NATIONAL COALITION AGAINST DOMESTIC VIOLENCE
NCADV

Male Victims of Intimate Partner Violence

DID YOU KNOW?

- 1 in 4 men have been physically abused (slapped, pushed, shoved) by an intimate partner.[i]
- 1 in 7 men have been *severely* physically abused (hit with a fist or hard object, kicked, slammed against something, choked, burned, etc.) by an intimate partner at some point in their lifetime.[ii]
- Nearly 1 in 10 men in the United States has experienced rape, physical violence, and/or stalking by an intimate partner and reported at least one measured impact related to experiencing these or other forms of violent behavior in the relationship (e.g., being fearful, concerned for safety, post-traumatic stress disorder (PTSD) symptoms, need for healthcare, injury, contacting a crisis hotline, need for housing services, need for victim's advocate services, need for legal services, missed at least one day of work or school).[iii]
- 1 in 18 men are severely injured by intimate partners in their lifetimes.[iv]
- Male rape victims and male victims of non-contact unwanted sexual experiences reported predominantly male perpetrators. Nearly half of stalking victimizations against males were also perpetrated by males. Perpetrators of other forms of violence against males were mostly female. [v]
- From 1994 to 2011, the rate of serious violence (rape, sexual assault, robbery and aggravated assault) committed by an intimate partner declined 64% for males[vi]
- During the most recent 10-year period (2002-11) for which data is available, nonfatal serious violence accounted for more than a third of intimate partner violence against males (39 percent).[vii]

TEEN DATING VIOLENCE

- 13.4% of male high school students report being physically or sexually abused by a dating partner.[viii]

PSYCHOLOGICAL ABUSE

- 48.8% of men have experienced at least one psychologically aggressive behavior (being kept track of by demanding to know his whereabouts, insulted or humiliated, or felt threatened by partner's actions) by an intimate partner in their lifetime.[ix]
- 4 in 10 men have experienced at least one form of coercive control (isolation from friends and family, manipulation, blackmail, deprivation of liberty, threats, economic control and exploitation) by an intimate partner in their lifetime.[x]

SEXUAL ASSAULT/SEXUAL VIOLENCE

- Approximately 1 in 71 men in the United States reported being raped in his lifetime, which translates to almost 1.6 million men in the United States.[xi]
- 8% of men have experienced sexual violence other than rape (forced to penetrate someone, sexual coercion, unwanted sexual contact, and non-contact unwanted sexual experiences) by an intimate partner at some point in their lifetime.[xii]

If you need help:
Call The National Domestic Violence Hotline 1-800-799-SAFE (7233)
Or, online go to DomesticShelters.org

TAKE A STAND AGAINST DOMESTIC VIOLENCE
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NATIONAL COALITION AGAINST DOMESTIC VIOLENCE

NCADV

Male Victims of Intimate Partner Violence

STALKING

- 1 out of every 19 U.S. men have been stalked in their lifetime to the extent that they felt very fearful or believed that they or someone close to them would be harmed or killed.[xiii]
- Among male stalking victims, almost half (44.3%) reported being stalked by only male perpetrators while a similar proportion (46.7%) reported being stalked by only female perpetrators. About 1 in 18 male stalking victims (5.5%) reported having been stalked by both male and female perpetrators in their life. [xiv]

HOMICIDE

- 1 in 20 (5%) of male murder victims are killed by intimate partners.[xv]
- Between 1980 and 2008, in cases in which the victim/offender relationships were known, 7.1% of men were killed by an intimate.[xvi]
- The percentage of males killed by an intimate fell from 10.4% in 1980 to 4.9% in 2008, a 53% drop. [xvii]

[i] Black, M.C., Basile, K.C., Breiding, M.J., Smith, S.G., Walters, M.L., Merrick, M.T., Chen, J. & Stevens, M. (2011). *The national intimate partner and sexual violence survey: 2010 summary report*. Retrieved from http://www.cdc.gov/violenceprevention/pdf/nisvs_report2010-a.pdf.

