Making Distinctions Among Different Types of Intimate Partner Violence: *A Preliminary Guide*

national healthy marriage resource center

nrcdv
National Resource Center on Domestic Violence

The Annie E. Casey Foundation

Making Distinctions Among Different Types of Intimate Partner Violence

A Preliminary Guide

by Rachel Derrington, MSW, Michael Johnson, PhD, Anne Menard, BA, Theodora Ooms, MSW, and Scott Stanley, PhD

April 2010

We are grateful to the Annie E. Casey Foundation for their generous support of the development of this Guide. The authors wish to thank the conference participants for sharing their ideas and experiences and for their helpful comments on the draft. However, the authors assume sole responsibility for the views and conclusions expressed in this document.

This Guide is a joint publication of the National Healthy Marriage Resource Center and the National Resource Center on Domestic Violence.

Conference Background

The fields of Marriage and Relationship Education (MRE) and Domestic Violence (DV) share many values and are both concerned with the *quality* of intimate relationships. The two fields represent different sides of the same coin. MRE programs promote healthy marriage and couple relationships. They provide information and teach skills, attitudes and behaviors that help individuals and couples achieve these goals (see page 5: "What is Marriage and Relationship Education?"). Domestic violence programs promote safety in couple relationships. They provide and advocate for a wide range of legal and social services needed to empower and protect women and men from harmful and abusive relationships (see page 5: "What is the Domestic Violence Field?").

At a 2005 *Building Bridges* conference, national leaders from both fields (and from the field of Responsible Fatherhood) agreed that these fields share many of the same important goals, including the desire to "promote child well-being by ensuring that children grow up in a family environment that is free of violence and in which relationships are respectful, responsible and healthy" (Ooms et al., 2006). Historically the healthy marriage and domestic violence fields have very different origins, funding sources, and professional and advocacy bases. Though MRE has been in practice in various capacities for decades, publicly-funded MRE programs did not come into existence until the late nineties. In contrast, the first federal funding to support community-based domestic violence programs was secured in 1984. Until recently, these fields had little to do with each other, held many misconceptions about each other, and sometimes seemed to be working at cross-purposes. Recent federal mandates that all MRE grantees of the Administration for Children and Families consult with DV experts in the development of DV protocols has pushed them to get to know each other and find ways to collaborate.

In the last five years, the National Healthy Marriage Resource Center (NHMRC) and the National Resource Center on Domestic Violence (NRCDV) have brought together leaders from both fields, as well as leaders from the fatherhood field, for a number of meetings, conferences, and technical assistance activities. These activities were designed to build trust and respect while developing collaborative strategies to achieve common goals (see Ooms et al., 2006, Boggess et al., 2007, and Menard, 2007). In many states, local and state MRE and DV leaders are working collaboratively to develop site-specific guidelines or protocols to ensure that concerns about DV are identified and appropriately addressed in MRE programs (Lyon & Menard, 2008).

As a result of these interactions, a number of questions have been raised about the commonly accepted definition of domestic violence—the use of physical, economic and psychological tactics to exert power and control over an intimate partner—and the implications it has for MRE programs. Over the past decade, a number of scholars have argued that a growing body of research demonstrates there is not one but several different "types" of violence that occurs in intimate relationships and these different types require different kinds of intervention. In recent research literature on typologies, these types are commonly referred to as:

1. "Intimate terrorism" (IT)—When one intimate partner uses a variety of tactics to exert power and control over another;
2. "Situational couple violence" (SCV)—When an argument between partners gets "ugly" and escalates out of control; and
3. "Violent resistance" (VR)—When a victim, usually a female, uses violence to retaliate against being abused.

These terms have been carefully delineated by Michael Johnson, Ph.D., and are discussed in more detail below, but other terms have also been used (Kelly & Johnson, 2008; Pence & Das Gupta, 2006). Further, there have been studies focused on describing typologies of violent men (Holtzworth-Munroe & Meehan, 2004; Jacobson & Gottman, 1998). **However, the use of the terms above and others to describe intimate partner violence are not well understood by either healthy marriage or domestic violence practitioners and their use has therefore created a good deal of anxiety and confusion.**

Note: Throughout this document we use the umbrella term "intimate partner violence" (IPV) to cover all types of violence between intimate partners. We will generally use the term "domestic violence" (DV) as an adjective, as in "domestic violence advocates" or the "domestic violence field," or to refer to the definition of IPV most commonly used by DV advocates.

In May 2009, the NHMRC and NRCDV co-sponsored the conference *Toward a Common Understanding: Domestic Violence Typologies and Implications for Healthy Marriage and Domestic Violence Programs* at the Airlie Conference Center in Warrenton, VA. The conference was designed to bring together a diverse set of experts to critically examine the underlying research on different types of intimate partner violence and consider their implications for practice. The thirty-five invitees included leading scholars, practitioners, advocates and public officials from both fields and members of cross-field partnerships from six states—Alabama, Florida, Maryland, Kansas, Oklahoma and Texas. Based in part on the field experience of these state and local DV/MRE partnerships, participants were invited to develop some preliminary guidelines for practitioners. (See Appendix A for participant list.)

The key questions addressed at the conference were:

- What is the academic debate about intimate partner violence "typologies" and why is it important to practitioners? What more do we need to know?
- What questions and dilemmas do practitioners face in responding appropriately to domestic violence concerns in healthy marriage programs?
- How can we best move from research to practice?
- What difference does understanding different types of intimate partner violence make?
- What promising strategies and practices for addressing different types of intimate partner violence are emerging?

This Guide summarizes the conference presentations and work group discussions and, based on these, puts forward some conclusions and recommendations.

Outline of the Guide

Part One: Research Perspectives **(pages 6-10)** outlines the best known "typologies" of couple violence and male batterers and discusses gaps in the research.

Part Two: Practitioners' Perspectives **(pages 11-15)** begins with a discussion of the key elements involved in creating collaborative partnerships between MRE and domestic violence at state and local levels. It next summarizes the processes and tools MRE programs use to address DV concerns and promote safety throughout their activities. It also presents the dilemmas and questions they have experienced in doing so that in part arise from the existence of different types of IPV.

Part Three: Guidelines for MRE Programs **(pages 16-18)** describes key differences among MRE programs and identifies core IPV strategies and tools that all MRE programs should use, as well as those that depend upon how well program staff get to know their participants (the Personal Acquaintance Dimension).

Part Four: Conclusions and Recommendations **(pages 21-23)** begins with a discussion of key elements involved in creating collaborative partnerships between MRE and DV at the state and local levels. It next summarizes the conclusions and recommendations of conference participants about how to respond to different types of IPV, and what more we need to know, followed by a list of references and resource organizations mentioned in the text.

The **Appendices** **(pages 28-32)** include a list of conference participants and samples of two of the tools being widely used by MRE programs to address IPV issues (samples of other tools are available).

Text Boxes inserted throughout the report summarize six state MRE/DV partnerships and highlight some of the emerging strategies and practices being used.

What is Marriage and Relationship Education?

In the late nineties several states launched healthy marriage initiatives. The Administration for Children and Families in 2001 created the first federal initiative to fund marriage and relationship education (MRE) programs. MRE programs provide information and teach attitudes, skills and behaviors designed to help individuals and couples achieve long-lasting, happy and successful marriages and intimate partner relationships. This includes making wise partner choices and avoiding or leaving abusive relationships.

MRE is based on decades of research into risk and protective factors as well as laboratory studies identifying couple interactions associated with successful marriages. This research led to the pilot testing of demonstrations that showed relationship skills and behaviors can be learned. The evidence basis of MRE gains additional support from related neuroscientific studies underpinning the concept of "emotional intelligence."

Originally developed for middle-class, committed (engaged or married) couples, MRE programs are now being offered to individuals and couples across various life stages, from teens and single young adults to dating, engaged, married, divorced and separated couples. MRE can also help single parents (never-married, separated or divorced) learn to co-parent effectively, when appropriate, and to choose more successful relationships in the future.

As a result of the recent infusion of government funding, MRE programs are now serving large numbers of individuals and couples from economically disadvantaged populations and from cultural minorities, racial and ethnic minorities. Substantial efforts are being made to customize program design, setting, and curriculum content to be more effective with these diverse populations.

MRE can be provided to the general public through media campaigns, Web site resources, DVDs, self-guided internet courses and other community outlets. Most commonly, MRE refers to structured programs, classes and workshops provided to groups of couples, offered on a voluntary basis in the community (in faith-based organizations, campuses, schools, social service agencies, etc.).

MRE aims to be preventative in nature, to provide information to enrich, protect and strengthen relationships before serious problems arise. MRE is generally distinguished from face-to-face individualized couples counseling or therapy. However, some MRE programs are designed for couples whose relationships are already in crisis.

What is the Domestic Violence Field?

The domestic violence (DV) movement dates back to the seventies when the first shelters and battered women's programs were set up and grassroots activists worked hard to get critical legal protections in place, educate police and increase public awareness. Congress passed the Family Violence Prevention and Services Act in 1984 to create a federal funding stream for core DV services throughout the country. The Violence Against Women Act of 1994 (VAWA) provided federal resources to encourage community-based, coordinated responses to combat sexual and domestic violence.

DV programs typically provide 24-hour crisis hotlines; individual and group support and counseling primarily for women, but also for men; legal and medical advocacy; support groups for adults and children; and other specialized services. A major emphasis of these services is safety planning with DV victims.

More than half of the community-based programs also provide emergency shelters to family members who are not safe in their own homes. Some larger programs also provide employment services, respite care, economic advocacy, and child care programs. Some also offer batterer intervention programs either directly or through a collaborative relationship.

