
Public Hearing

before

COMMISSION ON SEX DISCRIMINATION IN THE STATUTES

"To study whether State legislation can intervene to stop
the occurrence or the harm done by violence directed
primarily toward women"

LOCATION: Room 8
Legislative Office Building
Trenton, New Jersey

DATE: March 20, 1992
1:00 p.m.

MEMBERS OF COMMISSION PRESENT:

Senator Wynona M. Lipman, Chair
Assemblyman Robert L. Brown
Roberta Francis
Viola Van Jones, Ph.D.
Phoebe Seham, Esq.



ALSO PRESENT:

Melanie S. Griffin, Esq.
Executive Director

New Jersey State Library

ATTORNEY GENERAL'S LIBRARY

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State of New Jersey

**COMMISSION ON SEX DISCRIMINATION
IN THE STATUTES**

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NOTICE OF PUBLIC HEARINGS

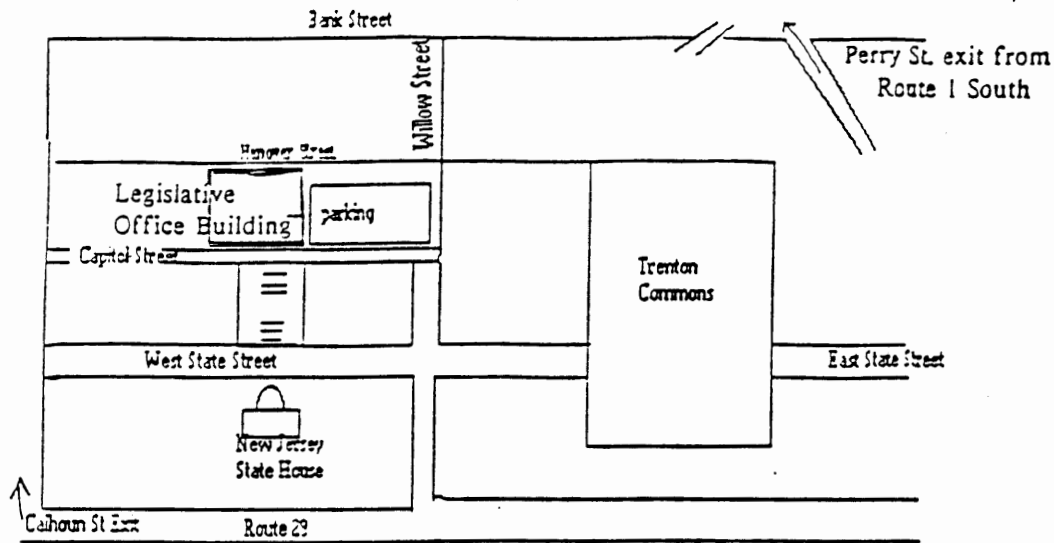
MARCH 20, 1992 MARCH 27, 1992

1:00 P.M. - 6:30 P.M.

The Commission on Sex Discrimination in the Statutes will take public testimony on the issue of violence against women during (2) two public hearings. The March 20th hearing will be held in Room #8 of the Legislative Office Building in Trenton, and the March 27th hearing will be held at the S.I. Newhouse Center for Law and Justice (Rutgers Law School) in Newark. The Commission is studying whether state legislation can intervene to stop the occurrence or the harm done by violence directed primarily toward women, which it has found in other studies to be a major impediment to the legal equality of the sexes.

As the Commission defines it, violence includes but is not limited to: sexual assault, sexual harassment in employment housing and public accommodations, domestic violence, prostitution, inappropriate medical treatment, incest, the systematic impoverishment of women, violent pornography, bias crimes based on gender, date rape, and dating violence. Anyone wishing to testify should prepare a written statement. Each witness will be scheduled for a 20-30 minute presentation at the location he or she prefers.

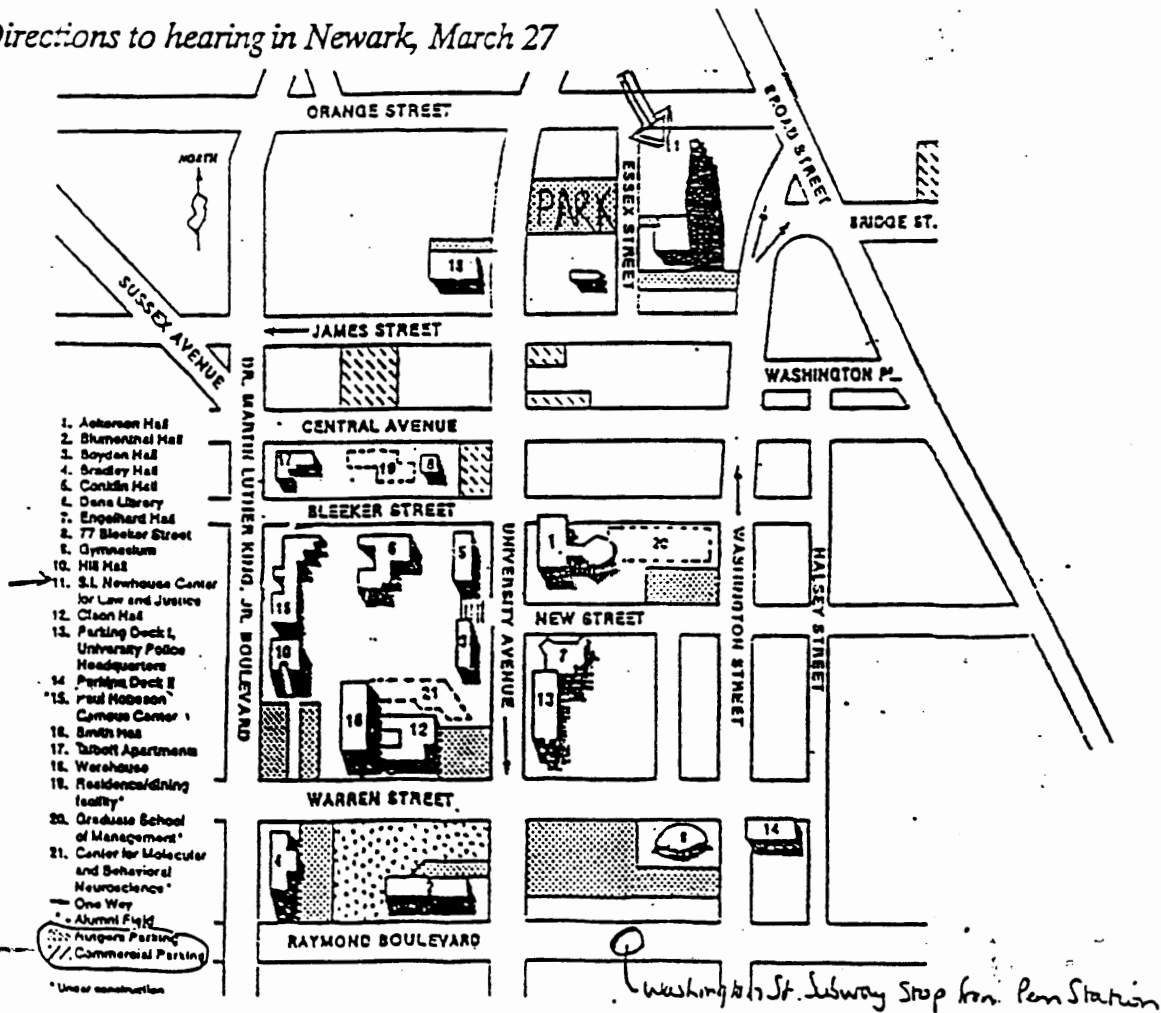
Please call Maureen Swearingen at the Commission office if you wish to attend or give testimony. Written testimony will be accepted for inclusion in the record until April 6, 1992.



From South: Rte 206 or Route 295 North to South Broad Street in Trenton. Turn left following signs to Route 29. Exit at Cahoun Street toward Princeton, turn right at second light onto Hanover Street. Legislative Office Building is on the right before the next light.

From North: Rte 1 to Perry Street Exit. Turn left at top of ramp, go to Willow Street and turn left. Turn right at next light (Hanover Street); Legislative Office Building is the first building on the left.

Directions to hearing in Newark, March 27



From Garden State Parkway: Take exit 145 to Route 280 towards Newark-Harrison. As you come off the ramp, bear right and follow signs for Route 280 East, Newark-Harrison. Once on Route 280, stay in the right-hand lane. Follow signs to Harrison. Continue until Martin Luther King Blvd., exit 14A. Take exit to bottom of ramp and turn right onto M.L.King Blvd.

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SENATOR WYNONA M. LIPMAN (Chair): Since we sat down here, everybody got quiet out there. Isn't that nice? So, I guess we can open this hearing. Can you all hear me? You seem so far away.

I welcome you all today for the first of two public hearings to be held by the Commission on Sex Discrimination in the Statutes. Over the years, the Commission has heard from the public on a variety of issues that affect the relative legal position of women and men. But today we are faced with an awesome public awareness of the issue we are to examine, combined with a difficult political configuration in the State, and an even more difficult economy. We are here today to try to avoid the disaster for women that is almost certainly the result of this combination of events.

In hard times, violence against women becomes more frequent and more extreme. We are already hearing from the fringes that welfare mothers and minimum wage earners -- many of whom are women -- are the source of our economic problems. This is patently ridiculous, and thinking, feeling human beings know it. An easy fix that blames women is acceptable to some, however, precisely because it feeds their need to blame the victims and trust the established powers that be. Our new domestic violence law is encouraging this horrible crime's victims to come forward, and the courts are becoming crowded. There are actually rumblings in the Legislature that the solution to this sad state of affairs is to change the law to withhold relief from the victims. We are here to look for more creative ways to solve problems than to ignore them.

Economic violence, domestic violence, sexual violence: all are phenomena that could have as their victims both men and women. But the people who overwhelmingly bear the burdens of these injustices are women. We are here to talk about why that happens and what this government can do about it. I thank you for coming, beg for your continued attention,

and will seek your support for the work of this Commission as it goes forward with this very important task.

All right. So now we will call Ms. Ruth Ann Koenick, Director of Sex Assault Services, Rutgers University. Are you going to testify with Ms. Jill Greenbaum?

R U T H A N N K O E N I C K: Jill and I are going to split the half hour, so, yes.

SENATOR LIPMAN: Okay. All right. Very good.

MS. KOENICK: Let me begin by thanking you for your kind invitation to offer testimony about violence against women. I'm honored to share with you a small piece of what I have learned in the over 21 years that I have worked with victims of sexual assault. What I'm going to talk about this afternoon are really only two areas that look at violence against women.

In 1971, there were a series of sexual assaults at the University of Maryland in College Park, where I was then a graduate student. The victims abducted from the same parking lot were left to deal with the system that was, at times, overwhelming, abusive, and frightening. The University chose to ignore these crimes until forced to acknowledge their existence when it hit the front page of the local newspaper, The Washington Post. Let me say that this was not unusual as our knowledge about sexual assault was limited, the literature was scant, and our attitudes and laws archaic, at best. I, along with other residence hall staff, with the support of the Division of Student Affairs, responded to the needs of the victims and the campus community by developing what was the first rape crisis center on a college campus. Since that time, colleges and universities with varying levels of interest and commitment have grappled with the issue of sexual violence.

This testimony which I present to you this afternoon will provide you with some information about sexual violence,

primarily, acquaintance rape, and propose a set of recommendations.

Some will charge that sexual violence is a fantasy of feminists and that acquaintance rape is an oxymoron, but I'm here to tell you that the consistent and often rewarded sexual violence against women on our college campuses is neither fantasy nor contradictory, but what I consider to be a national tragedy causing thousands of women each year to be denied the opportunity of an education free from fear. It denies them the right to live, love, or learn in an environment that fosters personal rights, development of boundaries, and respect for human dignity.

Current research conducted by Mary Koss, involving 6000 college women and men on 32 different campuses, indicates that one in four college-age women have been the victim of a completed or attempted sexual assault. What is even more surprising to many, is that it also said that one in twelve men acknowledge committing an act of sexual violence. Confirmed by other studies, over 80 percent of these assaults occur between people who know each other. Although the surveys consistently support the numbers, there is a large discrepancy between the incidence of the crime, the reporting to police, administrators, and health or counseling center clinicians. The Koss research suggests that a full 42 percent of the victims told no one, ever, and only 5 percent reported the crime to the police. Another 5 percent sought assistance from a rape crisis center. What happened to the other 50 percent?

This is the epitome of a safe victim, for who is safer to be terrorized than the person who tells no one? There are many reasons why women choose not to report a crime of sexual violence. Some aren't sure how to define the act, knowing something awful happened to them, knowing that they feel different, that they hurt both inside and outside, but not

quite sure of its legality or illegality. Or, perhaps they aren't aware of how to report. Perhaps they have a belief system that is self-blaming and often project that belief onto others. Perhaps they have an intense sense of fear, the sense of shame and humiliation prohibits seeking help. Or as with many colleges and universities who emulate our society as a whole, women are discouraged, whether overtly or covertly from reporting this crime.

There is another type of violence, almost always sexually based, that permeates our universities. This assault, primarily verbal, yet focusing on the body, is beginning to receive some attention in the literature. Primarily written by Dr. Bernice Sandler of the Center for Women Policy Studies, it is the crime of peer harassment. Similar in nature to sexual harassment, it is often dismissed as a normal part of our culture, a kind of boys will be boys, or they're just having fun, what's the matter, don't you have a sense of humor? Let me illustrate this crime for you: There are places on our campuses that women avoid walking because they know gangs of men will be hanging out of windows, sitting on steps, blocking sidewalks, commenting on the women's sexual attributes or desirability, or perhaps, just visually harassing. Some women report that they avoid certain dining facilities, as men will congregate at a particular table and scope -- that's the current word for this; scoping -- the women as they wait in line, sometimes holding up numbers to judge their physical appearance, such as breast size.

The list can go on, but I think each one of you, and all the other women in this room, can think of instances in your own history where you have made changes based on your need for safety, security, and desire to be free from harassment. Let me just say that when a name is given to a behavior, a name such as scoping or acquaintance rape, or gang rape, it not only allows us to study that behavior but it suggests, at least to

me, that there is a tremendous occurrence in order to warrant a title.

Time limits me from providing you with the many examples of the violence against women that occur on a daily, hourly, or even minute-by-minute basis on our campuses. I'm providing you with some literature that will give you some further information on both sexual violence and other forms of violence against women, and the impact that it has on the students.

Prior to coming here today I wrote to many colleagues, including students at Rutgers, and so what I'm about to recommend is a compilation of their comments as well as some of the suggestions made by some of the literature. I would also encourage you to obtain a recent opinion by the Honorable John E. Bachman, a Judge in the Superior Court, Middlesex County, regarding a specific case that he just decided. He discusses some of the difficulties universities have in assuring the safety of their students, as well as some of the things that Rutgers did that were within his view of good practice. I'm also providing you with the Rutgers University Acquaintance Rape Task Force Report accepted by President Lawrence last spring and currently being implemented by my office, The Office of Sexual Assault Services.

Let me list a couple of recommendations for you and give you a little bit of information about them: I feel it is extremely important that we adopt a policy condemning sexual violence; that each and every college and university in this State have such a policy. It must be distributed to every student and parent, informing them that this behavior will not be tolerated; that there are consequences to this behavior, and that those of us who send our daughters as victims and our sons as assailants must understand those consequences; that there is disciplinary action against those who offend. This policy also needs to state that the university will pursue, to

the full extent of its power, discipline when this occurs. This policy needs to be distributed to faculty and staff as well, and should outline the legal definition as well as the manner in which it is addressed in the student conduct code. It should also include information on the causes of sexual violence with the particular emphasis on how alcohol use precedes most acquaintance rapes, specific information on reporting, crisis intervention. Medical and counseling services must be included.

Just an aside from something here, as probably most of the people in the room know, Rutgers has had a rough time of it in the last two or three weeks, and many of our students who have been sexually assaulted are continuing to experience a tremendous amount of pain. Some people have suggested that the college and the university will suffer some pain as well. I'm under the belief that the university will survive and hopefully, that the women who have been assaulted, and the impact it's had on their families, will survive as well. One of the suggestions was that we send a policy statement to parents of students -- of incoming first-year students, and I think this needs to be considered as well.

The Acquaintance Rape Task Force Report as well as most people in this field believe there should be a specific provision that prohibits sexual violence in the code of conduct. Schools are not eager to do this because many people believe that by acknowledging the crime, it says that we have the problem. I'd like believe by acknowledging the crime, we are seeking to reduce the incidence of it. So, I think that to include a specific notation in the conduct of code, the code conduct would be a move in the right direction.

This also needs to include procedures which protect the rights of victims during hearing procedures. This is outlined in one of the resources that I provided for you. But, for example, the victim should have the right to be free of

harassment from her assailant's peers prior to, during, and after the hearing. Additionally, she should have access to the decision reached by the hearing officer or board.

What has often happened is that in many of the procedures the assailant, the defendant, has the right to say whether it will be a closed or open hearing. That is the way the procedure at Rutgers is right now and is in the process of being changed. What I would like to see happen with this is that the victim also has the right to say it can be a closed hearing. In the past, particularly when the assailant has been a member of a large male organization, he has sought to bring his friends in to pack the hearing to intimidate, for no other reason than to intimidate and harass the victim. So, I believe that she should have the right to have the hearing closed, as well.

Establishment of a comprehensive sexual assaults services program that provides crisis intervention, counseling, educational programming all in a confidential manner, is a necessity. Establishment of this office must include adequate funding and support services. This cannot be someone's-- I guess the best way to put it is, this cannot be someone's other assigned duties. It has to be a specific office with staff to support this effort.

Additionally, this person -- or the office -- must have access to and be included in the administrative structure which makes decisions regarding sexual violence. This person should also review all administrative policies and protocol regarding sexual violence.

Comprehensive educational programming is another area of concern. It's not enough to say that sexual violence will not be tolerated. It's much more complex than just saying, "just say no," or, "no means no." Students come to college with a well-developed sense of general stereotypes and consequent behaviors. This, as well as specific information

about sexual violence needs to be discussed in a variety of methods. We all learn differently and we need to teach people in different ways, including the development of literature, brochures, articles in school newspapers, and mandatory attendance at rape awareness programs.

I can't begin to tell you how many calls I get from schools across the country asking me how we're doing at Rutgers, and as we begin to talk, many of them say, "I can't get anything in the school newspaper. You have to pay to have an ad in it. You can't get reporters to report on this because it's their belief that this is not an important issue." We need to assure that this is an important issue on our college campuses.

The data tells us that the most vulnerable time to be sexually assaulted is the summer after high school and the first year of college. It is important that this issue be addressed from the time that students state their intentions to attend a particular university. Mandatory programming at orientation sessions for all incoming students need to occur. We have often focused our energy on first-year women, or only our first-year students, both men and women, but colleges and universities have a tremendous amount of transfer students and we must educate them as well.

The research also tells us that there's a higher propensity for the occurrence of rape, and in particular, gang rape, in all male housing units such as fraternities and in particular when alcohol is present. Some would suggest that the behavior in these residences is predatory in nature. Therefore, I'm suggesting that a mandatory program is a must for these groups. All Greek organizations need to be included as there's often a tremendous amount of pressure put on sorority members not to report a rape by a fraternity member. These programs must include information on the strong correlation between alcohol and sexual violence and how it contributes to

becoming victim as well as victimizer. This demands that programming be provided for both men and women. Additionally, the topic and issues involved in sexual violence should be included in the curriculum, for example, in introductory writing courses so that students continue to learn from a variety of sources and gain an understanding of the level of importance the university places on this issue.

Training for faculty and staff on how to assist a person who's been sexually assaulted is also very important. Often the residence hall staff are the first people or persons the victim discloses the crime to, and they need to be trained on this subject. Training must also be provided for police. This type of programming needs to be on an annual basis and must be supported by the administrative structure. Although the literature states that only 16 percent of the rapes on college campuses happen between strangers, priority has to be given to this issue. The safety and security of students cannot be compromised. Lighting, shuttle buses, escorts all need to be reviewed whenever a crime occurs.

I have been extremely brief in my comments, but hope that this gives you a sense of some of the issues and some of the difficulties that people in my field have been facing for a number of years in trying to get colleges and universities to respond to the need of victims who have been sexually assaulted.

Since coming to Rutgers over a year ago, there has been a consistent amount of comments on the location of my office. Located on Douglas Campus, almost everyone, including my 14 year-old son, have commented that it's an appropriate place because, surely more rapes occur on Douglas since it's a women's college and that we all know that rape is a women's issue. I want to clarify that misperception, in closing.

Sexual violence is not a women's issue. Sexual violence is a cultural issue and needs to be addressed in that context. No longer can we focus our attention on telling women

how to feel safe, warning women to stay inside and providing self-defense courses. Timothy Beneke, in his book states, "It is men who rape and men who collectively have the power to end rape." I believe that you and I have the power to make them listen and respond.

Thank you.

SENATOR LIPMAN: Thank you, Ms. Koenick. Does anybody have a question?

MS. FRANCIS: I guess I have one, Ruth Ann. Rutgers has, within the last year, right, hired you into this position. Do you know how many other campuses, if any, have a full time person working on the issue?

MS. KOENICK: Princeton.

MS. FRANCIS: It's the only other one in the State?

MS. KOENICK: It's the only other one that I know of that has a full time office. I know that Kean does not. It's other assigned duties at Kean. And most of the other colleges don't have the kind of support office that provides this.

SENATOR LIPMAN: How large is your staff?

MS. KOENICK: You're looking at it.

SENATOR LIPMAN: Oh, my.

MS. KOENICK: I do Camden and Newark, too. Thus, you understand the comment I made about the financial support and support staff that's needed. I'm part of the Department of Health Education so I do have some support staff, and there are other people who I work with, but the responsibility for this program is mine. We do a lot of-- We use students a lot because my program is primarily funded by student fees. We have a commitment to turn money back to students and hire them to do some of the work. So, I do have students as peer counselors and peer educators that do some of the programming, but that's a very small proportion of it and weeks like this week, when they're on spring break or during other breaks in the summer, it's primarily me alone.

MS. VAN JONES: Are you tied in with the Rape Crisis Center, Ruth?

MS. KOENICK: Which one?

MS. VAN JONES: 56.

MS. KOENICK: I do training for 56 Place. They are generally kind of a comprehensive hotline rather than a rape crisis center. The Womens' Resource and Support Center focuses more of their energies on violence against women and other issues about women. They recently had-- They have, I think, an ongoing dialogue on "living with your mother" or something like that. I'm not quite sure what it is, but it's on issues of interest to women, and I do training for them as well. One of the problems is that none of the help lines -- whether they're at any of the campuses -- are more than a couple of hours a day, and they do not go 24 hours. We're in the process also, of putting together-- The Advisory Board in my office is in the process of putting together a backup support network of professional staff that will assist at least during the crisis kinds of times we've had the last couple of weeks.

MS. FRANCIS: I've just got one other short question in connection with the recommendations you might make to State government as to what role we could play. Would you see any role in the Department of Higher Education? Is there any coordinating function they perform that would help encourage the other campuses to follow through on your good suggestions?

MS. KOENICK: Not that I know of. I don't know.

MS. VAN JONES: You seem like you have a large, large responsibility, you know, trying to implement this kind of thing on the campus both with the Camden and the Newark campus. What is the prognosis for the future and longevity, is there going to be more staff support, faculty support? Since President Lawrence-- You mentioned a report of some sort that President Lawrence had issued. What is the longevity, what is the prognosis? Is it because of--

MS. KOENICK: I'm not--

MS. VAN JONES: --the recent things that happened, you know?

MS. KOENICK: I'm really not sure, Viola, what the prognosis for this type of work is. At this point in time it is a hot issue, so the prognosis is good at least in the immediate future.

I would really like to see some mandating that there be offices like this on each campus. And, although I travel back and forth to Newark fairly regularly -- I go at least once a week to see students for counseling -- I do not go to Camden very often, and they really need some assistance there. But I would like to see offices such as mine mandated on all colleges and universities in the State, that they have a support system in place, that they develop the policies. And then I think that if it's precedent, there's more of it, that the prognosis is better, particularly if it's legislatively mandated. With some money and staff-- (laughter)

MS. VAN JONES: Seems like you have a 24-hour job.

MS. KOENICK: I do.

MS. VAN JONES: I commend you.

MS KOENICK: Thank you.

SENATOR LIPMAN: Thank you.

Ms. Jill Greenbaum, Director of Bergen County Rape Crisis Center.

J I L L G R E E N B A U M, Ed.D.: Good afternoon. I have prepared a variety of materials for you, which Riki Jacobs has passed out. Not that you need to look at it now because I'll be going over all of it and there's things that you can take with you. It's a heavy stack.

At any rate I am here today, not only as the Director of the Bergen County Rape Crisis Center, but also as Vice-President of the New Jersey Coalition Against Sexual Assault. So I hope that I'm representing the viewpoint of many

different groups. I'm also Chair of the Bergen County Coalition Against Rape.

So, I am very pleased to be here also, to be a part of these hearings to discuss the many interrelated issues which passively and actively contribute to the victimization and revictimization of women. While broad philosophical questions which underly our day-to-day interactions must be addressed, the practical realities of living with our present laws and systems must be examined. In my direct service work on behalf of survivors, as a leader and active participant in various coalitions, and as a presenter at local, national and international conferences, I have addressed a variety of topics.

The following areas are all fragments of the whole picture which is violence against women:

With regard to factors and issues influencing our psychological environment and the formulation of society's members opinions of violence against women, please refer to attachment A -- not right now, I used to be a teacher so I know, never read while someone else is talking -- which briefly delineates many of the issues surrounding sexual victimization.

Attachment B outlines the position of the New Jersey Coalition Against Sexual Assault regarding the "naming" of victim survivors of rape, a practice commonly used by some newspapers in New Jersey, fortunately not within my own county, but in surrounding counties;

Lack of commitment on the part of the State of New Jersey, both philosophically and fiscally, to the needs of survivors of violence, specifically with regard to rape care programs;

The inability to find an appropriate place within governmental departments or divisions -- in other words, the rape care programs are part of the Department of Health, Division of Family Health Services, and my reason behind, or my

difficulties with that particular placement are outlined in attachment C;

Deliberate nonprioritizing or inattention to the needs of information and services for other than english-speaking populations. In other words, materials developed by the Department of Health, for example, for dissemination through the rape care programs, are available only in english.

Fourth, lack of coordinated examination of the present levels of functioning of the law enforcement criminal justice systems, and the impact of the judicial process upon victims and their families. Attachment D;

Lack of training for local law enforcement personnel regarding sex offenses, the needs of victims' survivors, and the role of rape crisis center staffs, the often politically motivated assignment of investigators to sex crimes units, without regard to professional capabilities -- and then with no further training;

The cessation of advanced training opportunities for law enforcement and criminal justice personnel regarding sex offenses and the proper disposition of such cases;

Lack of prosecution of husbands or partners who sexually assault their wives and inadequate recognition of in response to stalking as the prelude to a crime.

Fifth, difficulty in securing funds through the Violent Crimes Compensation Board, for example: for counseling for adequate lengths of time for victims and covictims of sexual abuse.

Sixth, a delineation of the anticipated breakdown of funds to be generated by passage of Public Law 1991, Chapter 327 -- which was a recently passed law just this year.

Seventh, no enforcement of Public Law 1987, the law which requires that both local police departments and hospitals inform victims of the local rape crisis centers. See attachment E-1;

The need for development and routine utilization of standard operating procedures regarding sexual assault victim survivors in their interaction with other systems, such as hospitals, local police, or sex crimes unit investigators;

The development and use of a "standardized kit" for evidence collection across State, consistent medical prophylactic treatment for rape survivors regarding sexually transmitted diseases and pregnancy;

The education for service providers and law enforcement and criminal justice personnel regarding sexual assault and the transmission of HIV, attachment E-2.

Eighth, insufficient understanding of, attention to, and funding for programs for both adult and adolescent sex offenders, attachment F;

Recognition of, and treatment programs for, female sex offenders;

The development of appropriate treatment programs within prison probation and parole programs with treatment components and available and affordable after care and therapy for sex offenders for the remainder of their lives.

Ninth, the initiation and ongoing training of judges, with regard to issues of sexual victimization.

Tenth, the ability of school systems and colleges and universities to "overlook" the problem of sexual victimization, such as no development of state sanctioned relationships across systems such as rape care programs with high schools, colleges, law enforcement, criminal justice systems and hospitals.

Eleventh, the purely monetary concerns of New Jersey Bell regarding the Caller I.D. service in New Jersey over the objections of rape care program and domestic violence personnel, attachment G.

Twelfth, finally, I have included in the packet of information, a letter written to The New York Times detailing

what I would consider adequate coverage of the topic of sexual victimization, attachment H.

I have given you a whole lot of material. This is really my-- I saw this when I was talking with Riki as my opportunity to just raise a lot of issues. Over the past few years I've written a number of position pieces for the coalitions that I work with and for my particular office. So I've included those because that will be a more full understanding and, you know, delineation of the topics that I've raised. I thought that would be the easiest way to approach it. I'm not sure you see it that way, but--
(laughter)

SENATOR LIPMAN: All right. Can we look now?
(laughter)

DR. GREENBAUM: Absolutely. Absolutely.

MS. FRANCIS: That's a great shorthand way to do it, Jill. I think it's wonderful and in fact, all of this will go into the hearing record, and so on. But if you would pick out, maybe, your top three initiatives that you think should be worked on first, could you do that for us?

DR. GREENBAUM: Sure. I guess I would say the need for coordination of services across various systems and that would encompass a lot, for instance, rape care programs working with hospitals and law enforcement. There is clearly no overlap in terms of what we do. We all have distinct jobs. However, we need to work together for those survivors who want to use those systems. And there is a public law in place that says that hospitals and law enforcement must inform the victim of the local rape crisis center. Well, invariably, it is not done, or if it is done it's done as a person is walking out of the office, rather than when a person arrives at someone's office. So, I'm very concerned about coordination of systems.

I would also like to see the laws actually utilized. I mean in my county, Bergen County, you know as well as I do

there's never been a case where the Prosecutor's office has brought forward a man who's been charged with sexually assaulting his wife. Now, I know they have such cases because I have referred them there. They have met with the woman. They have said, "Clearly what happened to you is against the law, but we're virtually unable to bring this to a jury because the jury is not going to come back with a conviction." And, one of my concerns as a rape crisis center person is, if you wait until the juries are ready to hear this kind of thing, we're going to be waiting an awful long time. We need to do a lot of things to get those juries ready to come back with a conviction.

But also, I guess, training is really important to me. Ruth Ann and I both had worked with the State Police Training Bureau out of Sea Girt, and we had worked on a three-day program that was aimed at law enforcement and criminal justice personnel so that they could come in, learn the skills necessary to work effectively in their jobs -- not as rape crisis counselors --- with victims of rape. And, after approximately two years, the program ceased because it was found to be too time-consuming and costly. And this was on the part -- from what I heard from my sources, however accurate they may be -- part of the Attorney General's Office. It was found to be too costly. And my concern is: To whom? We had a great program going and, in fact, I'm going to try and get some of that information out at the Federal level through the National Victim Center, but that's a grave concern of mine.

MS. FRANCIS: No, that's good, all three. In fact, just to follow up. For instance, the coordination of services across the systems from right here: hospitals, employees. Would you see that done best on a county basis? In other words the County Prosecutor's office would play some roll, and the hospitals in the county, and so on. What roll would you see at the State level relative to doing it county-wise?

DR. GREENBAUM: I think at the State level it could be mandated that this has to be done. I'm concerned about the fact that in Bergen County we have a certain evidence collection kit and in Middlesex County they do something completely different. I think there has got to be standardization, perhaps a standard operating procedure at the State level as to how things should happen and then relationships worked out on the county level. Because I think the way things are at the county level now, it's too easy to just not make things work because there's no accountability. You know, there is no accountability.

When I approached the 70 towns in my county-- We put out letters and follow-up phone calls to every single police department in our county several years ago, gave them the law that you've got in your packet, about they've got to inform that victim of the local rape crisis center. We were allowed into three police departments to talk with them because the rest of them told us either number one, it doesn't happen in their town -- literally, one chief said that -- to another who said, "I'd have to bring in too many people on overtime to make this worthwhile. We don't get enough cases."

You know, I understand economic constraints, but I go into hospitals all kinds of crazy times to meet with their shifts of nurses and doctors, so it's not that we're not flexible; it's that they didn't perceive it to be a priority. And you know the way the law works. People are supposed to report to the local P.D. before it gets kicked over to the sex crimes unit. If that person isn't believed at that first level, it doesn't get any further unless they call us and we refer them on, you know, to the sex crimes unit. There's no guarantee at that point either because those people do not have adequate training.

MS. FRANCIS: I have one more follow-up on the marital rape issue. Who, if anyone in the State, has statistics on whether other counties are prosecuting any of those cases?

DR. GREENBAUM: I don't know, but it's certainly something that I can put out through the coalition and get back to you, because I love developing materials as you can tell. (laughter) And I'd be happy to do that research and get it to you within a fairly short period of time.

MS. FRANCIS: I assume the Chair would be interested in finding out about that?

SENATOR LIPMAN: Oh, yes, we would.

DR. GREENBAUM: Okay, I'll do it.

MS. SEHAM: As far as there being a law that looks good but simply isn't enforced, that's not unusual. That happens a lot, particularly where women are concerned, I think.

DR. GREENBAUM: Right.

MS. SEHAM: I'm just wondering, when you're trying to accomplish these things through contact with police stations-- I just have the feeling that there has to be a part of the public that's aware of it, and that lobbying and making noise and writing to the newspapers and having whatever meetings, and so on, that that would help make this a priority, at least in the minds of governmental people, people who care about public opinion. And I know that before the Bergen County Commission on Women wrote its report on crimes of violence against women in 1977, no hospital in Bergen County had any protocol for dealing with rape cases. They do now, of course, so we made some progress. We need to go on making progress. What was progress from 1977 is no longer adequate.

But I'm just wondering about the possibility of getting together, or having some sort of public forum, and airing some of these facts to women's organizations in the county, or in any county, who may not know what the law is, who may not know what a woman's rights are in a situation. If the public were more aware of it, it might help.

DR. GREENBAUM: You're absolutely right. It's certainly an avenue that we have considered in the past and

will continue to consider because it is so important. But, I can tell you in my-- We also went through-- Every year we try something different. You know, we try a couple of things every year. One year we reached out to every single library in the county to come and do a public speaking engagement there for residents of the town. Certain towns told us, "Forget it. That doesn't happen in my town." This was from the librarian, not the Police Chief. (laughter) Seriously, the problem was in my home town -- which is Teaneck -- which, at that time, had 40,000 people in it. We did publicity, press releases, public service announcements, flyers, the whole thing; one person came. Okay? One person. So I wrote a letter to the editor, which, of course, got published because it was the town throw-away paper, and it was my outrage over how can this be. Okay, the 10,000 kids in the town -- or the 15,000 -- they didn't need to come because it's not appropriate for them, blah, blah, blah. But, all these other people. How could this be? Because the paper carries stories all the time of what's happening in our area. And so, I was completely disgusted and we had similarly low turnouts in the few towns that would have us in.

That doesn't mean we stop trying. What I've started to do instead is to write letters to the editor and, in general, if it's around a pertinent topic they'll print it. You know, like I got into The New York Times and did the caller I.D. thing, then New Jersey Bell paid attention to us. And I worked out a special relationship with rape care programs and domestic violence if they wanted it, but it wasn't until that letter was in the Times and they came into the public eye. So what you're saying is very true. It's just they are a tough nut to crack because nobody believes -- the public, this is -- that it's going to happen to them, or it happens to other people, it happens to girls that go to the county compound, it happens to girls that do this, this and this. It's not them,

it's not their families. If they don't perceive it to be something that affects them, they're not going to come out around it. It doesn't mean we won't try but it's been really discouraging.

SENATOR LIPMAN: How does your center hear about rapes if the referral is so slipshod from the police or from the hospital? How do you get the information?

DR. GREENBAUM: We are very active in the high schools in our particular county. We're in approximately half of them which you would say is kind of low, but it's better than most of the other agencies in the county in that we are aggressive every year and we offer things to teachers. We'll come in and do the unit, this is the kind of materials we can offer you when we come in, follow-up tapes, books, you know, the whole nine yards. So we get referrals in that way because teenagers will call us up after seeing us speak. We have press releases in the newspaper almost every month. We have public service announcements on cable TV, and I write these letters to the editor and I sign my name and my affiliations, so people find out about us in that way. In addition we're listed, in our particular county, in the crisis and abuse hotline square, or rectangle, in the phone book. Telephone operators know about us. They're a big source of referral because our program has been around since the late 1970s, and so when someone in Passaic, Hudson or Bergen calls the 911 or the operator, they refer them to us because we've been around consistently for a very long period of time.

SENATOR LIPMAN: I see.

MS. VAN JONES: And a large percentage of the operators are females.

DR. GREENBAUM: Absolutely.

SENATOR LIPMAN: Very good. Thank you very much.

DR. GREENBAUM: You're welcome. Happy reading.

(laughter)

SENATOR LIPMAN: Dr. Marsha Kleinman, the New Jersey Psychological Association.

M A R S H A K L E I N M A N, Psy.D.: Good afternoon. My name is Dr. Marsha Kleinman and I'm a licensed practicing psychologist at the Center for Behavior Therapy in New Brunswick. Today, I am before you as a representative of the New Jersey Psychological Association to discuss the issue of domestic violence.

I'm, perhaps, better equipped to talk about the problems that I encounter daily with battered women and the judicial system than to put forth solutions, although I've managed to come up with about 14 recommendations. I worked on it. However, I hope today to be able to translate my experiences and my concerns with battered women and the judicial process into suggestions that will enable you to bring about needed changes in our laws. And some of the suggestions, I'm not sure the law is the right place, but I share them with you anyway.

Although we all know there are laws on the books to protect battered women -- and I believe all would agree there are battered in this society in need of protection -- there seems to be a serious problem that the courts have in identifying a particular woman who fits that assessment. The public at-large, mental health professionals and judges still hold many myths about battered women and seem to believe they'll be able to identify these women and their abusers by sight. In my experience, nothing could be further from the truth. Battered women and their abusers present in different ways than one might expect, and without knowledge and expertise in the area, in their assessment many go unrecognized and doubly victimized by our court system.

The issues that I've raised are sometimes subtle issues with battered women and maybe difficult to legislate. However, I believe it is imperative that we try. Further, it

may be necessary to put women attorneys on the bench who themselves have been formerly battered women. We may need to do something with the whole system to bring about some change. The issue is so important to me that perhaps judges may need to be screened or specially trained in the area of battered women, not just given courses afterwards. This may need to be a requirement. Battered women need to be recognized as a special subgroup who come before judges, their concerns and those of their children are that serious.

Some of the problems with battered women and their presentations before judges is that they often change attorneys many times during the course of the matrimonial or custody action. Judges view their having changed attorneys as reflecting something wrong with these women. Let me add that my bugaboo currently is custody with battered women because I have been involved with cases and this is really where I'm coming from today, is talking about battered women in the court system and not getting the protection they need, specifically in cases where there is custody action or a divorce action.

The truth is that this behavior -- the women changing attorneys -- more accurately reflects the difficulty battered women have in finding good and appropriate advocates and having the resources to pay for them. The nature of abuse, the fear instilled by an abusive partner in his female victim will often inhibit a battered woman from taking the appropriate legal steps necessary which will identify her to the courts as a battered woman. She may get a temporary restraining order, but then not follow through with a permanent order, as you all know. She may behave in ways which appear contradictory, such as getting a temporary restraining order and then allowing her abuser back in the home. She may allow an abusive husband to share custody, making the decision while she was still in danger and then away from, able to reflect clearly, realized that her children are in danger and go back into court to

change custody. This behavior on her part is viewed as being "addictive and wanting retribution." These behaviors which appear contradictory create confusion in the minds of the judges and in my experience tend to reflect badly on the battered women when judicial decisions are made. All these behaviors and others equally aberrant and strange make her appear to be a "flake" and thus she is doubly victimized at a time when she needs the system to protect her.

Another problem often seen is that women coming out of relationships in which there was psychological abuse and perhaps intimidation without serious physical battering often have not yet labeled themselves as "battered women" although they are every bit as battered as another woman who ends up in the emergency room. Therefore, no agreement should be made until they have been referred for treatment. Attorneys often do not put forth the battering and do not utilize this information in court papers thereby not giving the court the benefit of all the information or the client the benefit of the court's consideration of her as a battered.

When the issue of custody or visitation arises and the attorney first presents it or when the woman changes to another attorney who understands and takes battering seriously, this information is then viewed suspiciously by the court and ends up hurting her, and I could go on.

But let me go to my suggestions. Some may be my "wish list" and hopefully, some will be able to be addressed:

- 1) There should be a presumption that when a woman has obtained a temporary restraining order at some time during a relationship, even if she does not follow through with a permanent restraining order, that there is reason to believe she was in danger and that perhaps she'll be in more danger if she attempts a hearing for a permanent restraining order. She should thus not be penalized for not having obtained a permanent order, although it has to be recognized that no files

of abuse have been made. Perhaps women need something like the Witness Protection Program to encourage them to come forward without fear.

