



Articles

A Brief Review of Intimate Partner Violence in the United States: Nature, Correlates, and Proposed Preventative Measures

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Abstract

Aggression and violence are themes which characterize a significant proportion of many close romantic relationships. Both women and men may find themselves caught in a web of intimate terror – controlled, manipulated, and hurt by a coercive and violent partner. In this brief review article, we summarize existing literature on the form of intimate partner violence known as coercive controlling violence (CCV), domestic abuse, or intimate terrorism. We begin by discussing the nature and consequences of CCV relationships. Personal or individual (e.g., biological sex, age, immigrant status, socioeconomic status, attitudes and beliefs, mental health and psychopathology), relational or interpersonal (e.g., relationship type, relationship satisfaction), and environmental (e.g., economic strain, social isolation) risk factors associated with the occurrence of domestic abuse are identified. Finally, potential preventative measures at the individual, interpersonal, and sociocultural level that may serve to reduce the likelihood of this pernicious interpersonal phenomenon are considered.

Keywords: intimate partner violence, domestic abuse, risk factors, gender differences

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Different types of violence can occur between adult partners in romantic (e.g., dating, cohabiting, married) relationships. One widely accepted typology was developed by Johnson (e.g., Johnson, 1999, 2008), who identified four basic varieties of intimate partner violence: situational couple violence, separation-instigated violence, coercive controlling violence, and violent resistance. Of these, *coercive controlling violence* (CCV; also called *intimate terrorism* and commonly referred to as *domestic violence*, *spousal abuse*, or *battery*) is the type of intimate partner violence that workers in community or agency settings – hospitals and clinics, domestic abuse or homeless shelters, public safety or law enforcement departments, courts and the legal system – are most likely to encounter (Coker, Smith, McKeown, & King, 2000; Graham-Kevan & Archer, 2003; Johnson, 2006). In this brief review, we consider research on the nature, consequences, and correlates of CCV relationships in the United States, and propose possible preventative measures that may reduce the likelihood of this particular interpersonal dynamic developing between romantic partners.

Nature and Consequences of Coercive Controlling Violence

Unlike other forms of intimate partner violence (e.g., situational couple violence), which often arise in the context of interpersonal conflict and tend to involve minor forms of physical aggression, CCV involves physical violence that is associated with a chronic pattern of emotionally abusive intimidation, coercion, and control directed by one partner (the perpetrator) against the other (the victim) (e.g., [Johnson, 1999, 2008](#); [Kelly & Johnson, 2008](#)). Abusers often employ a variety of tactics in their quest to control their targets, including physical abuse (e.g., pushing, hitting, choking), sexual abuse (e.g., forced sexual activities), emotional abuse (e.g., name-calling, insults, public or private humiliation), economic abuse (e.g., controlling finances, preventing the partner from having a job), coercion and threats (e.g., threatening to harm or leave the partner), intimidation (e.g., destroying the partner's property, harming the partner's pet), social isolation (e.g., monitoring or limiting the partner's social contacts and outside activities), and denial (e.g., denying or minimizing the abuse, blaming the partner for the abuse) (see [Hines, Brown, & Dunning, 2007](#); [National Domestic Violence Hotline, 2015](#); [Pence & Paymar, 1993](#); [U.S. Department of Justice, 2008, 2014](#)). Perpetrators do not necessarily use all of these tactics to dominate their partners; rather, they use the combination of abuse strategies that are the most effective at maintaining control. For example, in many CCV relationships the abuser may no longer need to employ physical force to dominate the partner – the prior history of physical violence often is sufficient to maintain the partner's compliance. As a result, CCV relationships are not always characterized by high levels of overt physical aggression (see [Johnson, 2008](#)).

