8,000 U.S. women ages 18 and older if they had been victims of IPV at any time in their lives or within the 12 months preceding the survey.

Intimate partner rape. Of the female NVAWS respondents, 7.7% had been raped by an intimate partner at some point in their lifetimes; 0.2% reported intimate partner rape in the past 12 months.[1] Extrapolating these percentages to U.S. Census population data, nearly 7.8 million women have been raped by an intimate partner at some time in their lives, and an estimated 201,394 women are raped by an intimate partner each year.

Because some respondents reported multiple intimate partner rapes in the 12 months preceding the survey, the incidence of rape exceeded the prevalence. Women who were raped in that year experienced an average of 1.6 victimizations. This calculates to an estimated 322,230 rapes by intimate partners each year, an annual victimization rate of 3.2 intimate partner rapes per 1,000 women [322,230 rapes / 100,697,000 women = 0.0032 or 3.2 per 1000].

Intimate partner physical assault. The NVAWS found that 22.1% of women had been physically assaulted by an intimate partner at some time in their lives, and 1.3% reported such an event in the 12 months preceding the survey.

Thus, an estimated 1.3 million women are victims of physical assault by an intimate partner each year. Women who were physically assaulted by an intimate partner in the previous 12 months experienced an average of 3.4 separate assaults. Using these data, an estimated 4.5 million IPV physical assaults occur annually, a victimization rate of 44.2 per 1,000.

Intimate partner stalking. The survey found that 4.8% of women reported being stalked by an intimate partner at some time in their lives. One-half percent of women had been stalked in the 12 months preceding the survey, which equates to an estimated 503,485 women stalked by intimate partners each year.

Because stalking, by definition, involves repeated acts of harassment and intimidation, and because no woman in the NVAWS reported being stalked by more than one intimate partner in the 12 months preceding the survey, the incidence and prevalence of intimate partner stalking are identical. Thus, the annual victimization rate for intimate partner stalking among women is 5.0 per 1,000.

Injuries Among Victims of Intimate Partner Violence

To explore the extent and nature of injuries associated with intimate partner violence, respondents disclosing rape or physical assault were asked whether they were injured during their most recent victimization, and if so, what types of injuries they sustained. Victims of stalking were not asked about injuries because the NVAWS definition of stalking does not include behaviors that inflict physical harm.

The NVAWS found that 36.2% of the women who were raped by an intimate partner sustained an injury (other than the rape itself) during their most recent victimization (Figure 1), and 41.5% of physical assault victims were injured (Figure 2). The majority of women who were injured during the most recent IPV episode sustained relatively minor injuries, such as scratches, bruises, and welts. Relatively few women sustained more serious types of injuries, such as lacerations, broken bones, dislocated joints, head or spinal cord injuries, chipped or broken teeth, or internal injuries.[2]

Victims' Use of Medical Care Services

Respondents who were injured were asked if they received medical treatment and, if so, what type of care.[3]

NVAWS Findings

Of the women injured during their most recent intimate partner rape, 31.0% received some type of medical care, such as ambulance/paramedic services, treatment in a hospital emergency department (ED), or physical therapy (Figure 1). A comparable proportion (28.1%) of IPV physical assault victims who were injured received some type of medical care (Figure 2).

More than three-quarters of the rape and physical assault victims who received medical care were treated in a hospital setting (79.6% and 78.6%, respectively). Among women seeking medical care, 51.3% of rape victims and 59.1% of physical assault victims were treated in an ED, while 30.8% of rape victims and 24.2% of physical assault victims received some other type of outpatient service. Of those who were treated in a hospital, 43.6% of rape and 32.6% of physical assault victims were admitted and spent one or more nights in the hospital (Figures 1 and 2).

National Estimates of Medical Care Service Use

Of the estimated 322,230 intimate partner rapes each year, 116,647 result in injuries (other than the rape itself), 36,161 of which require medical care. And of the nearly 4.5 million physical assault victimizations, more than 1.8 million cause injuries, 519,031 of which require medical care. Nearly 15,000 rape victimizations and more than 240,000 physical assault victimizations result in hospital ED visit.

Multiple medical care visits are often required for each IPV victimization. For example, victims of both rape and physical assault averaged 1.9 hospital ED visits per victimization, resulting in an estimated 486,151 visits each year to hospital EDs resulting from rape and physical assault

victimizations. Consequently, the total number of medical service uses exceeds the total number of victimizations resulting in medical care.

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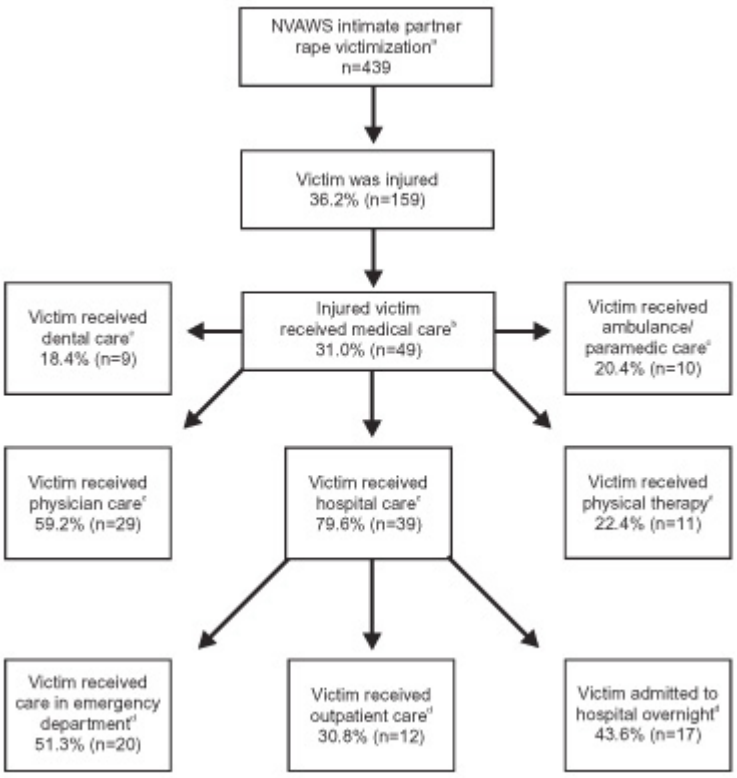
[1] Only 16 women participating in the NVAWS reported IPV rape in the 12 months preceding the survey. Estimates based on this small number are marginally stable and should be viewed with caution.

[2]For information about specific injuries, see Tjaden P, Thoennes N. *Extent, Nature, and Consequences of Intimate Partner Violence: Findings from the National Violence Against Women Survey*. Washington (DC): U.S. Department of Justice, Office of Justice Programs, National Institute of Justice; 2000. NCJ 181867.

[3]To yield more reliable estimates for service use, all most-recent IPV victimizations reported in the NVAWS— including those that occurred more than 12 months before the interview—were used to establish use patterns.

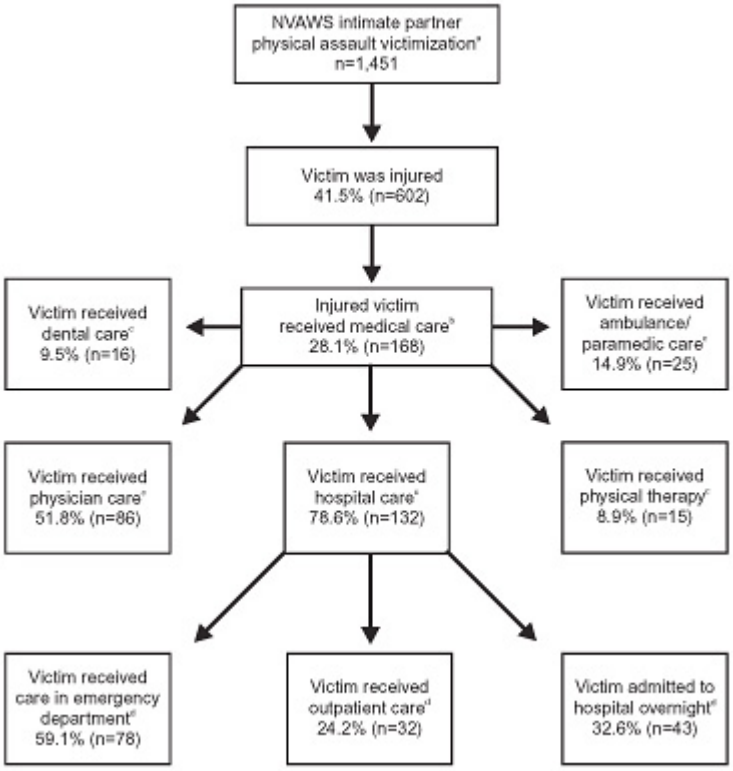
Figure 1.
Percentage Distributions of U.S. Adult Female Victims of Intimate Partner Rape by Medical Care Service Use, 1995



[a] Estimates are based on the most recent intimate partner victimization since the age of 18.
[b] The percentage of victims who received medical care is based on 158 responses from victims who were injured, excluding one "don't know" response.
[c] Estimates are based on responses from victims who received medical care.
[d] Estimates are based on responses from victims who received hospital care.

Note: Total percentages for type of medical and hospital care received exceed 100 because some victims had multiple forms of medical/hospital care.

Figure 2.
Percentage Distributions of U.S. Adult Female Victims of Intimate Partner Physical Assault by Medical Care Service Use, 1995



[a] Estimates are based on the most recent intimate partner victimization since the age of 18.
[b] The percentage of victims who received medical care is based on 598 responses from victims who were injured, excluding 4 "don't know" responses.
[c] Estimates are based on 168 responses from victims who received medical care, although the percentage of victims who received physician care is based on 166 respondents, excluding 2 "don't know" responses.
[d] Estimates are based on responses from victims who received hospital care.

Note: Total percentages for type of medical and hospital care received exceed 100 because some victims had multiple forms of medical/hospital care.

Sources: Tjaden and Thoennes 2000; Bardwell Consulting, Ltd. (unpublished data) 2001.

Victims' Use of Mental Health Care Services

NVAWS respondents who were victimized by an intimate partner were asked whether they talked to a psychologist, psychiatrist, or other type of mental health professional about their most recent victimization, and if so, how many times.

NVAWS Findings

One-third of female rape victims, 26.4% of physical assault victims, and 42.6% of stalking victims said they talked to a mental health professional, most of them multiple times. Among these women, rape victims averaged 12.4 visits, physical assault victims averaged 12.9 visits, and stalking victims averaged 9.6 visits.

National Estimates of Mental Health Care Service Use

Of the estimated 5.3 million rapes, physical assaults, or stalking incidents by intimate partners each

year, nearly 1.5 million result in some type of mental health counseling. The total number of mental health care visits by female IPV victims each year is estimated to be more than 18.5 million.

Victims' Lost Productivity

The NVAWS asked IPV victims whether their most recent victimization caused them to lose time from routine activities, including employment, household chores, and childcare. Victims who lost time from employment and household chores were asked how many days they lost from these activities. This information was then applied to the estimated number of women victimized each year by intimate partners to produce annual estimates of total lost productivity.

NVAWS Findings

Of adult female IPV victims, 35.3% who were stalked, 21.5% who were raped, and 17.5% who were physically assaulted lost time from paid work. Women stalked by an intimate partner averaged the largest number of days lost from paid work (10.1). Women raped by an intimate partner lost an average 8.1 days from paid work, and victims of IPV physical assault lost 7.2 days on average per victimization.

Among IPV stalking victims, 17.5% lost days from household chores; IPV rape and physical assault victims lost 13.5% and 10.3% respectively. Victims of IPV rape lost the largest average number of days from household chores (13.5), followed by stalking (12.7) and physical assault (8.4) victims.

National Estimates of Lost Productivity

According to NVAWS estimates, U.S. women lose nearly 8.0 million days of paid work each year because of violence perpetrated against them by current or former husbands, cohabitants, dates, and boyfriends. This is the equivalent of 32,114 full-time jobs each year. An additional 5.6 million days are lost from household chores.

Intimate Partner Homicides Among Women

Data about fatal IPV were obtained from the Federal Bureau of Investigation's Uniform Crime Reports (UCR) Supplementary Homicide Reports. Data in the UCR are submitted to the FBI by nearly 17,000 law enforcement agencies nationwide. In 1995, the same year as data from the NVAWS, 1,252 U.S. women ages 18 and older were killed by intimate partners.

Summary

Nearly 5.3 million intimate partner victimizations occur among U.S. women ages 18 and older each year. This violence results in nearly 2.0 million injuries and nearly 1,300 deaths. Of the IPV injuries, more than 555,000 require medical attention, and more than 145,000 are serious enough to warrant hospitalization for one or more nights. IPV also results in more than 18.5 million mental health care visits each year. Add to that the 13.6 million days of lost productivity from paid work and household chores among IPV survivors and the value of IPV murder victims' expected lifetime earnings, and it is clear to see that intimate partner violence against women places a significant burden on society.

Table 1. Percentage of NVAWS Respondents and Estimated Number of U.S. Adult Women Nonfatally Victimized by an Intimate Partner in Their Lifetimes and in the Previous 12 Months, by Type of Victimization, 1995

	In Lifetime		In Previous 12 Months	
	Percent in NVAWS[a]	Estimated No. Women[b]	Percent in NVAWS[a]	Estimated No. Women[b]
Type of Victimization				
Rape	7.7	7,753,669	0.2c	201,394
Physical assault	22.1	22,254,037	1.3	1,309,061
Stalking	4.8	4,833,456	0.5	503,485
TOTAL Victimized	25.5	25,677,735	1.8	1,812,546

[a] Percentage of respondents is based on NVAWS interviews with 8,000 U.S. women ages 18 and older.
[b] Estimated number of women is calculated by applying the NVAWS percentage to the 1995 projected population estimate of women ages 18 and older in the U.S. (100,697,000).
[c] Only 16 women participating in the NVAWS reported IPV rape in the 12 months preceding the survey. Estimates based on this small number are marginally stable and should be viewed with caution.
[d] The individual types of victimizations do not sum to the total number of women victimized because some victims reported multiple types of victimization.

Sources: Tjaden and Thoennes 2000; Wetrogen 1988.

Table 2. Estimated Number of Nonfatal Intimate Partner Rape, Physical Assault, and Stalking Victimizations Against U.S. Adult Women, 1995

Type of Victimization	No. of Victims	Average No. of Victimizations Per Victim[a]	Total No. of Victimizations	Annual Rate of Victimization Per 1,000 Women
Rape	201,394	1.6	322,230b	3.2[b]
Physical assault	1,309,061	3.4	4,450,807	44.2
Stalking	503,485	1.0	503,485	5.0

[a] The average number of victimizations per victim is based on the previous 12 months. Because stalking by definition means repeated acts, and because no woman was stalked by more than one intimate partner in the 12 months preceding the survey, the number of stalking victimizations was imputed to be the same as the number of stalking victims. Thus, the average number of stalking victimizations per victim is 1.0.
[b] Relative standard error exceeds 30 percent. Based on 16 women who reported intimate partner rape in the previous 12 months, this estimate is unstable and used only as part of intermediate calculations to determine the total costs associated with IPV.

Sources: Tjaden and Thoennes 2000; Bardwell Consulting, Ltd. (unpublished data) 2001.

Table 3. Estimated Victimization Outcomes and Medical Care Service Use by U.S. Adult Female Victims of Nonfatal Intimate Partner Rape and Physical Assault, 1995

Victimization Outcomes and Medical Services Used	Rape	Physical Assault	Total
Victimizations	322,230	4,450,807	4,773,037
Victimization resulting in injury[a]	116,647	1,847,085	1,963,732
Victimization resulting in some type of medical care[b]	36,161	519,031	555,192
Victimization resulting in:			
Hospital care[c]	28,784	407,958	436,742
Physician care[c]	21,407	268,858	290,265
Dental care[c]	6,654	49,308	55,962
Ambulance/paramedic care[c]	7,377	77,336	84,713
Physical therapy[c]	8,100	46,194	54,294
Victimization resulting in hospital:			
ED care[d]	14,766	241,103	255,869
Outpatient care[d]	8,865	98,726	107,591
Overnight care[d]	12,550	132,994	145,544

A Derived by applying the injury percentages (Figures 1 and 2) to the total number of victimizations.
B Derived by applying the medical care percentages (Figures 1 and 2) to the number of victimizations resulting in injury.
C The number of victimizations resulting in each particular type of medical care (e.g., physician care) was derived by applying the percentage of victimizations resulting in that particular service (Figures 1 and 2) to the overall number of victimizations resulting in some type of medical care.
D The number of victimizations resulting in each particular type of hospital care (e.g., ED care) was derived by applying the percentage of victimizations resulting in that particular type of care (Figures 1 and 2) to the overall number of victimizations resulting in hospital care.

Sources: Tjaden and Thoennes 2000; Bardwell Consulting, Ltd. (unpublished data) 2001; Max, Rice, Golding and Pinderhughes (unpublished data) 1999.

Table 4. Estimated Average and Total Number of Medical Care Service Uses by U.S. Adult Female Victims of Nonfatal Intimate Partner Rape and Physical Assault, 1995

	Rape		Physical Assault		Rape and Physical Assault
Type of Medical Service	Average No. of Uses	Total No. of Uses	Average No. of Uses	Total No. of Uses	Total No. of Uses
ED visits	1.9	28,055	1.9	458,096	486,151
Outpatient visits	1.6	14,184	3.1	306,051	320,235
Hospital overnights	3.9	48,945	5.7	758,066	807,011
Physician visits	5.2	111,316	3.2	860,346	971,662
Dental visits	2.3	15,304	4.4	216,955	232,259
Ambulance/paramedic services	1.3	9,950	1.1	85,070	95,020
Physical therapy visits	13.4	108,540	21.1	974,693	1,083,233

[a] The total number of uses for each type of medical care service for rape and physical assault victimizations was derived by multiplying the total number of victimizations resulting in that medical care service by the average number of uses of that service.

NOTE: Estimates were derived separately for each type of victimization. Overall totals for service use were subsequently derived by summing the respective estimates across victimization types. Consequently, the overall average number of medical care service uses was not derived.

Sources: Tjaden and Thoennes 2000; Bardwell Consulting, Ltd. (unpublished data) 2001; Max, Rice, Golding and Pinderhughes (unpublished data) 1999.

Table 5. Estimates of Mental Health Care Service Use by U.S. Adult Female Victims of Intimate Partner Violence by Victimization Type, 1995

Victimization and Mental Health Use Estimates	Rape	Physical Assault	Stalking	Total
Total number of victimizations	**322,230**	**4,450,807**	**503,485**	5,276,522
Percent of victimizations resulting in mental health care services	**33.0%**	**26.4%**	**42.6%**	N/A
Number of victimizations resulting in mental health care services	**106,336**	**1,175,013**	**214,485**	1,495,834
Average number of mental health care visits per victimization	12.4	12.9	9.6	**N/A**
TOTAL number of mental health care visits	**1,318,566**	15,157,668	2,059,056	18,535,290

NOTE: Estimates were derived separately for each type of victimization. Overall totals for victimizations and mental health care visits were subsequently derived by summing the respective estimates across victimization types. Consequently, the overall percentage receiving mental health care services and overall average number of mental health care visits per victimization were not derived.

Table 6. Estimated Percentage of Victims and Number of Nonfatal Victimizations of Intimate Partner Rape, Physical Assault, and Stalking Against U.S. Adult Women, by Time Lost from Paid Work and Household Chores, 1995[a]

Victimization Type	Activity	Percent Victims	Number of Victimizations
Rape	Paid Work	21.5	69,279
	Household Chores	13.5	43,50
Physical assault	Paid Work	17.5	778,891
	Household Chores	10.3	458,433
Stalking	Paid Work	35.3	177,730
	Household Chores	17.5	88,110
TOTAL	Paid Work	N/A	1,025,900
	Household Chores	N/A	590,044

[a]Estimates are derived from the NVAWS based on the most recent intimate partner victimization since age 18.

NOTE: Victimization estimates of time lost from both paid work and household chores were derived separately for each victimization type. The total number of victimizations was subsequently derived by summing the respective estimates across victimization types. Consequently, the overall percentages of victims reporting time lost from paid work and household chores were not derived.

NOTE: See Appendix A for calculations of lost productivity and related values.

Sources: Tjaden and Thoennes (unpublished data) 1999; Bardwell Consulting, Ltd. (unpublished data) 2001.

Table 7. Estimated Lost Productivity Among U.S. Adult Female Victims of Nonfatal Intimate Partner Violence, by Victimization Type and by Time Lost from Paid Work and Household Chores, 1995 [a]

		Days Lost		
Victimization Type	Activity	Average	Total	Lost Full-Time Job Equivalent[b]
Rape	Paid Work	8.1	561,160	2,263
	Household Chores	13.5	587,264	N/A
Physical assault	Paid Work	7.2	5,608,015	22,613
	Household Chores	8.4	3,850,837	N/A
Stalking	Paid Work	10.1	1,795,073	7,238
	Household Chores	12.7	1,118,997	N/A
TOTAL	Paid Work	N/A	7,964,248	32,114
	Household Chores	N/A	5,557,098	N/A

[a]Estimates are derived from the NVAWS based on the most recent intimate partner victimization since age 18.
[b]The estimates of lost full-time job equivalents for paid work conservatively assume 248 work days per year.

NOTE: Victimization estimates of the average and total number of days lost from both paid work and household chores were derived separately for each victimization type. The overall total number of days lost was subsequently derived by summing the respective estimates across victimization types. Consequently, the overall average number of days lost from paid work and household chores were not derived.

