It's Not Healthy If It's Not Safe:

Responding to Domestic Violence Issues within Healthy Marriage Programs

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Proponents of funding for healthy marriage programs have repeatedly affirmed that policies or programs designed to encourage and support marriage are not intended to force anyone into unwanted, unhealthy relationships, trap women in abusive relationships, or withdraw support from single mothers. Despite these assurances, however, there remains considerable concern among domestic violence advocates and others about the potential impact of marriage promotion initiatives on survivors of domestic violence or those currently in abusive relationships. There is a growing consensus that identifying and responding to domestic violence issues within these marriage strengthening programs will be extremely important. However, given the diversity of these programs – the nature of the interventions and activities, the backgrounds and credentials of the providers, the settings in which they are offered, and the communities and individuals being targeted – how to do this safely and well is less clear.

And key questions remain: In what ways do programs targeting culturally diverse, low-income communities need to be different than the marriage programs developed for largely white, middle and upper income couples? What steps can be taken to ensure that an individual's or couple's decision to participate in marriage strengthening programs is voluntary and informed, particularly when recruitment or referral is linked to programs providing government benefits or services? How will these healthy marriage programs ensure that there are safe, confidential opportunities for individuals to disclose domestic violence issues in current or past relationships? What should happen when disclosures of domestic violence occur or domestic violence is suspected?

And once domestic violence issues are disclosed or detected – On what basis are decisions made to include or exclude couples from these programs and what are the implications of these decisions? When might it be appropriate, if ever, for a domestic violence victim to participate in a healthy relationship or healthy marriage program, with or without the abusive partner? When might healthy co-parenting – or ending the relationship altogether – be a more appropriate goal than marriage? If a domestic violence victim is clear that she needs to leave an unsafe relationship, will she be forced to stay by policy or the courts in order to receive supports or other services? What supports and protections must we continue to provide to single mothers to ensure the health and safety of these parents and the well-being of their children? Is there a domestic violence prevention potential to healthy marriage programs and how can we realize that potential? How will

the success of these programs and initiatives be measured? What roles can local and state domestic violence experts play in the design and implementation of marriage programs to ensure that adequate safeguards are in place?

This paper does not argue the merits of policy and programs promoting marriage (that would be another paper), but instead explores the challenges, opportunities and lessons learned from domestic violence protocol development at sites currently receiving federal funds for healthy marriage activities and with domestic violence advocates attempting to partner with these programs and others. By way of establishing a context for this analysis, we provide a brief discussion on domestic violence prevalence and impact and its links to the marriage promotion debate. Throughout the paper, you will find more questions that answers, but that is the nature of where we are.

Understanding Domestic Violence

It is sometimes confusing for those in the public policy arena – never mind practitioners in the legal, social services and health fields – to sort through the broad range of terms used and definitions associated with violence and abuse within intimate relationships. Domestic or family violence, battering, spouse abuse, intimate partner violence, and intimate terrorism are all terms in common use, sometimes interchangeably but often times ascribed different meanings. Some are defined in federal and state statutes, which of course vary across jurisdiction; others are more commonly used in research settings or within the social service field, with varying degrees of precision as to the types of behaviors or characteristics they encompass.

Domestic violence, the term we'll use here, is most usefully understood to be a pattern of abusive behaviors, including physical, sexual, and psychological attacks as well as economic coercion, that adults and adolescents use against an intimate partner. It is characterized by one partner's need to control the other, and the instrumental use of a range of tactics to secure and maintain that control.[1] Domestic violence includes behaviors that frighten, intimidate, terrorize, manipulate, hurt, humiliate, blame, often injure, and sometime kill, a current or former intimate partner. Under this definition, therefore, it is possible to distinguish between the use of singular acts of "low-level" physical aggression, absent the use of coercive control, and behavior that serves to assert or maintain control over a partner and leaves them fearful and intimidated.[2]

It is critical not to view intimate partner violence as a natural consequence of conflict. Most people respond to interpersonal conflict in non-violent and non-abusive ways. In contrast, partners who batter a partner use violence and abuse to resolve conflict and to control a situation. They tend to be carriers of this behavior from one relationship to the next. These distinctions, always important, have taken on particular significance in the context of marriage promotion, as we will explore in more detail later.