[ii] Ibid.

[iii] Ibid.

[iv] Black, M. C., Basile, K. C., Breiding, M. J., Smith, S. G., Walters, M. L., Merrick, M. T., Chen, J. & Stevens, M. (2011). *The national intimate partner and sexual violence survey: 2010 summary report*. Retrieved from http://www.cdc.gov/violenceprevention/pdf/nisvs_report2010-a.pdf.

[v] [v] Black, M.C., Basile, K.C., Breiding, M.J., Smith, S.G., Walters, M.L., Merrick, M.T., Chen, J. & Stevens, M. (2011). *The national intimate partner and sexual violence survey: 2010 summary report*. Retrieved from http://www.cdc.gov/violenceprevention/pdf/nisvs_report2010-a.pdf.

[vi] Catalano, S. (2013). Intimate Partner Violence: Attributes of Victimization, 1993-2011, BJS. http://www.bjs.gov/content/pub/pdf/ipvav9311.pdf

[vii] Ibid.

[viii] Vagi, K. J., O'Malley Olson, E., Basile, K. C., & Vivolo-Kantor, (2015). Teen dating violence (physical and sexual) among US high school students: Findings from the 2013 national youth risk behavior survey. *JAMA Pediatrics, 169*(5), 474-482.

[ix] Breiding, M. J., Chen, J. & Black, M. C. (2014). *Intimate partner violence in the United States – 2010.* Retrieved from http://www.cdc.gov/violenceprevention/pdf/cdc_nisvs_ipv_report_2013_v17_single_a.pdf.

[x] Ibid.

[xi]Black, M.C., Basile, K.C., Breiding, M.J., Smith, S.G., Walters, M.L., Merrick, M.T., Chen, J. & Stevens, M. (2011). *The national intimate partner and sexual violence survey: 2010 summary report*. Retrieved from http://www.cdc.gov/violenceprevention/pdf/nisvs_report2010-a.pdf.

[xii] National Intimate Partner and Sexual Violence Survey 2010

[xiii] Black, M.C., Basile, K.C., Breiding, M.J., Smith, S.G., Walters, M.L., Merrick, M.T., Chen, J., & Stevens, M.R. (2011). *The national intimate partner and sexual violence survey (NISVS): 2010 summary report*. Retrieved from http://www.cdc.gov/violenceprevention/pdf/nisvs_executive_summary-a.pdf.

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[xiv] National Intimate Partner and Sexual Violence Survey 2010
[xv] Bridges, F.S., Tatum, K. M., & Kunselman, J.C. (2008). Domestic violence statutes and rates of intimate partner and family homicide: A research note. *Criminal Justice Policy Review, 19*(1), 117-130.
[xvi] Homicide trends in the US 1980-2008, cooper smith. http://www.bjs.gov/content/pub/pdf/htus8008.pdf
[xvii] Ibid.

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Leigh Saint-Louis, M.D.
Family Physician (ABFM)
Eugene, Oregon USA

Approach to Men's Sexual Health Exams

Many issues can arise during a men's sexual health care encounter – too many things to put into a checklist and cover them all. Here is an algorithm to help focus the process.

- First, pre-screen the patient before starting the encounter, by collecting demographic, vital-sign, historical, and medicine and substance use data.
- Next, use "ice-breakers" and a "warning shot" to prepare the patient for the discussion.
- Then ask three basic questions, following the answers to focus on the underlying problem/s. This enables you to formulate your plan for testing, treatment, and follow-up.