NOTE: See Appendix A for illustrations of calculations of lost productivity and related values

Understanding the economic costs of intimate partner violence (IPV) can aid policymakers in allocating resources more effectively and efficiently. This chapter provides the estimated annual costs of medical care, mental health care, lost productivity, and present value of lifetime earnings associated with IPV against U.S. adult women. The data presented reflect costs associated with IPV victimizations that occurred in 1995; these data are the most appropriate, reliable data currently available. It should be noted, however, that costs related to victimization in a given year are not always incurred in that year. For instance, mental health care visits related to IPV could continue for years after victimization. Therefore, estimated costs for victimization in a given year may underestimate the total costs of an incident of IPV victimization.

Calculating the Costs of Intimate Partner Violence

The economic costs of IPV are divided into two components—direct and indirect costs.

- **Direct costs** are the actual dollar expenditures related to IPV. They include spending for health care–related services such as emergency department (ED) visits; hospitalizations; outpatient clinic visits; services of physicians, dentists, physical therapists, and mental health professionals; ambulance transport; and paramedic assistance. To calculate the total costs of each medical and mental health care service, the unit cost of a particular service was multiplied by the number of times that service was used (Bardwell 2001).

- **Indirect costs** of IPV represent the value of lost productivity from both paid work and household chores for injured victims and the present value of lifetime earnings for victims of fatal IPV. Lost productivity was measured by the number of days victims were unable to perform paid work and/or household chores (including household chores and childcare for women not employed outside the home) because of illness, injury, or disability related to IPV victimization. The value of lost productivity was calculated using the mean daily values of work and household production, which are based on data from the U.S. Bureau of Labor Statistics (1996; 1999), Miller (1997), and the U.S. Bureau of the Census (1996). The present value of lifetime earnings was calculated by multiplying the number of IPV homicides for each age group by the average present value of the anticipated future earnings of women in those age groups. These calculations account for differential life expectancy by age group, labor force earning patterns and participation rates at successive ages, and imputed household production values for women in the labor force and women not in the labor force (Rice, Max, Golding and Pinderhughes 1997).

To yield more reliable estimates for service use and lost productivity, all most-recent IPV victimizations reported in the NVAWS—including those that occurred more than 12 months before the interview—were used to establish patterns of service use and lost productivity.

Data Sources Used to Calculate Costs of Intimate Partner Violence

As discussed previously, the National Violence Against Women Survey (NVAWS) and Uniform Crime Reports Supplementary Homicide Report were used to measure the incidence of fatal and nonfatal IPV, incidence of IPV-related health care service use among survivors, and lost productivity. Additionally, the following sources were used to calculate the health care costs of IPV:

- **Medical Expenditure Panel Survey (MEPS), 1996.** This survey by the Agency for Healthcare Research and Quality lists expenditures for medical care in the U.S. The MEPS is the main data

source for unit costs of health care presented in this report. These unit costs were deflated to 1995 dollars using the appropriate health care components of the Consumer Price Index.

- **Medicare 5% Sample Beneficiary Standard Analytic Files.** This data source, which reflects physician/supplier claims, was used to calculate expenditures for ambulance and paramedic services, which are not available in MEPS.

Health Care Costs

In this report, service use estimates were restricted to services required as a result of the most recent victimizations by intimate partners, as derived from the NVAWS. In the NVAWS, only women who were injured as a result of IPV were asked about their use of medical care services. In contrast, all women who were victimized, regardless of injury, were asked about their use of mental health care services. Unit costs of medical and mental health care services for rape and physical assault victims were derived from the MEPS using medical and mental health visits related to injuries for women ages 18 and older. The unit costs of mental health care services for stalking victims were based on MEPS using mental health visits for women ages 18 and older who did not also sustain physical injuries.

Medical Care Costs

Medical care costs include ambulance transport and paramedic care; ED care; physician, physical therapy, and dental visits; inpatient hospitalizations; and outpatient clinic visits. Victims seeking medical care often received more than one service. We estimated the medical care costs of rape and physical assault separately. Rapes that involved physical assault were classified as rape only to avoid counting victimizations twice. No medical care costs were associated with stalking.

Rape. According to estimates from the NVAWS, 322,230 IPV rapes occur among women each year. Slightly more than one-third of these rapes (36.2%) result in physical injuries, 31.0% of which require medical care. In all, 36,161 IPV rapes result in women receiving medical care for injuries. Table 8 presents the number of times IPV rape victims use each medical care service, along with the unit costs of those services.

The mean medical care cost per IPV rape is about $516. The mean medical care cost per rape among victims who actually receive treatment is $2,084 per victimization. Not all victims who reported receiving medical care used all types of medical services. Therefore, the average cost of medical care for victims receiving treatment reflects variations in service use; it does not equal the total of each of the individual service costs per rape.

Nearly half of the medical care costs associated with IPV rape are paid by private or group insurance; victims pay more than one-quarter of the costs.

Physical Assault. Based on NVAWS estimates, 4,450,807 IPV physical assaults occur against women annually; 41.5% of these assaults cause injuries. Medical care for injuries is required in 519,031 incidents (28.1% of those injured). Table 10 presents the number of times physical assault victims use medical care services and the unit costs of those services.

The mean medical care cost per incident of IPV physical assault is $548. The mean medical care cost per physical assault among victims who actually receive treatment is $2,665. Not all victims who reported receiving medical care used all types of medical services. Therefore, the average cost of

medical care for victims receiving treatment reflects variations in service use; it does not equal the total of each of the individual service costs per physical assault.

As with IPV rape, private or group insurance pays for nearly half of medical care costs for IPV physical assaults; victims pay more than one-quarter of the costs.

Mental Health Care Costs

All women in the NVAWS who reported IPV were asked if they used mental health care services. Because mental health care often requires multiple visits over a long period of time, the cost of these services is substantial.

Rape. According to NVAWS estimates, one-third (33.0%) of IPV rapes result in the victim's speaking with a psychologist, psychiatrist, or other mental health professional about the incident. On average, each incident requires 12.4 mental health care visits, for a total of 1.3 million mental health visits per year, at a mean cost of $78.86 per visit. The mean mental health care cost per incident of IPV rape is $323; the mean cost per IPV rape among victims who actually receive treatment is $978. Victims pay for more than one-third of mental health care services; private health insurers pay only slightly more than victims.

Physical Assault. More than one-quarter (26.4%) of IPV physical assaults result in the victim's speaking with a psychologist, psychiatrist, or other mental health professional, according to NVAWS estimates. On average, each incident requires 12.9 visits, for a total of 15.2 million visits annually, at a mean cost of $78.86 per visit. The mean mental health care cost per incident of IPV physical assault, is $269; among victims who actually receive treatment, the mean cost per incident is $1,017. Victims pay for approximately one-third of the costs.

Stalking. NVAWS estimates indicate than more than half a million women are stalked by intimate partners each year. Forty-three percent of these victims seek mental health care services, at an average of 9.6 visits per person. That's a total of nearly 2.1 million mental health care visits related to IPV stalking annually at a mean cost of $71.87 per visit. The mean mental health care cost per stalking incident by an intimate partner is $294; the mean cost per stalking incident among victims who actually receive treatment is $690. Private insurance pays for 34.7% of this mental health care; victims pay for 32.0%.

Total Health Care Costs

The estimated total health care costs of IPV each year, including medical and mental health care services, is nearly $4.1 billion. Of these costs, 89.7% are attributable to intimate partner physical assaults due to the large number of victimizations: 4,450,807 physical assaults compared with 322,230 rapes (6.7% of costs) and 503,485 stalking victimizations (3.7% of costs). The total medical and mental health care cost per victimization by an intimate partner was $838 per rape, $816 per physical assault, and $294 per stalking.

Lost Productivity

Victims of IPV lose time from their regular activities due to injury and mental health issues. They may also be at greater risk for other health problems, such as chronic pain and sleep disturbances, which can interfere with or limit daily functioning (McCauley et al. 1995).

Rape. Among IPV rape victims, mean daily earnings lost are $69, and the mean daily value of household chores lost is $19.1 According to NVAWS estimates, more than one-fifth (21.5%) of the women raped by an intimate partner report losing time from paid work, and 13.5% lose time from household chores. Rape victims lose an estimated 1.1 million days of activity each year, which is equivalent to 3,872 person-years.

Physical assault. Among IPV physical assault victims, mean daily earnings lost are $93, and the mean daily value of household chores lost is $24. Approximately one in six (17.5%) victims report time lost from paid work, and 10.3% report lost time from household chores. Victims of IPV physical assault lose an estimated 9.5 million days of activity each year; that equals 33,163 person-years of lost productivity.

Stalking. Among IPV stalking victims, mean daily earnings lost are $93, and the mean daily value of household chores lost is $24. More than one-third (35.3%) of stalking victims report time lost from paid work, according to NVAWS estimates; 17.5% report time lost from household chores. Stalking victims lose an estimated 2.9 million days of productivity—or 10,304 person-years—annually.

Total Lost Productivity

As shown in Table 12, the estimated total value of days lost from employment and household chores is $858.6 million. The value of lost productivity from employment is $727.8 million, representing 84.8% of the total; the value of lost productivity from household chores is $130.8 million. More than 13.5 million total days are lost from job and housework productivity, which is equivalent to 47,339 person-years. Nearly three-quarters (71.6%) of lost productivity is due to physical assault; 22.6% of lost productivity is due to stalking.

Present Value of Lifetime Earnings

The present value of lifetime earnings (PVLE) measures the expected value of lost earnings that IPV homicide victims would have otherwise contributed to society had they been able to live out their full life expectancies. An estimated 1,252 women are killed by an intimate partner each year. The PVLE for these victims is an estimated $892.7 million—an average of more than $713,000 per fatality. (See Appendix B for PVLE by age group.)

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[1]See Appendix A for calculations of lost productivity and related values as illustrated for rape estimates.

Summary: Total Costs of Intimate Partner Violence

The costs of IPV against women exceed an estimated $5.8 billion. These costs include nearly $4.1 billion in the direct costs of medical care and mental health care and nearly $1.8 billion in the indirect costs of lost productivity and PVLE. Statistically, the overall total cost estimate of $5.8 billion varies from more than $3.9 billion to more than $7.6 billion, as indicated by the 95% confidence interval for the total costs.

The largest proportion of the costs is derived from physical assault victimizations because that type of IPV is the most prevalent (Figure 3). The largest component of IPV costs is health care, accounting for nearly $4.1 billion—more than two-thirds of the total costs (Figure 4).

Figure 3.
Percentage of Costs of Intimate Partner Violence Against U.S. Adult Women by Victimization Type, 1995

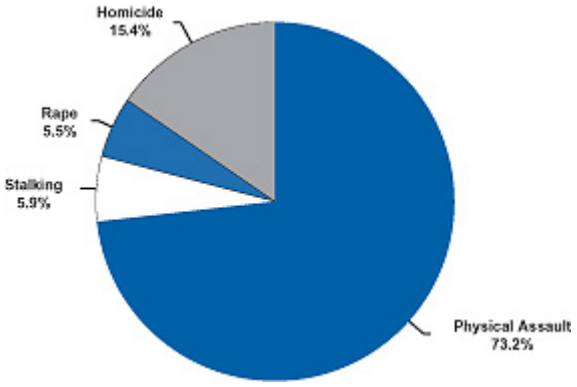
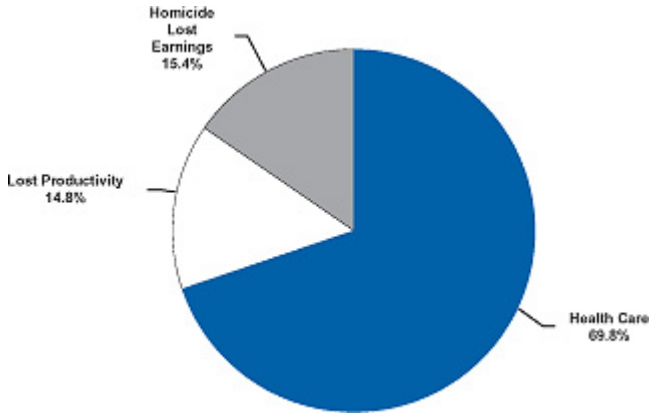


Figure 4.
Percentage of Costs of Intimate Partner Violence Against U.S. Adult Women by Cost Type, 1995



Discussion

This report presents estimates of the incidence, prevalence, and costs of intimate partner violence against U.S. women ages 18 and older. In addition to data about IPV fatalities obtained from existing FBI sources, it uses data from the first large-scale survey to collect information about injuries IPV victims sustained, the medical and mental health care services victims used, and the time victims lost from paid work and household chores. The report reflects the most appropriate, reliable data currently

available about the costs associated with IPV. Standard public health methods were applied to recent data on IPV-related injuries to estimate their incidence, estimate resulting health care costs and lost productivity, and to review strategies for reducing the incidence of IPV.

As reported in previous chapters, nearly 5.3 million intimate partner victimizations occur each year among U.S. women ages 18 and older, and nearly 1,300 women lose their lives as a result of IPV. Based on these estimates, such violence costs our nation more than an estimated $5.8 billion dollars annually—nearly $4.1 billion for medical and mental health care, $0.9 billion in lost productivity, and $0.9 billion in homicide lost earnings. These figures are believed to underestimate the problem of IPV for many reasons, and additional efforts are needed to better determine the costs of IPV against women in the U.S.

Using the Cost Figures in this Report

The cost estimates presented in this report can be used to—

- Calculate the economic cost savings from reducing a given number of injuries resulting from IPV;
- Demonstrate the economic magnitude of IPV in the U.S.;
- Evaluate the impact of IPV on a specific sub-sector of the economy, such as consumption of medical resources or effects on employers.

However, because of some limitations in the data—the discussion of which follows— these estimates are not comprehensive. Therefore, the estimates in this report should not be used in direct comparisons with the costs of reducing IPV, namely to produce benefit/cost ratios in analyses of interventions to prevent IPV.

Data Limitations

The cost estimates presented in this report have several limitations, the most obvious of which is the fact that 1995 incidence data were used to generate annual estimates. CDC recognizes that direct costs, value of lost productivity, and present value of lifetime earnings resulting from IPV today may differ from that of IPV that occurred in 1995. However, this report reflects the most appropriate, reliable data available to date about the costs associated with IPV. Other limitations involve the exclusion of certain costs potentially associated with IPV and the use of average rather than actual medical care costs.

Excluded Costs

Several cost components were excluded from this report because data were unavailable or insufficient. Perhaps the largest omission is criminal justice costs. NVAWS data indicate that an estimated 1.5 million intimate partner rape, physical assault, or stalking victimizations result in police reports each year; nearly 79,000 of these victimizations result in a jail or prison sentence. While IPV-related criminal justice service use is significant, current data about unit costs do not allow for reliable, nationally representative cost estimates associated with these services.

Some medical care costs, including home care visits, treatment for sexually transmitted diseases (STDs), and terminated pregnancies were excluded because there were too few victimizations resulting in these outcomes reported in the NVAWS to generate reliable cost estimates. Also excluded were cost components for which either no data were available or only incidence data were available: social

services such as women's shelters and counseling clinics; shelter, moral support, and financial assistance from IPV victims' friends and family; medical or mental health costs of treating children who witness IPV; foster care for children as a result of IPV; and the value of time lost from volunteer work, school, and social and recreational activities.

Although the mental health care costs associated with IPV were calculated, it was not possible to estimate the intangible costs of pain and suffering associated with IPV that did not result in a mental health care visit, or that did not result in a visit where IPV was identified as associated with the suffering. Because costs of this type may be quite high, this report should be viewed as presenting very conservative estimates, or as the lower limit of the costs related to IPV.

Because the NVAWS reports on the survivors of IPV, data about victims' use of medical and mental health services were collected only for victims of nonfatal IPV. No data were collected about the health care costs associated with treating victims who ultimately die as a result of IPV.

Limitations of the Medical Care Data

Health care service use resulting from IPV is not always readily reported. Therefore, the health care costs in this report are underestimates and should be viewed as lower limits of the magnitude of the problem.

Evidence has shown that victims of IPV manifest a wide range of physical symptoms that are not directly related to abuse. These can include headaches, reproductive health problems, chronic pain, digestive problems, and sleep disturbances. To the extent that medical care service use associated with indirect physical symptoms of IPV was not reported by victims, related costs are excluded from the health care estimates in this report.

Limitations of the Mental Health Care Data

Data about mental health–related costs of IPV are limited for several reasons. First, incidence estimates derived from the NVAWS are based on the response to a question about whether or not the victim spoke to a mental health professional. As no definition of mental health professional was given, this question was subject to the interpretation of the respondent. Furthermore, mental health professionals are not the only individuals from whom victims may seek mental health care.

Second, respondents were asked only about mental health care providers with whom they discussed their experience of IPV victimization. Some women may have sought care for mental health problems but not identified that it was related to past experiences of IPV.

Finally, the cost of unmet mental health needs is not estimated. This is a critical gap in IPV research because the violence itself may limit women's use of needed services. That is, men who physically abuse their partners are also likely to control and coerce them, including restricting their access to mental health care.

Underestimate of a Particular Type of Victimization

Although some incidents involved more than one type of victimization (e.g., a woman whose former husband stalks and then rapes her), the NVAWS counted each incident only once and classified it according to the severity of abuse. Rape was considered more severe than physical assault, and physical assault more severe than stalking. Women who sustained injuries during incidents involving more than one type of victimization were asked to report services used as a result of these injuries for the most severe type of victimization involved in these incidents. They were asked not to report service use for the same injuries when asked about the less severe type(s) of victimization involved in the particular incident. These procedures prevented double-counting of both service use and associated

costs resulting from these incidents. However, these procedures likely resulted in an underestimate of health care costs resulting from physical assault, because some costs are included under rape. Likewise, some stalking costs are likely included under physical assault and rape.

Conservative Cost Estimation

The cost estimates of IPV in this report are generally conservative for several reasons. First, the NVAWS estimates of IPV victimization among women are lower than estimates in other studies. Second, the estimates presented in this report are based on services that victims of IPV reported using. Some NVAWS respondents may not have reported IPV due to embarrassment or shame. Consequently, any services used as a result of these victimizations also went unreported.

Finally, the estimate of present value of lifetime earnings relies on criminal homicide data that include the relationship between victim and perpetrator and the victim's age. The relationship between victim and perpetrator was not known for all homicide cases, which likely results in an undercounting of IPV homicides. Additionally, about 1% of homicide cases determined to be the result of IPV did not report victim's age. The present value of lifetime earnings could not be calculated for those cases, thus resulting in a conservative estimate.

A Need for More Data

This report is an important step in understanding the current knowledge about intimate partner violence in the U.S. However, it highlights a need for more data to fully appreciate the economic and human costs of this problem. Obtaining these data will involve creating standard definitions of IPV, expanding quantitative data collection efforts, and employing methods to gather qualitative data.

Standardizing the Definition of Intimate Partner Violence

Definitions of intimate partner violence vary among agencies collecting data. For example, some definitions include same sex partners, and some do not. Some consider IPV among both current and former intimate partners, some do not. Because of these variations, survey data also vary, making it difficult to firmly state the magnitude of IPV.

To address problems posed by varying definitions, CDC recently facilitated a national process to develop standard definitions of IPV. At the same time, CDC funded several states to develop IPV surveillance systems that use these definitions to gather data from the health care, social service, and criminal justice systems. This project serves as a pilot test of the IPV definitions and the feasibility of developing statewide public health surveillance to estimate the magnitude of the problem.

Improving Quantitative Data

The information about service use provided in this report includes medical and mental health care obtained from the traditional medical care system. Many survivors of IPV do not seek out these health care providers, especially for mental health care. Instead, they may go to support groups and rape crisis centers or contact crisis hotlines. Researchers should find ways to gather data from such service providers. Additionally, many women experience repeated IPV victimizations, yet little is known about the cumulative effects of such repeat abuse on service use.

One area for which costs of IPV may be substantial is criminal justice services. The NVAWS asked survivors about their involvement with the criminal justice system, but inadequate unit cost data exist to allow for generating unbiased estimates of the costs of those services. In fact, only one county at the time of the survey had unit cost data. Nationally representative data about the costs of individual criminal justice services—police reports, arrests and detainment, legal and judicial services, incarceration, and probation—are needed.

While health system data about IPV, primarily derived from hospital discharge and emergency department records, have improved in recent years, future efforts will allow for even better data collection. The clinical modification of ICD-10 (ICD-10 CM) will provide information about abuse, neglect, abandonment, and the perpetrator's relationship to the victim. This will enable better IPV data collection from health sources.

Collecting Qualitative Data

Perhaps more compelling than the economic costs are data about the human costs. But how do you quantify pain, suffering, and decreased quality of life associated with intimate partner violence, both on survivors and on children exposed to such violence? Data are needed to assess the long-term, psychosocial effects of IPV and to demonstrate more clearly the social burden of this problem. Researchers should explore methods for collecting data about indirect or intangible costs of IPV, such as using in-depth interviews with survivors and service providers.

A Need for Primary Prevention of Intimate Partner Violence

To reduce both the economic and human costs of intimate partner violence against women, we must focus on primary prevention—finding ways to stop such violence before it ever occurs—rather than only treating victims and rehabilitating perpetrators. To that end, CDC has identified several priorities to address IPV prevention. These priorities, set forth in CDC's *Injury Research Agenda*, represent the research issues that warrant the greatest attention and extramural and intramural research from CDC for the next three to five years. (The agenda can be viewed online at: www.cdc.gov/ncipc/pub-res/research_agenda/agenda.htm.)

