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Violence against women: Physical and mental health effects. Part I: Research findings

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Abstract

Interpersonal violence is a ubiquitous source of fear, distress, and injury in the lives of women in the United States, crossing lines of age, race, ethnicity, and economic status (Coley & Beckett, 1988; Frieze & Browne, 1989; Koss, 1988; Straus, Gelles, & Steinmetz, 1980). In recent years, the public health community has become increasingly aware that "this violence is a serious public health problem . . . [and that] nonfatal interpersonal violence has far-reaching consequences in terms of morbidity and quality of life" (Center for Disease Control, 1985, p. 739). This article reviews the physical and mental health effects on adult women of physical abuse and sexual assault, and describes their implications for mental health research and practice.

Key words: Violence, Abuse, Physical assault, Sexual assault, Rape, Trauma

Violence against women takes many forms including physical abuse and sexual assault. The term physical abuse includes acts of violence likely to cause injury—ranging from slight pain to murder—although an injury does not have to occur (Gelles, 1988). Common forms of physical violence include hitting, pushing, punching, choking, slapping, throwing objects, biting, kicking, and threatening with or using a lethal weapon (Straus et al., 1980).

The term sexual assault encompasses a broad range of acts ranging from unwanted petting to rape (Russell, 1986). Although definitions vary by state, statutes often define rape as the "nonconsensual sexual penetration of an adolescent or adult obtained by physical force, by threat of bodily harm, or when the victim is incapable of giving consent by virtue of mental illness, mental retardation, or intoxication" (Bohmer, 1990; Koss & Harvey, 1991; Searles & Berger, 1987).

Both physical and sexual assault can be perpetrated by strangers or by intimates (in heterosexual or homosexual relationships). Forms of male violence against women in intimate relationships include acquaintance rape, date rape, marital rape, courtship violence, dating violence, and battering. Acquaintance rapes are assaults by anyone who is not a complete stranger to the victim. Courtship or dating violence includes act of physical violence perpetrated by someone who has some level of romantic relationship with the victim. Partner violence encompasses both marital rape and wife battering and refers to assaults by adult men against adult women with whom they share or have previously shared a marriage or cohabitating relationship.

Although psychological violence will not be discussed in detail in this article, it is important to note its frequent occurrence, particularly within marital relationships. Psychological violence may include coercion, degradation, intimidation, and humiliation. A perpetrator may attempt to control his victim by threatening to beat her, to harm her pets, to take away or hurt her children, or to commit suicide (Schechter, 1982; Walker, 1979). Violence against a woman's property may also be used to

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display a perpetrator's potential for destruction (Sonkin, Martin, & Walker, 1985). Given the power of psychological abuse, physical or sexual violence need not be constant or severe to perpetuate an environment of unremitting terror. The effects of the *threat* of violence can be psychologically devastating.

This article reviews the physical and mental health effects on adult women of physical abuse and sexual assault (particularly rape) with special attention to intimate violence. As health-care providers, policy makers, and the public have become increasingly aware of the prevalence and consequences of violence against women in our society, they have come to recognize the importance of identifying and treating victims of violence. Mental health professionals have important roles—as researchers, service providers, and policy advocates—in educating and training service providers in all health-care professions to identify, treat, and refer victims of violence. The goal of this article is to help equip psychologists for these roles by stimulating a more sophisticated, research-based understanding of the mental and physical health effects of male violence on women.

The Prevalence of Violence

Sexual and physical violence against women in the United States is widespread. According to prevalence estimates from several large community samples, one in five women has been the victim of completed rape (Bagley et al., 1984; Kercher & McShane, 1984; Russell, 1982, 1983; Wyatt, 1985). A woman reports a rape to the police every 5–6 minutes (Uniform Crime Reports, 1989).

Most sexual assaults are committed by perpetrators who are known to their victims (Koss, 1988). Indeed, women are more likely to be assaulted, killed, or raped by a current or former male partner than by all other categories of assailants combined (Browne & Williams, 1989; Finkelhor & Yllö, 1985; Koss, 1985; Koss, Woodruff, & Koss, 1991; Russell, 1982). Furthermore, over 80% of sexual assaults reported by college-age and adult women are perpetrated by an acquaintance (Koss, 1985, Koss, Dinero, Seibel, & Cox, 1988; Russell, 1983); nearly half of the aggravated assault and completed rapes identified in a recent criminal victimization survey were perpetrated by men with whom the victims were romantically involved (Kilpatrick et al., 1987); of the physical and sexual assaults reported by psychiatric patients, 90% are perpetrated by family members (Carmen, Reiker, & Mills, 1984).

Sexual assaults, particularly rape, are underreported, and when women are raped by acquaintances, friends, or partners, they are even less likely to report the experience (Finkelhor & Yllö, 1983; Gelles, 1979; Pagelow, 1984; Russell, 1983); an estimated one-third of stranger rapes and 13% of acquaintance rapes are reported (Koss et al., 1988). Yet rape by an intimate produces mental health effects that are at least as severe as rape by strangers (Browne, 1992). Chances of injury appear particularly great for marital rape, possibly due to its link to wife battering (Pagelow, 1984).

Research indicates that between one-quarter (Straus & Gelles, 1990; Straus, Gelles, & Steinmetz, 1980) and one-half (Stark & Flitcraft, 1988) of all wives are physically battered by their husbands. More than 2 million women experience severe assault—being punched, kicked, choked, hit with an object, beaten up, or threatened with a knife or gun—during an average 12-month period in the United States (Langan & Innes, 1986; Straus & Gelles, 1990; Straus et al., 1980). The rate of severe intimate violence in cohabitating or dating partners appears to be increasing (Browne & Williams, 1989) and now reaches the rate for married couples (Center for Disease Control, 1989).

Although some studies have reported that men and women commit acts of physical violence in roughly equal numbers (see, e.g., Straus et al., 1980), the form, severity, and consequences of that violence differ between the sexes. Women's physical violence is almost always in self-defense and is much less severe in consequences than men's violence (Saunders, 1986).

The Physical Consequences of Violence

Experiences of physical assault and sexual assault (particularly rape) result in acute medical conditions and are associated with lowered self-perceptions of health and increased self-reported symptomatology across nearly all body systems (except eyes and skin), higher levels of injurious health behaviors such as smoking or failure to use seat belts, and greater utilization of medical services (Fellitti, 1991; Koss & Heslet, 1992; Koss, Koss, & Woodruff, 1991). A high prevalence of physical or sexual victimization appears in a variety of patient populations, including patients diagnosed with chronic pelvic pain, other chronic pain syndromes, premenstrual syndrome, and alcoholic liver disease (Cunningham, Pearce, & Pearce, 1988; Drossman et al., 1990; Golding, Stein, Siegel, Burnam, & Sorenson, 1988; Koss & Heslet, 1992; Sedney & Brooks, 1984).

