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Effective Methods to Reach Victims of Domestic Violence

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Running head: EFFECTIVE METHODS

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Table of Contents

List of Tables

List of Figures

Abstract

The estimated number of women in abusive relationships in the United States is almost 2 million (Pyles & Postmus, 2004; Tjaden & Thoennes, 1998; Tjaden & Thoennes, 2000). Each year 1,500 of these women are murdered by their partners (Shostack, 2001). Yet there are 3 times as many shelters for abused animals then shelters for abused women and children (NiCarthy, 2004*)* this is at odds with the number of victims in need of services.

This study explored a variety of methods to reach victims of domestic violence. To provide a basic understanding of domestic violence in the United States is presented, various definitions of domestic violence are discussed and the history of domestic violence in the United States is explored.

The study attempted to understand ways women who utilized their services learned about what was available, the services they utilized and suggestions they had for improving outreach. The findings indicated women often learned about the services from friends and medical professionals who suggested they seek help. The study also revealed that only after leaving the abuser did the women feel safe enough to see help.

Effective Methods to Reach Victims of Domestic Violence

The purpose of this research study is to explore possible methods to reach victims of domestic violence. A number of research studies have shown domestic violence occurs at all levels of our society regardless of race, ethnicity and socioeconomics (Greenfeld et al., 1998; Rennison & Welchans, 2000; Straus, Gelles, & Steinmetz, 1980; Van Hightower & Gorton, 2002; Centerwall, 1984; Walker, 1984; Walker, 2000). In the United States alone a woman is battered every nine seconds (Roberts & Roberts, 2005; Roberts, 2007). Roberts and Roberts (2005) estimated 8.7 million women were physically abused each year. Approximately 2 million of these were victims of severe violence (Pyles & Postmus, 2004; Tjaden & Thoennes, 1998). NiCarthy (2004) estimated between 25 percent and 50 percent of women will be physically abused at least once in their relationship; emotional abuse is even more prevalent. Victims of domestic violence are often isolated from others and their movement limited by the abuser (Grigsby & Hartman, 1997; NiCarthy). This makes it challenging to educate women about services for victims of domestic violence while still maintaining their safety. This study explores the needs of women who have sought services at a women's shelter in the Northeastern United States on effective outreach methods. In addition a variety of outreach programs geared towards domestic violence victims are discussed.

Review of the Literature

This study will present the following: several definitions of domestic violence, domestic violence as a public health problem, the history of domestic violence in the United States and a variety of outreach programs. The outreach programs

explored will be divided into three board categories: criminal legal-system based outreach methods, health care outreach methods, and coordinated Community Response methods. A rational for the research will also be presented.

Definitions of Domestic Violence

The term domestic violence had evolved over the years moving from wife beating to gender-neutral terms like spousal abuse, intimate partner violence and marital violence (Breines & Gordon, 1983; Cattaneo, Deloveh, & Zweig, 2008). When the topic of domestic violence first began to be explored the term wife abuse and beating was used. Strube and Barbour (1983) defined the problem of wife abuse as women being beaten by their husbands and estimated 1.8 million women were beaten in 1983. Being beaten was classified as a series of incidents where they are pushed and shoved (Strube & Barbour). More then half the women they interviewed indicated experiencing five or more attacks (Strube & Barbour). According to their 1978 research project nearly 1,700 women died each year of "beatings" (Strube & Barbour). In 1998, the National Crime Victimization Survey estimated 1,000,000 violent crimes were committed by intimate partners and one third of all murdered women were killed by their partner (Rennison & Welchans, 2000; Shurman & Rodriguez, 2006). These numbers are based on the number of assaults officially reported; the belief was these numbers were actually much higher as the result of underreporting incidents (Rennison & Welchans, Shurman & Rodriguez).

The National Domestic Violence Hotline (n.d.) defines domestic violence as "a pattern of behavior in any relationship that is used to gain or maintain power and control over an intimate partner". Many criminologists, sociologists, psychologist, and

anthropologists define wife beating as a “strategy of patriarchal power” normally employed to discourage women from challenging men’s authority or rein in women who strayed from established gender role expectations (Adler, 2003). Moore Parmley (2004) defined violence against women as aggressive behaviors, which adversely and disproportionately affects women including violence committed by intimates, acquaintances, and strangers. Moore Parmley defined intimate partner violence as threatened or actual use of physical force against an intimate partner, which resulted in or has potential to end in injury, harm, or death. Gordon (2000) and Nicarthy (2004) defined intimate partner violence as physical, verbal, and psychological acts used to achieve dominance and control over their partner. Intimate partner violence is defined by Erez (2002) as including not only verbal abuse, and psychological abuse, but also control of finances, property damage, harming pets, threatening victim’s children, and stalking which often takes place after ending a relationship. Erez expanded the definition of domestic violence to include abuse in same sex relationships and between people who have ended their relationship.

In 1999 the Center for Disease Control expanded their definition to violence committed by a spouse, ex-spouse, current or former partner (same or opposite sex partner) in any of the following forms: physical, sexual, threats of physical or sexual violence and psychological/emotional abuse (Chang et al., 2005; Saltzman, Fanslow, McMahon, & Shelley, 1999; Trabold, 2007). At that time they recommended the term intimate partner violence be used to indicate any partner perpetrated violence (Chang et al., Saltzman, Fanslow, McMahon, & Shelley, Trabold). Bonomi et al. (2006) estimated that intimate partner violence will affect 25% to 54% of women in their lifetime.

As noted above physical, emotional, sexual and financial abuses are the cornerstones of domestic violence. To better facilitate an understanding of these a brief definition of each is provided.

Physical Abuse – Dutton (1992) referred to physical abuse as behaviors which involve the intentional use of one's body against the body of another person in a manner that may cause physical injury, regardless of whether the behavior causes an actual injury. This included hitting, slapping, throwing the victim to the floor, assaulting the victim with a weapon or object, kicking, and any physical action which is understood by the victim to cause bodily harm (Epstein, 2006; Goodman & Epstein, 2008; Tjaden & Thoennes, 2000)

Psychological Abuse – Walker (1984) "divided psychological abuse into eight categories: (1) isolation of the victim, (2) induced debility, producing exhaustion, weakness, or fatigue (i.e. sleep or food deprivation), (3) monopolization of perception, including oppressiveness and possessiveness, (4) threats of harm to the victim or her family and friends and other forms of threat, (5) degradation including humiliation, name calling and insults, and denial of privacy or personal hygiene, (6) forced drug or alcohol states, (7) altered states of consciousness produced through hypnotic states, and (8) occasional random and variable reinforces or indulgences, partial reinforcers that keep alive the hope that the torture will cease" (p3). Psychological abuse also referred to as emotional abuse resulted in the erosion of the victims' self-esteem and self-worth (Walker, 1994).

Sexual Abuse – Dutton defined this as "any unwanted sexual activity" (Dutton, 1992; Epstein, 2006; Goodman, Dutton, Vankos & Weinfurt, 2005) Moore Parmley

(2004) further defined it as the use of physical force or threat of force to compel a person to engage in sexual acts against his or her will, regardless of if the act is completed.

For the purpose of this research article a broad definition of domestic violence will be use encompassing any intentional violence or controlling behavior against intimate partners.

Domestic Violence as a Public Health Problem

In 1994 the United States government passed the Violence Against Women Act domestic violence, which made domestic violence a public health concern (Trabold, 2007). At that time it was estimated abused women have a 60% higher incidence of health problems (Trabold). They were more likely to use alcohol and drugs to cope with the abuse (Trabold). Many mental health problems were also associated with domestic violence including depression, anxiety, eating disorders and suicide attempts (Trabold).

A Bureau of Justice Statistics Special Report released in 2003 on intimate partner violence indicated that in 2001 there were 391,710 nonfatal incidents of domestic violence (National Center For Injury Prevention and Control, 2003; Rennison & Welchans, 2000; Trabold, 2007). In 1998, it was reported 7.8 million women were raped by their partner and 1.3 million women are physically assaulted annually (Tjaden & Thoennes, 1998; Trabold)

Domestic violence also had an impact on health care costs. National Center for Injury Prevention and Control (2003) estimated the annual health cost of domestic violence at 4.1 billion dollars. Research by Coker, Smith, McKeown, and King (2000) indicated victims of domestic violence used a disproportionate share of health care

services, utilized the emergency room, primary care facilities and mental health agencies more often then women who were not abused. Research showed battering was the largest cause of injury to women in the United States, more then auto accidents, mugging and rapes combined (Keller, 1996; Werner-Wilson, Schindler Zimmerman, & Whalen, 2000). The Centers for Disease Control and Prevention found family violence was the leading cause of death in the United States making domestic violence a public health issue (Werner-Wilson, Schindler Zimmerman, & Whalen).

History of Domestic Violence in the United States

Breines and Gordon (1983) noted in their research article there has been very little written about the history of family violence. Peterson (1992) stated only a few historians had researched wife beating. Most of the work that has been done, was written without a good understanding of the historical context (Breines & Gordon).

Concerns about family violence has waxed and waned in the United States (Peterson, 1992). Throughout history the issue of family violence and “wife beating” was not recognized as a serious social problem rather an acceptable even encouraged method of correction sanctioned by law (Breines & Gordon, 1983; Minnesota Center Against Violence And Abuse, 1999; Peterson). Cultural norms made a marriage license a license to hit (Straus et al, 1986). This is explored further below.

Before the late 1800s

Early settlers of the United States brought with them English common law (Erez, 2002; Griswold ,1986; Straus & Gelles, 1986; Whetstone, 2001). In English common law women were viewed as chattel (Draucker, 2002; Erez; Straus & Gelles; Whetstone). They were first the property of their fathers then their husbands (Draucker;

Erez; Griswold; Straus & Gelles ; Whetstone). Husbands frequently used physical violence against their wives (Draucker; Erez; Griswold; Straus & Gelles; Whetstone). Husbands were allowed, even encouraged to beat their wives with rods no bigger around then his thumb, for disciplinary purposes provided they did not murder them (Draucker; Erez; Straus & Gelles; Whetstone). Men's physical and economic strength reinforced women's views that they needed to accept this "right to discipline" (Whetstone). Violence was often the result of a husband's anger at his wife for failure to perform her "duties" (Keetley, 2008). Since women were property they were also forced into having sexual intercourse (Keetley).

During much of the 1800's United States courts refused to convict husbands of battering their wives unless permanent injury was caused or excessive violence was used (Draucker, 2002; Straus & Gelles, 1986). Courts believed family arguments were best left behind closed doors and were not proper matters for the court (Erez, 2002; Straus, 1992). The courts even went so far as to recognize the husband's right to use a degree of force to make the women "behave" and "know her place" (Erez, 2002).

End of the 1800s

The late 1800's brought about some changes in the United States' view on domestic violence (Draucker, 2002). Progressive reformers attempted to control family violence by developing punitive and moralistic "charitable endeavors and moral purity reforms" (Gordon,1986, p 454). Legal reform began making it illegal to beat wives and in some states punishable by 40 lashes or one year in prison (Draucker). Many of the legal rights men had to chastise their wives were abolished (Erez, 2002). Paternalistic laws developed during this time which offered meek-appearing women a measure of

protection against male brutality (Peterson, 1992). Members of the community also stepped in to assist women caught in abusive situations (Peterson). In 1885, Chicago established the Protective Agency for Women and Children to protected assaulted wives and rape victims (Pleck, 1983).

Peterson (1992) indicated wife beaters in the 1890s were more restraint in their use of violence then men would be later in history. Court records from women in the 1890s seeking divorce indicated overall men were reluctant to use physical violence (Peterson). A note to this is only women of means could afford a divorce during this time and these resources often deterred the man from abusing them (Peterson). There is speculation women minimized the abuse in court records because at the time seeking divorce was a risk (Peterson). They may also have felt shame and fear about the abuse (Peterson).

It should also be noted abusive Victoria era men abhorred and avoided physical violence, and would not lay hands on a women in anger (Peterson, 1992). Wives during this period spoke of broader cruelties including accusations of adultery, harsh language, failure to support and in many cases no concern for their physical and social needs (Peterson). The seeming low rate of abuse during this period might be the result of men's unquestionable dominance and power in the relationship (Peterson).

1900s

In the 1900's criminal charges began to be brought against abusers (Erez, 2002). In 1911 the first family court was founded in Buffalo, New York to help resolve family problems including domestic violence (Minnesota Center Against Violence And Abuse, 1999). Peterson (1992) indicated wife beaters in the 1970s were much more violence

then they had been in the 1700 and 1800s. Research by Gordon (1986) and Lane (1979) of reported homicides and complaints of beatings concurred with Peterson's statement that violence escalated in the twentieth century. Peterson (1992) speculated this was the result of changes in men's views of their responsibility to women. The women's movement expanded women's views of their role in society and changed the power dynamics of male/female relationships (Peterson). Goode (1971) argued husbands resorted to violence against their spouses when other advantages disappeared.

Public awareness of domestic violence and social service programs flourished in the 1970s and 1980 but steady progress was uneven (Van Hightower & Gorton, 2002). The first large-scale campaign to end violence against women began in the 1970's as part of the women's movement together with advocates on behalf of victims of rape and domestic violence (Breines & Gordon, 1983; Erez, 2002; Tiefenthaler, Farmer, & Sambira, 2005; Tjaden & Thoennes, 1998). Their work moved domestic violence from a private issue to a public concern and redefined it as a crime (Davis, Hagen, and Early, 1994; Erez; Grauwiler & Mills, 2004; Tiefenthaler, Farmer, & Sambira; Tjaden & Thoennes).

Providing shelter for abused women began to emerge during this time (Erez, 2002; Davis, Hagen, & Early, 1994). In 1972, women's advocates in St Paul, Minnesota started to offer shelter to battered women (Sedlak, 1988). At that time there were 11 known shelters in the United States (Sedlak). In the early 1980 there were over 500. (Sedlak). By 1985 this number had risen to a thous& but was still not sufficient to provide for the number of abused women in need (Straus, Gelles, & Steinmetz,1980).

The first large-scale national study of family violence was undertaken in 1975 by Straus, Gelles, & Steinmetz (1980). This study was replicated ten years later (Straus et al.). Results of the study provided a better understanding of the underlying cases of physical abuse (Straus et al.). It showed the cause was a social arrangement rather then individual psychopathology (Straus et al.).

Beginning in the 1980s there were major developments in the scientific knowledge surrounding the causes of domestic violence (Pollitz Worden & Carlson, 2005). The 1980's also resulted in dramatic shifts in law and policies directed at domestic violence (Pollitz Worden & Carlson; Tiefenthaler, Farmer, & Sambira, 2005). National, state and local policy makers criminalized partner violence and increased penalties for some types of violence (Pollitz Worden & Carlson). Resources for victims also increased during this period. In 1985, United States Surgeon General, Everett Koop declared the battering of women a significant health problem (Draucker, 2002). Mandatory training in the essentials of domestic violence intervention was a recommendation of the Surgeon General's Workshop on Violence and Public Health (Draucker). Congress passed the Violence Against Women Act in 1994 as part of the Violent Crime Control and Law Enforcement Act (Draucker).

2000s

Research by Werner-Wilson, Schindler Zimmerman, and Whalen (2000) indicated that still in the 2000's spousal abuse remained a social problem. In 2000, the Violence Against Women Act was amended to the Victims of Trafficking and Violence Prevention Act of 2000 establishing new programs, strengthening federal laws and reauthorizing grant funding (Draucker, 2002). In 2004, Scott Peterson was sentenced

to life in prison for killing his wife and unborn son (Ramsey, 2006). Although Peterson's case resulted in severe penalty this is an abnormally even today (Ramsey).

Methods and effectiveness of outreach to victims of domestic violence

There are many factors, which make it difficult to connect with women who want to escape from abusive situations. Among these is a lack of access to community resources including housing, legal assistance, employment, education, finances, childcare and social support systems (Sullivan, 1991). Many studies have validated Gondolf's (1988) results which showed women rarely find the help they are seeking in their community (Donato & Bowker, 1984; Flynn 1977; Gayford, 1978; Hofeller, 1982; Kuhl, 1982; Rounsaville, 1978; Schulman, 1979). These resources included the police, legal system, counseling, health care and social services agencies. Schulman's (1979) research found only 1 in 12 battered women located the help they needed. NiCarthy (2004) pointed out the lack of connection to information regarding the dynamics of abuse, where they can go for safety, community resources and legal options are often the result of social isolation experienced by battered women. Information is such a powerful tool for women seeking to leave abusive situations that abusers go to extreme lengths to keep women uninformed including keeping them out of touch with friends and families, removing phones or wires from the car, locking her in the house, locking her in a room, having his relatives or friends stay with her when they leave and accompanying her in public at all times (Grigsby & Hartman, 1997).