One key area of CDC's IPV research is social norms. Social norms—what a community views as acceptable behaviors for its citizens—can profoundly affect efforts to prevent public health problems. In October 2000, CDC began exploring how social norms affect intimate partner violence. Findings are guiding development of a campaign to change social norms that accept or promote IPV against women. The campaign will target boys in sixth through eighth grades, a population in which strong social norms are developing quickly and in which we can effect lasting changes. It will focus on the characteristics of healthy relationships, in which violence is unacceptable.

CDC is also working to find ways to intervene with individuals, families, and communities in ways that stop violence before it happens. Its research agenda calls for developing programs and policies that provide counseling for batterers and prevent dating violence as means of intervening with perpetrators and potential perpetrators. The agenda also sets a priority to better understand how violent behavior toward intimate partners develops, so that researchers can implement strategies to reduce factors that increase the risk of IPV perpetration.

Other areas of research about preventing intimate partner violence include developing and evaluating training programs about IPV detection and prevention for health professionals, evaluating the health

consequences of IPV across the life span, developing and evaluating surveillance methods to better collect data about incidence and prevalence of IPV, and disseminating information about IPV prevention strategies that work.

Conclusion

With an estimated economic cost of $5.8 billion, and the untold intangible costs, intimate partner violence against women is a substantial public health problem that must be addressed. Significant resources for research are needed to better understand the magnitude, causes. and risk factors of IPV and to develop and disseminate effective primary prevention strategies. Until we reduce the incidence of IPV in the United States, we will not reduce the economic and social burden of this problem.

Calculating Lost Productivity and Related Values

Total Days Lost from Paid Work and Household Chores

To determine the total days lost from paid work and household chores for each victimization type, we first determined the total number of victimizations that resulted in days lost from each of those activities:

Percent victimizations resulting in days lost X
Total number of victimizations =
Total number of victimizations resulting in days lost.

For example, to determine the number IPV rape victimizations that resulted in lost paid work:

21.5% of rapes resulting in days lost from paid work X
322,230 total rape victimizations =
69,279 rapes resulting in days lost from paid work.

Next, multiply the number of victimizations resulting in lost days of a given activity by the mean number of days lost from that activity per victimization. For example, to determine the total number of paid work days lost for rape victimizations:

69,279 rapes resulting in lost paid work days X
8.1 mean number of days lost from paid work per rape =
Approximately 561,000 total days lost from paid work due to rape victimization.

Person-Years Lost from Paid Work and Household Chores

Total time lost may also be expressed in person-years lost. For paid work, these calculations assumed 248 work days per year; for household chores, 365 days per year. To calculate person-years:

Total number of days lost for a given activity for a given victimization type /
Number of productivity days per year =
Total person-years lost for that victimization type.

For example, to calculate person-years of household chores lost for rape victimizations:

561,000 total days lost / 365 days of household chores =
2,262 person-years lost.

NOTE: Total person-years presented here may be slightly different than those presented elsewhere in this report; rounded figures are used here, but unrounded estimates were used elsewhere.

Mean Daily Values and Total Value of Lost Productivity

To estimate the total value of lost productivity for each victimization type, we need to first estimate the respective mean daily value of earnings from work. Mean daily values of earnings are based on the mean age of women at the time of victimization. For rape, the mean age at the time of victimization is 24.5 years; for physical assault, 27.5 years; and for stalking, 26.5 years (Max, Rice, Golding and Pinderhughes 1999). For each victimization type, the mean daily value of earnings is, in turn, based on the respective mean annual earnings for women of the mean victimization age group (U.S. Bureau of Census 1996; U.S. Bureau of Labor Statistics 1996).

To calculate the mean daily value of earnings for each victimization type:

Mean annual earnings of the mean victimization age group /
Number of paid work days per year =
Mean daily value of earnings.

For example, to calculate the mean daily value of earnings for rape victims:

$17,058 (mean annual earnings for mean victimization age) /
248 paid work days per year =
$68.78 daily value.

To calculate the total value of lost days from paid work:

Mean daily value of earnings X total days of earnings lost =
Total value of lost days.

For example, for rape victimizations:

$68.78 X 561,000 total days of earnings lost due to rape =
Approximately $38,600,000.

Follow the same calculations to determine the total value of days lost from household chores.

Calculating Age Group–Specific Present Value of Lifetime Earnings Estimates

Present Value of Lifetime Earnings (PVLE) Among Adult Female Victims of Intimate Partner Homicide by Age Group, U.S., 1995

Age Group	No. of Homicides	Mean PVLE	Total PVLE
18–19	50	$ 938,545	$ 46,927,268
20–24	176	958,434	168,684,384
25–29	182	924,842	168,321,244
30–34	217	852,312	184,951,704
35–39	207	754,284	156,136,788
40–44	148	637,849	94,401,652
45–49	73	509,876	37,220,948
50–54	58	380,019	22,041,102
55–59	26	257,641	6,698,666
60–64	23	156,178	3,592,094
65–69	24	86,713	2,081,112
70–74	22	45,029	990,638
75–79	25	21,336	533,400
80–84	16	8,682	138,912
85 and older	5	2,557	12,785
OVERALL TOTAL	**1,252**	**N/A**	**$ 892,732,697**

NOTE: The mean PVLE for each age group was multiplied by the number of intimate partner homicides in that age group to arrive at the total PVLE for that group. Then, all age group–specific PVLEs were added to arrive at the overall total PVLE.

Intimate Partner Violence: Fact Sheet

Occurrence

Statistics about intimate partner violence (IPV) vary because of differences in how different data sources define IPV (see Overview section for the CDC definition) and collect data. For example, some definitions include stalking and psychological abuse, and others consider only physical and sexual violence. Data on IPV usually come from police, clinical settings, nongovernmental organizations, and survey research.

Most IPV incidents are not reported to the police. About 20% of IPV rapes or sexual assaults, 25% of physical assaults, and 50% of stalkings directed toward women are reported. Even fewer IPV incidents against men are reported. Thus, it is believed that available data greatly underestimate the true magnitude of the problem. While not an exhaustive list, here are some statistics on the occurrence of IPV. In many cases, the severity of the IPV behaviors is unknown.

- Nearly 5.3 million incidents of IPV occur each year among U.S. women ages 18 and older, and 3.2 million occur among men. Most assaults are relatively minor and consist of pushing, grabbing, shoving, slapping, and hitting.
- In the United States every year, about 1.5 million women and more than 800,000 men are raped or physically assaulted by an intimate partner. This translates into about 47 IPV assaults per 1,000 women and 32 assaults per 1,000 men.
- IPV results in nearly 2 million injuries and 1,300 deaths nationwide every year (CDC 2003).
- Estimates indicate more than 1 million women and 371,000 men are stalked by intimate partners each year.
- IPV accounted for 20% of nonfatal violence against women in 2001 and 3% against men.
- From 1976 to 2002, about 11% of homicide victims were killed by an intimate partner.
- In 2002, 76% of IPV homicide victims were female; 24% were male.
- The number of intimate partner homicides decreased 14% overall for men and women in the span of about 20 years, with a 67% decrease for men (from 1,357 to 388) vs. 25% for women (from 1,600 to 1,202).
- One study found that 44% of women murdered by their intimate partner had visited an emergency department within 2 years of the homicide. Of these women, 93% had at least one injury visit.
- Previous literature suggests that women who have separated from their abusive partners often remain at risk of violence.

- Firearms were the major weapon type used in intimate partner homicides from 1981 to 1998.
- A national study found that 29% of women and 22% of men had experienced physical, sexual, or psychological IPV during their lifetime.
- Between 4% and 8% of pregnant women are abused at least once during the pregnancy

Consequences

In general, victims of repeated violence over time experience more serious consequences than victims of one-time incidents. The following list describes just some of the consequences of IPV.

Physical

At least 42% of women and 20% of men who were physically assaulted since age 18 sustained injuries during their most recent victimization. Most injuries were minor such as scratches, bruises, and welts

More severe physical consequences of IPV may occur depending on severity and frequency of abuse These include:

- Bruises
- Knife wounds
- Pelvic pain
- Headaches
- Back pain
- Broken bones
- Gynecological disorders
- Pregnancy difficulties like low birth weight babies and perinatal deaths
- Sexually transmitted diseases including HIV/AIDS
- Central nervous system disorders
- Gastrointestinal disorders
- Symptoms of post-traumatic stress disorder
    - Emotional detachment
    - Sleep disturbances
    - Flashbacks
    - Replaying assault in mind
- Heart or circulatory conditions

Children may become injured during IPV incidents between their parents. A large overlap exists between IPV and child maltreatment (Appel and Holden 1998). One study found that children of abused mothers were 57 times more likely to have been harmed because of IPV between their parents, compared with children of non-abused mothers (Parkinson et al. 2001).

Psychological

Physical violence is typically accompanied by emotional or psychological abuse (Tjaden and Thoennes 2000a). IPV—whether sexual, physical, or psychological—can lead to various psychological consequences for victims (Bergen 1996; Coker et al. 2002; Heise and Garcia-Moreno 2002; Roberts, Klein, and Fisher 2003):

- Depression
- Antisocial behavior
- Suicidal behavior in females
- Anxiety
- Low self-esteem
- Inability to trust men
- Fear of intimacy

Social

Victims of IPV sometimes face the following social consequences (Heise and Garcia-Moreno 2002; Plichta 2004):

- Restricted access to services
- Strained relationships with health providers and employers
- Isolation from social networks

Health Behaviors

Women with a history of IPV are more likely to display behaviors that present further health risks (e.g., substance abuse, alcoholism, suicide attempts).

IPV is associated with a variety of negative health behaviors (Heise and Garcia-Moreno 2002; Plichta 2004; Roberts, Auinger, and Klein 2005; Silverman et al. 2001). Studies show that the more severe the violence, the stronger its relationship to negative health behaviors by victims.

- Engaging in high-risk sexual behavior
    - Unprotected sex
    - Decreased condom use

    - Early sexual initiation
    - Choosing unhealthy sexual partners
    - Having multiple sex partners
    - Trading sex for food, money, or other items
- Using or abusing harmful substances
    - Smoking cigarettes
    - Drinking alcohol
    - Driving after drinking alcohol
    - Taking drugs
- Unhealthy diet-related behaviors
    - Fasting
    - Vomiting
    - Abusing diet pills
    - Overeating
- Overuse of health services

Economic

- Costs of IPV against women in 1995 exceed an estimated $5.8 billion. These costs include nearly $4.1 billion in the direct costs of medical and mental health care and nearly $1.8 billion in the indirect costs of lost productivity (CDC 2003).
- When updated to 2003 dollars, IPV costs exceed $8.3 billion, which includes $460 million for rape, $6.2 billion for physical assault, $461 million for stalking, and $1.2 billion in the value of lost lives (Max et al. 2004).
- Victims of severe IPV lose nearly 8 million days of paid work—the equivalent of more than 32,000 full-time jobs—and almost 5.6 million days of household productivity each year (CDC 2003).
- Women who experience severe aggression by men (e.g., not being allowed to go to work or school, or having their lives or their children's lives threatened) are more likely to have been unemployed in the past, have health problems, and be receiving public assistance (Lloyd and Taluc 1999).

Groups at Risk

Certain groups are at greater risk for IPV victimization or perpetration.

Victimization

- The National Crime Victimization Survey found that 85% of IPV victims were women (Rennison 2003).
- Prevalence of IPV varies among race. Among the ethnic groups most at risk are American Indian/Alaskan Native women and men, African-American women, and Hispanic women (Tjaden and Thoennes 2000b).
- Young women and those below the poverty line are disproportionately victims of IPV (Tjaden and Thoennes 2000b).

Perpetration

- Studies show that for low levels of physical violence, men and women self-report perpetrating physical IPV at about the same rate. However, a common criticism of these studies is that they are generally lacking information on the context of the violence (e.g., whether self-defense is the reason for the violence) (Archer 2000).

Risk Factors for Victimization and Perpetration

Risk factors are associated with a greater likelihood of IPV victimization or perpetration. Risk factors are not necessarily direct causes of IPV—these may be contributing factors to IPV (Heise and Garcia-Moreno 2002). Not everyone who is identified as "at risk" becomes involved in violence.

Some risk factors for IPV victimization and perpetration are the same. In addition, some risk factors for victimization and perpetration are associated with one another; for example, childhood physical or sexual victimization is a risk factor for future IPV perpetration and victimization.

The public health approach aims to moderate and mediate those contributing factors that are preventable, and to identify protective factors which can reduce the risk of victimization and perpetration.

A combination of individual, relational, community, and societal factors contribute to the risk of being a victim or perpetrator of IPV. Understanding these multilevel factors can help identify various points of prevention intervention.

Risk Factors for Victimization

Individual Factors

- Prior history of IPV
- Being female
- Young age
- Heavy alcohol and drug use
- High-risk sexual behavior
- Witnessing or experiencing violence as a child

- Being less educated
- Unemployment
- For men, having a different ethnicity from their partner's
- For women, having a greater education level than their partner's
- For women, being American Indian/Alaska Native or African American
- For women, having a verbally abusive, jealous, or possessive partner

Relationship Factors

- Couples with income, educational, or job status disparities
- Dominance and control of the relationship by the male

Community Factors

- Poverty and associated factors (e.g., overcrowding)
- Low social capital—lack of institutions, relationships, and norms that shape the quality and quantity of a community's social interactions
- Weak community sanctions against IPV (e.g., police unwilling to intervene)

Societal Factors

- Traditional gender norms (e.g., women should stay at home and not enter workforce, should be submissive)

Risk Factors for Perpetration

Individual Factors

- Low self-esteem
- Low income
- Low academic achievement
- Involvement in aggressive or delinquent behavior as a youth
- Heavy alcohol and drug use
- Depression
- Anger and hostility
- Personality disorders
- Prior history of being physically abusive
- Having few friends and being isolated from other people
- Unemployment

- Economic stress
- Emotional dependence and insecurity
- Belief in strict gender roles (e.g., male dominance and aggression in relationships)
- Desire for power and control in relationships
- Being a victim of physical or psychological abuse (consistently one of the strongest predictors of perpetration)

Relationship Factors

- Marital conflict—fights, tension, and other struggles
- Marital instability—divorces and separations
- Dominance and control of the relationship by the male
- Economic stress
- Unhealthy family relationships and interactions

Community Factors

- Poverty and associated factors (e.g., overcrowding)
- Low social capital—lack of institutions, relationships, and norms that shape the quality and quantity of a community's social interactions
- Weak community sanctions against IPV (e.g., unwillingness of neighbors to intervene in situations where they witness violence)

Societal Factors

- Traditional gender norms (e.g., women should stay at home and not enter workforce, should be submissive)

(Black et al. 1999; Heise and Garcia-Moreno 2002; Kantor and Jasinski 1998; Stith et al. 2004; Tjaden and Thoennes 2000a)

Extent, Nature, and Consequences of Intimate Partner Violence: Findings From the National Violence Against Women Survey

Executive Summary
U.S. Department of Justice

This report presents findings from the National Violence Against Women (NVAW) Survey on the extent, nature, and consequences of intimate partner violence in the United States. The National Institute of Justice and the Centers for Disease Control and Prevention cosponsored the survey through a grant to the Center for Policy Research. The survey consists of telephone interviews with a nationally representative sample of 8,000 U.S. women and 8,000 U.S. men about their experiences with intimate partner violence.

The survey compares victimization rates among women and men, specific racial groups, Hispanics and non-Hispanics, and same-sex and opposite-sex cohabitants. It also examines risk factors associated with intimate partner violence, the rate of injury among rape and physical assault victims, injured victims' use of medical services, and victims' involvement with the justice system.

Analysis of the survey data produced the following results:

o Intimate partner violence is pervasive in U.S. society. Nearly 25 percent of surveyed women and 7.5 percent of surveyed men said they were raped and/or physically assaulted by a current or former spouse, cohabiting partner, or date at some time in their lifetime; 1.5 percent of surveyed women and 0.9 percent of surveyed men said they were raped and/or physically assaulted by a partner in the previous 12 months. According to these estimates, approximately 1.5 million women and 834,732 men are raped and/or physically assaulted by an intimate partner annually in the United States. Because many victims are victimized more than once, the number of intimate partner victimizations exceeds the number of intimate partner victims annually. Thus, approximately 4.9 million intimate partner rapes and physical assaults are perpetrated against U.S. women annually, and approximately 2.9 million intimate partner physical assaults are committed against U.S. men annually. These findings suggest that intimate partner violence is a serious criminal justice and public health concern.

o Stalking by intimates is more prevalent than previously thought. Almost 5 percent of surveyed women and 0.6 percent of surveyed men reported being stalked by a current or former spouse, cohabiting partner, or date at some time in their lifetime; 0.5 percent of surveyed women and 0.2 percent of surveyed men reported being stalked by such a partner in the previous 12 months. According to these estimates, 503,485 women and 185,496 men are stalked by an intimate partner annually in the United States. These estimates exceed previous nonscientific "guesstimates" of stalking prevalence in the general population. These findings suggest that intimate partner stalking is a serious criminal justice problem, and States should continue to develop constitutionally sound and effective anti-stalking statutes and intervention strategies.

o Women experience more intimate partner violence than do men. The NVAW survey found that women are significantly more likely than men to report being victims of intimate partner violence whether it is rape, physical assault, or stalking and whether the timeframe is the person's lifetime or the previous 12 months. These findings support data from the Bureau of Justice Statistics' National Crime Victimization Survey, which consistently show women are at significantly greater risk of intimate partner violence than are men. However, they contradict data from the National Family Violence Survey, which consistently show men and women are equally likely to be physically assaulted by an intimate partner. Studies are needed to determine how different survey methodologies affect women's and men's responses to questions about intimate partner violence.

o Rates of intimate partner violence vary significantly among women of diverse racial backgrounds. The survey found that Asian/Pacific Islander women and men tend to report lower rates of intimate partner violence than do women and men from other minority backgrounds, and African-American and American Indian/Alaska Native women and men report higher rates. However, differences among minority groups diminish when other sociodemographic and relationship variables are controlled. More research is needed to determine how much of the difference in intimate partner prevalence rates among women and men of different racial and ethnic backgrounds can be explained by the respondent's willingness to disclose intimate partner violence and how much by social, demographic, and environmental factors. Research is also needed to determine how prevalence rates vary among women and men of diverse American Indian/Alaska Native and Asian/Pacific Islander groups.

o Violence perpetrated against women by intimates is often accompanied by emotionally abusive and controlling behavior. The survey found that women whose partners were jealous, controlling, or verbally abusive were significantly more likely to report being raped, physically assaulted, and/or stalked by their partners, even when other sociodemographic and relationship characteristics were controlled. Indeed, having a verbally abusive partner was the variable most likely to predict that a woman would be victimized by an intimate partner. These findings support the theory that violence perpetrated against women by intimates is often part of a systematic pattern of dominance and control.

o Women experience more chronic and injurious physical assaults at the hands of intimate partners than do men. The survey found that women who were physically assaulted by an intimate partner averaged 6.9 physical assaults by the same partner, but men averaged 4.4 assaults. The survey also found that 41.5 percent of the women who were physically assaulted by an intimate partner were injured during their most recent assault, compared with 19.9 percent of the men. These findings suggest that research aimed at understanding and preventing intimate partner violence against women should be stressed.

o Women living with female intimate partners experience less intimate partner violence than women living with male intimate partners. Slightly more than 11 percent of the women who had lived with a woman as part of a couple reported being raped, physically assaulted, and/or stalked by a female cohabitant, but 21.7 percent of the women who had married or lived with a man as part of a couple reported such violence by a husband or male cohabitant. These findings suggest that lesbian couples experience less intimate partner violence than do heterosexual couples; however, more research is needed to support or refute this conclusion.

o Men living with male intimate partners experience more intimate partner violence than do men who live with female intimate partners. Approximately 23 percent of the men who had lived with a man as a couple reported being raped, physically assaulted, and/or stalked by a male cohabitant, while 7.4 percent of the men who had married or lived with a woman as a couple reported such violence by a wife or female cohabitant. These findings, combined with those presented in the previous bullet, provide further evidence that intimate partner violence is perpetrated primarily by men, whether against male or female intimates. Thus, strategies for preventing intimate partner violence should focus on risks posed by men.

o The U.S. medical community treats millions of intimate partner rapes and physical assaults annually. Of the estimated 4.9 million intimate partner rapes and physical assaults perpetrated against women annually, approximately 2 million will result in an injury to the victim, and 570,457 will result in some type of medical treatment to the victim. Of the estimated 2.9 million intimate partner physical assaults perpetrated against men annually, 581,391 will result in an injury to the victim, and 124,999 will result in some type of medical treatment to the victim. Because many medically treated victims receive multiple forms of care (e.g., ambulance services, emergency room care, or physical therapy) and multiple treatments (e.g., several days in the hospital) for the same victimization, medical personnel in the United States treat millions of intimate partner victimizations annually. To better meet the needs of intimate partner violence victims, it is suggested that medical professionals receive training on the physical consequences of intimate partner violence and appropriate medical intervention strategies.

o Most intimate partner victimizations are not reported to the police. Only approximately one- fifth of all rapes, one-quarter of all physical assaults, and one-half of all stalkings perpetrated against female respondents by intimates were reported to the police. Even fewer rapes, physical assaults, and stalkings perpetrated against male respondents by intimates were reported. The majority of victims who did not report their victimization to the police thought the police would not or could not do anything on their behalf. These findings suggest that most victims of intimate partner violence do not consider the justice system an appropriate vehicle for resolving conflicts with intimates.