Many programs are actively involved in community education and awareness activities and conduct violence prevention activities in schools and communities. The network of services is now extensive in most states; however, migrant populations remain critically underserved in many areas of the country.

Within the domestic violence community there is growing interest in:

- Greater collaboration between DV and child abuse services, given the growing recognition of the co-occurrence of domestic violence and child abuse and concern for children who witness domestic violence in their own families.
- Engaging men more actively in violence prevention, organizing and education efforts.
- Seeking to develop innovative primary prevention activities in the community.

PART ONE
Research Perspectives

Definitions and measures of "domestic violence"

It is sometimes confusing for MRE practitioners to sort through the broad range of terms used to describe violence and abuse within intimate relationships. Domestic violence, family violence, battering, spouse abuse, intimate partner violence, and intimate terrorism are all terms in common use. These terms are sometimes used interchangeably, although they are frequently ascribed different meanings. Some of these terms are defined in federal and state statutes, which vary across jurisdiction. Others are more commonly used in research settings or within the social service field, with varying degrees of precision as to the types of behaviors or characteristics they encompass.

Domestic violence practitioners and family violence researchers can appear to contradict each other when they describe and report on the extent and nature of intimate partner violence (IPV). As scholar Michael Johnson explained at the conference, part of this is due to the way the term "domestic violence" has been used in different contexts to describe different types of couple conflict. These seeming contradictions may also stem from a misunderstanding by both parties regarding where the statistics come from and what the strengths and limitations are of the two main sources of data—general population surveys and agency data (such as data collected by criminal justice, health system or domestic violence agencies). Each source has certain strengths, limitations and inherent biases (see Johnson, 2009b).

Each source of IPV statistics generates very different prevalence rate estimates. National survey data have reported that 16% of U.S. married couples had been violent within the previous twelve months and as many as two-thirds have experienced such an incident at least once in their marriage (Johnson, 2009a). Agency-related data yielded much smaller estimates. In terms of built-in biases, agency data (including agency-sponsored surveys) underreport situational couple violence (SCV). In contrast, data obtained in general population surveys at national or state levels refer almost exclusively to SCV and greatly undercount intimate terrorism (IT) and violent resistance (VR). These terms are defined in more detail below.

Domestic violence as defined by the domestic violence field

Domestic violence is typically described by domestic violence advocates as a pattern of abusive behaviors that adults and adolescents use against an intimate partner. Domestic violence is characterized by one partner's need to control the other and the intentional and instrumental use of a range of physical, economic and psychological tactics and weapons to secure and maintain that control (Johnson, 1995). This includes behaviors that frighten, terrorize, manipulate, hurt, humiliate, blame, injure, and even kill a current or former intimate partner. This type of intimate partner violence is the most often reported to authorities, and domestic violence victims of this type are more likely to seek social and health services, as well as legal protections. Domestic violence, defined in this way, is highly gendered, and in heterosexual relationships, is nearly always perpetrated by a man against his female partner. However, women can and do perpetrate domestic violence, against male and female intimate partners.

The domestic violence community has worked long and hard to help the public understand and accept the dynamics of domestic violence this definition reflects and to take appropriate action. But increasingly, the DV community is hearing from practitioners and victims/survivors that not all violence between intimate partners fits this definition. For example, some women referred to domestic violence programs for services and support do not feel that there is a pattern to the abuse or their partner is trying to control them. They describe a different set of interpersonal dynamics that, while problematic, fall outside the definition of domestic violence provided above.

In communities of color, some leaders have pointed out that the dominant definition and interventions provided by the DV field in the United States do not fit well with the complex interactions between historical experience, poverty, and cultural and racial attitudes and values. These interactions can profoundly influence and shape violent behavior in families, affecting the kinds of interventions that would be most effective (Boggess et al., 2007; Menard, 2007; Perilla, 2006).

Typologies: Different types of intimate partner violence

A variety of studies, by a number of authors, using different data sets and measures have established that domestic violence is not a unitary phenomenon (Johnson, 2009b). A variety of "typologies" have been developed to describe different types of intimate partner violence. Each type has somewhat different causes and implications for marriage and relationship programs. In all types of couple violence, women are more likely to get hurt. While one of the most common types, SCV, generally has less serious consequences, all types of violence are unacceptable and can result in serious injuries or death. At the conference, the work of two of the best-known scholars on IPV and batterers typologies was described.

Typologies of Couple Violence. Michael Johnson's typology of IPV, first published in the *Journal of Marriage and Family* (Johnson & Ferraro, 2000), is based on his own research and field experience, analyses of national data sets, and reviews of numerous other studies as summarized in publications over the years (Johnson 2009a & b, and 2008). Johnson's typology has become the most widely referred to and commonly accepted typology of couple violence and is outlined below:

- **Intimate Terrorism (IT)** is when one partner, typically the male, employs a variety of physical, economic and psychological tactics and weapons in a general pattern of maintaining power and control over his intimate partner. These may or may not include physical acts of violence, though the threat of physical violence is often implicitly there. This is the kind of violence most domestic violence advocates refer to when using the term "domestic violence." Research and experience tell us that IT affects well over 1 million women a year, resulting in serious injury and psychological trauma. Over 1,200 women were killed by an intimate partner in 2000.

- **Violent Resistance (VR)** is the use of violence in response to intimate terrorism, generally by women against their male perpetrators. The resistor may believe her attack will prevent further attacks, is long-overdue retribution, or, when it results in killing her partner, may be a desperate attempt to escape.

- **Situational Couple Violence (SCV)** does not involve any attempt at general power and control but is typically provoked by a situation or incident when tensions or emotions get out of control, escalate and get physical as one or both partners react with violence. SCV may be initiated by either partner and is generally interactive. SCV is by far the most common type of couple violence. Johnson estimates that SCV is three to four times as common as intimate terrorism, and is probably more prevalent in dating relationships. Johnson and others repeatedly make the point that SCV can be very serious. In his analysis of Irene Frieze's Pittsburgh data, 29% of women experiencing situational couple violence had suffered at least one serious physical injury (Johnson, 2006).

Intimate partner typologies and dimensions can be misunderstood or misused. For example, couples involved in situational couple violence may be told that it is "not dangerous." Batterers arrested for domestic violence and the attorneys representing them may attempt to characterize their acts of intimate terrorism as situational couple violence –" just a one-time angry outburst" – to reduce their culpability. IPV typologies are also criticized because they can sometimes be used to "normalize" situational couple violence or to make erroneous generalizations such as "men and women are equally violent." A belief that all intimate partner violence is "gender symmetrical" can lead to unwarranted arrests and mutual protection orders, or custody or visitation awards that are dangerous for children and their victimized parent. Finally, typologies can be misused to perpetuate racial and class stereotypes.

Johnson proposes that the term "intimate partner violence" should be used as an umbrella term to cover all types of violence between intimate adults, with the term "domestic violence" restricted to describing "intimate terrorism."

Batterers' Typologies. Batterers are usually assumed to be "intimate terrorists" (IT). However, Holtzworth-Munroe and Stuart (1994) reviewed 15 existing typologies and grouped them into three types of batterers. Accordingly, they do not restrict the term batterer to IT (Holtzworth-Munroe & Meehan, 2004). The three types they identify are as follows:

- **Family-Only Batterers (FO**) describes men acting violently only in the home and who use relatively low levels of violence. Typically, these men are not generally hostile to women or regularly seek to control them. They exhibit little psychopathology although they may have poor relationships skills. They may exhibit violence, especially in reaction to extreme stress, and are more likely to have been exposed to marital violence during their childhood.

- **Dysphoric or Borderline Batterers (DB)** do not show much violence outside the home, but use relatively high levels of violence and score high on measures of borderline personality disorders. They are very emotionally dependent upon and insecure in their intimate relationships and are prone to jealousy.

- **Generally Violent and Antisocial Batterers (GVA**) engage in moderate to severe marital violence *and* extra-familial violence. They are most likely to show evidence of anti-social personality disorders.

Johnson has argued that the first type, FO, corresponds to situational couple violence (SCV) and the second two of these are subtypes of intimate terrorism (Johnson & Ferraro, 2000).

Implications of IPV typologies

Practitioners and advocates at the conference generally agreed with the scholars that these typologies are useful in the sense that they corresponded closely not only with the data, but also with their on-the-ground experiences. Yet conference participants also agreed that the practical implications of the typologies remain unclear (as discussed later in the Guide) and that the typologies discussion left a number of unanswered questions that require further discussion, research and testing.

For example, participants generally agreed that there are no clear-cut "bright lines" between the different types. It is not known whether IT and SCV are distinct categories or how they develop over time. Surveys of violence consistent with SCV tend to show violence diminishing with age (Kim et al., 2008). Could an individual who participates in SCV at some point become an "intimate terrorist"or a "violent resister"? This lack of clear demarcating line between IPV types, especially how they develop and unfold, makes it even harder to know how to determine into which type a particular couple's relationship fits.

Participants also questioned whether practitioners can learn to identify different types of violence. Whereas several useful research instruments exist, no simple screening or assessment tools are readily available for practitioners to use to distinguish between the types. The expression of fear is believed by some to be a "red flag" indicator to use to distinguish between types, but fear is not always present in potentially dangerous situations. Some situational couple violence is chronic or severe enough to create fear. One researcher, a consultant to the Domestic Violence Enhanced Home Visitation Project (DOVE) in Baltimore, reported using danger assessment instruments in screening mothers—combining indicators of fear with severity—to make distinctions and plan different types of intervention on the basis of IPV severity (i.e., referral to shelters versus staying in the home with safety planning).

Johnson (2009a) asserts that the present state of research requires any report of intimate partner violence be taken seriously, and it is most prudent (and ethical) to assume every case may be a case of intimate terrorism, until there is evidence to the contrary. Once violence is identified, the initial focus should be on assuring confidentiality and supporting safety planning until further information reveals it is in fact a case of situational couple violence.

