An Analysis of Programs and Services Designed to Ameliorate Intimate Partner Violence and Sexual Violence Among Women with a History of Child Sexual Abuse

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ABSTRACT

SCHOOL OF SOCIAL WORK

MCSWAIN, JOHNETTA D. B.S. KENNESAW STATE UNIVERSITY, 2006
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AN ANALYSIS OF PROGRAMS AND SERVICES DESIGNED TO
AMELIORATE INTIMATE PARTNER VIOLENCE AND
SEXUAL VIOLENCE AMONG WOMEN WITH A
HISTORY OF CHILD SEXUAL ABUSE

Committee Chair: Richard Lyle, Ph.D.
Dissertation dated December 2015

This study examines program and services designed to ameliorate and prevent
intimate partner violence (IPV) and sexual violence (SV) among women with a history of
child sexual abuse (CSA) under the Violence Against Women Act and the Department of
Justice Reauthorization Act, 2005. Fifty-seven (57) survey participants at the 30th
National Symposium on Child Abuse Conference were selected for the study utilizing
non-probability convenience sampling. The survey participants comprised of workers or
volunteers in all aspects of child maltreatment. In sum, 55 (or 100%) of the participants
revealed that they agreed that there is a critical need for more program and services
designed to ameliorate and prevent IPV, DV and SV among women with a history of
CSA.
AN ANALYSIS OF PROGRAMS AND SERVICES DESIGNED TO
AMELIORATE INTIMATE PARTNER VIOLENCE AND
SEXUAL VIOLENCE AMONG WOMEN WITH A
HISTORY OF CHILD SEXUAL ABUSE

A DISSERTATION
SUBMITTED TO THE FACULTY OF CLARK ATLANTA UNIVERSITY
IN PARTIAL FULFILLMENT OF THE REQUIREMENTS FOR
THE DEGREE OF DOCTOR OF PHILOSOPHY

BY
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ATLANTA, GEORGIA

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I want to first thank my almighty heavenly father; without Him there would be no me, because He brought me from Alabama with a 10th grade education, a GED, and an steadfast determination to break the many cycles that plagued my family from generation to generation. I want to thank my committee, Dr. Lyle, Dr. Waymer, and Dr. Jackson, for their unwavering support. I owe a debt of gratitude to Mrs. King for her guidance and assistance through the administrative process of my dissertation submission. I want to thank my best friend, Tammi, for 30 years of unconditional love and support. I also acknowledge my other special friends for their support. I want to thank my husband, Willie, for his patience and support and for realizing that this is what I was born to do. Lastly, I pray that my two sons, RaShod and Jahleel, can be proud of me and continue to break the cycles in our family as well as start new ones with their families. As Fantasia sang in the Color Purple, “I am Here.”
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CHAPTER I
INTRODUCTION

In 2000, 1,247 women and 444 men were killed by an intimate partner. Intimate partner violence is responsible for approximately 33% of all female murder victims and 4% of all male murder victims in the United States (Rennison, 2003). Additionally, between 1998 and 2002, the U.S. Department of Justice reported that of 3.5 million violent crimes committed against family members, 49% of these were crimes against spouses, and that 84% of spouse abuse victims and 86% of dating partner abuse victims were female (Durose, 2005). The Centers for Disease Control and Prevention and the National Institute of Justice reported that nearly 25% of women reported being physically battered, raped, or stalked by an intimate partner throughout their life, with 1.5 million of these women reporting the abuse annually (Tjaden & Thoennes, 2000).

In the course of 20 years, intimate partner violence has spiraled, and has received expanded consideration from politicians throughout the United States. Nearby laws have been implemented more regularly (Martin, 1994). Among the progressions has been an endeavor to regulate the operation of victim intervention programs. Many states have established benchmarks for the treatment of court-mandated and self-assigned clients of intimate partner violence intervention programs by gathering research-based, hypothetical, and philosophical viewpoints to cultivate the most maximum services
possible (Maiuro, Hagar, Lin, & Olson, 2001). However, only a small number of states have acknowledged suitable services for women who have been in violent relationships.

Preceding the execution of obligatory arrest, pro-arrest, and mandatory arraignment, the judicial system did little to uphold laws restricting violent behavior against an intimate partner (Martin, 1994). Intimate partner violence crimes were more likely to be indicted than related crimes against outsiders, and carried more tolerant sentences. Law enforcement agencies for the most part endeavored to intervene in violent situations or refer one partner to go away for a while, to calm down (Stalans & Finn, 1995).

Required and pro-apprehension procedures were established to energize, if not oblige, police to make a capture if there is a sensible reason to infer that intimate partner violence at home has happened. Moreover, required indictment strategies oblige that these cases be indicted when the evidence is adequate, regardless if the victim chooses not to participate in the prosecution against the accused batterer (Martin, 1997).

After the implementation of required apprehension programs, the request for intimate partner violence representation expanded significantly (Gelles, 2002). These amenities are offered mainly on a fee-for-service premise, due to both a yearning to hold offenders responsible and the restricted accessibility of financing for intimate partner violence programs. The interest for administrations and the plea to secure an expanding rate of the court-requested business has brought some revenue driven associations into the matter of intimate partner violence intervention, creating existing programs to search
for ground-breaking approaches to provide intervention services. As indicated by Gelles (2002) this element has “rewarded entrepreneurship over effectiveness” (p. 13).

Martin (1997) stated:

The pro-arrest changes have led to dramatically increasing arrest rates for women in the past decade. One factor driving increased arrest rates for women is dual arrest, which refers to the practice of arresting both parties in a domestic violence incident at the same time. (p. 341)

Since it is perplexed to evaluate who is the actual offender (Mignon & Holmes, 1995), the law enforcement agency elects to leave that choice to the courts by arresting both offenders. States report that dual arrests have accounted for between 11% and 50% of domestic violence arrests since the implementation of mandatory arrest (Martin, 1997). In an effort to proliferate responsibility to families and update services, states have started to create benchmarks to monitor intimate partner violence programs. In spite of the fact that laws differ from state to state, states are progressively commanding that perpetrators convicted of intimate partner violence obtain batterer mediation services. It is projected that approximately 80% of partakers in batterer intervention services across the United States are court authorized to be present (Healey, Smith, & O’Sullivan, 1998).

Since many victims are mandated into therapy, they might not have the choice of deciding on the treatment that they feel best addresses their needs. Likewise, members of this community may be a challenge to serve because they may not have the inspiration to change or even to partake. This can cause high dropout rates or fruition of time in the project without any substantial behavioral changes (Danis, 2003).
Studies assessing intimate partner violence intervention services have reported alternative points of view on viability. Studies report that during counseling, 90% of men do not physically hurt their partners, and two-thirds to three-quarters do not re-offend within a year following counseling (Edleson & Syers, 1991).

Yet, it is not known whether this change is accredited to the treatment of group effectiveness, distress of legal consequences, or absence of interaction with companion. In the course of the two-year follow up, nearly 40% of couples had parted, possibly subsidizing to the changes in violent behavior (Gortner, Gollan, & Jaconson, 1997). In light of these dynamics, it is challenging to delineate the efficiency of treatment.

Irrespective of the irregularities in research on the efficacy of intimate partner violence intervention services, the courts remain to have faith in these programs to treat those arrested for intimate partner violence. Danis (2003) opposed that enrollment in court mandated intimate partner violence intervention programs may offer victims unrealistic expectations that the violence will expire. However, research indicates that intimate partner violence intervention services may not certainly be viable with some clients allocated to problems such as extreme dropout rates and services that are not personalized to the specific needs of clients. Hence, observance is needed to warrant that programs are based on the best plausible data and services to the families that are served.

**Statement of the Problem**

Intimate partner, dating, and sexual violence are exorbitant and prevalent concerns in this nation, causing victimized people, as well as onlookers and eyewitnesses, in every locality, to undergo enormous torment and misfortune. In some of the lives taken
and wounds endured, intimate partner violence rescinds the sentiment of success that permits individuals to flourish. Likewise it can be the foundation to long lasting health problems, and reduce children’s projections in school and later in life. The United States has made headway in the most recent couple of decades in confronting this violence, bringing about wanted declines – yet, there is further work to do to execute the methods that hold the most guarantee. These incorporate educating the next generation that violence is not right, training mental health providers with cutting edge data that will aid them to better evaluate victims for abuse, executing prevention in the work environment, strengthening victim support services, and providing services that are accessible to all exploited people, including settlers and children who observe violence (Catalano, 2007).

On average, more than three women a day are killed by their husbands or boyfriends in the United States. In 2005, 1,181 women were murdered by an intimate partner (Catalano, 2007). In 2008, the Centers for Disease Control and Prevention published data collected in 2005, which revealed that women experienced two million injuries from intimate partner violence each year. Nearly one in four women in the United States reported experiencing violence by a current or former spouse or boyfriend at some point in her life (Centers for Disease Control and Prevention, 2008).

Women are much more probable than men to be victimized by a present or former intimate partner (U.S. Department of Justice, Bureau of Justice Statistics, 2008). Women are 84% of spouse abuse victims and 86% of victims of abuse at the hands of a boyfriend or girlfriend, and about three-fourths of the persons who commit family violence are male (U.S. Department of Justice, Bureau of Justice Statistics, 2005).
There were 248,300 rapes/sexual assaults in the United States in 2007, more than 500 per day, up from 190,600 in 2005. Women were more likely than men to be victims; the rate for rape/sexual assault for persons age 12 or older in 2007 were 1.8 per 1,000 for females and 0.1 per 1,000 for males (U.S. Department of Justice, Bureau of Justice Statistics, 2008). Young women age 20 to 24 also experience the highest rates of rape and sexual assault, followed by those 16 to 19 (U.S. Department of Justice, Bureau of Justice Statistics, 2008). American Indian and Alaska Native women experience the highest rates of intimate partner violence (Catalano, 2007).

The primary focus of this study was to ascertain if there is a critical need to implement more prevention and intervention program services, and whether or not program prevention and intervention services for the amelioration of intimate partner violence and sexual violence among women with a history of child sexual abuse overall offers effective client services. The study sought to explain the critical need, magnitude, and the effectiveness of program prevention and intervention services for intimate partner violence and sexual violence victims by gathering data from the participants at the 30th National Symposium on Child Abuse. The data pertained to areas such as: job position, victim of domestic violence (intimate partner violence) and/or sexual assault (sexual violence), working with domestic violence and/or sexual assault victims, child sexual abuse, prevention/intervention services, and re-victimization.

The data measured the critical need to implement more program prevention and intervention services, along with the efficacy of program prevention and intervention services’ ability to provide the most successful strategies for crisis intervention, short
term and long term individual and group support services, counseling, advocacy through community, medical, criminal justice, and social support services. In addition, this study explored the mass psychological and social risk factors, barriers, and cycles of intimate partner violence and sexual assault among women with a history of re-victimization. This study sought to explain how these factors further exacerbate the prevalence of violence against women.

In closing remarks, the prevalence of domestic, dating, and sexual violence is a global epidemic. The United Nations Development Fund for Women (2003) estimates that at least one of every three women globally will be beaten, raped, or otherwise abused during her lifetime. In most cases, the abuser is an individual from her own family. All women, regardless of age, are at risk for domestic, dating, and sexual violence, and those age 20-24 are at the greatest risk of encountering nonfatal intimate partner violence (Catalano, 2007).

**Purpose of the Study**

The purpose of the study was to explain whether participants at the 30th National Symposium on Child Conference believed there is a critical need for the implementation of more prevention and intervention program services. The study also sought to explain whether or not program prevention and intervention services for the amelioration of intimate partner violence and sexual violence among women with a history of child sexual abuse offered effective services to the clients they served.

The study was designed to explain the critical need, magnitude, and the effectiveness of program prevention and intervention services for intimate partner
violence and sexual violence victims by gathering data from participants at the 30th National Symposium on Child Abuse. The data pertained to areas such as: job position, victim of domestic violence (intimate partner violence) and/or sexual assault (sexual violence), working with domestic violence and/or sexual assault victims, child sexual abuse, prevention/intervention services, and re-victimization.

The participants of the study were victim advocates and nationally-recognized experts from all facets of the child maltreatment field at the 30th National Symposium on Child Abuse, which is a conference designed to bring awareness to program prevention and intervention services for intimate partner violence, sexual violence, child abuse and neglect, and other forms of child maltreatments. The latest research on the effectiveness and successes of agencies and client services under the Violence Against Women Act and Department of Justice Reauthorization Act of 2005 is presented at the symposium.

Research Questions

The research questions of the study were as follows:

1. Is there evidence of a critical need for the implementation of more prevention/intervention program services for the amelioration of intimate partner violence and sexual violence among women with a history of child sexual abuse under the Violence Against Women Act and Department of Justice Reauthorization Act of 2005, based on data from the participants who attended the 30th National Symposium on Child Abuse Conference?

2. Is there evidence of a need for present job positions to work with victims of intimate partner violence under the Violence Against Women Act and Department
of Justice Reauthorization Act of 2005, based on data from participants who attended the 30th National Symposium on Child Abuse Conference?

3. Is there a statistically significant relationship between the participants who were victims of repeat intimate partner violence (IPV) under the Violence Against Women Act and Department of Justice Reauthorization Act of 2005, and the ability of the participants to provide the latest research information that addresses all aspects of child maltreatment, and the opportunity to develop and enhance participants’ skills among the participants at the 30th National Symposium on Child Abuse Conference?

4. Is there a statistically significant relationship between the awareness of the Violence Against Women Act and Department of Justice Reauthorization Act of 2005, and organizations that are funded by a state and government program under the Violence Against Women Act and Department of Justice Reauthorization Act of 2005, among participants who attended the 30th National Symposium on Child Abuse Conference?

5. Is there a statistically significant relationship between participants who have been victims of intimate partner violence (IPV) and participants who are repeat victims of intimate partner violence under the Violence Against Women Act and Department of Justice Reauthorization Act of 2005 among the participants who attended the 30th National Symposium on Child Abuse Conference?

6. Is there a statistically significant relationship between participants who have been victims of sexual violence and participants who are repeat victims of sexual violence?
violence under the Violence Against Women Act and Department of Justice Reauthorization Act of 2005 among the participants who attended the 30th National Symposium on Child Abuse Conference?

7. Is there a statistically significant relationship between participants who have been victims of child sexual abuse and participants who work with victims of child sexual abuse under the Violence Against Women Act and Department of Justice Reauthorization Act of 2005 among the participants who attended the 30th National Symposium on Child Abuse Conference?

8. Is there a statistically significant relationship between participants who are victims of repeat sexual violence and the participants who are victims of repeat intimate partner violence under the Violence Against Women Act and Department of Justice Reauthorization Act of 2005 among the participants who attended the 30th National Symposium on Child Abuse Conference?

9. Is there a statistically significant relationship between organizations that offer prevention/intervention services for victims of sexual violence and intimate partner violence and the overall quality of effective program prevention and intervention services for clients under the Violence Against Women Act and Department of Justice Reauthorization Act of 2005 based on data from the participants who attended the 30th National Symposium on Child Abuse Conference?
Hypotheses

The null hypotheses of the study were as follows:

1. There is no evidence of a critical need for the implementation of more prevention/ intervention program services for the amelioration of intimate partner violence and sexual violence among women with a history of child sexual abuse under the Violence Against Women Act and Department of Justice Reauthorization Act of 2005, based on data from the participants who attended the 30th National Symposium on Child Abuse Conference.

2. There is no evidence of a need for present job positions to work with victims of intimate partner violence under the Violence Against Women Act and Department of Justice Reauthorization Act of 2005, based on data from participants who attended the 30th National Symposium on Child Abuse Conference.

3. There is no statistically significant relationship between the participants who were victims of repeat intimate partner violence (IPV) under the Violence Against Women Act and Department of Justice Reauthorization Act of 2005, and the ability of the participants to provide the latest research information that addresses all aspects of child maltreatment, and the opportunity to develop and enhance participants’ skills among the participants at the 30th National Symposium on Child Abuse Conference.

4. There is no statistically significant relationship between the awareness of the Violence Against Women Act and Department of Justice Reauthorization Act of 2005, and organizations that are funded by a state and government program under
the Violence Against Women Act and Department of Justice Reauthorization Act of 2005, among participants who attended the 30th National Symposium on Child Abuse Conference.

5. There is no statistically significant relationship between participants who have been victims of intimate partner violence (IPV) and participants who are repeat victims of intimate partner violence under the Violence Against Women Act and Department of Justice Reauthorization Act of 2005 among the participants who attended the 30th National Symposium on Child Abuse Conference.

6. There is no statistically significant relationship between participants who have been victims of sexual violence and participants who are repeat victims of sexual violence under the Violence Against Women Act and Department of Justice Reauthorization Act of 2005 among the participants who attended the 30th National Symposium on Child Abuse Conference.

7. There is no statistically significant relationship between participants who have been victims of child sexual abuse and participants who work with victims of child sexual abuse under the Violence Against Women Act and Department of Justice Reauthorization Act of 2005 among the participants who attended the 30th National Symposium on Child Abuse Conference.

8. There is no statistically significant relationship between participants who are victims of repeat sexual violence and the participants who are victims of repeat intimate partner violence under the Violence Against Women Act and
Department of Justice Reauthorization Act of 2005 among the participants who attended the 30th National Symposium on Child Abuse Conference.

9. There is no statistically significant relationship between organizations that offer prevention/intervention services for victims of sexual violence and intimate partner violence and the overall quality of effective program prevention and intervention services for clients under the Violence Against Women Act and Department of Justice Reauthorization Act of 2005 based on data from the participants who attended the 30th National Symposium on Child Abuse Conference.

**Significance of the Study**

There is no appraisal of the worldwide prevalence of either intimate partner violence or sexual violence. Approximations differ by country, as do per study systems (i.e., how these types of violence are measured) and which practices or encounters are incorporated in the commonness gauge. Case in point, approximations of the predominance of IPV measure physical abuse alone, overlook essential measurements of IPV and, subsequently, are lesser than approximations that also include sexual and mental abuse (Garcia-Moreno, 2005).

Population-based studies from various countries indicate that between 10% and 69% of women report that an intimate partner has physically abused them at least once in their lifetime (Heise, 1999; Heise & Garcia-Moreno, 2002), and between 6% and 47% of women report attempted or completed forced sex by an intimate partner in their lifetime (Jewkes, 2002). According to international crime victimization surveys, between 0.8%
and 8% of women aged 16 years and older report having experienced sexual assault in the previous five years (Jewkes, 2002).

This study aimed to bring awareness to the policy makers, social workers, advocates, law enforcement, community, and other allies on how to improve program prevention and intervention services for the amelioration of intimate partner violence and sexual violence. Information was gathered from the participants at the 30th National Symposium on Child Abuse Conference on the effectiveness and success of policy and programs that are being implemented globally at domestic violence and sexual assault shelters and crisis centers, schools, colleges, substance abuse centers, health care facilities, government agencies and educational programs.

The success or failure of these program prevention and intervention services depends largely upon primary prevention which means reducing the number of new cases of intimate partner violence and sexual violence by intervening before any violence occurs. This method contrasts with other effective services from social networks and support providers, which include community, medical, and mental, and city, state and local resources. The more successful the programs are, the less likely the survivors of intimate partner violence and sexual violence will be re-victimized.

It is, therefore, of great significance to demonstrate with these data whether there is a critical need for more program prevention and intervention services for the amelioration of intimate partner violence and sexual violence among women with a history of child sexual abuse, and whether the overall quality of client services is effective and reduces re-victimization.
CHAPTER II
REVIEW OF LITERATURE

The purpose of presenting this review of the literature is to provide a scholarly foundation to ascertain a need for the study. This chapter review of the current literature is to inform readers of the urgency of the continuation and implementation of effective program prevention and intervention services for the amelioration of the prevalence of intimate partner violence and sexual violence among women with a history of child sexual abuse.

The literature review covers a historical perspective of the prevalence of intimate partner violence and sexual violence which includes the origin of the Battered Women’s Movement and the openings of the first shelters for battered women. The study also outlines the prevalence, risks, and prevention of intimate partner violence and sexual violence, as well as identifies interdisciplinary prevention and intervention services and campaigns that provide the most effective services for intimate partner violence and sexual violence victims. Furthermore, the Violence Against Women Act (VAWA), and Violence Against Women and Department of Justice Reauthorization Act of 2005; Title II-Improving Services for Victims of Domestic Violence, Sexual Assault, and Stalking, H.R. 3402-34, are covered. Lastly, the literature review discloses the epidemic physical,
social, and psychological impact associated with intimate partner violence, sexual
violence, and child sexual abuse.

**Battered Women’s Movement and Creation of the Wife Beating Problem**

An awareness of batterer intervention services has expanded dramatically as a
result of the increasing problems of violence against women. In 1971, Chiswick
Women’s Aid was one of the first significant safe houses for battered women and was
secured in London, England. Erin Pizzey, who was one of the shelter’s original
organizers, set forward to expand the awareness of the harsh reality of intimate partner
violence by organizing a radical movement and advocating through different sources,
which included speaking tours and a book entitled *Scream Quietly or the Neighbors Will
Hear*. In 1976, Pizzey’s frustration spiraled a movement to ameliorate violence against
women which led numerous advocates, political figures, and legislators to examine
intimate partner violence, which brought about a law that was passed giving a widespread
range of protection to abused women (Pizzey, 1974).

Thus, by 1980, the National Women’s Aid Federation had roughly sponsored 150
shelters, which mostly provided services to underprivileged and deprived women and
their children (Johnson, 1981). Moreover, in 1973, the United States reacted to the
turmoil of wife beating by focusing on the conveyance of shelters and emergency
services. Finally, the United States joined the movement and opened its first known
shelter for battered women called the Rainbow Re-Treat, in Phoenix, Arizona.
Subsequently, in 1974, Haven House in Pasadena, California, La Casa de las Madres in
San Francisco, and Transition House in Cambridge, Massachusetts opened up its doors and began protecting abused women from their abusers (Tierney, 1982).

Throughout the 1970s, a passionate social worker, named Maria Roy, and other advocates aided organizations and groups such as Women’s Advocates Inc. in St. Paul, Minnesota and Abused Women’s Aid in Crisis (AWAIC) in New York City to create a hotline to offer crisis counseling to end violence against women (Roy, 1977).

According to the U.S. News and World Report (1979):

Estimates of the number of groups currently serving battered women in the United States vary but, by all accounts, assistance for battered women has dramatically improved since 1975. Ms. (1976) listed 20 sources of assistance; Davidson (1978) listed 65 shelters in 26 states and the District of Columbia; the U.S. Commission on Civil Rights (1978) named over 300 shelters, hotlines, and groups performing as advocates for battered women with the police, the courts, and housing and public assistance agencies. Between 1975 and 1978 more than 150 shelters opened in the United States. (p. 208)

Since 1975, the movement has made significant progression in three areas besides emergency shelter: legislation, government policy and programs, and research and public information.

(1) Legislation: According to the scholars of the U.S. justice system, all except the vicious and blatant cases involving battered wives who file charges against their husbands have been difficult to prosecute. Protective and restraining orders have also
proved to be unsuccessful against intimate partner violence (Field & Field, 1973). The effort has stimulated lawmakers to expand safeguards for abused women, create tougher laws, implement severe punishments for abusers, and increase fines, while reinforcing women’s safety and making it less stressful for them to file charges against their abusers (Kalmuss & Straus, 1981).

Between 1979 and 1980, masses of states followed closely and passed identical laws to combat intimate partner violence cases. Although, previously, some state laws were passed successfully, that has not always been the case. In 1977, Congress proposed two intimate partner violence laws; both failed. In 1978, the Domestic Violence Assistant Act was unsuccessful. And once again in 1980, the Domestic Violence Prevention and Services Act was terminated by its organizers (Kalmuss & Straus, 1981).

(2) Government Policy and Programs: According to the U.S. government agencies, new, current, or prolonged programs have been created and designed for battered women to better expound on the causes of intimate partner violence. In late 1970, the Law Enforcement Assistance Administration (LEAA) put millions of dollars into ameliorating family violence. Initially, LEAA aid was directed through Victim Witness Assistance Programs and the Neighborhood Justice Programs (McGillis & Mullen, 1977; Viano, 1979). According to New York Times (1977), “LEAA triplicated its allocation to $1 million a year, precisely for intimate partner violence programs” (p. 209).

(3) Research and Information: Data sources have thrived on the causes and outcomes of intimate partner violence. In early 1970, The National Institute of Mental
Health began allocating funds for studying family violence (Family Violence Research Program, 1979). According to the National Clearinghouse on Domestic Violence (1980), the Office on Domestic Violence also funds research projects and publishes a series of articles on how to set up programs and advocate for battered women.

