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Author: Jennifer Grotpeter, Scott Menard, Danielle Gianola

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**INTIMATE PARTNER VIOLENCE: JUSTICE SYSTEM RESPONSE AND PUBLIC
HEALTH SERVICE UTILIZATION IN A NATIONAL SAMPLE
NIJ Grant # 2006-WG-BX-0003**

FINAL REPORT DRAFT

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Jennifer Grotmeter
Scott Menard
Danielle Gianola

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EXECUTIVE SUMMARY

Intimate partner violence (IPV) affects over one and a half million women each year (Tjaden & Thoennes, 2000). Although this issue was historically shrouded in secrecy, public attention to the problem emerged in the early 1970s. Since that time, research has focused on a number of issues and questions, including evaluating the extent of the problem, identifying the antecedents and consequences and developing theoretical models of the causes of IPV, and more recently, developing effective prevention and treatment programs, including how the justice and victim services systems respond to the problem.

Although there is clear indication that the criminal justice and public health systems recognize and are targeting the problems of IPV, yet to be adequately determined are the extent to which these resources are accessible and utilized by all IPV victims and perpetrators, whether a satisfactory outcome occurs, and whether available resources are effective at preventing IPV.

Between the mid-1980s and 2000, a number of new policies and practices involving law enforcement and the criminal justice system were enacted to protect victims of IPV. However, there is little consensus as to the effectiveness of these interventions which include mandatory arrest of offenders. Even less information is available about prosecution and court response. Of particular concern, problems exist with the use of police and court records to document recidivism, since a fairly high proportion of repeat incidents are not reported to the criminal justice system.

The public health system also engages in many forms of community-based advocacy for victims of IPV, but most evidence of the effectiveness of these interventions is anecdotal or based on non-representative samples. There is some information in the National Violence Against Women Survey (Tjaden & Thoennes, 2000) regarding use of medical services that indicated the prevalence of service utilization, but little is known about the characteristics of victims and batterers who seek help and the conditions under which the help is sought.

Because the focus of public health system services in this report is on agencies to which IPV victims and perpetrators may go to seek help (such as safe houses, clergy, and the police), and not on broader public health issues, we will refer to health, mental health, and social services, as appropriate.

The Current Study: Research Objectives

The research conducted here was designed to fill in some of the gaps from previous studies and add new knowledge about criminal justice system and mental health and social service resources used by victims and perpetrators of IPV.

Using a longitudinal, multigenerational, national probability sample (the National Youth Survey Family Study—NYSFS), we identified the resources that victims and perpetrators of IPV use to cope with and resolve IPV (including law enforcement), examined victim and offender characteristics and the conditions under which they utilized these resources, and determined their

satisfaction with the resources, and whether resource utilization was associated with reduced IPV in subsequent years.

The NYSFS provides information for both relatively minor and serious male and female IPV victims, as well as perpetrators. The advantages of the NYSFS include: (1) a large national sample, thus avoiding the use of only select subsamples; (2) information about male and female victims and perpetrators (often for both male and female married or cohabitation partners); (3) law enforcement data; (4) information on a wider range of community services than typically available in studies, and (5) information on IPV and help-seeking behavior in two generations.

- *Objective 1: Perpetration: Examine the prevalence of perpetration of different forms of IPV. Determine the prevalence of arrest and whether perpetrator arrest results in a differential outcome.* We examined the differences between those IPV perpetrators who were arrested and those who were not.
- *Objective 2: Victimization: Examine the prevalence of victimization by different forms of IPV. Determine the prevalence of calling the police and whether calling the police results in a differential outcome.* We compared victimization by IPV over time for those who call the police and seek other help (e.g., safehouses, therapists, clergy) and those who do not. We assessed the relationship between IPV and help-seeking from law enforcement in the original respondents and IPV and this help-seeking behavior in children's relationships with intimate partners.
- *Objective 3: Use of Public Health Services.* (A) We examined the utilization rates of informal resources and formal community resources for identified victims and perpetrators and for demographic subgroups, arrest status, and victims who report to the police vs. non-reporters. (B) We examined whether the services were deemed helpful by the victims and compare the current rates of IPV with the rates in subsequent years by use of any resource and by specific type of resource used. (C) We investigated under what conditions resource utilization reduced, increased, or had no effect on future IPV. (D) We compared IPV resource utilizers with IPV non-resource utilizers to assess potential differences by demographic, sociocultural and behavioral variables and whether service utilization had a differential impact in these two groups on future IPV. (E) We determined whether IPV victims and perpetrators were more or less likely to use health and social services than the general population by examining resource utilization prevalence rates for those who reported IPV and those who did not. (F) We determined whether help-seeking among the original respondents is related to their children's IPV and help-seeking behaviors.
- *Objective 4: Unmet Needs.* To understand the extent of unmet needs of victims/perpetrators who were arrested or who were using public health system resources for problems other than IPV, we examined the prevalence of IPV victims/perpetrators (in the total IPV population, by demographic subgroups, and by those with mental health diagnoses) who sought help for problems *other than IPV* in the health and social services systems, but did not seek help for IPV.

The Current Dataset

The current dataset includes the six most recent waves of the National Youth Survey Family Study (NYSFS), a longitudinal, prospective study of multiple birth cohorts who were aged 11-17 when first examined in 1976. Additionally, the parents and spouses of these original respondents were invited to participate in separate interviews. Finally, all of the original respondents' children who were aged eighteen and older were invited to participate in two waves of data collection.

Subjects

- *Original respondents.* Of the 1,550 members of the active sample, we were able to interview 1,263 or 81% in wave 10 and 1,171 or 76% in wave 11. Of the total number of original participants, this resulted in rates of 73% and 68% in waves 10 and 11, respectively.
- *Spouses/partners.* In wave 11, we interviewed 843 spouses/partners, which was 87.7% of known spouses/partners.
- *Parents.* In wave 11, we interviewed 872 parents, which was 70% of the known parents.
- *Offspring of the original respondents.* In wave 11, we interviewed 453 children of the original respondents who were aged 18 and older. Including the children aged 11 to 17 interviewed, 71.6% of the known children were interviewed in wave 11. In wave 12, we interviewed only the children of the original respondents. In wave 12, we were able to interview 595 of the adult children. Including the children aged 11 to 17, 74% of the known children were interviewed in wave 12.

Measurement

The NYSFS historically has tapped a very broad domain of sociodemographic, social psychological, attitudinal, and behavioral data as exemplified in publications dealing with causes, correlates, and epidemiological patterns of crime, domestic and nondomestic violence perpetration and victimization, alcohol and illicit drug use and problem use, mental health problems, and sexual behavior (see Elliott, et al., 1989). Though the NYSFS has been used with respondents aged 11 and older, only those respondents aged 18 and older were asked questions about IPV.

- *Intimate Partner Violence (IPV).* IPV was measured using three instruments, the Self-Report of Delinquency (SRD; Elliott, et al., 1989), Self-Report of Victimization (SRV; Menard, 2000; Menard & Huizinga, 2001; Menard, 2002), and the Conflict Tactics Scale (Straus, 1979; Straus & Gelles, 1990). Perpetration of IPV was measured using the SRD and the CTS, whereas victimization was measured using the SRV and the CTS.
- *Justice System Response.* Self-report data on arrest were available for the original respondents and their adult children. There are several sources of self-report information about arrest and the justice system processing for IPV offenses contained in the NYSFS

interview schedules, most available from wave Six (1983) to wave 11 (2002). These include information on arrest and justice system processing that is included in each NYSFS interview schedule, information about police contact in a separate section of the schedules on IPV victimization and offending, information from a victimization section that included identification of IPV and whether incidents were reported to the police, and information about arrests within the SRD section of the interview schedules.

- *Health and Social Services Help-Seeking Variables.* Responses to two measures were examined. The first asked whether the respondent or their spouse ever contacted specific sources (e.g., police, safehouse/shelter, social service agency, clergy, therapist, friends, relatives, etc.) as a result of their disagreements and IPV. The second was a series of questions that asked respondents to indicate whether they have sought help for problems with mental health in the past year; responses were used to measure respondents' seeking of help for mental health issues possibly related to IPV and for issues broader than IPV.
- *Demographic and sociocultural variables.* A variety of sociodemographic variables have been assessed for all categories of NYSFS respondents (i.e., original respondents, parents of original respondents, and adult children of original respondents). In addition to sex, race/ethnicity, and age, data are available for each wave on occupational status (Duncan SEI), educational attainment, marital status, and whether or not they have children, and whether the respondent lives in an urban, suburban, or rural area. Additional information available for most waves is residential stability and the degree of social disorganization in their neighborhood.

Results

Objective 1: Perpetration

- Perpetration of IPV among the original respondents increased steadily from ages 18 to 24 to a peak in the tenth wave, ages 36 to 42. The highest rates reported were by the parents of the original respondents, who were asked to recall IPV over their lifetime rather than just in the previous year. The adult offspring reported similar rates of IPV as their parents' reports at the same age.
- Verbal, Psychological, and Relational Aggression reported among the original respondents (93% of the sample) was related to: being female, not being African-American (i.e., being white or of another ethnicity), being married, not living in a rural area, having lower occupational status, and having fewer neighborhood social disorganization problems.
- Aggression, Threat of Violence, and Less Serious Violence reported among the original respondents (53% of the sample) was related to: being female, being African-American, not being married, not having children, living in an urban area, completing a lower grade in school, and having a lower status occupation.

- Serious Violence reported among the original respondents (22% of the sample) was related to: being female, being African-American, not being married, living in an urban area, having completed a lower grade in school, and having lower occupational status. Among spouses, it was also related to living in a suburban area, and among spouses and adult offspring, serious violence was related to a greater number of neighborhood social disorganization problems.
- A small number of original respondents reported being arrested for IPV (2%), and about a third of those reported being convicted of domestic violence.

Objective 2: Victimization

- Victimization by IPV among the original respondents increased steadily from ages 18-24 to a peak at wave 10, ages 36-42. The highest rates reported were by the parents, who were asked to recall IPV over their lifetime rather than just in the previous year. The adult offspring reported similar rates of IPV as did their parents at the same age.
- Victimization by Verbal, Psychological, and Relational Aggression among the original respondents (92% of the sample) was related to: being female, being White, being married, having children, living in an urban area, having completed a lower grade in school, and having a lower status occupation. Among adult offspring, living in a rural area was related to this form of IPV, and among spouses of the original respondents, living in a suburban area was related to this form of IPV.
- Victimization by Aggression, Threat of Violence, and Less Serious Violence among the original respondents (53% of the sample) was related to: being male, being African-American, not being married, not having children, living in an urban area, completing a lower grade in school, and having lower occupational status.
- Victimization by Serious Violence among the original respondents (28% of the sample) was related to: being male, being African-American, not having children, living in an urban setting, completing a lower grade in school, and having lower occupational status. Among the adult offspring, this type of victimization was related *not* living in an urban setting and having more neighborhood social disorganization problems.
- The most frequently contacted sources of help for IPV among original respondent victims and also their adult offspring, were friends and family, then therapists, then clergy, and then the police, and the percentages who contact these sources increased with the severity of the IPV.
- When victims of verbal, psychological, and relational aggression contacted the police, they tended to report being victims of the same type of aggression and of serious violence in the following year.
- Victims reported reasons for not contacting the police included fear of reprisal by the offender, that it was not important enough, and that it was a private matter. Reasons cited

for calling the police included to get help, to prevent recurrence by the offender, and to punish the offender.

Objective 3: Use of Public Health Services

- The most frequently sought services were informal resources of friends and family, as well as somewhat more formal services such as self-help groups, as well as clergy, therapists, and medical doctors.
- We next examined the resources that IPV victims and perpetrators used, but that they did not indicate they were using the resources to help with IPV. Women were more likely than men to seek out the help of friends and family, therapists, medical doctors, and self-help groups. Males were more likely than women to seek Non-IPV help at alcohol clinics and drug clinics.
- When we considered perpetrators who had been arrested for IPV compared with those who had not been arrested, perpetrators reported seeking out help from another person and social service agencies.
- When we considered the non-IPV resource utilization of IPV victims who reported the IPV to the police compared with those who did not, we found that victims who called the police were most likely to seek out non-IPV help with therapists, medical doctors, emergency rooms, social services, and inpatient admission to a hospital.
- Service utilization not specifically related to IPV, whether in general or a specific type, formal or informal, was rarely related to decreases in future IPV.
- Females and urban residents were more likely than males and rural residents to access mental health and social services.
- For both verbal, psychological, and relational aggression, and aggression, threat of violence and less serious violence, service utilization significantly predicted later victimization, but not in the direction that would be expected – service utilization was related to increased victimization. For serious violence, service utilization was not statistically significant, predicting neither more or less later victimization.
- Both perpetrators and victims were more likely to contact social services for mental health issues than were non-perpetrators and non-victims.
- There was no evidence in this sample for an intergenerational relationship between IPV perpetration or victimization, or for seeking help from formal or informal services between the original respondent generation and their children's generation.

Objective 4: Unmet Needs

- Results indicated that those males who were depressed and suffered from injury at the hands of their spouses and partners may either not be finding the help for IPV that they need, or they may be unwilling to acknowledge that their problems are related to IPV and have been treating other symptoms instead.
- Similar to the victims, when it appears that perpetrators are also seeking help for non-IPV related issues, and that this occurs more frequently in female depressed individuals who, despite being perpetrators, also sustained injury at the hands of their spouses or partners.

Discussion and Implications for Policy

The finding in this report that may be most surprising to some is that for each kind of IPV studied, females were more likely than males to report being perpetrators, and for the two physical forms of IPV studied here, males were more likely than females to report being victims. This result has been found in prior analyses of NYS data (e.g., Mihalic & Elliott, 1997), and has previously been discussed as supportive of the theory that women may hit men more often, but that men may hit harder and do more damage, which is supported in the result that women report more injuries than do males. Perhaps most interesting in this report on a descriptive level is that sociodemographic profiles for perpetrators and victims differed by the specific types of IPV that were studied here: (1) verbal, psychological, and relational aggression; (2) aggression, threat of violence, and less serious violence; and (3) serious violence. However, evidence from this large, multigenerational sample did not support intergenerational transmission of IPV, whether from the parent to original respondent generations or the original respondent to their children generations.

The reasons that victims reported for both contacting and declining to contact the police were consistent with past research and work with victims, that victims (reasonably) fear reprisal from their attackers and that they believe the police cannot or will not do anything about the IPV. Further analysis revealed that contacting the police after IPV was not related to a reduction in IPV in the following year. Further, beyond contacting the police, victims reported making use of a wide variety of mental health and social services, and that they reported feeling that these services were helpful. Though analysis of the data longitudinally indicated that use of these services were generally not related to a reduction in IPV in following years, the available data were not sufficiently specific enough about IPV to draw strong conclusions.

When we sought to analyze unmet needs, we found that there were a significant number of respondents who reported either perpetrating or being victimized by IPV, and who sought help from the health and social services system, but did not specify that these services were for IPV, and as was found earlier, these non-IPV-specific services did not result in lower levels of IPV in later years. As such, there seem to be two main types of unmet needs of which the practitioner community should be aware: (1) those who are IPV victims and perpetrators who seek help specifically for IPV, but do not find the help they need; and (2) those who may be victims of IPV but are seeking help through other social services, and are not receiving effective help for the IPV in their relationships.

INTRODUCTION

Intimate partner violence (IPV) is a well-identified public health issue affecting over one and a half million women each year (Tjaden & Thoennes, 2000). Although this issue was often shrouded in secrecy prior to the 1970s, public attention to the problem emerged in the early 1970s. Over time, research has focused on a number of issues and questions (Gelles, 1990). The first question that merited attention was to determine the extent of the problem. The first national study of violence in American homes was the National Family Violence Survey in 1976 (Straus, et al., 1980). Estimates of the prevalence of intimate partner violence confirmed the public health issue that previously had been identified using data from clinical and shelter samples and criminal justice studies (Mihalic & Elliott, 1997). Studies then turned to identifying the antecedents and consequences and developing theoretical models of the causes of IPV (Crowell & Burgess, 1996; Straus & Gelles, 1990; Yllo & Bograd, 1988). More recently, the trend of research has focused on effective prevention and treatment programs, including how the justice and victim services systems respond to the problem (Buzawa & Buzawa, 1990; Chalk & King, 1998).

Although there is clear indication that the criminal justice and public health system are recognizing and targeting the problems of IPV, the extent to which these resources are accessible and utilized by all IPV victims and perpetrators, whether a satisfactory outcome occurs, and whether available resources are effective at preventing IPV has not been adequately determined. Between the mid-1980s and 2000, a number of new policies and practices involving law enforcement and the criminal justice system were enacted to protect victims of IPV. However, there is little consensus as to the effectiveness of these interventions. The nationwide movement toward arrest began after a study in Minneapolis produced some promising results (Sherman & Berk, 1984). Subsequent replications in five communities sponsored by NIJ failed to show that arrest was the panacea originally believed (for review, see Dutton & Corvo, 2006). The varying and inconsistent results found in these studies suggest that the efficacy of criminal justice sanctions may have more to do with the characteristics of the offender receiving the sanction (Dutton & Corvo, 2006; Jordan, 2004). Less information is available about prosecution and court response (Jordan, 2004). Of particular concern, problems exist with the use of police and court records to document recidivism, since a fairly high proportion of repeat incidents are not reported to the criminal justice system.

The public health system also engages in many forms of community-based advocacy for victims of IPV, but most evidence of the effectiveness of these interventions is anecdotal or based on non-representative samples. There is some information in the National Violence Against Women Survey (Tjaden & Thoennes, 2000) regarding use of medical services that indicated the prevalence of service utilization, but little is known about the characteristics of victims and batterers who seek help and the conditions under which the help is sought. Research on intervention programs is not promising (Dutton & Corvo, 2006), and there are methodological issues with most of these studies.

The intent of the research conducted here was to fill in some of the gaps from previous studies and add new knowledge about criminal justice and public health response system resources used by victims and perpetrators of IPV. Using a longitudinal, multigenerational,

national probability sample (the National Youth Survey Family Study—NYSFS), we sought to identify the resources that victims and perpetrators of IPV use to cope with and resolve IPV (including law enforcement), to examine victim and offender characteristics and the conditions under which they utilize these resources, and to determine their satisfaction with the resources, and whether resource utilization was associated with reduced IPV in subsequent years. The use of the NYSFS overcomes many of the problems that exist in prior studies that were only able to provide information on resource utilization among special populations (such as clinic and shelter samples) and usually focused only on the victim. The NYSFS provides information for both serious and less serious male and female IPV victims, as well as perpetrators. The advantages of the NYSFS include: (1) a large national sample, thus avoiding the use of only select subsamples; (2) information about male and female victims and perpetrators; (3) self-report law enforcement data; (4) information on a wider range of community services than typically available in studies, and (5) information on IPV and help-seeking behavior in two generations.

The ultimate goal was to determine to what extent criminal justice and public health resources such as arrest, calling the police after an incident, social services or informal contacts (i.e., social support network) were being used and were effective in reducing or eliminating future IPV. A secondary goal was to identify the factors that influence help-seeking by victims and perpetrators of IPV. The study focused on six waves of data from various subgroups to determine whether resource utilization, satisfaction, and outcome was different among IPV victims and perpetrators among various ethnic, racial, socioeconomic, educational, and urban/suburban/rural groups, as well as those who lived in socially disorganized neighborhoods. Analyses were also designed to test the theory that stake in conformity as illustrated by age, occupational status, marriage, children, and residential stability, could help explain when criminal justice or health and social service resources are effective in reducing subsequent IPV. The use of intergenerational data provides information on how the IPV behaviors and help-seeking behaviors of the original respondents' generation is related to their children's IPV and help-seeking behaviors.

Literature Review

In 2001, there were 691,710 nonfatal violent victimizations committed by intimate partners (i.e., current or former spouses, boy/girlfriends). About 85% of these victimizations by intimate partners were against women. Although this number is high, the rate of intimate violence against females declined by nearly half between 1993 and 2001, and fell 42% for males during the same time period (BJS, 2003). The declining trend suggests that public awareness campaigns and the creation of criminal justice and public health system resources to respond to the problem may have been successful, although the research evidence is not conclusive as to what interventions and resources have been most effective in reducing IPV.

Criminal Justice System

The influence of criminal justice sanctions on IPV recidivism is grounded in deterrence theory which postulates that pro-arrest laws act as a general deterrence mechanism and individual arrest and prosecution as a specific deterrent. Deterrence must be perceived as severe and certain to be effective (Paternoster et al., 1997; Klepper & Nagin, 1989). Although a great

deal of money has been invested in criminal justice to reduce violence against women, we know little about the impact of these investments (Parmley, 2004). Court-mandated batterer intervention programs have proliferated since 1980, although most experiments fail to demonstrate their effectiveness, or results are, at best, mixed (for a review of research, see Davis & Taylor, 1999; Saunders & Hamill, 2000). The prevailing criminal justice model, the Duluth model, is based on feminist theory assumptions of power and control as being an exclusively male problem. Despite lack of scientific support, treatment based on the Duluth model is mandated in most states (for a review of research, see Dutton & Corvo, in press; Jackson et al., 2003).

A significant body of research exists that examines the response of police in incidents of domestic violence. Prior to the reform movement in the 1970s, which recognized intimate partner violence, the criminal justice response to family violence was restoring order, and arrests were rarely made. Between the mid-1980s and 2000, a variety of new policies and practices designed to respond to victimization were instituted in law enforcement agencies and criminal and civil courts. Urban police departments began adopting a mandatory arrest policy when called to domestic disputes after an early experiment in Minneapolis (Sherman & Berk, 1984) showed promising results. With a strong endorsement by the federal Violence Against Women Act of 1994, the policy became institutionalized in many police departments despite methodological problems in the original study and inconsistent findings from experiments in five other jurisdictions (NIJ's Spouse Assault Replication Program). Reanalysis of pooled data across the replication sites (Garner, Fagan, & Maxwell, 1995; Garner & Maxwell, 2000) showed that prevalence and frequency of offending was less in the arrested group than the non-arrest group when victim reports were used, but not significant when official arrest data were used. Even with victim interviews, the effect sizes were moderate and results indicated that individual characteristics were more important in generating cessation than arrest, and cessation also occurred independent of arrest (i.e., trend of cessation held for both the arrest and non-arrest groups). Even though 21 states and the District of Columbia have made arrest mandatory when the officer determines that probable cause exists, the evidence for a positive impact of arrest is small and in some cases arrest escalates violence (Dutton & Corvo, 2006). One factor that did influence offender behavior subsequent to arrest was being employed, i.e., having something to lose by being arrested (Sherman et al., 1992).