In addition, abuse may be the most important precipitating factor in female suicide. An estimated one in four female suicide attempts is preceded by physical violence (Stark et al., 1981) and suicidal ideation is reported in 33–50% of rape victims (Ellis, Atkeson, & Calhoun, 1981; Koss, 1988; Resick, Jordan, Girelli, Hutter, & Marhoefer-Dvorak, 1989). During the posttraumatic period of rape recovery, victims are nine times more likely than nonvictims to attempt suicide (Kilpatrick, Saunders, Veronen, Best, & Von, 1987).

Physical or sexual violence may also result in mild to moderate head injuries that can underlie symptoms of physical and psychological distress. Head injuries can lead to changes in cognition, affect, motivation, and behavior that are similar to those found in individuals suffering from a dementia or clinical depression (Kwentus, Hart, Peck, & Kornstein, 1985). Such injuries may remain undetected because of lack of overt neurological distress or failure to obtain medical attention (McGrath, Keita, Strickland, & Russo, 1990).

Sexual Assault

Among rape victims, 39% report sustaining a nongenital physical injury including abrasions about the head, neck, and face; the extremities; and the trunk region; of these, 54% seek medical treatment (Beebe, 1991). Severe injuries include multiple traumas, major fractures, and major lacerations (Geist, 1988). Posttrauma skeletal muscle tension is reflected in fatigue, tension headaches, and sleep disturbances. Gastrointestinal irritability is also frequent and includes stomach pains, nausea, no appetite, and inability to taste food.

Nearly one-third of rapes involve oral or anal penetration in addition to vaginal contact, and one-half of rape victims seen in trauma centers have vaginal and perineal trauma (Geist, 1988; Woodling & Kossoris, 1981). Fifteen percent of raped women have significant vaginal tears, and 1% require surgical repair (Cartwright & The Sexual Assault Study Group, 1987). Anorectal injuries may be produced by penetration of the penis as well as of digits, hands, blunt objects, or foreign bodies into the rectum. They include disruption of anal sphincters, retained foreign bodies, mucosal lacerations, and transmural perforations of the rectosigmoid (Chen, Davis, & Ott, 1986; Elam & Ray, 1986).

The physical aftermath of rape may also include any one of 15 different sexually transmitted diseases (Koss & Heslet, 1992), estimated to occur in 3.6–30% of victims (Beebe, 1991; Forster, Estreich, & Hooi, 1991; Lacey, 1990; Murphy, 1990). Gonorrhea, chlamydia, trichomonal infections, and syphilis are the most common, but there is also the life-threatening risk of hepatitis B and human immunodeficiency virus infection.

Rape results in pregnancy in about 5% of cases (Beebe, 1991; Koss et al., 1991). Rape victims who are already pregnant when assaulted have vulvar, oral, and anal penetration in proportions similar to those found in nonpregnant women: 95, 27, and 6%, respectively (Satin, Hemsell, Stone, Theriot, & Wendel, 1991). No catastrophic effects of rape on pregnancy have been identified.

Current statistics on the physical consequences of sexual assault may severely misrepresent the nature and underestimate the scope of effects. Only those with relatively severe injuries may seek trauma center care. Effects on victims who are not asked about the origin of their injuries, those who saw private physicians, and those who sought no treatment in the immediate posttrauma period, only to present themselves to the medical system later with delayed consequences of violence, are unknown (Koss & Heslet, 1992). One longitudinal study found that adult victims of sexual assault sought help from physicians twice as frequently as other women (Koss et al., 1991), most often in the second year following victimization. Frequency of physician visits increased 56% in the 2nd year following victimization compared to increases of 2% during the same period among nonvictimized women. The single most powerful predictor of total yearly physician visits and outpatient costs was severity of victimization, exceeding the predictive power of age, ethnicity, self-reported symptoms, and morbidity-related injurious health behaviors (Koss & Heslet, 1992).

Battering

An estimated 1 million women each year seek medical assistance for injuries resulting from wife battering (Stark & Flitcraft, 1988). One fifth to one third of women seen in emergency services, regardless of their stated presenting complaint, have symptoms directly linked to battering (Council on Scientific Affairs, 1987; Goldberg & Tomlanovich, 1984; Stark, Flitcraft, & Frazier, 1979), accounting for more injuries than automobile accidents, muggings, and rapes combined.

The most extreme physical consequence of violence is, of course, death. More women are killed by their male partners than by all other categories combined (52% of all murders of women are by male partners). Black women are more likely then white women to be killed by their spouse (Plass & Strauss, 1987).

For women that survive, physical injuries associated with partner violence most often involve multiple injuries to the face, head, neck, breast, or abdomen (Randall, 1990). Additionally, common presenting symptoms of such victims include evidence of past injury (Burge, 1989), chronic headaches, abdominal pain, sexual dysfunction, joint and muscle pain, sleeping and eating disorders, and recurrent vaginal infections (Randall, 1990, 1991).

Battering and Pregnancy

Women are at highest risk for battering in young adulthood, during their most active childbearing years (Gelles, 1988). The rate of husband-to-wife violence experienced by pregnant women is 35% higher than that experienced by nonpregnant women; if only severe violence is considered, the rate is 60% higher. In addition, women with a history of being battered are three times more likely to be injured during pregnancy than nonbattered women; those reporting current abuse, then, are

clearly at risk for future abuse (Helton, McFarlane, & Anderson, 1987; Hillard, 1985; Stark & Flitcraft, 1988).

The abdomen is targeted twice as frequently in pregnant women as compared to nonpregnant victims (Berenson, Stiglich, Wilkinson, & Anderson, 1991). Physical assault during pregnancy may result in premature labor, rupture of the membranes, placental separation, antepartum hemorrhage, fetal fractures, and rupture of the uterus, liver, or spleen (Saltzman, 1990). Women battered during pregnancy are more likely than nonbattered women to experience negative pregnancy outcomes including miscarriages and stillbirths and delivery of low-birthweight infants (Bullock & McFarlane, 1989; Helton et al., 1987; McFarlane, 1989; Satin et al., 1991). The Surgeon General has recommended that all pregnant women be evaluated for battering as part of routine prenatal assessments (Surgeon General's Workshop on Violence, 1985).

The Mental Health Consequences of Violence

Victims of rape and battering experience a wide range of emotional and cognitive sequelae. Research has yet to delineate the relationships between particular types of violence and specific psychological outcomes; numerous overlapping factors can shape a victim's posttrauma response, including the frequency, severity, form, and duration of the violence, the age of the victim when it occurred, the relationship between the victim and the perpetrator, a prior history of abuse, and other sources of life stress (Browne & Finkelhor, 1986; Kilpatrick et al., 1987; Koss, 1988; Russell, 1986). An individual's particular psychological resources and coping ability prior to the violence and the nature of the recovery environment also exert important influences on a victim's posttrauma adaptation (Green, Wilson, & Lindy, 1985). Thus, although women of diverse circumstances experience physical and sexual assault, those who live under high stress and have few coping resources—including women living in poverty (Belle, 1990) and homeless women (Goodman, Saxe, & Harvey, 1991)—are at especially high risk for negative psychological sequelae.

