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The Association Between Protective Actions and Homicide Risk: Findings From the Oklahoma Lethality Assessment Study

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This study focuses on the relationship between women’s risk of homicide as measured by the Danger Assessment and 13 protective actions. Participants (N = 432) experienced an incident of police involved intimate partner violence (IPV) and subsequently completed a structured telephone interview. Most women in this sample experienced severe violence and were classified as being at high risk for homicide. Participants engaged in an average of 3.81 (SD = 2.73) protective actions. With the exception of the use of formal domestic violence services, women in the high-risk category were significantly more likely than women in the lower risk category to have used each of the protective actions examined. Implications for research and practice are discussed.

Keywords: intimate partner violence; domestic violence; safety planning; help-seeking; risk assessment

The most recent estimate of lifetime prevalence of intimate partner violence (IPV) for women in the United States is 35%, with 25% of women experiencing severe IPV in their lifetimes (Black et al., 2011). IPV is a risk factor for myriad emotional and physical health problems that women and children experience throughout the world (World
Repeated, escalating, and severe IPV is associated with chronic illness, disability, and IPV fatalities (Campbell, 2002; Campbell et al., 2003; Campbell, Woods, Chouaf, & Parker, 2000; Ruiz-Perez, Plazaola-Castano, & Del Rio-Lozano, 2007; Tadegge, 2008). Physical IPV has been found to precede intimate partner homicide in 65%–80% of cases (Campbell et al., 2003; Campbell, Glass, Sharps, Laughon, & Bloom, 2007; Moracco, Runyan, & Butts, 1998; Pataki, 1997; Sharps, Campbell, Campbell, Gary, & Webster, 2003). Children who witness IPV and/or intimate partner homicide are at risk for being fatally wounded during IPV incidents (Sillito & Salari, 2011).

A primary goal of IPV early responders, service providers, and state domestic violence fatality review teams is to reduce and prevent further IPV injury and homicide and to ensure the safety of survivors and their children. Despite the clarity of this goal and the ubiquity of intimate partner homicide, there are few studies that examine the association between protective actions and safety, danger, or risk. Therefore, this study focuses on the intersection between women’s risk of reassault/homicide as measured by the Danger Assessment (Campbell et al., 2003) and protective actions among women who have had an incident of police involved IPV. We specifically seek to answer three research questions: (a) What protective actions are being taken by women in this sample and how are various protective actions related? (b) What is the relationship between protective actions and experiences of violence? and (c) What is the relationship of protective actions to risk of reassault/homicide controlling for experiences of violence and other demographic, mental health, and relationship characteristics previously found to be associated with IPV?

HELP-SEEKING AMONG WOMEN EXPOSED TO INTIMATE PARTNER VIOLENCE

Research has shown that women exposed to IPV are active in seeking help and in devising an array of safety strategies to protect themselves and their children (Gondolf & Fisher, 1988; Goodkind, Sullivan, & Bybee, 2004; Goodman, Dutton, Vankos, & Weinfurt, 2005; Nurius, Macy, Nwabuzor, & Holt, 2011). For example, the mean number of protective strategies used by a sample of 160 urban mothers who were experiencing violence was 16.19 out of a possible 28 strategies; most commonly, women reported talking to their abusive partner, calling police, avoidance, and trying to end the relationship (Goodkind et al., 2004). Women who were in more danger from their abusive partner engaged in the highest number and widest variety of protective strategies (Goodkind et al., 2004). Most of the protective strategies that the women engaged in fell into one of five categories: placating, resisting, escape planning, informal help-seeking, and formal help-seeking (Goodkind et al., 2004).

No one strategy is effective for everyone, but women report that contacting a domestic violence service provider and going to a domestic violence shelter are helpful or make the situation better in most cases (Goodkind et al., 2004; Goodman et al., 2005), and shelter services were shown to be most effective in reducing severe and moderate reassault in one prospective study (Campbell, O’Sullivan, Roehl, & Webster, 2005). However, a minority of women seek out these formal avenues of assistance; in published research, the percentage of women accessing shelter services ranges from 3% to 36% (Brookoff, O’Brien, Cook, Thompson, & Williams, 1997; Gondolf, 1998; Goodkind et al., 2004; Goodman, Dutton, Weinfurt, & Cook, 2003; Hutchinson & Hirschel, 1998; Wiist & McFarlane, 1998), and the percentage of women accessing domestic violence services ranges from 4.8% to 68% (Brookoff et al., 1997; Coker, Derrick, et al., 2000; Gondolf, 1998; Goodkind et al., 2004;
Goodman et al., 2003; Hutchinson & Hirschel, 1998; Macy, Nurius, Kernic, & Holt, 2005). Among samples of women not recruited from shelters or domestic violence service agencies, 3.0%–8.9% accessed shelter services (Brookoff et al., 1997; Gondolf, 1998; Hutchinson & Hirschel, 1998; Wiist & McFarlane, 1998) and 4.8%–38.0% of women report seeking domestic violence services (Brookoff et al., 1997; Coker, Derrick, et al., 2000; Gondolf, 1998; Hutchinson & Hirschel, 1998; Macy et al., 2005). These women were generally recruited after coming into contact with the police or seeking an order of protection. A single study examined domestic violence service usage among a sample of women who were not seeking help for IPV in a formal criminal justice or social service setting (10.9% had used domestic violence services; Coker, Derrick, et al., 2000), and a single study examined shelter usage among a sample of women seeking prenatal health care (3% had used shelter services; Wiist & McFarlane, 1998).

Women appear to use the police more often, with between 6.7% and 56.0% reporting that the police had been called because of domestic violence among women not seeking help for IPV from the criminal justice or social service systems; it is worth noting that the top of this range may be lower when including only women who called the police themselves (Bachman & Coker, 1995; Catalano, Smith, Snyder, & Rand, 2009; Kantor & Straus, 1990; West, Kantor, & Jasinski, 1998). As Kantor and Straus (1990) point out, the higher numbers in this range were gathered from the National Crime Victimization Survey and, therefore, may reflect that a higher proportion of women report their victimization to the police if they consider domestic violence a crime. When examining samples of women who were seeking social service assistance because of IPV, the proportion of women who have received police intervention is in the middle to high end of this range (Berk, Berk, Newton, & Loseke, 1984; McFarlane, Soeken, Reel, Parker, & Silva, 1997; Wiist & McFarlane, 1998). Reports of the effectiveness of calling the police are mixed. Research conflicts on the deterrent effects of arrest (Heckert & Gondolf, 2004; Maxwell, Garner, & Fagan, 2001), but arrest has been shown to protect against fatal IPV (Campbell et al., 2003). When relying on victim self-report, although 74.8% of one sample found contacting law enforcement to be helpful (Goodman et al., 2003), only 42% of another sample stated that calling the police made the situation better (Goodkind et al., 2004).

As the severity of physical violence increases, so does formal help-seeking; this includes the usage of domestic violence services (Coker, Derrick, et al., 2000; Gondolf, 1998; Henning & Klesges, 2002; Macy et al., 2005), shelter (Gondolf, 1998; West et al., 1998), and police services (Bonomi, Holt, Martin, & Thompsonon, 2006; Gondolf, 1998; Johnson, 1990; West et al., 1998). Women are more likely to use formal services as the frequency of physical assault increases (Berk et al., 1984; Johnson, 1990; Macy et al., 2005) and when they have experienced sexual assault (Henning & Klesges, 2002; Macy et al., 2005), injury (Bachman & Coker, 1995; Bonomi et al., 2006; Henning & Klesges, 2002; Macy et al., 2005), or psychological abuse (Bonomi et al., 2006; Henning & Klesges, 2002; Macy et al., 2005). Research examining the frequency of calls to the police reports conflicting results; one study found that women are likely to call the police more often when they experience severe sexual IPV and/or severe physical IPV (Bonomi et al., 2006), whereas another study concluded that the severity of violence was not significantly different among those who made one call to the police and those that made multiple calls (Houry et al., 2008). Similar conflicting findings have been found regarding previous calls to the police; Berk and colleagues (1984) found that women who had called the police for IPV in the past were more likely to call the police again, whereas Bachman and Coker (1995) found that women were more likely to report a first-time offense.
Women who seek out formal domestic violence services may also have greater biopsychosocial needs, such as depression, negative social relationships, and poor physical health (Macy et al., 2005). Demographic and relationship variables have also been related to formal help-seeking. Women who are married or formerly married, older, have higher socioeconomic status, and higher education are more likely to seek formal services (Henning & Klesges, 2002). African American women experiencing IPV are more likely than White women to call the police for help (Bachman & Coker, 1995), whereas White women are more likely than African American women to seek domestic violence services (Henning & Klesges, 2002). When children witness abuse or are present in the home where abuse occurs, assistance from police and domestic violence services is more likely to be sought (Berk et al., 1984; Henning & Klesges, 2002). Women who are concerned about privacy, are afraid of their partner’s retaliation, or want to protect their abuser are less likely to call the police (Felson, Messner, Hoskin, & Deane, 2002).

Although formal help-seeking has been shown to be helpful, most women who experience violence use informal social support networks (Beeble, Bybee, Sullivan, & Adams, 2009; Bosch & Schumm, 2008; Feder et al., 2011; Goodman & Smyth, 2011; Jacinto, Turnage, & Cook, 2010; Latta & Goodman, 2011; Macy, Johns, Rizo, Martin, & Giattina, 2011; Nurius, Macy, Nwabuzor, & Holt, 2011; Paranjape & Kaslow, 2010; Song, 2012). Informal support has been demonstrated to be protective against reabuse among women not experiencing severe violence and for those with more emotional and material resources and social support networks (Goodman et al., 2003). Women who are experiencing severe abuse or are at higher risk for homicide have been found to engage in emergency safety planning strategies—such as hiding money or valuables (Campbell et al., 2005; Goodkind et al., 2004). These emergency safety planning strategies tend to be useful, with more than half of women reporting that they are helpful or make the situation better (Goodman et al., 2003; Goodkind et al., 2004). The informal strategies of placating and resisting (e.g., fighting back physically, sleeping separately) have been associated with higher levels of reabuse (Goodman et al., 2003).

Determining which strategies are the most effective at keeping women and children safe is an important goal of research and can inform intervention. Research suggests that low-cost, clear, simple assessments and referrals—such as teaching women safety strategies over the telephone—can be effective in helping women in abusive relationships enhance their safety skills (McFarlane et al., 2004). Although referral has been shown to increase safety behaviors and decrease violent victimization, it may be more protective to include assessment and case management; the assessment process itself may be a helpful intervention that increases victim awareness of violence levels and safety behaviors (McFarlane, Groff, O’Brien, & Watson, 2006). Theoretically, there may be an optimal time for intervention shortly after an abusive episode when women are likely to believe that violence will not cease and are more likely to reach out for help (Curnow, 1997). Women have reported no longer practicing safety behaviors once they feel safer because they want to forget about abusive incidents (McFarlane et al., 2004).

This study seeks to examine the protective strategies used by women who have experienced IPV and subsequent police involvement. In particular, given prior research finding that women who access services engage in multiple protective actions (Goodkind et al., 2004; Goodman et al., 2005), it is expected that various protective strategies will co-occur. It is also expected that experiences of severe violence will be associated with the usage of protective strategies because of prior research that has found that the usage of formal services increases as the severity of violence increases (Bonomi et al., 2006; Coker, Derrick,
Risk and Protective Actions

et al., 2000; Gondolf, 1998; Henning & Klesges, 2002; Johnson, 1990; Macy et al., 2005; West et al., 1998). Finally, given the extant literature (Goodkind et al., 2004), it is expected that increased risk for reassault/homicide as measured by the Danger Assessment will be associated with the increased usage of protective strategies. It is further expected that this relationship will remain significant in multivariate analyses when controlling for variables that have been previously associated with help-seeking, IPV, and homicide risk. These include demographic/relationship characteristics, violence and injury, women’s subjective feelings of fear and safety, and the psychological effects of abuse (anxiety, depression).

METHOD

Sample Recruitment and Data Collection

Structured telephone interviews were conducted with female victims of IPV who were referred to the research study by police officers at the scene of domestic violence incidents in seven police jurisdictions in one Southwestern state. Women were eligible for referral if the responding officer believed that she was the victim of IPV, the police had been to that location or had encountered the victim/perpetrator before, or the officer believed that the abuser was dangerous. Eligible victims were asked if researchers could contact them using an institutional review board (IRB)–approved script. If the victim responded that researchers could contact her, her information (name, telephone number, safe time to call) was forwarded to researchers (see Messing et al., 2011). On average, referrals were contacted within 1 day of their receipt by the research team; women were asked to participate in a confidential telephone interview lasting 45 min to 1 hr. All interviewers received extensive training on maintaining victim safety (see Wilson et al., 2011). To thank the participant for her time, a $15 gift card was provided. This study was approved by the IRBs of the University of Oklahoma Health Sciences Center, Arizona State University, Johns Hopkins University, the Oklahoma State Department of Health, and the Cherokee Nation.

Police departments referred 1,137 women over approximately 18 months. Of these referrals, interviewers were unable to contact 486 (42.74%) women because of unanswered, disconnected, or wrong numbers, and 47 (4.1%) women were not eligible to participate in the study (e.g., younger than 18 years old or not a victim of IPV). There were 604 eligible referrals contacted; of these, 440 (72.8%) women agreed to participate in the research study and were interviewed by telephone. Because of missing data on pertinent variables (n = 8, 1.8%), the final sample size is 432.

Measures: Dependent Variable

Risk for Reassault/Homicide. The Danger Assessment (DA), a 20-item clinical and research instrument designed to identify women at risk for intimate partner homicide, was used to assess risk. The DA has been shown to be predictive of intimate partner reassault, severe reassault, and femicide in eight separate research studies (Campbell et al., 2005; Campbell et al., 2003; Campbell, Webster, & Glass, 2009; Goodman, Dutton, & Bennett, 2000; Heckert & Gondolf, 2004; Hilton, Grant, Rice, Houghton, & Eke, 2008; Hilton et al., 2004; Weisz, Tolman, & Saunders, 2000). When examining the ability of the DA to predict reassault, the average receiver operating characteristic area under the curve weighted by sample size is 0.618 (Messing & Thaller, 2013). Items on the DA include an increase in the severity and/or frequency of violence, gun ownership, separation, partner unemployment,
partner use of a deadly weapon, threats to kill, partner avoidance of arrest for domestic violence, having a child that is not her partner’s child, forced sex, strangulation, partner use of drugs, partner alcohol abuse, controlling behaviors, extreme jealousy, abuse during pregnancy, partner threats to commit suicide, threats to harm children of the victim, victim belief that her partner is capable of killing her, and partner stalking and/or harassment. These items are weighted and summed to produce an overall score ranging up to 37 where higher numbers indicate more risk (http://www.dangerassessment.org). Scores are then placed into the following categories: variable danger (0–7), increased danger (8–13), severe danger (14–17), and extreme danger (18 or higher). For this analysis, given both the distribution of participants across the categories of risk (12.73%, variable danger; 24.54%, increased danger; 21.53%, severe danger; and 41.2%, extreme danger) and the interpretation of danger levels, participants with scores in the variable and increased danger categories (13 and below) were grouped together as “lower risk” (= 0) and participants in the severe and extreme danger categories (14 and above) were grouped together as “high risk” (= 1).

**Measures: Independent Variables**

**Victim Characteristics.** Participants were asked to report their age, racial/ethnic background, employment status, and educational achievement. Age in years was used as a linear variable. Participants were able to indicate as many racial/ethnic identities as appropriate; these were then collapsed into five mutually exclusive categories: White, African American, Latina, Native American, and Other/multiracial. Employment status was dichotomized, and participants working either part-time or full-time were coded as “1,” whereas participants not working part-time or full-time were coded as “0.” Education was also dichotomized; participants who reported completing high school (or the equivalent) or lower were coded as “0,” whereas participants who reported attending any college or higher were coded as “1.”

**Family and Relationship Characteristics.** Participants reported their legal marital status as single, married, or separated/divorced; as the largest group, single was the referent. Because a person’s legal marital status does not always describe their relationship, participants were also asked whether they currently lived with their abusive partner. An affirmative response was coded as “1” and a negative response was coded as “0.” Participants were asked how many children were currently living in their household, and this question was dichotomized to group participants who had children living in their household (= 1) and participants who did not have children living in their household (= 0). Participants were also asked if they were currently pregnant; those who responded yes were coded as “1” and those that responded no were coded as “0.”

**Intimate Partner Violence and Injury.** An adapted version of the revised Conflict Tactics Scale (CTS-2) was used to assess experiences of IPV, including questions from the physical assault subscale, injury subscale, and sexual coercion subscale (Straus, Hamby, Boney-McCoy, & Sugarman, 1996). Responses were dichotomized into “this has happened” (= 1) and “this has never happened” (= 0). Additional injury items were taken from the Risk Assessment Validation Study (Campbell et al., 2005). The following three items were combined to examine loss of consciousness because of violence: “Have you ever lost consciousness because of [your partner] choking you?”, “Have you ever blacked out from being hit on the head?” and “Have you lost consciousness for more than an hour because of head injuries?” An affirmative response to any of these questions resulted in a “yes” (= 1) indicator for loss of consciousness because of violence and a negative response...
to all of these questions resulted in a “no” (= 0) indicator for this variable. Two additional questions about near-lethal violence were asked: “Has your partner tried to kill you?” and “Has your partner ever done anything that might have killed you or nearly killed you whether or not he intended to?” These questions were combined; an affirmative response to either or both of these questions resulted in a yes (= 1) indicator for near-lethal violence and a negative response to both questions resulted in a no (= 0) indicator.

**Psychological Experience of Abuse.** Items from the Women’s Experience of Battering Scale (Smith, Earp, & DeVellis, 1995) were used to assess women’s psychological experience of abuse. The following statements were provided to participants: “I hide the truth from others because I am afraid” and “My partner makes me feel unsafe even in my own home.” Participants were asked to respond to these statements using a 6-point Likert scale where “1” indicates that the participant agrees strongly and “6” indicates that the participant disagrees strongly. These items were dichotomized with “1” indicating agreement with the statement (agree a little, agree somewhat, agree strongly) and “0” indicating disagreement with the statement (disagree a little, disagree somewhat, disagree strongly).

**Mental Health.** Participants were asked single items about their feelings of depression and anxiety in the past month. Feelings of depression were assessed with the following question: “During the past month, how much of the time have you been bothered by feeling down, depressed, or hopeless?” Feelings of anxiety were assessed with the following question: “During the past month, how much of the time have you felt anxious or nervous?” Participants were asked to respond using a 5-point Likert scale, and these responses were dichotomized into 1 = most/all of the time and 0 = none/a little/some of the time.

**Protective Actions.** Protective actions were assessed using an adapted version of McFarlane and colleagues’ (2004) Safety-Promoting Behavior Checklist. Participants were asked to answer yes (= 1) or no (= 0) as to whether they had taken any of the following actions during the relationship with their abusive partner: (1) hidden money, an extra set of house keys, car keys, or another belonging or object that may help you to flee your relationship; (2) established a code with family or friends (to let them know when you are in trouble); (3) asked neighbors to call the police if violence begins; (4) removed or hidden their partner’s weapons; (5) made available paperwork such as Social Security numbers, rent and utility receipts, birth certificates, bank account numbers, driver’s license or identification, or insurance policies or numbers; (6) hidden valuable jewelry; (7) hidden extra money; and (8) made available a hidden bag with extra clothing. We added the following dichotomous (yes/no) questions regarding protective actions: (9) “Have you ever applied for an order of protection/restraining order against your partner?” (10) “Have you ever received services related to domestic violence in this relationship?” (11) “Have you gone someplace where your partner couldn’t find you or see you?” (12) “Has there been a period in the 6 months before the police came when you didn’t see your partner for a while because one or both of you chose not to?” and (13) “Have you ever been treated by a doctor or nurse for injuries or trauma that your partner caused in this relationship?” Women who responded that they had received formal services related to IPV in their relationship (Question 10) were able to specify whether they had received shelter services, counseling services, safety planning services, and/or legal services.

**Analysis**

The characteristics of the sample—including participant and relationship characteristics, participant experiences of violence, risk for lethality, and protective actions—are described using univariate analyses. To assess the co-occurrence of protective actions and the
relationship of protective actions to experiences of severe violence and injury, chi-square analyses were conducted. Chi-square analyses were also conducted to examine the bivariate relationship between protective actions and lower versus high risk on the DA.

To examine the relationship between risk and protective actions while controlling for other potentially significant associations, logistic regression was used. Independent variables, which were primarily ordinal in nature, were dichotomized to aid with interpretation of the data. The dependent variable, lower versus high risk on the DA, was included in a logistic regression model with each potential independent variable alone; those variables significant at the $p < .10$ level were examined for inclusion in the final multivariate logistic regression model. With the exception of receiving “services related to domestic violence” (referred to as formal services related to IPV), all of the help-seeking variables were significantly related to being in the high-risk category on the DA. Because of collinearity (see Table 1), only protective actions with the strongest relationship to the dependent variable were included in the final model. Given previous research showing associations between IPV and/or protective actions and age (Black et al., 2011), marital status (Coker, Smith, McKeown, & King, 2000; Henning & Klesges, 2002), education and employment (Henning & Klesges, 2002; Smith, Thornton, DeVellis, Earp, & Coker, 2002), having children (Berk et al., 1984; Henning & Klesges, 2002), and mental health (Golding, 1999; Macy, Giattina, Sangster, Crosby, & Montijo, 2009), these variables were included in the final model as control variables, although they were not significantly related to the outcome of risk on the DA. Also, given previous literature demonstrating that women are more likely to be right than wrong in their assessment of risk (Bell, Cattaneo, Goodman, & Dutton, 2008; Campbell et al., 2009; Cattaneo, Bell, Goodman, & Dutton, 2007; Cattaneo & Goodman, 2003; Connor-Smith, Henning, Moore, & Holdford, 2010), and suggestions to include women’s own assessments of risk to compliment standardized risk assessment (Campbell et al., 2004), we have included women’s subjective feelings of fear and safety in the final model as a proxy for their assessment of risk in the relationship. Because these data are cross-sectional, all reported odds ratios are measures of association.

RESULTS

Univariate Analyses

Demographic, relationship, and violence characteristics reported by the participants are provided in Table 2. Participants ranged in age from 18 to 62 years with a mean age of 32.54 ($SD = 9.45$) years. The largest racial/ethnic group was White (42.13%), followed by African American (30.79%), Native American (10.42%), Other or multiracial (10.19%), and Latina (6.48%). More than half of the participants describe their marital status as single (57.64%), and less than one-quarter of participants’ report that their abusive partner is living with them (21.76%). Nearly 70% of participants report that they have children living in their household (67.82%). Approximately half of the participants have attended some college or higher (49.54%), and less than half of participants are employed part-time or full-time (42.36%). There were 28 participants who reported that they were currently pregnant at the time of the interview.

Many participants in this research study had experienced severe IPV; 45.14% ($n = 195$) reported experiencing near-lethal violence, 73.55% ($n = 317$) reported that their partner had strangled or attempted to strangle them, 67.13% ($n = 288$) reported that their partner
### TABLE 1. Chi-Square Tests Examining the Relationship Between the Various Measured Protective Actions

<table>
<thead>
<tr>
<th>Variable (Number Indicates Which Column Contains the Same Variable)</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
<th>10</th>
<th>11</th>
<th>12</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Hidden money, keys, other belongings/objects</td>
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<tr>
<td>2. Established a code with family/friends</td>
<td>35.24**</td>
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<td>3. Asked neighbors to call police if violence begins</td>
<td>16.30**</td>
<td>9.08**</td>
<td></td>
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<td></td>
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<tr>
<td>4. Removed/hidden weapons</td>
<td>21.21**</td>
<td>26.24**</td>
<td>6.30*</td>
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<tr>
<td>5. Made available paperwork</td>
<td>54.21**</td>
<td>10.98**</td>
<td>15.68**</td>
<td>25.23**</td>
<td></td>
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<tr>
<td>6. Hidden valuable jewelry</td>
<td>14.53**</td>
<td>8.96**</td>
<td>3.73†</td>
<td>16.79**</td>
<td>20.01**</td>
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<tr>
<td>7. Hidden extra money</td>
<td>90.46**</td>
<td>21.24**</td>
<td>11.65**</td>
<td>25.87**</td>
<td>37.15**</td>
<td>28.66**</td>
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*(Continued)*
<table>
<thead>
<tr>
<th>Variable</th>
<th>Chi-Square Tests</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1</td>
</tr>
<tr>
<td>8. Packed a bag with extra clothing</td>
<td>57.21**</td>
</tr>
<tr>
<td>9. Applied for an order of protection</td>
<td>6.45*</td>
</tr>
<tr>
<td>10. Received formal services related to IPV</td>
<td>19.14**</td>
</tr>
<tr>
<td>11. Gone someplace partner can’t find you</td>
<td>9.99**</td>
</tr>
<tr>
<td>12. Didn’t see your partner for a while by choice</td>
<td>1.07</td>
</tr>
<tr>
<td>13. Treated by a doctor or nurse for IPV injuries</td>
<td>7.07**</td>
</tr>
</tbody>
</table>

Note. IPV = intimate partner violence.  
†p < .10. *p < .05. **p < .01.
had beaten them up, 35.19% (n = 152) reported that their partner had threatened them with or used a lethal weapon against them, and 26.16% (n = 113) reported that their partner forced them to have sex against their will. The vast majority of participants (n = 369, 85.42%) reported that their partner had perpetrated at least one of these violent acts, with 66.43% reporting that their partner perpetrated two or more of these violent acts,
and 37.06% of participants reporting that their partner perpetrated three or more of these violent acts. According to the DA, 62.73% of participants are at high risk for homicide (severe/extreme danger). Approximately two-thirds of participants reported that their partner makes them feel unsafe in their own home (65.05%) and/or that they are afraid of their partner (66.44%). Slightly less than half of the participants in this study reported feelings of depression (42.13%) and/or anxiety (43.75%).

Participants engaged in 0–12 protective actions as a result of the violence in their relationship; the vast majority (89.12%) of participants engaged in one or more protective actions, with a mean of 3.81 ($SD = 2.73$). When examining only participants in the high-risk category, 96.68% of participants had engaged in one or more protective actions. The most used protective action was hiding money, keys, or other belongings or objects (47.92%), followed by hiding extra money (42.59%) and not seeing their partner for a while by choice (42.36%). The least used protective actions were hiding valuable jewelry (15.74%), removing or hiding weapons (15.74%), and receiving formal services for IPV (16.98%).

**Bivariate Analysis**

With the exception of the use of formal services related to IPV, women in the high-risk category were significantly more likely than women in the lower risk category to have used each of the protective actions that they were asked about. Each significant chi-square test presented in Table 3 indicates that women in the high-risk category were more likely to engage in a particular protective strategy. For example, approximately 55% of women in the high-risk group had hidden money, keys, or other belongings or objects, whereas a significantly ($\chi^2 = 16.10, p < .001$) smaller proportion of women in the lower risk group had done so (35%). There is a positive correlation between the number of protective actions used and the linear DA score ($r = .4625, p < .001$). In addition, the number of protective actions that a woman engages in is positively correlated with the number of severe violent acts (strangulation, forced sex, use or threats with weapons, being beaten up) that have been perpetrated against her by her partner ($r = .3710, p < .001$). Each significant chi-square analysis shown in Table 4 demonstrates that women who have had any experience of severe violence are more likely to engage in 10 (out of 13) protective actions. Furthermore, engaging in one or more protective actions is significantly associated with fear ($\chi^2 = 43.79, p < .001$) and feeling unsafe ($\chi^2 = 40.22, p < .001$).

In addition to reporting the results of the multivariate logistic regression, Table 5 reports the bivariate associations between independent and dependent variables in the Unadjusted Odds Ratio column. In bivariate analyses, Latina women were less likely to be in the high-risk category, but this association was not significant in the multivariate analysis. Perhaps in this case, the influence of ethnicity was subsumed by the influence of another independent variable. For example, Latinas were significantly less likely to have attended any college ($\chi^2 = 12.02, p < .001$) and significantly less likely to have lost consciousness because of violence ($\chi^2 = 4.25, p < .05$) than women of another race/ethnicity in this sample. Feeling depressed or anxious most or all of the time and being afraid are related to being in the high-risk category in bivariate analyses, but these relationships are no longer significant with the addition of other variables in the model.

A participant’s current pregnancy is associated with being in the high-risk category in bivariate analysis ($OR = 3.81, p < .05$); because these participants have called the police
<table>
<thead>
<tr>
<th>Protective Actions: The participant has . . .</th>
<th>Lower Risk Group (n = 161)</th>
<th>High-Risk Group (n = 271)</th>
<th>Chi-Square Analysis</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hidden money, keys, other belongings or objects</td>
<td>Yes: n (%)</td>
<td>Yes: n (%)</td>
<td>( \chi^2 )</td>
</tr>
<tr>
<td>Established a code with family/friends</td>
<td>57 (35.40)</td>
<td>150 (55.35)</td>
<td>( \chi^2 = 16.10^{***} )</td>
</tr>
<tr>
<td>Asked neighbors to call the police if violence begins</td>
<td>25 (15.53)</td>
<td>84 (31.00)</td>
<td>( \chi^2 = 12.81^{***} )</td>
</tr>
<tr>
<td>Removed/hidden weapons</td>
<td>31 (19.25)</td>
<td>98 (36.16)</td>
<td>( \chi^2 = 13.79^{***} )</td>
</tr>
<tr>
<td>Made available paperwork</td>
<td>39 (24.22)</td>
<td>118 (43.54)</td>
<td>( \chi^2 = 16.29^{***} )</td>
</tr>
<tr>
<td>Hidden valuable jewelry</td>
<td>16 (9.94)</td>
<td>52 (19.19)</td>
<td>( \chi^2 = 6.52^{*} )</td>
</tr>
<tr>
<td>Hidden extra money</td>
<td>50 (31.06)</td>
<td>134 (49.45)</td>
<td>( \chi^2 = 13.97^{***} )</td>
</tr>
<tr>
<td>Packed a bag with extra clothing</td>
<td>23 (14.29)</td>
<td>82 (30.26)</td>
<td>( \chi^2 = 14.01^{***} )</td>
</tr>
<tr>
<td>Applied for an order of protection</td>
<td>20 (12.42)</td>
<td>78 (28.78)</td>
<td>( \chi^2 = 15.41^{***} )</td>
</tr>
<tr>
<td>Received formal services related to IPV</td>
<td>23 (14.29)</td>
<td>50 (18.45)</td>
<td>( \chi^2 = 1.25, ns )</td>
</tr>
<tr>
<td>Gone someplace partner can’t find you</td>
<td>43 (26.71)</td>
<td>124 (45.76)</td>
<td>( \chi^2 = 15.45^{***} )</td>
</tr>
<tr>
<td>Not seen partner for a while by choice</td>
<td>49 (30.43)</td>
<td>134 (49.45)</td>
<td>( \chi^2 = 14.95^{***} )</td>
</tr>
<tr>
<td>Been treated by a doctor or nurse for injuries because of IPV</td>
<td>23 (14.29)</td>
<td>74 (27.31)</td>
<td>( \chi^2 = 9.83^{**} )</td>
</tr>
</tbody>
</table>

Note. IPV = intimate partner violence.  
* \( p < .05 \)  ** \( p < .01 \)  *** \( p < .001 \).
because of violence during pregnancy, and a risk factor on the DA is being beaten while pregnant, this variable was determined to be collinear with the outcome and excluded from the multivariate analysis. Thirteen (46.43%) of the 28 participants who reported that they were currently pregnant responded yes to the following DA question: “Have you ever been beaten by him while you were pregnant?”

Multivariate Logistic Regression

In the multivariate analysis (see Table 5, Adjusted Odds Ratio column), African American women were at nearly 2 times higher odds of being in the high-risk category than White women and Native American women had 2.55 times higher odds of being in the high-risk category in the multivariate analysis. Although marital status was not related to risk category, women who currently lived with their intimate partner had approximately half the odds of being in the high-risk category.

Women whose partners have perpetrated near-lethal violence have nearly 3 times the odds of being in the high-risk category on the DA. Participants who have lost consciousness because of violence have nearly 2 times the odds of being in the high-risk category. Women in the high-risk category have more than 3 times the odds of feeling unsafe in their home.

Finally, four protective actions are included in the multivariate analysis. Women who have established a code with family or friends have 2 times the odds of being in the high-risk category.

### Table 4. The Relationship Between Severe Violence and Protective Actions

<table>
<thead>
<tr>
<th>Protective Action</th>
<th>(\chi^2) Examining the Relationship of the Protective Action to Any Experience of Severe Violence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hidden money, keys, other belongings/objects</td>
<td>(\chi^2 = 9.32, p &lt; .01)</td>
</tr>
<tr>
<td>Established a code with family/friends</td>
<td>(\chi^2 = 4.68, p &lt; .05)</td>
</tr>
<tr>
<td>Asked neighbors to call police if violence begins</td>
<td>(\chi^2 = 5.41, p &lt; .05)</td>
</tr>
<tr>
<td>Removed/hidden weapons</td>
<td>(\chi^2 = 13.78, p &lt; .01)</td>
</tr>
<tr>
<td>Made available paperwork</td>
<td>(\chi^2 = 6.36, p &lt; .05)</td>
</tr>
<tr>
<td>Hidden valuable jewelry</td>
<td>(\chi^2 = 0.12, ns)</td>
</tr>
<tr>
<td>Hidden extra money</td>
<td>(\chi^2 = 8.92, p &lt; .01)</td>
</tr>
<tr>
<td>Packed a bag with extra clothing</td>
<td>(\chi^2 = 10.75, p &lt; .01)</td>
</tr>
<tr>
<td>Applied for an order of protection</td>
<td>(\chi^2 = 4.19, p &lt; .05)</td>
</tr>
<tr>
<td>Received formal services related to IPV</td>
<td>(\chi^2 = 0.35, ns)</td>
</tr>
<tr>
<td>Gone someplace partner can’t find you</td>
<td>(\chi^2 = 4.24, p &lt; .05)</td>
</tr>
<tr>
<td>Didn’t see your partner for a while by choice</td>
<td>(\chi^2 = 0.22, ns)</td>
</tr>
<tr>
<td>Treated by a doctor or nurse for IPV injuries</td>
<td>(\chi^2 = 13.26, p &lt; .01)</td>
</tr>
</tbody>
</table>

*Note. IPV = intimate partner violence.*
TABLE 5. Multivariate Logistic Regression

<table>
<thead>
<tr>
<th>Variable</th>
<th>Category of Variable</th>
<th>Unadjusted Odds Ratio</th>
<th>Adjusted Odds Ratio</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>Years (linear)</td>
<td>1.02</td>
<td>1.01</td>
</tr>
<tr>
<td>Race/ethnicity</td>
<td>White Referent</td>
<td>Referent</td>
<td>Referent</td>
</tr>
<tr>
<td></td>
<td>African American</td>
<td>1.18</td>
<td>1.94*</td>
</tr>
<tr>
<td></td>
<td>Native American</td>
<td>1.17</td>
<td>2.55*</td>
</tr>
<tr>
<td></td>
<td>Latina</td>
<td>0.38*</td>
<td>0.79</td>
</tr>
<tr>
<td></td>
<td>Other</td>
<td>0.84</td>
<td>1.02</td>
</tr>
<tr>
<td>Legal marital status</td>
<td>Single Referent</td>
<td>Referent</td>
<td>Referent</td>
</tr>
<tr>
<td></td>
<td>Married</td>
<td>0.89</td>
<td>0.87</td>
</tr>
<tr>
<td></td>
<td>Separated/ divorced</td>
<td>1.22</td>
<td>0.94</td>
</tr>
<tr>
<td>Partner living with participant</td>
<td>Yes</td>
<td>0.38***</td>
<td>0.53*</td>
</tr>
<tr>
<td>Education</td>
<td>High school degree or less Referent</td>
<td>Referent</td>
<td>Referent</td>
</tr>
<tr>
<td></td>
<td>Some college or higher</td>
<td>1.12</td>
<td>1.20</td>
</tr>
<tr>
<td>Victim employed: part-/full-time</td>
<td>Yes</td>
<td>0.93</td>
<td>1.00</td>
</tr>
<tr>
<td>Children living in the household</td>
<td>Yes</td>
<td>1.00</td>
<td>0.90</td>
</tr>
<tr>
<td>Partner has perpetrated near-lethal violence</td>
<td>Yes</td>
<td>5.76***</td>
<td>2.73***</td>
</tr>
<tr>
<td>Lost consciousness because of violence</td>
<td>Yes</td>
<td>3.52***</td>
<td>1.93*</td>
</tr>
<tr>
<td>Past month: down, depressed, or hopeless</td>
<td>None/a little/ some of the time Referent</td>
<td>Referent</td>
<td>Referent</td>
</tr>
<tr>
<td></td>
<td>Most/all of the time</td>
<td>1.85**</td>
<td>1.12</td>
</tr>
<tr>
<td>Past month: anxious, nervous</td>
<td>None/a little/ some of the time Referent</td>
<td>Referent</td>
<td>Referent</td>
</tr>
<tr>
<td></td>
<td>Most/all of the time</td>
<td>1.73**</td>
<td>1.34</td>
</tr>
<tr>
<td>Participant feels unsafe in her home</td>
<td>Yes</td>
<td>6.40***</td>
<td>3.21***</td>
</tr>
<tr>
<td>Participant is afraid of her partner</td>
<td>Yes</td>
<td>3.59***</td>
<td>1.40</td>
</tr>
<tr>
<td>Established a code with family/friends</td>
<td>Yes</td>
<td>2.44***</td>
<td>2.07*</td>
</tr>
<tr>
<td>Participant has removed/hidden weapons</td>
<td>Yes</td>
<td>9.45***</td>
<td>3.39*</td>
</tr>
<tr>
<td>Participant applied for an order of protection</td>
<td>Yes</td>
<td>2.85***</td>
<td>1.98*</td>
</tr>
<tr>
<td>Chose not to see partner for some time</td>
<td>Yes</td>
<td>2.24***</td>
<td>2.07**</td>
</tr>
<tr>
<td>Pseudo $R^2$</td>
<td></td>
<td></td>
<td>.2866</td>
</tr>
<tr>
<td>$N$</td>
<td></td>
<td></td>
<td>432</td>
</tr>
</tbody>
</table>

*p < .05. **p < .01. ***p < .001.
risk category on the DA. Women who have removed or hidden weapons from their partner have 3.39 times the odds of being in the high-risk category. Participants who applied for an order of protection have nearly 2 times the odds of being in the high-risk category. Women who chose not to see their partner had 2 times the odds of being in the high-risk category.

**DISCUSSION**

This study examined the relationship between protective actions and risk as measured by the DA, a clinical and research tool that has been shown to be predictive of reassault, attempted femicide, and femicide in previous research studies (Campbell et al., 2005; Campbell et al., 2009; Campbell et al., 2003; Goodman et al., 2000; Heckert & Gondolf, 2004; Hilton et al., 2008; Hilton et al., 2004; Weisz et al., 2000). Women who experienced police involved IPV and subsequently participated in this research study engaged in several protective actions. Many of the protective actions measured in this study were related to one another, demonstrating that women often engage in multiple strategies to keep themselves and their children safe. Women in the high-risk group were more likely to engage in all of the protective actions except receiving formal services for IPV. No previous peer-reviewed research has examined the relationship of protective actions to risk as measured by a validated risk assessment instrument, making this analysis a unique contribution to the literature.

Women in the high-risk category were not more likely to seek formal services related to IPV. The proportion of women seeking formal services (16.98%) is lower than the proportion of women engaging in most other protective actions, including other formal protective actions (e.g., applying for an order of protection, seeking medical care). Of the women who reported that they received formal services related to IPV \( (n = 73) \), 22 (5.09% of the sample) reported that they had received shelter services and 55 (12.73% of the sample) reported receiving safety planning assistance, legal advocacy, and/or counseling. Although consistent with previous help-seeking samples not recruited at shelters or domestic violence services (Brookoff et al., 1997; Coker, Derrick, et al., 2000; Gondolf, 1998; Hutchinson & Hirschel, 1998; Macy et al., 2005; Wiist & McFarlane, 1998), the low number of women seeking formal IPV services and the lack of association between accessing these services and high levels of danger is troubling, particularly given that these services have been demonstrated to be helpful in most cases (Campbell et al., 2005; Goodkind et al., 2004; Goodman et al., 2005). Interventions for women in abusive relationships who have called the police should include education as well as access to domestic violence service providers. The Lethality Assessment Program (http://www.mnadv.org/lethality/), in which the police place women who are at high risk for homicide (as determined through the use of a risk assessment instrument) in telephone contact with a domestic violence service provider, is an example of an intervention that may be effective at empowering women who have called the police to seek out available community resources. Future research should examine the effectiveness of this and other approaches for increasing access to formal domestic violence services among high-risk survivors.

Women in this sample experienced severe abuse and face high levels of danger from their intimate partners. The significant relationships between forms of severe violence, injury, and risk on the DA were expected and suggest that the DA is capturing women at high risk for homicide in this sample. This research adds to the literature indicating that
women who call the police because of violence from their intimate partner are experiencing high levels of violence (Bonomi et al., 2006; Gondolf, 1998; Johnson, 1990; West et al., 1998). Women who are classified as high-risk in this study also reported that they felt unsafe. Combined with the data on women’s increased use of protective actions in the high-risk category, this suggests that women are aware of their risk and are seeking to mitigate it through protective actions. This is consistent with previous research findings that women may be able to accurately predict their own risk, although not as well as some risk assessment instruments (Messing & Thaller, 2013). Future research should specifically examine the relationship between women’s perceptions of risk and protective actions.

This study has several limitations. First, not all women who experienced police involved IPV during the study time frame were interviewed by researchers. Some women refused to allow researchers to contact them, and others who were recruited by police officers at the scene of the incident were unable to be contacted by researchers. It is unknown whether women who refused to allow researchers to contact them or who could not be contacted after recruitment were somehow different from the women who completed the interview. The cross-sectional nature of the data means that it is not possible to know the temporal order of variables. Although it is thought that women who are at high risk are engaging in more protective actions, given the cross-sectional nature of this study, it may be that engaging in these behaviors leads to higher levels of risk in an abusive relationship. Both of these explanations are consistent with previous research. For example, Dugan, Rosenfeld, and Nagin (2003) have found support at the policy level for both exposure reduction and retaliation hypotheses. That is, among particular groups of people, an increase in the availability of some domestic violence resources appears to decrease homicide (exposure reduction), whereas an increase in other resources appears to increase homicide (retaliation). Finally, the single-item measures of depression and anxiety used are neither reliable nor valid measures of these mental health constructs; although, in multivariate analyses, they were not found to be related to risk/danger in this sample, it may be that this is an artifact of measurement error.

These limitations are balanced by study strengths. Few previous studies have recruited women at the scene of police involved IPV incidents (Brookoff et al., 1997; Henning & Klesges, 2002; Hutchinson & Hirschel, 1998); therefore, this sample is unique and provides data on women experiencing police involved IPV that cannot be found elsewhere in the literature. The sample is diverse, particularly in terms of Native American representation. Although the number of Native Americans in the sample is small (n = 45), the proportion of Native Americans in the sample (10.42%) is larger than in many studies of IPV. Further, 30 (66.67%) of the Native American women in this sample were at high risk for homicide and, like African American women, Native American women in this sample were more likely than White women to be at high risk. This research adds to the literature on violence, risk, and protective actions among a relatively unique sample of survivors of IPV.

Given the findings of this study, it is important that service providers be aware that survivors seeking medical care or protection orders are likely to be at high risk for homicide, reassault, and severe reassault. Conducting the DA with survivors will educate them about their risk and risk factors and may empower them to take additional protective actions (Campbell, 2001). It is additionally important that researchers and practitioners develop unique ways to reach out to survivors who are not accessing traditional domestic violence services. Internet-based interventions are an example of a unique and accessible delivery format (Glass, Eden, Bloom, & Perrin, 2010). Finally, many women in abusive relationships are actively protecting themselves and their families, and it is important to build on
their strengths and provide empowering interventions while respecting women’s autonomy and self-determination.

REFERENCES


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Anger-Related Dysregulation as a Factor Linking Childhood Physical Abuse and Interparental Violence to Intimate Partner Violence Experiences

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Objective: Childhood family violence exposure is associated with increased risk for experiencing intimate partner violence (IPV) in adulthood, but the mechanisms underlying this relationship remain inadequately understood. Difficulties with emotion regulation may be one factor that helps to explain this relationship. Method: Childhood physical abuse and interparental violence, as well as subsequent IPV experiences, were assessed in a large sample of young adults ($N = 670$). Several indicators of anger-related dysregulation were also assessed. Structural equation modeling was used to create a latent variable of anger-related dysregulation, which was examined as a potential mediator of the associations between childhood family violence exposure and IPV. Results: Childhood physical abuse and interparental violence were associated with greater physical, sexual, and emotional IPV victimization. Childhood physical abuse and interparental violence were also associated with anger-related dysregulation, which was positively associated with all three types of IPV experiences. Anger-related dysregulation fully mediated the association between witnessing interparental violence and physical IPV. Anger-related dysregulation partially mediated the association between witnessing interparental violence and psychological IPV and the associations of childhood physical abuse with all three forms of IPV. These associations were consistent across gender. Conclusions: Interventions aimed at reducing IPV risk among survivors of childhood family violence may benefit from including techniques to target anger-related emotion regulation skills.

Keywords: domestic violence; childhood maltreatment; emotion dysregulation; anger; gender
Intimate partner violence (IPV) is a significant public health problem impacting women and men in the United States (Black et al., 2011). IPV is most common among young adults, with the highest prevalence rates documented among individuals in their late teens and early- to mid-20s (O’Leary, 1999). In this age group, physical and/or sexual IPV victimization occurs in approximately 20%–37% of dating relationships (Shorey, Cornelius, & Bell, 2008). Psychological abuse is also common among young adults (Shorey et al., 2008). The mental health consequences of each of these three forms of IPV experiences include shame; guilt; and elevated risk for post-traumatic stress disorder (PTSD), other anxiety disorders, depression, substance misuse, somatic complaints, and suicidality (Campbell, 2002; Iverson et al., 2012; Street & Arias, 2001).

Several studies suggest that childhood family violence exposure is associated with increased risk for experiencing IPV in adulthood (Coid et al., 2001; Desai, Arias, Thompson, & Basile, 2002; Whitfield, Anda, Dube, & Felitti, 2003). In particular, a growing literature demonstrates that childhood physical abuse and witnessing interparental violence are associated with subsequent IPV victimization in both cross-sectional and longitudinal studies (Bensley, Eenwyk, & Wynkoop Simmons, 2003; Ehrensaft et al., 2003; Iverson, Jimenez, Harrington, & Resick, 2011; McKinney, Caetano, Ramisetty-Mikler, & Nelson, 2009). For example, a 20-year prospective study found that witnessing interparental violence was associated with a threefold increase in risk for IPV victimization in adulthood (Ehrensaft et al., 2003). However, previous work suffers from several methodological limitations, including substantial variations in definitions and measurements employed across studies and scant attention to mediators of associations between childhood family violence exposure and IPV experiences (Riggs, Caulfield, & Fair, 2009). In particular, there has been limited empirical attention to individual characteristics of individuals who experience IPV because of concerns related to “victim blaming.” Although such concerns are legitimate, it is critical to identify factors that can be identified by clinicians and survivors of childhood family violence to help reduce their risk for IPV (Cattaneo & Goodman, 2005).