There are significant challenges that prevent a person from using the justice system as a means of support when involved in IPV. Courts are adversarial by nature, and sometimes confusing and slow. Victims often feel that nothing may be accomplished and often fear social stigma and retaliation by the offender (Jordan, 2004). Data from the National Crime Victimization Survey (Jasinski, 2003) indicate that police were called in nearly half of IPV incidents (47%) in which the victim was female and the offender was male, and arrests were made in one-third of the incidents. Nearly half of the incidents occurred among victims whose household income was less than \$15,000. In more than half, the victims indicated that the offender was under the influence of either drugs or alcohol. One-time IPV was more likely to be reported to the police than recurring IPV. Police were more likely to be called if the offender was African American. Use of a weapon and injury also significantly increased the likelihood that the police would be called. None of the characteristics of the victim, offender, or the incident were significantly associated with the police decision to arrest. An examination of the National Crime

Victimization data between 1998 and 2002 show that among both males and females that 62% of IPV committed by a spouse is reported to the police, spousal violence is more likely to be reported than violence against a boyfriend or girlfriend, females are more likely to report than males (also see Stets & Straus, 1992), victims of races other than White more likely to report (also see Bachman & Coker, 1995), and an arrest was made in about one-third of the cases reported to the police (BJS, 2005). The most common reasons for not reporting were that the incident was a private matter (23%), the incident was reported to some other official (20%), or the incident was not important enough (16%).

The National Violence Against Women Survey show lower rates of reporting to the police with only 17% of the women who were raped and 27% of the women who were physically assaulted reporting their victimization to the police (Tjaden & Thoennes, 2000). The reasons for not reporting included a feeling that the police could not do anything about the victimization or would not believe them, not wanting the police or courts involved in a private matter, believing the incident was minor or a one-time event, and fear of the perpetrator. Only about 7% of women who were raped and assaulted by their partners said their perpetrator was criminally prosecuted, and less than half of those were convicted.

Other studies have shown that cohabiting individuals are more likely than married individuals to call the police (Hutchison et al., 1994), severity and frequency of violence are associated with police contact (Johnson, 1990), and arrests are more likely in lower class neighborhoods (Friday et al., 1991; Smith, 1987).

Studies of prosecution have shown little effect on offender recidivism. However, when the outcome measure is victim satisfaction, at least one study found that victims reported that they felt more secure and in control of their situation after court action (Ford & Regoli, 1992). Studies also show low rates of conviction and limited jail time in IPV cases (see Jordan, 2004, for a review of the criminal justice response and civil remedies). In one study, prosecution reduced violence only if the victims made a personal choice to participate in the prosecution and were not coerced into doing so (Ford & Regoli, 1993).

The data as a whole suggest that many victims do not consider the criminal justice system a viable intervention for IPV and thus often do not report IPV. There is also some indication that a stake in conformity may be an important link in discovering the effectiveness of these interventions.

Public Health System Services. Victims of IPV rely on a number of community resources in addition to the justice system to protect them and to help them to deal with the problems they face. The importance of resources in preventing and reducing IPV is grounded in resource theories of IPV. Resource theory is based on the assumption that all social systems rest to some degree on force or its threat (Goode, 1971). When one has inadequate resources to obtain one's goals, then force is the ultimate weapon. Three other resources that serve people's ends are economic resources; prestige or respect; and likeability, attractiveness, friendship, or love. Resource theory postulates an inverse relationship between available resources and the use or experience of violence. Since personal resources empower a person within an intimate relationship, it is assumed that possession of resources would enable a person to change or

handle a situation once violence erupts. Therefore, it is expected that the lack of personal resources would constrain one to remain in an abusive relationship, thus remaining at a higher risk for continued violence.

Women victimized by IPV are as likely, if not more so, to utilize the services of primary and specialty health care systems. The number of physician visits due directly to IPV each year is estimated by the CDC to be more than 971,000, more than 486,000 emergency department visits, 320,000 outpatient hospital visits, 95,000 ambulance calls, and more than 807,000 overnight hospital stays. In the National Violence Against Women survey, 31% of the women who were injured in the most recent intimate partner rape, and 28% injured in the most recent physical assault, received medical treatment (Tjaden & Thoennes, 2000). Several population studies found that between 17-34% of women injured by IPV seek medical care for the injuries (CDC, 1996, 1998; Greenfield et al., 1998, reported in Plichta, 2004). Similar rates of care seeking were found among abused women identified through police reports (Brookoff et al, 1997; Duncan et al., 1999). Yet, IPV victims have unmet needs as many do not seek care for injuries or other health problems stemming from IPV, and when they do seek medical attention, their problems of abuse often go undetected because health care providers do not routinely screen women for IPV (Plichta, 2004). There is some evidence that undetected IPV may damage the patient-provider relationship, with victims reporting less satisfaction and worse communication with their providers (Plichta, 1996).

Among the most pressing issues facing the public health system response to IPV is removing the stigma associated with IPV that deters victims from seeking help, inducing health care providers to consistently screen for IPV (Plichta, 2004), and providing referrals to community or clinic based programs to address the violence and its health impact. Although screening tools are available, the barriers are substantial. Many providers do not want to deal with the issue of abuse within the family, and the systems in which they work are often discouraging of any efforts in this direction. However, studies suggest that women are comfortable being screened for IPV (Dowd et al., 2002) and will take help if offered (Krasnoff & Moscati, 2002). Medical personnel should also receive information and training on prevalence of IPV, the medical needs of the victims, and the resources available to help them.

Because the focus of public health system services in this report is on agencies to which IPV victims and perpetrators may go to seek help (such as safe houses, clergy, and the police), and not on broader public health issues, we will refer to health, mental health, and social services, as appropriate.

Informal Social Support

A growing body of research supports the key role that women's informal social support networks play in IPV. It is theorized that social support buffers a victim from stress or increases the quality of life regardless of the stress level and may protect a victim from further abuse (Bybee & Sullivan, 2002; Tan et al., 1995). Abusive men often try to isolate their partners from family and friends, and reduced social support is found to be associated with more frequent and severe post-victimization outcomes (Ozer et al., 2003, Ullman, 1995) and with the ability to follow through on prosecution (Bennett, Goodman, & Dutton, 1999). On the other hand, when

informal sources of support are available, women are less likely to contact the police (Kaukinen, 2002).

Sociocultural Variables. Criminal justice and public health solutions are not used by all victims of IPV and may not be equally effective with all groups. Resource utilization may be influenced by factors such as living in extreme poverty or in neighborhoods that are highly disorganized, or in rural areas where access to resources is difficult. People of different cultural and ethnic backgrounds may not be inclined to discuss problems with public health workers or enter the doors of the criminal justice system. African American, Latino, and Asian women may be less likely to report their victimization to the police for fear that the abuser will be arrested and incarcerated, although research to date does not support this assumption (Hutchison et al., 1994). Research indicates that employed, residentially stable, and higher SES perpetrators have a greater “stake in conformity,” meaning they have more to lose by being arrested or incurring other sanctions (Carlson et al., 1999; Thistlethwaite et al., 1998).

Most of what is known about the characteristics of victims and perpetrators using the criminal justice and public health systems comes from official records and methodologically weak samples. National studies, however, shed light on the demographic correlates of IPV. Income is a risk factor for IPV (Magdol et al., 1998; Straus et al., 1980) and may also be a factor that influences resource utilization. Women with monetary resources may be able to keep their abuse hidden by using private doctors, while poorer and minority women may rely more on the police to resolve partner conflicts (Jasinski, 2003). In one national study, education had a curvilinear relationship to IPV, with high school graduates having the highest rates of violence, and the highest rates of IPV were found among younger respondents, lower SES individuals, and those who lived in large cities and rural areas (Straus et al., 1980).

Victims who seek help are varied in relationship status, coping strategies, and approach to ending the violence, thus interventions may need to be tailored to accommodate these differences (Dutton, 2004). Treatments may also need to be tailored to address comorbid problems such as PTSD and depression. In a population study, over half of the women victimized by violence suffered a DSM-III-R disorder (Danielson et al., 1998).

Intergenerational Transmission. Intergeneration patterns of criminal justice and public health resource utilization may be explained by social learning theory which indicates, among other learning situations, that we model behavior that we have been exposed to as children. From this perspective, violence is learned, through role models provided by the family (parents, siblings, relatives, and boyfriends/girlfriends), either directly or indirectly (i.e., witnessing violence), and reinforced in childhood and continued in adulthood as a coping response to stress or a method of conflict resolution (Bandura, 1973).

There are numerous studies that support the cycle of violence theory (Burgess et al., 1987; Fagan et al., 1983; Hotaling & Sugarman, 1986; McCord, 1988; Mihalic & Elliott, 1997; Okun, 1986; Roy, 1982; Steinmetz, 1977; Straus et al., 1980; Walker, 1984; Widom, 1989), however, much of this work is derived from small cross-sectional studies of distinctive populations, such as clinical populations and children of battered women in shelters. While results have generally supported the association between witnessing or experiencing violence in

childhood with later negative outcomes, such as IPV, the linkage is somewhat less pronounced in nonreferred, community samples (Margolin, 1998; Stith et al., 2000). Meta-analysis suggests the relationship between witnessing or experiencing violence in the family of origin and later adult IPV is weak to moderate, with correlations ranging from .08 to .35 (i.e., .0064 to .1225 explained variance), depending upon the relationship examined (Stith et al., 2000). There are also several potentially confounding social, family, and contextual factors that may be associated with both childhood exposure to violence and increased risks of later adjustment problems or intimate partner violence (Fergusson & Horwood, 1998). The extent to which resource utilization patterns to cope with IPV is intergenerationally transmitted has not been studied; that is, whether resource utilization (including calling the police) follows from observations of parental resources utilization.

Taken together, the results of the literature review reveal two major themes. First, the efficacy of the current judicial system response is uncertain. Though there has been a movement to increase arrests for IPV, it is not clear that arrest decreases future IPV behavior by the perpetrator, or whether or not victims calling the police decreases future IPV behavior toward them. Past studies indicate the value of these actions may vary for different sociodemographic subgroups. The current study was designed to address these issues by examining the impact of arrest and calling the police on IPV behaviors of perpetrators toward victims identified via self- and partner-report measures and official records of a national sample of people who have not necessarily been in contact with the judicial system. In addition, estimates of the rates of reporting to police vary widely – 27% to 62%, so that further work on this estimate is needed. The second theme of the literature review reveals that victims of IPV may be seeking help from public health services, but the frequency of use of these services is not known and it is not clear whether these services are effective in meeting the needs of the victims. Among other reasons, the stigma of IPV may keep perpetrators and victims from getting help specifically for IPV, and they may instead seek help under the guise of different problems, allowing IPV to remain undetected and thus untreated. This study will attempt to address this issue by examining the degree to which victims and perpetrators access services from formal and informal sources, the degree to which they find these services useful, and the relationship to future IPV behavior. It will further examine the degree to which perpetrators and victims have mental health needs that are going unaddressed by any formal health and social services. The large national, multigenerational sample will also allow us to examine differences in utilization and satisfaction with IPV services by different demographic and sociocultural subgroups, and also to examine patterns of IPV and services utilization across generations.

The Current Study: Research Objectives

Objective 1: Perpetration: Examine the prevalence of perpetration of different forms of IPV. Determine the prevalence of arrest and whether perpetrator arrest results in a differential outcome. We assessed the differences between those IPV perpetrators who were arrested and those who were not. Specifically, we examined differences in demographic and sociocultural variables (e.g., sex, ethnicity, SES, urban/suburban/rural), the severity and frequency of IPV, and stake in conformity variables. These analyses were conducted on data from the original respondents and their adult children.

Objective 2: Victimization: Examine the prevalence of victimization by different forms of IPV. Determine the prevalence of calling the police and whether calling the police results in a differential outcome. We compared victimization by IPV over time for those who call the police and seek other help (e.g., safehouses, therapists, clergy) and those who do not. We assessed differences in this help seeking behavior by demographic and sociocultural variables. Additionally, we examined the specific reasons provided by the victims for calling or not calling the police and how often a weapon was used. To investigate whether IPV is less likely to be reported than non-partner violence, we compared prevalence of assault for IPV victims who call the police with rates of victimization not perpetrated by an intimate partner. We assessed the relationship between IPV and help-seeking from law enforcement in the original respondents and IPV and this help-seeking behavior in children's relationships with intimate partners.

Objective 3: Use of Public Health Services. (A) We assessed the utilization rates of informal resources (i.e., friends/relatives) and formal community resources (e.g., safehouse/shelter, private psychologist, clergy, social service or community agency) for all identified victims and perpetrators, for demographic subgroups, by arrest status, and for victims who report to the police vs. non-reporters. (B) We examined whether the services were deemed helpful by the victims and compare the current rates of IPV with the rates in subsequent years by use of resources. (C) We investigated under what conditions (e.g., specific form of violence, injury sustained, victim/perpetrator characteristics, and family of origin influences including IPV) resource utilization was related to reduction, increase, or no effect on future IPV. (D) We compared IPV resource utilizers with IPV non-resource utilizers to assess potential differences by demographic, sociocultural and behavioral variables (e.g., frequency and severity of violence) and whether service utilization had a differential impact in these two groups on future IPV. (E) We determined whether IPV victims and perpetrators were more or less likely to use social services than the general population by examining resource utilization prevalence rates for those who reported IPV and those who did not. (F) We determined whether help-seeking among the original respondents is related to their children's IPV and help-seeking behaviors.

Objective 4: Unmet Needs. To understand the extent of unmet needs of victims/perpetrators who were arrested or who were using health or social service resources for problems other than IPV, we examined the prevalence of IPV victims/perpetrators (in the total IPV population, by demographic subgroups, and by those with mental health diagnoses) who sought help for problems *other than IPV* in the health or social services, but did not seek help for IPV. How did this group differ from the group that did seek help for IPV?

For the purposes of this research, IPV is defined as “any behavior within an intimate relationship that causes physical, psychological, or sexual harm to those in the relationship” (Heise & Garcia-Moreno, 2002, p. 89). The use official and self-report arrest and victimization data in combination with the Conflict Tactics Scale in a national representative sample enabled us to examine forms of physical aggression (minor and serious violence), threat of physical aggression, and psychological and emotional abuse for *both* male and female married or cohabiting partners.

METHOD

Original Respondents

The NYSFS study design is a multiple cohort sequential design (Baltes, et al., 1979) with eleven waves of data collected over a 26-year period. The survey sample is based on a probability sample of households in the continental United States selected using a multistage, cluster sampling design. The sample was drawn in late 1976 and contained 2,360 eligible youth respondents aged 11-17 at the time of the initial interview. Of these, 1,725 (73%) agreed to participate in the study, signed informed consents and completed interviews in the initial survey. An age, sex, and race comparison between nonparticipating eligible youth and participating youth indicates that the loss rate from any particular age, sex, or racial group appears to be proportional to that group's representation in the population in 1976. Further, with respect to these characteristics, participating youth appear to be representative of the total 11 through 17 year old youth population in the United States as established by the U.S. Census Bureau in 1976.

The original sample was: 47% male and 53% female; 0.5% American Indian, 1.0% Asian/Pacific Islander, 15.1% black, and 4.4% Hispanic. The initial interviews were conducted in a face-to-face format in a private setting, usually in the respondent's home. Later waves of the survey were conducted worldwide, including in prisons and jails, usually in a private face-to-face setting, though some interviews in later waves and all Wave 9 (1993) interviews were conducted by telephone following strict privacy procedures. Formal examination of in-person and telephone interviews for the NYS sample has indicated no effects of interview modality.

Sample Retention. The NYS Staff attempted to re-contact and interview each of the original 1,725 respondents in each of the first four (annual) follow-up surveys. Overall completion rates over the first three waves were above 94 percent, 87% for wave 5. At wave 5, NYS researchers also attempted to identify, contact, and interview the youth who had refused at the time of the initial interview. This was done because most of the initial refusals were "parent refusals" and it was hoped that as the youth themselves reached the age of majority or became older teenagers, the parents and the youth would be willing to participate in the survey. This effort resulted in identifying all original "refusal households", documenting that the same family lived in the household continuously since 1976, and then obtaining consents and interviews with the eligible youth in such households. The identified households contained 193 youth who would have been eligible in 1976, of which 131 agreed to participate in the survey and completed wave 5 interview schedules. This "initial loss sample" was also interviewed in waves 6 and 8. Although not a probability sample of refusals, this sample provides information about survey effects and is, in fact, part of the originally selected sample.

A comparison of participants and non-participants in each survey after wave 1 revealed some selective loss by sex (W4), race (W2 and W3), class (W2 and W3), age (W5), and residence (W2 and W3). There did not appear to be any selective loss relative to self-reported levels of delinquency. In fact, the direction of the observed differences indicates that those lost tended to be slightly less delinquent than those participating each year. While the comparison of participants and non-participants revealed some small but significant differences, a comparison of those participating in each survey with the total sample on the first survey revealed no

significant differences by age, race, class, place of residence, or level of delinquency. There was also no significant difference in W1-W9 by gender; however, there was a slight disproportionate loss of males in Wave 10 (48). The selective loss has thus been very small and has not had a major influence on the underlying distribution on these variables (as established on the first survey). It appears that the representativeness of the sample with respect to these variables has not been affected in any serious way by respondent loss. Between waves 5 and 6 (1984), we identified 15 “hard refusals” and removed them from our active sample list. For wave 6, the active sample was thus 1,710. During waves 6 and 7, we identified 14 subjects who were deceased, further reducing our active sample to 1,696. During wave 8, we identified another 6 subjects who had died, reducing the sample to 1,690. At the start of wave 9, we removed from the sample 103 cases we had been unable to locate or who had refused to participate for several waves, although not asking to be dropped from the study. This provides an active sample list of 1,587. At the end of wave 9, an additional 4 subjects had died and an additional 14 cases were identified whom we had not found for several waves, leaving an active sample of 1569 for the start of wave 10. Based on the original sample size of 1725, completion rates were 87% for wave 6, 80% for wave 7, 83% for wave 8, and 78% for wave 9. Data for waves 10 and 11 were collected in 2002-2003. In wave 10 it was found that an additional 19 subjects had died, resulting in an active sample size of 1550 and 81% of these remaining respondents (73% of the original sample) were interviewed in W10. Lower rates of completion in waves 7 and 9 reflect budgetary constraints that limited the ability to either mount a full field effort from the beginning of the study (wave 7) or to conduct face-to-face interviews in situations where respondents lacked access to a telephone or were willing to be interviewed in person but not by telephone (wave 9).

Attrition rates. Compared to other major longitudinal studies, NYSFS attrition rates appear quite reasonable. With regard to participation rates, de Leeuw & van der Zouwen (1988) indicate that average participation rates are approximately 75% for face-to-face and 69% for telephone surveys, and de Leeuw and Heer (2002) and Groves et al. (2004) offer evidence that there have been substantial increases over time in rates of nonresponse and refusal to participate in surveys, both in the United States and internationally. With regard to attrition, Bachman, et al., (1971) report a 27 percent attrition rate over 4 years in the Youth in Transition Project; Cordray and Polk (1983) describe 4 studies with attrition rates of 22% to 55% over 12-15 years, and Newcomb and Bentler (1988) report a 55 percent attrition rate in an 8 year study. Moreover, there is evidence that the departure from randomness of the attrition in the NYSFS has little or no impact on substantive findings (Brame & Paternoster, 2003; Elliott, et al., 1989; Jang, 1999; Lackey, 2003; Menard & Elliott, 1993).

Wave 10 and 11 sample demographic characteristics. Of the 1,550 members of the active sample, we were able to interview 1,263 or 81% in wave 10 and 1,171 or 76% in wave 11. Of the total number of original participants, this results in rates of 73% and 68% in waves 10 and 11, respectively. For wave 10, the 1,263 participants included 620 males (49.1%) and 643 females (50.9%). At wave 11, the 1,171 participants included 569 males (48.6%) and 602 females (51.4%). Regarding ethnicity, at wave 10, 79.7% of the sample identified themselves as Anglo/White, 1.0% American Indian, 0.6% Asian/Pacific Islander, 13.6% African American, and 4.0% Hispanic/Latino. At wave 11, the sample was 79.9% Anglo/White, 0.8% American Indian, 0.7% Asian/Pacific Islander, 13.6% African American, and 3.7% Hispanic/Latino. The

age range at wave 10 was 35 to 44, with an average age of 39.12, and the age range at wave 11 was 36 to 45, with an average age of 40.31.

Spouse/Partner, Parent, and Child Samples

In addition to the original NYSFS respondents, the ongoing data collection included interviews with the current “spousal partners” (either married or living together), the children of the original respondents aged 11 and older in 2003, and the parents of the original respondents. We originally projected that there would be 1,176 spouses, 1,643 parents, and 1,904 children of the original respondents. After conducting the original respondent interviews at wave 10, these numbers were revised to reflect the following known family members: 961 spouses (82% of the projected total), 1,245 parents (78% of the projected total), and 1,752 children (92% of the projected total). Additional details on the projected versus actual samples are available in a footnote.¹

At Wave 11, we interviewed 843 spouses/partners, which was 87.7% of known spouses/partners. Of the 843, 389 were male (46.1%) and 454 were female (53.9%). Ethnicity reports indicated 81.4% Anglo/White, 0.5% American Indian, 1.2% Asian, 12.1% African American, and 3.4% Hispanic/Latino. The spouses’ ages ranged from 20 to 62, with an average age of 40.8.