Although CCV is one of the least common types of intimate partner violence in the U.S. (e.g., [Michalski, 2005](#)), it has the most serious consequences for victims. In particular, CCV relationships typically contain a greater amount of physical violence – with respect to both frequency and severity – than is observed in relationships characterized by other types of intimate partner violence. For example, [Johnson \(1999\)](#) derived a data set from interviews of married or formerly married women collected by Frieze in the late 1970s (e.g., [Frieze, 1983](#); [Frieze & Browne, 1989](#); [Frieze & McHugh, 1992](#)). Frieze's sample included two groups of women: (1) an agency sample consisting of women who had sought assistance from a domestic violence shelter or who had filed Protection from Abuse Orders in court, and (2) a community sample of women who lived in the same neighborhoods as the agency sample. Each participant was extensively interviewed about the interpersonal dynamics of her marriage, including the extent to which her husband engaged in physical violence as well as various control tactics (e.g., threats, economic control, assertion of male privilege, isolation, emotional abuse). On the basis of the interview data, participants subsequently were divided into two relationship groups: (1) a group whose marriages contained physical violence coupled with coercive control (the CCV group) and (2) a group whose marriages contained conflict-motivated physical violence in the absence of coercion and control (the non-CCV or situational violence group). The results revealed that these two groups differed dramatically in the amount, severity, and developmental course of the physical violence they experienced in their marriages. On average, women in the CCV group reported experiencing 58 instances of physical violence at the hands of their husbands prior to the time of the interview session (compared to 14 instances reported by women in the non-CCV situational violence group), and 76% had experienced severe or permanent injury (compared to 28% of women in the other group). In addition, 76% of the women in the CCV group indicated that their husbands' violence had escalated over the course of the relationship, whereas the majority of women in the non-CCV group (54%) reported that their husbands' violent behavior had de-escalated over time.

Large-scale survey research conducted with samples drawn from the general population corroborates these findings. In one investigation, [Michalski \(2005\)](#) analyzed data on intimate partner violence collected as part of a

national survey. Over 16,000 men and women involved in romantic relationships were asked whether their partners had ever engaged in acts of physical violence (e.g., “beaten you,” “kicked, bit, or hit you with his/her fist,” “choked you”) and coercive control (e.g., “tried to limit your contact with family or friends,” “put you down or called you names,” “damaged or destroyed your possessions or property”). The results revealed that participants in CCV relationships experienced twice as many instances of physical violence as other participants, and the violence that occurred was more severe.

In addition to physical injury and trauma, victims of domestic violence experience a number of serious and adverse psychological outcomes. Women who are terrorized by their intimate partners often live in a state of chronic fear and anxiety; they also frequently report lowered self-esteem, depression, and symptoms of post-traumatic stress (e.g., Basile, Arias, Desai, & Thompson, 2004; Dobash & Dobash, 1979; Gelles & Harrop, 1989; Golding, 1999; Johnson & Leone, 2005; Tyson, Herting, & Randell, 2007; for a review, see Wong & Mellor, 2014). Although less is known about the consequences of domestic violence for male victims, there is evidence that men who are abused experience the same constellation of physical and psychological outcomes as their female counterparts (for reviews, see Dutton, 2007; Hines & Malley-Morrison, 2005). They may also experience an additional adverse psychological consequence – namely, re-victimization by a domestic violence system that is designed to assist female victims and that consequently often does not recognize that men, too, can be abused. An analysis of calls made by male victims to a national domestic abuse hotline (Hines et al., 2007) revealed that many men indicated having sought help in the past but having been turned away, laughed at, not taken seriously, and treated as batterers (rather than victims) by agency workers.

Risk Factors for Coercive Controlling Violence

As with so many interpersonal experiences, domestic violence is a complex phenomenon with multiple causal origins and correlates. Comprehensive reviews of the CCV literature as well as large-scale empirical investigations have identified a number of factors that may serve to encourage or inhibit the likelihood of domestic abuse perpetration and/or victimization (see Christopher & Lloyd, 2000; Hines & Malley-Morrison, 2005; Smith Slep, Foran, Heyman, & United States Air Force Family Advocacy Research Program, 2014; Wong & Mellor, 2014). In general, these risk factors can be divided into three broad classes or categories: personal factors, relational or interpersonal factors, and environmental factors.

Personal factors are variables that are associated with the individual partners, including demographic attributes, life history variables, attitudinal and cognitive variables, and mental and physical health status, among others. These are the most commonly investigated category of risk factor. Research reveals that *biological sex* is strongly correlated with CCV risk – among heterosexual couples, the majority of perpetrators are male and the majority of victims are female. For example, Johnson’s (1999) investigation (referenced earlier in this article) revealed a striking difference between the two relationship groups included in his study with respect to perpetrator sex. Specifically, in the domestic violence/CCV group, almost all (97%) of the abuse was perpetrated by husbands, providing evidence of sex asymmetry in this type of intimate partner violence. However, physical aggression was enacted by roughly equal proportions of husbands (55%) and wives (45%) in the non-CCV or situational violence group. More recent national surveys corroborate these findings, with significantly higher proportions of women than men reporting having a violent and coercively controlling partner (e.g., Michalski, 2005; also see Truman & Morgan, 2014).