Bogal-Allbritten and Rogers-Daughaday's (1990) study surveyed 696 directors of shelters, safe home and support services in rural communities who were listed in Warrior's Battered Women's directory to measure the methods of outreach used by

programs, which served their clients. The results indicated the most frequently cited referral source were self referrals (57%), social services (46%), police (45%) and friends and relatives (35%) (Bogal-Allbritten & Rogers-Daughaday). The directors indicated the reasons for low usages of their services was lack of awareness of the services (45%), lack of transportation (42%), negative attitudes (8%) and needs not as great (6%) (Bogal-Allbritten & Rogers-Daughaday).

Kernic and Bonomi (2007) pointed out although domestic violence is better understood now then it has in the past, evaluation research of interventions is in its infancy and many programs were widely used despite the lack evidence showing their effectiveness. Below several intervention methods to connect women with services are explored. The majority of interventions currently used fall into the following categories: criminal legal-system bases programs, health care based programs and coordinating councils developed to bring community systems together (Sullivan, 2006).

Criminal Legal-System Based Outreach Methods

Historically because women were seen as property of their husbands', police have avoided getting involved in domestic violence (Whetstone, 2001). Walter (1981) discovered many police officers believed husbands who abuse their wives do so as a result of drinking. Walter continued pointing out this cynicism provides a rational for officers to ignore domestic disturbance calls until physical incident is imminent or has occurred; only at this point do the officers feel their involvement was justified. This corresponds with findings by Corcoran, Stephenson, Perryman, and Allen (2001) in which police placed a low priority on these calls. Whetstone indicated historically in

some cases domestic violence calls had been screened out by dispatchers. In others, police served to escalate the crisis and often sided with the abuser (Whetstone).

Researchers have begun to look at the concept of coordinating services within the community between police and court resources (Fleury-Steiner, Bybee, Sullivan, Belknap, & Melton, 2006). The preliminary results were positive and hold promise in reducing domestic violence (Fleury-Steiner et al.). Below several response teams are reviewed briefly.

Curnow (1997) found battered women are often more willing to seek help and identify their situation as abusive following an incident of domestic violence. This idea combined with recognition of the broad range of resources needed to successfully leave a relationship is the fundamental concept behind response teams (Kernic & Bonomi, 2007). Police are the first point of contact for victims of domestic violence and play a critical role in the resolution of the incident (Corcoran, Stephenson, Perryman, & Allen, 2001). Given this, in the police department- involved crisis intervention team approach the call is normally initiated on request of a responding officer. Due to the subjective nature of this selection process in determining who received the services of the team, it was difficult to effectively evaluate the programs (Kernic & Bonomi).

Corcoran, Stephenson, Perryman, and Allen (2001) surveyed police officers that worked with the domestic violence response team (DVRT) in a suburban area of a southwestern state two years after the program was initiated. DVRT's law enforcement goal was to increase the amount of cooperation from the victim in the arrest and prosecution of the abuser (Corcoran et al.). A secondary goal was to increase the effectiveness of domestic violence investigations (Corcoran et al.). The social work's

goal was to provide crisis intervention creating a safer and more stable environment for the victim (Corcoran et al.,). These included legal referrals, assistance with the offense report, providing information about the criminal justice system, explaining victim's rights, describing orders of protection, as well as providing counseling and advocacy (Corcoran et al.,). DVRT also followed up on cases through consultation with victims, community agencies and police officers (Corcoran et al.,). DVRT teams were composed of five professional who work for the police department and held bachelor's degrees in human services (Corcoran et al.,). Responding officers assessed the situation and determine if the team was needed (Corcoran et al.,). Corcoran et al. survey of 219 officers found that of those 144 (66%) had called out the response team and 89 had been on calls when the team had been called in. Seventy nine percent of the officers thought the team were helpful, 3% thought it was not and the remaining did not think the questions were applicable. Of those who though the team was not helpful, 2% had left before the team arrived, less then 1% stated the team was not available, less then 1% felt the team had done nothing new and 1% had never called the team (Corcoran et al.,). When asked about the services provided, 28% of the officers felt the team provided follow up services to the victims, 16% helped with uncooperative victims, 62% helped with emergency orders of protection, 28% helped transport the victim to a shelter, 46% helped explain the criminal justice system provided referrals as well and 31% counseled the victim while the officer either apprehended or questioned the suspect. When asked how the team could be more helpful, 32% requested more available hours, 19% felt they could assist other calls beside domestic violence and 22% felt they could help educate the officers through continuing education (Corcoran et al.,).

Corcoran and Allen (2005) initiated a study of a crisis team in a high-crime sector of mid-size southwestern city in 1997. The team consisted of a uniformed detective from the Family Violence Unit and a crisis intervention volunteer (Corcoran & Allen). The unit was available upon request of the responding officer (Corcoran & Allen). The detective investigated the case and gather evidence while the volunteer worked with the victim to provide crisis intervention services, educating them about the criminal justice system, validating their concerns, teaching them about the elements of domestic violence, providing referrals to social and legal services and if needed transporting them to a shelter (Corcoran & Allen). Corcoran and Allen found the majority of victims were willing to work with the crisis team and engage in the services they offered (Corcoran & Allen). Corcoran and Allen's study found the number of arrests were significantly greater when the crisis team was called to respond. The limitations to their study was the newest of the program, the limited times the team was available to be called out and that data for the study was obtained from police reports which excluded responses from the victims (Corcoran & Allen).

Greenspan et al. (2005) studied Richmond's Second Responder Program. This program differed from the other as the second responders were employee of the Department Of Social Services (DSS) based at the first and second precincts and could interact informally with the officers on a daily basis (Greenspan et al.). This allowed them to build informal relationships with the officers and increase the likelihood that they would be called to a domestic violence scene (Greenspan et al.). The second responders ensured the safety of the victims and assessed for needed services (Greenspan et al.). They also provided guidance in creating a plan to receive services

and complete service applications (Greenspan et al.). Emergency housing was provided if needed (Greenspan et al.). The Richmond's Family Violence Prevention Program at DSS would check the victim's history to see if a caseworker was already assign, if not, one was assign to assist with advice on other expanded services which were available (Greenspan et al.). Greenspan et al. completed a quasi-experiment by comparing the results from the first and second precincts with a control group created from the other two precincts. They interviewed victims a few days after the incident and again six months later (Greenspan et al.). Overall the victims rated the second responders very highly with 83% feeling the responders listened carefully to their stories and took their situations very seriously (Greenspan et al.). Ninety-two percent felt the responders really wanted to help (Greenspan et al.). Seventy-nine percent stated they would very strongly recommend second responders to others in their situation (Greenspan et al.). The victims who worked with second responders felt they had received better service from the police (Greenspan et al.). Overall the perception of the program was that it enhanced the traditional police services (Greenspan et al.).

New York City Police Department and Victims Service started an education and outreach program called Domestic Violence Intervention Education Project (DVIEP) in the mid-1980s (Davis & Taylor, 1997). The team was comprised of a police officer and a social worker who were dispatched within a few days of an initial police response to a domestic violence call (Greenspan et al., 2005). During the visits social workers educated victims of their rights and available services (Greenspan et al.). The police officer spoke with the abuser to let them know the house was being monitored and provide referrals to treatment programs (Greenspan et al.). In addition DVIEP provided

educational outreach to the housing projects within their service area. The program's goal was to reduce the risk of future crime (Greenspan et al.). Greenspan et al. found no differences between the treatment and control group in the number of victim-reported violence incidents or reduction in future violence (Greenspan et al.). Given Curnow's (1997) study which showed women were often more willing to seek help following an incident perhaps the time between the incident and dispatch of the team may have had an impact on the success.

A totally different invention involved helping victims move through the legal system (Bell & Goodman, 2001). Due to the shortage of legal advocates to help victims of domestic violence many women experience fear, confusion and frustration with the legal system (Bell & Goodman). Bell and Goodman explored an experimental program in Washington DC which linked second and third year law students from Georgetown University and Catholic University of America laws schools with victims of domestic violence. The law students were assigned domestic violence victims and worked as their legal advocates (Greenspan et al., 2005). The law students met with the victims on an average of four times a week for up to six weeks (Greenspan et al.). The emphasis of these meetings was to provide legal representation and support throughout the court process (Greenspan et al.). After six weeks women who took part in this study indicated significantly lower levels of psychological and physical reabuse and an increased emotional support (Greenspan et al.). The results suggested law school advocacy can make an important contribution to the victims' physical well-being and feelings of emotional support (Greenspan et al.).

Gondolf (1998) took a slightly different tack on reaching victims utilizing the court system. During the course of two years the staff from a women's center contact women listed on the court docket to see how the women were doing and to explain three outreach options available to them (Gondolf). The three outreach options were: a special weekly support group designed to educate women about domestic violence and how to deal with it; individual counseling; and phone counseling where counselors contacted the women on a weekly basis and asked several questions about the abusive relationship (Gondolf). This intervention was relatively unsuccessful (Gondolf). Only 4% of those contact actually participated in the study and of those only 19% of the women accepted services many of who did, did not participate extensively in the services (Gondolf). This outreach may indicate how difficult it is to provide resources to victims until they are ready to seek help (Gondolf).

Health Care Outreach Methods

Pakieser, Lenaghan, and Muelleman (1998) found victims of domestic violence sought help from a number of sources among them are: emergency rooms, family/friends, private physicians, social workers/psychologists, police, lawyers and clergy (Reisenhofer & Seibold, 2007).The third most common source for help and the first point of assistance in the healthcare system is the emergency room (Reisenhofer & Seibold). Edwardsen, Pless, Fiscella, Horwitz, and Meldrum (2004) noted studies documented among primary care patients a high rate of undetected intimate partner violence yet most physicians do not routinely screen patients. (Hamberger, Ambuel, Marbella, & Donze, 1998).

Straus (1986) estimated 1.5 million women seek medical care for injuries, which result from domestic violence each year. Campbell (1998) pointed out in addition to injuries women also seek assistance for stress related illness resulting from the violence. Davis (1984) reported 25% of women treated for injuries in the emergency room of a large city hospital were likely to be victims of domestic violence yet only 2.8% of them were identified by emergency room personnel as battered women (Hamberger, Ambuel, Marbella, & Donze, 1998). Sugg and Inui (1992) found more then half of the physicians surveyed in the United States were not comfortable asking patients about the cause of the injuries they treated. Given the number of women who sought medical attention several studies have looked at health care facilities to provided support and education to women in abusive situations and in some cases help them to connect to resources.

Chang et al. (2005) noted in their article that in 1992 Joint Commission on Accreditation of Healthcare Organizations required hospital departments and clinics to provide intervention for identified victims of domestic violence. Since that time numerous research studies have indicated they think providers should routinely ask about violence and provide information about community resources (Caralis & Musialowski, 1997; Chang et al.; Friedman, Samet, Roberts, Hudlin, & Hans, 1992; McNutt, Carlson, Gagen, & Winterbauer, 1998; Panagiota & Musialowski, 1997; Rodriguez, Quiroga, & Bauer, 1996).

Gerbert, Abercrombie, Caspers, Love, and Bronstone (1999) interviewed twenty five women who were victims of domestic violence in the San Francisco area. They described physicians' intervention behaviors ranged from direct to indirect comments, to

completely ignoring signs of abuse (Gerbert et al.). Despite this range most women described at least one experience in which a provider validated them (Chang et al., 2005). Women reported this validation from a health care provider not only provided "relief" and "comfort" but also put them on the path toward realizing the seriousness of the situation and changing it (Chang et al.). Over sixteen of the women stated the validation received from the health care providers changed how they thought about themselves and their situation (Chang et al.).

McFarlane, Soeken, and Wiist (2000) stated some experts believe with identification and intervention offered in primary care settings abuse could be reduced by 75%. The Panel on Research on Violence Against Women stated that despite the increase in training and screening protocols in medical setting domestic violence victims are frequently overlooked (McFarlane et al.).

McFarlane, Soeken, and Wiist (2000) studied the effectiveness of three intervention strategies offered to pregnant women in two prenatal clinics within the health department of a large city in the southwestern United States. The clinics each served 2,000 to 3,000 new patients each year (McFarlane et al.). During a 12 month period all of the patients were screened for abuse during routine interview assessments on their first visit (McFarlane et al.). Women who reported abuse were assigned to one of three intervention groups (McFarlane et al.). The three interventions were: brief; counseling; or outreach (McFarlane et al.). Brief intervention consisted of providing a wallet-sized card with phone numbers of local agencies that could assist with domestic violence, police, legal aid, the local women's center and information about keeping safe (McFarlane et al.). Counseling consisted of unlimited access to counseling services

that have expertise in domestic violence (McFarlane et al.). Outreach included unlimited counseling as well as a "mentor mother" who offered support, education, referral, and assistance in connecting with community services (McFarlane et al.). All three interventions included a follow-up interview 2 months after the birth of their child (McFarlane et al.). McFarlane's et al. study revealed physical violence 2 months after the intervention was significantly lower in the women who received both counseling and mentoring during their pregnancy then the women who only received counseling (McFarlane et al.). Threats of violence and physical violence decreased in all groups regardless of the intervention used. McFarlane et al. stated they believe actually completing the assessment was enough of an intervention to reduce the risk of violence.

Studies have also looked at physicians and patients' attitudes towards domestic violence intervention. Gerbert et al. (2000) led 6 focus groups of physicians in the San Francisco Bay Area. All 45 physicians were selected because they had provided interventions to domestic violence victims (Gerbert et al.). The physicians in the group believed addressing domestic violence was part of their job and used several techniques to connect with victims in their practices (Gerbert et al.). Among the techniques utilized by the physicians were providing validation, helping to break through denial of the abuse in order to plant seeds for change, listening in a nonjudgmental manner, documenting the abuse, providing referrals and assisting with the creation of safety plans (Gerbert et al.). Gerbert et al. found most felt interventions required a team effort to successfully intervene (Gerbert et al.). Some physicians used on-site resources to refer women directly to counselors, social workers, behavioral medicine counselors or

psychologist who conducted interviews and follow-ups (Gerbert et al.). The physicians observed patients change their lives following the interventions (Gerbert et al.). The battered women interviewed were patients of these physicians reported being validated and treated with compassion were the most desirable interventions and equated them to the safety planning and referrals in their importance (Gerbert et al.) This research supported the findings of Hamberger, Ambuel, Marbella, and Donze (1998).

Hamberger et al. (1998) surveyed 115 battered women recruited from on going support groups and programs run by a battered women's shelter. All participated were from a 5 county areas in southeastern Wisconsin (Hamberger et al). The women surveyed indicated several behaviors they would like from physicians, among them were: to provide sensitive and careful exam of injuries where procedures are explained; taking social history; being careful listeners and responding with compassion; providing information and phone numbers for resources; displaying posters and literature on domestic violence in the office; requiring the abuser to leave the room during the exam; offering to use a telephone to call a shelter and encouraging them to develop a safety plan (Hamberger et al). When asked how often the women received these, the results were relatively poor: only 56% reported having careful exams where procedures were explained; only 24% reported having social histories taken; 53% received reassurance from their physicians, 33% had their injuries minimized, and 24% implied the women were to blame for the abuse; 10% felt their physicians acted angrily towards them and 3% reported their physicians joked about domestic violence during the exam (Hamberger et al). A little more then half of the women received practical support

including providing information about resources, and less then 5% had physicians who assisted with safety planning (Hamberger et al).

Friedman, Samet, Roberts, Hudlin, and Hans (1992) also surveyed victims of domestic violence to assess their feelings about physicians' interventions. They surveyed 164 patients and 27 physicians in private and public primary care sites in New England. Friedman et al. found the patients favored routine inquires by physicians for physical abuse by 78% and sexual abuse by 68% yet only 7% were ever asked about physical abuse and 6% about sexual abuse (Friedman et al.). When asked it they believe physicians could help with problems from physical abuse 90% felt they could and 89% felt they could help with sexual abuse (Friedman et al.). Thirty-three percent of physicians who were asked felt the questions about physical and sexual abuse should routinely be asked yet when asked if they believe they could help with problems associated from abuse 81% believe they could help with problems from physical abuse and 74% felt they could for sexual abuse (Friedman et al.).

Evidence points to the importance of physician intervention in screening for domestic violence (Trabold, 2007). A higher disclosure rate resulted from routine screening of patient (Trabold). As seen from the research, women favored routine screening and desired compassion and validation from their physicians (Chang et al., 2005; Gerbert, 1999; Gerbert, Abercrombie, Caspers, Love, & Bronstone, 1999; Hamberger, Ambuel, Marbella, & Donze, 1998; Trabold). Many women indicated screening by their physician helped them to recognize the abuse and the isolation they experienced (Gerbert, Abercrombie, Caspers, Love, & Bronstone, 1999; Hamberger, Ambuel, Marbella, & Donze, 1998; Trabold).

Coordinated Community Response Methods

Berghron and Siracusa (1982) stated domestic violence is multidimensional requiring a comprehensive treatment which incorporated many elements and community resources. Domestic violence attacks the core of the social structure, the family unit (Berghron & Siracusa). Due to the multiple factors leading to domestic violence the more comprehensive treatment the less likely something maybe missed and falls through the cracks (Berghron & Siracuse).