Although childhood family violence exposure appears to be a risk factor for experiencing IPV in adulthood, the mechanisms underlying this association are poorly characterized. Impaired psychosocial functioning, as indexed by the presence of mental health symptoms, has been proposed as a potential pathway through which childhood family violence exposure increases vulnerability to IPV experiences (see Classen, Palesh, Aggarwal, 2005). However, a recent longitudinal study of young adults demonstrated that neither symptoms of depression and anxiety nor substance abuse mediated the relationship between childhood physical abuse and IPV victimization (Lindhorst, Beadnell, Jackson, Fieland, & Lee, 2009). Milner et al. (2010) found that trauma symptomatology was a mechanism linking childhood physical abuse to violence perpetration among adults; however, this study did not examine whether trauma symptoms mediated the relationship between childhood physical abuse and IPV victimization.

Theoretical writings posit that emotion regulation problems stemming from childhood family violence exposure may underlie the psychosocial problems documented among adult interpersonal trauma survivors (e.g., Cloitre, Cohen, & Koenen, 2006; Ford, Courtois, Steele, van der Hart, & Nijenhuis, 2005). Emotion dysregulation refers to a broad array of difficulties in understanding, responding to, expressing, and managing emotional responses (Mennin, Holaway, Fresco, Moore, & Heimberg, 2007). Emotion regulation abilities develop in early childhood, with the family environment substantially impacting the success of emotion regulation development (Cummings & Davies, 1994; Linehan, 1993).
There is reason to believe that emotion dysregulation may be an important factor linking childhood family violence exposure to risk for IPV experiences. First, it is well documented that early stressful life events, including childhood physical abuse and exposure to interparental violence, lead to an array of emotion regulation deficits (e.g., emotional awareness, poor management of frustration and anger) and contributes to emotion dysregulation among children (Camras et al., 1988; McLaughlin & Hatzenbuehler, 2009; Repetti, Taylor, & Seeman, 2002). It is possible that emotion dysregulation displayed by parents through aggressive acts toward a child and/or partner negatively affects the ability of children to learn to effectively regulate their emotions (Cummings & Davies, 1994).

In addition to theoretical and empirical support for the link between childhood family violence exposure and emotion dysregulation, a burgeoning literature demonstrates an association between emotion dysregulation and interpersonal victimization in adulthood, although most work has focused on sexual revictimization among women as opposed to IPV per se (see Marx, Heidt, & Gold, 2005). For example, Cloitre, Scarvalone, and Difede (1997) found that women who experienced sexual abuse in childhood and adulthood had greater difficulty labeling and expressing their emotions relative to women who experienced no such revictimization. Early abuse experiences were postulated to contribute to the development of emotion regulation difficulties, which in turn, contributed to victimization risk through interference with risk detection abilities (Cloitre et al., 1997). In a more recent study, Berzenski and Yates (2010) found that childhood emotional abuse was positively associated with emotion dysregulation as well as IPV perpetration and victimization. Similar relations were evident with respect to childhood physical, sexual, and emotional abuse and witnessing interparental violence. Moreover, emotion dysregulation emerged as a significant mediator of the observed relation between childhood emotional abuse and IPV (Berzenski & Yates, 2010). Although preliminary, these studies provide initial support for the notion that emotion dysregulation may help explain the association between childhood family violence exposure and IPV experiences in adulthood.

To inform prevention efforts, it is important to identify specific emotion dysregulation processes that increase IPV victimization risk among survivors of childhood family violence. One form of emotion dysregulation associated with both a history of childhood family violence exposure and IPV victimization is anger-related dysregulation (Sappington, Pharr, Tunstall, & Rickert, 1997). Drawing on social learning theory (Bandura, 1973), anger-related dysregulation, or an inability to manage and express anger effectively, may be learned through the observation and imitation of others’ behaviors and through direct behavioral conditioning from parental figures. Anger dysregulation (e.g., experiencing high levels of anger arousal in the absence of effective methods for regulating the arousal to meet one’s goals) may increase risk for victimization through interfering with information processing and risk detection (Marx et al., 2005). For example, individuals who have experienced childhood family violence and have difficulties regulating angry affect may experience high-intensity anger responses in various situations, making it difficult to identify potential partners and situations that truly portend danger. Someone who experiences anger dysregulation may be so overwhelmed or focused on these internal cues that they have trouble detecting cues in their environment that signal risk (Marx et al., 2005).

Consistent with this theory, empirical work has demonstrated that childhood physical abuse and interparental violence exposure are associated with anger-related dysregulation in children and adults (Cicchetti & Toth, 2005; Repetti et al., 2002; Sappington et al., 1997). For example, exposure to family violence has been shown to increase sensitivity to anger in children (Repetti et al., 2002). Similarly, preliminary data suggest a link between anger-related dysregulation and IPV victimization.
(2012) found that various indicators of anger, including suppression and expression, were associated with IPV victimization among young adults. Although significant associations were found between anger and IPV victimization for men and women, the strength of associations were generally stronger for men than women (Rutter et al., 2012).

Although anger-related dysregulation is a potentially important psychological sequelae of childhood violence exposure and potential determinant of IPV experiences, the role of anger-related dysregulation as a factor linking childhood family violence exposure and IPV victimization has rarely been examined. The purpose of this investigation was to address this gap in the literature using cross-sectional data from a large sample of young adults that included assessments of childhood exposure to physical abuse and interparental violence, experiences of IPV in current or former relationships, and anger-related dysregulation. We hypothesized that both childhood physical abuse and witnessing interparental violence would be positively associated with anger-related dysregulation and with IPV victimization. Furthermore, we hypothesized that anger-related dysregulation would mediate the association between childhood family violence exposure and IPV victimization. A secondary aim of this study was to explore these associations in men and women because there may be gender differences in psychosocial functioning and IPV risk following family violence exposure (Afifi et al., 2008; Desai et al., 2002; Iverson et al., 2011). Similarly, prior work suggests that the strength of the associations between anger-related dysregulation and IPV may differ by gender (Rutter et al., 2012).

METHOD

Participants

Participants were 670 young adults (442 women, 228 men) at a large midwestern university who were participating in a larger survey study of dating violence (Monson & Langhinrichsen-Rohling, 2002). An initial sample of 2,000 students (1,000 men, 1,000 women) was randomly selected from a list of registered undergraduates to receive the survey; thus, the response rate was 34%. The mean age of the sample was 21.22 (SD = 3.60) years. The sample was predominantly White (93.8%) and included 1.2% Hispanic, 1% African American, 1.2% Asian American, and 2.8% who described themselves as “other” racial/ethnic backgrounds. Additional information on the parent study can be found in Monson and Langhinrichsen-Rohling (2002).

Measures

Childhood Family Violence Exposure and IPV. The revised Conflict Tactics Scales (CTS-2; Straus, Hamby, McCoy, & Sugarman, 1996) was used to assess participants’ exposure to childhood physical abuse, interparental violence, and early adult IPV victimization. The CTS-2 measures psychologically aggressive (e.g., insults or swearing), physically abusive (e.g., push, grab, or slap), and sexually coercive (e.g., used threats to have oral or anal sex) behaviors in interpersonal relationships. The internal consistency and reliability of the CTS-2 scales is good, and support for the CTS-2’s construct and discriminant validity has been established (Straus et al., 1996).

The CTS-2 was modified in this study to simplify and shorten the assessment of constructs of interest. First, only the severe physical abuse items for the CTS-2 were combined into one dichotomous question (“yes” or “no” response option) to assess for the presence of exposure to childhood physical abuse and interparental violence. Specifically,
childhood physical abuse was assessed by the following question: “Has/have parent(s) or stepparent(s) done any of the following things to you: used a knife or gun against you, punched you, hit you with something that could hurt you, choked you, slammed you against the wall, beat you up, burned or scalded you, or kicked you?” Although using the CTS-2 to assess childhood physical abuse has limitations (Straus & Hamby, 1997), the modification has had success in measuring childhood physical abuse and has been used in many other research studies (Straus, 1995). Witnessing interparental violence was assessed by the following question: “Have you ever seen or heard your parents or stepparents do any of the following things: use a knife or gun against the other, punch or hit the other with something that could hurt, choke the other, slam the other against a wall, beat the other up, burn or scald the other, or kick the other?”

In addition, only physical and psychological IPV victimization were assessed using the CTS-2. Sexual IPV victimization was assessed with another measure described later. Lifetime exposures to physical and psychological IPV victimization were assessed by summing the number of positively endorsed items for each scale, with total scales ranging from 0 to 12 for physical IPV and 0–8 for psychological IPV. This computation method, referred to as the variety score, has desirable psychometric properties, reduces estimation errors common in the recall of high-frequency behaviors, and circumvents the need to weight different acts by their presumed severity (Moffitt et al., 1997). These changes to the CTS-2 are consistent with modifications of this measure used in previous research on childhood family violence and IPV (McKinney et al., 2009; Milner et al., 2010; Whitfield et al., 2003). The internal consistency of the subscales of the CTS-2 was good in this study (KR20 = .79 and .78, for physical and psychological IPV, respectively).

The Sexual Assault Measure (SAM; Monson & Langhinrichsen-Rohling, 1997) was used to assess sexual IPV victimization. The SAM is a compilation of the items from the Sexual Experiences Scale (Koss & Oros, 1982) and the sexual coercion subscale of the CTS-2 (Straus et al., 1996). Sexual IPV was measured with the SAM because the CTS-2 provides a relatively limited number of sexual IPV experiences and has been shown to have less than ideal psychometric properties (Vega & O’Leary, 2007). The SAM includes nine sexual behaviors, performed without the respondent’s consent by a past or current intimate relationship partner (defined as current or former girlfriend or boyfriend). The behaviors identified on the SAM assess the presence or absence of three levels of various forms of unwanted sexual activity (i.e., sex play, vaginal sexual intercourse, oral/anal intercourse). Similar to the assessment of psychological and physical IPV using the CTS-2, sexual aggression on the SAM was assessed by summing the number of different abusive acts endorsed. The internal consistency of the SAM in this sample was good (KR20 = .78).

**Anger-Related Emotion Dysregulation.** The Multidimensional Anger Inventory (MAI; Siegel, 1986) is a 38-item self-report scale that assesses several dimensions of anger: frequency, duration, magnitude, mode of expression, hostile outlook, and range of anger-eliciting situations. The MAI includes three primary subscales: anger arousal, anger-eliciting situations, and hostile outlook. We drew our items from the anger arousal scale of the MAI, which includes items reflecting both under- and overregulation of anger. Example items used in this study include the following: “Other people seem to get angrier than I do in similar situations,” “When I hide my anger from others, I forget it pretty quickly,” “It’s difficult for me to let people know I’m angry,” “It is easy to make me angry,” and “I am surprised at how often I feel angry.” Respondents rate the degree to which the items are characteristic of them on a 5-point scale ranging from completely
uncharacteristic to completely characteristic. Higher scores reflect higher levels of anger-related dysregulation. Siegel (1986) reports adequate test–retest reliability and high internal consistency for the MAI. The MAI demonstrated good internal consistency in this study ($\alpha = .85$).

Respondents also completed the Structured Clinical Interview for DSM-III-R-Personality Disorders (SCID-II), Screening Questionnaire—Modified (Spitzer, Williams, Gibbon, & First, 1990). Given that borderline personality disorder can be conceptualized as a problem of chronic emotion dysregulation (Linehan, 1993), two items from the Borderline Personality Disorder subscale were used, including one indicator of mood dysregulation (“I am a moody person”) and one indicator of anger arousal (“Even little things get me very angry”). In its original form, the screening questionnaire asks the respondent to indicate whether or not each characteristic is indicative of the person they “generally are, that is, how you usually have felt or behaved over the past several years.” Responses are provided on a 5-point scale ranging from “completely undescriptive of me” to “completely descriptive of me.” The two borderline personality items demonstrated adequate internal consistency in this sample ($\alpha = .65$).

Procedure

Participants were mailed a packet of study materials consisting of a cover letter inviting them to participate, self-report questionnaires, and a stamped self-addressed envelope. The cover letter indicated that participants who mailed back their self-report packets were providing their consent to participate in the study. Four participants were randomly selected to receive $75 cash at the conclusion of data collection. All of the procedures described in this study were approved by a university institutional review board.

Data Analytic Plan

Structural equation modeling was used to perform the mediation analyses using AMOS 6.0 software (Arbuckle, 2005). Analyses were conducted using the full information maximum likelihood estimation method, which estimates means and intercepts to handle missing data. As described in the following text, a latent variable representing anger-related dysregulation was created using 11 observed variables of anger and mood dysregulation. After testing the fit of the measurement model, the mediation analyses first examined the association between childhood family violence exposures and subsequent IPV victimization. Childhood physical abuse and exposure to interparental violence were examined separately. Second, associations between childhood family violence exposures and anger-related dysregulation were examined. Third, we examined the associations between anger-related dysregulation and physical, sexual, and psychological forms of IPV victimization. The full mediation model was examined using the product of coefficients method to evaluate the hypothesis that anger-related dysregulation mediates the association between childhood family violence exposures and IPV victimization in adulthood. Sobel’s (1982) standard error approximation was used to test the significance of the intervening variable effect. The product of coefficients approach is associated with low bias and type 1 error rate, accurate standard errors, and adequate power to detect small effects (MacKinnon, Lockwood, Hoffman, West, & Sheets, 2002). The mediation model was examined for physical, sexual, and psychological forms of IPV separately to determine whether mediation effects were consistent across subtypes of IPV experiences.
Finally, we examined participant sex as a moderating variable. Multigroup analyses were conducted to examine whether the process of mediation was moderated by sex. Each of the mediation paths was constrained to be equal for men and women, and the difference in model fit was examined using a chi-square test.

RESULTS

Descriptive Statistics

Table 1 displays the prevalence of exposure to childhood physical abuse; to interparental violence; and to physical, sexual, and psychological forms of IPV by sex. The proportions of exposure to victimization in this sample is similar to what has been observed in other samples of young adults (e.g., McKinney et al., 2009). Women were more likely to report sexual IPV relative to men, $F(1,669) = 31.62, p < .001$. No other sex differences were observed. Table 2 provides the bivariate correlations among IPV victimization and childhood family violence variables. As expected, childhood physical abuse and witnessing interparental violence was positively associated with early adult IPV victimization and anger-related dysregulation, which were positively associated with one another. The only exception was that witnessing interparental violence was not associated with sexual IPV victimization.

Measurement Model

The measurement model of anger-related dysregulation was constructed using 11 indicator variables: 9 indicators of dysregulated expression of anger and anger arousal drawn from the MAI and 2 indicators of mood dysregulation from the Personality Disorders Screening Questionnaire. The specific items were selected using exploratory factor analysis (Costello & Osborn, 2005). Specifically, we conducted an exploratory factor analysis to determine whether the anger arousal items from the MAI loaded onto a single factor in our data in a similar fashion as has been reported in other studies (e.g., Siegel, 1986). Some items on the anger arousal scale did not load with the other items in our sample (e.g., “Other people seem angrier than I do in similar circumstances”). These items were dropped. We completed the confirmatory factor analysis on the 9 items from the anger arousal scale

<table>
<thead>
<tr>
<th>Type of Contact</th>
<th>Women n (%)</th>
<th>Men n (%)</th>
<th>Total n (%)</th>
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</thead>
<tbody>
<tr>
<td>Physical IPV victimization</td>
<td>165 (37.3)</td>
<td>99 (43.4)</td>
<td>264 (39.4)</td>
</tr>
<tr>
<td>Sexual IPV victimization</td>
<td>134 (30.3)</td>
<td>21 (9.2)</td>
<td>155 (23.1)</td>
</tr>
<tr>
<td>Psychological IPV victimization</td>
<td>304 (68.8)</td>
<td>147 (64.5)</td>
<td>451 (67.3)</td>
</tr>
<tr>
<td>Childhood physical abuse</td>
<td>145 (33.1)</td>
<td>89 (39.0)</td>
<td>234 (35.1)</td>
</tr>
<tr>
<td>Interparental violence</td>
<td>83 (18.8)</td>
<td>43 (19.1)</td>
<td>126 (18.9)</td>
</tr>
</tbody>
</table>

Note. Some of the percentages reported in the table may not add up to 100% because of missing data. IPV = intimate partner violence.
Anger-Related Dysregulation and IPV

that loaded onto a single factor in our sample along with 2 items from the SCID-II that tapped a similar dimension of anger-related dysregulation. The measurement model that provided the best fit to the data was selected using standard model fit indices. Values of the comparative fit index (CFI) exceeding .95 indicate adequate fit, and the root mean square error of approximation (RMSEA) should be less than .06 (Hu & Bentler, 1999). For the hypothesized model, CFI = .95 and RMSEA = .06 (90% CI [.05–.07]). Thus, fit indices indicated that the measurement model of anger-related dysregulation fit the data well. However, the chi-square test of independence revealed a significant difference between the observed and reproduced covariance matrices \( \chi^2(54) = 190.75, p < .001 \). In large samples, even small differences between the observed and reproduced matrices can lead to a significant chi-square test. The large sample size of this study may be driving the significant chi-square value.

Mediation Analyses

**Childhood Physical Abuse.** Anger-related dysregulation was first examined as a mediator of the association between childhood physical abuse and early adult IPV victimization. Childhood physical abuse was significantly associated with physical, \( \beta = .14, p < .001 \); sexual, \( \beta = .11, p < .005 \); and psychological IPV victimization, \( \beta = .15, p < .001 \). Childhood physical abuse also was associated with anger-related dysregulation, \( \beta = .18, p < .001 \). Anger-related dysregulation, in turn, was associated with physical, \( \beta = .17, p < .001 \); sexual, \( \beta = .13, p < .005 \); and psychological IPV victimization, \( \beta = .17, p < .001 \).

In the full mediation model, the association between childhood physical abuse and physical, \( \beta = .12, p = .003 \); sexual, \( \beta = .09, p = .019 \); and psychological IPV victimization, \( \beta = .12, p = .002 \) were attenuated when anger-related dysregulation was added to the model but remained significant. Sobel’s (1982) z-test revealed a statistically significant indirect effect of childhood physical abuse on early adult physical, \( z = 2.46, p = .014 \); sexual, \( z = 2.36, p = .018 \); and psychological IPV victimization, \( z = 2.52, p = .012 \) through anger-related dysregulation, suggesting that anger-related dysregulation represents a partial mediator of these associations.

**Witnessing Interparental Violence.** We also examined the role of anger-related dysregulation as a mediator of the association between witnessing interparental violence and early adult IPV victimization. Witnessing interparental violence was associated significantly with physical, \( \beta = .08, p < .05 \) and psychological IPV, \( \beta = .14, p < .001 \) but not

<table>
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<tr>
<th>TABLE 2. Bivariate Associations Between IPV and Childhood Family Violence Exposure (N = 670)</th>
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<tr>
<td>1. Physical IPV victimization</td>
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<td>2. Sexual IPV victimization</td>
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<td>3. Psychological IPV victimization</td>
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<td>4. Childhood physical abuse</td>
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<td>5. Interparental violence</td>
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<td>1. Physical IPV victimization</td>
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<td>2. Sexual IPV victimization</td>
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<td>3. Psychological IPV victimization</td>
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*Note. IPV = intimate partner violence.

*p < .05. **p < .01.
Iverson et al.

Figure 1. Figure represents final mediational model for witnessing interparental violence and physical IPV victimization. Numbers represent standardized path coefficients ($\beta$). All paths shown are significant ($p < .05$), except those drawn with broken lines. The construct shown in a circle was modeled as a latent variable. Indicator variables are not displayed.

with sexual IPV victimization, $\beta = .01, p = .893$. Witnessing interparental violence was also associated with anger-related dysregulation, $\beta = .13, p < .001$, which was associated with physical, sexual, and psychological IPV victimization, as reported earlier.

In the full mediation model, the association between witnessing interparental violence and physical IPV victimization was no longer significant when anger-related dysregulation was added to the model, $\beta = .06, p = .123$ (see Figure 1). Sobel’s (1982) z-test revealed a statistically significant indirect effect of witnessing interparental violence on physical IPV victimization through anger-related dysregulation, $z = 2.52, p = .012$, indicating that anger-related dysregulation was a full mediator of this association. In contrast, the association between witnessing interparental violence and psychological IPV victimization was attenuated when anger-related dysregulation was added to the model but remained significant, $\beta = .11, p = .004$. Sobel’s z-test revealed a statistically significant indirect effect of witnessing interparental violence on psychological IPV victimization through anger-related dysregulation, $z = 2.48, p = .013$, suggesting that anger-related dysregulation was a partial mediator of these associations.

Moderation Analyses

We examined whether the role of anger-related dysregulation as a mediator of the associations between childhood exposures and early adult IPV victimization was modified by sex. We did not evaluate this possibility for witnessing interparental violence and sexual IPV because anger-related dysregulation did not mediate this association. When the mediation paths of interest were constrained to equivalence across men and women, the model fit for witnessing interparental violence did not significantly worsen for physical, $\chi^2(3) = 6.5, p = .091$, or psychological IPV victimization, $\chi^2(3) = 4.5, p = .216$. The model fit for childhood physical abuse did not worsen significantly for physical, $\chi^2(3) = 7.7, p = .052$; psychological, $\chi^2(3) = 4.7, p = .198$; or sexual IPV victimization, $\chi^2(3) = 6.3, p = .099$, indicating that the process and strength of mediation was consistent for participant sex.
DISCUSSION

Associations between childhood family violence exposure and IPV experiences in adulthood have been observed in previous studies (Bensley et al., 2003; Coid et al., 2001; Desai et al., 2002; Whitfield et al., 2003), yet it is not well understood how and why childhood family violence exposure might increase risk for experiencing IPV. Our results indicate that anger-related dysregulation is a factor that helps to explain, in part, why individuals exposed to childhood family violence are more likely to experience IPV in early adulthood. We found statistical evidence that anger-related dysregulation fully mediated the association between witnessing interparental violence and physical IPV victimization and partially mediated the association between witnessing interparental violence and psychological IPV victimization for both men and women. Furthermore, we found statistical evidence that anger-related dysregulation partially mediated the associations between childhood physical abuse and physical, sexual, and psychological IPV victimization.

The current findings extend previous work by demonstrating that childhood violence exposure is associated with deficits in anger-related dysregulation that, in turn, are associated with increased risk for IPV victimization in young adulthood. The significant associations between anger-related dysregulation and both childhood physical abuse and exposure to interparental violence are consistent with theoretical work arguing that childhood family environments characterized by violence hinder the development of effective emotion regulation skills, particularly in the expression and modulation of anger (Cicchetti & Toth, 2005; Cummings & Davies, 1994; Linehan, 1993). Specifically, our findings are consistent with the notion that anger-related dysregulation may develop in childhood and persist into early adulthood, which may increase risk for experiencing IPV.

Anger-related dysregulation might increase vulnerability to IPV in several ways. For example, high levels of anger arousal paired with an inability to effectively modulate such arousal may interfere with one’s ability to accurately identify and respond effectively to dangerous situations or people (Marx et al., 2005). Specifically, individuals who have difficulty expressing anger in a modulated way may experience high-intensity anger responses in various situations, making it difficult to identify those situations that are truly dangerous. Alternatively, individuals may partner with others with similar emotion regulation tendencies (Segrin, 2004), increasing the likelihood of becoming involved in relationships with partners who also experience high levels of anger-related dysregulation, elevating risk for IPV victimization. Importantly, previous research suggests that anger-related dysregulation strongly relates to a wider range of emotion regulation problems, including poor emotional awareness and engagement in maladaptive cognitive emotion regulation strategies, such as suppression and rumination (McLaughlin, Hatzenbuehler, & Hilt, 2009; McLaughlin, Hatzenbuehler, & Phil, 2009; McLaughlin, Hatzenbuehler, Mennin, & Nolen-Hoeksema, 2011). As a result, there are various emotion regulation deficits—in addition to anger-related dysregulation—that likely contribute to heightened risk of IPV victimization among those with exposure to child maltreatment. Examination of these additional emotion regulation pathways using prospective longitudinal studies represents an important goal for future research to more fully determine if childhood family violence exposure leads to problems with anger dysregulation which then account partially or fully for the risk of adult IPV experiences.

It is important to acknowledge existing evidence suggesting that the relationship between childhood maltreatment and IPV perpetration among male young adults is mediated by emotion dysregulation (Gratz, Autumn, Jakupcak, & Tull, 2009). Emotion regulation deficits also have been observed among couples who engage in bidirectional IPV (i.e., both
partners experience IPV in the relationship; McNulty & Hellmuth, 2008). Such research suggests that emotion regulation difficulties stemming from childhood violence exposure may also increase risk of IPV perpetration, which in turn increases risk for IPV victimization through bidirectional IPV. Clearly, additional research is needed to elucidate the manner by which specific emotion dysregulation processes—including, but not limited to, anger-related dysregulation—contribute to IPV risk. Although anger-related dysregulation may contribute to IPV risk, it should not be used to blame individuals for the aggression they experience. The responsibility for IPV belongs to the individual who uses the aggression.

It is important to note that anger-related dysregulation was as a partial mediator of most of the associations observed between childhood family violence exposure and IPV victimization. Thus, it is likely that additional factors, such as psychopathology, social skills deficits, dissociation, or attachment styles may also underlie the observed association between child family violence exposure and IPV victimization. Children who experience childhood family violence are more likely to develop mental health problems, such as PTSD, which may interact with emotion regulation difficulties or contribute independently to increased risk for IPV (Messman-Moore & Long, 2003). Although our findings indicate that anger-related dysregulation is an important factor linking child abuse or witnessing interparental violence and adult IPV victimization, additional pathways linking violence exposure to subsequent victimization warrant further investigation. This study focused on a specific form of emotion dysregulation, specifically, anger-related dysregulation; however, further characterization of the emotion dysregulation processes associated with both childhood violence exposure and IPV victimization is critical to informing treatment and prevention efforts.

Examination of potential sex differences revealed that the associations observed in this study were consistent for men and women in this sample. These findings are inconsistent with those of a previous study that found anger to be more strongly associated with IPV victimization among men than women (Rutter et al., 2012); however, variations in study methodologies may account for inconsistent findings between studies, including differences in the measures of anger. Because both childhood family violence exposure and IPV are prevalent among women and men, potential sex differences and similarities should continue to be examined in future research.

The findings should be evaluated in light of several limitations. First and foremost, this study relied on cross-sectional data. As such, the temporal ordering of the observed relationships is unclear. It is possible that individuals who experienced IPV developed subsequent increases in anger-related dysregulation because of IPV as opposed to being a determinant of IPV victimization. Thus, our findings require replication in prospective studies. Second, the response rate for this study was modest, and participants in this study were primarily White university students, reducing the generalizability of the findings. Third, we used self-report measures of childhood family violence exposures, IPV victimization, and anger-related emotion dysregulation, raising concerns about shared method variance and retrospective recall bias. However, self-report measures of childhood family violence exposure have been found to be reliable, and when errors do occur, they are most often in the direction of underreporting previous trauma (Hardt & Rutter, 2004). Fourth, the assessments of childhood physical abuse and interparental violence lacked detail about the timing and frequency of the events that occurred. Although young children are at highest risk for family violence (U.S. Department of Health and Human Services, Administration for Children and Families, Administration on Children, Youth and Families, Children’s Bureau, 2012), it would have been ideal to have data regarding the age(s) at which violent episodes occurred to state definitively that family violence exposure occurred during childhood. Future investigations should use measures that are specifically designed to provide
detailed assessments of these constructs, including contextual variables such as age of onset, duration, and frequency of the abuse. Fifth, childhood sexual and emotional abuse were not measured in this study. It will be critical to address both of these constructs in future research in this area. Finally, this study only evaluated IPV victimization; therefore, it is unknown whether participants in this study also engaged in IPV, including bidirectional violence. Evaluating anger-related dysregulation as a mechanism linking childhood family violence exposure to bidirectional aggression is a promising avenue for future research (Kuijpers, van der Knaap, & Winkel, 2012).

If replicated, our findings hold promise with respect to informing clinical interventions with survivors of childhood family violence exposure. Although preliminary, these data suggest that individuals exposed to childhood family violence are important targets for preventive interventions focused on improving anger-related emotion regulation skills, such as skills to improve the modulation and expression of anger. Fortunately, researchers have already developed effective interventions to treat emotion regulation deficits based on emotion regulation theory and dialectical behavior therapy (DBT) for survivors of child abuse (Cloitre et al., 2006; Linehan, 1993). DBT has been applied to IPV survivors as a method for teaching emotion regulation skills, including anger modulation and expression, and the intervention appears to lead to decreases in emotional distress (Iverson, Shenk, & Fruzzetti, 2009). The emotion regulation skills targeted in this treatment and other interventions that target anger-related emotion dysregulation may help reduce risk for IPV when applied to individuals who have experienced childhood family violence exposure and experience anger-related dysregulation.

REFERENCES


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Administrators’ Perceptions of College Campus Protocols, Response, and Student Prevention Efforts for Sexual Assault

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Background: Sexual assault disproportionately affects college students. Because most survivors do not report sexual assault, research has explored individual factors related to the reporting, with limited research exploring institutional-level factors related to victims’ decisions to report their experiences. Objective: The purpose of this research was to describe three key areas: (a) campus assault adjudication, (b) protocols and campus responses to assault, and (c) provision of student prevention education regarding sexual violence. Participants: A nationally representative sample of 1,067 campus administrators responded to a survey regarding institutional sexual assault policies and procedures. Conclusions: Findings suggest that although many institutions are responding adequately to sexual assault in these three areas, improvements are possible. Implications for improving campus responses and further research are discussed.

Keywords: sexual violence; reporting; campus policy; campus adjudication; college students

Sexual assault is a significant problem affecting about 25% of college women (Fisher, Cullen, & Turner, 2000). Research has documented the immediate health consequences stemming from injury and trauma, as well as long-term threats to health and well-being (Fisher et al., 2000; Rennison, 2002; Tjaden & Thoennes, 2006). With 4%–8% of college women survivors reporting victimization to campus authorities and
Underreporting presents campus administrators with several issues. Reporting helps survivors to access community resources and referrals that assist in healing from sexual violence. Reporting also helps to identify and sanction perpetrators of violence, thus ensuring community safety. If sexual assault is not reported, then perpetrators can remain in the campus community without consequences. Studies have explored individual factors related to reporting of sexual assault. Limited research has explored institutional factors that may influence victims’ decisions to report their experiences. The purpose of this study was to describe three key areas that influence survivors’ decisions to report sexual assault: (a) campus adjudication of sexual assault, (b) protocols and campus responses to sexual assault, and (c) provision of student prevention education.

BARRIERS TO REPORTING

Commonly reported barriers to sexual assault disclosure include a lack of recognition that the experience was a crime, a wish to avoid public disclosure, and concern regarding an inability to prove a crime occurred (Sable, Danis, Mauzy, & Gallagher, 2006; Tillman, Bryant-Davis, Smith, & Marks, 2010; Walsh, Banyard, Moynihan, Ward, & Cohn, 2010). Trust was a significant issue that determined if and to whom survivors reported (Sable et al., 2006). Other factors include survivors’ concern over how they would be treated, specifically fearing that they might experience a lack of sensitivity (Amar, 2008; Logan, Evans, Stevenson, & Jordan, 2005) and a fear of the loss of confidentiality (Logan et al., 2005; Sable et al., 2006).

Factors in the campus environment can influence students’ decisions to report their experiences. Barriers at an institutional level include requiring victims to participate in adjudication processes, unintentionally condoning victim blaming during violence prevention programs, and sanctioning victims who have used drugs or alcohol through strict policies (Karjane, Fisher, & Cullen, 2005). Campus adjudication processes, protocols and responses to survivors, and student education are important considerations in reporting decisions.

CAMPUS ADJUDICATION OF SEXUAL ASSAULT

The national baseline study on campus sexual assault surveyed voting delegates of the National Association of Student Personnel Administrators on the campus-based adjudication of sexual assault cases. Despite prevalence rates, judicial officers at half of the institutions studied did not receive any reports of sexual assault, and nearly two-thirds had not held any adjudicatory hearings during a 3-year period (Penney, Tucker, & Lowry, 2000). Directors of campus-based women’s centers reported perceiving that students are more likely to report sexual assault if they believe that campus judicial procedures will hold perpetrators accountable by providing adequate sanctions (Strout, Amar, & Astwood, in press; Brubaker, 2009). Limited research explores campus-based judicial procedures relating to sexual assault. Most of the research focuses on elements of due process with little published literature providing descriptions of the processes or their effects on students.
PROTOCOLS AND CAMPUS RESPONSE TO SEXUAL ASSAULT

The needs of survivors of sexual violence are vast and include medical, legal, and psychological interventions. Medical needs include the detection and management of injuries, screening and treatment for sexually transmitted infections, and the provision of emergency contraception. Legal interventions include evidence collection, forensic evaluation and documentation, and the initiation of advocacy services. Psychological interventions include crisis intervention and referral for support and follow-up treatment (Campbell, 2006; Decker & Naugle, 2009). Campus protocols for responding to survivors can be helpful in assuring consistency in treatment, referrals, and services.

The California Campus Blueprint to Address Sexual Assault (Blueprint; California Campus Sexual Assault Task Force, 2004) has been used as a model for comprehensive responses to sexual assault (Lichty, Campbell, & Schuiteman, 2008; McMahon, 2008). The recommendations resulted from a comprehensive study of California universities’ sexual assault responses and prevention activities and pertinent legislation. The Blueprint proposes action in key areas such as protocols for responding to reported sexual assaults and the development of coordinated victim services delivery systems using campus and community-based resources (California Campus Sexual Assault Task Force, 2004). In addition to the Blueprint, other key stakeholders, such as The Higher Education Center for Alcohol, Drug Abuse, and Violence Prevention; the American College Health Association; and Futures Without Violence, have published similar recommendations (American College Health Association, 2008; Fleck-Henderson, 2012; Langford, 2004).

Limited research explores campus sexual assault–related protocols and responses to survivors. However, Karjane and colleagues (2005) report that most campus administrators believe that the presence of a dedicated person or office related to sexual violence is beneficial for survivors. Trained, dedicated staff can benefit survivors by providing a coordinated, comprehensive, and centralized response (Strout, Amar, & Astwood, in press). An adequate response to sexual violence could positively influence reporting behavior. Having and publicizing designated offices for response lends an importance to sexual assault as an issue on campus. Campuses could be proactive in informing students of all services related to sexual assault (Penney et al., 2000).

PROVISION OF STUDENT PREVENTION EDUCATION

Although education alone is not effective in changing behavior, research findings suggest that students want more education about sexual violence and campus resources (Garcia, Lechner, Frerich, Lust, & Eisenberg, 2012). Because survivors frequently disclose their experiences to their friends, it is important to train friends to respond and on campus and community resources for victims (Fisher et al., 2003). After examining literature reviews on the effectiveness of sexual assault prevention programs, Vladutiu, Martin, and Macy (2011) determined that although most programs report success, the use of different outcome measures made comparisons difficult. Although many programs report changes in attitudes, beliefs, and knowledge, few report decreased prevalence of sexual assault. Anderson and Whiston (2005), in a meta-analysis of education programs, noted inconsistent findings in the effectiveness and long-term impact of sexual assault educational programs. In addition, Karjane and colleagues (2005) have
suggested that some messages of prevention programs could unintentionally blame victims, for example, by focusing on individual students’ responsibilities to avoid sexual assault.

Limited research explores how campuses are preventing and responding to sexual violence. The aim of this study was to fill this gap by using an exploratory design to understand the perspectives of campus administrators regarding sexual assault policies, protocols, and practices. The purpose of this research was to describe institutional factors that may influence victims’ decisions to report their sexual assault experiences, specifically in terms of (a) campus-based adjudication, (b) protocols and campus responses, and (c) provision of student prevention education.

METHODS

Study Design
To address the aim of this study, we conducted a descriptive study using a survey of campus administrators, similar to the approach used during the Campus Response to Sexual Assault Survey (Karjane et al., 2005). The Institutional Review Board at Boston College approved this study.

Sample and Setting
We invited campus administrators, defined as individuals holding positions such as dean of student services; director of resident life, health services, police forces, or public safety; or women’s center directors to participate in the study. Potential participants were identified through review of publicly available data sources, such as institutional Websites and telephone or e-mail directories. A sample size including 1,000 participants was determined adequate to gather a nationally representative sample (Cohen, 1988). The total number of public universities invited to participate was 600, whereas the total number of private universities invited to participate was 1,544 ($n = 2,144$).

Data Collection Procedures
Data collection occurred over the course of 1 academic year. During the first 2 months of this study, potential participants received electronic surveys from the research team. Electronic data collection is an effective means of collecting large amounts of data in a confidential manner, and most college administrators have computer access at work. Following the methods of Dillman, Smyth, and Christian (2009), on Day 1, potential participants received an e-mail that introduced the study and advised them that another e-mail would arrive with further study details. On Day 4, potential participants received an e-mail encouraging participation and containing the link to the survey. On Day 7, the researchers sent thank you/reminder electronic messages encouraging participation and containing the survey link, with a final thank you/reminder distributed on Day 11 (Dillman et al., 2009). To ensure that the electronic survey format did not present a barrier to participation, potential participants received pencil-and-paper–based surveys via the U.S. Postal Service during 3–8 months of the study. The same methodological principles guided for the mail-based surveys, except that correspondences were sent out weekly rather than daily.
Measures

**Campus Response to Sexual Assault.** A survey modeled on the Campus Response to Sexual Assault Survey was used to describe campus policies, protocols, and practices (Karjane et al., 2005). The original 75-item survey was developed after conducting focus groups with campus administrators on mandated issues on campus, such as policy dissemination strategies, reporting of sexual assault, communicating resource availability, effects of policies and procedures, campus-based judicial proceedings, and sanctions (Karjane et al., 2005). Items used in this study specifically related to adjudication procedures, protocols for responding to victims, and student education. Participants had the opportunity to respond with more detail in open-ended items.

Data Management and Analysis

Participants’ responses were confidential because identifiable information such as individual or institutional names was not collected. Participants did provide an institutional zip code, used only to ensure geographic representation. The Qualtrics Survey Research Suite (Qualtrics Labs, Inc., Provo, UT), a secure electronic, web-based survey site was the platform to collect study data. Before participants began the survey, they provided informed consent. Although the mail surveys were delivered to participants using their names, the provided return envelopes for completed surveys listed only the work address of the first author (AA) as the return address. Consistent with the descriptive nature of this study and in light of the limited amount of existing research, analysis consisted of frequencies and percentages. The researchers analyzed the responses to open-ended questions qualitatively to augment and describe quantitative responses.

RESULTS

Sample

The number of surveys sent out was 2,144; the number of participants responding to the survey was 1,442. The number of surveys with complete data available for analysis was 1,067 (50%). Most survey participants were from 4-year private universities \((n = 545, 51\%)\), followed by 4-year public universities \((n = 401, 38\%)\). As previously described, the total number of public universities invited to participate was 600, whereas the total number of private universities invited was 1,544. Thus, our sample consisted of 67% of invited public universities and 35% of invited private universities. Of those institutions represented, 40% indicated a religious affiliation \((n = 431)\). Less than 1% of the sample was made up of either tribal institutions or historically Black universities and colleges. Administrators representing institutions from every U.S. state participated in the survey, making this a nationally representative sample. Institution size ranged from 100 to 64,000 students. The mean number of students attending participating institutions was 7,664 \((SD = 7,664)\).

In selecting a role on campus, participants chose the role that best described their job. As seen in Table 1, the largest group of respondents identified themselves as deans/assistant/associate of students or vice presidents of student affairs/services. Other terms used included student support, development, and activities, among others. The next largest group of participants represented campus housing or residential life followed by campus
mental health/counseling, campus police, campus security, safety officer, campus health services, and director or president. Finally, 288 participants chose “other,” with the largest other category being director/coordinator of women’s center or studies. Some of the more common other roles included violence prevention specialist/advocate, director of Greek Life, director of diversity, faculty member, student conduct administrators, and health education.

Campus Adjudication of Sexual Assault

Institutional judicial procedures most commonly involved a hearing board \((n = 788, 87\%)\) with a closed hearing process \((n = 728, 92\%)\). Hearing boards were composed of students \((n = 800, 88\%)\), faculty \((n = 811, 89\%)\), staff \((n = 753, 83\%)\), and administrators \((n = 717, 79\%)\). Hearing boards received training from Judicial Affairs, legal counsel, student conduct administrators, the Office of Student Services/Affairs/Development, and outside community sexual assault agencies. Content of the training included judicial board process and procedures, school policies, rape and sexual assault information, sanctioning, state and federal laws and codes, student handbook, student code of conduct review, and fundamentals of due process. Most participants reported that board members receive an average of 16 hr of training per year, with a range of 4–40 hr. Although most training occurred on campus, some administrators reported sending board members to external local, regional, and national training sessions and bringing in national speakers for training.

Only a few participants reported that their institutions do not require sexual assault survivors to participate in the judicial process. These administrators described a belief that once a violation of the campus behavior or conduct code had occurred, the university had a responsibility to investigate and did not need to further involve, and potentially retraumatize, the survivor. Finally, 351 participants (33%) reported institutional use of a single fact-finder outcome. Fact finders were described as being an individual within student affairs not associated with the case or an outside investigator who interviews the survivor and the accused.

Elements of due process used included informing defendants of their rights before a hearing \((n = 817, 90\%)\), providing defendants with written notice of the charges they faced prior to a hearing \((n = 790, 87\%)\), and informing the defendants and victims of their right to bring attorneys or advisors to hearings \((n = 745, 82\%)\). The standard of proof used

<table>
<thead>
<tr>
<th>Job Title</th>
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<tbody>
<tr>
<td>Dean/assistant/associate or vice president of students/student affairs/services</td>
<td>218</td>
</tr>
<tr>
<td>Campus housing or residential life</td>
<td>212</td>
</tr>
<tr>
<td>Campus mental health/counseling</td>
<td>168</td>
</tr>
<tr>
<td>Campus police/security/safety officer</td>
<td>153</td>
</tr>
<tr>
<td>Campus health services</td>
<td>145</td>
</tr>
<tr>
<td>Director/coordinator women’s center/studies</td>
<td>43</td>
</tr>
<tr>
<td>Director/president</td>
<td>27</td>
</tr>
</tbody>
</table>

TABLE 1. Study Participants’ Roles
was most often “a preponderance of the evidence” (n = 554, 61%), followed by “clear and convincing evidence” (n = 272, 30%), and “beyond a shadow of a doubt” (n = 45, 5%). Many administrators reported an institutional move to the “preponderance of evidence” standard to increase compliance. Penalties imposed on sexual assault offenders included suspension (n = 832, 92%), expulsion (n = 821, 90%), no-contact orders (n = 724, 80%), counseling (n = 680, 75%), community service (n = 551, 61%), restitution (n = 389, 43%), and fines (n = 294, 32%). Here, participants could choose all the sanctions that applied to their setting. In open-ended responses, most participants reported a need for strict penalties so that survivors could feel safe and the safety of the campus environment could be ensured.

Open-ended responses centered on policy changes and concern for the regard of survivors and accused perpetrators. Participants described making changes to policies and procedures regarding the campus judicial process, such as standard of proof, in an effort to ensure that the best process occurred. Many respondents reported working in this area for years and described a wealth of experience on these issues. Participants described knowing that by following the process, regardless of the outcome, the needs of both survivors and accused perpetrators were met. Participants were clear that the purpose of the judicial process was determining whether violations of student conduct had occurred rather than determining criminal charges. Most felt that the process works, and they trust it to bring the best outcomes. Many expressed strong opinions that not holding perpetrators accountable for their actions would undermine the process and would not help survivors or other students to feel safe on campus.

Finally, participants discussed taking steps to reduce undue harm to the survivor and accused perpetrator. Examples included working with campus and local authorities so that survivors did not have to retell their stories and having objective investigators who gathered data from both parties and made recommendations for the case outcome. In addition, participants described not requiring survivors to participate in the campus-based hearings to avoid retraumatization. Although some participants described not having students involved in the hearing process, others extolled the benefits of student participation. In these cases, participants described judicial boards composed of a majority of students with limited numbers of staff and faculty. Participant responses indicated a commitment to reviewing and revising judicial processes. They expressed belief in the process, wanted to get it right, and felt that negative feedback about the process would discourage survivors from reporting sexual assault to campus administrators. Continuing education and training for hearing board members occurred at least annually and consisted of activities on campus, in the local community, and outside the local area. One participant also described conducting an annual mock hearing as part of training activities so that all board members learned. Although institutions benefit from the campus adjudication process, most participants expressed more concern about identifying survivors so they could be linked to resources and services.

Protocols and Campus Response to Sexual Assault

A team approach was used by two-thirds of the sample (n = 516, 66%). As seen in Table 2, campus and community services represented various professionals. The most common team members for both the campus and community were representatives from law enforcement, mental health/counseling, and health services. Other responses (n = 101) include women’s center director, campus ministry, athletics, and case manager. Respondents could
select all the responses that applied. A written protocol guided the team activities in 37% (n = 259) of the institutions. At some institutions, students served on the response team. These students received extensive and special training. Many of the institutions maintained a 24-hr response line or program so that survivors had access to resources at all times. Many institutions reported having a task force composed of the representatives from the team to review sexual assault protocols, policies, and practices on an ongoing basis.

Services available on campus and in the community include professionals who could meet the medical, psychological, safety, and legal needs of survivors. Other community-specific services available to sexual assault survivors include local community rape crisis hotline (n = 711). Table 3 provides a list of campus and community resources available to survivors. Again, individuals could select all that applied. Other responses included housing/residential life, sexual assault nurse examiner, sexual assault response team, sexual violence task force, and chaplain.