In January 1978, the U.S. Commission on Civil Rights (1978):

Held a nationwide conference on policy concerning intimate partner violence. The National Coalition Against Domestic Violence was a representative at the conference. Later that year, the Washington-based Feminist Alliance Against Rape began producing a magazine called Aegis, which focuses on intimate partner violence against women. These national activities and information sources are complemented by numerous local programs in communities throughout the United States. (pp. 209-210)

Today, there are nationwide events, including marches, candle light vigils, silent witness walks, conferences, organizations, websites, reading materials, fund raisers, testimonials, documentaries, biographies, research, medical findings, and tons of resources that are provided free by various local programs, schools, libraries, churches, shelters, and organizations in neighborhoods throughout the United States (The U.S. Commission on Civil Rights, 1978).

**Violence Against Women Act (VAWA)**

Since the 1970s, violence against women has been recognized as a severe problem; in the 1980s, legislation initially presented a federal reply to such violence.
Congressional action to take a look at gender-related violence climaxed in the representation of two major laws—The Family Violence Prevention and Services Act (FVPSA) and the Violence Against Women Act (VAWA), which is Title IV of the Violent Crime Control and Law Enforcement Act of 1994.

In 1984, an act was approved and the FVPSA supported states in deterring occurrences of family violence and offered shelter and similar assistance to victims of family violence and their dependents. The act permits programs that offer technical assistance and training on family violence to states, local public agencies, nonprofit private organizations, and others. Although appropriations for programs for both acts are incorporated in this report, the emphasis of the discussion is VAWA (Laney, 2010).

The Violence Against Women Act, originally enacted in 1994 as Title IV of the Violent Crime Control and Law Enforcement Act of 1994 (P. L. 103-322), highlights funding of enforcement efforts as well as educational and communal programs to ameliorate crime. The emphasis of the funding is on local government programs, a tactic that the sponsors of the legislation assumed was the most favorable practice for reducing crime and violence.

The largest funded VAWA program, the Services-Training-Officers-Prosecutors (STOP) formula grants, is to assist state governments, Indian tribal governments, and entities of local government to strengthen law enforcement, prosecution, and victims’ services in cases involving violent crimes against women. These STOP grants could be utilized to offer personnel training, technical assistance, collecting data, and other tools to
accelerate the trepidation, prosecution, and adjudication of persons committing violent crimes against women (Laney, 2010).


The Violence Against Women Act of 2000 continued to support VAWA by reauthorizing current programs and adding advantages, including grants to assist victims of dating violence, transitional housing for victims of violence, an experimental program designed to protect children while visiting with a parent who has been accused of domestic violence, and protection for elderly and disabled women from violence. It also prepared technical amendments, and required grant recipients to submit reports on the efficacy of programs funded by the grants to assist with the distribution of information on successful programs (VAWA, 2000).

The legislation amended the Public Health Service Act (P.L. 98-457) to entail that certain funds be used entirely for rape prevention and education programs. Likewise, the bill made it more accessible for a battered immigrant woman to leave her abuser and to aid in prosecuting him. Under the previous law, battered immigrant women could be extradited if they left abusers who are their supporters for residency and citizenship in the
United States. VAWA 2000 generated a special set of rules for alien battered spouses and children to allow them to continue living in the United States (Laney, 2010).

**Violence Against Women and Department of Justice Reauthorization Act of 2005**


The act accentuates cooperation within law enforcement, health and housing professionals, and women, men, and adolescent groups, and inspires communal initiatives to make aware of these concerns. Innovative programs strive to pay more attention to young victims of violence, advance the health care system’s reaction to violence, notify the public and employers about domestic and dating violence, sexual assault, and stalking, safeguard the privacy of victims of violence, offer housing assistance, including public housing for battered women and children, and rally behind outreach efforts to underserved populations such as ethnic, immigrant, and racial populations (Laney, 2010).

In a determination to carefully monitor the position and performance of some programs, VAWA 2005 allows for some grant providers to submit reports on the policies and techniques they followed. The act also offers funding for studies and research on operative interventions that inhibit both acts and outcomes of domestic and dating violence, sexual assault, and stalking (Laney, 2010).
In 2005, Congress improved more services for victims of domestic violence, dating violence, and sexual assault. Some improvements included, improving services for domestic elder abuse, disabled women and immigrant women. This study focuses on Title II, Sections 201, 2014 and 40295. These findings of the Violence Against Women Act and Department of Justice Reauthorization Act of 2005, HR 3402 policy will improve services for victims of domestic violence, dating violence, sexual assault, and stalking (Violence Against Women Act and Department of Justice Reauthorization Act of 2005, H. R. 3402-34).

**Violence and Types of Violence**

There are countless ways to define violence. For the purpose of this study, violence is defined by the World Health Organization (1994) as:

The intentional use of physical force or power, threatened or actual, against oneself, another person, or against a group or community that either results in or has a high likelihood of resulting in injury, death, psychological harm, mal-development or deprivation. (p. 4)

The definition excludes unintentional incidents – such as most road traffic injuries and burns. This definition covers an extensive range of outcomes – including psychological harm, scarcity and mal-development. This mirrors a growing acknowledgement among researchers and practitioners of the essential need to include violence that does not
usually result in injury or death, but on the other hand poses a significant weight on individuals, families, communities and health care systems worldwide (World Health Organization, 1996).

Countless forms of violence against women, children, and seniors can cause physical, mental, and social difficulties that do not inevitably lead to injury, disability, or death. These outcomes can be instantaneous, as well as suppressed, and can continue for years after the preliminary abuse. Outlining results exclusively in relations to injury or death therefore can restrict the understanding of the thorough effect of violence on people, populations and humanity as a whole (World Health Organization, 1996).

Additional facets of violence, although not obviously mentioned, are also included in the definition. Case in point, the definition verifiably incorporates all demonstrations of brutality, whether they are open or private, whether they are responsive (because of past occasions, for example, incitement) or proactive (instrumental for or envisioning more self-serving results) or whether they are illegal or non-illegal. Each of these perspectives is imperative in comprehending the origins of violence and in creating prevention programs (Dodge & Colie, 1987).

In its 1996 purpose, WHA49.25, announcing violence as a primary public health issue, the World Health Assembly approached the World Health Organization to generate a typology of violence that classified the diverse types of violence and the associations amongst them. Limited typologies exist already and none is very inclusive (Foege, Rosenberge, & Mercy, 1995).
The typology featured here divides violence into three broad categories according to characteristics of those committing the violent act: (1) self-directed violence; (2) interpersonal violence; and (3) collective violence. This initial categorization differentiates between violence a person inflicts upon himself or herself, violence inflicted by another individual or by a small group of individuals, and violence inflicted by larger groups such as states, organized political groups, militia groups, and terrorist organizations. These three broad categories are each divided further to reflect more specific types of violence (World Health Organization, 1996).

Self-directed violence is subdivided into suicidal behavior and self-abuse. The former includes suicidal thoughts, attempted suicides – also called “para-suicide” or “deliberate self-injury” in some countries – and completed suicides. Self-abuse, in similarity, includes acts such as self-mutilation (World Health Organization, 1996, p. 19). Suicidal behavior varies in degree from simply contemplating about ending one’s life, to preparing for it, discovering the resources to do so, making an effort to kill oneself, and carrying out the act. Nevertheless, these should not be seen as different points on a single scale. Countless people who bore suicidal thoughts by no means act on them, and even individuals who attempt suicide may have no intent of dying (World Health Organization, 1996).

Interpersonal violence is divided into two subcategories: (1) family and intimate partner violence – that is, violence mainly among family members and intimate partners, generally, though not solely, taking place in the household; (2) community violence – violence between people who are not related, and who may or may not be acquainted
with each other, usually taking place outside of the household (World Health Organization, 1996).

The previous group contains forms of violence such as child abuse, intimate partner violence, and elderly abuse. The latter includes adolescent violence, unplanned acts of violence, rape or sexual assault by unfamiliar persons, and violence in unofficial settings such as schools, workplaces, prisons, and nursing homes (World Health Organization, 1996).

Collective violence is the contributory use of violence by individuals who distinguish themselves as followers of a group against another group or set of people, in an effort to attain governmental, monetary, or social goals. It takes an assortment of structures: armed clashes inside or between states; genocide, repression and other human rights abuses; terrorism; and organized violent crime (World Health Organization, 1996). The typology, likewise, describes the nature of violent acts, which can be physical, sexual, or psychological, or include deprivation or neglect. The typology also takes into consideration the significance of the setting, the association between the offender and victim, and in the case of collective violence – the conceivable intentions for the violence (World Health Organization, 1996).

Numerous danger elements such as alcohol misuse, the availability of guns, or financial inconsistencies are also shared in most types of violence. These connections are essential on the grounds that they demonstrate the potential for preventing numerous kinds of violence through interventions to address lesser risk factors. They likewise
bolster the need for more noteworthy cooperation between organizations operating in the prevention of dissimilar forms of violence (Paolucci, 2001).

Worldwide and national statistics are limited. Yet, it is estimated that 1.6 million people died from violence in 2000, which corresponds to 2.8.8 per 100,000 population. Just about half of these deaths were suicides, nearly a third was homicides, and a fifth were war-related. Rates differ significantly between and inside nations (Krug, Dahlberg, Mercy, Zwi, & Lorano, 2002). Lacking dependable information, worldwide estimates for the dissimilar types of abuse are challenging to create. Be that as it may, the widespread nature of violence is clear; in 48 population-based studies from around the world, between 10% and 69% of women reported having been physically assaulted by an intimate partner during their lifetime (Heise et al., 1999), about 20% of women and 5% to 10% of men reported having been sexually abused as children (Finkelhor, 1988; 1994).

Abundant research has proven that the health consequences of violence are far more extensive than death and wounds. Victims of violence are at risk of psychological and behavioral problems, including depression, alcohol abuse, anxiety, and suicidal behavior, and reproductive health problems, such as sexually transmitted diseases, unwanted pregnancies, and sexual dysfunction (Heise et al., 1999; Fergusson, Horwood, & Lynskey, 1996; Davidson, Hughes, George, & Blazer, 1996; Wiederman, Sansone, & Sansone, 1998).

Violence cannot be ascribed to a solitary variable. Its causes are difficult and arise at diverse stages. To characterize these difficult stages, this report uses an ecological model with four levels (Garbarino & Crouter, 1978; Bronfenbrenner, 1979; Garbarino,
1985; Tolan & Guerra, 1994; Heise, 1998; Schiamberg & Gans, 1999; Carp, 2000). The first level classifies natural and individual factors that impact how people act and improve their probability of becoming a victim or perpetrator of violence: demographic characteristics (age, education, and income), personality disorders, substance abuse, and a history of experiencing, witnessing, or engaging in violent behavior.

The second level concentrates on close affiliations, such as those with family and friends. One example for youth violence, is having friends who participate in or encourage violence can escalate an adolescent’s risk of being a victim or perpetrator of violence. For intimate partner violence, the most unwavering indicator at this level of the model is martial conflict or not being able to see eye-to-eye in the relationship (Thornberry, Huizina, & Loeber, 1995; Lipsey & Derzon, 1998).

The third level investigates the community connection-i.e., schools, place of work, and neighborhoods. The threat at this level may be caused by factors such as the existence of a local drug trade, the scarcity of social networks, and poverty. Altogether, these factors have been made known to be momentous in many types of violence.

Lastly, the fourth level gazes at the extensive social factors that help produce an environment in which violence is encouraged or withdrawn. These social factors include the receptiveness of the criminal justice system, social and cultural norms concerning gender roles or parent-child relationships, income disparity, the power of the social welfare system, the social tolerability of violence, the accessibility of guns, the introduction to violence in mass media, and political uncertainty.
Intimate Partner Violence (IPV)

For the sake of this study, the phrase “intimate partner violence (IPV)” is used, previously referred to as domestic violence, which is a prevalent and severe social problem of a noteworthy scope (U. S. Department of Justice, 2006). According to the World Report on Violence and Health (1996), “intimate partner violence refers to any behavior within an intimate relationship that causes physical, psychological or sexual harm to those in the relationship” (p. 341). Such behavior includes: (1) acts of physical aggression – such as slapping, hitting, kicking, and beating; (2) psychological abuse – such as intimidation, constant belittling, and humiliating; (3) forced intercourse and other forms of sexual coercion; and (4) various controlling behaviors – such as isolating a person from their family and friends, monitoring their movements, and restricting their access to information or assistance. When abuse occurs repeatedly in the same relationship, the phenomenon is often referred to as battering (World Health Organization, 1996).

While estimates vary, as many as six million women are assaulted each year in the United States, of which nearly two million experience serious assaults (CDC, 2008; Tjaden & Thoennes, 2000; Wood, 1997). The lifetime prevalence estimates of interpersonal violence ranges between 22% and 33% (CDC, 2008). Each year in the United States, approximately 30% of female homicides are perpetrated by intimate partners (Ellison & Anderson, 2001). The social problem of intimate partner violence ranges beyond the United States. Yearly estimates of female murder victims worldwide
indicate that 40-70% of all female murder victims are killed by an intimate partner (U.S. Department of Justice, 2006).

Intimate partner violence affects women of all racial, ethnic, socioeconomic, and religious groups (Adams, 1994; Brade & Bent-Goodley, 2009; Nason-Clark, 2004; Tjaden & Thoennes, 2000). In short, “a victim of IPV may be anyone with whom you interact with on a daily basis” (Adams, 2000, p. 162).

According to Wood (1997), “There is no common denominator to distinguish victims of intimate partner violence from anyone else” (p. 61). Women that live in the suburbs experience intimate partner violence at nearly the same degrees and magnitudes as women belonging to lower financial classes. Certainly, women are not the only victims of IPV. Men and children are not exempted from experiencing intimate partner violence. However, 95% of victims of domestic, sexual, and intimate partner violence are women (Adams, 1994; CDC, 2008; Schlueter, 1996).

The physical, mental, and social degrees of intimate partner violence are plentiful, multi-faceted, and far-reaching. Professionals who respond to situations involving intimate partner violence must have a clear-cut understanding of the problems, susceptibilities, and actions needed to respond compassionately and with sympathy. Intimate partner violence crimes are the most dominant cause of injuries for which women seek medical care. More women in America are being assaulted by people they associate with than by strangers (Wood, 1997; Coleman, 2004). According to the National Crime Victimization Survey, 232,960 women were raped or assaulted in 2006.
Even in older reports, Adams (1994) noted that rape and sexual assault were frequently part of the abuse perpetrated against women.

Aside from observable physical signs of abuse, such as bruising, cuts, and broken bones, researchers have logged several other adverse physical and psychological health outcomes from abuse (Kelley & Johnson, 2008). These include body mutilation, prolonged pain, migraines/tension headaches, chronic pelvic pain, spastic colon, repeated indigestion, diarrhea or constipation, gastric reflux, stomach ulcers, hearing loss, cardiovascular illnesses such as hypertension and tachycardia, sexually transmitted diseases, and bladder and kidney infections (Coker, Smith, Bethea, King, & McKeown, 2000; Stop the Violence Against Women, 2006).

Abused women were 80% more likely to have a stroke, 70% more likely to have heart disease and arthritis, and 60% more likely to have asthma. These antagonistic health illnesses are produced by the immediate infliction of physical abuse on the victim and the mental effects of encountering physical and psychological abuse. In addition to physical health issues, victims of IPV may likewise develop adverse psychological conditions (CDC, 2008).

Jones and Schecter (1992) identified five primary feelings that women who are abused by their partners experience: fear, shame, guilt, anger, and a sense of “going crazy” (pp. 42-44). Additionally, victims may experience other adverse psychological conditions, including anxiety, depression, impaired affect modulation, self-destructive and impulsive behavior, dissociative symptoms, feelings of ineffectiveness, increased arousal and hyper-vigilance, despair or hopelessness, disempowerment (Beaulieuır,
Seff, & Newman, 2008), feeling permanently damaged, a loss of previously-held beliefs, hostility, social withdrawal, feeling constantly threatened, insomnia or hypersomnia, or a change in previous personality characteristics. In fact, victims of intimate partner violence may meet full or partial criteria for posttraumatic stress Disorder (Kelly & Johnson, 2008).

Intimate partner violence yields other negative effects besides physical and psychological disorders. An IPV victim may possibly suffer an unfavorable change in her social environment or relationships. Reports from Women’s Rural Advocacy Programs (2010) corroborate Adams’ (1994) findings. According to Adams:

In response to battering, the victim changes something about herself in an effort to accommodate the perpetrator. Frequently, this involves restricting her freedom, stopping relationships with friends and family [the abuser] has objected to (which is usually all of her friends and family since they all pose a threat to his control), or even quitting work. Often, his behavior limits her access to a car or her ability to even leave the house. (p. 17)

Therefore, over a period of time, the victim becomes progressively secluded from the community of loved ones who might then offer love and support and assist her with leaving the abusive relationship. Surely, feelings of isolation are mutual among women that are abused. This logic of lonesomeness develops from the indiscernibility of the difficulties of abuse. Since intimate partner violence is not generally conversed in public, a victim may sense that she is the only individual who is encountering abuse (C. Reardon, Personal Communication, January 30, 2008). Eventually, a violent involvement can lead
to a progressively remote and lonely way of life, as the perpetrator consistently applies control and forces a victim to become even more reliant on the perpetrator.

Wood (1997) states several reasons why a woman stays, but proffers that the primary reason for staying is fear of being killed. Wood reports that:

A woman is 75% more likely to be killed if she leaves her violent relationship than if she stays. Second, she may not have other means of financial support for herself or her children. Third, she may feel guilty or ashamed and may want to hide what happened to her. She may have low self-esteem and even believe she does not deserve better. Finally, she may not know who to turn to or where to go. (p. 61)

Current reports point out that there is an extensive list of additional causes as to why women continue to stay in abusive relationships. This list encloses a variation of situational causes, emotional causes, and individual philosophies that possibly can be a reason for a woman to stay. Situational causes can consist of financial dependency, fear of being stalked, fear of the unfamiliar, adverse retorts from public, law enforcement agency, and preachers, living with prolonged abuse until one turn out to be emotionless (a reply described as “acceptable violence”) reluctance to disturb the children’s school locations, family burdens (“you made your bed, now lie in it”), and incapability to acquire resources because of language or ethnic barriers (Women’s Rural Advocacy Program, 2010).
Sexual Violence (SV)

Sexual violence (SV) emerges throughout the United States. While in most countries there has been little research piloted on the issue, accessible information proposes that, in some countries, nearly one in four women may experience SV by an intimate partner (Hakim, 2001; Ellsberg, 1997; Mooney, 1993) and up to one-third of adolescent girls report their first sexual experience as being forced (Jewkes, Vundule, Maforah, & Jordaan 2001; Matasha, 1998; Buga, Amoko, & Ncayiyana, 1996).

Krug et al. (2002) defined sexual violence (SV) as:

Any sexual act, attempt to obtain a sexual act, unwanted sexual comments or advances, or acts to traffic, or otherwise directed, against a person’s sexuality using coercion, by any person regardless of their relationship to the victim, in any setting, including but not limited to home and work.

Coercion can cover a whole spectrum of degrees of force. Separately from physical force sexual violence: may comprise of psychological intimidation, extortion or other terrorizations – for example, the promise of physical harm, of being discharged from employment or of not finding employment that is pursued. It may also occur when the person is unable to give approval – for instance, while drunk, drugged, asleep or mentally incompetent of understanding the circumstances. Sexual violence includes rape, defined as physically forced or otherwise coerced penetration – even if slight – of the vulva or anus, using a penis, other body parts or an object. The attempt to do so is known as attempted rape. Rape of a person by two
or more perpetrators is known as gang rape. Sexual violence can include other forms of assault involving a sexual organ, including coerced contact between the mouth and penis, vulva or anus. (p. 163)

Sexual violence has a riveting effect on physical and mental health. As well as producing physical harm, it is affiliated with an increased risk of a range of sexual and reproductive health problems, with both instantaneous and long-term consequences (Jewkes et al., 2001; Holmes, 1996; Eby, 1995; Leserman, Li, Drossan, & Hu, 1998; McCauley, 1995; Coker et al., 2000; Letourneau, Holmes, & Chasendunn, 1999; Plichta & Abraham, 1996; Campbell & Soeken, 1999; Collett, 1998; Boyer & Fine, 1992).

Its influence on mental health can be as severe as its physical sway, and may be similarly long lasting (Briggs, 1997, Creamer, Burgess & McFarlane, 2001; Cheasty, Clare, & Collins, 1998; Darves, 1997; Fergusson, Horwood et al., 1996; Levitan, 1998; Acierno, 1999). Deaths resulting from sexual violence may be as a result of suicide, HIV infection (Miller, 1999) or murder – the latter occurring either during a sexual assault or subsequently, as a murder of “honor” (Mercy, 1993). In addition, sexual violence can also have a profound emotional impact on the social wellbeing of victims; individuals may be hated and detested by their families and others as a result (Mollica & Son, 1989; Omaar & deWaal, 1994).

Statistics on sexual violence usually is obtained from police reports, clinical settings, non-governmental organizations and survey research. The association between these sources and the problem of sexual violence may be regarded as equivalent to an iceberg floating in water (Jewkes & Abraham, in press).
Overall, sexual violence has been a desolate area of research. The available data are flimsy and incoherent. For example, police data are often unfinished and restricted. Many female victims do not report sexual violence to police because they are ashamed, or fear being blamed, not believed or mistreated (Krug et al., 2002). On the other hand, statistics from medico-legal clinics may be partial towards the more violent incidents of sexual violence. The number of women who seek medical services for problems associated with sexual violence is relatively small. Though there have been significant developments over the previous decade in measuring the phenomenon through survey research, the definitions applied have varied extensively across studies (Krug et al., 2002).

Apart from crime surveys, there have been a small number of surveys, with representative samples, that have asked women about sexual violence. For example, in a national survey conducted in the United States of America, 14.8% of women over 17 years of age reported having been raped in their lifetime (with an additional 2.8% having experienced attempted rape) and 0.3% of the sample reported having been raped in the previous year (Tjaden & Thoennes, 2000). A survey of a representative sample of women aged 18-49 years in three provinces of South Africa found that, in the previous year, 1.3% of women had been forced, physically or by means of verbal threats, to have non-consensual sex (Jewkes & Abraham, in press).

In a survey of a representative sample of the general population over 15 years of age in the Czech Republic, 11.6% of women reported forced sexual contact in their lifetime, 3.4% reporting that this had occurred more than once. The most common form
of contact was forced vaginal intercourse (Weiss & Zverina, 1999). In 2008, there were 89,000 incidents of forcible rapes or sexual assaults reported to U.S. law enforcement, with 92.5% of rapes completed, and the remaining falling into the categories of attempted rape or aggravated assaults in association to rape (U.S. Department of Justice, 2008).

However, according to the National Crime Victimization Survey (NCVS), which assesses victimization annually in U.S. households, the rates of sexual assault and rape are thought to be much higher. According to the NCVS, in 2007, there were an estimated 248,300 incidents of rape and sexual assault, with women being the targeted victim \( n = 236,980 \) more often than men \( n = 11,300 \) (U.S. Department of Justice, 2010). Because of the stigma and internalized shame that victims of sexual assault and rape often experience (see Koss, 2000), it is believed that rates reported by the NCVS are dramatically underrepresented. When assessing prevalence rates of rape, it should be noted that date rape is more common than stranger rape (Koss, Koss, & Woodruff, 1991).

A study of college students examined that of the women who were raped, 84% knew their attacker, and 57% of rapes occurred on a date (Koss, 1988). It is a fact, college students are particularly at risk for sexual assault. One study found that more than half of the 1,000 female students surveyed on campus had experienced unwanted sex (Abbey, Ross, McDuffie, & McAuslan, 1996a).

A less than representation of factual prevalence rates of rape may be delayed by the fact that men and women may not define their sexual assault as rape because of situational causes such as being familiar with their attacker (Kahn, Jackson, Kully, Badger, & Halvorsen, 2003). An additional significant factor that has been found to play
a role in the reporting of rape is the extent of force or scuffle involved (Kahn et al., 2003). Researchers established that when a violent force or a substantial struggle followed, then the woman was more probable to define the episode as rape. There are countless sexually forcible tactics used to acquire sex that can also effect whether or not an unwelcomed sexual experience is categorized as rape (Kahn et al., 2003).