2) The law should reflect that any woman who alleges to have been abused in any way should be counseled by an expert in battered women before a judge accepts any matrimonial or custodial agreement. This would prevent women who go along out of fear from reprisal from an abusive mate from making any agreements while they believe they are in danger. It further gives battered women time to get themselves psychologically together so they can make reasoned and educated decisions.

3) The law should acknowledge that the psychological state battered women are in, immediately coming out of an emotionally or physically abusive relationship, reflects the effects of battering and does not necessarily indicate her general overall functioning or ability to care for herself and for her children. In fact, often her emotional state reflects the effects of the continued abuse and harassment and the frustration of not being able to effectively influence the court to understand her experience as a battered woman or to protect her and her children.

4) Although the law states that there should be a presumption that when there has been abuse the children should reside with the nonabusive parent, that is not enough from my point of view. Joint custody should never be granted where there's the possibility that there has been abuse. Further, divorce mediation should not be allowed where there has been psychological and/or physical abuse. Mediation is only appropriate in an equal relationship and since marital relationships are often not equal -- one person has control either through money or through using intimidation -- mediation is often not appropriate. Our law should reflect that men who are abusers generally fight for custody as a way to continue to exert their control and dominance over their mates rather than

out of the normal parental feelings of love and concern. And I can't tell you how strongly I feel that the court's judges need to know this is normal so that they don't look askance when they hear this, often for the first time.

The law should also perhaps reflect certain personality characteristics of batterers so that they would more likely be recognized by judges even when they come into court wearing a three-piece suit. For example: it should be acknowledged that abusers tend to defy court orders, twist the facts to be in their favor, not pay child support although they want custody and allegedly care for their children, make visitation difficult in an attempt to blame their spouse for difficulties, lie in court papers, etc. Perhaps a psychological profile placed in the legislative findings would be helpful to the judges.

5) The law should reflect that battered women are most likely to be abused or even killed after having left their batterers. This is the most dangerous time and it is this threat which keeps women in abusive relationships long after they want to go. What happens, I've seen, when women are in court, judges say, "The marriage is over, why is this going on? Why do you keep coming back?" So, the woman, again, is viewed and victimized again that there's something wrong with her. Abusive men often threaten that he will take custody of the children, a threat which he's often able to implement by way of having the resources to do so. The courts may need to recognize that families of abuse victims are often themselves threatened and in danger and that they need to be protected as well. While judges often believe that battering is part of a matrimonial part of the marriage, and that once the marriage is dissolved the battering is over, the facts from the FBI statistics indicate otherwise; that is, that 75 percent of all battered women have the greatest chance of being most severely harmed or even killed after they leave the abuser, and perhaps

if judges understood that, they would understand why it's so hard for women to leave. Therefore, custody actions, continued harassment -- however subtle -- nonpayment of support, all represent continued harassment and abuse of the battered woman and need to be viewed and understood in this context.

6) Judges need to recognize that abuse can lead to death for battered women, and often does, and need to take her danger seriously. Battered women, therefore, need to have their fears and concerns taken seriously by police and judges. A judge should not be able to use any discretion if there is a finding of abuse such as saying, "The man has a problem with alcohol, etc., and that the abuse is therefore related to alcohol, and let's get him help and then we'll give you a permanent restraining order if he's still abusive" -- which I have recently heard about.

7) Judges should be required to view abuse as though there was an assault on one person to another as though they were strangers. This would give the clear message that women do not provoke a person to violence. Nonviolent men will not be provoked. Battered women are victims no different than the victim of a car theft, house robbery, etc. and yet the myths about battered women and women in general, prevail in our court system.

Therefore, once the marriage is dissolved, the judge needs to understand that particular abusive man is still a violent individual, that he has seen a sample of his behavior and his battering represents who he is, not a reflection of the marriage, and that his children are also at risk for being abused. Judges have a tendency, in my experience, to separate, "Well, he beat her, doesn't mean he's a problem for the children." It should be mandatory that judges obtain a full documentation on a man who's been alleged to be abusive, if he wants custody. They should get his work history, his school history, going back forever, police records, speeding tickets,

mental health history, etc. before disposing of custody cases. Judges should be required to view the abuse as part of the man's character and not in the context of a couple who cannot get along.

8) The Legislature needs to recognize that men who abuse their wives often sexually abuse daughters and psychologically and/or physically abuse their sons. There's a real problem in that women who finally get out of these marriages then when they go to file papers will allege that the husband has been abusive to a child and at that moment, neither her attorneys believe her and the courts are not believing. She is viewed as being now vindictive; she is saying this to get back at him. And this is very serious because as soon as she does that the judges-- There seems to be a favor towards the man because you now have an evil, vindictive woman in the courts. This has really been my repeated awful experience. Judges need to know this is usual that there's abuse to children, sex abuse in these families is where it's normal and abuse of male sons and females -- this is normal. This is not the rare case. This is why these are the circumstance in which children are abused. Therefore, women claiming that their abusive husbands have been sexually inappropriate with their daughters need to be taken seriously and, again, not viewed as suspect because there is an ongoing custody dispute.

Judges need to know that women leave husbands because of this behavior. Further, Judges again need to know something about the profile of someone who would sexually abuse a child and abuse a wife.

9) Judges should not have discretion in custody decisions where there is a suspicion of abuse -- men who abuse and do so in front of their children -- they should know that just having abused the mother is enough to take control and dominate a child. This is abuse. You never have to hit someone who is physically intimidated by you to get control.

You can go like this. (raises fist) You can watch someone throw something or have a temper tantrum, therefore, it's enough just to see a parent be violent to gain control and dominance. In these situations, fathers should be given supervised visitation and not in the home or the presence of any member of his family. Judges should be directed to grant supervised visitation when there have been allegations of abuse -- and they don't unless it's so obvious to them, they rarely do.

10) And perhaps most important, although not last, I think the Legislature needs to establish a fund for battered women because the most important thing they need that they don't have are the resources to fight in the courts. And, unfortunately, what happens in custody decisions, and I have watched battered women lose custody of their children time and time again, and children who are sexually abused be given to their fathers. I have been called a whore and a hired gun by judges. I had a woman who, when a child ran away after telling the court appointed expert that she would run away, when she did and ran back to the mother, the mother called me and said, "What do I do?" I said, "I don't know how to tell a mother not to fight." Because what happened was the judge brought her in court and said, "If your child runs away again you will be in jail." I said to the mother, "You tell the child to complain to her school." She was in a Catholic school. "You tell her to complain." She did, she ran away to the convent, DYFS was involved, the convent got custody for the weekend, another psychologist evaluated and the judge said, "Stays with the father. This is an evil woman brainwashing this kid."

This is why I'm here today, because-- You're looking shocked. I get phone calls, and I won't do custody cases anymore because I don't have the stomach for them. I'm involved in one currently because I couldn't turn it down, but I will just assume I'll be another hired gun because I'm rushed

in there at the end, how come no one said this before? And this is very serious and I think the judges need-- It has to be mandated, some of these things.

So, they need a fund. They cannot win. They do not have the money and the resources to fight for custody, and you're talking about the next generation of abusers.

11) Judges should have the benefit of an expert consultant to the bench to help them assess cases in which there are allegations of violence. Perhaps they need someone right there with them going through these cases and teaching them how to pick out the fact from the fiction, how to pick out the holes because the abusers are the best con artists in the world. The best in the world. I had a woman recently who killed, who ended up killing, and I'm involved in a murder case with her -- for her -- and as she said, the man schemed his way into her life. It's a wonderful phrase, and indeed, he did. And when judges and people ask me, "How come she didn't know he was a batterer?" and I say to them, "You know, I don't find judges know it either. What's wrong with them?" You know, something's wrong with them, also.

12) There's a problem with our system of court appointed experts -- and I hate to criticize my colleagues, but I do. They don't know, and they do these evaluations and then when I get called in, or someone else who really is an expert on battered women, the judges then dismiss us. And I know apparently there is something in the Legislature that says that a not a court appointed expert should have the same weight, although the judge can then dismiss you as a hired gun or a whore; and that shouldn't be allowed to happen. I think judges really need a lot more information before they should be allowed to do this work.

There also was a debacle in Ocean County which a court appointed expert -- who has since lost his license and had the largest fine against him of any psychologist who lost his

license -- gave all of the abusive, or known to be abusive fathers, custody of their children -- some are still fighting, some women gave up, and one woman got her child back -- even though there had been evidence of sexual abuse, physical evidence. This is going on every single day.

13) No one should be considered an expert in the custody case where there have been allegations of abuse who does not recognize the battered women syndrome. There's a court appointed expert in New Jersey, a psychologist who is used frequently, who does not recognize the battered women syndrome and yet it's recognized in the courts of New Jersey in State vs. Kelly. So, I don't know that that person should be accepted and recognized as an expert. I'm not singling this person out, but it's the concept.

14) Therefore, the system by which experts are chosen and appointed by the courts needs to be looked into carefully. Many times experts want to say what the judges want to hear. I shared a brief part of a joke that I remember which is: a husband and wife are having an argument and there's a house guest, and during the argument one turns to the house guest and says, "What do you think?" and the house guest says, "I'm staying two more weeks." And many of these court appointed experts are staying two more weeks.

15) I believe we could be doing -- if there's funding, and I've been designing this in my head -- some longitudinal studies to follow up on custody decisions that have been made where allegations of abuse were made, and where the judge dismissed them and had not taken them seriously, and in my opinion, made decisions that were not made in the best interests of the woman or the child. Perhaps if we do longitudinal studies and show them what happens to these children, and then go back and train them with the papers that were presented in court, they can learn from these mistakes because there's a tremendous correlation. Judges are not aware of what they're doing, I'm sure.

That is what I had to say. Now that I've given you the suggestions, I don't have to worry anymore.

Any questions, or-- I wish that were true, that I didn't have to worry anymore. To me, it's heartbreaking because it's an opportunity for prevention, and that's really what we should all be about, in my opinion.

MS. SEHAM: I could add to your list. Yes, these men are con artists. They tend to be extremely personable. I can remember-- I don't do matrimonial work anymore, for part of the reason that you don't do custody anymore, but I can remember a husband and wife being evaluated at the county hospital and they said about the husband, "He's very upset about the divorce." And they said about the wife, "It's hard to believe the story she tells." So I think there's a basic lack of credibility that women have in the courts at bottom and which causes a lot of these problems. And too many attorneys and too many judges just don't believe the allegations and battering to begin with. They believe that it's being said in order to gain an advantage in the divorce, that there's no basis to it at all. Now a lot of your premises start out with some sort of recognition that this is a battered woman and yet -- and yet, she's denied this and she's denied that. But I think that part of it is that the battering just isn't taken seriously or isn't believed to begin with.

So going to your statement, "This is usual. This is the profile, these are the things that happen," I was going to ask you whether there are any studies. You're saying this is usual, but I think where judges are concerned, they really do believe that they're being impartial. They really do think that they know, so you really have to give them statistics.

DR. KLEINMAN: No, that's why you-- What happens in my experience is I will stand there and say before a judge, and they would dismiss that he's lying, that lies are found, that the attorney is able to-- They dismiss that. I say, "Well

you're going to choose a parent--" He's a liar. The guy lies to the court. They dismiss that.

Are there studies as to the impact of these decisions, or studies as to the correlation between abusive children and abusive women?

MS. SEHAM: Well, those I know exist, but the profile of the abuser, the correlation between abusive women and abusive children, that kind of thing--

DR. KLEINMAN: Yes, that exists.

MS. SEHAM: I don't mean just in court, but in the training of judges, I think some of these have to be used.

DR. KLEINMAN: Absolutely.

MS. SEHAM: I think judges need an awful lot of training.

DR. KLEINMAN: And some judges shouldn't be, frankly, on the bench, because in my opinion I'm not sure you can train a good gut. You may be able to if someone is really open to it, really doesn't have a point of view, but if they already believe that these are vengeful creatures, these dangerous women here, I don't know that you're going to be successful. But there was a study done by Harvard Law School, done in the Boston juvenile court system, that found a 90 percent correlation between those children who showed up in the juvenile court system and those children coming from abusive families.

The problem that happens is when I get into court and the judge says, "Why didn't this come up before?" And I'm already starting from scratch and saying, "I don't know, your Honor, the attorney--" I don't know. I can't criticize the attorney. And I say, "Well, battered women don't always--" "Well, what do you mean she--" So the whole thing is lousy, but I think what I have been thinking about writing in my spare time is really a manual for judges, and if there's some funding-- What has to be is I could write for them the court

papers that abusive men write. I've seen them. I could write their own papers and I could tell them-- I spoke with the Judicial College this past fall, and what I think we need to do is put out there how battered women present in the courtroom. What do they look like? They do look flaky. They sometimes say this and they sometimes say that. Because they could be trying battered women at the stage that they're coming into the system -- they're not coming in cool, calm, and collected -- they are frightened, and they know how powerful and how able this guy is able to convince other people. And that gives him the power and when he can convince the court system--

So I think that they need training, they need to know how they present, they need to know something about their papers, they need to have their own cases presented back in their faces, the decisions they made with some follow up. I think they need all this and I think there perhaps needs to be something in the legislative -- in the findings, perhaps -- which makes these things normal so when someone finally points to it, they can take it seriously. They do not, even though I tell the lawyer-- I always say to the attorneys, "Point out that it says there's a correlation between child abuse--" "But not in this case," judges say, "Yeah, they're battered women, and yeah but she's not one, and just because he hit her doesn't mean he's a bad father, does it?" And I want to-- I'm not sure what I want to do, but I know that it's very frustrating.

I also know that I personally feel endangered with many of these men. And Lenore Walker, who you probably know, is the woman who worked with the battered women syndrome in State vs. Kelly was as the result of her testimony in the New Jersey court system-- She and I spoke a few years ago at a meeting and I said I can't stand them. I'm not doing them. I do the criminal cases because in my experience in the criminal cases in New Jersey, women who have killed in self defense in

all but one case -- she didn't kill, it was a little different -- they've been acquitted or given probation. So I feel very good about my work in the criminal system. And she said she stopped doing them when an attorney she was with was shot by an abusive guy and paralyzed. And I often fear; I don't want them near my office. I don't want to be the target and I don't think judges understand. We know the Mafia's dangerous; we put people in the Witness Protection Plan. But they don't understand we're dealing with often this kind of a mentality in a three-piece suit, and he's a doctor, or a lawyer, or a legislator, or store clerk, or judge. He's many judges. So I have a lot of frustrations and I was trying to put them into suggestions. I don't know how viable they are. You have to determine that.

MS. SEHAM: I think your manual is a good idea.

SENATOR LIPMAN: For the judges.

DR. KLEINMAN: Yes, well I'm trying to see if we can get some funding together so that I could take the time to write, because I think that's what has to happen.

SENATOR LIPMAN: I would like to ask another of the panel-- Bobbi?

MS. FRANCIS: Well I just-- I wanted to ask again, this is opening up a whole huge issue and I don't look for an in-depth answer, but my sense is if you start doing psychological profiles and putting some findings together and that sort of thing, wouldn't -- this sounds like a leading question, but don't you believe we would be beginning to get at the bigger issue of just violence in our society, that a lot of the answers that might be uncovered as we do this relative to spouse abuse or family violence--

DR. KLEINMAN: In terms of rape and--

MS. FRANCIS: In terms of-- I guess what I'm picturing is that for people who think they may not be particularly interested in domestic violence or the violence

against women issue, but are interested in crime prevention and a violent society kind of challenge, we hold a piece of the answer, don't you believe, and if we started looking more closely at these profiles we might be able to address that bigger violent society issue?

DR. KLEINMAN: Well, I think that, yes. Because I think that raising children in violent homes raises more violent people and I think as complicated and simple as that is, I would ask the question that I always ask when no one's listening and that is: How come when I go into the criminal court system I'm treated respectfully by the judges, they take it seriously, they understand it, and the very principle that they base their decisions on is somehow missing in the family court system. And that is, and psychologists know this better than anything else -- it's a thing we can bank on -- past behavior is the best predictor of future behavior. Criminal courts know you're getting probation or you're going to jail this time. Have you done this before? The sentence is different. How come it doesn't happen in Family Court?

I would tell you that I think judges identify with the men, they identify with fathers. I have seen male attorneys in custody cases where I had an attorney who was identifying with the adversary. I mean I was-- I kept saying to him, "You're not an abuser. Don't worry. What I'm saying doesn't pertain--" So I could get him detached, so he could do the job. So the answer is yes. But I would wonder whether perhaps custody cases should be jury trials. Perhaps they should be juries because I think that perhaps the public would be a lot more sympathetic and understand because they have these experiences with neighbors, with friends. I always wonder, "Don't judges watch TV?" Watch Hard Copy. Watch the news. Don't they see it happens? They only think it happens on TV land? I mean, I'm always-- I see this and I say, "Oh God, he'll probably have watched this. He'll understand it." And

they don't, because there is this-- You know, one of the things that I've said laughingly and perhaps I should raise it here as a serious suggestion, there should be a uniform for men and women coming into custody decisions because as soon as a man puts on a three-piece suit or a suit, he's respectable. There is no such outfit for women, you know? Because then it depends on what color, whether it's too tight, too short, too long, too masculine, too feminine, too sexy, too this. Men don't have that problem and if we came in perhaps because I think judges believe that an abuser -- they would know one. He'd have three horns, six arms, you know, warts right here. They would know. And when he comes in and he says, "Oh, Your Honor--" And he wears his-- It's not even a polyester suit. He wears a suit and the judges can't deal with the contradiction between the way he presents and who he really is. And they wonder how the women get fooled.

MS. FRANCIS: Could I just ask if the Harvard or the Boston study, was it Harvard Medical School, you said did that?

DR. KLEINMAN: It was Harvard Law School.

MS. FRANCIS: Oh, okay. Is that provided or could you provide that for us?

DR. KLEINMAN: I will see if I could get you the reference. I'd be happy to try.

MS. FRANCIS: Okay, very good.

SENATOR LIPMAN: Bobbi, the Division on Women, I know you have been encouraging training and identifying and identification and all that. Did you ever train judges?

MS. FRANCIS: Well, we at the Division are involved in a big initiative the last few months of last year with people from the Administrative Office of the Courts and Coalition for Battered Women and a bunch of other groups in training court personnel on the new law. But that was a very concentrated, gee, I forget, nine or so sessions around the State and in terms of ongoing training I know the Judicial College-- People

are looking at doing it, but it's not at all institutionalized as well as it should be.

DR. KLEINMAN: But they don't get it.

MS. FRANCIS: Is that the right answer for all concerned?

SENATOR LIPMAN: Yes.

DR. KLEINMAN: And I think perhaps they need the kind of training, when police are trained to be sensitized so they can feel what it feels like to someone else, judges need the same kind of training. They really need to get off the bench and perhaps they need to spend-- This is another idea. I forgot this as I was typing. Perhaps they need to spend some time in a battered woman's home before they, or experience with a battered woman, before they're allowed on the bench, as part of their training. They need to live with a family. Let them meet-- Well, I know. I said it's my wish list. It's my wish list.

MS. SEHAM: It's not going to happen.

DR. VAN JONES: They're so sophisticated. You know how they are.

DR. KLEINMAN: They think they are. They don't know. And women, too, it's not just male judges it's, unfortunately, women judges, too. I was on a panel with a variety of some women judges recently. I asked them if they're tougher on women and they said, yes, they think that they probably are tougher, because women are still fighting for their own place -- to be taken seriously by their male colleagues -- and so they come down harder on women, too.

SENATOR LIPMAN: I know that's true.

DR. VAN JONES: There's a middle road.

MS. FRANCIS: Well, I was just going to say, in the new law-- Thank you, Senator Lipman, and everyone else. It requires ongoing training and every two years, I think, a reevaluation of the curriculum for judicial training. So, I

think legislatively, if I'm not mistaken, we have what we need in place.

DR. KLEINMAN: Two hours at a judicial college is not enough.

MS. FRANCIS: Well, no, what I'm saying is, the mechanism is there but we have to make sure, just as Jill Greenbaum was saying, laws can be on the books and to reiterate, they can be there but not enforced well. Perhaps what we need to look at is really implementing what's behind the new law.

SENATOR LIPMAN: Yes, we could.

MS. SEHAM: One of the things that I think causes a problem, or it's part of the problem, is that family court is very low prestige and when you get a judge who gets good, that judge gets rotated out to a more prestigious assignment.

DR. KLEINMAN: Right, that's what I've heard.

MS. SEHAM: It's not highly thought of, and it's too bad because some judges are good at it.

DR. KLEINMAN: It's the most important job.

MS. SEHAM: Of course it is, and they should be rewarded rather than being considered at the bottom of the heap.

DR. KLEINMAN: Absolutely, and if I told you some of the decisions that I've heard that have come down, it's mind boggling and I can't believe-- It seems to me someone with common sense-- You don't need to even have a law degree sometimes to understand this and--

MS. SEHAM: I don't think having a law degree helps at all.

DR. KLEINMAN: No, I don't think it does. I don't think it does.

DR. VAN JONES: A degree in psychology. That may not even help.

DR. KLEINMAN: Well, not always every psychologist either. I think you have to have some experience with living,

seeing what this is really about. I think sometimes you need to have special training, psychologists who are interested, who care, who are trained, but then you have to also have some life experience, perhaps be in the trenches in some capacity

Thank you very much.

SENATOR LIPMAN: Thank you. Thank you, Dr. Kleinman.

Ms. Vicki Gaudreau, and is Ms. Bonnie Garner coming with you? (affirmative response) Very good.

DR. B O N N I E G A R N E R: I just wanted to say, speaking of being in the trenches, having been in the trenches-- Both of us are survivors of incest and child sexual abuse, and we're here today to raise some issues to hopefully clarify some of the needs that women and children have in order to be protected, and to protect the other people in our culture.

V I C K I G A U D R E A U: I'm Vicki Gaudreau and I'm going to briefly discuss two issues, and I use the pronoun she, but, I do want to say that sexual abuse happens to boys, too.

I was physically and sexually abused and raped as a child. I have a list of between 18 and 25 perpetrators -- dependent upon my state of denial -- who violated me between the ages of 7 and 17. One of my perpetrators was my father, two were police officers. It's not uncommon for a child who has been molested to have multiple perpetrators. Offenders seem to have a kind of radar for children who are vulnerable to victimization.

I grew up believing there was nothing I could do about this because I thought everyone knew it was happening and that maybe it was my fault because sometimes it even felt good. When I was 10 years old, one perpetrator said, "I won't do anything you don't want me to do. Doesn't it feel good." I was 10 years old. He was kind and gentle and I was starved for love and affection. Of course it felt good. No matter what age, it's a body's natural response to feel pleasure when stroked or touched in a gentle way. If a child strips naked, it's an adult's responsibility not to touch that child.

As far as I knew, there was no help available because there was no choice -- this is what adults do to children, at least to me. I was taught that I had no rights. If an adult wanted to do something with me or to me, I had to allow it.

What I would have given to have had someone stand up at an assembly or in a class during Junior High or High School and say, "I'm a survivor of sexual abuse. If it's happening to you, you're not alone and it's not your fault. It's not supposed to happen. There is help available."

PARENTS UNITED statistics show that at least one in four girls and one in five boys are sexually molested by the time they reach age 18. I and other concerned professionals have begun presenting an educational and preventative forum at high schools and colleges in Monmouth County. The response has been tremendous. We believe funding needs to be made available so that a forum of this nature can be presented at schools throughout the state. Children need to know that they have a right to tell and to stop any abuse that may happen and the resources that are available if they are being molested.

I don't know if I can convey to you the damage that is done when a child is violated by someone they trust and love. Her ability to trust and to have healthy relationships is affected. Most often, there is little or no self-esteem, resulting in continued victimization. Sometimes the pain is so excruciating that survivors inflict physical pain upon themselves because it's easier to feel than the emotional anguish.

As a survivor now aware of how having been sexually molested has affected my life, I have no recourse for criminal or civil sanctions against those who have committed these horrendous crimes. I spend thousands of dollars a year for therapy and because of the statute of limitations, I can receive no compensation from those who are guilty of violating me. Even with delayed discovery, it is not realistic to expect someone who has been sexually abused as a child to have the

ability to seek recourse until they have undergone therapy -- usually several years. I was in therapy for three years before I was aware of the ramifications the abuse had had on me, and was strong enough to confront my abusers. There is no statute of limitations for murder, and sexual abuse is the murder of a child's soul.

Sexual abuse is conducted and thrives in secrecy which results in a child being engulfed in a tremendous sense of aloneness and isolation from the rest of humanity, isolation which continues until the survivor is emotionally safe enough to deal with the reality and most often overwhelming emotions of her childhood. There are survivors in their 50's, 60's, 70's, even 80's, just getting in touch with what happened to them as children. Some never do. Some commit suicide or end up in mental hospitals. The horrifying effects of sexual abuse are all around us. All we have to do is open our eyes.

The sexual abuse of children is a difficult topic to discuss. Who wants to think of a child having her innocence and dignity stripped away. But it must be discussed and more needs to be done to prevent it. If we can give our children the opportunity to be aware of their rights and empower them with the needed resources, and make those who perpetuate these crimes responsible for the damage they have done, maybe we can at least lower the statistics.

Thank you.

SENATOR LIPMAN: Thank you.

Okay, go ahead.

DR. GARNER: My name is Bonnie Garner. I've had the opportunity to work with about 500 survivors of incest and sexual abuse through my private practice and also in volunteer work, as well as go through and very long arduous process of recovery myself.

One of the concerns that repeatedly comes up between my clients and I that we share over and over again is, due to

the fact that the memory comes back so late it is so traumatic, it is so scary that the kinds of triggers are often that a woman has her own child or a man has a child that's around the same age, so it can take 10, 15, 20 years, as Vicki was saying, sometimes 30. Due to that fact, the perpetrators are-- They're not held accountable for this crime, but there's also no way to find out if they hurt other children, and we know statistically that they have. We know that it's very rare that someone sexually abuses one time one child. And as Vicki was saying, too, it's more common for children to have more than one perpetrator. I also am the victim of more than one perpetrator. And there's no profile for the child. I was the homecoming queen, you know, I was the cheerleader, homecoming queen, happy looking kid, straight A student, and being sexually abused for 10 years. So there just-- The crime is so vicious, it is so-- When the psychologist before said how you can threaten someone with your hand and you don't have to hit them, the nature of this kind of abuse forces someone to either split or separate or repress the memory in order to survive. And those that aren't able to do that are often the ones that we meet later on who are alcoholic or a drug addict or in some way acting out hurting themselves or hurting others and then if they're fortunate to get sober and get clean, then they have to deal with these kinds of memories that begin to surface.

So, I really would hope that we could find some way to insure some safety that somebody -- not to have a statute of limitations -- would be able to go back and explore the perpetrator and to be able to investigate what other possibilities there are, whether or not they've hurt other children. If for anything-- I think it's important to have civil suits; therapy costs thousands and thousands of dollars. I could own another house if I hadn't had this to deal with, but also for the peace of mind, the peace of mind of the person. You know, most of my clients over a period of time are

able to go back to their perpetrator, and not everyone chooses to do that. I don't think it's the responsibility of the victim, actually. I wish there was a system that they could report to and it could be investigated, again, for the safety of the other children, for the grandchildren, for the nieces and nephews, for the children in the neighborhood who this person has access to.

I also think it would be so helpful if a judge did have available to him, or her, someone who was a specialist in this field, who didn't interview the people; didn't interview the mother or father. When the allegations come out in divorce, as stated before, there's a real tendency to assume that this is a vicious, vindictive thing that's being said to insure the custody of the children, and to hurt the husband, and blah, blah, blah. Usually it's when the child begins to feel safe enough, the thought that maybe the perpetrator is not going to be around gives them an opportunity -- it's a little opening, and they will sometimes then tell, where before they never would. So I think it would be helpful if there was someone who sat next to the judge, someone who had facts and information and who wasn't involved with the people, because there is a great deal of con-- The person who would batter a wife has a similar-- And the person who would sexually abuse a child-- It's both done in secrecy. So the capacity to keep a secret like that creates a great ability to be a con and child abusers are cons also.

And child abusers are men and women. This is not an issue of gender. Unfortunately it isn't. It would be a little bit easier if we could say everybody with, you know, blue hair, well we know what you are. It's not that easy. We're finding out more and more that there are many, many women who sexually abuse as well as there are many, many men and it happens pretty much now equally between boys and girls.

There was another-- I like that wish list. I wish, I wish, I wish the children could be safe, and that there was more information in the colleges -- the judicial college -- and that there would be groups of people like Vicki and myself, and men and women -- and that they would be equal men and women -- going into the college and spending a half of a day or a day with future judges, and letting them talk about what it was like because, while there's similarities, each story has a uniqueness about it that if they were exposed to it, I believe, over and over again, it might break that fog -- whatever that fog is that people get so scared when they hear about incest or sexual abuse, or they don't want to really believe that it happened. They don't want to believe it happens in nice homes, and it does. It happens everywhere.

MS. GAUDREAU: Through the forums that we've been presenting at the high schools and colleges, we've gotten a lot of real positive response as far as wanting to continue, repeating the forum, and we get a lot of kids that come up and say, "It's happened to me. What can I do." It's a lot easier for a child or a young adult to identify with somebody who says, "It happened to me. You're not the only one and there's resources available," than for some authority figure to come up and say, "Well, you know, sexual abuse does happen. Here's where you can go."

DR. VAN JONES: What happens to that child when the child does tell you in a situation like that -- in a school setting and afraid to return home after talking to you that this has happened to them? What do they do?

MS. GAUDREAU: We've been not going into elementary schools, but into high schools and colleges, and what we do is set up the safe room so they can speak to somebody anonymously or not anonymously, in private, and then referrals are made.

DR. GARNER: And that is the problem, the system, that once somebody-- My big bugaboo is I've watched and worked with

families where the children were able to finally come forward and say this was happening, whether they said it at the school, it was reported. The State stepped in to protect the children and the husband got sent to jail. And it's not a happy ending; the mother then lost the house. It's not a happy ending. I don't know, I really don't know what an alternative is but certainly if someone is a perpetrator, that they earn money to help pay for the care of these children as they grow up, and their therapy. Because sitting in jail for four or five years is a reprieve and they go back out on the streets, as you all know, I mean, we all know that. One person can do tremendous harm and it costs us; it costs our culture tremendously. We pay and pay and pay.

MS. FRANCIS: I have two different questions. One would be with relationship to the law right now, Senator Cafiero and others have a bill in that would allow the clock to start ticking -- is it two years -- after a reasonable discovery of, you know--

MS. GAUDREAU: I think it's two years. It's still somewhat limited but it's better--

MS. FRANCIS: That's what I was going to ask. From your comments both of you would favor no limitation on--

MS. GAUDREAU: That would be--

DR. GARNER: The ideal.

MS. GAUDREAU: --the ideal situation. I read through the bill that has been presented and while it's better than what's available now, it's very limiting.

DR. GARNER: Also, the State of Virginia had one year which if anyone was sexually abused in that state, they could bring this to trial. Criminal--

DR. VAN JONES: No matter how long ago the incident occurred. Like turning in all your guns and--

DR. GARNER: A little bit like that.

MS. FRANCIS: And yet that's arbitrary. Why would it be only one year? Why, for someone who, on the 366th day--

DR. GARNER: It was a start, though, in the change of the law.

MS. FRANCIS: Right. Yes, certainly.

My other question goes to what you had said about fairly equal numbers of both victims and perpetrators of either sex. Is that what you said?

DR. GARNER: There's more and more awareness of-- We say there's fairly equal numbers of perpetrators being men and women, now. Although my own experience is that we probably will discover in the next 10 or 20 years that this is not a gender issue. It's an abuse of power and women abuse power as much as men abuse power, and that's what it has to do with.

MS. FRANCIS: Well I wanted to ask if anybody's looked one step behind that to look for abuse of those perpetrators when they were children? And do you know if, perhaps, both those adult men and women had been equally victims of abuse when they were young, or do you believe that we might find -- I'm not presuming a conclusion here -- perhaps many of the women perpetrators had undergone abuse? Or perhaps it would come out fairly neutral in terms of gender.

DR. GARNER: Well, so far what the studies do indicate is that most who are sexually abusing children have been sexually abused themselves. But there are many people that I've worked with in my practice that were sexually abused, who don't sexually abuse children. So I think we need to be careful with that one and certainly we can see where it strongly influences someone who doesn't get recovery. But there are many, many people who are abused who do not do this.

MS. FRANCIS: I guess I wasn't looking for the correlation if you were abused you might more likely abuse, but whether there was some differential in male and female perpetrators having been abused as children. In other words,

perhaps more of the women perpetrators might have been victims of abuse.

DR. GARNER: No, because most of the men were. So, no.

SENATOR LIPMAN: If you had no limitation on when you could report, would you be afraid to report your perpetrators now?

DR. GARNER: Some people would be.

MS. GAUDREAU: Some people would.

DR. GARNER: Yes, it's not the best solution either, but it allows the opportunity-- Yes, some people would be very afraid for a number of reasons and that's when Vicki said that--

SENATOR LIPMAN: Just like the battered women.

DR. GARNER: Right. That's when Vicki said, too, that the whole notion of someone having some amount of time in recovery and healing is important.

MS. GAUDREAU: A real difficult aspect of it, even if the ability to report it is there, is the fact that it happens in secrecy.

I initiated an investigation with the sheriff's department of the two officers who molested me and they wanted to know if I had any proof. I was 15 years old.

DR. GARNER: The burden of proof is a difficult one and it's a he said/she said often, and that's what you would find when people get all their-- Except that you might be able to have lot more situations like in Colorado where the sisters all were able to tell the same story. They all got into therapy and recovery and they were able to try the case as a result of that.

In my particular case, a couple of my perpetrators are dead, but at the time I recalled, I did write to one of them and it was terrifying. I had a friend deliver the letter; I was afraid to put it in the mail. And this was a man who now is probably 78, 80 years old and had a heart attack. What was there to be scared of? And I wanted a friend of mine who was a

fourth-degree black belt in karate to come with me. First I thought I was going to confront him in person and I said, well actually, this is to make sure that I don't commit any crime when I talk to this guy. (laughter) So nobody could stop me-- But it brings up the same terror that you felt as a child. That's what gets activated.

MS. GAUDREAU: When I contacted the sheriff's department -- it's in another state -- I got a post office box. I had my phone number unlisted. I contacted the postal inspector -- the post master -- and said, "Look, if a police officer contacts you, can you guarantee me that my home address won't be released?" "Well, I don't know." I said, "This is why." And they did; they put a note on my post office box. And it was because of my fear of the power that that man had. He's a police officer and now he's head of internal affairs. It's scary.

SENATOR LIPMAN: Oh, my goodness.

DR. GARNER: It is scary. The other thing I'd like to add, too, is that if you can get a sense by hearing it and by feeling it with us, how scary it is as adults to report, it's so much more so for children to report. And I think the judges need to know this, the trauma, and to be allowed to have the video tapes go in the court room and to make it as gentle and as easy as possible for the child because it's an enormous amount of power. This person literally has power over your body and over your mind. They tell you how to think. They tell you this doesn't hurt. They tell you there's nothing wrong with it. And they tell you not to tell. And it's an enormous amount of power.

MS. FRANCIS: May I ask, in psychological theory we've really laid to rest Freud's thought that this is all fantasy?

DR. GARNER: Freud was a fraud. (laughter)

MS. FRANCIS: But I mean it's generally accepted not only by feminists purists, but by the community in general.

DR. GARNER: Yes. Well, more and more it's becoming-- Except that there was a publication that talked about-- There's a book written that addresses that whole issue, that when he first put this forward, that it in fact happened, he received a lot of problems. People didn't like it, as you know, and then he changed his tune. But, unfortunately, there's some institutions that don't really believe that. I met a candidate at the Institute for Self-Psychology -- it's an analytic school -- and fortunately they do believe that sexual abuse occurs but we get a lot of contact with other professors and there's still a hesitancy around it.

SENATOR LIPMAN: Thank you very much.

DR. GARNER: Thanks. Thanks for listening.

SENATOR LIPMAN: Ms. Sandy Clark, New Jersey Coalition for Battered Woman, Domestic Violence.

S A N D Y C L A R K: Melanie's distributing my testimony and you can feel free to refer to it while I'm speaking. (laughter) I was never a teacher.

MS. FRANCIS: That's not right, Sandy. We learn a lot from you.

MS. CLARK: On the first page of the testimony I've summarized the specific recommendations that I've made. I would first, however, like to underscore the remarks of Marsha Kleinman, earlier, particularly with the issue of women -- who are battered women usually -- who are alleging child sexual in civil court cases. The situation is absolutely horrendous. If they do that they're taking a very big chance of possibly losing custody themselves, and in some cases, losing the right to unsupervised visitation.

I believe Joan Pennington will be testifying? And I think she'll be more extensively addressing this specific area, so I chose not to talk about it a whole lot, today. And I think she'll have very specific legislative recommendations.

This is an area that we really haven't gotten into legislatively in the way that we might, and that there are many things that could be done.

I have limited my testimony to five specific areas where I think there are some legislative initiatives that could be taken. So, I'm going to read at you for a little while.

As you know, last year the New Jersey Legislature passed a revised and improved version of the Prevention of Domestic Violence Act. The Coalition concurs with those who consider the Act the strongest, most comprehensive Domestic Violence Law in the country. For this, New Jersey can be very proud. Essentially the new law does not so much change the original law as it adds new provisions to the Act designed to address those response areas which were failing to provide maximum protection and relief available to victims. Consequently, the revised law is demanding more from those of us whose work involves protection of victims. Since no appropriation was attached to the law, there are no additional resources to assist with the implementation of the new provisions.

Obviously, this is not an ideal scenario. Already only four months into the new law, we are hearing discontent about the situations, primarily from the courts and, probably less so, from law enforcement. Probably the most important concern the Coalition wants to express to the Commission regarding the Act, is our concern that the Legislature might consider diluting the law, and thereby compromising protection to victims, due to a premature assessment of the situation and/or an unwillingness to provide the necessary resources.

First, we would like to point out that the original Act we also passed without an appropriation and posed a strain on the system of a far greater magnitude than the revised Act. It took some time, but eventually the new law was learned and incorporated into the system with as much efficiency as

possible. In many cases resources were found to meet the challenge the law posed. Much of what some courts and police are experiencing today will settle with time. To assess the situation at this early stage is far too premature.

Second, we would point out that the passage of the new Act coincided with the issuance by the Supreme Court and the Attorney General's Office of the Domestic Violence Procedures Manual. The Manual is an excellent document which reflects a commitment to the proper implementation of both the old and new provisions of the law. It also is an attempt to achieve uniformity of implementation across the State. There is no question that the Procedures Manual entails some additional work for some counties and is doubtless the source of some of the current discontent. However, diluting the new provisions of the law will not serve to significantly reduce the impact of the standards set by the Manual.

Finally, we stress that domestic violence is far too important an issue to deny additional resources needed to both protect victims and prevent the incidence of this violence. The Coalition urges the Commission to oppose any legislative effort to dilute the Act and to support efforts to increase resources for implementing the law.

Although the Coalition thinks it best to refrain from any further amendments to the Prevention of Domestic Violence Act at this time, I have been asked to address areas which might have been overlooked when the revised law was drafted, or new areas which have developed since that time.

Do you mind if I stop reading and start talking?

SENATOR LIPMAN: No. We like that.

MS. CLARK: First of all, if we were to redo the Act, there are two things that I think that we could have added that we didn't add because, perhaps, we thought the situation was under control. First is that we would prohibit the use of mediation in court actions whenever domestic violence is

involved. The Supreme Court has by and large prohibited mediation of domestic violence cases, however, there's currently a recommendation which would allow and even encourage mediation of custody and visitation cases where domestic violence, child sexual abuse and child physical abuse are involved. We're very concerned about this. We don't know how far it will go. So we will feel a lot more comfortable if the law just said, no mediation of domestic violence in any court case or no mediation where domestic violence is involved.

The second thing that the law might have prohibited -- and does not at this point -- is the issuance of mutual restraints and that refers to the situation where an individual signs a complaint and when they leave the court they wind up with an order that not only restrains the batterer from themselves, but also restrains them from the batterer and places them in the same kind of jeopardy of having criminal sanctions placed against them should there be any contact between the two parties.

Now recently the Supreme Court issued what amounts to directives which would prohibit mutual restraints unless both parties have signed complaints and both parties were found to have committed an act of domestic violence. However, because mutual restraints are just so popular very, very recently, it's another area I think it would be better if they were just prohibited in the law, period, because I think there will be some way where they'll have a comeback.

The new provisions of the law extend who can be protected under the law and the biggest category there are former and current household members, including people of the same sex who are not related by blood. However, there's one area that we just weren't able to satisfactorily capture when the revisions of the law happened and that's the whole area of people who have never resided together, who do not have a child in common and who are not married. You're basically talking

about dating relationships and this is an area of concern because you have people who are very real victims of domestic violence who have never resided with the abuser, and they are not entitled under the law to the 24-hour civil protection that the law provides. And what happened is that when the many people who were involved with the new provisions of the law were talking about it, no one could come up with a way to define that kind of relationship that could be easily interpreted and verified, especially by law enforcement people trying to enforce the law. Because of that, it sort of remained out of the Act, but I think it's an area that we need to look at again and perhaps come up with some terminology that would be acceptable to the parties involved.