Introduction

Research on intimate partner violence has increased dramatically over the past 20 years. While greatly enhancing public awareness and understanding of this serious social problem, this research has also created much controversy and confusion. Findings of intimate partner victimization vary widely from study to study. Some studies conclude that women and men are equally likely to be victimized by their partners, but others conclude that women are more likely to be victimized. Some studies conclude that minorities and whites suffer equal rates of intimate partner violence, and others conclude that minorities suffer higher rates.

In addition, there are many gaps in the scientific literature on intimate partner violence, such as the level of violence committed against men and women by same-sex intimates. Little empirical data exist on the relationship between different forms of intimate partner violence, such as emotional abuse and physical assault. Finally, little is known of the consequences of intimate partner violence, including rate of injury and victims' use of medical and justice system services.

This Research Report addresses these and other issues related to intimate partner violence. The information presented in this report is based on findings from the National Violence Against Women (NVAW) Survey, a national telephone survey jointly sponsored by the National Institute of Justice (NIJ) and the Centers for Disease Control and Prevention (CDC). The survey consists of telephone interviews with a representative sample of 8,000 U.S. women and 8,000 U.S. men. Survey respondents were queried about their experiences as victims of various forms of violence, including rape, physical assault, and stalking by intimate partners. Victimized respondents were asked detailed questions about the characteristics and consequences of their victimization, including the extent and nature of any injuries they sustained, their use of medical services, and their involvement with the justice system.

This Research Report also summarizes the survey's findings on victimization rates among women and men, specific racial groups, Hispanics and non-Hispanics, and opposite-sex and same-sex cohabitants. It examines risk factors associated with intimate partner violence, rates of injury among rape and physical assault victims, injured victims' use of medical services, and victims' involvement with the justice system. Although this report focuses on women's and men's experiences as victims of intimate partner violence, complete details about men's and women's experiences as victims of rape, physical assault, and stalking by all types of assailants are contained in earlier NIJ and CDC reports.

Because of the sensitive nature of the survey, state-of-the-art techniques were used to protect the confidentiality of the information being sought and to minimize the potential for retraumatizing victims of violence and jeopardizing the safety of respondents.

o The sample was generated through random-digit dialing, thereby ensuring that only a 10-digit telephone number linked the respondent to the survey. The area code and telephone exchanges were included as part of the completed interview for each case in the dataset for analysis purposes, but the last four digits of the telephone number were eliminated.

o The survey introduction informed respondents that their answers would be kept confidential and that participation in the survey was voluntary.

o Respondents were given a toll-free number to call to verify the authenticity of the survey or to respond to the survey at a later date. Respondents also were told to use this number should they need to hang up suddenly during the interview.

o Only female interviewers interviewed female respondents. (To measure the possible effects of interviewer gender on male responses to survey questions, half of the male respondents were interviewed by male interviewers and half by female interviewers.)

o Interviewers were instructed to schedule a callback interview if they thought someone was listening to the interview on another line or was in the room with the respondent.

o Interviewers, out of concern that the interview might cause some victims of violence to experience emotional trauma, were provided with rape crisis and domestic violence hotline telephone numbers from around the country. If a respondent showed signs of distress, he or she was provided with an appropriate hotline referral.

In addition to lessening the possibility that respondents might be harmed due to their participation in the survey, these techniques improved the quality of the information gathered.

Defining Intimate Partner Violence

There is currently little consensus among researchers on exactly how to define the term "intimate partner violence." As a result, definitions of the term vary widely from study to study, making comparisons difficult. One source of controversy revolves around whether to limit the definition of the term to acts carried out with the intention of, or perceived intention of, causing physical pain or injury to another person. Although this approach presents a narrow definition of intimate partner violence that can be readily operationalized, it ignores the myriad behaviors that persons may use to control, intimidate, and otherwise dominate another person in the context of an intimate relationship. These behaviors may include acts such as verbal abuse, imprisonment, humiliation, stalking, and denial of access to financial resources, shelter, or services.

Another source of controversy revolves around whether to limit the definition of the term to violence occurring between persons who are married or living together as a couple or to include persons who are dating or who consider themselves a couple but live in separate domiciles. At present the research literature is bifurcated, with some studies focusing on violence occurring in marital or heterosexual cohabiting relationships and others focusing on violence occurring in heterosexual dating relationships. Only a handful of studies examine violence in same-sex cohabiting or dating relationships.

The definition of intimate partner violence used in the NVAW Survey includes rape, physical assault, and stalking perpetrated by current and former dates, spouses, and cohabiting partners, with cohabiting meaning living together at least some of the time as a couple. Both same-sex and opposite-sex cohabitants are included in the definition. The survey's definition of intimate partner violence resembles the one developed by CDC because it includes violence occurring between persons who have a current or former dating, marital, or cohabiting relationship and same-sex and opposite-sex cohabitants.

However, it deviates from CDC's definition because it includes stalking as well as rape and physical assault. For purposes of the survey, "rape" is defined as an event that occurs without the victim's consent and involves the use of threat or force to penetrate the victim's vagina or anus by penis, tongue, fingers, or object or the victim's mouth by penis. The definition includes both attempted and completed rape. "Physical assault" is defined as behaviors that threaten, attempt, or actually inflict physical harm. The definition includes a wide range of behaviors, from slapping, pushing, and shoving to using a gun. "Stalking" is defined as a course of conduct directed at a specific person involving repeated visual or physical proximity; nonconsensual communication; verbal, written, or implied threats; or a combination thereof that would cause fear in a reasonable person, with "repeated" meaning on two or more occasions. The definition of stalking used in the survey does not require stalkers to make a credible threat against victims, but it does require victims to feel a high level of fear. The specific questions used to screen respondents for rape, physical assault, and stalking victimization are behaviorally specific and are designed to leave little doubt in the respondent's mind as to what is being measured.

Prevalence and Incidence of Intimate Partner Violence

The NVAW Survey generated information on both the prevalence and incidence of intimate partner violence. "Prevalence" refers to the percentage of persons within a demographic group (e.g., female or male) who are victimized during a specific period, such as the person's lifetime or the previous 12 months. "Incidence" refers to the number of separate victimizations or incidents of violence committed against persons within a demographic group during a specific period. Incidence can also be expressed as a victimization rate, which is obtained by dividing the number of victimizations committed against persons in a demographic group by the number of persons in that demographic group and setting the rate to a standard population base, such as 1,000 persons.

Intimate partner rape

Using a definition of rape that includes completed or attempted forced vaginal, oral, and anal sex, the survey found 7.7 percent of surveyed women and 0.3 percent of surveyed men reported being raped by a current or former intimate partner at some time in their lifetime, and 0.2 percent (n = 16) of surveyed women reported being raped by a partner in the 12 months preceding the survey. Based on U.S. Census estimates of the number of women aged 18 years and older in the country, an estimated 201,394 women were forcibly raped by an intimate partner in the 12 months preceding the survey.

Because women raped by an intimate partner in the previous 12 months averaged 1.6 rapes, the incidence of intimate partner rape (number of separate victimizations) exceeded the prevalence of intimate partner rape (number of victims). Thus, there were an estimated 322,230 intimate partner rapes committed against U.S. women during the 12 months preceding the survey.

(This national estimate is based on only 16 women who reported being raped by an intimate partner in the previous 12 months and should be viewed with caution.) This figure equates to an annual victimization rate of 3.2 intimate partner rapes per 1,000 U.S. women aged 18 years and older (322,230 divided by 100,697,000 = 0.0032 x 1,000 = 3.2).

Intimate partner physical assault

Using a definition of physical assault that includes a range of behaviors, from slapping and hitting to using a gun, the survey found that 22.1 percent of surveyed women and 7.4 percent of surveyed men reported being physically assaulted by a current or former intimate partner at some time in their lifetime, whereas 1.3 percent of all surveyed women and 0.9 percent of all surveyed men reported being physically assaulted by such a partner in the previous 12 months. Thus, approximately 1.3 million women and 834,732 men were physically assaulted by an intimate partner in the 12 months preceding the survey.

Because women and men who were physically assaulted by an intimate partner in the previous 12 months averaged 3.4 and 3.5 physical assaults, respectively there were approximately 4.5 million intimate partner physical assaults perpetrated against women and approximately 2.9 million intimate partner physical assaults perpetrated against men in the 12 months preceding the survey. These figures equate to an annual victimization rate of 44.2 intimate partner physical assaults per 1,000 U.S. women aged 18 years and older (4,450,807 divided by 100,697,000 = 0.0442 x 1,000 = 44.2) and 31.5 intimate partner physical assaults per 1,000 U.S. men aged 18 years and older (2,921,562 divided by 92,748,000 = 0.0315 x 1,000 = 31.5).

Results from the survey show that most physical assaults committed against women and men by intimates are relatively minor and consist of pushing, grabbing, shoving, slapping, and hitting. Fewer women and men reported that an intimate threw something that could hurt them, pulled their hair, kicked or beat them, or threatened them with a knife or gun. Only a negligible number reported that an intimate actually used a knife or gun on them.

Intimate partner stalking

Using a definition of stalking that requires victims to feel a high level of fear, the survey found that 4.8 percent of surveyed women and 0.6 percent of surveyed en reported being stalked by a current or former intimate partner at some time n their lifetime; 0.5 percent of surveyed women and 0.2 percent of surveyed en reported being stalked by such a partner in the 12 months preceding the survey. These figures equate to an estimated 503,485 women and 185,496 men who were stalked by an intimate partner in the 12 months preceding the survey.

Because stalking by definition involves repeated acts of harassment and intimidation because respondent reported being stalked by more than one intimate in the 12 months preceding the survey, the incidence of intimate partner stalking is equivalent to the prevalence of intimate partner stalking.

Thus, there were an estimated 503,485 stalking victimizations perpetrated

against women and 185,496 stalking victimizations perpetrated against men by

intimates in the year preceding the survey. These figures equate to an

annual victimization rate of 5 intimate partner stalkings per 1,000 U.S. women

aged 18 years and older (503,485 divided by 100,697,000 = 0.005 x 1,000 = 5.0) and 1.8 intimate partner stalkings per 1,000 U.S. men aged 18 years and older (185,496 divided by 97,748,000 = 0.0018 x 1,000 = 1.8).

Comparison With Previous Estimates

Intimate partner rape

No previous national survey has generated estimates of the lifetime prevalence of intimate partner rape. However, a study of 930 women in San Francisco found that 8 percent were survivors of marital rape, and a study of 323 ever-married/cohabited women in Boston found that 10 percent were survivors of wife or partner rape. Though not directly comparable, the NVAW Survey finding that 7.7 percent of U.S. women have been raped by an intimate partner at some time in their lifetime is similar to these earlier community-based estimates.

The Bureau of Justice Statistics' National Crime Victimization Survey (NCVS), which is administered yearly, generates annual rape and sexual assault victimization estimates for women and men. One study based on 1992-93 NCVS data found that the average annual rate of rape and sexual assault by an intimate was 1.0 per 1,000 women aged 12 years and older. This estimate is lower than the average annual rate of intimate partner rape for women generated by the NVAW Survey, which is 3.2 per 1,000 women aged 18 years and older. However, direct comparisons between the findings of the two surveys

are difficult to make because estimates reported by the two surveys refer to somewhat different populations and sexual victimizations, and the two surveys differ substantially methodologically.

Intimate partner physical assault

Several community-based studies have generated estimates of the lifetime prevalence of physical assault by an intimate. Estimates from these surveys range from 9 to 30 percent for women and from 13 to 16 percent for men. In addition, a 1997 Gallup poll, which surveyed a nationally representative sample of 434 women and 438 men, found that 22 percent of women and 8 percent of men have been physically abused by a spouse or companion. NVAW Survey estimates that 22.1 percent of women and 7.4 percent of men have been physically assaulted by an intimate at some time in their lifetime are nearly identical to the Gallup estimates.

National estimates of the annual rate of physical assault by an intimate come from two primary sources--the previously mentioned NCVS and the National Family Violence Survey (NFVS), which was first conducted in 1975 and then repeated in 1985. Portions of the NFVS were also included in the 1992 National Alcohol and Family Violence Survey and a special component of the 1995 National Alcohol Survey.

Annual rates of physical assault by an intimate generated from the NVAW Survey are substantially higher than those generated by the NCVS. One study based on 1992-93 NCVS data found that the average annual rate of simple and aggravated assault by an intimate was 7.6 per 1,000 women aged 12 years and older and 1.3 per 1,000 men aged 12 years and older. A more recent study that used 1996 NCVS data and Federal Bureau of Investigation Uniform Crime Report homicide data--and combined data on intimate partner murder, rape, sexual assault, robbery, aggravated assault, and simple assault--found the annual rate of violent victimization by an intimate was 7.5 per 1,000 women aged 12 years and older and 1.4 per 1,000 men aged 12 years and older. In comparison, the NVAW Survey annual rate of physical assault by an intimate was 44.2 per 1,000 women aged 18 years and older and 31.5 per 1,000 men aged 18 years and older. Thus, the NVAW Survey annual rate of physical assault by an intimate far exceeds the NCVS annual rate of violent victimization by an intimate.

On the other hand, annual rates of physical assault generated from the NVAW Survey are substantially lower than those generated by the NFVS. The 1975 and 1985 NFVS found that 11 to 12 percent of married/cohabiting women and 12 percent of married/cohabiting men were physically assaulted by their intimate partner annually. The 1992 National Alcohol and Family Violence Survey found that approximately 1.9 percent of married/cohabiting women were severely assaulted by a male partner annually, and approximately 4.5 percent of married/cohabiting men were severely assaulted by a female partner annually. The 1995 National Alcohol Survey found that 5.2 to 13.6 percent of married/cohabiting couples experienced male-to-female partner violence, and 6.2 to 18.2 percent of married/cohabiting couples experienced female-to-male intimate partner violence. In comparison, the NVAW Survey found that only 1.3 percent of surveyed women and 0.9 percent of surveyed men were physically assaulted by a current or former intimate partner annually. The disparity in NFVS and NVAW findings is particularly striking because both surveys used similar behaviorally specific questions to screen respondents for physical assault victimization.

As discussed in this report, studies are needed to determine why the NCVS, NFVS, and NVAW Survey produced such disparate findings on the prevalence and incidence of intimate partner violence in the United States.

Intimate partner stalking

Prior to the NVAW Survey, information on stalking prevalence was limited to guesses provided by mental health professionals based on their work with known stalkers. The most frequently cited "guesstimate" was made by forensic psychiatrist Dr. Park Dietz, who reported in 1992 that 5 percent of U.S. women are stalked at some time in their lifetime, and 500,000 are stalked annually. Because these figures pertain to stalking by all types of perpetrators, not just intimates, it is fair to say the NVAW Survey estimates--that 4.8 percent of women have been stalked by an intimate in their lifetime and 503,485 women are stalked by an intimate each year--are higher than previous stalking estimates.

Women Experience More Intimate Partner Violence Than Do Men

The NVAW Survey found that women were significantly more likely than men to report being victimized by an intimate partner, whether the period was the individual's lifetime or the 12 months preceding the survey and whether the type of violence was rape, physical assault, or stalking. Moreover, the survey found that differences between women's and men's rates of physical assault by an intimate partner become greater as the seriousness of the assault increases. For example, women were two or three times more likely than men to report that an intimate partner threw something that could hurt them or pushed, grabbed, or shoved them. However, they were 7 to 14 times more likely to report that an intimate partner beat them up, choked or tried to drown them, or threatened them with a gun or knife.

The NVAW Survey finding that women are significantly more likely than men to report being victimized by an intimate partner supports results from the NCVS, which have consistently shown that women are at significantly greater risk of intimate partner violence. However, it contradicts results from the NFVS, which have consistently shown that men and women are nearly equally likely to be physically assaulted by marital or cohabiting partners.

Deciphering Disparities in Survey Findings

It is difficult to explain why the NCVS, NFVS, and NVAW Survey generated such disparate estimates of intimate partner violence or why the NCVS and NVAW Survey produced evidence of asymmetry in women's and men's risk of intimate partner violence while the NFVS produced evidence of symmetry. For years, researchers have attributed the low rate of intimate partner violence uncovered by the NCVS to the fact that it is administered in the context of a crime survey. Because they reflect only violence perpetrated by intimates that victims are willing to label as criminal and report to interviewers, estimates of intimate partner violence generated from the NCVS are thought to underestimate the true amount of intimate partner violence.

At first glance, results from the NVAW Survey appear to support this theory. The NVAW Survey--which was administered in the context of a survey on personal safety rather than crime--generated substantially higher intimate partner victimization rates than those generated by the NCVS. It is likely,

however, that methodological factors other than the overall context in which the two surveys were administered account for some of the differences in the findings.

For example, the two surveys differ substantially with respect to sample design and survey administration. The NVAW Survey sample was drawn by random-digit dialing from a database of households with a telephone. Moreover, NVAW Survey interviewers used state-of-the-art techniques to protect the confidentiality of the respondents and minimize the potential for retraumatizing victims of violence. In comparison, the NCVS sample consists of housing units (e.g., addresses) selected from a stratified multistage cluster sample. When a sample unit is selected for inclusion in the NCVS, U.S. Census workers interview all individuals in the household 12 years of age and older every 6 months for 3 years. Thus, after the first interview, respondents know the contents of the survey. This may pose a problem for victims of domestic violence who may be afraid that disclosing abuse by a family member may put them in danger of further abuse. Although census interviewers document whether others were present during the interview, time and budget constraints prevent them from ensuring privacy during an interview.

In addition, screening questions used by the NVAW Survey and the NCVS differ substantially. For example, the NVAW Survey uses 5 questions to screen respondents for rapes they may have sustained over their lifetime and 12 questions to screen respondents for physical assaults they may have sustained as adults. Respondents disclosing victimization are asked additional questions about the victim-perpetrator relationship and the frequency, duration, and consequences of their victimization. In comparison, the NCVS uses four questions--each with multiple components--to screen respondents for threats, physical and sexual attacks, and property crimes they may have experienced in different locations and by different offenders. Although empirical data on this issue are lacking, researchers assume that both the number of screening questions used and the manner in which they are asked affect disclosure rates.

Another possible reason for the difference in the NVAW Survey and NCVS findings is that published NCVS estimates count series victimization--reports of six or more crimes within a 6-month period for which the respondent cannot recall details of each crime--as a single victimization. Thus, published NCVS estimates of the number of intimate partner rapes, sexual assaults, and physical assaults are lower than would be obtained by including all incidents reported to its survey interviewers. To produce NCVS estimates more directly comparable to those generated by the NVAW Survey, each crime in a series of victimizations reported to NCVS interviewers would have to be counted.

Finally, the sampling errors associated with the estimates from the NVAW Survey and the NCVS would have to be compared to determine whether estimates generated by the two surveys actually differ or whether apparent differences are not statistically significant.

Differences between the NVAW Survey and the NFVS estimates are somewhat harder to explain because the two surveys used similar sampling strategies and the Conflict Tactics Scale to screen respondents for physical assaults by intimates. Straus argues the NVAW Survey generated annual rates of physical assault by an intimate partner that were substantially lower than those generated by the NFVS because it was presented to respondents as a survey on personal safety. According to Straus, the term "personal safety" led many respondents to perceive the NVAW Survey as a crime study and, therefore, to restrict their reports to "real crimes."

Aside from being inherently unconvincing--the terms "crime" and "personal safety" conjure very different images--this explanation fails to explain why the NVAW Survey generated high lifetime intimate partner victimization rates that are generally consistent with findings from other surveys or why the NVAW Survey uncovered high rates of other forms of family violence, such as incest and physical abuse of children by adult caretakers. It is unlikely that using the term "personal safety" in the NVAW Survey introduction would have set up a perceptual screen for intimate partner violence experienced in the previous 12 months but not for intimate partner violence experienced over the course of the respondent's lifetime. Similarly, it is unlikely that using the term "personal safety" in the NVAW Survey introduction would have set up a perceptual screen for one type of family violence (e.g., physical assaults by marital/cohabiting partners) but not for other types of family violence (e.g., incest and physical assault by caretakers in childhood).

A more plausible explanation for the disparity in the NFVS and NVAW Survey findings is the different ways the two surveys frame and introduce screening questions about intimate partner violence. In the NFVS, respondents are queried about specific acts of intimate partner violence they may have committed or sustained against their current partner. Published NFVS estimates of the number of women and men who experience intimate partner violence annually count reports of both perpetration and victimization. In other words, if a woman reports that she assaulted her husband, her report is counted as a male victimization. Similarly, if a man reports that he assaulted his wife, his report is counted as a female victimization. To produce NFVS estimates directly comparable with NVAW Survey estimates, perpetrations reported to NFVS interviewers would have to be excluded.

In addition, the NFVS introduces screening questions about intimate partner violence perpetration and victimization with an exculpatory statement that acknowledges the pervasiveness of marital/partner conflict. Although this approach may seem more accepting of intimate partner violence and, therefore, more likely to result in disclosure of intimate partner violence, it may also be considered more leading.

Finally, the NFVS frames its screening questions in terms of how many times in the past 12 months respondents have committed or sustained these violent acts rather than whether they have ever committed or sustained these violent acts. This approach assumes intimate partner violence is the norm and requires respondents who neither committed nor sustained such violence to provide an answer to the contrary.

By contrast, the NVAW Survey queries respondents only about their experiences with victimization. Furthermore, the NVAW Survey does not use an exculpatory statement to introduce screening questions. Rather than asking respondents how many times they have sustained acts of intimate partner violence in the past 12 months, the NVAW Survey asks respondents whether they ever sustained violent acts at the hands of any type of perpetrator and, if so, whether their perpetrator was a current or past intimate partner. Only respondents who report they have ever experienced such acts are asked whether these acts were perpetrated in the past 12 months. While this approach may be considered less accepting of intimate partner violence and therefore less likely to result in disclosure, it may also be considered less leading.