Victim-specific services were provided for males who were sexually assaulted (n = 342) and sexual minority students (n = 379). Participants explained that institutions provide services and information for all students as opposed to specific groups. Rather, everyone is served and attempts are made to meet each student’s needs. The most common place that students could find information about what to do in the case of a sexual

TABLE 2. Team Members for Sexual Assault Response

<table>
<thead>
<tr>
<th>Campus Personnel</th>
<th>n</th>
<th>Community Personnel</th>
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<tbody>
<tr>
<td>Law enforcement</td>
<td>486</td>
<td>Law enforcement</td>
<td>190</td>
</tr>
<tr>
<td>Mental health services</td>
<td>473</td>
<td>Mental health</td>
<td>86</td>
</tr>
<tr>
<td>Health services</td>
<td>433</td>
<td>Community clinics/hospitals</td>
<td>181</td>
</tr>
<tr>
<td>Housing/residential services</td>
<td>413</td>
<td>Victim assistance/advocacy</td>
<td>114</td>
</tr>
<tr>
<td>Legal services</td>
<td>49</td>
<td>Legal services</td>
<td>49</td>
</tr>
</tbody>
</table>

TABLE 3. Campus and Community Services Provided

<table>
<thead>
<tr>
<th>Campus Services</th>
<th>n</th>
<th>Community Services</th>
<th>n</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental health services</td>
<td>749</td>
<td>Mental health services</td>
<td>582</td>
</tr>
<tr>
<td>Health services</td>
<td>716</td>
<td>Health services/hospital</td>
<td>593</td>
</tr>
<tr>
<td>Law enforcement</td>
<td>673</td>
<td>Law enforcement</td>
<td>682</td>
</tr>
<tr>
<td>Victim assistance/advocacy</td>
<td>322</td>
<td>Victim assistance/advocacy</td>
<td>625</td>
</tr>
<tr>
<td>Women’s centers</td>
<td>247</td>
<td>Women’s centers</td>
<td>304</td>
</tr>
<tr>
<td>Legal services</td>
<td>146</td>
<td>Legal services</td>
<td>366</td>
</tr>
<tr>
<td>Campus-specific services for males</td>
<td>342</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Campus-specific services for sexual minorities</td>
<td>379</td>
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</table>
assault was the student handbook or code of conduct. Table 4 contains the other sources of information. Other responses were school counselors, victim advocate, sexual assault center, and women’s center. As in previous responses, individuals could check all the answers that applied.

Open-ended responses described an ideal environment, the importance of advocates, collaborations with local community resources, and the importance of resources to guide individuals to whom a survivor disclosed. The ideal environment was supportive, where survivors felt respected. Ideally, survivors would find a coordinated, comprehensive, centralized, and consistent response protocol. Sexual assault response persons and advocates were seen as key to an effective response to survivors because they have extensive training on sexual assault, its aftermath, and the skills to respond in a caring and trauma-informed manner. Some institutions reported positively on training students to serve as peer advocates or peer counselors. Some participants reported the use of a Website to guide faculty or staff who received a disclosure of sexual assault. The Website contained information on what to say to survivors, available campus and community resources, and a systematic guide for an adequate response. Participants reported collaborating with offices across the campus and in the local community for resources and services to ensure meeting the needs of all survivors.

### Provision of Student Prevention Education

Most institutions \((n = 907, 85%)\) provided some type of training for students on responding to sexual assault. Of those, 248 individuals reported that attendance was voluntary for most students, and 704 reported that attendance was mandatory for resident assistants. Some common responses were presentations at new student orientation \((n = 425, 60%)\), by sexual assault peer educators \((n = 452, 42%)\), and curriculum infusion \((n = 625, 59%)\). Some institutions targeted educational programs to specific populations. Athletics programs were present at 80% \((n = 853)\) of represented institutions, and of those, 80% \((n = 682)\) provided targeted programming for student athletes. Similarly, the Greek system was present at 74% of institutions \((n = 790)\), and 72% \((n = 569)\) of those colleges or universities provided targeted programming. Training was provided by staff or faculty of the institution \((n = 423, 47%)\), staff or faculty from a community agency \((n = 212, 23%)\), or by peer educators or trainers \((n = 168, 19%)\).

Open-ended responses regarding content included general information on sexual assault, resources for victims, school policies and procedures, and how to respond and help a victim. The educational programming used various modalities, including use of videos, theater, visual arts, dance, peer-led discussion, and self-defense classes. Participants

<table>
<thead>
<tr>
<th>Information Source</th>
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<tbody>
<tr>
<td>Handbook/code of conduct</td>
<td>748</td>
</tr>
<tr>
<td>University website</td>
<td>614</td>
</tr>
<tr>
<td>New student/freshman orientation</td>
<td>583</td>
</tr>
<tr>
<td>Annual security report</td>
<td>421</td>
</tr>
<tr>
<td>Posted on campus</td>
<td>336</td>
</tr>
</tbody>
</table>

TABLE 4. Student Sources of Information
described the successful implementation of bystander-oriented programs and the provision of additional training to students who serve on judicial boards. Faculty education was provided so that they could include this content in their courses, as appropriate. One participant described collaborating with academic units or departments on campus in an attempt to increase the number of students hearing relevant messages. The underlying premise was that classroom discussion of issues related to sexual violence would send a message to students regarding the institutional stance on sexual violence and would reinforce the messages. However, this participant noted that not enough faculty members participated on that particular campus to make a meaningful difference.

Respondents also described challenges in deciding when and how to provide students with sexual assault training. Many campuses not only described providing information during freshman orientation but also recognized that new students receive so much information that retention can be difficult. They reported a perception that new students do not have relevant contextual knowledge of the institution and campus social culture to be able to effectively apply and use the training they receive. Several participants described providing information to students on an ongoing basis at least yearly and using social marketing campaigns to increase student awareness.

Other best practices described by participants included conducting freshman-specific classes and online education for all students. One participant reported that all freshmen were required to attend a 2-month class addressing first-year issues that included content on date rape and sexual assault. Another participant spoke highly of a mandatory online sexual assault prevention education program that introduced the problem of sexual assault, gender dynamics, ways to resist sexual violence, the importance of reporting and seeking assistance, and on-and-off campus resources. The university enforced participation by blocking registration if the student did not complete the training. Multiple participants reported positively on the use of education on bystander training to prevent sexual assault and to assist students to respond to survivors. Finally, several participants spoke of successful interventions that specifically engaged men in efforts to prevent sexual violence.

DISCUSSION

This study provides an exploration of how college and university campuses are responding to sexual assault, specifically regarding judicial processes, campus response, and prevention efforts. Although this data collection occurred just before the Dear Colleague letter from the U.S. Department of Education, the findings are discussed in light of the recommendations. Hearing boards, composed of faculty, staff, students, and administrators, was the most common method of campus-based adjudication following sexual violence. However, there does seem to be some movement to a single fact-finder model. The single fact-finder model exists primarily in practice with limited research available. This model uses an independent and neutral investigator to serve as a fact finder and gather evidence in sexual assault investigations (Fleck-Henderson, 2012). The investigator is someone with training and expertise in sexual assault cases. They may be an external contract employee or a university employee with no ties to the case. The rationale for this model is that having a smaller number of trained investigators can ensure impartial and reliable investigations. The investigator reviews the documents, interviews all parties, including any witnesses, and prepares a report.
Although most administrators acknowledge the benefits of not mandating survivor presence at adjudicatory hearings, not all institutions have embraced this concept. It was evident from participant comments that sexual violence on campus is an issue of great concern and institutional policies and procedures undergo review in a search for best practices. The most common institutional response described was a team of campus and local community individuals providing a wide range of services. Many institutions report the use of a 24-hr response system, a dedicated staff person, and a task force that reviews the response and policy on an ongoing basis. Finally, most participants reported providing training at new student orientation with some institutions targeting Greek letter organizations and athletics.

**Campus Adjudication of Sexual Assault**

Most institutions offer confidential reporting, and the hearing board was the most common model for investigating and sanctioning offenders. Confidential reporting could decrease barriers such as fear of reprisal by offenders or others and not wanting family or other people to know what happened (Fisher et al., 2003). A closed hearing board with faculty, staff, and students was the most common model. Limited research explores the effectiveness of campus adjudication boards. Research suggests that students are more likely to report sexual assault if they have confidence in the adjudication process (Brubaker, 2009). However, bringing a case before a hearing board diminishes the confidentiality and exposes the survivor to the feared consequences of reporting. Research indicates that survivors often feel secondary victimization when seeking help in the legal system (Campbell, Wasco, Ahrens, Seifl, & Barnes, 2001; Herman, 2003). Similarly, our participants recognized the potentially retraumatizing effect of the campus judicial process on survivors who report.

**Protocols and Campus Response to Sexual Assault**

A great number of institutions use a multidisciplinary team approach to respond to sexual assault. Limited research explores the team approach used by college campuses. The most common team approach to sexual assault is the Sexual Assault Response Team (SART) model. SARTs are a group of interdisciplinary service providers representing health care, mental health, law enforcement, and victim advocates who collectively respond to the needs of sexual assault survivors (National Sexual Violence Resource Center, 2006). However, most teams did not have an established protocol. Protocols are useful to guide the team and to ensure that each victim receives consistent intervention strategies. Our findings are consistent with a baseline study of SARTs found that most teams had verbal, rather than written, protocols (National Sexual Violence Resource Center, 2006). It was also encouraging to note that 80% of institutions have some type of task force or committee addressing sexual violence. In their study of college and university response to sexual assault, Karjane and colleagues (2005) reported that most campus administrators felt this to be a useful strategy. Furthermore, in describing an approach for campus-wide change in response to sexual assault, Lichty and colleagues (2008) support the use of a task force or committee to examine the environment and implement change.

**Provision of Student Prevention Education**

Most institutions provide some type of training for all students, although voluntary training is the most common model for students who are not resident assistants or security officers. A meta-analysis of campus education programs reports success in changing
rape supportive attitudes and knowledge, but little success in decreasing the incidence of sexual assault (Anderson & Whiston, 2005). It is important to note that education alone does not change behavior, but it can change the ways in which individuals respond to victims (Prochaska & DiClemente, 1983). Two promising strategies include a bystander education model and social marketing campaigns (Banyard, Moynihan, & Plante, 2007; Coker et al., 2011; Potter & Stapleton, 2011). Social marketing extends the learning in educational settings with branding via posters, campus media advertisements, T-shirts, and other paraphernalia. Curriculum infusion is another strategy to infuse prevention education into targeted courses within a curriculum that has been used effectively on other campus problems, such as student drinking (White, Park, & Cordero, 2010). However, there is a scarcity of research on curriculum infusion regarding sexual assault (Karjane et al., 2005).

Because survivors frequently disclose to their friends, peers should receive training on how to respond to survivors and on the campus and community resources (Fisher et al., 2003). When an adequate response to violence is mobilized, the physical and mental health needs of victims are met, reducing undue burdens on individuals and society. To effectively identify and respond to victims, campuses must use a comprehensive approach in their policies, practices, and protocols related to prevention and intervention of sexual assault.

**Limitations**

The major limitations of this study include the use of self-report data and our use of a convenience sample. With self-report data, there are no objective means with which to validate participant responses. Furthermore, because individuals completed the survey anonymously, there was no way to confirm the responses or to ask further questions regarding open-ended responses. However, individuals’ perceptions of their campuses response are indicative of the level of awareness and recognition of the problem and the level of communication about sexual assault prevention and response. We used a convenience sample of individuals who responded to our survey. Although the response rate was adequate for survey research, we cannot assume that the sample is representative of all potential participants. Strengths of this research include having a sample with representation from all geographic regions of the United States and from multiple types of institutions of higher education. Despite the limitations, this study adds to the science and knowledge base on campus response to sexual violence. By describing the policies, practices, and protocols of colleges and universities related to sexual assault, this study provides a foundation for future research and practice implications.

**Implications**

From a practice perspective, college and university officials are encouraged to review their practices, policies, protocols, and services related to sexual violence on their campuses (Lichty et al., 2008). Use of protocols derived from professional organizations and research evidence could make the team approach more consistent and effective (American College Health Association, 2008; Barry & Cell, 2009; Langford, 2004). University officials are also encouraged to have employee roles related to sexual violence, such as a task force, advocate, or prevention specialist (Karjane et al., 2005). These positions send an institutional message of commitment to preventing and responding to sexual violence that could increase reporting. Institutions may also consider increasing the educational efforts to increase awareness and knowledge of sexual assault. Student education can use one of the empirically tested campus prevention programs. Health providers on college
Campus Administrators may be involved in providing health education, mental health counseling, and physical health evaluations. Sexual assault nurse examiners, who may be involved in forensic evidence collection, can benefit from an understanding of the campus environment. Administrators can use knowledge of practices from other campuses to advocate for survivors and for policy change.

The study findings highlight areas for further research. Analysis of institutional climate and comparisons of students and administrations’ perceptions of the response to sexual violence would be useful in planning campus strategies to address sexual violence. Research could also explore the effectiveness of staff and faculty training efforts, comparisons of methods and outcomes of the adjudication process, impact of sexual assault related task forces, and comparisons of reporting options and rates. Finally, research that compares different types of institutions on responses to sexual violence will help to identify best practices. The previously mentioned research can enhance campus prevention, inform policy and protocol efforts, and enrich victim services delivery.

Conclusions

In summary, the campus environment shapes the culture for the prevention and response to sexual violence. Three key areas, campus adjudication of sexual assault, protocols and campus response to sexual assault, and provision of student prevention education, provide insight into the campus response and areas for change. Administrators strive toward best practices and continuously assess the processes for campus adjudication. The findings suggest movement from the traditional model of hearing boards, composed of faculty, staff, students, and administrators, to a single fact-finder model. Many institutions report the use of a 24-hour response system, a dedicated staff person, team response to sexual assault survivors, and a task force that reviews the response and policy on an ongoing basis. Finally, most participants reported providing training at new student orientation with some institutions targeting Greek letter organizations and athletics. This research increases the knowledge base on how campuses are responding to sexual violence. Campuses must use a comprehensive approach in their policies, practices, and protocols related to prevention and intervention of sexual assault.

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An Exploration of the Role of Employment as a Coping Resource for Women Experiencing Intimate Partner Abuse

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There has been a growing interest amongst researchers and practitioners regarding the various coping strategies adopted by women experiencing intimate partner abuse (IPA). These studies have tended to adopt and adapt the stress-coping model developed by Lazarus and Folkman (1984) and thus make the distinction between emotion and problem-solving coping strategies and the resources available for women to cope. Even though, contemporary coping scholars acknowledge the role of employment and coping, it is still unclear as to how employment facilitates women’s coping strategies. Drawing on findings from a qualitative study, this article explores how employment and workplace environments provide survivors of IPA with resources that allow them to cope with the abuse. By incorporating theoretical insights developed in the field of organizational studies, namely boundary work and organizational identities, these findings develop our understanding of the role of employment in survivors’ coping strategies. Finally, the findings demonstrate the valuable contribution of interdisciplinarity in furthering our knowledge of coping strategies and the positive aspects of employment for survivors of IPA.

Keywords: intimate partner abuse; employment; coping strategies; boundary work; identity theory

Several studies have examined the coping strategies adopted by women experiencing intimate partner abuse (IPA; Baly, 2010; Davis, 2002; Hamby, 2009; Hamby & Gray-Little, 1997; Lempert, 1996; Lempert, 1997; Lewis et al., 2006; Smith, Murray, & Coker, 2010; Sullivan, Schroeder, Dudley, & Dixon, 2010; Taft, Resick, Panuzio, Vogt, & Mechannic, 2007; Zink, Jacobson, Pabst, Regan, & Fisher, 2006). Overwhelmingly, these studies have adopted and adapted the stress-coping model developed by Folkman, Lazarus, Dunkel-Schetter, Delongis, and Gruen (1986) and Lazarus and Folkman (1984). Yet, as Smith et al. (2010) suggest, although the early Lazarus and Folkman model of coping is useful, it does not capture the full range of coping experiences among survivors of abuse. Accordingly, Smith et al.’s Coping Window takes account of the fact that survivors constantly assess their situation and respond accordingly with a combination of interpersonal/emotional, intrapersonal/emotional, and problem-focused/interpersonal coping strategies depending on their assessment of risk and resources available to them. Smith et al.’s model of coping strategies is extremely informative because it highlights the
importance of resources in women’s coping strategies; the specific psychological, social, and economic context of a particular woman will inform the type of resources available to them in their ability to cope. Although previous studies have illustrated how employment provides access to social support and a means of escaping the violence (Elger & Parker, 2006; Rothman, Hathaway, Stidsen, & De Vries, 2007; Swanberg, Macke, & Logan, 2006), our understanding of the role of employment in relation to coping is still limited.

Drawing on findings from a qualitative study exploring the impact of IPA on women’s employment, this study explores the various coping strategies adopted by employed women experiencing IPA. By bringing together disparate theoretical insights developed in the fields of organization studies, such as the role of organizational identities and boundary theory, and the coping literature emanating predominantly from social psychology, the findings presented in this study reaffirm the importance of interdisciplinarity in furthering our understanding of the connections between employment and the coping strategies adopted by women experiencing IPA. Indeed, the theoretical insights developed in organizational studies can help further develop our knowledge of coping strategies in terms of the resources available to employed women and how these differ depending on their occupational status, employment sector, workplace environment, and socio-economic status. The interconnections between the organizational and coping literature and how this can develop our understanding is discussed in the first section of this article. From this discussion, the author indicates how the present findings relating to compartmentalization and role immersion, provide women with emotional resources allowing them to cope. This article concludes with a discussion of the paradoxical nature of coping strategies adopted by participants and the need for further research that explores the role of employment in women’s coping strategies.

LITERATURE: INTEGRATING THEORETICAL INSIGHTS

Lazarus and Folkman’s (1984) conceptualization of coping in response to stressful situations has made an important contribution to our understanding of the different coping strategies adopted by women experiencing IPA. Lazarus and Folkman distinguish problem-focused coping from emotion-focused coping, with the former referring to the way one addresses the origin of the stressful situation to neutralize the issue and the latter associated with behaviors that seek solace, disengagement, or support from others without addressing the cause of the stress. Lazarus and Folkman comment that coping strategies have to be placed within a context and that environmental and personal constraints and the perception of threat to aspects of self-need to be taken into consideration. Folkman et al. (1986) suggest that individuals tend to employ fewer problem-solving strategies when a stressful situation involves a loved one’s well-being. Many victims of abuse continue to love their abusers and experience “positive aspects to the relationship” and therefore are reluctant to implement problem-solving strategies that may jeopardize the status quo (Davies, Lyon, & Catania, 1998, p. 78). Scholars examining the coping strategies of abused women (Smith et al., 2010; Taft et al., 2007) have developed Lazarus and Folkman’s taxonomy, taking into account the complexity of coping. Indeed, Smith et al. (2010) emphasize the individuality of women’s contexts and how this informs the type of coping and availability of coping resources. It is this individuality of women’s situations that has led many coping theorists (Hamby, 2009; Hamby & Gray-Little, 1997; Smith et al. 2010) to challenge the assumption that problem-solving strategies, that is, those
that address the cause of the violence, are more affective and call for a more nuanced and “victim”-centered approach to understanding coping. Smith et al. argues that women continually reassess their situation and adopt appropriate forms of coping depending on their particular situation and available resources. Furthermore, these strategies are not binary in terms of emotional or problem-solving strategies but are rather a combination of different strategies. Others, such as Taft et al. (2007), note that the type, severity, and duration of abuse affect the coping strategies adopted. Undoubtedly, the type, frequency, and duration of abuse need to be taken into consideration in relation to coping. However, for some women, emotion-focused coping strategies may be more appropriate, particularly if they believe problem-solving strategies could endanger certain positive aspects of their lives, such as their employment. Coping scholars highlight employment as providing particular resources for coping, in terms of providing access to informal or formal support networks and allowing women to psychologically disengage from the abuse. Yet, it is not clearly understood how employment facilitates these coping strategies.

Organizational scholars, particularly in the United States (Crowne et al., 2011; Lloyd, 1997; Rothman et al., 2007; Shepard & Pence, 1988; Swanberg & Logan, 2005; Swanberg et al., 2006, 2007; Wettersten et al., 2004) but also in the United Kingdom (Elger & Parker, 2006; Parker & Elger, 2004) and Australia (Franzway, Zufferey, & Chung, 2009), have explored the issue of IPA and employment. Leaving aside the difficulties of transposing research findings from different geographical locations, there is a broad consensus among these scholars that work can provide informal and formal support networks (Perrin, Yragui, Hanson, & Glass, 2011; Swanberg et al., 2006), that it can be a sanctuary from abuse (Elger & Parker, 2006; Hochschild, 1997; Wettersten et al., 2004) and can improve self-esteem (Lynch & Graham-Bermann, 2004; Rothman et al., 2007). It has been noted that the perceived quality of work is a major factor in providing abused women with an improved sense of self (Lynch & Graham-Bermann 2004), with Hochschild (1997) indicating class, occupational status, employment sector, and the gendered nature of the workplace environment as having a tremendous impact on women’s perceptions and experiences of employment.

For some women, employment provides them with other roles which they can immerse themselves in and emotionally disengage themselves from their “abused” or “inauthentic” self. Denzin (1984) found that some abused women differentiate between aspects of self as “authentic” or inauthentic in terms of their attachment to the world. Similarly, Zink et al. (2006) found that some women immerse themselves within particular roles, such as “carer” or “mother” to maintain a positive aspect in their lives and to emotionally disengage from the abuse. Identities that provide emotional rewards and contribute to a positive feeling of self are thought of as connected with one’s “idealized self” (McCall & Simmons, 1966). Qualitative research exploring abused women’s concept of self suggests that identities are constructed and reconstructed to protect their self-concept (Davis, 2002; Lempert, 1996; Zink et al., 2006). Identities considered valuable are protected from those perceived as less so via the construction of a mental boundary. The process of constructing and negotiating this mental boundary is referred to by organizational scholars as “boundary work” (Ashforth, Kreiner, & Fugate, 2000; Campbell Clark, 2000; Kreiner, Hollensbe, & Sheep, 2009; Nippert-Eng, 1996). The compartmentalization of different identities imposes a sense of order in addition to protecting “territories of the self” that are either completely distinct or nebulous (Nippert-Eng, 1996, p. 34). Ben-Ari and Dayan (2008) note that compartmentalization of different aspects of self provides women in professional occupations with a sense of balance and “management” of their experience of abuse. For women
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experiencing abuse, the workplace environment will provide a different physical space as well as a distinct “experiential realm” that offers an opportunity to express certain characteristics of self that cannot be displayed within their relationship, such as assertiveness, self-determination, and decision making (Nippert-Eng, 1996). It is also the case that the workplace may be the only means by which some women can socially interact with others and display certain emotions, such as happiness and anger, or disagree with opinions or decisions without the fear of reprisal. Consequently, some women will come to perceive their workplace identities as providing particular emotional needs or resources that are commonly attributed to the “private” sphere. It can be suggested that because certain forms of employment allow abused women to construct positive identities and provide other resources for coping, that women will go to great lengths to maintain their employment.

More than offering emotional resources, the workplace can provide individuals with the resources to construct a positive workplace identity which provides an improved sense of self. These identities are then maintained through the process of boundary work, which consists of placing meaning on items, symbols, and movement between geographical locations (Kreiner et al., 2009; Nippert-Eng, 1996). Employees will also draw on organizational “scripts,” that is, relating to “professional” or “workplace” identities, to compartmentalize different aspects of self (Hochschild, 2003). Dress codes and uniforms, often interpreted as a managerial tool demarcating positions of authority, status, and power within the workplace (Ashforth, Kulik, & Tomiuk, 2008; Pratt & Rafaeli, 1997), are other resources individuals use to facilitate the protection and construction of workplace identities and act as identity markers in an individual’s negotiation of the boundary between different aspects of self (Campbell Clark, 2000). Another component of boundary work is the management of realm-specific information, or what Goffman (1990) refers to as the presentation of self, when individuals prevent information about their “abused” self from “spilling over” into the workplace, because doing so could jeopardize workplace identities that provide a positive sense of self. By integrating insights developed by coping, organizational identities and boundary work scholars, allows for a more nuanced and “bottom-up” understanding of the resources that employment can provide women in their coping strategies. The findings presented further demonstrate the value of adopting this interdisciplinary perspective.

METHODOLOGY

This study employed a phenomenological approach, which rests on the premise that individuals construct and make sense of their everyday lives by bestowing meaning on material objects and their interactions with others. The concept of self is at the core of this approach (Denzin, 1984). Adopting a grounded theory approach (Glaser & Strauss, 1967) facilitated a rich and nuanced insight into the relationship between employment and the coping strategies adopted by the women interviewed. As with many qualitative studies, the aim of this study was not to test a particular hypothesis or define a particular causal relationship, but rather to develop our understanding of employed women’s experiences of abuse.

Women were recruited via snowballing and purposive sampling in the following ways: recruitment through women’s organizations (Women’s Aid Federation England and Haven); recruitment via informal approaches, that is, the author using personal contacts to recruit individuals; and the research being advertised in private
and public organizations. For logistical purposes and to avoid any inconvenience or apprehension about participating in the research, respondents were given the option of conducting the in-depth interview via telephone, via computer-mediated communication (CMC), or face-to-face.

Because of the sensitive nature of the project and the difficulty of recruiting survivors of abuse, no target sample size nor selection criterion was imposed in terms of occupation, length of time in employment, whether the occupation was full- or part-time, duration of the abusive relationship, type or severity of the abuse, or whether the participants were still in or had left the relationship. Of the women interviewed, 25 out of 28 had left/divorced their abusive partner more than 12 months prior to the interview, with the remaining 3 having left the relationship within 12 months. Therefore, all participants were relying on their memory of events and experiences. Of the 28 semistructured in-depth interviews, 19 were conducted on the telephone, 7 face-to-face, and 2 via the Internet. Informed consent was agreed in principle orally and/or textually before commencing telephone and CMC interviews, with signed copies of consent forms being collected post-interview. Prior arrangements were made with a counselling service, and contact details were offered to respondents at the end of the interview.

The interview schedule included questions such as the following: Has the abuse affected your relationship with work colleagues? What is your workplace like? Did you disclose your situation to your co-workers? During the course of the interview, the author asked respondents to clarify certain points and explored areas of interest. Over the course of data collection, certain questions, particularly those addressing aspects of coping and perceptions of self were incorporated into the interview schedule. Interviews conducted face-to-face and via telephone were digitally recorded, transcribed, and anonymized, with codenames being assigned to transcripts. In the case of Internet interviews, transcripts were produced ipso facto via CMC (MSN Messenger software).

ANALYSIS

Digital recordings were transcribed verbatim, and the computer software NVivo 7 was used to analyze the data. The major themes that developed were largely shaped by the areas covered in the interview schedule, examples being enjoyment at work, negative aspects of work, disclosure, and workplace environments. Prior knowledge of the literature pertaining to IPA and employment, as well as the author’s personal experience that those suffering from abuse are not “passive” victims, but people who employ strategies to minimize danger to themselves and their children, informed the analysis. Thus, the initial analysis went beyond the “theoretical sensitivity” espoused by Glaser (1992). It is only through the process of reflexivity that the author realized that he was imposing established concepts on the data, thus inhibiting new themes from emerging (Charmaz, 1990). Accordingly, the author revisited the data and noticed the repetition of certain expressions such as “the real me” or “being myself” and how these related to other experiences associated with workplace or home. Exploring these themes, it became apparent that these different aspects of self related to other positive themes, such as “control” and “escape,” with “disclosure” and “nondisclosure” also being intimately connected with these aspects of self.

Through the process of comparison, it became apparent that certain themes such as “autonomy” and “being in control” were associated with other themes, such as positive perceptions of the workplace. It became clear that occupation, the gendered nature of the workplace and
the level of autonomy granted at work were themes associated with positive perceptions of self. Also, organizational symbols, the commute between home and work, positive social interactions with co-workers, and organizational boundaries were connected to different perceptions of self. These emerging themes led to a further and more focused literature search. This cyclical process of consulting the literature and returning to the data facilitated the validation of themes in terms of their use (Denzin, 2009, p. 104). These themes were further refined not only in terms of meanings placed on resources, such as workplace uniforms and how these facilitated participants’ detachment from their abused self, but also how they contributed to the construction of mental boundaries and the maintenance of positive workplace identities that provided them with a positive sense of self. It is these themes exploring the use of these emotional resources as a means of “coping” that are explored in the findings.

SAMPLE

Respondents’ ages are as follows: 18–21 years (n = 3), 22–31 years (n = 10), 32–41 years (n = 13), and 42–51 years (n = 2). The nature of relationship with the abuser is as follows: 20 were married and 8 were cohabiting. Respondents self-identified their ethnicity as follows: White British (n = 25), White Australian (n = 1), White Hungarian (n = 1), and British Caribbean (n = 1). In terms of employment, 21 were in full-time and 6 in part-time employment and 1 was self-employed. Participants’ occupations are as follows: health care professionals (midwife and nurse; n = 4), managerial mental health (n = 1), retail management (n = 1), managerial banking sector (n = 1), teacher (n = 1), social worker (n = 1), dental nurse (n = 1), managerial administrative (n = 3), administration (n = 9), retail (n = 1), hairdresser (n = 1), self-employment (catering [n = 1]), and unskilled labor (n = 3). At the time of the abuse, 5 women had no children, 4 had 1 child, 13 had 2, and 6 had 3 or more.

FINDINGS: COMPARTMENTALIZATION

More than half of the women interviewed described the process of compartmentalizing different aspects of self. Respondents would justify this compartmentalization on the grounds that one should not bring one’s private life into the workplace. In adopting this perspective, many respondents noted that the abuse had little impact on their ability to conduct their work, with several women stating that they “threw themselves into their work,” assumed a more “professional” identity at work, or wore a “mask” or different “hats” denoting different personalities.

I was always still able to carry out my duties and not let that get in the way because at the end of the day, I was still having to provide the service for the clients and I couldn’t let personal issues get in the way, so it all came under the mask kind of thing, so everything was sort of hidden (Alison, social worker).

I don’t think that it ever really impacted on my work; I do believe I could wear two hats, and I had this happy hat on when I went into work and I would be this kind of life and soul and people said, “Oh you know, she is great to work with,” and that kind of thing (Bridget, nurse).

I almost lived a different life, so when I was at work, I was me and I was the Charlotte that everybody knows, and when I came home, I was a different person (Charlotte, managerial mental nurse).
It was a major coping mechanism; you know, it was an area where I had some control: I could just be a bit more me I suppose when I was at work; I could express my point of view; I could disagree with people without worrying about what impact that would have. It was almost like a refuge for me I suppose, for many years, it was an escape for me; it was a way to help me cope with what was happening (Jains, managerial administrator).

This emotional separation of different aspects of self and immersion within workplace roles can be seen as an emotional form of coping. These responses also illustrate how discourses typically associated with organizational control of employees, such as “not bringing one’s personal life into the workplace,” are used by survivors as a means of demarcating aspects of self. However, depending on a survivor’s position, that is, whether they have made the decision to leave their abuser, this discourse could prevent their seeking help or assistance within the workplace.

COMMUTE FACILITATING COMPARTMENTALIZATION AND PSYCHOLOGICAL DETACHMENT

Respondents noted how their partners would physically attack them as they were getting ready or leaving for work. A few even noted that they were sometimes restrained by their partner or sustained serious physical injuries, thus preventing them from going to work. For many women, the desire to physically and emotionally escape provided them with the inner strength to overcome these experiences of abuse. The commute between home and work aided the process of detachment and provided the emotional space within which women could traverse the boundary between home and workplace identities.

I would be going into work feeling very upset, and sometimes, I would have to stop on my journey into work to sort of get my head together and compose myself; I would just sort of deal with the emotions, but once I was in work, I just developed this ability to just sort of cut off and just focus on my work. I sort of like cut the emotion off if you like in order to cope with work; it was this coping mechanism. I developed this ability to cut off my feelings (Janis, managerial administrator).

When you are at home, you’re frightened [sic] to say anything; you are frightened to talk just in case you say the wrong thing, but when you go to work, you walk out the door and it seems as though the weight’s been lifted off your shoulders. You go into work and it’s totally different; it is unbelievable how much you can sort of change when you are at work because I am not one for taking my problems to work as such; I leave mine at home because I think that work’s work and home’s home (Jessica, unskilled worker).

Composing oneself and adopting the “correct” displays of emotion associated with the workplace identity are indicative of compartmentalizing aspects of self. Moreover, it is indicative of the process of emotionally disengaging from their situation and therefore could be considered an emotion-focused strategy, with the journey from one experiential realm to another, facilitating emotional composure and preparation to enter different roles. A few respondents also noted a reverse of this process, that is, emotionally preparing oneself to exit their workplace identities at the end of their shift.

Issues at home wasn’t on my mind during the day [at work], but when it was sort of like I only had another 10 minutes to go, I used to think, “Oh God, yeah, ok,” and then, I would always take my time. So it didn’t affect me whilst I was working because as I say, you have to put on this sort of; you have to be professional (Andrea, administrator).
The importance of the commute in assisting individuals’ emotional detachment is further illustrated by Judith, who was self-employed and was in a business partnership with the abuser.

There was no difference between the workplace and my private life; he brainwashed me if you like. I didn’t have my own identity; I didn’t have an identity. I didn’t know who I was (Judith, self-employed).

The physical separation between home and work not only allows women to physically escape, but also assists individuals’ emotional detachment and facilitates the construction of positive identities. However, other aspects such as not being isolated, having positive social interactions with others, and feeling valued in the workplace were important contributing factors in women’s positive perception of self.

UNIFORMS AND GATEWAYS AIDING COMPARTMENTALIZATION

Respondents working in the health sector not only placed significant meaning on their workplace uniforms as a resource that facilitated their compartmentalization of home and work, but also facilitated their construction of positive workplace identities. Uniforms had significant symbolic meaning and acted as a barrier between their home and work domains.

It affected me less at work because with our job, you put on a uniform; if you had interviewed me at the delivery suite, you would see a different side of me to what you are seeing now; you tend to hide behind the uniform, and that uniform’s a bit of protection. You leave your personal life at home, and you have to deal with other people’s problems. I don’t bring much home and I don’t take my home life to work. As soon as I put that uniform on, I was more confident—I’m a different me. Even now, I’ve always been a different me in the uniform (Louise, midwife).

Other participants noted the importance of physical organizational boundary markers in aiding the transition between different perceptions of self.

Like I said, it didn’t affect me much because at the gate at the hospital, I know that I am going to have a good day and I am not going to worry about this. The moment that I walk through the hospital gate, I forgot about him because of the environment I worked in was good; I have a very good environment in the workplace . . . I get lots of positive feedback from the patients, and I am wearing my name badge with my name on it and some patients ask for me; you know, “We want Karen,” so it makes you feel important that people love you (Karen, nurse).

Organizational symbols and objects are thus identity markers and emotional resources used by women to separate positive and negative perceptions of self, but these responses also highlight the importance of the workplace environment and positive interactions with colleagues and service users.

INTERACTIONS WITH SIMILAR OTHERS

Even when participants do not disclose their situation, simply interacting with others can be an emotion-focused coping strategy. However, the workplace can be a site in which abused women interact with others experiencing abuse. A small number of respondents
noted how even though they did not disclose their circumstances, conversing with other women who were or had experienced abuse was a source of emotional and practical support, in that they would offer each other advice on how to cope with their abuse and the tactics they could use to maximize their emotional and physical safety.

_I would just listen to her as she would say things and she would listen to me and pitch in and go “That's terrible; why don’t you try this or that.” We looked at solutions for each other_ (Sarah, social worker).

_There was this lady there that suffered with her husband, and I used to find myself asking her questions, as if I was asking for someone else but really I was asking for me_ (Alison, social worker).

Even though Sarah discussed these issues with her co-worker, she did not consider herself to be experiencing IPA, nor did her coworker identify her situation as abuse. Consequently, different emotion-focused strategies can be simultaneously adopted.

_He was very physical with her, but I didn’t actually think that I was the same as her you know. We used to talk about, I mean her physical abuse actually ended, but there was a lot of mental abuse going on. So we would talk about that, but we didn’t actually recognize; I never recognized the abuse and she never actually said to me you know. This is a form of abuse_ (Sarah, social worker).

Interactions with similar others may be a means of sharing coping strategies and may lead survivors to come to a realization that they are experiencing IPA. However, as these findings suggest, women may not recognize, or choose not to recognize, their situation as abusive, particularly if those they interact with are experiencing different forms of abuse.

**DISCUSSION AND CONCLUSION**

Many of the studies examining the coping strategies employed by women experiencing abuse have highlighted the distinction between emotion-focused and problem-focused coping strategies, with the latter historically being perceived as a more positive form of coping. By drawing on theoretical frameworks developed in the field of organizational studies, namely organizational identities (Hochschild, 1997; McCall & Simmons, 1966) and the compartmentalization of different aspects of self via the process of boundary work (Ashforth et al., 2000; Ashforth et al., 2008; Campbell Clark, 2000; Nippert-Eng, 1996), this study contributes to our understanding of how employment can provide certain coping resources to women experiencing IPA.

For many of the women interviewed, they perceived their employment as a means of physical and emotional escape from the abuse. In addition, they perceived the workplace as a sphere in which they could display certain aspects of their personality that were prohibited within their relationship, such as voicing their opinion, or assertiveness. For some, work gave them a sense of purpose, whereas others felt valued by co-workers. Even though work provided a level of psychological detachment, work was also a necessity, and, in several cases, abusers exploited their partners financially and harassed them at work. Paradoxically, then, work for several respondents not only simultaneously provided resources by which they could “cope,” but also contributed to their exploitation in terms of economic abuse. For many women, employment acted as a bulwark against the process of isolation adopted by many abusers. Indeed, interacting with co-workers, both male
and female, certainly provided a large number of women with emotional and practical resources. Interacting with similar others also facilitated the transfer of knowledge in terms of risk-reducing strategies. A small number of respondents noted that interacting with work colleagues and overhearing conversations pertaining to their relationships, they came to a realization that they were suffering IPA. This was not the case for all participants.

Not all forms of employment offered women emotional or practical resources, for example, the respondent who was self-employed and in business with her abuser and therefore did not have access to different aspects of self or the ability to physically or emotionally separate herself from the abuse owing to the lack of boundary markers, such as the commute between home and the workplace. In addition, respondents working in unskilled positions and environments in which there was a distinctly gendered hierarchy in terms of management reported fewer distinctions between aspects of self. There was also a notable distinction between those women occupying managerial occupations or skilled occupations and those in unskilled and self-employed roles in terms of positive experiences of work and their positive perception of self at work. It is understandable that organizational roles that offer more autonomy in terms of flexible working hours, less managerial surveillance, and the ability to make decisions in the workplace provide a more positive sense of self, because women’s autonomy and freedom within abusive relationships are often curtailed. Consequently, depending on how women perceive their workplace identities and environment will inform their level of psychological detachment and the degree to which immersion within this role provides them with interpersonal, intrapersonal emotional, and practical resources in terms of coping. The findings indicate that aspects such as class, occupational status, and gender are connected with the coping resources provided vis-a-vis employment.

Although this process of compartmentalization and immersion into positive roles may allow employed women to cope with the abuse, it also raises the difficult and problematic question of whether such coping mechanisms prolong the experience of IPA. As noted in the findings, women psychologically prepare themselves to enter and exit different roles, and organizational symbols and items assist this transition. Constructing such a rigid mental boundary between different aspects of self, although assisting women to cope, can prevent positive and empowering characteristics associated with organizational identities, such as problem-solving skills and the feeling of control, from being enacted in one’s private life. However, rather than being difficult for women to enact workplace aspects of self within their relationship, some may choose not to do so because displaying these characteristics could be perceived as challenging the abuser and thus could place women at an increased risk of violence. Moreover, enacting characteristics that are domain specific could undermine women’s compartmentalization of self and thus undermine the resource of employment in their coping strategy. But this is not to say that integration of these different aspects of self cannot be achieved in certain situations, for instance, after women have left the abuser, the empowering aspects of workplace identities could assist in their post-leaving coping strategies.

Finally, compartmentalization, identity construction, and role immersion may be perceived negatively by co-workers and supervisors/managers, especially if they are affected by the abuse, such as being a target of workplace violence or conducting additional work because of the victims’ absence or inability to conduct their workplace duties. For some co-workers and employers, leaving is the only legitimate and effective strategy. Perrin et al. (2011) indicate that this could have a significant impact on a women’s decision to seek formal assistance from co-workers, particularly if they are not ready to leave. It is
also the case that this will inform women’s decision to disclose the abuse because doing so could jeopardize their compartmentalization strategy. Leaving an abusive relationship takes time, and if the workplace provides positive social interactions with others, women may begin to question their home lives and thus provide them with the interpersonal, intrapersonal emotional resources, and practical resources to leave.

LIMITATIONS

Given the small sample on which this study is based makes it difficult to generalize from these findings or to draw conclusions about the importance of organizational symbols and items in assisting the compartmentalization process. Yet, qualitative research provides a valuable insight into the nuanced and complexity associated with survivors’ negotiation of their position and the strategies adopted to cope. It has been suggested that drawing on narratives of women who have left the abusive relationship 12 months prior to data collection is problematic, because they are relying on recollections of abusive episodes and their cognitive and behavioral responses rather than grappling with current experiences (Hamby & Gray-Little, 1997). But being a “survivor” of IPA by definition means that one will be collecting retrospective narratives. Retrospective accounts are not a banal method, for it induces reflexive thought (Gherardi & Poggio, 2007). Nevertheless, one needs to exercise caution when using such accounts to draw causal relations. Indeed, the very act of leaving an abusive relationship, accessing external resources and support systems, and employing problem-focused strategies distinguishes these participants from those who remain in abusive relationships. More qualitative research therefore needs to be conducted with employed women who are currently experiencing abuse to gain a clearer understanding of the relationship between employment, resources, and the coping strategies adopted. More specifically, further research is needed to examine the degree to which coping strategies differ in relation to occupational status and employment sector and whether the gendered nature of the workplace informs women’s coping strategies.

REFERENCES


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Barriers to Compliance With Oregon Batterer Intervention Program Standards

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Although standards for batterer intervention programs (BIPs) have been adopted in nearly all U.S. states, there is no evidence that standards are implemented and no information about challenges programs may encounter in efforts to comply with standards. This study uses qualitative survey data from BIPs in the state of Oregon (N = 42) to identify barriers to implementation during a 2-year period following the introduction of state standards. Nine challenges were identified including difficulty finding qualified facilitators, inadequate funding, difficulty meeting training requirements, high workloads, trouble creating and maintaining collaborations, inability to accommodate diverse participant needs, conflict between state standards and county requirements, and perceived gaps between standards and evidence-based practices. These findings inform controversy surrounding BIP standards and efforts to increase BIP effectiveness.

Keywords: intimate partner violence; legislative standards; policy; perpetrators; batterer intervention programs

The formation of regulatory standards for batterer intervention programs (BIPs) began in the mid-1980s in the United States after mandatory arrest laws encouraged an increased use of BIPs (Austin & Dankwort, 1999a). Because of inconsistent findings regarding the efficacy of BIPs in preventing further violence coupled with concerns about specific practices and the large degree of variation in practices between programs, state standards were developed (Bennett & Piet, 1999). To judge the quality of services offered, promote consistency, and prohibit practices that may jeopardize victim safety, 45 states and the District of Columbia have developed standards (Geffner & Rosenbaum, 2001; Gelles, 2001; Maiuro & Eberle, 2008). In theory, creating standards will lead to changes in or elimination of programs that use practices perceived to cause more harm than good. Standards might produce a system of quality assurance for judges, probation officers, and victims (Geffner & Rosenbaum, 2001; Gelles, 2001).

The widespread implementation of standards is intended to improve practice and lower the prevalence of intimate partner violence (IPV). However, there is considerable debate in academic and practitioner communities as to whether the field of batterer intervention is ready for standards and whether standardized practices will improve program effectiveness. Some reviewers are cautious about the use of standards and question the extent to
which standards are based on scientific evidence (Austin & Dankwort, 1999a; Holtzworth-Munroe, 2001), their potential to limit innovation in the field and future research (Austin & Dankwort, 1999a), the possibility that standards may prohibit potentially beneficial population-specific practices (e.g., process-oriented psychotherapy groups for men that display high levels of dependency; O’Leary, Heyman, & Neidig, 1999; Saunders, 1996), and the fact that efficacy of standards in improving BIP outcomes and reducing recidivism is unknown (Holtzworth-Munroe, 2001).

These critiques notwithstanding standards have been widely adopted. In the absence of purely evidence-based practices, they have been developed based on what is believed to be best practice in the field and are the result of experiential knowledge from those working actively in communities to prevent IPV (Dankwort & Austin, 1999). Although standards vary from state to state, the broad components of standards tend to be similar across states (Austin & Dankwort, 1999a; Maiuro & Eberle, 2008). The most recent assessment of standards across the United States found that common components include requirements addressing treatment philosophy and curriculum, length of treatment, treatment modalities, participant assessment, victim contact, confidentiality of records, release of information policies, and facilitator training (Maiuro & Eberle, 2008). It is important to note that although one critique of standards is the fact that their impact on recidivism is unknown, research demonstrates the possible benefits of various aspects of standards for outcomes beyond recidivism (e.g., greater collaboration among community partners, greater linkage of victims to resources, and increased feelings of safety among victims; Austin & Dankwort, 1999b; Gondolf, 2000; Klevens, Baker, Shelley, & Ingram, 2008).

Oregon began developing standards in 2002 after Senate Bill 81 (SB 81), which called for the creation of standards to regulate BIP practices, was passed by the state legislature. This was accomplished through the passage of Oregon Administrative Rules (OARs) for BIPs in Oregon. Administrative rules are regulations that are intended to be followed as law and describe requirements that a given agency is expected to follow. The OARs, or state standards, for BIPs were formally adopted in 2006 and regulate BIPs working specifically with abusive men in heterosexual relationships (Oregon Department of Justice [ODOJ], 2009). The requirements of the Oregon state standards are generally similar to those of standards nationwide, although there is some variation in the exact content of the requirements. Given the history of community collaboration in the intervention and prevention of IPV (Shepard, Falk, & Elliot, 2002), it is not surprising that 92% of state standards, including Oregon’s, named collaboration as an important component in stopping IPV (Austin & Dankwort, 1999a). Oregon standards indicate that programs should be in communication with victim advocacy programs, the local domestic violence (DV) council, the criminal justice system, and other BIPs (ODOJ, 2009). As with most states, Oregon does not require a bachelor’s degree for facilitators (Maiuro & Eberle, 2008) and instead requires a combination of face-to-face contact hours, education, and training (e.g., victim advocacy training, BIP training; ODOJ, 2009). In line with the 45% of states whose standards require continuing education (Maiuro & Eberle, 2008), facilitators should accrue 32 additional training hours every 2 years after initial training requirements are satisfied (ODOJ, 2009). One requirement in which Oregon differs from national norms is program length. Oregon is one of only approximately 20% of state standards that require 36–52 weeks of intervention (Maiuro & Eberle, 2008). More precisely, Oregon requires completion of 48 weekly sessions and 3 monthly aftercare sessions (ODOJ, 2009). Regarding the composition of the group facilitators, Oregon’s standards do not require the use of a male and female co-facilitation team in each group, but if programs are unable to use
this co-facilitation strategy, they are expected to notify the local supervisory authority and provide a justification (ODOJ, 2009). Despite the fact that the number of states that have similar requirements or guidelines surrounding co-facilitation is unknown, a national survey of BIP practices revealed that mixed gender co-facilitation was the most often used facilitation strategy, with one-third of the programs reporting that most of their groups use co-facilitation as opposed to facilitation by a male only, female only, or two facilitators of the same gender (Price & Rosenbaum, 2009).

As appears to be the case in most states (Austin & Dankwort, 1999a; Dankwort & Austin, 1999), there is no formal monitoring or enforcement system ensuring compliance with standards in Oregon. This begs the question of whether standards are affecting BIP practices as intended. A recent study addressing this question indicated that standards may have impacted at least one BIP practice in the state of Oregon. Boal and Mankowski (2014) investigated practices before and after the implementation of standards and found that program length increased over time, especially from 2004 to 2008. However, other practices such as programs’ coordination with community partners were unchanged before and after the adoption of standards. This preliminary evidence indicating that only one program practice changed following the adoption of standards while others remained stable suggests a need to identify and address barriers to implementation.