I'll also just briefly mention the problem of teen violence. The law doesn't cover teen violence. It doesn't cover it first of all because it doesn't cover dating violence, secondly because the Act does not protect people under 18 years of age. Jeanie Brahm, I believe, will be here to testify about teen dating violence, therefore I'm not going to say too much more about that at this time. We think, however, that this is an important area to look at and perhaps an area that needs some legislative efforts.

Regarding new developments since the law passed, we're happy about a new bill, S-25-- I have 6 here. Is it 6 or 7? It's 6, S-256, and that is the stalking bill. That would create the new crime of stalking, and stalking is-- It would make it a crime of the fourth degree if a person purposely and repeatedly follows or harasses another person and makes a credible threat intended to place that person in reasonable fear of death or serious bodily harm. We think this is an excellent new crime. We think that is a crime which is directed primarily towards women and, therefore, is good in and of itself. And we would also not only like to see that passed into law as a crime, but eventually see it incorporated in the

Prevention of Domestic Violence Act as an act of domestic violence. That would be the next step.

Okay, I'm going to shift gears and talk about New Jersey's interference with custody law. There were amendments to the interference with custody law that went into effect in November of 1990, and the major thing I suppose that the law did was it increased the penalty or the crime of interference of custody from a fourth degree crime to a third degree crime. If the children are taken out of the country, it would then be a second degree crime. We think this increase in the severity of the crime is appropriate, however, we have two very serious problems with some of the rest of the language and provisions of the law.

First of all, another very significant thing that the new amendments did was that it equated interference with custody to interference with visitation. There's absolutely no distinction in the law between those two crimes. It doesn't define what interference with custody is or what interference with visitation is.

Subsequently, I have the following horrible story to tell you. In this situation there was a battered woman and she agreed to change the scheduled visitation at the request of the noncustodial parent. I think it was scheduled for Wednesday and he asked if he could have the children over the weekend, and she agreed. So, when the Wednesday came along and the kids did not appear -- or whatever they're supposed to do -- for a visit, he signed an interference with custody charge against her because it was interference with visitation. She was charged with that crime. Bail was set at \$10,000. She didn't have the 10 percent to get out of jail. She spent 10 weeks in jail before she got out. She lost her apartment. She lost her job and she lost custody while she was in jail. And this was because of one missed visit. Now, I know this is an extreme situation, and I can hardly believe, myself, that it happened;

but it did happen. I think one of the reasons why it happened is because the law does not define what interference with visitation is, but it's certainly nothing like interference with custody. It just shouldn't exist that one missed visit could equate into a third degree crime.

The second problem we have with interference law is that although it does provide an affirmative defense if a parent is fleeing an abusive situation either for the protection of themselves or for the protection of the children that affirmative defense is contingent upon her or him notifying specified agencies or initiating a custody action. We don't believe that that's quite good enough because the person who's fleeing in that kind of crisis situation, the average person is not going to be aware of the fact that if they don't take these certain steps they are, technically, relinquishing their affirmative defense in this situation. So we believe that this particular affirmative defense should be based solely on the fact that the individual was abused and that that's something that will need to be shown in court and not upon these specific contingencies. So those are two recommendations we have for amending the interference with custody law.

I've mentioned our concern with child sexual abuse and protective parents. And we believe that we have an incredibly far way to go in terms of correcting this situation, in our courts in the civil actions. We are aware of dozens of situations where women who have made these allegations have, indeed, lost custody of the children based on nothing else except that they made the allegations, and we really need to do something about this. But I'll let Joan talk to you more about that.

The next area I want to mention is domestic violence resource centers. There's currently some draft legislation which isn't quite complete which would create a pilot project

which would establish three county domestic violence resource centers in the State. The centers would be responsible for assessing court-referred persons found to have committed an act of domestic violence. It would assess the nature and severity of the violence and screen for substance abuse, mental health problems and other factors which act to exasperate the violence. They would submit recommendations to the court regarding an individualized intervention plan for people who batter. If a person is court-ordered to participate in the intervention plan then the centers would be responsible for monitoring the attendance of that person and submitting progress reports to the courts. They would also reach out to victims to insure that the victims are aware of available services.

The legislation includes a \$750,000 appropriation for start-up costs. The only thing holding back introduction of this legislation -- and I think I mentioned there's a copy of it in your packet -- is that we have not yet located a governmental agency that has expressed willingness to oversee this project. I wish Bobbi were here because we have spoken to her about it and really have not yet received a reply.

SENATOR LIPMAN: She'll be back.

MS. CLARK: I want to add that this concept -- and if you have questions, let me know because I didn't go into all the details-- The concept for this and the legislation itself was developed jointly by representatives of the Coalition, the Network for the Treatment of Spouse Abusers, and the Division of Alcoholism, Drug Abuse and Addiction Services.

The Coalition for Battered Women has expressed some concerns regarding the centers. They revolve around the fact that: 1) no one has shown that this type of intervention -- violence intervention treatment for individuals who batter -- is effective for reducing the violence. That's the first concern.

The second concern is that although the centers are planned to become self-sufficient the Coalition has some concerns they will not be and that they eventually would be competing for very scarce domestic violence resources. However, my Coalition supports the idea of this pilot project, a start-up appropriation, and give it a try. Because we're putting-- We could use many, many resources just for dealing with battered women and their needs, but we do believe that we need to start paying -- in addition to criminal sanctions -- some more attention to working with individuals who batter.

Regarding funding of battered women services, there has not been an increase in State appropriation for expansion of domestic violence services since 1986 and right now, the State's share-- Right now there's \$6.6 million of governmental moneys going for battered women services, of this, the State's share is \$2.6 million. We estimate that we need \$15 million to provide just a basic standard of priority domestic violence services in every county. The programs have been able to come up with significant amounts of private sector money, however, that money tends to be nonrecurring money; it's not stable money. People from the programs have to every year, every month, continue to go after that money, draining resources from the programs just to survive. We need \$15 million. We get \$2.6 from the State, \$4 million from federal programs, some of which are not stable programs either -- will not be recurring programs.

That leads me into the infamous marriage license fee bill which we've been trying to get passed for at least five years now; we've gone through two whole sessions of the Legislature. What happens is that if you purchase a marriage license today -- if you're not familiar with this -- you will pay \$8. Five of those dollars will go into a State fund or into the State treasury and then be distributed for domestic violence services in the State. What the amendment to that

bill would do would be to raise that \$5 surcharge to \$25 surcharge. Now this is not unreasonable. Not only is the \$25 fee for a license -- think about other licenses -- incredibly reasonable in terms of the surcharge itself it's also reasonable. Right now, 25 other states have surcharges for domestic violence attached to the marriage license. They range from \$5 to \$33 with an average of \$16, and New Jersey has the very lowest one in the country. Most of them started out low and then were amended and increased.

If we could get this passed -- and Senator Cafiero is sponsoring it in the Senate -- and as March 16 Assemblyman Lance is sponsoring it in the Assembly. We would generate an additional \$1.2 million for domestic violence services which is nearly half of what the State is providing right now.

We encourage the Commission. We know the Commission's force is felt. We encourage you not only to continue your support but to really push, to make it a priority because as each year goes by, programs are more desperate for an increase in stable funding.

Finally, I just want to mention the federal Violence Against Women Act which you're probably familiar with. Senator Joseph Biden from Delaware and House Representative Barbara Boxer from California are sponsoring this Act in their respective Houses of Congress. This is a very comprehensive piece of legislation that deals with areas of domestic violence, sexual assault and sexual harassment. It's awaiting a vote in the Senate right now, so the Senate version looks pretty good. The House version, however, is just beginning a journey through five House committees and in some of those committees and subcommittees. Right now, nearly half of the Representatives in this country are cosponsoring that bill, but we're being told that there needs to be more cosponsors on the House version to insure that it's going to move.

So, what New Jersey can do is to reintroduce-- Senator Lipman had introduced last year, a resolution that would urge Congress by the New Jersey Legislature to prioritize the Act and to pass it in Congress. So I think that would really help if we had that resolution pass, if we send it to remaining Representatives that are not sponsoring it. I think that would be at least a help.

So we would recommend, Senator Lipman, that you reintroduce that and maybe we can also find an assembly person willing to do it in the Assembly.

So, those are the areas we chose to cover today. I want to thank you for providing this hearing. Do you have any questions?

SENATOR LIPMAN: Yes. Would you tell Bobbi what you wanted to a little while ago, while she was out?

MS. FRANCIS: I'm sorry.

MS. CLARK: That's okay. Bobbi, I spoke about the domestic violence resource centers and the draft legislation which we have provided. And I mentioned that the reason why we haven't been able to introduce it at this point is because we have not yet located a governmental agency that has said that they'd be willing to oversee the project. So, that's what Senator Lipman is referring to. I did also mention that we spoke with you about it.

MS. FRANCIS: I was going to say we had some discussion about this and obviously think the premise is excellent. It also obviously hooks into the need for more resources to underwrite this and other components of the issue. But I think that just as our topic at these hearings is violence against women, as you know, and others know, we've talked about broadening the Division's mission in whatever we're doing, to be not only domestic violence, but violence against women issues. If we could, under that premise -- or under that initiative -- get some more resources into the

Division, perhaps, then that might be grounds for moving ahead with that. I certainly would be very receptive to looking at this as a piece of what an enlarged mission for the Division's program might incorporate.

SENATOR LIPMAN: And this will be a pilot program of three or do you intend to cover all counties?

MS. CLARK: No, it would be a pilot program involving three counties -- only three counties.

SENATOR LIPMAN: Three counties only? And finally, do you intend to try to have one in each county?

MS. CLARK: Well, if we found that this, indeed, worked; if it was a good idea and if it had good results in terms of increasing protection for battered women, and in terms of reducing the violence among violent individuals; and if we found that these centers could actually remain self-sufficient -- which is the hope, so that it wouldn't need to require large amounts of funding from other places -- then I think people would be willing to say, "Yes, let's do this thing statewide." But that's going to need, you know, a little bit of time to set up and do, and just see how it goes.

DR. VAN JONES: There are other domestic violence resource centers in the United States. Did you mention a couple of others in other States?

MS. CLARK: No, I didn't mention that, but this concept was built on a few other programs that are happening in other places in the country. They may not be exactly like this one but the principle is the same. One of them actually is in Duluth, Minnesota -- that's where Duluth is, right? -- which is much more manageable because you're just talking about a city and I think there are other cities that have this kind of program. I don't know if another state has it.

DR. VAN JONES: How are they funded? How are they funded in the city?

MS. CLARK: Frankly, I don't know, or I don't remember offhand, but the idea is really to get the people who are court referred to be carrying the cost of the programs. So, if they were referred to it there would be an initial fee for the evaluation and assessment. Then, if they were ordered into a treatment program, they would also be responsible to pay for that treatment. So, the idea is to put the burden on the person who's perpetrating the violence, instead of on the victim or the government.

MS. FRANCIS: It might have come out in what you said before, but it's modeled, in fact, on our alcohol--

MS. CLARK: That thought just entered my head, yes. We started working on this like five years ago; it's been so long. But yes, we somewhat borrowed from the IDRC model -- Intoxicated Drivers Resource Center model -- and there is one in every county in the state, here. They attempt very hard to be self-sufficient in that the offender pays for that treatment, and they're making out pretty well in that area being self-sufficient. Not entirely, but--

MS. FRANCIS: The model is there, in other words, even if it's not on the domestic violence issue. The model is there with the Intoxicated--

I apologize that I wasn't here but I know that a number of these issues we have talked through and also, I commend you because as always the Coalition has pulled together a lot of really germane thoughts that I would hope we could put into actions. So, thanks a lot.

SENATOR LIPMAN: Thank you very much, Sandy.

I think I have, is it Milon? Juanita Milon? Is she here?

JUANITA LYNNE MILON: I wanted to speak to you, today, about the bill S-157 that addresses survivor's rights to sue.

I'll give you a little, brief introduction about me, who I am. My name is Juanita Milon. I'm 31. I'm a married

mother of three boys. I have a B.A. degree in public health administration and I am applying for graduate admission into Rutgers for an M.S.W. concurrently and A.C.S.W.

I currently have a civil case pending against my adopted father for sexually abusing me from the ages of four, until I was 22 years-old.

I began therapy about a year-and-a-half ago. I have attended therapy twice a week for well over a year-and-a-half, both individually and in group.

I guess, basically, what I want to say to you first of all, is I want to give you a little bit of statistical background, some that you may have; some that you may not have. Current statistics indicate that 38 percent of women and 27 percent of men will be sexually abused before they reach the age of 18. Further, 2 percent to 6 percent of that abuse will be reported. I think that the next statistic is the one that I find the most important piece and that is that out of the 2 percent to 6 percent that is actually reported, 26 percent is a purposeful disclosure and 74 percent is accidental. Which means that, when this happens to children, the tendency is not to report the abuse. Usually the abuse is found out through, maybe, behavior in a classroom. They might slip and say something to another adult, and that's how the abuse is discovered. That has really nothing to do directly with this bill except that that also shows you what population is left -- where the abuse is never addressed in terms of within their childhood.

There are a lot of things that happen with the memory of what has happened to people who have been sexually abused. There is some discussion about how people are splitting and having multiple personalities. There's a great population in terms of mental illness. They might suffer from a variance of dysfunctions.

I was looking at a TV program the other night and they said that 90 percent of the prostitutes that they interviewed in a study disclosed that they were sexually abused within their childhood, and that's a very high number. I think that if you look into your AA's and your MA's you will find that there is a dramatic amount of that population that will also talk about sexual abuse as a child.

The reason why I point all of this out is because I think that in terms of healing some of our societal problems if we look at the amount of people that are being sexually abused and what the ramifications are for these people when they attain adulthood, you look at the need for actually addressing it if it reaches adulthood without being addressed. And the last population of people who suffer from sexual abuse many times end up as your teenage suicides, your suicides that happen in the early 20's and 30's, because they can no longer sustain the lifestyle or what has happened to them as a result of the abuse.

This bill recognizes repression as one of the coping behaviors that comes out of sexual abuse and I think that that's very important. And what the bill basically is saying to survivors is, "We understand that when abuse happens, it is likely that you can repress this memory. And when the memories come back to you, we are going to give you the same legal rights you had, had you kept the memory of what happened to you, sustained it throughout the years that you actually repressed it."

As my case stands, we have sued under five or six other civil actions, and none of them directly say incest. I think that being able to sue people and say, "We're suing you because this is what you did. You perpetrated the crime of incest" -- versus breaking fiduciary rights and all the other things they tend to sue under now would be a very important thing, especially in terms of the survivor. So, this still does address that.

The other thing that I think is important in this bill is that it has the rape shield clause. What the rape shield piece says is the behavior that you might have had prior to you suing your perpetrator has nothing to do in this legal action. You'll find that a lot -- like I said, 90 percent of the prostitutes that were sexually abused, this would not be able to be used against them. Any behavior that they had resulting from the abuse-- A lot of people who are survivors will discuss their promiscuity through therapy. They'll tell you that they had an amount of years where they were acting out sexually and it makes perfect sense in that at a very young age they were told that the only thing that they were useful for and the only reason that they had, so to speak, was their body and their sex. So using that acting out in that way is a very normal or natural thing to come out of abuse and I think it's important that this bill says that that behavior will not be used against them.

Many times when you watch a rape case, the woman becomes actually the person who was attacked and everything that she has done, the way or what she wears or whatever all, becomes an issue. This keeps that issue under control and I think that that's a very important piece of this bill.

I think the other thing that is important in terms of this bill is that it speaks to the nonoffending parent, the person who might stay and acquiesce while the abuse is occurring. I think understanding the nonoffending parental role is a very hard thing to do because of the subtle nature of what that parent is doing. I don't know legally how they're going to address that and how they're going to get to being able to say that, "Yes, in fact, this person acquiesced or knew that the abuse was going on and didn't do anything." I think that's going to be very difficult, however that the bill recognizes it is a step. People are starting to understand the very important issues that come about in terms of sexual abuse.

One of the things that I always take time to tell people is that I don't believe sexual abuse is a crime that is between a perpetrator and the victim. I think that incest could not exist in a healthy environment. I think if you had a functioning family, the incest could not exist, especially for an extensive amount of years. I look at it as a family dysfunction and it a very holistic view that I take of it, and I think the nonoffending parent has a piece of it and I think the other siblings in the house also, whether they know or don't know about the abuse, are part of the dysfunction in that whole family. And for the survivor to look back and say that, "Yes, I can address both the offending parent and the nonoffending parent," is going to be important.

The other thing that doesn't really stick out about that is that many times, if these people have remained married and you go to sue twenty years later, and they're still married, legally you cannot attach anything that is just of that offending parent which gives you very, very limited resources, if the house is in both names, if the car is in both names, if the bank accounts are in both names. That gives the survivor absolutely nothing to go after because you can't touch that nonoffending party.

I know in my own case, it is exactly that. My parents are still married, everything that they own they own jointly. The only thing that I could legally attach is what my father brings in separately which is a social security check and a very limited pension.

So I think that including that nonoffending parent is not only just recognizing their role in it but is also giving the survivor something to go after in terms seeking some kind of financial remedy.

I also would like to speak to you about-- I know that since I made the decision to sue I've been asked many, many, many times, "Why do people sue their parents?" This is a basic

relationship; you don't sue your mother and father. It's just something that you don't do." And I oftentimes say to people that the suing process-- To make the decision to sue is not an easy decision to make but it recognizes for me what was wrong and who was wrong in it. People who have survived sexual abuse usually carry a lot of guilt. They carry the responsibility of what has happened. Many times the perpetrator has told them they were responsible for what happened. And being able to say to this person, "You were responsible. The law says that I can sue you because you did something wrong," is very important, especially therapeutically.

The other thing that I often tell people is that in making this decision to sue, I have lost my entire support system as I have known it up until now. I have lost mother, father, cousins, aunts, uncles. People do not look at this and say, "Yes, she was the wounded person and she was the victim and we will support her." What often happens is that they stay right within the family realm, and the whole system turns against you. So not only are you recovering from something as dramatic as sexual abuse, you're also recovering without the support system that you've known all of your life. So people, I don't think, make this decision on a whim.

I know when I spoke to one of the Senators about the bill one of the things that was said was, you know, what keeps the child 30 years from now from saying, "I don't like my parents. They made me mad. I think I'll sue them for sexual abuse." I don't think that that is, in fact, going to be the case, as I have known it. I think that, as with any civil suit, you're going to have those who are going to take advantage of it, but I don't think that in this case, people are going to accuse their parents of sexual abuse to get back at them.

I think that the other reason that you make in terms of the suing processes is that the average length of recovery

for a victim is five years; that's the average length. I don't think I'll ever come to a point in my life where I say I'm no longer a survivor. I think that I will always be a survivor of incest. The flashbacks get less. The depression is lessened over time, however I don't think there will be a point in my life that I'll look back at this and say, "Well, I don't have flashbacks anymore and I don't have memories anymore and this is all better for me." It doesn't heal and it doesn't go away, so you're talking about something you're going to sustain for the rest of your life.

I often draw an analogy that helps people understand, and what I say to them is, "If you left this room today and you got into your car and you hit somebody with that car, that person will be able to take you to court and say, "Okay, now you must pay me for the damages that I've incurred, the lost wages, pain and suffering," so on and so forth. This is what the law gives us. This law is giving the person who is recovering from sexual abuse the same thing. It's giving them some attention in terms of their therapy bills.

My therapy bill averages \$65 a week. It has done that for a year-and-a-half. My family and I have had to incur this loss with me unable to work because of depression and many of the other things that I've suffered from. So, you're talking about an enormous therapeutic bill. You're talking about loss of wages as you would in a car accident. You're talking about pain and suffering to some extent.

However, I don't think there's enough money in the world to repay a person to look back on their childhood and see everything that they have missed. And that is exactly what an incest survivor must do. They did not play with dolls. They lost a lot of things that can never be regained. So I don't think there's a sufficient amount of money to give back to this person and say, "This will make you whole again." But I do think we can at least give them some opportunity to refocus and

regain some perspective in their life, to give them some therapeutic help. And I think that if you give these people the help that they would be asking for, what you're going to do is a couple of things: The first thing you're going to do is you're going to give these people a chance to have a proper perspective in terms of their parenting rules, their relationships. You find many sexually abused children picking a physically abusive husband or a drunkard husband and reexperiencing that abuse again through their adulthood. If they were able to get some kind of therapeutic redress I think that those decisions would be different.

I had a horrible time parenting my children. It was very, very hard for me. When you look at your four-year-old child and you start seeing the abuse that you sustained at four-years-old and not understanding that you're pushing that child away, it's a very hard thing to work through and I think that there is some therapeutic redress for that. Once again, the financial piece would help that.

I also think-- I also strongly believe that there is a repetition in terms of generations. What happened in my family was that my father sexually abused me and then he turned around and sexually abused two of my children, so it does not stop. It goes on and it goes on and it goes on. And as one survivor per family stands up and stops this abuse what you will see is that now they can become health and their children can become healthy and so on and so on.

I think that the statistics that I've quoted to you are this large because of this generational process. I think that as each one of us stop the abuse in our own family and get the kind of support that we need to stop the abuse, you'll see some reduction in terms of what's going on in a societal kind of aspect.

So, that was kind of the things that I wanted to say to you and I would be very open for any questions that you might have.

SENATOR LIPMAN: Yes. I was going to ask about your case -- the case of your suit. Some other people today have testified that it's very difficult, they ask for the statute of limitations to be taken off so they could go back and get their perpetrators, but it would be very difficult to prove. You have gone the extra step, right? And you are in the act of suing?

MS. MILON: Yes, I am.

SENATOR LIPMAN: Okay. I was going to ask how were you going to prove it since it was so long ago. But you just answered your own question. You said he abused you, your father, and he abused two of your children. So, it has continued.

MS. MILON: Also my father has admitted to the abuse of me in order to dissuade from the prosecutor's office from prosecuting him for my children. See he realized that criminally he could still be prosecuted for abusing my children and I guess out of stupidity, ignorance, or whatever you might want to call it, he admitted to sexually abusing me and then said, "No, I did not do it to the children," and I guess that that made it a little bit more believable.

SENATOR LIPMAN: I see.

MS. MILON: So I actually have admissions to base on my suit.

SENATOR LIPMAN: You do.

MS. FRANCIS: On what grounds-- You were saying it's only the new law that would enable you to truly do it on the basis of the incest.

MS. MILON: In terms of incest, yes.

MS. FRANCIS: You are doing it on what grounds at this point?

MS. MILON: The breaking of the fiduciary relationship, diminished childhood. My lawyer could give the six counts that he kind of listed off in terms of addressing it but there are six other civil actions that I can go with.

MS. FRANCIS: I know the issue of the nonoffending parent is one that we have talked about and, in fact, the original bill left liability wider open for the nonoffending parent and we have worked to have an affirmative defense -- is that the right phrase? -- be that the nonoffending parent is herself -- I will use that generically -- abused. That, in fact, if she's an abused spouse, perhaps the dynamic there has kept her from intervening as much as she should have relative to the abuse of the child. Do you have any perspective on that in terms of liability?

MS. MILON: It's a very difficult thing because I think that people can say, "Well, you know, I was sexually abused and I didn't know what to do when this started occurring with my children," and it might be very true, however, there is a responsibility that you must take for your children, and I personally responsible the same way in terms of a nonoffending parent. I mean, I was there when my father was perpetrating against my children. And yes, I do feel like I should have been more responsible. The reason why I don't think I could be held legally responsible before is because I was not aware of my own abuse. I was not aware enough in terms of what had gone on. I have suffered this course of repression and I think that my abuse began to unfold for me when my children themselves were abused. And at that point, I did everything under God's earth to protect my children. I have cut my children completely off from my parents. So I think that when the abuse is there and you can see it and identify it, if we don't do anything there is no excuse for that. There just isn't.

One of the reasons why I take the time to come and speak to people is because I think that everyone must take the responsibility when they see this kind of abuse -- to understand the symptoms, to look at it. The child cannot tell you, you know, and people think that educating children about

bad touching/good touching is going to be helpful. For some children it's going to be, but I think the greater majority of children that are going to be abused is going to take an adult's perspective looking at that abuse to identify it and to work on it.

So that nonoffending piece, yeah, there is a liability. And if someone came to me and said, "You know, you allowed your father to abuse your children." It did happen. You know, I can't go back and make it not happen, but I do know that I did everything that was possible when I found out that it did happen, to stop it.

MS. FRANCIS: I was just going to say to follow up. It makes me think of what Marsha Kleinman testified to about the need for expert support for judges' decision-making. This is extremely complex and it's just another example of why need the most in-depth understanding on the part of the judiciary of all this very complicated dynamic.

MS. MILON: I know it must be very hard. I think it's hard for us as survivors to work through it and I think it's even harder to gain perspective from and outside, you know, kind of view.

I know that one of the things that was particularly disarming to people was when I said that I was abused until I was 22, and people don't understand how the abuse continues past the age of what you would think from a knowing. And what I say to them is that when you start abusing a child at four-years-old and when you get up every day and you eat every day and you get dressed every day and your father molests you every day, it's part of the normal life and you don't think of it as being as anything but what everyone else does. Well everybody's daddy must do this. And when you get to the point and you have some perspective and you think, "Oh there's something wrong with this," and I'd like to question this, you have the parent's who threaten their children. Because I was

an adoptive child in the home, my father said to me, "You're going to break up this family. Your mother's going to leave you. I'm going to leave. They're going to say you did it. They're going to put you in a foster home again." I knew the experience of a foster home. I didn't want to go back there.

There are like a million ways to silence a child. I have heard of perpetrators threatening dolls, and cats, and their other siblings, and there's such a variety of things that these adults use against a child. And you do have to use the child's framework and the mind set in terms of understanding the impact of the abuse.

So, you know, I tried to give you as much information as I possibly can.

MS. FRANCIS: And that's been very helpful. Thanks.

DR. VAN JONES: I wanted to ask you something about dysfunctional families and the causes of all of that, and to have a kind of a holistic approach, and we're also talking about the nonoffending parent. Your mother -- that was your stepmother?

MS. MILON: That was my adoptive mother.

DR. VAN JONES: Yes, adoptive mother, rather. She wasn't aware of this from four to 22?

MS. MILON: I had a real hard time with that, too. And up until now she has stayed very-- Now stepped forward, "No, I did not know this was going on." I've talked to her about different behaviors that I, now, can remember that I exhibited. I was very promiscuous as a teenager. Why was there never a question? And, for whatever reason, she didn't want to look at it. Does that make her less responsible? I don't think so.

DR. VAN JONES: No, because the whole clause nonoffending parent and the other parent, then the environment, you have a dysfunctional family, it just seems to me that that parent is part of that, especially with that legally--

MS. MILON: That is exactly what I say to people. It has to be part of it. It really does because like I said I think that incest can't survive in a healthy family. I think that if my mother were the type of mother who let me know that it was okay to talk about things to her, to come to her and say, you know, "If you have a problem you can discuss this me" I think I would have gone to her. But I, as a child, knew that she was not going to be supportive and I didn't take that avenue. So, yes, she does have a very important piece in it. And I think all nonoffending parents do because I think that, to an extent as a mother, you say, "I should know what's going on with my child." I mean, that's part of my responsibility and when I see something that's out of the ordinary, when they behave differently, when they have nightmares--

One of the things that blew this whole thing up for us was that our two sons went over to my parents' house for a weekend visit, and when they came back my two-year-old went from a child who enjoyed baths to when I put him in the bathtub he crawled up to the back of the tub and started shrieking. He had nightmares; he had loss of appetite. It causes you to ask questions, and that's what we did. We asked our therapist, "What do you think this is?" Because I still wasn't aware of what had happened to me, and he said, "Do you know this seems like classic, that something went on, you know, with some kind of trauma at your parents' house. What do you think it was?" And we went to speak to him -- and my father still denies ever touching that child -- but something happened to change that child's behavior. And it is up to the parent to say, "What caused this? What happened that made this child behave this way?" And I think that if you're watching your children, most of the time you'll see a difference in behavior, something that's going to clue you in that something's different about this child and maybe something has gone on.

SENATOR LIPMAN: Anybody else?

MS. FRANCIS: I have no more questions, but thank you very much.

SENATOR LIPMAN: Thank you very much for coming.

MS. MILON: Thank you.

SENATOR LIPMAN: Donna Paluka, President of the National Organization of Women.

MS. FRANCIS: Could you just announce that the bill is going to be heard Monday in session?

SENATOR LIPMAN: S-257 by Senator Cafiero will be heard by the full Senate on Monday.

MS. FRANCIS: Is it 157?

SENATOR LIPMAN: Two-fifty-seven. She corrects me.

MS. FRANCIS: This is the stalking bill?

MS. GRIFFIN: It's the extension of the statute of limitations for the child sexual abuse.

MS. FRANCIS: The bill we were just talking about.

SENATOR LIPMAN: Donna, how are you?

D O N N A P A L U K A: Thank you. I'm the President of the National Organization for Women of New Jersey. I wanted to start by just reiterating again something that Sandy Clark had presented to you as an idea, and that's the importance of promoting the Violence Against Women Act as much as possible, as you can as a Commission.

I'm sure you're aware of the shockingly high likelihood that women in this country face of being a victim of a violent crime just because of her gender. So, anything that this Commission can do to promote the passage of that Federal legislation, as well as promoting anything statewide that would create safer environments for women in college campuses -- higher security in dormitories and in residence halls for women, in apartments that are inhabited by women, would be very helpful as well as promoting the addition of gender to the Hate Crime statute which is something that the Senator has been pushing for awhile.

SENATOR LIPMAN: Yes, that's right.

MS. PALUKA: The other thing that I'd just like to take a few minutes to-- A few things that I'd like to take a few minutes to talk about: It is NOW's belief that the term "violence against women" really needs to be a term that's broadly defined and to include other than just physical forms of abuse and attack.

We think that oppression through discrimination and exclusion is still very prevalent today and we consider that a form of violence against women, especially we think in the business world. And we also believe that we're seeing excessive manifestations of violence against women in a political and legislative sense in New Jersey lately. And I have a few examples of this: 1) There's been an inability on the part of any administration to implement a study that's probably seven years old -- maybe even longer -- on pay equity regarding State employees. And, if our own State government can't set an example what kind of progress do we expect the business community is going to make. 2) There's been a consistently understaffed department in the Division of Youth and Family Services and you know, the people who are working there are committed and trying to protect the women and children of the State and they're just literally unable to because of workload and just, you know, the number of hours and their inability to manage their caseloads. That also happens, we think, in the Division on Civil Rights which is the agency that's supposed to investigate claims of discrimination and sexual harassment in the workplace.

And again, New Jersey has really very terrific laws in those areas and it's difficult to implement them because we're looking at women who are coming to the Division on Civil Rights and they're taking, you know, four and five years to work through a system, and that's sending a message back to employers who are doing the harassing and discrimination, as

well as the women who are working with them. You know, "What am I up against if I bring these claims?" and "I'm up against an impossible system."

We also have seen a continuous attack throughout the country -- and also here in New Jersey -- on abortion rights through restrictive legislation. And this legislation, in our opinion, is specifically designed to stop abortion among specific groups -- certain groups of individuals. We've seen parental notification and consent which we believe is a way to control young women and then endanger their lives when they seek alternate means for abortion. We haven't seen this in New Jersey yet, but around the country we've seen waiting periods which, again, hurt young women and poor women who have to make double trips to clinics or doctors' offices, and that could possibly delay them into having abortions which are unsafe or just not having them at all.

We've seen, federally, the possible denial of funding for abortion centers which is a way of controlling the poor women again and making them unable to have abortions, and then relegating them into tasks of just completely having babies over and over again, and probably keeping them poor, if they're unable to just decide for themselves when they want to have their families.

And, specifically in New Jersey, we've seen the inability to pass legislation to keep clinics open -- any kind of clinic access bill. So we've, again, seen the attack on mostly young and poor women who are going to clinics.

A fifth thing I'd like-- Well, again, the Commission always does look at this. We've had an inability in New Jersey to pass a gender balance legislation or actually even get sponsors for it. But again, this cuts out women from a political process statewide. So, again, we think that this violence.

And finally, just recently we've seen the passage of a welfare reform bill which has a provision to deny funding to families if they have a child while they're on AFDC -- well, they're AFDC dependents -- and again, we think this an attempt to control the reproductive rights of poor women. It's being promoted really based on the myth that that's what poor women do for money; it promotes stereotypes, and we think that's appalling.

Those are just some of the areas that we hope the Commission will be able to look at over the next session.

SENATOR LIPMAN: All right. Any questions for Donna?
(negative response)

The gender bill has been reintroduced.

MS. PALUKA: Yes, I did know that. One of your first groups, I think, wasn't it?

SENATOR LIPMAN: Yes, the first ten bill. Like you say, in the last session I think we went before the Assembly Judiciary Committee, not on this subject but on another subject. Remember this Melanie? One of the legislators really let me have it because I had sponsored that bill. We didn't even discuss the subject of the bill before the Committee. I was condemned because I had the idea there should be a gender balance.

MS. PALUKA: Well, good for you.

SENATOR LIPMAN: How could I do this? (laughter)

MS. PALUKA: Some people just don't get it, Senator, and probably won't. (laughter) But we thank you for all that work.

MS. SEHAM: I think you could add to your list, Donna, the noncollection of child support which is another example of high caseload, low pay--

MS. PALUKA: I think that you're right.

MS. SEHAM: --and it's very pervasive and has an effect on an awful lot of people.

MS. PALUKA: Actually, I think that, very generally, divorce laws-- I can't speak articulately on this subject, unfortunately, but I do think that, generally, divorce laws in the State have some problems, too, with the distribution equitably of funds, which is something to look into.

MS. FRANCIS: I don't know, Donna. I'd love to spend a lot of time discussing it because I have, as I said before, tried to broaden our Division's Domestic Violence Prevention Program to be dealing with violence against women, and it really is where both public policy is moving and you know, sort of theoretical academic analysis of the issues and so on, to, say, do this more holistically. I agree with the discrimination component of everything you say here and it's role in oppression of women, but where can we strike a balance between using the term violence related to all of it so that we don't dilute the concept of violence against women -- physical and psychological -- so that we would end up using the term violence against women for every instance of discrimination? We don't want to go too far overboard in using the word violence for all of it. And you know, you and I are both on the same wavelength about all the issues, but I just think it's a balance that we all need to strike somehow so that we're not losing a little edge to our arguments. So, I don't know where you--

MS. PALUKA: Yes, I understand that. I don't know where you draw that line either. I guess that maybe some of this is just systematic oppression. That might translate better under that very general term.

MS. FRANCIS: And violence is certainly not just physical. There's no question. And the psychological harm, the harm to the human spirit that's done by oppression is--

MS. PALUKA: Is violent.

MS. FRANCIS: --it's own form of violence. I guess I'm just always concerned that we don't, as I say, lose an edge

to our argument on all the issues by making it easy for people to say, "Well, what do you mean noncollection of child support is violence against women?" You know, I can just see people thinking they're one up on us by saying that.

MS. PALUKA: Right. I don't know. I guess we could get into semantic arguments about that, but it really is, though, violence. It is violence against, if not women, certainly that child.

MS. FRANCIS: It can translate into physical or real deprivation.

MS. PALUKA: Right because the denial of clothing and just basic needs of that child is very violent.

MS. FRANCIS: You know the Biden bill which we all obviously support -- and would love to see happen yesterday -- that is a much more strictly physical violence definition, so in a sense--

MS. PALUKA: Doesn't it apply for counseling, though?

MS. FRANCIS: Yes, I guess, but I mean it's more what would be obvious to most people as violence against women. So, in one sense I'd almost say it might be more productive for us to use that term more narrowly first, and then once we get the Biden bill and some other things under belts be talking more broadly. I'm not admonishing you at all. You know I'm completely tuned in, but--

MS. PALUKA: Oh, I know. I know, and you know that this is my job, too. (laughter)

MS. FRANCIS: Oh, absolutely. No, it's almost that I'm sort of asking you to help, you know, organize my thoughts about it, too.

MS. PALUKA: Right. I understand.

MS. FRANCIS: No, I think it's great and as I say, you know, the Division on Women really is trying to move in the direction of doing violence against women holistically.

MS. PALUKA: That's right.

SENATOR LIPMAN: This is a sidebar discussion.

MS. PALUKA: I'm sorry?

MS. FRANCIS: We're defining power.

MS. PALUKA: Right. And, obviously, violence does have a lot to do with power. I mean, this is a web of terms that really do cross at various points in their definitions. In the very strictest sense we could define violence as, you know, the emotional and the physical, but I think in a very broad sense we can incorporate all of these things under violence.

MS. FRANCIS: In fact, we were trying to articulate within the Division -- you know, policy discussions -- what we would include in that term; why we would include certain things and not others, and the common denominator of the elements like sexual harassment, you know, which may or may not look physical. We felt that the common thread -- the common denominator -- was the issue of power and control of one individual over another based on sex. When you get into talking about violence against women, it's that systematic oppression or power or control of one over the other, and that analysis could be carried through into things like child support or divorce laws. So you could, as we develop public awareness of this, certainly carry the analysis through.

MS. PALUKA: I would agree with that.

SENATOR LIPMAN: Anyone else? (negative response)

Thank you, Donna. Thank you very much.

MS. PALUKA: Thank you for your time.

SENATOR LIPMAN: Call Ms. Peggy Newman, the AIDS Coalition of Southern New Jersey. Is she here? (no response) She's not here yet. Okay. Ms. Courtney Esposito, is she here? Hello.

C O U R T N E Y E S P O S I T O: Hello. Good afternoon. I did bring some copies of my testimony but I'm not going to give them to you until I'm done because I want all your attention.

Good afternoon. My name is Courtney Esposito. I'm a domestic violence consultant and educator. I've worked in the field of domestic violence prevention since -- what seems like 100 years ago -- 1978. I'm a survivor of abuse and I serve on the Boards of WomanSpace, here in Mercer County, and the National Women Abuse Prevention Center in Washington, D. C., and also on the New Jersey Advisory Council on Domestic Violence.

I'd like to begin my testimony with an excerpt from a letter to editor of Ms. Magazine which did a survey to their national readership about violence against women. The writer of the letter is Mary Bryant of Fulton, Missouri.

"The fear is always there -- on the street, in the workplace and at home. We avert our eyes, refuse ground floor motel and hotel rooms. We lock doors and windows. We stand to one side and act as if we're waiting for someone rather than get on an elevator with a man. We walk quickly through dim parking garages with keys gripped in one hand and a mace cartridge in the other. Sometimes we ridicule ourselves for being paranoid. Then we read the morning paper."

A broad definition of violence -- and this relates to the conversation said from the last conversation of the last witness into this -- or of abuse, would be any behavior which treats a person like a thing. More specifically, violent or abusive behavior is behavior which physically harms, like battering, rape or incest; that's the kind of abuse that most people think of, when they think of battered women. It's the kind of abuse that physicians are beginning to learn to look for although it obviously goes far beyond that. Abuse is also behavior which arouses fear, like threats of physical harm or threats to kidnap or kill the children, sexual harassment on the street, on the job, in a bar or in an elevator. It is also behavior which prevents a woman from doing what she wishes, like not allowing her to wear a certain color, to see her

family or friends, to go to school, to properly feed and adequately clothe her children or herself, to apply for a certain job or run for public office, to have the right to choose to have an abortion, to preach a sermon, or lead a congregation. It is also behavior which forces a woman to behave in ways she does not want to, like making her only wear a certain color, making her have sex with her husband's friends every Friday night in front of a video camera, or making her return to live with an abusive husband because he can afford a good lawyer but she cannot access those funds, or because there's no decent affordable housing available for her or her children to move into.

There's a prominent comedian -- who's name I won't mention because I don't want to give him further publicity -- who jokes that it's okay for men to have sex with their daughters because they pay for their tuition and boasts on video that he'll burn a woman with a cigarette if she doesn't screw him with enough enthusiasm. This is violence against women.

In 1980, while commenting on pending marital rape legislation, State Senator Bob Wilson of California asked -- on the record, because he didn't know there was anything wrong with doing this -- "If you can't rape your own wife, who can you rape?" And this is violence against women.

Heavy metal and rap musicians harmonize to the world and to our children about raping a woman with a flashlight, suggesting that a woman be smoked with an Uzi submachine gun, and brag "I used to love her, but I had to kill her -- and now I'm happier this way." And this is violence against women.

There's a video game called "Custer's Revenge" which shows a naked General Custer raping an Indian woman tied to a post. And this is violence against women.

Congresswoman Pat Schroeder maintains that most women are one man away from poverty. And I believe that this is also violence against women.

Twenty-five percent of college women in one survey experienced rape or attempted rape. Fifteen percent of the college men in another survey admitted they had forced a woman to have sex. Fifty-one percent of college men in a third survey said that they would rape if they were certain they would get away with it. And this is violence against women.