The most recent, reliable, and comprehensive studies of intimate partner violence reveal that:

- Women are more likely than men to be victimized by intimate partners and women are harmed more severely in those assaults; males who are victims of assault are generally assaulted by other males.[3] Domestic violence in all its forms, including sexual assault and homicide, occurs across all relationship structures -- dating, cohabiting, and marital relationships, with the highest rates between separated and divorced couples.[4]
- Well over half of the women receiving welfare report having experienced physical abuse by an intimate partner at some point during their adult lives. As many as 30% of women receiving welfare report abuse in a current relationship.[5] A significant number of women receiving welfare also report physical and/or sexual abuse in childhood.[6]
- In homes where domestic violence occurs they are six times more likely to come to the attention of the child welfare system associated with abuse or neglect.
- Each year over 300,000 pregnant women in the U.S. are battered by the men in their lives.[7]
- Studies suggest that between 3.3 and 10 million children witness domestic violence annually[8]
- Nearly all children living in violent homes hear or see the abuse of their mother.[9] Slightly more than half of female victims of intimate violence live in households with children under age 12.[10]
- Children who witness domestic violence are more likely to exhibit behavioral and physical health problems including depression, anxiety, and violence towards peers.[11] They are also more likely to attempt suicide, abuse drugs and alcohol, run away from home, engage in teenage prostitution, and commit sexual assault crimes.[12]
- Children exposed to domestic violence are often injured or killed in an attempt to protect their mother from the attack by their biological father, step-father, or mother's boyfriend.
- False allegations of domestic violence occur infrequently, and there is in fact a significant *underreporting* of domestic violence.[13]

Experts in the field often assert that domestic violence is virtually impossible to measure with absolute precision due to the social stigma that inhibits victims from disclosing their abuse and the varying definitions of abuse used from study to study, among other factors. The National Violence Against Women Study, one of the most recent prevalence and incidence studies, found that over 22% of women had been physically assaulted by an intimate partner at some time in their lives, and 1.3% reported such an event in the 12 months preceding the survey. Thus, an estimated 1.3 million women are victims of physical assault by an intimate partner each year, and an estimated 4.5 million intimate partner violence physical assaults occur annually. Over 80% of women stalked by a current or former intimate partner are also physically assaulted by that partner.[14]

Other insights into the extent of the problem are provided in reports by the National Domestic Violence Hotline, which has received more than 1.2 million calls for assistance since February 1996, when it opened its phone lines. The Hotline currently averages over 16,000 calls a month, and even that number spikes when there is a highly publicized domestic homicide or trial or following a public awareness campaign providing information about the Hotline. Many of these calls are from domestic violence victims who have no crisis services in their community or who have not been able to access the protections and supports needed, whether that is a safe bed for themselves and their children, an advocate who speaks their language, response to an immigration issue, or help for their abusive partner. The Hotline reports receiving an increasing number of calls from men – men abused by their male or female partner, men looking to help an abusive or abused friend or relative, and men looking for support to stop their own abusive behavior.

Also important to understand here is the network of domestic violence services that now exists in this country. During the past two decades, over 2,000 community-based domestic violence programs have been organized throughout the United States, providing 24-hour crisis hotlines, individual and group support and counseling, legal and medical advocacy, support groups for adults and children, and other specialized children's services. Approximately 1,200 of these programs have shelter facilities providing emergency beds to family members not safe in their own home, although stays are often limited to 30 – 60 days due to limited space and constant demand for those emergency beds. Some large programs provide employment services, respite care or childcare programs, therapeutic counseling for women and children dealing with trauma, legal representation, and other specialized services. An increasing number of domestic violence programs are culturally-specific in their approach, organized by and for a particular racial or ethnic community and providing a new range of culturally-relevant services to African American, Latina, and Asian- Pacific Islander survivors. An extensive network of batterers intervention programs has been developed over the past 15 years as well, most commonly providing specialized groups for abusers within a coordinated community response and serving as a referral option for the courts.

Before moving on, it is important to note that, while there are many states with at least one domestic violence program in every county, there are still too many areas, particularly in rural, low population states, where a battered women must travel more than 150 miles to reach the nearest domestic violence shelter or support group or advocacy services. The lack of programs is particularly acute for Native American women and within migrant and immigrant communities, and access to services remains limited for women and children with disabilities and older women in abusive relationships, although specialized approaches and services are beginning to be developed.