Assessments of sexual assault prevalence have been constructed on numerous sources including police reports, national random samples of crime victims, interviews with jailed rapists, interviews with victims who seek medical treatment, surveys of women in the general population, and surveys of male and female college students (Crowell & Burgess, 1996). In these studies, the assessments’ sufficiency fluctuates with the sources of data collected. A great number of researchers have agreed that the most dependable estimates originate from studies using multi-item scales, that is, measures comprising of several questions describing behaviors which establish sexual assault in simple, non-legal language (Koss, 1988).

Based on such measures, traditionalist estimates suggest that at least 25% of American women have been sexually assaulted in adolescence or adulthood and that 18% have been raped. Moreover, at least 20% of American men report having perpetrated sexual assault and 5% report having committed rape (Crowell & Burgess, 1996; Spitzberg, 1999; Tjaden & Thoennes, 2000).

Due to their ease of access, college students’ surveys incline to provide the most in-depth measures of sexual assault by containing the largest number of behaviorally precise questions. These studies suggest that approximately 50% of college women have
been sexually assaulted, and 27% have experienced rape or attempted rape; in contrast, 25% of college men have committed sexual assault, and 8% have committed rape or attempted rape (Crowell & Burgess, 1996; Koss, 1988; Spitzberg, 1999). Research further points out that the prevalence of sexual assault among college women is approximately three times greater than the prevalence rates of sexual victimization amid women who belong to the general population (Koss, Gidycz, & Wisniewski, 1987; Muehlenhard & Linton, 1987). Lastly, there is evidence that approximately 15%-25% or one out of four college women will have been a victim of sexual assault by the time she begins her college career (Koss et al., 1987).

Likewise, with an increased risk for sexual assault, college females are more probable to be assaulted by someone they are acquainted with and are less likely to effectively evade these assaults when they are familiar with the perpetrator (Rozee, Bateman, & Gilmore, 1991; Russell, 1984). Date or acquaintance rape accounts for 80%-90% of sexual assaults, and stranger rape occurs 10%-20% of the time (Koss, Dinero, Siebel, & Cox, 1988; Russell, 1984). In contrast to the fable that sexual assault usually occurs only on first dates, statistics suggest that 31% of rapes are perpetrated by steady dating partners (Koss et al., 1988). In addition, research suggests that one out of 13 men report having sexually assaulted a woman at some point in their lives, and that approximately 35% of college men would sexually assault a woman if they knew that they would not get caught for the offense (Malamuth, Sockloskie, Koss, & Tananka, 1991). Hence, although we might like to believe that sexual assault is sporadic, and that
only a small percentage of men would be likely to commit such an offensive act, the numbers shows otherwise.

One strategy that was designed to eliminate the prevalence of sexual violence on college campuses has been the formation and implementation of sexual assault prevention programs (Parrot & Bechhofer, 1991). The surplus of current programs proposes that it is presumed by researchers and educators equally that sexual victimization is an avoidable occurrence, or, at the very minimum, that rates of sexual violence can be shortened. Nonetheless, regardless of the propagation of such programs, not many sexual assault prevention programs have been empirically measured. Programs like these are often evaluated in a manner which does not eradicate problematic conventions about mechanisms convoied with change (Schewe & O’Donohue, 1993a).

Though it is challenging to measure what the long-term effects of a sexual violence experience may be defined as, victims frequently report experiencing, among other symptoms, shock, humiliation, anxiety, depression, substance abuse problems, suicidal ideation, low self-esteem, social isolation, difficulties with anger, distrust of others, fear of AIDS, guilt, and sexual dysfunction (Kilpatrick, Veronen, & Resick, 1982; Koss, 1988). In addition, there is some evidence to suggest that women who are sexually assaulted by associates experience higher levels of general psychological distress than women who are assaulted by outsiders (McCahill, Meyer, & Fischman, 1979).

Sexual violence has been linked with numerous mental health and behavioral problems in adolescence and adulthood (Briggs, 1997). In one population-based study, the prevalence of symptoms or signs suggestive of a psychiatric disorder was 33% in
women with a history of sexual abuse as adults, 15% in women with a history of physical violence by an intimate partner, and 6% in non-abused women (Mullen, 1988).

Sexual violence by an intimate partner exacerbates the effects of physical violence on mental health. Women that are abused reporting experiences of forced sex are at a significantly greater risk of depression and post-traumatic stress disorder than non-abused women (Campbell, Soeken, Creamerr, 1999; McFarlane, Fergusson, Horwood, Lynskey, & Miller, 1999). Posttraumatic stress disorder after a sexual assault is more likely to transpire if there is harm during the course of the sexual assault, or a history of hopelessness or substance abuse (Acierno, 1999).

In France, a study of adolescents found a relationship between being a victim of rape and current sleep complications, depressing symptoms, somatic grievances, tobacco intake, and behavioral problems (such as aggressive behavior, theft, and truancy) (Choquet, 1997). In the lack of trauma treatment, adverse psychological effects have been known to persevere for nearly a year succeeding a rape, whereas physical health problems and indications have a tendency to lessen over a period of time. Even with counseling, up to 50% of women maintain symptoms of stress (Foa, 1999; Tarrier, 1999; Kilpatrick, Edmonds, & Seymour, 1992).

HIV infection and other sexually transmitted diseases are known significances of rape (Jenny, 1990). Research on women residing in shelters has revealed that women who experience both sexual and physical abuse from intimate partners are more likely to have had sexually transmitted diseases (Wingood, Diclemente, & Raj, 2000).
Whereas the fear of rape is normally linked to being outside the home, the majority of sexual violence essentially takes place in the home of the victim or the abuser. Nevertheless, kidnapping by an unfamiliar person is relatively often the preface to a rape and the chances for such an abduction are swayed by the physical environment. The social environment inside a community is typically more significant than the physical surrounding (Madge, 1997; Pain, 1997).

For example, in some places, rape can happen in public, with bystanders declining to interfere. Grievances of sexual assault may be treated mildly by the police, mostly if the assault had taken place while on a date or by the victim’s husband. Wherever police investigations and court cases do precede, the process may be either exceptionally slack or fraudulent – for example, with legal papers being unaccounted for or missing in return for a payoff (Jenkins, 1998).

Poverty is mutually connected to the perpetration of sexual violence and the risk of being a victim. Numerous authors have disputed that the connection among poverty and the execution of sexual violence is arbitrated through methods of crisis of masculine distinctiveness (Morrell, 2001).

**Rape Crisis Prevention Programs**

Despite the fact that data from the Federal Bureau of Investigation (FBI) indicate that forcible rape decreased in the United States by 1.6% between 2007 and 2008 to the lowest figure in 20 years (FBI, 2009), rape continues to be an everyday event. According to the National Crime Victimization Survey, there were 248,300 incidents of rape and
sexual assault in the United States in 2007 (Rand, 2008), and 203,830 incidents in 2008 (Rand, 2009).

According to the FBI’s *Uniform Crime Report*, there were an estimated 90,427 reports of rape in 2007 (FBI, 2008), and 89,000 in 2008 (FBI, 2009). Although society’s combined conscience has been elevated in current years regarding sexual violence against women, the acknowledgement that rape victims need specific services did not generally exist. The requirement for and creation of rape crisis centers arose in the early to mid-1970s out of the second rush of the feminist movement. Rape crisis centers started as grassroots organizations that were run jointly and presented a mixture of direct services to rape victims and delivered education to the community (Maier, 2011).

Also, early rape crisis centers began working toward a social mission, and their main attention was to eradicate rape and protect legislative reform that would award rape victims additional rights and security. The mission of rape crisis centers has changed through the years, particularly as they began to receive public funds (Clemans, 2004; Riger 2002). Rape crisis centers and rape prevention programs reformed by becoming more proficient (Macy, Giattina, Parish, & Crosby, 2009; Matthews, 1994; Townsend & Campbell, 2007), more administrative and hierarchical (Campbell & Martin, 2001), less drastic and governmentally active (Campbell, Baker, & Mazurek, 1998; Gornick & Meyer, 1998; Martin, 2005; Matthews, 1994; Whittier, 1995), and more cooperative with other mainstream organizations (Ferree & Martin, 1994; Martin, 2005).

In spite of the fact research indicates that rape crisis centers have changed throughout the years (Campbell et al., 1998; Gornick, Burt, & Pittman, 1985; Koss &
Harvey, 1991; Martin, DiNitto, Byington, & Maxwell, 1992; Matthews, 1994), exploration of the structure, exercises, philosophies and battles of early rape crisis centers is dated and concentrates on the starting phases of their improvement, when the anti-rape movement had only been in existence for less than a decade. Research has found that as more organizations collaborate, services for rape victims will progress (Burt, 2000; Burt, 2001; Campbell & Ahrens, 1998; Zweig & Burt, 2003; Zweig, Burt, & Van Ness, 2003).

Furthermore, institutionalization has permitted centers to deliver services on a smaller level while retaining stable funding on a larger level (Schmitt, 1994; Simon, 1982; Staggenborg, 1996). Despite the fact that the structure and sources of funding have changed and rape crisis centers have become less involved in political activism, the core services offered have remained steady. Most rape crisis centers supply direct services to victims, including phone therapy, short-term face-to-face counseling, and transportation to police stations, hospitals, and court proceedings (Wasco, 2004). Presently, rape crisis centers, much like other women’s activist associations, display both governmental and collectivist philosophies (Bordt, 1997).

Attempting to explain sexual violence against women is problematical by the various forms it displays and the settings in which it happens. There is substantial overlay between forms of sexual violence and intimate partner violence; a lot of the causes are equivalent to those previously discussed in the IPV section. There are factors increasing the risk of somebody being threatened into sex, factors increasing the risk of a man imposing sex on someone else, and factors inside the social environment – including friends and family – prompting the possibility of sexual assault and the response to it.
Research proposes that numerous factors can have an additive outcome, and the more factors that are current, the more chances sexual violence can occur. Also, a specific factor may differ in significance rendering to the life phase (Krug et al., 2002).

One of the most recognized forms of sexual violence throughout the world is that which is committed by an intimate partner, leading to the indication that one of the utmost significant risk factors for women – in terms of their susceptibility to sexual violence – is being married or living with a partner. Other factors influencing the risk of sexual violence include: (a) being young; (b) consuming alcohol or drugs; (c) having previously been raped or sexually abused; (d) having many sexual partners; (e) being involved in sex work; (f) becoming more educated and economically empowered, at least where sexual violence perpetrated by an intimate partner is concerned; and (g) living in poverty (Krug et al., 2002).

At least one-half of all violent crimes consist of alcohol consumption by the perpetrator, the victim, or both (Collins & Messerschmidt, 1993). Sexual assaults coincide with this formation. As a result, across the dissimilar populations studied, researchers steadily have found that approximately one-half of all sexual assaults are committed by men who have been drinking alcohol. Contingent on the sample studied and the measures utilized, the approximations for alcohol use among perpetrators have ranged from 34% to 74% (Abbey, Ross, & McDuffie, 1994; Crowell & Burgess, 1996a).

By the same token, approximately one-half of all sexual assault victims report that they were drinking alcohol at the time of the assault, with estimates ranging from 30% to 79% (Abbey et al., 1994; Crowell & Burgess, 1996). It is imperative to accentuate,
however, that even though a woman’s alcohol intake may put her at a greater risk of sexual assault, she is in no means accountable for the assault. The perpetrators are lawfully and ethically in control of their behavior.

Lastly, alcohol intake by perpetrators and victims have a tendency to coincide which means, when one of them is drinking, the other one is usually drinking as well (Abbey, McAuslan, & Ross, 1998; Harrington & Leitenberg, 1994). Seldom is only the victim drinking alcohol. This finding is not shocking, because in social circumstances (e.g., in bars or at parties), drinking is likely to be a conjoint activity. Yet, this result thwarts researchers’ exertions to unravel the distinctive effects of alcohol ingestion on the perpetrators’ as opposed to the victims’ behavior.

**Child Sexual Abuse (CSA)**

Definitions of child sexual abuse (CSA) may vary between studies, but this study used the broad definitions summarized previously, including any forced or coerced sexual contact (not just penetration) between a child or adolescent (under age 18) with an adult or someone at least five years older than the child when the abuse occurred. Researchers have documented a strong association between CSA and later engagement in sexual risk behaviors (Greenberg, 2001; Koenig, Doll, O’Leary, & Pequegnat, 2004).

The predominance of child sexual abuse in America is obscure. In light of the disgrace and stigma connected with abuse, numerous victims never reveal such encounters. Incest was once believed to be so rare that its occurrence was insignificant. Yet, in the previous 25 years there has been expanded acknowledgement that incest and
other forms of child sexual abuse happen with disturbing recurrence (Hendricks-Matthews, 1992). Researchers have established that victims emanate from all cultural, racial, and economic groups (Tjaden, 1998).

Present estimations of incest and other child sexual abuse range from 12% to 40% depending on surroundings and population. Most studies have found that, among women, approximately 20% - or one in five - have experienced CSA (Tjaden, 1998). Consistent with this range, studies have revealed that among girls who had sex before they were 13 years old, 22% reported that first sex was non-voluntary (Moore & Driscoll, 1997). Twelve percent of girls in grades 9 through 12 reported they had been sexually abused; 7% of girls in grades 5 through 8 also reported sexual abuse. Of all the girls who experienced sexual abuse, 65% reported the abuse occurred more than once, 57% reported the abuser was a family member, and 53% reported the abuse occurred at home (Schoen et al., 1997).

Approximately 40% of the women surveyed in a primary care setting had experienced some form of child sexual contact; of those, one in six had been raped as a child (Walker, Torkelson, Katon, & Koss, 1993). A national telephone survey on violence against women conducted by the National Institute of Justice and the Centers for Disease Control and Prevention found that 18% of 8,000 women surveyed had experienced a completed or attempted rape at some time in their lives. Of this number, 22% were younger than 12 years and 32% were between 12 and 17 years old when they were first raped. Tjaden (1998) found that some common symptoms in adult survivors of child sexual abuse are:
a) gastrointestinal symptoms/distress;
b) obesity;
c) eating disorders;
d) insomnia;
e) sleep disorders;
f) sexual dysfunction;
g) asthma/respiratory ailments;
h) addiction;
i) chronic headache;
j) psychological and behavioral presentation;
k) depression and anxiety;
l) posttraumatic stress disorder symptoms; and
m) lying and many more.

While there is no one particular disorder that is commonly current in adult survivors of child sexual abuse, there is a broad collection of data that documents unfavorable short-term and long-term causes of such abuse. To properly treat and oversee survivors of CSA, it is helpful to comprehend that survivors’ symptoms or behavioral continuation frequently signify adapting methodologies engaged in retort to irregular, traumatic occasions. These surviving components are used for defense during the course of the abuse or in the future to protect against feelings of vast powerlessness and fear. Albeit some of these adapting methodologies might, in the long run, lead to health
problems, if symptoms are assessed outside their normal settings, survivors may be inadequately diagnosed or mislabeled (Hendricks-Matthews, 1997).

In addition to the mental anguish that may infiltrate survivors’ indications, there is proof that abuse may result in bio-physical changes. Case in point, one study found that in the wake of a controlling cycle of psychiatric aggravation, adult survivors had lowered thresholds for pain (Scarinci, McDonald-Haile, Bradley, & Richter, 1994). Likewise, it has been recommended that an unending or traumatic incitement (particularly in the pelvic or stomach) elevates affectability, bringing about steady pain such as abdominal and pelvic pain or other bowel symptoms (Cervero & Janig, 1992; Drossman, 1994).

Despite the fact that reactions to sexual abuse differ, there is surprising consistency in mental health indications, particularly hopelessness and apprehension. These mental health indications may be discovered alone or all the more frequently in coupled with physical and behavioral indications. More compelling indications are connected with abuse onset at an early age, prolonged or recurring abuse, and incest by a parent, or use of force (Medical Association, 1995).

Reactions may be alleviated by such factors as inherent resiliency or supportive responses from people who are significant to the victim though. Indeed, even without therapeutic intermediation, a few survivors keep up the outward appearance of being unaffected by their abuse. Most, on the other hand, experience pervasive and pernicious results (Medical Association, 1995).

The primary after effects of CSA have been divided into seven distinct, but overlapping categories. Courtois’ (1993) study found the following:
(a) emotional reactions;
(b) symptoms of posttraumatic stress disorder (PTSD);
(c) self-perceptions;
(d) physical and biomedical effects;
(e) sexual effects;
(f) interpersonal effects; and
(g) social functioning.

Responses can be greatly varied and idiosyncratic within the seven categories. Also, survivors may fluctuate between being highly symptomatic and relatively symptom free. Health care providers should be cognizant that such inconsistency is normal.

Women CSA survivors attend counseling with an extensive assortment of indications and symptoms clusters. There is some proof that the indication clusters are associated to factors such as onset, length of abuse, ages at which abuse happened, and whether or not the abuse involved violence or threats of violence (Loeb et al., 2002). Irrespective of the particular nature of the abusive occurrences, these clusters normally include mental, emotional, interpersonal, and trauma-response concerns. Symptom clusters related to mental health include psychiatric disorders common to adult women CSA survivors, who have a two to four times greater risk for an expansive number of psychiatric disorders, including depression, apprehension, fears, eating disorders, and substance abuse (Lundqvist, Svedin, & Hansson, 2004).

Emotional indications that are common among women CSA survivors incorporate social maladjustment, self-blame, anger, low self-esteem, self-destruction, and anxiety
(Kessler, White, & Nelson, 2003; Ullman, 2006). Women survivors are prone to experience challenges in five noteworthy territories of emotional functioning: trust, safety, intimacy, self-esteem, and control (Shiperd, Street, & Resick, 2006). Furthermore, women may hate their own bodies (Svedin, Back, & Soderback, 2002) and experience dysfunctional sexual feelings (Vandeusen & Carr, 2003). CSA survivors identify with trauma indications, regularly defined in terms of posttraumatic stress disorder (PTSD). The Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revised (DSM-IV-TR; American Psychiatric Association, 2000) identifies PTSD as a disorder resulting from exposure to a traumatic event characterized by re-experiencing aspects of the trauma, avoidance of reminders of the trauma, and symptoms of hyper arousal.

Posttraumatic stress anxiety reactions are diagnosis of women survivors and may manifest as disassociation, sleep disturbances, memory problems, irrational guilt, or an intensification of symptoms when exposed to situations or stimuli similar to the original trauma event (Kessler et al., 2003; Risser, Hetzel-Riggin, Thomsen, & McCanne, 2006; Ulman, 2006). Child physical and sexual abuse has been connected to an extensive array of physical, emotional, social, and cognitive deficiencies in later life (Toth, 1995; MacMillian, 2000). These deficiencies may cause an increase in health care costs and, all the more vitally, in human enduring. Studies of mental health issues have demonstrated that psychiatric issues can prompt a level of inability equivalent to that of physical disease (Wells et al., 1989).
Researchers who have found that practical disability and its relationship with a stated history of abuse have done so by utilizing clinical specimens (Leserman et al., 2006; Alexander et al., 1998; Scarinci et al., 1994). Abuse exposure during child and adulthood was found to have a relationship with disability. For example, patients who were abused had considerably greater psychosocial and total disability scores, contrasted to patients who had not been abused (Alexander et al., 1998).

CSA is predominant among adult patients with borderline personality disorder (BPD), where it is reported in 40% to 76% of patients, significantly higher than among groups of related disorders (Zanarini, 2000, for review). Patients with BPD encounter more sorts of abuse in childhood, starting prior in life, and rehearsed over longer periods of time than contrasting groups (Herman, Perry, & Van der Kolk, 1989; Links, Steiner, Offord, & Eppel, 1988; Shearer, Peters, Quaytman, & Ogden, 1990; Zanarini, Gunderson, Marino, Schwartz, & Frankenburg, 1989; Zanarini, 1997).

Severity of borderline psychopathology is associated with relentless child abuse, especially sexual abuse, physical abuse, and observed violence (Ogata, 1990; Silk, Lee, Hill, & Lohr, 1995). In numerous, however not all, people with BPD, and a background marked by a history of child abuse, may be an etiologic factor in the development of self-destructive conduct (Dubo, Zanarini, Lewis, & Williams, 1997; Gunderson & Sabo, 1993; Links & Van Reekum, 1993; Van der Kolk, Perry, & Herman, 1991; Wagner & Linehan, 1994).

CSA survivors are 10 times more likely to have tried suicide, and have more suicidal attempts than non-abused people with BPD (Soloff, Lynch, & Kelly, 2002). CSA
survivors frequently report physical complications in addition to mental, emotional, and social encounters. Women survivors are also more likely to report somatic difficulties, such as cardiopulmonary, female reproduction, gastrointestinal tract, pseudo neurologic, and sexual symptoms (Dickerson, deGruy, Dickinson, & Candib, 1999; Modestin, Furrer, & Malti, 2005).

Child sexual abuse can influence long-haul physical health results and health care services in adulthood (Arnow, 2004). Females with CSA histories have higher use rates for universal medicinal services, including more doctor visits, surgical procedures, and somatic complaints than those with no history of sexual abuse (Sickel, Noll, & Moore, 2002; Arnow, 2004; Toomey, Seville, Mann, & Abashian, 1995; Polusny & Follette, 1995; Newman, Clayton, & Zuellig, 2000). Survivors of CSA also report physical indications more often, seriously, and in more prominent numbers than non-abused individuals (Newman et al., 2000; Hulme, 2000).

Moreover, a history of CSA is linked with considerably higher yearly health care expenses (Hulme, 2000; Walker, Unutzer, & Rutter, 1999) and influences women’s capabilities to secure and to save their sexual wellbeing (Wyatt, Carmona, & Loeb, 2002). Given the long-term symptomatology connected with a background of CSA, it is imperative for human service experts to screen for trauma histories among female patients in medical centers irrespective of status (Farley & Patsalides, 2001).

Adult female CSA survivors reported more social challenges, particularly relationships with men and significant others (Loeb et al., 2002; Svedin et al., 2002), and difficulties in sexual functioning are not unusual. A few issues range from low sexual
longing and excitement to a failure to endure touch or to experience climax. Women survivors likewise reported other interpersonal problems, such as large amounts of undesirable sexual influence (Meston, 2006); lesser levels of alleged emotional backings from partners (Schilling, 2007); and sentiments of disloyalty, helplessness, and stigmatization in relationships (Vandeusen & Carr, 2003).

The relationship of CSA is especially solid with issues in women’s adult couple relationships. Contrasted to their non-abused associates, females marked with a background of CSA have multiplied the rate of marital separation and are more disappointed with their relationships (Colman & Widom, 2004; Fleming, Mullen, Sibthorpe, & Bammer, 1999; Liang, Williams, & Siegel, 2006). Although the robust relationship between CSA and adult relationship complications, many females with a history of CSA have secure and fulfilling adult couple relationships (Colman & Widom, 2004; Davis & Petretic-Jackson, 2000).

In addition to the immediate impacts of CSA, families in which CSA happens regularly have other dysfunction that can impact victims’ long-haul adult alteration. In particular, the family-of-origin of CSA victims have greater rates of parental separation (Colman & Widom, 2004); inter-parental hostility (Fergussen, Horwood, & Lyskeys, 1997; Vigil, Geary, & Byrd-Craven, 2005); child abuse (Black, Heyman, & Smith-Slep, 2001); parental psychiatric difficulties, joblessness, and family poverty (Colman & Widom, 2004; Drake & Pandey, 1996; Fergussen et al., 1997; Paveza, 1988); and lower family structure (Weissmann-Wind & Silven, 1994) than families of non-abused associates. At any rate some of these structures are more apparent in families in which
CSA was executed by a relative, instead of in families in which CSA was executed by somebody outside the family (Bennett, 2000; Dong, 2003; Hulme & Agrawal, 2004).

Suicide endeavors are a real indicator of suicide consummations (Kachur, Potter, James, & Powell, 1995); hence, determining indicators of suicide endeavors are valuable for understanding and averting suicide culminations. One danger element for suicide endeavors among women is child abuse (Moeller, Bachmann, & Moeller, 1993). The relationship between various kinds of child abuse, primarily physical and/or sexual abuse, and suicidal behavior is reasonably well reported, and the couple of studies that have inspected child emotional abuse demonstrate that it is related with suicidal behavior also (McCauley, 1997; Romans, Martin, Anderson, Herbison, & Mullen, 1995; Thompson, Kaslow, Bradshaw, & Kingree, 2000; Twomey, Kaslow, & Croft, 2000).