Dr. Gloria Bachman of Robert Wood Johnson Medical Center found that one in four women she surveyed -- and she was not prepared for these survey results, she was, as we say, in denial -- were sexually abused as children. This only represents the women who remembered it. And this violence against women.

Thirty-one percent of all female homicide victims in 1988 were killed by their husbands or boyfriends, and 25 percent of all pregnant women -- of all pregnant women -- are being abused. In pregnant battered women the dominant targets of assault are breasts, abdomen and genitalia. That means that it's purposeful, and it's not a loss of control. And this violence against women.

In 1987, approximately 375,000 women and children sought refuge in over 1200 shelters and safe homes across the country. But nearly 40 percent of women seeking immediate shelter were turned away because of the lack of space. The same dilemma is faced daily by New Jersey's domestic violence programs. And I believe that this violence against women.

I could go on and on with alarming statistics and horrifying examples of violence perpetrated against women in our society. Instead, I'll leave you with some handouts and you can look them up for yourselves. I'm sure you've heard lots of them already.

So, I'm leaving with you, Violence Against Women which is the Ms. Magazine Report on Life in Our Times; the January 6, 1992 edition of American Medical News which focuses on "Seeing the Pain -- America's Physicians Confront Family Violence," the

AMA's Report on Violence Against Women, which is one of the best compendia of data and survey reports that I have ever seen. So, if you're trying to figure out who said that or where it came from, you could probably find it -- of all places -- the AMA's Report on Violence Against Women, and their Policy and Planning Report for a National Campaign Against Family Violence.

I would like to, instead, focus on personal, professional and institutional minimization, avoidance and denial of the systematic violence against women. I would like to begin with victim-blaming as our national pastime.

Most often, exhortations to women concerning their personal safety are based on a "blame the victim" mentality. We are told not to go out alone at night -- a clear predicament if you happen to be female and work the 3:00 to 11:00 shift at the hospital. We're told not to wear attractive clothing, not to be friendly on the street or to make eye contact ever with any stranger. The underlying assumption is that what we do is decisive -- our demeanor, our wardrobe, our carelessness, the visibility of our curves or the mere existence of our body parts -- these invite violence and allow it to happen. From the flawed premise that being a woman must necessarily equal being victimized comes the conclusion that it is up to us, by changing our behavior, to prevent our own victimization. Truth be told, what we do does not decrease the incidence of men's attempt at violent acts against women. As one battered woman said of her husband's violence, "I may be his excuse, but I have never been his reason."

Men must stop committing violence against women, take away permission from each other to commit it, stop condoning it in others and stop blaming women for it. When Israeli legislators proposed a curfew on women in order to lower the incidence on rape, Golda Meir -- bless her heart -- protested, "But it is the men who are attacking women. If there's to be a curfew, let the men stay home."

SENATOR LIPMAN: That's great.

MS. ESPOSITO: I submit also for your consideration another handout, a summary sheet of myths that support violence against women and contaminate our ability to help the victims of violence. By assigning fault to the victim -- which we almost do automatically -- even those of us who are learned on this issue, who have experienced violence in our lives, we distance ourselves from the issue. The victim, and not the violence, becomes the problem. It's a problem that we will never solve should we accept this falsehood. As a pattern of power and coercive control, violence works very well, thank you. And it works particularly well when our response of choice to it is to neglect, stigmatize and even punish it's victims. Violent behavior against women and children, as you very well know, both within the family and within the fabric of society, has historically been accepted and tolerated as a natural and inevitable dynamic. It has thus been legitimated by the community and by our social and legal institutions. I believe it's time for a major change, and we are the ones that have to make it, and that if we allow them to mess around with words and undercut our attempts by using semantics against us, I think we just need to not accept those arguments and go beyond them.

The process of change can only begin if we recognize violence against women as pervasive, and redefine it as illegitimate and intolerable and then provide safety and support for the victims. This is going to cost money, folks. Don't think for a moment that it isn't costing us more to not address violence and it's prevention; and the key word here is prevention. Family violence researchers, alone, just those looking into violence in the family, including the American Medical Association and the Centers for Disease Control, believe that domestic violence may, in fact, be the primary fiscal drain on the American economy. By denying that violence

against women exists and minimizing the extent to which it occurs, avoiding the real fact that it can and has happened to any one of us who is female, we might be able to feel untouched, safe and healthy for a short period of time. This self-protective technique, which plays itself out on both individual and institutional levels, initiates and perpetuates a dynamic which increases the isolation of every single victim and ultimately and inevitably leads to her entrapment -- whether that entrapment be physical, social, legal or financial.

I'd like to give your Susan Schechter's definition of entrapment: Entrapment is repeated and consistent trauma, the abuser does that, the rapist does that, the abusive husband, the incest perpetrator, but it's also coupled with outside negative treatment; we do that when we don't pass laws, when we don't hand out appropriations, when a doctor turns his or her back because they don't know what to say or how to say it, when a police officer was called and could not respond appropriately because we didn't have laws to protect them inside homes. What I'm saying is that you don't have entrapment of a victim if you only have the abuser. Entrapment is pulled off by negative outside treatment and we do have power and control over them. When we refuse to recognize, hear or help women victimized by any and all forms of violence, we insure that their lot will never change.

I'd like to give you two major national examples of Denial with a capital D: The first, despite the fact that we've known for a decade that as many as half the women murdered in this country -- and the statistics change depending on the year; it's gone from something like 24 percent to 29 percent, to in the 30's to 40 percent to close to a half -- each year are killed by a male partner or ex-partner. And despite the fact that we've known for a decade now, the battering is the single major cause of injuries to women. The original draft of the U.S. Department of Health and Human

Services document from which we derive our State Health Plan which is called "Promoting Health/Preventing Disease: Year 2000 Objectives for the Nation" omitted four words: domestic violence and battered women. Although violence and abusive behavior was discussed, women as its primary victims were never even mentioned. How did they miss that? And how can we let them get away with it?

And the Hate Crimes Statistics Act, signed by President Bush, directs the U.S. Department of Justice to collect statistics on crimes motivated by a victim's race, religion, ethnicity, or sexual orientation. The Act purposefully ignored gender-biased crimes. Women as lightning rods for male abuse were once again officially rendered invisible.

As my mother used to say, there is simply no excuse for this. This is just not good enough. The costs to our society, to this state, to individual women and their families, of this very far-from-benign neglect are inestimable. It is time to talk prevention, to follow that talk with action, and to include dollar signs in the action. Survivors of violence against women want the beginnings -- just the beginnings -- of their fair share in the fiscal scheme of things.

I implore you to move and to shake the powers that be in this State to do better by women:

* Advocate for every effort that proposes to assist victims and educate and sensitize the general public and helping professionals about the prevalence and effects and prevention of violence against women.

The governing bodies of this State and can and should, holistically and in a coordinated fashion, formulate and create policies and programs around the issue of violence against women, not freeze them, not decimate them, but formulate them and create them. The New Jersey Advisory Council on Domestic Violence, on which I sit, has not had one penny allocated to

its voluminous and crucial work over the past five years. The Division on Women in 1984 had \$350,000 from the Governor's budget to conduct a public awareness campaign and to train health care professionals, educators, and the clergy on domestic violence awareness and intervention. That dollar figure in this year's budget is zero. I challenge the specious reasoning that our State cannot afford stationery, let alone staff, to deal effectively with this issue. I think if women ran the State, that would not be the case.

* Move and approve every law that you can that will in any way ease the physical, emotional and financial devastation of women.

The newly amended Prevention of Domestic Violence Act is one of the best of its kind in the nation. Victims of family violence are being assisted greatly by the expanded provisions of this statute. Yet, as some of you know from very close up, it was not easy to pass.

The Marriage License Surcharge Bill -- I say surcharge because we cannot say tax -- never came to a vote. Domestic Violence Programs are forced to serve more and more clients at frozen funding levels. Additional resources that could be provided by this legislation are desperately needed in every county in the State.

* Encourage every study and stimulate every research effort that you can that will bring this problem out of the shadows of the alleys or behind closed doors and expose it to the light of public scrutiny.

* Initiate and support every appropriation possible to empower women and their children to live lives free from fear and violence.

I can assure you that all of us who work to prevent violence against women, including yourselves, will continue to bring opportunities to safeguard our clients to your attention. I appreciate the opportunity to speak before you today.

SENATOR LIPMAN: And you did very well.

MS. ESPOSITO: Thank you.

MS. FRANCIS: No more than we expect though, but excellent. Let me ask, Courtney-- We've talked about this before, but when we talk about looking for new resources to support this -- and people say there's no money -- we've discussed the fact that we don't begin to have a handle on what it is costing society to be neglecting the issue and I know we can't even find very much hard data on, for instance, the medical costs of even just the domestic violence piece, let alone the larger sexual assault, and the others. Has the AMA begun to get a handle on that, just for the medical, for instance, or other areas?

MS. ESPOSITO: Well the AMA really now -- and thank goodness -- is focusing on trying to get their member physicians and agencies to begin assessing for violence in female patients. One of the articles in this newspaper, which is a good newspaper, but I must, I must-- I have to tell you. There's a picture on the front -- and I've been talking about myths and stereotypes and victim-blaming -- well you can't see it from where you are, but I see it in my dreams, and it has a family, one child and a male and female parent sitting around a table. The man's holding a knife and the woman is nagging him, a perpetuation of the myth that women get stabbed because they won't shut their mouths soon enough.

Anyway, that wasn't your question was it? The Centers for Disease Control and the AMA are looking into this, and will they get around to doing more than that? I don't know. There was a hospital in Chicago that had a domestic violence program within its ER and it counted up the number of acute care only patients that were identified as domestic violence victims that looked at only their acute care services -- that's not counseling; that's not long-term care; that's not who's taking care of the children and how many days of work they missed --

and found that in one year 708 patients ran up charges of over \$1 million; one million, one-hundred thousand and change.

MS. FRANCIS: And that was one hospital in one city?

MS. ESPOSITO: Right. So, if we can do prevention, and people can end up not being hurt or being able to leave and have places to go to, and services and housing and medical care, and the appropriate kind of counseling instead of getting blamed when they talk to a physician about this, if we can train people to do that -- and I believe that we can-- I know that they listen. Not all of them will listen, but enough of them to make a difference in hundreds of lives; you're talking about hundreds of lives. It's going to be cheaper. And, Dr. Gellis, Richard Gellis estimates \$5 billion to \$10 billion, but he's talking about social costs of the problem more broadly than just health care. And if you look at foster care alone -- children removed from homes -- he thinks consumes an additional \$5 to \$10 billion. So violence is a rather crucial issue in our country's economy and people are going to end up having to look at that and do something about it as opposed to, "Why does some people do these things?" as if they don't know any of them, because they do.

MS. FRANCIS: Well, in that context, I wish we were speaking to a room not only of, certainly, all women who are concerned about this as a violence against women issue, but we should be speaking to a room of people whose primary concern is keeping a lid on health care costs; a roomful of people whose concern is criminal justice costs and better enforcement of criminal justice laws; people who care about homelessness because, as we understand it, the primary cause of homelessness for women with children is escaping an abusive home situation. I'm preaching to the choir but I think it needs to go on record that this is an issue for people who don't think it's their issue.

MS. ESPOSITO: An I believe that that's the way that we'll get them, through money, through explaining, through giving some kind of proof -- that perhaps we're not so accustomed to doing -- that it's more cost effective to do prevention and to put money into that than to do what the U.S. Department of Health and Human Services did, which is bury the issue.

MS. FRANCIS: You did raise their consciousness. Is that not right?

MS. ESPOSITO: I did, yes. It made it into the final plan. They found those four words.

MS. FRANCIS: Thank you.

MS. ESPOSITO: Thank you.

SENATOR LIPMAN: Thank you very much.

Call Marion Banzhaf?

R I K I E. J A C O B S, ESQ.: She's not here yet. She's not scheduled until 5:15.

SENATOR LIPMAN: Oh, okay. Is Joan Pennington here?

MS. JACOBS: She's not here yet, either.

SENATOR LIPMAN: Oh, thanks. Is there anybody else here who would like to give us some testimony? (no response)

We're going to listen to Marion Banzhaf of the Women and AIDS Network.

M A R I O N B A N Z H A F: Yes. Good afternoon. Good evening -- almost evening. Thank you for having these hearings and thank you also for defining violence broadly. My remarks are going to focus on the fact that the untimely deaths of women due to AIDS is violence against women, and the lack of inappropriate health care services is violence against women.

AIDS is the leading cause of death for New Jersey African-American women and the second leading cause of death among all New Jersey women between the ages of 18 and 44. I don't use the term "reproductive age -- childbearing years" because if you don't have children, what age are you? But, if

women were diagnosed with HIV disease earlier and had access to health care, women would have longer lives and a higher quality of life following an HIV diagnoses. Discrimination against women in the AIDS epidemic has resulted in undercounting of AIDS cases among women, misdiagnosis of AIDS in women, and exclusion from potentially life saving treatments by virtue of having a uterus and/or by lack of access to primary health care.

The New Jersey Women and AIDS Network was founded in May, 1988 to advocate for the needs of women in the AIDS epidemic. The New Jersey Women and AIDS Network is a statewide, independent membership organization representing 350 agencies and individuals concerned with increasing women's visibility in the AIDS crisis and with advocating for appropriate public policies specific to women. We have worked to educate health care providers, state officials, and the general public about AIDS prevention for women and care and treatment issues specific to women. In June, 1990, NJWAN published "Me First: Medical Manifestations of HIV in Women." The only document of its kind in the country and since then we have distributed over 23,000 brochures and pamphlets to people across the country. The demand for information about women and AIDS is quite high.

New Jersey has the highest percentage of AIDS cases among women in the country: we're at 23 percent compared to 11 percent nationally. In Essex County, women are 35 percent of all AIDS cases. Nationally, as many women were diagnosed with AIDS in the last two years as in the first eight years of the epidemic, so we're going to see a sky-rocketing increase in the number of women with HIV, and the State is not prepared to meet their needs.

The Department of Health estimates that approximately 25,000 women in New Jersey may be infected with HIV. This number could very well be low, however, since women have been under counted by being excluded from the AIDS case definition.

The Centers for Disease Control continues to discriminate against women by refusing to add women-specific opportunistic infections and cancers to the AIDS case definition. The male-based AIDS case definition results in lack of education to health care providers about women-specific presentations of HIV and contributes to the untimely deaths of women. HIV disease in women usually presents itself first through a chronic vaginal yeast infection. Similarly, women with HIV have very high rates of cervical cancer and may die from cervical cancer without ever being counted as having died of AIDS, even though they have HIV infection.

In New Jersey, 62 percent of the women with AIDS were infected through unsafe injection drug use, however, I should say that the-- We don't really know whether or not those women were infected through injection drug use or through heterosexual contact. The State uses a hierarchical form and if you have ever used IV drugs, even once, that's how you are listed as being infected. So even if you've had 100 sexual partners and you only used IV drugs twice or once, you'd still be listed as an IV drug user. Thirty-two percent are defined as contracting the disease through unprotected sexual behaviors and heterosexual transmission which is rapidly on the rise. In fact, heterosexual transmission is equal to transmission by injection drug use in women in Essex County and already accounts for over half of the cases among Hispanic women.

Women of color and low income women have been disproportionately affected by the AIDS crisis: 68 percent of women with AIDS in New Jersey are African-American, 21 percent are white, and 11 percent are latina. The majority of women with HIV have little access to the sparse network of available AIDS-related education and health programs. There are only two AIDS clinics for women in the entire State and although support groups for women have expanded, no support groups exist in many areas of the State. It's not unusual for a woman to have to

travel five hours to get to a support group in some areas. Institutionalized racism and sexism, as well as the gross inadequacy of health care services for low income people, are significant contributing factors to the incidence of AIDS and HIV infection in women.

Several factors have impeded effective action on HIV disease in women. These include, but aren't limited to:

- * Women are grossly underrepresented in cohort studies and clinical drug trials. Women are excluded from experimental clinical trials based on pharmaceutical liability fears due to the potential risk to women's reproduction. However, the same standard is not applied to fear of an adverse reaction to sperm and men's reproductive capacity. And we know that these drugs can affect sperm as well as they can affect ovaries.

- * The emphasis on women has been as vectors of transmission, especially to their infants, rather than as women needing care themselves.

- * Women are generally held responsible for infection prevention during sexual encounters even if they do not have power in their relationships.

- * Many women are isolated in their homes or are in other ways outside the mainstream of currently direction prevention efforts.

- * Women are the primary caretakers of infected men and children, often postponing their own health. Even if no one else in a woman's family is infected, she is still the primary caretaker.

- * There is a paucity of research on the progression of HIV infection in women, and that which does exist is discounted because it is smaller than the body of research on men -- the classic catch-22.

While AIDS services are beginning to address the needs of women and AIDS, most concern women only as potential

transmitters of HIV infection and bearers of infected children. Services are needed for all women, regardless of their reproductive capacity or intent. Due to continued emphasis on risk groups instead of risk behaviors, most women do not consider themselves at risk for HIV infection. Conducting nonjudgmental, thorough risk assessments are necessary if women are to be diagnosed early, therefore increasing their life expectancy. Services for women must include comprehensive medical and psychosocial care, as well as the protection of their legal and human rights.

I have about five recommendations.

1) **Medical Services:** Medical programs which address the HIV-related needs of all women, regardless of childbearing status, must be established. Most family planning, sexually transmitted disease, and prenatal clinics now include some HIV risk assessment in their services. However, the elimination of anonymous testing in those sites restricts women's choices in getting anonymously tested and provides a coercive intent to have them test confidentially. Anonymous testing should be reinstated at all locations. These programs should include staff who are knowledgeable about the medical manifestations of HIV in women and who have been specifically trained to counsel and assist women.

Ideally, we should develop comprehensive care centers which offer medical, psychosocial, legal and mental health services to HIV infected women, all in the same spot. These facilities would provide direct care, in addition to being a resource for women's centers throughout the State. One model for this is the Children's Hospital AIDS Program which offers direct care for children and then ancillary support services for the rest of their family. At the same time, all treatment and assessment programs should establish women's clinics so that women with HIV have access to gynecologic care. Currently, only one treatment assessment program has a

gynecological clinic. The gynecological clinic is the Newark Women's AID clinic out of UMDNJ. And additionally, slated to start is a treatment assessment program at the Atlantic City Medical Center which will have a gynecological clinic, but it doesn't exist yet. The other problem is that gynecologists and infectious disease doctors have to talk to each other. When desired by the woman, all efforts should be made to schedule pediatric visits and mothers' visits at the same time so that childcare and transportation are lesser barriers to women's access to health care.

The next recommendation concerns education and prevention. Culturally sensitive prevention and education, counseling, and voluntary HIV screening programs for women must be expanded. These programs need to reach poor, minority, and drug using women, particularly women who are uninfected but at risk. Education and counseling aimed at altering risky behaviors, such as the sharing of needles for injection drug use and unprotected sex, are critical. Drug treatment programs must expand to be accessible to women, including pregnant women, and to allow women flexibility in maintaining family relations. Threatened with losing their children, women may not seek out the treatment they need. Policies must reflect support of the family unit, and not be punitive against a mother.

Programs also must be expanded to target teenage girls, college students, divorcees, women whose husbands engage in risky behaviors, and lesbians and bisexual women. Outreach efforts should be conducted in places women go: beauty parlors, nail salons, aerobic and fitness centers, bars, laundromats, and malls.

Can't you just see it? HIV booth in a mall? Quakerbridge. (laughter)

The next recommendation is about health care workers: restrictions on health care workers, as well as calls for

mandatory testing of health care workers, disproportionately affect women as the majority of all health care workers. Mandatory testing for any population must be opposed as counter to the public health interest. Mandatory testing only drives people away from being tested. Instead, the enforcement of universal precautions would take care of people's concerns about health care workers.

All health care providers in the State should become familiar with HIV disease because of the continually expanding population of men, women, and children infected with HIV. Training for gynecologists is particularly essential. A protocol for the treatment of women with HIV disease should be developed. Currently, only protocols for treating HIV-positive men, pregnant women, and children have been developed by the State Department of Health. Training and education in HIV disease must be mandated for all health care providers. This education should be culturally sensitive and gender-specific.

My final recommendation concerns reproductive rights. The current policy of the Centers for Disease Control and the New Jersey State Department of Health is for HIV-positive women to postpone and avoid pregnancy. This policy results in limiting women's choices. HIV-positive women have the same rights to bear children as do all other women. At the same time, HIV-positive women's access to abortion services are limited and/or denied based on hysteria and fear by some abortion providers.

New Jersey's AIDS epidemic is a harbinger of things to come for the nation. We have the opportunity to lead the country in providing humane, compassionate and comprehensive care to women. The New Jersey Women and AIDS Network is committed to advocating for such leadership. We hope you will join in our efforts. Thank you.

SENATOR LIPMAN: Thank you. Can you tell me if the new appropriation from the New Jersey Department of Health is going to do any of these things that you recommend?

MS. BANZHAF: It's woefully inadequate. For example, although they did ask for expanded funds for treatment assessment programs, they did not ask for funds to include gynecologic care. We think that's essential. Treatment assessment programs need to be expanded but women cannot be expected to have to go twice to a health care provider. So, they're woefully inadequate.

Additionally, the development of the Ryan White Care funds and that federal influx of money, I think, has contributed to the fact that the State Department of Health has not fought for more funds, thinking that the federal dollars can help pick up the tab.

SENATOR LIPMAN: Funds will replace State dollars. Right.

MS. BANZHAF: Right. However, the Ryan White Care Act does not include money for education and prevention which is, of course, the most cost-effective way to spend dollars.

SENATOR LIPMAN: And you say that all anonymous testing has been now cut out?

MS. BANZHAF: No. Anonymous testing has been restricted to 17 sites around the State that are run by the Department of Health. Previously, to January '91, any place that provided HIV testing could offer someone either anonymous or confidential testing. However, now, only anonymous testing is offered at those State Department of Health sites. So, if you go to your normal family planning clinic for your annual checkup and you decide that you want to get HIV tested, unless you decide to make an additional trip, you're stuck with confidential testing. That move coincided with the State Department of Health requiring reporting of names and addresses of all cases of HIV infection that were revealed through a confidential test. So, it's sort of, you know-- It's a self-serving mechanism. They wanted to have people be reported so they eliminated anonymous testing.

MS. FRANCIS: To 17 places you said?

MS. BANZHAF: Yes, 17 places.

MS. FRANCIS: Fairly well distributed geographically?

MS. BANZHAF: Yes. It's most counties, I guess, up in the northwest, who have to travel.

SENATOR LIPMAN: Has there been any real concerted action by any governmental agency to try to prevent women with HIV from having babies? They are, you said, recommended that they do not have babies.

MS. BANZHAF: Right. Unfortunately, the reports are anecdotal rather than documented. Women will report being counseled in such things as: "You don't want to kill your baby, do you?" I mean, it's the exact opposite of sort of the pro-choice message, by passing on HIV infection that would be the irresponsible thing to do. At the same time, because New Jersey has-- But we don't have hard data on coercion to get abortions. We have more the soft data, the pressures, the judgments. HIV-positive women who are pregnant mainly find out about their HIV positive status when they're about three to four months pregnant, so imagine being hit with that all at once.

SENATOR LIPMAN: But doesn't the child have a fifty-fifty chance of not having it?

MS. BANZHAF: No. It's gone down, actually, to anywhere from 7 percent to 40 percent; the average is about 30 percent.

MS. FRANCIS: Are not HIV positive?

MS. BANZHAF: Are HIV positive. So 70 percent are not HIV positive.

MS. FRANCIS: Oh, oh, okay. I read it the other way.

MS. BANZHAF: However, we don't know a lot about when maternal-fetal transmission occurs, but we do know that if a woman has been very recently infected or if she is at very late stages of her HIV disease and has actual AIDS or a T cell count

of under 200, that she has a greater likelihood of passing on the infection. But for an HIV-positive asymptomatic woman who's healthy, herself, it seems as though she has a very low risk of transmitting HIV to her baby.

SENATOR LIPMAN: What kind of count was that you said? A T cell?

MS. BANZHAF: It's a T cell count. It's one of the markers of the immune system and you could get a laboratory test done to determine what your count is. The normal count is about 1200 and the AIDS case definition may be revised to include everyone with a T cell count under 200. If that happens, not only does it not include women specific opportunistic infections and cancers, but it also would explode the numbers of people who have AIDS. But it still wouldn't necessarily capture women in that diagnoses, in that definition.

MS. FRANCIS: Could you recap? I started to write down that of the women in New Jersey, is it HIV-positive women or women with AIDS, or do we sometimes use that interchangeably?

MS. BANZHAF: The actual percentages, for example, of populations?

MS. FRANCIS: Yes. You had said 68 percent were--

MS. BANZHAF: Those are AIDS cases.

MS. FRANCIS: AIDS, okay.

MS. BANZHAF: Right.

MS. FRANCIS: What were the numbers again? Sixty-eight percent African-American--

MS. BANZHAF: Twenty-one percent white and 11 percent latina.

SENATOR LIPMAN: How much African-American?

MS. BANZHAF: Sixty-eight percent.

SENATOR LIPMAN: That's what I thought you said.

MS. BANZHAF: Yes. In Essex County it's 91 percent African-American. I didn't even talk about orphans, you know, and the potential stresses and concerns that the entire State

will have from the untimely deaths of women due to HIV and AIDS. I mean, if we're talking about 25,000 women infected with HIV, potentially we could be talking about 50,000 children, at minimum.

SENATOR LIPMAN: There was a large article recently in the newspaper about grandmothers who were very resentful about having to take care of their grandchildren. They had finished all the day care, and so forth, and now that their children have died and left children, they're now being pressed into service.

MS. BANZHAF: Yes. I was raised by my grandmother, myself, so I know how hard it is on them. At the same time, we don't hear the stories about how the grandmothers continue to give and give and give and give.

SENATOR LIPMAN: And give. Right.

MS. FRANCIS: Could I ask you to amplify a little on the fact that you said the CDC hasn't yet added the gynecological manifestations as part of the -- whatever the technical term is--

MS. BANZHAF: AIDS case definitions.

MS. FRANCIS: AIDS case definitions. I know that there's been a lot more awareness about that. Are they just working it through their process to do it or are they resisting doing it?

MS. BANZHAF: They're completely resisting doing it and it's really a case of-- I can't figure it out. It seems like nothing more than sexist discrimination in that they say, "Well women in the general population who don't have HIV infection get chronic vaginal candidiasis so we don't want to alarm those women." Well, why not alarm them?

MS. FRANCIS: Because a percentage of them will be HIV positive.

MS. BANZHAF: Exactly. Exactly.

SENATOR LIPMAN: May be. They may be HIV positive.

MS. BANZHAF: Similarly, they have herpes on the list of AIDS case defining illnesses and it's qualified; it's herpes lesions that last longer than a month. Well, so we can qualify vaginal candidiasis. We can say three cases of vaginal candidiasis occurring within six months, something like that. Additionally, the cervical cancer concern is very real and women who have HIV infection and human papilloma virus -- or HPV -- have very rapidly progressing cervical cancer, like cervical cancer that can go from Class III to full cancer in a period of two months. And cervical cancer is a completely preventable kind of cancer. I mean, albeit it might take surgery, but if you catch it earlier enough it doesn't have to spread to other parts of the body. That has been well documented but it is a standard catch-22, because the CDC didn't start a natural history study of women five years ago or ten years ago, even with smaller numbers they say, "Oh, we don't have the research." Then we say, "But these things are happening," and they say, "Oh, but, you've got to have more research."

MS. FRANCIS: Let me hook that to what you said about our Department of Health having protocols for the treatment of pregnant women-- Recap what you said, for males, for pregnant women and for children, but not for non pregnant women.

MS. BANZHAF: Exactly.

MS. FRANCIS: Is that something that's being resisted developing that protocol or is it something that's in the works?

MS. BANZHAF: It is supposed to be in the works. It's that pregnant women have taken priority. I should say that the State Department of Health is conducting a data base study to determine whether or not women with HIV have died from cervical cancer in this State as grist for continuing to pressure the CDC to acknowledge cervical cancer and other women-specific diseases. That was one of the things that was recommended out of the State AIDS Plan. It hasn't been finished yet, though, and it got started about a year after it was proposed.

MS. FRANCIS: Do you have a sense-- Well, the National Institute of Health is now headed by a woman who seems fairly aware of such issues. Is that something that helps?

MS. BANZHAF: She is fairly aware and progress is being made. There are a number of natural history studies that are due to start on women. And, in fact, the Newark Women's AIDS clinic and Dr. Pat Closer there is heading up a women's research consortia to compete for the federal funds for those large-scale natural history studies. We feel very strongly that one of those natural history studies should take place in New Jersey. Her clinic sees 500 women and they have--

SENATOR LIPMAN: It should take place in Essex.

MS. BANZHAF: Right. Yes.

MS. FRANCIS: Excuse me, I didn't mean to interrupt. If it doesn't take place in Essex County, somebody's missing a major point.

MS. BANZHAF: That's right. Exactly. I mean, when 35 percent of AIDS cases in Essex County are women, we ought to wake up and smell the coffee.

Similarly, it is projected by the National Institute of Health that AIDS in men and women will be equal by the year 2000.

MS. FRANCIS: Nationally?

MS. BANZHAF: Nationally. So, we aren't prepared, but we can get there if we stop looking at women as vectors of transmission and if we stop focusing on only pregnancy. I'm not saying stop focusing on pregnancy, but don't make that be our only focus, which by and large it has been.

SENATOR LIPMAN: All right. Does anybody else-- We've been monopolizing this conversation.

Well, thank you very much.

MS. BANZHAF: Thank you.

SENATOR LIPMAN: I look forward to discussing HIV and tuberculosis with you.

MS. BANZHAF: I'd be happy to. Thanks.

SENATOR LIPMAN: All right, Ms. Joan Pennington. She's from the National Center for Protective Parents in Civil Child Sexual Abuse Cases. Ms. Pennington.

H. J O A N P E N N I N G T O N, ESQ.: Senator, members of the panel, I'd like to thank you for this opportunity to contribute information and recommendations for new or revised legislation which would help to overcome existing obstacles to the legal equality of the sexes in the context of violence directed primarily towards women. As defined by the Commission, these acts of violence include the crime of incest. This most heinous of crimes is often the first, but rarely the last act of violence directed primarily towards women as young girls, as children, and yes, even as babies.

Child sexual abuse is a sexual act imposed upon a child. Children lack the emotional, maturational and cognitive development to consent to such acts. Sexual abuse is defined in most states as any non-consensual sexual contact, and in most states a child less than 17 years old is held to be incapable of consent to such an act.

Statistics indicate that one in four females is likely to be sexually victimized before she is 18 years old. Reported cases of all types of child abuse increased from 416,000 in 1976 to 1.7 million in 1984. The percentage of child sexual abuse cases increased from 3 percent of all child abuse to 13 percent in 1984. Thus, the number of reported child sexual child abuse cases rose from 12,480 cases in 1976 to 220,000 in 1984. At least 90 percent of the abusers are male. Fifty percent of the sexual abuse perpetrators in the 1984 sample were natural parents, and 31 percent were either step-parents, foster-parents or adopted parents. Therefore, 82 percent of child sexual abuse is committed by parents, or parent-figures in the child's life. A large number of child sexual abuse cases are never reported to information gathering organizations

that produce statistics, such as the American Humane Association and the National Center for Child Abuse and Neglect, and the unreported incidents may compose the majority of all of the cases.

Any act of alleged intrafamily sexual abuse is viewed in our society as inherently unbelievable because it is difficult to believe that any parent would seek sexual gratification by exploiting their own child. This choice not to believe is reinforced by deeply rooted taboos against incest. Most cases of child sexual abuse are processed through the criminal justice system, initiated by criminal complaints, or through the juvenile justice system, initiated by abuse and neglect petitions. The majority of these cases can never be proven because there are no witnesses other than the child and the abuser. The truth is hard to determine as well when the allegations are raised in the context of civil cases, such as divorce, custody and visitation disputes.

A child who is sexually abused by a parent may be the most vulnerable of all victims. Most children are dependent upon their parents for virtually all physical and emotional nurturance. In addition, they are subject to their parent's authority and control. A child is ill-equipped to defend herself from a parent's sexual abuse, therefore, the society and the legal system must provide adequate protection. The reported cases of child sexual abuse increased by the thousands, indicating recognition of the problem, and indicating that those who become aware of the problem are turning to the legal system for relief. However, the rate at which the courts are making findings of sexual abuse is disproportionately low to the actual incidence.

When allegations of sexual abuse are raised during a divorce, custody or visitation dispute, the burden proof is on the accuser. Since these allegations are so difficult to prove many such allegations are found to be unsubstantiated. This

does not mean that the allegations are untrue, or fabricated, merely that there's not enough evidence to overcome the burden of evidentiary proof. The final result, then, is that the final finding is a finding of no abuse.

As stated above, 90 percent of child sexual abuse is perpetrated by males, therefore, when allegations of child sexual abuse arise, they are nearly always raised by the mother. In these instances equal justice is denied to females as child victims, and as mothers of the victims seeking to protect them through the courts. Generally, these allegations are not believed by the courts. Even though there is not enough evidence to substantiate the allegations the abuse, in fact, may well have occurred. In the ensuing custody or visitation litigation the child's right to be free from abuse is subsumed in the process. Sending a child who has actually been abused into a dangerous environment may merely be incidental to a court order, instead of the child's interest being the primary focus of the court's decision.

Mothers who otherwise would be awarded custody because they have been the primary care givers of the children before the separation, generally lose custody, if they raise allegations of sexual abuse. These mothers bring their case to the legal system first, but the legal system does not believe them and orders them to turn the children over to the alleged abuser. Out of sheer frustration and desperation, some mothers place the children in hiding, or go underground with them. In these situations everyone loses. The protecting parent and the child become fugitives. The other parent, who might even be innocent, loses all contact with the child, and the legal system is viewed by all as a failure.

Judge Charles B. Schudson, a Wisconsin Circuit Court judge, is a member of the faculties of the National Council of Juvenile and Family Court Judges and the National Judicial College, and is considered the nation's foremost expert on new

laws and techniques that affect children in the courtroom. In a book he recently co-authored with Billie Wright Dziech, entitled "On Trial: America's Courts and their Treatment of Sexually Abused Children," he advocates for legislative reform. He states that the best defense against false allegations of sexual abuse is implementation of procedures that will increase childrens' participation in the legal system. To those who claim that innocent defendants are being prosecuted because of malicious stories from devious children, Judge Schudson points out that one must first allow the children to tell their stories, even if it means telling that story while seated in the lap of the other parent in the courtroom, using puppets in the courtroom, or television cameras, it is better than no testimony at all, because the child has frozen up at the sight of a crowded courtroom, the presence of her rapist, or this man towering over her in a black robe.

"There is no validity to the claim by VOCAL" -- this Judge Schudson, a quote from his book -- "and other opponents of legal reform that attention to child victim's rights somehow threatens the constitutional rights of the defendants. Child advocates have not argued that American courts should abandon traditional protections for defendants. Responsible professionals have not advocated rejecting the constitutional principle that the accused is innocent until proven guilty. They have not maintained that defendants be denied the right to confront their accusers. They have argued only that sometimes in order to facilitate discovery of truth, confrontation of a child must occur in ways not usually employed in courtrooms. Child advocates have not maintained that the admittance of hearsay evidence should be the rule in sexual abuse trials. They have argued only that in special instances, certain hearsay statements by children should be considered under the long-accepted category of exceptions to the hearsay rule.

Respect for the rights of child victims does not limit the rights of defendants; it helps balance the scales of justice so that the system can foster the quest for the truth."

A comprehensive review of the rules of evidence and court rules and procedures should take place with an eye toward reforms which could be implemented to augment the "quest for truth," and indeed better balance 'the scales of justice.'" Other reforms should require an immediate halt to a custody or visitation proceeding when allegations of sexual abuse are raised, and investigation initiated by the court. If a child alleges that a parent has abused her, the child should remain in the custody of the nonabusive parent during the investigation. We must stop punishing children for disclosing sexual abuse of a parent by tearing them from the only safe relationship they may have. Obviously, in weighing the conflicting harms, it is far more equitable that a parent visit with the child in a supervised setting during the investigation than that a child who has in fact been raped be forced to submit to the control of her rapist. Custody or visitation should never be decided until the investigation has been conducted and a report submitted.

In every child abuse sexual abuse case an attorney should be appointed to represent the interests of the child as opposed to the interest of both or either of the parents. This appointment, however, should not be made as a meaningless gesture as it is in most cases today. Standards must be implemented in order that these Guardians Ad Litem know what is expected of them, who they are accountable to, and the standards to which they are to be held. Judges must be encouraged to appoint qualified, neutral attorneys and must enforce standards requiring aggressive representation of the interests of the child. It is imperative that these standards or guidelines be applicable throughout the State of New Jersey and that they be enforced just as uniformly.

Equal treatment of women in the courts, fair and unbiased investigation of allegations of child sexual abuse and procedural reforms in the way in which these cases are tried, would make parental abduction in civil child sexual abuse cases unnecessary.

Other concerns exist in the area of gender bias in the courts. New Jersey was the first State to appoint a task force to study the issue and is still the forerunner in evaluating and making recommendations to alleviate the problem.

It was not only determined that gender bias did exist in the judicial system, but that it had a particular negative impact on women who were victims of domestic violence and women who were victims of rape. The study did not address civil child sexual abuse cases, but it does not take a large leap in logic to determine that women are not believed because first and foremost, they are women. It would help to remedy many problems in these cases if a study was undertaken to discover exactly how, and in what context gender bias in the courts has a negative impact on this type of case. As concluded in the evaluation, recommendations and implications of the task force study:

"Some judges appear to believe that once they eliminate gender bias in matters such as forms of address and appointments to fee-generating cases, they have eliminated gender bias in the courts. They are reluctant to move beyond court interaction to the complexities of gender bias in substantive decision-making. Although reducing gender bias in the court environment creates conditions favorable to its reduction in the more difficult areas of case outcome, and understanding of one aspect of the problem does not necessarily lead to an understanding of the other.

"A second problem is that many judicial acts and omissions that are manifestations of gender bias are not understood as such. A primary duty of a task force is to

explain why indifference to spouse abuse in custody awards, failure to enforce child support and de minimus to the family of a homemaker in a wrongful death suit, to cite three examples, constitute gender bias, and why gender bias is inimical to fundamental fairness."

Thus, equal justice cannot be achieved for victims of child sexual abuse cases until the impact of gender bias is addressed as an integral part of the outcome of these cases. Our Center has just begun to analyze each of the components of civil child sexual abuse cases, and to set our own objectives so that we may better serve our clients. We are interested in any reforms that will improve the current failures in the system.

In closing, I would like to quote Judge Schudson one more time, and he says, "At the very heart of the American experience lies the conviction that when laws and traditions are unjust, they must be changed. That theme dominates our legal traditions from the Declaration of Independence to the Constitutional Convention to countless Supreme Court decisions and reminds -- indeed, requires us -- to re-examine our laws to assure that they provide justice for all. We cannot forsake that history; if in our passion to protect one individual's rights, we ignore those of another, especially those of a child, we cannot claim to be a just society."

Thank you.

SENATOR LIPMAN: Thank you. We're going to ask you back.

MS. FRANCIS: I had actually two different questions. Toward the end when you were talking about--

SENATOR LIPMAN: Gender bias.

MS. FRANCIS: Gender bias not understood as such, and you mentioned the wrongful death. For instance, homemakers wrongful death doesn't get the--

MS. PENNINGTON: The amounts of money.

MS. FRANCIS: The compensatory award that wrongful death of a wage earner would get.

MS. PENNINGTON: An accountant.

MS. FRANCIS: Right. You gave a few other examples that I think I missed.

MS. PENNINGTON: The other one was the importance of spousal abuse to be considered in award of custody. The thing is that gender bias is so pervasive and it hits in so many different ways, it's hard sometimes to point out to judges themselves how they've even been gender biased. And I think this is what the next step is. Okay, we've said gender bias exists. It exists if you're a judge, women judges against women attorneys and against women litigants.

SENATOR LIPMAN: Really?

MS. PENNINGTON: Oh yes, yes. That was what the report had said. But the main thrust of it was, because they focused, they knew that the big problem areas at court were domestic violence cases. I must point out that for six-and-a-half years I was a staff attorney with Legal Services here in Trenton, and I represented battered women, and I represented in custody and visitation cases. I can tell you that the court systems are absolutely and totally biased against women. I had custody cases that were involving suspicions of child sexual abuse and actual child sexual abuse and nobody wanted to believe it. And I've had attorneys tell me that they have advised clients, "If you go and raise these allegations that your child has been sexually abused, you're going to lose custody," and have advised these women not to raise this issue. Now that's a pretty serious thing.

SENATOR LIPMAN: Yes, very deep bias.

MS. FRANCIS: That issue has been raised in a context I work in which is representing our Department on the Governor's Task Force on Child Abuse and Neglect and it's been discussed from the child protection direction, not from our

women's right direction, and I'm interested in whether you see that as one wedge into that issue?