When intimate partner violence is present in a relationship, an assessment should be conducted by an experienced trained staff person to identify the best course of intervention or treatment. Response to IT or VR should include immediate referral to a domestic violence program or experts and the services and protections they can provide or facilitate.

If the situation is identified as likely to be SCV, the following could be important considerations (Johnson 2009a):

- For conflicts that appear to be triggered by problems/stresses external to the couple—such as job loss or financial problems—a referral to appropriate services and supports to address the problem would be indicated (e.g., job counseling/employment and/or financial education services), along with conflict resolution and anger management services.

- For fights that appear to be triggered by the behavior of a partner who has an alcohol or substance abuse problem, the focus of intervention would be on helping the individual and/or couple overcome the addiction. Substance abuse treatment programs that include the partner have been found to be the most effective (Fals-Stewart et al., 2002).

- One member of the couple may have serious personality problems—such as an impulse disorder or anger management problem—which would call primarily for an individual level intervention (counseling, therapy or medication).

- The evaluation might reveal that the violent behavior emerges primarily as a result of dysfunctional couple processes and interactions. In this case, participation in an intensive couple relationships skills educational program would probably be the intervention of choice.

In all instances, attention needs to be paid to reducing the risk of violence and abuse and offering safety options where appropriate.

MRE/DV Partners: Oklahoma Marriage Initiative/ Family Expectations and OK Coalition Against Domestic Violence and Sexual Assault

The Oklahoma MRE/DV state and local level partnerships began a decade ago between the Oklahoma Coalition Against Domestic Violence and Sexual Assault (OKCADVSA) and the statewide Oklahoma Marriage Initiative (OMI). These relationships facilitated the partnership forged several years later between the local domestic violence coalition members based at the Oklahoma City YWCA and staff of the federally-funded *Building Strong Families* (BSF) / *Supporting Healthy Marriage* (SHM) program, *Family Expectations*, operated by Public Strategies in Oklahoma City.

State Level Partnership

The OMI, managed by Public Strategies and funded primarily with state TANF funds, has grown and evolved over the decade. Currently, trained volunteer facilitators offer MRE workshops, *Forever. For Real.*, in every county in the state. Additionally, programs are in place within public schools, youth service agencies, male and female prisons, and throughout county human service centers. These institutional programs complement numerous one-time community events and weekend retreats available to married and engaged couples. In these MRE programs, formal intake and screening is generally not employed.

State Level Partnership Highlights:

- Cross-training at annual OMI staff meetings and OKCADVSA coalition meetings focus on general information about DV and DV resources and identify "red flag" indicators
- Developed decision charts that detail steps to be taken in responding to reports of IPV at intake, registration or other disclosures
- A few DV shelter programs invited the OMI to hold healthy relationship workshops specifically designed for battered women
- Jointly developed a general information flier "Getting Help for More Serious Problems" to give to all workshop participants which includes DV information embedded in information about employment, mental health, and substance abuse. This flier is aimed at encouraging self-referral
- In marketing materials, the OMI Statement of Services emphasizes services are educational in nature, not one-on-one counseling for individual problems
- In the OMI *Guide for Marrying Couples*, given out to all couples applying for marriage licenses in the state, one page of information is included on "unhealthy" relationships and where to go for help

Local Level Partnership

The federally-funded *Family Expectations* (FE) program, administered by Public Strategies, is offered to low-income unmarried and married couples expecting a baby. It is a combined site for the BSF and SHM federal random assignment experimental programs. FE includes formalized intake, screening and referrals "out" of the program. The program includes 3 months of weekly MRE workshops, family support workers/case management services, and various ancillary social events. Participants may participate in ongoing events and booster sessions until their child is one year of age. It is highly "incentivized" (see definition on page 14).

Local Level Partnership Highlights:

- Use of questionnaire to screen the women for DV that includes both Yes/No questions and open-ended questions. There is a mid-program assessment and continuous tracking for level of safety risk. This questionnaire is in the revision process to be better able to distinguish between different types of DV
- Both intake screening/assessment staff and case managers are trained to assess safety in the home
- DV technical assistance is provided to the ongoing case managers to discuss specific cases and a DV liaison is available to meet one-on-one with a victim on site or in her home to assess her situation and service needs

PART TWO
Practitioners' Perspectives

Building successful collaboration between MRE and DV programs

This section draws from *Promoting Safety*: *a Resource Packet for Marriage and Relationship Education and Program Administrators* (*Menard, 2007*).

All healthy marriage federal grantees are required to consult with domestic violence experts to decide how domestic violence issues and concerns are going to be addressed in the program. This requirement arose from a response by government officials to concerns expressed by domestic violence advocates and others that joint exposure of a couple to certain relationship education content could exacerbate existing violence and put the victim at risk of harm.

In general, the marriage education and domestic violence fields do not know each other well. Each field has its own unique history, language, funding streams, and approach to serving its constituents. There may also be very different understandings and perspectives of community and family needs. The mission of each field can sometimes appear at odds with the other—for example, marriage education programs focus on keeping couples together, and domestic violence advocates work with many victims who are trying to separate from a current or former partner.

There are many positive reasons for healthy marriage and relationship education projects and domestic violence programs to work together cooperatively. The directive from federal and state funders for healthy marriage grantees to consult with domestic violence experts is often what initially prompts MRE practitioners to involve domestic violence advocates in program design and implementation. While forced collaborations are sometimes necessary, they are less effective, meaningful and long-lasting than those born of a self-identified and shared commitment to address common interests, such as ensuring that programs being offered are safe and appropriate for all participants.

Successful collaborations involve creating connections between people and purposes and sometimes require building bridges where none previously existed. In many communities, there was limited or no prior contact between marriage projects and domestic violence programs. In others, a strained relationship may already exist. Identifying common ground, creating a shared sense of purpose, and building mutual trust are keys to not only building collaborative relationships, but to sustaining them over time. Other elements to successful partnerships include paid compensation for technical assistance and training and addressing barriers to tracking referrals, such as confidentiality issues.

Included in this Guide as text boxes are summaries of healthy marriage and domestic violence partnerships in six states that participated in the *Towards a Common Understanding Conference* which illustrate many of these points.

In the process of these consultations with domestic violence experts (who are often members of local or state domestic violence coalitions), grantees are encouraged to develop written, site-specific "protocols"—guidelines tailored to the specific population and nature of the program. Protocols can be brief or very detailed. These guidelines are expected to cover some or all of the following tasks and challenges (for more detail see Menard, 2007).

- **Create partnerships between the healthy marriage programs and domestic violence experts at state and local levels**. In many communities, there have been little or no prior contact between marriage educators and program staff and domestic violence programs. When

contact has occurred, there may be tension and misunderstanding. Building a collaborative partnership between MRE and domestic violence organizations includes planning activities designed to help the partners get to know each other, developing shared values and a common language, and learning about each other's services. Ultimately, some programs develop a Memorandum of Understanding (MOU) that spells out specific ways the two programs plan to work together on a regular basis in the future.

- **Build an understanding of domestic violence through staff training.** Many MRE programs invite local DV experts to train administrative and front-line staff and volunteers on domestic violence issues. These trainings involve providing general information about what DV is and how it manifests itself, what DV resources exist in the community, and how to safely handle disclosures and referrals. Some programs offer cross-training events at which DV practitioners learn about healthy marriage program goals and services and healthy marriage practitioners learn about intimate partner violence. These trainings need to be conducted periodically in order to address new issues as they arise and to train any newly hired staff.

- **Address screening and referral.** Screening involves a formal or informal intake interview—usually conducted separately with each member of the couple—during which the woman is asked a number of questions. The questions include whether she has ever felt afraid of her partner or has ever been hurt by her partner. Many different screening tools are used to assess IPV, some more complex than others. In the military, family advocacy programs use assessments that apply scientifically-tested criteria to determine "maltreatment" of adults and children (Heyman & Slep, 2006). In some MRE programs, if the woman reports experiencing a violent incident, protocol requires the program refer her "out" to domestic violence services, explaining that the program is not designed to address complex relationship issues such as IPV. Alternatively, some programs will probe for further information to assess how recent the incident was and whether anyone was hurt. These programs may hold off on referring until they have consulted with their DV experts. (The male partner is not asked these questions at his intake interview out of concern that he will be "tipped off" that his partner has disclosed his abuse.)

- **Provide later opportunities for safe disclosure.** Often victims of IPV will not disclose abuse at intake, either because they do not trust the interviewer, do not feel safe disclosing, or because they do not understand that what they are experiencing is abuse. Therefore, MRE program staff are encouraged to create multiple opportunities throughout the program for confidential disclosure and safety planning. Staff are also taught to be alert for "red flags"—comments, behaviors or physical signs that may suggest IPV is a problem.

- **Improve curricula content**. Most MRE programs use a written curriculum. While all MRE curricula focus on couple disagreement and conflict and how to deal with these disagreements respectfully and constructively, they generally have not specifically addressed physical or emotional violence and abuse. Some curriculum developers are now revising their curricula to include explicit discussions of healthy, unhealthy and unsafe relationships. Where the curriculum used does not do so, some MRE programs are inserting these topics themselves.

- **Provide information to enable self-identification and self-referral.** Many programs do not conduct formal intakes, and thus do not have an opportunity for one-on-one screening conversations. These "open admissions" programs can find other ways to provide information that will encourage participants to identify themselves as being in an unhealthy, abusive relationship and to know where to go to get appropriate help. One commonly used tool has been handing out an informational flyer about DV and other special problems to *all* program participants. Another tactic is posting IPV-related information in women's rest rooms (See Appendix B).