In 1995, the US Congress allocated funding to help nonprofit organizations create collaborative projects to coordinate domestic violence intervention and prevention efforts (Klevens, Baker, Shelley, & Ingram, 2008). In 1999 and 2000 additional funding was provided (Klevens et al.).

Many Coordinated Community Response (CCR) programs are based on work completed by the Duluth, Minnesota Model Abuse Intervention Project initiated in 1980 (Holtfreter & Boyd, 2006). CCR programs often were able to provide assistance to victims at many stages from initial contact to the criminal justice system. The goals of CCR programs was to make sure victims can easily access services from multiple agencies thereby receiving better treatment then they would if they accessed the agencies on their own (Holtfreter & Boyd). Potential benefits of this model were: more effective enforcement; improved victim safety; connection to service needed to leave the abuser and improved investigation and prosecution of the abuser (Holtfreter & Boyd).

Hamilton and Pehrson (1996) stated the current system creates large gaps in the coordination of services which places abused women at greater risks. These gaps

include gaps in actual service provisions, the knowledge helping professionals have of available services, failure to identify victims of abuse, attitudes towards victims and the many different service providers who need to be accessed for assistance (Hamilton & Pehrson). To over come these a model was purposed which organized spouse abuse services within communities (Hamilton & Pehrson). These teams serve to coordinate the community resources providing case consultation, resource identification and development, education and prevention activities as well as treatment (Hamilton & Pehrson). The rational was in order to be effective teams must recognize the following: women prefer to return home if the abuse is eliminated (Hamilton & Pehrson; Rounsaville, 1978); most women who use a shelter return to their abusers (Caputo, 1988); clinical interventions alone will not reduce incidents of abuse; community prevention and education must be linked to clinical interventions and multidisciplinary/multi-service must be focused, comprehensive and coordinated to break the cycle of violence (Hamilton & Pehrson). Hamilton and Pehrson felt in order to be effective teams must be composed of police, judicial services, social services, as well as include an educational and prevention component. Each team would have a different task: direct service and consultation unit would focus on assessment, treatment, consultation and referral services; prevention and education unit would develop community wide prevention and education programs; law enforcement officers would be primary points of contract for victims and would provide referrals; and local hospitals would also provide referrals (Hamilton & Pehrson). While not implement, this model provides a comprehensive and coordinated response to domestic violence (Hamilton & Pehrson).

In 2000, the Massachusetts Department of Public Health created a Collaborative for Abuse Prevention in Racial and Ethnic Communities (CARE) project for two Latino communities in Massachusetts (Whitaker et al., 2007). One in the city of Chelsea and the other in Berkshire County (Whitaker et al.). The goal of the CARE project was to develop collaborations between existing service providers. Their model assumed that greater collaboration between existing service organizations would increase culturally competent services to minority populations experiencing domestic violence (Whitaker et al.). Whitaker et al. noted existing collaborative approaches were very broad and did not place specific emphasis on ethnic and racial minorities, which may have resulted in a reduction in their willingness to utilize services. CARE's goals were to increase collaboration between existing services specifically for racial and ethnic minorities in the hope that it would encourage individuals to seek assistance (Whitaker et al.). Similar to Hamilton and Perhson's (1996) model, CARE incorporated an education and outreach component, and a network building component. CARE found one of the limitations to their success was the staff turnover, which resulted in inconsistence of meeting attendance and a reduction in the ability to build interagency relationships (Whitaker et al.). Funding cuts were also a limitation to the program as was the location of several services which were not in the city limits (Whitaker et al.). CARE also realized the importance of considering cultural issues when developing educational programs and outreach to the community (Whitaker et al.). CARE was able to increase awareness of service to individuals as well as community organizations through meeting with other state organizations (i.e. Department of Social Services and Child Protection Agencies); creating resource books in Spanish which were distributed to social service agencies,

schools, clinics, hospitals, and adult learning programs; maps showing location of service agencies; hosting an annual conference to educate social workers, counselors, teachers, attorneys and others to become culturally competent when offering services to the Latino community (Whitaker et al.). CARE also hosted a morning radio show and cable access television program which provided information about domestic violence (Whitaker et al.). CARE helped sponsor activities not focused on domestic violence including an Immigrant Day were people could speak with attorney for free as well as learn about the steps to take for citizenship and services available to them (Whitaker et al.). CARE also worked to educate the Domestic Violence Unit of the police department (Whitaker et al.). While CARE experienced some success, lack of funding may make this model unsustainable long term (Whitaker et al.). Whitaker et al. stated more rigorous studies need to be done to measure the success of this program.

Maciak, Guzman, Santiago, Villalobos, and Israel (1999) described a similar program call LA VIDA started in 1995 and located in Southwestern Detroit. LA VIDA also attempted to develop culturally competent preventive and support services for the Latino community (Maciak et al.). Maciak et al. reviewed two years worth of minutes from monthly meetings, field notes, held structured group discussions and feedback sessions with partners, and interviewed 15 individuals from LA VIDA partners. LA VIDA's objectives were to: increase coordination and collaboration among community partners; identify prevention resources and barriers to services; increase the domestic violence knowledge of the community members, service providers, policy makers and researchers/professionals; increase the number of Latina women referred to prevention and intervention services; increase support services to Latina women experiencing

abuse; increase preventions and intervention services of Latino men at risk for battering; increase knowledge about healthy relationships to adolescent girls and boys as well as increase support to Latino children who witnessed domestic violence (Maciak et al.). LA VIDA experienced a number of challenges including: lack of trust and respect from the Latino community to “outsiders”; lack of ownership within the Latino community that domestic violence was a problem; creating a balance between research and action; lack of funding and lack of knowledge about culturally differences regarding domestic violence (Maciak et al.). Even with these limitations LA VIDA was able to collaborate with partners who had diverse skills, knowledge, and expertise to address a complex, multifaceted issue (Maciak et al.). They were able to overcome the distrust of researchers by a community who had historically been “subjects” of research (Maciak et al.). LA VIDA was able to overcome the cultural gaps and developed a cultural sensitivity (Maciak et al.). The lessons learned at LA VIDA have helped others to understand and address domestic violence in ethnic minority communities (Maciak et al.).

A Canadian Study focused on a variety of ethnic populations found similar results (Kamateros, 2004). In 1997, the Ethnic Media Outreach Project (EMOP) was launched with a goal to raise awareness in communities where language and culture create barriers to accessing information about family violence and available services (Kamateros). Four community agencies launched the EMOP in three areas of Canada (Kamateros). The campaign had two themes: address domestic violence and make it visible as well as returning the responsibility for it to the communities (Kamateros). EMOP worked to obtain community support by recruiting professionals, politicians and

community leaders as well as securing assistance from other agencies when possible (Kamateros). Twenty-five television programs in 15 different languages were created in a 2 year period to generate awareness about domestic violence, as well as explain police and judicial procedures (Kamateros). Kamateros stated the programs could not be evaluated in a quantitatively manner but qualitative results indicate there was an increase in domestic violence awareness within the ethnic populations. Kamateros indicated there may also be latent effects as people might not call right away. Due to the programs the broadcast companies have become the connection between victims and existing resources (Kamateros). The EMOP demonstrated community outreach can increase public awareness and connect people to needed services (Kamateros).

In 2006 Sullivan (2006) researched the effectiveness of advocates with victims of domestic violence. Her study of women who worked with advocates after leaving a domestic violence shelter showed that over time women who had worked with advocates reported less violence, a higher quality of life, increased social supports and have greater ease of connecting with community resources (Sullivan). Sullivan stated 1 out of 4 women experienced no physicals abuse during a 24 month follow up period after advocate services were completed. This is compared to a control group which did not receive advocates where only 1 out of 10 women were free of violence during the same 24 month period (Sullivan).

Holtfreter and Boyd (2006) studied a new coordinated community response located on a large state university in a medium-size Midwestern city. The CCR included representatives whose primary function was academics (Holtfreter & Boyd). Holtfreter & Boyd interviewed 15 service providers. Results indicated the participants interviewed

believed the gap between their current CCR and their ideal was within reach if deficiencies in training and resources were corrected (Holtfreter & Boyd). Participants felt although the CCR was new it was evident that all involved were dedicated to the program and the response to domestic violence although not ideal was strong and improving (Holtfreter & Boyd). Holtfreter & Boyd stated more time was needed to judge the influence this CCR would have on domestic violence.

Rationale for Research

Several studies explored the types of resources and services women needed (Chang et al., 2005; Du Mont, Forte, Cohen, Hyman, & Romans, 2005; Epstein, 2006). Chang et al. (2005) recruited twenty-one women from local domestic violence shelters to participate in their study. Their study revealed most women definitely wanted posters/flyers with hotline numbers in waiting room and women's rest rooms (Chang et al., 2005). Fourteen of the 21 women wanted brochures or cards with information handed out during medical visits (Chang et al.). When asked what specific information they wanted 17 indicated legal information regarding their children, and 15 wanted information about how to receive legal help with filing for protection from the abuser or filing for divorce (Chang et al.). When asked about counseling needs 17 of the 21 participants were interested in safety strategies and 15 wanted counseling for mental health and relationship issues (Chang et al.). The women indicated in addition to counseling they wanted "help getting a job, childcare, housing, food or other needs", "getting help with drug of alcohol abuse" and "medical treatment for depression/anxiety" (Chang et al., p 25).

Du Mont's et al. (2005) work compared two large Canadian population-base telephone surveys; the Violence Against Women Survey completed in 1993 and the General Social Survey completed in 1990. The results indicated while women many want to access the services there are many barriers preventing them (Du Mont et al.). Among the barriers found were: not feeling they needed or wanted help; lack of awareness of resources; perception that the incidents were too minor; feeling too much time had passed since the incident; fear of safety; concerns about losing their children; fear of retaliation; reluctance to call police; too expensive; long waiting times; lack of trust in physicians; lack of privacy; and feelings of shame and embarrassment (Du Mont et al.).

Epstein (2006) conducted interviews with seven Latina women who attend a support group for victims of domestic violence run by a community mental health agency in Northern California. She found Latina women were least likely to seek help from a social services agency when compared to other ethnic groups (Epstein). The goal of the research was to determine how women did seek services, the time which pass from when they first learned about the services and when they used them, factors which help facilitate this, factors which impeded it, and what suggests they had for the agencies to better reach victims of domestic violence. (Epstein). Epstein's results indicated the seven women came to the services in one of three ways: their children presented with problems at school and were referred to the medical doctor who referred the child to therapy, the therapist then referred the mother to a domestic violence group based on the work with the child; the child was removed by Child Protective Services (CPS) for failure to protect and the court mandated the domestic violence group; or the

women presented with a co-morbid mental health issues and was identified during intake then referred to the domestic violence group. The women all indicated experiencing barriers to treatment including denying the abuse, not realizing what they were experiencing was abuse, fear of the abuser, helplessness, low self-esteem, embarrassment, fear of recognition by others in the community, legal and finance concerns, custody concerns, cultural issues (i.e. keeping family secret within the family), and lack of outreach by those who knew about the abuse (Epstein). All of the women indicated limited or no knowledge about services as a result of their isolation and limited socializing with others (Epstein).

Expanding on the existing body of research this researcher conducted a survey of women at a battered women's shelter in the Northeastern United States to explore how they learned about the services, the length of time between learning about the services and accessing them, and suggestions the women had for other areas of outreach.

Method

Setting

Services available for victims of domestic violence are relatively new and have limited funding. The purpose of this exploratory research was to assess the most effective methods to educate women who are in abusive relationships about services.

The question becomes: what is the best way to educate victims about services? Women who attend community support groups at a battered women's shelter in the Northeastern United States were asked to complete a demographic sheet, and a survey.

Materials

Permission to use this instrument was given to the researcher by Program Coordinator for Transitional Support Services. A consent form (Appendix A) and demographic sheet (Appendix B), were provided along with the instrument (Appendix C) to all women who attend support groups by the principle investigator. No research assistant was needed for this study. All costs were incurred by the principal investigator. There were no fees, extra credit or other items received for participation in this study. The principal investigator attended support groups to explain the purpose of the study, how women can participate if they wish, the steps taken to ensure their confidentiality and what the survey will be measuring.

Procedures

The survey measured the means by which women who attend the meetings learned about the shelter and their thoughts on effective ways to educate other women about services.

To protect the anonymity of the women, all women were provided the information and asked to take it home to complete. Instructions to return these forms to the principle investigator's office were also included along with a stamped, self addressed envelope for return of the completed survey via mail. For women who do not feel safe taking the survey home, an option to complete the survey on site was provided. Surveys and consent forms were placed on site along with a sealed drop box. At their convenience women could complete the forms and place them in the drop box. The instrument, consent form and demographic sheet contained no identifying information; therefore all surveys were anonymous. There was a number placed in the top right side of each

page for data collection purposes and to make sure the forms did not get separated. Once data were collected and analyzed, all instruments, consent forms and demographics were stored in a secure filing cabinet until the completion and acceptance of this project. After that time all information was shredded**.** The safety and well being of the women was the most important concern. If at any time while completing the study or after they felt the need to talk with someone the number to the shelter's hotline was provided. The hotline operates 24 hours a day 7 days a week.

Participants

Thirty women were provided an envelop with the demographics sheet, survey, consent form and a stamped envelop to return the completed surveys in. All women were over the age of 18. Of the thirty women only 13 women completed and returned the survey. The survey attempted to measure how they learned about the services provided, what information they were given, how long it was between learning about the shelter and seeking assistance, who they would have been open to hearing about the shelter from and if they had suggestions on other means to educate women about the services.

Results

The study consisted of twenty two questions including demographics. Each of these will be presented along with the findings.

Item 1 –What is your ethnic identification?

This survey question asked women to identify their ethnicity. Ten of the women indicated they were Caucasian. One woman indicated African American and two

women indicated none of the categories listed were appropriate, these women indicated being of mixed race.

Ethnic Identification	Frequency	Percentage
Caucasian	10	76.90%
Hispanic/Latino	0	0.00%
Asian/Pacific Islander	0	0.00%
African American	1	7.70%
Native American/ Aleutian	0	0.00%
Other	2	15.40%

Table 1 – Ethnic Identification

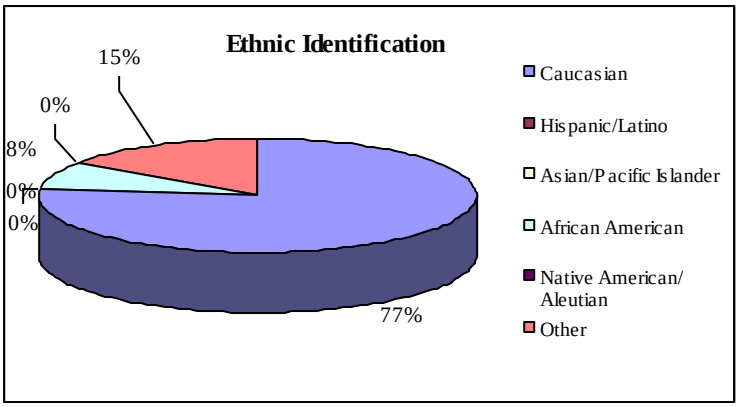

Figure 1 – Ethnic Identification

Item 2 – How old are you?

This survey question asked women to identify the age range they fell within. The age ranges were pretty evenly distributed between the age ranges with the exception of the 40-49 age range. Two women indicated they were between the age of 18-29; 2 women indicated they were between the age of 30-39; 5 women indicated they were between

the age of 40-49; 2 women indicated they were between the age of 50-59; and 2 women indicated they were between the age of 60-69. No one indicated being 70 or older.

Age	Frequency	Percentage
18-29	2	15.40%
30-39	2	15.40%
40-49	5	38.50%
50-59	2	15.40%
60-69	2	15.40%
70 or older	0	0.00%

Table 2 –Age

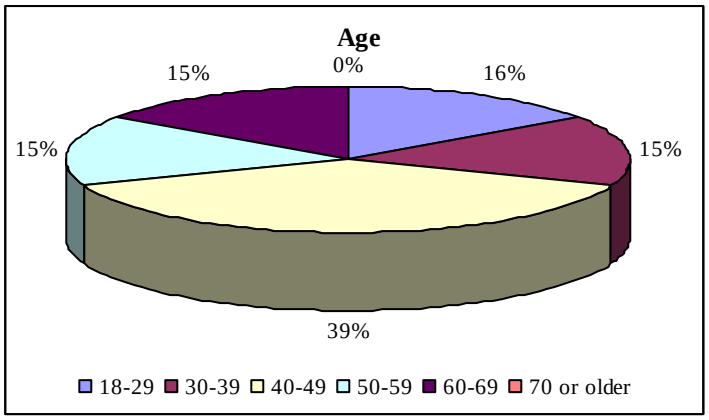

Figure 2 –Age

Item 3 – Do you have children?

This question measured the number of women who had children. Ninety-two point three percent (12) indicated they did have children.

Children	Frequency	Percentage
Yes	12	92.30%
No	1	7.70%

Table 3 – Do you have children?