Rape

Immediate impact. Rape victims are likely, during and just after the assault, to focus on physical and emotional survival. Initial responses may include talking with, or fighting, the perpetrator in an effort to escape, remaining calm so as not to provoke more severe violence, praying, and attempting to remember advice on how to deal with rape (Burgess & Holmstrom, 1979a, 1979b; Gelles & Straus, 1988). If escape is perceived to be impossible, victims may attempt to dissociate (Burgess & Holmstrom, 1979a, 1979b).

Shock, intense fear, numbness, confusion, extreme helplessness, and/or disbelief may follow the experience (Burgess & Holmstrom, 1974, 1979a, 1979b; Kilpatrick, Veronin, & Resick, 1979; Koss & Harvey, 1991). Women may fear that their rapist will return and harm them further, particularly if they contact the police. Victims of rape by intimates or acquaintances may be stunned that someone they trusted could attack them (Browne, 1992). Indeed, when women are raped by a partner, their shame and humiliation may be so intense that it becomes impossible for them to disclose the experience to anyone, even when anonymity is guaranteed (Finkelhor & Yllö, 1983; Gelles, 1979; Pagelow, 1984; Russell, 1982; Walker, 1984).

For some victims, overall symptom elevation subsides by the third month, but approximately one-quarter of rape victims go on to experience severe and long-term symptoms (Hanson, 1990). Although research suggests that mental health status at the end of the third month is a good indicator of long-term adjustment (Burgess & Holmstrom, 1974; Roth & Lebowitz, 1988), for some women symptomatology disappears temporarily and then returns several months after the assault (Forman, 1980). At this time the woman may seek help for these symptoms without informing service providers about the rape experience underlying them (Browne, 1992).

Long-term Impact. Victims of sexual assault may suffer from a wide variety of disturbing long-term psychological aftereffects (Browne, 1992; Koss & Harvey, 1991). Victimization is an "overwhelming assault" on the survivors "world of meaning" (Conte, 1988, p. 325; Janoff-Bulman, 1992). A woman whose body is violated, particularly by someone she knows, may cease believing that she is secure in the world, that the world has order and meaning, and that she is a worthy person (Janoff-Bulman, 1992; Janoff-Bulman & Frieze, 1983). Such perceptions may lead to feelings of vulnerability and loss of control (Burgess & Holstrom, 1979a, 1979b; Kilpatrick, Vernonen, & Best, 1985; Resick, Calhoun, Atkeson, & Ellis, 1981).

Furthermore, cultural myths about rape, including notions such as the victim provoked the assault, she enjoyed it, only promiscuous women get raped, and raped women are "damaged goods," can shape the victim's perceptions of the event and create feelings of guilt, shame, and self-blame (Roth & Lebowitz, 1988).

The most common psychiatric sequelae of sexual assault include anxiety and fear, depression, sexual dysfunction, substance abuse, and posttraumatic stress disorder (PTSD). Victims of sexual assault have reported heightened fear and anxiety even long after the attack (Ellis et al., 1981; Ellis, Calhoun, & Atkeson, 1980; Kilpatrick, Resick, & Veronen, 1981). Fear may be triggered by stimuli directly associated with the attack itself, by potential consequences of the rape such as testifying in court or contracting a sexually transmitted disease, or by situations that appear to pose a new threat of attack (Kilpatrick et al., 1981). Even in the absence of specific

triggers, anxiety can become generalized, leading to "jumpiness" (Burgess & Holmstrom, 1979a, 1979b), sleep disruptions (Burgess & Holmstrom, 1979a, 1979b; Ellis et al., 1981; Nadelson, Notman, Zackson, & Gornich, 1982), lack of concentration (Nadelson et al., 1982), and distrust or fear of men (Finkelhor & Yllö, 1985).

A variety of depressive symptoms have been noted in victims of sexual assault (Becker, Skinner, Abel, Axelrod, & Treacy, 1984), including sleep and appetite disturbance, loss of interest in normal activities, and decreased concentration (Frank & Stewart, 1984; Frank, Turner, & Duffy, 1979). They may exhibit symptoms such as nightmares, catastrophic fantasies, and feelings of alienation and isolation (Koss & Harvey, 1991). Rape victims may withdraw from people and activities, becoming virtually immobile (Burgess & Holmstrom, 1979b). Even when they continue their activities, many sexual assault victims report less enjoyment and satisfaction with their daily lives (Ellis et al., 1981). Self-blame is common and often severe (Burgess & Holmstrom, 1979a, 1979b; Frieze, 1979), and many rape victims develop major depressive disorders (Burnam et al., 1988; Frank et al., 1979). Among women in the community not in treatment, almost one in five rape victims have attempted suicide (Kilpatrick et al., 1985; Resick et al., 1989).

Victims of sexual assault may suffer from a variety of sexual dysfunctions including fear of sex, arousal dysfunction, and decreased sexual interest (Becker et al., 1984; Becker, Skinner, Abel, & Cichon, 1986; Ellis et al., 1980). Such dysfunction may result from victims' increased insecurities concerning sexual attractiveness, lowered sexual self-esteem, and negative feelings about men (Koss & Harvey, 1991; McCahill, Meyer, & Fischman, 1979). Rape victims are also more likely than nonvictims to receive diagnoses of alcohol abuse/dependence and drug abuse/dependence, even several years postassault (Burnam et al., 1988).

Finally, the diagnosis PTSD encompasses many of the preceding symptoms and can be applied to a large proportion of rape victims. Indeed, rape victims are thought to be the largest single group of PTSD sufferers (Foa, Olasov, & Steketee, 1987). In a prospective study of hospital-referred rape victims, 94% met full criteria for PTSD at initial assessment, a mean of 12 days after the assault (Rothbaum, Foa, Riggs, Murdock, & Walsch, in press), and the lifetime prevalence of PTSD in a national sample of rape victims was 31% (National Victims Survey, 1992). The hallmark of PTSD is intrusive reexperiencing of the trauma. Recollections are in the form of daytime memories or nightmares and are accompanied by intense psychological distress including reactivation of the emotions and physiologic sensations experienced during the attack. To reduce the distress of reexperiencing, trauma victims often go to great lengths to avoid reminders of the trauma, which results in phases of diminished responsiveness to the external world.

Predictors of response to sexual assault. Income and education do not appear to be related to type or severity of symptoms exhibited by adult victims of sexual assault (Becker, Skinner, Abel, & Tracey, 1982; Kilpatrick & Veronen, 1984; Kilpatrick et al., 1985; Ruch & Leon, 1983), but being elderly (Atkeson, Calhoun, Resick, & Ellis, 1982; Burgess & Holmstrom, 1974; Frank & Stewart, 1984; Ruch & Chandler, 1983), married (McCahill et al., 1979), or Asian or Mexican American (Ruch & Chandler, 1983; Ruch & Leon, 1983; Williams & Holmes, 1981) has been linked to greater postassault distress. Women with preexisting psychological distress are also at higher risk for negative mental health consequences following sexual assault (Atkeson et al., 1982; Ellis et al., 1981; Frank & Anderson, 1987; Frank, Turner, Stewart, Jacob, & West, 1981; Gidycz & Koss, 1990; Lurigio & Resick, 1990).