Barriers to policy implementation have been investigated in the context of numerous social policies to better understand how to support successful implementation. Studies that assess barriers to implementation have been conducted with a diversity of policy content areas, with health policy being one area of focus. For example, health policy implementation has been examined for policies aimed at influencing smoking (Longo et al., 1998), sodium intake (Gase, Kuo, Dunet, & Simon, 2011), alcohol use (Mosher, 1999), prenatal care (Miller, Margolis, Schwethelm, & Smith, 1989), and postpartum care (Watt, Sword, & Krueger, 2005). These studies have each examined perceived barriers to implementation, which across studies include issues related to organizational capacity, attitudes of those in leadership positions, and system complexity. Although there was some alignment in the barriers discussed in these studies, each study discusses barriers that are unique to the nuances of the policy at hand. Thus, although having knowledge of common barriers to implementation may provide a foundation for anticipating barriers to implementation, the particular policy must be examined in context to generate a comprehensive understanding of the barriers faced by those responsible for implementation.

**Purpose of this Study**

To inform the debate about the potential value and effects of standards on BIP practices, we need to understand barriers faced by programs attempting to comply with the standards. Without this knowledge, it is difficult to address problems in implementation and to assist programs in complying with the standards. Furthermore, standards are occasionally updated and revised, and information about such obstacles could inform this process. Such back and forth communication between policymakers, researchers, and practitioners is at the heart of true evidence-based practice (Gondolf, 2012). Thus, the goal of this study is to identify and describe challenges and obstacles to implementation of state standards faced by BIP providers in the state of Oregon. Given the similarities in the content of the standards in Oregon compared to national norms (Maiuro & Eberle, 2008), Oregon may be a constructive example to highlight the barriers faced when attempting to implement components of standards that are common across the United States.
METHOD

Participants

BIP staff members in the state of Oregon participated in the study (i.e., BIP directors, program managers, and/or facilitators). In total, 58 BIPs across the state were identified from a statewide directory on the Oregon Department of Justice website. Forty-eight BIPs were successfully contacted and 42 (88%) completed a survey. The remaining 10 programs could not be contacted because of inactive or incorrect telephone numbers, e-mail, and/or mailing addresses.

Procedure

This project is part of an ongoing evaluation of BIPs in Oregon that began in 2001 and has surveyed BIP practices in the state on four occasions. In recent years, this survey has been conducted in collaboration with the Oregon Attorney General’s BIP Standards Advisory Committee. This committee has developed, updated, and maintained the state standards since SB 81 mandating the development of standards was passed. This committee includes representatives from multiple aspects of the criminal justice system, victim advocates, BIP providers, and an academic researcher (currently, the second author [EM]).

In the fall of 2008, the 2008 Oregon BIP Survey was administered with approval from the Portland State University Institutional Review Board. The survey was distributed to program directors via e-mail using WebSurveyor software or via paper mail, depending on participant preferences. Although program directors typically completed the survey, knowledgeable program managers or facilitators completed the survey in some instances. The survey included items with predetermined response options, as well as open-ended items. The survey gathered information about BIP practices and characteristics relevant to the content of the state standards such as program length, training of facilitators, intake procedures, completion requirements, community collaboration, and many other areas of practice. In addition, the survey included one open-ended question that asked participants “What (if any) are the biggest barriers to your program’s compliance with the BIP guidelines?” This study explores the qualitative responses to this open-ended item. Four additional survey items were also evaluated as they related to the qualitative responses provided by participants. These items included asking the number of group facilitators who have achieved victim advocacy training requirements, the average fees charged to participants per group, whether a representative from the program attends DV council meetings, and whether culturally specific services are offered.

Analysis

To develop a comprehensive list of barriers, the first step of the analysis involved familiarization with the data (Ritchie, Spencer, & O’Connor, 2003). During the familiarization process, one graduate (the first author [AB]) and one undergraduate research assistant reviewed the item responses and independently generated a list of barriers described by providers. Descriptions of barriers ranged up to 136 words in length. After separately compiling an initial list of barriers, the research assistants met and discussed the barriers. A high degree of consistency in the identified barriers was evident, and the two assistants collaborated to determine the most appropriate name and definition for each barrier. For instance, both research assistants identified a barrier because of programs being located in a rural
area. To ensure consistency in subsequent coding, the research assistants determined this barrier should be referred to as “rural location.” After barriers were identified and named, the research assistants together reviewed each survey response as a whole and coded it as representing one or more of the barriers through discussion until consensus. Because of the straightforward nature of the responses, coding the relevant barriers was unambiguous, and the research assistants always agreed on the appropriate barrier(s) for each response.

After coding was complete, the content and frequency of various barriers was examined. First, the number of instances of each barrier was determined to describe the frequency by which each barrier was discussed. Next, all text corresponding to each barrier code was evaluated to identify exemplar quotes that convey the meaning of each barrier. This process produced two relatively common barriers and seven relatively uncommon barriers to implementation of the standards. The relatively common barriers included those mentioned by at least 20% of programs, whereas relatively uncommon barriers included those mentioned by less than 20% of programs. To fully explore the meaning of each identified barrier, descriptive statistics for other related survey items were computed. These descriptive statistics provide further explanation and context relevant to the barriers introduced by providers.

FINDINGS AND DISCUSSION

On average, programs in 2008 reported 1.2 barriers to compliance (SD = 1.1). Of the 42 programs, 29 (69%) reported at least one barrier to implementing the standards. The relatively common barriers, reported by at least 20% of programs, included difficulty finding facilitators (n = 9, 21%) and lack of funding (n = 9, 21%; see Table 1). Relatively uncommon barriers, reported by less than 20% of programs, included training requirements (n = 7, 17%), rural location (n = 7, 17%), time and workload difficulties (n = 6, 14%), difficulty creating and maintaining collaborations (n = 5, 12%), inability to accommodate participants (n = 4, 10%), conflict with county requirements (n = 3, 7%), and

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lack of evidence-based requirements (n = 2, 5%; see Table 1). To better understand the meaning of these barriers, we analyzed responses and describe in the following text the content of responses relevant to each of the barriers identified.

Difficulty finding facilitators was coded when participants described challenges finding or retaining qualified group facilitators. Oregon standards indicate that programs should use mixed-gender co-facilitation, and in situations where this is not possible, the program must inform the local supervisory authority (ODOJ, 2009). This barrier was often expressed in terms of the encouragement toward the use of mixed-gender co-facilitation that is included in the standards. For example, one participant noted, “... it is difficult to find men with appropriate power/equality attitudes. To find a man who is also bilingual is harder. [There are] less to choose from who are bilingual and have appropriate training.” Other participants described how finances of the program affected their ability to find appropriate or qualified facilitators, “[barriers stem from limited] financial resources and finding a male co-facilitator that I think knows how to not compromise what we are trying to accomplish.” These examples point to challenges programs face in finding and maintaining multiple facilitators (both male and female) who uphold the ideals of the program and have adequate training to facilitate groups. Furthermore, financial considerations must be made when requiring programs to use multiple facilitators in a single group. Although financial concerns arose when discussing the barrier of finding facilitators, these concerns were also raised more generally.

Lack of funding was coded when programs described difficulties implementing the standards because of a general sense that their program had limited financial capabilities. One participant explained, “We are a very small program on a very tight budget. The time and money available for completion of the guidelines [are barriers].” Another participant voiced, “... meeting all the training requirements is difficult. They [facilitators] have to take time off of work with no pay; for a position that pays very little, this is a great sacrifice.” Thus, some programs find it difficult to implement changes and ensure practices are consistent with the standards given their financial resources. The vast majority of BIPs in the United States are funded at least in part, if not completely, by fees paid by program participants (Price & Rosenbaum, 2009). The use of participant payment to fund the program, coupled with the need to maintain competitive costs, may create financial challenges for programs. For instance, in Oregon in 2008, participants paid an average of $35 per session. If a program provides services to a small number of participants, the extent to which they generate income beyond payment of facilitators, space rental, and material costs may be limited and present challenges.

The next barrier, fulfilling training requirements, was coded whenever participants described facing challenges when attempting to obtain training required by the standards. Barriers to training stemmed from multiple causes ranging from financial limitations, location, and challenges identifying appropriate training. For example, one provider explained this barrier, “Finding and obtaining approved training. Because of distance to the [facility in another town]—supervision was obtained in [a different town 30 miles away].” The location of the program relative to sources of training may create logistical challenges in meeting the requirements of the standards that are not experienced by programs closer to training opportunities. Alternatively, providers may not feel aligned with those providing training in their area, “I do not believe the victim advocacy programs with which I have had contact with in the past are appropriate groups to do training.” This introduces further complexity as achieving training requirements may be hindered by prior interactions between programs and training providers. Thus, it appears that barriers around training
requirements are both structural and interactional in nature. When considering this barrier, it is important to note that some discussion within the local victim advocate community in the metropolitan areas of Oregon included concerns regarding the lack of attendance by BIP providers at available trainings, despite direct announcement of, and invitation to, the trainings (Tri-County Batterer Intervention Provider Network [TCBIPN] Meeting, personal communication, October 9, 2012). There are several plausible reasons for differences in provider and advocate views about training attendance. First, some providers may know of the trainings but do not attend because they do not share the training organization’s views about IPV and BIPs. Second, trainings may be held a great distance from programs in need of training, making it prohibitively difficult and costly for staff to attend. Third, it is possible that providers are not learning about trainings and thus do not attend when they are available. Finally, providers may have already accumulated the number of hours they are required to receive and do not have a need for the training. This final possibility seems less likely when the proportion of programs that have achieved the required training is considered. Specifically, 70% of programs had at least one facilitator that had not fulfilled the victim advocacy training requirement, and 49% of facilitators across programs had not fulfilled this requirement. Thus, the trainings are needed but creating compliance with the standard will require efforts to address the barriers identified and any discrepancies between providers’ and advocates’ perspectives on BIPs and their role in ending IPV.

Structural barriers because of location are not exclusive to training requirements. The fourth barrier, rural location, captures difficulties experienced by providers because of the location of the program in the state. Program directors who described rural location as a barrier expressed that some aspects of the standards are not possible or not applicable in the rural context. For example, programs are required to collaborate with a DV council, but as one provider explains, this is not possible in some places, “Some of the BIP guidelines are more applicable to an urban area and we are rural. For instance, there is no Local Domestic Violence Coordinating Council in [our] County.” Although this example of the barrier was expressed in terms of DV councils, it is important to note that in 2008, eight programs in the state (19%) indicated they could not attend a DV council meeting because a council did not exist in their county. Upon further investigation by the author with those counties, it was determined that only two programs (5%) were actually located in counties where a DV council did not exist. It is possible that while a DV council is functional in the county, meetings may be held at a location that is far from the BIP. Alternatively, meetings may be held infrequently or communication between the agencies as to when and where meetings are held might be limited. Future research should examine this discrepancy more fully to better understand how to address this gap. Additional portions of the standards call for individualized intervention when necessary, and this may be problematic for small or rural programs that do not have the resources or staff to allow individualized intervention. As one provider explains, “How rural we are. We have a small service area and would not be able to provide culturally appropriate groups.” These examples point to the need to consider whether context, such as location or size, should be taken into account when creating standards. Furthermore, if programs perceive that their location precludes them from certain aspects of the standards, it may be important to work with them to identify potential resources.

Although meeting the individualized needs of participants can be challenging in a rural location, programs also described the inability to meet participants’ needs as a general barrier to implementation. One provider discussed how financial constraints limit their ability to meet participants’ needs, “We are a small program and do not have the resources
to serve clients who need classes in a language other than English.” Another provider described the physical space accessible, “. . . availability of group rooms . . .”, as a barrier to meeting participants’ needs. Thus, providers expressed barriers in their ability to provide services in ways that suit the needs of their participants. Despite barriers in providing individualized services, half of the programs reported having culturally specific groups (e.g., groups in languages other than English, culturally specific curriculum). Although this is far from ideal, it is promising to see that 50% of programs have some programming or services in place to address this specific need of their participants.

The sixth barrier mentioned by programs was time and workload difficulties. This barrier captured instances where the number of tasks and time it takes to complete tasks relevant to implementing the standards exceeds what the participant views as possible or reasonable. One provider described that the staff’s time is limited because of other obligations, “. . . most of our facilitators work full-time jobs outside of group time.” A second provider explained that challenges stem from the fact that, “. . . we are not a public agency and do not have a paid staff.” Finally, one provider summarized, “. . . [we don’t have] enough time to dedicate to ensure the program meets the requirements.” These examples highlight the multifaceted commitments and experiences of providers. It appears that it is not uncommon for facilitators to assume multiple roles across different jobs, thus limiting their ability to devote time to focus on implementing standards. This may be especially true in agencies that provide services in addition to BIP groups and employ facilitators that must maintain multiple types of credentials or trainings to facilitate various groups they are expected to offer. Time and workload limitations were not only experienced within programs but also as a challenge when working across agencies.

One aspect of the regulations inherent in the explicit goals of the standards is that of community collaboration (ODOJ, 2009). Although collaboration is an overt aim of the standards, collaboration was identified as a barrier to implementation of the standards. The seventh barrier, difficulty creating and maintaining collaborations, captures challenges experienced when attempting to start or sustain relationships with collaborative partners. For example, one provider noted,

The guidelines assume cooperation from the local victim program. We do not have that in our county. We have for years attempted to work with the victim program but have had little success. Our phone calls do not get returned; meetings are canceled. . . .

This points to the need for both parties to participate to foster collaboration; a program on its own will not be able to achieve this aspect of the standards. Scholars have discussed the difficulties inherent in collaboration in situations of intergroup conflict and have noted that IPV is one area in particular that is marked with a history of difficulties (Allen, 2006; Foster-Fishman, Perkins, & Davidson, 1997). Active involvement of partners from diverse aspects of the response to IPV is necessary for the success of collaborative councils (Allen, 2006). Thus, addressing longstanding tensions among collaborative partners is vital for the collaborative relationship to yield desired outcomes. Another provider described difficulties maintaining these relationships for both partners, “The one barrier I see is the ability to collaborate with other BIPs and advocacy agencies. Everyone is struggling to keep their programs together and [is] just barely getting by with the time they have to serve their clients.” This statement suggests that the lack of greater collaboration may not necessarily stem from lack of interest in collaboration but rather that other factors, such as the perceived or actual willingness and availability of collaborative partners, play a role in creating successful collaborations.
Although the standards have been created at the state level, the eighth barrier arose from the fact that some county governments within the state of Oregon have modified the standards or created their own set of standards. The barrier, conflict with county requirements, was coded when providers described an inability to implement the state standards because of county requirements. Two providers listed specific aspects of the county requirements that they are expected to follow, which contradict the state standards. Specifically, these providers noted that “the requirement to have 12-, 24-, and 48-week programs” and “separation of groups into high/medium and low/limited” impact their ability to implement the state standards. These participants are referring to the fact that the state standards require 48 weekly sessions and 3 monthly aftercare sessions for all program participants, whereas some counties determine program length based on the perpetrator’s violence recidivism risk level. To sum, one provider noted that their biggest barrier to implementing the state standards is, “individual counties’ ‘tweaking’ of [the state standards].” These examples point to inconsistencies between local and statewide requirements and the impact of these discrepancies for implementation of the state standards (TCBIPN Meeting, personal communication, January 11, 2011). These inconsistencies may place programs in a difficult position and force providers to select which set of requirements to follow. It is likely that programs weigh the potential consequences of noncompliance with each set of standards and decide which to comply with based on perceived consequences. This discrepancy raises questions regarding best practice in the context of BIPs and how best practice can be implemented when there is disagreement among authoritative bodies.

Finally, providers reported the lack of evidence-based requirements as a barrier. This code was used when providers indicated that they perceive discrepancies between evidence-based practice and the standards. One participant explained that the discrepancy between county and state requirements stems from the issue of evidence-based practice, “Per evidence-based practices, programs are required to level batterers [into different intervention lengths] using approved assessment tools as opposed to requiring . . . 48 weeks plus transition.” Thus, this provider experienced an intersection of barriers because of county and evidence-based requirements. Specifically, this individual believed that county standards, which permit varying lengths of intervention, were more consistent with evidence-based practice than the standardized length prescribed by the state standards.

Limitations

As with any study, this study has several limitations that must be considered before drawing conclusions. First, this study does not evaluate the validity of the content and scope of BIP standards and instead focuses on barriers to implementation of existing standards. BIP standards have been critiqued as not being based on empirically supported best practices in the field (Holtzworth-Munroe, 2001); from this perspective, removing barriers to compliance with standards would not be a means of increasing BIP effectiveness and victim safety. Second, this study is contextually specific to the state of Oregon, and thus, transferability may be limited. Even though there is a high degree of uniformity of content across states’ standards, there are some differences. In addition, each state likely has a particular history of IPV-relevant policy that shapes how standards were created and implemented, as well as the barriers experienced by providers. For instance, Oregon state standards differ from a large proportion of other states such that the required weeks of intervention exceed national norms (Maiuro & Eberle, 2008; ODOJ, 2009). This and other possible differences that have not been systematically assessed across standards nationally (e.g., mixed-gender...
co-facilitation, monitoring and enforcement protocols) may impact the quality of barriers experienced by providers. Although variation in state standards may impact transferability, Oregon state standards do include many of the same elements (e.g., components mandating specific program length, completion requirements, training requirements) in state standards nationally. Based on this similarity, the findings from this study have relevance to other states. Third, program directors’ self-reports of barriers may be selective and likely motivated by impression management to a certain degree. For example, although providers described difficulty collaborating with other agencies as a barrier, discussion in the community-raised questions regarding the extent to which providers are actively collaborating with and attending trainings held by victim advocates. Although this may be the case, because this study is part of an ongoing evaluation, the researchers have developed a longstanding involvement in the Oregon IPV community. Consequently, we were able to interpret reported barriers to the standards with knowledge of context beyond that in the responses and opinions of the providers. Future studies should assess the experiences of other participants in a coordinated community response to IPV (e.g., victim advocates, judges, probation officers) regarding the implementation of BIP standards to identify discrepancies and similarities across experiences. In addition, survey responses were confidential to encourage honesty. Fourth, only one representative from each program was included in the study. Although it is possible that other individuals from the programs may have experienced additional or different barriers, program directors or key staff members were sampled in this study because they are likely the most familiar with the challenges inherent in implementing the standards.

SUMMARY AND CONCLUSIONS

Developing an understanding of the barriers to compliance with state standards may provide insight that can enable improvement in the content of the standards and the ways in which programs implement the various components. This study aims to understand barriers to implementation of state standards for BIPs in Oregon. If standards promote positive outcomes such as increasing victim safety, increasing victim’s access to resources, and reducing recidivism as intended (Austin & Dankwort, 1999b; Geffner & Rosenbaum, 2001; Gelles, 2001), identifying barriers to implementation is vital to aiding programs in achieving compliance with standards.

Findings from this study indicate that Oregon BIP providers face varied barriers when attempting to implement standards. Most programs (69%) voiced at least one barrier that had been experienced over the course of the 2-year span from the introduction of the standards to the survey assessment. These barriers ranged in content and frequency, but most barriers can be subsumed by a broader theme of limited resources, which aligns with the barrier of organizational capacity identified in other studies of implementation. Whether the programs faced barriers because of finances, geographic location, or issues with collaborative partners, the common thread among these barriers is that the resource needed was not easily accessible.

To address challenges in implementation faced by providers in Oregon, it is important to consider the implications of the barriers voiced by providers and identify policy and practice implications that the findings suggest. As many barriers are related to a lack of resources, this may be the most important challenge to consider. When providers discussed difficulties finding facilitators, lack of funding, meeting training requirements, time and
workload challenges, and meeting participants’ needs, some reference to financial capacity was consistently raised. Put simply, it appears that some providers believe that a lack of financial resources is a barrier to implementation and impacts their ability to meet various components of the standards. This is perhaps not surprising when some aspects of the Oregon state standards are considered. For example, the Oregon state standards’ expectation that groups be co-facilitated by a male and female co-facilitation team whenever possible introduces the practical consequence of requiring two facilitators rather than one. This change has direct financial ramifications because programs will have to finance multiple providers for a single group. Thus, if compliance with standards is a priority, discussion regarding how to aid programs that may not have the capacity to meet all aspects of the standards should occur. For instance, policymakers should examine how BIPs are monitored and funded in other countries where compliance and certification is required and is accompanied by governmental funding (e.g., the United Kingdom; Respect, 2010).

Although lack of resources was a prominent and overarching theme that captures many Oregon providers’ experiences, the full range of barriers should be considered. For instance, although financial difficulties were discussed in the context of finding facilitators, other aspects of this barrier were also introduced. Providers noted that finding qualified facilitators with beliefs and working styles consistent with the organization is difficult. This highlights a different aspect of this barrier; the need to ensure that individuals with philosophical and educational backgrounds consistent with the work of BIPs are entering this field becomes prominent.

An additional barrier that should be addressed is that of rural location. Providers described being located in a rural setting as a barrier to successful implementation of the standards. Rural location appears to impact various areas, including the ability to find and attend trainings, collaborate with community partners, and meet the needs of participants. These findings suggest that the standards may need to be modified for programs in rural locations where some mandates of the standards are not currently realistic (e.g., collaboration with community partners that do not exist or are located extremely far from the program). Alternatively, outreach efforts could be made to aid rural programs in identifying training opportunities or connecting with potential community partners. This need may be unique to states such as Oregon that have both large metropolitan cities and expansive rural areas.

Although community collaboration as a barrier was discussed in the context of rural program location, it was also mentioned in other contexts. Specifically, Oregon providers noted that maintaining collaborations can be difficult because of perceived disinterest or lack of time from community partners. This highlights an important issue when examining standards and their potential impact. Standards in Oregon were developed to guide BIP functioning, but they have no bearing on the functioning of other organizations. Potential solutions to address lack of collaboration may include training regarding the value of collaboration for all relevant partners or creating networks of agencies interested in working collaboratively so that programs can draw on these resources as necessary. Furthermore, given discrepancies between the barriers reported by the providers and discussion among advocates in the field, additional work to identify the dynamics of this relationship and to determine how providers and advocates are interpreting the value of collaboration would be useful.

Finally, providers discussed conflict between state and county requirements, as well as lack of evidence-based practice as barriers to compliance. Although standards in Oregon have been created at the state level, at least one county has elected to develop their own
standards for practice. The primary discrepancy that arose because of these two sets of standards was in the area of program length. State standards require a fixed program length for all participants, whereas county requirements determine length after an assessment of perpetrator risk. This appears to be a substantial barrier to implementation for programs in areas where local standards are in place. Program enrollments stem largely from local criminal justice referrals, and because there is no enforcement or monitoring of standards at the state level, it may be more important for programs to adhere to local standards that may be enforced more rigorously. Further work is needed to explore the impact of local standards and how successful implementation should be conceptualized in these situations, both within Oregon and nationally. From a policy standpoint, if implementation of state standards is viewed as important and valuable, it may be necessary for individuals from the state and county to discuss divergences, their rationale, and come to consensus regarding the discrepancies to promote consistency across the state.

This study reveals the challenges Oregon BIP providers report when implementing state standards. Although the introduction of state standards has been met with some resistance among practitioners and researchers, the widespread use of standards in the United States speaks to the importance of understanding their implementation and impact on practice. Additional research should investigate the extent to which these barriers exist nationally, as well as the process of implementation and the factors that impact successful implementation. For state standards to have their intended impact on BIP effectiveness and in turn on IPV prevalence, barriers to their implementation must be overcome.

REFERENCES


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Does Childhood Sexual Abuse Victimization Translate Into Juvenile Sexual Offending? New Evidence

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The cycle of violence thesis posits that early exposure to maltreatment increases the likelihood of later maladaptive and antisocial behaviors. Childhood sexual abuse (CSA) specifically has been shown to increase the likelihood of sexual offending, although less is known about its linkages to other forms of crime. Based on data from 2,520 incarcerated male juvenile offenders from a large southern state, hierarchical logistic regression models suggested that CSA increased the likelihood of later sexual offending nearly sixfold (467% increase). However, CSA was associated with an 83% reduced likelihood of homicide offending and 68% reduced likelihood of serious person/property offending. These findings suggest further support for the cycle of violence where CSA promotes sexual offending but novel findings regarding the linkages between CSA and other forms of crime.

Keywords: childhood sexual abuse (CSA); sex offending; juvenile sex offender; cycle of violence; victimization; crime

The cycle of violence hypothesis is one of the most influential conceptual models for antisocial behavior in the social and behavioral sciences. Essentially, the cycle of violence model asserts that various forms of abuse, neglect, trauma, and violence exposure during childhood create significant developmental problems and significantly increase the likelihood of maladaptive, delinquent, and violent behaviors later in the life course (Bifulco, Brown, & Adler, 1991; Chauhan & Widom, 2012; Dodge, Bates, & Pettit, 1989; Maxfield & Widom, 1996; Segh Horn, PretKty, & Boucher, 1987; Sharp, Peck, & Hartsfield, 2012; Widom, 1989a, 1989b; Widom & Ames, 1994; Widom & Maxfield,
The cyclic nature of the hypothesis also relates to the enduring negative consequences that various forms of victimization exert over time and the ways these victimization experiences enhance risks for offending. For example, in a 12-year prospective study, Lansford et al. (2002) found that maltreatment during childhood predicted adolescent aggression, anxiety, depression, dissociation, social problems, thought problems, social withdrawal, school absence, and perceptions of attending college beyond the effects of family and child traits that are correlated with maltreatment.

The cycle of violence hypothesis is theorized to be particularly acute in the case of childhood sexual abuse (CSA). From an array of conceptual vantage points, CSA is problematic because the sexual harm denoted in the victimization causes immediate, synergistic, and ongoing physical, psychological, and developmental problems (Browne & Finkelhor, 1986; Maxfield & Widom, 1996). The cascade of problems associated with CSA creates liabilities in several domains of life and is associated with maladaptive behavior in relationships, school and work functioning, and behavioral functioning. In short, CSA catastrophically alters psychosexual development.\(^1\)

Given the overlapping developmental problems that stem from childhood sexual victimization, it is not surprising that CSA is a risk factor for sexual aggression (Browne & Finkelhor, 1986; Hanson & Slater, 1988; Johnson & Knight, 2000; Salter et al., 2003; Vizard, Hickey, French, & McCrory, 2007; Widom & Ames, 1994). In a systematic review, Hanson and Slater (1988) reported that 28% of offenders who sexually abused children were themselves sexually abused during childhood. The prevalence of CSA among sexual aggressors of children ranged from 0% to 67% (also see, Goldman & Padayachy, 2000).

The negative consequences of CSA are seen in both correctional and community settings. For instance, in a study of 813 confined juvenile delinquents, DeLisi et al. (2010) found that the youth with greater childhood trauma experiences, such as rape victimization, were significantly more likely to engage in sexual misconduct, suicidal activity, and total misconduct during their confinement. In a comparative study of juvenile sex offenders in residential treatment with and without CSA history, Burton, Duty, and Leibowitz (2011) found that juvenile sex offenders who had been victimized had much greater psychopathology including worse trauma histories, early exposure to pornography, sexual aggression, deviant sexual arousal, use of pornography, and generalized criminal behavior.

Two relatively recent meta-analyses attest to the importance of CSA and its association with sexual offending. Jespersen, Lalumière, and Seto (2009) examined the “sexually abused sexual abuser” hypothesis by conducting a meta-analysis of 17 studies involving 1,037 adult sex offenders and 1,762 adult non–sex offenders. They found that CSA history was 3.4 times more likely among adult sex offenders compared to non–sex offenders. In a larger and more comprehensive meta-analysis, Seto and Lalumière (2010) reviewed 59 studies including 3,855 adolescent male sex offenders and 13,393 male adolescent non–sex offenders and reported a significant association between CSA and sexual offending.

Despite the robustness of these meta-analytic findings, there remain equivocal findings about the association between CSA and subsequent sexual aggression or offending.\(^2\) To illustrate, in a longitudinal study of 224 former male victims of CSA followed between 7 and 19 years, Salter and colleagues (2003) found that 88.4% of CSA victims did not become sexual abusers themselves. Among the 11.6% of CSA victims who did become sexual offenders, there were several significant risk factors including childhood cruelty to animals, material neglect, lack of parental supervision, and witnessing serious intrafamily violence.
In addition, it is unclear whether CSA confers a unique risk for future sexual offending, or whether CSA confers an increased likelihood to engage in an assortment of antisocial behaviors. Again, there is mixed evidence. Widom and Ames (1994) reported that CSA victims were at increased risk for status offending (e.g., runaway) during adolescence and prostitution arrests during adulthood. Although CSA also predicted sex crimes later in life, there were also significant effects for physical abuse and neglect on subsequent sex offending (also see, Chauhan & Widom, 2012; Rivera & Widom, 1990). A recent study of CSA and subsequent offending among boys in the Pittsburgh Youth Study reported a linkage between CSA and official and self-reports of adult violent crime; however, the focus of their analyses was not specifically on sexual violent offending (Lee et al., 2012).

Drawing on data selected from males in the Christchurch (New Zealand) Health and Development Study, Fergusson, Boden, Horwood, Miller, and Kennedy (2011) found that CSA was associated with conduct problems, violent offending and convictions, and property convictions. Based on a large sample of more than 10,000 adolescent students in Iceland, history of sexual abuse was the strongest predictor of sexual offending for males (Sigurdsson, Gudjonsson, Asgeirsdottir, & Sigfusdottir, 2010). Finally, Mallie, Viljoen, Mordell, Spice, and Roesch (2011) conducted a meta-analysis of 11 published and unpublished studies producing 29 effect sizes and including 1,542 adolescent sexual aggressors. They found significant albeit small relationships between CSA and sexual recidivism.

**CURRENT FOCUS**

Although the balance of research indicates that CSA is a risk factor for sexual offending, there remain equivocal trends in the literature whether the CSA crime effect is also seen for other forms of criminal offending. For instance, in their recent 45-year follow-up study of offending behaviors of CSA victims, Ogloff, Cutajar, Mann, and Mullen (2012) advised that prior research on linkages between CSA and subsequent sexual offending have been limited by small samples, lack of juvenile samples, mostly female samples, and self-reports of victimization histories. This study design responds to each of these concerns by using a large sample of institutionalized male delinquents and official measures of abuse. In addition, this study empirically examines the relationship between CSA and sexual offending in addition to other forms of serious antisocial behavior including homicide and serious person/property delinquency.

**METHOD**

**Participants**

Data are derived from a large sample of \( N = 2,520 \) adjudicated male delinquents committed to confinement facilities in a large southern state. Information on each juvenile offender was compiled by the juvenile correctional system at a statewide intake unit upon the youth’s commitment and during their institutionalization. All state-committed youth stayed at the intake facility for approximately 2 months and then were transferred to specific facilities around the state to complete their commitment period. Additional offender data were collected during the youth’s confinement from numerous sources including state- and county-level official records, on-site diagnostic procedures at intake,
observations from professional and correctional staff, self-report information from youth, or a combination of these sources, which bolsters its concurrent validity. The dataset has been used primarily to study misconduct and noncompliance with correctional rules and regulations (DeLisi, Trulson, Marquart, Drury, & Kosloski, 2011; Trulson, Caudill, Haerle, & DeLisi, 2012; Trulson, DeLisi, Caudill, Belshaw, & Marquart, 2010; Trulson, Haerle, DeLisi, & Marquart, 2011).

**Measures**

**Dependent Variables.** Three dependent variables indicating the commitment offense for which the youth is currently confined were used. *Sexual commitment offense* included the following offenses: aggravated sexual assault, attempted aggravated sexual assault, attempted sexual assault, and sexual assault. These are completed or attempted contact sexual offenses that include rape, rape by instrumentation, rape with a weapon, rape with codefendants, and various forms of nonintercourse sexual contact. The presence of or use of a weapon and presence of codefendants made the sexual assault aggravated. Nearly 37% of youths were adjudicated and committed for a sexual offense that included sexual-oriented behavior ($M = 0.37, SD = 0.48$, range $= 0–1$). *Homicide commitment offense* included crimes such as capital murder, attempted capital murder, murder, attempted murder, criminally negligent homicide, and voluntary manslaughter. Slightly more than 27% of youth were adjudicated and committed for a homicide offense ($M = 0.27, SD = 0.44$, range $= 0–1$). *Serious person/property commitment offense* included crimes such as aggravated robbery and attempted aggravated robbery. Nearly 20% of the sample was adjudicated and committed for a serious person/property offense ($M = 0.20, SD = 0.40$, range $= 0–1$).

**Family Risk Factors.** Various dichotomous family risk factors were created by the youth correctional system. Sexual abuse (11% prevalence) measures whether the youth had experienced moderate-to-severe sexual abuse by parents or guardians prior to commitment to the confinement facility. Physical abuse (13% prevalence) measures whether the youth had experienced moderate to severe physical abuse by parents or guardians prior to commitment. Emotional abuse (23% prevalence) measures whether the youth had experienced moderate to severe emotional abuse from parents or guardians prior to commitment. Also included are measures of whether the youth lived in a home environment prior to state juvenile commitment characterized by evidence of poverty (56% prevalence), chaos (69% prevalence), or whether any family members were involved in gangs (9% prevalence).

**Behavioral Risk Factors.** Various behavioral risk factors were created by the youth correctional system. Substance abuse (44% prevalence) measures whether the youth has a substance abuse problem based on an assessment of drug use history at intake. Juvenile commitment onset ($M = 15.29, SD = 1.14$, range $= 10–18$) measures the age that the youth was first committed to a juvenile justice facility. Felony adjudications ($M = 1.27, SD = 0.58$, range $= 0–5$) measures the severity of the youth’s delinquency history. Total adjudications ($M = 1.60, SD = 0.95$, range $= 0–10$) measures the totality of the youth’s delinquency history. Previous placements ($M = 0.45, SD = 1.12$, range $= 0–15$) measures the total of out-of-home placements prior to the current commitment.

**Race/Ethnicity.** Dichotomous term for the three largest race and ethnic groups were included as controls. The largest group was Hispanics (38% prevalence), followed by Blacks (35% prevalence) and Whites (24% prevalence). Descriptive statistics for all study variables appear in Table 1.
Analytical Strategy. The analytical strategy is to empirically examine the association between CSA and criminal offending using hierarchical logistic regression. In the baseline model, only CSA is used as a predictor. In Model 2, the remaining family risk factors are entered into the model. In Model 3, behavioral risk factors are entered. In the full model, race and ethnicity are entered. The stepwise, sequential procedure begins with the bivariate relationship between CSA and the dependent variable and then evaluates how much this effect can withstand when other important predictors are considered. Odds ratios (ORs) are used because of their intuitive appeal based on conversion to percentage change ([OR − 1] × 100) between the predictor and outcome variables. In addition, to provide a visual of the association between CSA and sexual offending, a bar graph showing the prevalence of CSA by sexual commitment offense with measures of association is also provided.

Sensitivity analyses were also conducted to examine if the association between CSA and sexual offending was potentially spurious. It could be argued that CSA is such a pernicious risk factor for antisociality that it is not associated specifically to sexual offending but to antisocial behavior in general. Identical hierarchical logistic regression models were examined with different specifications for the dependent variable. In the first set of models, sexual offending as commitment offense was replaced with homicide as the commitment offense (shown in Table 2). In the second set of models (shown in Table 3), serious property offending was used as the dependent variable. This allows an investigation of the CSA effect and various forms of antisocial behavior to see if there are unique effects for sexual offending.
### TABLE 2. Hierarchical Logistic Regression Model for Homicide Commitment Offense ($n = 2,520$)

<table>
<thead>
<tr>
<th>Variable</th>
<th>Model 1</th>
<th></th>
<th>Model 2</th>
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<th>Model 3</th>
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<th>Model 4</th>
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</thead>
<tbody>
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<td></td>
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<td>OR (SE)</td>
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<td>Family risk factors</td>
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</tr>
<tr>
<td>Sexual abuse</td>
<td>0.15 (.04)</td>
<td>$-7.44^\dagger$</td>
<td>0.15 (.04)</td>
<td>$-7.37^\dagger$</td>
<td>0.15 (.04)</td>
<td>$-7.30^\dagger$</td>
<td>0.17 (.05)</td>
<td>$-6.68^\dagger$</td>
</tr>
<tr>
<td>Physical abuse</td>
<td>0.86 (.14)</td>
<td>$-0.89$</td>
<td>0.92 (.16)</td>
<td>$-0.48$</td>
<td>0.95 (.16)</td>
<td>$-0.32$</td>
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</tr>
<tr>
<td>Emotional abuse</td>
<td>1.28 (.16)</td>
<td>1.97*</td>
<td>1.34 (.17)</td>
<td>2.28*</td>
<td>1.47 (.19)</td>
<td>2.92***</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Poverty</td>
<td>1.11 (.11)</td>
<td>1.05</td>
<td>1.13 (.12)</td>
<td>1.12</td>
<td>0.98 (.11)</td>
<td>0.16</td>
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<tr>
<td>Chaotic home</td>
<td>0.82 (.09)</td>
<td>$-1.80$</td>
<td>0.95 (.11)</td>
<td>$-0.46$</td>
<td>1.0 (.12)</td>
<td>0.04</td>
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</tr>
<tr>
<td>Gang family</td>
<td>1.47 (.22)</td>
<td>2.58**</td>
<td>1.66 (.26)</td>
<td>3.23***</td>
<td>1.46 (.23)</td>
<td>2.40*</td>
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<tr>
<td>Behavioral risk factors</td>
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<tr>
<td>Substance abuser</td>
<td>0.72 (.07)</td>
<td>$-3.23^{***}$</td>
<td>0.74 (.08)</td>
<td>$-2.94^{**}$</td>
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<td>Juvenile commitment onset</td>
<td>0.85 (.04)</td>
<td>$-3.82^\dagger$</td>
<td>0.84 (.04)</td>
<td>$-4.01^\dagger$</td>
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<tr>
<td>Felony adjudications</td>
<td>1.60 (.16)</td>
<td>4.83$^\dagger$</td>
<td>1.61 (.16)</td>
<td>4.84$^\dagger$</td>
<td></td>
<td></td>
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<tr>
<td>Total adjudications</td>
<td>0.67 (.05)</td>
<td>$-5.47^\dagger$</td>
<td>0.65 (.05)</td>
<td>$-5.86^\dagger$</td>
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<tr>
<td>Previous placements</td>
<td>0.91 (.05)</td>
<td>$-1.74$</td>
<td>0.95 (.05)</td>
<td>$-0.97$</td>
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<tr>
<td>Race/ethnicity</td>
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<tr>
<td>White</td>
<td>0.58 (.22)</td>
<td>$-1.41$</td>
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<tr>
<td>Black</td>
<td>1.38 (.51)</td>
<td>0.86</td>
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<tr>
<td>Hispanic</td>
<td>1.43 (.53)</td>
<td>0.97</td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>LR$x^2$</td>
<td>91.96$^\dagger$</td>
<td></td>
<td>105.21$^\dagger$</td>
<td></td>
<td>182.33$^\dagger$</td>
<td></td>
<td>229.87$^\dagger$</td>
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</tr>
<tr>
<td>Pseudo $R^2$</td>
<td>.031</td>
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<td>.036</td>
<td></td>
<td>.062</td>
<td></td>
<td>.078</td>
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</tr>
</tbody>
</table>

* $p < .05$. ** $p < .01$. *** $p < .001$. † $p < .0001$. 
TABLE 3. Hierarchical Logistic Regression Model for Serious Property Offending as Commitment Offense \((n = 2,520)\)

<table>
<thead>
<tr>
<th>Variable</th>
<th>Model 1</th>
<th>Model 2</th>
<th>Model 3</th>
<th>Model 4</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>OR (SE)</td>
<td>z</td>
<td>OR (SE)</td>
<td>z</td>
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<tr>
<td>Family risk factors</td>
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</tr>
<tr>
<td>Sexual abuse</td>
<td>0.20 (.05)</td>
<td>-5.91†</td>
<td>0.25 (.07)</td>
<td>-5.00†</td>
</tr>
<tr>
<td>Physical abuse</td>
<td>0.97 (.19)</td>
<td>-0.18</td>
<td>0.97 (.19)</td>
<td>-0.14</td>
</tr>
<tr>
<td>Emotional abuse</td>
<td>0.54 (.08)</td>
<td>-3.95†</td>
<td>0.53 (.09)</td>
<td>-3.90†</td>
</tr>
<tr>
<td>Poverty</td>
<td>0.91 (.10)</td>
<td>-0.80</td>
<td>0.91 (.10)</td>
<td>-0.80</td>
</tr>
<tr>
<td>Chaotic home</td>
<td>1.03 (.12)</td>
<td>0.21</td>
<td>0.96 (.12)</td>
<td>-0.36</td>
</tr>
<tr>
<td>Gang family</td>
<td>1.15 (.20)</td>
<td>0.82</td>
<td>1.04 (.18)</td>
<td>0.20</td>
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<tr>
<td>Behavioral risk factors</td>
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<tr>
<td>Substance abuser</td>
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<td>Black</td>
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<td></td>
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<td></td>
</tr>
<tr>
<td>Hispanic</td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>LRX²</td>
<td>54.34†</td>
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<td>77.05†</td>
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</tr>
<tr>
<td>Pseudo R²</td>
<td>.022</td>
<td>.031</td>
<td>.095</td>
<td>.062</td>
</tr>
</tbody>
</table>

*p < .05. **p < .01. ***p < .001. †p < .0001.
RESULTS

CSA is significantly associated with sexual commitment offense across the models and irrespective of the number of confounders that are used as shown in Table 4. In the baseline model, CSA is associated with a nearly ninefold (OR = 8.68) increased likelihood of adolescent sexual offending. When additional family risk factors are entered, the effect for CSA declines to a more than sevenfold (OR = 7.31) increased likelihood. In Model 3, when behavioral risk factors are considered, the CSA effect declines but is still robust at a nearly sevenfold (OR = 6.78) increased likelihood. In the full model that also includes race and ethnicity, youth who were moderately to severely sexually abused by parents or guardians were more than five times (OR = 5.67) more likely to be sex offenders. In addition to these effects, in the full model, three additional significant effects were found. Poverty predicted sexual offending and gang family was negatively associated with sexual offending. The largest effect in Model 4 is for Whites who were more than seven times (OR = 7.53) more likely to commit a sexual offense.

Figure 1 shows clear differences in the prevalence of CSA by sexual commitment offense status. The prevalence of CSA among youth not committed for a sexual offense was 3.6%, whereas the prevalence of CSA among youth who were committed for a sexual offense was 24.4%. This is a significant difference (Pearson’s $\chi^2 = 254.45$, Cramér’s $V = .32$, $p < .001$).

An entirely different relationship was found for CSA and homicide and serious person/property offending. As shown in Table 2, the baseline association between CSA and having homicide as a commitment offense was significant and negative (OR = 0.15) such that the youth who had been sexually abused were 85% less likely to be committed for a homicide offense. This association was stable across models. When other family risk factors were introduced, the effect of CSA was still an 85% reduced likelihood (OR = 0.15), and it remained so when other behavioral risk factors were introduced. In the full model (Model 4 in Table 2), CSA was associated with an 83% reduced likelihood (OR = 0.17) to be committed for a homicide offense.

CSA was also significantly negatively associated with serious person/property offending as commitment offense, although there was greater variability of the CSA effect across models. In Model 1, the youth who had been sexually abused were 80% less likely (OR = 0.20) to be committed for a serious person/property offense. The CSA effect was also significant when other family risk factors were considered (OR = 0.25 or 75% less likely), when behavioral risk factors were considered (OR = 0.26 or 74% less likely), and in the full model when demographics were also considered (OR = 0.32 or 68% less likely). In other words, net the battery of controls, CSA was positively associated with sexual offending but negatively associated with other serious forms of crime, such as homicide and serious person/property offending.

The models show that other family and behavioral risk factors were differentially associated with sexual, homicide, and serious person/property offending. In the sexual commitment offense model, only poverty (positively related) and gang family (negatively related) were significant suggesting that CSA accounted for most of the power in the model. For homicide and serious person/property offending, a host of family risk factors and behavioral risk factors were significant. In terms of race and ethnicity, Whites were more likely to be committed for a sexual offense and less likely to be committed for a serious person/property offense, such as aggravated robbery.
### TABLE 4. Hierarchical Logistic Regression Model for Sexual Commitment Offense \((n = 2,520)\)

<table>
<thead>
<tr>
<th>Variable</th>
<th>Model 1</th>
<th></th>
<th>Model 2</th>
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<th>Model 3</th>
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<th>Model 4</th>
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<tbody>
<tr>
<td></td>
<td>OR (SE)</td>
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<td>OR (SE)</td>
<td>z</td>
<td>OR (SE)</td>
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<tr>
<td><strong>Family risk factors</strong></td>
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<tr>
<td>Sexual abuse</td>
<td>8.68 (1.35)</td>
<td>13.95†</td>
<td>7.31 (1.2)</td>
<td>12.37†</td>
<td>6.78 (1.10)</td>
<td>11.80†</td>
<td>5.67 (0.95)</td>
<td>10.41†</td>
</tr>
<tr>
<td>Physical abuse</td>
<td>1.110 (.16)</td>
<td>0.700</td>
<td>1.050 (.16)</td>
<td>0.330</td>
<td>0.999 (.15)</td>
<td>−0.000</td>
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<tr>
<td>Emotional abuse</td>
<td>1.41 (.16)</td>
<td>2.96**</td>
<td>1.36 (.16)</td>
<td>2.57**</td>
<td>1.22 (.15)</td>
<td>1.61</td>
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<tr>
<td>Poverty</td>
<td>1.02 (.10)</td>
<td>0.20</td>
<td>1.03 (.10)</td>
<td>0.29</td>
<td>1.28 (.14)</td>
<td>2.37**</td>
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<tr>
<td>Chaotic home</td>
<td>1.29 (0.14)</td>
<td>2.31**</td>
<td>1.25 (0.14)</td>
<td>1.99*</td>
<td>1.15 (.13)</td>
<td>1.24</td>
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<tr>
<td>Gang family</td>
<td>0.408 (0.07)</td>
<td>−5.000†</td>
<td>0.419 (0.08)</td>
<td>−4.790†</td>
<td>0.518 (.10)</td>
<td>−3.560†</td>
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<tr>
<td><strong>Behavioral risk factors</strong></td>
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<tr>
<td>Substance abuser</td>
<td>1.020 (.10)</td>
<td>0.170</td>
<td>0.942 (.09)</td>
<td>0.600</td>
<td>0.927 (.04)</td>
<td>−1.890</td>
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<tr>
<td>Juvenile commitment onset</td>
<td>0.921 (.04)</td>
<td>−2.090*</td>
<td>0.927 (.04)</td>
<td>−1.890</td>
<td></td>
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<tr>
<td>Felony adjudications</td>
<td>0.864 (.08)</td>
<td>−1.660</td>
<td>0.859 (.08)</td>
<td>−1.670</td>
<td>0.864 (.08)</td>
<td>−1.660</td>
<td>0.859 (.08)</td>
<td>−1.670</td>
</tr>
<tr>
<td>Total adjudications</td>
<td>1.02 (.06)</td>
<td>0.39</td>
<td>1.06 (.06)</td>
<td>1.12</td>
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<td></td>
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<tr>
<td>Previous placements</td>
<td>1.13 (.05)</td>
<td>2.84**</td>
<td>1.07 (.05)</td>
<td>1.60</td>
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<tr>
<td><strong>Race/ethnicity</strong></td>
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<tr>
<td>White</td>
<td>7.53 (3.7)</td>
<td>4.06†</td>
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<tr>
<td>Black</td>
<td>2.25 (1.1)</td>
<td>1.64</td>
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<tr>
<td>Hispanic</td>
<td>2.43 (1.2)</td>
<td>1.80</td>
<td></td>
<td></td>
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<tr>
<td>LR (x^2)</td>
<td>249.63†</td>
<td>298.91†</td>
<td>314.58†</td>
<td>440.53†</td>
<td></td>
<td></td>
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<tr>
<td>Pseudo R(^2)</td>
<td>.075</td>
<td>.090</td>
<td>.095</td>
<td>.133</td>
<td></td>
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</table>

* \(p < .05\). ** \(p < .01\). *** \(p < .001\). † \(p < .0001\).
DISCUSSION

It is difficult to overstate the tragic and negative consequences of child abuse and neglect, and this is especially true in the case of CSA. CSA creates a tangle of physical, emotional, developmental, psychological, and spiritual harms that increase psychopathology and maladaptive behavior in multiple domains. For various theoretical and conceptual reasons relating to social learning, sexual development, family dynamics, biosocial development, and other, there is evidence of an association between being the victim of CSA and being the perpetrator of sexual abuse factors (Browne & Finkelhor, 1986; Jespersen et al., 2009; Johnson & Knight, 2000; Seto & Lalumière, 2010).