Abused children regularly encounter more than one manifestation of abuse (Moeller et al., 1993). Studies have proven that encountering different kinds of child abuse escalates the risk for other adverse aftermaths, including physical or sexual abuse in college (Schaaf & McCanne, 1998) and poorer physical wellbeing in later life (Moeller et al., 1993). This present study looks at the effect of exposure to numerous types of child abuse on suicide efforts among low-income African American women. In this study, suicide attempters indicated exposure to more types of abuse than non-attempters. In particular, the rate of suicide attempters and non-attempters reporting no child abuse was 34% versus 66%; one type of abuse, 52% versus 48%; two types of abuse, 57% versus 43%; and three types of abuse, 82% versus 18%. Additionally, each kind of abuse, as measured by the Child Trauma Questionnaire (CTQ), was essentially identified with
making a suicide endeavor: emotional abuse r (360) = .34, p < .0001; physical abuse r (360) = .25, p < .0001; sexual abuse r (360) = .22, p < .0001.

This examination of the relationship between the experience of different methods of childhood abuse and suicidal behavior among low-income, African American women uncovered that 54% of women in this study encountered some method of child abuse and that 49% of those who were abused during child experienced more than one type of abuse. Women who reported any type of abuse (emotional, physical, and sexual) were more prone to endeavor suicide than women who reported non-abuse. Furthermore, results showed that women reporting three kinds of abuse were more likely to endeavor suicide than women reporting one kind of abuse.

Why women that are exposed to various forms of child abuse might be at a greater risk for suicidal behavior? One potential reason could be that adults who were exposed to various forms of child abuse may have gained coping abilities that capitalize on the emotional prevention of negative inward states (Polusny & Follette, 1995). Research on CSA proposes that emotional concealment and refutation are the most well-known tactics used by adult sexual abuse survivors in a struggle to cope with their history of abuse (Leitenberg, Greenwald, & Cado, 1992).

Some suicidal behavior may be conceptualized as one method of emotionally avoidant coping, along with other different types of mentally avoidant behavior, such as dissociation and substance abuse. One more conceivable reason is that children who are exposed to various forms of abuse also are exposed to abuse for a lengthier period of time
and, therefore, may be more likely to employ in suicidal behavior owed to interruptions with trust and amplified levels of self-hate (Chu, 1999; Herman, 1992).

Women who dropped out of high school or who were out of work were more liable to report being abused as children, reliable with further research. For instance, poor children are more probable to be abused over and over, report one or more forms of child abuse, and fathers of abused children are more likely to be jobless (Ley, Markovic, Chaudhry, Ahart, & Torres, 1995; Moeller et al., 1993). Low levels of schooling, minimum wages, and unemployment may add to the development of hopelessness (adverse expectations regarding the future), an eminent risk factor for suicidal behavior (Beck, Steer, Kovacs, & Garrison, 1985).

By a wide margin, the most widely recognized strategy for suicide endeavor was overdose, including aspirin, psychotropic medication, and illegal substances. In fact, 80% of the suicide attempters overdosed on medication, 3% cut themselves severely enough to warrant medical attention, and 3% ingested poisonous substances. Different endeavors for suicide attempters included jumping from a high place, hanging oneself, asphyxiation, and shooting oneself.

There are approximately 1.2 million people living with HIV infection in the United States (UNAIDS, 2006). Of the 75% who are aware of their infection (Marks, Crepaz, & Janssen, 2006), the majority remain sexually active after learning of their diagnosis (Bingman, Marks, & Crepaz, 2001; Crepaz & Marks, 2003). While it is estimated that those who are unaware of their infection are three and one-half times more likely to transmit HIV than those who are aware of their infection, nearly half of all new
sexually transmitted HIV infections result from HIV-positive persons who knew of their infection and engage in sexual risk behavior (Marks et al., 2006).

Women of color are one of the fastest growing HIV-positive populations in the United States (Center for Disease Control and Prevention [CDC], 2004). Although black and Latina women together represent about one-fourth of all U.S. women, they account for 83% of the female AIDS cases reported in 2003 (CDC, 2004).

In the past 15 years, the dissemination of AIDS cases in California has changed significantly, reflecting what was being depicted across the country as the changing face of AIDS. In 1991, 15% of new AIDS cases occurred among African Americans (Winningham, Corwin, & Moore, 2004). By 2001, this proportion had increased to 53% of all California AIDS cases, even though the percentage of African Americans in the general population had slightly decreased (CDC, 2004). While HIV/AIDS affects all groups, black women are at heightened risk (Winningham et al., 2004).

One of the most significant factors that increase risks for HIV infection is a history of CSA (Wyatt, Myers, & Williams, 2002). However, histories of sexual abuse before age 18 are common among women. It is estimated that the prevalence of CSA in the United States is approximately 33% in community samples of females under the age of 18 (Finkelhor, 1994).

Early sexual exploitation is connected with greater sexual risk-taking, including earlier initiation of consensual sexual activity, lower condom self-efficacy, less frequent and unreliable use of condoms, (Riggs, Alario, & McHorney, 1990; Donalson, Whalen, & Anastas, 1989; Mason, Zimmerman, & Evans, 1998; Brown, Lourie, & Zlotnick,
2000) and higher rates of sexually transmitted infections (STIs) (Wyatt et al., 2002; Bensley, Eenwyk, & Simmons, 2000; Johnson, & Harlow, 1996). Wyatt and colleagues (2002) reported that HIV positive women were two and one-half times more likely to report sexual abuse before age 18 than a HIV-negative cohort. Black women with histories of CSA also reported higher rates of unintended pregnancies, (Wyatt, Guthrie, & Notgrass, 1992) and are less likely to use contraceptives, including condoms (Mason, Zimmerman, & Evans, 1998; Johnson, & Harlow, 1996; Heise, Moore, & Toubia, 1995).

Moreover, rates of both CSA and HIV infection are high in clinical and high risk populations, such as the homeless, the severely mentally ill (Van Dorn, 2005) and substance abusers (Boles, Joshi, Grela, & Wellisch, 2005). Additionally, CSA often results in psychological difficulties, such as helplessness, hopelessness, low self-esteem, denial, avoidance, self-destructiveness, which have also been linked to HIV-risk behavior (Briere, 2004). Further, among HIV-positive adults, those with sexual assault histories were more probable than those without to have abused substances and reported currently engaging in unprotected sex (Kalichman, 2002).

In an effort to develop and shape operative secondary HIV prevention interventions for HIV-positive persons with CSA histories, it is imperative to understand the dynamics that are related with sexual risk behavior in this population. These prognosticators may encompass variables related to CSA itself (e.g., age when abuse occurred, chronicity of abuse, relationship to perpetrator), as well as adversities of abuse (e.g., traumatic symptoms, shame, poor affect regulation). Unluckily, HIV-positive persons with CSA also face stigma connected with their illness (Comer, Kenker,
Kemeny, & Wyatt, 2000), which may strengthen premature feelings of hopelessness, disloyalty, and victimization, and contribute to continuous sexual risk behavior. Furthermore, the mental and behavioral tactics employed by people to cope with both CSA and HIV infection may be significant predictors of continuous sexual risk behavior.

Lastly, comorbid psychiatric conditions and substance abuse are heighted in this population, which may also play a part in risk behavior (Lazarus & Folkman, 1984). Hence, with the framework of self-trauma theory, CSA explicit predictors of continued sexual risk should be scrutinized within samples of HIV-infected people who have been victims of CSA. These variables related to: (1) the disturbing stressor (age when abuse happened, occurrence of abuse, total of perpetrators, abuse including oral, anal, or vaginal penetration, and suffering at time of abuse); (2) self-capacities (humiliation associated with HIV infection and sexual abuse, and mental and behavioral tactics for dealing with CSA); and (3) traumatic indications and substance abuse (Lazarus & Folkman, 1984).

Kirkpatrick and colleagues found that young people who reported sexual assault in the year prior to the study were two point four times more likely to report alcohol use, one point six times more likely to report marijuana use, and two point six times more likely to report hard drug use than other youth after controlling age, sex, ethnicity, familial drug and alcohol problems, and physical assault (Kilpatrick, 2000). The research on the impact of sexual abuse propose some indications as to mechanisms that may connect child victimization and later substance use. Finkelhor and Kendal-Tackett (1997)
insist that trauma and stress resulting from child sexual victimization can change the normative progression of mental and social growth for children.

It has been significantly written that women with a history of CSA are more prone to have difficulties with alcohol and other substances (Briere & Runtz, 1987; Miller, Downs, Gondoli, & Keil, 1987; Miller, Downs, & Testa, 1993; Mullen, 1996; Wilsnack, Vogeltanz, Klassen, & Harris, 1997). It has been theorized that the amplified use of alcohol and other drugs by child sexual abuse survivors (CSAS) may aid in lessening the suffering connected with victimization experiences. Many researchers have hypothesized substance use by CSAS as a method of emotional avoidance (e.g., Briere, 1992; Briere & Runtz, 1993; Follette, 1994; Polusny & Follette, 1995).

Consumption of alcohol or other substances may assist CSA to distress negative feelings linked with CSA, to be unable to remember the abuse experience, and to evade abuse-specific recollections and emotional responses, which are features of posttraumatic stress disorder (Briere & Runtz, 1987, 1993; Follette, 1994; Young, 1990). Briere and Runtz (1987) have suggested that alcohol and drug intoxication function as forms of “chemically induced dissociation, invoked as a chronic coping response to aversive affects, memories, and situations” (p. 374).

Their affirmation unites with an affluence of statistics binding sexual abuse to difficulties with essential developmental tasks such as the creation of individuality and self-concept (e.g., Briere & Elliott, 1994; Feiring, Taska, & Lewis, 1996) and behavioral self-discipline (e.g., Brodsky, 2001; Herrera & McCloskey, 2001; Katz, 2000). Adverse self-concept (Harter, 1999) and lacking self-discipline have been recognized, in turn, as
possibilities for adolescent substance use (Hawkins, Catalano, & Miller, 1992; Neumark-Sztainer, Story, French, & Resnick, 1997). Thus, it is likely that negative self-concept and behavioral under-control (BUC) create pathways from CSA to adolescent substance use.

Four risk factors that arbitrate the association among child and illicit drug use in young adolescents. Research proposes that prostitution is connected both with a history of child abuse and drug use. A sum of cross-sectional studies have interconnected child abuse and neglect to prostitution (e.g., McClanahan, 1999; Nixon, 2002; Potter, 1999; Van Brunschot & Brannigan, 2002). Likewise, results from a forthcoming study discovered that victims of CSA were more probable to be engaged in prostitution by young adulthood (Wilson & Widom, 2008). Based on the findings of this documentation, the present study consist of prostitution as an arbitrator of the pathway from child abuse and neglect to illicit drug use in young adolescence.

Homelessness has also been connected to both child abuse and drug use. Research have conveyed an association between child maltreatment and homelessness (Herman, 1997; Stein, 2002). Homeless adolescents frequently report running away from an abusive or neglectful household (Paradise & Cauce, 2002; Yoder et al., 2001). Furthermore, children taken from their home because of abuse face countless difficulties in terms of access to and the ability to withstand living alone, which places them at a greater risk for homelessness when they age out of state-run foster care (Mendes & Moslehuddin, 2006). In another study, discussions with youths that were homeless discovered numerous pathways distinguishing relationships among family conflict (at
times including physical or sexual abuse), drug and alcohol use, and homelessness (Mallett, 2005).

A different study connecting abusive family relationships, homelessness, and drug use reported that approximately 60% of young adults with histories of both homelessness and injection drug use reported leaving home as teenagers because of physical abuse (Hyde, 2005). In the present study, homelessness is included as an arbitrator of the pathway from child abuse and neglect to drug use in young adolescence. Criminality also seems to be linked with both child abuse and substance use. Numerous forthcoming studies have ascribed a relationship among child abuse and criminal behavior in adolescence and/or adulthood (Maxfield & Widom, 1996; Smith & Thornberry 1995; Strouthamer-Loeber, 2001). The present study includes participation in criminal behavior as a mediator of the path from child abuse and neglect to illicit drug use. School difficulties are an added risk factor possibly connecting child abuse and neglect to drug use in the future. Children that are abused and neglected are at risk for a variation of emotional, behavioral, and cognitive difficulties that interfere with their success at school (Veltman & Browne, 2001).

Quite a few potential studies have recognized that poor school performance (e.g., poor grades, poor scores on standardized achievement tests, grade retention, and placement in special education) is frequently a result of child abuse and neglect (e.g., Johnson-Reid, 2004; Leiter, 2007). Other research also supports a link between child abuse and additional school problems, such as absenteeism and school dropout (Garnefski & Arends, 1998; McBroom, 1994). The present study takes a look at school
difficulties as a possible arbitrator of the association between child abuse and neglect and illicit drug use.

**Prevention of Child Sexual Abuse (CSA)**

Society, as a whole, must take part in raising awareness that CSA is unacceptable, and supporting the notion that stopping this abuse is everyone’s responsibility; everyone needs to know that child sexual abuse is a crime that frequently causes severe trauma to children, that assistance is accessible for those who pursue it, and that children cannot at any time assent to sexual activity (Nisonoff & Bittman, 1978). Furthermore, a comprehensive prevention approach must include increasing the awareness and information of parents and other caregivers about protective procedures they can develop to protect their children.

A momentous education message must be communicated to the overall public inspiring everybody in the word to become aware that CSA is everybody’s problem and obligation. The objective of public education determinations are to ameliorate any leniency for sexual abuse or misunderstanding over what the general public justifies as suitable interactions between adults and children (Daro, 1994). A widespread distribution of precise facts to the community, specifically to policymakers, will aid in breaking the silence and taboo that’s associated with CSA, and may assist with devising operative solutions to the problem. The massive mainstream of child sexual abusers is comprised of somebody the child is acquainted with such as a parent or other relative, teacher, clergy, neighbors, and friends (Freeman, 2000).
Approximately 60% of boys and 80% of girls who were sexually victimized were abused by someone the child knows. Only a fraction of those who commit sexual assault are apprehended and convicted for their crimes. According to the Center for Sex Offender Management, only 32% of sexual assaults against persons 12 years or older were reported to law enforcement (Freeman, 2000).

Juveniles as well as adults perpetrate child sexual abuse. Forty percent of reported sexual assaults against children ages six and under are attributable to juvenile abusers, as are 39% of reported sexual assaults against children ages 6 through 11 (Snyder, 2000). Adolescent boys make up approximately 23% of sexual offenders (Nisonoff & Bittman, 1978). Research findings indicate that from 40 to 80% of juvenile sex offenders have themselves been victims of sexual abuse (Becker, 1997).

Although not all child sexual abusers are untreatable pedophiles, the abusive behavior of some child sexual abusers appears obstinate. Research documents a 42% reconviction rate for a group of child sexual abusers whose criminal histories were followed for 15-30 years following incarceration (Hanson, Steffy, & Gauthier, 1995). Thus, a different response is selected, one that places interest on repression and/or treatment contingent on the level of continuous risk posed to children and the possible for treatment efficacy.

**Re-Victimization among Women with a History of Child Sexual Abuse**

Child sexual abuse is a major risk factor for the expansion of an array of long term complications, including depression, anxiety disorders, and substance use disorders
(Molnar, Buka, & Kessler, 2001). On the other hand, other related difficulties are more social in nature, and can consist of reduced gratification in spousal and other relationships (DiLillo, 2001) and increased risk for later victimization (Arata, 2002).

Re-victimization is one disturbing result linked with CSA because later victimization possibly infuses or escalate the effects of a previous abuse experience. Though adult sexual victimization in the lack of child abuse may have its own negative effect, re-victimization has been connected with increased levels of trauma indications paired to a specific occurrence of sexual victimization (see Classen, Palesh, & Aggarwal, 2005, for a review). Specifically, women experiencing re-victimization report higher levels of depression (Messman-Moore, Long, & Siegfried, 2000), posttraumatic stress disorder (Arata, 1999a; 1999b), other anxiety disorders (Cloitre, Scarvalone, & Difede, 1997), dissociation (Cloitre et al., 1997), and alcohol use (Kilpatrick, Acierno, Resnick, Saunders, & Best, 1997).

Introduction to abuse and trauma during childhood can possibly have an effect on the risk for dating violence in one’s future. One fact, is that research on the long-term effects of child trauma proposes that survivor’s lack some resiliency abilities that may safeguard them from relationship violence (van der Kolk & Fisler, 1994). Another possibly damaging early life experience that is connected with relationship violence is CSA. Coid (2001) determined that child abuse substantially increases the risk of re-victimization in adulthood.

Definitely, CSA is the strongest self-governing predictor of being abused as an adult by involuntary assault when equated with child physical and emotional abuse and
neglect (e.g., Briere & Runtz, 1987; Walsh, Blaustein, Knight, Spinazzola, & van der Kolk, 2007; Whitfield, Anda, Dube, & Felitti, 2003). Furthermore, CSA can foresee dating violence victimization. In a study that included 126 females, age 13 to 17 years, more than 45% of CSA victims reported experiencing physical violence in their dating relationships (Cry, McDuff, & Wright, 2006).

Even though earlier research has discovered the relationship between CSA and dating violence, a small number of studies provide proof for a mechanism that describes this relationship. An exception is a study by Wolfe et al. (2004), which found that trauma-related symptoms arbitrated the relationship between child maltreatment and dating violence perpetration. Additional research has validated that trauma symptoms include increased fearfulness and hyperactive attention to danger (van der Kolk, 1989).

Collectively, the outcomes from this study have suggestions for the role of fearfulness in the relationship between child abuse and dating violence. Studies have proven that increased fearfulness, a devastating feeling that can utterly have an emotional impact on long-term functioning (Hudson, Flannery-Schroeder, Kendall, Dozois, & Dobson, 2004; Ramirez, Feeney-Kettler, Flores-Torres, Kratochwill, & Morris, 2006; Warren, Sroufe, Ollendick, & March, 2004), may be coupled with increased exposure to dating violence victimization.

Feelings of fear and absence of control have been linked with the expectation of being victimized. This conviction may produce maladaptive reactions to danger (e.g., incompetently assessing and responding to risk), which in return objectifies this expectation (Finkelhor & Browne, 1985). These outcomes propose that increased
trepidation may be an arbitrator in the relationship between CSA and dating violence abuse.

**Program Prevention and Intervention Services**

Intimate partner violence has been a portion of the fabric of many cultures globally—it is so routine, actually, that it has regularly gone unnoticed and neglected to get the level of concern it merits in light of the overwhelming impacts it can have on children and families. At the point when there have been social reactions to intimate partner violence, they have been generally fixated mostly around crisis intervention, on offering services to people and families previously impacted by intimate partner violence in order to end anticipated damage (Wolfe, Wekerle, & Scott, 1997).

Though crisis intervention is a vital reaction to intimate partner violence and can be exceedingly powerful at specific focuses in time, it single-handedly cannot address the complicated subtleties of intimate partner violence. Also, there is a major need for hands-on procedures of prevention. Current modifications in public policy, legislation, and service delivery demonstrate a mounting obligation to discovering ways to lessen the harmful impact of IPV. Nonetheless, rare wide-ranging policies that address the prevention of IPV have been established, and even less have been assessed (Wolfe & Wilson, 1990).

Public health campaigns to eradicate health dangers and to support healthy behaviors within specific sections of a population can assist as one kind of model for IPV prevention tactics. Methodologies inside this model pinpoint and confront the primary
bases of this health problem and regularly utilize positive messages about what institutes improved behavior to elevate change to those healthier behaviors (Millstein, Petersen, & Nightingale, 1993). By the same token, IPV prevention policies must incorporate some comprehension of the primary reasons for IPV and, in addition, a revelation of what defines a healthy, solid, peaceful family (Andrews, Leshield, & Hogge, 1992).

It is exceptionally hard to recognize the primary origins of IPV; specialist in the field do not concur as to what these reasons seem to be. Thus, there are a few distinctive, and at intervals overlying, theories of causativeness. In spite of these distinctions, every one of these theories impart a few shared characteristics, which can serve as a groundwork for IPV prevention strategies (Cicchetti & Tucker, 1994).

**Public Health Model for Intimate Partner Violence (IPV) Prevention**

Another public health model that can advise the advancement of intimate partner violence prevention strategies distributes prevention endeavors into three categories: primary, secondary, and tertiary. Primary prevention includes endeavors to decrease the occurrence of a problem in a population before it happens. The objective of secondary prevention is to target people to lessen the prevalence of a problem by curtailing or decreasing its seriousness and the furtherance of its initial signs (Lorion, Myers, & Bartels, 1994).

Tertiary prevention includes endeavors to decrease the course of a problem as soon as it is already visibly obvious and causing detriment. Primary prevention strategies can acquaint to specific population groups new values, thinking processes, and
relationship abilities that are inconsistent with violence and that support healthy, non-abusive relationships. Case in point, assets can be utilized to concentrate on respect, trust, and supportive growth in relationships. These endeavors can be focused at populations that may be in danger of violence in their intimate relationships but who have not yet displayed indications of agony, or they can be focused commonly at population groups, such as school-age children or associates of a particular community (Millstein, Petersen, & Nightingale, 1993).

As opposed to a population-based focus, secondary prevention endeavors in IPV address recognized people who have displayed specific behaviors linked with IPV. An example of secondary prevention is an indistinctive procedure for the way teachers can support students who have conferred witnessing IPV in their homes but who do not display severe signs of harm (Sherman, Gottfredson, & MacKenzie, 1997).

Tertiary prevention endeavors are the most well-known and accentuate the identification of IPV and its perpetrators and victims, control of the behavior and its complications, reprimand and/or therapy for the perpetrators, and care for the victims. Thorough teamwork and organized services among organizations may be fundamental in tertiary prevention endeavor to address prolonged IPV and to help prevent forthcoming generations of perpetrators and victims. Though, tertiary endeavors can be very costly and often display only partial success in ameliorating IPV, addressing long-term ills, and inhibiting impending acts of violence (Albee, 1985).

Table 1 uses the primary, secondary, and tertiary prevention paradigm to arrange a broad scope of domestic violence prevention strategies. A few of the strategies
indicated in the table are described in more detail in another section, which examines
innovative primary and secondary prevention strategies presently being implemented in
the United States and Canada. (For information regarding tertiary prevention efforts for
children exposed to domestic violence, see the articles by Lemon; Findlater and Kelly;
Saathoff and Stoffel; Culross; and Groves.)
# Table 1

*An Introductory Public Health Model for Domestic Violence Prevention*

<table>
<thead>
<tr>
<th>Life Stage</th>
<th>Primary (Targeted to Populations Before Domestic Violence Occurs)</th>
<th>Secondary (Targeted to Individuals, following early signs of Domestic Violence)</th>
<th>Tertiary (Targeted to Victims and Perpetrators after Domestic Violence is evident)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Infants and Preschoolers (0 to 5 years)</td>
<td>Home visitation. Public health nurses and trained paraprofessionals assisting new parents.</td>
<td>Home visitation with high-risk families. Support and services for family members identified as being at high risk of perpetrating or becoming victims of domestic violence.</td>
<td>Home visitation with abused victims and their children. Specialized services for those identified by domestic violence specialists as having been harmed by domestic violence.</td>
</tr>
<tr>
<td>School Age children (6-12 years old)</td>
<td>School-based awareness and skill development. Collaborative efforts by schools and communities to teach violence awareness and alternative conflict-resolution skills.</td>
<td>Community-based early intervention. Children exposed to violence are offered crisis support, individual counseling, and educational groups.</td>
<td>Disorder-based treatment services. Same as above, with the possible involvement of the juvenile justice system as an identification and access point for treatment.</td>
</tr>
<tr>
<td>Adolescents and high school age youths (13 to 18 years)</td>
<td>School-based awareness and skill development. Same as above, with emphasis on issues related to dating violence and forming healthy intimate relationships.</td>
<td>Community-based early interventions. Same as above, tailored for adolescents exposed to violence and emphasizing dating relationships.</td>
<td>Disorder-based treatment services. Same as above, with the possible involvement of the juvenile justice system as an identification and access point for treatment.</td>
</tr>
</tbody>
</table>

Current primary prevention endeavors are frequently coordinated toward particular population groups, and secondary endeavors toward recognized people inside those groups. Programs for children normally target particular age groups and employ, in their configuration, what is known about child development at that specific age. Therefore, programs for young children are uniquely different from programs for adolescents (Wolfe & Jaffe, 1999). Unfortunately, there is no information presently accessible specifying the total number of primary and secondary prevention programs that address IPV (Wolfe & Jaffe, 1999).