- **Use public messaging.** MRE programs have many opportunities to educate the public about the nature of "unhealthy and unsafe" relationships and the availability of IPV services in the course of their outreach and marketing, or in public communication messages about healthy marriage.

- **Look through the lens of race and culture.** MRE programs are offered to populations of diverse races, ethnicities, economic backgrounds and faith traditions. These factors can all affect how domestic violence is understood, reflected in language and addressed by these communities. (See Menard, 2007 Guide #4).

To find out about how they were implementing the requirement to address DV issues and concerns in their programs, the NRCDV conducted a survey in 2007 of a sample of MRE programs. The study found that programs varied considerably in whether and how they addressed these different components of promoting safety within their programs (Lyon & Menard, April 2008). It is also not clear how many of the MRE programs have integrated information about different types of IPV into their various activities. At the Airlie conference, a few such examples were discussed and ultimately highlighted in the state MRE/DV Partnership boxes.

Practitioners' Dilemmas

Some of the questions and concerns about the experience of MRE programs in addressing IPV issues have existed for some time, but came into sharper focus at the conference as a result of the presentations and discussions about different types of domestic violence. These discussions were wide ranging, but four questions in particular stood out and are presented here.

1. What are the implications of screening "out"?

As discussed earlier, a disclosure of domestic violence at intake or at any point in a couple's participation in MRE program leads many of these programs to immediately screen "out" the individual or couple and refer them to domestic violence services. Alternatively, some programs conduct a fuller assessment of the domestic violence issues involved, often in consultation with their DV experts, and make decisions about program participation and referrals based on that assessment. A number of questions and concerns have arisen about this screening "out" practice and the *Towards a Common Understanding: Domestic Violence Typologies and Implications for Healthy Marriage and Domestic Violence Programs* conference afforded an opportunity to examine these and possible alternatives more closely.

During the conference, a number of questions, concerns and dilemmas were raised by MRE and DV practitioners and researchers:

- Programs primarily serving young, low-income parents find that many of these couples are quite isolated, and participation in the MRE program gives them access to sources of valuable support. If they are referred to DV services and, at the same time, excluded from the MRE program, there is often no way of knowing whether they received the help they need, whether the victim is protected, or whether they are now even more isolated. Due to safety-related confidentiality laws and protocols, many MRE providers are not able to follow-up to see if the victim contacted the DV provider and received DV services; for some, this raises a serious ethical issue.

- Seeking voluntary participation in relationship education services could represent the first or most recent attempt by the victim or the couple to get help for the abuse. For these couples, the mere fact that they walked through the MRE program door is significant. One researcher noted that even if a couple does not initially enter the ideal "room" for their particular needs and issues, that room may be the only room (metaphorically speaking) where this couple is going to show up at all. It represents an important starting point for gaining trust in providers who can help them identify and address issues and connect them with resources, services and supports.

- Concerns about screening "out" were especially acute when it appeared that the couple's conflict met the description of "Situational Couple Violence" (SCV). For couples engaged in what appeared to be SCV, having the option to remain in the program might allow them to receive important benefits and perhaps even learn to control their conflicts and negative emotions better, with consequent reductions in physical violence.

- Others felt that sometimes it is not until an individual or couple participates in the program for some time that they begin to understand that they are in an abusive and potentially dangerous relationship and need to take action. Because of the "relationship knowledge" gained in the MRE program, there may be a greater readiness to follow through with a referral to DV services. Some participants even felt that a victim of "intimate terrorism" might learn more about what a healthy relationship is, which could strengthen her resolve to get the help she needs to escape her current situation. Others felt such an approach to disclosures of IT was dangerous given the limitations of our current knowledge and experience in MRE settings.

- Participants agreed that an important factor related to the efficacy of the screening issues described above was the degree to which participation in MRE services is either mandatory or highly incentivized (e.g., the couples receive gifts or a monetary incentive for participating). Most experts agree that batterers engaged in intimate terrorism would be unlikely to seek out voluntary MRE services or allow their partner to do so. In general, perpetrators of intimate terrorism do all they can to isolate their partner and relationship and are not seeking increased contact with observant caregivers. Hence, voluntary services are less likely to attract couples for whom such services are obviously risky. However it is possible that these types of couples are more likely to be interested in MRE services that are highly incentivized.

Participants at the conference acknowledged that there is little empirical evidence on whether MRE programs have either led to an increase in IPV in particular cases or had a positive effect on reducing SCV. A recent small-scale experimental study has shown promising results: a group intervention for couples experiencing SCV was found at the six-month follow-up to be effective at nearly eliminating recidivism of violence and improving the marital/partner relationship, with no increase in risk (Stith et al., 2004). A demonstration program is currently testing the effectiveness of a 22-week group-based psycho-educational intervention, *Creating Healthy Relationships*, designed to improve relationships in couples experiencing situational violence. The evaluation is being conducted by the program designer, Dr. John Gottman, and colleagues at the Relationship Research Institute. (The evaluation is funded by Administration for Children and Families, the Office of Planning Research and Evaluation.)

2. Is there a need for a third type of service—a "Third Room"?

Participants from both the MRE and DV fields came to the conclusion that many couples currently being screened "out" of MRE programs need an intervention that is neither the typical spectrum of DV services (generally based on the "power and control" model of DV) nor the typical, short-term healthy relationship/marriage education program. What seemed to be needed was a third type of service—one participant dubbed it a "Third Room"—designed for groups of couples who admit to fights that "get out of control" and both want help with this issue. This program would need to be more intensive and more focused. The staff running such a program would need to be highly experienced and well trained in recognizing and handling intimate partner violence in all its forms.

At present, few such services seem to exist, although the Relationship Research Institute demonstration discussed above is testing such an approach (see also Stith et al, 2004). At the *DOVE Project* in Baltimore, a demonstration of a nurse-home visiting program serving low-income, pregnant women, is sorting out couples exhibiting IPV according to fear, severity and risk of danger. Those who show low levels of risk receive a tailored intervention different from the intervention received by those who exhibit higher risk. This approach is currently being studied but results are not yet available.

3. Should men also be screened for DV?

Currently, in most MRE programs that conduct intake interviews to screen for IPV, only women are asked questions about their experience of violence and abuse. While this practice is intended to protect women—since it is feared that if men were also asked about their experience with IPV it could exacerbate an already violent relationship—some participants recommended that this approach be reconsidered. The gender symmetry of the most common form of IPV disclosed to MRE programs, situational couple violence, suggests screening of both female and male partners might be more appropriate, but only once IT has been ruled out. Additionally, batterer's typology research suggests asking men questions about violence may be especially helpful for those men who fit the category of SCV/Family-Only violence. Such questions could also help reveal whether the man would like to find a way to stop the fighting.

Fatherhood programs that have integrated domestic violence responses into their programs and batterers intervention programs addressing fatherhood issues can be helpful resources as MRE and DV programs further explore these screening issues. There are also some good examples of how to safely screen men and women in child welfare and some health settings. Another reason why this broader collaboration is essential is the limited nature of IPV services for batterers. While many communities have batterers' intervention programs, virtually no program takes into consideration the typologies of couple violence or batterers. In addition, batterers programs are filled with predominately court-ordered participants and, though fees vary considerably, are sometimes costly. (The Family Violence Prevention Fund has developed useful materials to help abusive men renounce violence and become responsible fathers, as well as to involve men in violence prevention efforts. *Stop Abuse for Everyone*, or SAFE, has information about services available for male victims of IPV).

4. When programs do not have an intake procedure, do they still have to address concerns about IPV?

The short answer is yes, they do. The discussion about screening for IPV at intake has focused so much on the practices at the "flagship" federal demonstration programs, *Building Strong Families* (BSF) and *Supporting Healthy Marriage* (SHM), that it has often forgotten that most of the MRE grantees do not conduct a formal or even informal intake process. Therefore, questions about screening and referral "out" are not relevant to their programs. Conference participants agreed, however, these MRE programs should still develop guidelines for how they will address IPV concerns in other ways, such as staff training, curriculum content and marketing messages that are described in this Guide. In addition, all MRE programs should adopt as a standard practice giving an informational flyer about special problems (including DV) to all the participants, as well as posting appropriate information in the women's rest rooms (see Appendix B & C). (Guidelines to help programs decide how to integrate concerns about IPV into their particular programs are provided in Part Three.)

PART THREE
Guidelines for MRE Programs

A theme throughout the conference and highlighted by the presentations of the state MRE/DV partners was that major differences exist among MRE programs—differences in target population, length and intensity of the intervention, program context, institutional setting and type of activity and importantly whether there is a formal intake process or not. These differences shape and constrain how programs may need to respond to IPV.

In the authors' view, a critical element affecting how the individual MRE programs can best address domestic violence issues is how well the relevant staff get to know individual program participants and develop a relationship with them – what we call the **personal acquaintance (PA) dimension**.

Some MRE program staff can get to know their participants quite well over several weeks or months of contact. These programs thus have a variety of opportunities for directly asking about and otherwise being alert to evidence that IPV may be a problem for particular individuals or couples, and get them appropriate help. However other programs that have only fleeting personal contact with participants at workshops or during a special one-time, daylong or weekend event will have few such opportunities for personal IPV assessment, and instead need to focus on providing general information about IPV and related services in the course of the program. Similarly, programs that conduct public communications or internet-based MRE activities never have any face-to-face contact with their audience, though they have a responsibility to educate them about healthy and unhealthy relationships.

Below, we have developed four broad categories of programs along this personal acquaintance (PA) dimension and suggest which IPV strategies are most relevant to each type. It's important to note that all types of programs need to incorporate a core set of components into their IPV guidelines or protocol as standard practice, as indicated below. Then, depending on their degree of personal acquaintance with the participants they should add the additional components that are appropriate.