This study clearly supports this empirical statement. Without considering other confounds, the association between CSA and sexual offending was substantial representing a 768% increased risk in the baseline model. Even in the full model, with a range of family risk factors, behavioral risk factors, and races/ethnicities considered, CSA still conferred a 467% increased likelihood of sexual offending. These ORs—between five and nine times more likely—are large effects and much higher than suggested by recent research (see Mallie et al., 2011). Moreover, the prevalence of CSA victimization was nearly sevenfold higher among youth committed for sexual offenses compared to those committed for other serious crimes, such as murder and aggravated robbery.

An entirely different empirical picture emerged when assessing the association between CSA and other forms of serious delinquency, such as homicide and serious person/property offending. Across models, CSA was associated with between an 83%...
and an 85% reduced likelihood of being committed for a homicide offense and between a 68% and an 80% reduced likelihood for serious person/property offending, such as aggravated robbery. Prior investigators have linked CSA to diverse forms of antisocial behavior beyond sexual offending, including drug use (Chauhan & Widom, 2012), violent offending (Beaver, 2008; Fergusson et al., 2011; Lee et al., 2012; Rivera & Widom, 1990), and generalized antisocial behavior (Burton et al., 2011; Fergusson et al., 2011). These prior works suggest a generalized criminogenic effect for CSA and subsequent offending that is similarly seen in the victim–offender overlap (Berg, 2012; Jennings, 2012; Jennings, Higgins, Tewksbury, Gover, & Piquero, 2010; Katz, Webb, Fox, & Shaffer, 2011; Silver, Piquero, Jennings, Piquero, & Leiber, 2011) and criminal careers (DeLisi, 2005; DeLisi & Piquero, 2011) literatures. Both perspectives have shown that extremely violent offenders evince substantial victimization histories where it appears that the abuse plays a role in the subsequent infliction of violence. Indeed this idea is the essence of the cycle of violence hypothesis.

Although linkages between CSA and offending are often general and reflect the versatile nature of antisociality, the current models showed that CSA translated into commensurately similar forms of offending while significantly reducing the likelihood of other violent offending. To our knowledge, the strong positive association between CSA and sexual offending and the strong negative association between CSA and homicide and serious person/property offending are relatively new. These effects are not entirely without precedent, however. In their typology of adolescent sex offenders, for example, Butler and Seto (2002) advanced two types. Sex-only offenders are those without nonsexual offenses in their criminal history and sex-plus offenders are those with nonsexual offenses in their criminal history. Butler and Seto found that sex-only offenders had fewer conduct problems during childhood, more prosocial attitudes, better social adjustment, and a lower risk for future delinquency than their more versatile peers, the sex-plus offender. The current findings appear similar to the sex-only typology.

Despite the significant effects in the logistic regression models, it is important to note that most delinquents who were committed for a sexual offense were not themselves sexually abused. Of the 930 youth committed for a sexual offense, 24.5% (n = 227) had been sexually abused, whereas 75.5% (n = 703) had not been sexually abused. This suggests there are multiple pathways to sexual offending among juvenile justice system involved adolescents (Burton et al., 2011; Johnson & Knight, 2000; Knight & Sims-Knight, 2005). On the other hand, 79.9% of the youth who had been sexually abused were also committed for a sexual offense.

What becomes of youth who experience CSA and engage in sexual offending during adolescence in adulthood? To date, research shows surprisingly little continuity in sexual offending across criminal careers (Caldwell, 2007; Reingle, 2012). For example, Zimring, Jennings, Piquero, and Hays (2009) found that only 10% of juvenile sex offenders had a sex-related offense through age 26 years based on data from the 1958 Philadelphia birth cohort. Moreover, 92% of males with sexual offenses during adulthood had zero sexual offenses during adolescence. Substantively similar studies based on data from birth cohorts from Racine, Wisconsin (Zimring, Piquero, & Jennings, 2007) and the Cambridge Study in Delinquency Development (Piquero, Farrington, Jennings, Diamond, & Craig, 2012) also found little evidence of continuity in sexual offending. Importantly, these prior studies did not include CSA as a background factor for either juvenile sexual offending or adult sexual offending, thus it is unclear whether these findings would hold with CSA specified in multivariate models.
Study Assets and Limitations

This study offers several strengths, including a large sample of juveniles, official measures of diverse forms of childhood abuse, and an exclusively male sample. Nevertheless, the current data lacked various important measures that will help to further specify the relationship between CSA, sexual offending, and other forms of criminal offending. Various attitudinal, clinical, and personality (Bouffard, 2010; Burton et al., 2011; Knight & Sims-Knight, 2005; Seto & Lalumière, 2010), lifestyle/criminal career (Amirault & Lussier, 2011; Fergusson et al., 2011; Lee et al., 2012; Lussier, Bouchard, & Beauregard, 2011), and other factors are significantly associated with sexual violence perpetration and criminal offending generally, but we were not able to examine the potential ways these factors moderate or mediate the linkages between CSA and the various forms of criminal offending in the models. This segues into another important limitation, which is the cross-sectional design. Only longitudinal data can establish temporal connections. This is particularly important given the prior discussion about discontinuity between juvenile sexual offending and adult sexual offending.

The risk measures used in the study were dichotomous, which precludes an investigation of whether commitment offense was influenced by the degree of family risk and behavioral risk. Criminal career researchers recurrently document a small subgroup of severe offenders (Jennings & Reingle, 2012; Moffitt, 1993; Vaughn et al., 2011) who not only commit crime with greater frequency and severity but also display the greatest number of risk factors. A more expansive measure of CSA that captures the type of abuse, frequency of abuse, duration of abuse, and other dimensions would allow a more nuanced investigation of its potential influences on sexual offending, homicide, and serious person/property offending.

Another limitation is the absence of measures that explain more precisely the mechanisms by which CSA unfolds into sexual offending. For example, Fergusson et al. (2011) found that CSA and violent crime were connected among males with the low-activity allele of the monoamine oxidase A (MAOA) polymorphism. Indeed, several recent studies have shown the ways that genetic factors interact with CSA to manifest in serious criminal violence (Beaver, 2008; Caspi et al., 2002; Widom & Brzustowicz, 2006). Given the proliferation of biosocial perspectives in criminology, psychology, and related fields, this is an important avenue for future research.

Beyond the theoretical implications of these findings, this study also has pragmatic directions for early identification and treatment for sexual abuse victims. If, as our findings suggest, earlier life sexual abuse experiences increase the likelihood of later sexual offending, then early interventions for sexually abused youth may circumvent future maladaptive sexual behaviors. Early identification and appropriate treatment for sexual abuse has the potential to reduce the cycle of violence’s impact on future behaviors and, thereby, reducing the likelihood of further victimization. Given that CSA was negatively associated with other serious crime, such as homicide and aggravated robbery, the treatment effects should largely focus on sexual offending.

CONCLUSION

Although the pattern of findings in previous studies have not always showed that CSA is robustly associated with later sex offending during adolescence, this study’s large effects, even in the face of numerous confounds, provides new evidence confirming the cycle of
violence paradigm among residually incarcerated youth. That there are hundreds of thousands of youth who are detained or incarcerated in residential treatment centers in a given year (Sickmund, Sladky, Kang, & Puzzanchera, 2008) suggests that the robust relationship between CSA and juvenile sex offending be investigated further. Moreover, because CSA was negatively associated with other serious criminal violence, more research is needed to clarify these new findings in the cycle of violence.

NOTES

1. The cycle of violence hypothesis is also supported in the criminological literature by research, which shows there is substantial empirical overlap between criminal offenders and crime victims (Berg, 2012; Jennings, 2012; Jennings, Piquero, & Reingle, 2012; Katz et al., 2011; Maldonado-Molina, Jennings, Tobler, Piquero, & Canino, 2010; Silver et al., 2011). Several criminological theories, such as social learning theory, routine activities theory, subcultural theory, and state dependence/population heterogeneity theory provide explanations for the victim–offender overlap (Berg, 2012) that are consistent with the cycle of violence.

2. It is important to note that much of the equivocal relationship of a CSA sex offending link relates to sex/gender. For instance, in an investigation of male and female sexual aggressors selected from school and juvenile institutions in the Netherlands, Slotboom, Hendriks, and Verbruggen (2011) found that prior sexual abuse victimization was the strongest predictor of sexual offending among males but was not significant for females. In contrast, an investigation of 258 delinquent female offenders from the United Kingdom found that female sexual aggressors were significantly likely to have been sexually abused (McCartan, Law, Murphy, & Bailey, 2011). The current sample contains only males and thus unfortunately cannot address this empirical question.

3. The current data contain contact sexual offenses and do not contain noncontact offenses. It is important to acknowledge, however, that noncontact sexual offenses, such as consumption of pornography, exhibitionism, voyeurism, and others have been shown to play a role in antisocial development (cf., Mancini, Reckdenwald, & Beauregard, 2012; Pednault, Harris, & Knight, 2012; Seto & Eke, 2005; Seto, Maric, & Barbaree, 2001; Sheldon & Howitt, 2008; Terry, 2006; Webb, Craissati, & Keen, 2007). The lack of noncontact sexual offenses is a limitation of the current data.

4. All measures of abuse indicated moderate-to-severe abuse by parents or guardians and were measured dichotomously. As noted by an anonymous reviewer, this potentially obscures important variance in the degree or severity of abuse that the youth incurred. In addition, in terms of sexual abuse, the measure does not include abuse perpetrated by peers, siblings, or other nonparent/guardians, which is a limitation (cf., Browne & Finkelhor, 1986; Finkelhor, Moore, Hamby, & Straus, 1997; Finkelhor, Ormrod, Turner, & Hamby, 2005).

REFERENCES


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Cold or Caring? Adolescent Sexual Assault Victims’ Perceptions of Their Interactions With the Police

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Rebecca Campbell, PhD
Michigan State University

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Harder+Company Community Research

One-third of sexual assault cases that are reported to the police involve adolescent victims (Snyder, 2000), yet little is known about adolescent victims’ interactions with law enforcement. Through semistructured interviews with 20 adolescent sexual assault victims, this study sought to understand—from the perspectives of the adolescents—how the police interacted with them on an interpersonal level and the impact this had on the adolescents’ emotional well-being and engagement in the criminal justice system. Findings revealed that when the police engaged in behaviors that the victims perceived as caring, compassionate, and personable (vs. behaviors that were perceived as uncaring, insensitive, and intimidating), there was a positive impact on victims’ emotional well-being and criminal justice system engagement. Implications for improving adolescents’ help-seeking experiences are discussed.

Keywords: rape; help-seeking; criminal justice system; rapport; reporting

One-third of sexual assault cases that are reported to the police involve adolescent victims, yet very little is known about adolescent survivors’ interactions with law enforcement (Snyder, 2000). Prior research has illustrated that adult victims frequently have negative experiences with law enforcement, and these experiences have serious repercussions for their well-being (see Campbell, 2008 for review). However, these issues have not yet been examined among adolescent victim populations. This is a key limitation because adolescence is a distinctive developmental period and the dynamics between the police and adult versus adolescent victims are likely to differ. This may impact how the police engage with victims interpersonally, may impact how victims perceive police officers’ actions, and may also influence the effect of how the victims were treated by the police on their well-being. Therefore, the aim of this study was to examine adolescent sexual assault survivors’ perceptions of how the police interacted with them on an interpersonal level: what was helpful versus not and the impact this had. To set the stage for this work, we will begin with a brief review of the prevalence of adolescent sexual assault and victims’ help-seeking with the criminal justice system.
Sexual victimization of adolescent girls is common in the United States. Overall, 6% of adult women report that they were raped when they were 12–17 years old (Tjaden & Thoennes, 2006). In a more recent nationally representative study of youth, 6% of 14–17-year-old girls have been raped, and 8% had been sexually assaulted in the past year alone (Finkelhor, Turner, Ormrod, & Hamby, 2009). Although sexual assault is widespread, most of these crimes do not come to the attention of the police (see Campbell, 2008 for review), and this appears to also hold true for assaults of adolescent girls. In a representative sample of adults in Washington, only 8% of women who had been raped during adolescence reported the assault to the police (Casey & Nurius, 2006). To date, this is the only study to examine reporting rates specific to rapes/sexual assaults that occurred when the victim was an adolescent.3

For many victims, reporting initiates a long and grueling criminal justice process. Prior research on adult sexual assault survivors suggests that the ways in which police officers engage with victims can make the process easier or more difficult (see Campbell, 2008 for review).4 During the investigation of the case, a survivor may have to describe the assault repeatedly in great detail (Logan, Evans, Stevenson, & Jordan, 2005). Given the invasive, traumatic nature of sexual assault, this can be quite upsetting. When investigators begin interviewing victims by immediately asking difficult questions rather than building rapport, survivors are likely to feel grilled and rushed (Patterson, 2011). Many police are perceived as cold, intimidating, and unsupportive (Ahrens, Campbell, Ternier-Thames, Wasco, & Sefl, 2007; Konradi, 2007; Logan et al., 2005; Maier, 2008). On the other hand, the police can be viewed as caring and responsive when they console the survivor or let her answer questions at her own pace (Konradi, 2007; Patterson, 2011).

Survivors’ experiences with the police also impact their participation in the legal system. A key study of adult rape victims revealed that when detectives paced their questions slowly and attended to their well-being, survivors felt it was easier to remember and share information (Patterson, 2011). On the other hand, survivors who felt interrogated described how the detectives’ actions (e.g., rushing them) made it harder for them to disclose. Interactions with the police also affect survivors’ participation in the later stages of the legal process. Maddox, Lee, and Barker (2011) found that victims’ ratings of the empathy of the police they worked with were positively correlated with the survivors’ ratings of their willingness to prosecute.

Overall, the extant literature suggests that most adult survivors have negative perceptions of the ways in which the police interacted with them on an interpersonal level, and such negative experiences are detrimental to survivors’ well-being, as well as their participation in the legal system. To date, these issues have not been studied in adolescent populations. This is a serious limitation because adolescence is a unique developmental period and may have implications for the interactions between the police and the victims.

The victim being an adolescent increases the power differential between the police and the sexual assault victims; such a differential already exists between the adult victims and the police. Adult survivors can generally choose how they will participate in the legal process and respond to police actions (e.g., Greeson & Campbell, 2011; Konradi, 2007), but the police have the authority to determine how to investigate the case (if at all), how they will treat the victim, and whether they will send the case forward for prosecution (Martin, 2005). The distribution of power is even more lopsided when the victim is an adolescent. Adolescents, as minors, may have less knowledge of the criminal justice process, and such knowledge has been shown to be a resource in helping survivors advocate to get their needs met (Konradi, 2007). In addition, adolescents have less control over their participation.
in the legal process because their parents may either force or inhibit their participation (Campbell, Greeson, Bybee, & Kennedy, 2011). Furthermore, the cultural differences between youth and adults may influence how the police and the adolescent victim perceive and relate to one another. Developmentally, adolescence is a time of experimentation and sometimes risk-taking (American Psychological Association [APA], 2002), and adults and authority figures (such as the police) may stereotype adolescents as flighty, irresponsible, and/or untrustworthy. This could lead a police officer to conclude an adolescent victim is exaggerating or lying and not a credible witness, particularly if they were engaged in behaviors that are considered inappropriate for their age prior to the assault (e.g., drinking, consensual sexual activity). On the other hand, because adolescents are children, they may be perceived by the police as more vulnerable and less likely to be (unfairly) blamed as “bringing the assault on themselves” than adult women; this in turn may lead to the officer engaging in a maternal/paternal, sympathetic approach with the adolescent.

The differences between youth and adults may also influence adolescents’ perceptions of the police. Adolescence is characterized by growing independence and often, a corresponding rejection of authority. This may lead adolescents to be wary of the police and fearful of getting in trouble. Indeed, there is some evidence that adolescents are more mistrusting of the police than adults (Taylor, Turner, Esbensen, & Winfree, 2001). Furthermore, adolescents are still in the midst of cognitive, social, emotional, and identity development (APA, 2002). After the trauma of an assault, adolescents may simply need or want different things from the people they tell about the assault than adults. Once they do disclose, adolescents may view certain reactions, particularly coming from authority figures, differently than adult victims would. For example, an adult victim may find a police officer assuring her that she will be a good witness at trial supportive, whereas an adolescent may be frightened and feel pressured. Finally, the impact of experiences with the police may be different for adolescents. External factors, particularly their parents, may be more influential over adolescents’ participation in the criminal justice system, and therefore, how they are treated by the police may matter less. Because they may perceive different things to be positive or negative than adults do, the same police interactions may have a different impact on adolescents.

Because of the many differences between adult and adolescent sexual assault victims, a study unique to the experiences of adolescent survivors’ interactions with the police is warranted. To this end, face-to-face qualitative interviews were conducted with 20 adolescent sexual assault victims who reported the assault to the police to examine their perceptions of how law enforcement engaged with them on an interpersonal level: what was positive, what was negative, and the consequences of the police’s behavior on their emotional well-being and criminal justice system engagement.

**METHOD**

**Sample and Recruitment**

To identify adolescent sexual assault victims who had contact with the police, this study was conducted in collaboration with two sexual assault nurse examiner (SANE) programs and rape crisis centers in a Midwestern state. SANE programs provide medical services and forensic evidence collection to sexual assault victims postassault. The two SANE programs were similar with respect to program practices, population served, and client demographics. Adolescents who met eligibility criteria were recruited when they came to the
SANE program for services. Victims were eligible to participate if they were 14–17 years old at the time of the assault, received a full medical/forensic exam from one of the focal SANE programs, and were sexually assaulted in one of the focal counties the SANE programs serve. At the time of data collection, the first county (a mixture of urban and rural areas) had a total population of 100,000–150,000 persons, with the largest city in the county accounting for approximately half of the county’s population. The second and more densely populated county was primarily urban and suburban, with some rural areas, and a population of 500,000–1,250,000 residents.

The forensic nurses provided eligible patients with information about the project and asked them if they were willing to be contacted by a member of the research team about the study. If they were willing, the patient filled out an “Agree to Be Contacted Form” indicating how and when they could be contacted by the research team. The research team attended SANE program monthly staff meetings to monitor recruitment. Survivors who agreed to be contacted were called by the research team approximately 4 weeks after they received the SANE exam. Recruitment proceeded until saturation was reached, meaning that existing themes had adequate coverage and no new themes had emerged (Starks & Trinidad, 2007).

Participant demographics were consistent with the demographics of the clientele of the SANE programs and the counties they serve. On average, participants were 15.65 years old at the time of the assault (SD = 1.04 years), and all participants were female. Most participants identified as White, (75%), with three African American (15%), one Asian American (5%), and one multiracial (5%) participant. In most of the cases, the assailant used physical force (60%), and in 20% of cases, the victim was incapacitated at the time of the assault. Three of the girls were assaulted by multiple perpetrators (15%). More than half of the victims were assaulted by a friend or acquaintance (55%), and 30% were assaulted by a dating partner or ex-partner; familial assaults (5%) and stranger assaults (5%) were rare.

With respect to control over reporting, three of the girls (15%) were assaulted while they were unconscious (because of intoxication) and were still unconscious when the police were contacted about the assault. For eight of the girls, reporting was voluntary (40%): They immediately wanted to report or initially hesitated but after encouragement from their friends and family decided that it was what they—the victim—wanted. For the remaining nine girls (45%), reporting the assault to the police was against their will. In some instances, someone else (usually a parent) reported the assault against their wishes. In other instances, the survivor “agreed” to report but only because she felt she had to because of the negative reactions of their family and friends to the assault, not because she actually wanted police involvement.

**Measurement and Procedures**

In-depth, semistructured interviews were conducted by two highly trained female interviewers. The study focused on adolescents’ perceptions of how the police interacted with them on an interpersonal level. Relevant questions included “What was your experience with the police like?” “What did the police do that was helpful?” and “What do you wish had been different with the police?”

Interviews were conducted in the offices of the local rape crisis centers. Typically, research with minors would require parental consent; however, requiring parental consent could have biased the sample toward adolescents who felt comfortable disclosing the assault to their parents. Therefore, the research team received institutional review board
approval for a substitute in loco parentis consent process whereby a rape crisis center counselor provided consent for the adolescent to participate, and the adolescent provided their assent. At the end of the interview, the participant received $30 as compensation for their time. With participant permission, all interviews were audio-recorded. Interviews typically lasted 1.5–2 hr, and all interviews were transcribed. Interviewer meetings were held regularly to discuss emerging themes to explore further in subsequent interviews and monitor interviewer quality and monitor saturation.

**Analyses**

Analyses involved open coding, followed by analytic induction (AI; Corbin & Strauss, 2007; Erickson, 1986). The analyst, who was also one of the primary interviewers, began by reading through the data multiple times. In the next step (data reduction), the analyst open coded the data and also created detailed case summaries for within-case analysis. These steps were used to enhance the AI phase of analyses. AI begins with the development of initial assertions that explain the phenomenon of interest, based on a deep understanding of the data (Erickson, 1986). The analyst’s prior work with the data informed the development of these initial assertions. Next, the analyst engaged in a systematic, iterative process of testing the assertions against all data, revising the assertions, and retesting new versions of the assertions. Specifically, as prescribed by Erickson (1986), the analyst examined the data to determine whether the assertions met any of the following criteria for evidentiary inadequacy: inadequate amount of evidence, inadequate variety in the kinds of evidence, faulty interpretation of evidence, inadequate possibility for disconfirming evidence, and inadequate discrepant case analysis. This process continued until a set of well-supported assertions remained. Results were examined for site differences and differences between responding officers and detectives; none were found.

**RESULTS**

Overall, survivors had mixed perceptions of the ways in which law enforcement engaged with them interpersonally. In fact, most survivors had both positive and negative perceptions of police actions: 16 out of 20 survivors reported negative actions, and 11 out of 20 reported positive actions. The focus of the study was not to make generalized statements about whether the police were “good” or “bad” but rather to understand what specifically the police did that the adolescents perceived as positive versus negative and how the adolescents believed their interactions with the police affected their well-being and criminal justice system engagement.7

**Negative: Uncaring, Insensitive, and Intimidating**

When survivors expressed negative perceptions of the ways in which the police interacted with them on an interpersonal level, they characterized officers’ behavior as uncaring, insensitive, and/or intimidating. Examples of behaviors that were interpreted as uncaring, insensitive, and/or intimidating are provided.

*Insensitivity to Emotions.* Often, survivors felt the police were insensitive or uncaring because they ignored or failed to account for the impact of the crime on the victim’s well-being—that they had been hurt, typically very recently. A common example was the officer failing to ask the victim if she was okay or failing to comfort her when she was
visibly upset. A 15-year-old survivor who was assaulted by a friend described her experiences reporting to the police the morning after the assault:

Like as soon as I got up, I felt like I just went straight to the police department. So I was really upset; I was still crying. So I think they [the police] should be a little more calm and actually listen and try to feel what’s going on.

Interviewer (I): What do you mean by “feel what’s going on?”
Well, I was really upset, and [the police] didn’t seem like they were too caring.
I: Did they do anything to address the fact that you were upset or that you were crying?
No, they just asked what happened, and [the investigator] was just getting frustrated with me.

In this example, the officers did not respond to the fact that she was crying. Generally, the survivors interpreted the police as cold and uncaring when they felt that officers ignored their emotions and well-being.

**Rushing the Survivor.** A common theme was that answering questions about the assault was inherently emotionally difficult. The assault was upsetting, and it was upsetting for the girls to talk about the assault and answer questions about it so soon after it had occurred. Several survivors described the police asking questions in a way that made them feel rushed, when they needed a moment to steady themselves emotionally. This was interpreted as the police being insensitive to the fact that it was difficult for the survivors to talk about the assault; it also made the girls feel flustered and wrong-footed. A 17-year-old who was assaulted by her boyfriend described the detectives who interviewed her:

They were sensitive to a certain point, but I think they could have been more sensitive on saying, “You can take your time.” I just felt so rushed, like I need to get this done, I need to get this done. It’s just not the easiest thing in the world for somebody to just bluntly come out and tell you what just happened to them.

As she pointed out, it was hard to tell people about the rape, and she felt that the detectives’ behavior did not make it easier on her.

**Jumping Into Talking About the Assault.** Another way that some police made it harder for survivors to talk about the assault was beginning the interview by immediately asking about the assault, without any preamble. This approach felt extremely “blunt” to the survivors, and they wished the police would have made them feel more comfortable by talking about other things first. A 15-year-old described the officer who came to pick her up after she left the scene of the assault:

The officer that picked me up was grumpy . . . He wasn’t really talkative. He was kind of like, cut to the chase, right away, and everything, huh. He didn’t talk to me; he just went right to it.
I: Can you tell me what you mean by that? I’m not sure I understand.
Like, he didn’t really talk to me at all, like ask me if I was okay or anything like that. He just started asking about the incident.

His “grumpy” demeanor made her feel like she was in trouble and made her uncomfortable talking to him.

**Intimidating Interviewing Style.** Often, officers not only lacked sensitivity but were also intimidating. The survivors’ descriptions of these officers were consistent with a “tough interrogator” stereotype. A common complaint was that these officers failed to be calm and patient. Specific words that survivors used to depict these officers included “strict,” “uptight,” “tough,” “cocky,” and “rude.” Examples of behaviors that were
interpreted in this way included the officer pressuring the victim for information; acting frustrated or angry with her; and exhibiting a harsh, accusatory tone and/or body language.

A 15-year-old survivor who was assaulted by a friend while she was drunk had difficulty remembering some of the details of the assault. She described being interviewed by an officer who demanded information and acted angry with her when she could not remember information:

I think it was just to get—hard to exactly remember, but he was just, we were just kind of both rushing through it . . . and if I didn’t, wasn’t, knew exactly what happened, then he would get mad. Like, “Well, you know. You’ve got to know.” And I told him, well I was drunk, I don’t remember. And he would go, “Well, you’re going to have to remember!”

She wanted to provide the information he wanted, but she had no control over what she could remember. She felt that the officer, who was focused on the case rather than her, did not take this into account.

Several survivors who described an officer with an intimidating interpersonal demeanor specifically noted dissatisfaction with the verbal tone and/or body language the police employed. They described a raised voice; a harsh questioning tone; and a severe, closed-off body language. A 14-year-old who was assaulted by an acquaintance described how she wished officers would talk to victims, in comparison to how the officer talked to her:

I: What should police officers know about dealing with something like this?

Like talk to them as if it was more of a conversation like, you know, like me and you [referring to the interviewer], not so much of the whole question and strictness and everything like that. Like, what do you mean by that . . . be careful with the questions, man. Ease off.

I: Was there something, it sounds like, when you talk about him you go, well, why you say that, [imitates her voice imitating the police officer] like was there something about his tone that was bothering you?

Yeah, he was just like . . . by that you mean [voice gets louder, goes up as if questioning, harsher] and I’m like, I mean that he was just kind of scary or something like that.

The way he talked was intimidating and off-putting. In the next example, a 16-year-old who was assaulted by an acquaintance described the police as strict and uptight, in part because of their body language and tone.

Just to be a little bit not so uptight.

I: Okay. Say more about how they were uptight?

Just how they seemed so strict with, the police officers and everything.

I: Okay. Sometimes it is really helpful if I can say like really specifically about what they did that made them seem strict.

I’m not sure, just like their body language . . . tone of voice.

These behaviors were particularly problematic because many of the girls were already intimidated or felt put on the spot before the police started asking them questions. Some were intimidated by characteristics of the physical setting where the interview took place (e.g., knowing the interview was being videotaped), whereas others were generally fearful of talking to the police and were wary of how they might be treated. When the police then demanded information, expressed anger at the survivor, or exhibited harsh tone of voice and body language, it exacerbated the intimidation survivors already felt.
Adolescent Victims' Perceptions of the Police

Positive: Caring, Compassionate, and Personable

Although there were many things that police officers did that were perceived negatively, there were also myriad examples of positive things the police did. Under this theme, the survivors perceived their behavior as caring, compassionate, and personable. Examples of specific positive behaviors are provided.

**Caring for the Survivor’s Emotions and Well-Being.** Several survivors described how the police helped them to calm down and comforted them when they were upset. For example, a 16-year-old who was assaulted by an ex-boyfriend discussed how the officer treated her:

> It was caring and he was trying to get me to calm down and just tell me everything was going to be okay; he actually cared about me and what happened. He was really nice.

Other victims described a police officer offering them a tissue or a glass of water when they were crying as examples of being nice and comforting.

Another example of caring for the victims’ well-being occurred when the police took actions to look out for survivors’ well-being even when they were not visibly upset. This took various forms that were specific to individual situations. In several cases, survivors felt cared for because the police attended to their physical safety. Other police officers attended to victims’ emotional well-being outside of the context of interviewing them. For example, one police officer followed up with the victim after the interview to check on how she was doing emotionally. A 16-year-old survivor who was assaulted by her custodial parent said,

> Sometimes, he’ll [the police officer] call me and check up on me and, you know, just make sure that I’m okay, and, you know, I really need that ‘cause I don’t have anybody to do it.

After the assault, she did not have support from her family. Because of that gap, it was especially meaningful to her that the officer followed up with her to check on how she was doing. Generally, these victims saw the officers as going out of their way to help them and that made them feel cared for.

**Engaging Them on Topics Other Than the Assault.** After the assault, many of the survivors felt like they were under a great deal of pressure. They were overwhelmed by the significance of what had happened to them, their emotions, others’ reactions to their disclosure, and participating in the legal process. When the police engaged with them about something other than the assault, it was helpful to the survivors and made them feel cared for. A 17-year-old—who was assaulted by two guys at a party—described why it was helpful that the officers talked to her about other things (besides the assault):

> Like that’s all you can think about . . . and you are still really upset. But like when they try and talk to you about something else, you are not really thinking about that at the time; you are thinking about how to answer their questions and like they are asking you personal questions like where do you go to school and you know, what you like to do. So it is like you are trying to answer them questions: you are not really thinking about what just happened.

This survivor (and several others) appreciated the distraction of talking about other things. Similarly, a few girls mentioned that it was helpful when the police used humor.
A 17-year-old who was assaulted by an ex-boyfriend described why using humor was helpful:

When I was giving [the officer] the report, [rapist]’s full name and stuff, he was making jokes with me, ‘cause I know like [rapist’s] every phone number to get a hold of him, his birthday, and all that. So he was joking around with me to make me feel more at ease to tell him and stuff.

**Slow Interviewing Pace.** Many victims got upset when they told the police about the assault; police officers were perceived as compassionate when they let the survivors take their time to steady themselves emotionally or offered them a break from answering questions. A 14-year-old who was assaulted by multiple acquaintances described the police officer that interviewed her:

He had me tell him what happened and stuff and I was like, at first, I was going good with telling him, but then I just broke down crying again. He was like, you know it is okay, he was being real, honestly like, normally I don’t like police, but like he like, that made me think when I was just like, you know, it ain’t that bad, they ain’t that bad, so you know, I was like talking to him. He was like it is okay, you know, you can take a minute and then you can finish telling me if you want, you know, you don’t have to just rush into it. So, he was very real sweet about the situation.

His actions made her feel like the police officer was looking out for her, not just the case. **Easing Into Talking About the Assault.** Victims also noted that it was helpful when the police eased into talking about sensitive issues, particularly the details of the assault. This usually involved the officer getting to know the victim or asking easier questions before asking questions that would be more emotionally difficult for her to answer. The victims felt that these officers understood that it was difficult and were trying to make it easier on them. A 16-year-old who was assaulted by an ex-dating partner felt like the officer treated her like his own family because of how he interacted with her interpersonally:

Before he sat down, he told me what I had to do and what the process was going to be like after he took a report and what happens next. He told me that, that I had to—more information I gave him is the better. The more he can help me and so he made me feel comfortable like there was, he broke like you know, the awkward barrier . . . He was finding my information out like my name, my age, you know, the comment, and then he wanted to know who the person was, not exact, he didn’t jump right to like, you know, what happened, he wanted to know more about like who he was, if I knew him, when it happened, and then he got into what actually happened.

He let her know what to expect and started with questions that would be easier for her to answer.

**Personable.** In addition, several officers behaved in ways that helped the victims to see them as people, not just police officers. This personable touch made the victims more comfortable talking to them. Examples included the police letting the victims know that they could tell them anything, the police letting the victims know that they could relate to being a teenager, and the police sharing personal information about themselves with the victim. A common example was the police officer telling the victim that they had a daughter and would not want their daughter to go through a similar situation. A 17-year-old who was assaulted by an ex-boyfriend said,

He was telling me that he would be outraged, and he was telling me about his; he has three daughters and stuff like that if that would happen, he would be mad and want to go blow up their house type situations . . . Pretty much the fact that he was talking about his family, his life, and stuff like that, that was comfortable and more, you know, get my mind off things.

The officer talking about his family made her more comfortable.
Conversational, Approachable Interviewing Style. Survivors were also appreciative when officers talked to them in an attentive, conversational style rather than making them feel interrogated. Behavioral examples included listening carefully, smiling, making eye contact, being calm, speaking in a soft tone, asking for information and clarification rather than pressuring the victim for information, and attending to the victim carefully (rather than the parents). A 14-year-old who was assaulted by multiple acquaintances described how it felt to have the police officer pay attention to her rather than her parent:

Um, I don’t know, like it made me happy, like it made me go like, okay, yeah, you know, because I, normally don’t, nobody listen to me . . . I don’t really like get 100% of anybody’s attention, so it felt good like, you know, he listening and I know that I can talk and it is not going in one ear and out the other. He was like, eye contact type of stuff. So it felt really right. Good.

The victims appreciated this kind of personable, attentive interviewing style because it helped them feel more comfortable.

Impact on the Victim

Survivors believed that a caring, consistent, personable approach was better for their own well-being, as well as their ability to participate in the interviews about the assault. When survivors felt that the police were uncaring toward their emotions, insensitive to the fact that it was difficult to talk about the assault, and intimidating, this had a negative influence on their emotions. It hurt. A 15-year-old survivor who was assaulted at a party by a friend described how her experience with the police made her feel:

Like I said about like being rushed through [the interview] and [the detective] just being frustrated with me, and [it] just made it more upsetting.

On the other hand, when the officers were perceived as caring, sensitive to the fact that it is difficult to talk about the assault, and engaged with them in a personable and conversational way, it helped the survivors feel a little bit better. It was still a difficult situation, but the way the people engaged with them made the situation better. For example, a 17-year-old survivor who was assaulted by an ex-boyfriend appreciated her police officer’s use of humor:

How you feel and the way you feel is like a horrible feeling. You already are just tired and want to go home, and somebody is sitting there talking to you and joking with you and it makes you more comfortable and relieved.

His efforts relieved some of the emotional burden of the assault at that time.

Although many victims noted the connection between how they were treated and their well-being, several also noted a connection between the police’s actions and their own participation in the victim interviews. Specifically, when the police were sensitive and personable, they were more comfortable and able to talk to them during the interview; when they were insensitive and intimidating, it was more difficult to talk to them. A 15-year-old who was assaulted by a friend described her interaction with the responding officer:

Like it is hard to go through and hard to talk about it . . . I was trying; I was crying really bad and I couldn’t breathe, and I was hyperventilating, and she [the officer] just like, come on, you got to tell me. So it was kind of like, oh my gosh, are you serious? And she like understood what I was going through I think she would have like helped me calm down enough to tell her clearly.
This victim felt that she could have given a better account of the assault if the police officer would have given her the space to steady herself emotionally.

Another survivor who was 17 years old when she was assaulted by two acquaintances at a party compared her experiences with the responding officers to her experiences with the detective. She said,

You got to try and like put yourself in a compassionate place and just try and deal with [the victim] because, you know, you can’t, you are just trying like bombard them with questions and like make them feel uncomfortable. It is really bad because, you know, it is hard to deal with, like even being asked the questions. But like [as the victim] . . . you like trying to help and trying to be in compliance, but sometimes, it is just so overloading that you are like, I can’t even answer these questions anymore, I’m going to rip my head off, you know. Like it is just, you know, it is easier to have someone asking you questions who actually like it feels like they care what happened to you and they feel bad about what happened to you.

It was easier for her to talk with the officers who were caring than the detective who overwhelmed her.

DISCUSSION

This study was the first to examine adolescent sexual assault victims’ perceptions of how police officers interacted with them on an interpersonal level. Several findings were quite similar to what has previously been found regarding adult women’s interactions with the police. Like adults, many adolescent sexual assault victims have positive experiences with the police and are treated with compassion and sensitivity, whereas some have negative experiences are treated in a cold, intimidating manner. There were also similarities between behaviors that adolescents in this study found to be helpful and behaviors that adult women found to be helpful in prior research. Points of similarity were that survivors want the police to acknowledge their emotions, let them take their time to answer questions, ask for rather than demand information, and talk about other things first before asking questions about the assault (Ahrens, Cabral, & Abeling, 2009; Ahrens et al., 2007; Konradi, 2007; Logan et al., 2005; Maier, 2008; Patterson, 2011). Finally, like studies of adult women, the way in which the police interacted with victims on an interpersonal level influenced victims’ emotional well-being, as well as their ability to participate in interviews about the assault (Campbell et al., 2001; Campbell, 2005; Konradi, 2007; Patterson, 2011).

This study identified several new themes that have not yet been identified in the adult literature. First, the survivors appreciated when the police were personable. This included assuring them that they could tell them anything and let them know that they understood what it was like to be a teenager. Many of the girls in our sample were afraid of how the police would react to their stories, particularly when they had engaged in behaviors that would be considered developmentally inappropriate around the time of the assault (e.g., drinking alcohol, hanging out with older guys). They were afraid to disclose sensitive information to the police. By letting the survivors know that they could tell them anything and that they understand what it was like to be a teenager, the police helped the girls be comfortable enough to divulge information to them. This is an important finding because the police want as much information from crime victims as possible, and this strategy enabled this within the context of adolescent sexual assault victims. It may also prove helpful for adolescent victims of other types of interpersonal crimes.
A second unique finding was that the adolescents appreciated when the police disclosed personal information about themselves. Again, many of the adolescents were intimidated when they began interacting with the police. It may be that by sharing personal information about their own lives, the police humanized themselves—The adolescents were able to see them as more than the police officer role and also saw them as people who could relate and care for them. This is consistent with principles of feminist interviewing, as well as certain therapeutic approaches that suggest that careful self-disclosure can be a method of building rapport (Hesse-Biber & Piatelli, 2011; Oakley, 1981; Reinharz & Chase, 2001).

A similar explanation may account for the third distinct finding in this study. The adolescent survivors in our sample appreciated the police who listened carefully; smiled; established eye contact; and used a calm, soft-tone of voice. They were put off by the police having closed-off body language, expressing anger/or frustration, and using a harsh verbal tone. The softer, gentler approach may have helped survivors feel more comfortable with the police authority figure. This may have also had prominence in this study because of the role that parents played for these girls. Most of the survivors had already disclosed to their parents by the time that they talked to the police, and many of the parents reacted poorly and disbelieved, criticized, or punished the girls. A police officer with closed-off body language, expressing anger and frustration, and using a harsh verbal tone was probably a reminder of an angry parent and furthered the girls’ concerns that they were being treated like they, not the assailant, were in the wrong. Thus, simply softening tone and body language may be very helpful to the police in establishing rapport with adolescents.

A summary of the study’s findings for police building rapport with adolescent victims is provided in Table 1.

These findings should be considered in light of three main limitations. First, the study involved a unique sample of survivors who received medical/forensic care from a SANE program. This means that the sample is limited to adolescents who disclosed and reported the assault quickly enough to be eligible for medical/forensic evidence collection (typically within 72–108 hr of the assault). Research shows that many cases involving victims younger than the age of 18 years are not disclosed that rapidly (Broman-Fulks et al., 2007). Thus, this study does not capture the experiences of adolescents who take more time to disclose and report. Delayed reporting may influence victims’ interactions with the police and their perceptions of what is and is not helpful. In addition, all of the victims in the sample had submitted to forensic evidence collection, which some police may take as evidence of credibility and thereby affect how they interacted with the victims (Martin, 2005). Despite this limitation, the study still provides a first look into adolescent sexual assault victims’ interactions with the police.

A second limitation stems from the demographic makeup of the sample. Although the sample is consistent with the clientele of the two SANE programs, the vast majority of participants (75%) identified as White. Future research on this topic with diverse samples could examine the influence of race/ethnicity on adolescent sexual assault survivors’ interactions with the police. Prior research on adult survivors suggests that women of color who have been raped receive more negative reactions to disclosing the assault than do White women (Campbell et al., 2001; Ullman & Filipas, 2001). Future studies can examine whether such racial differences occur for adolescent girls within the legal system.

A third limitation stems from interviewing victims’ about their interactions with the police; in doing so, this study only collected data from one side of a two-sided interaction. On the one hand, the purpose of the study was to capture the adolescents’ perceptions of their interactions with the police, and this objective was achieved. One the other hand, had
### TABLE 1. Recommendations for Police Building Rapport With Adolescent Sexual Assault Victims

<table>
<thead>
<tr>
<th>Behaviors That Build Rapport and Help Survivors Emotionally</th>
<th>Behaviors That Damage Rapport and Hurt Survivors Emotionally</th>
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</thead>
<tbody>
<tr>
<td>Care for the survivor emotionally while interviewing her (e.g., by asking how she is doing, trying to help her calm down, tell her it’s okay, offering her a tissue or glass of water) and take actions to care for her well-being outside the context of the investigation (e.g., calling to check up on how she is doing emotionally, offering to sit with her parent during the medical/forensic exam, help arrange protections for her physical safety).</td>
<td>Ignore the victim’s emotions (e.g., failing to ask her if she is okay, failing to comfort her when they are visibly upset).</td>
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<tr>
<td>Talk about other things besides the assault case to help take her mind off the assault (e.g., where she goes to school, what she likes to do with her friends) and use humor when appropriate (about things other than the assault case).</td>
<td>Ask questions rapidly and rush her to answer them.</td>
</tr>
<tr>
<td>Avoid rushing her to answer questions (e.g., tell her she can take her time to answer, give her time to gather herself emotionally if she is upset, offer her a break).</td>
<td>Jump into asking questions about the assault itself (without talking about or asking about other things first).</td>
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<tr>
<td>Get to know the victim and ask about other things before asking about the assault and topics that are more difficult emotionally for the victim.</td>
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<tr>
<td>Let the victim know she can tell you anything, that you can relate to being a teenager, and share personal information (as appropriate).</td>
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<tr>
<td>Ask for information and clarification.</td>
<td>Pressure the victim for and/or demand information.</td>
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<tr>
<td>Stay calm.</td>
<td>Express anger/frustration toward the victim.</td>
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<tr>
<td>Use a soft verbal tone, open-body language, and make eye contact.</td>
<td>Use a harsh/accusatory verbal tone, raised voice, and closed-off body language.</td>
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<tr>
<td>Smile.</td>
<td>Do not smile.</td>
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<tr>
<td>Listen carefully and pay attention to the survivor herself.</td>
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data been collected from the police as well, the study would have achieved a fuller picture of how the interactions unfolded and why the police acted in certain ways. This would not have negated the adolescents’ perceptions but could have provided richer contextual information that could have been used to identify strategies to improve the legal response to adolescent victims. Future work can advance the literature by interviewing both survivors and the police they worked with to further our understanding of how these dynamic interactions unfold.

Despite these limitations, this study’s findings have several important implications for policy and practice. This study revealed how adolescent sexual assault victims want responding officers and detectives to engage with them on an interpersonal level. Although many of the adolescents had positive experiences with the police, this study also clearly indicates that there is plenty of room for improvement. To be successful at achieving rapport with adolescent victims and facilitate their emotional recovery, police officers need to be caring, sensitive, gentle, and personable, and intimidation and insensitivity need to be avoided. See Table 1 for specific recommendations for building rapport with adolescent victims.

The finding that most of the girls had negative experiences with the police underscores the need for victim advocates, who support rape victims as they navigate the legal system. Such advocates have specialized knowledge and experience in the legal processing of sexual assault cases and among other things, can advise victims on what to expect from the police, their rights as victims, and their options for taking action if they are unsatisfied. In fact, prior research on adult rape victims has shown that medical and legal personnel tend to be more responsive to victims’ needs when an advocate is present (Campbell, 2006). As such, advocates would be well-placed to promote a positive response to adolescent victims and can provide avenues for recourse when victims feel they have been treated poorly.

Although advocacy represents an intervention outside of the legal system, the study’s findings can also support interventions within the legal system. The participants identified various behaviors that help and hinder the police in building rapport with adolescent victims; interventions that target these behaviors and thereby increase the extent to which the police are viewed as approachable, personable, and caring toward adolescent victims may be particularly effective at promoting adolescents’ well-being and full participation in the criminal justice system. Trainings and mentoring could use information from this study (see recommendations in Table 1) to help officers gain the necessary knowledge and skills to build rapport with adolescent victims. This could be combined with organizational-level changes that monitor the response to adolescents and hold officers to high standards in working with victims would provide incentives to create changes in officers’ behavior. For example, developing policies that outline how the police are expected to work with adolescent victims and then for each case collecting data to assess whether the desired response was followed would be a mechanism that can be used to hold officers accountable to working with victims in a responsive manner.