The Four Public Health Approaches to the Primary Prevention of IPV and SV

Violence and sexual assault is grounded in four stages: (1) Define IPV and SV and document their scope and magnitude; (2) Identify factors that increase the risk of IPV and SV or have a protective effect; (3) Design prevention strategies using knowledge of risk and protective factors and grounded in social science theory for modification of those factors. Evaluate the impact of any strategy; (4) Implement proven and promising strategies on a larger scale, in various settings, continuing to monitor their impact (World Health Organization, 2007).

Universally, problem explanation and estimation is the best-created segment. Consciousness of intimate partner violence and sexual violence has ignited many ingenuities to gauge the magnitude of the problem, mostly of violence by intimate partners, in distinctive countries. The worldwide evidence based on predominance and penalties, particularly of intimate partner violence, has extended significantly in the most
recent five years, including research journals such as the WHO Multi-Country Study on Women’s Health and Domestic Violence Against Women, and the availability of data from an increasing number of demographic and health surveys, reproductive health surveys (led by United States of America’s Centers for Disease Control and Prevention), and other national surveys of violence against women (Garcia-Monroe, 2005).

Additional work is necessary to enhance measurement and reach unanimity on operational definitions, especially in admiration of sexual and emotional violence. Most suggestions for addressing IPV and SV include incorporating proposals for reinforcing data gathering and research. At a national level, this may be the first vital venture before the following stages can happen (Garcia-Monroe, 2005). As specified above, endeavors to counteract IPV and SV are being made and are getting to be more various in specific locales. The majority of such methodologies that are documented in the public province, nonetheless, are not grounded in an understanding of risk factors or in social science theory concerning behavior and social modification (Garcia-Monroe, 2005).

Additionally, the evidence base for prevention approaches suffers from the following deficits: (a) few result assessments, and even less from low and middle-income countries; (b) few methodical assessments of the same program over the long-haul; (c) assessment designs are regularly frail, depending on pre-test and post-test measurements of people’s information, disposition, and behavioral goal over short follow-up periods and without contrast groups. Endeavors to measure the effect of interventions on genuine violent behavior and rates of IPV and SV are greatly restricted; and (d) few assessments
of the effect of community and society-level change procedures (Krug, 2002; Dahlberg & Butchart, 2005).

The only prevention methodologies executed on a substantial scale, up to this point, are public awareness campaigns and developments of the criminal justice division; however, their outcome is not clearly comprehended. Assessments of awareness campaigns too frequently end at procedure markers; for example, amount of materials dispersed, introduction to materials, or measures of changes in data only, and restricted efforts have been prepared to measure the effect of criminal equity reactions on rates of IPV or SV (Garcia-Monroe, 2005).

There is a vital requirement for concluded assessments of evidence-based strategies and a systematic method to primary prevention that guarantees broad usage of techniques conveyed as early as possible at the suitable formative stage, over the life span, and addressing factors at all phases of the ecological model. The remainder of this study investigates numerous approaches presently used in prevention of IPV and SV (Garcia-Monroe, 2005).

The fourth step of the public health approach is to execute operative and hopeful interventions in an extensive variety of settings and, through ongoing observation of their impacts on the risk factors and the target problem, to assess their effect and cost-effectiveness. To date, as officially noted, public awareness campaigns and reforms of the criminal justice sector are the only interventions executed on an enormous scale; however, their effect remains poorly understood because of insufficient monitoring and assessment (Garcia-Monroe, 2005).
A Global Picture of IPV and SV Prevention

Global reactions to IPV and SV against women have been grounded for the most part in the human rights framework, which comprehends the prevalence of violence against women to be a hindrance to parity, growth, and women’s full satisfaction of their fundamental moralities and freedoms (Beijing Declaration, 1995, paragraph 112). A mixture of worldwide instruments and agencies give a decree for taking action to ameliorate violence against women. The call for prevention is not truant among them.

The United Nations Declaration on the Elimination of Violence Against Women calls on states to exercise due diligence to, in addition to other things, prevent acts of violence against women whether they are executed by the state or private sectors (Article 4.c), and to create exhaustive preventive methodologies (Article 4.f). The Beijing Declaration and Platform for Action calls on states to take incorporated measures to prevent and eradicate violence against women (Strategic Objective D.1), and particularly to practice due diligence to prevent acts of violence against women (124.b), to adopt, implement and review legislation to guarantee its effectiveness in ameliorating violence against women—highlighting prevention (124.d), and to embrace measures to alter social and cultural forms of conduct of men and women (124.k).

The World Health Organization has called for increased attention to primary prevention of IPV and SV, through the recommendations of the World Report on Violence and Health (Krug, 2002), World Health Assembly Resolution 56.24 on implementing the report’s recommendations (WHA, 2003), and in the recommendations
of the WHO *Multi-Country Study on Women’s Health and Domestic Violence Against Women* (Garcia-Moreno, 2005). In light of this call, remedies sponsored by the international community have concentrated on suggestions such as lawful and legal change, terminating freedom for perpetrators, giving survivors access to justice tools, and improving entree to services such as shelters for abused women and quality medico-legal care.

These endeavors are certain and have enhanced the circumstances of countless women living with violence; however, they may be of restricted value in their capacity to address the fundamental factors that cause IPV and SV (Garcia-Moreno, 2005). They may have value for perverting additional deeds of violence after violence has been revealed, and for diminishing unsafe outcomes; yet, there is a lack of scientific evidence that they can avoid new occurrences of IPV and SV due, to some degree, to an absence of evaluations (Garcia-Monroe, 2005).

The limited primary prevention approaches that have been broadly embraced incorporate widespread advocacy campaigns and endeavors to establish and execute laws to deflect probable perpetrators. Different activities have accentuated interventions to safeguard and support women who have previously experienced violence. United Nations Development Fund for Women (UNIFEM), for instance, notes that its campaigns created more interest for services for survivors than numerous nations could meet. Remembering the downstream/upstream situation, this type of response to awareness-raising is normal (Garcia-Monroe, 2005).
At the point when individuals get to be mindful of the genuine degree of IPV and SV, the sense of most is to request justice and care for the survivors, and chastisement for the perpetrators. It is hard to look past the sheer numbers of victims who are currently battling violence, to the more remote elements that would need to be adjusted to keep more individuals from winding up in the position of being victimized people or perpetrators (Garcia-Monroe, 2005).

**Prevention and Intervention Campaigns and Services for IPV and SV**

One common approach to the primary prevention of IPV and SV are public information and awareness campaigns. These campaigns have been used globally to address the causes, effects, and outcomes of IPV and SV. Numerous campaigns have utilized a human rights framework. The 16 Days of Activism Against Gender Violence Campaign has spawned a variation of awareness-raising activities around the world (Garcia-Monroe, 2005).

Since 1991, roughly 1700 organizations in 130 countries have taken part in organizing annual awareness campaigns (Center for Women’s Global Leadership, 2007). Such campaigns frequently spread messages through mass media channels (television, radio, newspapers, magazines, posters, billboards, town meetings, and a community theatre). These campaigns have the likelihood to influence large numbers of people.

Successful campaigns are: 1) grounded in proof of the issue, the risk, and protective mechanisms; 2) define clear and quantifiable objectives; 3) distinguish pointers to measure the effect of the campaign, how they will be surveyed, and guarantee standard
measurement is taken; 4) elect the target group; 5) employ consumer research with the target group to create messages and recognize the best sources, channels and resources to reach them; 6) construct an assessment component from the beginning; and 7) utilize research to observe impact and enhance the campaign (NCI, 2002; UNIFEM, 2003).

Campaigns that use a social promoting framework apply the standards of commercial advertising to create and adjust correspondences procedures to impact behavioral and social change (NCI, 2002; Donovan & Vlais, 2005).

The social promotion of framework seeks to cultivate persuasive messages by understanding the conduct of the proposed audience and involving them in program development, rather than concentrating mainly on the distribution of material, as many health communications efforts have done. This framework is progressively being employed to address men’s social norms and behavior, including in relation to IPV and SV (Garcia-Monroe, 2005).

As indicated by the latest research, 13 campaigns were uncovered focusing on perpetrators of domestic violence in five English-speaking countries as follows: United States (1), Canada (1), UK (6), Australia (4), and New Zealand (1). Also, three international English-language campaigns were detected that were simultaneously running in many countries. The vast majority of the 16 campaigns uncovered by our quest were created by governments or activist associations, even though some private associations, for example, Glaxo-Smith Kline, have likewise been included in developing campaigns targeting IPV perpetrators (Cismaru, Magdalena, & Lavack, 2011).
As far as their particular goals, numerous campaigns have an extensive scope to increase awareness of IPV as a problem inside a society (Hitting Home Campaign by BBC and Women’s Aid, UK), to expand the comprehension of family violence and inspire changes in violent behaviors (Family Violence in Not OK by Government of New Zealand), as well as persuading laws, policy and practice (Women’s Aid – Act Until Women and Children are Safe by Women’s Aid, U.K. Department of Health). In addition, there are campaigns that are designed to increase public awareness, emerge education programs, and provide services to aid victims involved in violent relationships (Cismaru, Magdalena & Lavack, 2011).

A few different campaigns concentrate on forestalling intimate partner violence and advancing healthy relationships from the earliest starting point, before a relationship is harmed by violence. Such campaigns have as an objective primary prevention of a problem that is not in existence yet. Case in point, Men Make Choices, by Texas Council on Family Violence (U.S.A.), assists and bolsters the participation of men and boys in addressing the underlying reason for men’s violence against women (Cismaru, Magdalena, & Lavack, 2011). Correspondingly, Violence Against Women, It’s Against All the Rules, by Specialist Unit (Australia), strive at increasing men’s ability to address the problems connecting to violence against women and to decrease the use of violence against women; while Men Can Stop Rape’s Strength campaign by Men Can Stop Rape Inc. (International) holds men as vital partners with the will and personality to create healthy choices and foster harmless, neutral relationships (Cismaru et al., 2011).
A few campaigns have as an objective secondary prevention of a problem that has officially happened; in this manner, they inspire victims to find aid for their abuse. For instance, some campaigns inspire men to understand the signs of domestic violence and seek out guidance (Domestic and Family Violence: See the Signs. Be the Solution by Queensland Government, Australia), and to address behaviors that adversely affect their relationships (White Ribbon Day initiated by a handful of Canadian men) (Cismaru et al., 2011). Different campaigns intend to help men to assume liability for their behavior and take action, and terminate the abuse (Everymen Project by Porticus UK and others; Freedom From Fear by the Western Australian Government) by endorsing, supporting, conveying, and creating successful interventions (Respect by Respect, U.K.), offering services, pamphlets, and training to assist victims of domestic violence (Safe-Stop Abuse for Everyone by Stop Abuse for Everyone, an International Human Rights Agency), or assisting men in groups (Move Ireland Men Overcoming Violence by Move Ireland) and offering professional counseling (via help-line) to perpetrators (Violence Against Women – Australia Says NO by Australian Government Office for Women) (Cismaru et al., 2011).

In the majority of the campaigns, men are presumed to be the IPV perpetrators; nonetheless, there are hardly any campaigns that address female IPV perpetrators (i.e., Respect). Pursuing female perpetrators is suitable because, though most studies indicate that women are more probable than men to endure harm in the course of intimate partner violence assaults (Henning & Feder, 2004), a meta-analytic assessment of 82 such studies shows that men and women may have the same prospective for participating in violent
marital interface (Archer, 2000). Different campaigns target homosexual or bisexual IPV perpetrators (Safe-Stop Abuse for Everyone and London Metropolitan Police Domestic Violence Campaign by London Metropolitan Police). A separate campaign addresses Aboriginal male perpetrators and highlights the empowerment of Aboriginal men to take accountability and make modification (Kanawayhitowin: Taking Care of Each Other’s Spirit by Ontario Government and others). The London Metropolitan Police Domestic Violence Campaign is, to some degree, exceptional because it seeks domestic violence criminals with the severe message that police will pursue men who abuse their spouses and detain them, even if the victim declines to make a report or give proof in court (Cismaru et al., 2011).

The campaigns incorporate an extensive variety of dissimilar mass persuading components, such as: print resources (i.e., posters, brochures, handouts, and self-help handbooks); public service announcements for print, radio, and TV; websites; and help lines. In addition, numerous of the recognized campaigns comprise a range of program fundamentals intended to help men comprehend why they have engaged in abusive behavior, how they can change this, and how they can work towards creating non-violent and dutiful relationships (Cismaru et al., 2011).

The Avon Foundation for Women has provided a new grant to Futures Without Violence, formerly Family Violence Prevention Fund, to launch a groundbreaking campaign to address dating violence, stalking, and sexual assault on college campuses. In 2009, the Bureau of Justice Statistics found that young women in college are a particularly vulnerable population, experiencing the highest rates of Intimate Partner
Violence. Additionally, in 2000, a National Institute of Justice Report estimated that one out of five women will be sexually assaulted while in college (Futures Without Violence, 2011).

Each April, the National Sexual Violence Resource Center (NSVRC) launches a national campaign for Sexual Assault Awareness Month (SAAM) that advises communities and individuals on how to prevent sexual violence. Sexual violence is a prevalent public health problem that impacts one in six boys and one in four girls. The Centers for Disease Control and Prevention (CDC) reveals that one in five female victims and one in seven male victims who ever experience rape, physical violence, or stalking by an intimate partner were first victimized between the ages of 11 and 17 years old (Breiding, Chen, & Black, 2014). The campaign discloses national efforts to ameliorate SV and is supported by our President Barack Obama. On April 2011, President Barack Obama proclaimed this day to be National Sexual Assault Awareness and Prevention Day, (Obama, 2013). (See Presidential proclamation: National Sexual Assault Awareness and Prevention Month, 2013, in Appendix E.)

**Theoretical Framework**

It is obvious that survivors need to be empowered and resilient to break the cycles of silence, and humiliation of IPV, DV, and SV and re-victimization. The term “resiliency” originates from the word resilience, which means the capability of a strained body to recover its size and shape after deformation caused specially by compressive
stress; an ability to recover from or adjust easily to misfortune or change (Webster’s Ninth New Collegiate Dictionary, 1983, p. 1003).

The theoretical framework for this study is Resiliency Theory. Resilience commonly refers to one’s capability to return to healthy functioning after encountering a traumatic circumstance (Luthar, Cicchetti, & Becker, 2000; Tugade & Frederickson, 2004). Being resilient does not imply that people are without problems or unaffected by troubles. It does mean drawing on individual philosophies, behaviors, abilities, and the mentality to move through anxiety, trauma, and tragedy instead of succumbing to them. It means rising up from traumatic circumstances, feeling ordinary and maybe much stronger than before (National Center for Victims of Crime, 2005).

There are numerous meanings of resilience, and a few inconsistencies in the conceptualization of resilience as a personality trait versus a dynamic methodology. Resilience refers to a dynamic process of adaptation to significant adversity; resiliency refers to a personal trait rather than a process (Luthar, 2000). Following on Masten (1994), the term resilience is used in this chapter to focus on positive adjustment under challenging conditions—a process of specific attitudes, behaviors, and skills that can be learned.

This chapter defines resilience as the power to deal with adversity and adjust to difficulties or change. The theory of resilience is comparable to other known concepts, such as altruism (Monroe, 1996; Luks, 1993)—the act of helping others without sympathy toward oneself or what one might acquire in revenue—and stamina (Maddi &
Kobasa, 1984; Kobasa, Maddi, & Courington, 1981; Bartone, 1999)—the capability to tolerate anxiety without becoming physically sick.

Emmy Werner, professor of human development at the University of California at Davis, was one of the first people to study resilience. Werner, who had endured the bombing of Germany during World War II as a child, began researching resilience in children in the 1950s, and distributed a longitudinal study of resilient children in 1982 (Werner, 1982; Werner & Smith, 1992). Her research, which monitored high-risk children from conception through the age of 32, recognized the accompanying behaviors of resilience among those who became efficient and successful adults: (a) the proficiency needed to create and retain friends, as well as a sense of humor; (b) problem-solving abilities, which may be connected to parental proficiency—particularly throughout the first year of conception; (c) internal locus of control or the capability to perceive that an individual has control over quite a bit of what transpires with him or her; (d) hope, including a sense of determination and an attainment of orientation; (e) a warm, constructive relationship with at least one other individual; and (f) faith and prayer.

Flach (1990) perceived that those who adapt best to trauma are those who have knowledge of the sensitive effect of what they had been through and have the capacity to express their feelings to another about traumatic endeavors. Thus, different pioneers in the field of resilience research have recognized six resilience traits: (1) insight; (2) independence; (3) ability to develop and maintain intimate relationships; (4) initiative in creative problem-solving; (5) sense of humor; and (6) morality (knowing right from wrong and being willing to take risks for those beliefs) (Wolin & Wolin, 1993).
Enthusiasm in resilience has provoked three distinct consecutive waves of analysis. Richardson (2002) and others bring up that scholars initially recognized substantial resilient traits, as noted previously. This movement was trailed by studies that began to examine problematic and re-integrative methodologies of resiliency amid difficulty. The present movement of interest is in perceiving resilience as the main force that inspires or aids people to develop when confronted with hardship and disorder.

Palmer (1997, 1999) has now identified four hierarchical degrees of resilience in children, suggesting that resilience can be developed and strengthened. They are: (1) anomic survival reflects the pattern of children who live in a constant state of chaos or disruption; (2) regenerative resilience reflects children’s initial learning of new, more effective ways of dealing with challenges; (3) adaptive resilience refers to relatively sustained periods when children become accustomed to using constructive and positive strengthening strategies; (4) flourishing resilience is a function of self-actualized children who use effective and constructive coping strategies extensively and view their lives as meaningful and manageable, or resilient (Zastrow & Kirst-Ashman, 1990).

Fresh traumatic movement can start a change back to a previous level of resilience, but “flourishingly resilient” children have increased or extra means to help them pilot through the task. The most recent decade of empirical research on resilience has made an effort to comprehend the fundamental protective techniques of resilience that increase positive results (Cowen, Work, & Wyman, 1997).

One particular study found that between 30% and 90% of people who endure some form of traumatic event, at the end of the day, experience some positive change as
well (Calhoun & Tedeschi, 1999). Individuals may change their life beliefs, learn to appreciate each day to the fullest, and rethink what really matters to them. They may accept that their experience made them smarter or urged them to act more selflessly in the service of others; they may commit themselves to social regeneration or governmental activism; or they may upgrade their relationships -- case in point, appreciating friends and family more (Linley & Joseph, 2003).

Regarding the recuperation of direct trauma survivors, expressions like *posttraumatic growth*, *stress-related growth*, and *adversarial growth* are becoming to be more standard in the texts (Linley & Joseph, 2004; Ai & Park, 2005). This part of trauma research offers a strong foundation for integrating hands-on strategies for victim service providers and their organizations to lessen the potential adverse impacts of trauma labor. Though numerous social and biological theories dispute that most human behavior is centered on self-interest, this cynical viewpoint does not clarify the many courageous acts committed by individuals who jeopardize much to assist others (Finegan & Flannigan, 2004).

Many individuals seem to be less resilient than they once were. For instance, resilience in children has a tendency to be debilitated by violence, physical or sexual abuse, introduction to alcoholism, and expulsion from the home (Reynolds as cited in Gorman, 2005). Among adults, past experiences of trauma and intensity of response to severe trauma (which may have included neuroendocrine changes) have been revealed to lessen resilience (Yehuda, 2004). But, regardless of any previous components that
may make some individuals more resilient than others, everybody can fortify their resilience by creating extra resilience skills (Waite & Richardson, 2004; Trine, 2004).

The spearheading scholars whose works have been referred to earlier in this chapter, and more contemporary ones, have distinguished various procedures for constructing resilience. Resilience can be produced through responsiveness to external supports (organizational and community resources), inner strengths (individual personality characteristics), and learned skills (coping skills). Creating these resilience components works synergistically—implying that change in one component is liable to influence change in the others, and the other way around (Lord & O’Brien, 2007).

The features of resilience distinguished in this chapter recap current resilience theory and research into six core components: (1) self-knowledge and insight; (2) developing resilience; (3) a sense of hope; (4) healthy coping; (5) strong relationships; and (6) personal perspective and meaning. Each of these six core components of resilience has unique mechanisms that are offered with particular tactics for providers and associations to encourage individual, professional, and organizational resilience in assisting crime victims. Although the majority of these methodologies are research-based, many are resultant from the shared common sense wisdom and experience of victim service providers and leaders in the field. This chapter offers methods to be applied by individual victim service providers (Lord & O’Brien, 2007).
CHAPTER III
METHODOLOGY

Chapter III presents the methods and procedures that were used in conducting the study. The following are described: research design; description of the site; sample and population; instrumentation; treatment of data, and limitations of study.

Research Design

A descriptive and explanatory research design was employed in this study. The study was designed to ascertain data to describe and explain if there is a critical need to implement more prevention and intervention program services and whether or not program prevention and intervention services for the amelioration of intimate partner violence and sexual violence among women a history of child sexual abuse offers effective client services overall under the Violence Against Women Act and Department of Justice Reauthorization Act of 2005.

The descriptive and explanatory research design allowed for the descriptive analysis of the demographic characteristics of the participants. Also, the research design facilitated the explanation of the statistical relationship between the critical need to implement more program prevention and intervention services for the amelioration of intimate partner violence and sexual violence among women with a history of child sexual abuse, present job position, IPV or SV victimization and repeat victimization and
the overall quality of effective program prevention and intervention services that were offered to clients under the Violence Against Women Act and Department of Justice Reauthorization Act of 2005, based on data collected from the participants who were at the 30th Annual Symposium on Child Abuse Conference.

**Description of the Site**

The research study was conducted in Tuscaloosa, Alabama. Tuscaloosa, Alabama is home of the National Children’s Advocacy Center (NCAC). The NCAC had the nation’s response to child sexual abuse since its creation under the leadership of Bud Cramer. The work of the NCAC serves as a beacon of hope for more than 54,000 child abuse professionals from all 50 states and 20 countries. The surveys were administered at the 30th Annual Symposium on Child Abuse Conference. The Alabama site was selected because it is an informative and innovative multidisciplinary conference that offers more than 130 workshops presented by nationally-recognized experts from all faces of the child maltreatment field. Additionally, the Alabama site was selected because of the opportunity to gather data from advocates, intimate partner and sexual violence survivors, social workers, mental health providers, law enforcement, and other allies that are passionate about the amelioration of violence against women and children. As a result, they were cooperative, accessible, and accompanied me in the purpose and outcome of the proposed research.
Sample and Population

The target population for the research was composed of thousands of participants from all 50 states and 20 countries who worked or volunteered in all aspects of child maltreatment, including but not limited to physical abuse, sexual abuse, neglect, exposure to violence, poly-victimization, exploitation, intervention, and prevention. Fifty-seven (57) participants were selected utilizing nonprobability convenience sampling from among the participants of the selected Alabama site for the study.

Instrumentation

The research study employed a survey questionnaire entitled, Program Prevention and Intervention Services for the Amelioration of Intimate Partner Violence (IPV) and Sexual Violence (SV) among Women with a History of Child Sexual Abuse (CSA). The survey questionnaire consisted of two sections with a total of twenty-nine (29) questions. Section I petitioned for demographic information about the characteristics of the participants. Section II consisted of participants’ present job position, victimization of the participants, funded state and government organizations, participants’ awareness of the VAWA 2005, and the effectiveness of prevention and intervention programs and services for the amelioration of intimate partner violence and sexual violence among women with a history of child sexual abuse.

Section I of the survey questionnaire consisted of 14 questions (1-14). Of the fourteen questions, selected questions were used as independent variables for the study. The questions in Section I were concerned with gender, age, ethnicity, education, full- or part-time employment, current field job position is held, first time attending or presenting
at the 30th National Symposium on Child Abuse Conference, victim of sexual violence, intimate partner violence, sexual child abuse, re-victimization and generational violence. These questions provided information for the presentation of a demographic profile on the respondents of the research study.

Section II consisted of 15 program prevention and intervention questions (15-29). Section II utilized questions which measured (present job positions) held among participants who worked with victims of sexual violence (SV), intimate partner violence (IPV), child sexual abuse (CSA), repeat sexual violence, and repeat intimate partner violence; whether or not participants were a victim of intimate partner violence, sexual violence, child sexual abuse, and re-victimization; the critical need for program prevention and intervention services for the amelioration of intimate partner violence and sexual assault among women with a history of child sexual abuse; the participants’ view on whether there needs to be more program prevention and intervention services for the amelioration of intimate partner violence and sexual assault among women with a history of child sexual abuse and client services. Items on the survey were responded to on a four-point continuum Likert scale. The scale was as follows: 1=Strongly Disagree; 2=Disagree; 3=Agree; 4=Strongly Agree.