MS. PENNINGTON: Well, the problems I've seen-- When child sexual abuse is raised in the context of an abuse and neglect proceeding it gets the serious focus that it deserves, and when it's raised in the context of a criminal complaint. The problem areas, and there have been many articles and I cite some of them in my end notes, there are studies that just totally disbelieve allegations merely because they're raised in the context of a divorce or a custody proceeding. This is why we are focusing particularly on those cases. Those are the cases where mothers had to go underground because nobody believed them. They went through the court system. Many of these cases have been going on for years.

There was one case that's still in the courts that the mother caught the father sexually abusing the child when she was a year-and-a-half old. She left him and she divorced him. She could not get the court to accept evidence -- medical evidence that the child had been abused -- by three different doctors, one of which was a children's hospital in New Orleans that had expertise in diagnosing child sexual abuse, had found scarring tissue, had found permanent damage that was caused by constant and continual sexual abuse of this child. The child is now nine years old; the case is still not over. When the mother first tried to take her into hiding, the mother died of a brain aneurysm. The child turned up in a court represented by the Legal Services for children in San Francisco. Because of the interstate custody laws, the judge in California notified the authorities in Mississippi where the child came from. The father and the father's attorney and the District Attorney from Mississippi came up and the court turned the child over to them with conditions that when they took her back they would appoint a guardian. They would see that she was placed in a neutral setting; all of these conditions. They

went back to Mississippi and the conditions were either not complied with at all or were just sham proceedings that pretended to do what they had promised to do. And this child still lives in the home of her father's parents where he has actual and total access to her. And right after she went there it hit the newspapers that the child had recanted and said her father never did anything to her.

MS. FRANCIS: Now in 25 words or less, if a woman believes her male partner is abusing a child, if she stays with the partner and has someone else bring a child welfare claim, it's more likely to be believed. If she essentially takes more control of the situation, chooses to ask for a divorce, or you know, seek a divorce, she's less likely to have the child sexual abuse claim dealt with. So, it's again a case of women taking control and generating negative reaction.

SENATOR LIPMAN: Right.

MS. PENNINGTON: Yes, and you have to understand, too, that when a judge tells a woman, "I don't believe you. You're trying this man from having his rightful visitation. And so you either turn the child over to him for visitation or I'm going to change custody, and he'll get custody and you won't even have visitation." So, that's when they run. They know that this father has sexually abused the child. They can't prove it. I mean, this mother that went underground and died of a brain aneurysm, she saw with her own eyes, but it was her word against his. But she could not bring herself to do what the court had said. Once you disobey a court order, you're dead meat, because judges are very angry about it.

That was the whole issue in the Elizabeth Morgan case. The judge was outraged because she refused to comply with his orders. And that's when women run, and it's a terrible life to have to go underground. And yet the underground sprang up because of other people who had sympathy for these women who were willing to risk law suits, willing to

risk going to jail themselves for aiding and abetting in a felony. Because if a felony warrant is issued and the FBI goes after somebody, which is very, very common in these cases, anyone who helps them can be held for aiding and abetting the obstruction of justice.

MS. FRANCIS: I just had a kind of reaction that what you said about the underground going up; and I don't know as much of the history of the battered woman shelter movement as others here, but it seems as though that movement sprang up as sort of an underground of safe houses and so on. And this issue seems to be where that issue was, what, 15 years ago?

MS. PENNINGTON: Except for one difference. It wasn't against the law to help a battered woman. I mean, you could be in trouble with the batterer; he might come after you as well as the woman. However, under these situations it's against the law, and it is an illegal practice. I equate it more with the underground railroad during the Civil War, or the people who were evading the draft who went to Canada, and the people that helped them on the way there.

But you see, what always happens is when a great injustice occurs, people will not just accept it. That's what this country's about; that's what Judge Schudson was talking about. When something's wrong with our laws, we have to change them. And if we don't do it, the people will do it through acts of civil disobedience. So the consequences of these acts of civil disobedience-- I mean, you have to accept the consequences of what you do.

But all of this could be avoided if women and children would be given a fair chance to present their case in court. It's as simple as that. That's the way to stop child abductions and the whole underground movement. Just listen to what they have to say. Give them a little bit of credibility and investigate what they say. Help children learn how to testify in court. If they need to tell their stories sitting

on their mothers lap, let them. And as Judge Schudson also said, "We're not saying to deny the defendant their right to their constitutional heritage."

MS. FRANCIS: To change the subject: You said 90 percent of child sexual abusers are male, when the previous witnesses, Vicki Gaudreau and Bonnie Garner talked -- I was asking some questions because their testimony -- they said that essentially the perpetrators of child sexual abuse are fairly evenly distributed between men and women. I'm really puzzled by the great discrepancy there. Without trying to presume an answer, my sense is that the way we are socialized would lead me to believe that the power and control -- the acting out of that -- would be more male against female, and yet I'm not looking for that to have to be the answer. But there's a real big discrepancy between 50 percent and 90 percent.

MS. PENNINGTON: The figures that I got were taken from David Finkelhor, who is I guess probably the best known researcher in child sexual abuse cases, and the American Humane Association which is pretty much recognized.

MS. FRANCIS: I'm sorry, could you repeat the two sources there?

MS. PENNINGTON: David Finkelhor, who is at the University of New Hampshire, is recognized as the country's leading researcher on child sexual abuse. And these figures were taken from two of his articles and the American Humane Association.

MS. SEHAM: Bobbi, I think that was more of a theory of hers rather than figures.

MS. PENNINGTON: Now, we're not denying that females do commit child sexual abuse, and a lot of the discrepancy is when you say reported cases. See the greatest number of cases-- If you think domestic violence cases are under reported, these are even more so, whether it's more of the male

perpetrators that are coming to view-- And you're also adding in pedophiles, and boys that are being targets of child sexual abuse as well.

One article I read does say there are many statistics out there and the only one you can absolutely and truly rely on is that it's the most under reported crime that there is.

SENATOR LIPMAN: If there are no more questions? Thank you very much.

(HEARING CONCLUDED)

APPENDIX

I WELCOME YOU ALL HERE TODAY FOR THE FIRST OF TWO PUBLIC HEARINGS TO BE HELD BY THE COMMISSION ON SEX DISCRIMINATION IN THE STATUTES. OVER THE YEARS THE COMMISSION HAS HEARD FROM THE PUBLIC ON A VARIETY OF ISSUES THAT AFFECT THE RELATIVE LEGAL POSITION OF WOMEN AND MEN, BUT TODAY WE ARE FACED WITH AN AWESOME PUBLIC AWARENESS OF THE ISSUE WE ARE TO EXAMINE, COMBINED WITH A DIFFICULT POLITICAL CONFIGURATION IN THE STATE AND AN EVEN MORE DIFFICULT ECONOMY. WE ARE HERE TODAY TO TRY TO AVOID THE DISASTER FOR WOMEN THAT IS ALMOST CERTAINLY THE RESULT OF THIS COMBINATION OF EVENTS.

IN HARD TIMES, VIOLENCE AGAINST WOMEN BECOMES MORE FREQUENT AND MORE EXTREME. WE ARE ALREADY HEARING FROM THE FRINGES THAT WELFARE MOTHERS AND MINIMUM WAGE EARNERS (MANY OF WHOM ARE WOMEN) ARE THE SOURCE OF OUR ECONOMIC PROBLEMS. THIS IS PATENTLY RIDICULOUS AND THINKING, FEELING HUMAN BEINGS KNOW IT. AN EASY FIX THAT BLAMES WOMEN IS ACCEPTABLE TO SOME, HOWEVER, PRECISELY BECAUSE IT FEEDS THEIR NEED TO BLAME THE VICTIMS AND TRUST THE ESTABLISHED POWERS THAT BE. OUR NEW



Ruth Anne Koenick, M.A.

Coordinator • Sexual Assault Services
Rutgers Student Health Service
210 Willets Health Center
Douglass Campus
Suydam Street
New Brunswick • New Jersey 08903
908/932-1181

THE NEXT FEW WEEKS

You have just been through an experience which may have been very frightening. You may have experienced something that you thought would never happen to you or which only happens to other people. However, you used to think about sexual assault, your recent experience may change your thoughts and feelings. During the next few days or weeks, you may experience some feelings that are unfamiliar or different than you normally feel. Although this may be difficult to accept, understand that these feelings are normal for someone who has experienced a crisis and they will diminish with time. You may feel confused about what you are experiencing and that too, is normal.

Some of the feelings others have experienced which you may too include: anger, feeling isolated as if no one understands, unclean and dirty, different from your friends, frightened of your assailant, or fearful of being alone. You may experience difficulty in sleeping and eating. You may have "aches and pains" throughout your body and feel as though you have no energy. At times, you may feel out of control of your emotions.

It is important that during this time of extra stress you take extra care of yourself. Some people feel that if they ignore the symptoms and pretend nothing happened, they will feel better faster. Although this may work for some, many people need to acknowledge what happened and talk about their feelings. During the immediate aftermath, you may want to lessen your responsibilities so that you can rest physically and mentally, then return to your regular routine at your own pace. Let people know how they can help you during this time.

Sometimes, talking about the assault will help you feel more in control and you may need to talk to a relative or friend, or with someone who has experience helping people who have been sexually assaulted. You can contact the Sexual Assault Services office at Rutgers University, located in 210 Willets Health Center on Douglass Campus. The phone number is (908) 932-1181. If no one is there when you call, consider leaving a message with the receptionist or on the answering machine and it will be returned as soon as possible. Although an appointment is not necessary, there are times during the day when the coordinator is on other parts of the campus and unavailable.

All services are confidential.

THE STATE UNIVERSITY OF NEW JERSEY
RUTGERS

Office of Sexual Assault Services • Rutgers Student Health Service
210 Willets Health Center • New Brunswick • New Jersey 08903 • 908/932-1181

COMMISSION ON SEX DISCRIMINATION IN THE STATUTES
TESTIMONY
PRESENTED BY RUTH ANNE KOENICK
MARCH 20, 1992

In 1971, there were a series of sexual assaults at the University of Maryland in College Park, Maryland. The victims, abducted from the same parking lot, were left to deal with a system that was at times overwhelming, abusive and frightening. The university chose to ignore these crimes until forced to acknowledge their existence by the local press. Let me say that this was not unusual, as our knowledge about sexual assault was limited, the literature was scat, and our attitudes and laws archaic at best. I, along with other residence hall staff, with the support of the division of student affairs, responded to the needs of the victims and the campus community by developing the first rape crisis center on a college campus. Since that time, colleges and universities, with varying levels of interest, have grappled with the issue of sexual violence.

This testimony which I present to you this afternoon, will provide you with information about sexual violence, primarily acquaintance rape, and propose a set of recommendations. Much of what I have to say is not new nor terribly profound. Some would charge that sexual violence is a fantasy of feminists and acquaintance rape and oxymoron. But I am here to tell you that the consistent, and often rewarded sexual violence against women on college campuses is neither fantasy nor contradictory but rather a national tragedy causing thousands of women each year to be denied the opportunity of an education free from fear..it denies them the right to live, love or learn in an environment that fosters personal rights, development of boundaries and respect for human dignity.

Current research conducted by Mary Koss involving 6,00 college women and men on 32 different campuses, indicates that one in four college age women have been the victim of a completed or attempted sexual assault. It also indicates that 1 in 12 men acknowledge committing an act of sexual violence. Confirmed by other studies, over 80% of these assaults happened between people who knew each other. Although the surveys consistently support the numbers, there is a large discrepancy between the incidence of the crime and the reporting to police, administrators, and health or counseling center clinicians. The Koss research suggests that a full 42% of the victims told no one, ever, with only 5% reporting the crime to the police and another 5% reporting the incident to a rape crisis

Testimony
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center. This is the epitome of a safe victim for who is safer to be terrorized than the person who tells no one. There are many reasons why women chose not to report a crime of sexual violence...they aren't sure how to define the act, knowing something awful happened but unsure of its illegality, or, they aren't aware of how to report, perhaps they have a belief system that is self-blaming and often project that belief onto others as well, they have an intense sense of fear, the sense of shame and humiliation prohibits seeking help, or, as with many colleges and universities who emulate our society as a whole, women are discouraged, whether overtly or covertly, from reporting this crime.

There is another type of violence, almost always sexually based. that permeates our universities. This assault, primarily verbal yet focusing on the body, is beginning to receive some attention in the literature. Primarily written by Dr. Bernice Sandler of the Center for Women Policy Studies, it is the "crime" of peer harassment. Similar in nature to sexual harassment, it is often dismissed as a normal part of our culture...a kind of boys will be boys or they are just having fun...don't you have a sense of humor...attitude. Let me illustrate this crime for you. There are places on our campuses that women avoid walking because they know gangs of men will be hanging out of windows, sitting on steps, blocking sidewalks etc...commenting on the women's sexual attributes or desirability, or perhaps just visually harassing. Some women report that they avoid certain dining facilities as men will congregate at a particular table and "scope" the women as they wait in line..sometimes holding up numbers to judge their physical appearance such as breast size. The list can go on but I think each one of you can think of instances in your own history where you have made changes based on your safety, security and desire to be free from harassment. Let me just say that when a name is given to a behavior, a name such as scoping, acquaintance rape or gang rape, it not only allows us to study that behavior, but it suggests, at least to me, that there is a tremendous occurrence in order to warrant a title.

Time limits me from providing you with the many examples of violence against women that occurs on a daily, hourly, or even minute by minute basis on our campuses. I am providing you with some literature and resources on this topic. So, let me move on to some recommendations. Prior to coming here today, I wrote to my colleagues, including students, at Rutgers University. What I am about to recommend is a compilation of their comments as well as suggestions made by some of the literature. I would also encourage you to obtain a recent opinion by the Honorable John E. Bachman, J.S.C. on January 10, 1992 regarding the case of Christine Coverdale vs. Rutgers University, et al, where he discusses some of the difficulties universities have in assuring the safety of their

students as well as some of the things that Rutgers did that were within his view as good practice. I am also providing you with the Rutgers University Acquaintance Rape Task Force Report, accepted by President Lawrence in May 1991 and currently being implemented by the Office of Sexual Assault Services.

1. Adopt a written policy condemning sexual violence. Distribute this policy to every student and parent informing them that this behavior will not be tolerated, that there are consequences to this behavior, and that the university will pursue, to the full extent of its power, disciplinary action against those who offend. This policy needs to be distributed to faculty and staff as well and should outline the legal definition as well as the manner in which it is addressed in the student conduct code. Also, it should include information on the causes of sexual violence, with a particular emphasis on how alcohol use precedes most acquaintance rapes. Specific information on reporting, crisis intervention, medical and counseling services should be included.

2. The Acquaintance Rape Task Force Report as well as most people in this field believe there should be a specific provision that prohibits sexual violence in the code of conduct. This also needs to include procedures which protect the rights of victims during hearing procedures (outlined in a resource I have provided). For example, the victim should have the right to be free of harassment from her assailant's peers prior to, during, and after the hearing. Additionally, she should have access to the decision reached by the hearing officer or board.

3. Establishment of a comprehensive sexual assault services program that provides crisis intervention, counseling, educational programming all in a confidential manner. Establishment of this office must include adequate funding and support services. Additionally, this person/office must have access to, and be included in the administrative structure which makes decisions regarding sexual violence. This person should also review all administrative policies and protocol regarding sexual violence.

4. Comprehensive educational programming. It is not enough to say that sexual violence will not be tolerated. Students come to college with a well developed sense of gender role stereotypes and consequent behaviors. These, as well as specific information about sexual violence need to be discussed in a variety of methods including literature, brochures, articles in the school newspaper, and mandatory attendance at rape awareness programs. The data tells us that the most vulnerable time to be sexually assaulted is the summer after high school and the first year of college. It is important that this issue is addressed from the time that students state their intentions to attend a particular university.

Mandatory programming at orientations sessions for all incoming students needs to occur. The data also tells us that there is a higher propensity for the occurrence of rape, and in particular gang rape, in all male housing units such as fraternities...and in particular, when alcohol is present. Some would suggest that the behavior in these residences is predatory in nature. Mandatory programming is a must for these groups. All greek organizations need to be included as there is often lot of pressure put on sorority members not to report a rape by a fraternity member. These programs must include information on the strong correlation between alcohol and sexual violence and how it contributes to becoming victim as well as victimizer. This demands that programming be provided for both men and women. Additionally, the topic and issues involved in sexual violence should be included in the curriculum, for example in introductory writing courses, so that students continue to learn from a variety of sources and gain an understanding of the level of importance the university places on this issue.

5. Training for faculty and staff on how to assist a person who has been sexually assaulted is very important. Often the residence hall staff are the first people/person the victim discloses the crime to and they need to be trained on this subject. Training must also be provided for police. This type of programming needs to be on an annual basis and must be supported by the administrative structure.

6. Although the literature states that only 16% of rapes on a college campus happen between strangers, some priority has to be given to this issue. The safety and security of students can't be compromised. Lighting, shuttle buses, escorts, etc. all need to be reviewed whenever a crime occurs.

I have been extremely brief in my comments but hope that this gives you a sense of some of the issues. Since coming to Rutgers over a year ago, there have been consistent comments on the location of my office. Located on Douglass campus, almost everyone, including my 14 year old son, have commented that it is appropriate since more rapes surely occur there than anywhere else and that rape and its reduction are women's issues. I want to clarify that misperception. Sexual violence is no more a woman's issue than being a lawyer is a man's job. Sexual violence is a cultural issue and needs to be addressed in that context. No longer can we focus our attention on telling women how to feel safe, warning women to stay inside, and providing self defense courses. Timothy Beneke in his book states, "It is men who rape and men who collectively have the power to end rape." You and I have the power to make them listen and respond.

REPORT
OF
THE ACQUAINTANCE RAPE
TASK FORCE

Mary Hartman
William David Burns
Co-Chairs

Spring 1991

INTRODUCTION

The fall 1989 and spring 1990 semesters were times of tension and controversy for the University. Students confronted administrators on a number of issues ranging from tuition increases to acquaintance rape.

Because of questions raised concerning the University's manner of dealing with acquaintance rape, President Bloustein asked that the Acquaintance Rape Task Force assess how the University currently handles acquaintance rape and recommend improvements, if needed. As a result, the existing Task Force, composed of staff and students, was expanded, and Dean Mary Hartman and Assistant Vice President David Burns were named as co-chairs. The widest and most inclusive representation of interests was sought on the Task Force.

Subcommittees were formed to study education/prevention, student concerns, police/discipline, and counseling/health services. Three of the subcommittees completed their assessments and recommendations at the conclusion of the spring 1990 semester. Their reports are highlighted in this document and the complete reports are appended. Due to logistical and other problems the counseling/health services subcommittee has not yet concluded its work. It is anticipated that this subcommittee will reconvene over the spring 1991 semester.

TASK FORCE REPORT

Acquaintance rape, like the alcohol abuse that so frequently accompanies it, most often takes place in locations and at times when administrative attention is least available. Thus, under the best of circumstances, institutions can have only a limited impact on acquaintance rape; students themselves, particularly male students, must prevent acquaintance rape by altering their behavior and attitudes. However, this in no way minimizes the responsibilities that institutions do have for educating the community about acquaintance rape, for providing support services for victims/survivors, and for pursuing disciplinary action against assailants when acquaintance rapes occur.

The Task Force found current services available to the community to be good, especially noting the large number of knowledgeable and committed staff members and students working on the issue of acquaintance rape. The University has been dealing with acquaintance rape directly at least since 1984 when the first Acquaintance Rape Task Force, composed of representatives of

counseling, health services, University police, deans of students, residence life, and student life policy offices, first came together to study the issue and to coordinate the efforts of the different offices.

The Task Force found that the University currently has the following in place:

1.) A written policy on acquaintance rape printed in brochure form. The policy defines acquaintance rape, discusses the contexts in which it may occur, and lists resources and options (including disciplinary and criminal) available to victims/survivors. Rutgers also distributes two other brochures of a more general nature.

2.) Programs which educate students about acquaintance rape and its incidence. There are a large number of programs offered to students through a number of different offices including Health Education, University Police, Counseling, and Deans of Students. Some of these programs involve peer educators.

3.) Programs to educate staff members. A number of in-service training programs have been held since 1985 aimed at sensitizing key personnel to the issue of acquaintance rape.

4.) Comprehensive medical and counseling support services.

5.) Mechanisms to pursue charges against assailants internally and to report charges to external authorities. The Task Force found both police and disciplinary personnel to be knowledgeable about acquaintance rape and supportive of victims/survivors. The Task Force noted that while the University can and does provide victims/survivors with information on their options, both internal and external, it cannot, and should not be in a position to guarantee outcomes of hearings; the facts of individual cases must be decided by appropriate hearing bodies.

There are, however, specific reforms which the subcommittee on police/discipline have put forward which should be implemented in order to better define the offense and to reduce the stress that complainants may encounter in the disciplinary procedure.

RECOMMENDATIONS

The subcommittees made a number of suggestions for the University to consider implementing. The full set of recommendations are contained in the appended subcommittee reports and each should be considered carefully. The recommendations in some cases seek to expand upon efforts already in place, in others to formalize them, and in still others to propose new ways of dealing with the difficult issue of acquaintance rape on campus. This section

highlights the most immediate of the recommendations.

All Subcommittees

All the subcommittees recommended that a coordinator for sexual assault services be hired to work with victims/survivors, staff members, and students. At this time an offer has been made and accepted. It is anticipated that the position will be filled in January, 1991. The position is to be funded by student fees through the Department of Health Education.

Several committees recommended the development of written guidelines/protocols by each office that deals with acquaintance rape. These guidelines would serve to assist the staff of each office, and, by being made available to other appropriate offices, would permit referrals to be made more knowledgeably.

Subcommittee on Police/Discipline

This subcommittee made a number of suggestions many of which involved formalizing existing practices. Representatives of the police and the deans offices on the subcommittee drafted written guidelines for the handling of acquaintance rape cases. These guidelines were derived from existing practices. They also drafted statements describing victim/survivor rights.

The Subcommittee proposed a number of specific changes for the internal disciplinary hearing procedure. These are:

- 1.) Having a specific disciplinary charge for non-consensual sexual activity and sexual assault.
- 2.) Having a specific University level charge that covers the illegal distribution of alcohol.
- 3.) Having closed hearings in all cases with especially sensitive subject matter upon the request of either the complainant or defendant.

The subcommittee recommends that these changes be proposed to the Board of Governors and implemented at the earliest possible date.

Subcommittee on Education and Prevention

As with all crimes of violence, prevention must be the first priority. The subcommittee found extensive services currently available and recommended many more. The recommendations include:

- 1.) Holding workshops on acquaintance rape for all first year students and incoming students to be conducted at, or before, orientation.

2.) Developing an ongoing media campaign to inform the entire University community about acquaintance rape. This was also strongly recommended by the Student Subcommittee.

3.) Integrating acquaintance rape education into the classroom. The Student Subcommittee recommended integrating the issue of acquaintance rape into expository writing courses.

4.) Developing programs specifically geared toward athletic teams.

5.) Involving student leaders in the efforts to educate the community on acquaintance rape.

6.) Increasing programming and education efforts within the Greek system.

7.) Involving graduate students and TAs in education and prevention efforts.

8.) Discussing the connection between the use of alcohol and other drugs and the incidence of acquaintance rape in all education efforts.

9.) Focusing education and prevention efforts on men and women equally.

Student Concerns Subcommittee

The Student Concerns Subcommittee reviewed the work of the other subcommittees and of the Task Force as a whole and also considered the recommendations of SASHA in formulating its recommendations. The Subcommittee recommendations include:

1.) Developing programs for men which force them to confront their behaviors and assess how those behaviors can foster acquaintance rape.

2.) Reporting to the University community periodically about the incidence of acquaintance rape and what the University is doing to deal with the problem.

3.) Developing programs to sensitize the police on how to deal with sexual assault victims/survivors.

4.) Developing programs for international students to discuss acquaintance rape in the context of cultural differences.

The Student Subcommittee also issued a general endorsement of the work of the other subcommittees and the Task Force as a whole, asking that these suggestions become formalized in a systematic way. There was a qualified exception made concerning how much involvement certain student leaders should have. The Subcommittee realizes that some students are more committed to

acquaintance rape education than others and that this should be considered when assigning responsibility to students for planning and coordinating acquaintance rape education.

The Student Subcommittee also drafted a letter to student leaders encouraging them to hold seminars and support educational efforts for their members.

Subcommittee on Counseling and Health Services

The Subcommittee on Counseling and Health Services issued preliminary recommendations. These will be expanded upon over the fall, 1990. The two principal recommendations concern:

1.) Training and sensitizing clinicians and counselors to acquaintance rape, particularly to identify the signs and symptoms which a victim/survivor of acquaintance rape might exhibit.

2.) Designing a system that would enable a network to be developed which would assure that medical, counseling, student life, and judicial/legal personnel consult with one another in order to provide the services a victim/survivor of rape might need. Such a system would need to take into account confidentiality issues and the wishes of the victim/survivor.

CONCLUSION

It now remains for individuals and offices within the University to act upon the recommendations of the Task Force and its subcommittees. A meeting of the full Task Force will be scheduled after all Task Force members and other interested parties have had a chance to consider this report. The meeting will provide for a discussion and critique of the complete report and of the individual recommendations. At that time strategies will be developed to ensure the implementation of recommendations. The Task Force will continue to meet regularly and to monitor progress on the University's efforts to deal with acquaintance rape.



President

New Brunswick • New Jersey 08903

March 12, 1992

An Open Letter to the University Community About Recent Sexual Assaults on and near Campus:

In the wake of the recent reports of sexual assaults (three by acquaintances and one by a stranger) of four female students on campus, I want to update the university community on what is being done to reduce the possibility of future attacks. As I have stated previously, the university community is deeply concerned for the victims of these incidents; no one should have to fear for his or her personal safety.

Last May, I accepted a report from the Acquaintance Rape Task Force chaired by Douglass College Dean Mary Hartman and Assistant Vice President for Student Services and Policy William David Burns. That report made many excellent recommendations. Most have been implemented in the months since I accepted the report.

While rape is certainly a national problem, I believe we have a unique opportunity to address this issue in our community and to provide the appropriate education and leadership in this area. It is important to note that students and staff, as well as the administration, must play a role in addressing the problem.

The main focus of this letter will be on acquaintance rapes and their prevention, but I first want to emphasize that the stranger rape that was reported on the Douglass campus is still under investigation. The university is examining whether additional security measures would help prevent further attacks of this type. Several university administrators have been meeting with students to discuss their suggestions in this area. In addition, the assault of a Rutgers student in Johnson Park is also still being investigated by park police.

The first recommendation of the task force was to hold workshops on acquaintance rape for all first-year students and incoming students to be conducted at orientation. Such workshops have been held for all first-year students on the Douglass, Livingston and Cook campuses while Rutgers College has incorporated the training into its social decision-making programs. Ruth Anne Koenick, the university's sexual assault services coordinator, has done additional acquaintance rape awareness programs in the residence halls. At the suggestion of the task force, special emphasis in these programs has been given to the connection between the use of alcohol and other drugs and acquaintance rape; to helping men confront certain behaviors that may foster acquaintance rape; and to making sure that education efforts target men and women equally.

Ms. Koenick has also developed programs specifically for the athletic teams and the Greek system at Rutgers. Every athletic team at the university, male and female, will have taken part in these programs by the end of the semester as will the new pledges of the fraternities and sororities in April. These programs are ongoing and will be held every year.

A subcommittee of the task force recommended that the university adopt a specific disciplinary charge for nonconsensual sexual activity and sexual assault. I believe that students need to be put on special notice that they risk severe punishment for this violation of our code of conduct. I am directing our University Counsel to add appropriate language to the University's Student Disciplinary Hearing Procedure which will identify sexual assault as a separation offense. I am further directing the Office of Student Life Policy and Services to issue a special notice to the University community on this subject. However, let there be no mistake about our present policy. We have always considered nonconsensual sexual activity and sexual assault to be violations of the code of the University Student Disciplinary Hearing Procedure specifically under its prohibitions on "the use of force" and committing "heinous acts."

In response to another task force recommendation, a Sexual Assault Services Advisory Board has been established, comprising residence life and health center staff, students, counselors, university police and deans of students. The purpose of the board is to implement the task force recommendations and to set up a network to provide the services a rape victim might need.

Briefly, other recommendations implemented include: providing additional training to Rutgers Police, clinicians and counselors in dealing with rape victims; incorporating the issue of acquaintance rape into expository writing courses; involving student leaders in efforts to educate the community on acquaintance rape; and including information on acquaintance rape in the context of cultural differences in the handbook for international students.

In addition, written guidelines and protocol have been developed or are being developed for each office that deals with acquaintance rape so that students in need of their services receive consistent information and help.

I am encouraged that these incidents have been reported so promptly. Let me reconfirm to you that Rutgers takes the issue of rape — both acquaintance and stranger attacks — very seriously and will continue to seek ways to lessen the possibility of future incidents.


Francis L. Lawrence

njcasa

new jersey coalition against sexual assault

PUBLIC TESTIMONY RE: VIOLENCE AGAINST WOMEN
March 20, 1992

Developed by: Jill Greenbaum, Ed.D.
Affiliations: Vice-President, New Jersey Coalition Against Sexual Assault
Chair, Bergen County Coalition Against Sexual Assault
Director, Bergen County Rape Crisis Center

I am so very pleased to be a part of these hearings to discuss the many interrelated issues which passively and actively contribute to the victimization and revictimization of women. While broad philosophical questions which underlie our day to day interactions must be addressed, the practical realities of living with our present laws and systems must be examined.

In my direct service work on behalf of survivors, as a leader and active participant in various coalitions and as a presenter at local, national and international conferences I have addressed a variety of topics. The following areas are all fragments of the whole picture, which is violence against women:

- 1) With regard to factors and issues influencing our psychological environment and the formulation of society's members opinions of violence against women, please refer to Attachment A which briefly delineates many of the issues surrounding sexual victimization.
 - * Attachment B outlines the position of the New Jersey Coalition Against Sexual Assault regarding the "naming" of victims/survivors of rape - a practice commonly used by some newspapers in New Jersey
- 2) Lack of commitment, on the part of the State of New Jersey, both philosophically and fiscally, to the needs of survivors of violence. Specifically with regard to rape care programs, the inability to find an appropriate place within governmental departments/divisions, i.e., Rape Care Programs are a part of the Department of Health's Division of Family Health Services; (Attachment C)
- 3) Deliberate non-prioritizing/inattention to the need for information and services for other-than-English-speaking populations (i.e., materials developed by the Dept. of Health, for dissemination through rape care programs are available only in English);

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- 4) Lack of coordinated examination of the present levels of functioning of the law enforcement and criminal justice systems and the impact of the judicial process upon victims and their families; (Attachment D)
- * lack of training for local law enforcement personnel re: sex offenses, the needs of victims/survivors and the role of rape crisis center staffs;
 - * the (often politically motivated) assignment of investigators to sex crimes units, without regard to professional capabilities and then with no further training;
 - * the cessation of advanced training opportunities for law enforcement and criminal justice personnel re: sex offenses and the proper disposition of such cases;
 - * lack of prosecution of husbands/partners who sexually assault their wives;
 - * inadequate recognition of and response to "stalking" as the prelude to a crime;
- 5) difficulty in securing funds (through the V.C.C.B. for counseling for adequate lengths of time for victims and co-victims of sexual abuse;
- 6) a delineation of the anticipated "breakdown" (of funds to be generated by passage of P.L.1991, Chapt. 329
- 7) no enforcement of A 1949/P.L.1987, Chapt.327, the law which requires that both local police departments and hospitals inform victims of the local rape crisis center, (see Attachment E-1);
- * the need for development and routine utilization of standard operating procedures re: sexual assault victim/survivor and her interactions with other systems (hospital, local police, sex crimes unit investigators)
 - * use of a standard "kit" for evidence collection across the State;
 - * consistent medical prophylactic treatment for rape survivors re: STD's, pregnancy;
 - * education for service providers and law enforcement/criminal justice personnel regarding sexual assault and the transmission of HIV, (Attachment E-2);

- 8) insufficient understanding of, attention to and funding for programs for both adult and adolescent sex offenders, (Attachment F);
- * recognition of and treatment programs for female sex offenders;
 - * the development of appropriate treatment programs (within prisons), probation/parole programs with treatment components and available and affordable aftercare/therapy for sex offenders for the remainder of their lives ;
- 9) the initiation and ongoing training of judges re: issues of sexual victimization;
- 10) the ability of school systems and colleges/universities to "overlook" the problem of sexual victimization - no development of State sanctioned relationships across systems (such as rape care programs with high schools, colleges, law enforcement, criminal justice, hospitals);
- 11) the purely monetary concerns of NJ Bell re: Caller ID service in New Jersey over the objections of rape care program and domestic violence personnel (Attachment G)
- 12) And finally, I have included in the packet of information a letter written to the New York Times detailing what I would consider adequate coverage of the topic of sexual victimization, (Attachment H).

I would be delighted to expand upon any of these ideas and to work with any working groups on these and other relevant issues.

njcasa

new jersey coalition against sexual assault

To the Editor,

Across the nation August is recognized as "Stop Rape Month." It is fitting and timely, in view of the continuing controversies surrounding recently reported allegations of rape which have attracted media attention, to address the issues from a larger perspective - the context of sexual victimization.

Sexual victimization is the mis-use of power and control to commit acts which are the ultimate intrusions upon the victim's intellectual, physical and sexual being. Victims typically are the more vulnerable among the population, i.e., children, women, the elderly, and people with handicapping conditions. Those who abuse use various forms of pressure (psychological and/or physical), coercion, and/or intimidation, without regard for the feelings, interests or needs of their victims.


Rape is one form of sexual victimization, one which draws the attention of the media if the victim/survivor is particularly pretty, young, old, handicapped, famous or famous-by-association. If the victim does not conform to the stereotype/victim profile which our society has developed we question the veracity of her complaint, not wishing to believe that we live with offenders among us; not recognizing that our willful ignorance of sexual victimization and its consequences condemns us to inadequate understandings of the larger issues of violence against the vulnerable, the spectrum of sexual abuse and the need for objective assessment and treatment of sex offenders.

What needs to be made explicit is the many, varied forms of sexual victimization which we "shut out" of our daily consciousness, perhaps assuming that they do not affect our daily lives, or the formation of our opinions or judgments. Voyeurism, lewd remarks/sexual harassment/intimidation, exhibitionism, nonconsensual touching of the genitals (whether the victim is being acted upon, or forced to act upon the victimizer), rape - whether between acquaintances, a dating couple, partners/married couples or by a gang, pornography and prostitution: these are the components of the spectrum of sexual victimization, of the abuse of power. All the above-mentioned nonconsensual acts have the goal of gratification of unhealthy psychological needs, which cause long-lasting trauma to victims.

Rape is one of the fastest rising violent crimes in America today. However, more heat than light has been generated in many of the articles about recent cases. Rape is sex without consent - and if one is incapable of giving consent, (due to extreme youth, use/misuse of drugs or alcohol, or mental deficiency), then it is rape. To excuse the behavior of sex offenders based upon the actions of the victims, (such as her dress, consumption of alcohol/drugs, or previously consenting behavior) is delusional. Regardless of what we may wish to believe, most sex offenders begin their history of "offending" in their early teens, with acts at the least intrusive end of the spectrum of sexual victimization. Unfortunately, when these acts are not understood and allowed to continue without recourse, these offenders often "progress" in terms of the severity of the offenses committed.

During this month of August we hope to better educate the public (who comprise the juries) about the true nature of sex offenders and the impact of their crimes upon their victims. It is only through our active efforts to support those who have been victimized, to reject the implication that victims ask to be abused and to hold sex offenders responsible for their behavior that we will begin to stem the tide of rising sex offenses.

Sincerely,


Jill Greenbaum, Ed.D.

Vice President and Media Chair, New Jersey Coalition Against Sexual Assault
Director, YWCA of Bergen County's Rape Crisis Center

8/14/91

To the Editor,

The nationwide debate as to whether and when to "name" victims of sex crimes appears to have focused too narrowly upon either the "special privilege" of anonymity for victims or the "right" of the public to know all of the facts pertinent to the case. The reality of the issues surrounding sexual victimization and criminal justice procedures have been forgotten in the quest for a simple resolution of the "problem" recently created by several key decision-makers in the media.

Sexual victimization involves heinous acts which cause psychological, emotional and, in many cases, physical damage. The stigma attached to sex crimes, (i.e., violent acts perpetrated through sexual means) will be diminished only through coordinated efforts to recognize and address the following areas: an in-depth analysis of the components within our society which promote and legitimize violence against those who are perceived to be vulnerable (primarily women and children); the true nature of the crimes of sexual victimization (involving the issues of aggression/power, control, and degradation, rather than sexual satisfaction); the impact of sexual victimization/Rape Trauma Syndrome, (the psychological, physiological and behavioral sequelae which affect a victim's/survivor's intimate and social relationships, her ability to work, and her physical health (in addition to injuries, she is at risk of becoming pregnant, and/or contracting sexually transmitted diseases and HIV)). In addition, a delineation of the psychological profiles of sex offenders would further elucidate the nature of the crime and the point to the need for both incarceration and rehabilitation.

Extensive literature exists regarding all of the aforementioned topics, and professionals within the field are knowledgeable and eager to educate decisionmakers in the media. However, when the question arose as to the ramifications of identifying the victim the professionals were not consulted. Decisions were made by people with no in-depth understanding of the complex and interrelated issues.

Sex crimes are like no other, and to assume that identifying the individual who has been victimized will reduce the stigma is faulty logic. If the task were so simple, rape crisis centers across the nation would have actively promoted such a tactic years ago, as it is our mission to empower victims/survivors and educate the public. In fact, what has resulted from the "naming" of the victim is that once again she has been the victim of someone else's control (i.e., that of the initial decisionmakers in the media, and those editors who followed like sheep). What more has been revealed about the actual incident that night at the Kennedy compound as a result of identifying the victim? Aspects of her (and her mother's) life have become common knowledge, but these are irrelevant to the case. The victim is once again victimized by the media, and the public is duped into believing that they now have some degree of insight into the incident.

Those who do not work in the area of victims' rights perhaps don't realize the constitutional safeguards for defendants in criminal justice proceedings which include: the defendant is provided with legal representation if necessary, due process is guaranteed, the accused will face his accuser in open court, the jury for the trial is comprised of his peers and a defendant is presumed innocent until proven guilty. Victims of violent crimes are mere

witnesses for the state (and in criminal cases do not chose their own legal representation) and are informed of the "Crime Victim's Bill of Rights", which are just statements (not constitutional guarantees) regarding how they are to be treated within the criminal justice system.

The mission of the New Jersey Coalition Against Sexual Assault (a coalition of rape care program providers and concerned individuals) is: to work toward the elimination of violence against all people by effecting attitudinal change in individuals, institutions, and the culture at large; and, to promote the healing of injuries resulting from sexual violence by effecting the responses of institutions to survivors of sexual assault and their loved ones. NJCASA members know that the identification of victims of sex crimes in the media is: detrimental to the individuals so identified - unless the "naming" is of their own choice - which is inevitably months to years after the assault, (rape survivors' greatest fear - after that of revictimization - is that following the reporting of the crime to the police, their names will appear in the media, and their family, friends, co-workers and acquaintances will learn of the sexual assault); mis-educative to the public, in that it deludes them into thinking that they are better informed, when in fact they have learned only some extraneous details which shed no light on the actual incident; and, will ensure that people (women, children and men) who have been sexually victimized will hesitate to come forward, even to those professionals who preserve their anonymity.

It is our hope that the revelation of the identity of the woman in Florida, which we regard as a gross error in judgement, will ultimately lead to a greater understanding of the issues surrounding sexual victimization. We are working toward a future when victims/survivors will feel the support of members of society, and come forward to share their pain without fear of prejudgment.

Sincerely,

Jill Greenbaum, Ed.D.
Vice-President, NJCASA



BERGEN COUNTY RAPE CRISIS CENTER

Jill Greenbaum, Ed.D.
Program Director

Lydia Pizzute
Program Coordinator

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December 21, 1990

Dear Governor Florio,

I am writing on behalf of the members of the New Jersey Coalition Against Sexual Assault regarding the imminent changes in the New Jersey State Department of Health.

As per "The Commissioner's Recommendations to the Governor on the Organizational Review for the New Jersey State Department of Health" it appears that once again the Rape Care Program, which is not readily categorized among existing divisions, is being relegated to a theoretically appropriate niche. Many questions arise from a practical consideration of the changes, in general:

- 1) Rape is not perceived as a family health issue. Neither the victims'-survivors' nor the general public's primary practical health concerns vis-a-vis rape, focus upon "family" health. Rather, they are in need of accurate information regarding the prevention and treatment of sexually transmitted diseases, the prevention of pregnancy and the most current information about sexual assault and the transmission of HIV/AIDS, and local testing/counseling sites. These realities point to the appropriate placement of the Rape Care Program within the Div. of Epidemiology and Communicable Disease Control.
- 2) Quite honestly, relegating the Rape Care Program to a "family" health care issue is also dysfunctional from theoretical point of view, in that we in the field of rape care seek to be inclusive in our perceptions and descriptions of sexual victimization, (i.e., while the crime disproportionately affects women, children and men are also the targets of such crimes). Though the crime will affect men in relation to their families, they most certainly will not think of their victimization in terms of "family health."