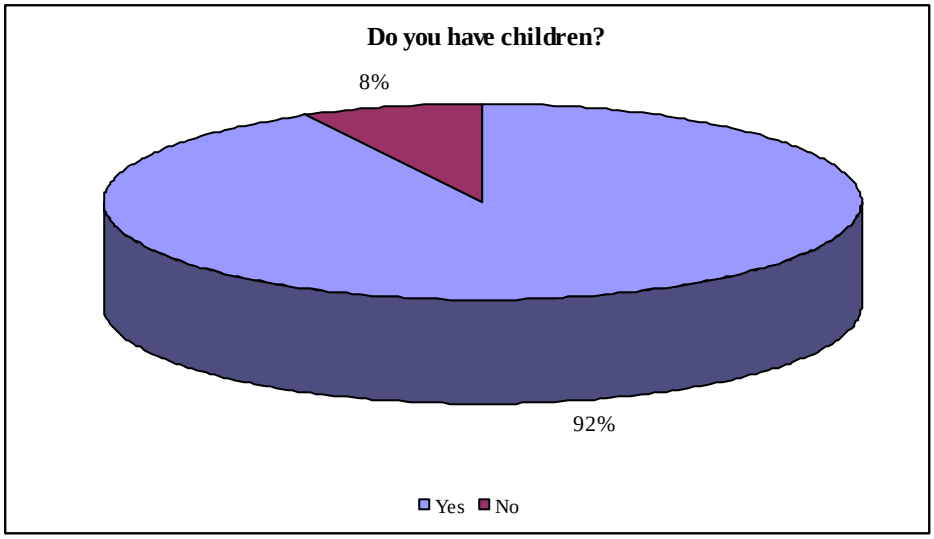

Figure 3 – Do you have children?

Item 4 – Do your children live with you?

This question determined the number of women whose children were living with them. It was pretty evenly spilt between the number of women who had their children and those who did not have their children. Slightly more women had their children not living with them then who did. Fifty-three point eight percent (7) of the women indicated their children were not living with them only 46.2% had their children with them.

Children living with you	Frequency	Percentage
Yes	6	46.20%
No	7	53.80%

Table 4 – Do your children live with you?

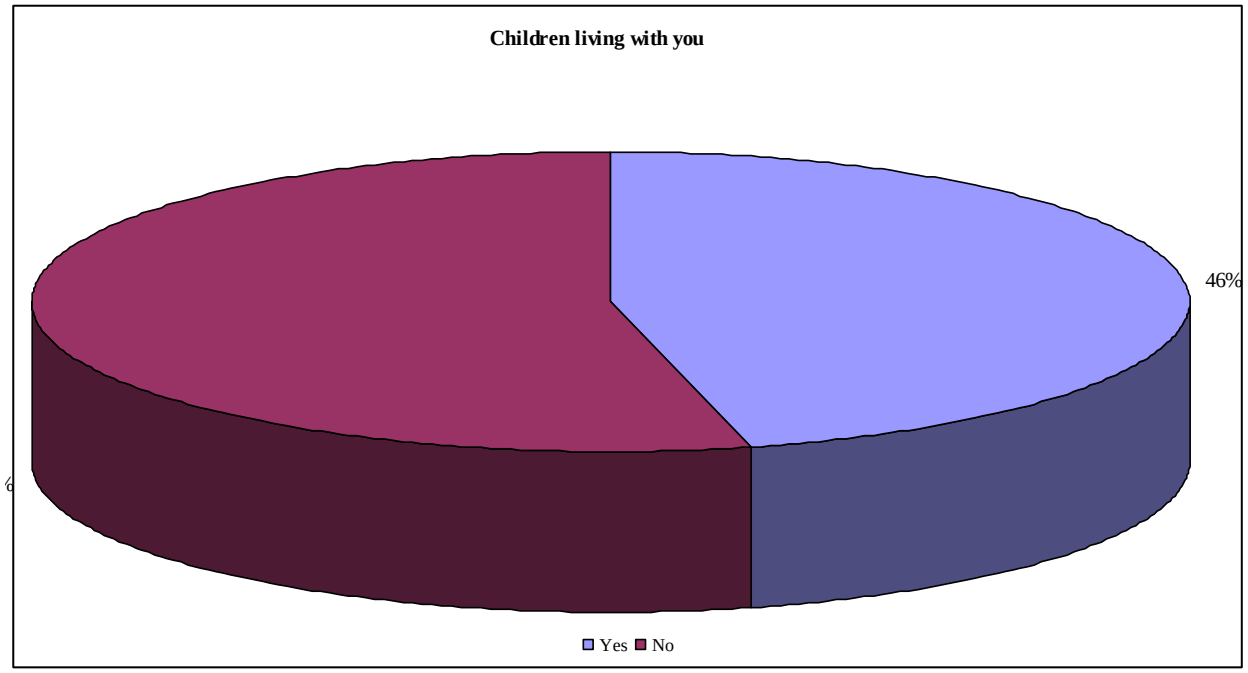

Figure 4 – Do your children live with you?

Item 5 – How long have you been in the most recent abusive relationship?

This question determined the length of the women's most recent abusive relationship. Most of the women, 38.50%, indicated their relationship had been between one and five years in length. The next two most frequent lengths of time with 23.10% each were six to ten years and eleven to fifteen years. No one indicated being in a relationship longer then 20 years.

Length of most recent abusive relationship	Frequency	Percentage
Less then 1 year	1	7.70%
1-5 years	5	38.50%
6-10 years	3	23.10%
11-15 years	3	23.10%
16-20 years	1	7.70%
21-25 years	0	0.00%
26-30 years	0	0.00%
more than 30 years	0	0.00%

Table 5 – How long have you been in the most recent abusive relationship?

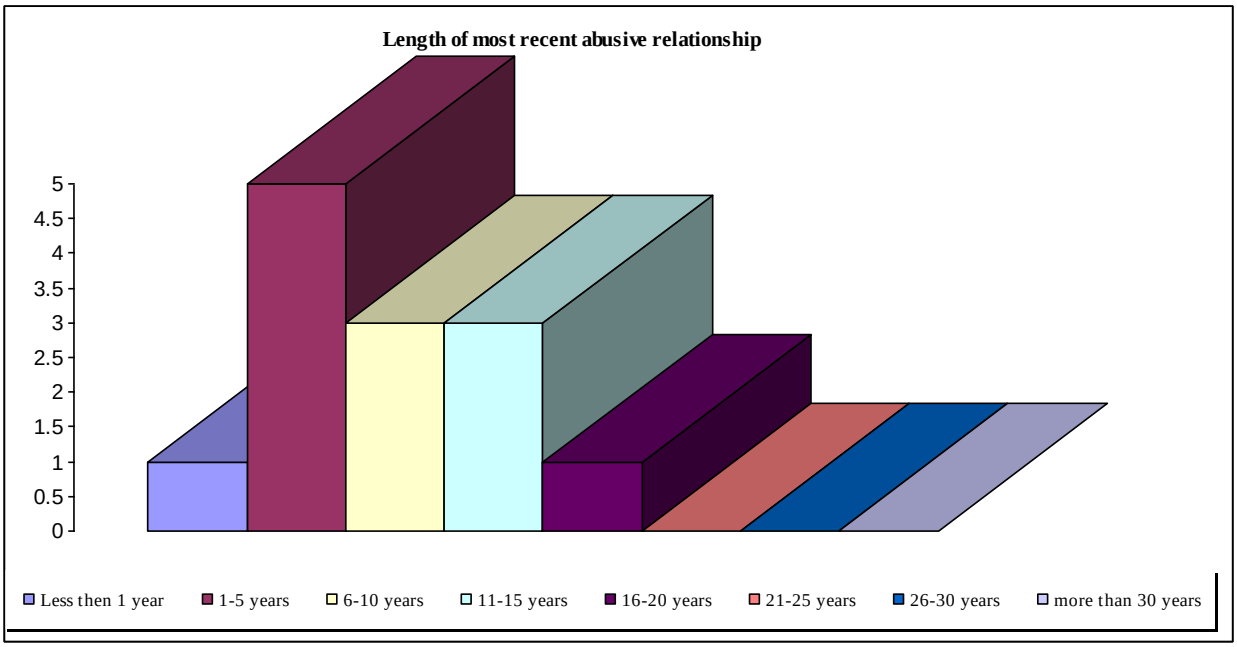

Figure 5A – How long have you been in the most recent abusive relationship?

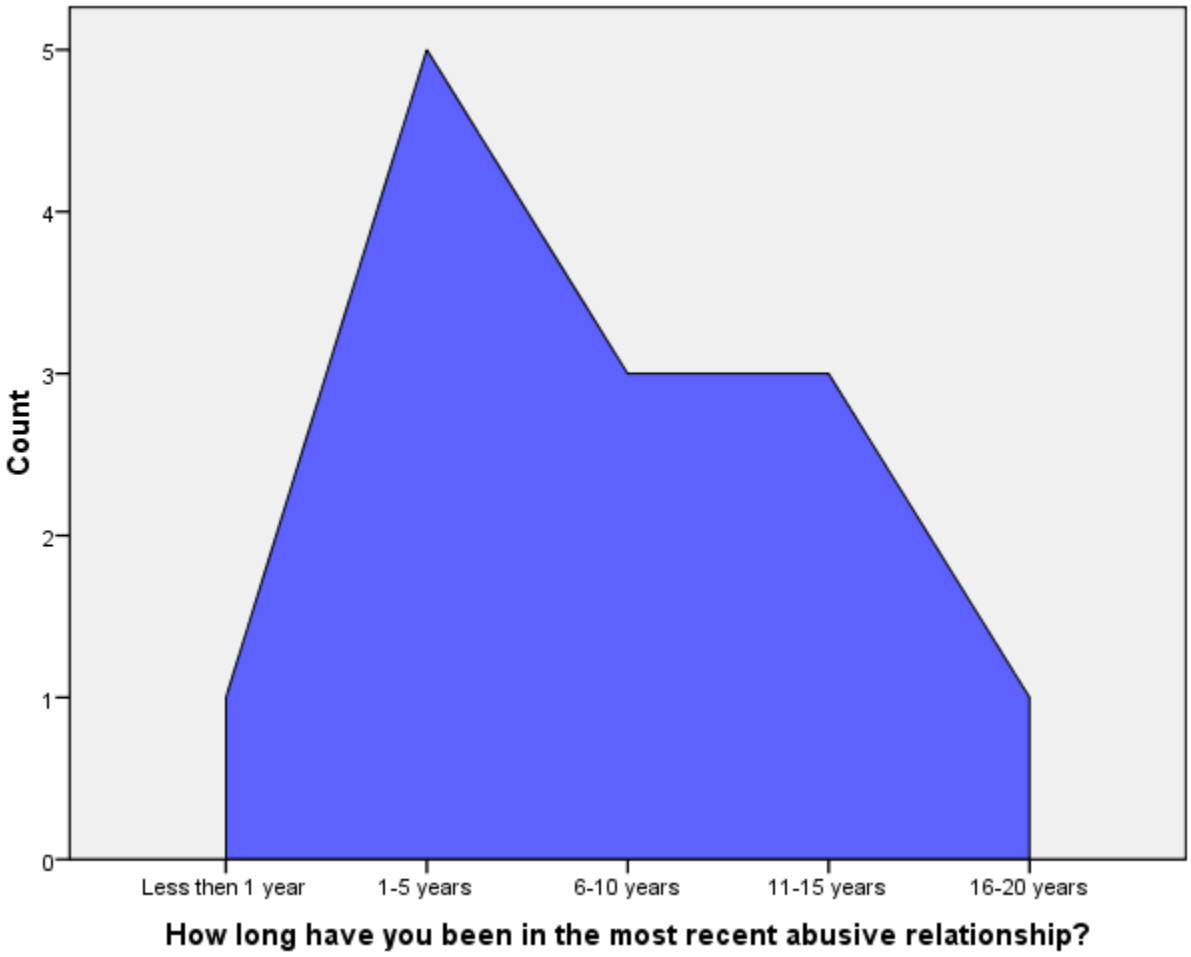

Figure 5B – How long have you been in the most recent abusive relationship?

Item 6 – Were you abused in a relationship before this one?

Item 6 measured the number of women for whom the current relationship was their first abusive relationship and the number who had been in abusive relationships prior to the current one. Sixty-nine point two percent of the women (9) indicated this was their first abusive relationship. Thirty point eight percent (4) indicated they had been in previous abusive relationship.

Prior abusive relationship	Frequency	Percentage
Yes	9	69.20%
No	4	30.80%

Table 6 – Were you abused in a relationship before this one?

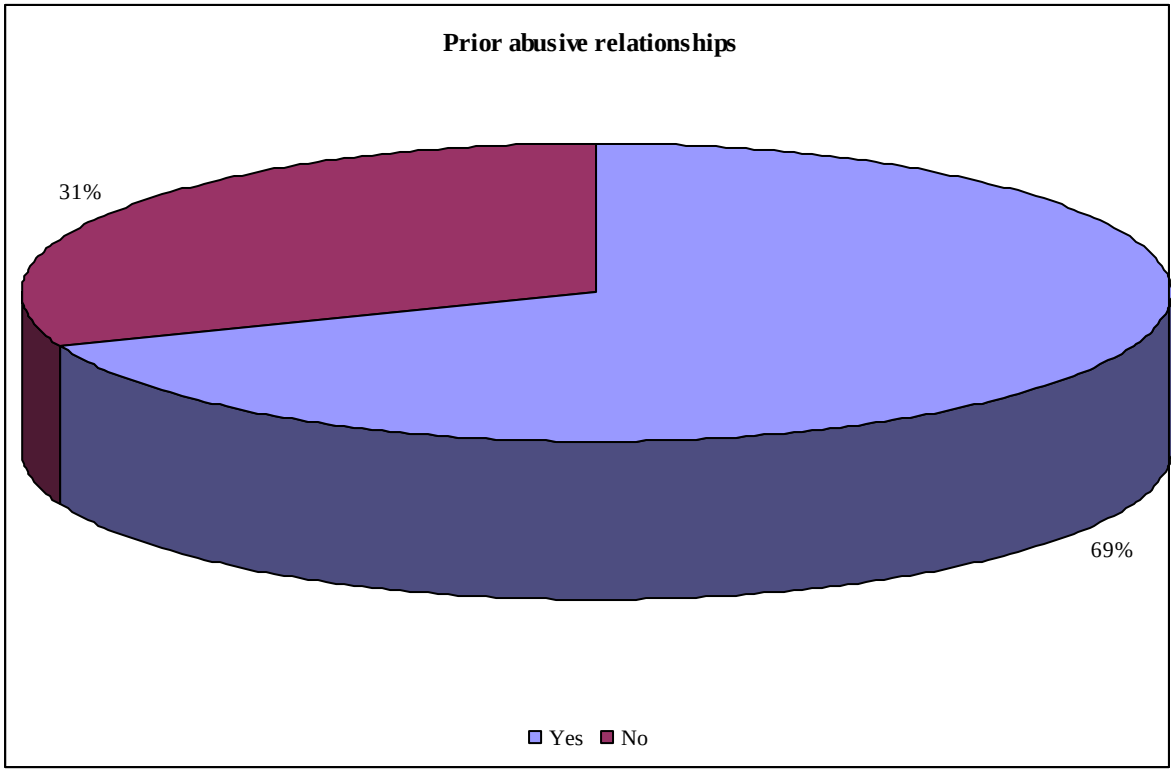

Figure 6 – Were you abused in a relationship before this one?

Item 7 – Have you been involved with other domestic violence programs/shelters before ABW?

This survey question measured the number of women who have sought assistance from other domestic violence programs or shelters before coming to Alternatives for Battered Women (ABW). The majority of the women 84.60% indicated they had not sought help prior to coming to ABW.

Involved with other Domestic Violence Programs/Shelters before ABW	Frequency	Percentage
Yes	2	15.40%
No	11	84.60%

Table 7 – Have you been involved with other domestic violence programs/shelters before ABW?