Treatment of Data

Statistical treatment of the data employed statistics, which included measures of central tendency, frequency distribution, and cross tabulation. The test statistics for the study were phi and chi square. Frequency distribution was used to analyze each of the variables of the study in order to summarize the basic measurements. A frequency
distribution of independent variables was used to develop a demographic profile and to gain insights about the respondents of the study.

Cross tabulations were utilized to demonstrate the statistical relationships between independent variables and the dependent variable. Cross tabulations were conducted between a critical need for the implementation of more prevention/intervention program services, effectiveness of program prevention and intervention services that were offered to clients, present job positions among participants at the 30th National Symposium on Child Abuse Conference that consist of participants working with victims of IPV, SV, CSA, and re-victimization, for the amelioration of intimate partner violence and sexual violence among women with a history of child sexual abuse under the Violence Against Women Act and Department of Justice Reauthorization Act of 2005.

Two test statistics were engaged. The first test was Phi (φ) which is a symmetric measure of association that is used to demonstrate the strength of relationship between two or more variables (Bromstead & Knoke, 1995). The following are the values associated with Phi (φ):

- .00 to .24 “no relationship”
- .25 to .49 “weak relationship”
- .50 to .74 “moderate relationship”
- .75 to 1.00 “strong relationship”

The second test statistics engaged in the research study was chi square. Chi square was used to test whether there was a statistical significance at the .05 level of probability among the variables in the study.
Limitations of the Study

There were basic limitations of the study. The first limitation was the amount of time allocated for the presentation of the workshop, “Breaking the Cycle, Beating the Odds, 12 Step Self Awareness Model (SAM). The workshop depicts the researcher’s personal and professional journey through overcoming childhood sexual, physical, and emotional abuse and self-destruction. The workshop was 90 minutes in duration and consisted of a powerpoint presentation, viewing of a documentary, questions, and feedback. Thus, it was difficult to pass out and collect surveys and interview participants before and after the workshop.

The second limitation was the mass amount of workshops offered at the same time as the researcher’s, making it difficult for participants to choose which workshop to attend causing participants to travel back and forth and in and out of the SAM workshop. The third limitation was the restricted amount of time and distance between workshops, making it difficult for participants to have adequate time to gather more information about the study before they had to be at the next workshop.
CHAPTER IV
PRESENTATION OF FINDINGS

The purpose of the chapter was to present the findings of the study in order to describe and explain the critical need to implement more program prevention and intervention services and the overall quality of effective program prevention and intervention services that were offered to clients for the amelioration of intimate partner violence and sexual violence among women with a history of child sexual abuse under the Violence Against Women Act and Department of Justice Reauthorization Act of 2005, based on data collected from participants at the 30th National Symposium on Child Abuse Conference. This chapter presents the findings of the study. The findings are organized into two sections: demographic data and research questions and hypotheses.

Demographic Data

This section provides a profile of the study participants. Descriptive statistics were used to analyze the following: gender, age, ethnicity, education, full- or part-time employment, and the current job positions of the participants. Additionally, descriptive statistics analyzed whether it was the participants’ first time attending or presenting at the 30th National Symposium on Child Abuse Conference, whether participants had ever been a victim of sexual violence, intimate partner violence, child sexual abuse, or re-
victimization, and their knowledge of other family members that had been a victim of sexual, intimate, and/or dating violence.

A target population for the research was composed of participants and volunteers who worked or volunteer in all aspects of child maltreatment, including but not limited to physical abuse, sexual abuse, neglect, exposure to violence, poly-victimization, exploitation, intervention, and prevention. Fifty-seven (57) participants were selected utilizing convenience sampling from among the participants of the selected site.
Table 2

Demographic Profile of Study Participants (N=57)

<table>
<thead>
<tr>
<th>Variable</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gender</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>4</td>
<td>7.0</td>
</tr>
<tr>
<td>Female</td>
<td>53</td>
<td>93.0</td>
</tr>
<tr>
<td>Age Group</td>
<td></td>
<td></td>
</tr>
<tr>
<td>18-30</td>
<td>17</td>
<td>29.8</td>
</tr>
<tr>
<td>31-39</td>
<td>12</td>
<td>21.1</td>
</tr>
<tr>
<td>41-49</td>
<td>12</td>
<td>21.1</td>
</tr>
<tr>
<td>Over 50</td>
<td>16</td>
<td>28.1</td>
</tr>
<tr>
<td>Ethnicity</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Black</td>
<td>19</td>
<td>33.3</td>
</tr>
<tr>
<td>White</td>
<td>34</td>
<td>59.6</td>
</tr>
<tr>
<td>Hispanic</td>
<td>3</td>
<td>5.3</td>
</tr>
<tr>
<td>Other</td>
<td>1</td>
<td>1.8</td>
</tr>
<tr>
<td>Marital Status</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Married</td>
<td>28</td>
<td>49.1</td>
</tr>
<tr>
<td>Never Married</td>
<td>12</td>
<td>21.1</td>
</tr>
<tr>
<td>Divorced</td>
<td>13</td>
<td>22.8</td>
</tr>
<tr>
<td>Separated</td>
<td>4</td>
<td>7.0</td>
</tr>
<tr>
<td>Variable</td>
<td>Frequency</td>
<td>Percent</td>
</tr>
<tr>
<td>--------------------------------------</td>
<td>-----------</td>
<td>---------</td>
</tr>
<tr>
<td>Education</td>
<td></td>
<td></td>
</tr>
<tr>
<td>High School Grad</td>
<td>1</td>
<td>1.8</td>
</tr>
<tr>
<td>Some College</td>
<td>6</td>
<td>10.5</td>
</tr>
<tr>
<td>College Grad</td>
<td>50</td>
<td>87.7</td>
</tr>
<tr>
<td>Employment</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Full Time</td>
<td>49</td>
<td>90.7</td>
</tr>
<tr>
<td>Part Time</td>
<td>5</td>
<td>9.3</td>
</tr>
<tr>
<td>First Child Abuse Symposium</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>32</td>
<td>56.1</td>
</tr>
<tr>
<td>No</td>
<td>25</td>
<td>43.9</td>
</tr>
<tr>
<td>Victim of Sexual Violence</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>7</td>
<td>12.3</td>
</tr>
<tr>
<td>No</td>
<td>50</td>
<td>87.7</td>
</tr>
</tbody>
</table>

As shown in Table 2, the typical respondent of the study was a white American female who was married, 18-30 years old, a college graduate, was employed full time in Child Protective Services, first time attending the 30th National Symposium on Child Abuse Conference, and had not been a victim of sexual violence.
Table 3

*Employment of National Symposium Study Participants*

<table>
<thead>
<tr>
<th>Variable</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Administration</td>
<td>8</td>
<td>14.3</td>
</tr>
<tr>
<td>Child Protective Services</td>
<td>14</td>
<td>25.0</td>
</tr>
<tr>
<td>Law Enforcement</td>
<td>4</td>
<td>7.1</td>
</tr>
<tr>
<td>Victim Advocacy</td>
<td>13</td>
<td>23.2</td>
</tr>
<tr>
<td>Mental Health Treatment</td>
<td>9</td>
<td>16.1</td>
</tr>
<tr>
<td>Legal</td>
<td>1</td>
<td>1.8</td>
</tr>
<tr>
<td>Medical</td>
<td>2</td>
<td>3.6</td>
</tr>
<tr>
<td>Prevention-Intervention</td>
<td>5</td>
<td>8.9</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>56</strong></td>
<td><strong>100.0</strong></td>
</tr>
</tbody>
</table>

As shown in Table 3, the majority, 14 (or 25.0 %) of the participants were employed in Child Protective Services; 13 (or 23.2 %) were employed in Victim Advocacy; nine (or 16.1%) were employed in Mental Health Treatment; eight (or 14.3%) were employed in Administration; five (or 8.9%) were employed in Prevention-Intervention; four (or 7.1%) were employed in Law Enforcement; two (or 3.6%) were employed in Medical, while one (or 1.8 %) was employed in Legal.

Table 4 is a frequency distribution of the sub-facets of sexual abuse and sexual violence among 57 National Symposium on Child Abuse Conference attendees. Table 4
indicates whether or not the participants agreed or disagreed that they had been a victim of childhood sexual abuse, sexual violence, and intimate partner violence and have had family members that had been a victim of sexual violence.

Table 4

**Sexual Abuse and Sexual Violence among Participants**

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>%</th>
<th>No</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q7 Have you been a victim of Childhood Sexual Abuse</td>
<td>10</td>
<td>17.5</td>
<td>47</td>
<td>82.5</td>
</tr>
<tr>
<td>Q8 Have you been a victim of Sexual Violence</td>
<td>7</td>
<td>12.3</td>
<td>50</td>
<td>87.7</td>
</tr>
<tr>
<td>Q9 Have you been a victim of Intimate Partner Violence</td>
<td>11</td>
<td>19.3</td>
<td>46</td>
<td>80.7</td>
</tr>
<tr>
<td>Q11 Have family members been victims of Sexual Violence</td>
<td>27</td>
<td>47.4</td>
<td>30</td>
<td>52.6</td>
</tr>
</tbody>
</table>

As shown in Table 4, the participants at the 30th National Symposium on Child Abuse Conference disagreed (82.5%) that they had been a victim of childhood sexual abuse. Also, attendees at the 30th National Symposium on Child Abuse Conference disagreed (87.7%) that they had been a victim of sexual abuse, and they disagreed (80.7%) that they had been a victim of intimate partner violence. The participants at the 30th National Symposium on Child Abuse Conference also disagreed (52.6%) that they had a family member that had been a victim of sexual violence.
Table 5 is a frequency distribution of the sub-facets of participants working with sexual abuse and sexual violence victims among 57 National Symposium on Child Abuse Conference attendees. Table 5 indicates whether or not the participants agreed or disagreed that they had worked with sexual abuse and sexual violence victims.

Table 5

Participants Working with Sexual Abuse and Sexual Violence Victims

<table>
<thead>
<tr>
<th>Question</th>
<th>Statement</th>
<th>Discagree #</th>
<th>Discagree %</th>
<th>Agree #</th>
<th>Agree %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q15</td>
<td>My job is working with victims of Sexual Violence</td>
<td>6</td>
<td>10.7</td>
<td>50</td>
<td>89.3</td>
</tr>
<tr>
<td>Q16</td>
<td>I work with victims of Intimate Partner Violence</td>
<td>19</td>
<td>34.5</td>
<td>36</td>
<td>65.5</td>
</tr>
<tr>
<td>Q17</td>
<td>I work with victims of Childhood Sexual Abuse</td>
<td>8</td>
<td>14.0</td>
<td>49</td>
<td>86.0</td>
</tr>
<tr>
<td>Q18</td>
<td>I work with victims of repeat Sexual Violence</td>
<td>18</td>
<td>32.7</td>
<td>37</td>
<td>67.3</td>
</tr>
</tbody>
</table>

As shown in Table 5, the participants at the 30th National Symposium on Child Abuse Conference agreed (89.3%) that they had worked with sexual abuse and sexual violence victims. Also, attendees at the 30th National Symposium on Child Abuse Conference agreed (65.5%) that they had worked with victims of intimate partner violence, and the participants agreed (86.0%) that they had worked with victims of childhood sexual abuse. The participants at the 30th National Symposium on Child Abuse Conference agreed (67.3%) that they had worked with victims of repeat sexual violence.
Table 6 is a frequency distribution of the sub-facets of symposium participants as victims of sexual abuse and sexual violence among 57 National Symposium on Child Abuse Conference attendees. Table 6 indicates whether or not symposium participants agreed or disagreed that they were victims of sexual abuse and sexual violence.

Table 6

*Symposium Participants as Victims of Sexual Abuse and Sexual Violence*

<table>
<thead>
<tr>
<th>Question</th>
<th>Disagree</th>
<th></th>
<th>Agree</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Q19</td>
<td>45 80.4</td>
<td>11 19.6</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Q20</td>
<td>45 80.4</td>
<td>11 19.6</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Q21</td>
<td>46 82.1</td>
<td>10 17.9</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Q22</td>
<td>53 94.6</td>
<td>3 5.4</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Q23</td>
<td>52 92.9</td>
<td>4 7.1</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

As shown in Table 6, the participants at the 30th National Symposium on Child Abuse Conference disagreed (80.4%) that they had not been a victim of sexual violence nor had they been a victim of intimate partner violence. Also, participants disagreed (82.1%) that they had not been a victim of childhood sexual abuse. The participants at the 30th National Symposium on Child Abuse Conference disagreed (94.6%) that they had
been a repeat victim of sexual violence and (94.9%) disagreed that they had been a repeat victim of intimate partner violence.

Table 7 is a frequency distribution for the computed value of the participants’ organization offering prevention intervention services for victims of sexual violence and intimate partner violence.

Table 7

Q24 My organization offers prevention intervention services for victims of Sexual Violence and Intimate Partner Violence

<table>
<thead>
<tr>
<th>Value</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Disagree</td>
<td>15</td>
<td>27.8</td>
</tr>
<tr>
<td>Agree</td>
<td>39</td>
<td>72.2</td>
</tr>
<tr>
<td>Total</td>
<td>54</td>
<td>100.0</td>
</tr>
</tbody>
</table>

Mean 2.72  Std. Dev .452

As shown in Table 7, of the 57 respondents of the 30th National Symposium on Child Abuse Conference participants, 39 (or 72.2%) agreed that their organization offered prevention intervention services for victims of sexual violence and intimate violence, while 15 (or 27.8%) of the participants disagreed that their organization offered prevention intervention services for victims of sexual violence and intimate violence.
Table 8 is a frequency distribution for the computed value of participants that attended the National Symposium on Child Abuse Conference because the participants provided the latest research.

Table 8

Q25 I attended the National Symposium on Child Abuse Conference because the participants provided the latest research

<table>
<thead>
<tr>
<th>Value</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Disagree</td>
<td>1</td>
<td>1.8</td>
</tr>
<tr>
<td>Agree</td>
<td>54</td>
<td>98.2</td>
</tr>
<tr>
<td>Total</td>
<td>55</td>
<td>100.0</td>
</tr>
</tbody>
</table>

Mean 2.98  Std. Dev .135

As shown in Table 8, of the 57 respondents of the 30th National Symposium on Child Abuse Conference participants, 54 (or 98.2%) agreed that they attended the National Symposium on Child Abuse Conference because the participants provided the latest research, while one (or 1.8%) of the participants disagreed that that they attended the National Symposium on Child Abuse Conference because the participants provided the latest research.

Table 9 is a frequency distribution for the computed value of the critical need for the implementation or more prevention/intervention program services for the
amelioration of intimate partner violence (IPV) and sexual violence (SV) among women with a history of child sexual abuse (CSA).

Table 9

Q26 Critical need for the implementation of more services for the amelioration of IPV and SV among women with a history of CSA

<table>
<thead>
<tr>
<th>Value</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Disagree</td>
<td>0</td>
<td>0.0</td>
</tr>
<tr>
<td>Agree</td>
<td>55</td>
<td>100.0</td>
</tr>
<tr>
<td>Total</td>
<td>55</td>
<td>100.0</td>
</tr>
</tbody>
</table>

Mean 3.00 Std. Dev .000

As shown in Table 9, of the 57 respondents of the 30th National Symposium on Child Abuse Conference participants, 55 (or 100%) agreed that there was a critical need for the implementation or more prevention/intervention program services for the amelioration of intimate partner violence and sexual violence among women with a history of child sexual abuse.

Table 10 is a frequency distribution for the computed value of the organization funded by the state.
Table 10

Q27 *My organization is funded by the state government program*

<table>
<thead>
<tr>
<th>Value</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Disagree</td>
<td>16</td>
<td>29.6</td>
</tr>
<tr>
<td>Agree</td>
<td>38</td>
<td>70.4</td>
</tr>
<tr>
<td>Total</td>
<td>54</td>
<td>100.0</td>
</tr>
</tbody>
</table>

Mean 2.70  Std. Dev .461

As shown in Table 10, of the 57 respondents of the 30th National Symposium on Child Abuse Conference participants, 38 (or 70.4%) agreed that their organizations were funded by the state government program, while 16 (or 29.6%) of the participants disagreed that their organizations were funded by the state government program.

Table 11 is a frequency distribution for the computed value of the awareness of the Violence Against Women Act and the Department of Justice Reauthorization Act of 2005.
Table 11

Q28 I am aware of the Violence Against Women Act and the Department of Justice Reauthorization Act of 2005

<table>
<thead>
<tr>
<th>Value</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Disagree</td>
<td>17</td>
<td>30.9</td>
</tr>
<tr>
<td>Agree</td>
<td>38</td>
<td>69.1</td>
</tr>
<tr>
<td>Total</td>
<td>55</td>
<td>100.0</td>
</tr>
</tbody>
</table>

Mean 2.69  Std. Dev .466

As shown in Table 11, of the 57 respondents of the 30th National Symposium on Child Abuse Conference participants, 38 (or 69.1%) agreed that they were aware of the Violence Against Women Act and the Department of Justice Reauthorization Act of 2005, while 17 (or 30.9%) of the participants disagreed that they were aware of the Violence Against Women Act and the Department of Justice Reauthorization Act of 2005.

Table 12 is a frequency distribution for the computed value of the overall quality program prevention and intervention services our organization offer our clients are effective.
Table 12

Q29 The overall quality of program prevention and intervention services our organization offers our clients are effective

<table>
<thead>
<tr>
<th>Value</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Disagree</td>
<td>11</td>
<td>20.8</td>
</tr>
<tr>
<td>Agree</td>
<td>42</td>
<td>79.2</td>
</tr>
<tr>
<td>Total</td>
<td>53</td>
<td>100.0</td>
</tr>
</tbody>
</table>

Mean 2.79 Std. Dev .409

As shown in Table 12, of the 57 respondents of the 30th National Symposium on Child Abuse Conference participants, 42 (or 79.2%) agreed that the overall quality of program prevention and intervention services their organization offered their clients were effective, while 11 (or 20.8%) of the participants disagreed that the overall quality of program prevention and intervention services their organization offered their clients were effective.

**Research Questions and Hypotheses**

There were nine research questions and nine null hypotheses in the study. This section provides an analysis of the research questions and a testing of the hypotheses.

**Research Question 1:** Is there evidence of a critical need for the implementation of more prevention/intervention program and services for the amelioration of intimate partner violence, and sexual violence, among women with a history of child sexual abuse
under the Violence Against Women Act and Department of Justice Reauthorization Act of 2005, based on data from the participants at the 30th National Symposium on Child Abuse Conference?

**Hypothesis 1:** There is no evidence of a critical need for the implementation of more prevention/intervention program and services for the amelioration of intimate partner violence, and sexual violence, among women with a history of child sexual abuse under the Violence Against Women Act and Department of Justice Reauthorization Act of 2005, based on data from the participants at the 30th National Symposium on Child Abuse Conference.

Table 13

**Critical need for the implementation of more services among participants at the 30th National Symposium on Child Abuse Conference**

<table>
<thead>
<tr>
<th>Value</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Disagree</td>
<td>0</td>
<td>0.0</td>
</tr>
<tr>
<td>Agree</td>
<td>55</td>
<td>100.0</td>
</tr>
<tr>
<td>Total</td>
<td>55</td>
<td>100.0</td>
</tr>
</tbody>
</table>

As shown in Table 13, 55 (or 100%) of the participants at the 30th National Symposium on Child Abuse Conference agreed that they believed that there was evidence of a critical need for the implementation of more prevention/intervention
program services for the amelioration of intimate partner violence and sexual violence among women with a history of child sexual abuse.

**Research Question 2:** Is there evidence of a need for present job positions to work with victims of intimate partner violence under the Violence Against Women Act and Department of Justice Reauthorization Act of 2005, based on data from participants who attended the 30th National Symposium on Child Abuse Conference?

**Hypothesis 2:** There is no evidence of a need for present job positions to work with victims of intimate partner violence under the Violence Against Women Act and Department of Justice Reauthorization Act of 2005, based on data from participants who attended the 30th National Symposium on Child Abuse Conference.

Table 14

*Present job position that consists of participants at the 30th National Symposium on Child Abuse Conference working with victims of IPV*

<table>
<thead>
<tr>
<th>Value</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Disagree</td>
<td>19</td>
<td>34.6</td>
</tr>
<tr>
<td>Agree</td>
<td>36</td>
<td>65.4</td>
</tr>
<tr>
<td>Total</td>
<td>55</td>
<td>100.0</td>
</tr>
</tbody>
</table>

As shown in Table 14, 36 (or 65.4%) of the participants at the 30th National Symposium on Child Abuse Conference agreed that their present job position consisted
of working with victims of IPV, while 19 (or 34.6%) of the participants at the 30th National Symposium on Child Abuse Conference disagreed that their present job position consisted of working with victims of IPV.

**Research Question 3:** Is there a statistically significant relationship between the participants who were victims of repeat intimate partner violence (IPV) under the Violence Against Women Act and Department of Justice Reauthorization Act of 2005, and the ability of the participants to provide the latest research information that addresses all aspects of child maltreatment, and the opportunity to develop and enhance participants’ skills among the participants at the 30th National Symposium on Child Abuse Conference?

**Hypothesis 3:** There is no statistically significant relationship between the participants who were victims of repeat intimate partner violence (IPV) under the Violence Against Women Act and Department of Justice Reauthorization Act of 2005, and the ability of the participants to provide the latest research information that addresses all aspects of child maltreatment, and the opportunity to develop and enhance participants’ skills among the participants at the 30th National Symposium on Child Abuse Conference.

Table 15 is a cross tabulation of the 30th National Symposium on Child Abuse Conference participants who were a victim of repeat intimate partner violence (IPV) and the ability of participants to provide the latest research information that addresses all aspects of child maltreatment, and the opportunity to develop and enhance participants’ skills and knowledge among participants. It shows the association of the 30th National
Symposium on Child Abuse Conference participants that were victims of repeat IPV and the ability of participants to provide the latest research information that addresses all aspects of child maltreatment, and the opportunity to develop and enhance participants’ skills and knowledge, and indicates whether or not there was a statistically significant relationship between the two variables.

Table 15

*Repeat victim of IPV and the ability of participants to provide the latest research among the 30th National Symposium on Child Abuse Conference participants*

<table>
<thead>
<tr>
<th></th>
<th>Disagree</th>
<th>Agree</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>#</td>
<td>%</td>
<td>#</td>
</tr>
<tr>
<td>Disagree</td>
<td>1</td>
<td>1.8</td>
<td>50</td>
</tr>
<tr>
<td>Agree</td>
<td>0</td>
<td>0.0</td>
<td>4</td>
</tr>
<tr>
<td>Total</td>
<td>1</td>
<td>1.8</td>
<td>54</td>
</tr>
</tbody>
</table>

Φ = .038
df = 1
ρ = .777

As shown in Table 15, the majority (90.9%) of participants of the 30th National Symposium on Child Abuse Conference agreed that they attended the 30th National Symposium on Child Abuse Conference because the conference provided the latest research information that addressed all aspects of child maltreatment, and the opportunity to develop and enhance their skills and knowledge, and indicated that they were not a repeat victim of IPV. One (or 1.8%) of the participants disagreed that he or she attended
the 30th National Symposium on Child Abuse Conference because the conference provided the latest research information that addressed all aspects of child maltreatment, and the opportunity to develop and enhance his or her skills and knowledge, and indicated that he or she was not a repeat victim of IPV.

As shown in Table 15, the statistical measurement phi (Φ) was employed to test for the strength of association between the 30th National Symposium on Child Abuse Conference participants’ ability to provide the latest research information that addresses all aspects of child maltreatment, and the opportunity to develop and enhance participants’ skills and knowledge and participants that were victims of repeat IPV. As indicated, there was no relationship (Φ = .038) between the two variables. When the chi-square statistical test for significance was applied, the null hypothesis was not rejected (ρ = .777), indicating that there was not a statistically significant relationship between the two variables at the .05 level of probability.

**Research Question 4:** Is there a statistically significant relationship between the awareness of the Violence Against Women Act and Department of Justice Reauthorization Act of 2005, and organizations that are funded by a state and government program under the Violence Against Women Act and Department of Justice Reauthorization Act of 2005, among participants who attended the 30th National Symposium on Child Abuse Conference?

**Hypothesis 4:** There is no statistically significant relationship between the awareness of the Violence Against Women Act and Department of Justice Reauthorization Act of 2005, and organizations that are funded by a state and government program under the
Violence Against Women Act and Department of Justice Reauthorization Act of 2005, among participants who attended the 30th National Symposium on Child Abuse Conference.