United Way of Bergen County

More specifically:

- 3) Over the past several years refinements in the "Request for Proposal" - both programmatic and fiscal have simplified the process and enabled the development of positive working relationships with Department of Health personnel. At any time, (much less at this point in the grant cycle, with applications due by mid-March), what is the benefit of severing efficient relationships of NJCASA members with the Department's fiscal personnel?
- 4) What is the advantage of splitting parts of the total Rape Care Program, i.e., "Injury and Rape Surveillance" in The Division of Epidemiology and Communicable Disease Control" and "Rape Services Program" in the Division of Family Health Services?

Perhaps what is most disturbing about the proposed reorganization is the disregard of professionals and their knowledge of the perceptions and needs of victims-survivors. Our work is predicated upon the exchange of ideas and sensitivity to both the theoretical and practical. We seek to strengthen our positive working relationships; "reorganization" with regard to the Rape Care Programs appears to have been devised for its own sake, and not that of the victims-survivors nor the providers of direct services.

I would be pleased to discuss any issues surrounding the provision of services to victims-survivors of sexual assault.

Sincerely,

Jill Greenbaum, Ed.D.
President, New Jersey Coalition Against Sexual Assault

To the Editor.

With all the recent media attention focused upon the more sensational aspects of high-profile investigations of sexual assault, several glaring omissions should be noted. In particular, of great importance to the eventual outcomes of these cases is an examination of the present levels of functioning of the law enforcement and criminal justice systems, and the impact of the judicial process upon the current victims, future victims and society. While these issues are not likely to incite impassioned arguments, they are central to our understanding and improvement of the process.

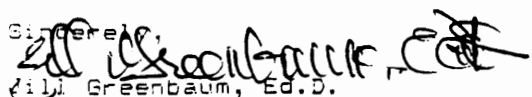
In New Jersey questions need to be asked regarding:

- 1) To whom are the initial reports made (i.e., local police departments), and what are the levels of training/expertise of the personnel responding to these types of cases? In my experience, victims-survivors prefer to talk with people with whom they are not familiar, in settings outside of their respective communities, thereby perhaps ensuring that friends and neighbors do not inadvertently learn of their victimization.
- 2) Who then investigates and prosecutes the cases (and what specialized training is mandatory prior to being assigned to such work)? In my work with the New Jersey State Police Training Bureau over the past two years, local police officers and prosecutor's office personnel have discovered the subtleties to working with victims and the complex nature of sex offenders through attending a three day intensive program. Unfortunately, the training sessions offered through the State Police are merely voluntary. The vast majority of law enforcement and criminal justice personnel have not received formalized training specifically regarding the investigation and prosecution of sex offenses, victimology and/or the psychology of sex offenders. (The brief session new police recruits receive in some counties is basic and inadequate for such complex work.) Sexual victimization is like no other crime, and it is erroneous to assume that personnel can do the job adequately without proper training.
- 3) What is the amount of time elapsed between the date of report and a jury trial - in Bergen County approximately one year - (and how might this influence a decision to prosecute)? And, how can we reduce this amount of time? The victims/survivors I work with are very concerned with attempting to return their lives to a pre-assault level of functioning. The specter of a lengthy judicial process is often a deterrent to entering into the process.
- 4) Which "types" of sexual assault cases are brought before juries and with what degree of success (i.e., stranger vs. acquaintance vs. date vs. marital rape)? For example, though the law in New Jersey is clear regarding sexual abuse within the family setting, the cases which I have worked with involving marital rape, while having been reported to the police, have never gone to trial. In my opinion this is due to the continuing conception of wives as the property of husbands, to do with as they see fit. And it is this conceptualization by the public (who comprise juries), which, 1) stymies the prosecutors, 2) denies justice for these women, and 3) negatively influences all relationships.
- 5) Is there a conscious and concerted effort, on the part of leaders within the law enforcement and criminal justice communities, to educate the public regarding the prevalence and nature of sex offenses?

As can be seen, I know the answers to almost every one of these questions. Sadly, the answers indicate, in many instances a lack of understanding of the very nature of sexual victimization and the special expertise/care needed by those who work with victims. Concomitantly, the inadequate allocation of funds and personnel (which reflects the public's true level of interest and concern) negatively impacts the possible enactment of change and solutions.

In my direct service work and as a member of various coalitions throughout the state, part of my work is to promote change within systems. Change within the existing systems and within workers can only be achieved with an understanding of the psychological, emotional and social impacts of sexual victimization, and analyses of the present levels of functioning of the systems affecting victims-survivors.

Sincerely,


Bill Greenbaum, Ed.D.

Vice President and Media Chair, NJCASA

10/29/91

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To the Editor,

With all the recent media attention focused upon the more sensational aspects of high-profile investigations of sexual assault, several glaring omissions should be noted. In particular, of great importance to the eventual outcomes of these cases is an examination of the present levels of functioning of the law enforcement/criminal justice systems, and the impact of the judicial process upon the current victims, future victims and society. While these issues are not likely to incite impassioned arguments, they are central to our understanding and improvement of the process.

In New Jersey questions need to be asked regarding:

- 1) to whom initial reports are made (i.e., local police departments), and what are the levels of training/expertise of the personnel responding to these types of cases;
- 2) who then investigates and prosecutes the cases (and what specialized training is mandatory prior to being assigned to such work);
- 3) in each county, what is the percentage of cases deemed "false reports" (and by whom, under what circumstances), and is this percentage basically consistent with national statistics;
- 4) what is the amount of time elapsed between the date of report and a jury trial (and how might this influence a decision to continue prosecution).
- 5) which "types" of sexual assault cases are brought before juries and with what degree of success (i.e., stranger vs. acquaintance vs. date vs. marital rape);
- 6) what is the vision of the victim by the law enforcement and criminal justice personnel - as merely a witness for the state or as a whole person requiring the coordinated efforts of medical, victim advocacy and criminal justice personnel;
- 7) how do the Prosecutor's Office actually function to provide a victim with current information about: the status of the case, the development of a victim impact statement, the possibility of violent crime victim's compensation, the assailant's parole eligibility;
- 8) do the various components of the criminal justice system understand the sense of scrutiny and re-victimization felt by victims, regardless of the eventual outcome of the case;
- 9) what are considered problems with the process/stumbling block to successful prosecution by people in the criminal justice system;
- 10) is there a conscious and concerted effort, on the part of leaders within the law enforcement and criminal justice communities, to educate the public (who comprise juries) regarding the prevalence and nature of sex offenses?

In all honesty, I know the answers to almost every one of these questions. Sadly, the answers indicate, in many instances a lack of understanding of the very nature of sexual victimization and the special expertise/care needed by those who work with victims.

It is the work of the members of the NJCASA to promote change within systems. It is work that can only be achieved with an understanding of the psychological, emotional and social impacts of sexual victimization, and analyses of the present levels of functioning of the systems affecting victims-survivors.

Sincerely,

Jill Greenbaum, Ed.D.
Vice President and Media Chair, NJCASA

[SECOND OFFICIAL COPY REPRINT]
SENATE, No. 1949

P.L. 1987 Chapt. 327
NJSA 52:4b-22

STATE OF NEW JERSEY

INTRODUCED MARCH 10, 1986

By Senators COSTA, LIPMAN and RAND

Referred to Committee on Law, Public Safety and Defense

AN ACT concerning victims of sexual **[assault]** **offenses**
and **[supplementing Title 52 of the Revised Statutes]** **amend-**
ing P. L. 1981, c. 256.

1 BE IT ENACTED *by the Senate and General Assembly of the State*
2 *of New Jersey:*

1 ***[1. a. Every State, county and municipal police department and**
2 **hospital or other place of emergency medical care shall refer a**
3 **victim of sexual assault to a rape crisis center in the victim's im-**
4 **mediate geographical area. If a rape crisis center is not available in**
5 **the immediate geographical area, the victim shall be referred to the**
6 **county victim-witness coordinator appointed by the Chief of the**
7 **Office of the Victim-Witness Advocacy established pursuant to**
8 **P. L. 1985, c. 404 (C. 52:4B-39 et seq.).**

9 **b. As used in this act:**

10 (1) "Victim" means a person who suffers personal, physical or
11 psychological injury as a result of a crime committed against that
12 person.

13 (2) "Rape crisis center" means an office, institution or center
14 offering assistance to victims of sexual assault through crisis inter-
15 vention, medical and legal information and follow-up counseling.]*

1 ***1. Section 1 of P. L. 1981, c. 256 (C. 52:4B-22) is amended to**
2 **read as follows:**

3 **1. a. Every State, county, and municipal police department and**
4 **hospital or other place of emergency medical care shall have avail-**
5 **able and shall post in a public place information booklets, pamphlets**

EXPLANATION—Matter enclosed in bold-faced brackets [thus] in the above bill
is not enacted and is intended to be omitted in the law.

Matter printed in italics thus is new matter.

Matter enclosed in asterisks or stars has been adopted as follows:

***—Senate committee amendments adopted May 19, 1986.**

****—Assembly committee amendments adopted May 21, 1987.**

6 or other pertinent written information, to be supplied by the Violent Crimes Compensation Board, relating to the availability of crime victims' compensation including all necessary application blanks required to be filed with the board.

10 *b. Included in the information supplied by the Violent Crimes Compensation Board shall be information for victims of sexual*
 11 *12 ****[assault]**** ****offense****. This information shall contain the*
 13 *location of rape crisis centers in all geographical areas throughout the State and shall instruct victims of sexual*
 14 *15 ****[assault]**** ****offenses**** that if a rape crisis center is not available in a victim's immediate geographical area, the victim may contact the appropriate county victim-witness coordinator appointed by the Chief of the Office of Victim-Witness Advocacy established pursuant to P. L. 1985, c. 404 (C. 52:4B-39 et seq.). Unless the victim requires immediate medical attention, this information shall be personally*
 16 *17 conveyed to the victim of a sexual*
 18 *19 ****[assault]**** ****offenses**** by a representative of the hospital or place of emergency care before a medical examination of the victim is conducted, or by a representative of the police department before the victim's statement is taken, to afford the victim the opportunity to arrange to have assistance from the rape crisis center or county victim-witness coordinator during these procedures. Hospitals shall be held harmless from suits emanating from a hospital's carrying out the obligation to convey information to victims of sexual*
 20 *21 ****[assault]**** ****offenses****.*

22 *23 "Rape crisis center" means an office, institution or center offering assistance to victims of sexual*
 24 *25 ****[assault]**** ****offenses**** through crisis intervention, medical and legal information and follow-up*
 26 *27 counseling.*

28 *29 c. Every police department shall, upon the filing of a report of a violent crime, make available to any victim information concerning crime victims' compensation.**

30 1 2. This act shall take effect immediately.

LAW AND PUBLIC SAFETY—GENERAL

Requires hospitals and police departments to provide information to victims of sexual assault.

August 14, 1991

To the Editor,

One of the "hot" topics for the public and therefore in the media has been whether sex offenders should be forced to submit to testing for the Human Immunodeficiency Virus/HIV. Opinions with regard to whether and under what circumstances convicted, or even alleged, sex offenders should be tested have been formed often without consideration of several key factors:

- 1) When will the mandatory testing take place?
Assuming only convicted rapists will be tested (as testing alleged assailants would violate their constitutional rights), several questions arise: How long after the rape is the testing going to be completed? In most counties in New Jersey it takes an average of one year for a trial to go from the time of report to a jury trial. Will the testing be done once, at the time of conviction/one year after the assault?
Presumably the (previously considered) alleged assailant will be out on bail (or even if he is in jail), perhaps he will contract HIV AFTER the assault but BEFORE the mandatory testing - thereby perhaps testing positive, but having been negative at the time of the assault - mis-informing the victim as to her/his probability re: the transmission of HIV.
- 2) How will the testing be done - once, after he's convicted, or every three months for a year, or for five years or ten years? How long is his prison term, i.e., how long is there "access" to test the perpetrator? What if the HIV is transmitted during his term in prison and not as a result of seroconversion from transmission prior to the assault?
- 3) Who will guarantee the confidentiality of the test results? Will the results be passed through the criminal justice system/Prosecutor's Office that was responsible for the case?
- 4) What kind of "psychological safeguards" are being put into place for the victim/survivor? When/Each time she receives the results of the testing for HIV in the assailant will she also receive supporting information about the reliability of the results, the possible need for further testing of the assailant, and/or the possible need for continuing testing for herself? Is she being advised by knowledgeable individuals about the need for testing of herself in a confidential setting which offers pre- and post-test counseling re: assessing her risk, testing procedures, the meaning of the results, perhaps planning for changes in her future sexual life, etc.?

The afore-mentioned questions point to the many complex and interrelated issues involved in mandatory testing for convicted rapists.

It is my experience that the majority of people responding to polls do not know about the many immediate concerns of victims/survivors (future safety, possible transmission of STDs, possible pregnancy, the often negative responses of members of the victim's/survivor's support network, considering whether to report the crime and follow through with prosecution), nor the state-of-the-art of testing for HIV, much less the time lag between reporting the crime and conviction (which impacts upon the accuracy of any results

obtained).

The only way in which to ascertain whether HIV has been transmitted is testing on a regular basis/every three months for a year following the assault. The probability of transmission of HIV, as the result of a one-time contact/sexual intercourse with an infected individual is projected to be 1 in 500, according to Hearst & Hullen, (in the Journal of the American Medical Association, 1988:2429) . Though the risks are greater for victims of rape, as they often sustain wounds that could allow for direct transmission to the bloodstream, the risk remains relatively small. A testing schedule initiated and followed by the victim/survivor is also a small step in regaining control over her life and the information regarding the many aspects of her victimization.

Sincerely,

Jill Greenbaum, Ed.D.
Vice President and Media Chair, New Jersey Coalition Against Sexual Assault
(201) 488-7110

BC CASA

bergen county Coalition against sexual assault

2.20.92

Dear Freeholder

We are writing on behalf of the Bergen County Coalition Against Sexual Assault regarding the status of treatment of adolescent sex offenders. In Bergen County with a population of 825,380, there is one program, TREAD (Teen Readjustment Program) under the auspices of the Bergen County Division of Family Guidance. Further, in the state of New Jersey there is one residential treatment center, the Pinelands, which can treat 18 adolescent offenders in a secure setting. It is further notable that there is no residential treatment center for adolescent girls who have committed sexual offenses.

Though there are acknowledged funding limitations, it is imperative that freeholders be aware of the critical importance of providing continued and expanded assessment and treatment for adolescents who have been identified as having significant sexually deviant behavior, and which is often indicative of their own sexual victimization.

Criteria for secure residential care are such that the SNAP panel (Special Needs Assessment Panel) is forced to approve treatment at Pinelands only for those adolescents boys who are under 18 and young enough to allow for 18 months to two years of treatment, as less time would be insufficient. Thus an 18 year old identified as a sex offender would be ineligible for treatment at the Pinelands despite his identified need. Further, even those juveniles treated at Pinelands, when discharged, face adjustment without adequate support. Housing, vocational needs as well as out patient treatment need to be in place to foster the young person's continued recovery, a life long process. Most importantly, funding sources need to be mindful of government's mandate to protect society. This function which is ignored if adequate aftercare planning as well as adequate out patient treatment facilities for those juvenile offenders not sent to Pinelands is unavailable.

As statistics indicate, 80% of adults incarcerated for sex offenses are survivors of sexual abuse. Therefore, it becomes a matter of great concern that juvenile offenders receive adequate treatment to reduce their risk of recidivism. Early intervention in this cycle may serve to interrupt the cycle of abuse as the "average" adult offender entering treatment has committed 380 offenses.

We are supporting the development of a comprehensive plan for juvenile offenders focused on continuity of care including:

- 1) An increased number of residential treatment beds.
- 2) Upon discharge from residential treatment juveniles aftercare should include out patient sex offender treatment including individual, group and family therapy as well as vocational, educational and housing components.

- 3) For those adolescents in need of residential treatment, though not requiring a secure setting, consideration needs to be given to the development of residential programs.
- 4) For those juveniles who can remain at home, out patient treatment in a day treatment setting with sufficient staff to provide comprehensive treatment (including individual sessions three times weekly, group treatment daily, family treatment weekly as well as education in life skills).
- 5) Early identification of juvenile offenders and prevention of the cycle of abuse through education.

We are interested in a response to our concerns in the form of adequate funding for the ideas presented; this would clearly entail an expansion of the existing TREAD program (and additional funding at the state level). Coalition members would be pleased to discuss these issues with you, and to work toward the realization of the goals. We look forward to your response.

Sincerely,

Jill Greenbaum, Ed.D, Chair
Bergen County Coalition Against Sexual Assault

JG/lp



BERGEN COUNTY RAPE CRISIS CENTER

Jill Greenbaum, Ed.D.
Program Director

Lydia Pizzute
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May 31, 1989

Good Morning,

I am writing to you as President of the New Jersey Coalition Against Sexual Assault, as a founding member of the Bergen County Coalition Against Sexual Assault, and as director of the Bergen County Rape Crisis Center.

I am compelled to write you regarding my professional and personal concerns surrounding the introduction of Caller ID service into New Jersey. There is no doubt in my mind that my staff and volunteers will be placed at personal risk by the widespread introduction of such a service. While I understand the benefits for emergency police, fire and medical services, I will outline major areas of concern to those involved in direct service to victims/survivors of sexual assault.

1) Callers into the Sexual Assault Care Centers throughout the state of New Jersey expect (through assumption and publicized descriptions of services) their confidentiality to be preserved in all respects. It is the work of rape crisis hotlines to respond to the stated needs of callers, and to respect and maintain privacy. Merely paying for advertisements which state our non-utilization of the Caller ID service will not convince the many individuals in need of complete confidentiality that we are in fact telling the truth.

2) Though the consumer Affairs Manager of Bell of Pennsylvania suggests several safeguards which might be employed by agencies requiring privacy, (see attached), the need for such safeguards and the questions as to whom should bear the costs obfuscate the true nature of the problem. The reality of working as a member of a rape crisis center entails the following: 1) returning calls at the convenience of the client (i.e., primarily after work hours/from one's own home); 2) knowing that in over half the cases reported to hotlines the victim/survivor knows her assailant, and that her assailant may live in her home and have access to the incoming telephone numbers; 3) realizing that we live in relatively small areas and that oftentimes we receive calls from our neighbors and acquaintances, who would not call if they knew the identity/town of origin of the hotline worker; 4) working with clients who may desire to speak with a worker at their discretion (i.e., at your home); 5) returning calls (picked up by answering services) to people assuming the guise of a victim and in reality being psychiatrically ill individuals and/or rapists.



United Way of Bergen County

49X

(While the "guise" might be discovered in time to contact the police, what if it isn't - and any rape crisis counselor becomes a victim of a sexual assault as the result of such a "service". Would NJ Bell be willing to risk the civil liability of such a case? What if it was discovered in criminal court that the rapist had utilized the NJ Bell Caller ID service to target rape crisis counselors? This particular scenario may appear farfetched, however I speak from professional/personal experience with a man who called into and received counseling at the Bergen County Rape Crisis Center. Through working with the Bergen and Passaic County Police Departments we discovered that the "client" possessed multiple personalities and was a drug addict who, in the words of his psychiatrist, "probably wouldn't hurt anyone". What if this man had had access to my home telephone number (and perhaps address)? Those of us working with survivors of sexual assault are committed to our work, but not at the expense of safety to ourselves and our families.

3) Members of the New Jersey Coalition Against Sexual Assault have not been approached for comment regarding the Caller ID service. All sexual assault care centers/hotline telephone numbers are well publicized, and it is surprising that NJ Bell did not contact NJCASA members. It was certainly clever of the Consumer Affairs Manager of Pennsylvania Bell to state, "...New Jersey Bell has received no formal complaints involving the use of Caller ID." NJ Bell has not adequately "educated" the public and private sectors regarding Caller ID. All those who will be affected by such a service should be informed and given sufficient time to respond to such a dramatic change in the nature of telephone service before a final decision is rendered.

The abovementioned is merely a brief response to the Caller ID service offered by NJ Bell. It is my hope that this correspondence will influence the Public Utility Commissioners to suspend the proposed Caller ID service until the issues raised by the Pennsylvania Office of the Attorney General, the Pennsylvania Coalition Against Domestic Violence, the Pennsylvania Coalition Against Rape and the New Jersey Coalition Against Sexual Assault have been satisfactorily answered.

Sincerely,

Jill Greenbaum, Ed.D.
President, New Jersey Coalition Against Sexual Assault

March 5th, 1989

To the Editor,

I am very pleased that those who make the decisions as to what is "newsworthy" have finally realized the import, depth and breadth of the issues which surround sexual assault, and/or had the conscience to break through personal and professional barriers to begin to address the subject. However, it concerns me that such pieces either briefly survey professionals within the field ("The Rape Laws Change Faster Than Perceptions", Feb. 19, 1989) or are relegated to the "Hers" column, ("Speaking of the Unspeakable", Feb. 26, 1989).

Ms. Sebold's column speaks with the power of a survivor sharing her experiences, and it is the perfect prologue to the in-depth examination of the various aspects of this problem, such as: 1) The factors influencing the commission of the crimes of sexual assaults, (legally defined much more broadly than the public's perception of "rape"); 2) Personal and societal (class, race and ethnic) reactions; 3) A delineation of the medical and psychological needs of survivors (from appropriate medical care and emotional support to an examination of the steps involved in the reporting and prosecution of the crime); 4) The possible socio-cultural factors influencing the the commission of the crime, nature and prevalence of the various acts labelled sexual assaults; 5) The differing age groups most affected by this violent crime; 6) The various psychological profiles/"types" of offenders; 7) The reasons for the silence of those who have been victimized; 8) The immediate and long term needs of survivors of sexual assault; 9) The feelings and concerns of those who care about survivors; 10) Rape care/support programs available to survivors; 11) The reasons underlying the inadequate funding of programs which seek to advocate for survivors.

Until an intense scrutiny is focused upon the myriad factors surrounding sexual assault, and their interrelationships, this work will be incomplete.

Sincerely,

Jill Greenbaum, Ed.D.
Director, Bergen County Rape Crisis Center
Founding Member, Bergen County Coalition Against Sexual Assault
President, New Jersey Coalition Against Sexual Assault

CENTER FOR BEHAVIOR THERAPY

4 STRATFORD PLACE

NEW BRUNSWICK, N.J. 08901

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MILTON L. KLEINMAN, PH.D.
DIRECTOR

MARSHA J. KLEINMAN, PSY.D.
LICENSED CLINICAL PSYCHOLOGIST

Good afternoon ladies and gentlemen. My name is Dr. Marsha Kleinman and I am a licensed practicing psychologist at the Center for Behavior Therapy in New Brunswick. Today, I am before you as a representative of the New Jersey Psychological Association to discuss the issue of domestic violence.

I am perhaps better equipped to talk about the problems that I encounter daily with battered women and the judicial system than to put forth solutions which the legislature can act on; however, I hope today to translate my experiences and concerns with battered women and the judicial process, into suggestions which will enable you to bring about needed changes in our laws.

Although there are laws on the books to protect battered women and I believe all would agree there are battered women in society in need of protection, there seems to be a serious problem that the courts have in identifying a particular women who fits that assessment. The public at large, mental health professionals, and Judges, still hold some myths about battered women and believe they would be able to identify both them and their abusers by sight. Nothing could be further from the truth. Battered women and their abusers present in different ways than one might expect and without knowledge and expertise in the area in their assessment, many go unrecognized.

The issues that I will raise are sometimes subtle and may be difficult to legislate; however, I believe it is imperative that we try. Further, it may be necessary to put women attorneys on the bench who themselves have been formerly battered women. The issue is so important that before our judges are selected, perhaps they need to be screened by a committee of experts in this particular area. Battered women need to be recognized as a special subgroup who come before Judges. Their concerns and those of their children are that serious.

Some of the problems with battered women and their presentation before Judges is that they often change attorneys many times during the course of a matrimonial or custody action. Judges view their having changed attorneys as reflecting something wrong with these women. The true is that this behavior more accurately reflects the difficulty battered women have in finding good and appropriate advocates and having the resources to pay for them.

The nature of abuse, the fear instilled by an abusive partner into his female victim, will often inhibit a battered woman from taking the appropriate legal steps necessary which will identify her to the courts as a battered women. She may get a temporary restraining order but then not follow through with a permanent order. She may behave in ways which appear contradictory such as getting a temporary restraining order and then allowing her abuser back in the home. She may allow an abusive husband to share custody, making the decision while she was still in danger and then, away from him and able to reflect clearly,

realize that her children are in danger and go back into court to change custody. This behavior on her part is viewed as being "vindictive" and as wanting "retribution". These behaviors which appear contradictory create confusion in the minds of the Judges and in my experience tend to reflect badly on the battered women when judicial decisions are made. All of these behaviors and others equally aberrant and strange make her appear to be a "flake." Thus, she is doubly victimized.

Another problem often seen is that women coming out of relationships in which there was psychological abuse and perhaps intimidation without serious physical battering, often have not yet labelled themselves as "battered women" although they are every bit as battered as another women who ends up in the emergency room. Therefore, no agreements should be made until they have been referred for treatment. Attorneys often do not put forth the battering and do not utilize this information in court papers, thereby not giving the court the benefit of all of the information or the client the benefit of the court's consideration of her as a battered women. When the issue of custody or visitation arises, and the attorney first presents it, or when the women changes to another attorney who understands that and takes it seriously, this information is viewed suspiciously by the courts. I could go on and on.

Perhaps changes in our laws will address some of the issues that I have raised.

1. There should be a presumption that when a woman has obtained a temporary restraining order at some time during a relationship, even if she does not follow through with a permanent restraining order, that there is reason to believe she was in danger and that perhaps she will be in more danger if she attends a hearing for a permanent restraining order. She should thus not be penalized for not having obtained a permanent order although it has to be recognized that no findings of abuse have been made. Perhaps women need something like the witness protection program to encourage them to come forward without fear.

2. The law should reflect that any women who alleges to have been abused in any way should be counseled by an expert in battered women before a judge accepts any matrimonial or custodial agreement. This would prevent women who go along out of fear from reprisal from an abusive mate from making any agreements while they believe they are in danger. It further gives battered women time to get themselves psychologically together so they can make reasoned and educated decisions.

3. The law should acknowledge that the psychological state battered women are in immediately coming out of an emotionally or physically abusive relationship reflects the effects of the battering and does not necessarily indicate her general overall functioning or ability to care for herself and her children. In fact, often her emotional state reflects the effects of the continued abuse and harassment and the frustration of not being able to effectively influence the court to understand her experi-

ence as a battered woman or to protect her and her children.

4. Although the law states that there should be a presumption that where there has been abuse the children should reside with the nonabusive parent, that is not enough. Joint custody should never be granted where there is the possibility that there has been abuse. Further divorce mediation should not be allowed where there has been psychological and/or physical abuse. Mediation is only appropriate in an equal relationship and since marital relationships are rarely equal since one partner generally controls the lions share of money, mediation is often not appropriate. Our laws should reflect that men who are abusers generally fight for custody as a way to continue to exert their control and dominance over their mates rather than out of the normal parental feelings of love and concern. The law should reflect certain personality characteristics of batterers so that they will more likely be recognized by Judges even when they come into court wearing a three-piece suit. For example, it should be acknowledged that abusers tend to defy court orders, twist the facts to be in their favor, not pay child support (although they want custody and allegedly care for their children), make visitation difficult yet attempt to blame their spouse for the difficulties; lie, etc. Perhaps a psychological profile placed in the legislative findings would be helpful.

5. The law should reflect that battered women are most likely to be abused or even killed after having left their batterers. This is the most dangerous time and it is this threat

which keeps women in abusive relationships long after they want to go. He often also threatens that he will take custody of the children, a threat which he is often able to implement. The courts may need to recognize that families of abuse victims are often themselves threatened and in danger and they need to be protected as well. While judges often believe that battering is part of a matrimonial and once over, ceases, the facts and FBI statistics indicate otherwise; that is, that 75% of all battered women are in the greatest danger when they leave the relationship. Therefore, custody actions, continued harassment, however subtle, nonpayment of support, all represent continued harassment and abuse of a battered women and need to be viewed and understood in this context.

6. Judges need to recognize that abuse can lead to death for a battered women and often does. Battered women therefore need to have their fears and concerns taken seriously by the police and by Judges. A judge should not be able to use any discretion if there is a finding of abuse, such as saying that the man has a problem with alcohol, etc. and that the abuse is therefore related to alcohol.

7. Judges should be required to view abuse as though there was an assault on one person to another as though they were strangers. This would give a clear message that women do not provoke a person to violence: nonviolent men will not be provoked. Battered women are victims no different than the victim of a car theft, house robbery, etc. Therefore, once the marriage

is dissolved, the Judge needs to understand that particular abusive man is still a violent individual and his children are at risk for being abused. It should be mandatory that Judges obtain a full documentation, work, school, and police records, speeding tickets, mental health history, etc. before disposing of custody cases. Judges should be required to view the abuse as part of the man's character and not in the context of a couple who cannot get along.

8. The legislature needs to recognize that men who abuse their wives often sexually abuse daughters and psychologically and/or physically abuse their sons. This is the usual circumstances. Therefore, women claiming their abusive husbands have been sexually inappropriate with their daughter need to be taken seriously and again, not viewed as suspect because there is an ongoing custody dispute. Judges need to know that women leave husbands because of this behavior not the other way around. Further, judges again need to know something about the profile of someone who would sexually abuse a child and abuse a wife. They need to know that this is commonplace not rare and that men who abuse come from all walks of life, are even doctors, lawyers, teachers, legislators, etc.

9. Judges should not have discretion in custody decisions where there is a suspicion of abuse. Men who abuse and do so in front of their children obtain control and dominance over their children through the threat of harm and through observing their violent outbursts. Therefore, it is enough just to see a parent

be violent to gain control and dominance. In these situations fathers should be given supervised visitation and not in the home or in the presence of any member of his family. Judges should be directed to grant supervised visitation only where there has been abuse.

10. The legislature needs to establish a fund for battered women who are in matrimonial and custody matters. Justice is not served for these women and their children because rarely can they afford the expense to litigate effectively have the resources to get adequate legal counseling. This is critical.

11. Judges should have the benefit of an expert consultant to the bench to help them assess cases in which there are allegations of violence.

12. All qualified experts not just those appointed by the courts should be granted full respect by the Judge in his decision making. Although they are granted equal weight to a court-appointed expert, they should be viewed as "experts" if their credentialing warrants that respect and not referred to by the Judges as "hired guns". A debacle similar to what happened in Ocean County with a court appointed psychologist who subsequently lost his license and where battered women lost their children should be avoided at all costs.

13. No one should be considered an expert in a custody case where there have been allegations of abuse who does not recognize the battered women's syndrome since it is recognized and accepted in the courts in New Jersey.

14. The system by which experts are chosen and appointed by the courts need to be looked into carefully. Many times experts reflect what the Judges want to hear. Perhaps custody decisions need to be taken away from Judges unless there are very specially trained Judges to undertake this weighty responsibility.

15. Longitudinal studies need to be undertaken immediately following up on custody decisions that have been made where allegations of abuse were made and where the Judge has dismissed these allegations. This information is crucial in order to train and educate Judges about their mistakes in the area of domestic violence. Currently Judges make no connection in their findings between abuse against a woman and abuse against their children despite the legislative findings which state otherwise. Somehow Judges need to be ordered to accept this correlation.

I wish you luck as you continue to refine the laws that protect our women and children.

Thank you.

**Testimony to the NJ Commission on Sex Discrimination
in the Statutes; Violence Against Women Public Hearing**

Submitted by:

The New Jersey Coalition for Battered Women

March 20, 1992

SUMMARY OF RECOMMENDATIONS

The Prevention of Domestic Violence Act

- Oppose any legislative attempt to dilute the new provisions of the Act.
- Support an increase in the Family Court and Law Enforcement appropriation for the purpose of implementing the Act.
- Study the feasibility of extending the Act's protection and relief to victims who have never resided with, have a child in common with, or are married to, the perpetrator.
- When further amendments to the Act are considered, support legislation to:
 1. Prohibit mediation in any court case where domestic violence is involved;
 2. Prohibit the issuance of mutual restraining orders unless both parties are found to have committed an act of domestic violence;
 3. Prohibit the issuance of restraining orders without a finding of domestic violence;
 4. Include stalking as a domestic violence crime.

Interference with Custody Law

- Support amendments to the law which:
 1. Define and distinguish between interference with custody and interference with visitation;
 2. Strengthen the affirmative defense for parents who flee an abusive situation by establishing abuse as the sole affirmative defense requirement.

Domestic Violence Resource Center Legislation

- When introduced, support the creation of the Domestic Violence Resource Center pilot project legislation.

Funding for Battered Women's Services

- Support an increase in the state appropriation for battered women's services.
- Support and prioritize passage of S-522, which would increase the domestic violence surcharge of the marriage license fee.

Federal Violence Against Women Act

- Reintroduce and prioritize a NJ Resolution urging Congress to pass the Act.

Introduction

The New Jersey Coalition for Battered Women is a non-profit, statewide organization whose membership consists of all the non-governmental battered women's programs in New Jersey. The Coalition advocates for battered women and their children with the Legislature, the Judiciary, the Governor's Office and every governmental Department and Agency whose work and policies impact battered women. Additionally, the Coalition serves to provide coordination of all the domestic violence services in New Jersey and provides technical assistance, information, resources, and training to battered women's programs as well as numerous other governmental and private organizations and individuals. The Coalition also works with national advocacy groups and other state coalitions to advocate for Federal legislation and policies which serve to discourage domestic violence and improve the governmental, social service and private sector response to persons who are battered.

Founded in 1977 the Coalition's mission is to end violence in the lives of women. Its primary goal is to end domestic violence in the lives of women and children.

While recognizing that the many forms of violence against women share the same origin, overlap in the lives of women and serve to maintain and perpetuate each and every other form of violence, domestic violence has the distinction of being the most prevalent and insidious form of violence against women. Moreover, it is probably the single most prevalent social problem posing such a high risk to the physical and emotional well-being of residents of this state. It is estimated that one out of two adult women will be physically abused by a partner at some point in their lifetime and one in five suffer chronic and severe abuse. ¹ Bearing in mind that most domestic violence is not reported, in 1990 police responded to 50,823 domestic violence calls. In 85% of these cases the victim was a woman.² In the 1989-1990 court year 35,166 individuals signed civil domestic violence complaints, 87% of whom were women.³ In 1991 battered women's services sheltered 4,317 women and children, provided in-person counseling and advocacy to an additional 13,561 women, provided violence intervention services to 1,240 batterers and responded to 91,408 hot-line calls. ⁴

The Prevention of Domestic Violence Act

As you know, last year the NJ Legislature passed a revised and improved version of the Prevention of Domestic Violence Act (P.L. 1991, Chap. 261). The Coalition concurs with those who consider the Act the strongest, most comprehensive domestic violence law in the country. For this, New Jersey can be very proud. Essentially, the new law does not so much change the original law as it adds new provisions to the Act designed to address those response areas which were failing to provide the maximum protection and relief available to victims. Consequently, the revised law is demanding more from those of us whose work involves the protection of victims. Since no appropriation was attached to the law, there are no additional resources to assist with the implementation of the new provisions.

Obviously, this is not an ideal scenario. Already, only four months into the new law, we are hearing discontent about the situation. Probably the most important concern the Coalition wants to express to the Commission regarding the Act, is our concern that the Legislature might consider diluting the law, and thereby compromising protection to victims, due to a premature assessment of the situation and/or an unwillingness to provide the necessary resources.

First, we would like to point out that the original Act was also passed without an appropriation and posed a strain on the system of a far greater magnitude than the revised Act. It took some time, but eventually the new law was learned and incorporated into the system with as much efficiency as possible. In many cases resources were found to meet the challenge the law posed. Much of what some courts and police are experiencing today will settle with time. To assess the situation at this early stage is far too premature.

Second, we would point out that passage of the new Act coincided with the issuance by the Supreme Court and the Attorney General's Office of the Domestic Violence Procedures Manual. The Manual is an excellent document which reflects a commitment to the proper implementation of both the old and new provisions of the law. It also is an attempt to achieve uniformity of implementation across the state. There is no question that the Procedures Manual entails some additional work for some counties and is doubtless the source of some of the current discontent. However, diluting the new provisions of the law will not serve to significantly reduce the impact of the standards set by the Manual.

Finally, we stress that domestic violence is far too important an issue to deny additional resources needed to both protect victims and prevent the incidence of this violence. The Coalition urges the Commission to oppose any legislative effort to dilute the Act and support efforts to increase resources for implementing the law.

Although the Coalition thinks it best to refrain from any further amendments to the Prevention of Domestic Violence Act at this time, I have been asked to address areas which might have been overlooked when the revised law was drafted, or new issues which have developed since that time.

The Coalition would be more comfortable if the Act prohibited the use of mediation in any court action where the mediation would include a batterer and person subjected to violence by that batterer, including custody and visitation cases. Although the Supreme Court has done a fine job in prohibiting mediation of domestic violence cases, there is currently a potential recommendation to the Court that mediation be used and indeed encouraged in custody and visitation disputes, including cases where domestic violence, child abuse and child sexual abuse are involved. Because the Coalition believes that mediation is both inappropriate and ineffective in these cases, and quite unfair to the victim(s), we would be more comfortable if the Legislature prohibited this practice once and for all. Likewise, we would prefer the law prohibited the issuance of mutual restraining orders (where both plaintiff and defendant are restrained from one another) unless both parties are found to have committed an act of domestic violence. In this same vein, restraining orders should

never be issued without a finding of domestic violence. Again, the Supreme Court has issued very recent directives which address these issues. Nevertheless, due to the recent popularity of mutual restraints in some courts, we would prefer they be prohibited by law.

Although the new provisions of the Act extend protection to same-sex victims who have resided with the abuser, the law continues to fail to provide protection to victims who have never resided with the perpetrator (unless the parties are married or have a child in common). Consequently, very real victims who have dating relationships with the perpetrator cannot utilize the 24 hour, civil protection afforded by the Act. This was not an oversight by those drafting the legislation, rather it was an inability to find a definition of this relationship which could be easily interpreted and verified. The legitimate concern was that the law would inadvertently cover all adult relationships. However, this is an area that could use some reconsideration due to the number of adult victims it involves and we encourage the Commission to study it further. Likewise, teen dating violence is not addressed by the law, not only because dating violence is not included, but also because parties under 18 are not covered under the Act. Teen violence is an issue which will be addressed by another presenter, but the Coalition emphasizes that it is an area which needs serious consideration and possible legislation.

Regarding new developments, the Coalition is pleased that the Legislature is considering the creation of a new crime, that of "stalking". Senate Bill 256/Assembly Bill 807 would make it a crime of the fourth degree if a person purposely and repeatedly follows or harasses another person and makes a credible threat intended to place that person in reasonable fear of death or serious bodily harm. (See Attachment A) Generally, this bill addresses a form of violence directed primarily towards women. More specifically, this persistent following, harassing and threatening behavior is a type of domestic violence very commonly employed following separation of the parties. Despite the terror such behavior can cause to a victim, this crime is generally relegated to a harassment charge, which is a petty disorderly persons offense. Furthermore, if harassment accompanies a violation of a restraining order, the contempt charge is a disorderly persons offense as opposed to a fourth degree crime. The Coalition urges the Commission to support the stalking bill and later to support the inclusion of stalking as a crime which constitutes domestic violence.

Interference with Custody

In November of 1990 amendments to N.J.S. 2C:13-4, the interference with custody law, became effective (P.L. 1990, Chap. 104). (See Attachment B) The amendments increase the penalty for interference with custody from a fourth to a third degree crime and, if the child is taken from the country, to a second degree crime. Although increasing the severity of this crime is appropriate, the Coalition has two major problems with the current language and provisions of the law.

The first problem is that the new amendments equate interference with custody to interference with visitation. Consequently, one battered woman we are aware of

was arrested and jailed for 10 weeks because she agreed to change a visitation date at the request of the non-custodial parent. He subsequently charged interference with custody. Because she could not make the \$10,000 bail, she subsequently lost her job and home and had to fight to regain custody of the children.

Visitation schedules are frequently altered for any number of reasons. Unless there is a persistent pattern of refusal to allow the other parent visitation, there should be no possibility that a person could be charged with a third degree crime. This is particularly problematic for battered women where charges signed against them for interference with visitation can literally constitute one more act of domestic violence. The Coalition therefore recommends that this law be amended to define and distinguish between interference with custody and interference with visitation, and to exclude the possibility that one missed visit could constitute a crime.

The second problem the Coalition has with this law is that it does not provide an adequate defense for persons who are fleeing the other parent to avoid danger to themselves and/or the children. Although the law does include an affirmative defense to charges in these situations, the defense is contingent upon notifying a specified agency or initiating a custody action. The problem with these contingencies is that the average person in crisis will not be aware of them. If a person is trying to protect oneself and/or one's children, and feels forced to flee and hide, they will most likely have a healthy reluctance to notify the authorities. Unless a battered woman has consulted with a knowledgeable attorney, or flees to a battered women's shelter in NJ, she will very possibly fail to fulfill the requirements of the affirmative defense. Attempts to charge battered women who are fleeing from abuse do occur. We are aware of several such incidents.