Also at Wave 11, we interviewed 872 parents, which was 70% of the known parent. Of the 872, 335 were male (38.5%) and 535 were female (61.5%). Ethnicity reports indicated 86.6% Anglo/White, 0.5% American Indian, 0.3% Asian, 8.6% African American, and 2.5% Hispanic/Latino. The parents’ ages ranged from 49 to 88 with an average age of 66.7. Note that the parents interviewed could have been the stepparents of the original respondents.

Finally, at Wave 11, we interviewed 801 children of the original respondents who were aged 11-17 (n.b., not used in this study) and 453 children of the original respondents who were aged 18 and older. These 1254 children of the original respondents reflect 71.6% of the known children.

Of the 453 adult offspring, 202 were male (44.6%) and 251 were female (55.4%). Ethnicity reports indicated that 70.9% were Anglo/White, 0.7% were American Indian, 21.9% were African American, and 7.1% were Hispanic/Latino. Ages ranged from 17 to 42 with an average age of 20.8. In a small number of cases (2), 17 year old children were inadvertently given the adult interview. The offspring interviewed included stepchildren of the original respondents.

¹ In Wave 11, we interviewed 843 spouses/partners, which was 87.7% of known spouses/partners and 71.7% of originally projected spouses/partners. Also in Wave 11, we interviewed 872 parents, which was 70% of the known parents and 53% of the projected number of parents. Also during this wave, we interviewed 1254 children of the original respondents reflect 71.6% of the known children and 65.8% of the projected number of children. In Wave 12, we interviewed 1,297 children, which reflected 74% of the known children and 68% of the originally projected number of children.

In wave 12, we interviewed only the children of the original respondents. One adult child died between wave 11 and wave 12. In wave 12, we were able to interview 702 children aged 11 to 17 and 595 of the adult children. These 1,297 children are 74% of the known children.

Of the 595 adult offspring, 271 were male (45.5%) and 324 were female (54.5%). Ethnicity reports indicated that 71.4% were Anglo/White, 0.3% were American Indian, 0.2% were Asian, 21.7% were African American, and 5.5% were Hispanic/Latino. The age range was 18 to 45 with an average age of 21.0.

The sample is not necessarily representative of parents, partners, or children in the general population, but it is (with the exception of initial loss and attrition effects) a probability and representative sample of parents, partners, and children of individuals born in the 1959-1965 period.

The logic of maintaining sample representativeness across generations requires that all members of the replacement generation be assessed as they reach adolescence. For some children, this is not possible. Some (about 27%) of the children born to the NYSFS respondents had already *passed* age 18 by the start date of the data collection. However, because NYSFS assessed young adults in later waves, it is possible to compare levels of problem behavior in these older children with levels in their parents at the same age. Other children will not reach adolescence during the course of the grant. It is necessary, however, that there will not be any systematic bias in the selection of adolescents to be interviewed, particularly if a factor like divorce represents both a reason why adolescents are harder to track and to interview, and a potential risk factor for increased problem behavior. For this reason, we pursued all children born to the respondents who reached an interviewable age by 2003, the first year for child interviews.

Measurement

The NYSFS historically has tapped a very broad domain of sociodemographic, social psychological, attitudinal, and behavioral data as exemplified in publications dealing with causes, correlates, and epidemiological patterns of crime, domestic and nondomestic violence perpetration and victimization, alcohol and illicit drug use and problem use, mental health problems, and sexual behavior (e.g., Ageton, 1983; Elliott, et al., 1985; Elliott, et al., 1989; Elliott, 1987; Elliott, 1994; Elliott & Morse, 1989; Esbensen & Elliott, 1994; Menard & Elliott, 1994; Mihalic & Elliott, 1997; Roitberg & Menard, 1995; Wofford, et al., 1994). Detailed discussion of the measurement space of the NYSFS is available in Elliott, et al., 1989; however, much of this extensive measurement is beyond the scope of the current study.

All measurement is from the National Youth Survey Family Study (NYSFS). A full description of the longitudinal measurement space is described in Elliott, Huizinga, and Menard (1989). Appendix A details the availability of needed measures for each wave of respondents over the age of 18 in the NYSFS. Though the NYSFS has been used with respondents aged 11 and older, only those respondents aged 18 and older were asked questions about IPV.

Demographic and sociocultural variables. A variety of sociodemographic variables have been assessed for all categories of NYSFS respondents (i.e., original respondents, parents of original respondents, and adult children of original respondents). In addition to sex, race/ethnicity, and age, data are available for each wave on occupational status (using the Duncan SEI), educational attainment, marital status, whether or not they have children. Additional information available for each wave is residential stability, whether the respondent lives in an urban, suburban, or rural setting, and the degree of social disorganization in their neighborhood. These data will be used (e.g., examining justice system response and health and social services help seeking behavior in urban compared with rural and suburban settings) to measure stake in conformity as it relates to desistance or reduction in IPV behavior) to address the goals of this study.

Intimate Partner Violence (IPV). IPV was measured using three instruments that have been previously demonstrated to be reliable and valid, the Self-Report of Delinquency (SRD; Elliott, et al., 1989), Self-Report of Victimization (SRV; Menard, 2000; Menard & Huizinga, 2001; Menard, 2002), and the Conflict Tactics Scale (Straus, 1979; Straus & Gelles, 1990). Perpetration of IPV was measured using the SRD and the CTS, whereas victimization was measured using the SRV and the CTS.

The SRD has been used in numerous studies to measure previous year prevalence and frequency of a variety of delinquent, aggressive, and criminal behavior in the NYSFS. In the current study, we focused on two categories of questions: (1) simple assault (e.g., hitting someone); and (2) aggravated assault (e.g., attacking someone with the intention of seriously hurting or killing them). Though the questions were asked regarding any potential target, follow-up questions were asked in which the respondents were asked to provide their relationship with the victim. When these follow-up questions were examined and the victim was identified as a spouse or cohabiting partner, the respondent was identified as a perpetrator of IPV. Other follow-up questions that were examined included if the perpetrator was arrested and whether or not a weapon was used. Most of these data were available for the original respondents in Waves Six through Eleven, for the parents once in Wave Eleven, and for the adult children of the original respondents twice, in Waves Eleven and Twelve.

Similarly, the SRV was designed to measure previous year prevalence and frequency of victimization by a variety of delinquent, aggressive, and criminal measures (Menard, 2000). In the current study, we focused on physical assault (e.g., being beaten up by someone). The questions were asked regarding any potential perpetrator; however follow-up questions were asked in which respondents were asked to identify their relationship with the perpetrator. When these follow-up questions were examined and the perpetrator was identified as a spouse or partner, the respondent was identified as a victim of IPV. Additional follow-ups examined include whether or not the incident was reported to the police and whether or not a weapon was used. These data were available for the original respondents in Waves Six through Eleven, for the parents once in Wave Eleven, and for the adult children of the original respondents twice, in Waves Eleven and Twelve.

The CTS has been used for nearly 30 years to measure the form that conflict takes between two persons in an intimate relationship (Straus, 1979; Straus & Gelles, 1990; Straus, et

al., 1996). The respondents were asked to report on their own strategies for dealing with conflict with their partner, and were then asked to report on their partner's strategies for dealing with this conflict. Respondents were asked to indicate the number of times the behaviors occurred using a six point scale that ranges from "0" to "20 or more" times in the past year. Since the sixth wave of the NYSFS, a subset of items from the CTS has been asked of all respondents over the age of 18. These ten items include verbal aggression (i.e., insulted or swore at partner, threatened to hit the partner), "minor" violence (i.e., threw something at partner, pushed/grabbed/shoved partner, slapped partner) to "serious" violence (i.e., kicked/bit/hit partner, hit or tried to hit partner with something, beat up partner, threatened partner with knife/gun, used knife or fired a gun). Additional questions measuring psychological aggression (Straus, et al., 1996) and relational aggression (Crick & Grotpeter, 1995; Grotpeter & Crick, 1998) have been used with some waves of original respondents, and also their adult children. These forms of aggression are also measured when available (see Appendix B for a list of all items used in the CTS by wave and by sample).

Simple prevalence (i.e., lifetime, ever-prevalence) for the two violence scales were used to identify perpetrators and victims. These "prior year" data were available for the original respondents in waves six through eleven, and for the adult children of the original respondents. The parents of the original respondents were not asked about the prior year, but instead were asked to report retrospectively about the time period when their children (i.e., the original respondents) were living at home. The NYSFS measurement of IPV expands upon CTS with the addition of follow up questions that address whether they contacted police or other social support services as a result of their fights. These follow-up questions were available for the original respondents and for their adult children.

Justice System Response. Self-report data on arrest were available for the original respondents, their parents, and their adult children. There were several sources of information about arrest and the justice system processing for IPV offenses contained in the NYSFS interview schedules. Most of these were available from Wave Six (1983) to the current time. These included: (1) Information contained in a section on arrest and justice system processing that is included in each NYSFS interview schedule; (2) Information about police contact in a separate section of the schedules on IPV victimization and offending (NYSFS item added following the CTS); (3) Information from a victimization section that included identification of IPV and whether incidents were reported to the police; and (4) For the 1992 survey, information about arrests, including arrests for IPV, was also included as a part of the SRD section of the interview schedules.

There were thus several indicators of justice system involvement in IPV offenses available for analysis. An advantage of the multiple sources of information in the NYS self-report surveys overcomes the limitations that IPV may be reported in only one section of a self-reported instrument. For instance, Mihalic and Elliott (1997) found that framing questions within a family context generates higher estimates of IPV than questions framed in a criminal context.

Health and Social Services Help-Seeking Variables. In order to address help-seeking behavior, responses to three measures were examined. The first was a question that immediately

followed the IPV questions in the CTS, “Have you or your spouse ever contacted any of the following sources as a result of your disagreements?” The respondents were presented with a list of six possible resources (and a seventh, “other” category) that they or their spouses may have contacted as a result of their disagreements with their spouses. They were then asked to respond affirmatively or negatively for self and for partner for each of the following options, explained exactly as: (1) police; (2) safehouse or shelter; (3) social service or community agency; (4) minister, priest, rabbi, or spiritual counselor; (5) private psychotherapist, psychiatrist, counselor, or therapist; (6) friends or relatives; or (7) other. Specifically, respondents could indicate that they had contacted as many resources as they wish to indicate, both for themselves, and their partners. Responses were coded yes/no for “contacted” or “did not contact.”

An additional measure of help-seeking behavior was a series of questions that asked respondents to indicate whether they have sought help for problems with mental health in the past year. Respondents were read a list of seventeen potential resources (e.g., friends and family, medical doctor, mental health center, alcohol/drug clinic, emergency room, community program) and were asked to indicate whether or not they had used these services (see Appendix C for greater detail on how these resources were described to the respondents). If they had, they were asked how many times they had used this resource in the past year, to indicate for what problem they sought help (e.g., drugs, alcohol, family relationships, depression, sexual relations, trouble with the law, personal, or other), and to indicate how much the service helped them (5 point scale, ranging from 1=None at all to 5=A great deal). Responses to these items were used to measure respondents’ seeking of help for mental health issues possibly related to IPV (family relationships, personal, or other) and for issues broader than IPV (drugs, alcohol, depression, trouble with the law).

Finally, the NYSFS has used adaptations of the Diagnostic Interview Schedule (DIS; Robins, et al., 1988) and the Quick Diagnostic Interview Schedule (QDIS; Marcus, et al., 1990) to measure a variety of mental health disorders in the original respondents since Wave Six. In particular, a diagnosis of major depression (MD) was available in Waves 6 through 9 and for the children of the original respondents in their second wave of data collection. This measure was examined to determine if mental health disorder was a factor in IPV help-seeking behavior, and the degree to which mental health disorders were prevalent in IPV arrestees and victims.

RESULTS

For each of the main research objectives, in addition to findings stemming from the total sample, comparisons of findings across gender, race/ethnicity, stake in conformity (marital status, have children, occupational status, education level), neighborhood social disorganization, and location of residence (urban, suburban, rural) were made when possible (provided the subgroup sample sizes were adequate to support such analyses).

Objective 1: Perpetration: Examine the prevalence of perpetration of different types of IPV. Determine the prevalence of arrest and whether perpetrator arrest results in a differential outcome. Assess the differences between those IPV perpetrators who were arrested and those who were not.

Identification of IPV Perpetration: Conflict Tactics Scale

We first computed the prevalence of IPV perpetration of any degree of severity for each wave, for each of the samples in the NYSFS who answered IPV questions in the Conflict Tactics Scale. In the Tables 1-1 through 1-10, we report these by sex, race/ethnicity (Anglo/White, African-American, other), and location of residence (urban, suburban, and rural). The number of respondents varies by wave and is smaller than the total number of participants in a given wave because only those respondents living with a spouse or partner were asked to complete the CTS items.

Tables 1-1 through 1-6 illustrate the responses of the original respondents over time (six waves). It is important to note that because the measure of IPV used here included all forms of IPV that we measured, including the most common forms of verbal aggression, the vast majority of respondents (75 to 90%) endorsed these items at least once in a given year. When the respondents were ten years older in the tenth wave, the prevalence rates continued to rise slightly, and began to reduce in the eleventh waves. It is important to note that additional verbal, psychological, and relational aggression items were added in later waves (see Appendix B), and because these types of items were commonly endorsed, this may have contributed to the sustained rise over time.

This pattern remained consistent throughout the other samples during this wave (i.e., eleven), the spouses and adult children of the original respondents. Distinctions between the types of aggression and violence will be explored in Tables 1-11 through 1-16 and in the remainder of this report. The highest prevalence rates reported were the longitudinal retrospective accounts of the parents. This could be due in part to imperfect recall over a lifetime compared with annual assessment (Grotper, 2008), though it could represent an historical difference between the two generations.

Another important trend to note is that females were the only subgroup in the sample that consistently appeared to have higher prevalence rates than their comparison subgroup, males. This distinction will be explored further in the different types of aggression and violence used.

Table 1-1
 Endorsement of Any Items in the Conflict Tactics Scale
 Original Respondents, Wave 6 (n=475, total sample=1710, 28%)
 Ages 18-24

Total	Sex		Ethnicity			Location of Residence		
	Male	Female	White	African American	Other	Urban	Suburban	Rural
Perp. 382	132 (75%)	250 (84%)	318 (80%)	41 (82%)	23 (88%)	89 (88%)	173 (82%)	120 (74%)
Non-Perp. 93	44 (25%)	49 (16%)	81 (20%)	9 (18%)	3 (12%)	12 (12%)	38 (18%)	43 (26%)
Total	176	299	399	50	26	101	211	163

Table 1-2
 Endorsement of Any Items in the Conflict Tactics Scale
 Original Respondents, Wave 7 (n=723, total sample=1696, 43%)
 Ages 21-27

Total	Sex		Ethnicity			Location of Residence		
	Male	Female	White	African American	Other	Urban	Suburban	Rural
Perp. 593	245 (76%)	348 (87%)	511 (83%)	62 (78.5%)	20 (77%)	170 (84%)	301 (84%)	106 (75%)
Non-Perp. 130	76 (24%)	54 (13%)	107 (17%)	17 (21.5%)	6 (23%)	32 (16%)	59 (16%)	36 (25%)
Total	321	402	618	79	26	202	360	142

Table 1-3
 Endorsement of Any Items in the Conflict Tactics Scale
 Original Respondents, Wave 8 (n=959, total sample=1690, 57%)
 Ages 24-30

Total	Sex		Ethnicity			Location of Residence		
	Male	Female	White	African American	Other	Urban	Suburban	Rural
Perp. 763	342 (75.5%)	421 (83%)	637 (79%)	84 (81%)	42 (84%)	209 (82%)	396 (80%)	145 (75%)
Non-Perp. 196	111 (24.5%)	85 (17%)	168 (21%)	20 (19%)	8 (16%)	45 (18%)	98 (20%)	49 (25%)
Total	453	506	805	104	50	254	494	194

Table 1-4
 Endorsement of Any Items in the Conflict Tactics Scale
 Original Respondents, Wave 9 (n=1002, total sample=1587, 64%)
 Ages 27-33

Total	Sex		Ethnicity			Location of Residence		
	Male	Female	White	African American	Other	Urban	Suburban	Rural
Perp. 908	432 (88%)	476 (93%)	765 (90%)	106 (94%)	37 (90%)	248 (92%)	451 (91%)	163 (88%)
Non-Perp. 94	59 (12%)	35 (7%)	83 (10%)	7 (6%)	4 (10%)	21 (8%)	46 (9%)	23 (12%)
Total	491	511	848	113	41	269	497	186

Table 1-5
 Endorsement of Any Items in the Conflict Tactics Scale
 Original Respondents, Wave 10 (n=959, total sample=1263, 75%)
 Ages 36-42

Total	Sex		Ethnicity			Location of Residence		
	Male	Female	White	African American	Other	Urban	Suburban	Rural
Perp. 731	336 (73%)	395 (79%)	624 (77%)	70 (68%)	37 (86%)	137 (81%)	463 (77%)	125 (69%)
Non-Perp. 228	124 (27%)	104 (21%)	189 (23%)	33 (32%)	6 (14%)	33 (19%)	135 (23%)	55 (31%)
Total	460	499	813	103	43	170	598	180

Table 1-6
 Endorsement of Any Items in the Conflict Tactics Scale
 Original Respondents, Wave 11 (n=888, total sample=1171, 76%)
 Ages 37-43

Total	Sex		Ethnicity			Location of Residence		
	Male	Female	White	African American	Other	Urban	Suburban	Rural
Perp. 716	328 (76.5%)	388 (84.5%)	621 (82%)	64 (70%)	31 (86%)	120 (78%)	461 (83%)	132 (77%)
Non-Perp. 172	101 (23.5%)	71 (15.5%)	140 (18%)	27 (30%)	5 (14%)	34 (22%)	95 (17%)	39 (23%)
Total	429	459	761	91	36	154	556	171

Table 1-7
 Endorsement of Any Items in the Conflict Tactics Scale
 Spouses of Original Respondents, Wave 11 (n=796, total sample=843, 94%)
 Ages 20-62

Total	Sex		Ethnicity			Location of Residence		
	Male	Female	White	African American	Other	Urban	Suburban	Rural
Perp. 716	328 (88%)	388 (91%)	590 (90%)	79 (89%)	47 (87)	116 (88%)	442 (91%)	136 (89%)
Non-Perp. 80	43 (12%)	37 (9%)	63 (10%)	10 (11%)	7 (13)	16 (12%)	42 (9%)	17 (11%)
Total	371	425	653	89	54	132	484	153

Table 1-8
 Endorsement of Any Items in the Conflict Tactics Scale
 Lifetime Retrospective, Parents of Orig. Respondents, Wave 11 (n=861, total sample=872, 99%)
 Ages 49-88

Total	Sex		Ethnicity			Location of Residence		
	Male	Female	White	African American	Other	Urban	Suburban	Rural
Perp. 650	236 (70%)	414 (79%)	563 (75%)	53 (77%)	34 (81%)	111 (78%)	375 (74%)	156 (77%)
Non-Perp. 211	99 (30%)	111 (21%)	187 (25%)	16 (23%)	8 (19%)	31 (22%)	130 (26%)	46 (23%)
Total	335	525	750	69	42	142	505	202

Table 1-9
 Endorsement of Any Items in the Conflict Tactics Scale
 Adult Offspring of the Original Respondents, Wave 11 (n=139, total sample=453, 31%)
 Ages 18-42

Total	Sex		Ethnicity			Location of Residence		
	Male	Female	White	African American	Other	Urban	Suburban	Rural
Perp. 129	49 (88.5%)	80 (96%)	90 (92%)	17 (100%)	8 (89%)	22 (88%)	79 (93%)	27 (96%)
Non-Perp. 12	7 (12.5%)	3 (4%)	8 (8%)	0 (0%)	1 (11%)	3 (12%)	6 (7%)	1 (4%)
Total	56	83	98	17	9	25	85	28

Table 1-10
 Endorsement of Any Items in the Conflict Tactics Scale
 Adult Offspring of the Original Respondents, Wave 12 (n=163, total sample=595, 27%)
 Ages 19-45

Total	Sex		Ethnicity			Location of Residence		
	Male	Female	White	African American	Other	Urban	Suburban	Rural
Perp. 141	42 (76%)	99 (92%)	106 (89%)	20 (71%)	15 (94%)	15 (71%)	69 (89%)	32 (94%)
Non-Perp. 22	13 (24%)	9 (8%)	13 (11%)	8 (29%)	1 (6%)	6 (29%)	9 (11.5%)	2 (6%)
Total	55	108	119	28	16	21	78	34

Type and Severity of Aggression and Violence

Next, we combined the responses across waves so that there were just four samples (i.e., original respondents, their spouses, their parents, and their adult children), and split the types of perpetration into three types: (psychological and relational aggression, physical aggression/less serious violence, and serious violence). *A specific note is in order at this point. We recognize that no form of aggression and violence perpetrated toward anyone, including spouses, is unacceptable and thus the terms “less severe” or “more serious” may be unpalatable terms to some. However, we have elected to distinguish between non-physical violence (aggression) and two levels of violence in order to examine potential differences in predictors and outcomes for these potentially different behaviors.* These three types data were then examined for each sample group by Sex, Ethnicity, Location of Residence, and the Stake in Conformity variables that were available and relevant for each sample (married, children, highest educational level achieved, occupational status, residential stability, and social disorganization in the neighborhood).

Verbal, Psychological, and Relational Aggression (Perpetration)

Original Respondents. We first examined the responses of the original respondents by creating a pooled, cross-sectional dataset that allowed us to examine the demographic predictors in the same year that the IPV behaviors were or were not occurring. Thus, we linked the demographics in wave 6 to the IPV behaviors in wave 7, the demographics in wave 7 to the behaviors in wave 8, through wave 10 demographics and wave 11 behaviors. This resulted in five comparisons that we then stacked and analyzed as a whole. Chi-square tests were then conducted for sex, ethnicity, marital status, whether or not they have children, and location of residence. ANOVAs were conducted for highest educational level achieved, occupational status (Duncan SEI), and social disorganization in the neighborhood). The vast majority of the results were statistically significant, and are reported in Table 1-11.