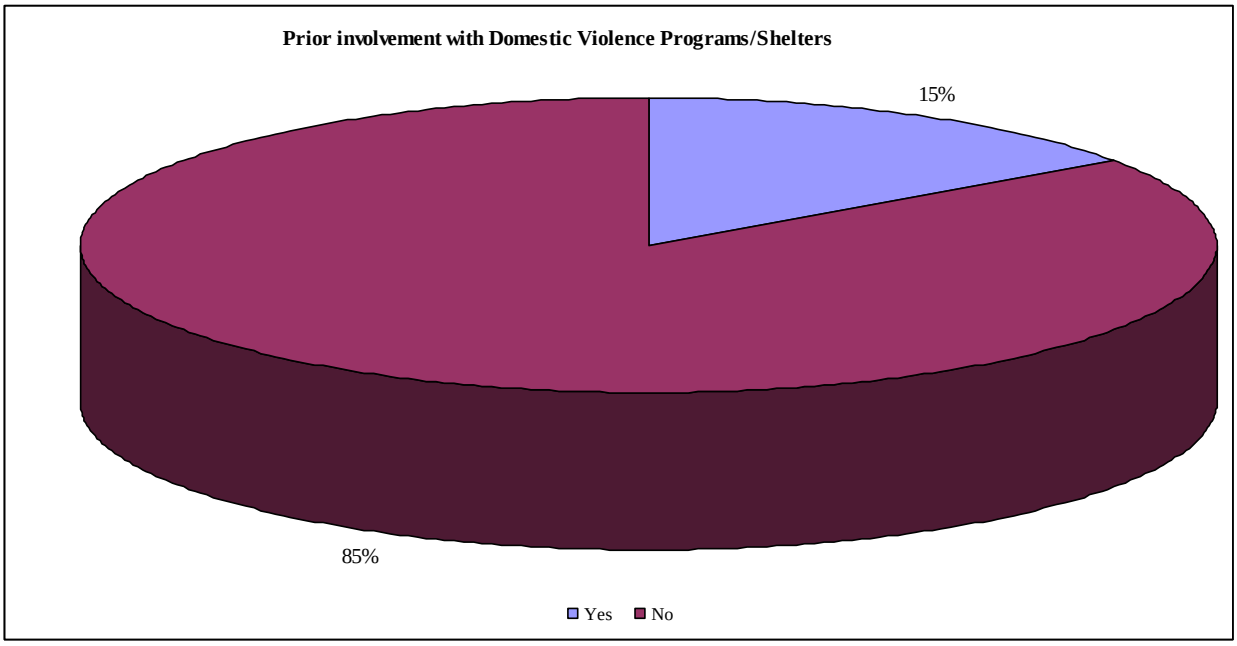

Figure 7 – Have you been involved with other domestic violence programs/shelters before ABW?

Item 8 – Who or where did you learn about ABW?

This questions measured the various ways women learned about ABW. Women were asked to indicate all ways they heard about ABW. Overall friends and doctors/medical personnel were the most frequent ways women learned about the services. Substance abuse treatment centers, law enforcement, and counselors/therapist were the next most frequent. This mirrors the findings of Bogal-Allbritten and Rogers-Daughaday (1990).

Fifteen point four percent (2) of the women indicated learning about the services through each of the following means; the hospital, 2-1-1/ LIFE LINE, ABW court advocacy program, lawyer/legal representation, and the Internet. Only seven point seven percent learned about the services through one of the following means; family, Child Protective Services, news story, phonebook, Survivors Advocating for Effective Reform (SAFER) program, social worker, or poster about ABW.

Learn about ABW from	Frequency	Percentage
Doctor/Medical Personnel	4	30.80%
Hospital	2	15.40%
Family	1	7.70%
2-1-1/ LIFE LINE	2	15.40%
ABW Court Advocacy Program	2	15.40%
Dating Violence Education Program	0	
Project Keepsafe	0	
Health Fair	0	
Safety First Program	0	
CPS	1	7.70%
News Story	1	7.70%
Phonebook	1	7.70%
Radio	0	
Survivors Advocating for Effective Reform (SAFER) Program	1	7.70%
Lawyer/Legal Representation	2	15.40%
Friends	6	46.20%
Substance Abuse Treatment Center	3	23.10%

United Way	0	
Law Enforcement	3	23.10%
Children's Program	0	
ABW Nail File	0	
Counselor/ Therapist	3	23.10%
Social Worker	1	7.70%
Poster about ABW	1	7.70%
Fundraiser	0	
Internet	2	15.40%
United Way Video	0	
Other	3	23.10%
Don't Remember	0	

Table 8 – Who or where did you learn about ABW?

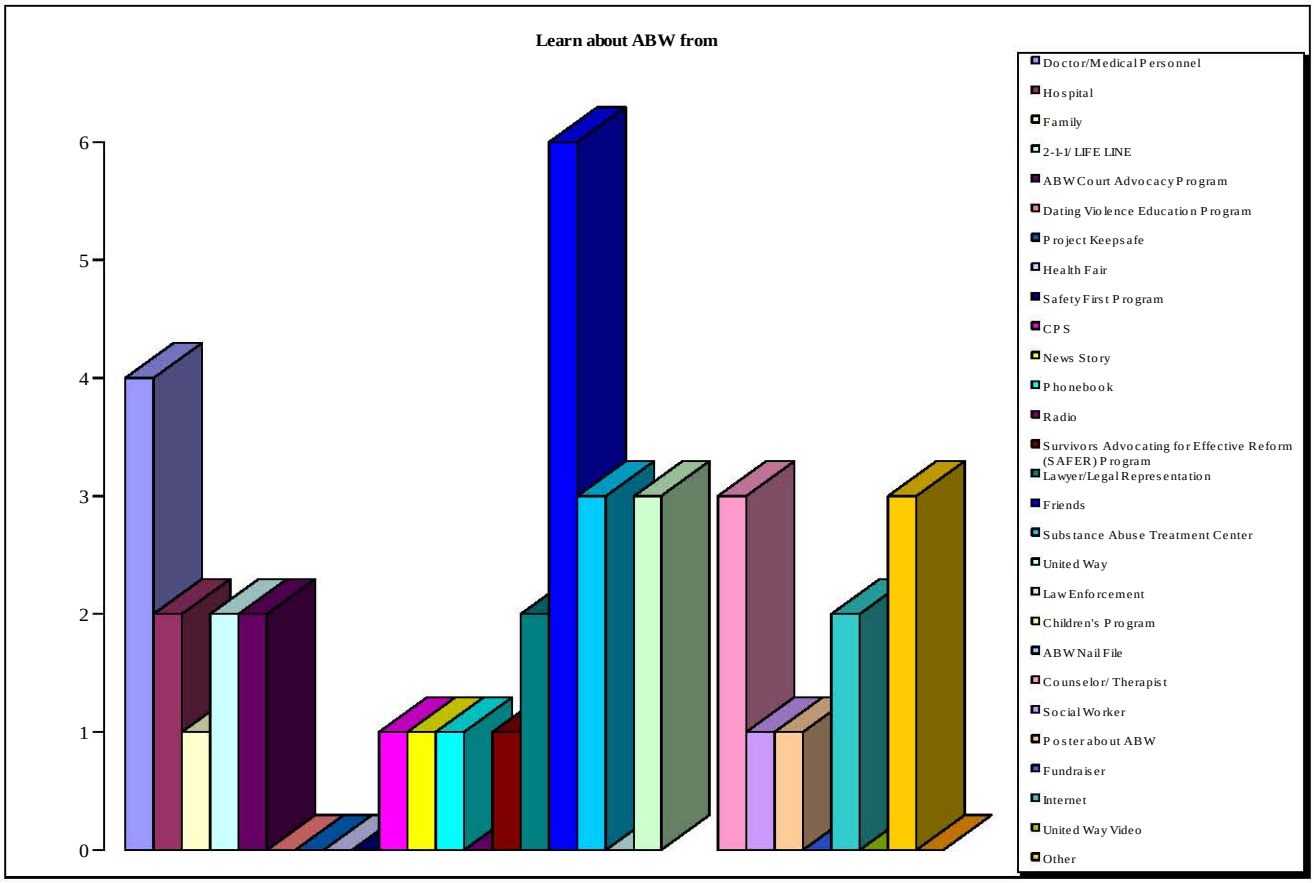

Figure 8– Who or where did you learn about ABW?

Item 9 – Did the referral source give you printed material about ABW?

This survey question measured how often printed materials are provided to the women from the referral source. Most of the women (69.2%) indicated they had not received written material about ABW when they were referred.

Referral source gave printed material about ABW	Frequency	Percentage
Yes	4	30.80%
No	9	69.20%

Table 9 – Did the referral source give you printed material about ABW?

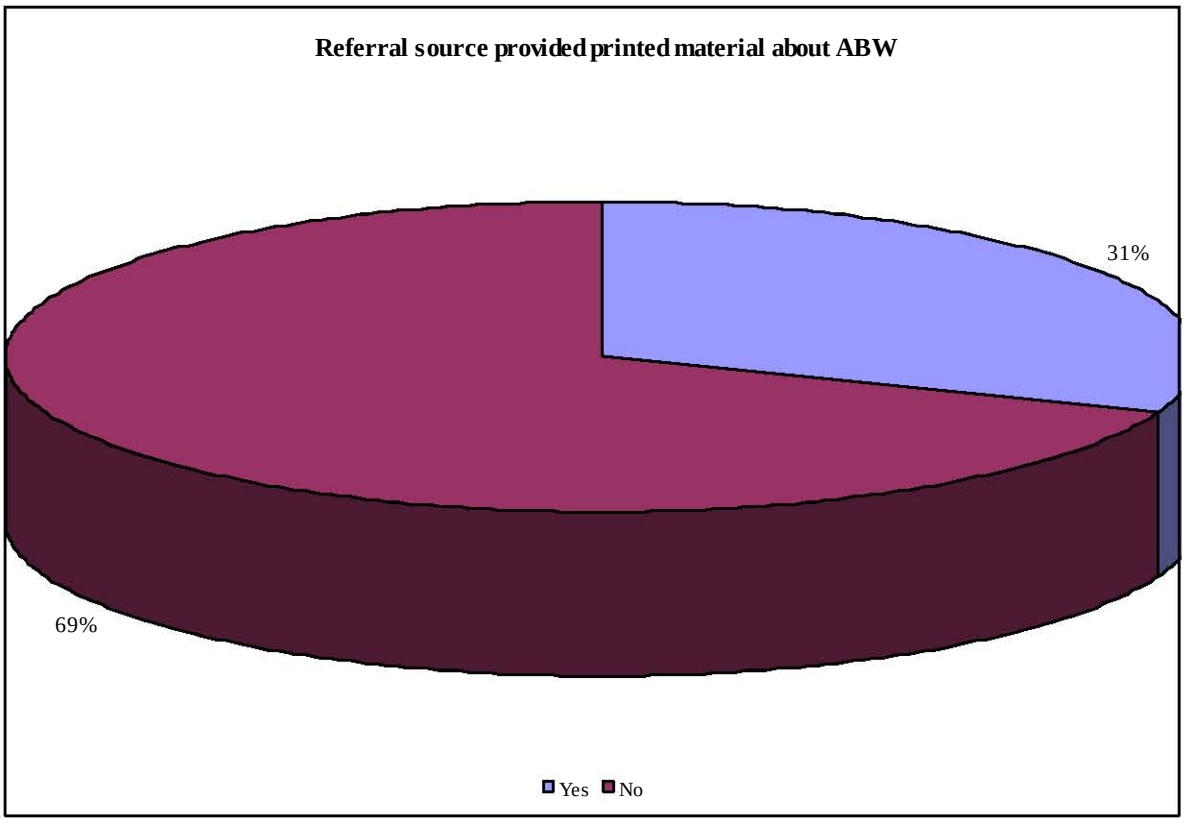

Figure 9– Did the referral source give you printed material about ABW?

Item 10 – If yes, what were you given?

This question measured what was provided to the women who received written materials. Only 4 women indicated they had received written information in question 9. The materials these women indicated getting were brochures (3), business care/palm card (1), ABW Court Advocacy Program brochure (2), and community support group announcement (2).

Referral source provided	Frequency	Percentage
Brochure	3	23.10%
Business Card/Palm Card	1	7.70%
ABW Court Advocacy Program Brochure	2	15.40%
Dating Violence Prevention Education	0	

Program Brochure		
Community Support Group		
Announcement	2	15.40%

Table 10 – If yes, what were you given?

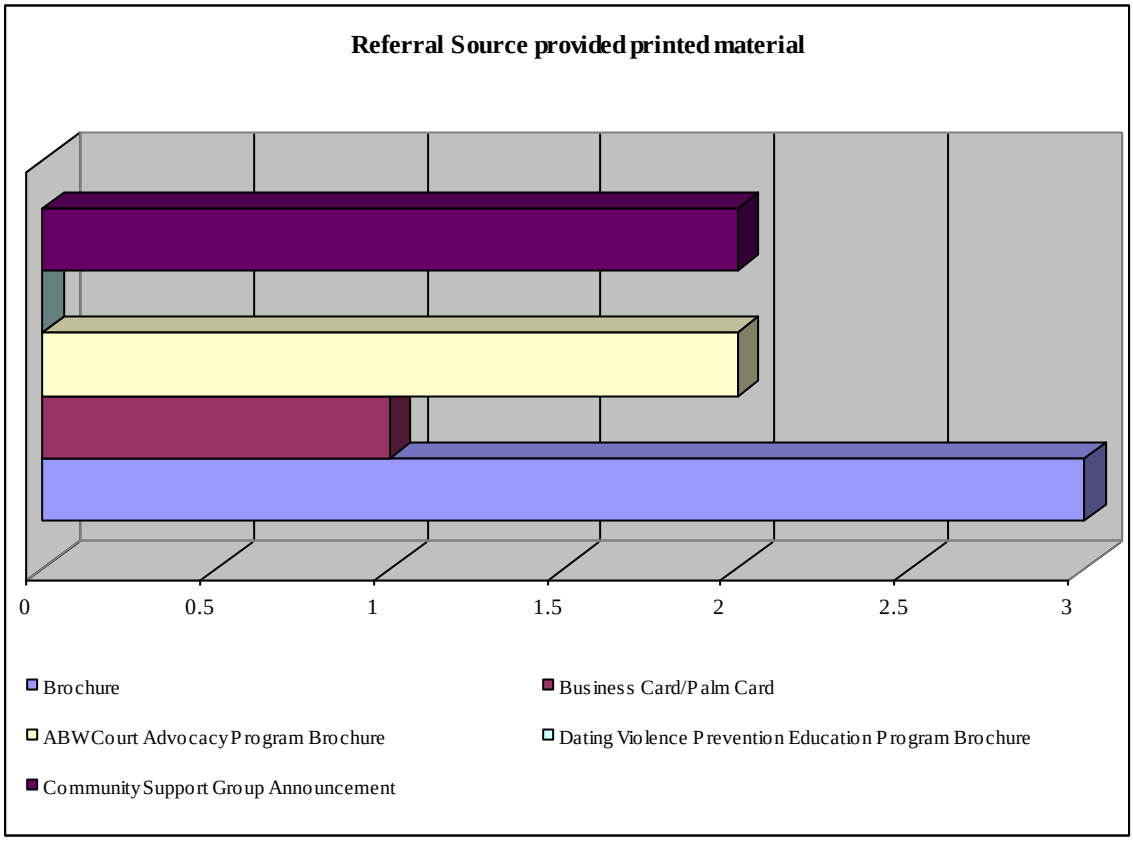

Figure 10 – If yes, what were you given?

Item 11 – Did the referral source give you information about ABW services?

Survey question 11 measured if information was provided about the services provided at ABW. Sixty one point five percent of the women indicated their referral source provided information about ABW's services.

Referral source provided information about ABW services	Frequency	Percentage
Yes	8	61.50%
No	5	38.50%

Table 11 – Did the referral source give you information about ABW services?

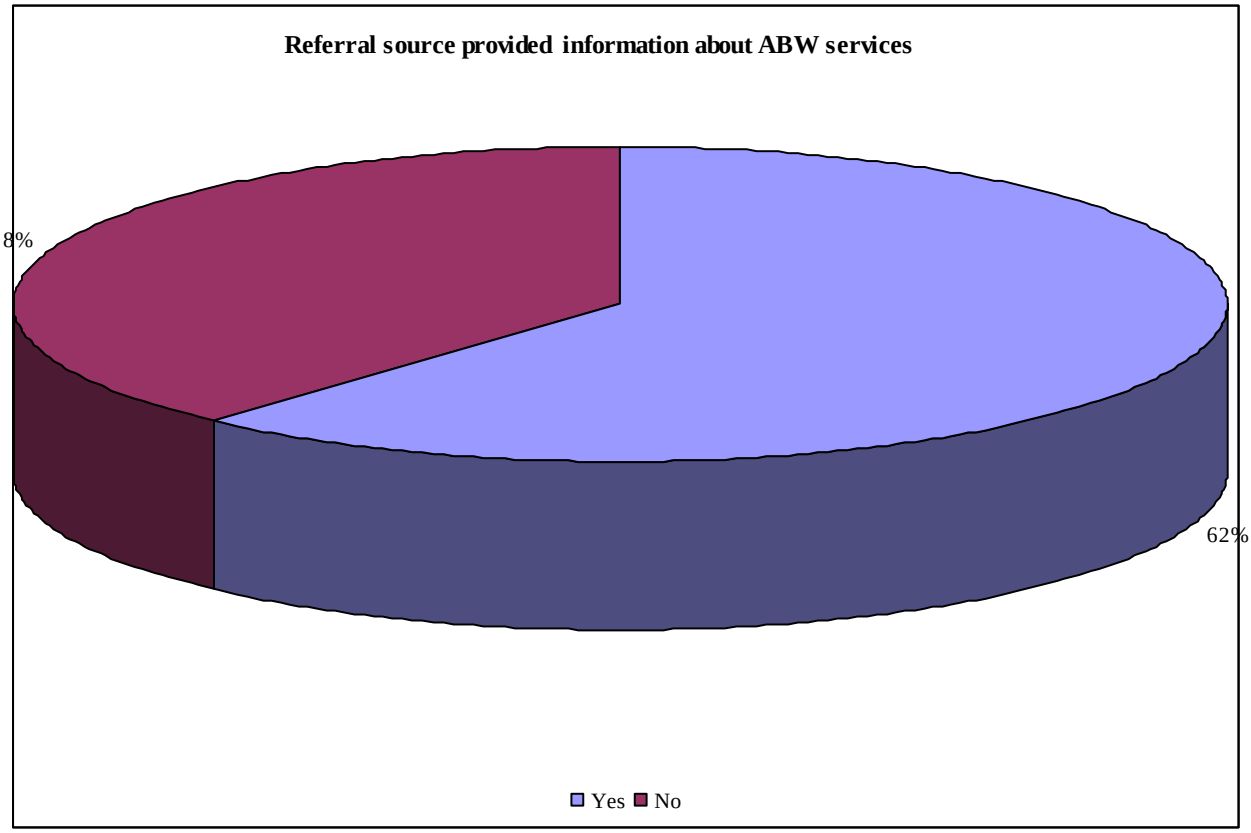

Figure 11– Did the referral source give you information about ABW services?