A host of other individual-level factors are linked with the likelihood of CCV perpetration/victimization. Researchers have discovered, for example, that *age* is associated with CCV risk, with likelihood peaking among adults in their 20s and declining in older cohorts. *Socioeconomic status* also is strongly correlated with likelihood of experiencing CCV. Low income, poverty, lower occupational status (e.g., blue collar or working class as opposed to white collar or middle class), and lower educational attainment are among the strongest predictors of domestic violence. Another demographic correlate of CCV victimization, at least among women living in the United States, is *immigrant status*. (Evidence linking immigrant status and CCV risk is stronger in other countries, in part because the question has received greater empirical attention from researchers employing non-U.S. samples). Other personal-level risk factors represent life history experiences, including *prior exposure to domestic violence* and *childhood abuse*. Specifically, women who were exposed to inter-parental violence and/or who were psychologically, physically, or sexually abused as children are more likely to experience domestic abuse later in their own lives, whereas men who witnessed inter-parental violence and/or who were abused as children are more likely to be violent toward their female partners.

In addition to these life history and demographic variables, there are a number of *cognitive and attitudinal* predictors of CCV risk. Abusers (and, often, their victims) tend to endorse interpersonal violence and hold highly traditional attitudes toward marriage and sex or gender roles (e.g., they believe that husbands should be the dominant partner in marriage and that it is acceptable for a husband to hit a wife). *Mental and physical health* variables also have been linked with the likelihood of experiencing CCV. For example, male batterers are more likely than non-batterers to exhibit symptoms of diminished mental health, as well as a variety of severe clinical disorders ranging from major depression and anxiety to personality disorders (e.g., antisocial, borderline, narcissistic). And men who perpetrate, and women who experience, domestic abuse report poorer physical health (e.g., greater pain, lower energy, more sleep disturbances) than those who are not in CCV relationships.

Relational factors are located in neither partner but instead emerge from the couple's interactions or result from the combination of their characteristics. Relationship status (e.g., dating, cohabiting, married), conflict resolution strategies, communication styles, satisfaction and commitment, and other interpersonal factors fall in this category of risk factor. Although less investigated than personal or individual-level factors, there is evidence that at least two relational factors – *relationship status* and *satisfaction* – are associated with likelihood of CCV perpetration/victimization. Specifically, compared with dating and married couples, couples who cohabit experience higher rates of serious physical assault. A higher likelihood of domestic abuse is also found among couples reporting lower levels of relationship satisfaction.

Environmental factors include variables located in the physical and social/cultural environments surrounding the individual partners and in which their relationship is embedded. Examples of physical environmental factors include access to drugs, alcohol, or other substances which might influence affective responses and impulse control, as well as economic, occupational, or living conditions which might affect an individual's physical or mental health. Social/cultural environmental factors include sociocultural norms or customs, laws, and religious doctrine pertaining to gender relations and the acceptability of interpersonal violence, as well as the existing political climate. Indeed, *alcohol use* is correlated with the likelihood of intimate partner violence, such that men who abuse alcohol are more likely to assault their romantic partners and women who abuse alcohol are more likely to be assaulted by an intimate partner. So, too, is *economic pressure*; the greater the financial stress a couple is under, the more likely they are to be in a marriage marked by domestic abuse. *Social isolation* is another potent environmental

risk factor for CCV. Domestic abuse is more likely to occur when a couple is socially isolated and the partners (both perpetrator and victim) have few sources of social support.

It is important to recognize that the research in this area is correlational and researchers thus cannot know with any degree of certainty the extent to which these personal, relational, or environmental risk factors function as true *causes* of intimate partner violence. For example, it is likely that marital conflict or dissatisfaction contributes to a hostile interpersonal climate that is conducive to physical violence; at the same time, it is quite likely that the occurrence of physical abuse leads to marital distress and dissatisfaction. Similarly, individuals with poor mental and physical health may be more likely to perpetrate (or experience) intimate partner violence; yet intimate partner violence itself contributes to difficulties with mental and physical function. Longitudinal research assessing multiple domains of risk factor (personal, relational, environmental) across the lifespan of partners and their relationships is both needed and strongly encouraged.