1. High Personal Acquaintance

These programs actively engage in community outreach activities to enroll participants and conduct formal intake interviews to determine their eligibility. These programs often provide multiple services including regular and ongoing MRE workshops, individualized case management referral and support, and other ancillary peer services. They may last from two months up to a year. In the process, staff get to know the couples well and generally develop close trusting relationships with them. Examples include *Building Strong Families* and *Supporting Healthy Marriage* federal demonstration programs which are required, as part of the evaluation protocol, to carefully screen for and refer "out" most or all IPV cases.

The IPV protocol/guidelines should address:

- Core components (as standard practice)
- Developing partnerships with IPV experts
- Regular all-staff in-service orientation and training on IPV issues and resources
- Content of recruitment and marketing materials
- IPV-related content included in curriculum
- Provide "safe" information about IPV indicators and DV services for self-referral in women's restrooms and in a flyer given to all participants with DV information included along with other specialized services (See samples in Appendices B & C)

Additional program-specific components:

- IPV screening at intake, assessment and referral "out" for IPV services; in some programs the woman may choose to remain in the program, understanding the risks
- Staff training to observe verbal or behavioral "red flags" at registration or during the program and related services
- Provision of opportunities for "safe disclosure" of IPV
- Case consultations with IPV expert as needed

2. Moderate-to-Low Personal Acquaintance

These are institution-based MRE programs for targeted individual/couple participants such as high school students, prison inmates, TANF clients, and adoptive and foster parents (child welfare agency sponsored). Some of these populations may be at higher risk of IPV. Classroom instruction or weekend retreats provide 6-20 hours of MRE. The classroom facilitator may get to know participants fairly well. Other staff at the institution will often have some additional information about the participant and opportunities to observe his/her behavior. Examples: Oklahoma *Prison PREP*, TANF *Within My Reach* orientation classes, Oklahoma *Making Connections* high school classes, and *Love Notes* program in YouthBuild sites. The IPV protocol should address the following.

Core components (as standard practice):

- Developing partnerships with IPV experts
- Regular all-staff and volunteer in-service orientation and training on IPV issues and resources
- Content of recruitment and marketing materials
- IPV-related content included in curriculum
- Provide "safe" information about IPV indicators and DV services for self-referral in women's restrooms and in a flyer given to all participants with DV info included along with other specialized services (See samples in Appendices B & C)

Additional site-specific components:

- Training to observe verbal or behavioral "red" flags in registration, program and related activities
- Provision of opportunities for "safe disclosure" of IPV
- Case consultation as needed to include other institution staff and DV experts

3. Minimal Personal Acquaintance Workshops and Special Events

Workshops or classes are "open admission" (no eligibility criteria) programs offered in a community setting or agency. The program only provides MRE services. Participants register for the program but there is no intake process. The program typically meets weekly for 6-8 weeks. Example: *Oklahoma Forever. For Real.* community workshops.

MRE special events are open participation, community setting, one-time (half-day, evening, or weekend) large audience events that provide little or no one-to-one contact between staff and participants. They are registration only with no intake process. Example: Oklahoma Marriage Initiative's *Sweethearts' Weekends*.

Core components (as standard practice):

- Developing partnerships with IPV experts
- Regular all-staff and volunteer in-service orientation and training on IPV issues and resources
- Content of recruitment and marketing materials
- IPV-related content included in curriculum
- Provide "safe" information about IPV indicators and DV services for self-referral in women's restrooms and in a flyer given to all participants with DV info embedded along with other specialized services (See Appendices B & C)

Additional site-specific components:

- Training to observe verbal or behavioral "red flags" in registration, program, and related activities

4. No Personal Acquaintance

These types of MRE programs and activities serve the general public, allowing open, anonymous participation. They do not use registration or an intake process. MRE information/education is made available to the public on Web sites and/or in media marketing messages. Individuals and couples may use internet-based self-guided, interactive curricula. They may purchase out-of-the-box MRE program curricula and use them without any prior training. MRE community- and state-wide initiatives prepare and disseminate brochures, posters, TV and radio ads including basic public health messages about healthy marriage and relationships.

These programs IPV guidelines need to address:

- Developing partnerships with IPV experts
- Reviewing IPV content in advertising, web-based information, brochures, guides for couples, media messaging, etc.
- Being prepared to respond to information requests that may relate to IPV

MRE/DV Partners: Twogether in Texas and Texas Council on Family Violence

Twogether in Texas is a statewide, state funded MRE initiative. It features a network of voluntary services available through partnerships with 12 regional intermediary organizations that facilitate the operation of a service delivery system to deliver eight hours of premarital education and other healthy marriage and relationship services to Texans in 254 counties. Since 2008, *Twogether* has trained nearly 60,000 participants with over 1,600 providers from public and private communities and faith-based organizations. The Texas Health and Human Services Commission and *Twogether* partners work with community leaders to build awareness, provide relationship training and support, and participate in research to improve existing healthy marriage programs and policies.

Partnership Highlights:

The Texas Council on Family Violence (TCFV) coordinates the local DV/MRE partnerships. The TCFV developed a template protocol that sites, in turn, can tailor. Some DV service providers are given modest monetary compensation for their time. The partnership at the state level is characterized by strong and trusting personal relationships, mutual respect and support. From the beginning, the leaders established a shared philosophy, a shared definition of DV, and a shared goal of protecting their couples. Some sites have the following characteristics:

- Local DV contact available at some MRE site in the community; DV regional coordinators assigned to each area
- MRE programs show support for DV providers by attending DV events
- Workshop providers are encouraged to create site-specific DV protocols
- With the exception of the *Building Strong Families* and *Supporting Healthy Marriage* programs, formal intake and screening is not a component of these programs
- Provide information to workshop participants about local resources including a list of DV services. This information may be located in each participant's workbook within a list of a multitude of community resources. Information may also be posted in the women's bathroom
- When a referral is made for DV services, due to confidentiality reasons, the healthy marriage sites do not follow up with the domestic violence providers

MRE/DV Partners: The Supporting Healthy Marriages Together Project, University of Central Florida and Harbor House of Central Florida

The *Together Project* is one of the eight federally-funded *Supporting Healthy Marriage* (SHM) program sites that provides and evaluates marital interventions for low-income married parents. The program consists of a 30-hour curriculum over 12 weeks with additional individualized family support services and extended marital activities.

Harbor House is an established organization providing a variety of legal, advocacy, DV prevention and public awareness, shelter, counseling and treatment services for residents of central Florida.

Partnership Highlights:

- One annual full day training in DV is provided by Harbor House to all project staff (including those who answer the phone)
- The partners developed a comprehensive protocol for the SHM program detailing the steps involved in administering the DV screening to the wife as part of the intake process; how to refer to Harbor House for DV services if DV is found to be an issue; and safety planning. If DV is discovered during the intake screening, the couple is informed by letter that they are not eligible for the SHM program. However, if DV is discovered when a couple is already a program services participant, they may continue to work with the family support workers and, if they participate in DV education services, with the approval of Harbor House may return to participate in the marriage education services
- The protocol states that a couple may be eligible to remain in the SHM *Together Project* if only "low level violence" is reported (i.e., there is no controlling behavior or presence of fear) and the supervisor reviews the situation with the staff who conducted the intake, as well as Harbor House
- If, as part of the intake process, the staff suspect DV is occurring that threatens the well-being of a child, they have to make a report to the Florida Child Abuse Hot Line, as required by law

MRE/DV Partners: Alabama Community Healthy Marriage Initiative & The Alabama Coalition Against Domestic Violence

The Alabama Community Healthy Marriage Initiative (ACHMI) is funded by the Office of Family Assistance (OFA) / Department of Health and Human Services (DHHS) and is a collaboration between Auburn University, the Alabama Cooperative Extension system, The Alabama Coalition Against Domestic Violence (ACADV), Family Resource Centers, and several other state partners. The mission is to promote public awareness of the benefit of healthy relationships and marriages for child well-being, increase access to MRE resources throughout the state, train partners in delivering research-based relationship education programs, and evaluate the program implementation process and outcomes. Currently, there are ten local MRE sites. The initiative has a special focus on programs designed for high school students, for co-parents and for stepfamily couples.

Partnership Highlights:

- The ACADV has served as an advisor to the ACHMI since its original planning stages
- All sites in Alabama have a protocol approved by the ACADV. In addition, the ACADV has played an active role in establishing partnerships between these programs and the local DV provider
- Some local DV providers refer clients to MRE classes that emphasize good decision-making and elements of healthy and unhealthy relationships
- The Coalition provides annual statewide 4-5 hour trainings on how batterers act, explanations of types of DV, and on protocol development
- The ACADV reviews all ACHMI curricula and resources to ensure there are no unintended messages related to DV risk
- Information on recognizing signs of abusive relationships was added to relationship education curriculum used for teens and is now part of the new edition of that curriculum
- The ACHMI Web site includes information for the public about domestic violence, including a checklist of indicators of types of abusive and violent behaviors (gender neutral) and resources for getting assistance
- The ACADV will be working with ACHMI's teen initiative to advise on appropriate messages for teens on healthy relationships and the recognition of abusive relationships for their Web site

MRE/DV Partners: Marriage for Keeps & Kansas Coalition against Sexual and Domestic Violence

Marriage for Keeps is a federally funded *Supporting Healthy Marriage* (SHM) program operated by Catholic Charities in four sites in the state. SHM is designed for low-income married parents and provides 12-14 weeks of educational relationship skills classes, family support services and ancillary activities for up to a full year.