Item 12 – If yes, what were you given?

Survey question 12 captured what services women were informed about. Women were informed about the hotline most frequently (61.50%). Shelter information and support group information were then next most frequent information given, 38.5% and 30.80% respectively. Information was also provided on outreach information, working with law

enforcement and dating violence prevention although at a much lower frequency (7.70% each).

Information provided	Frequency	Percentage
Shelter Information	5	38.50%
Hotline Information	8	61.50%
Support Group Information	4	30.80%
Outreach Information	1	7.70%
Non-Residential Counseling Information	2	15.40%
ABW Court Advocacy Program Information	3	23.10%
Information about working with Law Enforcement	1	7.70%
Dating Violence Prevention Education Program Information	1	7.70%
Other	1	7.70%

Table 12 – If yes, what were you given?

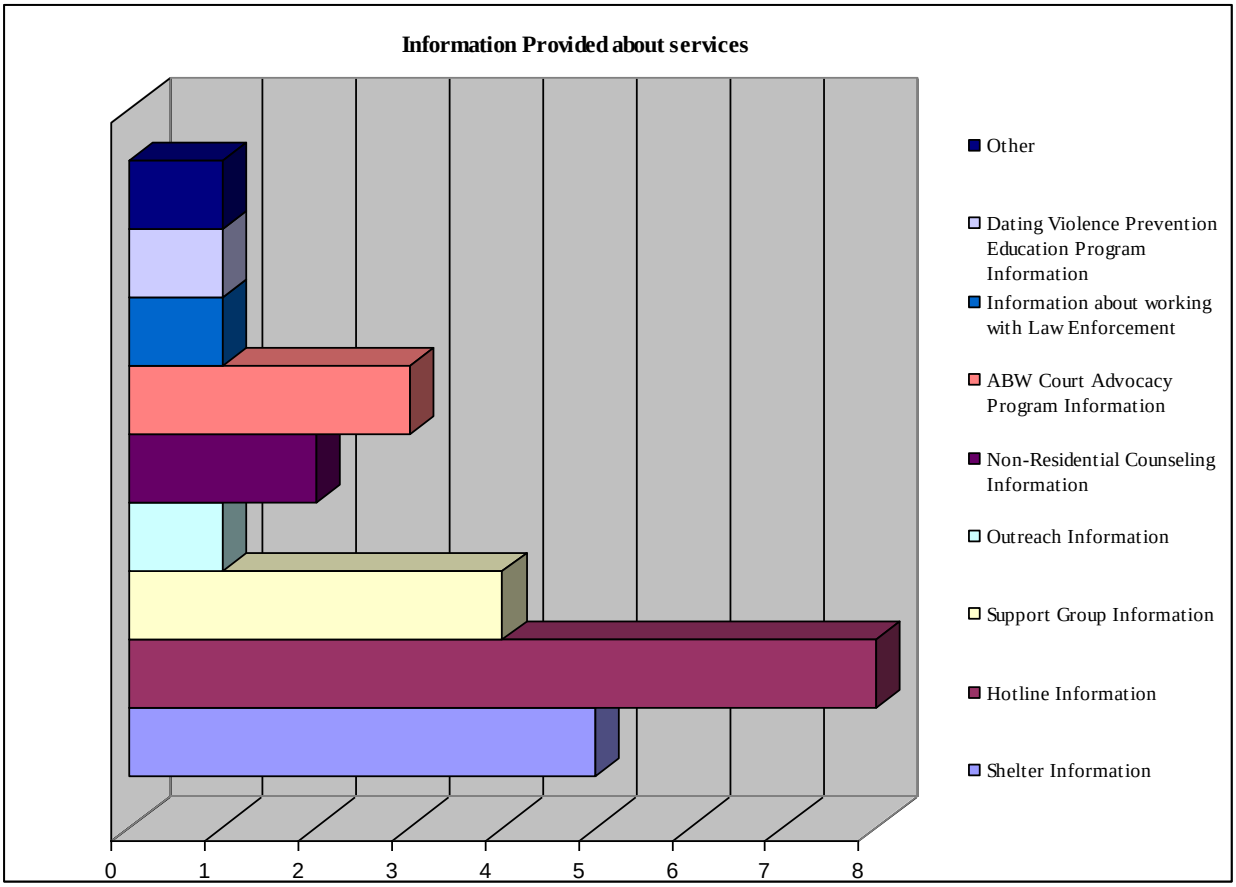

Figure 12 – If yes, what were you given?

Item 13 – Why did you choose ABW over other services in the area?

Item 13 measured why the women chose to come to ABW rather then another agency in the area. Most women indicated the counseling offered (76.90%), the hotline (69.20%) and support groups (61.50%) as the most common reasons they chose ABW over other services. Referral, community reputation and lack of awareness of other services were also influential in women choosing ABW with 53.80%, 46.20% and 46.20% respectively.

Chose ABW over other services

because	Frequency	Percentage
Counseling offered	10	76.90%
Hotline	9	69.20%
Outreach efforts	1	7.70%
Reputation in community	6	46.20%
Availability of support groups	8	61.50%
Referral/Recommendation from someone	7	53.80%
ABW was the only organization you were aware of	6	46.20%

Table 13 – Why did you choose ABW over other services in the area?

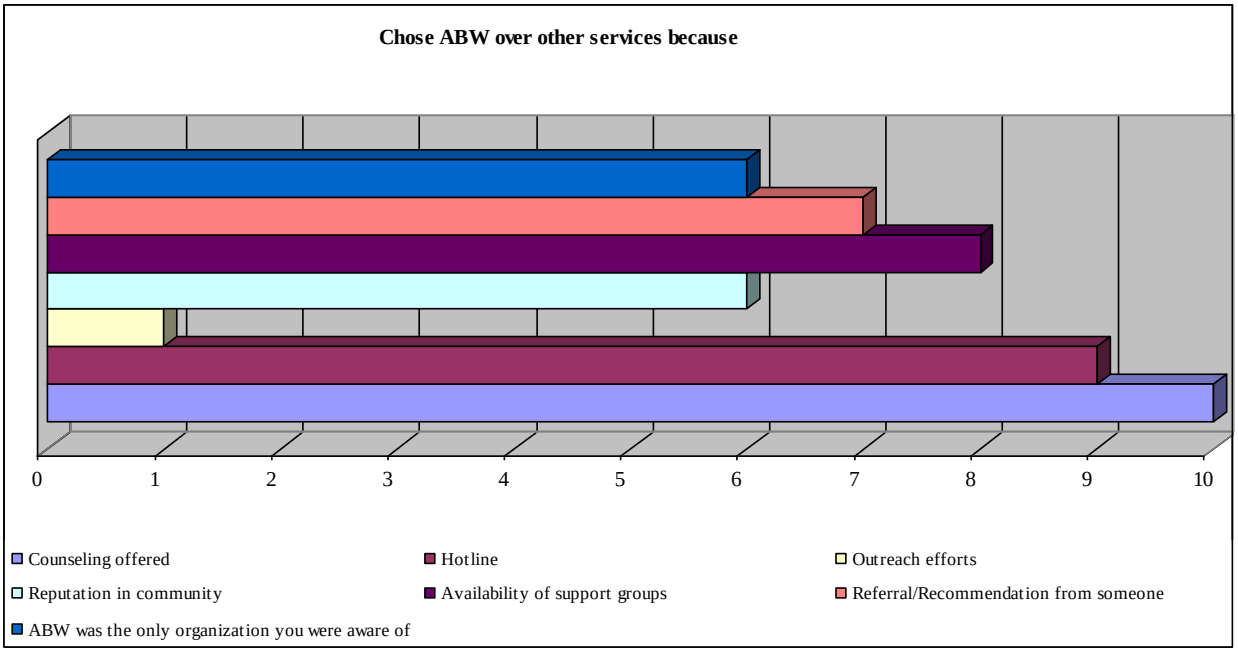

Figure 13 – Why did you choose ABW over other services in the area?

Item 14 – How long after learning about ABW was it before you sought services?

Item 14 sought to measure the length of time between when women learned about the services until they came to ABW for support. The majority of the women (53.80%) indicated it was less then 1 month from learning about the service to coming in for support. Fifteen point four percent indicated it was 1-3 months and another 15.4% indicated more then 2 years.

Length of time after learning about ABW before seeking support	Frequency	Percentage
Less then 1 month	7	53.80%
1-3 months	2	15.40%
3-6 months	1	7.70%
9-12 months	0	0.00%
1-2 years	1	7.70%
more then 2 years	2	15.40%

Table 14 – How long after learning about ABW was it before you sought services?

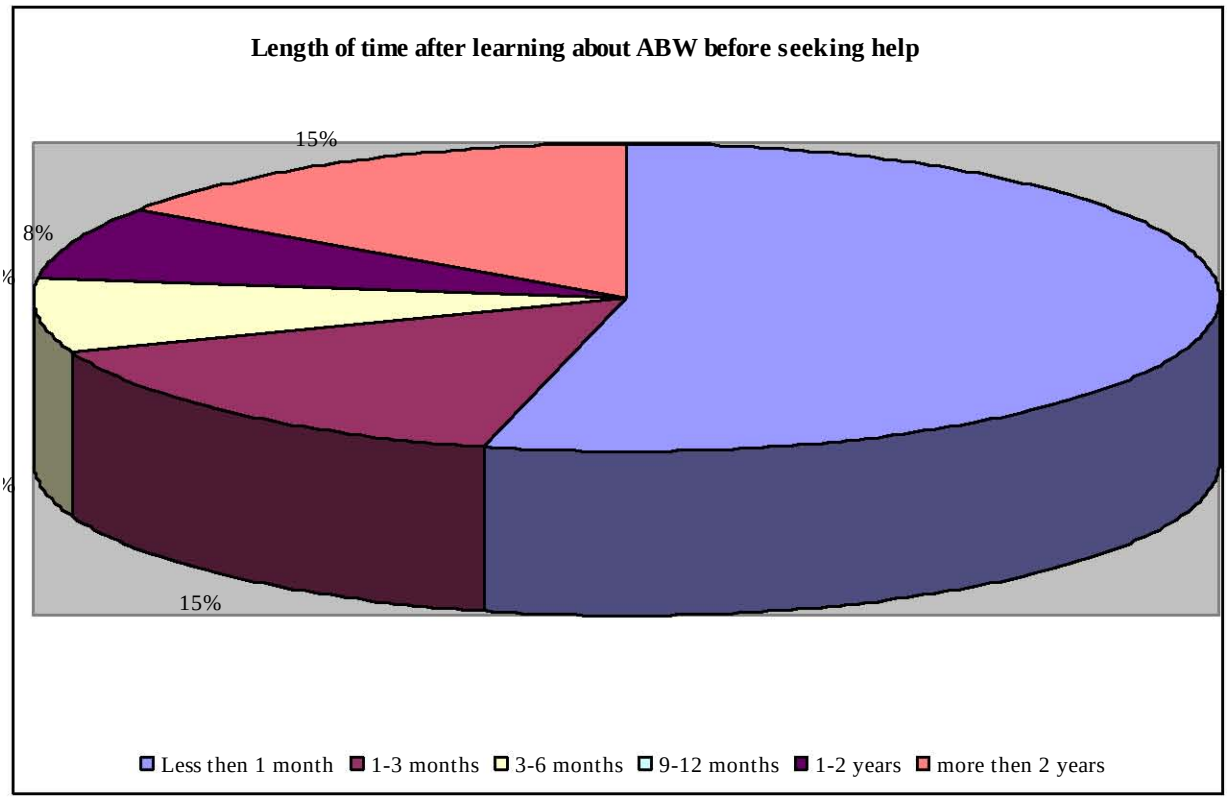

Figure 14 – How long after learning about ABW was it before you sought services?

Item 15 – Would you have sought services sooner if someone had approached you personally about the services offered?

Survey item 15 attempted to measure if women would have been receptive to being personally approached about the services offered. Women indicated that 61.50% would have been opened to this.

Would have sought services sooner if someone had approached them personally about services offered	Frequency	Percentage
Yes	8	61.50%
No	5	38.50%

Table 15 – Would you have sought services sooner if someone had approached you personally about the services offered?

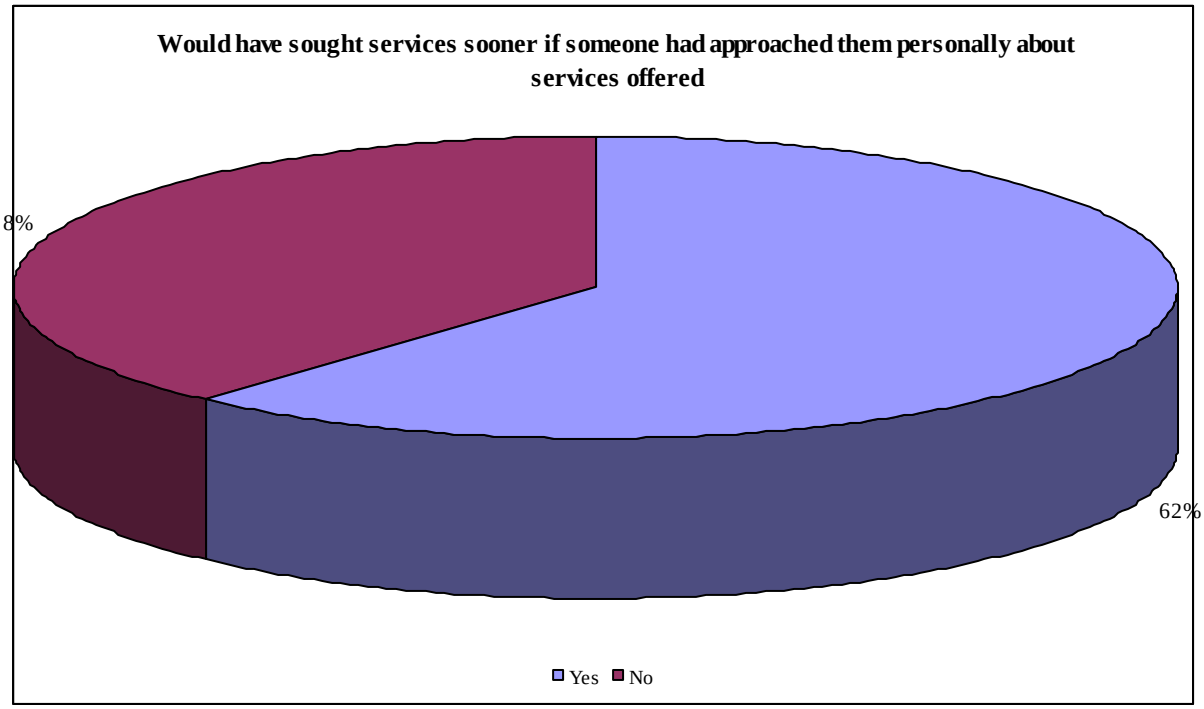

Figure 15– Would you have sought services sooner if someone had approached you personally about the services offered?

Item 16 - What do you think the best way to reach women in need of services?

Item 16 allowed women to describe outreach services they felt would be beneficial to women in need. The themes women indicated were: to increase visibility in the media by advertising on television and magazine- the more regularly the better; education programs for doctors and hospitals including outpatient and inpatient units about services available and methods to identify victims of domestic violence; brochures listing services available and signs of abuse (i.e. red flags) at doctors offices and hospitals; providing more community outreach including workshops at community centers (i.e. YWCA); and posters at the unemployment office, on RTS buses, in emergency rooms and other public places.

Item 17 – Would you have been open to hearing about ABW's services while seeking legal assistance (i.e. court, lawyer etc)?

This question measured if women would have been open to learning about services offered by ABW from someone working in the legal system. Eighty- four point six percent of the women indicated they would be open to this.

Would have been open to hearing about ABW's services while seeking legal assistance (i.e. court, lawyer etc)	Frequency	Percentage
Yes	11	84.60%
No	1	7.70%
Maybe	0	0.00%
Don't Know	1	7.70%

Table 16 – Would you have been open to hearing about ABW's services while seeking legal assistance (i.e. court, lawyer etc)?