Prior victimization has a complex relationship to postassault distress. First-time victims usually show more distress immediately following the rape, whereas prior victims have increased distress over time, ultimately becoming more distressed than first-time victims (Ruch & Leon, 1983; Ruch, Gartrell, Amedeo, & Coyne, 1991; 1991b). Women who are raped more than one time are more likely to abuse substances (Ruch et al., 1991) and have a lifetime diagnosis of depression (Kilpatrick et al., 1987). Having experienced other negative life stressors, including crimes other than rape or loss of a spouse, is also linked to greater postassault stress among victims (Burgess & Holmstrom, 1979c; Glenn & Resick, 1986; Kilpatrick et al., 1985).

The nature of the attack itself can affect postassault psychological functioning as well: Assault variables predictive of symptoms include number of assailants, physical threat, injury requiring medical care, and medical complications (Sales, Baum, & Shor, 1984). Interestingly, the absence of violence may also lead to enhanced postassault distress (McCahill et al., 1979). This association is particularly strong when the sexual assault included fondling and caressing. The victim of such an assault may confuse subsequent displays of physical affection with the coerced caresses of the rapist, leading to the emergence of anxiety and other symptoms (McCahill et al., 1979).

Finally, evidence suggests that women who have been sexually assaulted by acquaintances or family members suffer serious psychological aftereffects equal to those suffered by women assaulted by strangers (Koss et al., 1988). Women assaulted in environments that seemed safe, such as at home or with a trusted person, may suffer especially serious symptoms of depression and fear (Burge, 1989; Frank & Stewart, 1984).

Marital rape. Although marital rape can occur in the absence of other forms of violence, it is most frequent in relationships marked by ongoing physical abuse (Frieze, 1983; Russell, 1982; Walker, 1984). Of women physically

assaulted by partners, 33–46% report sexual assault as well (Frieze & Browne, 1989). In severely physically abusive relationships, forcible rape can occur several times a month (Browne, 1992). Furthermore, battered women who are raped by their partners are likely to experience more severe nonsexual attacks than other battered women (Bowker, 1983; Browne, 1987, 1992; Shields & Hanneke, 1983).

Sexual relations have been traditionally viewed as a means to express love and trust among partners. Women can lose their capacity for intimacy and trust when sexual relations with their partner become coerced or violent. Also, because the experience of marital rape is shameful and humiliating, its victims may have difficulty sharing their distress with others and become especially isolated (Finkelhor & Yllö, 1985; Russell, 1982; Shields & Hanneke, 1983). In addition to experiencing the typical aftereffects of physical battery (see the following section), victims of marital rape may experience terrifying flashbacks and nightmares, an aversion to sex, and a general inability to trust men, leading, in some cases, to total withdrawal from contact with men, including strangers and nonstrangers (Finkelhor & Yllö, 1985). Thus, the long-term effects of wife battering may be especially pronounced in women who have also been sexually abused by their partners.

Battering

Immediate impact. During and immediately after a physical attack by a partner, women are likely to focus on their own survival and the safety of their children. Victims' behavior might include crying, yelling and cursing at the perpetrator, using arms, legs, and feet to protect the body, or attempting to escape (Bowker, 1983; Gelles & Straus, 1988). As with sexual assault, after the initial attack, reactions such as shock, numbing, and intense fear are common. The fear of future violence continues and can be expressed in a variety of psychological and somatic symptoms even if no further physical violence occurs.

Long-term impact. The long-term effects of battering include depression, fear and anxiety, social isolation, and PTSD (Browne, 1992; Hilberman & Munson, 1977–1978; Walker, 1984). Battered women's feelings of vulnerability, loss, betrayal, and hopelessness are compounded by the fact that someone they love, trust, and depend on is their attacker (Browne, 1992). Violence in the home, a place traditionally conceived as a haven of safety and comfort, undermines women's sense of security and trust as well as confidence in their ability to judge another individual. Victims also may fear for the safety of their children or feel ashamed and humiliated by abuse that occurs in front of their children.

Of all the psychological sequelae associated with battery, the most prominent are symptoms of depression (Hilberman & Munson, 1977–1978; McGrath el al., 1990; Walker, 1984). Specific depressive symptoms noted in the literature include blunted affect, numbed responsiveness (Douglas, 1986; Hilberman, 1980; Hilberman & Munson, 1977–1978), reduced social involvement (Hilberman, 1980), feelings of worthlessness (Gelles & Straus, 1988; Mitchell & Hodson, 1983), self-blame, guilt (Walker, 1979, 1983), and self-hatred, often expressed actively through self-destructive behaviors and suicide attempts, some of which are successful (Hilberman, 1980; Stark et al., 1979).

Victims experience high levels of anxiety (Stark et al. 1979; Walker, 1984) and feelings of terror in anticipation of future violence (Hilberman, 1980; Hilberman & Munson, 1977–1978). Anxiety reactions may become particularly acute in response to environmental cues that serve to remind victims of the battering event (Douglas, 1986; Hilberman, 1980; Hilberman & Munson, 1977–1978). Symptoms of anxiety might include sleeping and eating difficulties, a heightened startle reaction, concentration difficulties (Douglas, 1986), and agitation and hypervigilance (Hilberman, 1980; Hilberman & Munson, 1977–1978).

Being battered often leads to a dramatic shift in women's interpersonal interactions. Battered women may socialize less with neighbors, decrease their contacts with friends, join voluntary organizations less frequently, and cease going out with their husbands over the course of their abusive relationships (Dobash & Dobash, 1979; Walker, 1984). Explanations for the increased social isolation of battered women vary. Some suggest that batterers isolate their wives to keep them dependent and helpless (Hilberman & Munson, 1977–1978); others suggest that battered women feel helpless and thus fail to reach out (Walker, 1984), or that friends, neighbors, and relatives respond negatively to the experience of battering (Mitchell & Hodson, 1983). Some people may blame battered women for failing to extricate themselves (Lerner, 1980; Ryan, 1971) or perceive them as "losers" (Bard & Sangrey, 1979). Still others perceive victims as depressed and therefore unpleasant to be with (Coates, Wortman, & Abbey, 1979). These negative, unsympathetic reactions can confirm and amplify victims' subjective feelings of isolation. In the absence of companionship, women may attempt to ameliorate their psychological pain by substance abuse, especially with prescription drugs (Hilberman & Munson, 1977–1978; Stark et al. 1979). They may also minimize or even deny the danger and personal loss they have experienced for reasons of shame, fear, or psychological self-protection (Bard & Sangrey, 1979; Douglas, 1986).

Recently, high rates of PTSD have been documented among battered women. Sixty percent of battered women at an outpatient clinic (Cimino & Dutton, 1991) and 89% of those living in a battered women's shelter (Kemp, Rawlings, & Green, 1991) were diagnosed with PTSD; studies of community samples remain to be done.