Table 16 is a cross tabulation of the 30th National Symposium on Child Abuse Conference participants who were aware of the Violence Against Women Act and Department of Justice Reauthorization Act of 2005, and organizations that are funded by a state and government program among the participants of the 30th National Symposium on Child Abuse Conference. It shows the association of the participants who were aware of the Violence Against Women Act and Department of Justice Reauthorization Act of 2005 and organizations that are funded by a state and government program, and indicates whether or not there was a statistically significant relationship between the two variables.

Table 16

<table>
<thead>
<tr>
<th></th>
<th>Disagree</th>
<th>Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>#</td>
<td>%</td>
<td>#</td>
</tr>
<tr>
<td>Disagree</td>
<td>8 (15.1)</td>
<td>8 (15.1)</td>
</tr>
<tr>
<td>Agree</td>
<td>8 (15.1)</td>
<td>29 (54.7)</td>
</tr>
<tr>
<td>Total</td>
<td>16 (30.2)</td>
<td>37 (69.8)</td>
</tr>
</tbody>
</table>

Φ = .284 df = 1 ρ = .039
As shown in Table 16, the majority, 29 (or 54.7%), of the 30th National Symposium on Child Abuse Conference participants agreed that they were aware of the Violence Against Women Act and Department of Justice Reauthorization Act of 2005 (VAWA 2005), and indicated that their organization was funded by a state and government program. Only 8 (or 15.1%) of the 30th National Symposium on Child Abuse Conference participants indicated that they disagreed that they were aware of the VAWA 2005 and their organization was not funded by a state or government program.

As shown in Table 16, the statistical measurement phi (Φ) was employed to test for the strength of association of the participants who were aware of the Violence Against Women Act and Department of Justice Reauthorization Act of 2005 and organizations that are funded by a state and government program. As indicated, there was a weak relationship (Φ = .284) between the two variables. When the chi-square statistical test for significance was applied, the null hypothesis was rejected (ρ = .039) indicating that there was a statistically significant relationship between the two variables at the .05 level of probability.

**Research Question 5**: Is there a statistically significant relationship between participants who have been victims of intimate partner violence (IPV) and participants who are repeat victims of intimate partner violence under the Violence Against Women Act and Department of Justice Reauthorization Act of 2005 among the participants who attended the 30th National Symposium on Child Abuse Conference?

**Hypothesis 5**: There is no statistically significant relationship between participants who have been victims of intimate partner violence (IPV) and participants who are repeat
victims of intimate partner violence under the Violence Against Women Act and Department of Justice Reauthorization Act of 2005 among the participants who attended the 30th National Symposium on Child Abuse Conference.

Table 17 is a cross tabulation of the 30th National Symposium on Child Abuse Conference participants who have been a victim of intimate partner violence (IPV) and participants that are a repeat victim of intimate partner violence among the participants that attended the 30th National Symposium on Child Abuse. It shows the association of participants that have been a victim of IPV and participants that are repeat victims of IPV and indicates whether or not there was a statistically significant relationship between the two variables.

Table 17

<table>
<thead>
<tr>
<th></th>
<th>Disagree</th>
<th>Agree</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>#</td>
<td>#</td>
<td>%</td>
</tr>
<tr>
<td>Disagree</td>
<td>44</td>
<td>1</td>
<td>45</td>
</tr>
<tr>
<td>Agree</td>
<td>8</td>
<td>3</td>
<td>11</td>
</tr>
<tr>
<td>Total</td>
<td>52</td>
<td>4</td>
<td>56</td>
</tr>
</tbody>
</table>

Φ = .386

Table 17

Victim of IPV and repeat victim of IPV among the participants at the 30th National Symposium on Child Abuse Conference

<table>
<thead>
<tr>
<th></th>
<th>Disagree</th>
<th>Agree</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>#</td>
<td>#</td>
<td>%</td>
</tr>
<tr>
<td>Disagree</td>
<td>44</td>
<td>1</td>
<td>45</td>
</tr>
<tr>
<td>Agree</td>
<td>8</td>
<td>3</td>
<td>11</td>
</tr>
<tr>
<td>Total</td>
<td>52</td>
<td>4</td>
<td>56</td>
</tr>
</tbody>
</table>

Φ = .386

df = 1

ρ = .004
As shown in Table 17, the majority, 44 (or 78.6%), of the 30\textsuperscript{th} National Symposium on Child Abuse Conference participants disagreed that they were a repeat victim of IPV and indicated that they have not been a victim of IPV. Only 3 (or 5.4%) of the 30\textsuperscript{th} National Symposium on Child Abuse Conference participants indicated that they agreed they were a repeat victim of IPV and that they have been a victim of IPV.

As shown in Table 17, the statistical measurement phi ($\Phi$) was employed to test for the strength of the association of the participants who have been a victim of intimate partner violence (IPV) and participants that are a repeat victim of intimate partner violence. As indicated, there was a weak relationship ($\Phi = .386$) between the two variables. When the chi-square statistical test for significance was applied, the null hypothesis was rejected ($\rho = .004$) indicating that there was a statistically significant relationship between the two variables at the .05 level of probability.

**Research Question 6:** Is there a statistically significant relationship between participants who have been victims of sexual violence and participants who are repeat victims of sexual violence under the Violence Against Women Act and Department of Justice Reauthorization Act of 2005 among the participants who attended the 30\textsuperscript{th} National Symposium on Child Abuse Conference?

**Hypothesis 6:** There is no statistically significant relationship between participants who have been victims of sexual violence and participants who are repeat victims of sexual violence under the Violence Against Women Act and Department of Justice Reauthorization Act of 2005 among the participants who attended the 30\textsuperscript{th} National Symposium on Child Abuse Conference.
Table 18 is a cross tabulation of the 30th National Symposium on Child Abuse Conference participants who have been a victim of repeat sexual violence (SV) and participants that have been a victim of sexual violence (SV) among the participants that attended the 30th National Symposium on Child Abuse. It shows the association of participants that are a repeat victim of SV and participants that have been a repeat victim of SV, and indicates whether or not there was a statistically significant relationship between the two variables.

Table 18

Repeat victim of SV and victim of SV among the participants at the 30th National Symposium on Child Abuse Conference

<table>
<thead>
<tr>
<th></th>
<th>Disagree</th>
<th>Agree</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>#</td>
<td>%</td>
<td>#</td>
</tr>
<tr>
<td>Disagree</td>
<td>45</td>
<td>80.4</td>
<td>0</td>
</tr>
<tr>
<td>Agree</td>
<td>8</td>
<td>14.3</td>
<td>3</td>
</tr>
<tr>
<td>Total</td>
<td>53</td>
<td>94.6</td>
<td>3</td>
</tr>
</tbody>
</table>

Ф = .481 df = 1 ρ = .000

As shown in Table 18, the majority (80.4%) of the participants at the 30th National Symposium on Child Abuse Conference disagreed that they were a repeat victim of SV and indicated that they have not been a victim of SV. Only three (or 5.4%) of the participants indicated that they agreed that have been a victim of SV and that they were not a repeat victim of SV.
As shown in Table 18, the statistical measurement phi (Φ) was employed to test for the strength of association between the participants who have been a victim of repeat sexual violence (SV) and participants that have been a repeat victim of sexual violence (SV). As indicated, there was a weak relationship (Φ = .481) between the two variables. When the chi-square statistical test for significance was applied, the null hypothesis was rejected (ρ = .000) indicating that there was a statistically significant relationship between the two variables at the .05 level of probability.

**Research Question 7**: Is there a statistically significant relationship between participants who have been victims of child sexual abuse and participants who work with victims of child sexual abuse under the Violence Against Women Act and Department of Justice Reauthorization Act of 2005 among the participants who attended the 30th National Symposium on Child Abuse Conference?

**Hypothesis 7**: There is no statistically significant relationship between participants who have been victims of child sexual abuse and participants who work with victims of child sexual abuse under the Violence Against Women Act and Department of Justice Reauthorization Act of 2005 among the participants who attended the 30th National Symposium on Child Abuse Conference.

Table 19 is a cross tabulation of the 30th National Symposium on Child Abuse Conference participants who have been a victim of child sexual abuse (CSA) and participants who work with victims of child sexual abuse (CSA) among the participants that attended the 30th National Symposium on Child Abuse. It shows the association of
participants that have been a victim of CSA and participants who work with victims of CSA, and indicates whether or not there was a statistically significant relationship between the two variables.

Table 19

Work with victims of CSA among the participants at the 30th National Symposium on Child Abuse Conference

<table>
<thead>
<tr>
<th></th>
<th>Disagree</th>
<th>Agree</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>#</td>
<td>%</td>
<td>#</td>
</tr>
<tr>
<td>Disagree</td>
<td>7</td>
<td>12.5</td>
<td>39</td>
</tr>
<tr>
<td>Agree</td>
<td>1</td>
<td>1.8</td>
<td>9</td>
</tr>
<tr>
<td>Total</td>
<td>8</td>
<td>14.3</td>
<td>48</td>
</tr>
</tbody>
</table>

Φ = .080  df = 1  ρ = .777

As shown in Table 19, the majority (69%) of the participants at the 30th National Symposium on Child Abuse Conference agreed that they work with victims of CSA and indicated that they have not been a victim of CSA. Of the 57 respondents, seven (or 12.5%) indicated that they disagreed that they work with victims of CSA and they have not been a victim of CSA.

As shown in Table 19, the statistical measurement phi (Φ) was employed to test for the strength of association between the participants who have been a victim of repeat sexual violence (SV) and participants that have been a repeat victim of sexual violence (SV). As indicated, there was no relationship (Φ = .057) between the two variables. When
the chi-square statistical test for significance was applied, the null hypothesis was not rejected (ρ = .777) indicating that there was not a statistically significant relationship between the two variables at the .05 level of probability.

**Research Question 8:** Is there a statistically significant relationship between participants who are victims of repeat sexual violence and the participants who are victims of repeat intimate partner violence under the Violence Against Women Act and Department of Justice Reauthorization Act of 2005 among the participants who attended the 30th National Symposium on Child Abuse Conference?

**Hypothesis Question 8:** There is no statistically significant relationship between participants who are victims of repeat sexual violence and the participants who are victims of repeat intimate partner violence under the Violence Against Women Act and Department of Justice Reauthorization Act of 2005 among the participants who attended the 30th National Symposium on Child Abuse Conference.

Table 20 is a cross tabulation of the 30th National Symposium on Child Abuse Conference participants who were a repeat victim of intimate partner violence (IPV) and participants who were a repeat victim of sexual violence (SV) among the participants that attended the 30th National Symposium on Child Abuse. It shows the association of participants who were a repeat victim of IPV and participants who were a victim of repeat SV, and indicates whether or not there was a statistically significant relationship between the two variables.
Table 20

Repeat victim of IPV and SV among the participants at the 30th National Symposium on Child Abuse Conference

<table>
<thead>
<tr>
<th></th>
<th>Disagree</th>
<th>Agree</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>#   %</td>
<td>#   %</td>
<td>#   %</td>
</tr>
<tr>
<td>Disagree</td>
<td>50 89.3</td>
<td>3 5.4</td>
<td>53 94.6</td>
</tr>
<tr>
<td>Agree</td>
<td>2 3.6</td>
<td>1 1.8</td>
<td>3 5.4</td>
</tr>
<tr>
<td>Total</td>
<td>52 92.9</td>
<td>4 7.1</td>
<td>56 100.0</td>
</tr>
</tbody>
</table>

Φ =.242 df =1 ρ=.070

As shown in Table 20, the majority, 50 (or 89.3%), of the participants at the 30th National Symposium on Child Abuse Conference disagreed that they were a repeat victim of IPV and indicated that they were not a repeat victim of SV. Only 1 (or 1.8%) of the participants indicated that he or she agreed that he or she was a victim of IPV and a repeat victim of SV.

As shown in Table 20, the statistical measurement phi (Φ) was employed to test for the strength of association between the participants who were a repeat victim of intimate partner violence (IPV) and participants who were a repeat victim of sexual violence (SV). As indicated, there was no relationship (Φ =.242) between the two variables. When the chi-square statistical test for significance was applied, the null hypothesis was not rejected (ρ =.070) indicating that there was no statistically significant relationship between the two variables at the .05 level of probability.
**Research Question 9:** Is there a statistically significant relationship between organizations that offer prevention/intervention services for victims of sexual violence and intimate partner violence and the overall quality of effective program prevention and intervention services for clients under the Violence Against Women Act and Department of Justice Reauthorization Act of 2005 based on data from the participants who attended the 30th National Symposium on Child Abuse Conference?

**Hypothesis 9:** There is no statistically significant relationship between organizations that offer prevention/intervention services for victims of sexual violence and intimate partner violence and the overall quality of effective program prevention and intervention services for clients under the Violence Against Women Act and Department of Justice Reauthorization Act of 2005 based on data from the participants who attended the 30th National Symposium on Child Abuse Conference.

Table 21 is a cross tabulation of the 30th National Symposium on Child Abuse Conference participants that worked in an organization that offered their clients effective overall quality program prevention and intervention services, and worked in an organization that offered program prevention and intervention services for victims of sexual violence and intimate partner violence. It shows the association of organizations that offered their clients effective overall quality program prevention and intervention services, and organizations that offered prevention/intervention services for victims of sexual violence and intimate partner violence, and indicates whether or not there was a statistically significant relationship between the two variables.
Table 21

*Prevention/intervention services for SV/IPV and overall quality program effectiveness*

<table>
<thead>
<tr>
<th></th>
<th>Disagree</th>
<th>Agree</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>#</td>
<td>%</td>
<td>#</td>
</tr>
<tr>
<td>Disagree</td>
<td>4</td>
<td>7.7</td>
<td>11</td>
</tr>
<tr>
<td>Agree</td>
<td>6</td>
<td>69.8</td>
<td>31</td>
</tr>
<tr>
<td>Total</td>
<td>10</td>
<td>19.2</td>
<td>42</td>
</tr>
</tbody>
</table>

Φ = .080 df = 1 ρ = .777

As shown in Table 21 the majority, 31 (or 59.6%), of the participants at the 30th National Symposium on Child Abuse Conference indicated that they agreed that the overall quality of program prevention and intervention services they offered their clients was effective, and indicated that their organization offered prevention and intervention services for victims of sexual violence and intimate partner violence.

As shown in Table 21, the statistical measurement phi (Φ) was employed to test for the strength of association between the participants that worked in an organization that offered their clients effective overall quality program prevention and intervention services and worked in an organization that offered program prevention and intervention services for victims of sexual violence and intimate partner violence. It shows the association of organizations that offered their clients effective overall quality program prevention and intervention services and organizations that offered prevention/intervention services for victims of sexual violence and intimate partner
violence. As indicated, there was a weak relationship ($\Phi = .386$) between the two variables. When the chi-square statistical test for significance was applied, the null hypothesis was not rejected ($\rho = .386$), indicating that there was no statistically significant relationship between the two variables at the .05 level of probability.

In sum, the 30th National Symposium on Child Abuse Conference participants responded to the survey by indicating that they strongly agreed with many facets which composed the critical need for program prevention and intervention services for the amelioration of intimate partner violence, domestic violence, and sexual abuse among women with a history of child sexual abuse. However, when the sub-facets that combined to compute an overall score for whether they experienced that there was a critical need for the implementation of more prevention/intervention program services for the amelioration of intimate partner violence and sexual violence, among women with a history of child sexual abuse, 55 (or 100%) of the participants indicated that they agreed that there was a critical need for need for program prevention and intervention services for the amelioration of intimate partner violence, domestic violence, and sexual abuse among women with a history of child sexual abuse.

In addition to finding out whether or not the participants at the 30th National Symposium on Child Abuse Conference agreed that there was a critical need for the implementation of more prevention/intervention program services for the amelioration of intimate partner violence and sexual violence, among women with a history of child sexual abuse, the researcher sought to find out whether or not the participants worked in an organization that offered their clients effective overall quality program prevention and
intervention services and whether they worked in an organization that offered program prevention and intervention services for victims of sexual violence and intimate partner violence.

It is concluded that the majority, 31 (or 59.6%), of the 30th National Symposium on Child Abuse Conference participants indicated that they agreed that they worked in an organization that offered their clients effective overall quality program prevention and intervention services, and they worked in an organization that offered program prevention and intervention services for victims of sexual violence and intimate partner violence. Only 6 (or 11.5%) indicated they disagreed that they worked in an organization that offered their clients effective overall quality program prevention and intervention services, and they did not work in an organization that offered program prevention and intervention services for victims of sexual violence and intimate partner violence under the Violence Against Women Act and Department of Justice Reauthorization Act of 2005.
CHAPTER V
CONCLUSIONS AND RECOMMENDATIONS

The research study was designed to answer nine questions concerning program prevention and intervention services for the amelioration of intimate partner violence and sexual violence among women with a history of child abuse among the participants of the 30th National Symposium on Child Abuse Conference. The 30th National Symposium on Child Abuse Conference is an informative and innovative multidisciplinary conference that offered more than 130 workshops presented by nationally-recognized experts from all 50 states and 20 countries who worked or volunteered in all aspects of child maltreatment, including but not limited to physical abuse, sexual abuse, neglect, exposure to violence, poly-victimization, exploitation, intervention, and prevention from all faces of the child maltreatment field.

Additionally, this allowed the researcher the opportunity to gather data from advocates, intimate partner and sexual violence survivors, social workers, mental health providers, law enforcement, and other allies that are passionate about the amelioration of violence against women and children.

As a result, the participants were cooperative, accessible, and accompanied the researcher in the purpose and outcome of the proposed research, A Study of Program Prevention/Intervention Services for the Amelioration of Intimate Partner Violence (IPV)
and Sexual Violence (SV) among Women with a history of Child Sexual Abuse (CSA) under the Violence Against Women Act and Department of Justice Reauthorization Act of 2005.

The conclusions and recommendations of the research findings are presented in this chapter. Recommendations are proposed for the future discussions for policy makers, social workers, advocates, stake holders, community allies, law enforcement agencies, universities, forensic experts, health/mental health professionals, psychologists, practitioners, and administrators. Each research question is presented in order to summarize the significant findings of interest.

Research Question 1: Is there evidence of a critical need for the implementation of more prevention/intervention program services for the amelioration of intimate partner violence and sexual violence among women with a history of child sexual abuse under the Violence Against Women Act and Department of Justice Reauthorization Act of 2005, based on data from the participants who attended the 30th National Symposium on Child Abuse Conference?

In order to determine if there was a critical need for the implementation of more prevention/ intervention program services for the amelioration of intimate partner violence and sexual violence among women with a history of child sexual abuse under the Violence Against Women Act and Department of Justice Reauthorization Act of 2005, based on data from the participants who attended the 30th National Symposium on
Child Abuse Conference, a personalized survey was distributed among participants and with questions referring to sub-facets such as: the critical need for improving program prevention and intervention services for the amelioration of intimate partner violence and sexual violence among women with a history of child sexual abuse, present job position, intimate partner violence, sexual violence, history of child sexual abuse, repeat victimization, and overall program effectiveness.

Of the 57 30th National Child Abuse Symposium Conference participants surveyed, a majority, 55 (or 100%) of the participants indicated that they agreed that there was a critical need for need for program prevention and intervention services for the amelioration of intimate partner violence, domestic violence, and sexual abuse among women with a history of child sexual abuse (See Table 9).

Research Question 2: Is there evidence of a need for present job positions to work with victims of intimate partner violence under the Violence Against Women Act and Department of Justice Reauthorization Act of 2005, based on data from participants who attended the 30th National Symposium on Child Abuse Conference?

In order to determine if there was a need for present job positions that consisted of working with victims of intimate partner violence (IPV), under the Violence Against Women Act and Department of Justice Reauthorization Act of 2005, among participants at the 30th National Symposium on Child Abuse Conference, participants were distributed
a personalized survey that presented the question: present job position that consist of working with victims of intimate partner violence (IPV).

Of the 57 30th National Child Abuse Symposium Conference participants surveyed, a majority, 36 (or 63.2%), of the participants indicated that they agreed with their present job position that consisted of them working with victims of IPV, while the minority, 19 (or 33.3%), indicated that they disagreed that their present job position consisted of them working with victims of IPV (See Table 14).

Research Question 3: Is there a statistically significant relationship between the participants who were victims of repeat intimate partner violence (IPV) under the Violence Against Women Act and Department of Justice Reauthorization Act of 2005, and the ability of the participants to provide the latest research information that addresses all aspects of child maltreatment, and the opportunity to develop and enhance participants’ skills among the participants at the 30th National Symposium on Child Abuse Conference?

The majority, 50 (or 90.9%), of the 30th National Symposium on Child Abuse Conference participants agreed that they attended the 30th National Symposium on Child Abuse Conference because the conference provided the latest research information that addressed all aspects of child maltreatment, and the opportunity to develop and enhance their skills and knowledge and indicated that they was not a repeat victim of IPV. Only one (or 1.8 %) of the participants disagreed that he or she attended the 30th National
Symposium on Child Abuse Conference because the conference provided the latest research information that addressed all aspects of child maltreatment, and the opportunity to develop and enhance his or her skills and knowledge, and indicated that he or she was not a repeat victim of IPV (See Table 15).

The statistical measurement phi (Φ) was employed to test for the strength of association between the 30th National Symposium on Child Abuse Conference participants’ ability to provide the latest research information that addresses all aspects of child maltreatment, and the opportunity to develop and enhance participants’ skills and knowledge, and participants that were victims of repeat IPV. As indicated, there was no relationship (Φ =.038) between the two variables. When the chi-square statistical test for significance was applied, the null hypothesis was not rejected (ρ =.777), indicating that there was not a statistically significant relationship between the two variables at the .05 level of probability.

Research Question 4: Is there a statistically significant relationship between the awareness of the Violence Against Women Act and Department of Justice Reauthorization Act of 2005, and organizations that are funded by a state and government program under the Violence Against Women Act and Department of Justice Reauthorization Act of 2005, among participants who attended the 30th National Symposium on Child Abuse Conference?
The majority, 29 (or 54.7%), of the 30th National Symposium on Child Abuse Conference participants agreed that they were aware of the Violence Against Women Act and Department of Justice Reauthorization Act of 2005 (VAWA 2005), and indicated that their organization was funded by a state and government program. Only 8 (or 15.1%) of the 30th National Symposium on Child Abuse Conference participants indicated that they disagreed that they were aware of the VAWA 2005 and their organization was not funded by a state or government program (See Table 16).

The statistical measurement phi (Φ) was employed to test for the strength of association of the participants who were aware of the Violence Against Women Act and Department of Justice Reauthorization Act of 2005 and organizations that are funded by a state and government program. As indicated, there was a weak relationship (Φ = .284) between the two variables. When the chi-square statistical test for significance was applied, the null hypothesis was rejected (p = .039) indicating that there was a statistically significant relationship between the two variables at the .05 level of probability.

Research Question 5: Is there a statistically significant relationship between participants who have been victims of intimate partner violence (IPV) and participants who are repeat victims of intimate partner violence under the Violence Against Women Act and Department of Justice Reauthorization Act of 2005 among the participants who attended the 30th National Symposium on Child Abuse Conference?
The majority, 44 (or 78.6%), of the 30th National Symposium on Child Abuse Conference participants disagreed that they were a repeat victim of IPV and indicated that they have not been a victim of IPV. Only three (or 5.4%) of the 30th National Symposium on Child Abuse Conference participants indicated that they agreed that they were a repeat victim of IPV and that they have been a victim of IPV (See Table 17).

The statistical measurement phi (Φ) was employed to test for the strength of the association of the participants who have been a victim of intimate partner violence (IPV) and participants that are a repeat victim of intimate partner violence. As indicated, there was a weak relationship (Φ = .386) between the two variables. When the chi-square statistical test for significance was applied, the null hypothesis was rejected (ρ = .004) indicating that there was a statistically significant relationship between the two variables at the .05 level of probability.

Research Question 6: Is there a statistically significant relationship between participants who have been victims of sexual violence and participants who are repeat victims of sexual violence under the Violence Against Women Act and Department of Justice Reauthorization Act of 2005 among the participants who attended the 30th National Symposium on Child Abuse Conference?

The majority, 45 (or 80.4%), of the 30th National Symposium on Child Abuse Conference participants disagreed that they were a repeat victim of SV and indicated that they have not been a victim of SV. Only three (or 5.4%) of the participants indicated that
they agreed that have been a victim of SV and that they were not a repeat victim of SV (See Table 6).