Pre-Screen:

1) **Gender/ correct pronouns:**
   a) Natal male, current male => queries about internal anatomy (pelvic floor, prostate, urinary system), external anatomy (penis, testes, skin), psychosexual issues
   b) Natal male, current female => see exam for female who is transgender (including prostate, skin, and penis/testes if present)
   c) Natal female, current male => queries about internal anatomy (pelvic floor, internal genital tract, urinary system), external anatomy (skin), psychosexual issues

2) **Physical health risk factors:**
   a) Age (when younger, higher risk of violence/ trauma, STIs, in/fertility issues, ejaculatory issues, testicular cancer; when older, higher risk of ED [erectile dysfunction], hypogonadism, depression, prostate cancer)
   b) Body mass index, or waist-height ratio (risk of adipose vasculopathic and neuropathic ED; cancer risk)
   c) Blood pressure (risk of hypertensive vasculopathic ED and nephropathy; medication effects)
   d) Blood glucose (risk of diabetic vasculopathic ED, neuropathic ED and chronic pain/medication effects, nephropathy)
   e) Nicotine use (risk of vasculopathic ED, bladder cancer)

3) **SBIRT (screening, brief intervention, referral to treatment) risk factors:**
   a) Depression/ PHQ9 (risk of sexual dysfunction; medication effects)
   b) Alcohol use disorder/ AUDIT (risk of sexual dysfunction, metabolic disease)
   c) Substance use disorder/ DAST (risk of opioid ED)

4) **Histories:**
   a) Past medical history of pelvic or spinal surgeries or radiation (risk of neurogenic ED, neurogenic urinary tract problems)
   b) Family history of reproductive cancers (risk of reproductive cancers)
   c) Psychosocial history of "3 I's": incarceration, immigration, in the military (higher risk of violence/ trauma, PTSD)

5) **Medication list:**
   a) Antidepressants, opioids, benzodiazepines, beta blockers (risk of sexual dysfunction, hypogonadism)
   b) Alpha blockers (e.g., "Flomax"), 5-alpha reductase blockers (e.g., "Avodart") (Pt being treated for benign prostatic hypertrophy; risk of ED, sexual dysfunction)
   c) PDE5 blockers (e.g., "Viagra") (Pt being treated for ED; risk of fatal acute hypotension if combined with nitrates [nitroglycerine, isosorbide mono- or di-nitrate])
   d) Testosterone (trans- or cis-gender Pt being treated for hypogonadism)
   e) Herbal/ over-the-counter remedies (Pt may be self-treating a genitourinary concern; unpredictable medication effects/ interactions)

Ice Breakers:

- ***"Who lives at home with you?"***

- Partnered => ***"Are you two sexually active these days?"***
- Single => ***"Are you dating, these days?"***

Warning Shot:

- ***"With your permission, I'd like to ask you some personal questions."***

Three Basic Questions:

1) ***"Any trouble with urination?"***

a) LUTS (lower urinary tract symptoms): nocturia more than twice a night, incomplete emptying, difficulty starting a stream =>
   - on exam, enlarged prostate with or without bogginess; elevated PSA (serum prostate-specific antigen) => BPH (benign prostatic hypertrophy) => consider alpha blockers (e.g., "Flomax"), 5-alpha reductase blockers (e.g., "Avodart")
   - on exam, nodular, asymmetric, enlarged, or normal prostate with symptoms nonresponsive to BPH meds => rule out prostate cancer by referral to Urology for evaluation and management

b) Dysuria +/- discharge/ "drip" => infection => test for and treat UTI +/- STI

c) Urinary frequency
   - normal or lower volume => test for and treat UTI +/- STI; screen for chemical irritants (e.g. caffeine, tannins, alcohol, nicotine); screen for deconditioning (pelvic floor weakness; consider pelvic physical therapy) and behavioral "overactive bladder" (due to lack of access to facilities, bladder hypervigilance; consider structured bladder training)
   - higher volume => hyperglycemia => test for and treat pre/diabetes

d) Hematuria
   - painful => stone (kidney, bladder), verify on urinaylsis and imaging; treat per guidelines
   - painless => cancer of kidney, bladder; refer to Urology for evaluation and management