As with sexual assault, the PTSD diagnosis encompasses many of the negative psychological sequelae of physical battery, thereby creating a clearer and more comprehensive understanding of battered women's postassault responses.

Predictors of response to partner violence. Battered women do not form a homogeneous group and the effects of spouse abuse are by no means uniform. Recent research indicates that the number and severity of symptoms that battered women suffer may be associated with frequency of abuse, adherence to traditional sex role values, the presence of emotional abuse, and victim perception of the violence as potentially lethal (Cimino & Dutton, 1991; Follingstad, Brennan, Hause, Polek, & Rutledge, 1991). A history of abuse in childhood also predicts greater psychological distress in the aftermath of physical battery or sexual assault by a partner (Cimino & Dutton, 1991). This last finding is buttressed by a growing body of research suggesting that childhood trauma can have a damaging and enduring effect on subsequent personality functioning and cause vulnerability to a variety of subsequent trauma (Van der Kolk, 1987, 1988).

Implications for Mental Health-Care Providers

These research findings have a number of general implications for mental health research and practice. Of highest priority is the need to identify victims of violence in health-care delivery systems, because neither physical nor mental health problems of victims of violence can be appropriately addressed and resolved without identifying and addressing underlying etiology. Intimate violence in particular is repetitive and cross-generational. Ignoring it may cause a client to return repeatedly for multiple physical and mental health problems and enhances the potential for members of the patient's family to become future victims/clients (Koss, 1988; Koss & Heslet, 1992).

Although violence against women is widespread and has serious consequences, it remains largely undetected in health-care settings. Victims are naturally reluctant to discuss their victimization experiences. The process of labeling oneself a victim of violence is difficult and becomes especially complicated when the experience has occurred within the family or if the actions were ambiguous (Browne, 1991). Inadequate identification on the part of service providers compounds the problem by communicating a lack of permission to discuss victimization.

Diagnostic assessments should always include taking a history of sexual and physical violence. Because of the struggle to avoid the devaluation inherent in being a victim, women who have experienced violence do not often label their experience with words such as rape, incest, molestation, child abuse, battering, wife beating, or domestic violence. Health-care providers conducting screenings or diagnostic assessments can be more effective in identifying violence if they avoid such terms and focus on describing the behaviors involved. For example, clients could be asked "When you were growing up, did a parent or relative or anyone older make you do sexual things?" "As a teenager or adult did anyone make you have sex when you didn't want to by using force?" and "Are you currently being physically hurt by anyone?" Positive responses should be followed up to assess the client's present danger by asking questions such as "Is there anyone at home you are afraid of?" "Do you have plans for getting help if he hurts you again?" and "How can I help?" It is essential that screening for violence, whether in person or by checklist, take place under circumstances that provide privacy and the safety to implicate intimates. A family member who accompanies an abused client may be the perpetrator.

Many victims, particularly those who have experienced sexual violence, have never told anyone about their experiences. The simple act of disclosing their secret trauma may have a significant impact on their health status. Even in the context of a safe and private space and supportive interviewer, it can be painful and retraumatizing to discuss the details of physical and sexual abuse. Difficulties are compounded by the fact that repression and dissociation are common survival strategies in response to trauma. Detailed information, however, is important because symptoms may have a symbolic value that cannot be ascertained unless the entire picture of the victimization experience is revealed. Time, patience, and persistence are needed to screen and treat victimized clients (McGrath et al., 1990).

In their roles as educators, trainers, and consultants, knowledgeable psychologists can increase the ability of health and mental health service delivery providers to screen and refer victims of violence to appropriate physical and mental health treatment. In particular, emergency room personnel, family practitioners, obstetrician-gynecologists, pediatricians, and psychiatrists need to be informed about the causes, prevalence, and physical and mental health consequences of violence. The American Medical Association has recently taken steps to encourage its members to seek such knowledge (Browne, 1992), and psychologists in hospitals and clinics have special roles to play in training medical students and providing continuing education to medical practitioners. They are also in special positions to build partnerships to facilitate referrals so that physical and psychological health interventions can be coordinated in treatment planning.

Psychologists must begin, however, by educating themselves about male violence against women—not only about its nature and effects, but also about the multiple and complex factors that cause and perpetuate it, and potential avenues toward reducing its prevalence. The ubiquity of violence against women demands an urgent response, and psychologists are in ideal positions to provide it.

REFERENCES

Atkeson, B., Calhoun, K. S., Resick, P. A., & Ellis, E. (1982). Victims of rape: Repeated assessment of depressive symptoms. *Journal of Consulting and Clinical Psychology, 50,* 96–102.

Bagley, C., Allard, H., McCormier, N., Proudfoot, P., Fortin, D., Ogilvie, D., Rae-Grant, Q., Gelinas, P., Pepin, L., & Sutherland, S. (1984). *Committee on sexual offenses against children and youth: Vol. 1. Sexual offenses against children.* Ottawa: Canadian Government Publication Center.

Bard, M., & Sangrey, D. (1979). *The crime victim's book.* New York: Basic Books.

Becker, J. V., Skinner, L. J., Abel, G. G., Axelrod, R., & Treacy, E. C. (1984). Depressive symptoms associated with sexual assault. *Journal of Sex and Marital Therapy, 10*(3), 185–192.

Becker, J. V., Skinner, L. J., Abel, G. G., & Cichon, J. (1986). Level of post-assault sexual functioning in rape and incest victims. *Archives of Sexual Behavior, 15,* 37–49.

Becker, J. V., Skinner, L. J., Abel, G. G., & Treacy, E. C. (1982). Incidence and types of sexual dysfunction in rape and incest victims. *Journal of Sex and Marital Therapy, 8,* 65–74.

Beebe, D. K. (1991). Emergency management of the adult female rape victim. *American Family Physician, 43,* 2041–2046.

Belle, D. (1990). Poverty and women's mental health. *American Psychologist, 45,* 385–389.

Berenson, A. B., Stiglich, N. J., Wilkinson, G. S., & Anderson, G. A. (1991). Drug abuse and other risk factors for physical abuse in pregnancy among white non-Hispanic, black, and Hispanic women. *American Journal of Obstetrics and Gynecology, 164,* 1491–1499.

Bohmer, C. (1990). Acquaintance rape and the law. In A. Parrot (Ed.), *Acquaintance rape.* New York: John Wiley.

Bowker, L. H. (1983). *Beating wife-beating.* Lexington, MA: Lexington Books.

Browne, A. (1987). *When battered women kill.* New York: Lexington Books.

Browne, A. (1991). The victim's experience: Pathways to disclosure. *Psychotherapy, 28,* 150–156.

Browne, A. (1992). Violence against women: Relevance for medical practitioners. *Journal of the American Medical Association, 267,* 23, 3184–3187.

Browne, A., & Finkelhor, D. (1986). Impact of child sexual abuse: A review of the research. *Psychological Bulletin, 99,* 66–77.

Browne, A., & Williams, K. R. (1989). Exploring the effect of resource availability and the likelihood of female-perpetrated homicides. *Law and Society Review, 23,* 75–94.