A key aspect of our advocacy involves safety planning with domestic violence victims. Safety planning must be understood as a process. Simply stated, a safety plan is each battered woman's unique strategy to reduce the risks generated by a partner's abuse and control. To be effective, a safety plan and the safety planning process must address the range of risks that an individual victim is facing, not just physical violence. Women's safety plans might include strategies for staying as well as for leaving, and may have short and long-term timeframes – she'll feed the kids early so he won't hit them during dinner; she'll save $10 a week from the food money he doles out to her until she can save enough to get a bus ticket to her mom's house in the next state over; she'll leave her abusive partner after the kids are through high school and out of the house or after she gets her GED. And of necessity, these safety plans will change – as his tactics change, so must her safety plan change. If he gets a gun, her safety plan will change; if his gun is taken away from him under a protective order, and now he's really angry, her safety plan will need to change again. Many aspects of a victim/survivor's safety plan may remain hidden, even from advocates, and certainly from others with whom she has not yet built a trusting relationship.[15]

We have also learned from our advocacy work that the decision to disclose domestic violence is a difficult one for many domestic violence victims. Battered women are often reluctant to disclose domestic violence incidents, whether current or well in the past, and with good reason. They fear that their complaints will not be taken seriously, that they will be blamed for their partners' violence, that they will lose custody of their children, that their source of family economic support will be jeopardized, or that this information will be shared with their abusive partner. In light of these reasonable fears, exploring domestic violence issues with individuals and couples – in any setting – must be undertaken with care and in ways that empower victims rather than further the abusive partner's control. It is through their safety planning lens that many women make disclosure decisions and those related to participating in services or programs that others think might be helpful to them.

What does any of this have to do with efforts to promote healthy marriage?

What joins domestic violence advocates, whether working at the local, state or national level, to this discussion about strengthening marriage? The first reason is rather obvious. A primary target of federally supported marriage promotion efforts is single mothers living in poverty. We know from research and experience that poverty and domestic violence are interwoven. Significant numbers of low-income women are battered, and the violence they experience often makes the climb out of poverty impossible. Poverty, in turn, makes it more difficult to end domestic violence and heal from its affects. We know that many domestic violence victims use welfare and child support as the economic bridge out of a violent relationship. Domestic and sexual violence, as children and/or as adults, is not a theoretical possibility here, but a reality for too many impoverished women, and particularly those targeted by these initiatives. Recent research by Edin and Kefalas[16] and Cherlin, Burton et al.[17] sheds new light on this reality and suggests that there may be even more direct – and complex – relationships between the victimization of girls and women and their relationship decisions.

Our constituency consists largely of women who became single parents when they left an abusive husband or decided not to marry the abusive father of their child, and those who are struggling with whether to stay or leave their current relationship**.** Many battered women have stayed in marriages and other types of intimate partner relationships because they love their partner. They want the abuse to end, not the relationship. After repeated experiences with the abuse, many eventually reach a decision to leave because the violence has not stopped and they and/or their children remain threatened and in danger. They conclude that the ability to reconcile and the likelihood of change have passed.

As anti-violence and anti-poverty advocates, we encourage the provision of supportive services to all families, regardless of their marital status or family composition, including improved employment and educational opportunities, increased funding for childcare, and enhanced services to address domestic and sexual violence and other barriers to employment and self-sufficiency. Therefore, the singular focus on “healthy marriage” rather than “healthy relationships” and on the proposed use of significant federal funding to “promote” rather than “support” marriage complicates our connections to these efforts in particular ways.

As advocates representing the needs and interests of domestic violence victims, we are deeply concerned about any effort that will potentially – either unintentionally or by design – stigmatize single parents and disrespect or devalue their efforts to create healthy and safe families for their

children. We believe strongly that further stigmatizing divorce or making divorce more difficult to obtain will *de facto* make it more difficult for some women to leave an unhealthy, abusive relationship.

Research and experience also tell us that concern for their children are central to many battered women's relationship decisions. Concern for their children's well-being drives many women to leave an abusive relationship. And concern for their children's well-being, and fears of poverty and homelessness, motivates other women to struggle to "save" the relationship at the same time they seek help to make his violence stop. Clearly, as domestic violence advocates, we have an interest in ensuring that initiatives organized to "enhance child well-being" also recognize and respond to the negative impact of children's exposure to domestic violence and fully support mothers who make decisions they consider to be in their children's interest.