e) Incontinence ("leaking urine") => any of the above; seek clinical correlation

2) ***"Any concerns about the equipment down there?"***

a) ED (erectile dysfunction)
   - ED secondary to low testosterone
     - History: trauma, chronic pain, opioid use disorder, chronic illness
     - Symptoms: reduction in spontaneous and self-pleasure erections; lower libido; deconditioning, lowered strength/ stamina, depressed mood and motivation
     - Physical exam: loss of muscle mass and testicular volume
     - Diagnosis: serum testosterone and SHBG (sex hormone binding globulin); calculate free and bioavailable testosterone
     - Treatment: testosterone replacement per guidelines
   - ED secondary to vasculopathy
     - History: depression/ anxiety, psychotropic medications, metabolic disease (obesity, hyperglycemia, hyperlipidemia, hypertension), nicotine
     - Symptoms: reduction in spontaneous and self-pleasure erections; latency, weakness, or loss of erections; normal libido unless impaired by chronic illness
     - Physical exam: normal, or metabolic disease
     - Diagnosis: clinical, with high suspicion of vasculopathy
     - Treatment: treat underlying conditions; consider PDE5 blocker (e.g., "Viagra") unless Pt uses cardiac nitrates; consider referral to Urology for evaluation and management for other modalities
   - ED secondary to sexual dysfunction
     - History: depression, antidepressant medication; heart attack, beta blocker medication; psychosocial conflicts
     - Symptoms: reduced libido, normal spontaneous erections with or without reduced sel-pleasure erections
     - Physical exam: within normal limits
     - Diagnosis: diagnosis of exclusion; rule out vasculopathic and testosterone-related abnormalities
     - Treatment: correct medication list/ interactions; behavioral-psychotherapeutic approaches

b) Skin lesions
- painful, severe and rapidly progressive => on exam, necrotizing fasciitis (Fournier gangrene) => to emergency department
- painful, less severe => on exam, herpes simplex (vesicles), bacterial skin infection (pustule/ boil), prepuce candidiasis => treat per guidelines; injury => treat appropriately or transfer to emergency department
- painless =>
  - on exam, condylomata => refer to Urology for evaluation and management
  - on exam, papule (chancre) which may be ulcerated => traditional or reverse sequence testing => treatment per guidelines
  - on exam, plaque/s or other unusual lesions which may be ulcerated => refer to Urology for evaluation and management

c) Lumps/ swelling
- painful, severe and rapidly progressive => on exam, unilateral swelling and exquisite tenderness => suspect testicular torsion => to doppler ultrasound and/ or emergency department
- painful, less severe => on exam, tenderness with or without swelling of the epididymis => epididymitis => STI testing; treatment per guidelines
- painless =>
  - on exam, groin bulge elicited by Valsalva maneuver => inguinal hernia => management per guidelines
  - on exam, nonfluctuant tendinous nodule or cord in body of penis, with or without report of curved erections => Peyronie's fibrosis => refer to Urology for evaluation and management
  - on exam, enlarged scrotal venous plexus palpable with Valsalva maneuver => varicocele => refer to Urology for evaluation and management (higher risk of impaired fertility)
  - on exam, diffuse fluid collection in scrotum bilateral or unilateral, transilluminates (flashlight applied to skin illuminates entire collection) => hydrocele => refer to Urology for evaluation and management (draining)
  - on exam, hard mass on or within testicle => suspicion of testicular cancer => refer to Urology for evaluation and management
  - on exam, unilateral or equivocal testicle without history of orchiectomy (testicle removal) => ultrasound to confirm undescended testicle => refer to Urology for evaluation and management (higher risk of testicular cancer)

d) Ejaculation issues
- Report of premature ejaculation, normal physical exam => behavioral-psychotherapeutic approaches
- Report of delayed ejaculation, normal physical exam, no contributing medications => behavioral-psychotherapeutic approaches
- Report of chronic "dry" ejaculations, additional hisotry of cloudy postcoital urine => retrograde ejaculation => refer to Urology for evaluation and management (higher risk of impaired fertility)
- Report of painful ejaculation =>
  - on exam, tender prostate => prostadynia => refer to Urology for evaluation and management
  - normal exam => consider reflex pelvic floor spasm, or pelvic venous congestion => consider referral to pelvic physical therapy