NOTES

1. In this article, the term “sexual assault” refers to sexual contact that occurs in the absence of consent because of force, threat of force, or the inability to consent (e.g., because of intoxication, certain mental disabilities, or age), whereas the term “rape” refers to a specific type of sexual assault that involves attempted or completed penetration of the victim’s body (Krug, Dahlberg, Mercy, Zwi, & Lozano, 2002). Some studies in this body of literature focus exclusively on rape (e.g., Tjaden &
Thoennes, 2006), whereas others focus more broadly on sexual assault (regardless of penetration). Therefore, both terms will be used in the literature review, consistent with the foci of the studies that are reviewed.

2. Women and girls who have been sexually assaulted will be referred to both as victims and survivors throughout this article to acknowledge the crime they have experienced, as well as their agency and strengths.

3. In community samples of women who were 14 years of age or older when they were assaulted—combining adolescent and adult victimizations—approximately one-fourth of participants (23%–26%) reported the assault to the police (Ahrens, Cabral, & Abeling, 2009; Ullman & Filipas, 2001). In two nationally representative studies of minors, researchers asked about lifetime victimization history, meaning assaults that occurred during adolescence or early childhood. In these studies, only 10%–13% of rapes were reported to the police, but the specific rate of reporting for adolescent rapes was not provided (Finkelhor, Omrod, Turner, & Hamby, 2011; Kilpatrick, Saunders, & Smith, 2003).

4. To date, no studies of sexual assault victims’ experiences with the police have been conducted specific to victimizations that occurred during adolescence. Therefore, it is necessary to draw from the literature on adult women’s perceptions of their interactions with the police postassault.

5. A full medical/forensic exam was conducted if a patient history was taken and medical/forensic evidence was collected.

6. Sexual assault was defined as nonconsensual sexual contact (because of force, threat of force, or inability to consent because age or incapacitation; Krug et al., 2002). This included attempted penetration, completed penetration, and fondling.

7. The analyst examined whether case characteristics (e.g., weapon use, whether the victim drank alcohol) and victim characteristics (e.g., desire to report to the police) related to how the police engaged with the survivors on an interpersonal level. There was no evidence that these factors influenced how the police treated survivors on an interpersonal level.

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Quality of Care for Intimate Partner Violence in South African Primary Care: A Qualitative Study

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Intimate partner violence (IPV) makes a substantial contribution to the burden of disease in South Africa. This article explores the current quality of care for IPV in public sector primary care facilities within the Western Cape. Only 10% of women attending primary care, while suffering from IPV, were recognized. Case studies, based on in-depth interviews and medical records, were used to reflect on the quality of care received among the women who were recognized. Care tended to be superficial, fragmented, poorly coordinated, and lacking in continuity. The recognition, management, and appropriate documentation of IPV should be prioritized within the training of primary care providers. It may be necessary to appoint IPV champions within primary care to ensure comprehensive care for survivors of IPV.

Keywords: domestic violence; primary health care; South Africa; quality of care; qualitative study

Internationally, abuse against women by intimate partners (intimate partner violence [IPV]) is a massive public health problem. In South Africa, more women are killed by their current or ex-intimate male partner than in any other country, with a rate of 8.8 per 100,000 women (Abrahams et al., 2009). Apart from femicide, fatal outcomes of IPV include suicide, maternal mortality, abortion, stillbirth, and AIDS.

Indeed, the health consequences of IPV add up to a substantial burden of disease for public health systems internationally (Garcia-Moreno & Watts, 2011). Physical consequences include unwanted pregnancies, burns, fractures, chronic illness and pain syndromes, problems with hearing and sight, arthritis, seizures, headaches, and sexually transmitted infections. Mental consequences include depression, anxiety, posttraumatic stress, eating disorders, and substance disorders (Campbell, 2002). IPV in pregnancy can seriously harm both mother and fetus. In India, IPV has been linked with fetal, infant, and maternal death; low-birth-weight infants; and developmental abnormalities (Ganatra, Coyaji, & Rao, 1998; Jejeebhoy, 1998). Strong links exist between IPV and risk of HIV infection (Jewkes, Dunkle, Nduna, & Shai, 2010), which is particularly relevant because South Africa has the largest number of people living with HIV/AIDS (Joint United Nations Programme on HIV/AIDS, 2009).

Despite the relevance of IPV to our burden of disease with its consequent impact on all South African communities, health providers tend to resist identifying and managing
IPV as a health issue (Joyner & Mash, 2012a). In South Africa, first-contact care is mostly offered by primary care nurses with the support of doctors. Baldwin-Ragaven (2010) testifies to the proliferation of peer-reviewed articles measuring the problem and documenting the consequences of our failure to act, commenting, “For any other disease process as costly in financial and human measures we would demand answers, find cures, and disseminate evidence about interventions. What is it about IPV?” There is a clear moral argument that health providers should attend to the problematic impact of IPV on health and family systems. Women experiencing IPV present to all health care settings, usually without naming the problem as IPV.

IPV is a complex phenomenon, where layers of emotional, spiritual, and financial abuse are intertwined with varying degrees of physical and sexual violence. Therefore, although the term intimate partner violence may bring to mind a violent physical assault, subtlety is often a key strategy, particularly in psychological abuse (Johnson, 2008). Thus, prevalence figures that only reflect physical violence do not actually measure IPV but merely the physical component thereof.

This article works with an understanding of IPV as words and behaviors that undermine and diminish the humanity of the other intimate partner. Intimate partner refers to a current or former dating, married, or cohabiting relationship or even a would-be rejected lover (Mathews et al., 2004). Johnson’s (2008) typology of domestic violence delineates four contrasting forms: intimate terrorism, violent resistance, mutual violent control, and situational couple violence. Intimate terrorism or coercive control describes the use of violence by one partner to control the other; violent resistance is the resister’s response to their partner’s attempts to gain control; mutual violent control refers to use of violence by each partner to control the other, whereas in situational couple violence, either partner can be violent because of escalating conflict but not to exert control.

Central to this range of violence and control is emotional abuse, which is clearly pervasive and usually concurrent with sexual and physical violence (Jewkes, 2010). Emotional abuse has various forms, but its consequences almost always include diminished social support, low self-esteem, and anxiety states. It has been found to be a primary contributor to postnatal depression (Ludemir, Lewis, Valongueiro, de Arújo, & Araya, 2010).

A Cape Town study found that sexual violence was common in intimate relations and was associated with the use of violence to solve problems, having more than one current partner, alcohol abuse, and verbally abusing a partner (Abrahams, Jewkes, Hoffman, & Laubsher, 2004). Internationally, studies connect abuse with unwanted pregnancies, especially in adolescent females (Campbell, 1998). Violence of all kinds significantly impedes women’s ability to use contraceptives or condoms to prevent sexually transmitted infections, including HIV/AIDS; unsafe abortions; and pregnancy (Adongo et al., 1997; Bawah, Akweongo, Simmons, & Phillips, 1999). In a national sample from Colombia, women’s adjusted odds of having had an unintended pregnancy were significantly elevated if they had experienced sexual or physical abuse (Pallitto & O’Campo, 2004). The need to include screening and treatment for IPV in reproductive health services, to promote male involvement in fertility control programs, and to improve the political and social response is highlighted.

Recent IPV prevalence studies in sub-Saharan Africa have focused on pregnancy (Eaton et al., 2012; Groves, Kagee, Maman, Moodley, & Rouse, 2012; Ntaganira, Muula, Siziya, Stoskopf, & Rudatsikira, 2009). A systematic review on IPV in pregnancy in Africa found it to be one of highest reported globally (Shamu, Abrahams, Temmerman, Musekiwa, & Zarowsky, 2011). Sexual risk taking, HIV infection, alcohol and drug use, and violence
were major risk factors. Shamu et al. (2011) urge for interventions in pregnant women as part of antenatal care. They recommend that such screening programs address prevention of HIV and IPV simultaneously because both relate to issues of women empowerment.

A South African study found that pregnant teenagers were significantly more likely to have been forced into sexual initiation and were beaten more frequently (Jewkes, Vundule, Maforah, & Jordaan, 2001). Multiple modelling revealed that both forced sexual initiation and unwillingness to confront an unfaithful partner are strongly associated with pregnancy and with each other. In Durban, almost 25% of women experienced some type of IPV during their current pregnancy, with psychological abuse the most common (Groves et al., 2012). The odds of emotional distress were significantly higher for each additional episode of psychological abuse and also for each additional episode of sexual violence during pregnancy. Reflecting these issues, a study conducted in Cape Town shebeens found that men with pregnant partners recorded the highest rates of assaulting intimate partners, forcing sexual intercourse on a partner, and being forced by their partner to have sex (Eaton et al., 2012). Men with pregnant partners were also more likely to report searching in bars for a new intimate partner. Alcohol abuse among pregnant women is reported as alarmingly high and appears to be closely linked to IPV in pregnancy.

South Africa’s Domestic Violence Act No. 116 of 1998 includes a definition of domestic violence so comprehensive that it is recognized to be a legislative standard-bearer internationally (South African Government Gazette, 1998). It recognizes physical, sexual, emotional and psychological, verbal, and economic abuse as well as intimidation, stalking, damage to property, and trespassing between any two people who are in a domestic relationship. Yet a shortcoming at legislative and policy levels is the failure to outline any specific responsibilities for the health sector. This deficiency has been exacerbated by inadequate health care provider training and poorly resourced implementation of the act.

The dismissal of IPV as a social or legal issue, and therefore not requiring comprehensive health care, seems to underlie a poor quality of health care for women affected by IPV. The failure to attend to psychosocial issues, within health services that are mainly orientated toward biomedical problems, is arguably exacerbated by a victim-blaming discourse prevalent among providers (Petersen, 2000). A victim-blaming discourse provides solutions for individuals and then blames them when they fail to comply, although not understanding their perspective or key contextual factors. Few studies, globally or locally, have focused on quality of care for IPV. This article explores the current quality of care for IPV in South African primary health care.

 METHODS

Study Design

The results presented here were drawn from a larger study that implemented, modified, and evaluated a screening and management protocol for IPV in the primary care sector (Joyner, 2009; Martin & Jacobs, 2003). In the larger study, women suffering from IPV were identified by primary care providers (nurses, doctors, allied health providers), who were asked to screen all women 18 years of age and older during a 4–8-week period using a simple open question that invited disclosure. These women were offered a referral to the study nurse for an initial consultation. This consisted of an in-depth biopsychosocial and forensic consultation of between 60 and 90 min (Joyner & Mash, 2012b). The consultation
was followed a month later by a semistructured interview, which focused on their experience of the management protocol.

The study reported here is based on an examination of the medical records of these women for any evidence of prior recognition or management of abuse by the primary care providers during the previous 2 years. Qualitative information arising from the consultation with the study nurse or follow-up interview, which related to prior attempts to obtain help at the health center, was also included.

Setting

Primary care in South Africa is predominantly offered by nurses, many of whom are trained clinical nurse practitioners. Nurses are supported by visiting doctors in offering care via a network of small mobile and fixed clinics. In larger urban areas, care is also offered at community health centers (CHC). These usually have a multidisciplinary team that includes nurses, doctors, a pharmacist, a social worker, lay counsellors, and a psychiatric nurse. CHCs also usually have a dedicated area for emergencies and trauma. Primary care services refer to district hospitals that are staffed by generalist medical officers. Because only about 15% of the population is insured, most rely on these public sector health care services.

Two urban and one rural CHC, as well as two smaller rural clinics in the Western Cape, were purposefully selected as study sites for the larger study according to the following criteria: having a psychiatric nurse, availability of a private room for the research assistant, and sufficiently comprehensive service to support the protocol being implemented (e.g., X-rays, HIV testing, and counseling).

All facilities had high workloads and served low socioeconomic English-, Afrikaans-, and Xhosa-speaking communities. Urban sites were in Cape Town, and rural sites were 120–200 km away in farming areas within the Cape Winelands district.

Selection of Women

In the screening phase of the larger study, 168 women were identified as survivors of IPV who had been attending the health centers during the past 2 years. Out of these 168, only 11 (9.6%) had been previously recognized as having a problem of IPV. This article reports on the quality of care received by these 11 women.

Data Collection

The management protocol required a structured record of the consultation, and the follow-up interview used a semistructured questionnaire. The authors recruited and trained two nurse practitioners to help provide the intervention. These study nurses, and the principal author (KJ), obtained consent and built rapport before proceeding with comprehensive assessment and management (Joyner & Mash, 2011). The two instruments provided qualitative data on the situation at home and previous encounters with their primary care providers. Each document contained sections where the patient’s story was captured verbatim or paraphrased in a narrative style.

Additional information on the care received was obtained by inspecting their medical records for the previous 24 months. The International Classification of Primary Care was used to code all reasons for encounter and diagnoses made (WONCA International Classification Committee, 1998; Joyner & Mash, 2012a). Qualitative data relating to the recognition or management of abuse was included in the analysis.
Data Analysis

Data on the specific elements of the management/care plans recorded by clinicians in the medical notes were categorized and quantified. Data from the medical records, initial consultation, and follow-up interviews were combined to give case studies of each woman’s experience of IPV, health-seeking behavior, and experience of health care. A thematic content analysis focusing on the quality of care was then performed on the case studies according to the framework method (Ritchie & Spencer, 1993).

Ethical Considerations

Guided by the Global Programme on Evidence for Health Policy (World Health Organization, 1999), the safety of respondents and the research team was paramount and underpinned all project decisions. The Health Research Ethics Committee of Stellenbosch University approved the investigation. The anonymity of the participants was protected by use of codes instead of names as identifiers. Written informed consent was obtained and each participant’s right to privacy and confidentiality was safeguarded.

FINDINGS

Profile of the Women

Table 1 provides an overview of the age of the women and the context and nature of the abuse experienced by the 11 women.

The mean age was 41 years, and average number of children was three. All but 1 were cohabiting with the abusive partner. Drawing on Johnson’s (2008) typology, 9 of the 11 women were in situations of intimate terrorism/coercive control. Violent resistance better described another, and mutual violent control was also evident in one case. Emotional abuse was the only form of abuse that was experienced by all 11 women.

The 11 patients presented an average of 11.7 times at the health centers over a 24-month period. The range varied between a minimum of 4 and a maximum of 27 visits. At some point, their experience of IPV was referred to in all of their medical folders. The management of IPV in the 11 patients identified by health care providers is summarized in Table 2.

Management mostly involved referral to other professionals or services. The most common elements of the management plan were referral to a social worker or prescription of psychiatric medication. Overall, social issues were addressed in eight patients, legal issues in two patients, psychological issues in seven patients, and clinical issues in two patients. Social issues were addressed through mobilization of social support and planning for emergency situations, whereas psychological issues were addressed through referral for counseling or prescription of psychiatric medication. The clinical component included family planning and general medical care. The number of different components to the management plan ranged from zero to five with an average of three.

Recognition of Intimate Partner Violence Without Action

Even when primary care providers, such as emergency staff and clinical nurse practitioners, acknowledged the abuse underlying injuries, their care remained focused on the injuries and did not address the abuse itself. For example, the first entry regarding IPV in Vuyi’s medical record revealed an injury that merited “advice about the disability grant
### TABLE 1. Profile of the Study Population

<table>
<thead>
<tr>
<th>Patient’s Pseudonym</th>
<th>Age</th>
<th>Context</th>
<th>Nature of Abuse</th>
</tr>
</thead>
<tbody>
<tr>
<td>Vuyi</td>
<td>43</td>
<td>Married with one son</td>
<td>Physical, emotional, and financial abuse, including attempted femicide After they married, he started attacking her with metal weapons all over her body while inebriated. He also hit and kicked her, insulted her, and controlled all financial decisions including refusing her permission to work. When she found a job, he burnt her clothes and official documents and even set fire to her shack (home) while she and her son were inside it. Intimate terrorism/coercive control</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Ex-husband abuses alcohol.</td>
<td></td>
</tr>
<tr>
<td>Nomsa</td>
<td>39</td>
<td>Married with four children and subsequently pregnant</td>
<td>Physical, emotional, and financial abuse, including threatened femicide For example, “verbal abuse is worse—he uses strong words, always blaming me. That makes me feel worthless, stupid . . . I hate myself most of the time.” Also, her husband does not allow her to meet people, not even neighbors—no friends, no work. Intimate terrorism/coercive control</td>
</tr>
<tr>
<td></td>
<td></td>
<td>History of psychotic depression and three suicide attempts</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Husband abuses alcohol.</td>
<td></td>
</tr>
<tr>
<td>Candy</td>
<td>49</td>
<td>Married with two teenage daughters</td>
<td>Emotional, social, sexual, and physical abuse, including use of a weapon For example, her husband expects sexual activities from her that she abhors. Intimate terrorism/coercive control</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Major depressive disorder with suicide attempts</td>
<td></td>
</tr>
<tr>
<td>Sylvie</td>
<td>39</td>
<td>Breadwinner for family with five children</td>
<td>Physical, emotional, financial, and sexual abuse, including use of a weapon For example, he becomes extremely verbally abusive if she refuses him sex. Sometimes, he wants it three times a night. He also has tramped on and kicked her with safety boots to gain her compliance. Intimate terrorism/coercive control</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Currently also supporting ex-husband who lives with them</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>He is addicted to methamphetamine.</td>
<td></td>
</tr>
<tr>
<td>Carolyn</td>
<td>51</td>
<td>Mother of four sons</td>
<td>Physical, sexual, and emotional abuse For example, he chopped a piece of her finger off, and her 10-year-old son commented that the dog had eaten it. Intimate terrorism/coercive control</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Currently cohabiting with ex-husband</td>
<td></td>
</tr>
</tbody>
</table>

(Continued)
### TABLE 1. Profile of the Study Population (Continued)

<table>
<thead>
<tr>
<th>Patient's Pseudonym</th>
<th>Age</th>
<th>Context</th>
<th>Nature of Abuse</th>
</tr>
</thead>
<tbody>
<tr>
<td>Meryl</td>
<td>27   years</td>
<td>Married with one foster son History of epilepsy and depression with psychotic features Husband abuses alcohol, also has a girlfriend, and is unemployed.</td>
<td>Emotional, financial, and sexual abuse For example, he sometimes wants to have sex three to four times per day; “my whole vagina is sore—inside, outside, it is sore. Even if I have my period, he wants sex. No foreplay, he just shoves it in and goes on and then leaves me lying there. I feel nothing.” He threatens to kill her if she won’t have sex with him. “... patient wants to kill her husband but admits to no specific plan.” Intimate terrorism/coercive control Violent resistance</td>
</tr>
<tr>
<td>Daphne</td>
<td>34   years</td>
<td>Married with two children and has a problem with alcohol</td>
<td>Emotional, sexual, and physical abuse, including death threats He has threatened to kill her with his gun. She also becomes aggressive when inebriated. Mutual violent control</td>
</tr>
<tr>
<td>Olive</td>
<td>46   years</td>
<td>Married with three children</td>
<td>Physical, sexual, financial, and emotional abuse, which culminated in attempted murder Intimate terrorism/coercive control</td>
</tr>
<tr>
<td>Thobeka</td>
<td>39   years</td>
<td>Mother of three and married for 8 years Lives with epilepsy and alcohol dependence Husband’s family is also hostile and complicit with abuse.</td>
<td>Emotional, financial, verbal, and physical abuse For example, husband is unfaithful, withholds money, and controls all financial decisions, restricts her contact with family and friends, and pushes her around and insults her. Intimate terrorism/coercive control</td>
</tr>
<tr>
<td>Shamiz</td>
<td>44   years</td>
<td>Married according to traditional Muslim rites, with five children Chronic depression</td>
<td>Emotional and social abuse For example, insults, shouting, restricting contact with family and friends, controlling her activities Intimate terrorism/coercive control</td>
</tr>
<tr>
<td>Jackie</td>
<td>40   years</td>
<td>Mother of four children who live with their fathers Now with abusive boyfriend History of epilepsy, substance abuse, depression, and anxiety</td>
<td>Physical, emotional, sexual, and financial abuse He assaults her physically and psychologically. Intimate terrorism/coercive control</td>
</tr>
</tbody>
</table>
TABLE 2. Management of Patients (N = 11)

<table>
<thead>
<tr>
<th>Management Plan</th>
<th>N</th>
</tr>
</thead>
<tbody>
<tr>
<td>Social issues</td>
<td></td>
</tr>
<tr>
<td>Referral to social worker</td>
<td>7</td>
</tr>
<tr>
<td>Referral to shelter</td>
<td>2</td>
</tr>
<tr>
<td>Referral to Family and Marriage Society of South Africa</td>
<td>1</td>
</tr>
<tr>
<td>Administrative procedure, for example, social grant, referral letter</td>
<td>3</td>
</tr>
<tr>
<td>Legal issues</td>
<td></td>
</tr>
<tr>
<td>Referral to domestic violence court for protection order</td>
<td>2</td>
</tr>
<tr>
<td>Referral to police</td>
<td>1</td>
</tr>
<tr>
<td>Psychological issues</td>
<td></td>
</tr>
<tr>
<td>Referral to psychiatric nurse</td>
<td>1</td>
</tr>
<tr>
<td>Referral to psychologist/psychiatrist/psychotherapeutic group</td>
<td>3</td>
</tr>
<tr>
<td>Admission to psychiatric hospital</td>
<td>1</td>
</tr>
<tr>
<td>Referral to marriage counselor</td>
<td>1</td>
</tr>
<tr>
<td>Prescription of psychiatric medication</td>
<td>7</td>
</tr>
<tr>
<td>Clinical issues</td>
<td></td>
</tr>
<tr>
<td>Referral to medical officer</td>
<td>1</td>
</tr>
<tr>
<td>Suture and dressing</td>
<td>1</td>
</tr>
<tr>
<td>Medication prescribed, for example, analgesics</td>
<td>1</td>
</tr>
</tbody>
</table>

application procedure” from the health care provider. “Injury due to domestic violence” ends the brief entry. There was no offer of assistance or referral. The next relevant entry appeared 7 months later on an accident and emergency form: “. . . patient allegedly fell and injured right arm yesterday.” A crepe bandage and anti-inflammatory and analgesic medications were prescribed, but no action was taken in terms of the underlying abuse.

Similarly, when Olive survived attempted murder at the hand of her knife-wielding husband on her kitchen floor, the attending doctor’s notes were purely clinical, with not one reference to her mental state nor any indication of her potential emotional needs.

**Biomedical Care Overlooks Intimate Partner Violence**

Carolyn presented the most times, 27 in all, over 2 years. For a long while, her medical record depicted a passive patient who had “no complaints,” yet her blood pressure remained uncontrolled. Over time, her record revealed that she often sent a relative to fetch her medicine or simply did not attend her monthly appointment. It was only when she complained to the facility manager about a provider’s attitude that she was referred to our study. On interview, we found that she was in urgent need of assessment for anxiety and depression. She admitted one of her husband’s abusive tactics was to throw away her chronic medication. It also became clear that she had been enduring vicious verbal, sexual,
physical, and financial abuse during the previous 2 years and yet had not felt safe enough to share these serious problems with her health providers.

Sylvie had been seen by a primary care provider 14 times for more than 2 years and had received medical care for tension headaches, neck pain, back pain, abdominal pain, genital pain, breast pain, intermenstrual bleeding, insomnia, dizziness, and reproductive health needs. Eventually, she was referred to the psychiatric nurse who noted a history of physical and sexual abuse from her cohabiting ex-husband. Sylvie was referred to our study where we discovered that she and their five children were living in severely abusive circumstances.

### Recognition of Mental Health Problems

Of the 11 women, 7 were known psychiatric patients referred to the study by their psychiatric nurses. Five came from one site, where the psychiatric nurse was as proactive as he could be in a scarcely resourced context. He provided a detailed description of all social and environmental stressors on Axis 4 of each patient’s *Diagnostic and Statistical Manual of Mental Disorders* (4th ed.; *DSM-IV*) diagnosis. It was clear that each woman felt comfortable enough to be honest with him. For example, Daphne admitted to drinking alcohol to cope with her nerves and to calm them. Apart from acknowledging her difficulties and providing a sounding board, he continued medication, included her in a psychosocial support group, and made good use of local resources. His approach was exceptional in that he obtained a psychosocial history and addressed issues of abuse and safety in a coordinated way. This was not evident in the other cases.

Candy’s story began with an attempted overdose of 16 paracetamol tablets whereupon she was referred to the psychiatric nurse at the health center. The multiaxial diagnosis specified “. . . husband—psychological abuse . . .” on Axis 4 and an Axis 1 diagnosis of major depressive disorder with anxiety. Antidepressants were prescribed. Two months later, the psychiatric nurse noted “. . . husband still violent and abusing” and planned to continue medication and refer the patient to both a psychologist and a marriage counsellor.

Candy’s medical record revealed that she had presented with insomnia and depressed mood, and the psychiatric nurse noted that her husband expected sexual activities from her that she abhorred. She “. . . wants to visit her sick sister, but her husband forbids her . . . manipulates her . . . and breaks her down emotionally.”

The psychiatric nurse’s management plan reads “(a) medication, (b) social worker for advice re ?divorce, (c) follow-up.” He referred her to a community-based organization, which arranged a place of safety for her.

When Candy presented to our study, her mental state clearly reflected the oppressive difficulties of her circumstances. In the previous week, she had been booked off work by her doctor because of injuries sustained. Her husband followed her everywhere. She said she had been in many shelters, but because she missed her children, she had always returned home. She claimed he was a good father, although their daughters were scared of him. She seemed to have made no progress with getting a protection order.

Although Candy scored as low-risk on our safety assessment scale, the relentlessly severe verbal abuse had still triggered a suicide attempt. On follow-up, she revealed that she was feeling “weak and scared to make decisions.” Candy’s disabling fear of the abuser was palpable. Health providers need to grasp the underlying power and control issues that are central to the violence of intimate terrorism (coercive control; Johnson, 2008). Candy provides an example of someone paralyzed by fear and disempowered by sexist social and economic factors that constrain her capacity to find another way out of her situation.
Arguably, it is precisely this type of hopeless scenario and internalization of IPV as culturally normative that deters providers from engaging with patients about their IPV issues in the first place.

By contrast, the rural psychiatric nurse only recorded that Carolyn was oriented and not psychotic. It appeared that in her psychiatric service, the concept of mental illness had been restricted to managing chronic psychosis, and she was mainly interested in excluding the presence of psychosis. It was only when Carolyn was explicitly required to respond to the issue of IPV, because of her dissatisfaction with the social worker, that she focused on IPV.

In the case of the seventh psychiatric patient, Nomsa, even though she was regularly attended to by medical officers, nurses, and mental health personnel, no one had recorded the diagnosis of agoraphobia in her folder. On interview, she explained that she feared social gatherings and crowds of people and sometimes felt as if the walls suffocated her and her head would burst. Yet her medical folder revealed no effort to assist her with this disabling anxiety condition other than the problematic prescription of lorazepam. The highly addictive nature of this short-acting benzodiazepine highlights another fault line in contemporary primary care, which aspires to be biopsychosocial in approach but is functionally biomedical.

Of the four patients who presented for general health complaints, all were found by respective study nurses to need further assessment and treatment for anxiety and depressive disorders, and three were found to be in need of assessment for posttraumatic stress disorder. No reference is made to any of this anywhere in their folders. No attempt seems to have been made to open a conversation that would enable discussion of these difficult psychosocial areas.

Yet when Vuyi answered about how useful she had found our intervention, she said, “After I’ve met her, I was so relieved. When I was talking, I was feeling very hurt and bad about what my husband has done to me, but after that day, I felt different.” In response to what had changed, if anything, “Yes, the following week, I came for checkup, and I dressed up nicely. I used to not want to wear clothes; I felt so dull . . . Now I always have a hope that things can be right for me—ideas about the future; before it was just darkness.”

Here, Vuyi refers to her experience of the interview with the study nurse. It seems to indicate that as little as an hour with an effective IPV champion can make a vast difference to the mental state of the woman concerned.

**Quality of Counseling**

It would appear that counseling was largely nonempathic and, at times, rather directive and judgemental in nature. Psychologists, social workers, clinical nurse practitioners, and psychiatric nurses alike provided examples of directive responses, which lacked an empathic understanding of the patient’s situation and perspective.

For example, a psychologist at an urban site recorded the advice given to Nomsa as follows: “. . . explained that she needs to be proactive, she needs to break cycle of abuse. Advised her to contact the National Institute of Crime Prevention and Rehabilitation of Offenders. She needs to protect herself and children. If husband will not stop drinking and abuse, then she needs to make the choice.”

Here, all the responsibility for the solution is put onto Nomsa while simultaneously dismissing potential contextual factors, which may constrain her agency. In this case, poverty made travel difficult, and she did not have her husband’s permission to speak to the neighbors or anyone else, so how could she risk making a trip further afield? She suffered
from agoraphobia, which is a disabling anxiety condition, and so, coping with the outside world would be difficult. For all these reasons, the counseling she received was essentially unhelpful.

Later, with a deteriorating mental state, she presented to the triage nurse, who was responsible for assessing the reasons for encounter and deciding on who should see the patient. “Sleep disturbance and nausea” is noted, and she was referred to the clinical nurse practitioner for further medication. The nurse also states that “social problems were looked at and counselled.” No indication is given of what that may have comprised, but the next time this patient presented to the health service, it was as a result of her fourth suicide attempt.

On interview, we discovered that Nomsa was scared that her partner will kill her. Even though she had presented 11 times to the health center and frequently discussed these difficulties, her reproductive health was neglected, and she had become pregnant with her fifth child. This seems to have been a trigger for the last suicide attempt.

This patient received far more attention than most, and yet the biomedical frame of the service meant that she was forced to rely on fragmented referrals linked by a notable lack of empathy and insight. This failure to think comprehensively and to accurately assess the severity of her problem was a common theme in the case studies.

Another case in a rural clinic exposed the cold, perfunctory nature of the social worker’s approach and how it focused on legislative procedures rather than emotional availability. Carolyn was so dissatisfied with the nontherapeutic nature of the encounter that she refused to see this social worker again. The social worker’s notes were as follows:

Woman seen about home circumstances. She was requesting advice about divorce. I explained that I can’t give advice but rather guidance with regard to therapeutic intervention. Further, I explained that I am not a lawyer and that she should preferably go for legal advice.

Woman threatened to kill herself. She feels helpless and is looking for answers.

Action plan:
- Refer for protection order.
- Undertake to phone Legal Aid.
- Discuss suicidal ideation with doctor.
- Follow up telephonically.

These notes reveal a management plan that appears reasonable but failed to build a therapeutic relationship or to recognize the mental health problems that would make dealing with the courts difficult. At this point, Carolyn was referred to our study where it transpired that she had been in an extremely abusive marriage for more than 30 years and that she was in urgent need of help for anxiety and depressive disorders.

**Continuity and Coordination of Care**

There was no consistent follow-up of patients by a specific health provider who could ensure ongoing continuity and coordination of plans. For example, even though a health care provider noted that Nomsa reported that her husband became violent under the influence of alcohol and that she was scared he would kill her, little progress was made. Referral was made to the Family and Marriage Society of South Africa (a local social service organization) “regarding her contemplation of divorce and the relationship problem and also the contravention of the marital contract. To see social worker in due course.” However, there was no further evidence of her seeing a social worker. Indeed, the last
management plan recorded in her folder 7 months after she was originally referred was for “urgent social work referral.”

In the case of Daphne, the psychiatric nurse noted many social problems, primarily marriage problems which had worsened since the death of her mother. However, the subsequent psychiatrist’s assessments made no reference to relationship issues or relevant management and follow-up despite the fact that her husband was extremely verbally abusive and had threatened to kill her with his gun. Perhaps the psychiatrist was concerned to protect confidentiality, but such omissions beleaguer continuity of care and effective teamwork, which is so critical if primary care services are to function efficiently.

**Record Keeping**

Continuity of care was further undermined by poor record keeping. Copies of referral letters were frequently not included. For example, Nomsa was seen by a nurse and the matter discussed with a doctor: “Contacted Saartjie Baartman Centre (local shelter for domestic violence) for alternative placement . . . client not keen to divorce husband. Letter written to court as per client’s request. Patient to be seen soon.”

No copy of the letter was included in her folder.

**Comprehensive Versus Fragmented Care**

Women suffered from a lack of a comprehensive approach with different providers each looking at one aspect of the problem. This implies that a generalist is needed who is willing to make a comprehensive assessment and at least coordinate care across the full range of issues while offering empathic understanding and continuity. The culture of vertical programs, such as for psychiatric, reproductive health, or HIV, contradicts the delivery of comprehensive and integrated care. IPV needs a generalist who is willing to provide a comprehensive response.

**DISCUSSION**

This study demonstrates that the quality of care in the district health system of the Western Cape, offered to the small percentage of women who are recognized as having a problem with IPV, is fragmented and inadequate. Documentation in the medical record tends to be scanty and superficial, reflecting similar findings elsewhere (Colombini, Mayhew, & Watts, 2008). This is problematic in the light of substantial evidence that IPV is linked to multiple immediate and long-term health consequences, including physical disability and death (Heise & Garcia-Moreno, 2002).

A decade into postapartheid South Africa, Andrews and Pillay’s (2005) assessment of progress in the health care system highlighted a failure to mainstream gender issues within the health sector. They suggested that this reflected ineptitude at addressing and resolving problems that require an integrated approach, exacerbated by a lack of collaboration and coordination within the Department of Health (Andrews & Pillay, 2005). Such a fragmented approach is unlikely to help.

Evidently, prior to our intervention, most health providers, both doctors and nurses, had failed to obtain a psychosocial history, to ask about a history of sexual or physical abuse, or to address issues of safety. Even if a woman does not choose to pursue interventions, a clinician’s support is an act that may, in the long run, contribute to her being able to change her situation (Hegarty, Taft, & Feder, 2008).
South African primary care nurses are fundamentally responsible for the service provided, yet their training and subsequent practice has remained biomedical and task-oriented. Clinical nurse practitioners struggle to provide a holistic and patient-centered approach—with significant implications for the provision of IPV care. For example, a recent morbidity survey of South African primary care demonstrated that psychological and social problems are rarely diagnosed or recognized (Mash et al., 2012). The training of clinical nurse practitioners should focus more on developing a biopsychosocial approach that can at least recognize the presence of psychological and social problems and initiate a response.

Current chronic care policy in the Western Cape initiates the concept of “champions” who provide continuity of leadership for chronic care and practice. The IPV champion would also take responsibility for coordinating care between all the role players and ensuring that the organization keeps focus on maintaining and strengthening the service. This model could work for IPV care if the “IPV champions” are selected according to specific characteristics and qualities that create a therapeutic environment. Policy must specify that this person should be capable of handling the demands of emotional labor as well as consistently exhibiting empathy and good listening skills, respect for client confidentiality and autonomy, a collaborative approach to problem solving, effective multidisciplinary teamwork, and good networking skills to foster intersectoral collaboration. Thus, the champion could be any member of staff at the CHC who is interested and able to work with IPV in this way.

Scant documentation of issues pertaining to a patient’s abuse is an international phenomenon (Buel, 2002). Yet medical records often comprise the sole documentation of patient’s injuries. Given their forensic significance, medical records should contain all key facts (Gerbert, Moe, & Caspers, 2000; Joyner & Mash, 2010). In our sample of medical records of IPV survivors, the only mention of IPV-related injuries is of the most reductionist kind. Minimalistic entries may represent the cursory manner in which the patient was handled or the overloaded nature of the health provider’s caseload, which leaves little time to make comprehensive notes.

Structural changes to documentation that make recording of IPV mandatory have a far higher success rate with changing health provider behavior than training and education alone (Harwell et al., 1988; Olson et al., 1996). A comprehensive approach to IPV should be formalized within health systems and training so that continuity and coordination of care can be improved. Not only is this a key feature of quality care, but it also has significant ethical implications. In the case of Nomsa, for example, a better coordinated, proactive approach could have prevented her fifth (unwanted) pregnancy. The growing evidence of the high risk of unwanted pregnancies in abusive relationships suggests that serious efforts should be made to integrate reproductive health with IPV care (Pallitto & O’Campo, 2004). Violence often results from sexual health problems and reproductive issues. For example, covert contraceptive use renders some women vulnerable to IPV (Njovana & Watts, 1996); women’s refusal of sex is frequently cited as a justification for violence (Jewkes, Penn-Kekana, Levin, Ratsaka, & Schreiber, 1999); fear of violence in the home and consequent ostracism is an important reason why pregnant women refuse an HIV test or do not return for the results (Heise & Garcia-Moreno, 2002). In South African antenatal care, IPV is significantly associated with HIV seropositivity (Dunkle et al., 2004).

Table 2 demonstrates that most women were referred to specialists such as psychologists, social workers, or psychiatric nurses. Clearly, no one sees each woman comprehensively but prefers to deal with only a piece of the problem. The primary care provider, who is the generalist, is either too busy or lacks the competencies required to coordinate comprehensive care. Consequently, the woman is treated in a fragmented fashion. Elsewhere, we recommend that following identification and the provision of appropriate clinical care,
the woman should be referred to an IPV champion (Joyner & Mash, 2012b). The IPV champion, if properly selected and trained, may be better able to complete a comprehensive biopsychosocial and forensic assessment and care plan, provide ongoing care, and refer to community-based support groups.

Services by health care providers that give patients a sense that they are being cared for has been termed emotional labor. This relates to the element of work that is involved in being sympathetic, empathic, and respectful. If emotional labor is unrecognized in health care systems, it may be that it does not easily fit the biomedical organizational culture (Small, 1995). Furthermore, care and emotion are concepts that have strong cultural associations within the private realm of love and feelings rather than the public world of work. Caring individuals and a safe environment have been found to be most beneficial in assisting women who live with IPV, “It’s not so much what people do to help but how they do it” (Stenius & Veysey, 2005, p. 1155).

A recent study of primary care doctors in Cape Town found high levels of burnout characterized by emotional exhaustion and depersonalization that would make it difficult for them to provide the necessary emotional labor (Rossouw, 2011). Similarly, the organizational culture in primary care facilities is characterized by poor communication, blame, control, and manipulation and can therefore also be seen as potentially abusive (Mash, Govender, Isaacs, de Sá, & Schlemmer, 2013). These issues may also be vitally connected to the failure of primary care nurses to recognize anxiety and depression (Mash et al., 2012).

Unsurprisingly therefore, the counseling offered by various health providers seems to be predominantly directive and judgemental and more characteristic of an “inhibitive helper response” (Limandri, 1987). Many providers internalize and subsequently perpetuate in their practice the misguided separation assumption of the dominant discourse on IPV. This is the assumption that separation from the partner will resolve her problems and is the only solution. This fails to acknowledge the autonomy of the women, the complexity of relationships, and the variety of choices or goals that may be reasonable in a specific context. By contrast, a “facilitative helper response” would acknowledge the seriousness of abuse and that the women are not to blame for it. Active and compassionate listening should be combined with assisting the woman to assess her internal strengths and to consider the full range of available options (Limandri, 1987). Limandri (1987) developed these categories during her pioneering qualitative work with abused women. Motivational interviewing terms this a guiding style (Rollnick, Miller, & Butler, 2008).

Vuyi provides a florid example of how pervasively abuse impacted on her mental health, with ongoing effects even after the relationship had ended. Indeed, findings confirm psychiatric disorders to be a persistent and disabling consequence of IPV, particularly depression, posttraumatic stress disorder, chronic anxiety, and substance misuse (Rees et al., 2011). In an investigation into the strength of association between adult mental health disorders and childhood sexual abuse, sexual assault in adulthood, or domestic violence, the latter showed the strongest associations with most mental health measures (Coid et al., 2003). These findings support the importance of all mental health clinicians and primary care providers actively seeking evidence for IPV and treating survivors proactively for mental health problems.

A cross-sectional investigation of 1,293 young rural South African women (Jina et al., 2012) found that emotionally abused young women are more at risk of suicide than those experiencing no abuse. The combined experience of emotional with physical and/or sexual abuse was strongly associated with poor mental health outcomes.

Patients’ entrapment tends to overwhelm health providers, preventing them from assisting such an IPV survivor. Yet empathic, constructive attention from the study nurse
impacted positively on their mental health. Women experiencing IPV want recognition and ongoing support from health care providers, without pressure for a specific course of action (Joyner & Mash, 2011).

The reengineering of primary care, and training of community health workers and nurses in community-based teams responsible for households, needs be predicated within a conceptual framework that prioritizes the problem of South Africa’s gender-based violence epidemic. A genuinely biopsychosocial and forensic approach should be implemented within primary care as a matter of urgency.

LIMITATIONS

Given the hidden nature of IPV and lack of standardized care guidelines, it was not possible to conduct an audit of the quality of care as one might do for other chronic diseases. Findings were based on a small number of case studies, and it is not possible to generalize to other primary care settings from a qualitative study based on several purposefully selected health centers. Nevertheless, we would expect that the findings are reasonably applicable to similar settings in the Western Cape. Since the health services in the Western Cape are generally better resourced than other provinces, we would anticipate that care may be worse elsewhere.

IMPLICATIONS AND RECOMMENDATIONS

1. Primary care providers need to be trained and enabled to offer a more comprehensive biopsychosocial and forensic approach to IPV. This means that IPV-related knowledge and skills should become a compulsory component of all nursing, medical, and community health workers’ curricula.

2. Primary care providers need to offer a more empathic and patient-centered approach to their interactions. These competencies should be embedded in the training of these three groups.

3. There is a need for a generalist at the heart of caring for women with IPV. This person should be able to provide holistic, ongoing care and to coordinate other services. Primary providers should have all these attributes, but their training does not seem to have provided them with these vital generalist skills.

4. Attention should be given to improving documentation of IPV within patients’ medical records so as to provide women with evidence of abuse sustained should they require it in the future.

5. Consideration should be given to making active case finding part of the structured medical record in specific settings, for example, family planning and antenatal and postnatal care.

CONCLUSION

This study suggests that most women living with IPV who attend primary care facilities are not recognized. Among the few that are identified, care tends to be superficial, fragmented, poorly coordinated, and lacking in continuity. The recognition, management, and appropriate documentation of IPV should be prioritized within the training of primary care providers. It may be necessary to appoint IPV champions within primary care to ensure comprehensive care for survivors of IPV.
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The Intergenerational Transmission of Violence: Examining the Mediating Roles of Insecure Attachment and Destructive Disagreement Beliefs

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Intimate partner violence has been recognized as a major problem on college campuses and is a source of concern for researchers, clinicians, policymakers, and the general population. Most research has focused on the intergenerational transmission of violence and identifying the intrapersonal mechanisms that enable violence in the family of origin to carry over to adult intimate relationships. This study expands the current literature by examining insecure attachment styles and destructive disagreement beliefs as mediators in the relationship between exposure to hostility or aggression in the family of origin and later experiences of dating aggression. Research questions were addressed with a sample of 1,136 college undergraduates (59% women). In all models, results of structural equation modeling indicated that an insecure attachment style and destructive disagreement beliefs mediated the intergenerational transmission of violence among both men and women. These findings have important implications for future research as well as relationship education programs and preventative interventions.

Keywords: interparental aggression; hostile parenting; insecure attachment; conflict; intimate partner violence

Dating violence has been recognized as a major problem on college campuses and is a great source of concern for clinicians, researchers, policymakers, and the general population. Prevalence studies regularly show that between 20% and 30% of college men and women experience physical dating violence perpetration; the same prevalence rates have been reported for victimization as well (Simons, Burt, & Simons, 2008). Rates of dating aggression, which includes psychologically aggressive acts, are even higher with 82% of college women and 87% of college men reporting victimization of dating aggression (Harned, 2002). Similar rates have been reported for perpetration, with 80% of men and 83% of women having perpetrated psychological aggression against a dating
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partner (Cornelius, Shorey, & Beebe, 2010). Importantly, recent research shows men and women experience couple victimization at comparable rates, if not severity (Straus, 2009). Given the high rates of dating aggression in college samples, much attention has been paid to risk factors for violence in dating relationships because understanding the etiology of such behavior is essential for prevention and intervention efforts.

Most research on risk factors associated with dating violence has focused on interparental aggression and hostile parenting (Simons et al. 2008; Tschann et al., 2009), which is consistent with the intergenerational transmission of violence hypothesis. This explanation holds that individuals learn violent patterns of interaction in their families of origin when they witness aggression between their parents and/or experience abusive parenting. Although a direct relationship between violent family of origin experiences and partner violence later in life has been well-established (Simons, Simons, Lei, Hancock, & Fincham, 2012), a meta-analysis revealed that the relationship between violent dating experiences and witnessing or experiencing violence as a child is fairly modest (Stith et al., 2000). Thus, several researchers suggest that a critical next step in dating violence research is to identify the intrapersonal mechanisms that enable violent family experiences in childhood to carry over to adult relationships because there is presently a lack of explanations for this continuity (Dutton, 2000).

Some recent studies have attempted to address this deficiency by examining individuals’ attitudes regarding issues such as gender roles or the legitimacy of violence as links in the relationship between family experiences and later dating violence (Lichter & McCloskey, 2004; Simons et al., 2012). Few studies, however, examine specific beliefs people hold about communication and conflict as possible links between early experiences in the family of origin and later experiences with a dating partner. This understudied area may provide important insights regarding the intergenerational transmission of violence. One possibility is destructive disagreement beliefs. Individuals who hold these beliefs think “disagreements regarding values, attitudes, goals, or preferences are threatening to an intimate relationship” (Eidelson & Epstein, 1982, p. 715). In other words, such individuals are likely to view even minor disagreements as a sign that their relationship is in trouble.

Past research that addresses the role of family of origin factors on offspring’s involvement in intimate partner violence has often relied on social learning theory (Simons et al., 2012); however, it has been suggested that other theoretical perspectives may be more useful in addressing intrapersonal processes (e.g., cognitions, beliefs) related to dating aggression. For example, Dutton (2000) asserts that social learning theory “does less well at accounting for the acquisition of private or internal events that are prominent in sustaining abusiveness” (p. 60). An appropriate avenue for the exploration of intrapersonal mechanisms linking intimate relationship patterns in the family of origin to those in adulthood is attachment theory. This perspective has a focus on the development of internal working models, or cognitions, that come about through early parent–child interactions and guide affect, behavior, and beliefs in adult intimate relationships (Bowlby, 1973; Mikulincer, 1998). In this study, we examine insecure attachment style and destructive disagreement beliefs as intrapersonal processes explaining the intergenerational transmission of violence (see Figure 1 for the conceptual model). Specifically, we are concerned with the extent to which exposure to hostile parenting or interparental aggression is associated with an increase in offspring’s dating violence perpetration and victimization. Furthermore, we will investigate the role of insecure attachment and destructive disagreement beliefs as potential mediating mechanisms in that relationship.
Studies have shown that hostility and aggression in the family of origin can impact the likelihood of experiencing intimate partner violence later in life. For example, hostile or harsh parenting is associated with an increased risk for involvement in intimate relationships characterized by aggression and violence during adolescence and emerging adulthood (Simons et al., 2008; Tyler, Brownridge, & Melander, 2011). Violence and aggression between parents has also been shown to increase the likelihood that offspring experience intimate partner violence. Specifically, more frequent interparental conflict and physical violence between parents is related to an increase in physical dating violence perpetration and victimization among offspring (Tschann et al., 2009). However, these relationships are moderate at best. Across studies, Stith et al. (2000) found that the relationship between experiencing violence as a child and subsequently becoming a victim of spouse abuse had weighted effect sizes ranging from an $r$ value of .10 to .27. Similarly, the relationship between witnessing interparental violence as a child and subsequently becoming a victim of spouse abuse had weighted effect sizes ranging from an $r$ value of .11 to .35. Thus, there is much left unexplained.