The statistical measurement phi (Φ) was employed to test for the strength of association between the participants who have been a victim of repeat sexual violence (SV) and participants that have been a victim of sexual violence (SV). As indicated, there was a weak relationship (Φ = .481) between the two variables. When the chi-square statistical test for significance was applied, the null hypothesis was rejected (ρ = .000) indicating that there was a statistically significant relationship between the two variables at the .05 level of probability.

Research Question 7: Is there a statistically significant relationship between participants who have been victims of child sexual abuse and participants who work with victims of child sexual abuse under the Violence Against Women Act and Department of Justice Reauthorization Act of 2005 among the participants who attended the 30th National Symposium on Child Abuse Conference?

The majority, 39 (or 69%), of the 30th National Symposium on Child Abuse Conference participants agreed that they work with victims of CSA and indicated that they have not been a victim of CSA. Seven (or 12.5%) of the participants indicated that they disagreed that they work with victims of CSA and that they have not been a victim of CSA (See Table 19).
The statistical measurement phi (Φ) was employed to test for the strength of association between the participants who have worked with victims of child sexual abuse (CSA) and participants that have been a victim of child sexual abuse (CSA). As indicated, there was no relationship (Φ = 0.057) between the two variables. When the chi-square statistical test for significance was applied, the null hypothesis was not rejected (ρ = 0.669) indicating that there was not a statistically significant relationship between the two variables at the .05 level of probability.

Research Question 8: Is there a statistically significant relationship between participants who are victims of repeat sexual violence and the participants who are victims of repeat intimate partner violence under the Violence Against Women Act and Department of Justice Reauthorization Act of 2005 among the participants who attended the 30th National Symposium on Child Abuse Conference?

The majority or 50 (or 89.3%) of the 30th National Symposium on Child Abuse Conference participants disagreed that they were a repeat victim of IPV and indicated that they was not a repeat victim of SV. Only one (or 1.8%) of the participants agreed that he or she was a victim of IPV and that he or she was a repeat victim of SV (See Table 20).

The statistical measurement phi (Φ) was employed to test for the strength of association between the participants who were a repeat victim of intimate partner violence (IPV) and participants who were a repeat victim of sexual violence (SV). As
indicated, there was no relationship ($\Phi = .242$) between the two variables. When the chi-square statistical test for significance was applied, the null hypothesis was not rejected ($\rho = .070$) indicating that there was no statistically significant relationship between the two variables at the .05 level of probability.

Research Question 9: Is there a relationship between organizations that offers prevention/intervention services for victims of sexual violence and intimate partner violence and the overall quality of effective program prevention and intervention services clients among the participants who attended the 30th National Symposium on Child Abuse under the Violence Against Women Act and Department of Justice Reauthorization Act of 2005?

The majority, 31 (or 59.6%), of the 30th National Symposium on Child Abuse Conference participants indicated that they agreed that the overall quality of program prevention and intervention services that they offered their clients were effective, and indicated that their organization offered prevention and intervention services for victims of sexual violence and intimate partner violence (See Table 21).

The statistical measurement phi ($\Phi$) was employed to test for the strength of association between the participants that worked in an organization that offered their clients effective overall quality program prevention and intervention services and the participants who worked in an organization that offered program prevention and intervention services for victims of sexual violence and intimate partner violence. It
shows the association of organizations that offered their clients effective overall quality program prevention and intervention services and worked in an organization that offered prevention/intervention services for victims of sexual violence and intimate partner violence. As indicated, there was a weak relationship ($\Phi = .386$) between the two variables. When the chi-square statistical test for significance was applied, the null hypothesis was not rejected ($\rho = .386$) indicating that there was no statistically significant relationship between the two variables at the .05 level of probability.

In sum, the 30th National Symposium on Child Abuse Conference participants responded to the survey by indicating that they strongly agreed with many facets which coupled the critical need for program prevention and intervention services for the amelioration of intimate partner violence, domestic violence, and sexual abuse among women with a history of child sexual abuse. However, when the sub-facets which combined to compute an overall score for whether they agreed that there was a critical need for the implementation of more prevention/intervention program services for the amelioration of intimate partner violence, and sexual violence, among women with a history of child sexual abuse, only 55 (or 96.5%) of the participants indicated that they agreed that there was a critical need for need for program prevention and intervention services for the amelioration of intimate partner violence, domestic violence, and sexual abuse among women with a history of child sexual abuse.

In addition to finding out whether or not the 30th National Symposium on Child Abuse Conference participants agreed that there was a critical need for the implementation of more prevention/intervention program services for the amelioration of
intimate partner violence, and sexual violence, among women with a history of child
sexual abuse, the researcher sought to find out whether or not the participants worked in
an organization that offered their clients effective overall quality program prevention and
intervention services and worked in an organization that offered program prevention and
intervention services for victims of sexual violence and intimate partner violence.

It is concluded that the majority, 31 (or 59.6%), of the 30th National Symposium
on Child Abuse Conference participants indicated that they agreed that they worked in an
organization that offered their clients effective overall quality program prevention and
intervention services and worked in an organization that offered program prevention and
intervention services for victims of sexual violence and intimate partner violence. Only
six (or 11.5%) indicated they disagreed that they worked in an organization that offered
their clients effective overall quality program prevention and intervention services and
they did not work in an organization that offered program prevention and intervention
services for victims of sexual violence and intimate partner violence under the Violence
Against Women Act and Department of Justice Reauthorization Act of 2005.

Recommendations

Studies concerning program prevention services for the amelioration of intimate
partner violence, sexual violence, child sexual abuse and re-victimization for women are
critical for their holistic physical, mental, and spiritual well-being.

As a result of the findings of this study, the researcher is recommending the
following:
1. Research should continue in order to pinpoint the causes, adverse effects, and latest statistics targeting sexual, physical, and emotional violence against women and children that will aid toward further effective indications and treatment.

2. States need to continue developing standards for the treatment of court mandated and voluntary clients of program prevention and intervention services by focusing on research-based, theoretical, and philosophical perspectives to develop the most effective services possible.

3. Policy makers should develop laws that mandate more punishable sentences and consequences for intimate partner violence, sexual violence, and child sexual abuse perpetrators.

4. More rape and crisis centers should be established in every state and offer women an array of services such as: medical exam, mental/family counseling, community resources, birth control, means tested programs (housing, Medicaid, food stamps, WIC, and daycare), job training, and self-empowerment, which will aid in their journey of healing.

5. Social workers should advocate for this population group to ensure that these women receive adequate treatment to aid in their journey of healing and living a healthy, productive, successful life.
APPENDIX A

A LETTER TO MARYLYN GRUNDY

Mrs. Marylyn Grundy
Symposium Coordinator
National Children’s Advocacy Center
210 Pratt Avenue
Huntsville, Alabama 35801

March 24, 2014

Dear Ms. Grundy,

I would like to thank you for giving me the opportunity to conduct my doctoral dissertation research study, “A Study of Program Prevention and Intervention Services for the Amelioration of Intimate Partner Violence and Sexual Violence among Women with a History of Child Sexual Abuse (CSA),” among the participants at the National Children’s Advocacy Center (NCAC), 30th Symposium on Child Abuse on March 22, 2014. The purpose of this study design is to ascertain data in order to describe and explain the urgency to improve program prevention and intervention campaigns and services to ameliorate the prevalence of Intimate Partner Violence (IPV) and Sexual Violence (SV) among women with a history of Child Sexual Abuse under the Violence Against Women Act and Department of Justice Reauthorization Act of 2005.

The descriptive and explanatory research design is allowed for the descriptive analysis of the demographic characteristics of the respondents. Also, the research design will facilitate the explanation of the statistical relationship between improving program prevention and intervention services for the amelioration of IPV and SV among women with a history of Child Sexual Abuse, job position, Intimate Partner Violence and/or sexual assault victim, IPV and/or SV repeat victim, program prevention and intervention service effectiveness.

In order for me to conduct this study, I will need to administer surveys at the 30th Annual Symposium on Child Abuse. The Alabama site was selected because it is an informative and innovative multidisciplinary conference which offers more than 130 workshops presented by nationally-recognized experts from all faces of the child maltreatment field. Additionally, I selected this site because of the opportunity to gather data from advocates, IPV and SV survivors, social workers, mental health providers, law enforcement, and other allies that are passionate about the amelioration violence against women and children.

In closing, I want to reinforce how much I appreciate your cooperation in this study. Please sign and date the bottom of this letter providing consent for me to conduct this study.

Sincerely,

Johnnetta McSwain, Doctoral Student at Clark Atlanta University (CAU)
Whitney M. Young, Jr., School of Social Work.

_____________________________  _________________  _______________
Name                      Signature  Date
APPENDIX B

CONSENT FORM

A STUDY OF PROGRAM PREVENTION AND INTERVENTION SERVICES FOR THE AMELIORATION OF INTIMATE PARTNER VIOLENCE AND SEXUAL VIOLENCE AMONG WOMEN WITH A HISTORY OF CHILD SEXUAL ABUSE (CSA).

You are invited to participate in a study that seeks to study the program prevention and intervention services for the amelioration of Intimate Partner Violence and Sexual Violence among women with a history of Child Sexual Abuse. This study consist of a questionnaire with twenty-nine (29) questions and a consent form.

There are no known risks to participants who agree to take part in this research. There are no known personal benefits to participants who agree to take part in this research. However, it is hoped that those who participate in this study will further help strengthen research in the field of social work education, social work curriculum development, social work policies, and the professional development of social workers globally.

All responses to the questionnaire will remain confidential. Participation in this study is strictly voluntary. If participants have any questions about the study, they may contact the principal investigator – Johnnetta McSwain by email: info@johnnettamcswain.com or the School of Social Work at Clark Atlanta University at 404-880-8561.

My signature below verifies that I have read the statement above and agree to participate in the research project.

______________________________       ___________________       __________
Print Name or Participant                  Signature of Participant                  Date
Appendix C

Survey Questionnaire

A Study of Program Prevention and Intervention Services for the Amelioration of Intimate Partner Violence and Sexual Violence among Women with a History of Child Sexual Abuse (CSA)

Dear Symposium Attendee:

I am a student in the Ph.D. Program at the Whitney M. Young, Jr., School of Social Work at Clark Atlanta University. I invite you to participate in a study to examine program prevention and intervention services for the amelioration of Intimate Partner Violence and Sexual Violence among women with a history of Child Sexual Abuse. The questionnaire will take no more than five minutes to complete. The purpose of this study is to obtain information on program prevention and intervention services to end the prevalence of Intimate Partner Violence and Sexual Violence among women with a history of Child Sexual Abuse; by gathering information on the effectiveness and successes of agencies, client services and the latest research and information that’s being implemented at the 30th National Symposium on Child Abuse, since the passage of the Violence Against Women Act and Department of Justice Reauthorization Act of 2005. The findings will be used in an analysis for my dissertation. I would appreciate your cooperation. Because we want all responses to remain confidential, please do not put your name on the questionnaire answer sheet. Choose only one answer for each question. Please respond to all questions. Again, thank you for your time and cooperation.

Johnnetta McSwain
3/22/2014

Section I: Demographic Information

Instructions: Check the appropriate answer below. Please Choose only one answer for each question.

1. My gender is: 1) ____ Male 2) ____ Female
2. My age group is: 1) ____ 18-30 2) ____ 31–39 3) ____ 41–49 4) ____ Over 50
3. The one racial category that best describes me: 1) _____ Black 2) ____ White 3) ____ Hispanic 4) ____ Other
4. My marital status is: 1) ____ Married 2) ____ Never married 3) ____ Divorced 4) ____ Separated 5) ____ Widowed
5. Is this your first time attending the 30th National Symposium on Child Abuse? 1) ____ Yes 2) ____ No
APPENDIX C
(continued)

6. Are you presenting at the 30th National Symposium on Child Abuse? 1) ____ Yes
   2) ____ No

7. Have you ever been a victim of Childhood Sexual Abuse? 1) _____ Yes  2) _____ No

8. Have you ever been a victim of Sexual Violence?  1) _____ Yes  2) _____ No

9. Have you ever been a victim of Intimate Partner Violence?  1) _____ Yes  2) _____ No

10. Number of times assaulted of any kind.  1) _____ Regular  2) _____ Seldom
     3) _____ Often

11. Have other members in your family been a victim of sexual, intimate and/or dating
    violence that you know of?  1) _____ Yes  2) _____ No

12. Highest grade completed:  1) _____ Elementary  2) _____ Some High School
     3) _____ High School Grad  4) _____ Vocational School  5) _____ Some College
     6) _____ College Grad

13. I am employed:   1 ______ Full-time          2 ______ Part-time

14. I am employed in:  1) _____ Administration  2) _____ Child Protective Services
     3) _____ Law Enforcement  4) _____ Victim Advocacy  5) _____ Mental/health
     Treatment  6) _____ Legal  7) _____ Medical  8) _____ Prevention/Intervention
     9) _____ Wellness  10) _____ Research

Section II: How much do you disagree or agree with the following statements?
Instructions: Please write the appropriate number in the blank space beside each statement
indicating your answer (1-4) on the questionnaire. Please choose only one answer for each
item and respond to all of the questions.

1= Strongly Disagree 2= Disagree 3= Agree 4= Strongly Agree

   _____ 15. My present job position consist of working with victims of Sexual Violence.

   _____ 16. My present job position consist of working with victims of Intimate Partner
              Violence.

   _____ 17. I work with victims of Childhood Sexual Abuse.

   _____ 18. I work with victims of repeat Sexual Violence and Intimate Partner Violence.
19. I have been a victim of Sexual Violence.

20. I have been a victim of Intimate Partner Violence.

21. I have been a victim of Child Sexual Abuse.

22. I am a repeat victim of Sexual Violence.

23. I am a repeat victim of Intimate Partner Violence.


25. I attended the National Symposium on Child Abuse Conferences because the participants provide the latest research and information that addresses all aspects of child maltreatment, and the opportunity to develop and enhance my skills and knowledge.

26. I believe there is a critical need for the implementation of more prevention/intervention program services for the amelioration of Intimate Partner Violence and Sexual Violence among women with a history of Child Sexual Abuse.

27. My organization is funded by a state/government program.


29. The overall quality of program prevention and intervention services we offer our clients are effective.

Thank you very much for your cooperation.
APPENDIX D

SPSS PROGRAM ANALYSIS

TITLE 'PROGRAM PREVENTION SERVICES'.
SUBTITLE 'JOHNNETTA MCSWAIN - School of Social Work 2014'.

DATA LIST FIXED/
ID 1-3
GENDER 4
AGEGRP 5
RACE 6
MARITAL 7
ATTEND 8
PRESENT 9
CHILD 10
SEXUAL 11
PARTNER 12
NUMBER 13
FAMILY 14
EDUCAT 15
IEMPLOY 16
EMPLOY 17
JOB 18
WORKING 19
ABUSE 20
WORK 21
HAVE 22
BEEN 23
VICTIM 24
REPEAT 25
INTIMAT 26
OFFERS 27
ASPECTS 28
BELIEVE 29
FUNDED 30
WOMEN 31
OVERALL 32.
APPENDIX D

(continued)

VARIABLE LABELS
ID 'Case Number'
GENDER 'Q1 My gender'
AGEGRP 'Q2 My age group'
RACE 'Q3 The one racial category that best describes me'
MARITAL 'Q4 My marital status'
ATTEND 'Q5 Is this your first time attending the 30th National Symposium on Child Abuse'
PRESENT 'Q6 Are you presenting at the 30th National Symposium on Child Abuse'
CHILD 'Q7 Have you ever been a victim of Childhood Sexual Abuse'
SEXUAL 'Q8 Have you ever been a victim of Sexual Violence'
PARTNER 'Q9 Have you ever been a victim of Intimate Partner Violence'
NUMBER 'Q10 Number of times assaulted of any kind'
FAMILY 'Q11 Have other members in your family been a victim of sexual, intimate, and or dating violence that you know of'
EDUCAT 'Q12 Highest grade completed'
IEMPLOY 'Q13 I am employed'
EMPLOY 'Q14 I am employed in'
JOB 'Q15 My present job position consist of working with victims of Sexual Violence'
WORKING 'Q16 My present job position consist of working with victims of Intimate Partner Violence'
ABUSE 'Q17 I work with victims of Childhood Sexual Abuse'
WORK 'Q18 I work with victims of repeat Sexual Violence and Intimate Partner Violence'
HAVE 'Q19 I have been a victim of Sexual Violence'
BEEN 'Q20 I have been a victim of Intimate Partner Violence'
VICTIM 'Q21 I have been a victim of Child Sexual Abuse'
REPEAT 'Q22 I am a repeat victim of Sexual Violence'
INTIMAT 'Q23 I am a repeat victim of Intimate Partner Violence'
OFFERS 'Q24 My organization offers prevention intervention services for victims of Sexual Violence and Intimate Partner Violence'
ASPECTS 'Q25 I attended the National Symposium on Child Abuse Conferences because the participants provide the latest research and information that addresses all aspects of child maltreatment and the opportunity to develop and enhance'
BELIEVE 'Q26 I believe there is a critical need for the implementation of more prevention intervention program services for the amelioration of Intimate Partner Violence and Sexual Violence among women with a history of Child Sexual Abuse'
FUNDED 'Q27 My organization is funded by a state government program'
WOMEN 'Q28 I am aware of the Violence Against Women Act and Department of Justice Reauthorization Act of 2005'
APPENDIX D

(continued)

OVERALL 'Q29 The overall quality of program prevention and intervention services we offer our clients are effective'.

VALUE LABELS
GENDER
1 'Male'
2 'Female'/
AGEGRP
1 '18-30'
2 '31-39'
3 '41-49'
4 'Over 50' /
RACE
1 'Black'
2 'White'
3 'Hispanic'
4 'Other' /
MARITAL
1 'Married'
2 'Never Married'
3 'Divorced'
4 'Separated'
5 'Widowed' /
ATTEND
1 'YES'
2 'NO' /
PRESENT
1 'YES'
2 'NO' /
CHILD
1 'YES'
2 'NO' /
SEXUAL
1 'YES'
2 'NO' /
PARTNER
1 'YES'
2 'NO' /
APPENDIX D

(continued)

NUMBER
1 'Regular'
2 'Seldom'
3 'Often'/

FAMILY
1 'YES'
2 'NO'/

EDUCAT
1 'Elementary'
2 'Some High School'
3 'High School Grad'
4 'Vocational School'
5 'Some College'
6 'College Grad'/

IEMPLOY
1 'Full Time'
2 'Part Time'/

EMPLOY
01 'Administration'
02 'Child Protective Services'
03 'Law Enforcement'
04 'Victim Advocacy'
05 'Mental Health Treatment'
06 'Legal'
07 'Medical'
08 'Prevention-Intervention'
09 'Wellness'
10 'Research'/

JOB
1 'Strongly Disagree'
2 'Disagree'
3 'Agree'
4 'Strongly Agree'/

WORKING
1 'Strongly Disagree'
2 'Disagree'
3 'Agree'
4 'Strongly Agree'/

ABUSE
1 'Strongly Disagree'
2 'Disagree'
APPENDIX D

(continued)

3 'Agree'
4 'Strongly Agree'/
WORK
1 'Strongly Disagree'
2 'Disagree'
3 'Agree'
4 'Strongly Agree'/
HAVE
1 'Strongly Disagree'
2 'Disagree'
3 'Agree'
4 'Strongly Agree'/
BEEN
1 'Strongly Disagree'
2 'Disagree'
3 'Agree'
4 'Strongly Agree'/
VICTIM
1 'Strongly Disagree'
2 'Disagree'
3 'Agree'
4 'Strongly Agree'/
REPEAT
1 'Strongly Disagree'
2 'Disagree'
3 'Agree'
4 'Strongly Agree'/
INTIMAT
1 'Strongly Disagree'
2 'Disagree'
3 'Agree'
4 'Strongly Agree'/
OFFERS
1 'Strongly Disagree'
2 'Disagree'
3 'Agree'
4 'Strongly Agree'/
ASPECTS
1 'Strongly Disagree'
2 'Disagree'
3 'Agree'
4 'Strongly Agree'/
APPENDIX D

(continued)

BELIEVE
1 'Strongly Disagree'
2 'Disagree'
3 'Agree'
4 'Strongly Agree'

FUNDED
1 'Strongly Disagree'
2 'Disagree'
3 'Agree'
4 'Strongly Agree'

WOMEN
1 'Strongly Disagree'
2 'Disagree'
3 'Agree'
4 'Strongly Agree'

OVERALL
1 'Strongly Disagree'
2 'Disagree'
3 'Agree'
4 'Strongly Agree'

RECODE JOB WORKING ABUSE WORK HAVE (1 THRU 2.99=2) (3 THRU 4.99=3).
RECODE BEEN VICTIM REPEAT INTIMAT OFFERS ASPECTS BELIEVE FUNDED WOMEN OVERALL
(1 THRU 2.99=2) (3 THRU 4.99=3).

MISSING VALUES
GENDER AGEGRP RACE MARITAL ATTEND PRESENT CHILD SEXUAL PARTNER

NUMBER FAMILY EDUCAT IEMPLOY EMPLOY JOB WORKING ABUSE WORK HAVE
BEEN VICTIM REPEAT INTIMAT OFFERS ASPECTS BELIEVE FUNDED WOMEN
OVERALL (0).

BEGIN DATA
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00623112222220161244441111344432
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APPENDIX D

(continued)

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02122122222201611424211111343114
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03723112222261840441411444444
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0502323122220161444441111133343
0512212222201615444411111433423
APPENDIX D

(continued)

0522331122220250011111111134123
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05424412212116253232411113444140
05522211222201618333211111444433
05623141111122614444444444444143
057211212222026123221111144422
END DATA.

FREQUENCIES
/VARIABLES GENDER AGEGRP RACE MARITAL ATTEND PRESENT CHILD
SEXUAL PARTNER NUMBER FAMILY EDUCAT IEMPLOY
EMPLOY JOB WORKING ABUSE WORK HAVE BEEN VICTIM REPEAT INTIMAT
OFFERS ASPECTS BELIEVE FUNDED WOMEN OVERALL
/STATISTICS = DEFAULT.
In the last 20 years, our Nation has made meaningful progress toward addressing sexual assault. Where victims were once left without recourse, laws have opened a path to safety and justice; where a culture of fear once kept violence hidden, survivors are more empowered to speak out and get help. But even today, too many women, men, and children suffer alone or in silence, burdened by shame or unsure anyone will listen. This month, we recommit to changing that tragic reality by stopping sexual assault before it starts and ensuring victims get the support they need.

Sexual violence is an affront to human dignity and a crime no matter where it occurs. While rape and sexual assault affect all communities, those at the greatest risk are children, teens, and young women. Nearly one in five women will be a victim of sexual assault during college. For some groups, the rates of violence are even higher -- Native American women are more than twice as likely to experience sexual assault as the general population. Moreover, we know rape and sexual assault are consistently underreported, and that the physical and emotional trauma they leave behind can last for years.
APPENDIX E
(continued)

With Vice President Joe Biden's leadership, we have made preventing Sexual Violence and supporting survivors a top priority. Earlier this month, I was proud to sign the Violence Against Women Reauthorization Act, which renews and strengthens the law that first made it possible for our country to address sexual assault in a comprehensive way. The Act preserves critical services like rape crisis centers, upholds protections for immigrant victims, gives State and tribal law enforcement better tools to investigate cases of rape, and breaks down barriers that keep lesbian, gay, bisexual, and transgender victims from getting help. It also expands funding for sexual assault nurse examiner programs and sexual assault response teams, helping States deliver justice for survivors and hold offenders accountable.

Just as we keep fighting sexual assault in our neighborhoods, we must also recommit to ending it in our military -- because no one serving our country should be at risk of assault by a fellow service member. Where this crime does take place, it cannot be tolerated; victims must have access to support, and offenders must face the consequences of their actions. Members of our Armed Forces and their families can learn more about the resources available to them at 1-877-995-5247 and www.SafeHelpline.org.

All Americans can play a role in changing the culture that enables Sexual Violence. Each of us can take action by lifting up survivors we know and breaking the silence surrounding rape and sexual assault.
To get involved, visit www.WhiteHouse.gov/1is2many.com, together, our Nation is moving forward in the fight against sexual assault. This month, let us keep working to prevent violence in every corner of America, and let us rededicate ourselves to giving survivors the bright future they deserve.

NOW, THEREFORE, I, BARACK OBAMA, President of the United States of America, by virtue of the authority vested in me by the Constitution and the laws of the United States do hereby proclaim April 2013 as National Sexual Assault Awareness and Prevention Month. I urge all Americans to support survivors of sexual assault and work together to prevent these crimes in their communities.
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