3) "Any concerns about sex in general?"

a) Relationships:
- differences in libido; concerns about commitment; concerns about fidelity => screen for IPV (intimate partner violence) => behavioral-psychotherapeutic approaches

b) Feelings:
- PTSD with or without endorsed history of sexual trauma => screen for safety => individual psychotherapy

c) Identity and orientation issues:
- These include Pt concerns around gender identity, sexual orientation, and "kink" or unusual sexual behaviors
- They are “not a problem unless they’re a problem”
- Reassurance as appropriate => screen for safety => individual and/ or group psychotherapy if desired

d) Fertility:

- Report of suspected infertility, or desire for vasectomy reversal => refer to Urology for evaluation and management
- Contraception methods and supplies review
- Vasectomy options => refer to Urology

e) <u>Safety:</u>
- Safer sex practices and supplies review
- PrEP (pre-exposure prophylaxis) to prevent HIV for those at risk (practicing unprotected receptive penetration, intravenous drug use, HIV seropositive partner/s) => offer and prescribe, follow up per guidelines
- Recovery from trauma; substance use disorder harm reduction; adjustment to chronic illness/ disability; end-of-life considerations => individual and/ or group psychotherapy

Updated 5/20/2017 by Leigh Saint-Louis, MD

Sexual health is part of being human.

Like anyone else, as a transgender man you want to feel positive about your body. You want to have sex that is safe, feels good, and is rewarding.

Each transman is unique.

- You may or may not have had surgery.
- You may or may not take hormones.
- What you like to do when you have sex is unique to you.

Take care of your body. It's important to being a healthy man.

Have more questions?

Every transman has his own set of concerns and questions. Here are a few resources that can help:

Center of Excellence for Transgender Health
transhealth.ucsf.edu

National Center for Transgender Equality
www.transequality.org

Transgender Law Center
www.transgenderlawcenter.org

National Center for Lesbian Rights
www.nclrights.org

To find a family planning clinic near you, go to:
www.hhs.gov/opa

cfhc California Family Health Council

center of excellence for TRANSGENDER health http://www.transhealth.ucsf.edu/

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All photos courtesy of Center of Excellence for Transgender Health except baby photo by Andrew Vargas.

TRANS HEALTH

sexual health FOR transmen

What about my chest health?

Even if you've had your chest redone, you may still be at risk of cancer. Talk with your provider about getting chest health screenings and mammograms.

Tell your provider about any family history of breast cancer.

What about STDs?

Like anyone else who has sex, transmen are at risk of getting a sexually transmitted disease (STD).

People get STDs from having oral, anal, and vaginal sex. But you can protect yourself:

- **Use a condom or a dental dam every time you have sex.**
- **Get tested for STDs and HIV. Ask your provider how often to get tested.**
- **If you have an STD, get treated right away.**

What if I take hormones?

Taking testosterone (T) will often cause your periods to stop in 1 to 6 months. You may get cramps during or after orgasm. If you have this pain often, talk to your provider.

T can also thin the walls of the vagina. You could to use a low dose estrogen cream inside the vagina to keep it from thinning too much. This will help the vagina from bleeding if you have vaginal sex , which lowers the chances of getting an STD, especially HIV.

What about the health of the cervix?

Transmen are at risk for cancer of the cervix, uterus and ovaries if they still have these parts.

The cervix is the opening part of the uterus that connects to the vagina. Cancer of the cervix is caused by certain types of a virus called HPV. It can be passed by skin to skin contact during sex. Ask your provider about getting the HPV vaccine to help protect you from HPV.

Transmen with a cervix may also need a Pap test. The Pap test looks at cells from the cervix to see if there are any signs of cancer. Talk to your provider about when and how often you should get a Pap test done.

Do I still need a pelvic exam?

If you haven't had surgery, yes. Your provider will check your organs with a pelvic exam. Your provider will check the uterus and ovaries for anything unusual. You may also need further tests.

Tell your provider what would make you feel most comfortable during the exam.

Can I still get pregnant?