Table 1-11
Original Respondents: IPV Perpetration
Verbal, Psychological, and Relational Aggression, by Demographics

Chi-Square Analyses				
Socio-Demographic Variable	X^2	p		
Sex Females more likely than males	34.31	.000		
Ethnicity Black less likely than White and Other	5.88	.05		
Married Married more likely than unmarried	7.77	.005		
Children No statistically significant differences	1.76	ns		
Residence Location Rural less likely than Urban or Suburban	10.38	.02		
Analyses of Variance (ANOVAs)				
Socio-Demographic Variable	F	p	Mean	Std Deviation
Highest Grade Completed No statistically significant differences	2.12	.15	ns	ns
Occupational Status (Duncan SEI) Lower occupational status, more likely	5.20	.02	43.36 41.25	22.73 22.29
Neighborhood Social Disorganization Fewer problems, more likely	7.87	.005	1.62 1.54	0.75 0.66

We next examined the results for the parents, spouses, and adult offspring of the original respondents. Results are offered in detail in paragraph form, and significant (and marginally significant) results are presented in Table 1-12.

Table 1-12
IPV Perpetration: Significant Results by Sample
Verbal, Psychological, and Relational Aggression

Parents of the Original Respondents	
	Sex (marginally significant) Females more likely than males
Adult Offspring of Original Respondents	
	Sex Females more likely than males
Spouses of Original Respondents	
	No statistically significant variables

Parents of the Original Respondents. First, the responses of the parents of the original respondents were examined. A chi-square test was conducted on these longitudinal, retrospective responses for sex and ethnicity, and an ANOVA was conducted on their responses

for highest educational level achieved. Other demographic variables could have been inconsistent over the reporting period and so could not be used.

The chi-square test for sex was marginally significant ($X^2=2.94, p=.09$), indicating that women tended to be more likely to endorse perpetration of verbal aggression than were males. The chi-square test for ethnicity was not significant. The ANOVA for highest educational level was also nonsignificant.

Offspring of the Original Respondents. Next, the responses of the adult offspring of the original respondents were examined. Chi-square tests were conducted for sex, ethnicity, marital status, whether or not they have children, and location of residence. ANOVAs were conducted for highest educational level achieved, residential stability, occupational status, and social disorganization in the neighborhood).

The chi-square test for sex was statistically significant ($X^2=8.83, p<.01$), indicating that females were more likely to report engaging in verbal, psychological, and relational aggression toward their spouses than were males. The chi-square analyses for ethnicity, marital status, children, and location of residence were not statistically significant.

None of the ANOVAs conducted for educational attainment, residential stability, occupational status, and social disorganization in the neighborhood were statistically significant for verbal, psychological, and relational aggression.

Spouses of the Original Respondents. Next, the responses of the spouses of the original respondents were examined. Chi-square tests were conducted for sex, ethnicity, and location of residence. Having children or not would have been included here as a stake in conformity variable, but examination of the responses indicated that too few respondents did *not* have children to this to be an adequate variable. ANOVAs were conducted for highest educational level achieved, residential stability, occupational status (Duncan SEI), and social disorganization in the neighborhood).

The chi-square tests for sex, ethnicity, and location of residence were not statistically significant. The ANOVAs for highest educational level achieved, occupational status, residential stability, and for social disorganization in the neighborhood were not statistically significant when comparing victims of verbal aggression with nonvictims.

Aggression, Threat of Violence, and Less Serious Violence (Perpetration)

Original Respondents. We examined the responses of the original respondents in the same way that we examined verbal, psychological, and relational aggression. Chi-square tests were then conducted for sex, ethnicity, marital status, whether or not they have children, and location of residence. ANOVAs were conducted for highest educational level achieved, occupational status (Duncan SEI), and social disorganization in the neighborhood. All of the results were statistically significant, and are reported in Table 1-13.

Table 1-13
Original Respondents IPV Perpetration
Aggression and Threat of Violence, by Demographics

Chi-Square Analyses				
Socio-Demographic Variable	X^2		p	
Sex Females more likely than Males	26.86		.000	
Ethnicity Black more likely than White or Other	56.41		.000	
Married Not married more likely than married	14.09		.000	
Children No children more likely than children	9.87		.002	
Residence Location Urban more likely than Suburban or Rural	28.35		.000	
Analyses of Variance (ANOVAs)				
Socio-Demographic Variable	F	p	Mean	Std Deviation
Highest Grade Completed Lower grade completed, more likely	105.162	.000	13.40 12.59	2.13 2.17
Occupational Status (Duncan SEI) Lower status occupation, more likely	59.29	.000	43.25 36.94	22.61 21.04
Neighborhood Social Disorganization Fewer problems, more likely	21.13	.000	1.59 1.48	0.72 0.54

We next examined the results for the parents, spouses, and adult offspring of the original respondents. Results are offered in detail in paragraph form, and significant (and marginally significant) results are presented in Table 1-14.

Table 1-14
 IPV Perpetration: Significant Results by Sample
 Aggression, Threat of Violence, and Less Serious Violence

Parents of the Original Respondents	
	Sex Females more likely than males
Adult Offspring of Original Respondents	
	Sex Females more likely than males
	Highest Grade Completed Lower attainment more likely than higher attainment
	Neighborhood Social Disorganization Greater neighborhood problems more likely than fewer
Spouses of Original Respondents	
	Sex Females more likely than males
	Ethnicity Non-White more likely than White
	Highest Grade Completed Lower attainment more likely than higher attainment
	Residential Stability (marginally significant) Frequent moving more likely than less frequent moving
	Occupational Status (Duncan SEI) Lower occupational status more likely than higher status
	Neighborhood Social Disorganization Greater neighborhood problems more likely than fewer

Parents of the Original Respondents. Again, first, the responses of the parents of the original respondents were examined. A chi-square test was conducted on these longitudinal, retrospective responses for sex and ethnicity, and an ANOVA was conducted on their responses for highest educational level achieved.

The chi-square test for sex was statistically significant ($X^2=5.70, p<.02$), indicating that women were more likely to report use of aggression, less serious violence, and threats of violence than were men. The chi-square for ethnicity and the ANOVA for highest educational level achieved did not yield statistical significance.

Offspring of the Original Respondents. Next, the responses of the adult offspring of the original respondents were examined. Chi-square tests were conducted for sex, ethnicity, marital status, whether or not they have children, and location of residence. ANOVAs were conducted for highest educational level achieved, residential stability, occupational status (Duncan SEI), and social disorganization in the neighborhood).

The chi-square for sex was statistically significant ($X^2=9.21, p=.002$), indicating that females were more likely to report engaging in aggression and less serious forms of violence

toward their spouses than were males. The chi-square analyses for ethnicity, marital status, children, and location of residence were not statistically significant.

The ANOVAs for occupational status and residential stability were not statistically significant for aggression and less serious forms of violence toward spouses. However, educational attainment was significant ($F=7.84, p=.006$), indicating that those respondents with higher levels of education ($m=12.48, sd=1.78$) were less likely to report engaging in aggression and less serious forms of violence toward their spouses than were those with lower levels of education ($m=11.72, sd=1.88$). Additionally, the ANOVA for neighborhood social disorganization was also significant ($F=4.04, p=.05$), indicating that those reporting more problems in their neighborhood ($m=1.41, sd=0.43$) were more likely to report engaging in aggression and less serious violence toward their spouses than were those who reported fewer neighborhood problems ($m=1.30, sd=0.32$).

Spouses of the Original Respondents. Next, the responses of the spouses of the original respondents were examined. Chi-square tests were conducted for sex, ethnicity, and location of residence. ANOVAs were conducted for highest educational level achieved residential stability, occupational status (Duncan SEI), and social disorganization in the neighborhood).

The chi-square test for sex was statistically significant ($X^2=30.10, p=.000$), indicating that females were more likely than males to report engaging in less serious forms of violence toward their spouses. The test for ethnicity was also statistically significant ($X^2=23.74, p=.000$), indicating that African Americans and other non-White respondents were more likely to report engaging in less serious forms of violence than were their White peers. The chi-square test for location of residence was not significant.

The ANOVA for highest educational level achieved was statistically significant ($F=16.36, p<.000$), indicating that those with higher levels of education ($m=13.78, sd=2.20$) were less likely to report engaging in aggression and less serious forms of violence with their spouses than were their peers reporting lower levels of education ($m=13.00, sd=2.21$).

The ANOVA conducted for residential stability was marginally significant ($F=3.22, p<.08$), indicating that those who moved more frequently in the past ten years ($m= 2.49, sd=3.08$) were more likely to report engaging in aggression and less serious forms of violence than were their more residentially stable peers ($m=2.12, sd=2.17$).

The ANOVA conducted for the Duncan SEI scores (occupational status) was statistically significant ($F=6.76, p<.01$), indicating that respondents with higher occupational status scores ($m=48.70, sd=23.24$) were less likely to report engaging in aggression and less serious form of violence than were their peers with lower occupational status ($m=43.37, sd=23.06$).

Finally the ANOVA conducted for neighborhood social disorganization was statistically significant ($F=11.15, p<.001$), indicating that those respondents reporting living in neighborhoods with more problems ($m=1.26, sd=0.35$) reported engaging in more aggression and less serious forms of violence than did their peers who reported living in neighborhoods with fewer problems ($m=1.18, sd=0.27$).

Serious Violence (Perpetration)

Original Respondents. We examined the responses of the original respondents regarding serious violence in the same way that we examined the other two forms of IPV. Chi-square tests were then conducted for sex, ethnicity, marital status, whether or not they have children, and location of residence. ANOVAs were conducted for highest educational level achieved, occupational status (Duncan SEI), and social disorganization in the neighborhood). Again, the majority of the results were statistically significant, and are reported in Table 1-15.

Table 1-15
Original Respondents: IPV Perpetration
Serious Violence, by Demographics

Chi-Square Analyses				
Socio-Demographic Variable	X^2		p	
Sex				
Female more likely than Male	45.26		.000	
Ethnicity				
Black more likely than White or Other	63.76		.000	
Married				
Not Married more likely than Married	10.62		.001	
Children				
No significant differences	0.02		ns	
Residence Location				
Urban more likely than Suburban or Rural	34.42		.000	
Analyses of Variance (ANOVAs)				
Socio-Demographic Variable	F	p	Mean	Std Deviation
Highest Grade Completed			13.30	2.13
Lower grade completed, more likely	105.26	.000	12.04	2.22
Occupational Stats (Duncan SEI)			42.36	22.43
Lower status occupation, more likely	45.00	.000	33.53	20.24
Neighborhood Social Disorganization				
No statistically significant differences	0.86	.353	ns	ns

We next examined the results for the parents, spouses, and adult offspring of the original respondents. Results are offered in detail in paragraph form, and significant (and marginally significant) results are presented in Table 1-16.

Table 1-16
 IPV Perpetration: Significant Results by Sample
 Serious Violence

<i>Parents of the Original Respondents</i>	
	Sex Females more likely than males
<i>Adult Offspring of Original Respondents</i>	
	Sex Females more likely than males
	Highest Grade Completed Lower attainment more likely than higher attainment
	Residential Stability (marginally significant) Frequent moving more likely than less frequent moving
	Neighborhood Social Disorganization Greater neighborhood problems more likely than fewer
<i>Spouses of Original Respondents</i>	
	Sex Females more likely than males
	Ethnicity Non-White more likely than White
	Highest Grade Completed Lower attainment more likely than higher attainment
	Location of Residence (marginally significant) Suburban more likely than Urban or Rural
	Neighborhood Social Disorganization Greater neighborhood problems more likely than fewer

Parents of the Original Respondents. As with the prior analyses, first the responses of the parents of the original respondents were examined. A chi-square test was conducted on these longitudinal, retrospective responses for sex and ethnicity, and a t-test was conducted on their responses for highest educational level achieved. The chi-square test for sex was statistically significant ($X^2=20.51, p<.001$), indicating that women were more likely to report use of serious violence than were the men in this sample. The chi-square for ethnicity was statistically significant ($X^2=7.02, p<.05$); however follow-up tests did not yield a significant difference between group. The ANOVA conducted to assess highest educational level achieved was nonsignificant.

Offspring of the Original Respondents. Next, the responses of the adult offspring of the original respondents were examined. Chi-square tests were conducted for sex, ethnicity, marital status, whether or not they have children, and location of residence. ANOVAs were conducted for highest educational level achieved, residential stability, occupational status (Duncan SEI), and social disorganization in the neighborhood).

The chi-square test for sex was statistically significant ($X^2=6.47, p=.02$), indicating that females were more likely to report engaging in serious violence toward their spouses than were males. The chi-square analyses for ethnicity, marital status, children, and location of residence were not statistically significant.

The ANOVA for occupational status was not statistically significant. However, the other three ANOVAs were significant. Specifically, the ANOVA for educational attainment was significant ($F=4.20, p=.04$), indicating that those respondents with higher levels of education ($m=12.31, sd=1.84$) were less likely to report engaging in serious forms of violence toward their spouses than were those with lower levels of education ($m=11.57, sd=1.81$).

The ANOVA for residential stability was marginally significant ($F=3.14, p=.08$), indicating that those who moved more often in the previous ten years ($m=6.09, sd=7.88$) were more likely to report engaging in serious violence with their spouses than were their peers who moved fewer times ($m=4.57, sd=3.21$).

The ANOVA for neighborhood social disorganization was also significant ($F=19.49, p=.000$), indicating that those reporting more problems in their neighborhood ($m=1.59, sd=0.47$) were more likely to report engaging in serious violence toward their spouses than were those who reported fewer neighborhood problems ($m=1.29, sd=0.32$).

Spouses of the Original Respondents. Next, the responses of the spouses of the original respondents were examined. Chi-square tests were conducted for sex, ethnicity, and location of residence. ANOVAs were conducted for highest educational level achieved, residential stability, and social disorganization in the neighborhood).

The chi-square test for sex was statistically significant ($X^2=23.68, p<.000$), indicating that females were more likely to engage in serious violence against their spouses than were males. The chi-square for ethnicity was statistically significant ($X^2=24.18, p<.000$), indicating that African Americans were more likely than their White and other ethnicity peers to engage in serious violence against their spouses. The location of residence chi-square was also significant ($X^2=6.59, p<.04$); however, follow up tests yielded only a marginally significant trend for suburban respondents to report more serious violence than did their urban and rural peers.

The ANOVAs conducted for occupational status and for residential stability were not statistically significant. However, the ANOVA for highest educational level attained was significant ($X^2=20.29, p<.000$), indicating that those with lower levels of education ($m=13.00, sd=2.21$) were more likely to report engaging in serious violence toward their spouses than were those with higher levels of education ($m=13.78, sd=2.21$).

Additionally, the ANOVA for neighborhood social disorganization was significant ($F=28.74, p<.000$), indicating that those reporting more problems in their neighborhoods ($m=1.26, sd=0.35$) were more likely to report engaging in serious violence toward their spouses than were those reporting fewer problems in their neighborhoods ($m=1.18, sd=.27$).

Identification of IPV Perpetration: Self Report of Delinquency

We next sought to identify additional perpetrators of IPV via their responses on the Self-Report of Delinquency scale. This scale only specifically identified spouses and partners as a potential target of their aggravated assault in the ninth and tenth waves of data collection. For the original respondents, assault rates on spouses reported on the SRD by this age group (i.e., age 25-43) were very low (fewer than 10 perpetrators) and so they cannot be discussed in further detail in this report, except to note that they had already been identified as perpetrators by the Conflict Tactics Scale. Additionally, for the adult offspring of the original respondents, there were no cases of assault on a spouse reported in the Self Report of Delinquency, and thus the SRD did not provide any new cases of IPV perpetrators beyond those identified by the Conflict Tactics Scale.

Arrest

Original Respondents. Domestic Violence (DV) was added to the NYS as an arrest code in 1989, with the eighth wave of the NYS. In that wave, the original respondents reported no arrests for DV/IPV. In the ninth through eleventh waves, however, 19 respondents reported being arrested for IPV and 7 of these respondents reported being convicted for the offense. When the self-reported arrests for these respondents was combined with their self reports from the SRD, complete overlap was found, and thus the total number of respondents arrested for IPV remained 19.

The small number of respondents does not allow for substantial demographic analysis or statistical analysis. Some descriptive statistics can be reported, though these results should be interpreted with caution because of the very small sample size. Of those arrested for IPV, 75% were male and 25% were female (marginally significant $X^2=3.23, p=.07$). 84% were Anglo/White, and 15% were African American (not statistically significant). Regarding residence, 35% of those arrested were from Urban areas, 41% lived in Suburban areas, and 24% lived in Rural areas.

ANOVAs were conducted on highest grade completed, occupational status, and neighborhood disorganization, and the results should again be interpreted with caution. The ANOVA for highest grade completed was significant ($F=10.969, p=.001$), indicating that those whose highest grade completed in school was higher ($m=13.59, sd=2.23$) were less likely to be arrested for IPV than those whose highest grade completed was lower ($m=11.83, sd=2.45$). The ANOVA for occupational status was also significant ($F=48.11, p=.01$), indicating that those with higher occupational status ($m=48.11, sd=23.4$) were less likely to be arrested for IPV than were those with lower occupational status ($m=31.93, sd=22.41$). The ANOVA conducted on social disorganization in the neighborhood was not statistically significant.

Adult Offspring of the Original Respondents. When we examined self-reported arrest within the adult offspring of the original respondent generation, analyses revealed that 28% of this sample had ever been arrested. However, when we considered only those respondents who reported having been arrested for IPV, only 0.3% of the sample had endorsed IPV as the reason

for arrest. Due to this extremely small sample, no further analyses could be conducted on arrest for IPV in the adult offspring generation.

Objective 2

Objective 2: Victimization: Examine the prevalence of victimization by different forms of IPV. Determine the prevalence of calling the police and whether calling the police results in a differential outcome. Compare victimization by IPV over time for those who call the police and seek other help (e.g., safehouses, therapists, clergy) and those who do not. Assess differences in this help seeking behavior by demographic and sociocultural variables.

Identification of IPV Victimization: Conflict Tactics Scale

We first conducted the same preliminary analyses for victims that we conducted for the perpetrators of IPV. We first computed the prevalence of IPV victimization *of any degree of severity* for each wave, for each of the samples in the NYSFS who answered IPV questions in the Conflict Tactics Scale. In the Tables 1-1 through 1-10, we report these by sex, race/ethnicity (Anglo/White, African-American, other), and location of residence (urban, suburban, and rural). The number of respondents varies by wave and is smaller than the total number of participants because only those respondents living with a spouse or partner were asked to complete the items.

Tables 2-1 through 2-6 illustrate the responses of the original respondents over time. Similar to preliminary analyses with the perpetrators of IPV, it is important to note that because the measure of IPV used here included the least serious forms of aggression, the vast majority of respondents (75 to 90%) endorsed these items at least once in a given year. The rates raised every wave through wave 10 (when they were ten years older than their last interview, when they backed off slightly). It is important to note that additional verbal, psychological, and relational victimization items were added in later waves (see Appendix B), and because these types of items were commonly endorsed, this may have contributed to the sustained rise over time.

Again, as with the perpetrators, this pattern paralleling perpetration remained consistent throughout the other sample during this wave, the spouses and adult children of the original respondents. Distinctions between the types of aggression and violence will be explored in Tables 2-11 through 2-16 and in the remainder of this report. As with perpetration, the highest prevalence rates reported were the longitudinal retrospective accounts of the parents. This could be due in part to imperfect recall over a lifetime compared with annual assessment (Grotper, 2008), or it could potentially reflect real historical differences between the two generations.