Proposed Preventative Measures

The fact that intimate partner violence is a complex interpersonal phenomenon associated with multiple and varied risk factors (that are themselves complex, interrelated, and multiply determined) means that preventative measures must occur at many different levels. At the individual level, it is critical that clinicians, counselors, physicians, and other health care practitioners be aware of the risk factors associated with intimate partner violence, as such knowledge may increase the ability to effectively identify at-risk persons (see [Roberts, Hegarty, & Feder, 2006](#)). For example, insofar as substance abuse and a developmental history of trauma (e.g., childhood abuse, inter-parental violence) are known correlates of domestic abuse, health professionals working with men and women with trauma histories and/or substance abuse issues or disorders should be alert to (and sensitively inquire about) the presence of intimate partner violence.

It is also imperative that professionals remain cognizant of the fact that heterosexual women are not the only victims (and heterosexual men are not the only perpetrators) of domestic abuse. Although much of the CCV literature has focused on the experiences of men and women in heterosexual unions, domestic abuse is not limited to that population. Men can be victimized by their partners, women can perpetrate relational violence, and same-sex unions can become abusive. Shame, stigma, and fear of discrimination may prevent men who are victimized by women, and men and women who are abused by a same-sex partner, from seeking redress from the health care and criminal justice systems ([Badenes-Ribera, Frias-Navarro, Bonilla-Campos, Pons-Salvador, & Monterde-i-Bort, 2015](#)). The elderly and persons with disabilities, who often possess additional vulnerabilities (such as physical limitations and financial dependency), also may be less willing or able to seek out assistance in the face of domestic violence ([Nixon, 2009](#); [Straka & Montminy, 2006](#)). The burden thus falls on the shoulders of the health care professional to remain aware of the unique situation faced by these individuals. It is not surprising, then, that there is an increasing call by members of the global health care community for domestic abuse training to be incorporated into health education and training programs in the United States and around the world (see [World Health Organization/London School of Hygiene and Tropical Medicine, 2010](#)).

To be effective, prevention must not simply occur at the individual level but also at the larger familial, community, societal, and cultural level. It is our belief that prevention must begin during early childhood and be integrated into educational settings (see [Durvasula, 2014](#)). Mentoring and educating boys and girls – particularly those at risk (e.g., who may be exposed to violent home environments) – in effective problem solving strategies, communication

skills, and coping mechanisms throughout primary and secondary school may be one way in which to reduce the likelihood of future domestic abuse victimization or perpetration. College campuses often witness higher-than-expected rates of physical and sexual violence; consequently, organized and sustained outreach and dissemination of information about domestic abuse (nature, risk factors, campus and community resources) is recommended (World Health Organization/London School of Hygiene and Tropical Medicine, 2010). Moreover, ongoing education and awareness beyond formal academic settings and across the lifespan can be instituted via health care, occupational, and community settings, places of worship, and a range of social and other media platforms.

Economic prevention may be one of the most significant means by which vulnerability to domestic abuse can be reduced. A key factor in the sustenance of relationships characterized by CCV is the victim's financial dependence on the perpetrator. Victims are often isolated from family and other social support networks, prevented from having a job or working outside the home, and unable to access financial resources (see Hines et al., 2007; National Domestic Violence Hotline, 2015; Pence & Paymar, 1993; U.S. Department of Justice, 2008). Prevention of a victim's return to an abusive relationship can be facilitated by the establishment of financial support, shelter, and safety programs that allow her (or him) to establish fiscal autonomy in a safe environment. However, training about fiscal autonomy is also a developmental and educational mandate. Girls in particular (as well as their families) should be mentored beginning at an early age about career choices, educational options, financial management, and self-support. Another factor which can disrupt educational attainment and thus place girls and women at greater risk of financial instability is early and/or unintended pregnancy – thus, pregnancy prevention programs, education about reproduction and sexuality, and access to contraceptives in high school, college, and the community may serve as distal-level domestic abuse prevention strategies. In sum, mentoring, training, and education that cultivate financial independence and the development of job skills can provide women with the tools they need to enter relationships at a more egalitarian level (and also serve as a means for departure in the face of any violence that should arise).

There is no easy prevention or “cure” for the problem of domestic abuse. CCV remains one of the most pernicious forms of interpersonal violence that can arise between partners in romantic relationships, and additional research on ways to prevent its occurrence and effectively combat its adverse effects clearly is needed.

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