Partnership Highlights:

- The state DV Coalition links the local DV services to each site to develop their protocol covering screening and referral procedures, etc. as part of the intake process
- The Coalition conducts staff trainings, and local DV consultation is available on a case-by-case basis
- When IPV— of the situational couple violence type—appears to be an issue, the woman is encouraged to make her own decision about whether to remain in the program. The philosophy is that she is the best judge of whether it is safe for her to stay. (Staff believe that referral "out" only increases the danger for the victim as she becomes even more isolated. The program's facilitator/support workers may be the only professionals she is in contact with)
- Programs are encouraged to make educational materials about IPV available, post the statewide DV hotline number and other info readily available in the women's restroom (depending on the site)

PART FOUR
Conclusions and Recommendations

Researchers, practitioners, advocates and others were brought together at the *Toward a Common Understanding: Domestic Violence Typologies and Implications for Healthy Marriage and Domestic Violence Programs* conference to consider a difficult conundrum. Are there in fact different types of intimate partner violence, and if so, what difference does this make for MRE programs working with couples and for the domestic violence programs with whom they partner?

Conclusions: Given the diversity of perspectives of conference participants, there was a remarkable level of agreement on the following points:

- Different types of intimate partner violence clearly exist, as do different types of batterers. These differences help explain apparent contradictions among various data sources documenting domestic violence and correspond with the on-the-ground experience of many practitioners.

- Even those who are not sure about the current categorization of typologies agree that making distinctions is important. Different types of IPV and different degrees of violence severity likely require different kinds of interventions.

- "Intimate Terrorism" (IT) affects well over 1 million women a year in the United States, resulting in serious injury and psychological trauma and death. (Over 1,200 women were killed by an intimate partner in 2000). "Situational couple violence" (SCV) is three to four times as common as "intimate terrorism" (IT). All types of interpersonal violence are problematic and whatever type of violence is involved, women are much more likely to get injured or killed.

- The research on IPV typologies has been both misunderstood and misused to imply that SCV is not a significant concern, or that men are as likely to be injured as women. In fact, SCV can be very severe and result in serious injury or death.

- Screening for IPV remains challenging. Importantly, although researchers have developed lengthy screening instruments to assess DV and danger severity, there is no agreement yet about easily administered tools or observational "red flags" that practitioners working in a range of MRE programs can use to determine what type of violence a couple is experiencing.

- Any report of intimate partner violence must be taken seriously and explored further, although the most appropriate responses to disclosures are still being developed. Disclosures or indications of abuse should never be dismissed, just as anyone talking about wanting to die or commit suicide should never be dismissed.

- Many conference participants had misgivings about the current practice in programs of referring "out" for domestic violence services an individual from the program who reports an incident of IPV. Some individuals referred to other services will not follow through and will then be denied the potential benefits they or their partner may gain from remaining in the program. In these situations, some MRE programs are experimenting with letting the victim herself determine if it is safe for her to remain in the program.

- A third type of service is needed for couples involved in SCV that is neither the typical DV spectrum of services—based on the power and control model and focused on assuring safety—nor the typical short term, MRE type of program (see below).

- Continued discussion is warranted regarding the practice of not asking men questions about their experience with IPV (either as perpetrator or victim). This issue may merit careful pilot testing of interview questions administered in a couples program setting, with ongoing consultation with experts who work with male batterers and men involved in responsible fatherhood programs.

- A strong partnership between the MRE programs and DV experts at national, state and local levels is needed to develop, test and monitor new approaches that are responsive to these and other practice dilemmas discussed at the conference.

- Responsiveness to DV does not rest simply on instituting "screening out" procedures. Since the majority of MRE programs do not conduct formal intakes or screen for DV, they need to pay attention to other program components that incorporate accurate information about definitions of IPV and available DV services—including the wording of outreach and marketing materials, cross-training of staff, inserting IPV information into the curriculum and classroom discussions, and in media and Web-based communications with the public.

Future Directions and Recommendations

- **Leadership within the DV and MRE fields should engage in continued work to develop a "Third Room."** Participants strongly agreed that a third type of service was needed to better respond to women and couples involved in SCV. Many of these women (or couples) do not want to be referred for domestic violence services. While participating in a MRE program is unlikely to do harm, it may not be sufficient to help deal with the complex factors that contribute to out of control fights. Drawing upon some pilot programs currently underway, we need to think creatively about what these "Third Room" programs would look like, who would sponsor them, what kinds of staff training would be needed, and where the funding could be found to develop and test these new types of programs.

- **Establish a national working group to design new models of training and new tools to assess different types of IPV.** New training models and tools need to be developed and tested for front-line DV staff and MRE staff working in high to moderate personal acquaintance programs, to help them safely distinguish between IT and SCV. In-depth assessments and planning tools also need to be developed for couples engaged in SCV to help determine the most appropriate intervention. To this end, conference participants recommended that the co-sponsors or other relevant government agencies convene a working group to critically examine a range of IPV screening instruments being used in a variety of clinical/program settings (including the military) with different populations to determine:

  - What research they are based on, whether they aim to make distinctions among different types of IPV, degrees of violence severity and risk, and identifying potential, external causal factors;
  - Whether and how they screen couples (men and women separately, and or together); and
  - When formal screening procedures are not used, what can we learn from these instruments about some key observational indicators—"red flags" that should be communicated to program staff and the general public.

  Based on these findings, the working group could help develop and test a series of more nuanced and practical IPV assessment procedures that could be used in a variety of program settings to help evaluate the service needs of women, men and couples.

- **Continue to support research in this area.** Three general types of research are needed in order to move forward. First, surprisingly little research has been done on the causes and consequences of the different types of IPV. Such research is sorely needed in order to plan effective interventions. Second, as discussed above, further development and evaluation are needed of risk assessment instruments for use in MRE settings where the intake process is informal or very brief. Before such instruments can be recommended for broad use, their effectiveness in identifying intimate partner violence and its implications for program participation needs to be determined. Third, there is a need for research that assesses the effectiveness of differential intervention strategies for both the victims and the perpetrators of different types of IPV.

- **IPV concerns need to be integrated into many MRE program components— it's not just screening that matters**. In consultation with DV experts, all healthy marriage curricula developers, program administrators and educators, including those with "open admissions" or no contact with their audience, need to take responsibility to integrate sound information about IPV, available services, and safety strategies in their curricula, marketing materials, and public information messages.

- **Wide dissemination of this *Making Distinctions Guide* is needed to help promote discussion, debate and move these fields forward.** Participants at this conference were a selected group of invited experts. Their views and perspectives on these issues are not widely known or necessarily shared by their peers across the country. Furthermore, the findings and conclusions of this conference are preliminary. There is a need to learn more about different types of intimate partner violence and what different kinds of interventions could be helpful. Participants urged that this conference Guide should be widely disseminated on websites, and discussed and debated at meetings, conferences and technical assistance and training events among members of the healthy marriage and the domestic violence communities at all levels throughout the United States.

MRE/DV Partners: The Center for Urban Families Baltimore and the House of Ruth

The **Center for Urban Families** (CFUF) is an established responsible fatherhood program providing a range of employment-related, financial, parenting education and peer support services to low-income, non-custodial African-American fathers living in inner city Baltimore. In recent years, it has developed several curricula that offer relationship education to co-parenting partners, and to low-income families (both unmarried/married). It is a site for the *Building Strong Families* (BSF) federal program for low-income parents offering MRE, case management and ancillary services around the time of the birth of their child.

The **House of Ruth** is a large agency providing a comprehensive array of domestic violence services in the Baltimore metropolitan area, including an abuser intervention program for males.

These two agencies have a long history of collaboration. Their initial tasks included activities designed to dispel mutual stereotypes and build trust, followed by intensive staff training and other activities. They co-developed intake and screening protocol tools for the basic fatherhood programming and engaged in many cross referrals. They provide technical assistance to other fatherhood programs regarding DV issues.

Partnership Highlights:

- Both agencies are committed to working on how to engage with men who have a history of being violent and want to change in order to have healthy relationships with their partners and their children
- When CFUF first began to develop programs for couples—the co-parenting education program and couples-relationship education for fragile families—considerable effort went into working with the House of Ruth to redesign their DV protocols for couples-based programs
- Staff turnover at both agencies is a constant challenge. Periodic two-day DV training for staff is held to address needs of newly hired staff; quarterly meetings between the two agencies are held to plan how to meet new challenges
- The House of Ruth participates in curriculum sessions in the *Fatherhood and Families* program at CFUF which helps raise awareness about DV to the client base. This process helps them raise their profile in the community and alleviate some of the stigma associated with the House of Ruth, especially among men. One of the new initiatives being explored is having House of Ruth host program sessions at the CFUF site
- If DV is indicated in the BSF intake screening interview, since the House of Ruth also has services for men, it is the couple, not only the woman, who is referred for IPV services. A referral form is filled out and the DV liaison staff will confirm if the couple follows through
- House of Ruth liaison provides consultation on a case-by-case basis and can be available to talk to the victim and/or her partner on site or on the phone

References

Boggess, J., May, R. & Roulet, M. (2007). *Collaboration and Partnership Guidebook: Fatherhood Practitioners and Advocates Against Domestic Violence Working Together to Serve Women, Men and Families*. Center for Family Policy and Practice.

Boggess, J., May, R. & Roulet, M. (2007). *Collaboration and Partnership Guidebook: Fatherhood Practitioners and Advocates Against Domestic Violence Working Together to Serve Women, Men and Families.* Center for Family Policy and Practice.

Fals-Stewart, W., Kashdan, T.N., O'Farrell, T.J. & Birchler, G.R. (2002). Behavioral couples therapy for drug abusing patients: Effects on partner violence. *Journal of Substance Abuse Treatment*, 21,1-10.