In summary, it is likely that the manner in which screening questions are introduced and framed has more of an effect on intimate partner victimization rates than does the overall context in which the survey is administered. Clearly, more research is needed to fully understand how methodological factors such as sample design, survey administration, survey introduction, and question wording affect research findings on intimate partner violence.

The four screening questions used in the NCVS are:

1) Were you attacked or threatened, OR did you have something stolen from you:

--a) At home, including the porch or yard?

--b) At or near a friend's, relative's, or neighbor's home?

--c) At work or school?

--d) In a place such as a storage shed or laundry room, a shopping mall, restaurant, bank, or airport?

--e) While riding in any vehicle?

-- f) On the street or in a parking lot?

--g) At such places as a party, theater, gym, picnic area, bowling lanes, or while fishing or hunting?

2) Other than any incidents already mentioned, has anyone attacked or threatened you in any of these ways:

--a) With any weapon, for instance, a gun or knife?

--b) With anything like a baseball bat, frying pan, scissors, or a stick?

--c) By something thrown, such as a rock or bottle?

--d) Include any grabbing, punching, or choking?

--e) Any rape, attempted rape, or other type of sexual attack?

-- f) Any face-to-face threats?

--g) Any attack or threat of use of force by anyone at all?

Please mention it even if you are not certain it was a crime.

3) People often don't think of incidents committed by someone they know. Did you have some thing stolen from you, OR were you attacked or threatened by:

--a) Someone at work or school?

--b) A neighbor or friend?

--c) A relative or family member?

--d) Any other person you've met or known?

4) Incidents involving forced or unwanted sexual acts are often difficult to talk about. Have you been forced or coerced to engage in unwanted sexual activity by:

--a) Someone you didn't know before?

--b) A casual acquaintance?

--c) Someone you know well?

Prevalence of Intimate Partner Violence Among Racial Minorities and Hispanics

As noted, previous studies have produced contradictory findings as to whether race and ethnicity affect one's risk for involvement in intimate partner violence. Most of these studies compare victimization rates of only one minority group with those of whites, and others compare victimization rates of all minority groups with those of whites. None compare victimization rates of several diverse racial groups.

To determine victimization rates for women and men of diverse racial backgrounds, respondents to the NVAW Survey were asked whether they would best classify themselves as white, black or African-American, Asian or Pacific Islander, American Indian or Alaska Native, or of mixed race. They were also asked whether they were of Hispanic origin. The response rate on both these questions was very high (98 and 99 percent, respectively).

When data on African-American, Asian/Pacific Islander, American Indian/Alaska Native, and mixed-race respondents are combined, nonwhite women and men report significantly more intimate partner violence than do their white counterparts. These findings suggest that all racial minorities experience more intimate partner violence than do whites.

However, a comparison of intimate partner victimization rates among persons of specific racial backgrounds shows that different types of minorities report significantly different rates of intimate partner violence. In general, American Indian/Alaska Native women report significantly higher rates of intimate partner violence than do women of other racial backgrounds, and Asian/Pacific Islander women and men report significantly lower rates. These findings underscore the need for research on intimate partner violence among specific racial and ethnic groups. As the survey results show, combining data on different minorities may exaggerate differences between whites and nonwhites and, at the same time, obscure very large differences among persons of diverse minority backgrounds.

The finding that American Indians/Alaska Native women report significantly higher rates of intimate partner violence is consistent with previous research that shows American Indian couples are significantly more violent than their white counterparts. However, a paucity of information on violence against American Indians makes it difficult to explain why they report more intimate partner violence. How much of the difference in intimate partner victimization rates among American Indian/Alaska Native women and those of other racial backgrounds may be explained by differences in willingness to report victimization to interviewers and how much by actual victimization experiences is unclear and requires further study. Moreover, there may be significant differences in intimate partner victimization rates among women (and men) of diverse American Indian tribes and Alaska Native

communities that cannot be discerned from the survey. Finally, research is needed to ascertain how much of the difference in intimate partner victimization rates among Native Americans and persons of different racial backgrounds may be explained by demographic, social, and environmental factors.

Because information on violence against Asian/Pacific Islander women and men is also limited, it is difficult to explain why they reported significantly less intimate partner violence than did women and men of other racial backgrounds.

It has been suggested that traditional Asian values emphasizing close family ties and harmony may discourage Asian women from disclosing physical and emotional abuse by intimates. Thus, the lower intimate partner victimization rates found among Asian/Pacific Islander women may be, at least in part, an artifact of underreporting. There may also be significant differences in rates of intimate partner violence between Asian and Pacific Islander women that cannot be discerned from the survey because data on these two groups are combined. Finally, there may be significant differences between Asian/Pacific Islander women born in this country and those who immigrated. A recent nonrepresentative study of immigrant Korean women found that 60 percent had been battered by their husbands. Clearly, more research is recommended on violence committed by intimates against Asian and Pacific Islander women.

The survey found little difference in Hispanic and non-Hispanic women's reports of intimate partner physical assault and intimate partner stalking. However, Hispanic women were significantly more likely than non-Hispanic women to report that they were raped by a current or former intimate partner at some time in their lifetime. These findings are noteworthy because previously published NVAW Survey findings show that Hispanic women report significantly less rape victimization than do non-Hispanic women when all types of perpetrators are considered. Future research should focus on why Hispanic women are less likely to be raped by a nonintimate but more likely to be raped by an intimate.

The survey found no significant difference in reports of intimate partner violence among Hispanic and non-Hispanic men. However, this finding must be viewed with caution, given the small number of Hispanic male victims.

Prevalence of Intimate Partner Violence Among Same-Sex Cohabitants

Research on violence in same-sex relationships has been limited to studies of small, unrepresentative samples of gay and lesbian couples. Results from these studies suggest that same-sex couples are about as violent as heterosexual couples.

Although the NVAW Survey did not ask respondents about their sexual orientation, it did ask them whether they had ever lived with a same-sex partner as part of a couple. As such, it is possible to compare intimate partner victimization rates among women and men who have a history of same-sex cohabitation with women and men who have a history of marital/opposite-sex cohabitation only.

The survey found that 1 percent of surveyed women (n = 79) and 0.8 percent of surveyed men (n = 65) reported living with a same-sex intimate partner at least once in their lifetime, and 90 percent of surveyed women (n = 7,193) and 86 percent of surveyed men (n = 6,879) reported marrying/living with an opposite-sex partner but never with a same-sex partner. For brevity's sake, the former will be referred to as same-sex cohabitants and the latter will be referred to as opposite-sex cohabitants. It is

unknown how many same-sex or opposite-sex cohabitants identified themselves as homosexual, bisexual, or heterosexual at the time of the interview.

The survey found that same-sex cohabitants reported significantly more intimate partner violence than did opposite-sex cohabitants. Among women, 39.2 percent of the same-sex cohabitants and 21.7 percent of the opposite-sex cohabitants reported being raped, physically assaulted, and/or stalked by a marital/cohabiting partner at some time in their lifetime. Among men, the comparable figures are 23.1 percent and 7.4 percent.

At first glance, these findings suggest that both male and female same-sex couples experience more intimate partner violence than do opposite-sex couples. However, a comparison of intimate partner victimization rates among same-sex and opposite-sex cohabitants by perpetrator gender produced some interesting findings: 30.4 percent of same-sex cohabiting women reported being victimized by a male partner, whereas 11.4 percent reported being victimized by a female partner. Thus, same-sex cohabiting women were nearly three times more likely to report being victimized by a male partner than by a female partner. Moreover, opposite-sex cohabiting women were nearly twice as likely to report being victimized by a male partner than were same-sex cohabiting women by a female partner (20.3 percent and 11.4 percent).

Somewhat different patterns were found for men. Like their female counterparts, same-sex cohabiting men were more likely to report being victimized by a male partner than by a female partner. Specifically, 15.4 percent of same-sex cohabiting men reported being raped, physically assaulted, and/or stalked by a male partner, but 10.8 percent reported such violence by a female partner. However, same-sex cohabiting men were nearly twice as likely to report being victimized by a male partner than were opposite-sex cohabiting men by a female partner (15.4 percent and 7.7 percent). These findings suggest that intimate partner violence is perpetrated primarily by men, whether against male or female partners.

Risk Factors Associated With Intimate Partner Violence

Risk factors are characteristics associated with an increased likelihood that a problem behavior will occur. It is important to note that the presence of a risk factor does not mean that the behavior will necessarily occur, only that the odds of it occurring are greater.

Numerous studies have examined risk factors associated with intimate partner violence. Results from these studies show that unmarried, cohabiting couples have higher rates of intimate partner violence than do married couples; minorities have higher rates of intimate partner violence than do whites; lower income women have higher rates of intimate partner violence than do higher income women; less educated women have higher rates of intimate partner violence than do more educated women; and couples with income, educational, or occupational status disparities have higher rates of intimate partner violence than do couples with no status disparity.

Research also shows that experiencing and/or witnessing violence in one's family of origin increases one's chances of being a perpetrator or victim of intimate partner violence. In addition, research shows that wife assault is more common in families where power is concentrated in the hands of the husband or male partner and the husband makes most of the decisions regarding family finances and strictly controls when and where his wife or female partner goes. Finally, research suggests that persons with a

disability are at greater risk of violence, although there is no empirical evidence that having a disability increases one's risk of intimate partner violence.

To increase understanding of risk factors associated with intimate partner violence, logistic regressions were conducted using a backward stepwise procedure on respondents married or cohabiting with a partner at the time of the interview to determine what characteristics of the relationship, respondent, or partner differentiated those who reported being victimized by their current partner from those who did not. Separate analyses were conducted for women (n = 4,896) and men (n = 5,056).

In each of the logistic regressions, the dependent variable was whether the respondent reported being raped, physically assaulted, or stalked by his or her current spouse or cohabiting partner. The independent variables were as follows:

--Whether the respondent was cohabiting versus married.

--Whether the respondent was white, African-American, American Indian/Alaska Native, Asian/Pacific Islander, or mixed race.

--Whether the respondent was Hispanic.

--Whether the respondent's race and/or Hispanic origin was different from the partner's.

--Whether the respondent's education level was a high school diploma or less.

--Whether the respondent's education level was higher than the partner's.

--Whether the respondent was physically assaulted as a child by an adult caretaker.

--Whether the partner was jealous or possessive.

--Whether the partner denied the respondent access to family, friends, or family income.

--Whether the partner called the respondent names or shouted or swore at the respondent in front of other people.

--Whether the respondent was physically disabled when the relationship started.

The logistic regressions were designed to provide a measure by which the relative importance of the independent variables could be assessed and to determine which variables increased the odds that a woman or man would be victimized by an intimate partner. Income variables were not included in the analyses because of the--large number of respondents who refused to provide information about their or their partner's income.

The results of the logistic regression reveal a strong link between child maltreatment and subsequent victimization by an intimate partner. Women and men who were physically assaulted as children by adult caretakers were significantly more likely to report being victimized by their current partner, even when the effects of other independent variables were controlled. It is possible that persons victimized

as children by adult caretakers were more tolerant of persons who engaged in violent and threatening behaviors as adults and, therefore, more likely to get involved with abusive partners. However, it is also possible that respondents who reported one type of victimization (e.g., child maltreatment) were simply more willing to report other types of victimization (e.g., intimate partner violence). Clearly, more research is recommended on the possible link between childhood victimization and intimate partner victimization.

Results of the logistic regression for women, but not men, support previous research that shows unmarried couples are at greater risk of intimate partner violence than married couples, and African-American couples are at greater risk than white couples. They also show a strong link between violence and emotionally abusive and controlling behavior in intimate relationships. Indeed, having a verbally abusive partner was associated with the largest change in the odds that a woman would be victimized by an intimate partner. These findings support the theory that much of the violence perpetrated against women by male partners is part of a systematic pattern of dominance and control, or what some researchers have called "patriarchal terrorism."

Results of the logistic regressions for both women and men support the theory that couples with status disparities experience more intimate partner violence than do couples with no status disparities. Women were significantly more likely to report violence by a current partner if their education level was greater than their partner's, and men were significantly more likely to report being victimized by their current partner if their race and/or Hispanic origin was different from their partner.

Point in Relationship When Violence Occurs

It is a common belief that the termination of a relationship poses an increased risk for, or escalation of, intimate partner violence. This assumption is based on two types of evidence: Divorced or separated women report more intimate partner violence than do married women. Also, interviews with men who have killed their wives indicate that either threats of separation by their partner or actual separation are most often the precipitating events that lead to the murder.

The NVAW Survey found that married women who lived apart from their husbands were nearly four times more likely to report that their husbands had raped, physically assaulted, and/or stalked them than were women who lived with their husbands (20 percent and 5.4 percent). Similarly, married men who lived apart from their wives were nearly three times more likely to report that their wives had victimized them than were men who lived with their wives (7.0 percent and 2.4 percent). These findings suggest that termination of a relationship poses an increased risk of intimate partner violence for both women and men. However, it should be noted that the survey data do not indicate whether the violence happened before, after, or at the time the couple separated. Thus, it is unclear whether the separation triggered the violence or the violence triggered the separation.

To test the assumption that the termination of a relationship leads to an increased risk of intimate partner violence, the NVAW Survey asked women victimized by a former spouse or cohabiting partner whether their victimization occurred before, after, or both before and after the relationship ended. Only 6.3 percent of the rape victims and 4.2 percent of the physical assault victims said their victimization started after the relationship ended. These findings suggest most rapes and physical assaults perpetrated against women by intimates occur in the context of an ongoing rather than terminated relationship. In comparison, 42.8 percent of the stalking victims said their victimization started after the relationship ended. Thus, stalking is more likely to occur in the context of a terminated relationship than is rape or physical assault.

It is not possible to ascertain from the data whether violence occurring before the relationship ended was linked to threats about leaving the relationship. It is also unclear whether women who said they were victimized before and after the relationship ended experienced more severe violence at the time of separation.

Finally, it is important to note that when a relationship ends is a matter of interpretation rather than objective reality. Some women may have equated the end of the relationship with when they or their partner first started talking about leaving the relationship, whereas others may have equated it with the formal dissolution of a marriage. Clearly, more research is needed on how terminating a relationship increases the risk of intimate partner violence for women and men.

Frequency and Duration of Intimate Partner Rape and Physical Assault

Results from the NVAW Survey confirm previous reports that much of the violence perpetrated against women by intimates is chronic in nature. Approximately half (51.2 percent) of the women raped by an intimate and two-thirds (65.5 percent) of the women physically assaulted by an intimate said they were victimized multiple times by the same partner. (Stalking victims were not asked how many times they were stalked by the same partner because stalking by definition means repeated acts of threat and harassment.) Overall, female rape victims averaged 4.5 rapes by the same partner, and female physical assault victims averaged 6.9 assaults. Among women who were victimized multiple times by the same partner, 62.6 percent of the rape victims and 69.5 percent of the assault victims said their victimization lasted a year or more. On average, women who were raped multiple times said their victimization occurred over 3.8 years, and women who were physically assaulted multiple times said their victimization occurred over 4.5 years.

The survey also found that much of the violence perpetrated against men by intimates is chronic in nature. Two-thirds (66.2 percent) of the physically assaulted men said they were assaulted more than once by the same intimate partner. Of these, 66.2 percent said their victimization lasted a year or more.

On average, male victims of intimate partner physical assault reported 4.4 assaults by the same partner. On average, men reporting multiple assaults said their victimization lasted 3.6 years. Although much of the physical assault perpetrated against men by intimates is chronic, it is important to note that both the average frequency and the average duration of physical assaults perpetrated against women by intimates are significantly higher than the average frequency/duration of physical assaults perpetrated against men by intimates. (Estimates were not calculated for male rape victims because there were fewer than five victims when stratified by variables.)

Rate of Injury Among Victims of Intimate Partner Rape and Physical Assault

To generate information on the extent and nature of injuries associated with violent victimization, respondents disclosing rape and physical assault were asked whether they were injured during their most recent victimization and, if so, the types of injuries they sustained. (Respondents disclosing stalking victimization were not asked these questions because the definition of stalking used in the survey does not include behaviors that inflict physical harm.)

The survey found that 36.2 percent of the women raped by an intimate since age 18 sustained an injury other than the rape itself during their most recent victimization. (Estimates were not calculated for male rape victims because there were fewer than five victims when stratified by variables.) The survey also found that women physically assaulted by an intimate were more than twice as likely as their male counterparts (41.5 percent and 19.9 percent, respectively) to be injured during their most recent victimization. This finding supports previous research that shows women are more likely than men to be injured during an assault by an intimate.

Injury estimates for female victims of intimate partner violence generated by the NVAW Survey are somewhat lower than injury estimates generated by the NCVS. A recent study conducted by the Bureau of Justice Statistics found that 51 percent of the assaults perpetrated against women by intimates during 1992-96 resulted in some type of injury to the victim. The higher rate of injury uncovered by the NCVS suggests that the context in which that study is administered and the type of screening questions used leads respondents to report more serious types of assaults to interviewers.

Most of the women who were injured during their most recent intimate partner rape or physical assault sustained relatively minor injuries, such as scratches, bruises, and welts. Relatively few women sustained more serious types of injuries, such as lacerations, broken bones, dislocated joints, head or spinal cord injuries, chipped or broken teeth, or internal injuries.

Risk factors associated with injury

Logistic regression was used to determine what characteristics of the victim, perpetrator, and incident may increase the risk of injury during intimate partner rapes and physical assaults. Separate regressions, using a backward stepwise procedure, were conducted for female victims of intimate partner rape (n = 374), female victims of intimate partner physical assault (n = 1,254), and male victims of intimate partner physical assault (n = 479).

In each of the regressions, the dependent variable was whether the victim was injured during her or his most recent victimization by an intimate. The independent variables were as follows:

--Whether the perpetrator was a spouse, cohabiting partner, or date.

--Whether the victim was white, African-American, American Indian/Alaska Native, Asian/Pacific Islander, or mixed race.

--Whether the victim was Hispanic.

--Whether the victim was 18 to 25 years of age.

--Whether the incident occurred in the victim's or perpetrator's home.

--Whether the perpetrator threatened to harm or kill the victim or someone close to the victim.

--Whether the perpetrator used a weapon.

--Whether the victim was using drugs or alcohol at the time of the incident.

--Whether the perpetrator was using drugs or alcohol at the time of the incident.

Results of the logistic regression show that women raped by an intimate partner were significantly more likely to be injured if they were Hispanic, if their perpetrator was a spouse or cohabiting partner (rather than a date), if their perpetrator threatened to harm or kill them or someone close to them, and if their perpetrator was using drugs or alcohol at the time of the incident.

In comparison, women who were physically assaulted by an intimate partner were significantly more likely to be injured if their perpetrator threatened to harm or kill them or someone close to them and if the perpetrator was using drugs or alcohol at the time of the incident.

Finally, results of the logistic regression show that men who were physically assaulted by an intimate partner were significantly more likely to be injured if their perpetrator threatened to harm or kill them or someone close to them and if their perpetrator used a weapon.

Results of the logistic regressions show a strong link between threats of bodily injury and actual occurrences of injury. These findings imply that threats of violence should be taken seriously, and violence prevention strategies should emphasize this fact. Results also show a strong link between drug and alcohol use on the part of the perpetrator and victim injury. These findings suggest that some of the inhibitors that may prevent persons from hurting others under ordinary circumstances are relaxed when persons are under the influence of drugs or alcohol.

Victims' Use of Medical Services

Approximately one-third (31 percent) of the women injured during their most recent intimate partner rape received some type of medical care (e.g., ambulance/paramedic services, care in a hospital emergency facility, physical therapy). Somewhat fewer women and men who were injured during their most recent physical assault received some type of medical care (28.1 percent and 21.5 percent, respectively). Injured women and men had similar rates and types of medical care. This indicates that injuries sustained by women and men were similar in severity.

Some victims received more than one type of medical care (e.g., hospitalization as well as outpatient physical therapy), whereas others received a specific type of medical care more than once (e.g., 13 physical therapy sessions). Thus, the annual number of medical treatments provided to intimate partner rape and physical assault victims exceeds the annual number of intimate partner victimizations that resulted in treatment.

Estimates of medical services utilization

The report provides estimates of the average number of nights spent in the hospital and the average number of visits made to specific medical providers by adult victims of intimate partner rape and physical assault. These estimates are based on responses from victims who received the specific type of medical care considered. For example, the estimate of the average number of nights spent in the hospital by female intimate partner rape victims (3.9) is based only on responses by female intimate partner rape victims treated in a hospital on an inpatient basis. Some of the average frequency estimates are based on a very small number of responses and, therefore, have a relatively high margin of error.

The report also presents estimates of the number of intimate partner rapes and physical assaults resulting in injuries annually, as well as estimates of the specific types of medical care provided for these rapes and physical assaults annually. The first row of estimates is based on reported incidents of intimate partner violence in the past 12 months. The remaining estimates are based on the most recent intimate partner victimization since age 18. As these estimates show, women and men made 557,929 visits to hospital emergency rooms for injuries sustained during rapes and physical assaults perpetrated by intimate partners in the year preceding the survey. Fully 87 percent (486,151) of these visits were made by women. These findings support results from previous studies that show a significant number of women who have experienced intimate partner violence are seen in hospital emergency rooms.