A key focus of our work as domestic violence advocates has always been on promoting healthy non-abusive relationships. In addition to our ongoing work with adult women, domestic violence advocates have provided education and relationship skills building programs in schools to address the high rates of dating violence among teens and provided services and supports to children in shelter with their abused mothers to help mitigate the impact of their exposure to domestic violence. In that sense, we share common ground with many in the movement to support healthy relationships and marriage. However, we come to this work through a different door, one framed by the reality and persistence of intimate violence.

For all these reasons and others, domestic violence advocates have found ourselves engaged – although critically – in this discussion about how to encourage and support healthy relationships and marriage. To date, the primary role that we have played has been to help identify ways to proceed that do not exacerbate the risks faced by domestic violence victims and survivors, but instead support their choices and options. Like the survivors with whom we work, advocates are driven by our own hopes and fears, and both have been borne out in the work to date.

Domestic Violence Protocol Development: What has it looked like?

The *process* of protocol development can be as important as the protocol itself. A good protocol can serve as an educational tool, underscore key concerns, articulate commitments that partners are making to each other, and help build trust. In the instance of marriage strengthening programs, a well-developed protocol can affirm a shared concern among the project partners for the safety of all family members, which can then facilitate a respectful collaboration between domestic violence advocates and other project partners.

To the credit of the Department of Health and Human Services (HHS), all sites currently receiving federal funding from HHS for marriage strengthening activities have been directed to develop a site-specific domestic violence protocol. Further, HHS authorized the provision of technical assistance to help funded sites in this protocol development process. Both the directive and the technical assistance have proven important. While it is not yet clear whether the types of programs currently receiving federal child welfare, child support, refugee resettlement, and faith-based funds to design and implement healthy marriage initiatives are typical of those likely to be funded in the much larger initiative awaiting Congressional authorization, the challenges and opportunities that have been identified to date and the lessons learned related to responding to domestic violence issues are worth noting.

As mentioned earlier, one of the first challenges presented by the current array of federally funded sites has been the significant variations across site related to key project partners, referral agencies, activities proposed, curricula and materials used, and current policies and practices related to identifying domestic violence within the funded agency itself. All of these factors affect the approach taken to identifying and responding to domestic violence issues within the project, and the role that domestic violence programs might need or want to play in its design and implementation.

Following are some of the threshold issues that have affected domestic violence protocol development within federally funded sites and underscore the need for *site-specific* protocols.

What is the target population for the marriage-related activities?
The target population might include, for example: newly engaged couples, single mothers receiving welfare benefits, families involved in the child welfare system (either voluntarily or involuntary), parents of newborns, including couples targeted by in-hospital paternity establishment programs, refugee families, “distressed” families, adoptive parents, a broad community population, low income couples, mixed income families, a particular racial or ethnic group, separated couples, divorcing couples, cohabiting couples, stepfamilies, linguistically diverse families, geographically isolated families, and others. Obviously, each of these groups raises different concerns in terms of risks for domestic violence and the need for particular types of intervention and support.

What types of marriage-related activities are being offered or proposed?
There is a wide range of activities that are currently being offered under funded healthy marriage projects. These can range from broad-based public education campaigns, to relationship classes in high schools, to specific marriage education workshops or classes that vary significantly in terms

of content and duration. The activities being offered may or may not have been designed for use with the population being targeted by the project. Some project sites are offering couples sessions as well as separate sessions for mothers and fathers.

How do the healthy marriage curricula and other program materials to be used in the project address domestic violence issues? Is domestic violence addressed directly in course material? Is there any content that might exacerbate the risk faced by a participant from an abusive partner, such as scenes/scenarios involving emotionally or physically abusive couples or exercises that encourage the outward expressions of anger or rage? Are scenarios used that depict conflict, anger and violence between couples? Do they send the message that violence and abuse are never acceptable ways to address conflict and that it is always a threat to a healthy marriage?

Who are the key partners in the project? To what extent are they "domestic violence competent"? If the healthy marriage initiative is connected to a state TANF, child support, or child welfare agency, how is domestic violence currently identified and addressed within the agency? Specifically, how do they create a safe environment for disclosure of past or current domestic violence? What is the agency's current response to disclosures of domestic violence? What specific procedures are in place to address safety concerns that may arise for adult victims of domestic violence? If intake into the healthy marriage project will be conducted by partner agencies, what is their current experience identifying and addressing domestic violence issues among clients?