Bullock, L. F., & McFarlane, J. (1989). The birth weight-battering connection. *American Journal of Nursing, 89,* 1153–1155.

Burge, S. K. (1989). Violence against women as a health care issue. *Family Medicine, 21*(September–October), 368–373.

Burgess, A. W., & Holmstrom, L. L. (1974). Rape trauma syndrome. *American Journal of Psychiatry, 131,* 981–986.

Burgess, A. W., & Holmstrom, L. (1979a). Adaptive strategies and recovery from rape. *American Journal of Psychiatry, 136,* 1278–1282.

Burgess, A. W., & Holmstrom, L. (1979b). *Rape: Crisis and recovery.* Bowie, MD: Robert J. Brady.

Burgess, A. W., & Holmstrom, L. (1979c). Rape: Sexual disruption and recovery. *American Journal of Psychiatry, 133* (49), 648–657.

Burnam, M. A., Stein, J. A., Golding, J. M., Siegel, J. M., Sorenson, S. B., Forsythe, A. B., & Telles, C. A. (1988). Sexual assault and mental disorders in a community population. *Journal of Consulting and Clinical Psychology, 56,* 843–850.

Carmen, E. H., Rieker, P. P., & Mills, T. (1984). Victims of violence and psychiatric illness. *American Journal of Psychiatry, 141,* 378–383.

Cartwright, P. S., & The Sexual Assault Study Group. (1987). Factors that correlate with injury sustained by survivors of sexual assault. *Obstetrics and Gynecology, 70,* 44–46.

Center for Disease Control, U.S. Department of Health and Human Services. (1985), December 13). Adolescent sex offenders—Vermont, 1984. *Morbidity and Mortality Weekly Report, 34*(49), 738–741.

Center for Disease Control. (1989). Education about adult violence in U.S. and Canadian Medical Schools: 1987–88. *Morbidity and Mortality Weekly Report, 38,* 17–19.

Chen, Y. M., Davis, M., & Ott, D. J. (1986). Traumatic rectal hematoma following anal rape. *Annals of Emergency Medicine, 15,* 122–124.

Cimino, J. J., & Dutton, M. A. (1991). *Factors influencing the development of PTSD in battered women.* Paper presented at the 99th annual convention of the American Psychological Association, San Francisco.

Coates, D., Wortman, C. B., & Abbey, A. (1979). Reactions to victims. In I. H. Frieze, B. Bar-Tal, & J. S. Carroll (Eds.), *New approaches to social problems: Applications of attribution theory.* San Francisco: Jossey-Bass.

Coley, S. A., & Becket, J. O. (1988). Black battered women: A review of empirical literature. *Journal of Counseling and Development, 66,* 266–270.

Conte, J. R. (1988). The effects of sexual abuse on children: Results of a research project. *Annals of the New York Academy of Sciences, 528,* 311–326.

Council on Scientific Affairs. (1987). Elder abuse and neglect. *Journal of the American Medical Association, 257,* 966–971.

Cunningham, J., Pearce, T., & Pearce, P. (1988). Childhood sexual abuse and medical complaints in adult women. *Journal of Interpersonal Violence, 3,* 131–144.

Dobash, R. E., & Dobash, R. P. (1979). *Violence against wives.* New York: Free Press.

Douglas, M. A. (1986). The battered woman syndrome. In O. J. Sonkin (Ed.), *Domestic violence on trial: Psychological and legal dimensions of family violence* (pp. 39–54). New York: Springer.

Drossman, D. A., Lesserman, J., Nachman, G., Li, Z., Gluck, H., Toomey, T. C., & Mitchell, M. (1990). Sexual and physi-

cal abuse in women with functional or organic gastrointestinal disorders. *Annals of Internal Medicine, 113,* 828–833.

Elam, A. L., & Ray, V. G. (1986). Sexually related trauma: A review. *Annals of Emergency Medicine, 15,* 576–584.

Ellis, E. M., Atkeson, B. M., & Calhoun, K. S. (1981). An assessment of long-term reactions to rape. *Journal of Abnormal Psychology, 90,* 263–266.

Ellis, E. M., Calhoun, K. S., & Atkeson, B. M. (1980). Sexual dysfunctions in victims of rape: Victims may experience a loss of sexual arousal and frightening flashbacks even one year after the assault. *Women and Health, 5,* 39–47.

Fellitti, V. J. (1991). Long-term medical consequences of incest, rape, and molestation. *Southern Medical Journal, 84,* 328–331.

Finkelhor, D., & Yllö, K. (1983). Rape in marriage: A sociological view. In D. Finkelhor, R. J. Gelles, G. T. Hotaling, & M. A. Straus (Eds.), *The dark side of families: Current family violence research* (pp. 119–131). Beverly Hills, CA: Sage.

Finkelhor, D., & Yllö, K. (1985). *License to rape: Sexual abuse of wives.* New York: Holt, Rinehart & Winston.

Foa, E. B., Olasov, B., & Steketee, G. S. (1987, September). *Treatment of rape victims.* Paper presented at the conference State of the Art in Sexual Assault, Charleston, SC.

Follingstad, D. R., Brennan, A. F., Hause, E. S., Polek, D. S., & Rutledge, L. L. (1991). Factors moderating physical and psychological symptoms of battered women. *Journal of Family Violence, 6,* 81–95.

Forman, B. (1980). Psychotherapy with rape victims. *Psychotherapy: Theory, research, and practice, 17,* 304–311.

Forster, G. E., Estreich, S., & Hooi, Y. S. (1991). Screening for STDs [Letter to the editor]. *Annals of Emergency Medicine, 324,* 161–162.

Frank, E., & Anderson, B. P. (1987). Psychiatric disorders in rape victims: Past history and current symptomatology. *Comprehensive Psychiatry, 28,* 77–82.

Frank, E., & Stewart, B. D. (1984). Depressive symptoms in rape victims: A revisit. *Journal of Affective Disorders, 7,* 77–85.

Frank, E., Turner, S. M., & Duffy, B. (1979). Depressive symptoms in rape victims. *Journal of Affective Disorders, 1,* 269–297.

Frank, E., Turner, S. M., Stewart, B. D., Jacob, J., & West, D. (1981). Past psychiatric symptoms and the response to sexual assault. *Comprehensive Psychiatry, 22,* 479–487.

Frieze, I. H. (1983). Investigating the causes and consequences of marital rape. *Signs, 8,* 532–553.

Frieze, I. H., & Browne, A. (1989). Violence in marriage. In L. Ohlin & M. H. Tonrey (Eds.), *Crime and justice—An annual review of research. Family violence.* Chicago: University of Chicago Press.

Geist, R. F. (1988). Sexually related trauma. *Emergency Medical Clinics of North America, 6,* 439–466.

Gelles, R. (1979). *Family violence.* Beverly Hills, CA: Sage.

Gelles, R. (1988). Violence and pregnancy: Are pregnant women at greater risk for abuse. *Journal of Marriage and the Family, 50,* 841–847.