Table 2-1
 Endorsement of Any Items in the Conflict Tactics Scale
 Original Respondents, Wave 6 (n=477, total sample=1710, 28%)
 Ages 18-24

Total	Sex		Ethnicity			Location of Residence		
	Male	Female	White	African American	Other	Urban	Suburban	Rural
Victim 371	131 (74%)	240 (80%)	308 (77%)	40 (80%)	23 (88%)	90 (89%)	164 (77%)	117 (71%)
Non-Victim 106	46 (26%)	60 (20%)	93 (23%)	10 (20%)	3 (12%)	11 (11%)	48 (23%)	47 (29%)
Total	177	300	401	50	26	101	212	164

Table 2-2
 Endorsement of Any Items in the Conflict Tactics Scale
 Original Respondents, Wave 7 (n=723, total sample=1696, 43%)
 Ages 21-27

Total	Sex		Ethnicity			Location of Residence		
	Male	Female	White	African American	Other	Urban	Suburban	Rural
Victim 583	258 (80%)	325 (81%)	505 (82%)	60 (76%)	18 (69%)	164 (81%)	293 (81%)	111 (78%)
Non-Victim 140	63 (20%)	77 (19%)	113 (18%)	19 (24%)	8 (31%)	38 (19%)	67 (19%)	31 (22%)
Total	321	402	618	79	26	202	360	142

Table 2-3
 Endorsement of Any Items in the Conflict Tactics Scale
 Original Respondents, Wave 8 (n=959, total sample=1690, 57%)
 Ages 24-30

Total	Sex		Ethnicity			Location of Residence		
	Male	Female	White	African American	Other	Urban	Suburban	Rural
Victim. 735	333 (73.5%)	402 (79%)	615 (76%)	78 (75%)	42 (84%)	200 (79%)	374 (76%)	148 (76%)
Non-Victim 224	120 (26.5%)	104 (21%)	190 (24%)	26 (25%)	8 (16%)	54 (21%)	120 (24%)	46 (24%)
Total	453	506	805	104	50	254	494	194

Table 2-4
 Endorsement of Any Items in the Conflict Tactics Scale
 Original Respondents, Wave 9 (n=1003, total sample=1587, 63%)
 Ages 27-33

Total	Sex		Ethnicity			Location of Residence		
	Male	Female	White	African American	Other	Urban	Suburban	Rural
Victim 875	428 (87%)	447 (87%)	736 (87%)	101 (89%)	38 (93%)	247 (92%)	430 (86%)	152 (82%)
Non-Victim 128	63 (13%)	65 (13%)	113 (13%)	12 (11%)	3 (7%)	22 (8%)	68 (14%)	34 (18%)
Total	491	512	849	113	41	269	498	186

Table 2-5
 Endorsement of Any Items in the Conflict Tactics Scale
 Original Respondents, Wave 10 (n=958, total sample=1263, 76%)
 Ages 36-42

Total	Sex		Ethnicity			Location of Residence		
	Male	Female	White	African American	Other	Urban	Suburban	Rural
Victim 675	330 (72%)	345 (69%)	575 (71%)	69 (67%)	31 (72%)	128 (75%)	428 (72%)	112 (62%)
Non-Victim 283	129 (31%)	154 (31%)	237 (29%)	34 (33%)	12 (28%)	42 (25%)	169 (28%)	68 (38%)
Total	459	499	812	103	43	170	597	180

Table 2-6
 Endorsement of Any Items in the Conflict Tactics Scale
 Original Respondents, Wave 11 (n=888, total sample=1171, 76%)
 Ages 37-43

Total	Sex		Ethnicity			Location of Residence		
	Male	Female	White	African American	Other	Urban	Suburban	Rural
Victim 695	339 (79%)	356 (78%)	602 (79%)	63 (69%)	30 (83%)	122 (79%)	443 (80%)	126 (74%)
Non-Victim 193	90 (21%)	103 (22%)	159 (21%)	28 (31%)	6 (17%)	32 (21%)	113 (20%)	45 (26%)
Total	429	459	761	91	36	154	556	171

Table 2-7
 Endorsement of Any Items in the Conflict Tactics Scale
 Spouses of Original Respondents, Wave 11 (n=796, total sample=843, 94%)
 Ages 20-62

Total	Sex		Ethnicity			Location of Residence		
	Male	Female	White	African American	Other	Urban	Suburban	Rural
Victim 678	321 (86.5%)	357 (84%)	565 (86.5%)	71 (80%)	42 (78%)	103 (78%)	419 (87%)	134 (88%)
Non-Victim 118	50 (13.5%)	68 (16%)	88 (13.5%)	18 (20%)	12 (12%)	29 (22%)	65 (13%)	19 (12%)
Total	371	425	653	89	54	132	484	153

Table 2-8
 Endorsement of Any Items in the Conflict Tactics Scale
 Lifetime Retrospective, Parents of Orig. Respondents, Wave 11 (n=861, total sample=872, 99%)
 Ages 49-88

Total	Sex		Ethnicity			Location of Residence		
	Male	Female	White	African American	Other	Urban	Suburban	Rural
Victim 594	219 (65%)	375 (71%)	518 (69%)	47 (68%)	29 (69%)	103 (72.5%)	350 (69%)	134 (66%)
Non-Victim 267	116 (35%)	150 (29%)	232 (31%)	22 (32%)	13 (31%)	39 (27.5%)	155 (31%)	68 (34%)
Total	335	525	750	69	42	142	505	202

Table 2-9
 Endorsement of Any Items in the Conflict Tactics Scale
 Adult Offspring of the Original Respondents, Wave 11 (n=139, total sample=453, 31%)
 Ages 18-42

Total	Sex		Ethnicity			Location of Residence		
	Male	Female	White	African American	Other	Urban	Suburban	Rural
Victim 127	49 (87.5%)	78 (94%)	90 (92%)	16 (94%)	8 (89%)	21 (84%)	79 (93%)	27 (96%)
Non-Victim 12	7 (12.4%)	5 (6%)	8 (8%)	1 (6%)	1 (11%)	4 (16%)	6 (7%)	1 (4%)
Total	56	83	98	17	9	25	85	28

Table 2-10
 Endorsement of Any Items in the Conflict Tactics Scale
 Adult Offspring of the Original Respondents, Wave 12 (n=163, total sample=595, 27%)
 Ages 19-45

Total	Sex		Ethnicity			Location of Residence		
	Male	Female	White	African American	Other	Urban	Suburban	Rural
Victim 136	44 (80%)	92 (85%)	102 (86%)	20 (71%)	14 (87.5%)	13 (62%)	69 (88.5%)	30 (88%)
Non-Victim 27	11 (20%)	16 (15%)	17 (14%)	8 (29%)	2 (12.5%)	8 (38%)	9 (11.5%)	4 (12%)
Total	55	108	119	28	18	21	78	34

Type and Severity of Aggression and Violence (Victimization)

To parallel the analyses we conducted on perpetration of IPV, we combined the responses across waves so that there were just four samples (i.e., original respondents, their spouses, their parents, and their adult children), and split the types of victimization into three types: (verbal, psychological, and relational aggression; physical aggression, threat of violence, less serious violence; and serious violence). *Again, a specific note is in order at this point. We recognize that no form of aggression and violence perpetrated toward anyone, including spouses, is unacceptable and thus the terms “less severe” or “more serious” may be unpalatable terms to some. However, we have elected to distinguish between non-physical violence (aggression) and two levels of violence in order to examine potential differences in predictors and outcomes for these potentially different behaviors.* These data were then examined for each group by Sex, Ethnicity, Location of Residence, and the Stake in Conformity variables that were available and relevant for each sample (married, children, highest educational level achieved, occupational status, residential stability, and social disorganization in the neighborhood).

Verbal, Psychological, and Relational Aggression (Victimization)

Original Respondents. We first examined the responses of the original respondents by creating a database that allowed us to examine the demographic predictors in the same year that the IPV behaviors were or were not occurring. Thus, we linked the demographics in wave 6 to the IPV behaviors in wave 7, the demographics in wave 7 to the behaviors in wave 8, through wave 10 demographics and wave 11 behaviors. This resulted in five comparisons that we then stacked and analyzed as a whole. Chi-square tests were then conducted for sex, ethnicity, marital status, whether or not they have children, and location of residence. ANOVAs were conducted for highest educational level achieved, occupational status, and social disorganization in the neighborhood). The results are reported in Table 2-11.

Table 2-11
Original Respondents: IPV Victimization
Verbal, Psychological, and Relational Victimization, by Demographics

Chi-Square Analyses				
Socio-Demographic Variable	X^2		p	
Sex Females more likely than Males	2.92		.09 (marginal)	
Ethnicity White more likely than Black or Other	8.24		.02	
Married Married more likely than Not Married	2.92		.09 (marginal)	
Children Children more likely than No Children	4.27		.04	
Residence Location Urban more likely than Suburban or Rural	11.34		.01	
Analyses of Variance (ANOVAs)				
Socio-Demographic Variable	F	p	Mean	Std Deviation
Highest Grade Completed Lower grade completed, more likely (trend)	3.12	.08	13.21 13.10	2.12 2.18
Occupational Status (Duncan SEI) Lower status job, more likely (trend)	3.31	.07	42.35 40.87	22.29 22.36
Neighborhood Social Disorganization No significant differences	1.93	.17	Ns	ns

We next examined the results for the parents, spouses, and adult offspring of the original respondents. Results are offered in detail in paragraph form, and significant (and marginally significant) results are presented in Table 2-12.

Table 2-12
 IPV Victimization: Significant Results by Sample
 Verbal, Psychological, and Relational Aggression

Parents of the Original Respondents	
	Sex Females more likely than males
Adult Offspring of Original Respondents	
	Sex Females more likely than males
	Location of Residence Rural more likely than Urban or Suburban
	Children (marginally significant) With children more likely than without children
Spouses of Original Respondents	
	Ethnicity White more likely than non-White
	Location of Residence Suburban more likely than Urban or Rural

Parents of the Original Respondents. First, the responses of the parents of the original respondents were examined. A chi-square test was conducted on these longitudinal, retrospective responses for sex and ethnicity, and an ANOVA was conducted on their responses for highest educational level achieved. Other demographic variables had potential to change over the reporting period (e.g., occupational status, neighborhood disorganization) and so could not be used. The chi-square test for sex was statistically significant ($X^2=5.07, p<.02$), indicating that women were more likely to report victimization by verbal aggression than were men. The chi-square test for ethnicity was not significant. The ANOVA for highest educational level was also nonsignificant for verbal victimization.

Offspring of the Original Respondents. Next, the responses of the adult offspring of the original respondents were examined. Chi-square tests were conducted for sex, ethnicity, marital status, whether or not they have children, and location of residence. ANOVAs were conducted for highest educational level achieved, residential stability, occupational status, and social disorganization in the neighborhood).

The chi-square test for sex was statistically significant ($X^2=5.04, p=.025$), indicating that females were more likely to report verbal, psychological, and relational victimization by their spouses than were males. The chi-square analysis for location of residence was statistically significant ($X^2=6.86, p=.03$), and follow up analyses indicated that rural respondents were more likely than urban or suburban respondents to report verbal, psychological, and relational victimization by their spouses. The chi-square analysis for children was marginally significant ($X^2=3.43, p=.06$), indicating that respondents with children tended to be more likely to report verbal, psychological, and relational victimization by their spouses than were those without

children. The chi-square analyses for ethnicity and marital status were not statistically significant.

None of the ANOVAs for educational attainment, residential stability, occupational status, nor neighborhood social disorganization were statistically significant for verbal, psychological, and relational aggression.

Spouses of the Original Respondents. Next, the responses of the spouses of the original respondents were examined. Chi-square tests were conducted for sex, ethnicity, and location of residence. Having children or not would have been included here as a stake in conformity variable, but examination of the responses indicated that too few respondents did *not* have children to this to be an adequate variable. ANOVAs were conducted for highest educational level achieved, residential stability, occupational status (Duncan SEI), and social disorganization in the neighborhood).

The chi-square test for sex was nonsignificant. The chi-square test for ethnicity was marginally significant ($X^2=4.85, p<.09$), indicating that White respondents were more likely than African American respondents and those respondents of other ethnicities to report victimization by verbal aggression. Test on location of residence yielded a statistically significant chi-square ($X^2=7.58, p<.03$), indicating that suburban respondents were more likely than their urban or rural peers to report victimization by verbal aggression.

None of the four ANOVAs conducted for education level, residential stability, occupational status, and social disorganization were statistically significant for verbal victimization.

Aggression, Threat of Violence, and Less Serious Violence (Victimization)

Original Respondents. We examined the responses of the original respondents in the same way that we examined verbal, psychological, and relational aggression. Chi-square tests were then conducted for sex, ethnicity, marital status, whether or not they have children, and location of residence. ANOVAs were conducted for highest educational level achieved, occupational status, and social disorganization in the neighborhood). The vast majority of the results were statistically significant, and so are reported in Table 2-13.

Table 2-13
Original Respondents: IPV Victimization
Aggression and Threat of Violence, by Demographics

Chi-Square Analyses				
Socio-Demographic Variable	X^2	p		
Sex Males more likely than Females	15.79	.000		
Ethnicity Black more likely than White or Other	41.0	.000		
Married Not Married more likely than Married	7.26	.007		
Children No Children more likely than Children	12.40	.000		
Residence Location Urban more likely than Suburban or Rural	25.63	.000		
Analyses of Variance (ANOVAs)				
Socio-Demographic Variable	F	p	Mean	Std Deviation
Highest Grade Completed Lower grade completed, more likely	128.45	.000	13.42 12.52	2.12 2.19
Occupational Status (Duncan SEI) Lower occupational status, more likely	84.05	.000	43.54 36.03	22.47 21.19
Neighborhood Social Disorganization Fewer problems reported, more likely	15.05	.000	1.58 1.49	0.72 0.55

We next examined the results for the parents, spouses, and adult offspring of the original respondents. Results are offered in detail in paragraph form, and significant (and marginally significant) results are presented in Table 2-14.

Table 2-14
 IPV Victimization: Significant Results by Sample
 Aggression and Threat of Violence

Parents of the Original Respondents	
	Educational attainment Lower educational attainment more likely than higher
Adult Offspring of Original Respondents	
	Sex Males more likely than females
	Children (marginally significant) With children more likely than without children
	Highest Grade Completed Lower educational attainment more likely than higher
	Occupational Status Lower career status more likely than higher status
	Neighborhood Social Disorganization More neighborhood problems more than fewer problems
Spouses of Original Respondents	
	Highest Grade Completed Lower educational attainment more likely than higher
	Occupational Status Lower occupational status more likely than higher status
	Neighborhood Social Disorganization More neighborhood problems more than fewer problems

Parents of the Original Respondents. Again, first, the responses of the parents of the original respondents were examined. A chi-square test was conducted on these longitudinal, retrospective responses for sex and ethnicity, and an ANOVA was conducted on their responses for highest educational level achieved. The chi-square tests for sex and ethnicity were not statistically significant. The ANOVA for highest education level achieved was statistically significant ($F=9.10, p<.01$), indicating that those respondents who reported being victimized by less serious forms of aggression and violence ($m=12.44, sd=2.52$) also reported lower levels of education achieved than those who were not victimized ($m=12.97, sd=2.48$).

Offspring of the Original Respondents. Next, the responses of the adult offspring of the original respondents were examined. Chi-square tests were conducted for sex, ethnicity, marital status, whether or not they have children, and location of residence. ANOVAs were conducted for highest educational level achieved, residential stability, occupational status, and social disorganization in the neighborhood).

The chi-square for sex was statistically significant ($X^2=6.90, p=.009$), indicating that males were more likely to report less serious forms of violent victimization by their spouses than were females. The chi-square analysis for children was marginally significant ($X^2=5.57, p=.02$), indicating that respondents with children tended to be more likely to report aggressive and less

serious forms of violent victimization by their spouses than were those without children. The chi-square analyses for ethnicity, location of residence, and marital status were not statistically significant.

The ANOVA for residential stability did not yield significant results. However, the other three ANOVAs that were conducted did. Specifically, the ANOVA for educational attainment was significant ($F=5.21$, $p=.02$), indicating that those respondents with higher levels of education ($m=12.43$, $sd=1.91$) were less likely to report being victimized by aggression and less serious forms of violence toward their spouses than were those with lower levels of education ($m=11.80$, $sd=1.69$).

The ANOVA for occupational status was statistically significant ($F=8.57$, $p=.004$), indicating that respondents with higher status careers ($m=36.90$, $sd=21.13$) reported less victimization by aggression and less serious forms of violence than did those with lower status careers ($m=27.27$, $sd=18.18$).

The ANOVA for neighborhood social disorganization was statistically significant ($F=11.25$, $p=.001$), indicating that those reporting more neighborhood problems ($m=1.46$, $sd=0.42$) were more likely to report victimization by their spouses in the form of aggression and less serious forms of violence than were their peers who reported fewer neighborhood problems ($m=1.28$, $sd=0.31$).

Spouses of the Original Respondents. Next, the responses of the spouses of the original respondents were examined. Chi-square tests were conducted for sex, ethnicity, and location of residence. ANOVAs were conducted for highest educational level achieved, residential stability, occupational status (Duncan SEI), and social disorganization in the neighborhood).

The chi-square tests for sex, ethnicity, and location of residence were not statistically significant for victimization by less serious forms of violence and aggression. The ANOVA for residential stability was not statistically significant.

The ANOVA for educational attainment was statistically significant ($F=15.27$, $p<.000$), indicating that those with higher levels of education ($m=13.76$, $sd=2.20$) were less likely to report victimization by aggression and less serious forms of violence than were their peers with lower levels of education ($m=12.99$, $sd=2.21$).

The ANOVA conducted for occupational status was statistically significant ($F=9.35$, $p<.002$), indicating that those with lower occupational status ($m=42.38$, $sd=23.62$) were more likely to report being victimized by aggression and less serious forms of violence than were their peers with higher occupational status ($m=48.83$, $sd=23.05$).

The ANOVA conducted for neighborhood social disorganization was also statistically significant ($F=21.69$, $p<.000$), indicating that those reporting more neighborhood problems ($m=1.29$, $sd=0.35$) also reported victimization by their spouses through aggression and less serious forms of violence, compared with their peers who reported fewer neighborhood problems ($m=1.17$, $sd=0.27$).

Serious Violence (Victimization)

Original Respondents. We examined the responses of the original respondents in the same way that we examined verbal, psychological, and relational aggression. Chi-square tests were then conducted for sex, ethnicity, marital status, whether or not they have children, and location of residence. ANOVAs were conducted for highest educational level achieved, occupational status (Duncan SEI), and social disorganization in the neighborhood). The results are reported in Table 2-15.

Table 2-15
Original Respondents: IPV Victimization
Serious Violence, by Demographics

Chi-Square Analyses				
Socio-Demographic Variable	X^2		p	
Sex Male more likely than Female	78.14		.000	
Ethnicity Black more likely than White or Other	68.24		.000	
Married No statistically significant differences	0.29		ns	
Children No Children more likely than Children	3.68		.06 (marginal)	
Residence Location Urban more likely than Suburban or Rural	52.51		.000	
Analyses of Variance (ANOVAs)				
Socio-Demographic Variable	F	p	$Mean$	$Std\ Deviation$
Highest Grade Completed Lower grade completed, more likely	109.42	.000	13.32 12.17	2.13 2.20
Occupational Status (Duncan SEI) Lower occupational status, more likely	60.43	.000	42.63 33.76	22.36 21.09
Neighborhood Social Disorganization No statistically significant differences	0.06	.81	Ns	ns

We next examined the results for the parents, spouses, and adult offspring of the original respondents. Results are offered in detail in paragraph form, and significant (and marginally significant) results are presented in Table 2-16.

Table 2-16
 IPV Victimization: Significant Results by Sample
 Serious Violence

Parents of the Original Respondents	
	Ethnicity Non-White more likely than White
	Highest Grade Completed (marginally significant) Lower educational attainment more likely than higher
Adult Offspring of Original Respondents	
	Sex Males more likely than females
	Location of Residence (marginally significant) Suburban and Rural more likely than Urban
	Highest Grade Completed Lower educational attainment more likely than higher
	Occupational Status Lower career status more likely than higher status
	Neighborhood Social Disorganization More neighborhood problems more likely than fewer
Spouses of Original Respondents	
	Highest Grade Completed Lower educational attainment more likely than higher
	Residential Stability Frequent moves more likely than less frequent moves
	Occupational Status Lower career status more likely than higher status
	Neighborhood Social Disorganization More neighborhood problems more likely than fewer

Parents of the Original Respondents. As with the prior analyses, first the responses of the parents of the original respondents were examined. A chi-square test was conducted on these longitudinal, retrospective responses for sex and ethnicity, and a t-test was conducted on their responses for highest educational level achieved. The chi-square test for sex was not statistically significant. The chi-square for ethnicity was statistically significant ($X^2=14.27$, $p=.001$), indicating that non-White respondents (both the African American and Other groups) reported being victimized by serious violence more than did their White counterparts. The ANOVA conducted to assess highest educational level achieved was marginally significant ($F=3.51$, $p=.06$), indicating that nonvictims ($m=12.84$, $sd=2.50$) tended to be more likely to report higher levels of education than did victims of serious violence ($m=12.43$, $sd=2.50$).

Offspring of the Original Respondents. Next, the responses of the adult offspring of the original respondents were examined. Chi-square tests were conducted for sex, ethnicity, marital status, whether or not they have children, and location of residence. ANOVAs were conducted

for highest educational level achieved, residential stability, occupational status (Duncan SEI), and social disorganization in the neighborhood).

The chi-square for sex was statistically significant ($X^2 = 18.02, p = .000$), indicating that males were more likely to report serious forms of violent victimization by their spouses than were females. The chi-square analysis for location of residence was marginally significant ($X^2 = 4.78, p = .09$), indicating that respondents from urban areas tended to be less likely to report serious forms of violent victimization by their spouses than were those from suburban and rural areas. The chi-square analyses for ethnicity, location of residence, children, and marital status were not statistically significant.

The ANOVA for residential stability was not statistically significant. However, the other three ANOVAs were significant. Specifically, the ANOVA for educational achievement was statistically significant ($F = 6.894, p < .009$), indicating that those with higher levels of education ($m = 12.37, sd = 1.91$) were less likely to report serious violence than were their peers with lower levels of education ($m = 11.51, sd = 1.39$).

The ANOVA conducted for occupational status was statistically significant ($F = 5.57, p < .02$), indicating that those with lower occupational status ($m = 25.94, sd = 15.56$) were more likely to report being victimized by serious forms of violence than were their peers with higher occupational status ($m = 35.29, sd = 21.32$).

The ANOVA conducted for neighborhood social disorganization was also statistically significant ($F = 8.21, p = .005$), indicating that those reporting more neighborhood problems ($m = 1.50, sd = 0.35$) also reported victimization by their spouses through aggression and less serious forms of violence, compared with their peers who reported fewer neighborhood problems ($m = 1.31, sd = 0.42$).

Spouses of the Original Respondents. Next, the responses of the spouses of the original respondents were examined. Chi-square tests were conducted for sex, ethnicity, and location of residence. ANOVAs were conducted for highest educational level achieved, residential stability, occupational status (Duncan SEI), and social disorganization in the neighborhood).

The chi-square tests for sex, ethnicity, and location of residence were not statistically significant for victimization by more serious forms of violence.

The ANOVA conducted for educational attainment and serious IPV victimization was statistically significant ($F = 7.48, p < .01$), indicating that those with higher educational attainment ($m = 13.67, sd = 2.21$) were less likely to report being victimized by serious violence than were those with lower educational attainment ($m = 12.81, sd = 2.25$).

The ANOVA conducted for residential stability was statistically significant ($F = 6.26, p < .02$), indicating that those who moved more frequently in the last ten years ($m = 2.98, sd = 4.45$) were more likely to report being victimized by serious forms of violence from their spouses than were those who moved less frequently in the last ten years ($m = 2.14, sd = 2.16$).