For community-based or agency-based initiatives, how will potential participants in the healthy marriage activities be identified? And this sets up a whole host of related questions: How and by whom will the healthy marriage project be introduced to individual clients? Will any HMI intake process proceed or follow current screening/assessment of domestic violence for agency services or benefits eligibility purposes? What types of domestic violence training will staff need to respond to disclosures, whenever they occur? How will domestic violence disclosure information be shared among the project partners? How will the confidentiality and privacy of domestic violence victims be maintained?

Given these realities, several important protocol development "first steps" were identified. These included identifying potential domestic violence partners and inviting them to the table, exploring how domestic violence issues are currently being addressed by the partner agencies, and identifying the types of technical assistance the project needed from local domestic violence experts or others.

Although each protocol needs **to** be site-specific, given some of the critical variables identified above, it was nevertheless possible and necessary to identify key components of a well-structured protocol and offer this as a "blueprint" for sites to work from. These key domestic violence protocol components include:

Mission Statement

- *What is the unifying mission of the healthy marriage initiative?*

Scope and purpose of the protocol

- *What role is the protocol meant to play within the healthy marriage initiative?*

Underlying principles

- *What are the shared values that will guide the partners' work together?*

Definition of domestic violence

- *How is the term "domestic violence" defined, as used in the protocol?*

Providing safe opportunities to disclose: screening and assessment for domestic violence

- *What information will be provided to all potential participants? Will it support self-assessment?*
- *Who will be screened for domestic violence and at what point(s) of contact?*
- *Who will be responsible for screening and assessment within each partner agency?*
- *How will screening for domestic violence occur?*

Responding to disclosures of domestic violence

- *What procedures will be followed when domestic violence is disclosed during intake or by a participant in an HMI activity, or when there are indications that a participant is in an abusive or controlling relationship (such as jumpiness or nervousness around a partner, signs of controlling or abusive behavior by one of the parties, or indications of distress or injury)?*

Three key types of response should include:

- *Crisis response – when someone is in immediate danger*
- *Responding to disclosures of past or current abuse that the victim does not identify as posing an immediate threat*
- *Responding to disclosures of domestic violence and interest in participating in marriage education or related activities*

Maintaining Confidentiality

Cross-Training on HMI and domestic violence

- *Who will receive training, and who will provide training to ensure that those responsible for implementing the protocol have the skills and confidence to do so?*

Given the experimental nature of these projects, and the range of design and implementation questions that remain unanswered, sites were also encouraged to build in to their protocol a 6-month review period. This would provide an opportunity for the project partners to examine the protocol in the context of actual experience and make necessary modifications informed by that experience.

Challenges and Lessons Learned to Date

What lessons and cautions can be drawn from these domestic violence protocol development experiences to date? There are several worth noting.

The first is that we are far from being at a "best practices" level in this area. While we have identified a rather full set of complex questions, some listed above and more to follow below, we are still grappling to find the answers to most of them. It is clear that the "requirement" to develop a domestic violence protocol, at least at many of the federally funded sites, was what prompted the healthy marriage project to involve domestic violence advocates in program design and implementation. We are not at all clear that an invitation to participate would have been extended at some sites absent such a requirement by the funder. While forced collaborations have their utility, they are less effective than those borne out of a self-identified and shared commitment to address common interests, such as the ensuring that programs being offered are safe and appropriate for all participants.

Another key lesson is that the "devil is in the details," which vary considerably across sites. For example, it matters a great deal the specific population(s) being targeted and their relative risk for domestic violence. Some projects are explicitly targeting families likely to be at high risk for domestic violence, such as families involuntarily involved in the child protection system, or under high stress, such as foster parents. These realities raise particularly complicated domestic violence screening, assessment and response issues even before you mix in marriage strengthening activities.

A related "devilish detail" that complicates screening and assessment in these projects is the perceived consequences of disclosing domestic violence in different settings. What will happen to a family, or to the children in that family, when domestic violence is disclosed in the context of exploring whether there is interest in participating in marriage related activities? Or, more precisely, what does the person being asked PERCEIVE will happen if they disclose domestic violence? This will be different if the person asking about domestic violence is a child protection caseworker, a TANF intake staff, the family's community-based case-manager, a Head Start

teacher, a home visitation nurse, someone from the in-hospital paternity establishment program, the family's minister, priest or rabbi, or a mentor couple working with the family.