Some transmen have had surgery to remove the uterus and ovaries. These transmen cannot get pregnant.

But, if you still have a uterus and ovaries, you can still get pregnant even if you take testosterone (T). If you don't want to get pregnant, be sure to use condoms or another birth control method.

There are a few birth control methods that do not have hormones. Talk to your provider about which methods are right for you.

What if I want to get pregnant?

If you still have a uterus and ovaries and want to get pregnant, you will need to stop taking T. High levels of T in your body during pregnancy can cause birth defects in the baby.

Talk to your provider before you try to get pregnant.

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Who is Doing What to Whom? Determining the Core Aggressor in Relationships Where Domestic Violence Exists.

Domestic violence, also known as Intimate Partner Violence, is an extremely complicated, multi-faceted issue. Studies widely identify women as victimized more often than men by their intimate partners,[i] but men can be victims of intimate partner violence, too, and women may use violence within relationships. What is often harder to determine, especially when both people in a relationship use violence, is who may be the core abuser and who may be the primary victim.

According to the Centers for Disease Control and Prevention's most recent National Intimate Partner and Sexual Violence Survey:

- 1 in 3 women and 1 in 4 men have been victims of [some form of] physical violence by an intimate partner within their lifetime.[1]
- 1 in 5 women and 1 in 7 men have been victims of severe physical violence by an intimate partner in their lifetime.[1]
- 1 in 7 women and 1 in 18 men have been stalked by an intimate partner during their lifetime to the point in which they felt very fearful or believed that they or someone close to them would be harmed or killed.[1]

What is also often harder to determine is a woman as the core abuser, especially within heterosexual relationships. Women are not typically identified as the primary abuser and in the studies examined or within the context of LGBTQ relationships. According to a 2012 report from the National Coalition of Anti-Violence Programs (NCAVP) of Lesbian, Gay, Bisexual, Transgender, Queer, and HIV-Affected Intimate Partner Violence:

- For the second year, close to a majority (47.6%) of IPV homicide victims were LGBTQ men and a majority of homicide victims were identified as gay (47.6%) and lesbian (28.6%).
- Women accounted for about a third (32.6%) of IPV survivors who reported to NCAVP member programs in 2012, while men accounted for a little more than a third (36.1%).
- Gay men were more likely to require medical attention and suffer injuries as a result of IPV. Gay men were close to two times (1.7) more likely to require medical attention and 16 times more likely to suffer injury as compared to individuals who did not identify as gay men.

Throughout our research, we were unable to find data that quantified how often women were identified as the primary abuser in the relationship. Anecdotally, we know they exist, but we were unable to find statistics that clarified how prevalent they may be. It can be implied that men are more often victimized by men and women are the abuser to other women in intimate relationships, but we were not able to quantify that, nor in cases where men are the primary victim with a female abuser.

With that said, advocates and those assisting victims of domestic violence may struggle to identify who is the primary aggressor in the relationship. To that end, the information that follows speaks to the characteristics of abusers, the characteristics of victims, and how violence and abuse may be used in a relationship to maintain control over another.

Characteristics of Abusers

Abusers main objective in intimate relationships is to dominate and control their victim. They are manipulative and clever and will use a myriad of tactics to gain and maintain control over their partner, often in cycles that consist of periods of good times and peace and periods of abuse. The cycle often starts to repeat, commonly becoming more and

more intense as time goes on. Each relationship is different and not every relationship follows the exact pattern. Some abusers may cycle rapidly, others over longer stretches of time. Regardless, abusers purposefully use numerous tactics of abuse to instill fear in the victim and maintain control over them.

The overarching strategy used by abusers is referred to as coercive control. Coercive control includes a combination of abusive tactics such as isolation, degradation, micromanagement, manipulation, stalking, physical abuse, sexual coercion, threats and punishment.[ii] An abuser may use some of these tactics or vary when they use them, but combined and used over time, they are effective in establishing dominance over their victim.