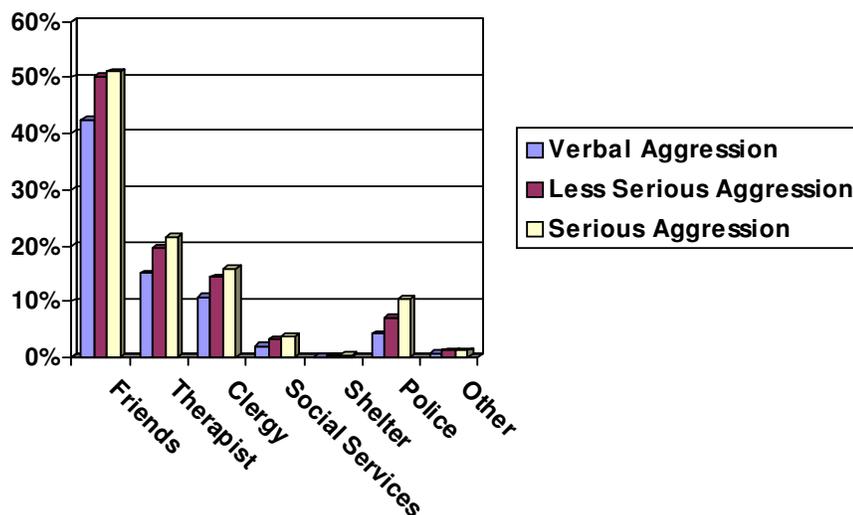
The ANOVA conducted for occupational status was statistically significant ($F=6.349$, $p<.02$), indicating that those with lower occupational status ($m=39.69$, $sd=21.33$) were more likely to report being victimized by aggression and less serious forms of violence than were their peers with higher occupational status ($m=48.15$, $sd=23.33$).

The ANOVA conducted for neighborhood social disorganization was also statistically significant ($F=17.28$, $p<.000$), indicating that those reporting more neighborhood problems ($m=1.35$, $sd=0.35$) also reported victimization by their spouses through serious forms of violence, compared with their peers who reported fewer neighborhood problems ($m=1.18$, $sd=0.28$).

Help-Seeking Behavior

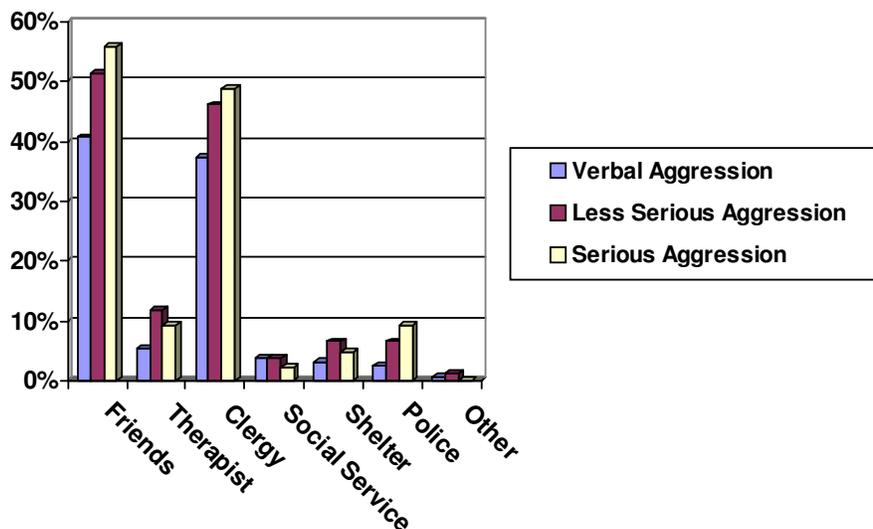
Among victims of IPV, we next sought to identify the sources of help they sought after a disagreement or fight. Respondents could indicate as many sources as they wanted, including friends, therapists, clergy, social services, a shelter, the police, or “other.” Figure 2-1 illustrates the responses by type of source from which the original respondents sought help. Results indicate that as the seriousness of the aggression and violence increased, victims were more likely to seek help outside their homes. Friends were the most common help source contacted, followed by therapists, clergy, and police.

Figure 2-1
IPV Victims Sources of Help Sought
After a Disagreement or Fight.
Original Respondents



We next examined the responses from the younger generation, the adult children of the original respondents. Their responses are illustrated in Figure 2-2. Friends and relatives as well as clergy were clearly the most commonly consulted sources for help for IPV. These two sources as well as the police were consulted more often as the seriousness of the IPV increased.

Figure 2-2
 IPV Victims Sources of Help Sought
 After a Disagreement or Fight.
 Adult Offspring of the Original Respondents



Contacting friends or relatives. We next sought to examine the sociodemographic characteristics of original respondent IPV victims who contacted friends, therapists, clergy, and the police, the most common sources contacted. Of those who contacted friends, 65% were female and 35% were male. When considering ethnicity, 81% were Anglo/White, 14% were African American, and 4% were of other ethnicities. Analysis of location of residence indicated that among those who contacted friends, 63% lived in suburban areas, 22% lived in urban areas, and 15% lived in rural areas.

Among the adult offspring of the original respondents who contacted friends or relatives as a result of IPV, 70% were female and 30% were male. When considering ethnicity, 77% were White, 15% were African American, and 8% were of other ethnicities. Analysis of location of residence yielded that 18% lived in urban areas, 60% lived in suburban areas, and 23% lived in rural areas.

Contacting private psychologist, psychiatrist, counselor, or therapist. Of those original respondents who sought the help of therapists, 60% were female and 40% were male. White respondents made of 90% of those who sought therapy, while 7% were African Americans and 3% were of other ethnicities. Further, 64% of therapy seekers lived in suburban areas, 20% were from urban areas, and 16% lived in rural areas.

Among the adult offspring of the original respondents who contacted private therapists, 60% were female and 40% were male. Among those who sought therapy, 50% were White, 20% were African American, and 30% were of other ethnicities, particularly Latino respondents.

Additionally, 10% lived in urban areas, 70% lived in suburban areas, and 20% lived in rural areas.

Contacting minister, rabbi, priest, or spiritual counselor. Of the original respondents who contacted clergy members for help with IPV, 55% were female and 45% were male. White respondents made up 80% of those who sought help from the clergy, 16% were African American, and 4% were of other ethnicities. Suburban residents made up 63% of those who sought clergy for help with IPV, while 16% were from urban areas and 21% were from rural areas.

Of the adult offspring of the original respondents who contacted clergy member for help with IPV, 69% were female and 31% were male. White respondents represented 72% of those who contacted the clergy, while 18% of African American respondents and 10% of respondents of other ethnicities also contacted clergy. Urban respondents represented 25%, suburban respondents represented 42%, and 32% lived in rural areas.

Contacting the police. Finally, those original respondents who sought the help of the police to deal with IPV were considered. Of those who contacted the police, 80% were female and 20% were male. Considered another way, among female IPV victims of any type, 7% contacted the police and 93% did not. Among male IPV victims, 2% contacted the police whereas 98% did not. Among the adult offspring of the original respondents, all of those who contacted the police were female.

Of those who contacted the police, 78% were White, 20% were African American, and 2% were of other ethnicities. Alternatively, of White IPV victims, 4% contacted the police while 96% did not. Among African American IPV victims, 7% contacted the police and 93% did not. Among those of other ethnicities, 2% contacted the police and 98% did not. There were too few adult offspring respondents in each cell to report ethnicity for this sample.

When location of residence was considered, 67% of those who contacted the police lived in suburban areas, 17% lived in urban areas, and 17% lived in rural areas. Considered another way, of urban IPV victims, 4% contacted the police but 96% did not. Among both suburban and rural IPV victims, 5% each contacted the police and 95% did not contact the police. Similarly, there were too few adult offspring respondents in each cell to report ethnicity for this sample.

Type of victimization and contacting the police. Victims of IPV contacted the police more often if the form of victimization they suffered was more serious. Specifically, of those IPV victims who were victims of verbal, psychological, and relational aggression, 4% contacted the police and 96% did not. Of those IPV victims who were victims of aggression and less serious violence, 7% contacted the police and 93% did not. Of those IPV victims of serious violence, 10% contacted the police while 90% did not. The sample of adult offspring who contacted the police was too small to conduct this analysis for that sample.

Contacting the police and future victimization. We created a pooled, cross-sectional dataset that allowed us to select only those respondents who reported having been victimized by

each of the three levels of IPV, and then examined how calling the police as a result of fights in that year predicted being victimized by IPV in the following year.

We first considered those who reported being victimized by verbal, psychological, or relational aggression. We first conducted a chi-square analysis to examine the number of respondents who called the police or not, and who then experienced victimization in the following year or not. Results of the analysis ($X^2=3.46$, $p=.06$) indicated that calling the police was related to marginally increased experience of verbal, psychological, or relational victimization in the following year. A logistic regression analysis predicting verbal aggression from calling the police, resulted in a significant model supporting this result, but the predictor (calling the police) was not significant, which casts further doubt on the strength of this result.

Results for aggression and less serious violence in the following year were not statistically significant. We next examined serious victimization in the following year. Results of the analysis ($X^2=9.206$, $p=.002$) indicated a higher number than expected victims of serious violence after calling the police after verbal, psychological, and relational aggression in the prior year. A logistic regression analysis predicting serious violence from calling the police in the prior year resulted in a significant model ($R^2=.013$, $p=.01$), and significant prediction (calling the police, $B=1.35$, $p=.005$, odds ratio=3.87).

We next considered those who reported being victimized by aggression and less serious violence and who contacted the police that same year. None of the three chi-square analyses indicated differential outcomes for future aggression and less serious violence for those who contacted the police. Examination of the crosstabs indicated that the counts and expected counts were virtually identical and so it is unlikely that this lack of significance was a power issue (despite a relatively small sample of victims who called the police, $n=20$).

Finally, we considered those who reported being victimized by serious violence and contacted the police that same year. Similarly none of the three chi-square analyses indicated differential outcomes for future serious violence for those who contacted the police as a result of their fights. Again, examination of the crosstabs indicated that the counts and expected counts were very similar and it is unlikely that this lack of significance was due to a power issue despite a small sample of those who contacted the police after serious violence ($n=15$).

We could not repeat this analysis for the adult offspring sample because the number of respondents who contacted the police as a result of their disagreements or fights was too small.

Identification of IPV Victimization: Self Report of Victimization

We next sought to identify IPV victims by using the Self Report of Victimization (SRV) scale. In the sixth through tenth waves, respondents were asked if in the past year someone had beaten them up or threatened to beat them up, and if someone attacked them with a weapon such as a gun, knife, or chair. Follow up questions were asked about the respondents' relationship with their attacker. In each year, spouse was one of the options, and in waves 9 and 10, cohabitating intimate partner was also an option. We selected those respondents who reported that their spouse or cohabitating partner was their attacker and created prevalence variables for

these items for each wave. We next created ever-prevalence variables (combining across the five waves) and were able to assess this group of respondents.

A total of 64 respondents reported being beaten up or attacked with a weapon by their spouse, 63 of whom also reported being victims of any type of IPV on the Conflict Tactics Scale, and 62 of whom specifically reported being victims of serious violence on the Conflict Tactics Scale. In comparison, using responses from the Conflict Tactics Scale in the same waves, we identified 1,214 victims of any type of aggression or violence, and 735 victims of serious violence, 674 of whom did not self identify as victims of IPV in the SRV. Of the 63 respondents who reported victimization on the SRV (and also on the CTS), 91% were female and 9% were male. When ethnicity was considered 91% were White, 8% were African American, and 1% were from other ethnic groups. Taken together, these results are consistent with prior research and indicate that though many respondents were willing to acknowledge IPV directed toward them by their spouses when asked specifically about their intimate partner relationship, fewer than 10% of these respondents responded about violence toward them when asked about it in an open context. Of those who did report IPV in that open context, White women represented over 90% respondents.

Victim reports of weapons and calling the police

Additional follow up questions were asked in the eighth, ninth, and tenth waves of data collection. In waves 8, 9, and 10, these included whether their attacker used a weapon, and in waves 8 and 9 the follow-ups included whether or not the respondent reported the attack to the police, and why or why not.

Weapon use by attacker. Results indicated that 8% reported that their attacker was their spouse and that their spouse used a weapon. These reflected a very small number of respondents and privacy rules did not allow us to examine the sociodemographic characteristics of these respondents.

Calling the police. When respondents replied about whether or not they contacted the police, 53% reported that they did, and 47% reported that they did not. The reasons they did not report to the police are included in Table 2-17. Most frequently provided reasons ranged from deeming the incident “not important enough”, being afraid or reprisal by the offender, that the matter was private, and “other” reasons.

Table 2-17
Reasons Respondents Gave for Not Contacting the Police about IPV
From the Self-Report of Victimization, Waves 8 and 9

Reason Given	Percentage
Private matter	10%
Not important enough	25%
Police would not doing anything	5%
Police would not do anything because ineffective	5%
Afraid of reprisal by offender	20%
Didn't want to get offender in trouble	5%
Because it was own fault	5%
Wanted to forget about it	5%
No real victimization	5%
Other	35%

The reasons they provided for reporting the incident to the police was included in Table 2-18. Common reasons provided for calling the police ranged from preventing further crimes by the offender, getting help and preventing recurrence, punishing the offender, and “other” reasons.

Table 2-18
Reasons Respondents Gave for Contacting the Police about IPV
From the Self-Report of Victimization, Waves 8 and 9

Reason Given	Percentage
Because it was illegal	6%
To get help/prevent recurrence	31%
Prevent further crimes by the offender	38%
Punish the offender	19%
Reinforce illegality of the crime	6%
Other	31%

Rates of contacting the police for IPV vs non-IPV. We next examined whether there were differences in the rates of contacting the police between those who reported their attacker was their spouse or cohabiting partner or someone else. Results using data from the eighth and ninth waves of data collection indicated that 53.3% of respondents contacted the police about IPV, and 33% of the rest of the assaults (presumed to be non-IPV because they were not specified to be spouse/partner attackers) were reported to the police. A chi-square analysis was conducted to assess whether this difference was statistically significant, and results indicated that they were ($X^2=4.62, p=.03$), specifically revealing that in this sample, victims of violence were more likely to contact the police when their attacker was a spouse or partner (i.e., IPV) than when their attacker was someone else. Further analysis using sex as an additional level in a chi-square analysis indicated that this difference was driven by the female victims in the sample.

IPV and contacting the police in two generations. Next, the relationship between IPV and seeking help from the police in the original respondent generation and in their children's generation was explored. We first conducted chi-square and logistic regression analyses between the two generations for each type of IPV perpetration and victimization. None of these analyses resulted in statistically significant findings. Next, similar analyses were conducted to examine the relationship between contacting the police in the parent (original respondent) generation and each type of IPV victimization in the adult offspring generation, and again, no statistically significant differences were found. The analyses were repeated to compare contacting the relationship between contacting the police in the original respondent generation and contacting the police in the adult offspring generation. Finally, similar analyses were conducted that assessed the relationship between IPV in original respondent generation and contacting the police for IPV in the adult offspring in the adult offspring generation. Overall, results indicated that there was no evidence in this sample for an intergenerational relationship between IPV perpetration or victimization, nor for contacting the police between the original respondent generation and their children's generation.

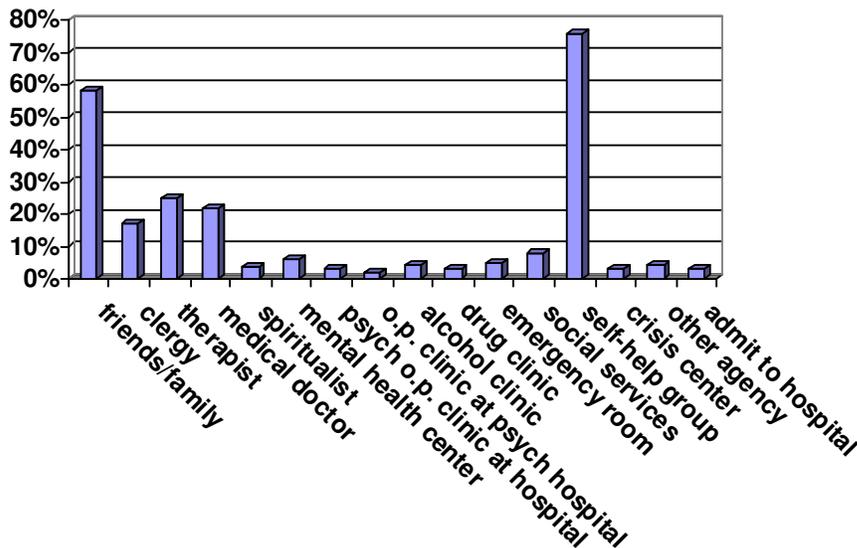
Objective 3 Use of Health and Social Services

Objective 3: Use of Health and Social Services. Assess the utilization rates of informal resources (i.e., friends/relatives) and formal community resources (e.g., safehouse/shelter, private psychologist, clergy, social service or community agency) for all identified victims and perpetrators. Examine whether the services were deemed helpful by the victims and compare the current rates of IPV with the rates in subsequent years by use of any resource and by specific type of resource used. Investigate under what conditions resource utilization reduced, increased, or had no effect on future IPV. Compare IPV resource utilizers with IPV non-resource utilizers to assess potential differences by demographic, sociocultural and behavioral variables and whether service utilization had a differential impact in these two groups on future IPV. Determine whether IPV victims and perpetrators were more or less likely to use health and social services than the general population by examining resource utilization prevalence rates for those who reported IPV and those who did not. Determine whether help-seeking among the original respondents is related to their children’s IPV and help-seeking behaviors.

A. Utilization rates of informal and formal services

We first examined utilization rates of formal and informal community resources overall across waves six through eleven for the original respondents. Results are shown in Figure 3-1, and highlight that the most frequently sought services were informal resources of friends and family, as well as somewhat more formal services such as self-help groups, as well as clergy, therapists, and medical doctors. See Appendix C for a more specific description of the service contexts.

Figure 3-1
Health and Social Service Resource Usage
Original Respondents, Waves 6,7,8,9, and 11



We next examined the resources that IPV victims and perpetrators used for help with mental health issues, but that they did not indicate they were using the resources to help with IPV. First, cases were selected to exclude those people who were using the services to help with IPV. The instrument did not have an option to list IPV, and so to be conservative, we allowed only the following reasons: drug use, alcohol use, depression, sexual relations, and trouble with the law, and excluded family relationships, personal, and other. The following analyses in this (A) section of Objective 3, then, were conducted on the assumption that the respondents sought help from these resources for reasons *other than* for IPV. The results are summarized in Table 3-1 and 3-2, following the detailed narrative below.

Sex of respondent. We first examined use of the services by sex of the respondent. Women were more likely than men to seek out the help of friends and family to deal with non-IPV issues ($X^2=25.01, p=.000$). They were also more likely than men to seek out the help of therapists ($X^2=8.59, p=.003$), medical doctors ($X^2=18.97, p=.000$), and self-help groups ($X^2=11.43, p=.001$). Males were more likely than women to seek help at alcohol clinics ($X^2=29.79, p=.000$) and drug clinics ($X^2=16.08, p=.000$).

Perpetrators of IPV. The next analyses compare study participants who were perpetrators of specific types of IPV to those study participants who were not perpetrators of that type of IPV. Those comparison respondents could have been non-perpetrators, perpetrators of another type of IPV, or victims of any type, including non-victims.

We next examined use of services by type of perpetration, beginning with verbal, psychological, and relational aggression. This type of perpetration was associated with increased usage of friends and family ($X^2=3.83, p=.05$) and self-help groups ($X^2=9.61, p=.002$) as resources.

We next examined use of services by perpetration of aggression, threat of violence, and less serious violence. This type of perpetration was associated with increased use of friends and family as a resource ($X^2=4.19, p=.03$), therapists ($X^2=6.88, p=.009$), medical doctors ($X^2=2.82, p=.09$), mental health centers ($X^2=6.15, p=.01$), drug clinics ($X^2=10.04, p=.002$), emergency rooms ($X^2=12.54, p=.000$), social service agencies ($X^2=6.72, p=.01$), crisis centers ($X^2=5.25, p=.02$), and inpatient admission to a hospital ($X^2=20.385, p=.000$).

Finally, we examined use of mental health services by perpetration of serious violence. Again, nearly all types of resources were utilized by the respondent perpetrators. Specifically, serious violence perpetration was associated with use of the following resources for non-IPV purposes: friends and family ($X^2=4.07, p=.04$), therapist ($X^2=17.71, p=.000$), medical doctors ($X^2=15.35, p=.000$), mental health centers ($X^2=10.66, p=.001$), psychiatric outpatient clinics at a general hospital ($X^2=2.83, p=.09$), drug clinics ($X^2=3.92, p=.05$), emergency rooms ($X^2=6.92, p=.009$), social services ($X^2=19.28, p=.000$), crisis centers ($X^2=16.67, p=.000$), and inpatient admission to a hospital ($X^2=18.87, p=.000$).

IPV perpetration and arrest. When we considered perpetrators who had been arrested for IPV compared with those who had not been arrested, perpetrators reported seeking out another person ($X^2=5.37, p=.02$) and social services (marginally significant, $X^2=3.32, p=.07$).

Table 3-1
 Summary of Service Utilization
 for Non-IPV Reasons
 IPV Perpetrators, Original Respondents

Resource Contacted	Perpetrators of Verbal, Psychological and Relational Aggression	Perpetrators of Aggression and Threats of Violence	Perpetrators of Serious Violence	Perpetrators who were arrested
Friend or Relative	●	●	●	
Clergy (priest, minister, other religious leader)				
Psychiatrist, Psychologist, Social Worker, Private Counselor		●	●	
Medical Doctor		●†	●	
Spiritualist, Herbalist, Natural Therapist				
Any Other Person				●
Mental Health Center		●†	●	
Psychiatric Outpatient Clinic at a General Hospital			●†	
Outpatient clinic at a Psychiatric Hospital				
Drug clinic		●	●	
Alcohol clinic				
Emergency Room		●	●	
Social Service Agencies		●	●	●†
Crisis centers		●	●	
Self Help Groups	●			
Inpatient Admission to a hospital		●	●	

● Indicates statistically significant < .05

† Indicates marginal significance

Victims of IPV. The next analyses compare study participants who were victims of specific types of IPV to those study participants who were not victims of that type of IPV. Those comparison respondents could be non-victims, victims of another type of IPV, or perpetrators of any type, including non-perpetrators.