The Coalition recommends that the affirmative defense to a charge of interference with custody rests solely on the basis of the abuse. This will work towards protecting hundreds of battered women in NJ who have justifiably sought to protect themselves from a violent person.

Child Sexual Abuse and Protective Parents

I will briefly mention the Coalition's concerns regarding the handling of child sexual abuse allegations made within the context of civil divorce, dissolution, custody or visitation cases. We are aware of dozens of cases whereby a parent making such allegations placed themselves in jeopardy of losing custody and/or unsupervised visitation, or actually lost custody, due to a perception that they were making intentionally false allegations. The cases of which we are aware generally involve domestic violence. It is estimated that one out of three girls, and one out of seven boys will be sexually abused, most often by an adult they know, before they reach the age of 18. 5 The Coalition believes there is a great deal of work to be done in the area of child sexual abuse in order to protect molested children as well as the parents who try to protect them. Joan Pennington, Esq. will be testifying extensively on this issue at this hearing.

Domestic Violence Resource Centers

The Coalition also urges the Commission to support the Domestic Violence Resource Center (DVRC) legislation when it is introduced. (See Attachment C) This legislation would create three pilot county Resource Centers which would be responsible for assessing court-referred persons found to have committed an act of domestic violence. The Centers would assess the nature and severity of the violence and screen for substance abuse, mental health problems and other factors which act to exacerbate the violence. The Centers would submit to the court recommendations regarding an individualized intervention plan. If a person is court-ordered to participate in the plan, the Centers would be responsible for monitoring attendance and submitting progress reports to the court. Center staff would also reach out to victims to insure that they are aware of available services. The legislation includes a \$750,000 appropriation for start-up costs.

The DVRC concept and legislation was developed jointly by representatives of the Coalition for Battered Women, the Network for the Treatment of Spouse Abusers and the Division of Alcoholism, Drug Abuse and Addiction Services. The Coalition has some concerns regarding the actual effectiveness of intervention for reducing violent and abusive behavior, and concerns regarding whether or not DVRC's can be self-sufficient and not become a drain on scarce domestic violence resources. However, the Coalition supports the creation of a DVRC pilot project as well as innovative techniques for reducing violence among individuals. A final step to be completed prior to introduction of this legislation is the identification and cooperation of an appropriate governmental agency to oversee the project.

Funding of Battered Women's Services

Based on a Needs Assessment recently conducted by the Coalition, \$15 million per year is required to support a minimum standard of domestic violence priority services in each of New Jersey's 21 counties. The current level of federal and state funding is \$6.6 million. Federal grant programs, some of which are not recurring, currently contribute \$4 million. The state currently contributes \$2.6 million, or 17% of the total required costs.

Although battered women's programs have proved quite creative in securing significant funding from the private sector, private grants are typically not recurring, stable sources of funding. This situation results in a chronic state of financial instability for most programs and necessitates the use of limited resources for constant fund-raising efforts.

There has been no increase in the state appropriation for expansion of domestic violence services since 1986. Additionally, battered women's programs can no longer depend on receiving an annual cost of living increase in their state funding.

Obviously, the Coalition would like to see an increase in New Jersey's financial commitment to domestic violence services. However, while a \$500,000 increase was requested by DYFS, it was cut from the final budget for FY 1993 presented to the legislature.

We have, however, proposed a partial solution to the funding problem through legislation which would increase the domestic violence surcharge of the marriage license fee from \$5 to \$25. (See Attachment D) This increase would set the cost of a marriage license at \$28. This is a more than reasonable cost for a license and well within the typical range across states. Of the 25 states which have attached domestic violence surcharges to the license, surcharges range from \$5 to \$33, with an average surcharge of \$16. New Jersey has the lowest surcharge at \$5. Only two other states have single digit surcharges, Nevada and Rhode Island, at \$7 and \$8, respectively.

The proposed increase would generate an additional \$1.2 million, nearly 50% of the current state appropriation.

We know that the Commission supports this legislation, currently Senate Bill 522 sponsored by Senator James Cafiero. The Coalition urges not only your continued support, but also the Commission's assistance with making S-522 a priority bill in 1992.

Violence Against Women Act

As you know, Senator Joseph Biden (DE) and House Representative Barbara Boxer (CA) are sponsoring the Violence Against Women Act in their respective Houses of Congress. Not only does this legislation bring unprecedented national attention to issue of Violence Against Women, if passed, it would commit significant levels of new funding for reducing the incidence of violence and providing protection and services to victims of domestic violence, sexual assault and sexual harassment.

Senate Bill 15 is currently awaiting a vote by the U.S. Senate having passed in the Senate Judiciary Committee last year. House of Representatives Bill 1502 is just beginning its arduous journey through five House Committees.

Congress needs to hear from New Jersey that we want the Act passed. Currently one of two NJ Senators is co-sponsoring the Senate version and six of 14 NJ Representatives are co-sponsoring the House version. We need to tell our remaining Congress persons that we want them to co-sponsor the Act, and prioritize its passage.

Last year Senator Lipman introduced a NJ Senate Resolution urging Congress to pass this legislation. The Coalition requests Senator Lipman to reintroduce this resolution, and requests the Commission to support its speedy passage.

References

1. Straus, M.A., Gelles, R.J. and Steinmetz, S.K. Behind Closed Doors: Violence in the American Family. New York, Doubleday, 1980.
2. 1990 Domestic Violence Report. State of New Jersey, Division of State Police, Uniform Crime Reporting Unit.
3. Report on the Prevention of Domestic Violence Act: July 1, 1989-June 30, 1990. NJ Administrative Office of the Courts.
4. 1991 Statewide Domestic Violence Program Statistics. NJ Coalition for Battered Women.
5. Los Angeles Times Phone Survey, 1985. (A nationally representative sample of 2,627 men and women were polled in this survey.)

AN ACT creating the crime of stalking and supplementing Title 2C of the New Jersey Statutes.

BE IT ENACTED by the Senate and General Assembly of the State of New Jersey:

1.a. As used in this act:

(1) "Course of conduct" means a pattern of conduct composed of a series of acts over a period of time, however short, evidencing a continuity of purpose. Constitutionally protected activity is not included within the meaning of "course of conduct."

(2) "Credible threat" means a threat made with the intent and the apparent ability to carry out the threat, so as to cause the person who is the target of the threat to reasonably fear for the person's safety.

(3) "Harasses" means a knowing and wilful course of conduct directed at a specific person which seriously alarms, annoys or harasses the person, and which serves no legitimate purpose. The course of conduct must be such as would cause a reasonable person to suffer substantial emotional distress, and must actually cause substantial emotional distress to the person.

b. A person is guilty of stalking, a crime of the fourth degree, if he purposely and repeatedly follows or harasses another person and makes a credible threat with the intent to place that person in reasonable fear of death or serious bodily injury.

c. A person is guilty of a crime of the third degree if he commits the crime of stalking in violation of an existing court order prohibiting the behavior.

d. A person who commits a second or subsequent offense of stalking which involves an act of violence or a credible threat of violence against the same victim is guilty of a crime of the third degree.

e. This act shall not apply to conduct which occurs during labor picketing.

2. This act shall take effect immediately.

STATEMENT

This bill would make "stalking" a crime. The bill is intended to protect victims who are repeatedly followed and threatened.

The bill is modeled on a California statute enacted in September, 1990. The bill provides that a person is guilty of stalking if he purposely and repeatedly follows or harasses another person and makes a credible threat with the intent to place that person in reasonable fear of death or serious bodily injury. Stalking would be a crime of the fourth degree. A crime of the fourth degree is punishable by a term of

imprisonment of up to 18 months, or a fine of up to \$7,500, or both.

If the defendant commits the crime of stalking in violation of an existing court order prohibiting the behavior, he is guilty of a crime of the third degree (punishable by a term of imprisonment of three to five years, or a fine of up to \$7,500, or both).

A second or subsequent offense of stalking which involves an act of violence or a credible threat of violence against the same victim is also a crime of the third degree.

The bill would not apply to conduct which occurs during labor picketing.

Makes "stalking" a crime.

CHAPTER 104
APPROVED 1/14/90

(FIRST REPRINT)
ASSEMBLY, No. 2847

STATE OF NEW JERSEY

INTRODUCED JANUARY 16, 1990

By Assemblywoman FORD and Assemblyman DOYLE

1 AN ACT concerning interference with custody, amending
2 N.J.S.2C:13-4 and supplementing Title 2A of the New Jersey
3 Statutes.

4
5 BE IT ENACTED by the Senate and General Assembly of the
6 State of New Jersey:

7 1. N.J.S.2C:13-4 is amended to read as follows:
8 2C:13-4. Interference with custody. a. Custody of children.
9 [A person commits an offense if he knowingly takes or entices
10 any child under the age of 18 from the custody of the parent,
11 guardian or other lawful custodian of the child, when he has no
12 privilege to do so, or he does so in violation of a court order. It is
13 an affirmative defense that:

14 (1) The actor believed that his action was necessary to
15 preserve the child from danger to his welfare; or

16 (2) The child, being at the time not less than 14 years old, was
17 taken away at his own volition and without purpose to commit a
18 criminal offense with or against the child.

19 Proof that the child was below the critical age gives rise to a
20 presumption that the actor knew the child's age.

21 Interference with custody is a crime of the fourth degree.] A
22 person, including a parent, guardian or other lawful custodian, is
23 guilty of interference with custody if he:

24 (1) Takes or detains a minor child with the purpose of
25 concealing the minor child and thereby depriving the child's
26 other parent of custody or visitation of the minor child; or

27 (2) After being served with process or having actual knowledge
28 of an action affecting marriage or custody but prior to the
29 issuance of a temporary or final order determining custody and
30 visitation rights to a minor child, takes, detains, entices or
31 conceals the child within or outside the State for the purpose of
32 depriving the child's other parent of custody or visitation, or to
33 evade the jurisdiction of the courts of this State;

34 (3) After being served with process or having actual knowledge
35 of an action affecting the protective services needs of a child
36 pursuant to Title 9 of the Revised Statutes in an action affecting
37 custody, but prior to the issuance of a temporary or final order
38 determining custody rights of a minor child, takes, detains,
39 entices or conceals the child within or outside the State for the

EXPLANATION—Matter enclosed in bold-faced brackets [thus] in the
above bill is not enacted and is intended to be omitted in the law.

Matter underlined thus is new matter.
Matter enclosed in superscript numerals has been adopted as follows:
Assembly AJL committee amendments adopted April 23, 1990.

1 purpose of evading the ¹(jurisdiction) jurisdiction¹ of the courts
2 of this State; or

3 (4) After the issuance of a temporary or final order specifying
4 custody, visitation or joint custody rights, takes, detains, entices
5 or conceals a minor child from the other parent in violation of
6 the custody or visitation order.

7 Interference with custody is a crime of the third degree ¹but
8 the presumption of non-imprisonment set forth in subsection e. of
9 N.J.S.2C:44-1 for a first offense of a crime of the third degree
10 shall not apply. However, if the child is taken, detained, enticed
11 or concealed outside the United States, interference with custody
12 is a crime of the second degree¹.

13 b. Custody of committed persons. A person is guilty of a
14 crime of the fourth degree if he knowingly takes or entices any
15 committed person away from lawful custody when he is not
16 privileged to do so. "Committed person" means, in addition to
17 anyone committed under judicial warrant, any orphan, neglected
18 or delinquent child, mentally defective or insane person, or other
19 dependent or incompetent person entrusted to another's custody
20 by or through a recognized social agency or otherwise by
21 authority of law.

22 c. It is an affirmative defense to a prosecution under
23 subsection a. of this section, which must be proved by clear and
24 convincing evidence, that:

25 (1) The actor reasonably believed that the action was
26 necessary to preserve the child from imminent danger to his
27 welfare. However, no defense shall be available pursuant to this
28 subsection if the actor does not, as soon as reasonably practicable
29 ¹but in no event more than 24 hours¹ after taking a child under
30 his protection, give notice of the child's location to the police
31 department of the municipality where the child resided, the
32 office of the county prosecutor in the county where the child
33 resided, or the Division of Youth and Family Services in the
34 Department of Human Services;

35 (2) The actor reasonably believed that the taking or detaining
36 of the minor child was consented to by the other parent, or by an
37 authorized State agency; or

38 (3) The child, being at the time of the taking or concealment
39 not less than 14 years old, was taken away at his own volition and
40 without purpose to commit a criminal offense with or against the
41 child.

42 d. It is an affirmative defense to a prosecution under
43 subsection a. of this section that a parent having the right of
44 custody reasonably believed he was fleeing from imminent
45 physical danger from the other parent, provided that the parent
46 having custody, as soon as reasonably practicable:

47 (1) Gives notice of the child's location to the police
48 department of the municipality where the child resided, the
49 office of the county prosecutor in the county where the child

1 resided, or the Division of Youth and Family Services¹ in the
 2 Department of Human Services¹; or

3 (2) Commences an action affecting custody in an appropriate
 4 court.

5 e. The offenses enumerated in this section are continuous in
 6 nature and continue for so long as the child is concealed or
 7 detained.

8 f. (1) In addition to any other disposition provided by law, a
 9 person convicted under subsection a. of this section shall make
 10 restitution of all reasonable expenses and costs, including
 11 reasonable counsel fees, incurred by the other parent in securing
 12 the child's return.

13 (2) In imposing sentence under subsection a. of this section the
 14 court shall consider, in addition to the factors enumerated in
 15 chapter 44 of Title 2C of the New Jersey Statutes:

16 (a) Whether the person returned the child voluntarily; and

17 (b) The length of time the child was concealed or detained.

18 g. As used in this section, "Parent" means a parent, guardian
 19 or other lawful custodian of a minor child.

20 (cf: P.L.1982, c.199, s.1)

21 2. (New section) After the issuance of any temporary or
 22 permanent order determining custody or visitation of a minor
 23 child, a law enforcement officer having reasonable cause to
 24 believe that a person is likely to flee the State with the child or
 25 otherwise by flight or concealment evade the jurisdiction of the
 26 courts of this State may take a child into protective custody and
 27 return the child to the parent having lawful custody, or to a court
 28 in which a custody hearing concerning the child is pending.

29 3. (New section) Every order of a court involving custody or
 30 visitation shall include a written notice, in both English and
 31 Spanish, advising the persons affected as to the penalties
 32 provided in N.J.S.2C:13-4 for violating that order.

33 4. This act shall take effect immediately.

34
 35
 36 CRIMINAL JUSTICE

37
 38 Revises the law concerning the criminal offense of interfering
 39 with custody of a minor child.

AN ACT concerning the establishment of Domestic Violence Resource Centers and providing for professional evaluations of domestic violence offenders; and making an appropriation.

BE IT ENACTED by the Senate and the General Assembly of the State of New Jersey:

1. This act shall be known and may be cited as the "Domestic Violence Resource Center" Act.

2. The Legislature hereby finds and declares that the solution to the complex problem of domestic violence requires a variety of legal and social interventions and that insufficient state resources have been allocated for the evaluation and rehabilitation of batterers. The Legislature finds that programs specifically designed to assist perpetrators of domestic violence can be effective if they have a clear goal of ending violent behavior, and if the rehabilitation includes indicated alcohol, drug and mental health treatment. The Legislature further finds that persons who batter rarely cease their abusive behavior or seek professional help without the imposition of court sanctions and professional intervention, and that there currently exists no comprehensive system for addressing this problem.

3. As used in this Act:

a. "Domestic Violence Resource Center" means a county based program responsible for the assessment, screening, evaluation, education and referral of court-ordered persons who have committed acts of domestic violence; for the monitoring of attendance of those persons court ordered to participate in a recommended intervention plan; and for participation in the coordination of victim outreach services.

b. "Division" means the Division on Women, the Department of Community Affairs.

c. "Domestic Violence Specialist" means a person who has fulfilled the requirements for certification established by the New Jersey Domestic Violence Certification Board.

d. A "designated domestic violence agency" is a county-wide organization whose primary purpose is to provide services to victims of domestic violence, who provides services that conform to the core domestic violence services profile as defined by the Division of Youth and Family Services and who is currently under contract with the Division of Youth and Family Services for the expressed purpose of providing such services.

e. "Intervention Plan" means an individualized program of educational, counseling and/or treatment services recommended by a Domestic Violence Resource Center for the purpose of ending violent behavior and addressing other problems which exacerbate such behavior.

f. "Violence Intervention Program" means services specially designed to assist persons in ending violent and other abusive behaviors.

g. "Referral Agency" means any agency or person who provides domestic violence services, alcohol and drug abuse services, mental health services or any other services recommended by the Domestic Violence Resource Center and who has entered into an affiliation agreement with the Domestic Violence Resource Center or is employed by an entity which has entered into such an agreement.

4. The Division of Youth and Family Services, the Department of Human services shall specify the designated domestic violence agency or agencies in each of the 21 counties.

5.a. There shall be established, as prescribed by this Act, three county-wide Domestic Violence Resource Centers on

a 18 month pilot project basis. These Centers shall be accessible to the physically disabled. The staff of each Center shall include but not be limited to one Director, who is a domestic violence specialist, one staff person who is a domestic violence specialist; one staff person certified in alcoholism or in alcoholism and other drugs of abuse; and one clerical person. These staff positions may be full or part time depending on available resources and the projected program demands of the county. The Centers may contract with outside professionals if mental health or other assessment is required. The Centers shall offer to the Family and Municipal Courts a prescribed program which shall include

- 1) assessment of the history of domestic violence;
- 2) screening for alcohol and substance abuse, mental health and other related problems;
- 3) a written evaluation which shall include recommendations for an individualized intervention plan with a primary focus of ending violent behavior and which shall include referral to appropriate agencies;
- 4) an educational component stressing the criminal nature of domestic violence and the legal, social and personal consequences of violent behavior.

The center shall provide the referring court with a written evaluation within 10 working days of the date of the initial appointment with the offender. Nothing in this subsection shall bar the centers from accepting persons into the program who voluntarily request evaluation and referral.

b. Upon failure of a court-ordered person to make initial contact with the Center within the time period specified by the court, the Center shall notify the person by certified mail of an initial appointment date and time and provide a warning that failure to appear will constitute non-compliance. Upon further non-compliance the Domestic Violence Resource Center will notify the court and request

that a hearing be scheduled for non-compliance.

c. An evaluation fee of \$200 shall be payable to the Domestic Violence Resource Center by each person entering into the DVRC program to support the functions of the Center, except that no person shall be excluded from the program due to inability to pay. The Center may waive part or all of the fee based on the person's ability to pay.

d. The Centers shall establish agreements with relevant community educational, counseling, treatment and rehabilitation resources qualified to serve as referral agencies. The Centers shall ensure that each referral agency provides and maintains appropriate and quality services. Standards for selected violence intervention programs shall be specified by the Division and shall include but not be limited to the following: 1) a clear intervention goal to eliminate violent behavior; 2) a close cooperative relationship with victim services and victims; 3) a required program duration of not less than six months and not less than 26 sessions; 4) an emphasis on transforming basic control and domination behavior; 5) the provision of a sliding-scale fee; 6) service staff who have undergone specific training in the field of domestic violence.

Nothing in this subsection shall bar the centers from developing and utilizing their own violence intervention programs provided they conform to the Standards set forth herein and are approved by the Division.

e. In cooperation with the referral agencies, the Center shall be responsible for monitoring attendance of all persons ordered to participate in the Center's recommended intervention plan. The Center shall document attendance of all such persons and provide attendance records upon request of the court. Upon two consecutive unexcused absences or upon the development of a pattern of absences, the center

will notify the offender and the court of non-attendance and request that the court schedule a hearing for non-compliance. The Center shall also provide to the court written progress reports at six month intervals on each person under an order to attend intervention programs. The progress reports shall include but not be limited to notification of successful completion of the intervention plan, recommendations for continued intervention or other relevant recommendations.

f. In conjunction with the designated domestic violence agencies of each county, the Centers shall ensure that outreach is attempted with any victim who signs civil or criminal domestic violence charges against a person. Outreach includes the provision of the following to the victim: 1) information regarding the legal rights of victims of domestic violence; 2) information regarding available community social and legal services for the victim and the victim's children, if any; 3) information regarding the Domestic Violence Resource Center program and how the program interfaces with court action; 4) an assessment of victim safety; 5) encouragement for the victim to utilize available services. Whenever possible, outreach services should be offered at the time of the signing of a complaint. Outreach services shall be provided by the designated domestic violence agencies of each county or such agencies' designees, and these agencies shall be funded to provide services from the appropriation authorized in Section 9.

g. The Centers shall be responsible for providing informational training sessions on the Domestic Violence Resource Center program to county and municipal personnel, including judges, law enforcement personnel, community social service providers, and other involved agencies. In conjunction with the New Jersey Advisory Council on Domestic Violence and the county's designated domestic violence agencies, the

Domestic Violence Resource Center may also assess the county's comprehensive domestic violence training needs and may participate in the provision and coordination of such training.

h. The Centers shall compile statistics regarding persons admitted to the program, persons court-ordered to participate in the Center's recommended intervention plan, rate of successful completion of the plan, recidivism of domestic violence incidents and any other pertinent statistics required by the Division. The Centers shall submit monthly statistical reports to the Division.

6a. The Division is authorized to contract for provision of the three Domestic Violence Resource Centers from amounts appropriated in this Act. The Division shall not approve contracts for establishment of Centers in counties that cannot demonstrate the following: 1) that a residential shelter for victims of domestic violence and their children has been established or that plans to establish a shelter are in progress; 2) that a county-wide Domestic Violence Standard Operating Procedure for law enforcement has been promulgated and 3) that there exists an active county domestic violence coordinating committee with representatives who are responsible for the law enforcement, court and social service response to domestic violence including the prosecutor's office and the designated domestic violence agencies. The Division shall be responsible for the following: 1) promulgating rules and regulations necessary to carry out the purposes of this Act; 2) developing and disseminating a request for proposals and exercising final approval of grant recipients; 4) providing technical assistance to grant recipients; 5) monitoring the activities of the Centers to insure conformance to the purposes of this Act, and to ensure the quality of services; 6) developing standards for violence

intervention programs; 7) designing, collecting and compiling monthly statistical reports for submission by the Centers; 8) issuing an Annual Fiscal and Statistical Domestic Violence Resource Center Report; 9) contracting for the provision of an independent evaluation of the pilot project as described in Section 8. The Division shall hire at least one full time staff person to fulfill the responsibilities of the Division under this Act. The Division shall make every effort to hire a person who is certified in domestic violence.

b. The Division shall establish a Domestic Violence Resource Center Advisory Committee. The Committee shall consist of eleven members including one representative each from the Division of Alcoholism, Drug Abuse and Addiction Services, the Division of Youth and Family Services, the New Jersey Advisory Council on Domestic Violence, the New Jersey Coalition for Battered Women, the N.J. Network for the Treatment of Spouse Abusers, and the Commission on Sex Discrimination in the Statutes, and five service providers who are domestic violence specialists. The Committee shall:

- (1) advise the Division of any regulations or standards necessary to carry out the purposes of this Act;
- (2) review any such regulations or standards before their effective date;
- (3) review grant proposals and advise the Division on the final selection of grant recipients; and
- (4) monitor, evaluate, and set standards for the quality of services provided by the Centers and projects funded pursuant to this Act.

The Committee shall organize within three months of the effective date of this ACT, and shall elect from among its members a chair and a deputy chair, who shall serve for one year terms so long as they hold the positions from which they sit on the Committee. The Committee shall at its organizational meeting, with the approval of the director of

the Division, establish rules for any matters that may be necessary for its efficient operation. The Committee shall, thereafter, meet at least once per month for the next succeeding 12 months, and shall invite at least one representative of the Division to attend each meeting. It may make such other administrative rules as are necessary for efficient and effective operation of the Centers and the Committee. After the first year of operation, the Committee shall meet at least four times per year.

7a. Any non-profit, public or county sponsored agency may apply for funding under this Act provided the agency submit the following assurances: 1) that the DVRC professional staff will have extensive training and experience in the field of domestic violence; 2) that the agency will maintain a cooperative working relationship with existent domestic violence service providers in the community; 3) that the county's designated domestic violence agencies have endorsed the applicant's proposal in writing; 4) that the establishment and activities of the Center has the support and cooperation of the judiciary and governing body of that county, which shall be assured in such manner as is acceptable to the Division; and 5) other assurances which may be deemed necessary or appropriate by the Division.

b. Nothing herein shall bar the designated domestic violence agencies from applying for DVRC funding and every consideration shall be given to proposals from these agencies.

8a. The Division will contract with an independent, professional agent to evaluate the pilot project with funds appropriated in Section 9. The selected agent will design, conduct and document the results of the study. The study will include but not be limited to an evaluation of the following: 1) the extent of judicial cooperation with the project including willingness to issue and enforce orders for

mandatory participation in intervention programs and the increase/decrease of such cooperation over time; 2) the rate of successful completion of prescribed intervention plans; 3) where feasible, the impact of the project on victims; 4) to the extent possible, the rate of recidivism of domestic violence among participants and common factors involved where recidivism is low.

The study will also include an analysis of the actual costs of operating the Centers.

b. The results of the study shall be distributed to the Governor, the Legislature, and the Chief Justice no later than 18 months after the effective date of this Act.

9. An appropriation of \$750,000 shall be made by the Legislature to cover the costs of the 18 month pilot project. Of this sum \$515,000 is designated for the establishment of the DVRC's, \$75,000 for victim outreach services through the designated domestic violence agencies or their designees, \$60,000 for the costs of an independent evaluation and \$100,000 for the Division to perform the administrative duties prescribed by this Act. This appropriation shall expire two years after the effective date of this Act.

10. This Act shall take effect on the 60th day after enactment.

BE IT ENACTED by the Senate and General Assembly of the State of New Jersey:

1. Section 1 of P.L.1981, c.382 (C.37:1-12.1) is amended to read as follows:

1. In addition to the fee for issuing a marriage license authorized pursuant to R.S.37:1-12, each licensing officer shall collect a fee of [\$5.00] **\$25** from the applicants which shall be forwarded on a quarterly basis to the Department of Human Services.

(cf: P.L.1981, c.382, s.1)

2. Section 2 of P.L.1981, c.382 (C.37:1-12.2) is amended to read as follows:

2. The Department of Human Services shall establish a trust fund for the deposit of the fees received pursuant to section 1 of this act. The moneys from the trust fund shall be used for the specific purpose of establishing and maintaining shelters for the victims of domestic violence, or a. for providing grants-in-aid to such shelters established by local governments or private nonprofit organizations; or b. for providing grants-in-aid to non-residential agencies whose primary purpose is to serve victims of domestic violence in those counties which do not have emergency residential shelters for victims; or c. for providing grants-in-aid to any non-profit, State-wide coalition whose membership includes a majority of the programs for battered women in New Jersey and whose board membership includes a majority of representatives of these programs and whose purpose is to provide services, community education, and technical assistance to these programs to establish and maintain shelter and related services for victims of domestic violence and their children.

(cf: P.L.1981, c.382, s.2)

3. This act shall take effect on the 30th day after enactment.

STATEMENT

This bill amends section 1 of P.L. 1981, c. 382 (C. 37:1-12.1) to increase the additional fee collected with a marriage license fee from \$5.00 to \$25. The base fee is retained by the issuing municipality and the additional fee is forwarded to the Department of Human Services and deposited in a trust fund used for establishing and maintaining shelters for the victims of domestic violence. The bill would also amend section 2 of P.L. 1981, c. 382 (C. 37:1-12.2) to expand the use of these trust fund

monies to include grants to non-residential agencies which provide services to victims of domestic violence in counties which do not have emergency shelters. Additionally, non-profit coalitions such as the N.J. Coalition for Battered Women, Inc. which are involved in providing services to victims of domestic violence would also be eligible for grants under this bill.

Increases the license fee and additional fee charged for marriage licenses; provides for certain organizations to be eligible for grants from trust fund in which fees deposited.

REPORT OF THE COUNCIL ON SCIENTIFIC AFFAIRS

Report:
(I-91)

Subject: Violence Against Women

Presented by: William C. Scott, MD

Referred to: Reference Committee
(, MD, Chairman)

1 The two decades since the 1960s have witnessed a new national
2 awareness of the violence faced by women in our society. Prior to
3 the 1960s, only a few forms of violence--such as assault or rape by
4 strangers or casual acquaintances--were seen as a danger to women.
5 Families were assumed to afford protection against this danger, and
6 women were advised to seek the shelter of their homes in order to
7 remain safe from harm. The study of assaults occurring within
8 families did not begin until the 1960s, with an emphasis on physical
9 child abuse.¹⁻³ At this time, there were almost no reports of
10 sexually molested children or abused wives. Violence in the family
11 was thought to be infrequent and to result from the psychopathology
12 in the individuals involved, rather than being viewed as a society-
13 wide problem with far-reaching consequences.

14
15 The new knowledge on violence against women began with the anti-
16 rape movement, which, in the 1960s, began to focus on sexual violence
17 against women by strangers and acquaintances.⁴ Such discussions
18 revealed the prevalence of women experiencing sexual assaults by
19 intimate males, rather than strangers, and led to the identification
20 of physical assaults of women by male intimates as a phenomenon of
21 previously unrecognized proportions.⁵ Studies now document that
22 women in the United States are more likely to be assaulted and
23 injured, raped, or killed by a current or ex-male partner than by all
24 other types of assailants combined.⁶⁻¹¹

25
26 Relevance for Medical Practitioners

27
28 There have been earlier periods in US history when the
29 victimization of women and children became topics of special
30 concern.¹² However, the past two decades represent the first time
31 that systematic data on prevalence and outcomes have been gathered or
32 that responses have been so wide-ranging, involving advocacy,
33 medical, mental health, criminal justice, governmental, and academic
34 communities.^{4,5} Major research and policy initiatives have been
35 developed to address aggression occurring within families. Rape laws
36 have been amended nation-wide to protect victims; in some cases
37 removing the exemption offered for assaults by husbands and ex-
38 husbands. Nearly every state has established new legislation
39 targeted for violence between adult partners, and federal legislation

1 on violence against women is now pending. Although the medical
2 community--along with the criminal justice system--is the most likely
3 to see women victims, and thus constitutes a frontline of
4 identification and intervention; and although police and others in
5 the legal community increasingly benefit from training and enhanced
6 procedures in responding to women victims, only rarely are physicians
7 and other medical staff provided with training or specific protocols
8 to aid in dealing with these cases.

9
10 In summarizing the concerns of physicians and public health
11 officials attending the AMA National Leadership Conference, Surgeon
12 General Antonia Novello, MD, cited a CDC study reporting that
13 violence by intimate partners is the leading cause of injury for
14 women, "responsible for more injuries than car crashes, rape and
15 muggings combined." Novello continued, "But sadly, the medical
16 community has yet to consistently identify these women as victims and
17 extend treatment beyond the physical manifestations of an abusive
18 relationship" ("Doctors urged to act in 'crisis' of violence"
19 American Medical News, Mar. 4, 1991).

20
21 The cost of a failure to identify and intervene with violence,
22 in terms of patients' suffering and the use of medical providers'
23 time and resources, is incalculable. Particularly with violence by
24 intimates, assaults tend: (a) to be repeated over time, (b) to
25 produce more injuries than assaults by strangers, and (c) to have
26 complicated sequelae with implications for further morbidity (e.g.,
27 the possible victimization of another family member by the original
28 abuser or victim). The long-term nature of the effects of trauma,
29 the pattern of repeated assaults by assailants in families, and the
30 frequency with which intimate assaults against women result in injury
31 typically mean repeated contacts with victims, involving various
32 medical personnel and services, with a low success rate for the
33 alleviation of symptoms. Moreover, as Robert McAfee, MD, vice
34 chairman of the AMA Board of Trustees noted, "In addition to the
35 terrible human toll, violence strains the resources of our health
36 care system....When we are being constantly criticized about health
37 care costs, this is one of the factors driving those costs up"
38 ("Doctors urged to act in 'crisis' of violence," American Medical
39 News, Mar. 4, 1991).

40 41 Overview of Topics Covered

42
43 This report reviews the following (overlapping) forms of
44 violence against women: rape, physical and sexual assaults by marital
45 or dating partners, and the long-term effects of child sexual
46 molestation in adult women. [Topics of child physical abuse and
47 elder abuse have been covered more generally in other Council
48 publications. See references 13 and 14.] Empirical evidence on
49 prevalence and the physical, psychosocial, and emotional outcomes of
50 these types of victimization are reviewed, relevance for the practice

1 of medicine discussed, and recommendations for enhanced
2 identification and response presented.

4 RAPE

5
6 In traditional definitions, rape has been defined as the "carnal
7 knowledge of a female forcibly and against her will."¹⁵(p174) The
8 meaning of 'carnal knowledge' is restricted to vaginal-penile
9 penetration; other types of sexual penetration are excluded. This
10 definition is used by the Federal Bureau of Investigation (FBI) for
11 its Uniform Crime Reports of offenses known to the police, as well as
12 by the National Crime Survey (NCS) to measure the extent of
13 unreported crime in the United States. Although data on rape is
14 gathered at the Federal level, actual legislation on rape varies by
15 state. In the last two decades, legal definitions of rape have
16 undergone extensive revisions: many states now utilize expanded (or
17 reform) statutes that define rape as the "nonconsensual sexual
18 penetration of an adolescent or adult obtained by physical force, by
19 threat of bodily harm, or when the victim is incapable of giving
20 consent by virtue of mental illness, mental retardation, or
21 intoxication."^{16,17} These reform definitions typically include other
22 types of sexual penetration, in addition to vaginal, as well as
23 attempts to commit rape by force or threat of force.¹⁸(pp1-4)

24 Incidence and Prevalence of Rape

25
26
27 According to FBI crime reports, a total of 92,486 rapes of women
28 were reported to the police for the year of 1988. Approximately 82%
29 of these rapes were completed by force; the remaining 18% were
30 forcible attempts. This yields a victimization rate of approximately
31 73 rapes per 100,000 adult women. Estimates based on the National
32 Crime Survey, which includes incidents not necessarily reported to
33 the police, are nearly twice as high: for 1987, the rate of rape
34 victimization was 1.3 per 1,000 women and girls (excluding children
35 under the age of 12), and 0.1 per 1,000 men and boys.¹⁹

36
37 However, parameters of both the Uniform Crime Reports (UCR) and
38 the National Crime Survey (NCS) exclude many incidents of forcible
39 sexual assault. Only a small percentage of crimes are reported to
40 the police. Significantly, officials consider rape to be the most
41 under-reported of all crime categories measured,²⁰ and, although the
42 NCS is designed to tap the incidence of unreported crime, no specific
43 questions regarding sexual assault are included. The single question
44 to probe for rape asks, "Has anyone attacked you in some other
45 way?"²¹ Unless a respondent volunteers information about sexual
46 assault, no further questions are asked.^{18,22} Further, the context
47 of a "crime" virtually guarantees underreporting of intrafamily
48 assaults in both surveys. Marital rape has been exempt from rape
49 laws in most states until recently, and still is almost never
50 reported to police. NCS respondents may view assaults occurring
51 between family members as personal problems, rather than as criminal

1 actions. Further, NCS interviews are frequently conducted with other
2 family members present, and thus privacy in responding is not
3 assured.

4
5 Epidemiological studies. Prevalence studies using epidemiologic
6 methods yield more reliable estimates. Such studies now indicate
7 that at least 20% of adult women, 15% of college women, and 12% of
8 adolescent girls have experienced sexual abuse and assault during
9 their lifetime.^{8,23} In a study using the California rape statute to
10 define rape as "forced intercourse...or intercourse completed when
11 the woman was drugged, unconscious, asleep, or otherwise totally
12 helpless and hence unable to consent..." and an intensive interview
13 format, 44% of a random sample of women had experienced at least one
14 attempted or completed rape.^{10(p64)} Similarly, in a community study
15 conducted in South Carolina, 23% of adult women had experienced a
16 completed rape (defined as nonconsensual penetration involving force
17 or the threat of force), and 13% had experienced attempted rape.²⁴
18 Estimates for African-American women are even higher. Again using a
19 strict definition of rape and a detailed interview format with a
20 community sample of women in Los Angeles, one in four African-
21 American women, and one in five white American women, reported at
22 least one incident of completed or attempted rape since their age
23 18.²⁵

24
25 Incidence figures (the number of new cases within a given time
26 frame) add dimension to these findings. In a study of 2,291 adult
27 women in Ohio, 28 per 1,000 women had experienced rape in the 12
28 months prior to the survey, based on the traditional FBI definition;
29 using an expanded reform definition, the rate rose to 62 women per
30 1,000. Even using the more restrictive parameters, these figures
31 mean that one out of every 55 adult women experienced a rape as
32 defined by the FBI during that one-year period. Using reform
33 definitions now adopted by many states, one in 24 women had
34 experienced a rape in the prior 12 months.²⁶

35
36 High risk populations. Groups in which the incidence of rape is
37 particularly high include children under the age of 12, adolescent
38 and young adult women up to the age of 25, women on college campuses,
39 minority women, elderly women, and the handicapped. Children are
40 most at risk from assaults by family members and other caretakers,
41 and least at risk from strangers (see section on childhood
42 molestation). Similarly, adolescents and young adult women are most
43 at risk for acquaintance and date rape and least at risk from someone
44 unknown to them (see dating violence). Both young adult and older
45 women are more vulnerable to sexual assaults by marital or ex-marital
46 partners than to rape from acquaintances or strangers combined (see
47 discussion of marital rape).

Impacts on Psychological and Social Well-being

1
2
3 Initial effects. Initial reactions to sexual assault include shock,
4 numbness, withdrawal, and denial. Victims of stranger attacks often
5 are afraid their assailant will return and further harm them, and
6 they may fear retaliation if they contact the police. Victims of
7 attacks by acquaintances or intimates are often stunned that someone
8 known to them or someone they trusted could attack them in this
9 manner. In initial presentations to police or medical staff, victims
10 may appear unnaturally calm and detached (although some physical
11 signs such as shaking or lowered skin temperature are usually
12 present); or they may be crying or angry and emotive.
13

14 Typically, there is a lessening of these initial symptoms after
15 the first two weeks and the victim may enter a denial phase, in which
16 there is an outward appearance of adjustment. Those surrounding the
17 victim may comment on how well she has recovered from the trauma and
18 assume that the worst is over. However, studies suggest a period,
19 occurring from two weeks to several months post-assault, in which
20 symptomatology returns and may intensify.²⁷ It is at this time that
21 the victim may begin a pattern of help seeking for these symptoms,
22 without informing those she contacts of the rape experience that
23 underlies them.
24

25 Long-term effects. Research documents that the 'aftereffects' of
26 rape are persistent and long-lasting.¹⁸ Victims often react with
27 chronic anxiety and continued feelings of vulnerability, loss of
28 control, and self-blame long after the assault.²⁸⁻³⁰ Common long-
29 term reactions include specific anxiety, nightmares, catastrophic
30 fantasies, feelings of alienation and isolation, sexual dysfunctions,
31 and physical distress.¹⁸
32

33 In cross-sectional research, women who have been raped tend to
34 score high on almost every kind of psychological measure, post-
35 assault.³¹ In one study, rape victims who were as much as sixteen
36 years post assault were found to have consistently higher levels of
37 fear and anxiety than women without rape experiences. Other long-
38 term effects include mistrust of others, resulting in disruption of
39 personal relationships or styles of relating; the development of
40 phobias; manifestations of depression and hostility; and somatic
41 symptoms.^{30,32,33} Manifestations of depression may include general
42 apathy or suicidal ideation. Suicidal thoughts are reported in
43 between 33% and 50% of rape victims in cross-sectional
44 studies.^{23,34,35} In a community sample of women not seeking
45 treatment, between 17% and 19% of rape victims made suicide
46 attempts.^{29,35}
47

48 High-risk groups for post-rape distress. Some studies have found
49 that women who were in situations in which they judged themselves to
50 be safe when they were raped (e.g., at home, with a trusted
51 acquaintance or partner) experience more intense fear and depression

1 after the assault than other victims.^{32,36,37} Women with prior
2 victimization histories also evidence especially severe aftereffects,
3 particularly depression, as the assault triggers memories of a past
4 assault or childhood molestation.^{24,38} Other factors, such as the
5 level of physical threat, injury, and medical complications increase
6 the vulnerability to post-rape symptoms.³⁹ Although it is often
7 assumed that women who are the victims of stranger rapes are more
8 severely traumatized than those victimized by persons they know,
9 research has not supported this assumption. In comparing victims on
10 measures of depression and anxiety, women assaulted by family members
11 or dates experience as severe levels of distress as women assaulted
12 by acquaintances or strangers.^{34,40}

13
14 Posttraumatic Stress Disorder. This complex of effects in the
15 aftermath of rape often meet the criteria for the diagnosis of
16 posttraumatic stress disorder (PTSD).⁴¹(pp247-251) In fact, rape
17 victims are believed to constitute the largest category of PTSD
18 sufferers.⁴² Hallmarks of PTSD include psychic numbing, intrusive
19 reexperiencing of the trauma months or even years after the event,
20 avoidance of stimuli associated with the trauma, and intense
21 psychological distress.