A dominant and controlling partner may initially present at the onset of a relationship as wonderful, loving, and attentive. They may be charming, successful, well-liked and are often very romantic and interested in their partner's interests and desires. They may want to be with them all the time, attentive and charming with their partner's friends and family, supportive and kind. However, over time, these behaviors start to change. The attention that may have initially felt exciting and flattering starts to feel isolating and controlling. The victimized person may start to feel isolated from friends and family because their partner dominates so much of their time. The abuser may start to object to their partner's time spent with others or make it so difficult to do things independently of them that the victim stops doing so.

Prolonged exposure to this type of treatment combined with periods of loving and desired behaviors by the controlling partner can lead to the victimized person feeling trapped, silenced, and lacking self-esteem. If the victimized person tries to assert themselves, the abuser often ramps up the abuse and may become more and more controlling and abusive. Soon, the victimized person may come to fear the abuser for various valid reasons and may feel they are unable to escape or leave. It is important to note that a victimized person may not be able to get away from their abuser because the abuser *will not let them do so.*

Abusive tactics used to establish dominance and control over a partner by an abuser include, but are not limited to the following. An abuser may:

- Be extremely jealous and/or possessiveness
- Try to convince others they are the true victim in the relationship
- Blame the victim for causing them to abuse them
- Be unpredictable
- Be cruel to animals
- Be physically, verbally, emotionally, or psychologically abusive
- Be extremely controlling
- Be rigid in their beliefs about roles of women and men in relationships
- Be particularly interested in guns or weapons
- Be forceful with sex or disrespectful their partner's wishes around sex
- Be vigilant about their partner's every move
- Blame their partner for anything bad that happens
- Have a bad temper or are easily angered
- Come from a violent household
- Sabotage birth control methods or refuse to honor agreed upon protection methods
- Sabotage or obstruct their partner's ability to work or attend school
- Control all the finances in the relationship
- Abuse of other family members, children, or pets

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Forms of Domestic Violence include:

- Battery – a pattern of abusive behavior that a person fearful of their physical and/or sexual safety; control; intimidation; coercion.
- Isolation – forcing a partner to account for their time and whereabouts and/or making a partner tell with whom they have visited; telling a partner that you exist for him only – you do not get to be a separate, autonomous person.
- Emotional Abuse – playing on a partner's insecurities; giving mixed messages; constant insults and degradation; telling a partner who they are or should be.
- Financial Abuse – controlling all monetary resources; exploiting a partner's social security number or credit; not allowing a partner access to money or financial documentation.
- Threat of Control of the Children - a partner must acquiesce to the abuser's needs, wants or desires or something will happen to the children; threat of taking the kids away.

Characteristics of Victims and Why Victims May Use Force of Violence within an Intimate Relationship

Anyone can be a victim of domestic violence. There is NO "typical victim." Victims of domestic violence come from all walks of life, varying age groups, all backgrounds, all communities, all education levels, all economic levels, all cultures, all ethnicities, all religions, all abilities and all lifestyles.

Over time, the victim becomes more and more oppressed by the abuser and may do whatever they can to not agitate or displease their partner. In other instances, Victims of violence often retaliate and resist domination and battering by using force themselves. Victims may use violence or force in effort to:

1. Escape and/or stop violence that is being perpetrated against them, and
2. Establish a semblance of equivalence in the relationship as a method of protecting themselves and their children against escalating abuse.

In relationships where domestic violence exists, violence is not equal, even if the victim fights back or instigates violence in effort diffuse a situation. Violence on victims' part is in larger part resistance to ongoing battering.