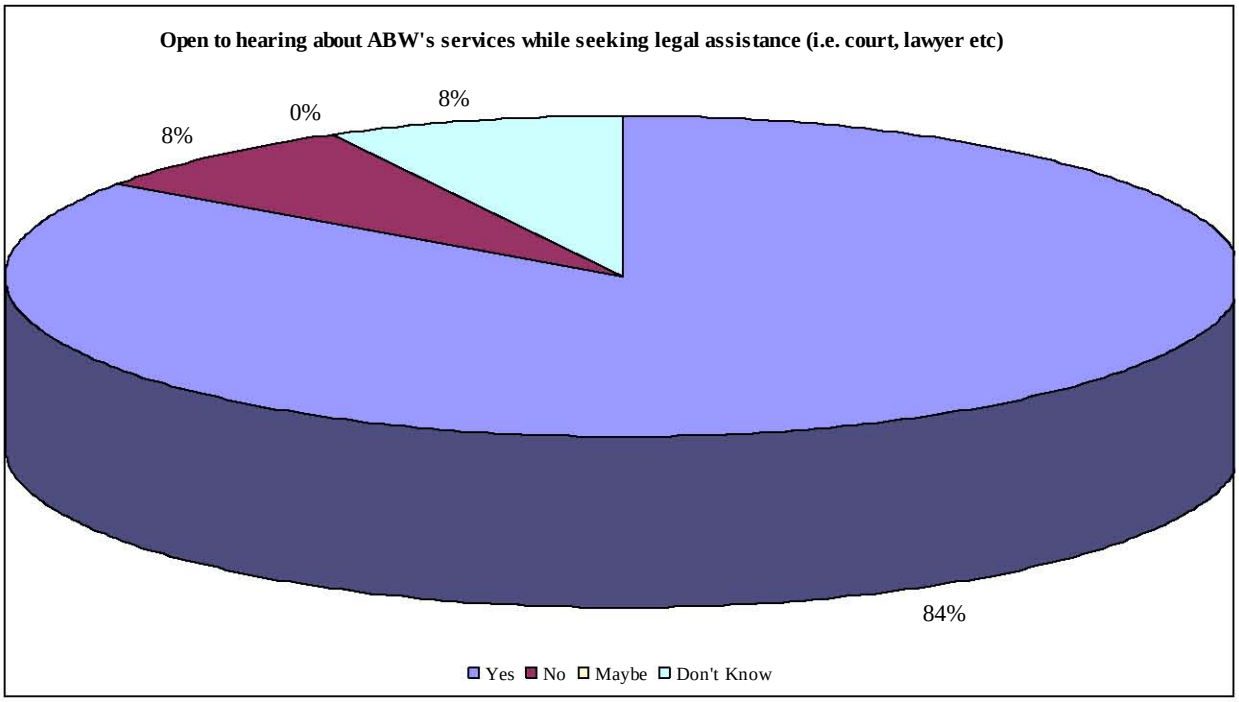

Figure 16 – Would you have been open to hearing about ABW's services while seeking legal assistance (i.e. court, lawyer etc)?

Item 18 – Would you have been open to hearing about ABW's services while seeking law enforcement assistance (i.e. police, victim's assistance)?

This question measured if women would have been open to learning about services offered by ABW from someone working in law enforcement. Eighty-four point six percent of the women indicated they would be open to this.

Would have been open to hearing about ABW's services while seeking law enforcement assistance (i.e. police, victim's assistance)	Frequency	Percentage
Yes	11	84.60%
No	1	7.70%
Maybe	1	7.70%
Don't Know		

Table 17 – Would you have been open to hearing about ABW's services while seeking law enforcement assistance (i.e. police, victim's assistance)?

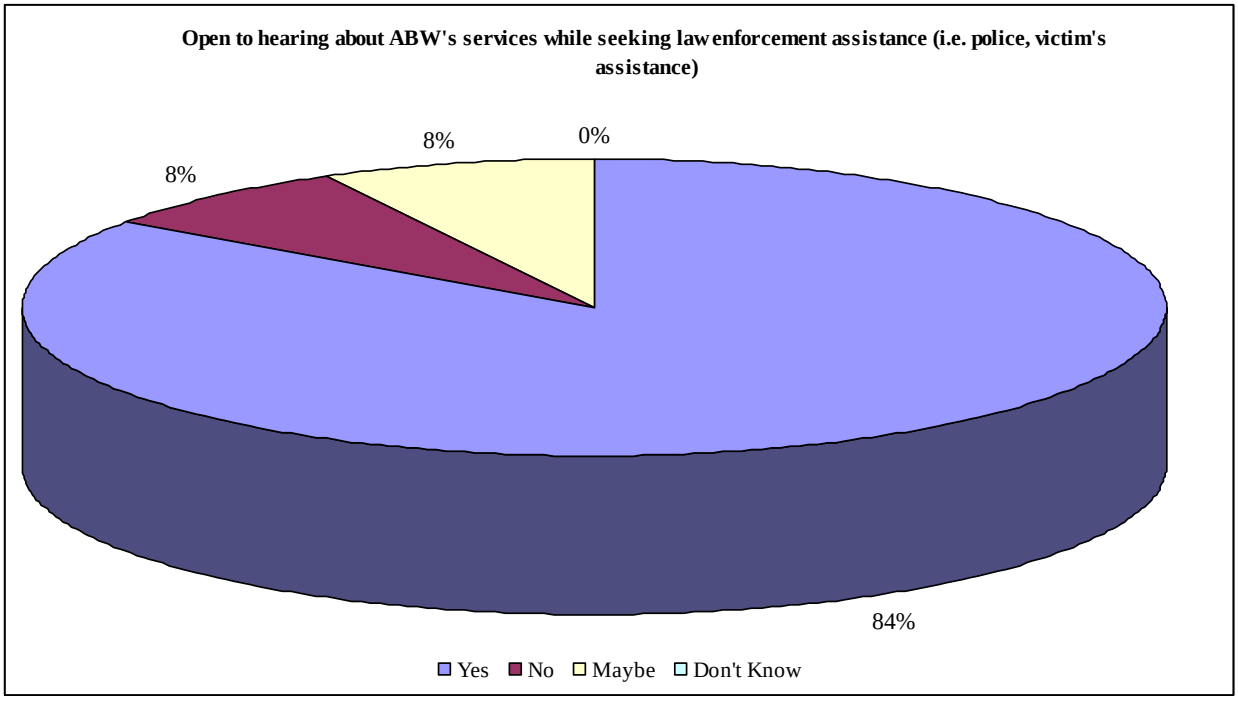

Figure 17 – Would you have been open to hearing about ABW's services while seeking law enforcement assistance (i.e. police, victim's assistance)?

Item 19 – Would you have been open to hearing about ABW's services while seeking medical assistance (i.e. hospital or doctor's office)?

This question measured if women would have been open to learning about services offered by ABW from a health care worker. Eighty-four point six percent of the women indicated they would be open to this.

Would have been open to hearing about ABW's services while seeking medical assistance (i.e. hospital or doctor's office)	Frequency	Percentage
Yes	11	84.60%
No	0	0.00%
Maybe	1	7.70%
Don't Know	1	7.70%

Table 18 – Would you have been open to hearing about ABW's services while seeking medical assistance (i.e. hospital or doctor's office)?

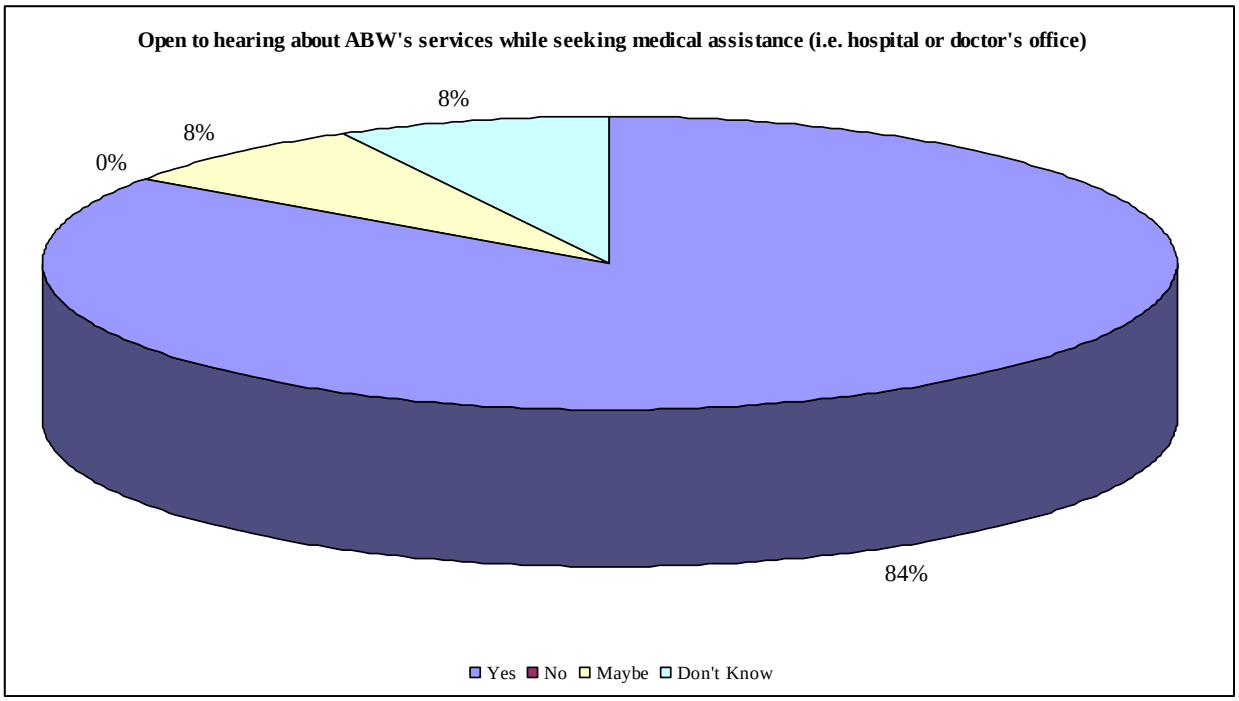

Figure 18 – Would you have been open to hearing about ABW's services while seeking medical assistance (i.e. hospital or doctor's office)?

Item 20 – Had you considered coming to ABW prior to when you actually sought services?

This questions measured if women had considered coming to ABW prior to when they sought services. Eight of the women indicated that they had.

Considered coming to ABW prior to when services were sought	Frequency	Percentage
Yes	8	61.50%
No	5	38.50%
Maybe		
Don't Know		

Table 19 – Had you considered coming to ABW prior to when you actually sought services?

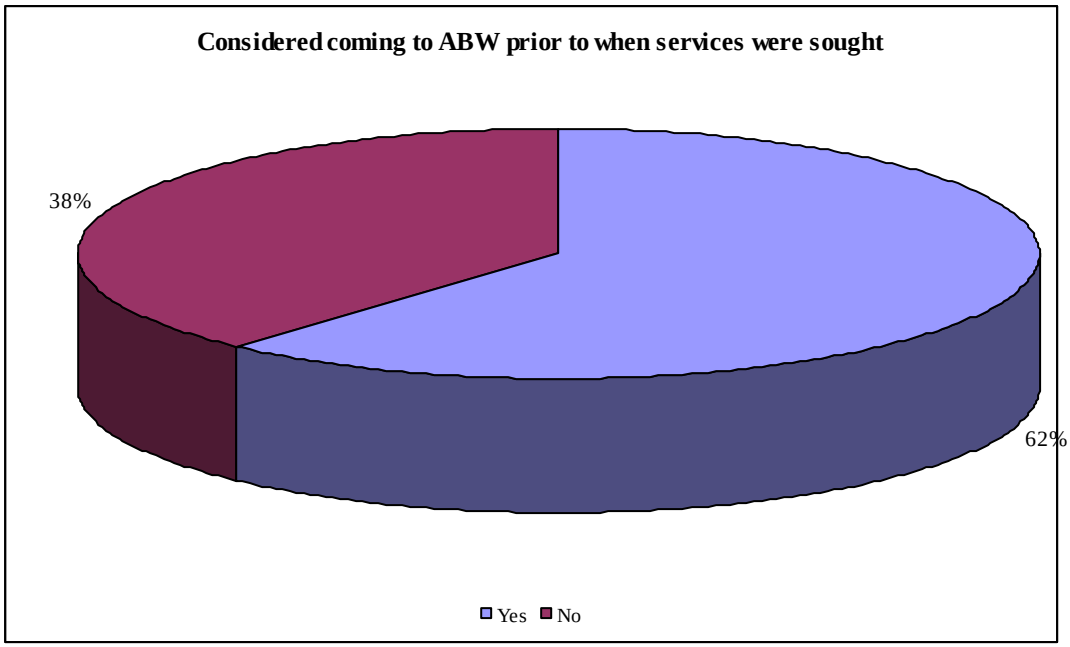

Figure 19 – Had you considered coming to ABW prior to when you actually sought services?

Item 21 – If yes, what stopped you?

This question measured what barriers women needed to overcome before they sought services. Fear of the abuser and not realizing they were in an abusive relationship were the leading barriers which needed to be overcome. Both were measured at 38.50%. Lack of transportation was the next most frequent reasons indicated at 15.40%

What stopped you from coming	Frequency	Percentage
Fear abuser might find out/retaliate	5	38.50%
Did not have a phone	0	
Did not think you were in an abusive relationship	5	38.50%
Lack of transportation	2	15.40%
Lack of time	0	

Table 20 – If yes, what stopped you?

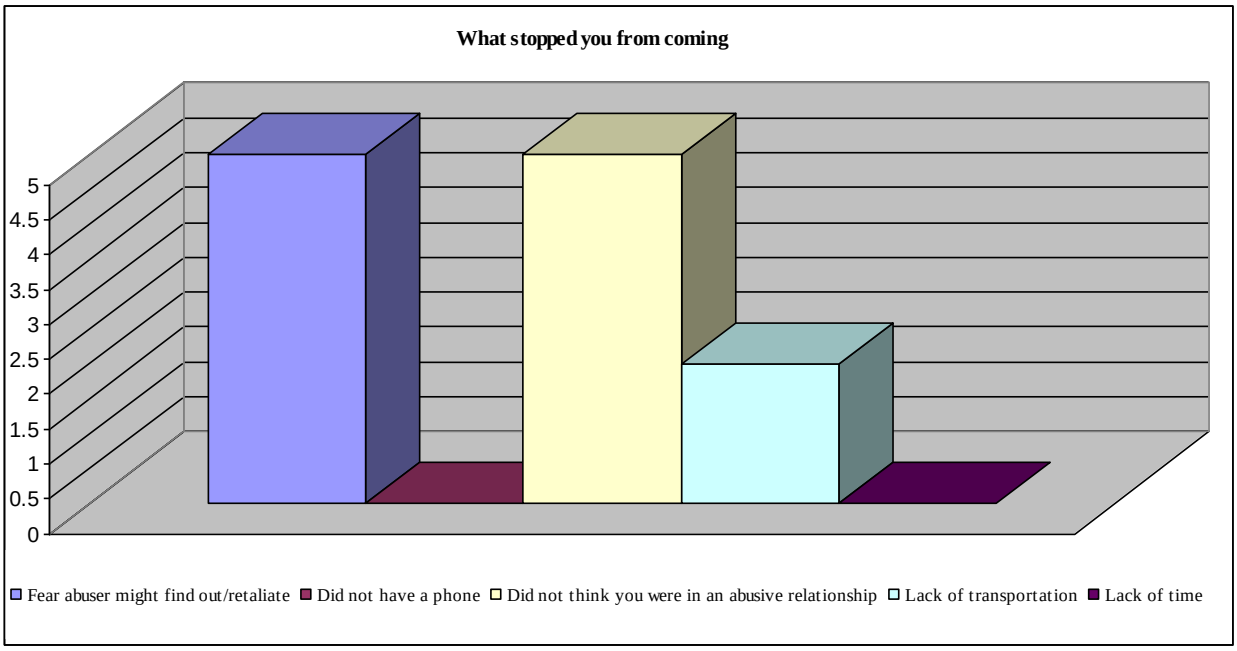

Figure 20 – If yes, what stopped you?

Item 22 – What made you decide to make the decision to seek services now?

Item 22 measured why women decided to seek services now. Ninety two point three percent of the women indicated they realized they needed support and/or had left their abusers. Realizing they were in an abusive relationship and realizing they could not do it alone were the next most frequently sited at 61.50% and 53.80% respectively. Friends, legal supports, law enforcement and medical providers were also noted as reasons women sought services now. One woman indicated complete strangers suggested she seek help. Another indicated a referral from a current shelter client and a third mentioned have a history of abusive relationships that up until this point she wasn't ready to work until something "just clicked" and she was "finally ready".