Gelles, R., & Straus, M. (1988). *Intimate violence: The definitive study of the causes and consequences of abuse in the American family.* New York: Simon and Schuster.

Gidycz, C. A., & Koss, M. P. (1990). A comparison of group and individual sexual assault victims. *Psychology of Women Quarterly, 14,* 325–342.

Glenn, F., & Resick, P. A. (1986). *The effects of family violence on coping ability to a later victimization.* Unpublished manuscript, University of Missouri–St. Louis.

Goldberg, W. G., & Tomlanovich, M. C. (1984). Domestic violence victims in the emergency department. *Journal of the American Medical Association, 251,* 3259–3264.

Golding, J. M., Stein, J. A., Siegel, J. M., Burnam, M., & Sorenson, S. B. (1988). Sexual assault history and use of health and mental health services. *American Journal of Community Psychology, 16,* 625–644.

Goodman, L., Saxe, L., & Harvey, M. (1991). Homelessness as psychological trauma: Broadening perspectives. *American Psychologist, 46* (11), 1219–1225.

Green, B. L., Wilson, J. P., & Lindy, J. D. (1985). Conceptualizing post-traumatic stress disorder. A psycho-social framework. In C. R. Figley (Ed.), *Trauma and its wake: The study of post-traumatic stress disorder* (pp. 53–69). New York: Brunner/Mazel.

Hanson, R. K. (1990). The psychological impact of sexual assault on women and children: A review. *Annals of Sex Research, 3,* 187–232.

Helton, A., McFarlane, J., & Anderson, E. (1987). Battered and pregnant: A prevalence study. *American Journal of Public Health, 77,* 1337–1339.

Hilberman, E. (1980). Overview: The "wife-beater's wife" reconsidered. *American Journal of Psychiatry, 137,* 1336–1347.

Hilberman, E., & Munson, K. (1977–1978). Sixty battered women. *Victimology: An International Journal, 2,* 460–471.

Hillard, P. J. (1985). Physical abuse in pregnancy. *Obstetrics and Gynecology, 66,* 185–190.

Janoff-Bulman, R. (1992). *Shattered assumptions: Towards a new psychology of trauma.* New York: Free Press.

Janoff-Bulman, R., & Frieze, I. H. (1983). A theoretical perspective for understanding reactions to victimization. *Journal of Social Issues, 39,* 1–17.

Kemp, A., Rawlings, E. I., & Green, B. L. (1991). Post-traumatic stress disorder (PTSD) in battered women: A shelter example. *Journal of Traumatic Stress Studies, 4*(1), 137–148.

Kercher, G., & McShane, M. (1984). The prevalence of child sexual abuse victimization in an adult sample of Texas residents. *Child Abuse & Neglect, 8,* 495–502.

Kilpatrick, D. G., Resick, P. A., & Veronen, L. J. (1981). Effects of a rape experience: A longitudinal study. *Journal of Social Issues, 37,* 1050–1121.

Kilpatrick, D. G., Saunders, B. E., Veronen, L. J., Best, C. L., & Von, J. M. (1987). Criminal victimization: Lifetime prevalence, reporting to police, and psychological impact. *Crime and Delinquency, 33,* 478–489.

Kilpatrick, D. G., & Veronen, L. J. (1984). *Treatment of fear and anxiety in victims of rape* (Final Rep., grant No. RO1 NG29602). Rockville, MD: National Institute of Mental Health.

Kilpatrick, D. G., Veronen, L. J., & Best, C. L. (1985). Factors predicting psychological distress among rape victims. In C. R. Figley (Ed.), *Trauma and its wake: The study and treatment of post-traumatic stress disorder* (pp. 113–141). New York: Brunner/Mazel.

Kilpatrick, D. G., Veronen, L. J., & Resick, P. A. (1979). Assessment of the aftermath of rape: Changing patterns of fear. *Journal of Behavioral Assessment, 1,* 133–148.

Kilpatrick, D. G., Veronen, L. J., Saunders, B. E., Best, C. L., Amick-McMullan, A., & Paduhovich, J. (1987). *The psychological impact of crime: A study of randomly surveyed crime victims* (Final Rep. on grant No. 84-IJ-CX-0039). Submitted to the National Institute of Justice, Washington DC.

Koss, M. P. (1985). The hidden rape victim: Personality, attitudinal, and situational characteristics. *Psychology of Women Quarterly, 9,* 193–212.

Koss, M. P. (1988). Women's mental health research agenda: Violence against women. *Women's Mental Health Occasional Paper Series.* Washington, DC: National Institute of Mental Health.

Koss, M. P., Dinero, T. E., Seibel, C., & Cox, S. (1988). Stranger, acquaintance, and date rape: Is there a difference in the victim's experience? *Psychology of Women Quarterly, 12,* 1–24.

Koss, M. P., & Harvey, M. (1991). *The rape victim: Clinical and community approaches to treatment.* Lexington, MA: Stephen Greene Press.

Koss, M. P., & Heslet, L. (1992). *Medical consequences of violence against women.* Unpublished manuscript.

Koss, M. P., Koss, P. G., & Woodruff, W. J. (1991). Deleterious effects of criminal victimization on women's health and medical utilization. *Archives of Internal Medicine, 151,* 342–347.

Koss, M. P., Woodruff, W. J., & Koss, P. G. (1991). Criminal victimization among primary care medical patients: Incidence, prevalence, and physician usage. *Behavioral Science and the Law, 9,* 85–96.

Kwentus, J. A., Hart, R. P., Peck, E. T., & Kornstein, S. (1985). Psychiatric complications of closed-head trauma. *Psychosomatics, 26,* 8–14.

Lacey, H. B. (1990). Sexually transmitted diseases and rape: The experience of a sexual assault centre. *International Journal of STD and AIDS, 1,* 405–409.

Langan, P. A., & Innes, C. A. (1986). *Preventing domestic violence against women.* Washington, DC: U.S. Department of Justice, Bureau of Justice Statistics.

Lerner, M. J. (1980). *The belief in a just world.* New York: Plenum Press.

Lurigio, A. J., & Resick, P. A. (1990). Healing the psychological wounds of criminal victimization: Predicting postcrime distress and recovery. In A. J. Lurigio, W. G. Skogan, & R. C. Davis (Eds.), *Victims of crime: Problems, policies, and programs* (pp. 51–67). Newbury Park, CA: Sage.

McCahill, T. W., Meyer, L. C., & Fischman, A. M. (1979). *The aftermath of rape.* Lexington, MA: D. C. Heath & Co.

McFarlane, J. (1989). Battering during pregnancy: Tip of an iceberg revealed. *Women and Health, 15,* 69–84.

McGrath, E., Keita, G. P., Strickland, B. R., & Russo, N. F. (Eds.). (1990). *Women and depression: Risk factors and treatment issues.* Washington, DC: American Psychological Association.

Mitchell, R. E., & Hodson, C. A. (1983). *Battered women: The relationship of stress, support, and coping to adjustment.* Paper presented at the meeting of the American Psychological Association, Washington, DC.