The NVAW Survey estimate of women and men treated by hospital emergency department personnel is substantially higher than an estimate generated from the Study of Injured Victims of Violence (SIVV), a hospital record-extraction study conducted for the Bureau of Justice Statistics by the Consumer Product Safety Commission. The SIVV found that, during 1994, hospital emergency department personnel treated an estimated 243,400 women and men for injuries sustained at the hands of spouses, ex-spouses, boyfriends, and girlfriends. Included in the SIVV estimate (but excluded from the NVAW

Survey estimate) is hospital emergency department care to child and adolescent victims of intimate partner violence, male victims of intimate partner rape, and male and female victims of intimate partner sexual assault and robbery. Because these groups were excluded from the NVAW Survey estimates, differences between the two studies' estimates are even larger than they appear. However, the SIVV could not identify the patient/offender relationship in 28.8 percent (407,600) of the hospital emergency department visits identified by the study. If just half of these visits were to victims of intimate partner violence, NVAW Survey and SIVV estimates would be more similar.

Victims' Involvement With the Justice System

Reporting to the police

Less than one-fifth (17.2 percent) of the women raped by an intimate said their most recent rape was reported to the police. Thus, of the estimated 322,230 intimate partner rapes perpetrated against U.S. women in the 12 months preceding the survey, only 55,424 were reported to law enforcement. (The 322,230 estimate is based on responses from 16 women and should therefore be viewed with caution.) The vast majority of the reported rapes were reported within 24 hours. Most of the reports were made by the victim, rather than a friend, relative, or other third party.

The survey found that women who were physically assaulted by an intimate were significantly more likely than their male counterparts to report their victimization to the police (26.7 percent and 13.5 percent, respectively). Similarly, female victims of intimate partner stalking were significantly more likely than their male counterparts to report their victimization to the police (51.9 percent and 36.2 percent, respectively). As with reports of intimate partner rape, most of the physical assault and stalking reports were made within 24 hours of the incident, and most were made by the victim.

Police response to reports of intimate partner violence

Survey findings confirm that the majority of reports of intimate partner violence made to the police result in an officer taking a statement, that is, conducting a face-to-face interview with the victim. The

survey found no evidence that police respond differently to women than men stalked by an intimate. However, there is some evidence that police respond differently to women than men who are physically assaulted by an intimate. A comparison of police responses to reports of physical assault committed against women and men by intimates showed that police were significantly more likely to take a report and to arrest or detain the perpetrator if the victim was female. Although it is unclear from the survey data why police respond differently to reports of physical assaults involving female than male victims, it is possible they do so because physical assaults committed against women tend to be more chronic and more injurious

Reasons for not reporting victimization to the police

When asked why they chose not to report their victimization to the police, approximately one-fifth (21.2 percent) of the female rape victims said they were afraid their attacker would retaliate, and one-fifth (20.3 percent) said the rape was a one-time or minor incident. In addition, 16 percent reported they were too ashamed or wanted to keep the incident private, and 13 percent said the police could not do anything.

When asked why they chose not to report their victimization to the police, nearly all of the physical assault victims said they did not think the police could do anything about their victimization, whereas 61.5 percent of the women and 45 percent of the men said the police would not have believed them. In addition, approximately one-third of the women and one-quarter of the men said they did not want the police or courts involved. These findings suggest that many victims of intimate partner violence--men and women alike-- do not consider the justice system a viable or appropriate intervention at the time of their victimization.

Note that significantly more women than men chose not to report their physical assault to the police because they were afraid of their attacker, whereas significantly more men than women chose not to report their physical assault to the police because they considered it a minor or one-time incident. These findings underscore the fact that violence committed against women by intimates tends to be more threatening and severe than violence committed against men by intimates.

The survey found no significant differences between women's and men's reasons for not reporting their stalking to the police. However, these findings should be viewed with caution given the small number of male victims.

Criminal prosecution

Information from the NVAW Survey shows that violence perpetrated against women by intimates is rarely prosecuted. Only 7.5 percent of the women who were raped by an intimate, 7.3 percent of the women who were physically assaulted by an intimate, and 14.6 percent of the women who were stalked by an intimate said their attacker was criminally prosecuted. These figures increase to 31.1 percent, 24.7 percent, and 25.4 percent, respectively, when only victims whose stalking was reported to the police are considered. According to women's perceptions of the outcome of the prosecution, less than one-half of the intimate partner perpetrators who had criminal charges filed against them were convicted of a crime.

The number of victims ($n < 5$) was insufficient to reliably calculate prosecution estimates for male victims of intimate partner rape or stalking. However, prosecution estimates for male victims of physical assault show that violence committed against men by intimates is even less likely to be

criminally prosecuted than violence committed against women by intimates. Only 1.1 percent of the men who were physically assaulted by an intimate since the age of 18 said their attacker was criminally prosecuted. This figure increases to 4.1 percent when only victims whose physical assault was reported to the police are considered.

Temporary restraining orders

The survey found that female victims of intimate partner violence were significantly more likely than their male counterparts to obtain a protective or restraining order against their assailant. Specifically, 17.1 percent of the women but only 3.5 percent of the men who were physically assaulted by an intimate obtained a restraining order against their assailant after their most recent victimization. Similarly, 36.6 percent of the women but only 17 percent of the men who were stalked by an intimate obtained a restraining order against their assailant. These findings suggest that women are more frightened by intimates who victimize them. They also underscore the fact that violence committed against women by intimates is more chronic and severe than violence committed against men by intimates.

The survey also found that women who were stalked by an intimate were significantly more likely to obtain a restraining order against their assailant than were women who were physically assaulted or raped by an intimate. Similarly, men who were stalked by an intimate were significantly more likely to obtain a restraining order than were men who were physically assaulted. A recent study by the American Bar Association may help explain these findings. The study found that victims of violence rarely seek restraining orders as a form of early intervention but rather as an act of desperation after they have experienced extensive problems. Because stalking by definition involves repeated acts of harassment and threats, stalking victims were more likely than rape or physical assault victims to have experienced extensive problems and to have felt a sense of desperation.

Information from the survey confirms previous reports that most temporary restraining orders are violated. More than two-thirds of the restraining orders obtained by women against intimates who raped or stalked them were violated, and approximately one-half of the orders obtained by women against intimates who physically assaulted them were violated. Similarly, more than two-thirds of the restraining orders obtained by men against intimates who physically assaulted them and nearly nine-tenths of the orders obtained by men against intimates who stalked them were violated.

Estimates of justice system utilization

The report also presents estimates of the number of intimate partner rape, physical assault, and stalking victimizations that result in a report to the police, an arrest, a criminal filing, a conviction, and a temporary restraining order annually. The first row of estimates is based on reported incidents of intimate partner violence in the past 12 months. The remaining estimates are based on the most recent intimate partner victimization since age 18. According to these estimates, law enforcement personnel receive 1,966,659 reports of intimate partner rape, physical assault, and stalking annually. It is unclear from the data how police personnel classify these reports.

For example, police may classify some physical assault reports as threats or intimidation, and they may classify some stalking cases as trespassing or vandalism. According to NVAW Survey estimates, law enforcement personnel arrest or detain 598,125 suspects of intimate partner rape, physical assault, and stalking annually, and 434,072 such suspects are criminally prosecuted annually. It is unclear how many of these suspects are charged with misdemeanor versus felony crimes. It is also unclear what

specific types of charges are filed against these suspects (e.g., simple versus aggravated assault, stalking, harassment).

Survey estimates show that 1,131,999 victims of intimate partner rape, physical assault, and stalking obtain protective or restraining orders against their attackers annually. Approximately 60 percent (646,809) of these orders are violated.

Policy Implications

The NVAW Survey provides compelling evidence of the prevalence, incidence, and consequences of intimate partner violence in the United States. Information generated from the survey and presented in this report also addresses many controversial issues surrounding intimate partner violence research, such as whether women and men suffer equal rates of violence at the hands of intimate partners, whether race and Hispanic origin affect one's risk of intimate partner violence, and whether violence is more prevalent among same-sex cohabitants compared with heterosexual cohabitants. Thus, information presented in this report can help inform policy and intervention directed at violence perpetrated against women and men by intimate partners. Based on findings from the survey, the following conclusions can be drawn.

1. Intimate partner violence should be treated as a significant social problem.

Analysis of the survey data validates previous research that shows intimate partner violence is a pervasive and serious social problem in the United States.

According to survey estimates, approximately 1.5 million U.S. women and 834,732 U.S. men are raped and/or physically assaulted by an intimate partner annually. Because many of these victims suffer multiple victimizations, the number of intimate partner rapes and physical assaults perpetrated annually exceeds the number of intimate partner victims annually. Thus, an estimated 322,230 rapes and 4.5 million physical assaults are committed against U.S. women by intimate partners annually, and an estimated 2.9 million physical assaults are committed against U.S. men by intimate partners annually. [The estimated number of rapes perpetrated against U.S. women annually is based on 16 women who reported being raped by an intimate partner in the 12 months preceding the survey and should be viewed with caution. Furthermore, the number of male victims was insufficient ($n < 5$) to calculate the number of intimate partner rapes committed against men annually.] In addition, 503,485 U.S. women and 185,496 U.S. men are stalked by intimates annually. Given the pervasiveness of intimate partner rapes, physical assaults, and stalkings committed against women and men annually, it is imperative that intimate partner violence be treated as a major criminal justice and public health concern.

2. Women report significantly more intimate partner violence than do men.

The survey found that women were significantly more likely than men to report being victimized by an intimate partner whether the type of violence was rape, physical assault, or stalking and whether the period was the victim's lifetime or the 12 months preceding the survey. Moreover, women who were physically assaulted by an intimate partner averaged significantly more assaults and suffered significantly more injuries than did their male counterparts. Given these findings, intimate partner

violence should be considered first and foremost a crime against women, and prevention strategies should reflect this fact.

3. Studies are needed to determine why different national surveys have produced such disparate findings with respect to women's and men's experiences with intimate partner violence.

Prior to the NVAW Survey, national information on women's and men's annual experiences with physical assault by an intimate came primarily from the Bureau of Justice Statistics' NCVS and the NFVS. The NVAW Survey finding that women report significantly more intimate partner violence than do men is consistent with findings from the NCVS but inconsistent with findings from the NFVS.

Although the NVAW Survey and the NFVS used similar behaviorally specific questions to screen respondents for physical assault, victimization estimates generated from the NVAW Survey are substantially lower than those generated from the NFVS. Conversely, NVAW Survey victimization estimates are substantially higher than those generated from the NCVS. Studies are needed to determine how methodological differences, such as the context in which the survey is administered and question wording, affect women's and men's reporting of intimate partner violence.

4. Studies are needed to determine why the prevalence of intimate partner violence varies significantly among women of different racial and ethnic backgrounds.

The survey found that American Indian/Alaska Native women report significantly more intimate partner rapes than do women from other racial backgrounds, and Asian/Pacific Islander women report significantly fewer intimate partner physical assaults. In addition, Hispanic women report significantly more intimate partner rapes than do non-Hispanic women. However, differences between minority groups diminish when certain demographic and relationship variables are controlled.

It is unclear from the survey data whether differences in intimate partner victimization rates among women of different racial and ethnic groups are caused by differences in reporting practices. It is also unclear how social, environmental, and demographic factors intersect with race and ethnicity to produce differences in intimate partner victimization rates among women of different racial and ethnic backgrounds. Thus, more research is needed to establish the degree of variance in the prevalence of intimate partner violence among women (and men) of diverse racial and ethnic groups and to determine how much of the variance may be explained by differences in such factors as cultural attitudes, community services, and income. Research is also needed to determine whether differences exist in intimate partner victimization rates for women of diverse Asian/Pacific Islander groups, American Indian tribes, and Alaska Native communities. Finally, research is needed to determine whether differences exist in intimate partner victimization rates among minority women born in the United States and those who have recently immigrated.

5. Intimate partner violence is more prevalent among male same-sex couples than female same-sex couples.

Findings from the NVAW Survey refute earlier findings that same-sex couples are about as violent as heterosexual couples. Male same-sex cohabitants were more likely to report victimization by a male partner than were male opposite-sex cohabitants by a female partner. In comparison, female same-sex cohabitants reported less violence by a female partner than did female heterosexual cohabitants by a male partner. These findings suggest that gay male couples are more violent than lesbian couples,

whereas lesbian couples are less violent than heterosexual couples. These findings also indicate that intimate partner violence is perpetrated primarily by men, whether against same-sex or opposite-sex partners.

6. Violence and emotionally abusive and controlling behavior in intimate relationships are interrelated.

The NVAW Survey provides compelling evidence of the link between violence and emotionally abusive and controlling behavior in intimate relationships. Women whose partners verbally abused them, were jealous or possessive, or denied them access to family, friends, and family income were significantly more likely to report being raped, physically assaulted, and/or stalked by their partners, even when sociodemographic factors such as race and education were controlled. These findings suggest that many women in violent relationships are victims of systematic terrorism; that is, they experience multiple forms of abuse and control at the hands of their partners. Future research should focus on the extent to which violence perpetrated against women by intimate partners consists of systematic terrorism and the consequences of this type of victimization.

7. America's medical community should receive comprehensive training about the medical needs of victims of intimate partner rape and physical assault.

The injury and medical utilization data generated from the NVAW Survey provide persuasive evidence of the physical and social costs associated with intimate partner violence. The survey found that in more than one-third of all rapes and physical assaults committed against women by intimates, the victim sustains an injury. Furthermore, in approximately one-third of all such injury victimizations, the victim receives some type of medical care (e.g., paramedic care, treatment in a hospital emergency facility, dental care, or physical therapy). The survey also found that approximately one-fifth of all physical assaults committed against men by intimates result in an injury to the victim, and in one-fifth of all such injury victimizations, the victim receives some type of medical treatment. Thus, of the estimated 7.7 million rapes and physical assaults committed against women and men annually by intimate partners, approximately 2.5 million will result in an injury to the victim, and approximately 680,000 will require some type of medical treatment to the victim.

Because many female and male victims of intimate partner rape and physical assault receive multiple forms of care for the same injury victimization, medical personnel in the United States treat millions of intimate partner injury victims annually. Given the large number of injury victimizations committed against women and men by intimate partners annually and the extensive nature of medical treatment to victims of intimate partner rape and physical assault, it is imperative that medical professionals receive information about the prevalence and physical consequences of intimate partner violence and the medical needs of victims and training on how to make appropriate referrals for victims with these needs.

8. The U.S. justice system community should receive comprehensive training about the safety needs of victims of intimate partner violence.

As previously noted, the NVAW Survey produced dramatic confirmation of the pervasive nature and injurious consequences of intimate partner violence. Information from the survey also shows that most

intimate partner rapes, physical assaults, and stalkings go unreported to law enforcement. Given these findings, criminal justice practitioners should receive comprehensive training about the safety needs of victims and the need to conduct community outreach to encourage victims of intimate partner violence to report their victimizations to the police.

Survey Screening Questions

Rape: Five questions were used to screen respondents for completed and attempted rape victimization:[a]

--[Female respondents only] Has a man or boy ever made you have sex by using force or threatening to harm you or someone close to you? Just so there is no mistake, by sex we mean putting his penis in your vagina.

--Has anyone, male or female, ever made you have oral sex by using force or threat of force? Just so there is no mistake, by oral sex we mean that a man or boy put his penis in your mouth or someone, male or female, penetrated your vagina or anus with their mouth.

--Has anyone ever made you have anal sex by using force or threat of force? Just so there is no mistake, by anal sex we mean that a man or boy put his penis in your anus.

--Has anyone, male or female, ever put fingers or objects in your vagina or anus against your will or by using force or threats?

--Has anyone, male or female, ever attempted to make you have vaginal, oral, or anal sex against your will but intercourse or penetration did not occur?

Physical assault: A modified version of the original Conflict Tactics Scale was used to screen respondents for physical assault they experienced as an adult at the hands of another adult:[b]

--Not counting any incidents you have already mentioned, after you became an adult, did any other adult, male or female, ever:

o Throw something at you that could hurt?

o Push, grab, or shove you?

o Pull your hair?

o Slap or hit you?

o Kick or bite you?

o Choke or attempt to drown you?

o Hit you with some object?

o Beat you up?

o Threaten you with a gun?

o Threaten you with a knife or other weapon?

o Use a gun on you?

o Use a knife or other weapon on you?

Stalking: The following questions were used to screen respondents for stalking victimization:

--Not including bill collectors, telephone solicitors, or other salespeople, has anyone, male or female, ever:
o Followed or spied on you?

o Sent you unsolicited letters or written correspondence?

o Made unsolicited phone calls to you?

o Stood outside your home, school, or workplace?

o Showed up at places you were even though he or she had no business being there?

o Left unwanted items for you to find?

o Tried to communicate in other ways against your will?

o Vandalized your property or destroyed something you loved?

Respondents who answered yes to one or more of these questions were asked whether anyone had ever done any of these things on more than one occasion and whether they felt frightened or feared bodily harm as a result of these behaviors. Only respondents who reported being victimized on more than one occasion and who were very frightened or feared bodily harm were counted as stalking victims.

Victim-perpetrator relationship: Respondents who answered affirmatively to the rape, physical assault, and/or stalking screening questions were asked whether their attacker was a current or ex-spouse, a male live-in partner, a female live-in partner, a relative, someone else they knew, or a stranger. Respondents disclosing victimization by an ex-spouse or cohabiting partner were asked to further identify which spouse/partner victimized them (e.g., first ex-husband, current male live-in partner). Respondents disclosing victimization by a relative were asked to further specify which relative victimized them (e.g., father, brother, uncle, cousin). Finally, respondents disclosing victimization by someone else they knew were asked to further specify the relationship they had with this person (e.g., date, boss, teacher, neighbor). Only victimizations perpetrated by current and former spouses, same-sex and opposite-sex cohabiting partners, and dates are included in the analyses discussed in this report.

Survey Methodology

The National Violence Against Women (NVAW) Survey was conducted by interviewers at Schulman, Ronca, Bucuvalas, Inc. (SRBI) under the direction of John Boyle. The authors of this report designed the survey and conducted the analysis.

The sample was drawn by random-digit dialing from a database of households with a telephone in the 50 States and the District of Columbia. The sample was administered by U.S. Census region. Within each region, a simple random sample of working residential "hundreds banks" of phone numbers was drawn. (A hundreds bank is the first 8 digits of any 10-digit telephone number.) A randomly generated 2-digit number was appended to each randomly sampled hundreds bank to produce the full 10-digit, random-digit number. Separate banks of numbers were generated for male and female respondents. These random-digit numbers were called by SRBI interviewers from their central telephone facility, where nonworking and nonresidential numbers were screened out. Once a residential household was reached, eligible adults were identified. In households with more than one eligible adult, the adult with the most recent birthday was selected as the designated respondent.

A total of 8,000 women and 8,005 men 18 years of age and older were interviewed using a computer-assisted telephone interviewing (CATI) system. (Five completed interviews with men were subsequently eliminated from the sample during data editing due to an excessive amount of inconsistent and missing data.) Only female interviewers surveyed female respondents. To test for possible bias introduced by the gender of the interviewer, a split-sample approach was used in the male sample whereby half of the interviews were conducted by female interviewers and half by male interviewers. A Spanish-language translation was administered by bilingual interviewers to Spanish-speaking respondents.

To determine how representative the sample was, select demographic characteristics of the NVAW Survey sample were compared with demographic characteristics of the general population as measured by the U.S. Census Bureau's 1995 Current Population Survey of adult men and women. Sample weighting was considered to correct for possible biases introduced by the fact that some households had multiple phone lines and multiple eligibles and for over- and under-representation of selected subgroups. Although there were some instances of over- and under-representation, the overall unweighted prevalence rates for rape, physical assault, and stalking were not significantly different from their respective weighted rates. As a result, sample weighting was not used in the analysis of the survey data.[b]

Data were analyzed using SPSS Base 7.0 for Windows software. Measures of association were calculated between nominal-level independent and dependent variables. The chi-square statistic was used to test for statistically significant differences between two groups (e.g., men and women), and the Tukey's B statistic was used to test for statistically significant differences among two or more groups (e.g., whites, African-Americans, Asian/Pacific Islanders, American Indian/Alaska Natives, and mixed-race persons). Any estimates based on fewer than five responses were deemed unreliable and, therefore, were not tested for statistically significant differences between or among groups and were not presented in the tables. Because estimates presented in this report generally exclude "don't know," "refused," and other invalid responses, sample and subsample sizes (n's) vary from table to table.

Because the actual number of victims that is insufficient to reliably calculate estimates varies depending on the rarity of the exposure and the denominator of the subgroup being analyzed, the

relative standard error (RSE) was calculated for each estimate presented. (RSE is the ratio of the standard error divided by the actual point estimate.) Estimates with RSEs that exceed 30 percent were deemed unstable and were not tested for statistically significant differences between or among groups. These estimates have been identified in the tables and should be viewed with caution.

The estimates from this survey, as from any sample survey, are subject to random sampling error. It presents the estimated standard errors multiplied by the z-score (1.96) for specified sample and subsample sizes of 16,000 or less at different response distributions of dichotomous variables (e.g., raped/not raped, injured/not injured). These estimated standard errors can be used to determine the extent to which sample estimates will be distributed (bounded) around the population parameter (i.e., the true population distribution). As it also shows, larger sample and subsample sizes produce smaller estimated bounds. Thus, the estimated bound at the 95-percent confidence level for a sample or subsample of 8,000 is 1.1 percentage points if the response distribution is a 50/50 split, whereas the estimated bound at the 95-percent confidence level for a sample or subsample of 50 is 14 percentage points if the response distribution is a 50/50 split.

About the National Institute of Justice

The National Institute of Justice (NIJ), a component of the Office of Justice Programs, is the research agency of the U.S. Department of Justice. Created by the Omnibus Crime Control and Safe Streets Act of 1968, as amended, NIJ is authorized to support research, evaluation, and demonstration programs; development of technology; and both national and international information dissemination. Specific mandates of the Act direct NIJ to:

--Sponsor special projects and research and development programs that will improve and strengthen the criminal justice system and reduce or prevent crime.