Reasons services were sought now	Frequency	Percentage
Needed support	12	92.30%
Left abuser	12	92.30%
Urged by friends	5	38.50%
Urged by family	2	15.40%
Realization that what you were experiencing was abuse	8	61.50%
Realization you could not do it alone	7	53.80%
Legal supports encouraged you	4	30.80%
Court ordered	1	7.70%
Law Enforcement encouraged you	2	15.40%
Medical provider encouraged you	5	38.50%
Other	3	23.10%

Table 21 - What made you decide to make the decision to seek services now?

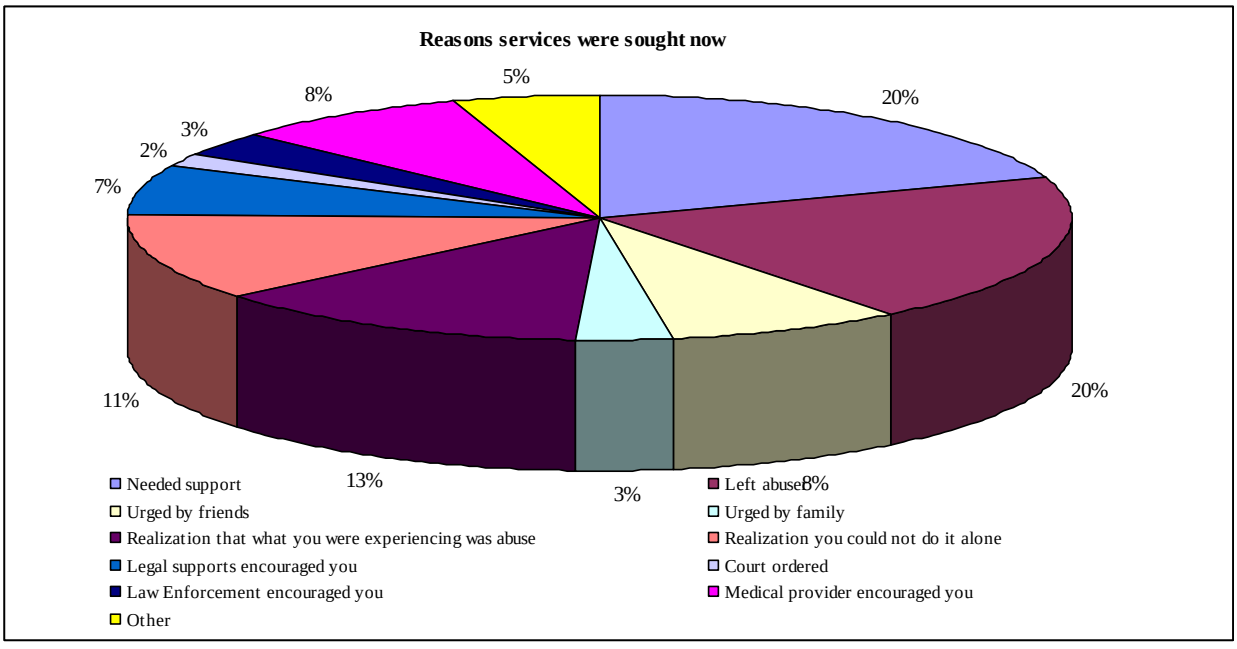

Figure 21 - What made you decide to make the decision to seek services now?

Discussion

The survey results showed the highest number of respondents were Caucasian women between 40 and 49 with children. Most of the women indicated having been in the relationship between one and five years with a few women in relationships between six and fifteen years. Only one woman indicated being in a relationship for longer then fifteen years.

More then half of the women indicated they had been in abusive relationships prior to their current one. Yet most of the women had not been involved with domestic violence programs for those relationships. For almost all of the women this was the first time they had sought assistance for the abuse.

Given how hard it is to reach women in abusive relationship due to the isolation experience by victims of domestic violence it was important to this study to discover how the women learned about the services available. When asked the women indicated that they most frequently learned about the services through friends and health care professionals including mental health providers. Pakieser, Lenaghan, and Muelleman (1998) indicated in their study that victims of domestic violence seek help from a number of sources; among them are emergency rooms, friends/family, private physicians, social workers/psychologists, police, lawyers and clergy. The survey results support this finding. The study also supports Change et al's and Trabold's (2007) statements about the importance of physician intervention. Once validated by the health care provider women seek assistance as evident in the percentage of women who indicated how they learned about the services at ABW. Medical personnel were the

second highest group of people right behind friends indicated by the women surveyed as how they learned about ABW.

Relatively few women were given printed material about the services at ABW. It has not been determined in this study if this is due to the referral source not having needed materials or if it is due to the women's need to keep safe and not take anything the abuser might be able to find. ABW brochures, court advocacy program brochures and support group information where among the items women did say they received. When asked if they received information about available services from their referral source all of the women indicated they were provided verbal information about the services. Most women indicated they received information about the hotline, shelter, court advocacy program and support group.

Women were asked why they chose ABW over other services in the area. A high percentage of the women indicated the counseling offered, availability of the hotline and having community support groups where the biggest reasons they chose ABW. A number of women indicated that referrals from others figured highly in their decision to come to ABW. A number of women indicated ABW was the only service they were aware. This may indicate that ABW's marketing and connections within the community have been successful in educating the community about services they can provide and increasing referrals from the health care community.

Studies discussed women's readiness to seek assistance (Shurman & Rodriguez, 2006). The view is that women can be provided the information but will not seek help until they have overcome other barriers created by the abuser (Shurman & Rodriguez). This survey bears that out. The majority of the women sought support

within one to three month of learning about the services. Three women waited a year or more to seek services. One woman indicated not seeking services until “something clicked” and she was ready. Most of the women indicated the reason they sought services now was because they had left their abusers.

This research project presented a number of ways to reach victims of domestic violence. Women were asked if they would have sought services sooner if they had been approached personally. The response indicated that women would have sought help if they had been approached personally. This maybe why the interventions mention in this paper are seeing some success as they are going out to where the women are rather then waiting for the women to come to them.

The interventions reviewed in this paper covered the health care system, criminal/legal system and coordinated community agencies. This study validates the importance of each of these systems in reaching victims of domestic violence (Donato & Bowker, 1984; Gondolf, 1988; Nicarthy, 2004; Schulman, 1979; Sullivan, 1991). The women surveyed overwhelmingly stated they would have been open to hearing about the services while seeking legal assistance, law enforcement assistance and medical assistance. These results may merit further examination of the education and outreach provided to these groups regarding the scale of domestic violence within the communities and ways they can effective help victims in order to reduce domestic violence rates.

As the research shows women are often kept from seeking services by the abusers (Grigsby & Hartman, 1997; NiCarthy). The women surveyed were asked if they had considered seeking services prior to when they actually did and more then half of

them indicated they had. When asked what stopped them from coming the two most highly rated reasons were fear of the abuser finding out and retaliating and not realizing they were in abusive relationships. A lack of transportation was also indicated. These results point to how much control the abusers have over the victim and how difficult it is to seek help. The majority of the women indicated they had left their abusers before feeling they could seek assistance. They also indicated encouragement from friends, legal support, law enforcement and medical providers gave them the strength to seek assistance.

Limitations of the study

There are several limitations to this study.Although all measure were taken to keep the women safe lack of participation may be been due in part to women's fears of being found by their abusers. In addition, given the control abusers have over the victims there may have been a lack of comfort in providing their opinions. The fact that the survey was completed on paper also means it would be a written record. Some victims fear creating any kind of written record in case it is somehow turned against them at a later time.

Other studies on this subject experience similar limitations in sample size and participation. Perhaps if the survey had been provided for a longer period of time there may have been more women willing to participate in the research.

Recommendations for future research

The exploratory study conducted by the researcher looked at ways victims of domestic violence learned about services available, barriers, which kept them from accessing services and what led them to seek assistance. Similar studies should be

conducted; however, certain factors need to be incorporated to get a more realistic understanding of how victims access services.

This researcher would recommend continued research to discover new methods for providing information to victims of domestic violence. The limited response rate and ethnic homogenous nature of the current research suggests taking a look at a broader cross section of society to see if the results change. Researchers may want to study a more diverse population and for a longer time. Given the number of women who enter and exit services at domestic violence shelters the number of responses could be increased by conducting the study for 6 12 months providing a better cross section of people and broadening the response results.

The need to protect women's safety when leaving violence relationships should be of utmost concern when undertaking research with this population. To maintain their safety anonymous surveys would allow for the collection of data while still protecting those who participate.

Implications for counselors

The large number of domestic violence victims in the United States has a number of implications for counselors. Due to this large number of domestic violence victims, an estimated two million per year, regardless of whether the counselor specializes in domestic violence or not they will encounter clients who are victims (Pyles & Postmus, 2004; Tjaden & Thoennes, 1998). All counselors should have a basic understanding of the dynamics of domestic violence. Understanding some basic needs of victims will prepare counselors to provide the support their clients will need. This includes listening in a non-judgmental manner, documenting the abuse, providing validation of the clients

experience and helping them break through the denial about the abuse in order to plant the seeds for change.

As indicated by this thesis one of the most difficult issues victims have is learning about what abuse is and the services, which are available to them. Information is a powerful weapon against continued abuse (Grigsby & Hartman, 1997). Counselors who provide validation and information to the client are key in helping them realized they are in abusive relationships and learning what options they have (Chang et al., 2005). If counselors do not feel prepared to help with the deeper issues that result from abuse, referring the client to other community resources is vital in order to provide them with the assistance they need to end the abuse. Counselors need to educate themselves about resources available in their community. Abuse is a multidimensional problem, which requires a multi-pronged solution (Berghron & Siracusa, 1982). Counselors are one piece; helping to build connections with others is vital in bringing an end to domestic violence.

Conclusion

Grigsby and Hartman (1997) and Nicarthy (2004) stated victims of domestic violence are often isolated from others. Their movements are frequently limited by their abusers (Grigsby & Hartman, Nicarthy). This impedes the ability of service providers to reach those most in need of their services. An estimated 25% to 54% of women will be affected by domestic violence in their lifetime (Bonomi et al., 2006).

This thesis explored several interventions methods used to reach domestic violence victims. Due to the infancy of outreach (Kernic & Bonomi, 2007) the efficacy of these programs have not been effectively measured. Preliminary reports indicate many

of them are successful in educating victims and in some cases connecting them with needed services.

The research survey completed for this study confirms the intervention and outreach strategies are in line with the needs of abuse victim. Given research on intereventions and outreach methods to domestic violence victims is in its infancy further work is needed to determine the long term effectiveness in decreasing domestic violence in the future (Bogal-Allbritten & Rogers-Daughaday, 1990).

The goal of this study was to provide researchers and counselors with a better understanding of domestic violence. The hope is the information presented will help individuals who work with domestic violence victims to better understand how they can help the victim become a survivor and end the cycle of domestic violence.

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Appendix A

Statement of Informed Consent

The purpose of this research project is to examine what is the most effective way to educate women in abusive relationships about the services available at Alternatives for Battered Women. This research project is also being conducted in order for me to complete my Master's thesis for the Department of Counselor Education at the College at Brockport, State University of New York.

In order to participate in this study, your informed consent is required. You are being asked to make a decision whether or not to participate in the project. If you want to participate in the project, and agree with statements below, your completion of the survey signifies your consent. <u>You may change your mind at any time and leave the study without penalty, even after the study has begun.</u>

Your safety and well being is the most important concern. If at any time while completing the study or after you feel the need to talk with someone Alternatives for Battered Women staffs a hotline operated 24 hours a day 7 days a week who are ready help you. You reach the hotline by calling 585-232-7353.

I understand that:

1. My participation is voluntary and I have the right to refuse to answer any questions.

2. My name will not be written on the survey. There will be no way to connect me to my written survey. If any publication results from this research, I cannot be identified by name.
3. There is a minor risk of time to complete the survey. There are no anticipated personal benefits because of my participation in this project.
4. My participation involves reading a survey. The survey has 11 questions. I will be asked to answer these surveys by placing an X next to the answer that best corresponds with my opinion and by answering all other questions in writing. It is estimated that it will take 15 minutes to complete this survey.

   A maximum of 30 people will take part in this study. The results will be used for the completion of a Master's thesis by Kate Stanford, Transitional Support Services Intern Counselor.
5. Data will be kept in a secure filing cabinet by the investigator. Data and consent forms will be destroyed by shredding when the research has been completed.

I am 18 years of age or older. I have read and understand the above statements. All my questions about my participation in this study have been answered to my satisfaction. I agree to participate in the study realizing I may withdraw without penalty at any time during the survey process. Returning the survey indicates my consent to participate. If you have any questions you may contact:

Kate Stanford

Alternatives for Battered Women

Transitional Support Services Intern Counselor

(585) 232-5200 x236 (this is a confidential voicemail)

kms1@frontiernet.net

or

Dr. Thomas Hernandez, Ed.D., LMHC

Associate Professor

College at Brockport, State University of New York

(585) 395-5498

thernandez@brockport.edu

Date:_____ Initals:_____

Appendix B

Demographics:

What is your ethnic identification?

☐ Caucasian ☐ Hispanic/Latino ☐Asian/Pacific Islander

☐African America ☐ Native American/Aleutian ☐ Other:_____

How old are you?

☐ 18-29 ☐ 30-39 ☐ 40-49

☐50-59 ☐60-69 ☐ 70 or older

Do you have children? ☐ Yes ☐ No

Do your children live with you? ☐ Yes ☐ No

How long have you been in the most recent abusive relationship?

☐ Less then 1 year ☐ 1-5 years ☐ 6-10 years

☐ 11-15 years ☐ 16-20 years ☐ 21-25 years

☐ 26-30 years ☐ more then 30 years

Were you abused in a relationship before this one? ☐ Yes ☐ No

Have you been involved with other domestic violence programs/shelters before ABW? ☐ Yes ☐ No

Appendix C

Survey

Who or where did you learn about ABW? (Check all that apply)

☐ Doctor/Medical Personnel ☐ Lawyer/Legal Representation

☐ Hospital ☐ Friends

☐ Family ☐ Substance Abuse Treatment Center

☐ 2-1-1/LIFE LINE ☐ United Way

☐ ABW Court Advocacy Program ☐ Law Enforcement

☐ Dating Violence Education Program ☐ Children's Program

☐ Project Keepsafe ☐ ABW Nail File

☐ Health Fair ☐ Counselor / Therapist

☐ Safety First Program ☐ Social Worker

☐ CPS ☐ Poster about ABW

☐ News Story ☐ Fundraiser

☐ Phonebook ☐ Internet

☐ Radio ☐ United Way Video

☐ Survivors Advocating for Effective Reform (SAFER) Program

☐ Other ☐ Don’t remember

Did the Referral Source give you printed material about ABW?

☐ Yes ☐ No

If yes, what were you given? (Check all that apply)

☐ Brochure

☐ Business Card / Palm Card

☐ ABW Court Advocacy Program Brochure

☐ Dating Violence Prevention Education Program Brochure

☐ Community Support Group Announcement

Did the Referral Source give you information about ABW services?

☐ Yes ☐ No

If yes, what were you given? (Check all that apply)

☐ Shelter Information

☐ Hotline Information

☐ Support Groups Information

☐ Outreach Information

☐ Non-Residential Counseling Information

☐ ABW Court Advocacy Program Information

☐ Information about working with Law Enforcement

☐ Dating Violence Prevention Education Program Information

☐ Other _____

Why did you choose ABW over other services in the area?

☐ Counseling offered ☐ Hotline ☐ Outreach efforts

☐ Reputation in community ☐ Availability of Support Groups

☐ Referral/Recommendation from someone

☐ ABW was the only organization you were aware of

How long after learning about ABW was it before you sought services?

☐Less then 1 month ☐ 1-3 months ☐ 3-6 months

☐ 9-12 months ☐ 1-2 years ☐ more then 2 years

Would you have sought services sooner if someone had approached you personally about the services offered?

☐ Yes ☐ No

What do you think the best way is to reach women in need of services?

_____

_____

Would you have been open to hearing about ABW's services while seeking legal assistance (i.e. court, lawyer etc)?

☐Yes ☐No ☐Maybe ☐Don't Know

Would you have been open to hearing about ABW's services while seeking law enforcement assistance (i.e. police, victim's assistance)?

☐Yes ☐No ☐Maybe ☐Don't Know

Would you have been open to hearing about ABW's services while seeking medical assistance (i.e. hospital or doctor's office)?

☐Yes ☐No ☐Maybe ☐Don't Know

Had you considered coming to ABW prior to when you actually sought services?

☐Yes ☐No ☐Maybe ☐Don’t Know

If yes, what stopped you? (Check all that apply)

☐ Fear abuser might find out/retaliate

☐ Did not have a phone

☐ Did not think you were in an abusive relationship

☐ Lack of transportation

☐ Lack of time

What made you decide to make the decision to seek services now? (Check all that apply)

☐ Needed support

☐ Left abuser

☐ Urged by friends

☐ Urged by family

☐ Realization that what you were experience was abuse

☐ Realization you could not do it alone

☐ Legal supports encouraged you

☐ Court ordered

☐ Law enforcement encouraged you

☐ Medical provider encouraged you

☐ Other_____