A significant challenge for domestic violence advocates derives from the very nature of the marriage education programs currently being offered, which primarily focus on intact couples. These couples-based programs vary considerably in how they approach "domestic violence issues", and this ranges from programs who "screen out" couples when ANY past or present abuse is disclosed or detected (using varying definitions of what constitutes abusive behavior) to those programs that feel fully prepared to address even serious and current domestic violence as part of their marriage education program. Both extremes in response raise their own questions.

On one hand, if any disclosure of domestic violence in a past or current relationship automatically disqualifies someone from participating in a relationship skills training and supports that they need and want, is that appropriate? Might this in itself be a disincentive to disclosure? Does that put any job training, respite care, or other services attached to participation in the marriage education program out of reach for that family, regardless of need? What alternative services will available to those "screened out" from marriage or relationship enhancement programs for reasons of domestic violence?

On the other hand, it is widely accepted, at least among domestic violence experts, that "couples counseling" is contraindicated as a response to domestic violence or relationships characterized by one partner's forcefully asserting control over their partner. For couples work to be successful and meaningful, both parties must able to speak freely and honestly about relationship dynamics. The very nature of domestic violence interferes with this. We have found this to be particularly true if the perpetrator denies their use of abusive tactics and control, blames the abuse victim or has little commitment to change their behavior. Similarly, if the abuse victim shows fear of further violence, assumes responsibility for their partner's violence and abuse, or feels that they deserve it, couples work is not only counterproductive but also potentially dangerous.[18]

How do these guidelines related to the use of couples counseling, developed in other settings, apply to this "new" couples-based healthy marriage work? What level of "violence" or "aggression" has to exist – or be identified – for a couple to be screened in or out of a particular program? If a violent partner completes a batterers intervention program first to arrest their violence, is assessed to be at lower risk, and commits to non-violence, how might a carefully designed program assist a couple jointly interested in "working on the relationship"? What on-going safeguards need to be in place to provide ongoing monitoring and accountability for the abusive partner and support and safety for the victim of his past abuse?

Alternatively, is it possible to create a different set of options for a battered woman who might be placed at risk in a couples group, but might be interested in participating in a relationships skills class to help her deal with her children, with a co-parenting relationship, or with future relationships, as well as different opportunities to raise issues of abuse within relationships, either generally or specifically? Can carefully designed gender-specific programs, or sessions within a particular program, be used to explore violence and abuse issues (with both intervention and prevention goals) in ways that are both effective and safe? This could include discussions about what domestic violence looks like, whether this mirrors her experiences, and what safety means, as well as what a healthy relationship looks and feels like.

This will not only require careful collaboration between domestic violence experts, including survivors, and marriage education providers – including responsible fatherhood programs engaged in similar efforts and faced with many of the same challenges and opportunities -- but also an opening up of the current "marriage promotion" paradigm at the political, policy and program levels to include a more inclusive investment in *relationship* skills and *relationship* health.

There are excellent curricula and programs being adapted for use in more diverse communities, and with families whose lives and needs are differently complex than those previously accessing traditional marriage education programs. As new programs are developed and join existing ones in being evaluated and fine-tuned, how will quality assurance be guaranteed as trainers are five times removed from the original curriculum developers? And when they leave the hands of professionally trained clinicians and social workers and move into those of lay trainers? The domestic violence movement makes full and effective use of community volunteers (although highly trained), so this is not meant to disparage the roles that they can play, but rather suggests the need to pay attention to maintaining high standards as these programs proliferate.

Finally (at least in terms of this paper), we remain concerned about the lingering ambiguity related to how "success" will be defined and measured by individual healthy marriage programs and at the community, state and federal levels. What performance and outcome measures will be identified and assigned value, and what will they really show? Obviously, counting an increase in marriage or a decrease in divorce over time tells you little about the quality of relationships. Similarly, if someone decides NOT to marry the father of their child because she or he recognizes the abusive nature of the relationship or a fundamental incompatibility, isn't that a positive outcome? Will child well-being measures fully account for the negative impacts of child abuse, child sexual abuse, and childhood exposure to domestic violence on children, along with those negative outcomes

commonly attributed to the absence of two biological parents? Will initiative goals be set based on what *we* (which begs the question of who "we" includes) want families to look like, or more fully account for the rich diversity and complex realities of the families and communities being targeted? Will communities or individual participants be afforded self-determination in identifying the goals and outcomes of most value to them?