When we considered victims of verbal, psychological, and relational aggression, we found that these victims sought out, for non-IPV purposes, clergy (marginally significant, $X^2=2.97, p=.09$), therapists (marginally significant $X^2=3.70, p=.06$), medical doctors ($X^2=4.28, p=.04$), emergency rooms ($X^2=3.60, p=.06$), self-help groups ($X^2=9.14, p=.002$),

We next considered victims of aggression, threat of violence, and less serious violence. Compared with non-victims and victims of IPV, this group sought non-IPV help with the following resources: clergy (marginally significant, $X^2=3.10, p=.08$), therapists ($X^2=14.89, p=.000$), mental health centers ($X^2=8.82, p=.003$), psychiatric outpatient clinics at a general hospital ($X^2=4.19, p=.04$), drug clinics ($X^2=9.02, p=.003$), alcohol clinics ($X^2=10.82, p=.001$), emergency rooms ($X^2=8.63, p=.003$), social services ($X^2=18.00, p=.000$), crisis centers ($X^2=5.95, p=.02$), and inpatient admission to a hospital ($X^2=21.74, p=.000$).

Finally, we considered victims of serious IPV. Compared with non-victims, this group sought out help for non-IPV issues from these services: therapists ($X^2=6.14, p=.01$), mental health centers ($X^2=11.78, p=.001$), drug clinics ($X^2=13.67, p=.000$), alcohol clinics ($X^2=10.28, p=.001$), emergency rooms ($X^2=8.76, p=.003$), social services ($X^2=6.92, p=.009$), crisis centers (marginally significant, $X^2=3.64, p=.06$), and inpatient admission to a hospital ($X^2=29.28, p=.000$).

Victims who reported to the police. We next assess the non-IPV mental health resource utilization of IPV victims who reported the IPV to the police versus those who did not. Victims who called the police were most likely to seek out non-IPV help with therapists ($X^2=12.93, p=.000$), medical doctors ($X^2=5.97, p=.02$), emergency rooms (marginally significant, $X^2=3.52, p=.06$), social services ($X^2=3.86, p=.05$), and inpatient admission to a hospital (marginally significant, $X^2=2.91, p=.09$).

Table 3-2
 Summary of Service Utilization
 for Non-IPV Reasons
 IPV Victims, Original Respondents

Resource contacted	Victims of Verbal, Psychological, and Relational Aggression	Victims of Aggression, Threat of Violence, and Less Serious Violence	Victims of Serious Violence	Victims who reported IPV to the police
Friend or Relative				
Clergy (priest, minister, other religious leader)	●†	●†		
Psychiatrist, Psychologist, Social Worker, Private Counselor	●†	●	●	●
Medical Doctor	●			●
Spiritualist, Herbalist, Natural Therapist				
Any Other Person				
Mental Health Center		●	●	
Psychiatric Outpatient Clinic at a General Hospital		●		
Outpatient clinic at a Psychiatric Hospital				
Drug clinic		●	●	
Alcohol clinic		●	●	
Emergency Room	●†	●	●	●
Social Service Agencies		●	●	●
Crisis centers			●†	
Self Help Groups	●			
Inpatient Admission to a hospital		●	●	●†

● Indicates statistical significance, $p < .05$

† Indicates marginal significance

B. Helpfulness of Services

We next examined how helpful IPV victims deemed the resources they utilized for ostensibly “not IPV” reasons among the original respondents. To this end, three ANOVAs were conducted. Victims of verbal, psychological, and relational aggression reported their services to be more helpful ($m=10.26$, $sd=5.40$) than did those not victimized by the same type of aggression ($m=7.67$, $sd=4.42$), but who still sought services for non-IPV reasons ($F=8.22$, $p=.004$). There were no significant differences for the other two types of victims, i.e., those victims of physical aggression and violence.

Next, we compared rates of IPV to the rates of IPV in the following waves, by overall service utilization and by specific types of service utilization. First, a pooled, cross-sectional database was created that included comparisons between IPV and service utilization in wave 6 and IPV in wave 7, between IPV and service utilization in wave 7 and IPV in wave 8, and between IPV and service utilization in wave 8 and IPV in wave 9. Comparisons between waves 9 and 10 were not used because 10 years had passed between the two waves, nor between wave 10 and 11 because service utilization was only measured in wave 11, not wave 10.

First, we examined the combined rates of verbal, psychological, and relational victimization, in waves 6, 7, and 8, which was 0.755 (75.5%). When only those who received any services were considered, the combined rate of the same type of victimization during the following waves (7, 8, and 9) was 0.860 (86.0%). Next, we examined the combined rate of aggression, threat of violence, and less serious violence for wave 6, 7, and 8, which were 0.375 (37.5%) and compared it with the following wave, which was 0.421 (42.1%). Finally, we examined the combined rate of serious violent victimization from the earlier waves, which was 0.164 (16.4%), and compared the rate with later victimization, which was 0.176 (17.6%). Overall, rates of victimization increased despite service utilization.

The following table, Table 3-3, shows the IPV victimization rate for each type of victimization in Wave A (waves 6, 7, and 8) and Wave B (waves 7, 8, and 9) after each type of service utilization during Wave A. Admission to a hospital was not used because it was not assessed in wave 6, and thus all of the wave 6 predictor variables would have been eliminated from analyses. Paired *t*-tests were used to compare pre- and post-help-seeking behavior rates of IPV for those services with more than twenty respondents. Overall, the only specific services related to a decrease in IPV were friends/relatives (i.e., for serious violence only, $t=2.37$, $p=.018$) and psychiatrists, psychologists, social workers, and private counselors (i.e., for less serious violence, $t=2.17$, $p=.032$, and for serious violence, $t=2.76$, $p=.007$).

Table 3-3
Summary of Service Utilization
IPV Victims, Original Respondents

Resource Utilized	Rate: Victims of Verbal, Psychological, and Relational Aggression		Rate: Victims of Aggression , Threat of Violence, and Less Serious Violence		Rate: Victims of Serious Violence	
	Wave A 6,7,8	Wave B 7,8,9	Wave A 6,7,8	Wave B 7,8,9	Wave A 6,7,8	Wave B 7,8,9
Overall	75.5%	81.8% **	35.7%	34.0%	13.9%	13.9%
Friend or Relative (n=481)	85.7%	87.3%	47.4%	43.0%	20.4%	15.6%*
Clergy (priest, minister, other religious leader)(n=103)	81.6%	85.4%	51.5%	49.5%	26.2%	19.4%
Psychiatrist, Psychologist, Social Worker, Private Counselor (n=135)	85.9%	88.9%	54.1%	43.0%*	24.4%	13.3%**
Medical Doctor (n=113)	87.6%	87.6%	44.3%	38.1%	15.8%	11.4%
Spiritualist, Herbalist, Natural Therapist (n=9, no testing)	66.7%	88.9%	33.3%	77.8%	33.3%	55.6%
Any Other Person (n=21)	95.24%	95.24%	61.9%	38.1%	28.6%	23.8%
Mental Health Center (n=26)	88.5%	96.2%	50.0%	38.5%	23.1%	19.2%
Psychiatric Outpatient Clinic at a General Hospital (n=10, no testing)	90.0%	100.0%	40.0%	50.0%	0.0%	20.0%
Outpatient clinic at a Psychiatric Hospital (n=4, no testing)	100.0%	100.0%	75.0%	0%	50.0%	0%
Drug clinic (n=11, no testing)	100.0%	100.0%	72.7%	63.6%	63.6%	54.6%
Alcohol clinic (n=17, no testing)	100.0%	100.0%	64.7%	64.7%	35.3%	35.3%
Emergency Room (n=22)	86.4%	90.9%	45.4%	50.0%	27.3%	22.7%
Social Service Agencies (n=47)	93.6%	89.4%	53.2%	53.2%	21.3%	17.0%
Crisis centers (n=14, no testing)	100.0%	92.9%	50.0%	35.7%	28.6%	21.4%
Self Help Groups (n=37)	94.6%	100.0%	64.9%	56.8%	35.1%	29.7%

Key: $p < .05^*$, $p < .01^{**}$, $p < .001^{***}$

Adult Offspring of the Original Respondents. We first examined utilization rates of informal and formal community resources overall and by identified victims and identified perpetrators. Of the seventeen types of community resources utilized (See Appendix C for the exact descriptions read to the respondents), by far the most common was the informal resource of friends and families (24% of all respondents). Therapists and medical doctors were each sought out by approximately 5% of the sample, and clergy members were sought out by 4% of the sample. No other resources were endorsed by more than 2% of the sample.

As a result of this finding, we then collapsed across formal services and compared them with informal services (family and friends), and compared usage for perpetrators compared with non-perpetrators and victims compared with non-victims. Three chi-square analyses were conducted, one for each type of perpetrator (i.e., verbal/psychological/relational, aggression and less serious violence, and serious violence). Each analysis compared perpetrator or not and three levels of services usages (no services, informal services, and formal services). None of the three analyses were statistically significant. A follow-up analysis was conducted that collapsed across formal and informal services and resulted in a use of services versus no use of services analysis, but this also was not statistically significant for any of the three forms of IPV.

We next compared victims versus non-victims use of formal and informal services. The first set of three chi-square analysis examined victims versus non-victims' use of services or not. The analysis for verbal, psychological, and relational aggression was statistically significant ($X^2=5.29, p=.02$) indicating a greater use of services by victims than by non-victims. A follow-up chi-square analysis that split service usage into formal versus informal services was not significant. The next analysis for aggression and less serious violence was marginally significant ($X^2=3.06, p=.08$), again indicating a greater use of services by victims than by non-victims. A follow-up chi-square analysis that distinguished between formal and informal services was significant ($X^2=5.97, p=.05$), indicating a greater use of informal (29%) than formal services (12%). The analysis for serious violence was not statistically significant.

We next compared the degree to which victims reported finding these services helpful. ANOVAs were conducted for each form of victimization. The ANOVA for verbal, psychological, and relational aggression was not statistically significant. The ANOVAs for aggression and less serious violence ($F=4.660, p=.04$) and for serious violence ($F=5.88, p=.02$) were statistically significant. Analysis of the means revealed that IPV victims ($m=3.70, sd=0.97$; $m=3.50, sd=0.88$, respectively) found the services less helpful than did non-IPV victims ($m=4.19, sd=0.87$; $m=4.13, sd=0.92$, respectively).

It was not possible to conduct any of the predictive analyses from resource utilization to future IPV with this sample because the adult offspring completed the resource utilization measure in wave 12, the second of two waves of data collection and thus IPV was not measured in a wave after resources utilization.

C. Further examination of conditions related to IPV and service utilization

First, logistic regression analyses were conducted to predict future verbal, psychological, and relational victimization. Predictors entered in the first step were sex, ethnicity, location of

residence, marital status, whether or not they had a child, and prior verbal, psychological, and relational aggression. Next, service utilization was entered in the second step. Though this step was significant, it was significant in the opposite direction expected, indicating that service utilization in this sample was related to higher levels of victimization in later waves. The same result was found for aggression, threat of violence, and less serious violence. For serious violence, the only difference was that service utilization was not statistically significant. Further analysis was not indicated because it appeared that the service measured here did not appear to be related to reductions in IPV, but instead perhaps to increases in IPV, and thus further analyses designed to examine the conditions under which programs had a greater effect would not be found.

D. Service utilization and impact on future IPV.

Of the 1,406 for whom there was data on resource utilization, the prevalence rate was .706, indicating that 70.6% of respondents contacted health and social services for assistance at some point between the sixth and eleventh waves of data collection. Next, those who contacted health and social services were compared by stable demographic characteristics (i.e., sex and ethnicity). Of those who contacted services for help, females (56%) reported doing this more frequently than did males (44%). Among females, 79.2% contacted services for help, compared with 62% of males ($X^2=50.17, p=.000$). Ethnicity was not related to resource utilization.

Location of residence was also considered, though the measure is suboptimal because it could have changed during the reporting period (the most recent measure of each was used). Results, which were statistically significant ($X^2=18.97, p=.000$), indicated that urban residents (74.9%) were the most likely to seek out health and social services, with suburban (71.5%) and rural (58.8%) residents following. This result may reflect availability of services, a variable that could not be measured here – that is, urban residents may have greater knowledge of and access to these types of resources than do rural residents.

Next, service utilization was examined to assess the degree to which it was related to future IPV. First, a pooled, cross-sectional database was created that included comparisons between IPV and service utilization in wave 6 and IPV in wave 7, between IPV and service utilization in wave 7 and IPV in wave 8, and between IPV and service utilization in wave 8 and IPV in wave 9. Comparisons between waves 9 and 10 were not used because 10 years had passed between the two waves, nor between wave 10 and 11 because service utilization was only measured in wave 11, not wave 10.

First, the type of IPV victimization in the first wave was used in a logistic regression analysis to predict the same type of IPV victimization in the next wave, to allow prior victimization to account for as much variance as it could. In the second step of the logistic regression, service utilization was entered in order to examine whether it would significantly predict following year victimization. Results from the logistic regression analyses are presented in Tables 3-4 to 3-6. For all three types of IPV, prior IPV statistically significantly predicted later wave (3 years later, in each case) IPV. For both verbal, psychological, and relational aggression, and aggression, threat of violence and less serious violence, service utilization significant predicted later victimization, but not in the direction that would be expected – service

utilization was related to increased victimization. Though the odds ratios are fairly substantial, caution must be taken in interpreting the predictors because the standardized regression coefficients (the calculated Betas shown in the tables below, and which are more appropriate to interpret than odds ratios) are relatively weak. For serious violence, service utilization was not statistically significant, predicting neither more nor less later victimization.

Table 3-4
 Logistic Regression Models Predicting IPV (Verbal, Psychological, and Relational Aggression) from Prior Wave IPV and Service Utilization
 Model $R^2=.22, p=.000$

Predictor	Beta	Standard Error	Statistical Significance	Odds Ratio
Step 1: $R^2=.22, p=.000$				
Prior IPV	0.40	0.134	.000	8.00
Step 2: $R^2=.22, p=.02$				
Prior IPV	0.39	0.136	.000	7.57
Service Utilization	0.08	0.154	.02	1.44

Table 3-5
 Logistic Regression Models Predicting IPV (Aggression, Threat of Violence, Less Serious Violence) from Prior Wave IPV and Service Utilization
 Model $R^2=.19, p=.000$

Predictor	Beta	Standard Error	Statistical Significance	Odds Ratio
Step 1: $R^2=.18, p=.000$				
Prior IPV	0.37	0.11	.000	5.21
Step 2: $R^2=.19, p=.000$				
Prior IPV	0.36	0.11	.000	4.90
Service Utilization	0.09	0.11	.000	1.51

Table 3-6
 Logistic Regression Models Predicting IPV (Serious Violence) from Prior Wave IPV and Service Utilization
 Model $R^2=.16, p=.000$

Predictor	Beta	Standard Error	Statistical Significance	Odds Ratio
Step 1: $R^2=.16, p=.000$				
Prior IPV	0.35	0.16	.000	8.00
Step 2: $R^2=.16, p=.355, n.s.$				
Prior IPV	0.34	0.16	.000	7.78
Service Utilization	0.03	0.15	.354	1.15

E. Utilization rates of mental health services for all respondents (IPV and non-IPV)

The next goal was to determine whether IPV victims and perpetrators were more or less likely to use health and social services than were the general population by examining resource utilization prevalence rates for those who report IPV and for those who did not. First, perpetrators were examined. Among those who reported any IPV perpetration, 66.9% reported contacting services for help. Among those who did not report any IPV perpetration, 53.1% reported contacting services for assistance. The chi-square test for this comparison was statistically significant ($X^2=7.97, p=.005$), indicating that those who reported IPV perpetration were more likely to contact health and social services than were those who did not report IPV perpetration.

Similar results (all with significant chi-square analyses) were found for those who specifically reported perpetrating verbal, psychological, and relational aggression, as 70% of perpetrators reported contacting health and social services and 51.4% of non-perpetrators reported contacting those services ($X^2=10.72, p=.001$). Further, 78.6% of those who specifically reported perpetrating aggression, threat of violence and less serious violence, reported contacting services for help, whereas 57.7% of those who did not perpetrate this sort of IPV contacted services for help ($X^2=65.86, p=.000$). Finally, 87.1% of those who reported perpetrating serious IPV also reported contacting health and social services for help, compared with 64% of their non-IPV-perpetrating peers ($X^2=60.02, p=.000$).

Victims were next assessed compared with non-victims. Among those who reported any IPV victimization, 69.9% reported contacting services for assistance ($X^2=7.97, p=.005$), indicating that those who reported IPV victimization were more likely to contact health and social services than were those who did not report IPV victimization. Specifically, among those who reported being victimized by verbal, psychological, and relational aggression, 70.3% reported contacting services for help, compared with 50% of non-victims ($X^2=14.83, p=.000$). Among those victims who reported being victimized by aggression, threat of violence, and less serious violence, 77% reported contacting services for help, compared with 59.5% of non-victims ($X^2=46.03, p=.000$). Finally, among those who reported being victimized by serious violence, 79.8% reported contacting services for assistance, compared with 64.7% of non-victims ($X^2=28.53, p=.000$). Overall, results indicate that both perpetrators and victims were more likely to contact health and social services for mental health issues than were non-perpetrators and non-victims.

F. IPV and help-seeking in two generations

Next, the relationship between IPV and seeking help from formal and informal services in the original respondent generation and in their children's generation was explored. Results were similar to those reported in Objective 2 that focused on contacting the police as a result of IPV. We conducted chi-square and logistic regression analyses to examine the relationship between contacting friends and relatives (informal services) and contacting therapists, clergy, safehouses/shelters, and the police (formal services) in the parent (original respondent) generation and each type of IPV victimization in the adult offspring generation. No statistically significant differences were found. The analyses were repeated to compare contacting the

relationship between contacting formal and informal services in the original respondent generation and contacting formal and informal services in the adult offspring generation. Finally, similar analyses were conducted that assessed the relationship between IPV in original respondent generation and seeking help from formal and informal services in the adult offspring generation. Overall, results indicated that there was no evidence in this sample for an intergenerational relationship between IPV perpetration or victimization, or for seeking help from formal or informal services between the original respondent generation and their children's generation.

Objective 4 Unmet Needs

Objective 4: Unmet Needs. Examine the prevalence of IPV victims/perpetrators (in the total IPV population, by demographic subgroups, and by those with mental health diagnoses) who sought help for problems other than IPV in the health and social services systems, but did not seek help for IPV.

Original respondents. As in Objective 3 above, because the measure of health and social services seeking did not include IPV as a specific problem the respondents could select as a reason for seeking help, a variable was created that used only responses for health and social service help seeking for drugs, alcohol, depression, sexual relations, and trouble with the law, and leaving out family relationships, personal, and other as it is reasonable to assume that a respondent seeking help for IPV may have selected one of these categories. A second variable was created for prior analyses that measured help seeking behavior for IPV.

The result of crossing those two new variables was that 47% of respondents used resources for both IPV and for non-IPV reasons, 32% reported using resources only for non-IPV reasons, 10% reported using resources for IPV only, and 11% reported using no services at all. A total of 263 respondents fit into the category of seeking help for non-IPV reasons and not for IPV reasons. Within each victim and perpetrator group, we explored whether there were differences by sex, ethnicity, injury sustained, or depression.

Victimization. Of the 263 respondents, 248 (94% of the total) respondents reported being victimized by verbal, psychological, or relational aggression. There were no significant differences within this victim group for sex, ethnicity, injury from IPV, or by being depressed. When victimization by aggression, threat of violence, or less serious violence was examined, 126 of the 263 respondents (48% of the total) reported this type of IPV. Within this type of victimization, there were significant differences by sex ($X^2=8.63$, $p=.003$), depression ($X^2=7.93$, $p=.005$), and injury ($X^2=17.35$, $p=.000$), indicating that males, depressed individuals, and those who sustained injury as a result of IPV were more likely than females, non-depressed individuals, and non-injured individuals to be victimized by less serious IPV while not seeking out help for IPV, but for non-IPV problems instead. When victimization by serious violence was considered, 69 (26% of the total) respondents reported this type of IPV. Within this type of victimization, there were significant differences by sex ($X^2=14.99$, $p=.000$) and injury ($X^2=25.25$, $p=.000$), indicating that males and those who sustained injury as a result of IPV were more likely than females and non-injured individuals to be victimized by serious IPV while not seeking out help for IPV, but for non-IPV problems instead. Taken together, these results indicate that those males who were depressed and suffered from injury at the hands of their spouses and partners may either not be finding the help for IPV that they need, or they may be unwilling to acknowledge that their problems are related to IPV and have been treating other symptoms instead.

Perpetration. Of the 263 respondents, 251 (95% of the total) respondents reported being perpetrators of verbal, psychological, or relational aggression. There were no significant differences within this victim group for sex, ethnicity, injury from IPV, though there was a

marginally significant difference for being depressed ($X^2=2.71, p=.10$), indicating that depressed individuals among perpetrators of verbal, psychological, and relational tended to be more likely to seek help for non-IPV reasons and not for IPV. When victimization by aggression, threat of violence, or less serious violence was examined, 138 of the 263 respondents (54% of the total) reported perpetrating this type of IPV. Within this type of perpetration, there were significant differences by depression ($X^2=10.39, p=.001$) and injury ($X^2=7.57, p=.006$), indicating that depressed individuals and those who sustained injury as a result of IPV were more likely than non-depressed individuals, and non-injured individuals to perpetrate less serious IPV while not seeking out help for IPV, but for non-IPV problems instead. When perpetration of serious violence was considered, 49 (19% of the total) respondents reported perpetrating this type of IPV. Within this type of perpetration, there were marginally significant differences by sex ($X^2=3.28, p=.07$) and significant differences by depress ($X^2=24.05, p=.000$) and injury ($X^2=20.48, p=.000$), indicating that females, depressed individuals, and those who sustained injury as a result of IPV were more likely than males, non-depressed individuals, and non-injured individuals to perpetrate serious IPV while not seeking out help for IPV, but for non-IPV problems instead. Similar to the victims, when these results are considered together, it appears that perpetrators are also seeking help for non-IPV related issues, and that this occurs more frequently in female depressed individuals who, despite being perpetrators, also sustained injury at the hands of their spouses or partners.