--Conduct national demonstration projects that employ innovative or promising approaches for improving criminal justice.

--Develop new technologies to fight crime and improve criminal justice.

--Evaluate the effectiveness of criminal justice programs and identify programs that promise to be successful if continued or repeated.

--Recommend actions that can be taken by Federal, State, and local governments as well as by private organizations to improve criminal justice.

--Carry out research on criminal behavior.

--Develop new methods of crime prevention and reduction of crime and delinquency.

In recent years, NIJ has greatly expanded its initiatives, the result of the Violent Crime Control and Law Enforcement Act of 1994 (the Crime Act), partnerships with other Federal agencies and private foundations, advances in technology, and a new international focus. Examples of these new initiatives:

--Exploring key issues in community policing, violence against women, violence within the family, sentencing reforms, and specialized courts such as drug courts.

--Developing dual-use technologies to support national defense and local law enforcement needs.

--Establishing four regional National Law Enforcement and Corrections Technology Centers and a Border Research and Technology Center.

--Strengthening NIJ's links with the international community through participation in the United Nations network of criminological institutes, the U.N. Criminal Justice Information Network, and the NIJ International Center.

--Improving the online capability of NIJ's criminal justice information clearinghouse.

--Establishing the ADAM (Arrestee Drug Abuse Monitoring) Program-- formerly the Drug Use Forecasting (DUF) program--to increase the number of drug-testing sites and study drug-related crime.

The Institute Director establishes the Institute's objectives, guided by the priorities of the Office of Justice Programs, the Department of Justice, and the needs of the criminal justice field. The Institute actively solicits the views of criminal justice professionals and researchers in the continuing search for answers that inform public policymaking in crime and justice.

To find out more about the National Institute of Justice, please contact:

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National Center for Injury Prevention and Control (NCIPC)

State Cooperative Agreements Coordinated Community Response

Part 1 Projects:

The **Chatham Hospital** (CH), Family Violence and Rape Crisis Services (FVRC), Chatham Primary Care (CPC), the Siler City Police Department (SCPD), and the University of North Carolina, Department of Family Medicine will work with community agencies in Siler City, North Carolina to initiate, develop, and coordinate a community-wide response to the problem of intimate partner violence. Chatham Hospital plans to use the PRECEED model, which has been used to address health and health-related issues. The following activities will be conducted: (1) a community awareness campaign, Zero Tolerance; (2) immediate placement of specially trained personnel in "point of entry" agencies and organizations for culturally and linguistically sensitive treatment and service; (3) professional providers' awareness workshops, concentration on culturally and linguistically appropriate screening, detection, and treatment (including referral) of partner abuse victims and their families; (4) establishment of culturally sensitive and linguistically appropriate treatment program for batterers; (5) completion of the enhanced arrest and prosecution program for SCPD; (6) expansion of school-based family violence education programs with special emphasis on elementary school children and "at risk" adolescents; (7) establishment of a pilot program, "Woman to Woman" offering a network of support to victims through trained volunteers in selected work sites. These volunteers will offer information and referral to suspected victims and provide emotional support; and (8) establishment of a community outreach program where caretakers from the Child Care Network, homemakers from Cooperative Extension neighborhood groups, and members from local church women's organizations volunteer as family advocates.

The **Maine Ambulatory Care Coalition** will implement and evaluate "A Rural Response to Intimate Partner Violence" in the rural communities served by their community health centers. The objectives of the program will include (1) developing and implementing programs to dispel misconceptions about intimate partner violence and to change attitudes, beliefs and behaviors that cause or promote intimate partner violence; (2) to enhance the services for and support to women who are victims of intimate partner violence; (3) to treat victims of intimate partner violence; and (4) to provide training, education and information about intimate partner violence. The target population for this project includes adolescents and women who have experienced, or are at risk of experiencing violence inflicted by persons known to them rather than by strangers.

The four health centers will develop local community coalitions which will involve family violence programs, law enforcement agencies, clergy, business and civic leaders, victims of intimate partner violence, and local education programs. They will also utilize a Continuous Quality Improvement (CQI) approach to develop protocols and programs within the health center to identify women and adolescents experiencing intimate partner violence. These local programs will be supported by a state-level structure that will include an advisory group and a comprehensive system for training, technical assistance, and other support.

The **Sauk County Task Force on Domestic Abuse/Hope House** is establishing and enhancing community responses to intimate partner violence in "core communities" of a five-county target area in Wisconsin, which include Baraboo/West Baraboo, Reedsburg, Sauk-Prairie, and Lake Delton. Project objectives are to: (1) establish and/or enhance primary prevention programs to prevent intimate partner violence; (2) expand and improve existing services in the "core communities" that will address the needs of victims of intimate partner violence and their children; (3) expand and improve existing

treatment programs to address long-term interventions for batterers, rapists, and battered women and their children; and (4) address training needs of service providers to ensure that multi-disciplinary services for victims of intimate partner violence operate in a coordinated manner.

This group will convene a community coalition composed of representatives from the pertinent community sectors to develop strategies for improving services and prevention interventions for battered women and their children through increased communication, cooperation, and coordination.

Part 2 Projects:

Northeastern University's School of Law and College of Nursing, in collaboration with the Dorchester Community Round table, propose to strengthen the existing community coalition by developing innovative collaborative prevention programs, providing interdisciplinary training on intimate partner violence to Roundtable members, and involving sectors of the community typically not involved but potentially important in coalitions for battered women, namely, job training, day care, and public housing.

Priorities of the project include: 1) enhancing professional and emotional support among collaboration partners; 2) utilizing new communications technologies to link collaborative partners' efforts; 3) focusing collaborative efforts on intergenerational aspects of intimate partner violence, that is, concentrating not only on women who are victims of partner violence, but on children who suffer from witnessing such violence and young adults who are involved in partner battering; and 4) focusing education, outreach, research and evaluation efforts on community residents, activities which will inevitably identify persons at current risk of violence.

The coalition plans to deliver new primary prevention and intervention programs for battered women including: expanding the use of trained domestic violence advocates to assist victims in utilizing community resources; establishing a Partner Violence Prevention Program and Advocacy Training Institute to train advocates and service providers; developing a program for protecting young children from the negative effects of witnessing intimate partner violence; providing an adolescent education outreach program delivered through school-based programs; expanding services for battered women; and expanding batterer treatment programs to focus especially on youthful offenders.

The goal of the **Spokane County Domestic Violence Consortium** is to reduce and prevent intimate partner violence and its effects on women and children through expansion of consortium activities. Objectives include (1) modifying attitudes toward and increasing awareness and knowledge about intimate partner violence; (2) reducing incidence of intimate partner violence against adolescents and adult women in Spokane County; (3) refining intimate violence prevention strategies and services through increased communication, cooperation, and coordination among all participating county programs; (4) expanding intimate violence prevention strategies/services by implementing previously identified interventions; and (5) refining a proposed outcome evaluation design to measure any differences resulting from implementation of interventions.

Activities include increasing the capacity of the following components: speakers bureau; educational, informational and training capabilities of the coalition; resource library; and comprehensive services directory. Efforts will be made to increase consortium membership, specifically media participation; expand media education on preventing intimate partner violence; provide parenting/early identification classes for prevention of intimate partner violence; provide intimate partner violence prevention training for professionals and other community groups, particularly the Children's and Family Services

Intervention Program and Children's Waiting Room; and provide specific training for professionals on batterers' treatment and indigent batterer's assistance.

Women's Resource and Shelter Space, or **Womenspace**, of Eugene, Oregon, in conjunction with the Lane County Domestic Violence Council, will address three goals through the proposed project: (1) increase community awareness of intimate partner violence through a public relations and education campaign; (2) enhance services to victims of intimate partner violence through increased advocacy, counseling and intervention; and (3) improve the community's ability to respond to crimes of intimate partner violence and rape by improving collaborative efforts among coalition members.

Project activities include primary prevention programs, services for battered women, their children, and batterers intervention. Primary prevention programs activities include: (1) a public awareness campaign; (2) school-based programs; (3) workplace violence prevention education programs; and (4) education and support groups.

Services for victims of intimate partner violence and rape will include: (1) increased advocacy by establishing a drop-in office in the community; (2) expanding the District Attorney's victim services; (3)expanding Parole and Probation's victim services; (4) expanding victim identification protocols in hospitals; and (5) expanding services in rural areas of the county. Support services for battered women and their children as well as court-ordered programs for batterers will be expanded.

Training and education efforts will include: (1) training for police officers in responding to intimate partner violence and rape; (2) training for health care providers to screen consistently for and respond appropriately to intimate partner violence.

Longitudinal Evaluation

Reducing Dating Violence. The University of North Carolina at Chapel Hill will collaborate with the Johnston County public schools, the Johnston County health department, and Harbor, Inc., a community-based organization. Selected 8th and 9th grade students in Johnston County will receive classroom instruction about gender stereotypes, conflict management skills, and social norms that contribute to dating violence. Classroom instruction will be supplemented with student-conducted dramatic performances. In addition, parents, police workers, and other key individuals in the community will be trained to be better resources for youths who seek assistance about teenage dating violence. Half of the middle and high schools in the county will be randomly selected as intervention schools. The 1200 students in grades 8 and 9 attending those schools will receive instruction in the topics listed above as part of their health education course. The 1200 students attending other schools in the county will be influenced only by the community activities (i.e., training of parents, police workers, and other key individuals). All 8th and 9th grade students will complete surveys concerning knowledge, attitudes, and behaviors relating to dating violence prior to, one month after, and one year after the classroom instruction. From these surveys, researchers will determine the differences in knowledge, attitudes (gender stereotyping), and behaviors (violent dating behavior and termination of violent dating relationships) among students in the intervention and control schools. (PI: Vangie Foshee; University of North Carolina)

Multifaceted Community-Based Projects

The **City of Houston Department of Health and Human Services** was awarded funds for a demonstration project to assess the ability of a "mentoring" project for abused pregnant women to

reduce the amount of postpartum abuse. The women who receive the "mentoring" would be compared with a group who receives "usual care" and a control group. The comparison would be conducted by randomly selecting 20% of abused pregnant women at each of three clinics who will be periodically contacted for two years after delivery. The City of Houston has seven clinics at which they administer Maternal and Child Health (MCH) services. For this project, three similar clinics would be selected. One clinic would receive no augmentation of services. At a second, staff would receive special training and consultation to help them coordinate counseling and referral services for abused clients. The third would receive the same augmentation in services as the second, plus a cadre of women from the neighborhood would be trained as "mentors." Each mentor would be assigned 28 abused pregnant women whom they would telephone at least weekly, visit at least monthly, and conduct a group session at least monthly. The evaluation would: 1) compare the number of women identified as abused among the three clinics through a random chart review; the clinic not augmenting its services would identify the fewest; 2) compare the number of counseling, shelter, and other referrals among the 3 clinics; and 3) follow the women chosen through a random selection of abused pregnant women, over a 2-year period, and compare the incidence of abuse among the 3 groups; the clinic receiving the mentoring is expected to have the lowest incidence.

The **Minnesota Program Development, Inc.** was awarded funds for a demonstration project to enhance and expand the Duluth Domestic Violence Prevention Project, an interagency network, begun in 1981. Target group: Domestic abuse victims and batterers, agency practitioners in Duluth and southern St. Louis County, Minnesota. Setting: The City of Duluth and southern St. Louis County, Minnesota. Description: The Domestic Abuse Intervention Project is a coordinated community response to domestic assault cases that includes 9-1-1, the jail, police, prosecutors, probation officers, several mental health agencies, and victim services. The project is being expanded to include additional segments of the criminal justice system, public health, employee assistance providers, county child protection workers, and other community agencies. Goals include expanding and enhancing intervention approaches; improving the coordination and communication on cases, computerizing the tracking of cases, and developing replication materials . All agency practices and procedures are designed to enhance victim safety. The goal is to make links between what individual practitioners do in a case and the overall effect of intervention. The evaluation plan assesses the effectiveness of the enhanced community response in reducing recidivism and the frequency of abusive behavior, and women's reports of their safety and well-being. One part of the evaluation focuses on determining whether enhanced assessment allows public health nurses and employee assistance counselors to better identify victims of domestic violence and make appropriate referrals. Another aspect of the evaluation is a comparison of two education models for men who batter by using random assignment from the point of intake. The evaluation examines the relationship between risk factors identified in the assessment process and the level of response provided by practitioners, and explores the relationship between risk factors and continued abuse and women's safety and well-being.

The **Milwaukee Women's Center, Inc. (MWC)** was awarded funds for a demonstration project to implement and evaluate multiple interventions aimed at reducing the incidence and severity of violence against women. The applicant proposes to collaborate with the Sojourner Truth House, Inc., ASHA Women of Color Project, and the University of Wisconsin Milwaukee/Center for Addiction and Behavioral Health Research in completion of the project. Stated goals for the project are: (1) development and implementation of a public awareness campaign to (a) increase the number of people who are aware that violence against women is a crime and (b) are aware of available resources; (2) demonstration of the effectiveness of differing treatment models for batterers in reducing the incidence and severity of violence against women; and (3) demonstration of the effectiveness of professional training centered around domestic violence prevention for differing audiences; and (4) demonstration

of the effectiveness of preventive intervention approaches with adolescents (age 12+) and young adults in reinforcing knowledge, attitudes, behavior, and beliefs in preventing violence against women. The applicant includes appropriate objectives with each goal. The interventions include: a public awareness campaign; psychological counseling treatments for batterers and those at high risk for battering; training of professionals to identify victims of violence and to act in ways to prevent further battering; preventive education of middle school, high school, and university students; coordination of services for victims. Evaluation procedures are particular to each intervention and are sensitive to issues that might obscure the ability to draw causal conclusions. (MWC) is currently working on a "Safe-at-Home" project. The Milwaukee Women's Center, Inc. (MWC) has won two awards for their media campaign. They received the "Gold" World Medal in the New York Festivals 1996 International Print Advertising Competition and also in 1996 won the "Silver" Medal in the United Nations Department of Public Information competition. This award was presented by the Assistant Secretary General of the United Nations Department of Public Information.

The Milwaukee Women's Center, Inc. has also adapted the stages of change model for use in evaluating their batterer interventions, and has produced a draft paper (Begun AL, Strodhoff T, Shelley G, & Short L; 1997).

The Milwaukee Women's Center, Inc. has conducted numerous professional training centered around family and intimate violence prevention for differing audiences.

Men Stopping Violence was awarded funds for a demonstration project to implement and evaluate a community intervention package to reduce domestic violence against women, by focusing on changing the criminal justice response to the abuse of women. The target population is primarily white and middle-class, living in urban and rural areas, in two counties in Metro Atlanta. The interventions will include: (a) a batterers' program as an alternative to jail; (b) law enforcement officers training regarding attitudes, behaviors, and consequences of battering; a media campaign to raise community awareness about sanctions against domestic violence. The goals of the program are to: (1) Increase awareness in the two counties about a new arrest policy; (2) Educate women in the two counties about greater self-protective behaviors and options such as temporary restraining orders, separation, and relocation to battered women's shelters. The 1-year objectives are to: (1) assess the baseline prevalence of violence using a household survey; (2) introduce an urban and a rural batterers' program as an alternative to jail for those guilty of domestic violence; (3) Raise awareness of community sanctions against violence through a media campaign. The 2-5 year objectives are to: (1) Use training to alter attitudes and behaviors of criminal justice professionals towards battering; (2)Increase the consequences for men who batter (increase arrests, prosecutions, convictions or referrals to a batterers' program); (3) evaluate the effects of training on police officers' attitudes and behaviors; (4) assess the change in the prevalence of women's self-protective behaviors; and (5) increase men's perception that battering will be met with sanctions. Data collection will entail yearly telephone surveys of households, review of criminal justice records, and interviews of criminal justice personnel. The evaluation will compare the two intervention counties with four control counties. As a result of this intervention project, the applicant expects to observe increased arrests, prosecutions, and convictions or referrals to batterers' programs and increased perceptions among men that battering carries legal sanctions.

State Health Department Project Summaries

The **Massachusetts Department of Public Health**, Division of Women's Health and Massachusetts Health Research Institute, Inc. were awarded a cooperative agreement for a joint program called,

"WATCH: Women Abuse Tracking in Clinics and Hospitals." The WATCH project is guided by three major goals: (1) to develop a statewide surveillance system utilizing new and existing data sources to track incidence and prevalence of intimate partner violence to women age 12 and over; (2) to design, implement, and evaluate a hospital emergency department-based surveillance system to track incidence and prevalence of intimate partner violence; and (3) to create replication guidelines that will serve as the blueprint for other states that wish to establish statewide surveillance for intimate partner violence. Existing and enhanced data sources being utilized in the surveillance system include: (1) the Behavioral Risk Factor Surveillance System (BRFSS), a statewide random digit-dial telephone survey administered by the Massachusetts Department of Public Health, which includes a newly developed violence module; (2) the Youth Behavior Risk Survey (YRBS), a survey administered by the Department of Education which includes a question about teen dating violence developed by WATCH; (3) the Weapon-Related Injury Surveillance System (WRISS), a mandated reporting system administered by the Massachusetts Department of Public Health which includes data on firearm, stabbing, and blunt instrument injuries; and (4) the National Incidence Based Reporting System (NIBRS), used by some community police departments to collect data on survivors and perpetrators of intimate partner violence. At the core of the statewide surveillance system is the piloting of an entirely new data source. WATCH is designing, implementing, and evaluating a surveillance system facilitated through selected hospital emergency departments. In order to achieve implementation of this surveillance system, the Project provides training for emergency department personnel in the effort to enhance identification, documentation, and appropriate treatment responses to survivors of intimate partner violence. The Project has also completed an inventory of State supported an/or funded intimate partner violence services that are available throughout the Commonwealth for female survivors of intimate partner violence.

The **Rhode Island Department of Health** in collaboration with the Coalition Against Domestic Violence, Family Violence Research Program at the University of Rhode Island, Department of the Attorney General, Rhode Island Medical Society, Office of the Medical Examiner, Joint Legislative Commission to Study Women's Health Issues, and the American College of Emergency Physicians-Rhode Island Chapter were awarded a cooperative agreement for a statewide program to reduce violence against women. The goals are to: (1) coordinate statewide planning and assessment of domestic violence prevention services; (2) provide technical assistance for the development of public education, victim identification training and referral protocols; and (3) develop and improve surveillance systems for violence against women. There will be a statewide inventory of existing programs. Among other possible programs, RIDH will support a public education and information campaign, coordination of domestic violence prevention services into community-based family centers, education targeting youth, training of health care providers in identification and referral, and placement of domestic violence advocates in health care settings to address the needs of abused women.

The **Michigan Department of Public Health**, Domestic Violence Prevention Unit was awarded a cooperative agreement to establish the Michigan Prevention of Violence Against Women Program. The program goals are to: (1) establish an ongoing surveillance system of Violence Against Women (VAW); (2) evaluate the usefulness of the surveillance system for assessing VAW; (3) establish a broadly representative advisory structure to address issues related to VAW; (4) assess and define the MDPH's capacity and role in addressing VAW; (5) develop, implement, and evaluate 4 multifaceted community level programs to prevent VAW; and (6) prepare and broadly disseminate replication guidelines describing all aspects of the VAW program in Michigan.

Community-Based Primary Prevention Programs to Prevent Intimate Partner Violence for a Safe America

Part I Projects:

The Albuquerque Area Indian Health Board
The Albuquerque Area Indian Health Board, in collaboration with the Albuquerque Indian Center, proposes a community based primary intimate partner violence prevention project with four objectives: 1) to develop a violence prevention task force; 2) implement a media campaign for IPV prevention; 3) conduct a school-based prevention awareness campaign; and 4) hold community gatherings to build skills, promote prevention and advocacy, develop long-term prevention plans, and promote messages of violence prevention, healthy families and healthy relationships.

The project will use a framework developed by American Indians to mobilize, plan and work toward preventing community problems. A four level process called the CIRCLE, Community Involvement to Renew Commitment, Leadership and Effectiveness, will be utilized. The four level approach includes belonging, mastery, interdependence, and generosity. Each area includes objectives. For belonging, a task force that meets monthly will develop prevention campaign ideas, to help implement prevention activities, to develop a network of resources for victims and families, and develop short and long term prevention action plans.

Mastery includes the development of a media campaign over a ten month period including public awareness events, TV spots, youth poster contest, development of brochures, local community events (four/year), and information booths set up at the State Fair Indian Village and the Gathering of Nations Powwow, and other powwows and Indian events. CIRCLE gatherings will include presentations and training sessions for the target population, which is the entire Albuquerque Indian community.

Interdependence includes the development of women's and children's support groups and a men's wellness group. Women's support groups will be for those affected by intimate partner violence; children's support groups will be set up to help children cope with family violence through activities planned in coordination with the Albuquerque Public Schools Indian Education program. The men's wellness group will be set up to help men address their own issues, learn about healthy relationships and reaffirm their importance to their families and community as Indian men. "Healing the healers" sessions will be conducted for service providers. The content and outline of these sessions was not described in detail.

Generosity will be addressed through Facilitation Skills Development Process Training for the task force and community members involved in capacity building training sessions. This series of sessions will be held "at the end of the project" to sustain project efforts over time.

The Albuquerque Area Indian Health Board and the Albuquerque Indian Center will share responsibility for overseeing and managing this project.