Characteristics of Resistive/Reactive Violence:

- The target of resistive violence is specific: the violator or abuser;
- Reactive violence is used to stop and/or escape ongoing battering. It may be considered by the victim as a form of self-protection.
- Reactive violence is often used by victims to reclaim and restore dignity and integrity that is destroyed by the batterer by their systematic abuse.
- The motivation behind the use of such force is to retaliate and/or resist battering. Such violence may also be used with the intention of stopping future violence.
- Targets of resistive violence generally hold the key to their own protection. That is, by stopping their own violence against their victims, they would also end their partners' use of violence towards them;
- Violence is rarely the first or only tactic used by victims of ongoing battering. They often use a variety of other methods to stop or reduce abuse, such as:

- Negotiation;
- Appeasement;
- Threats to withdraw from the relationship or actually leave the perpetrator;
- Solicit help from others such as family, friends, clergy, and police;
- Threats to expose the offender to others and shame him to end abuse; and
- Threats to hurt the offender emotionally, economically, or damage his property.

In brief, a victim's reactions to abuse fall into three classes:

- Coping (e.g., placating the abuser, enduring, etc.),
- Managing (e.g., anticipate abusers' moods, modify own behavior so as not to arouse anger in abuser, attempt to control situations that lead to violence, divert attention from the abuse through religion or other activities, etc.), and
- Resisting (e.g., create consequences for abuser such as arrest, seek outside help, hit back or strike preemptively, take other overt and covert actions to end or escape the abuse, etc.).

Domestic violence affects all aspects of a victim's life. When abuse victims are able to safely escape and remain free from their abuser, they often survive with long-lasting and sometimes permanent effects to their mental and physical health; relationships with friends, family, and children, their career and their economic well-being.

Victims of domestic violence experience an array of emotions and feelings from the abuse inflicted upon them by their abuser, both within and following the relationship. They may also resort to extremes in effort to cope with the abuse. Victims of domestic violence may:

- Want the abuse to end, but not the relationship
- Feel isolated
- Feel depressed
- Feel helpless
- Be unaware of what services are available to help them
- Be embarrassed of their situation
- Fear judgment or stigmatization if they reveal the abuse
- Deny or minimize the abuse or make excuses for the abuser
- Still love their abuser
- Withdraw emotionally
- Distance themselves from family or friends
- Be impulsive or aggressive
- Feel financially dependent on their abuser
- Feel guilt related to the relationship
- Feel shame
- Have anxiety
- Have suicidal thoughts
- Abuse alcohol or drugs
- Be hopeful that their abuser will change and/or stop the abuse
- Have religious, cultural, or other beliefs that reinforce staying in the relationship
- Have no support from friends of family
- Fear cultural, community, or societal backlash that may hinder escape or support

- Feel like they have nowhere to go or no ability to get away
- Fear they will not be able to support themselves after they escape the abuser
- Have children in common with their abuser and fear for their and their children's safety if they leave
- Have pets or other animals they don't want to leave
- Be distrustful of local law enforcement, courts, or other systems if the abuse is revealed
- Have had unsupportive experiences with friends, family, employers, law enforcement, courts, child protective services, etc. and either believe they won't get help if they leave or fear retribution if they do (e.g., they fear they will lose custody of their children to the abuser)

One of the most important mitigating factors in determining who is the primary abuser when violence is used by both partners in a relationship is when each partner ends their use of violence; the victim's use of violence ends when the relationship ends or the abuser stops using abuse. The abuser will continue to abuse their victim indefinitely and often more intensely as they feel a loss of control over their victim, either within the relationship, or when it ends. For far too many, this is when the victim is in the most danger; the more control the abuser feels they are losing, the more abusive they may become.

While data proves women are most often the victims of abuse in intimate relationships, again, anyone can be abused and anyone can be abusive. Understanding the dynamics of both abusers and victims is key to determining who is doing what to whom in a relationship.

[i] Black, M.C., Basile, K.C., Breiding, M.J., Smith, S.G., Walters, M.L., Merrick, M.T., Chen, J., & Stevens, M. (2011). *The national intimate partner and sexual violence survey: 2010 summary report.* National Center for Injury Prevention and Control, Centers for Disease Control and Prevention. Retrieved from: http://www.cdc.gov/violenceprevention/pdf/nisvs_report2010-a.pdf

[ii] Aronson Fontes, Lisa. *Invisible Chains: Overcoming Coercive Control in Your Intimate Relationship*. Guilford, 2015. Print.