Heyman, R.E. & Slep, A.M.S. (2006). Creating and field-testing diagnostic criteria for partner and child maltreatment. *Journal of Family Psychology,* Vol.20, No. 3. 307-408.

Holtzworth-Munroe, A. & Meehan J. C. (2004). Typologies of men who are maritally violent: Scientific and clinical implications. *Journal of Interpersonal Violence*, 18.

Holtzworth-Munroe, A., & Stuart, G.L. (1994). Typologies of male batterers: Three subtypes and the differences among them. *Psychological Bulletin*, 116 (3), 476-497.

Jacobson, N. & Gottman, J. (1998). *When Men Batter Women: New Insights Into Ending Abusive Relationships.* New York, NY. Simon & Schuster.

Johnson, M. P. (2006). Conflict and control: Gender symmetry and asymmetry in domestic violence. *Violence Against Women,* 12(11), 1-16.

Johnson M. P. (2006). *A Sociologist's Perspective on Domestic Violence*. Interview by Theodora Ooms. May 2006. Center for Law and Social Policy. Available at www.healthymarriageinfo.org.

Johnson, M.P. (2009a). Differentiating among types of domestic violence. In H.E. Peters & C.M.K. Dush (Eds.,), *Marriage and Family Perspectives and Complexities.* (pp282-297). New York, NY: Columbia University Press.

Johnson, M. P. (2009b). *Where do "domestic violence" statistics come from and why do they vary so much?* National Healthy Marriage Resource Center & National Resource Center on Domestic Violence. Available at http://www.healthymarriageinfo.org/docs/DomesticViolenceStatistics.pdf.

Johnson, M. P. & Ferraro, K. (2000). Research on domestic violence in the 1990s: Making distinctions. *Journal of Marriage and the Family*, 62, 948-963.

Johnson, M.P. (1995). Patriarchal terrorism and common couple violence: Two forms of violence against women. *Journal of Marriage and the Family*, 57(2), 283-294.

Kelly, K.B., & Johnson, M.P. (2008). Differentiation among types of intimate partner violence: Research update and implications for interventions. *Family Court Review,* 46(3), 476-499.

Kim, H. K., Laurent, H. K., Capaldi, D. M. & Feingold, A. (2008) Men's aggression towards women: A 10-year panel study. *Journal of Marriage and Family,* 70, 1169-1187.

Lyon, E., & Menard, A. (2008). Informing and Enhancing Response to Domestic Violence within Federally-Funded Healthy Marriage Projects. Prepared for Annie E. Casey Foundation. Available at http://www.healthymarriageinfo.org/docs/DVProtocolSummaryReport.pdf.

National Healthy Marriage Resource Center. (2010). *Male Victims of Domestic Violence: A Fact Sheet.* In press.

Menard, A. (2007). *Promoting Safety A Resource Packet for Marriage and Relationship Education and Program Administrators.* Available at http://www.healthymarriageinfo.org/about/domesticviolence.cfm.

Ooms, T., Boggess, J., Menard, A., Myrick, M., Roberts, P., Tweedie, J., & Wilson, P. (2006). *Building Bridges Between Healthy Marriage, Responsible Fatherhood, and Domestic Violence Programs*. Center for Law and Social Policy & National Conference of State Legislatures. Available at www.clasp.org.

Pence, E. & Das Gupta, S.D. (2006) *Re-Examining Battering: Are All Acts of Violence Against Intimate Partners the Same?* Praxis International. Available at www.vawnet.org.

Perilla, J. (2006). *A Community Psychologist's Perspective on Domestic Violence*. Interview by Theodora Ooms. May 2006. Center for Law and Social Policy. Available at www.healthymarriageinfo.org.

Stith, S. M., Rosen, K. H., McCollum, E. E. & Thomsen, C. J. (2004). Treating intimate partner violence within intact couple relationships: Outcomes of multi-couple versus individual couple therapy. *Journal of Marital and Family Therapy*, 30, 305-318.

Straus, M. A. & Gelles, R. J. (1990). Physical violence in American families: Risk factors and adaptations to violence in 8,145 families. New Brunswick, N.J.: Transaction Publishers.

Stuart, G. L., & Holtzworth-Munroe, A. (2006). Testing a theoretical model of the relationship between impulsivity, mediating variables, and marital violence. *Journal of Family Violence*, 20, 291-303.

Organizational Resources

ACF Office of Planning Research and Evaluation
http://www.acf.hhs.gov/programs/opre/

Alabama Coalition Against Domestic Violence (ACADV)
http://www.acadv.org/

Alabama Community Healthy Marriage Initiative (ACHMI)
http://www.alabamamarriage.org/

Building Strong Families (BSF)
http://www.buildingstrongfamilies.info/

Center for Urban Families (CFUF)
http://www.cfuf.org/

Domestic Abuse Intervention Programs, Duluth, MN
http://www.theduluthmodel.org/

Domestic Violence Enhanced Home Visitation Intervention (DOVE)
http://son.jhmi.edu/research/dove/

Family Expectations Program (FE)
http://www.familiesok.org/

Family Violence Prevention Fund
http://www.endabuse.org/

Harbor House of Central Florida
http://www.harborhousefl.com/

House of Ruth
http://www.hruth.org/

Kansas Coalition Against Sexual and Domestic Violence (KCSDV)
http://www.marriageforkeeps-ks.org/

Marriage for Keeps
http://www.marriageforkeeps-ks.org/

National Healthy Marriage Resource Center
http://www.healthymarriageinfo.org
http://www.twoofus.org

National Resource Center on Domestic Violence
http://www.nrcdv.org/

Oklahoma Coalition Against Domestic Violence and Sexual Assault
http://www.ocadvsa.org/

Oklahoma Marriage Initiative (OMI)
http://www.okmarriage.org/

Relationship Research Institute
http://www.rrinstitute.com/

Stop Abuse for Everyone (SAFE)
http://www.safe4all.org/

Supporting Healthy Marriage (SHM)
http://www.supportinghealthymarriage.org/

Texas Council on Family Violence (TCFV)
http://www.tcfv.org/

Twogether in Texas
http://www.twogetherintexas.org/

University of Central Florida Together Project
http://www.mfri.ucf.edu/together_project.php

YWCA Oklahoma City
http://ywcaokc.org/

Appendix A

Toward a Common Understanding: Domestic Violence Typologies and Implications for Healthy Marriage and Domestic Violence Programs.
Conference held on May 13-15, 2009, Airlie Conference Center, Warrenton VA.

Conference Participants

Francesca Adler-Baeder, Auburn University, AL
Kristin Anderson, Western Washington University, WA
Jacquelyn Boggess, Center for Family Policy and Practice, WI
Jacquelyn Campbell, Johns Hopkins University School of Nursing, MD
Esha Clearfield, Texas Council on Family Violence, TX
Cassandra Codes-Johnson, Center for Urban Families, MD
Kendy Cox, Oklahoma Marriage Initiative/Public Strategies, OK
Andrew Daire, University of Central Florida, FL
Yolanda Deines, El Paso Center for Children, TX
Rachel Derrington, National Healthy Marriage Resource Center, CO
Robin Dion, Mathematica Policy Research, Inc. Washington, DC
Carol Gundlach, Alabama Coalition Against Domestic Violence, AL
Jean Henningsen, Annie E. Casey Foundation, MD
Richard Heyman, Stonybrook University, State University of New York, NY
Ellen Holman, National Healthy Marriage Resource Center, OK
Michael Johnson, Penn State University, PA
Marylouise Kelley, Family Violence Prevention & Services Program, DHHS, Washington DC
Stacey Mann, Kansas Coalition Against Sexual & Domestic Violence, KS
Robin McDonald, Office of Family Assistance, DHHS, Washington DC
Anne Menard, National Resource Center on Domestic Violence, PA
Mary Myrick, National Healthy Marriage Resource Center, OK
Cyndee Odom, PAIRS, FL
Theodora Ooms, National Healthy Marriage Resource Center**,** MD
Patrick Patterson, National Healthy Marriage Resource Center, DE
Marline Pearson, Madison Area Technical College, WI
Janet Peery, YWCA of Oklahoma City, OK
Johnny Rice II, Maryland Department of Human Resources, MD
Julie Ann Rivers - Cochran, Florida Coalition Against Domestic Violence, FL
Maggie Russell, Family Services of Greater Houston, TX
Erin Simile, Family Wellness Associates, CA
Rozario Slack, Black Marriage Publications, TN
Beth Stanford, University of Denver, CO
Scott Stanley, University of Denver, CO
Carole Thompson, Annie E. Casey Foundation, MD
Michele Walters, Office of Family Assistance, DHHS Washington, DC
Joyce Webb, Kansas Healthy Marriage Institute, KS
Kelly White, Family Expectations, OK

Appendix B

To: Those Who Wish to Use PREP's Self-Referral Document

From: PREP, Inc (7/7/04)

Subject: Referral tool to be used as a handout for your workshop participants

One of the important opportunities that can grow out of you marital education efforts is that those attending can learn of other resources that may help participants in their desires to live happier, healthier, and more effective lives.

At PREP, we do *not* assume that all of what a couple or individual may need is included in our curriculum, nor is it included in any other. Some people you see in your workshops may benefit from any number of other services that are beyond the scope of your particular relationship education class. For example, an attendee may have a substance abuse problem, suffer from clinical depression, or may be involved in a pattern of domestic violence. These are very complex clinical issues that are subject areas beyond the scope of the educational program.