Adult offspring of the original respondents. Because the measure of health and social service help-seeking did not include IPV as a specific problem the respondents could select as a reason for seeking help, a variable was created that used only responses for public service help seeking for drugs, alcohol, depression, sexual relations, and trouble with the law, and leaving out family relationships, personal, and other as it is reasonable to assume that a respondent seeking help for IPV may have selected one of these categories. A second variable was created for prior analyses that measured help seeking behavior for IPV. When these two variables were crossed with each other, it was found that 36% sought help for IPV and for non-IPV, 48% sought help for IPV but not for non-IPV, 8% respondents met the criteria of seeking help for reasons other than IPV in the health and social services systems, but did not seek help for IPV, and 9% did not seek help of any type. Due to the small number of respondents who sought help for IPV, analyses could not be conducted comparing those who sought help for non-IPV and not for IPV with those who sought help for IPV.

Chi-square analyses were then conducted to measure whether IPV victims (regardless of their own help-seeking for IPV) were more or less likely than those not victimized by IPV to seek help for non-IPV reasons. None of the three chi-square analyses conducted (i.e., one for each type of IPV victimization) were statistically significant. Chi-square analyses could not be conducted for those perpetrators who had been arrested for IPV because in this sample there were no IPV arrestees.

DISCUSSION AND IMPLICATIONS FOR POLICY

Historically, the criminal justice response to IPV has vacillated from minimal attention to the problems of IPV to mandatory arrest and court-ordered intervention for batterers. Despite large amounts of resources dedicated to affecting the problem, there is little evidence that any of these modalities are effective. Worse yet, in some cases, IPV recidivism has been shown in some studies to be higher when criminal justice sanctions are applied (e.g., Pate & Hamilton, 1992; Berk, et al., 1992). There is much to be learned about what works and what does not work. We could not conduct a formal evaluation of the impact of arrest and service utilization, as our data were not designed as an evaluation but collected as a survey. However, we could provide useful information about the relationship between arrest and service utilization and IPV behavior.

The finding in this report that may be most surprising to some is that for each kind of IPV studied, females were more likely than males to report being perpetrators, and for the two physical forms of IPV studied here, males were more likely than females to report being victims. This result has been found in prior analyses of NYS data (e.g., Mihalic & Elliott, 1997), and has previously been discussed as supportive of the theory that women may hit men more often, but that men may hit harder and do more damage, which is supported in the result that women report more serious injuries than do males (Morse, 1995).

Profiles for perpetrators and victims differed by the specific types of IPV that were studied here: (1) verbal, psychological, and relational aggression; (2) aggression, threat of violence, and less serious violence; and (3) serious violence. Though all three types of perpetration were related to being female, and having lower occupational status, and generally living in urban (or at least not rural) areas. The first type was related to not being African-American and being married. This contrast strongly with the second type which was related to being African-American, not being married and not having children. The third type (serious IPV violence) was more similar to the second type, though there were some additional covariates, such as lower educational achievement. All of these results are consistent with, and support, prior work on perpetrators of IPV, and the results finding females as perpetrators using the available newer waves of data is consistent with older National Youth Survey data analyses.

Despite that learning that women are frequently perpetrators of IPV is not new, it is important to consider the policy implications of this result. While past work on the context of IPV reveals that this should not be taken as evidence that women are the true perpetrators of IPV and thus that programs targeting female victims and male perpetrators are out of date or should be discarded altogether. What this work could point to, especially given the results for verbal, psychological, and relational aggression, is that services available to victims and perpetrators should be made palatable to members of both sexes. That is, IPV victim services may provide greater service to victims in general if male victims know they are welcome and will be understood. Additionally, interventions for perpetrators should be able to address the needs of women as well as of men.

Perhaps surprisingly, in this multigenerational sample, there was no evidence for intergenerational transmission of IPV. That is, when the long-term recall of IPV in the oldest

generation, that was specifically supposed to be answered about when their children, the original respondents, lived in the home, was linked with original respondent IPV, no significant results were found, neither for IPV in general, nor for specific forms of IPV. Similarly, no links between the original respondent generation and their adult offspring were found for IPV, either.

Victims also differed by specific types of IPV. Particularly, those who reported being victims of verbal, psychological, and relational aggression were more likely to be females (marginally), white, married (marginally), with children, with lower educational achievement, and lower status occupations. Interestingly, where they lived varied by subject type, that is, there were significant results for living in an urban area (original respondents), a suburban area (spouses of the original respondents), and a rural area (adult offspring of the original respondents). For aggression and less serious violence, and also for serious violence, victimization was related to being male, African American, unmarried, with no children, living in an urban setting, having less education, and with low occupational status. Again, there were exceptions in other samples about location of residence; particularly, the rural setting was more prevalent among IPV victims of these more serious forms of violence.

Results regarding police contact were not particularly surprising, but are important to contribute to policy discussion. A small number of respondents reported being arrested for IPV and only about one third of those respondents reported being convicted of domestic violence. In this small sample, arrestees tended to be male, white, living in urban areas, with less education and lower occupational status than those not arrested for IPV. Interestingly, victims were more likely to contact the police about being assaulted when the perpetrator was an intimate partner than when their relationship to their attacker was not an intimate partner. Additionally, the reasons that victims reported for both contacting and declining to contact the police were consistent with past research and work with victims, that victims (reasonably) fear reprisal from their attackers and that they believe the police cannot or will not do anything about the IPV. These results are not surprising, but should continue to inform those in positions to encourage victims to come forward about IPV.

Additionally, and having greater policy implications is that contacting the police after experiencing IPV in a given year was not related to reduced rates IPV reduction in following years. Specifically, rates of some types of IPV increased in the following year when police were called after verbal, psychological, and relational aggression was used. Moreover, relative to the number of victims who reported contacting the police, very few respondents reported being arrested for IPV, and far fewer reported being convicted of domestic violence. These results could have implications in discussion of mandatory arrest laws, as that in this sample, it does not appear that arrest is consistent or, when used, effective at reducing future rates of IPV.

We also found that in addition to contacting the police, victims and perpetrators reported making use of many health and social services as well as their own support networks, contacting friends and family, clergy, and therapists after IPV. Many IPV victims also reported contacting both formal and informal services, including medical and psychiatric assistance for mental health reasons in the same year they reported IPV. Interestingly, IPV perpetrators also reported contacting formal and informal services for help with mental health in the years they reported perpetration of IPV. Both groups primarily made use of informal support more than formal

support. Both perpetrators and victims generally rated these physical and mental health services and social services to be helpful. Unfortunately, the service use for mental health tool did not specifically indicate whether the respondent was using the services for IPV or for other reasons and thus we can only assess whether help they sought in general was related to levels of IPV in future years and we do not know whether they were seeking help that would specifically target IPV. That said, if an IPV victim or perpetrator sought help for mental health in the same year they were a victim or perpetrator, it is possible, and even likely, that they sought help for a related or underlying mental issue related to IPV perpetration or victimization; at the least they are likely not unrelated.

For the most part, respondents who sought help for “mental health issues” reported feeling that these services were helpful; however, analysis of the data longitudinally indicated that use of these services were generally not related to lower levels of IPV in following years. Note that this does not imply that IPV interventions are ineffective. In particular, in the current dataset, it is not clear whether or not the victims were seeking help specifically for IPV or for something else, and this study was not designed to study the efficacy of specific IPV interventions. Moreover, because informal support was used more often than formal services, it is unlikely that calling the help a “program” is misguided. Informal support such as family and friends may be well intentioned, but untrained and inadvertently misguided.

Further, interventions of any type and IPV interventions in particular may not be expected to result in immediate change, and more delayed change would not have been detected in our analyses. Because respondents were asked to report on prior year IPV and this is not broken down by months, it is also possible that reduction in IPV could have occurred midway through a study year and thus prior-year prevalence would not detect that change. Thus, what can be drawn from these analyses is that victims and perpetrators of IPV do report making use of many health and social services and that they reported the services helping, and, separately, rates of IPV, as measured in this study, remained stable for these respondents, but limitations in the study do not allow us to conclude that these services are necessarily ineffective.

When we sought to examine unmet needs, we found that there were a significant number of respondents who reported either perpetrating or being victimized by IPV, and who sought help from the health and social services systems, but did not specify that these services were for IPV, and as was found earlier, these non-IPV-specific services did not result in lower levels of IPV in later years. This can be taken to indicate that perpetrators and victims may be seeking help for reasons underlying or peripheral to IPV, but that, at least in the following year, this is not translating into reductions in IPV. Thus, this study as identified two main types of unmet needs of which the practitioner community should be aware: (1) those who are IPV victims and perpetrators who seek help specifically for IPV, but do not find the help they need; and (2) those who may be victims of IPV but are seeking help through other health and social services systems, and are not receiving effective help for the IPV in their relationships. These may be addressed by developing and evaluating better intervention programs and by developing better screening in these services to identify victims and perpetrators of IPV so that they can be referred to appropriate intervention programs.

Overall, despite recent attention given to the importance of IPV and increased mandated law enforcement policy and increases in programs designed for IPV victims, it appears that IPV rates have remained stable among the perpetrators and victims in this sample. The data reported above demonstrate that perpetrators are not a homogeneous group, nor are victims. When both the original respondents and their spouses (i.e., distinct but similar-aged samples) and their adult offspring were considered, different sociodemographic characteristics were found to be representative of the samples. Moreover, beyond heterogeneity within groups, there were differences in the characteristics of perpetrators and victims of different types of IPV. Though different interventions specific to IPV (and not specific to IPV) may ultimately be found to work better with different subtypes of perpetrators and victims, the current data did not yield immediate clues about developing and directing interventions in this direction. Future work should be directed toward evaluating the efficacy of different types of programs for different subtypes of perpetrators and victims.

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Appendix A

Nation Youth Survey Family Study Items Used

(X=Past year, L=Lifetime)

WAVE OF INTERVIEW	W 6	W 7	W 8	W 9	W10	W11	Parent of Original Resp.	Spouse of Original Resp..	Adult Child of OR (W11)	Adult Child of OR (W12)
Referent Year	1983	1986	1989	1992	2001	2002	2002	2002	2002	2003
Respondent Age	18-24	21-27	24-30	27-33	36-42	37-43	49-88	20-67	18-42	19-42
Demographics and Sociocultural Variables										
Sex, Ethnicity, Age, Marital Status, Urban/Suburban/Rural, Education (Highest Grade Level Achieved), Occupational Status, Residential Stability, Neighborhood Disorganization.	X	X	X	X	X	X	X	X	X	X
Intimate Partner Violence										
CTS: Verbal Aggression (Perp/Vic)	X	X	X	X	X	X	L	X	X	X
CTS: Minor Physical Violence (Perp/Vic)	X	X	X	X	X	X	L	X	X	X
CTS: Serious Physical Violence (Perp/Vic)	X	X	X	X	X	X	L	X	X	X
CTS: Psychological/Relational Aggression (Perpetrator and Victim)			X	X	X	X		X	X	X
IPV while children growing up							L	L		
SRD/SRV: Sexual Assault (Perp & Vic)	X	X	X	X	X	X	X,L	X,L	X,L	X
SRD/SRV: Physical Assault (Perp & Vic)	X	X	X	X	X	X	X,L	X,L	X,L	X
Contact with the Judicial System										
Self-Report: Arrested	X	X	X	X	L,X	X	X,L	X,L	X,L	X,L
Self-Report: Disposition			X,L	X	X	X	X,L	X,L	X,L	X,L
Help Seeking Behavior related to IPV										
Respondent sought help for IPV from Friends/Family, Private counselor, Clergy, Social service/agency, Safe house, Police			X	X	X	X			X	X
Respondent sought help for mental health issues from formal and informal services including public health agencies	X	X	X	X		X				X
Mental Health										
DIS/QDIS: Major Depression	X	X	X	X		L				L

Appendix B CTS Items by Wave and Sample

Original Respondents-Perpetration

Between Christmas a year ago and Christmas just past, how many times have you personally...

1. Insulted or swore at your spouse/partner?
2. Threatened to hit or throw something at your spouse/partner?
3. Threw something at your spouse/partner?
4. Pushed, grabbed, or shoved your spouse/partner?
5. Slapped your spouse/partner?
6. Kicked, bit, or hit your spouse/partner with a fist?
7. Hit or tried to hit your spouse/partner with something?
8. Beat up your spouse/partner?
9. Threatened your spouse/partner with a knife or gun?
10. Used a knife or fired a gun?
11. Ridiculed or criticized your spouse's/partner's values, beliefs, religion, race, heritage or class? †
12. Damaged something belonging to your spouse/partner on purpose? †
13. Punished or deprived the children when angry at your spouse/partner? †
14. Abused, tortured, or killed pets to hurt your spouse/partner? †
15. Threatened to kill your spouse/partner? †
16. Tried to kill your spouse/partner? †
17. Threatened or tried to kill yourself? †
18. Sulked or refused to talk about an issue, or given you the "cold shoulder"? *
19. Done or said something opposite of what you asked, that is, did something to spite you? *
20. Criticized your intelligence, abilities, physical appearance, or sexual attractiveness? *
21. Accused you of having affairs with others? *
22. Watched over or restricted (his/her) use of the phone or car? ‡
23. Made or tried to make your (spouse/partner) feel guilty for disagreeing? ‡
24. Put down or shamed your (spouse/partner) in front of others? ‡
25. Been jealous of your (spouse/partner's) friends? ‡
26. Withdrawn sexually from your (spouse/partner)? ‡
27. Threatened divorce or separation from your (spouse/partner) in order to get them to give in to what you wanted? ‡
28. Encouraged the children to take sides against your (spouse/partner)? ‡
29. Choked your (spouse/partner)? ‡
30. Ignored your (spouse/partner) or gave them the "silent treatment"? ☼

Items without a following symbol were used in Waves 6 and 7

† Items added in Wave 8

* Items added in Wave 9

‡ Items added in Wave 10

☼ Items added in Wave 11

Appendix B (continued)

Original Respondents-Victimization

What about your (spouse/boyfriend/girlfriend)? Tell me how many times s/he ____ in the past 12 months?

1. Insulted or swore at you?
2. Threatened to hit or throw something at you?
3. Threw something at you?
4. Pushed, grabbed, or shoved your?
5. Slapped you?
6. Kicked, bit, or hit you with a fist?
7. Hit or tried to hit you with something?
8. Beat you up?
9. Threatened you with a knife or gun?
10. Ridiculed or criticized your values, beliefs, religion, race, heritage or class? †
11. Damaged something belonging to you on purpose? †
12. Punished or deprived the children when angry at you? †
13. Abused, tortured, or killed pets to hurt you? †
14. Threatened to kill you? †
15. Used a knife or fired a gun?
16. Tried to kill you? †
17. Threatened or tried to kill him/herself? †
18. Sulked or refused to talk about an issue, or given you the “cold shoulder”? *
19. Done or said something opposite of what you asked, that is, did something to spite you? *
20. Criticized your intelligence, abilities, physical appearance, or sexual attractiveness? *
21. Accused you of having affairs with others? *
22. Watched over or restricted your use of the phone or car? ‡
23. Made or tried to make you feel guilty for disagreeing? ‡
24. Put down or shamed you in front of others? ‡
25. Been jealous of your friends? ‡
26. Withdrawn sexually from you? ‡
27. Threatened divorce or separation from you in order to get them to give in to what you wanted? ‡
28. Encouraged the children to take sides against you? ‡
29. Choked you? ‡
30. Ignored you or gave you the “silent treatment”? ☼

Items without a following symbol were used in Waves 6 and 7

† Items added in Wave 8

* Items added in Wave 9

‡ Items added in Wave 10

☼ Items added in Wave 11

Appendix B (continued)

Spouses of Original Respondents - Perpetration

Wave 11

Between Christmas a year ago and Christmas just past, how many times have you personally...

1. Insulted or swore at your spouse/partner?
2. Ignored your (spouse/partner) or gave him/her the “silent treatment”?
3. Threatened divorce or separation from your (spouse/partner) in order to get them to give in to what you wanted?
4. Encouraged the children or other relatives to take sides against your (spouse/partner)?
5. Threatened to hit or throw something at your (spouse/partner)?
6. Thrown something at your (spouse/partner)?
7. Pushed, grabbed, or shoved your (spouse/partner)?
8. Slapped your (spouse/partner)?
9. Kicked, bit, or hit your (spouse/partner) with a fist?
10. Hit or tried to hit your (spouse/partner) with something?
11. Beaten up your (spouse/partner)?
12. Threatened your (spouse/partner) with a knife or gun?
13. Used a knife on or fired a gun at your (spouse/partner)?

Spouses of Original Respondents - Victimization

Wave 11

During the past year, from Christmas a year ago to Christmas just past, how many times has (he/she)...

1. Insulted or swore at you?
2. Ignored you or gave you the “silent treatment”?
3. Threatened divorce or separation from you in order to get you to give in to what (he/she) wanted?
4. Encouraged the children or other relatives to take sides against you?
5. Threatened to hit or throw something at you?
6. Thrown something at you?
7. Pushed, grabbed or shoved you?
8. Slapped you?
9. Kicked, bit, or hit you with a fist?
10. Hit or tried to hit you with something?
11. Beaten you up?
12. Threatened you with a knife or gun?
13. Used a knife on or fired a gun at you?

Appendix B (continued)

Parents of the Original Respondents - Perpetration

Wave 11

Thinking about the time you were married and/or living with your spouse or partner, how many times have you personally ever...

1. Insulted or sworn at your (spouse/partner)?
2. Threatened to hit or throw something at your (spouse/partner)?
3. Thrown something at your (spouse/partner)?
4. Pushed, grabbed, or shoved your (spouse/partner)?
5. Slapped your (spouse/partner)?
6. Kicked, bit, or hit your (spouse/partner) with your fist?
7. Hit or tried to hit your (spouse/partner) with something?
8. Beaten up your (spouse/partner)?
9. Threatened your (spouse/partner) with a knife or gun?
10. Used a knife on or fired a gun at your (spouse/partner)?

Parents of the Original Respondents - Victimization

What about your (spouse/partner)? During all the time you were married and/or living with your spouse or partner, how many times has (he/she) ever...

1. Insulted or sworn at you?
2. Threatened to hit or throw something at you?
3. Thrown something at you?
4. Pushed, grabbed, or shoved you?
5. Slapped you?
6. Kicked, bit or hit you with a fist?
7. Hit or tried to hit you with something?
8. Beaten you up?
9. Threatened you with a knife or gun?
10. Used a knife on or fired a gun at you?

Appendix B (continued)

Adult Offspring of Original Respondents - Perpetration

Waves 11 and 12

Thinking about the past year, how many times have you personally...

1. Insulted or sworn at your (spouse/partner)?
2. Watched over or restricted (his/her) use of the phone or car?
3. Made or tried to make your (spouse/partner) feel guilty for disagreeing?
4. Ignored your (spouse/partner) or gave (her/him) the "silent treatment"?
5. Been jealous of your (spouse/partner's) friend?
6. Withdrawn sexually from your (spouse/partner)?
7. Threatened divorce or separation from your (spouse/partner) in order to get them to give in to what you wanted?
8. Encouraged the children or other relatives to take sides against your (spouse/partner)?
9. Threatened to hit or throw something at your (spouse/partner)?
10. Thrown something at your (spouse/partner)?
11. Pushed, grabbed, or shoved your (spouse/partner)?
12. Slapped your (spouse/partner)?
13. Kicked, bit, or hit your (spouse/partner) with your fist?
14. Hit or tried to hit your (spouse/partner) with something?
15. Choked your (spouse/partner)?
16. Beaten up your (spouse/partner)?
17. Threatened your (spouse/partner) with a knife or gun?
18. Threatened to kill your (spouse/partner)?
19. Used a knife on or fired a gun at your (spouse/partner)?
20. Tried to kill your (spouse/partner)?
21. Threatened or tried to kill yourself?
22. Put down or shamed your (spouse/partner) in front of others? #

Item added in Wave 12

Appendix B (continued)

Adult Offspring of Original Respondents - Victimization

What about your spouse/partner? Tell me how many times in the last year (he/she) has...

1. Insulted or sworn at you?
2. Watched over or restricted your use of the phone or car?
3. Made or tried to make you feel guilty for disagreeing?
4. Ignored you or gave you the “silent treatment”?
5. Been jealous of your friends?
6. Withdrawn sexually from you?
7. Threatened divorce or separation from you in order to get you to give in to what they wanted?
8. Encouraged the children or other relatives to take sides against you?
9. Threatened to hit or throw something at you?
10. Thrown something at you?
11. Pushed, grabbed, or shoved you?
12. Slapped you?
13. Kicked, bit, or hit you with (his/her) fist?
14. Hit or tried to hit you with something?
15. Choked you?
16. Beaten up you?
17. Threatened you with a knife or gun?
18. Threatened to kill you?
19. Used a knife on or fired a gun at you?
20. Tried to kill you?
21. Threatened or tried to kill (him/herself)?
22. Put down or shamed you in front of others? #

Item added in Wave 12

Appendix C Public Health Help-Seeking Contexts

During the past year, that is, from Christmas a year ago to Christmas just past, have you gone to...

1. ...a friend or relative for help with any of these problems?
2. ...a minister, a priest, a rabbi, or other religious leader, for any of these problems?
3. ...a psychiatrist, psychologist, social worker, or counselor in private practice for any of these problems?
4. ...a medical doctor in private practice (except for a psychiatrist) or to any medical person in private practice?
5. ...a spiritualist, herbalist, natural therapist or reader for problems with emotions, nerves, drugs, alcohol, or mental health?
6. ...any other person (Please describe)?
7. ...a mental health center
8. ...a psychiatric outpatient clinic at a general hospital or university hospital?
9. ...an outpatient clinic in a psychiatric hospital?
10. ...an alcohol clinic?
11. ...a drug clinic?
12. ...an emergency room for problems with emotions, drugs, alcohol, or mental health?
13. ...a family service, child counseling or social service agency?
14. ...a self-help group like Alcoholics Anonymous, etc.?
15. ...a community program like a crisis center hotline (not including any clinics mentioned above)?
16. ...any other agencies or programs not mentioned already?
17. Have you been admitted to a hospital or clinic where you stayed overnight because of personal problems, mental or emotional problems, or a problem with drugs or alcohol?