The target population has one women's shelter, several homeless women/ children shelters and numerous counseling services for IPV victims. Indian-specific services are limited and poorly funded. Indian people are reluctant to use mainstream services.

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La Clinica de la Raza

La Clinica de la Raza, Fruitvale Health Project, Inc., Oakland, California, proposes the development of Proyecto Cambio (Project Change) to reduce the risk of intimate partner violence among the Latino residents of Oakland, California (Alameda County) by targeting women and children living in the East Oakland neighborhoods of Fruitvale and San Antonio, located in Oakland's federally designated Enhanced Enterprise Community Zone.

La Clinica De La Raza is a federally qualified community health center located in Alameda County's largest and most ethnically diverse city as well as a minority community-based organization having a 26-year working relationship with its target community. Fifty-one per cent of the Applicant's Board of Directors are members of the community who are elected by the community. Trained community health promoters are used strategically to gather information on community needs and demographics through focus groups and research.

The target population is predominantly immigrant, largely from Mexico and Central America. Thirty per cent of the population is under 18 years of age; 24% lives at poverty level; 50% lives below 200% poverty level; and 50.2% over 5 years of age does not speak English at home. The project seeks to reduce the risk of IPV among the Latino population through the use of culturally-based primary prevention strategies that will a) increase the awareness of IPV and its effects on individuals, families and communities; b) provide skills to community members to decrease their risk of IPV; and c) provide referrals for intervention services and support networks for individuals who are witnessing or experiencing IPV. The project is designed to prevent IPV by effecting change on three levels: individual, by providing knowledge and skills; the household, by providing similar information to various members of the family that will reinforce the messages given to individuals; and the community, by creating social structures to reduce isolation and create networks of support.

La Clinica de la Raza proposes to implement Proyecto Cambio, or Project Change utilizing four components: 1) A Rites of Passage ceremony, based on the traditional Quinceanera, a social and religious ceremony where young girls are introduced to their community as an adult during their 15th year (based on a model in Colorado); 2) Casa en las Escuelas (Home in the Schools), a 6 to8 week school-based education series that employs methods of interactive learning to empower students to analyze problems for their causes and find solutions, developed by Paulo Frier to empower the process of critical thinking and solution-building; 3) Comadres Group, based on Casa CHE's Casa en Casa (Home in the Home) model, a community-based health education program that takes place in the homes of community members; 4) A Speaker's Bureau composed of survivors of IPV, intended to strengthen the activities of the other three components by providing participants with first-hand accounts of IPV and how the cycle of violence can be broken.

Key partners in the project include 6 public elementary, middle and high schools serving community children, the Narcotics Education League, the National Organization of Latina Women's health, and the Spanish Speaking Citizens' Foundation. Working partners are divided into two groups, those working on the implementation of the school-based education series (Case en las Escuelas) and those collaborating on the development and implementation of the Rites of Passage program.

La Clinica's outpatient mental health department, Case del Sol, was founded in 1972, and has, among other services, provided child abuse and domestic violence treatment and support groups to the Latino population, having a strong focus on the family. Case del Sol is the only source of domestic violence interventions services for the monolingual Spanish-speaking community in northern Alameda County. Case del Sol will be the main point for referrals for participants identified as experiencing or witnessing IPV.

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Our House, Inc.
Our House, Inc. is a non-profit minority community-based organization ("CBO") located in Greenville (Washington County), Mississippi. Our House, Inc. will target Bolivar, Sunflower and Washington Counties, which all have over 60% minority residents. Its working partners are Delta State University Social Work Department (evaluation services provider) and Thompson & Associates (consultation and training on conflict resolution programs provider).

The main goal of the program is to reduce intimate partner violence ("IPV") by 10% among youth aged 12-21 in the target population by changing current knowledge, attitudes, beliefs and behaviors that promote IPV in the South. Other stated goals are to: 1) educate beginning level social work students, students in two local high schools and youth in four churches; 2) provide behavioral modification sessions to youth whose parents are mandated to attend anger management programs and compare these youth to those whose parents are not mandated to attend; 3) develop a replicable curriculum and evaluation plan that includes standard forms, evaluation materials, processed tracking procedures and reports; 4) provide school and community-based primary prevention programs designed to promote healthy relationships and prevent dating violence among school-age youth; and 5) develop an evaluation plan to assess the project.

The target population is at risk for IPV: one-half of all homicides in the locality occurred between intimates, the community has the highest poverty level in the United States, accompanied by severe economic depression, low educational achievements, unemployment, stress, racial disharmony, drugs, uncontrollable anger and a lack of trained law enforcement officials.

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The Tacoma Intimate Partner Violence Prevention Project
The Tacoma Intimate Partner Violence Prevention Project, located in Tacoma, Washington, has

planned a coordinated set of strategies which provide primary prevention to youth from African-American and Latino communities of the Hilltop Neighborhood, the southern half of Tacoma's federally designated Enterprise Zone; the northern half being the East side Neighborhood. Centro Latino SER is the primary Tacoma provider of human services to these communities.

Centro Latino SER (Jobs for Progress), intends to collaborate with the Tacoma Urban League, the YWCA of Tacoma and Pierce counties, the Tacoma-Pierce County Health Department, the Tacoma branch of the U. of Washington's College of Education, Renman Hall of Juvenile Justice, Tacoma schools, United Way agencies and the faith community.

The project plans to use a social development approach by coordinating a neighborhood information campaign regarding IPV and providing intensive primary prevention skills and other services by integrating DV curricula into already existing behavior change information and disseminating it through a peer group process.

High risk youth who appear in the rehabilitative systems (school student assistance programs for rules violations, and/or academic failure risk, juvenile justice system, health care network for neglected or abused youth, and the youth substance abuse prevention and treatment system) will be included for intensive prevention services.

The goals of the project are consistent with and will address identified gaps in prevention services such as: 1) coordinate a neighborhood information campaign in the Hilltop Neighborhood of Tacoma's Enterprise Zone which will result in lowered levels of risk behaviors in the target population and a longitudinal impact on IPV in the target population; 2) infuse IPV prevention skills building into the school and community social environment of Latino and African American youth of the Hilltop. IPV and other behavior change information will be disseminated through basic media messages, peer group processes and other appropriate channels of communication. This will result in an increase in attitudes that are resilient to IPV and a longitudinal decrease in risk behaviors and acts of IPV within this youth population; and 3) identify high-risk youth in the Hilltop community, using schools and juvenile justice systems, to refer into high-intensity prevention programs of building resiliency to future IPV behaviors. These youth will show a decrease in risk behaviors and lower levels of future IPV behaviors as compared to a control group.

These three goals are clarified in a series of activities around: 1) community level messages disseminated through appropriate channels of communication that are identified in a mapping process; 2) an adult mentor and peer program to model and teach appropriate attitudes and behaviors, and 3) an intensive intervention with identified high-risk youth that has yet to be developed.

The target population is defined as economically disadvantaged, crime-impacted and IPV-laden, its objectives, through these interventions, are to 1) reduce the number of IPV-related arrests; 2) decrease the number of youth exhibiting IPV profile behavior; and 3) reduce the number of IPV self-reports.

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The Women's Alcoholism Center
The Women's Alcoholism Center is a minority community-based organization located in San Francisco, California. This organization has a 19-year history of providing comprehensive substance abuse services to women of color and low income in general; in particular to African-American and Hispanic communities, and is committed to provide a continuum of care and a wide range of services specific to those individual needs.

Along with its collaborating partners, Standing Against Sexual Exploitation ("SAGE") and Manalive Education and Research Institute ("MERI"), the Women's Alcoholism Center proposes, through its existing project entitled Sisters Working in Community ("SWIC"), to expand prevention and education to the population of women and girls at risk of experiencing intimate partner violence ("IPV") and sexual assault who do not access existing services. MERI's role will be to implement and evaluate the project, including the development of resource materials for boys and men, while SAGE will continue to target immigrants, refugees, lesbians and prostitutes, as well as incarcerated women and girls.

The focus of the project will be four under-served communities of its target population in San Francisco: Bayview/Hunters Point, Mission District, Western Addition and Visitacion Valley. SWIC will employ a community organizing model to implement its primary strategies: 1) assessment of community needs to build the capacity of existing community organizations to incorporate IPV prevention education; 2) creation of public awareness of IPV through community-specific media and education materials; and 3) development of peer-based and prevention education programs that respond to the specific needs of women and girls in the target population for empowerment.

The target population is among the city's most disadvantaged and dangerous communities, defined by factors of poverty, early sexual trauma or abuse and substance abuse. Other demographics reveal that of the 92,551 people in the target population, 7% are African-American, 3% are Asian-Pacific Islander, 6.6% are Hispanic females ages 15-44, and 5% live at incomes under $10,000. Based on these factors, the Women's Alcoholism Center will develop and implement culturally appropriate services for African-American or Hispanic women who might be at greater risk of victimization by virtue of race or ethnicity.

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Part II Projects:

The Center for Battered Women
The Center for Battered Women, in collaboration with the Austin Independent School District and the University of Texas, will develop, implement and evaluate a primary prevention program to prevent intimate partner violence ("IPV") in elementary schools entitled **Expect Respect. Expect Respect** is a comprehensive program specifically designed for elementary school students and their parents to educate children about equality, respect and non-violence, and to present messages about relationships and violence to children which are consistent with those they receive from adults (i.e., their own

parents, parents of other children, teachers, counselors and cafeteria workers). This proposed project is unique in that it provides intensive education to all significant adults in a child's life to transform schools from increasingly violent places to peaceful places.

Expect Respect will positively influence pre-dating attitudes and prepare children for safe and healthy intimate relationships by promoting IPV prevention through a systematic approach. The proposed project activities include: 1) implementation of a 6-session IPV prevention curriculum in 5th grade classes that stresses equality, respect and non-violence; 2) incorporation of IPV prevention activities into the school day; 3) review of school policies and procedures to ensure the inclusion of non-violent values; 4) provision of educational information, consultations and referrals to parents living with IPV; 5) educator training to identify children living in IPV environments; and 6) support groups for children who currently live with or who have experienced or witnessed IPV.

The overall goal and outcome of **Expect Respect** is to reduce current and future IPV, and to prove the effectiveness of the proposed primary prevention activities for IPV prevention. The proposed project builds on, expands and complements its existing 8-year IPV prevention program targeted at dating teens, and aims to achieve the following objectives: 1) modification of attitudes which support development of IPV; 2) mitigation of trans-generational propensity to IPV; and 3) identification of targets for further assistance.

The target population are children age 11 who attend elementary school in Austin, Texas. The community has an identified high need for primary prevention services and is comprised of a large minority population which experienced 18 IPV-related deaths in the 1995-1996 time period. Child witnesses of IPV in the community are at a critical level, and to combat this problem, will target 15 schools in year 2 and 21 schools in year 3 of the proposed project. In response to the need of the target population for prevention services, the Applicant instituted a Center for Battered Women in 1977 and an Understanding Violence Against Women program in 1996.

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The Mental Health Center of Boulder County, Inc.
The Mental Health Center of Boulder County, Inc. and the Domestic Violence Prevention Steering Committee of Boulder County propose to reduce the incidence of intimate partner violence ("IPV") in Boulder County through a three-year comprehensive prevention project. The project will be coordinated by the Domestic Violence Prevention Steering Committee of the Boulder County Human Services Council which has representatives from every sector of the county. The program will build

upon previous collaborative efforts which have a twelve-year history. Throughout the course of the grant, the Mental Health Center of Boulder County, Inc. and its partners will develop mechanisms to integrate successful components into their county infrastructure so they will be sustained beyond the grant period.

The expected goals and outcomes are to change residents' knowledge, attitudes and behaviors regarding IPV by implementing the following: 1) a comprehensive, coordinated county-wide primary prevention program in schools and other key community sectors which will include public awareness media and community education campaigns directed toward children ages 5-11 and women ages 12-45 in the target population, and a follow-up referral line to direct services for victims, perpetrators and their children; 2) a reduction of the probability of IPV by providing young people the opportunity to unlearn beliefs that promote IPV, practice alternative conflict resolution techniques, and access support when violence is occurring in their lives; 3) prevention and intervention services to child witnesses of IPV and their mothers (the direct victims) through outreach services of the Boulder County Safehouse and the Longmont Coalition for Women in Crisis. Referral sources will include human service and criminal justice agencies throughout the county, as well as two other primary prevention components of the grant: school and community education programs and a media campaign referral line; 4) counseling for mothers, including non-violent discipline methods; and 5) training of high school students as peer educators.

The target population are racially diverse with Caucasian, Hispanic, African-American and Native American residents. This population was identified and selected based upon information contained in the 1993-1996 Boulder County law enforcement IPV reports. These reports provide information on the presence of weapons, alcohol or drugs, arrests, sex of defendant, recidivism, and child witnesses of IPV.

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Metropolitan Family Services
Metropolitan Family Services is the oldest non-profit, non-sectarian family service agency in metropolitan Chicago. In 1996, it provided service to approximately 100,000 families including more than 700 from Englewood, Chicago. In conjunction with its collaborating partners, the Chicago Department of Public Health ("CDPH"), the Illinois Council for the Prevention of Violence ("ICPV"), the Harris Young Women's Christian Association ("HYWCA"), People Abused Battered United ("PABU"), and the Jane Addams Center for Social Policy and Research of the University of Illinois at Chicago, Metropolitan Family Services will establish a program entitled Southside Teens About Respect ("STAR"). Additionally, Englewood Technical Preparatory Academy ("ETPA") and three of its feeder schools will serve as the primary sites for the program.

STAR will target adolescents both attending and not attending school, Englewood parents and faculty, and African-American communities in Southside Chicago. The purposes of STAR are to develop and implement primary prevention activities serving the target population and to evaluate the effectiveness of these activities in strengthening four key protective factors: 1) knowledge of the extent, causes and solutions of teen dating violence; 2) peer peace networks; 3) attitude, belief, and skill development;

and 4) use of school-based and community anti-violence resources. The working partners believe that strengthening these protective factors will reduce the onset of teen dating violence in Englewood.

STAR has six principal goals and several process and outcome objectives have been identified to address each of these goals: 1) Teen dating violence to learn about the extent and causes of teen dating violence; 2) Peer peace networks to develop and activate a network of pro-peace students; 3) Beliefs and attitudes to increase community identification of, and intolerance for, teen dating violence; 4) Resource knowledge and use to increase knowledge and use of resources for teen dating violence reduction; 5) Primary prevention to prevent the inception of teen dating violence; 6) Secondary prevention to prevent the maintenance of teen dating violence.

STAR's primary prevention activities include peer involvement, educational workshops and a media campaign. Metropolitan Family Services, HYWCA, and PABU will develop and present workshops on teen dating violence for youth at ETPA and the feeder schools, parents, and youth not attending school. ICPV will offer opportunities for Englewood youth to become involved as peer educators, mentors and community organizers. CDPH will develop and coordinate a local media campaign targeting youth, parents and faculty in Englewood and greater Chicago.

The target population in Englewood, Chicago, includes adolescents both attending and not attending school, Englewood parents and faculty, and African-American communities in Southside Chicago. The demographics of the target community includes: 1) the 7th highest rate of IPV against females ages 12-19 in the United States; 2) a predominantly African-American community comprised of a 54%/45% female/male ratio; 3) an unemployment rate of 26.8%; 4) a median income of $13,243; and 5) a large segment of the population, 46%, under 25 years of age.

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Planned Parenthood Mar Monte-East
Planned Parenthood Mar Monte-East is a community-based organization located in Sacramento, California will develop, implement and evaluate two 8-week educational programs on parenting and dating relationships. These programs are designed to prevent episodes of intimate partner violence ("IPV") in conjunction with its collaborating partners: the Sacramento County Juvenile Justice System, Women Escaping A Violent Environment ("WEAVE") and the University of California-Davis. The stated goals, objectives and outcomes of the proposed project are to: 1) increase awareness of IPV issues; and 2) improve communication and conflict resolution skills.

Implementation of the proposed project will include both male and female educators who will utilize interactive formats which contain specific content related to relationship skills, gender roles, power imbalance and the cycle of violence. There is a provision for child witnesses of IPV with the inclusion of support groups, and also includes a component for parents to enhance their relationship and child-rearing skills. Additionally, a time-series design with comparison groups will achieve the following results in the target population: 1) expansion of knowledge and attitudes related to IPV; 2) self-reports of efficacy, relationship skills and relationship violence; 3) changes in attitude and behavior toward non-violence; and 4) compilation of aggregate data on juvenile wards who are re-detained.

The target population is defined as high-risk parenting adolescents and young adult patients (females), and adolescent juvenile wards residing in non-secured facilities in Sacramento County (males) who have little linkage with human service agencies due to the lack of existing primary prevention programs. The project will be piloted and developed in trial form to allow for the expansion of programs at justice centers, and will include healthy relationship and parenting classes to women in the target population.

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Woman Against Abuse, Inc.
Woman Against Abuse, Inc. will implement and evaluate a community-based approach to prevent intimate partner violence ("IPV") among African-American adolescents in Philadelphia, Pennsylvania. Woman Against Abuse, Inc. has an extensive history of providing service to the community, and is partnering with the Dating Violence Prevention Project, Inc.; Elverson, Roosevelt, Leeds and Sayre Middle Schools; the School District of Philadelphia Board of Education; and the Office of Accountability, Assessment and Comprehensive Health Education Curriculum Office.

The project consists of five activities which are to: 1) modify, implement and evaluate the efficacy of a school-based, five-session curriculum to prevent IPV among middle school-aged youth in urban communities by utilizing the Dating Violence Prevention Project Curriculum which has been tested among high school students in Long Island, New York; 2) provide supportive counseling and advocacy to youth who may be IPV victims, perpetrators or witnesses; 3) modify, expand and evaluate the efficacy of the curriculum among youth witnesses of IPV ages 11-14 who reside at the organization's battered women's shelter with their mothers;

4) educate parents of middle school-aged youth about IPV to promote community awareness; and 5) develop in-service training for health and physical education teachers.

The target population is defined as male and female youth ages 11-14 who are at risk for violence. Over 90% of students in the target population are African-Americans, with the majority being from lower socioeconomic backgrounds. The shelter has the capacity for 61 women and children; approximately 26 residents are adolescents ages 10-13 each quarter. The shelter population is 86% African-American and 58% are second generation welfare recipients.

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POST TEST

Select the *best* answer to each of the following items. Mark your responses on the Answer Form.

1. According to the National Violence Against Women Survey (NVAWS), an estimated 5.3 million IPV victimizations occur among U.S. women ages 18 and older each year. This violence results in nearly 2.0 million injuries, more than 550,000 of which require medical attention.

a. True
b. False

2. That same group indicates that IPV victims also lose a total of nearly 8.0 million days of paid work—the equivalent of more than _____ full-time jobs—and nearly 5.6 million days of household productivity as a result of the violence.

a. 5,000
b. 20,000
c. 32,000
d. 54,000

3. In addition, they indicate that the costs of intimate partner rape, physical assault, and stalking exceed _____ each year, nearly 80%of which is for direct medical and mental health care services.

a. $700 million
b. $1.7 billion
c. $3.4 billion
d. $5.8 billion

4. Intimate partner violence—also called domestic violence, battering, or spouse abuse—is violence committed by a spouse, ex-spouse, or current or former boyfriend or girlfriend. It can occur among heterosexual or same-sex couples.

a. True
b. False

5. The consequences of IPV can last a lifetime. Abused women experience more physical health problems and have a higher occurrence of which of the following: _____ than do women who are not abused.

a. depression
b. drug and alcohol abuse
c. suicide attempts
d. All of the above

6. One problem in getting an accurate picture of the scope of this violence is that many victims do not want to report IPV because they may fear, love, depend on, or wish to protect the perpetrator. When medical care is required, women may attribute their injuries to other causes.

a. True
b. False

7. Stalking is repeated visual or physical proximity, non-consensual communication, and/or verbal, written, or implied threats directed at a specific individual that would arouse fear in a reasonable person. The stalker need not make a credible threat of violence against the victim, but the victim must experience a high level of fear or feel that they or someone close to them will be harmed or killed by the stalker.

a. True
b. False

8. IPV also results in more than _____ mental health care visits each year.

a. 500,000
b. 5.5 million
c. 10.3 million
d. 18.5 million

9. The mean medical care cost per incident of IPV physical assault is $548. The mean medical care cost per physical assault among victims who actually receive treatment is $2,665. Not all victims who reported receiving medical care used all types of medical services. Therefore, the average cost of medical care for victims receiving treatment reflects variations in service use; it does not equal the total of each of the individual service costs per physical assault.

a. True
b. False

10. While IPV-related criminal justice service use is significant, current data about unit costs do not allow for reliable, nationally representative cost estimates associated with these services.

a. True
b. False

11. In this study, some medical care costs were excluded, including _____, because there were too few victimizations resulting in these outcomes reported in the NVAWS to generate reliable cost estimates

a. home care visits
b. treatment for sexually transmitted diseases (STDs)
c. terminated pregnancies
d. All of the above

12. Victims of IPV lose time from their regular activities due to injury and mental health issues. They may also be at greater risk for other health problems, such as chronic pain and sleep disturbances, which can interfere with or limit daily functioning

a. True
b. False

13. Some risk factors for IPV victimization and perpetration are the same, and can include _____.

a. Prior history of IPV
b. Heavy alcohol and drug use
c. Witnessing or experiencing violence as a child

d. All of the above

14. Research suggests that persons with a disability are at greater risk of violence, although there is no empirical evidence that having a disability increases one's risk of intimate partner violence.

a. True
b. False

15. Results from the NVAW Survey confirm previous reports that much of the violence perpetrated against women by intimates is chronic in nature.

a. True
b. False

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