**Destructive Disagreement Beliefs**

Although a direct relationship between hostile experiences in the family of origin and dating aggression as a young adult has been well-established, studies also provide evidence that the beliefs an individual holds regarding conflict in relationships plays a role in this association. For example, one study found that married people who expect complete compliance from their mates during disagreements, often an unrealistic expectation, were more likely to express anger, to approve of aggression in relationships, and to be both physically and psychologically aggressive (Foran & Slep, 2007). Furthermore, Simons and colleagues (2008) found that the belief that violence is a legitimate tactic for solving
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Intimate relationship problems mediate the relationship between abusive parenting and physical dating violence for college-aged men. Although no studies have examined the relationship between family of origin variables and destructive disagreement beliefs, findings from previous studies provide rationale for the consideration of such beliefs as a possible mediating mechanism in the intergenerational transmission of violence.

Individuals holding destructive disagreement beliefs equate disagreements with a lack of love or sign of impending disaster for a relationship. Despite a dearth of studies on disagreement beliefs in relation to family factors, it is likely that growing up in a violent and abusive home primes individuals to be wary of even unimportant disagreements. As adults, these beliefs may manifest themselves as active attempts to avoid disagreement or the use of coercive tactics to swing a disagreement in one’s favor and may be expressed as physical violence or psychological aggression (Simon, Kobielski, & Martin, 2008). One recent study provides evidence that this is, indeed, the case. Specifically, destructive disagreement beliefs differentiated college men who had perpetrated dating violence from those who had not; furthermore, these beliefs also predicted the frequency of dating violence (Makin-Byrd & Azar, 2011). We contend that these destructive relationship beliefs are more prevalent among individuals who have experienced a hostile family of origin environment because previous experiences with disagreement and conflict have involved psychological and physical harm. Furthermore, we expect that destructive disagreement beliefs will function as a linking mechanism in the intergenerational transmission of violence, developing in the family of origin and continuing to negatively impact intimate relationships into adulthood.

Insecure Attachment

According to the basic tenets of attachment theory, a child develops his or her attachment style through interactions with primary caregivers (Bowlby, 1969/1982). Individuals who are raised by hostile parents and/or witness violence between parents are likely to become insecurely attached because they likely view their caregivers as unavailable or harsh and rejecting (Bowlby, 1973). Although Bowlby (1973) asserted that attachment styles would continue to influence one’s romantic relationships, Hazan and Shaver (1987) were the first researchers to test this idea. They found that avoidant individuals fear intimacy and closeness, whereas anxious–ambivalent individuals obsess over their relationship and desire a high level of reciprocity with their partner. During conflict with romantic partners, avoidant individuals can be hostile and selfish and rely on escapist strategies, sometimes including violence, to avoid engagement. Anxious–ambivalent individuals, on the other hand, are more aggressive, experience anger arousal at higher levels, and are prone to rumination (Mikulincer, 1998). Although a few studies report that attachment mediates the relationship between abuse or violence in the family of origin and interpersonal violence in adulthood (Chapple, 2003), more exploration of this relationship is needed.

The concept of internal working models provides an explanation for the lifelong influence of attachment style on intimate relationships. Internal working models are mental representations or beliefs about the self and significant others that guide affect, cognitions, and behavior in intimate relationships (Bowlby, 1973). These internal working models develop over time, from infancy throughout adolescence, via experiences with attachment figures. Bowlby (1973) believed that these working models influence later romantic relationships as they are internalized and become the default schema an individual uses to process experiences with intimate partners. In fact, using the Adult Attachment Interview
to infer internal working models, Roisman, Madsen, Hennighausen, Sroufe, and Collins (2011) found internal working models to mediate the relationship between parent–child interactions and later intimate partner relationship quality.

In this study, destructive disagreement beliefs are expected to be one such set of cognitions. Securely attached individuals are more likely to believe that their romantic partners ultimately want to maintain intimacy even when disagreements do occur (Bowlby, 1969/1982) and are unlikely to develop internal working models that incorporate destructive disagreement beliefs. However, both avoidant and anxious individuals are apt to view disagreements as a major threat to security rather than a normal part of a romantic relationship. For example, Stackert and Bursik (2003) revealed that both anxious and avoidant college students endorsed significantly more irrational relationship beliefs, including the belief that disagreement is destructive, compared to securely attached peers. Based on these findings, we expect insecure attachment to mediate the relationship between hostile parenting and disagreement beliefs. These beliefs, in turn, are expected to mediate the relationship between attachment style and dating violence.

THE CURRENT STUDY

The goal of this study is to examine insecure attachment style and destructive disagreement beliefs as intrapersonal mechanisms linking hostility and aggression in the family of origin to respondents’ dating violence perpetration and victimization. First, we expect to find a direct relationship between interparental aggression and hostile parenting, consistent with previous research (Krishnakumar & Buehler, 2000). Next, we expect that both exposure to hostile parenting and interparental aggression will be positively related to experiences of dating violence victimization and perpetration. Furthermore, we hypothesize that hostile parenting will be positively associated with an insecure attachment style and that this insecure attachment style will be positively related to destructive disagreement beliefs. In addition, we predict that the relationship between hostile parenting and destructive disagreement beliefs will be mediated by insecure attachment style. Furthermore, we expect insecure attachment style will be positively related to experiences of dating violence and that this relationship will be mediated by destructive disagreement beliefs. In summary, we hypothesize that an insecure attachment style and destructive disagreement beliefs will partially mediate the relationship between family of origin experiences (hostile parenting and interparental aggression) and experiences of dating violence perpetration or victimization. To ascertain whether these associations vary between men and women, models will be examined separately by gender of respondent.

METHOD

Sample and Procedure

Data were collected from 1,148 undergraduates enrolled in introductory family studies and sociology courses at a large state university during the fall semester of 2011. A pencil-and-paper survey was used, and questions covered several topics including experiences in the family of origin; romantic relationships; risky behaviors; and attitudes about dating, sexuality, and marriage. Participants provided informed consent during normal class time
a week before the planned implementation of the survey. Students received extra credit points for participating in this study. Participation was voluntary, and any students who did not wish to participate were offered an alternative extra credit assignment. Nearly all students who were present on the day that the survey was administered elected to participate and completed the survey, thus participation was nearly 100%. Because of the personal nature of some questions, the survey was proctored like an exam to protect each participant’s privacy. There were no identifiers on the survey instrument or answer sheets. No students discontinued the survey prior to completion.

After eliminating outliers and missing values listwise from our original sample of 1,148 undergraduates, complete data were available for 1,136 subjects, 673 women (59.2%) and 463 men (40.8%). Analyses indicated that those participants who were deleted from this study \( (n = 12, 1.0\%) \) did not differ significantly from those who participated regarding family income or parental family status. Most participants were White (81.3%), followed by African American (7.8%), Asian/Pacific Islander (7.1%), Other (2.4%), and Hispanic/Latino (1.6%). Most participants come from families in which parents have been continuously married (73.2%), 14.5% indicated that their parents were divorced and remarried, 7% reported that their parents were divorced and unmarried, 3.8% indicated that one or more parents were deceased, and 1.5% reported that their parents were never married to one another. Although information on age was not collected from study participants, approximately 95% of the students at this university are younger than age 25 years (College Portrait, 2008). Given that our sample is very similar to the university’s undergraduate student body in terms of the distribution of gender and race, it is reasonable to assume the same is true for age.

Measures

**Dating Violence Victimization.** The participants used a 6-item scale adapted from the Conflict Tactics Scale (Simons et al., 2008; Simons et al., 2012; Straus, Gelles, & Steinmetz, 1980) to indicate instances of violence during conflicts with current and past romantic partners. Respondents indicated how often a romantic partner had engaged in such behaviors (i.e., “shout or yell at you”; “insult or swear at you”; “call you bad names”; “threaten to hit you”; “hit, push, shove, or grab you”; and “hit you with an object or throw an object at you”) along a 4-point scale ranging from 0 = never, 1 = not too often, 2 = about half the time, 3 = fairly often, and 4 = always. The items were summed with a higher score indicating a higher frequency of dating violence victimization. Cronbach’s alpha for this scale is .89 for males and .83 for females.

**Dating Violence Perpetration.** Experiences of dating violence perpetration were assessed using the same six items, with the questions reworded to indicate perpetration of the earlier behaviors by the respondent toward a dating partner. The response format was the same, and a sum score was computed with higher scores reflecting a higher frequency of dating violence perpetration. Cronbach’s alpha for this scale is .85 for males and .82 for females.

**Interparental Aggression.** The measure for interparental aggression was adapted from the hostility and warmth subscales of the instruments developed for the Iowa Youth and Families Project (Conger et al., 1992; Conger & Elder, 1994). Interparental hostility was assessed using a 4-item scale to indicate aggressive and violent interactions between parents during the time the participant was living at home. Hostility between parents was examined by asking, “When they interacted with each other, how often did your parents . . .” “criticize each other’s ideas”; “shout or yell at each other because they were mad”; “hit, push, shove,
or grab each other”; and “insult or swear at each other.” The response format for these items was 0 = never, 1 = not too often, 2 = about half the time, 3 = fairly often, and 4 = always. **Interparental warmth** was assessed using a 4-item scale to indicate loving interactions between parents during the time the participant was living at home. Respondents were asked to indicate how often their parents “listened carefully to each other’s point of view,” “acted loving and affectionate toward one another,” “had a good laugh with each other about something that was funny,” and “said ‘I love you’ to each other.” Interparental warmth items were reverse coded then summed with interparental hostility items for an overall scale of interparental aggression. High scores for the scale indicate high hostility and low warmth. Cronbach’s alpha for this scale is .80 for males and .86 for females.

**Hostile Parenting.** The measure for hostile parenting by mothers and fathers was adapted from instruments developed for the Iowa Youth and Families Project (Conger et al., 1992; Conger & Elder, 1994; Simons & Conger, 2007). First, maternal hostility was assessed using a three-item scale to indicate how often hostility in interactions between the participant and a female caregiver occurred during the time the participant was growing up (i.e., “criticize your ideas,” “shout or yell at you because they were mad,” and “insult or swear at you or call you bad names”). Next, maternal warmth was assessed using a 4-item scale to indicate how often loving interactions between the participant and a female caregiver occurred during the time the participant was growing up (i.e., “listen carefully to your point of view,” “act loving and affectionate toward you,” “have a good laugh with you about something that was funny,” and “tell you she loves you”). The same items were used for paternal warmth and hostility. The response format for the items was 0 = never, 1 = not too often, 2 = about half the time, 3 = fairly often, and 4 = always. Maternal warmth and paternal warmth items were reverse coded then summed with maternal hostility and paternal hostility items for an overall scale of hostile parenting. Thus, higher scores reflected high parental hostility and low parental warmth. Cronbach’s alpha for this scale is .82 for males and .84 for females.

**Insecure Attachment.** The measure for insecure attachment was adapted from the Experiences in Close Relationships—Revised instrument (Fraley, Waller, & Brennan, 2000) and reflected participant’s attitudes about romantic relationships in general. Five items were assessed to represent avoidant attachment (e.g., “I don’t like showing my partner how I feel deep down,” “I find it difficult to allow myself to depend on romantic partners”) and five items represented anxious attachment (e.g., “I worry about being abandoned or rejected by my partner,” “My desire to be very close sometimes scares partners away”). The response format for the items was 0 = never, 1 = not too often, 2 = about half the time, 3 = fairly often, and 4 = always. Avoidant attachment and anxious attachment items were summed to form an overall insecure attachment scale, with high scores indicating greater avoidance and anxiety. Cronbach’s alpha for the combined scale is .85 for males and .87 for females.

**Destructive Disagreement Beliefs.** Participants completed a 3-item scale adapted from a modified version of the Disagreement is Destructive subscale (Cramer, 2001) to indicate their degree of acquiescence with statements regarding their own beliefs about disagreement in relationships. Specifically, respondents reported how often “I get very upset when my partner and I cannot see things the same way,” “I cannot tolerate it when my partner argues with me,” and “When my partner and I disagree, I feel like our relationship is falling apart.” The response format for the items was 0 = never, 1 = not too often, 2 = about half the time, 3 = fairly often, and 4 = always. A sum score was computed, and high scores indicated greater agreement with the belief that disagreement is destructive to romantic relationships. Cronbach’s alpha for this scale is .75 for males and .73 for females.
Control Variables. We controlled for parents’ marital status and family income because past research has shown that these variables are related to the dependent and independent variables.

Parental Marital Status. Parental marital status was measured using a single item. Responses were dichotomously coded into two categories: (a) continuously married parents and (b) non–continuously married parents.

Family’s Income. Family’s income level was measured using a single item, “Indicate your family’s approximate total income.” Response categories were 1 = less than $60,000, 2 = $60,001–$100,000, 3 = $100,001–$140,000, 4 = $140,001–$180,000, and 5 = more than $180,000.

Data Analysis

To test the hypotheses, structural equation modeling (SEM) using Mplus was employed. Separate models were run for dating aggression perpetration and victimization and by gender of respondent. Parents’ marital status was controlled for in all models. Next, models were retested controlling for family income. However, income level was unrelated to the outcome variable in all models, all paths remained significant, and model fit was somewhat poorer. Therefore, family income was dropped from the final models.

RESULTS

Descriptive Statistics

Most participants report some instance of dating violence, with a smaller proportion reporting experiences of physical violence. Specifically, 79.3% of men and 66.7% of women reported being a victim of any act of dating violence, and 28.1% of men and 13.0% of women reported that they have been victims of physical violence by a dating partner. For perpetration, 72.8% of males and 68.6% of females report having perpetrated at least one act of the dating violence, whereas 10.3% of men and 14.2% of women report that they have been physically violent toward a dating partner. Table 1 shows further information on rates of dating violence perpetration and victimization by item.

<table>
<thead>
<tr>
<th>Dating Violence Item</th>
<th>Perpetration</th>
<th></th>
<th></th>
<th>Victimization</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Men</td>
<td>Women</td>
<td></td>
<td>Men</td>
<td>Women</td>
</tr>
<tr>
<td>Shout or yell</td>
<td>320 (69.3%)</td>
<td>442 (65.6%)</td>
<td>343 (74.1%)</td>
<td>411 (61.1%)</td>
<td></td>
</tr>
<tr>
<td>Insult or swear</td>
<td>249 (53.8%)</td>
<td>308 (45.8%)</td>
<td>298 (64.4%)</td>
<td>324 (48.1%)</td>
<td></td>
</tr>
<tr>
<td>Call bad names</td>
<td>202 (43.6%)</td>
<td>223 (33.1%)</td>
<td>264 (57.1%)</td>
<td>216 (32.1%)</td>
<td></td>
</tr>
<tr>
<td>Threaten to hit</td>
<td>39 (8.4%)</td>
<td>49 (7.3%)</td>
<td>99 (21.4%)</td>
<td>29 (4.3%)</td>
<td></td>
</tr>
<tr>
<td>Hit with an object or throw an object</td>
<td>23 (5.0%)</td>
<td>41 (6.1%)</td>
<td>83 (17.9%)</td>
<td>25 (3.7%)</td>
<td></td>
</tr>
<tr>
<td>Hit, push, shove, or grab</td>
<td>48 (10.4%)</td>
<td>103 (15.3%)</td>
<td>130 (28.2%)</td>
<td>88 (13.1%)</td>
<td></td>
</tr>
</tbody>
</table>

Note. Valid percents reported.
TABLE 2. Correlation Matrix for Study Variables by Respondent Gender

<table>
<thead>
<tr>
<th></th>
<th>1.</th>
<th>2.</th>
<th>3.</th>
<th>4.</th>
<th>5.</th>
<th>6.</th>
<th>Mean</th>
<th>SD</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Interparental aggression</td>
<td></td>
<td>-.61**</td>
<td>.22**</td>
<td>.19**</td>
<td>.23**</td>
<td>.23**</td>
<td>9.57</td>
<td>9.75</td>
</tr>
<tr>
<td>2. Hostile parenting</td>
<td>.57**</td>
<td></td>
<td>.24**</td>
<td>.15**</td>
<td>.24**</td>
<td>.25**</td>
<td>13.19</td>
<td>9.84</td>
</tr>
<tr>
<td>3. Insecure attachment</td>
<td>.08*</td>
<td>.20**</td>
<td></td>
<td>.51**</td>
<td>.25**</td>
<td>.22**</td>
<td>16.79</td>
<td>14.95</td>
</tr>
<tr>
<td>4. Destructive disagreement beliefs</td>
<td>.09*</td>
<td>.12**</td>
<td>.36**</td>
<td></td>
<td>.36**</td>
<td>.31**</td>
<td>4.12</td>
<td>6.67</td>
</tr>
<tr>
<td>5. Dating violence perpetration</td>
<td>.14**</td>
<td>.21**</td>
<td>.15**</td>
<td>.28**</td>
<td></td>
<td>.74**</td>
<td>2.68</td>
<td>3.12</td>
</tr>
<tr>
<td>6. Dating violence victimization</td>
<td>.12**</td>
<td>.15**</td>
<td>.17**</td>
<td>.24**</td>
<td>.72**</td>
<td></td>
<td>4.59</td>
<td>8.65</td>
</tr>
</tbody>
</table>

| Mean | 9.10 | 10.50 | 12.95 | 3.69 | 2.80 | 2.40 |
| SD   | 7.50 | 9.83  | 9.63  | 4.28 | 6.07 | 3.12 |

Note. Correlations for men \(n = 463\) displayed above the diagonal, and correlations for women \(n = 673\) displayed below the diagonal. 
*p ≤ .05. **p < .01.

Table 2 presents the correlation matrix, along with means and standard deviations, for all study constructs. Values above the diagonal are for men, and values below the diagonal are for women. Although most of the sample had experienced some instance of dating violence, the low mean scores show that the average man or woman in the sample experienced violence infrequently. For example, for women’s victimization, a score of 4.59 out of a possible 24 points shows that the average woman in the sample experienced fairly low levels of violence. All variables are correlated in the expected direction, and all relationships are significant. Interparental aggression is significantly related to hostile parenting, and both of those constructs are positively correlated with destructive disagreement beliefs, dating violence perpetration, and dating violence victimization for both men and women. Furthermore, insecure attachment style is positively correlated with hostile parenting, interparental aggression, destructive disagreement beliefs, and perpetration and victimization for both men and women. Both perpetration and victimization are positively associated with destructive disagreement beliefs. Lastly, dating violence victimization is strongly correlated with dating violence perpetration for both genders.

To further explore these various relationships and to test our hypotheses, we examined several SEM models. Model fit was evaluated using three indices: chi-square tests, root mean square error of approximation (RMSEA), and comparative fit index (CFI). Chi-square tests are influenced by sample size, possibly making it a poor indicator of fit for this sample given its large size; to account for this, the other two fit indices were used as well. When testing model fit for the four models, the chi-square, RMSEA, and CFI all indicate a reasonable
fit of the data for each model, with slightly better indicators of fit for female than male models (Hooper, Coughlan, & Mullen, 2008); these results are shown in Table 3 along with the SEM results for all models. Although the chi-square $p$ values are relatively low for some male models, the other fit indices show good fit. Also, bootstrapping, a robust post hoc test, was performed for each model to correct for any non-normality (Nevitt & Hancock, 2001).

**Male Perpetration**

SEM results for all models are shown in Table 3. Contrary to our prediction, interparental aggression is not associated with an increased risk of dating violence perpetration for insecurely attached men. Rather, interparental aggression is related to perpetration through hostile parenting. Specifically, interparental aggression is directly related to hostile parenting ($0.86, p < .01$), which, in turn, is related to perpetration ($0.06, p \leq .05$) both directly and indirectly through insecure attachment style ($0.24, p < .01$), as predicted. Furthermore, an insecure attachment style is related to disagreement beliefs ($0.17, p < .01$), which in turn increase the likelihood of perpetrating dating violence ($0.39, p < .01$). Results also show a direct but weak relationship between interparental aggression and destructive disagreement beliefs ($0.05, p \leq .05$). Next, Sobel tests of mediation were employed using Mplus. Results of mediation analysis for all models are also shown in Table 3. As predicted, attachment fully mediates the relationship between hostile parenting and destructive disagreement beliefs ($0.04, p < .01$). Also, the relationship between insecure attachment and perpetration is fully mediated by destructive disagreement beliefs ($0.07, p < .01$). Given the weak but direct relationship between hostile parenting and perpetration, we can conclude that insecure attachment and destructive disagreement beliefs together partially mediate the relationship between family of origin factors and dating violence perpetration for insecurely attached men.

**Female Perpetration**

SEM results for females’ perpetration are very similar to those reported for men. Interparental aggression is not directly related to perpetration of dating violence. Instead, interparental aggression increases the likelihood of experiencing hostile parenting ($0.71, p < .01$), which in turn is directly associated with both perpetration ($0.07, p < .01$) and an insecure attachment style ($0.20, p < .01$) among women. This insecure attachment style increases the chances of holding destructive disagreement beliefs ($0.11, p < .01$), which is further related to violence perpetration ($0.35, p < .01$) by women. Contrary to the results for male perpetrators, there is no direct relationship between interparental aggression and destructive disagreement beliefs for women. However, the results of the mediation analyses are as expected for female perpetration. Specifically, insecure attachment significantly and fully mediates the relationship between the experience of hostile parenting and the belief that disagreement is destructive ($0.02, p < .01$), and these beliefs in turn fully mediate the relationship between insecure attachment and perpetration of dating violence ($0.04, p < .01$). The relationship between family of origin variables and dating violence perpetration is partially explained by an insecure attachment style and destructive disagreement beliefs.

**Male Victimization**

Turning to victimization, hostile parenting ($0.10, p < .01$), but not interparental aggression, was directly related to men’s dating violence victimization. Interparental aggression
### TABLE 3.  Models for Perpetration and Victimization

<table>
<thead>
<tr>
<th></th>
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<tbody>
<tr>
<td><strong>Interparental</strong></td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>aggression</td>
<td></td>
<td></td>
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<tr>
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<td>.86**</td>
<td>.71**</td>
<td>.86**</td>
<td>.71**</td>
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<td>Disagreement beliefs</td>
<td>.05*</td>
<td>.02</td>
<td>.05*</td>
<td>.02</td>
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<tr>
<td>Dating violence</td>
<td>.04</td>
<td>.00</td>
<td>.05</td>
<td>.01</td>
</tr>
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<td><strong>Hostile parenting</strong></td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Insecure attachment</td>
<td>.24**</td>
<td>.20**</td>
<td>.24**</td>
<td>.20**</td>
</tr>
<tr>
<td>Disagreement beliefs</td>
<td>−.01</td>
<td>.00</td>
<td>−.01</td>
<td>.00</td>
</tr>
<tr>
<td>Dating violence</td>
<td>.06*</td>
<td>.07**</td>
<td>.10**</td>
<td>.04</td>
</tr>
<tr>
<td><strong>Insecure attachment</strong></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Disagreement beliefs</td>
<td>.17**</td>
<td>.11**</td>
<td>.17**</td>
<td>.11**</td>
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<tr>
<td>Dating violence</td>
<td>.02</td>
<td>.01</td>
<td>.02</td>
<td>.04</td>
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<tr>
<td><strong>Disagreement</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>beliefs</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dating violence</td>
<td>.39**</td>
<td>.35**</td>
<td>.45**</td>
<td>.28**</td>
</tr>
<tr>
<td><strong>Marital status</strong></td>
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<tr>
<td>Dating violence</td>
<td>−.12</td>
<td>−.44</td>
<td>−.30</td>
<td>−.59</td>
</tr>
<tr>
<td>Sobel tests</td>
<td>$R^2$</td>
<td>Fit indices</td>
<td></td>
<td></td>
</tr>
<tr>
<td>------------</td>
<td>-------</td>
<td>-------------</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hostile parenting</td>
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<td>Chi-squared $p = .09$</td>
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<tr>
<td>Insecure attachment</td>
<td>.03**</td>
<td>RMSEA $p = .05$</td>
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<tr>
<td>Disagreement beliefs</td>
<td>.04**</td>
<td>CFI $p &lt; .01$</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Intergenerational Transmission of Violence, Attachment, and Beliefs

* $p \leq .05$, ** $p < .01$. 

Sobel tests: Hostile parenting $\rightarrow$ Insecure attachment $\rightarrow$ Disagreement beliefs $\rightarrow$ Dating violence.
increases the likelihood of experiencing hostile parenting (.86, \(p < .01\)), which in turn is directly related to victimization as well as indirectly through an insecure attachment style (.24, \(p < .01\)). Furthermore, an insecure attachment style is associated with disagreement beliefs (.17, \(p < .01\)), which in turn increase the likelihood of dating aggression victimization (.45, \(p < .01\)). There is also a direct relationship between interparental aggression and disagreement beliefs (.05, \(p \leq .05\)). As expected, the relationship between hostile parenting and the belief that disagreement is destructive to a relationship is fully mediated by an insecure attachment (.04, \(p < .01\)). Also, the relationship between an insecure attachment style and male victimization is fully explained by destructive disagreement beliefs (.08, \(p < .01\)). Taken together, these results show that insecure attachment and destructive disagreement beliefs are partial mediators in the intergenerational transmission of violence for male victims.

**Female Victimization**

Contrary to our predictions, there is no direct relationship between either hostile parenting or interparental hostility and dating violence victimization for women. However, there is an indirect relationship between these variables through insecure attachment and destructive disagreement beliefs. Specifically, interparental aggression is directly related to hostile parenting (.71, \(p < .01\)), which in turn is associated with an insecure attachment style (.20, \(p < .01\)) among women. This insecure attachment style then increases the chances of females having destructive disagreement beliefs (.11, \(p < .01\)), and these beliefs are directly related to the occurrence of dating violence victimization (.28, \(p < .01\)). Furthermore, an insecure attachment style fully mediates the relationship between hostile parenting and destructive disagreement beliefs (.02, \(p < .01\)), and these beliefs mediate the relationship between insecure attachment and victimization (.03, \(p < .01\)). Unlike the other models tested, for women, the relationship between family of origin experiences and dating violence victimization is fully mediated by insecure attachment and destructive disagreement beliefs.

**DISCUSSION**

Although past research has focused on the intergenerational transmission of violence, the link between family of origin violence during childhood and later experiences of dating violence is far from robust. Although past research has made progress in identifying potential mediators that link experiences in the family of origin to dating violence perpetration and victimization, few studies have examine intrapersonal mediators. This study attempted to address this underresearched area by identifying previously unaddressed intrapersonal processes that may initially develop in the family of origin and are then, in turn, associated with a greater risk of being the victim or perpetrator of intimate partner violence. Specifically, we investigated the extent to which having an insecure attachment style or holding destructive disagreement beliefs would mediate the relationship between exposure to harsh parenting or interparental hostility and experiences with intimate partner violence. Results generally supported our hypotheses.

First, in all models, there was a direct relationship between interparental aggression and hostile parenting, consistent with literature showing that negative marital interactions can impact parenting practices (Krishnakumar & Buehler, 2000). Furthermore, we
hypothesized that there would be a direct association between both interparental aggression and hostile parenting and later experiences of dating violence perpetration and victimization. This hypothesis is based on the large body of literature on the intergenerational transmission of violence and a recent meta-analysis of such studies (Simons et al., 2008; Stith et al., 2000; Tschann et al., 2009). Although these variables are strongly related at the bivariate level, there is only small, but significant, relationship between hostile parenting and perpetration of dating violence by men and women, as well as for male victimization, once insecure attachment and destructive disagreement beliefs were included in the model. For females’ victimization, there was no direct relationship between hostile parenting and dating violence because the inclusion of the intrapersonal processes fully accounted for this relationship. On the other hand, we did not find a direct relationship between interparental aggression and dating violence perpetration or victimization for either men or women. Instead, we found that the relationship between interparental aggression and offspring’s dating violence was indirect through hostile parenting. This pattern is consistent with studies that have also shown that conflict between parents is related to poor parenting (Conger & Elder, 1994; Krishnakumar & Buehler, 2000) and shows the importance of the inclusion of interparental interactions in studies that are interested in assessing the impact of parenting on youth outcomes (Lee, Wickrama, & Simons, 2013; Owen, Thompson, & Kaslow, 2006).

The remaining hypotheses concerned the mediating roles of an insecure attachment style and destructive disagreement beliefs on the intergenerational transmission of violence. First, we expected that the relationship between hostile parenting and the belief that disagreement is destructive would be mediated by an insecure attachment style. Because individuals with a secure attachment style are less likely to hold irrational relationship beliefs and are not fearful of either intimacy or abandonment (Bowlby, 1969/1982), we contended that individuals who experience hostile parenting are likely to develop an insecure attachment style, which in turn is associated with the belief that disagreement is always harmful in an intimate relationship. Our results support this contention. Furthermore, because an insecure attachment style mediated the relationship between hostile parenting and beliefs for both men and women, these findings show that experiences of hostile parenting alone do not account for the development of negative beliefs about conflict, and future studies should address the factors that contribute to a secure attachment style among children who experience hostile parenting.

Next, we predicted that destructive disagreement beliefs would act as a negative internal working model and thus would mediate the relationship between an insecure attachment style and dating violence. Our results support this hypothesis because destructive disagreement beliefs fully mediated the association between an insecure attachment style and dating violence perpetration and victimization for both men and women. Thus, insecure individuals with these beliefs may be at risk for making the escalation of minor spats into violence more likely. Few other studies have connected attachment style to specific beliefs or examined the mediating role of beliefs in the relationship between attachment style and dating violence (Mikulincer, 1998; Ross & Fuertes, 2010). Future studies would benefit from examining this relationship with other beliefs related to conflict and communication.

Taken together, these results show that an insecure attachment style and destructive disagreement beliefs partially mediate the relationship between hostile parenting and dating violence for men’s perpetration and victimization and for women’s perpetration. These intrapersonal processes fully mediated this relationship between family of origin factors and females’ victimization. Findings demonstrate the pivotal role of intrapersonal
processes in the continuity of intimate partner violence from the family of origin in childhood to dating relationships as a young adult. Future research on the etiology of dating violence would benefit from the inclusion of these types of intrapersonal processes given the evidence that they are important mechanisms accounting for the continuity of the intergenerational transmission of violence.

Although no specific predictions were made about variation in outcomes by gender, one interesting difference emerged. Although witnessing interparental aggression had no impact on females’ beliefs, it did directly influence the presence of destructive disagreement beliefs for male perpetrators and victims. Men experience less self-disclosure and communication in general with parents (Finkenauer, Engles, & Meeus, 2002) and thus may be more influenced by observations of overt expressions of emotion, especially hostility. Researchers should further explore gender differences in the development of irrational relationship beliefs to more fully understand these differences.

Although the study yielded significant findings, there are some limitations that should be acknowledged. First, the data used was cross-sectional making it difficult to establish causal priority. Also, the retrospective nature of the data makes recall bias a possibility. Future research is needed to replicate these findings using both prospective and longitudinal data so that causal priority can be established and proximal factors that may influence results (e.g., depression, current life stress) can be controlled for. Furthermore, the generalizability of our findings is limited in that our sample consists mainly of White college students. Future studies that replicate these findings using a sample that is more representative of both minorities and emerging adults not attending college from a range of income levels are warranted.

Despite these limitations, the findings of this study remain both theoretically and practically relevant. This study has identified previously unexamined mediators in the intergenerational transmission of violence and has also identified an intrapersonal process related to a broad attachment theory construct—attachment style. Researchers have called for studies to address both of these gaps in the literature (Dutton, 2000; Mikulincer, 1998; Ross & Fuertes, 2010; Tschann et al., 2009), and this study provides support for more research in both areas. Specifically, our study shows that beliefs about processes involved in romantic relationships, such as communication or conflict, play an important role in accounting for the continuity between hostile or aggressive experiences in the family of origin and later involvement in dating violence. In terms of attachment theory, our findings provide support for a relationship between an insecure attachment style and irrational relationship beliefs related to conflict. This study further shows that an insecure attachment style alone may not account for the negative relational outcomes seen among insecurely attached individuals; instead, very specific beliefs about relationships that develop over time through attachment experiences at least partially account for these unfortunate consequences. This implies that fostering healthy beliefs about relationships is an important protective factor against dating aggression for insecurely attached young adult. Lastly, this study offers an explanation for the research reporting similar experiences of dating violence for men and women (Medeiros & Straus, 2006).

Our findings suggest implications for dating violence prevention and intervention efforts. First, parental education programs that focus on helping parents develop warm parenting strategies and providing information on ways to avoid marital aggression could help reduce rates of dating violence among their offspring. Previous studies provide evidence that participation in parental education programs is related to an increase in the use of effective parenting strategies as well as a decrease in adolescent’s risk behaviors (Brody
et al., 2006). Second, the normative nature of disagreement and how to disagree with a partner in healthy ways could be an appropriate topic to include in dating violence prevention programs. For example, adolescents who view disagreements as a chance to clarify misunderstandings and increase closeness with a romantic partner are more likely to use negotiation over compliance or aggression during a conflict (Simon et al., 2008).

Last, although attachment style is usually viewed as a fairly stable trait, it could also be targeted in clinical interventions. A recent study on attachment-focused therapy found this type of intervention to be effective for reducing irrational relationship beliefs, including disagreement is destructive, as well as decreasing anger reactions and increasing control of anger (Kilmann, Urbaniak, & Parnell, 2006). In summary, the findings from this study suggest that dating violence prevention and intervention programs would benefit from helping parents develop positive and effective parenting practices and from helping individuals develop positive working models of relationships; learn to form secure attachments to warm, supportive intimate partners; eschew irrational relationship beliefs, and develop emotional regulation as well as positive conflict resolution strategies.

REFERENCES


Straus, M. A. (2009). Why the overwhelming evidence on partner violence by women has not been perceived and is often denied. Journal of Aggression, Maltreatment, & Trauma, 18(6), 552–571.


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Assessing the Psychometric Properties of the Turkish Version of Attitudes and Practice of Health Care Providers Regarding Intimate Partner Violence Survey Scale

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This study was planned to assess the psychometric properties of the Turkish version of the “attitudes and practices of health care providers regarding intimate partner violence” (APHCPs-IPV) survey scale. The sample consisted of 355 primary health care providers. A Likert-type scale composed of eight subfactors, and 43 items were used. Means and standard deviations were calculated for interval-level data. A p value of less than .05 was considered statistically significant. The Turkish version consisted of eight factor groups. The Cronbach’s alpha of the general scale was .66, and the Cronbach’s alpha of the factor groups ranged from .29 to .81. It was determined that the APHCPs-IPV scale was a valid and reliable scale to be used in Turkish society, on the condition that item number 33 be removed.

Keywords: intimate partner violence; reproducibility of results; primary health care; health occupations

Intimate partner violence (IPV) against women, along with its resultant negative physical and mental health consequences, is becoming increasingly recognized as a pervasive problem within both developed and developing countries, including Turkey (Kocacık, Kutlar, & Erselcan, 2007). It is estimated that approximately 20%–75% of women are beaten at some stage in their life in most populations surveyed globally (Ellsberg, Jansen, Heise, Watts, & Garcia-Moreno, 2008; Moreno, Jansen, Ellsberg, & Heis 2005). Although estimates of the prevalence of IPV within Turkey vary widely (from approximately 25% to 49%, with differences in study methods at least partly responsible for the diverse estimates), previous research suggests that IPV is a common occurrence within Turkey, as it is within many other countries (Altunay & Arat, 2007; Turkish Family Research Institute, 1998). According to a study conducted for the Turkish Institution of Statistics 4 years ago, 42.1% of women are the victims of physical violence by their husbands or partners at some point in their lifetime (Turkish Statistical Institute, 2010). This means that at least one in every four women has been subjected to and suffered from their partners’ violence at some point in their lives.
Culture is known to affect violence, and the meaning ascribed to different acts might differ depending on cultural differences (Heise, Ellsberg, & Gottemoeller, 1999). Turkey, as a patriarchal society with unequal gender relations supported by both deeply rooted social and cultural norms as well as economic problems is no exception to this rule (Ağır, 2012). Legal arrangements on issues such as women rights and violence have been developed in Turkey, but most women are not aware of their rights. Women tend to accept violence as something normal. This might be related to several factors: Culturally, men possess women; manhood is associated with violence; sexual roles are rigidly differentiated; and violence is widely accepted as a form of behavior. The Islamic rules that prescribe obedience to women may also contribute to this because women consider opposing their husband as a sin. In addition, domestic affairs are typically kept private (Kocacık & Doğan, 2006). Although the problem of IPV is extensive in Turkey, there is no comprehensive legislation concerning domestic violence. Very few women report IPV to the authorities. The few women who do go to the authorities claim that the police are not gender-sensitive and attempt to find a compromise between the husband and wife rather than treating the violence as a crime. In addition, when a complaint is successfully filed, the punishments are often weak, sometimes as little as 1 week in prison, if there is any punishment at all. Within such a system, most women prefer to stay silent than to report the crime to the police and risk retaliation by their husbands or other members of the family because the police will not likely take protective measures for the victim (World Organization Against Torture, 2003).

Abuse within families has a serious impact on the survival, well-being, and general health of women (Ellsberg et al., 2008; Garcia-Moreno, 2002; McCloskey et al., 2006; Svavarsdottir & Orlygsdottir, 2009). Many women seek medical treatment through hospital emergency rooms, clinics, and primary health care (PHC) offices for injuries they have received from physical or sexual assault (Ellsberg et al., 2008; Nicolaids & Touhouliotis, 2006; Sullivan & Hagen, 2005). Because women use their health systems more frequently than men for various reasons, one of the first professional groups encountered by abused women is that of health practitioners. However, practitioners often treat these women’s injuries only symptomatically. Consequently, the health care system often overlooks its significant responsibilities for treatment, and the victims continue to suffer with the physical and emotional results of abuse (Hamberger, Ambuel, Marbeila, & Donze, 1998).

Health care providers (HCPs) typically share the same cultural values and societal attitudes toward abuse that are dominant in the society at large (Heise et al., 1999). In Turkey, nurses sometimes do not intervene in IPV cases because of the personal attitudes they have previously developed regarding domestic violence. Personal attitudes and behaviors develop within the context of a society’s attitudes and behaviors. The family is considered a private institution in Turkish society. The society believes that problems within the family should be solved by the family. It is traditionally suggested that the women stay silent so that the family union can continue (World Organization Against Torture, 2003; Yaman & Taşkın, 2012). Nurses are also affected by this view and can accept the same attitudes. Yazıcı and Mamuk (2010) reported that 28.7% of the 94 health care workers in their study agreed with the following statement: “Family life is private, no one should intervene in what transpires.” Other studies from Turkey have similarly reported that HCPs do not intervene in domestic violence cases and see it as a family matter (Aksan & Aksu, 2007; Gömbül & Buldukoğlu 1997; Hotun, Dişiz, Sömek, & Dinç, 2008; Tunçel, Dündar, & Peşkel, 2007; Yaman & Taşkın, 2012). HCPs should realize that they are actually intervening in an important health care problem when they intervene in domestic violence. One may believe that domestic violence should be solved with family-related solutions.
because it takes place within the family. One needs to consider whether an HCP’s duty is to eliminate the problem of domestic violence completely. Looking at the problem and responsibility in this way, HCPs feel that domestic violence cannot be solved and that HCPs therefore do not intervene in these cases because they do not believe that there is anything they can do (Yaman & Taşkin, 2012).

These factors are important for research about the professionals to whom victims go for help, how these professionals detect women who have been subjected to abuse, and the factors that affect how HCPs work with these women (Campbell, Abrahams, & Martin, 2008; Gerbert et al., 2002; Glaister & Kesling 2002; Hinderliter, Doughty, Delaney, Pitula, & Campbell, 2003; Lutenbacher, Cohen, & Mitzel, 2003). Despite a rapid proliferation of descriptive studies of providers and intervention protocols, a lack of reliable instruments to assess the attitudes, beliefs, and behaviors of HCPs regarding IPV-related practices limits these efforts (John, Lawoko, Swanström, & Mohammed, 2010; Maiuro et al., 2000). Unfortunately, these studies have employed single items or a series of items that lack reliability and validity data (Moore, Zaccaro, & Parsons, 1998). Little work has been conducted to develop psychometrically sound, multidomain measures of IPV-related attitudes, beliefs, and behaviors specifically geared to HCPs (Cann, Withnell, Shakespeare, Doll, & Thomas, 2001; Dickson & Tutty, 1998; Gutmanis, Beynon, Tutty, Wathen, & Macmillan, 2007). Consequently, it is difficult to interpret the reliability, meaning, and practical implications of many previous studies. Dickson and Tutty (1998) designed The Public Health Nurses’ Responses to Women Who Are Abused (PHNR) scale to measure the degree of nurses’ helpfulness to women who are abused by their partners. This scale used two vignettes of nursing practice situations. Gutmanis et al. (2007) prepared a scale including 43 items related to the attitudes and practices of health care providers regarding intimate partner violence (APHCPs-IPV) with a review of the literature and an examination of instruments, particularly the work by Dickson and Tutty.

The rationale behind this research is that if attitudes and practices are adequately identified and measured, strategies to overcome them can be implemented in practical settings, thus improving women’s health. One question that arises is whether the scale, which was developed and tested in Canada (Gutmanis et al., 2007), can adequately reflect the perceptions of nurses in Turkey. From this point of view, the aim of this study was to assess the psychometric properties of the Turkish version of the survey scale on the APHCPs-IPV.

RESEARCH QUESTIONS AND HYPOTHESES

The following hypotheses were tested: “The APHCPs-IPV is a valid measurement tool for Turkish health care providers,” and “The APHCPs-IPV survey scale is a reliable measurement tool for Turkish health care providers.”

METHODS

Participants

Methodological research was conducted at PHC centers in Izmir from September to November 2010. The population of the study consisted of 2,330 HCPs (doctors, nurses, midwives, health officers) employed in 166 PHC centers (family health centers, community health centers,
mother–child health and family planning centers) in Izmir. The sample size was considered sufficient because it was 10 times the 43 items of the scale (Aksakoglu 2001; Özdamar, 2002). This research was conducted with a sample of 430 HCPs chosen with simple random and stratified weighted sampling methods at 75 PHC centers. In all, 430 HCPs from mother–child health and family planning centers were approached. Of these, 355 (including 284 from family health centers, 40 from community health centers, and 31 from mother–child health and family planning centers) individuals agreed to take part in the study, for a response rate of 83%.

**Measures**

The data were collected at the participating PHC centers by the researchers. Self-administered questionnaire forms were distributed to each HCP by the researchers and were collected 1 week later. A questionnaire was used for the demographic data in addition to the APHCPs-IPV survey scale, originally developed by Gutmanis et al. (2007). The questionnaire began with a practice scenario regarding a pseudonymous patient. The respondents were asked to respond to 43 statements designed to reflect either a barrier or a facilitator to their current practices of routine inquiry—termed screening in the survey questions—using either their own experience or the provided scenario. For each statement, the respondents were asked to select one of four possible responses: “strongly agree,” “agree,” “disagree,” or “strongly disagree.” Higher scores reflected greater self-reported preparedness, self-confidence, feelings of professional support, comfort with abuse inquiries, and comfort with discussions following disclosure as well as decreased concern about the consequences of abuse inquiries and decreased feelings of no control and system pressures (Gutmanis et al., 2007).

**Ethical Considerations**

Permission for use of the scale was obtained by e-mail from Gutmanis et al. (2007), and written approval was obtained at the planning stage of the study from the Ethical Committee of Ege University School of Nursing. When obtaining oral consent, the researchers informed the health professionals about the purpose of the research and their right to withdraw from participation in the research.

**Data Analysis**

To ensure the quality of the Turkish version of the scale, an internationally accepted forward–backward translation technique was used to translate the English version of the scale to a Turkish equivalent of the original instrument (Erefe, 2002; Erkut, Alarcon, Garcia Coll, Trop, & Vazquez Garcia, 1999). The APHCPs-IPV survey scale was first translated from English to Turkish separately by six teaching staff whose native language is Turkish. Subsequently, it was translated back from Turkish to English by two experts whose native language is English. All of the translators worked independently and were not associated with the research in any other way. After these forward and backward translations were completed, the original and back translations of both the English and Turkish versions were carefully compared. Then, the scale was evaluated by two teaching staff members, and the final version was adapted by the researchers according to the suggestions.

The Statistical Package for the Social Sciences (SPSS, version 15.0) was used to compute frequency and descriptive statistics related to demographic data. To ensure content validity, content analysis was based on a panel of experts. Content validity refers to the extent to which the instrument measures the phenomenon for which it is designed.
Confirma tory factor analysis (CFA) was performed for structural equation modeling. The LISREL program was used to perform the factor analysis of the 43 items (Kelloway, 1998). A p value of less than .05 was considered statistically significant. The Kaiser-Meyer-Olkin (KMO) test was used to measure sample adequacy, and Bartlett’s test of sphericity (BS) was used to examine the correlation matrix (Aksakoglu, 2001; Oztamar, 2002). Means, standard deviations, and the range of the adopted scale were calculated and presented as descriptive characteristics. The Kolmogorov-Smirnov test for normality was used to determine whether the responses had a normal curve around the mean. Reliability was assessed using the internal consistency approach, and Cronbach’s alpha coefficient was calculated to assess the degree of internal consistency and homogeneity between the items. Test–retest stability, separated by 3 weeks, was calculated using a Spearman rank correlation to determine the strength of the relationship between participants (Aksakoglu, 2001; Oztamar, 2002; Polit, 1996).

RESULTS

Descriptive Statistics

The mean age of the respondents was 40.51 years (SD = 6.42 years). There were 256 respondents (72.1%) who were females. Of the respondents, 154 (43.4%) were doctors, 98 (27.6%) were midwives, 93 (26.2%) were nurses, and 10 (2.8%) were health officers. Although only 9.6% of the HCPs had received education regarding domestic violence during their undergraduate education, 67% of them had in-service education.

Validity Analyses

To test content validity, which included item clarity, the translated version was submitted to a panel of six experts who were informed about the scale and the concepts involved. The experts included three nursing academics and three public health physicians with special interest and expertise in domestic violence. They reviewed the readability and acceptability of the APHCPs-IPV scale. Content validity indices (CVIs) were assessed by asking the panel members to rate each item’s relevance to the construct using a 4-point Likert scale. On this scale, 4 = very relevant, 3 = relevant with some adjustment to phrasing, 2 = only relevant if phrasing is profoundly adjusted, and 1 = not relevant. Each expert reviewed the instrument and critiqued the items for clarity and relevance. An acceptable CVI score is greater than .8 (Yurdugul, 2005). Thus, some items (11, 18, 26, 33, 38, and 42) that were less than .80 were rearranged and reevaluated by the expert panel. The CVI among the experts was .91 for the instrument. This result indicated that the items in the questionnaire were relevant to the measurement of APHCPs-IPV in Turkey. The experts’ feedback was used to revise the items before the scales were used for testing.

The 43-item scale was implemented in a pilot test involving a group of nurses. The scale form was then given to 20 nurses who were not involved in the sample, and necessary changes were made in accordance with the feedback that they provided. The nurses who had been subjected to the preimplementation phase were not included in the scope of the research.