Clearly, there are many questions to consider. And addressing them will require ongoing dialogue and collaborative problem-solving into which we hope domestic violence advocates will be invited as respected and valued partners.

We can end with the good news we take from domestic violence protocol development work to date. Funded sites appear to taking domestic violence issues and protocol development seriously. And the protocol development process itself has served to educate partners about domestic violence, clarify important implementation issues, and identify cross training needs. These are positive outcomes in and of themselves and on which we must continue to build.

ENDNOTES

[1] Ganley, A. & Schechter, S. (1996). *Domestic Violence: A National Curriculum for Child Protective Services*. San Francisco: Family Violence Prevention Fund, (p.5). Because domestic violence or battering is a pattern of behavior primarily carried out by males, and because the overwhelming number of primary caretakers for children are female, the terms battered woman or mother are used frequently here to refer to the adult victim of domestic violence. However, adult and adolescent heterosexual and homosexual males and lesbians also experience the pattern of assaults and coercion commonly identified as domestic violence or battering.

[2] Ganley, A.L. (1989). Integrating feminist and social learning analysis of aggression: Creating multiple models for intervention with men who batter. In P.L.Ceasar & L.K. Hamberger (Eds.), *Treating men who batter: Theory, practice, and programs* (pp. 196-235). New York, Springer; Hamberger, L.K., & Barnett, O.W. (1995). Assessment and Treatment of men who batter. In L. VandeCreek, S. Knapp, et al. (Eds.), *Innovations in clinical practice: A source book* (pp. 31 – 54). Sarasota, FL: Professional Resource Press.

[3] *See* Tjaden, P. & Thoennes, N. (2000). *Full Report of the Prevalence, Incidence, and Consequences of Violence Against Women*, National Institute of Justice and the Centers For Disease Control And Prevention, Washington, DC and Atlanta, GA. Available at http://www.ncjrs.org/pdffiles1/nij/183781.pdf. According to National Crime Victimization Survey data from the Department of Justice, about 1 million violent crimes in 1998 (a conservative estimate) were committed against people by their current or former spouses, boyfriends, or girlfriends. These crimes were committed primarily against women. About 85% of victimizations by intimate partners in 1998, or 876,340, were against women. Intimate partner violence made up 22% of violent crime against women between 1993 and 1998. By contrast, during this period intimate partners committed 3% of the violence against men. *See* Rennison, C. M. & Welchans, S. (May 2000). *Special Report, Intimate Partner Violence*. Department Of Justice, Bureau of Justice Statistics, Washington, DC.

[4] Rennison, C. M. & Welchans, S. (May 2000). *Special Report, Intimate Partner Violence*. Department Of Justice, Bureau of Justice Statistics, Washington, DC.

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[6] Lyon E. (2000). *Welfare, Poverty and Abused Women: New Research and Its Implications.* Policy and Practice Paper # 10. Building Comprehensive Solutions to Domestic Violence. National Resource Center on Domestic Violence. Harrisburg, PA. *See* Lawrence (2002) *supra* note 4. *See* Tolman & Raphael (2001) *supra* note 4.

[7] Gazmararian J.A., Petersen R., Spitz A.M., Goodwin M.M., Saltzman L.E., & Marks J.S. (2000) Violence and Reproductive Health: Current Knowledge and Future Research Directions, *Maternal and Child Health Journal* 4(2):79-84.

[8] Carlson, B. E. (1984). Children's observations of interpersonal violence in Roberts, A.R. *Battered Women and Their Families* at 147-167 (A.R. Roberts, ed) NY: Springer. *See* Straus, M.A. (1992). Children as witnesses to marital violence: A risk factor for lifelong problems among a nationally representative sample of American men and women. *Report of the Twenty-Third Ross Roundtable*. Columbus, OH: Ross Laboratories.

[9] See Saunders, D. (1994), Child Custody Decisions in Families Experiencing Woman Abuse, 39 *Social Work*: 51.

[10] See *Violence by Intimates: Analysis of Data on Crimes by Current or Former Spouses, Boyfriends, and Girlfriends*. (March 1998). U.S. Department of Justice, Washington, DC.

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[13] *See* American Psychological Association Presidential Task Force on Violence and the Family, *Violence and the Family* 10 (1996); Jaffe, P. et al. (2002) Child Custody and Domestic Violence: A Call for Safety and Accountability 58-59.

[14] *See* Tjaden, P. & Thoennes, N. (2000) at 3.

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