Murphy, S. M. (1990). Rape, sexually transmitted diseases and human immunodeficiency virus infection. *International Journal of STD and AIDS, 1,* 79–82.

Nadelson, C., Notman, M., Zackson, H., & Gornich, J. (1982). A follow-up study of rape victims. *American Journal of Psychiatry, 139,* 1266–1270.

National Victims Center (1992, April 23). *Rape in America: A report to the nation.* Arlington, VA: Author.

Pagelow, M. D. (1984). *Woman-battering: Victims and their experiences.* Beverly Hills, CA: Sage.

Plass, P. S., & Strauss, M. A. (1987). *Intra-family homicide in the United States: Incidence, trends, and differences by religion, race, and gender.* Paper presented at the Third National Family Violence Research Conference, University of New Hampshire, Durham, NC.

Randall, T. (1990). Domestic violence begets other problems of which physicians must be aware to be effective. *Journal of the American Medical Association, 264,* 940–943.

Randall, T. (1991). Hospital-wide program identifies battered women; offers assistance. *Journal of the American Medical Association, 266,* 1177–1179.

Resick, P. A., Calhoun, K., Atkeson, B., & Ellis, E. (1981). Adjustment in victims of sexual assault. *Journal of Consulting and Clinical Psychology, 49,* 704–712.

Resick, P. A., Jordan, C., Girelli, S., Hutter, C., & Marhoefer-Dvorak, S. (1989). A comparative outcome study of behavioral group therapy for sexual assault victims. *Behavior Therapy, 19,* 385–401.

Roth, S., & Lebowitz, L. (1988). The experience of sexual trauma. *Journal of Traumatic Stress Studies, 1*(1), 79–107.

Rothbaum, B. O., Foa, E. B., Riggs, D. S., Murdock, T., & Walsh, W. (in press). A prospective examination of post-traumatic stress disorder in rape victims. *Journal of Traumatic Stress.*

Ruch, L. O., & Chandler, S. M. (1983). Sexual assault trauma during the acute phase: An exploratory model and multivariate analysis. *Journal of Health and Social Behavior, 24,* 174–185.

Ruch, L. O., Gartrell, J. W., Amedeo, S., & Coyne, B. J. (1991). The sexual assault symptom scale: Measuring self-reported sexual assault trauma in the emergency room. *Psychological Assessment, 3,* 3–8.

Ruch, L. O., & Leon, J. J. (1983). Sexual assault trauma during the acute phase: An exploratory model and multivariate analysis. *Journal of Health and Social Behavior, 24,* 174–185.

Russell, D. E. H. (1982). *Rape in marriage.* New York: Macmillan.

Russell, D. E. H. (1983). The prevalence and incidence of forcible rape and attempted rape of females. *Victimology: An International Journal, 7,* 81–93.

Russell, D. E. H. (1986). *The secret trauma: Incest in the lives of girls and women.* New York: Basic Books.

Ryan, W. (1971). *Blaming the victim.* New York: Basic Books.

Sales, E., Baum, M., & Shore, B. (1984). Victim readjustment following assault. *Journal of Social Issues, 37,* 5–27.

Saltzman, L. E. (1990). Battering during pregnancy: A role for physicians. *Atlanta Medicine, 64,* 45–48.

Satin, A. J., Hemsell, D. L., Stone, I. C., Theriot, S., & Wendel, G. D. (1991). Sexual assault in pregnancy. *Obstetrics and Gynecology, 77,* 710–714.

Saunders, D. G. (1986). When battered women use violence: Husband abuse or self-defense? *Victims and Violence, 1,* 47–60.

Schecter, S. (1982). *Women and male violence: The visions and struggles of the battered women's movement.* London: Pluto Press; and Boston: South End Press.

Searles, P., & Berger, R. J. (1987). Factors associated with a history of childhood sexual experience in a nonclinical female population. *Journal of the American Academy of Child Psychiatry, 23,* 215–218.

Sedney, M. A., & Brooks, B. (1984). Factors associated with a history of childhood sexual experience in a nonclinical female population. *Journal of the American Academy of Child and Adolescent Psychiatry, 23,* 215–218.

Shields, N. M., & Hanneke, C. R. (1983). Battered wives' reactions to marital rape. In D. Finkelhor, R. J. Gelles, G. T. Hotaling, & M. A. Straus (Eds.), *The dark side of families: Current family violence research* (pp. 131–148). Beverly Hills, CA: Sage.

Sonkin, D. J., Martin, D., & Walker, L. E. A. (1985). *The male batterer: A treatment approach.* New York: Springer.

Stark, E., & Flitcraft, A. (1988). Violence among intimates: An epidemiological review. In V. B. Van Hasselt, R. L. Morrison, A. S. Bellack, & M. Hersen (Eds.), *Handbook of family violence* (pp. 293–318). New York: Plenum Press.

Stark, E., Flitcraft, A., & Frazier, W. (1979). Medicine and patriarchal violence: The social construction of a "private" event. *International Journal of Health Services, 9,* 461–493.

Stark, E., Flitcraft, A., Zuckerman, D., Grey, A., Robinson, J., & Frazier, W. (1981). Wife abuse in the medical setting: An introduction for health personnel. *Domestic Violence Monograph Series,* No. 7. Rockville, MD: National Clearinghouse on Domestic Violence.

Straus, M. A., & Gelles, R. S. (1990). *Physical violence in American families.* New Brunswick, NJ: Transaction Publishers.

Straus, M. A., Gelles, R. S., & Steinmetz, J. K. (1980). *Behind closed doors: Violence in the American family.* Garden City, NY: Anchor/Doubleday.

Surgeon General's Workshop on Violence. (1985). *Response, 9,* 19–21.

Uniform Crime Reports. (1989). Washington, DC: Department of Justice.

Van der Kolk, B. A. (Ed.) (1987). *Psychological trauma.* Washington, DC: American Psychiatric Press.

Van der Kolk, B. A. (1988). The trauma spectrum: The interactions of biological and social events in the genesis of the trauma response. *Journal of Traumatic Stress, 1,* 273–290.

Walker, L. E. (1979). *The battered woman.* New York: Harper & Row.

Walker, L. E. (1983). The battered woman syndrome study. In D. Finkelhor, R. J. Gelles, G. T. Hotaling, & M. A. Straus (Eds.), *The dark side of families: Current family violence research* (pp. 31–48). Beverly Hills, CA: Sage.

Walker, L. E. (1984). *The battered woman syndrome.* New York: Springer.

Williams, J. E., & Holmes, K. A. (1981). *The second assault: Rape and public attitudes.* Westport, CT: Greenwood Press.

Woodling, B. A., & Kossoris, P. D. (1981). Sexual misuse: Rape, molestation, and incest. *Pediatric Clinics of North America, 28,* 481–499.

Wyatt, G. E. (1985). The sexual abuse of Afro-American and White-American women in childhood. *Child Abuse & Neglect, 9,* 507–519.