In terms of structural validity, for the CFA, the KMO measure of sampling adequacy was .89, with a significant BS ($\chi^2 = 6063.51, p < .001$). The items’ relationship with the factors was explained by the factor loading value. In this model, the factor loading of the items in the scale ranged from .10 to .71 (Table 1). An acceptable $t$ score is greater than 1.96. Thus,
## TABLE 1. Item Analysis for Survey Scale

<table>
<thead>
<tr>
<th>Preparedness</th>
<th>Item Mean (SD)</th>
<th>Item—Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. I would like to talk about the issue of abuse but don’t know what to say.</td>
<td>2.86 (0.77)</td>
<td>0.36</td>
</tr>
<tr>
<td>2. I would be hesitant to ask about WA because I have little or no experience</td>
<td>2.85 (0.75)</td>
<td>0.52</td>
</tr>
<tr>
<td>3. I feel prepared asking about abuse of women who appear to me to be at risk</td>
<td>2.10 (0.60)</td>
<td>0.42</td>
</tr>
<tr>
<td>4. I feel prepared asking about abuse of women who do not appear to me to be</td>
<td>2.24 (0.68)</td>
<td>0.38</td>
</tr>
<tr>
<td>5. I feel ready to respond to a woman who says “no” to my question about</td>
<td>2.32 (1.24)</td>
<td>0.38</td>
</tr>
<tr>
<td>6. I feel ready to respond to a woman who says “yes” to my question about</td>
<td>2.04 (0.57)</td>
<td>0.34</td>
</tr>
<tr>
<td>7. I feel prepared sharing information on WA to clients who respond no.</td>
<td>2.13 (0.58)</td>
<td>0.27</td>
</tr>
<tr>
<td>8. I am hesitant to ask about WA because I have not been appropriately</td>
<td>3.03 (1.74)</td>
<td>0.43</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Self-Confidence</th>
<th>Item Mean (SD)</th>
<th>Item—Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. I am confident with my ability to address the issue of WA.</td>
<td>2.11 (0.71)</td>
<td>0.37</td>
</tr>
<tr>
<td>2. I feel that I am able to support this woman while she gets the right</td>
<td>2.08 (0.60)</td>
<td>0.42</td>
</tr>
<tr>
<td>3. I would feel confident if I were required to ask women about abuse.</td>
<td>2.19 (1.76)</td>
<td>0.52</td>
</tr>
<tr>
<td>4. I feel that I am a competent helper whether or not the woman and her</td>
<td>2.36 (0.69)</td>
<td>0.41</td>
</tr>
<tr>
<td>5. I feel comfortable supporting the woman during the interview even</td>
<td>1.96 (0.49)</td>
<td>0.29</td>
</tr>
<tr>
<td>6. I feel comfortable discussing these practice situations with</td>
<td>1.92 (0.58)</td>
<td>0.34</td>
</tr>
<tr>
<td>7. I feel comfortable helping this woman access resources to help deal</td>
<td>2.22 (0.64)</td>
<td>0.34</td>
</tr>
</tbody>
</table>

(Continued)
<table>
<thead>
<tr>
<th>Practitioner Lack of Control</th>
<th>Item Mean ( (SD) )</th>
<th>Item—Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Because this is a private family matter, I should not interfere.(^a)</td>
<td>3.10 (0.79)</td>
<td>0.45</td>
</tr>
<tr>
<td>2. There isn’t anything I can do unless she asks for help.(^a)</td>
<td>2.61 (0.85)</td>
<td>0.51</td>
</tr>
<tr>
<td>3. I would not ask her about WA because I don’t think she is ready to tell me.(^a)</td>
<td>2.80 (0.73)</td>
<td>0.40</td>
</tr>
<tr>
<td>4. I feel that I am not able to help women who are abused.(^a)</td>
<td>2.89 (0.77)</td>
<td>0.42</td>
</tr>
<tr>
<td>5. I am reluctant to intervene in case I make matters worse.(^a)</td>
<td>2.87 (0.73)</td>
<td>0.58</td>
</tr>
<tr>
<td>6. I would not offer any assistance because there is no effective treatment for WA.(^a)</td>
<td>2.84 (0.62)</td>
<td>0.37</td>
</tr>
<tr>
<td>7. I would give her written information about WA and/or available resources but would not talk about her situation.(^a)</td>
<td>3.09 (0.63)</td>
<td>0.47</td>
</tr>
</tbody>
</table>

**Comfort Following Disclosure**

<table>
<thead>
<tr>
<th></th>
<th>Item Mean ( (SD) )</th>
<th>Item—Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. I feel I am able to listen to women’s stories as they disclose the abuse they have experienced.(^b)</td>
<td>1.89 (0.53)</td>
<td>0.41</td>
</tr>
<tr>
<td>2. I am able to continue the discussion after a disclosure to assess the needs of the client.(^b)</td>
<td>1.89 (0.49)</td>
<td>0.43</td>
</tr>
</tbody>
</table>

**Professional Supports**

<table>
<thead>
<tr>
<th></th>
<th>Item Mean ( (SD) )</th>
<th>Item—Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. I feel comfortable discussing these practice situations with colleagues to help them deal effectively with WA.(^b)</td>
<td>1.91 (0.57)</td>
<td>0.38</td>
</tr>
<tr>
<td>2. I have enough supports from colleagues, mentors, supervisors, and so forth to help me feel comfortable in asking about WA and in dealing with the responses.(^b)</td>
<td>2.47 (0.74)</td>
<td>0.33</td>
</tr>
<tr>
<td>3. I participate with my practice colleagues in planning and evaluating methods to develop or improve program delivery regarding WA.(^b)</td>
<td>2.41 (0.66)</td>
<td>0.42</td>
</tr>
<tr>
<td>4. I have opportunities for consultations regarding how to deal with situations such as AB’s.(^b)</td>
<td>2.69 (0.73)</td>
<td>0.38</td>
</tr>
</tbody>
</table>

(Continued)
TABLE 1. Item Analysis for Survey Scale (Continued)

<table>
<thead>
<tr>
<th>Practice Pressures</th>
<th>Item Mean (SD)</th>
<th>Item—Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. I may forget to ask her about WA.(^a)</td>
<td>2.87 (0.68)</td>
<td>0.35</td>
</tr>
<tr>
<td>2. I just don’t have time today to address this possible abuse issue.(^a)</td>
<td>3.01 (0.70)</td>
<td>0.39</td>
</tr>
<tr>
<td>3. I am reluctant to ask about WA because there are no sufficient community resources to provide assistance.(^a)</td>
<td>2.86 (1.76)</td>
<td>0.70</td>
</tr>
<tr>
<td>4. I am hesitant to ask about WA because I might have to call the CAS or the police.(^a)</td>
<td>2.89 (0.68)</td>
<td>0.49</td>
</tr>
<tr>
<td>5. I feel frustrated because I don’t have the time to talk about abuse.(^a)</td>
<td>2.70 (0.72)</td>
<td>0.31</td>
</tr>
</tbody>
</table>

Abuse Inquiry

<table>
<thead>
<tr>
<th></th>
<th>Item Mean (SD)</th>
<th>Item—Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. I routinely initiate the topic of WA.(^b)</td>
<td>2.68 (0.80)</td>
<td>0.26</td>
</tr>
<tr>
<td>2. I would ask her directly if her husband has ever hit her.(^b)</td>
<td>2.45 (0.81)</td>
<td>0.24</td>
</tr>
<tr>
<td>3. I won’t put her on the spot by initiating the topic of abuse.(^a)</td>
<td>2.77 (0.75)</td>
<td>0.31</td>
</tr>
<tr>
<td>4. I am hesitant to ask about WA in case the woman stops seeing me.(^a)</td>
<td>3.03 (0.63)</td>
<td>0.40</td>
</tr>
<tr>
<td>5. I am hesitant to ask some clients about WA because to them, it is culturally acceptable.(^a)</td>
<td>2.02 (0.53)</td>
<td>0.18</td>
</tr>
<tr>
<td>6. I would introduce WA by stating that abuse frequently occurs and that often women are hesitant to talk about it.(^b)</td>
<td>1.89 (0.53)</td>
<td>0.36</td>
</tr>
</tbody>
</table>

Practitioner Consequences of Asking

<table>
<thead>
<tr>
<th></th>
<th>Item Mean (SD)</th>
<th>Item—Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. I worry about my own safety when inquiring about WA.(^a)</td>
<td>2.57 (0.81)</td>
<td>0.39</td>
</tr>
<tr>
<td>2. I think about possible legal consequences when asking about WA.(^a)</td>
<td>2.19 (1.24)</td>
<td>0.09</td>
</tr>
<tr>
<td>3. I am hesitant to ask about WA because I also treat/deal with other family members.(^a)</td>
<td>3.01 (0.61)</td>
<td>0.44</td>
</tr>
</tbody>
</table>

Note. WA = woman abuse; CAS = Children’s Aid Society. AB = abbreviation used instead of patient’s name.
\(^a\)Items scoring: strongly agree (1), agree (2), disagree (3), strongly disagree (4).
\(^b\)Items scoring: strongly agree (4), agree (3), disagree (2), strongly disagree (1).
Item 33 ("It is expected to inquire about abuse to women") was deleted because its \( t \) test score was 0.11. After deleting Item 33, the scale with 42 items was implemented in the CFA.

Nested model comparisons were performed, and the \( \chi^2/df \) (\( \Delta \chi^2 \)) differences of the model were compared. The goodness of fit index (GFI), adjusted goodness of fit index (AGFI), and root mean square error of approximation (RMSEA) were assessed.

The \( \chi^2/SD \) rate was found to be 3.34 for the model, which was considered an indicator of high goodness of fit. The RMSEA is an estimate of the mean difference between the observed and reproduced correlations. An acceptable fit requires a value of less than .08 (Hu & Bentler, 1999); the RMSEA for our data was .08. The GFI indicates how well the theoretical model reproduces the observed correlations, and the comparative fit index (CFI) indicates how well the model fits the data compared to a null model that represents no relationships among variables. The AGFI is a variant of the GFI that uses mean squares instead of total sums of squares in the numerator. A value of .90 or more is required for a good fit, and the obtained values were within the acceptable range (GFI = .96 and AGFI = .96).

### Reliability Analyses

The standard deviation of the total score of the scale was 0.17, and the total mean item score was 2.51 (95% CI [2.50–2.54]). The Kolmogorov-Smirnov test showed that the values of the scale were not normally distributed (Kolmogorov-Smirnov \( Z = .096, p = .001 \)).

Cronbach’s alpha coefficients were used to evaluate the internal consistency reliability of the scale. Cronbach’s alpha of the general scale was .66, and Cronbach’s alpha of the factor groups ranged from .29 to .81 (Table 2).

Because the values of the scale items were not distributed normally, a nonparametric correlation test was used to determine test–retest reliability. The test–retest reliability, separated by 3 weeks, was calculated using a Spearman rank correlation to determine the

<table>
<thead>
<tr>
<th>Table 2</th>
<th>Reliability Analyses Results of the Survey Scale (N = 355)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mean ± SD</td>
<td>Cronbach’s ( \alpha )</td>
</tr>
<tr>
<td>General Scale</td>
<td>2.49 ± 0.14</td>
</tr>
<tr>
<td>Subscales</td>
<td></td>
</tr>
<tr>
<td>Preparedness</td>
<td>2.39 ± 0.18</td>
</tr>
<tr>
<td>Self-confidence</td>
<td>2.08 ± 0.34</td>
</tr>
<tr>
<td>Practitioner lack of control</td>
<td>2.86 ± 0.43</td>
</tr>
<tr>
<td>Comfort following disclosure</td>
<td>1.87 ± 0.43</td>
</tr>
<tr>
<td>Professional supports</td>
<td>2.30 ± 0.46</td>
</tr>
<tr>
<td>Practice pressures</td>
<td>2.88 ± 0.42</td>
</tr>
<tr>
<td>Abuse inquiry</td>
<td>2.62 ± 0.35</td>
</tr>
<tr>
<td>Practitioner consequences of inquiry</td>
<td>2.62 ± 0.49</td>
</tr>
</tbody>
</table>

\(^{a}\)All correlations are statistically significant at \( p < .001 \).
Assessing the Turkish APHCPs-IPV Survey Scale

strength of the relationship between participants \( n = 50 \) and the APHCPs-IPV survey scale over time. A Spearman rank correlation coefficient of .90 for the total scores indicated that the instrument was stable over time.

DISCUSSION

This study evaluated the psychometric properties of the Turkish version of the APHCPs-IPV survey scale. The results show that the psychometric characteristics of the Turkish version of this scale are promising. The panel review regarding the content of the Turkish version of the APHCPs-IPV survey scale indicated that there was no need to modify its translation or content. However, a large sample size is needed to confirm the semantic equivalence.

When factor analysis is conducted, sample adequacy is a significant issue for consideration. The literature indicates that this study’s sample was sufficiently large for a satisfactory factor analysis and that further validation (factor solution) could proceed with a similar sample size in this study. This sample size was adequate for factor analysis (Ozdamar, 2002).

The items’ relationship with the factors is explained by the factor loading value. In this model, the factor loading of the items in the scale ranged from .10 to .71 (Table 1). According to the CFA, one model was developed in which the items were grouped into eight factor headings (preparedness, self-confidence of the practitioner, lack of control, comfort following disclosure, professional support, practice pressures, abuse inquiries, practitioner consequences of asking) that maintained the original conceptual model of the instrument (Gutmanis et al., 2007). Nested model comparisons were performed, and the \( \chi^2/df \) (\( \Delta \chi^2 \)) differences of the model were compared. The GFI, AGFI, and RMSEA goodness of fit indices were assessed. Because the \( \Delta \chi^2 \) difference test shows significant results and the model with the lower \( \chi^2 \) value meets the critical values expected by other fit indices, it is possible to state that a model that meets these conditions is a relatively more valid model (Kline, 1998).

Degrees of freedom \( (df) \) is a crucial criterion for the \( \chi^2 \) test. When \( df \) is high, \( \chi^2 \) has a tendency to yield significant results. Therefore, the ratio of \( df \) to \( \chi^2 \) can be used as a criterion for adequacy in certain cases. Kelloway (1998) states that when the chi-square/degrees of freedom \( (\chi^2/df) \) ratio is smaller than 5, it can be interpreted as an indicator of a good fit. In the current model, the \( \chi^2/df \) ratio was found to be smaller than 5 (3.34). This value was considered to indicate high goodness of fit. The GFI indicates the extent to which the model measures the sample variance–covariance matrix and is accepted as the sample variance revealed by the model. GFI values range from 0 to 1. Because they are sensitive to sample size, they yield small values in large samples. Values equal to .90 or more are considered to indicate good fit. The AGFI is a GFI value that is adjusted according to the sample size. AGFI values range from 0 to 1. Although .95 or more is considered a perfect fit, .90 or more is interpreted as a satisfactory fit (Kelloway, 1998).

In this study, the GFI and AGFI goodness of fit indices for the first and second models were the same, both yielding high fit values (GFI = 0.96 and AGFI = 0.96). The RMSEA is an absolute fit index of the difference between the covariance among the variables observed in the sample and the parameters suggested in the model; in other words, it is an index developed based on the degrees of error. In contrast to the GFI and AGFI, it is expected to yield values close to “0.” Values equal to or smaller than .05 are considered perfect, whereas values equal to .08 or less are considered reasonable, considering the
complexity of the model (Kelloway, 1998). The same RMSEA value (0.08) was obtained for the model and is considered to be a reasonable value. This scale yields separate scores for subscales and a single score for the entire scale. The goodness of fit indices for the second level of the CFA model were found to be high.

Based on the data obtained, the factor structure of the Turkish version of the scale was similar to that of the original instrument. The factors identified in this study were covered well by the basic concepts of the original scale items by Gutmanis et al. (2007), keeping in mind concerns about cultural sensitivity in the factorial results.

We tested the distributions of the items for skewness and kurtosis using the Kolmogorov-Smirnov test with an alpha level of \( p < .05 \). The results of the Kolmogorov-Smirnov test revealed that the scale scores were not normally distributed \( (p < .05) \). HCPs have different educational backgrounds and professional responsibilities and may have perceived the scale items differently than their colleagues.

The Cronbach's alpha coefficients of the Turkish version of the APHCPs-IPV scale domains ranged from .29 to .81 (Table 2). These coefficients are not high, but they are acceptable because internal consistency estimates are based on all parameters in a unidimensional scale. However, some instruments are multidimensional. The current scale includes several different dimensions and is not a homogeneous structure. Furthermore, the content of the scale is long and complex. Therefore, it would be inappropriate to appraise the APHCPs-IPV scale in the same way as other scales. If a measurement tool has multiple dimensions, the alpha coefficient can be lower (Woods & Catanzaro, 1988). Cronbach's alpha of the original scale domains indicated good results, with the Cronbach’s alpha index varying from .59 to .87 (Gutmanis et al., 2007).

Spearman’s rank correlation for the test–retest reliability of the current scale was \( r = .90 \) (Table 2). The literature suggests that the acceptable minimum point for test–retest reliability is .70 (Erefe, 2002). Therefore, the test–retest reliability was adequate for the scale.

**CONCLUSION**

Based on the results, there is sufficient evidence of acceptable reliability and validity to use the Turkish version of the APHCPs-IPV scale. This study provides further cross-cultural evidence for the usefulness of this scale in a country with a different cultural background. However, additional studies in diverse population groups are needed to confirm these findings and to measure IPV-related attitudes. Self-reported behaviors can be used to profile training needs and evaluate training programs and policy interventions for HCPs.

**REFERENCES**


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Individual and Social Network Predictors of Physical Bullying: A Longitudinal Study of Taiwanese Early Adolescents

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This study followed 125 7th-grade students in Taiwan for the entire school year and analyzed the individual and social network factors predicting their involvement in physical bullying over 5 waves of data. Using self-reports of bullying experiences, 20 classroom-level networks of bullying and friendship were constructed for 4 classrooms and 5 temporal points, from which 4 individual-level network measures were calculated. They included bully and victim centrality, popularity, and embeddedness in friendship networks. A series of mixed models for repeated measures were constructed to predict students’ bully and victim centrality in bullying network at time $t + 1$. Compared to girls, boys were more likely to be both the bullies and victims. Lower self-esteem and higher family economic status contributed to victim centrality. Having parents married and living together predicted lower bully centrality. Higher educational level of parents predicted lower victim and bully centrality. Regarding the social network factors, students’ bully centrality at $t$ positively predicted their bully centrality at $t + 1$, whereas victim centrality predicted their subsequent victim centrality. Interaction effects between friendship network and bullying network were observed. Embeddedness in friendship network reduced victim centrality at $t + 1$ except for those students with low victim centrality at $t$. For those with high victim centrality at $t$, popularity increased their risk of physical victimization over time. Implications for research and practice are discussed.

Keywords: physical bullying; social network; longitudinal; adolescents; Taiwan

Physical bullying is a common form of aggression that poses a serious threat to the well-being of students. Many children and adolescents have experienced being hit, kicked, shoved, or other forms of physical victimization in school (e.g., Khoury-Kassabri, Benbenishty, & Astor, 2005). A large body of research has revealed its prevalence around the world (Craig et al., 2009). A nationally representative survey of 7,182 American students in Grades 6–10 found that 20.8% of the students have physically bullied others or have been bullied at school at least once in the last 2 months (Wang,
Wei and Lee (2009). Another study with a representative population sample of 2,464 Norwegian adolescents aged 12–15 years old showed that 22.5% of the boys and 9.4% of the girls reported physically attacking others during the past 6 months, whereas 14.0% and 6.6% reported being physically assaulted (Undheim & Sund, 2010). Similarly, a recent large-scale, nationally representative survey of Taiwanese adolescents found that 22% of the students aged 12–15 years old had physically bullied others during the past year, whereas 15% reported being physically victimized (Wei, Sun, Liu, & Chen, 2011). These numbers not only highlight the universality of the problem but also call for more preventive efforts by school personnel and educating professionals on how to address this substantial student safety issue (e.g., Jenson, Dieterich, Brisson, Bender, & Powell, 2010).

Being bullied has been shown to be associated with various mental health problems, including depression, anxiety, and somatic symptoms (Farrington, Loeber, Stallings, & Ttofi, 2011; Fekkes, Pijpers, Fredriks, Vogels, & Verloove-Vanhoeck, 2006; Gladstone, Parker, & Malhi, 2006). It also leads to substance abuse, self-harm behavior, and suicide attempts (Fisher et al., 2012; Klomek, Marrocco, Kleinman, Schonfeld, & Gould, 2007; Radliff, Wheaton, Robinson, & Morris, 2012). Moreover, victims of school bullying often show reduced interest in school and poor academic performance (Boulton, Chau, Whitehand, Amataya, & Murray, 2009; Juvonen, Wang, & Espinoza, 2011; Wei & Williams, 2004). At the same time, school bullying, especially physical bullying (Bender & Lösel, 2011), has been found to be a strong predictor of delinquency and adulthood criminal offending (Farrington et al., 2011; also see Ttofi, Farrington, Lösel, & Loeber, 2011 for a review). It is therefore evident that involvement in bullying either as a victim or a bully has a negative effect on students’ psychosocial well-being and developmental trajectory, which constitutes a significant school health concern for adolescents.

INDIVIDUAL-LEVEL PREDICTORS OF BULLYING

To implement effective prevention and intervention measures, it is important for school professionals to identify potential bullies and victims. Previous studies have suggested several risk factors of bullying and victimization. For example, male students are consistently found to be both the perpetrators and targets of physical bullying (e.g., Scheithauer, Hayer, Petermann, & Jugert, 2006). In fact, compared to their female counterparts, males are also generally more involved in other aggressive acts, such as violent crimes (Lauritsen & Heimer, 2008; Lauritsen, Heimer, & Lynch, 2009). Individual characteristics, including low self-esteem and social withdrawal, have been found to be associated with peer victimization (Andreou, 2000; Wei & Chen, 2009). One nationwide study of bullying conducted in Ireland with 8,249 school children aged 8–18 years showed that bullies, victims, or bully/victims all had significantly lower global self-esteem than did students who had neither bullied others nor been bullied (O’Moore & Kirkham, 2001). At the same time, poor academic performance in school was associated with both perpetration and victimization (Hemphill et al., 2012; Tom, Schwartz, Chang, Farver, & Xu, 2010). A reciprocal effect is likely to exist between school violence and school performance because evidence also suggests that children who are bullied in school tend to obtain low levels of academic achievement, particularly when their liking of school is impacted by the victimization experience (Beran, Hughes, & Lupart, 2008).

In addition to the previously mentioned individual characteristics, demographic variables, such as parent’s education, socioeconomic status (SES), and parental marriage
status, have also been shown to be related to student’s bullying involvement. For example, a recent analysis of 162,305 students from nationally representative samples of 5,998 schools in 35 countries in Europe and North America found that adolescents from less affluent families reported a higher prevalence of being victims of bullying (Due et al., 2009). A longitudinal study of 1,666 seventh- and eighth-grade students from two Korean middle schools found that boys from lower SES families and girls from non-intact families were at an increased risk for bullying (Kim, Boyce, Koh, & Leventhal, 2009). One study of German primary school students showed that low parental educational levels significantly predicted their bullying status as a bully, victim, and bully/victim (Von Marées & Petermann, 2010). Another survey on a representative population sample of 2,464 Norwegian adolescents found that students who bullied or were bullied reported more parental divorce compared to their noninvolved peers (Undheim & Sund, 2010). However, the effects of these demographic variables are less than conclusive, and none of them are based on Taiwanese samples. Empirical investigation is needed to determine the predictive power of these factors on the bullying and victimization among Taiwanese adolescents.

THE SIGNIFICANCE OF SOCIAL NETWORK FACTORS

Bullying happens in social contexts and relationships, particularly in the peer context. The bullies and victims often have distinctive peer status and social network positions. Low popularity, peer rejection, and lack of friends are frequently suggested as strong risk factors for victimization (de Bruyn, Cillessen, & Wissink, 2010; Mouttapa, Valente, Gallaher, Rohrbach, & Unger, 2004). Similarly, having more friends and being liked by peers were associated with less victimization (Pellegrini, Bartini, & Brooks, 1999; Wang et al., 2009). Qualitative research has shown that the victims are likely to be marginalized and stigmatized in the peer group (Thornberg, 2011), which makes them increasingly isolated and unable to escape from their negative victim image. From a sociometric perspective, being victimized may contribute to one’s sequent victim status. On the other hand, the bullies are not necessarily rejected by peers (Sentse, Scholte, Salmivalli, & Voeten, 2007). Some longitudinal studies even found that high bullying led to the attainment of high social dominance (e.g., Reijntjes et al., 2013). It is suggested that bullying is one strategy through which the adolescents acquire social status and establish a power hierarchy in the peer group, and this aggressive behavior is expected to decrease as the individual develops satisfactory friendship and network position among the peers (Pellegrini, 2002). In summary, the bullies and victims differ significantly in their peer relation and sociometric status, and these social network factors may predict their bullying involvement over time.

Although recent findings suggest the relevance of peer contexts to school bullying (e.g., Huitsing, Veenstra, Sainio, & Salmivalli, 2012), most existing studies focused on the individual characteristics of bullies and victims while failing to fully appreciate its nature as a group phenomenon. At the same time, growing evidence highlights the significance of peer relationship and social network factors in students’ involvement in bullying. Some researchers regard bullying as a group process and suggest that more effort should be devoted to uncover the peer dynamics that contribute to the student’s role in such incidents (Salmivalli, 2010). In recent years, the researchers have begun to analyze the issue of school violence from the perspective of peer clusters and social networks (e.g., Swartz, Reyns, Wilcox, & Dunham, 2012).
Despite the increasing recognition of the importance of social network dynamics in bullying, only scattered investigations so far have used this approach, and many of them share several common shortcomings. For example, when relational factors such as peer relationships and popularity are included in analysis, they are usually measured by self-reports and suffer considerable subjective biases. Responses to items such as “I feel I have many friends in school” reflect merely personal perception and offer little information on the specific friendship matrices. In addition, past research has relied largely on cross-sectional data, which reveal only associations but make it difficult, if not impossible, to make causal inferences. It has been long suggested that longitudinal data is preferable for clarifying the direction of causality and enhancing the predictive power of the findings. Furthermore, the peer network is constantly changing, and many traditional analytic techniques are unable to capture its dynamic features.

THE PRESENT STUDY

In response to the previously mentioned issues, this study proposes an alternative approach by using social network analysis to examine students’ involvement in physical bullying. Social relationships and group structures heavily influence the individual’s action. For adolescents, peer group is the primary interpersonal context that shapes and maintains their behavior. The concept of social network analysis has recently been applied to several adolescent health topics, including young people’s eating behavior (Fletcher, Bonell, & Sorhaindo, 2011) and smoking behavior (Seo & Huang, 2012). In the middle school system of Taiwan, as in many other countries, every student is assigned to one homeroom class and stays with a fixed group of classmates every day throughout their school years. As a result, bullying in Taiwan occurs primarily between students within the homeroom class (Wei, Jonson-Reid, & Tsao, 2007). The class thus constitutes a bounded group that is suitable for social network analysis, and this study examines students’ involvement in bullying by their position in the class-wide peer network rather than by their self-reported scores. Moreover, to explore changes in the individual’s network position over time, a longitudinal dataset with multiple waves of social network measures is used, and the potential interaction between bully/victim position and friendship in predicting further bullying involvement is explored. It is hoped that by adopting a social network perspective, this study not only addresses several limitations of past research but also demonstrates the use of network in predicting student’s physical bullying involvement. Specifically, three research questions are explored in this study:

1. How do individual-level factors, including gender, self-esteem, academic performance, parental marital status, paternal education, and family economic status, predict student’s physical bully and victim centrality in the class-wide peer network?
2. How do network factors, such as students’ physical bully and victim centrality at time $t$ and centrality in friendship network, predict their bully and victim centrality at $t + 1$?
3. How do previous physical bully and victim centrality interact with students’ friendship network in predicting students’ subsequent involvement in bullying?

METHODS

Participants

This study followed four 7th-grade classes from two middle schools in Taipei, Taiwan for 1 entire year. The average class size was 31.25, with the largest class size being 34.
Individual and Social Network Predictors of Physical Bullying

and the smallest, 27. There were 125 students recruited, and five waves of data were collected during the period. Overall, 53.6% of the students were boys and 46.4% were girls. Furthermore, 86.2% of the respondents reported that their parents were married and living together, whereas about 9% of the parents were divorced.

Instruments

Physical Bully and Victim Centrality. As the key dependent variables, every student’s bully and victim centrality in the class was assessed five times during the year. A class roster with all the students’ names was distributed to each respondent. A behavioral description of physical bullying (hitting, kicking, pushing, etc.) was also provided. Students were asked to indicate the classmates that often bully them physically. Using the information, we constructed a binary matrix of bullying network, $B$, where element $b_{ij}$ denoted whether student $i$ nominated student $j$ as the one who ever physically bullied $i$ in the time period.

The number of nominations that a student received from all classmates was used to calculate his or her physical bully degree centrality (Freeman, 1978). Likewise, a student’s victim centrality was computed based on the number of ties that the individual directed to others (i.e., the number of bullies that the student nominated). Bully centrality for a class $a$ at $t$ is a vector of column sum of $B_{at}$, whereas victim centrality is a vector of row sum of $B_{at}$.

Popularity and Embeddedness in Friendship Network. A class roster with all students’ names was distributed to each respondent. Students were asked to nominate their friends from the list. From this, we constructed a binary matrix of friendship network, $F$, where element $f_{ij}$ denoted whether student $i$ nominated student $j$ as his or her friend at $t$. The number of nominations that each student received was used to calculate his or her popularity in $a$ at $t$, which was a vector of column sum of $F_{at}$.

Embeddedness in friendship networks for each student was calculated using a clustering coefficient (Watts & Strogatz, 1998), which measures how tightly the actor is connected within his or her friendship network. When two of his or her friends are also friends with each other, the student has a triangular relationship. In theory, if (s)he has friends $n$, the maximum number of triangles (s)he can have is $n(n-1)/2$. The clustering coefficient for a student is the actual number of triangles divided by the maximum number. We symmetrized $F$ to obtain clustering coefficients for individual students (see Reagans & McEvily, 2003; Sosa, 2011). When the clustering coefficient is high, the student’s friendship ties are considered strong because the two dyadic relationships are bound by the extra relationships among his or her friends (Granovetter, 1973). Likewise, the student is tightly embedded in the friendship network (s)he belongs to because a dyadic friendship is monitored and facilitated by other friends who are also friends to both parties (Gulati & Westphal, 1999).

To illustrate the four network measures calculated from bullying and friendship networks, consider the network diagrams depicted in Figure 1 for Class 1 at Time 1. The first diagram indicates who bullied whom and how much in Class 1 at Time 1. Larger node size indicates that the student got a larger number of nominations in the bullying survey.

On the other hand, nodes in the friendship network in Class 1 at Time 1 was weighted by the number of friend nomination and clustering coefficients, which made the second and third diagrams.
Figure 1. Centralities in bullying network, popularity in friendship network, and embeddedness in friendship network (Class 1, Time 1).
**Individual Factors.** Several individual variables identified in the literature were assessed through self-report surveys, which include the student’s gender (0 = female, 1 = male), self-esteem (measured by the 10-item Rosenberg Self-Esteem Scale [Rosenberg, 1965]), and his or her midterm exam score rank in the first semester as an indicator of academic performance. The score rank was based on a total exam score across all courses, and a higher percentile rank represents better academic performance.

**Family Condition.** Information on several relevant family socioeconomic factors was also collected through students’ self-reports. The respondents were asked to indicate their parents’ marital status on a 7-point scale ranging from “married and living together” to “both parents passed away.” Because most parents in those families were married and living together, the responses were further dichotomized to create a binary variable (1 = married and living together, 0 = else). Students also provided information on their parents’ educational degree (1 = illiterate to 6 = graduate school), and the educational levels of the two parents were averaged into an indicator of parental education level. Finally, the economic status of the family was assessed on a 5-item scale (5 = rich to 1 = very poor).

**Procedure**

Invitation letters were sent to local middle schools in Taipei. Two public schools agreed to participate in the study. From each school, two seventh-grade classes were recruited as the sample for this study. Seventh-grade students were selected because it was their first semester in middle school, and the homeroom classes were just assembled with unfamiliar members, providing a great opportunity to observe their group dynamics from the beginning. Written consents were obtained, and research descriptions were distributed to the students and teachers. All students in the four classes agreed to participate in the survey. Social network data was collected at five time points during the school year to record the physical bully/victim networks along with the friendship matrix within the class. The questionnaire battery requires about 20 min to complete and was administered during the lunch break or an independent study session; participants returned the questionnaires in sealed envelopes. The students also provided individual and family information through self-reported surveys early in the year.

**Data Analysis**

The focus of this study was to predict students’ longitudinal physical bullying involvement by examining individual-level and network-level factors. Because the data contains five waves of assessment from four classrooms in two schools, mixed model analysis with both fixed effect and random effect was used as the major statistical strategy of this study. These models are particularly suitable when repeated measures and clustered data are involved. In addition, the dependent variable and some of the independent variables in this study were network factors, which made the models become mixed endogenous–exogenous. In this case, maximum likelihood yields more efficient estimation (Doreian, 1981). Hence, the models were fitted using STATA 12.0 MP’s `xtmixed` module with maximum likelihood estimation. Students were assumed to be nested within their classes, and multilevel regressions were conducted to allow for the inclusion of random effects at student and classroom levels. Time-constant, subject-specific variables as well as the subjects’ friendship and bully/victim network centrality at \( t \) were employed to predict individual change in bullying and victimization (i.e., bully/victim network centrality at \( t + 1 \)). At the same time, fixed effects of time and classrooms were included to control for temporal and classroom-specific confounding influences (four classrooms and five waves of data).
RESULTS

Table 1 summarizes the results of the models predicting students’ centrality in victim/bully networks from \( t \) to \( t + 1 \) (approximately 1 month apart) during the five waves. The influences of individual level characteristics exhibited the same direction for both centralities. Although boys (gender = 1) were more actively involved in being either a victim or a bully over time, parents’ educational level was negatively associated with both centralities. When parents are neither divorced nor separated, the students are less likely to be a bully. Apparently, higher self-esteem correlates negatively with being a victim. Interestingly, higher family economic status correlated positively with the risk of being a victim.

The effects of network factors suggest two interesting points about school violence. First, the growth rate in centrality in either the victim or bully network is more than 1 (1.25 for victim, 1.54 for bully). It means that once classified as a victim or a bully, the student increasingly moves toward the center of the web of violence.

Second, popularity and embeddedness in friendship network do not appear to be directly related to either being a victim or a bully. However, the interactions between the network factors and victim/bully centralities are significant. It suggests that the effects of the network factors vary with the level of students’ past involvement in victimization and bullying (e.g., Faunce, 1984).

According to the coefficients in Table 1, the effect of embeddedness on the victim centrality at \( t + 1 \) is 1.15, \(-2.53^*\) victim centrality at \( t \). Likewise, the embeddedness effects on bully centrality at \( t + 1 \) is \(-0.19, -0.65^*\) bully centrality at \( t \), and the effects of popularity on victim and bully centrality at \( t + 1 \) are \(-0.05, +0.07^*\) victim centrality at \( t \) and \(-0.01, -0.05^*\)bully centrality at \( t \), respectively.

Figure 2 plots the relations between the effects of the network factors and victim/bully centralities. In the model predicting victim centrality at \( t + 1 \), embeddedness appears to be decreasing the victim centrality at \( t + 1 \) unless the student has low score on victim centrality at \( t \). Embeddedness also decreases the bully centrality at \( t + 1 \). It is consistent with sociological studies of school, which argues that “fictive kinship” of friends offers psychological and social supports to students (Carter, 2007).

On the other hand, popularity exhibits inconsistent signs. Although popularity largely decreases the bully centrality at \( t + 1 \), it turns out to be increasing the victim centrality at \( t + 1 \). Being popular is generally associated with successful school life for students (see Hansell, 1985). However, popularity can also generate grievance from schoolmates because the popular student has difficulty in satisfying all the social demands placed on them (Eder, 1985). The lower left plot in Figure 2 indicates that popularity is more likely to put the student in harm’s way when his or her victim centrality is higher at \( t \).

DISCUSSION

Students are constantly interacting with peers in school, and these interactions and relationships constitute social networks that have a substantial effect on several adolescent behaviors, including their involvement in school bullying as bullies and victims. Past
### TABLE 1. Multilevel Mixed Effects Regressions Predicting Centrality in Victim/Bully Network

<table>
<thead>
<tr>
<th>Predictor</th>
<th>Centrality in Victim Network ((t + 1))</th>
<th>Centrality in Bully Network ((t + 1))</th>
</tr>
</thead>
<tbody>
<tr>
<td>Centrality in victim network (t)</td>
<td>1.2500 (0.3900)**</td>
<td>-0.0700 (0.0200)**</td>
</tr>
<tr>
<td>Centrality in bully network (t)</td>
<td>-0.0200 (0.0800)</td>
<td>1.5400 (0.1900)**</td>
</tr>
<tr>
<td>Popularity (t)</td>
<td>-0.0500 (0.0300)</td>
<td>-0.0020 (0.0140)</td>
</tr>
<tr>
<td>Embeddedness in friendship network (t)</td>
<td>1.1500 (0.8600)</td>
<td>-0.1900 (0.4300)</td>
</tr>
<tr>
<td>Centrality in victim network (t) × popularity (t)</td>
<td>0.0700 (0.0100)**</td>
<td>—</td>
</tr>
<tr>
<td>Centrality in bully network (t) × popularity (t)</td>
<td>—</td>
<td>-0.0500 (0.0100)**</td>
</tr>
<tr>
<td>Centrality in victim network (t) × embeddedness in friendship network (t)</td>
<td>-2.5300 (0.6000)**</td>
<td>—</td>
</tr>
<tr>
<td>Centrality in bully network (t) × embeddedness in friendship network (t)</td>
<td>—</td>
<td>-0.6500 (0.2000)**</td>
</tr>
<tr>
<td>Family economic status</td>
<td>0.9000 (0.2300)**</td>
<td>0.1041 (0.0900)</td>
</tr>
<tr>
<td>Gender</td>
<td>0.9200 (0.2500)**</td>
<td>0.2500 (0.1000)**</td>
</tr>
<tr>
<td>Parents’ marital status</td>
<td>-0.5000 (0.3900)</td>
<td>-0.3900 (0.1500)**</td>
</tr>
<tr>
<td>Parents’ education</td>
<td>-0.2000 (0.0800)**</td>
<td>-0.0700 (0.0300)**</td>
</tr>
<tr>
<td>Self-esteem</td>
<td>-0.0700 (0.0200)**</td>
<td>-0.0100 (0.0100)</td>
</tr>
<tr>
<td>Academic performance</td>
<td>-0.0200 (0.0100)</td>
<td>-0.0030 (0.0100)</td>
</tr>
<tr>
<td>Class 1</td>
<td>0.3700 (0.3300)</td>
<td>0.1200 (0.1300)</td>
</tr>
<tr>
<td>Class 2</td>
<td>0.4400 (0.3200)</td>
<td>0.3300 (0.1200)**</td>
</tr>
<tr>
<td>Class 3</td>
<td>-0.2700 (0.3200)</td>
<td>0.0200 (0.1200)</td>
</tr>
<tr>
<td>Wave 1</td>
<td>0.3700 (0.2600)</td>
<td>0.2100 (0.1300)</td>
</tr>
<tr>
<td>Wave 2</td>
<td>-0.0300 (0.2500)</td>
<td>-0.2000 (0.1200)</td>
</tr>
<tr>
<td>Wave 3</td>
<td>-0.1400 (0.2300)</td>
<td>-0.1000 (0.1200)</td>
</tr>
<tr>
<td>Constant</td>
<td>1.2800 (1.3900)</td>
<td>1.2000 (0.6100)</td>
</tr>
</tbody>
</table>

| The number of observations | 404 | 404 |
| Wald \(\chi^2(df)\)      | 138.9000 (18.0000) | 797.5000 (18.0000) |

Note. Standard error is in parenthesis.

**\(p < .05\). ***\(p < .001\).
research has identified several individual-level risk factors, and some of these factors were examined empirically in this study with a sample of Taiwanese middle school students. Consistent with prior findings (e.g., Scheithauer et al., 2006; Wang et al., 2009), this analysis found that boys are more likely to be both physical bullies and victims. This is consistent with previous research showing that male adolescents have a higher engagement in direct aggression compared to female adolescents (for a review, see Card, Stucky, Sawalani, & Little, 2008). Similarly, low self-esteem was found to be predictive of later victimization. Although academic performance exhibited a negative correlation with future victimization and bullying, the effect did not reach the significant level. Interestingly, one recent study on Taiwanese adolescents revealed the moderating effect of Machiavellianism on the relationship between bullying and school adjustment (Wei & Chen, 2012). For those who were low in Machiavellianism condition, bullying was negatively linked to academic performance, whereas no significant association was found for the high-Machiavellianism group. Such findings highlighted the heterogeneity of bullies and suggest that certain aggressive adolescents do not necessarily perform poorly at school.

As for family factors, lower parental education level predicts a youth’s likelihood of being a physical bully and victim. Having parents married and living together also reduced the risk of being a bully over time, which largely corresponds to the previous findings in the school bullying literature. However, higher family economic status was associated with a higher risk of being victimized. One possible explanation for this unexpected finding is that the victim status in this study is determined by the respondent’s nominations of classmates who physically bullied him or her, reflecting the nominator’s subjective

Figure 2. Relations between effects of popularity/embeddedness and victim/bully centralities.
Individual and Social Network Predictors of Physical Bullying

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perception. Past research has suggested that people from different socioeconomic backgrounds hold different attitudes toward violence (Heimer, 1997), which may result in higher identification of peers’ physical acts (e.g., pushing, shoving) as aggressive bullying among adolescents from more affluent families because such acts are less tolerated in their culture.

Besides evaluating the effects of individual-level variables, the results of this study highlight the importance of peer network factors in students’ physical bullying involvement. First, a student’s centrality in the victim network at \( t \) predicts the student’s victim centrality at \( t + 1 \) positively. Although it is insignificant, the sign of the bully centrality’s effect on subsequent victimization is negative. Similarly, the student’s bully and victim centrality at \( t \) were both found to be positive and negative predictors of further bullying perpetration. Such results not only suggest a nonoverlap between bullies and victims but also reveal the continuity and even escalation of bullying network positions in the classroom. In addition to the stability of individual attributes, peers are also likely to contribute to this chronic aggression and victimization by conferring reputations on the offender and victim that secure them into fixed roles (DeRosier, Cillessen, Coie, & Dodge, 1994). In other words, the reputations of the bully and victim can shape the ways in which peers interact with them and lock the two parties into relatively stable positions in the social network (Biddle, 1986; Thye, 2000).

Regarding the peer friendship network, popularity and embeddedness in friendship had no main effect on bully centrality, showing that physical bullies are not necessarily rejected by peers or do not necessarily lack friends. In fact, recent studies showed that bullies can manage to avoid negative social consequences of their behavior through strategic aggression (Veenstra, Lindenberg, Munniksma, & Dijkstra, 2010; Wei & Chen, 2012). Interestingly, popularity and embeddedness in friendship network did not significantly contribute to lower risk of victimization. To have a better understanding of these results, the interaction between peer friendship and previous bully/victim status in predicting subsequent bully/victim centrality was further explored. It was found that popularity and embeddedness in friendship largely reduced the risk of bullying, especially for those with higher previous engagement in bullying. This finding is consistent with longitudinal research by Kreager (2004), who showed that social isolation in conjunction with problematic peer interaction in school significantly increases later delinquent behavior. These findings suggest that embeddedness in friendship can buffer such a trend, and it may be used as a potential social network mechanism for decreasing bullying behavior and curving negative role taking (Loch, Huberman, & Stout, 2000). At the same time, a close examination of the positive interaction effect of popularity and prior victim status in predicting further victimization reveals that friendship acts as a protective factor only for the students with low previous victimization. For those who had been highly victimized in the past, popularity actually increases their future risk of being bullied. A discrepancy in the definition of relationship nature may occur because a student’s friendship was calculated based on the number of classmates who nominated the target person as a friend, whereas the person’s victim status was assessed by his or her own nominations of classmates who physically bullied him/her. It is possible that one student’s gesture of playful fighting may have been perceived as harassment by another. Moreover, in one study of Taiwanese adolescents, Wei and Jonson-Reid (2011) showed that friendship and victimization might coexist for some students because some students reported that their friends bullied them. Further investigation needs to clarify the problematic interaction patterns in these companionable yet harmful relationships.
Limitations

Despite the strengths in data quality and analytic approach discussed earlier, this study has several limitations that are worth noting. First, past research has accumulated a large number of individual risk factors of school bullying, such as one’s delinquency and probullying beliefs, many of which are not included in this study. In addition, nonphysical types of bullying, such as rumor spreading and social isolation, are highly relevant to social network dynamics, but they are not examined here. Second, the interplay between peer relationship and bullying involvement revealed in this study suggests the potential existence of complicated social interactions among adolescents that awaits future exploration. For example, it was found that bullies often manage to minimize social cost by choosing victims who are not likely to be defended by same-gender peers (e.g., victims of male bullies are rejected by males only; Veenstra et al., 2010). More research effort can be paid to further clarify the mechanisms that contribute to the development and maintenance of the bully/victim structure within classroom. In addition, the bullying networks were constructed from the victims’ nominations of the students who bullied them. Such measures reflect the nominators’ self-report and may be biased by their personal perception. Multiple sources of data, such as teacher ratings or classroom observations, can be used in future research to provide a more comprehensive and balanced picture of the peer network. Finally, the four-classroom sample size of this study is relatively limited. However, with multiple waves of follow-up data collection, the actual number of observations was comparatively large, helping to achieve statistical stability and adding to the robustness of results.

CONCLUSIONS

This study is the first to examine physical bullying involvement among Taiwanese middle school students from a social network perspective. It is shown that besides individual and demographic characteristics, network factors also have substantial effects on students’ involvement in physical bullying. Multiple waves of social network data further allow a better appreciation of the relational dynamics in peer groups that contribute to one’s involvement in bullying as perpetrators and as victims. The interaction effect between friendship and bullying is of particular interest. In short, popularity in peer groups is not always rewarding. Because peer classroom contexts heavily influence the behavior and adjustment of adolescents, school health professionals are challenged with the task to design and implement group-level strategies to enhance students’ development and well-being. This study highlights the significance of social network factors in predicting adolescents’ physical bullying involvement and provides school health professionals with an alternative framework to understand this common aggression among youth. Teachers, school counselors, psychologists, and social workers should address student bullying as a group process phenomenon. Traditional focus on individual risks and vulnerabilities may misguide attention and preclude the possibility to enhance classroom climate and peer dynamics. In contrast, it is argued that school bullying is essentially a peer interaction issue, and more effort should be devoted to monitor interpersonal relationships and adjust network structures. By identifying the within-class network factors operating in school bullying, this study hopes to stimulate further research and service programs to target group dynamics as potentially effective measures to prevent physical bullying and promote students’ health in school.
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Violence and Victims

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