The simple fact is there will likely be some people in your audience who could use more help in any number of areas of which you may not be aware. For this reason, we have crafted a generic referral document for your use. **We advise you to add relevant local referral information by stapling local and state contact information for your region to this handout. The "Getting More Help…" form from PREP, Inc. itself is not to be changed or modified in any way for any use. You may use it as is, however, in your work.**

We think it is important that you stress to your audience that each person receives this document with a message that you distribute it because some people in group might find it useful to seek some further or more intense help in some area of concern or struggle. By doing this, you give everyone who attends some very basic information about situations where further help might be needed, and how they might seek these services in your community. The key is not to single anybody out but to increase awareness of resources for everyone.

Instructions (to You, the workshop leaders) for use:

1. We recommended that you hand this out (***the next two pages, NOT this page***) to all participants in the first session, and make it clear that this is routine. You will need to make copies for your participants using the version you have been given.

2. We recommend that you look into what services are available in your community and list the resource name and contact information where indicated. Some examples might be; a) county mental health centers; b) the county health department; c) county extension services; d) local domestic violence resources; or e) private counseling centers that specialize in couples therapy. If you include religiously linked services, please note the affiliation as part of the information so your participants will have information about who they were calling if they chose to do so.

3. Attach your list of local resources to the unaltered document from PREP, Inc.

We hope that you will find this tool useful to you in your work. We are confident that helping people seek other services when needed is one of the most powerful things you can do to help families in your communities.

Sample Handout for MRE Programs

Getting More Help When There Are Serious Problems

The workshop you are taking is an educational program that teaches you skills and principles that can help you build strong and healthy marriages, and couple or family relationships. However, it is not designed to address serious relationship and individual problems.
Since you are taking this time to think more about your life and relationships, it may also be a good time to think about other services that you or others you care about may need. **We provide this sheet of information to ALL couples and individuals in these workshops so that you will be aware of other available services.**

Even if your main goal right now is to improve your marriage or relationship, difficulties in other areas could make it that much harder to make your relationship work. Likewise, if you are having really severe problems in your relationships, it can make dealing with any of these other problems that much harder.

The good news is that participating in this workshop can be a gateway to getting other services. It can provide you with awareness, motivation and tools to help you take other steps to improve your life. Here are some areas where seeking additional help could be really important for you and your family.

Financial Problems

- Serious money problems make everything else harder.
- Unemployment/job loss can be one of the key sources of conflict and stress for couples.
- While this workshop can help you as a couple to work more as a team, you may need more help to learn to manage your finances or find a job.

Serious Marital or Other Family Problems or Stresses

- If you have serious marital or adult relationship problems where more help is needed than can be provided in this educational workshop, you can seek counseling from someone who specializes in helping couples.
- Coping with a serious, life threatening or chronic illness or disability in a child or adult can place a lot of stress on caregivers and their family relationships. Community resources often exist to help families with these kinds of issues.

Substance Abuse, Addictions and Other Compulsive Behaviors

- No matter what else you have to deal with in life, it will be harder if you or your partner, or another close family member, has a substance abuse problem.
- Drug or alcohol abuse and addiction robs a person of the ability to handle life well, have close relationships, and be a good parent.
- Alcohol abuse can also make it harder to control anger and violence.
- Other problems families sometimes face include eating disorders, sexual addictions, and gambling.

You need to decide to get help with these problems to make your life better and the life of those you love. It will make it easier if your partner or spouse supports this decision.

Mental Health Problems

- Mental health problems come in many forms, from anxiety to depression to schizophrenia, and place a great deal of stress on couple and family relationships.
- Depression is particularly common when there are serious relationship problems.
- Having thoughts of suicide is often a sign of depression. Seek help if you struggle with such thoughts.

The good news is that there are now many effective treatments for mental health problems with services available in all counties, including options for those with less means to pay.

Domestic Aggression and Violence

- While domestic violence can take many forms, *the key is doing whatever is needed to make sure you and your children are safe.*
- While domestic aggression and violence of any sort is wrong and dangerous, experts now recognize different types, for example:
    - Some couples have arguments that get out of control, with frustration spilling over into pushing, shoving or slapping. This can be dangerous, especially if you don't take strong measures to stop the patterns from continuing.
    - The type of domestic violence that is usually the most dangerous of all and least likely to change is when a male uses aggression and force to scare and control a woman. Verbal abuse, threats of harm, and/or forced sexual activity can be part of this pattern.
- This workshop/program is not a treatment program for physical aggression. If you are dealing with aggression and violence in your relationship, you need more help than what can be offered in this program. That might mean seeking marital or relationship counseling or seeking the advice of domestic violence experts.
- If you have any questions about the safety of your relationship, you should contact a domestic violence program or hot line, especially if you feel like you are in danger of being harmed.

The bottom line is doing what you need to do to assure that you and your children are safe. If you ever feel you are in immediate danger from your partner or others, call 911 for help or contact your Domestic Violence hot line.

Where Can We Get More Help?

If you, your partner, or your relationship experiences any of these special problems, we strongly recommend that you get more help.

Your workshop leaders may have attached additional contact information for some resources in your area. You can also ask your leaders directly (in person or by phone) if you would like any other suggestions.

National Resources:

A national domestic violence hotline: SAFELINE 1-800-799-7233

A national website with links for help with substance abuse and mental health issues: www.samhsa.gov/public/look_frame.html

A national hotline for referrals to substance abuse treatment: 1-800-662-HELP

A national hotline for suicide prevention: National Hopeline Network 1-800-SUICIDE (784-2433)

Local Resources To Consider:

There are community mental health centers in all areas of the U.S. Other counseling centers and mental health professionals are often available as well (both non-religious and religious). Also, both clergy and family physicians are usually well aware of resources for various needs in their communities, so consider asking them for suggestions.

This handout was produced and is distributed by PREP, Inc. Input was provided by the Oklahoma Marriage Initiative along with Scott Stanley, Howard Markman, Theodora Ooms, Natalie Jenkins, and Bruce Carruth. Special thanks to both Marcia Smith, the executive director of the Oklahoma Coalition Against Domestic Violence and Sexual Assault, for her feedback and recommendations, and to Larry Didier, Prevention Programs Coordinator for the Oklahoma Department of Mental Health and Substance Abuse Services.

Appendix C

Sample Poster for Ladies Room

from the National Domestic Violence Hotline
http://www.ndvh.org/resources/resource-download-center/

Quiz:

How is your relationship?

Does your partner:

- ❑ Embarrass you with bad names and put-downs?
- ❑ Look at you or act in ways that scare you?
- ❑ Control what you do, who you see or talk to, or where you go?
- ❑ Stop you from seeing or talking to friends or family?
- ❑ Take your money or Social Security, make you ask for money, or refuse to give you money?
- ❑ Make all the decisions?
- ❑ Tell you you're a bad parent or threaten to take away or hurt your children?
- ❑ Act like the abuse is no big deal, it's your fault, or even deny doing it?
- ❑ Destroy your property or threaten to kill your pets?
- ❑ Intimidate you with guns, knives or other weapons?
- ❑ Shove you, slap you or hit you?
- ❑ Force you to drop charges?
- ❑ Threaten to commit suicide?
- ❑ Threaten to kill you?

**If you checked even one,
you may be in an abusive relationship.
If you need to talk, call us.**

1-800-799-7233 (SAFE)

1-800-787-3224 (TTY FOR THE DEAF)

**Options • Connections • Support • Free • Anonymous
Confidential • 24 Hours a Day • Se Habla Español**

National Domestic Violence HOTLINE

Te has preguntado:

¿Cómo está la relación con mi pareja?

Tu pareja:

- ❑ ¿Te averguenza con insultos y humillaciones?
- ❑ ¿Te da miradas o acutúa de tal manera que te da miedo?
- ❑ ¿Controla lo que haces, con quien hablas, a quién ves o a donde vás?
- ❑ ¿No te permite que hables o visites amigos o parientes?
- ❑ ¿No te permite conseguir o tener un trabajo?
- ❑ ¿Te quita tu dinero o seguro social, hace que le pidas dinero o te niega darte dinero?
- ❑ ¿Hace todos las decisiones?
- ❑ ¿Te dice que eres mala madre y te amenaza con quitarte tus hijos?
- ❑ ¿ Actúa como que no hay abuso, que la culpa es tuya o niega que lo hizo?
- ❑ ¿Te destruye tus pertenencias o te amenaza con lastimar a tus mascotas?
- ❑ ¿Te amenaza con pistolas, cuchillos o otras armas?
- ❑ ¿Te trata con empujones, cachetadas o te golpéa?
- ❑ ¿Te obliga a retirar cargos criminales en su contra?
- ❑ ¿Te amenaza con suicidarse si le abandonas?
- ❑ ¿Te amenza con matarte?

**Si contestaste "Si" a tan sólo una pregunta,
puedes estar en una relación abusiva.
Llama gratis, es confidencial.**

1-800-799-7233

1-800-787-3224 (TTY PARA LOS SORDOS)

**Opciones • Apoyo • Contactos
Te atenderemos en español las 24 horas del dia.**

Línea Nacional sobre la Violencia Doméstica
National Domestic Violence HOTLINE

The Annie E. Casey Foundation

nrcdv
National Resource Center on Domestic Violence

national healthy marriage resource center

10530 Rosehaven St., Suite 400, Fairfax, VA 22030-2840
(866) 916-4672 or 866-91-NHMRC

The National Healthy Marriage Resource Center (NHMRC) is a clearinghouse for high quality, balanced, and timely information and resources on healthy marriage. The NHMRC's mission is to be a first stop for information, resources, and training on healthy marriage for experts, researchers, policymakers, media, marriage educators, couples and individuals, program providers, and others.

Funding for this project was provided by the United States Department of Health and Human Services, Administration for Children and Families, Grant: 90-FH-0001. Any opinions, findings, and conclusions or recommendations expressed in this material are those of the author(s) and do not necessarily reflect the views of the United States Department of Health and Human Services, Administration for Children and Families.