22
23 Impacts on Physical Health and Well-being

24
25 Initial effects. Intrusive thoughts about danger, fears about future
26 victimization, and the physiologic arousal associated with these
27 cognitions not only disrupt social and psychological functioning, but
28 often lead to physical symptoms as well.¹⁸ Immediate medical
29 concerns after rape include injury, infection, and documentation.
30 Most hospitals have protocols for intervention with rape victims who
31 present themselves to emergency rooms for medical care and testing.
32 In the first weeks immediately following a rape, physical effects of
33 trauma may include soreness, bruising, rectal bleeding and other
34 injuries. Gastrointestinal irritability, fatigue and chronic
35 fatigue, tension headaches, intense startle reactions, and disturbed
36 sleeping and eating patterns also often are noted.¹⁸

37
38 Long-term effects. Specific and ongoing health concerns after rape
39 include gynecological trauma such as vaginal tearing or injuries to
40 the vulva, the risk of pregnancy, and the potential for contracting
41 infections or sexually transmitted diseases.³² Currently, the risk
42 of HIV infection and therefore of AIDS is of increasing concern to
43 rape victims and those who treat them, and contributes to the sense
44 of fear and of irreparable damage with which survivors must deal.
45 Victims may also seek to escape the pain of rape's aftereffects
46 through alcohol and drugs, further disrupting physical and
47 psychological well-being.

Victims' Use of Health Care Services

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Rape victims appear to be frequent users of medical services in the months and years post-assault. Survivors perceive themselves as less healthy and report visiting physicians more often than non-victims, regardless of the length of time since the rape incident.^{43,44} They are more likely to report symptoms in every part of the body (except dermatology and eyes) than nonvictims.⁴⁴ They also report more injurious health habits than nonvictims, including smoking, drinking, and overeating. In one study, visits to physicians increased 18% in the year of the assault, 56% in the following year, and 31% the year after, compared to pre-victimization levels.²⁶ Nearly all victims made visits to primary care physicians in each of the two years after the assault.⁴⁴

Special considerations for health care providers. Although most emergency rooms have established protocols for rape victims who are seen soon after the incident and acknowledge they have been raped, only a small minority of victims seek this type of assistance. Other victims present to private physicians or emergency rooms with complaints based on the symptoms, but do not disclose that an assault has occurred. Still others do not present until months after the incident; but then contact the medical community repeatedly over time, in an attempt to deal with long-term effects and complications. Early identification of rape trauma by medical staff can help demystify non-specific medical complaints and legitimate the patient's distress, as well as enabling the physician to make appropriate referrals to help sources to assist with rape recovery. Some lessening of the emotional and psychological distress may, in turn, result in a lessening of symptoms and thus in the need for medical contacts.

Specific protocols that take into account the victim's relationship to the assailant will also contribute to a patient's well-being and the effectiveness of the treatment provided. As noted earlier, women are more likely to be sexually assaulted by their intimates than by strangers. Procedures developed for the victims of stranger rape work poorly in these cases. Victims of intimate assault are less likely to formally report the assault, either immediately or as a part of a medical history, and thus are unlikely to be assisted under established protocols. Even given rape disclosure, established procedures may not provide medical staff with guidance on what to do if the assailant--e.g., the partner--is present in the emergency room or doctor's office. Yet the long-term effects of partner rape are often as severe, and chances of injury greater, than with stranger rapes.⁴⁵ Medical protocols should take this into account through the development of procedures for cases of intimate violence. The physical and sexual assault of women by intimates is discussed further in the following section.

PARTNER VIOLENCE

1
2
3 Although the danger of victimization by strangers historically
4 has received the most attention, nationally representative studies
5 consistently indicate that women are most at risk from their
6 intimates, particularly from male partners. In a 1985 survey of
7 intact couples, self-reports indicated that nearly one out of every
8 eight husbands had carried out one or more acts of physical
9 aggression against their female partner during the survey year.⁴⁶
10 Although the stereotype of 'domestic violence' tends to be that of
11 relatively minor assaults and squabbles, over one-third of these
12 assaults involved severe aggression such as punching, kicking,
13 choking, beating up, or using a knife or a gun. These findings mean
14 that, in an average 12-month period in the United States,
15 approximately two million women are severely assaulted by male
16 partners.^{9,46,47} Victims of violence by intimates are much more
17 likely to be reassaulted within six months than those attacked by
18 non-intimates.⁹ Women who are separated or divorced from their
19 partners are at the highest risk of assault.⁴
20

21 As with other types of intimate violence, figures based on
22 national surveys are marked under-estimates. Such surveys typically
23 don't include the very poor, those who do not speak English fluently,
24 those whose lives are especially chaotic, and all individuals who are
25 institutionalized, hospitalized, homeless, or incarcerated at the
26 time the survey is conducted. Further, estimates are based on only
27 those respondents who are willing to report, even anonymously, acts
28 of violence they have perpetrated or experienced to an unknown
29 interviewer. Researchers on family violence agree that the true
30 incidence of partner violence is probably double the above estimates;
31 or four million severely assaulted women per year. Studies on
32 prevalence suggest that from one-fifth to one-third of all women will
33 be physically assaulted by a partner or ex-partner during their
34 lifetime.⁴⁸
35

Risks of Partner Violence for Women and Men

36
37
38 Although some surveys suggest nearly equal participation rates
39 for women and men (i.e., that about as many women as men have
40 perpetrated at least one act of aggression: threw something, pushed,
41 shoved, slapped, hit, etc.), some clarifications should be noted.
42 First, in this research, no questions are asked about the context
43 within which these actions occur, and thus there is no measure of
44 acts that are undertaken in self-defense. Second, the same surveys
45 find that the frequency and types of aggression perpetrated by women
46 and men in partner relationships differ:
47

- 48 a) Men perpetrate more aggressive actions against their female
49 partners than women do against their male partners;

- 1 b) Men perpetrate more severe actions--such as punching,
2 kicking, choking, beating up, or using a knife or gun; and
3
4 c) Men are more likely to perpetrate multiple aggressive
5 actions against a female partner during a single incident
6 than are women against male partners.^{46,47}
7

8 Even when compared with relationships in which women have perpetrated
9 at least one aggressive act, the offending rate for men for severe
10 violence is 42% higher.⁴⁶
11

12 Severity of Outcomes for Women. In combination with men's greater
13 average physical strength, these factors lead to quite different
14 physical outcomes for women and men. Women are much more likely to
15 be injured by their male partners than men are by their female
16 partners.⁴⁹ In analyzing injury reports from the National Crime
17 Survey in 1980, over 80% of all assaults against spouses and ex-
18 spouses resulted in injuries, compared to 54% of the victims of
19 stranger violence; victims of marital violence also had the highest
20 rates of internal injuries and unconsciousness.⁵⁰
21

22 Homicide figures for the US also demonstrate the differential
23 risk for women and the severity of physical outcomes of partner
24 assault. From 1976 through 1987, the deaths of approximately 38,648
25 people over the age of 15 were one partner killing another (including
26 homicides by married, common-law, ex-married, or dating partners).
27 Of these deaths, 61% of the victims were women killed by male
28 partners and 39% were men killed by female partners.⁵¹ For white
29 couples, the differences were more marked: 70% of partner homicide
30 victims were women and 30% were men. Rates for all female-
31 perpetrated partner homicides have dropped dramatically since the
32 mid-1970s: from 1976 to 1985, there was over a 25 percent decrease in
33 the overall numbers of women killing male partners.¹¹ This drop was
34 linked with the presence in a state of domestic violence legislation
35 and other services for abused women, such as shelters and crisis
36 lines. This decrease has not been matched by a similar decline in
37 men killing female partners, however. Over one-half of women
38 murdered in the US are killed by a current or former male partner.
39

40 Dynamics of Violence Against Wives

41
42 Types of partner abuse reported by women in epidemiologic
43 surveys range from being slapped, punched, kicked, or thrown bodily
44 to being scalded, choked, smothered, or bitten. In relationships
45 with ongoing severe abuse, typical assaultive episodes often involve
46 a combination of assaultive acts, verbal abuse, sexual assault, and
47 threats.^{52,53} The repetition of aggression in families is
48 facilitated by the fact that victims are readily available; the
49 amount of time at risk is high; assaults can be carried out in
50 private; and wife-assault is a relatively low-risk behavior for the
51 aggressor, in terms of identification and sanctions.⁴⁵

1 Until the mid-1970s, assaults against wives were considered
2 misdemeanors in most states--even when the same action would have
3 been considered a felony if perpetrated against a stranger or an
4 acquaintance instead of a wife; and police were not empowered to
5 arrest on a misdemeanor charge. Orders of protection usually were
6 not available on an emergency basis and typically carried no
7 provisions for enforcement or penalties for violation.⁵⁴ Moreover,
8 women who eventually killed their mates in protection of themselves
9 or a child found the plea of self-defense unavailable for their
10 case.⁵³ Only since the late 1970s have domestic violence laws and
11 the provision of shelters and other services begun to more seriously
12 sanction wife assault and offer some protection to abused women.^{4,5}

13
14 Characteristics of Persons Involved in Marital Violence

15
16 Victims. Early research on abused women focused primarily on women
17 who had sought special services. Accordingly, knowledge of victim'
18 characteristics was initially limited to women whose resources
19 directed them to public assistance. Nationally randomized samples
20 now document the diverse socioeconomic backgrounds of victims;
21 although younger women and women living in poverty are more at risk
22 for both non-marital and marital violence. However, empirical
23 studies have not found characteristics that differentiate women who
24 are victimized from women who are not, other than their socioeconomic
25 status and the fact that they are abused.

26
27 In a review of 52 studies with comparison groups, only one of 42
28 potential risk markers for women--witnessing parental violence as a
29 child or adolescent--was consistently associated with becoming a
30 victim of marital violence.⁵⁵ Studies also suggest that being
31 sexually abused as a child leaves women more prone to revictimization
32 in later life.⁵⁶ However, empirically, neither personality factors
33 nor behavioral characteristics distinguished women abused by male
34 partners from non-abused women.. Although studies from special
35 populations stress symptomatology, the symptoms that battered women
36 exhibit appear most likely to be sequelae of the violence, rather
37 than its antecedents.^{4,55,57}

38
39 Abusers. Some commonalities have been found among male abusers,
40 however. Men who assault female partners are more likely to have
41 witnessed or experienced violence in childhood, to abuse alcohol, to
42 be sexually assaultive to their wives, and to be at risk for violence
43 against their own or their partners' children than are men in
44 comparison groups of non-abusive males.⁵⁵ They are also more likely
45 to be involved in violence toward strangers than men who are not
46 assaultive in the family.

47
48 Impacts on Psychological and Social Well-being

49
50 Initial effects. As would be expected, women victims of a partner's
51 violence have many of the same reactions as other victims. During

1 assaults, the primary focus is on self-protection and survival.
 2 Reactions of shock, denial, withdrawal, confusion, psychological
 3 numbing, and fear are common. During--and even after--an assault, a
 4 victim may offer little or no resistance, in an attempt to minimize
 5 the threat of injury or renewed aggression.

6
 7 Long-term effects. Similar to rape victims, long-term reactions in
 8 women abused by male partners include fear, anxiety, fatigue,
 9 sleeping and eating disturbances, intense startle reactions, and
 10 physical complaints. As with other types of trauma, abused women may
 11 become dependent and suggestible and find it difficult to make
 12 decisions alone, and, during the period that follows, minimize the
 13 danger and personal loss.⁵⁸ Effects of trauma are exacerbated by the
 14 fact that the aggressor is someone they may love, someone they are
 15 supposed to be able to trust, and someone on whom they may depend.
 16 Unlike the victims of strangers, victims of marital violence in fact
 17 have a legal, financial, and role relationship with their assailants;
 18 confounding their decisions on what to do about the violence as well
 19 as the psychological sequelae.⁵⁹ In such cases, perceptions of
 20 vulnerability, loss, and betrayal or hopelessness may be especially
 21 severe. There is also a high prevalence of depression, and suicide
 22 attempts are common.⁶⁰ Violence at home typically leaves no place in
 23 which defenses can be let down.

24 25 Impacts on Physical Health and Well-being

26
 27 Injuries sustained by abused women range from bruises, cuts,
 28 black eyes, concussions, broken bones, and miscarriages to permanent
 29 injuries such as damage to joints, partial loss of hearing or vision,
 30 and scars from burns, bites, or knife wounds. The force with which
 31 an act is carried out, the number of repetitions of the act, and the
 32 clustering of different acts together play a major role in
 33 determining the amount of injury sustained.⁵³

34
 35 Injuries from domestic violence typically involve contusions or
 36 minor lacerations to the head, face, neck, breast, or abdomen. These
 37 are often distinguishable from accidental injuries, which are more
 38 likely to involve the periphery of the body. In a hospital-based
 39 study, victims of domestic violence were 13 times more likely to
 40 sustain injury in breast, chest, or abdomen than accident victims.⁶¹
 41 They are also more likely to have multiple injuries than accident
 42 victims, as well as medical evidence of old injuries (e.g., old and
 43 new fractures; bruises in various stages of healing).³² When this
 44 pattern of injuries is seen in a woman, particularly in combination
 45 with evidence of old injury and with vague complaints of aches and
 46 pains, physical abuse should be suspected, regardless of the
 47 explanation given for the current condition.

48
 49 Primary care complaints include chronic headaches, abdominal
 50 pains, muscle aches, recurrent vaginal infections, sleep and eating
 51 disorders, and depression. Abused women may also begin to abuse

1 alcohol or prescription drugs; although, in studies of general
2 populations, alcohol abuse does not distinguish battered women from
3 non-victimized women. In addition, recent research suggests an
4 association with delayed physical effects, particularly arthritis,
5 hypertension and heart disease (Corroa C. 1985. Unpublished data).
6

7 Victims' Use of Health Care Services

8

9 In studies of emergency room visits, 22% to 35% women presenting
10 with any complaint were there because of symptoms relating to
11 abuse.⁶² A NIMH-funded project estimated that 21% of all women using
12 emergency surgical services were there for sequelae of domestic
13 violence; that one half of all injuries presented by women to
14 emergency surgical services occurred in the context of partner abuse;
15 and that over one-half of all rapes to women over the age of thirty
16 had been perpetrated by an intimate partner.⁶³ Rather than stating
17 abuse as the problem, however, abused women are more likely to
18 present with depression, anxiety, family/marital/sexual problems, and
19 vague medical complaints. Rates are even higher in special care
20 populations. For example, it has been estimated that sixty-four
-- percent of hospitalized female psychiatric patients are the victims
22 of physical abuse as adults.⁶⁴
23

24 Due to the ongoing and injurious nature of domestic violence
25 toward women, abused women may visit physicians repeatedly, with
26 increasingly severe physical trauma.⁶⁵ In documenting the repeated
27 nature of abused women's visits to health providers, Stark &
28 Flitcraft found that nearly one battered woman in five had presented
29 at least 11 times with trauma; another 23% had brought 6 to 10
30 abusive injuries to the attention of clinicians.⁶⁰(p302)
31 Unfortunately, in most cases, the victimization history underlying
32 these injuries was never identified. (Also see reference 62.)
33

34 Special Considerations for Health Care Providers

35

36 Battering during pregnancy. Victims of a partner's violence during
37 pregnancy face the risk of especially severe outcomes.⁶⁶ There is
38 some controversy over whether the incidence of marital violence
39 increases during an abused wife's pregnancy; however, we know it does
40 not cease. Based on a representative sample, the 1985 National
41 Family Violence Survey found that 154 out of every 1,000 pregnant
42 women were assaulted by their mates during the first four months of
43 pregnancy, and 170 per 1,000 women were assaulted the fifth through
44 the ninth month.⁶⁷ Medical sources suggest that approximately 37% of
45 obstetric patients, across class, race, and educational lines, are
46 physically abused while pregnant.⁶⁸
47

48 Pregnancy is a particularly high risk time for an abused
49 woman.⁶⁶ Advanced stages of pregnancy leave her less able to
50 maneuver to avoid blows or escape an attack, and more at risk from
51 secondary injuries to herself as well as to the fetus. Further,

1 clinical reports suggest that assaults during pregnancy are
2 frequently related to jealousy or anxiety about the upcoming birth,
3 and that physically assaultive actions such as blows or kicks are
4 often directed toward the abdomen. Such assaults can result in
5 placental separation; antepartum hemorrhage; fetal fractures;
6 rupture of the uterus, liver, or spleen; and pre-term labor.⁶⁶ One
7 study found that abused women were three times as likely to sustain
8 injury while pregnant as non-abused women.⁶⁰

9
10 Physical abuse may lead to fractures, bruising, or hemorrhage.
11 Although few specific studies of the impact on birth outcomes have
12 been done, physical violence during pregnancy has been linked to low
13 birth weight in newborns.⁶⁹ Physical or sexual assault may stimulate
14 early labor by irritation of the uterus, premature rupture of the
15 membranes, or injury to the reproductive organs.⁷⁰ Indirect causes
16 of poor birth outcomes for a woman who is victimized at home include
17 social isolation, diminished personal and social support, inadequate
18 access to prenatal care and other services, inadequate maternal
19 nutrition, and a concentration of injury on the reproductive organ
20 systems.^{68,70-72}

21
22 Because of the high incidence of women who are assaulted during
23 pregnancy, those providing pre- and post-natal care have an excellent
24 opportunity to identify this abuse and to reduce the potential
25 negative outcomes. Abused women should be given intensified prenatal
26 care, appropriate for high-risk pregnancies. Guidelines for
27 physicians working in the area also urge that every effort be made to
28 identify women who are victims of abuse, and to provide them with
29 information about their rights under the law and available community,
30 social, and legal resources.^{73(p6)}

31
32 Marital violence and child abuse. Unfortunately, risk to the
33 children of abused women does not stop at birth. Studies of the co-
34 occurrence of wife and child abuse document that men who abuse their
35 wives are more likely to be abusive toward children than are non-
36 abusive men, and that extreme violence toward female partners is
37 highly associated with concurrent child abuse.^{53,74-76} There is also
38 a strong association between severe marital violence and the
39 frequency of child abuse. In a nationally representative survey,
40 more than half the males who were severely violent toward female
41 partners abused their children three or more times during the year
42 prior to the survey.⁷⁷

43
44 Conversely, in a hospital-based comparison study based on
45 reviews of all child abuse reports filed at a Boston emergency room
46 for a six-month period, records of 59% of the mothers were diagnostic
47 or highly suggestive of a victimization history.⁷⁸ This was
48 significantly higher than the prevalence of wife abuse among mothers
49 of children in a non-abused comparison group--16% of mothers in the
50 comparison group had been abused. Surprisingly, the rate of violence
51 against single mothers of child abuse victims was four times the rate

1 of mothers who were married, suggesting the need to consider the
2 possibility of trauma histories in all mothers regardless of their
3 marital status at the time they are seen. (Also see reference 79.)
4

5 Studies also find that mothers who are the victims of frequent
6 abuse are more likely to victimize their children than non-abused
7 mothers; and that mothers who experience severe violence are more
8 likely to use severe measures in resolving conflicts with their
9 children.^{22,77} Some in-depth research suggests that mothers are up
10 to eight times more likely to physically abuse a child when they are
11 in a violent relationship than when that same mother is with a non-
12 violent partner.⁵² Some child and adolescent abuse is also the
13 unintended result of parental violence.^{50,80} Adolescents who attempt
14 to intervene, and young children who may be in their mother's arms or
15 otherwise in close proximity to her when an attack occurs, are at
16 particularly high risk.

17 18 MARITAL RAPE 19

20 Although a neglected topic in both the areas of family violence
21 and medicine, empirical research has shown consistently that marital
22 rape is an integral part of the patterns of marital
23 violence.^{10,52,80,81} In a random sample in San Francisco, 14% of
24 ever-married women reported being raped by a husband or ex-husband,
25 more than twice as many as were assaulted by strangers. Similarly,
26 in a representative sample in Boston, 10% of women cohabiting with a
27 spouse or intimate male reported at least one sexual assault
28 occurring in that relationship.⁶
29

30 Marital rape has been reported in relationships in which no
31 other forms of physical abuse occur. However, it seems to be most
32 frequent as a form of aggression in relationships in which other
33 violent behaviors are ongoing.¹⁰ Sexual assault is reported by 33%
34 to 46% of women victims who are being physically assaulted by their
35 partners.⁴⁸ Research on severely violent relationships indicates
36 that the most violent assaults often include sexual as well as
37 physical attacks, and that battered women who are sexually assaulted
38 by their partners typically experience more severe non-sexual attacks
39 than other abused women.^{53,82,83} In severely abusive relationships,
40 violent, forcible sexual assault may occur as often as several times
41 a month.
42

43 Sexual abuse is an extremely serious form of marital violence.
44 It is possible to inflict an intense level of physical pain over a
45 long period of time, and to cause a wide range of injuries, from
46 superficial bruises and tearing to serious internal injuries and
47 scarring. The psychological impact of sexual assault by an intimate
48 can also be extreme. Victims of marital rape suffer many of the same
49 reactions as other rape victims, and are likely to exhibit
50 particularly severe sequelae, both emotionally and physically
51 (including very severe depression and suicidality). Yet, except for

1 child sexual molestation, this type of violence is least likely to be
 2 reported by victims, either to medical care providers or to police;
 3 due to the shame of the victims, fear that they will not be believed,
 4 or belief that forcible sexual relations are the "right" of a husband
 5 or male partner. An awareness of the potential for forcible sexual
 6 assault in marriage, particularly in cases in which other types of
 7 physical abuse have been identified, will enable the clinician to
 8 sensitively assess for marital rape as a tool for understanding the
 9 etiology of observed symptoms.

10 11 COHABITING AND DATING VIOLENCE

12
13 Although the prevalence of marital violence has led some
 14 researchers to call the marriage license "a hitting license" (at
 15 least 30% of all couples have had at least one act of physical
 16 aggression between them⁴⁷), recent investigations have found at least
 17 as high a prevalence of physical assault among dating and cohabiting
 18 couples. Findings on "dating violence" are quite new in the social
 19 science literature, and interpretations of those findings can be
 20 problematic.⁸⁴ However, studies are limited almost exclusively to
 21 students in high school and college. Very little is known about
 22 individuals between the ages of 14 and 22 who are not attending
 23 school or about those who are past college age and dating or living
 24 with their partners despite the fact that many who seek medical
 25 services at hospital and community health centers come from these
 26 groups.

27 28 Dynamics of Dating Violence

29
30 Data from the National Family Violence Survey in 1975 documented
 31 higher rates of partner aggression among cohabiting couples than
 32 married individuals.⁸⁵ Similarly, results from the 1985 Resurvey, as
 33 well as responses from students at a midwestern university, indicated
 34 a higher level of assaults between cohabitants than in the college
 35 sample of dating couples or the national sample of married couples;
 36 and higher rates among dating couples than married.⁸⁶ As with other
 37 types of intimate violence, the risk of injury--and of lethal
 38 injury--is quite different for women and men. In one study of
 39 college students, women were four times as likely to sustain moderate
 40 to severe injuries as a result of dating violence than were males.⁸⁷

41
42 Self-reported motivations for perpetrating dating violence also
 43 differ. Whereas most women give self-defense or retaliation as their
 44 motivation, male respondents were most likely to report that the
 45 purpose of their violence was to "intimidate," "frighten," or "force
 46 the other person to do something."⁸⁸ Violence as a response to
 47 sexual denial was also frequently reported by males. If violence
 48 occurs once in a dating relationship, it is very likely to occur
 49 again, with a mean number of 9.6 incidents.⁸⁹ Thus it is not
 50 surprising that these assaults may result in injury over time.

Sexual Assault in Dating Relationships

Rape victimization for females is highest in the 16-19 year age group, and next-highest in the 20-24 year age group; with overall rates about four times as high as the mean for all women.²¹ In some research on college campuses, 20% to 25% of college women reported forcible sexual attempts by a date, and 26% of college men reported making forcible sexual attempts or forcible rapes. In one study, 35% of male university students reported a willingness to commit rape under certain circumstances (i.e., if assured the rape would not be reported) and adhered to strongly rape-supportive beliefs and attitudes.⁹⁰ A carefully administered survey of over 6,000 college students found that 42% of women students reported some type of sexual assault, including forcible sexual contact, attempted rape, and completed rape.^{18,91} Rapes and attempted rapes involved greater levels of violence than did non-sexual assaults in dating relationships. Rates of rape victimization did not vary significantly based on whether the school was large or small, or located in an urban, metropolitan, or rural area. Current estimates suggest that one in 3.6 college women has been a victim of rape or attempted rape during their lifetime.^{91,92} In investigating the incidence of forcible rapes and attempted rapes of adolescent girls, a national survey (based on reports of the perpetrators) estimated a minimum of 540,000 assaults of female teenagers per year.⁹³

Increasing Severity of Non-Marital Violence for Women

The reported levels of both non-sexual and sexual physical assaults against girls or women by non-marital intimate partners have increased during the past 15 years. Although some of this may be due to a greater sensitivity to dating and cohabiting violence as an issue, levels of severe intimate violence against women do appear to be increasing. For example, although the rate of homicide victimization for male partners in dating or living-together relationships has varied unsystematically, the rate of females killed by dating or cohabiting partners increased sharply from 1976 through 1987.⁵¹ This may be due, in part, to a lack of interventions targeted for dating and cohabiting partners. Shelters, and most domestic violence legislation, tend to address problems of safety and access for those who are married or cohabiting. Few, if any, services--except on some high school or college campuses--are structured for individuals assaulted by a dating partner. Thus it is possible that the relationship types with the highest risk for violence, sexual assaults, and lethal violence are the ones least served by current societal interventions.

Considerations for Health Care Providers

Violence in dating relationships traditionally has been considered relatively non-serious, with few services or protocols designed to address it. However, recent evidence on the prevalence,

1 morbidity, and increasing number of male-perpetrated homicides in
2 these relationships requires serious attempts to identify violence
3 between non-married intimates and effectively intervene. Screening
4 techniques to assess for current or past victimization should be
5 utilized for all categories of female patients, regardless of
6 demographic or relational circumstances.

7 8 SEXUAL MOLESTATION IN CHILDHOOD 9

10 Finally, a history of childhood sexual molestation is highly
11 associated with enduring physical and psychological sequelae, so that
12 a lack of knowledge regarding this history may confuse the medical
13 and psychological picture as viewed by a physician. Child sexual
14 molestation is typically not assessed as part of an adult intake
15 evaluation. However, left unaddressed, the long-term effects in
16 victims can be pronounced. Further, clinical studies indicate an
17 exceedingly high prevalence of child sexual abuse histories in
18 psychiatric patients. Given its salience for treatment providers
19 working with adult (as well as child) populations, the effects of
20 child sexual molestation will be briefly discussed.

21
22 Cases of child sexual assault first became recognized in large
23 numbers in the 1970s.⁹⁴ Prior to this, sexual molestation of
24 children was thought to be relatively rare and to occur only in the
25 most pathological of families. General practitioners expected to see
26 one or two cases at most in their lifetime. In recent years,
27 however, the American Humane Association has documented an increasing
28 number of reported cases of child sexual victimization, and several
29 studies have been conducted. Again, some of the increase in
30 reporting is related to an increase in public sensitivity. In the
31 past, children were primarily at risk from fathers, other male
32 relatives, and close family acquaintances. While these risks remain,
33 children today may also be at risk from greater use of outside child
34 care by single and divorced working mothers; the use of foster care
35 as the treatment of choice for abuse within families, without
36 adequate screening procedures for foster care settings; and national
37 trends toward living together and shorter marital relationships,
38 which may put children at risk from stepfathers and mothers'
39 boyfriends.

40 41 Long-term Effects 42

43 Impacts on psychological and social well-being. Long-term effects of
44 the experience of child sexual molestation include impacts on
45 emotions, self-perception, social functioning, and physical well-
46 being.⁹⁵⁻⁹⁷ Depression is the symptom most commonly reported among
47 women molested as children.⁵⁶ Adult survivors are more likely to
48 report depression, and to have been hospitalized for depression, than
49 other types of victims or non-victims. A high incidence of self-
50 destructive behavior, both suicide ideation and deliberate self-harm
51 (e.g., cutting, burning, or otherwise inflicting self-injury) has

1 also been found in adult survivors of child sexual assault;
2 distinguishing them even within clinical populations. This includes
3 an exceptionally high prevalence of suicide attempts reported among
4 adult survivors in community and college (up to 16%), as well as
5 clinical (up to 51%), samples.⁹⁸⁻¹⁰⁰ Symptoms of anxiety or tension,
6 including chronic and severe sleep disorders, anxiety attacks,
7 chronic fearfulness, and hyper-vigilance, also frequently are noted
8 in survivors, along with disturbances in adult sexual pleasure and
9 comfort.^{56,95,101}

10
11 Survivors of child sexual molestation also report a general
12 sense of alienation persisting into adulthood; as well as difficulty
13 trusting others, relating to women and to men, and parenting.^{56,102}
14 Even in general populations, a high percent of the victims of child
15 sexual molestation continue to feel isolated and stigmatized as
16 adults. Although by no means inevitable, approximately one-fifth of
17 child sexual abuse victims evidence serious long-term psychological
18 effects.⁵⁶ These may include disassociative responses triggered by
19 specific stimuli or anxiety-producing stressors; as well as other
20 PTSD indicators such as numbing of affect, chronic states of
21 inappropriate arousal, nightmares, and flashbacks. Victims who have
22 experienced abuse by fathers or stepfathers, whose assaults involved
23 genital contact, or whose molestation involved force, appear to be at
24 especially high risk for severe long-term sequelae.⁵⁶

25
26 Perhaps most troubling is the apparent vulnerability of women
27 who have been sexually abused as children to be revictimized later in
28 life by both strangers and intimates. A persistent vulnerability to
29 revictimization is one of the most consistent findings in both
30 clinical and empirical literature. In one random-sample study, 33%
31 to 68% of the sexual molestation victims later experienced a rape
32 (depending on the seriousness of the childhood abuse they suffered),
33 compared with 17% of women who were not child victims.¹⁰³ In a
34 survey of college students, women who had been sexually abused before
35 the age of 13 were the most at risk to later become victims of
36 nonconsensual sexual experiences.¹⁰⁴ Victims of child sexual abuse
37 also are more likely to be physically abused by husbands or other
38 adult partners when they reach adulthood.^{99,103,105} Other evidence
39 shows that many women who engage in prostitution were victims of
40 abuse as children, and violence perpetrated against current
41 prostitutes is not uncommon.

42
43 Impacts on Physical Health and Well-being. Many of the long-term
44 physical effects discussed in the section on rape are also seen in
45 adult survivors of childhood sexual abuse. Somatic disorders include
46 abdominal pain, headaches, and eating disorders (e.g., anorexia or
47 bulimia). Adult victims may also evidence the effects of venereal
48 disease. In a study of children, sexual victimization resulted in
49 the transmission of venereal disease in 13% of 409 victims.¹⁰⁶
50 Documented sequelae of child sexual abuse include herpes, chlamydia,
51 gonorrhea, syphilis, and trichomoniasis.^{107,108} Female victims of

1 child sexual assault also are at higher risk for substance abuse and
 2 the development of alcoholism than women without this childhood
 3 history.^{94,99,109} Experiences with child or adolescent sexual
 4 molestation may also engender a pattern of early drug use, with
 5 cumulative long-term effects.⁵⁶

6 7 Special Considerations for Health Care Providers

8
9 In patients presenting themselves for medical care, a history of
 10 child sexual molestation is almost always masked by other presenting
 11 problems. Further, medical and psychological symptomatology may be
 12 compounded by revictimization experiences, as well as by other life
 13 experiences resulting from emotional or behavioral sequelae.
 14 Indications that a history of child sexual abuse should be explored
 15 include: (1) symptoms of posttraumatic stress disorder, without an
 16 apparent history of current or past rape, dating violence, partner
 17 abuse, or other trauma; (2) evidence of ongoing severe depression--
 18 especially if accompanied by self-harm, including physical
 19 disfiguring of the body, eating disorders, and/or suicide attempts;
 20 (3) evidence of sexual dysfunction or unusual anxiety involving
 21 sexual activities or exposure of the body (possibly including
 22 medical--and especially gynecological--examinations); (4) early onset
 23 of alcohol or drug abuse; (5) a childhood history of running away, or
 24 placement in foster care or institutions; and (6) a history of
 25 repeated physical or sexual victimization.

26 27 PSYCHOPATHOLOGY VERSUS THE EFFECTS OF TRAUMA

28
29 Clinical studies have identified a high incidence of depression
 30 and elevated levels of alcohol and other substance abuse in women
 31 victims of violence--particularly those seen in emergency and in-
 32 patient settings, sometimes leading to DSM-III-R Axis I
 33 diagnoses.^{29,60} Diagnoses of personality or developmental disorders
 34 (Axis II) are also frequently assigned to women with histories of
 35 rape, child sexual molestation, or battering. A personality disorder
 36 is a diagnosis of social dysfunction and does not take into account
 37 the influence of environmental factors extrinsic to the organization
 38 of the personality.¹¹⁰ It may also be a problematic diagnosis for
 39 cases in which a trauma history is present, particularly if that
 40 history is not known to the clinician.

41
42 For example, in one study of adult women with sexual molestation
 43 histories, two-thirds met the diagnostic criteria for posttraumatic
 44 stress disorder. However, none had received that diagnosis and, in
 45 most cases, dealing with the impact of the childhood trauma was not
 46 even considered in treatment.¹¹¹ Yet both substance abuse and
 47 chronic depression, rather than symptoms of an Axis I disorder, may
 48 be the long-term effects of a history of victimization and are
 49 frequently found as sequelae to child sexual assault. Similarly,
 50 battered women's reactions to the violence they have experienced may
 51 approximate behavioral descriptors for borderline or other (Axis II)

1 personality disorders, although the same individual might not have
2 met the criteria for the disorder before the onset of recurring
3 attack.¹¹² An adapted MMPI (Minnesota Multiphasic Personality
4 Inventory) is now available for the assessment of battered women, to
5 accommodate the presence of real danger in their lives.
6

7 Clinicians in medical settings suggest that, in many cases, a
8 diagnosis of Posttraumatic Stress Disorder (PTSD) is often the most
9 accurate for victims of intimate violence.^{18,32,113} The "most common
10 traumata" suggested in the DSM-III-R for PTSD is "a serious threat to
11 one's life or physical integrity, or a serious threat or harm to
12 one's children..."; the discussion suggests that the disorder is
13 "apparently more severe and longer lasting when the stressor is of
14 human design." Further, the presence of ongoing physical or sexual
15 abuse is listed under the "Extreme Stressor" category--category
16 number five on the Axis IV classifications of severity.⁴¹(pp247-250)
17 (The only category more severe is reserved for "Catastrophic" events,
18 and includes captivity as a hostage and concentration camp
19 experiences.) However, for behaviors to be seen as posttraumatic
20 stress reactions, the trauma must be known--something that is not
21 possible if a detailed victimization history is not obtained and
22 effects are interpreted in isolation.
23

24 Given the disruption of developmental tasks and stages, Axis II
25 diagnoses are undoubtedly appropriate for some family violence
26 victims. In other cases, extreme stressors (e.g., violent attack)
27 may contribute to the emergence of a psychiatric disorder.
28 Inclusionary criteria for PTSD, structured for situations in which
29 the primary stressor is no longer present, do not always fit current
30 reactions of victims who are faced with ongoing threat or danger.
31 New designations, now being field tested, may provide expanded
32 classifications to better account for both the reactions of
33 individuals who have been victimized in the past, as well as those
34 who must respond to periodic assault and threat in their present
35 environments.
36

37 IMPLICATIONS FOR POLICY AND PRACTICE

38

39 Physicians and other health care providers rarely probe for the
40 underlying causes of the injuries they treat.^{61,114} However, a
41 treatment plan based primarily on the treatment of symptoms is
42 ineffective for a victim of violence if assaults are ongoing and thus
43 sequelae continually recur. Physicians and medical staff become
44 frustrated with trauma patients who return frequently with non-
45 specific and chronic complaints--symptoms that the best medical care
46 seems unable to alleviate. Treating only the symptoms initiates a
47 cycle of patient contacts with medical and mental health service
48 providers; with the attendant risks of increasingly severe and
49 debilitating sequelae for the patient, as well as the exhaustion of
50 resources within the system providing care. A more efficient
51 response over time is for medical professionals to routinely screen

1 for victimization, including intimate physical and sexual assault, in
2 their initial as well as ongoing assessments; and to develop
3 treatment plans that address the cause of the trauma as well as its
4 manifestations.^{62,115} Often, knowledge of a history of victimization
5 provides a starting point from which to disentangle a confusion of
6 presenting complaints and symptoms.

7 8 Guidelines for Medical Settings

9
10 Structured resources within a medical setting will greatly
11 facilitate effective interventions. Basic components for targeted
12 responses to violence against women include:

13
14 Training - to develop sensitivity to these issues, including an
15 awareness of risk factors, indicators, estimated prevalence in the
16 general and patient population, sequelae, and considerations for
17 health care providers. Training should include becoming familiar
18 with assessment procedures and interviewing techniques as recommended
19 in the setting; as well as with risk assessment, safety planning and
20 procedures for linking to resources. Further, training on
21 interpersonal violence should be incorporated into core curriculums
22 for undergraduate, graduate, and continuing education for those in
23 the health professions.

24
25 Protocols - to assess for current or past victimization as a
26 routine part of obtaining a medical/psychiatric history. Procedures
27 established for cases in which victimization is identified should be
28 adequate to give specific guidance, based on the type of abuse and
29 the individuals at risk (e.g., protocols for the victims of stranger,
30 versus marital or date rape; for a woman victim where a child is also
31 at risk). Procedures should also include a system of tracking, in
32 which the numbers and types of cases seen can be tabulated and
33 patients who repeatedly evidence abuse can be identified.

34
35 Response Staff - within the medical setting if possible, to
36 whom victims can be referred. Tasks of response staff would include
37 immediate safety planning, making victims aware of their legal
38 rights, area resources for safety and intervention, and services
39 available within the hospital and their community. Staff would
40 follow up with patients, and act as a link with both in-house and
41 community resources. Other tasks of the response staff would include
42 coordination of the tracking system, identification of high-risk (and
43 repeat) cases, and coordination of triage efforts for intensive
44 intervention with special risk cases.

45
46 Referral Sources - within the community or area for women
47 victims of violence. Medical settings should make themselves aware
48 of and develop linkages with a variety of area resources including:
49 battered women's shelters and crisis services, rape crisis centers
50 and services, services for adult survivors of child sexual abuse,
51 services for homeless women, legal services for women victims,

1 treatment programs for men who abuse female partners, and services
2 for abusive parents. A priority on the development of a wide-ranging
3 referral network, and the maintenance of positive and reciprocal
4 relations with the entities in this network, will be of great
5 benefit--to patients and their families as well as to medical
6 personnel who would no longer be required to carry the full burden of
7 intervention.

8
9 These community resources could work collaboratively with
10 hospitals or practices to see victims in the medical setting or to
11 train staff to become more knowledgeable in these areas. At the same
12 time, the health care community--hospitals and residency training
13 programs as well as individual physicians--might provide in-kind
14 services such as evaluations, screenings, and testing. Such services
15 might best be provided on site wherever the community resources are
16 located.

17
18 Health Care Goals for Women Victims of Violence

19
20 Treatment goals for women victims of violence include the
21 attainment of physical health, mental health, and safety from further
22 harm. At the AMA National Leadership Conference, Robert McAfee, MD,
23 current vice chairman of the Board of Trustees, stressed that
24 violence in America has become a "public health crisis of epidemic
25 proportions," and urged doctors to take an active role in finding
26 solutions to the effects of violence on the patients they serve
27 ("Doctors urged to act in 'crisis' of violence," American Medical
28 News, Mar. 4, 1991). Although the problem of violence against women
29 is pervasive and complex, Surgeon General Novello has urged that
30 physicians not be deterred in finding a role for themselves in the
31 solution, noting, "the human cost alone more than justifies swift
32 action by physicians to reduce these deaths and injuries."

33
34 Recognition of the prevalence and severity of violence against
35 women can be overwhelming. Yet a place to begin is in incorporating
36 this knowledge into routine questions for assessment, sensitive
37 responses to disclosure, and effective referrals to resources.

38
39 Routine screening leading to identification of female patients
40 who are or have been victims of violence. Routine screenings
41 should be carried out at the entry points of contact between
42 women and medical care: e.g., primary care, emergency services,
43 obstetric and gynecologic services, psychiatric services,
44 pediatric care, etc. Protocols to assess for victimization will
45 vary somewhat, depending on the medical context, but should be
46 based on assessment instruments in the scientific literature and
47 address the various types of victimization women experience.
48 Guidelines for obtaining information on a trauma history,
49 identifying coping mechanisms, and assessing the potential for
50 further danger are provided by McLeer and Anwar¹¹⁵, Patten and

1 colleagues,¹¹⁶ and the American College of Obstetricians and
2 Gynecologists.⁷³

3
4 Validation of the experience of victimization and of observed
5 symptomatology as possible sequelae. An explanation that many
6 people experience physically aggressive actions from their
7 intimates; that often they are afraid to tell anyone about it;
8 and that such experiences can have painful and even dangerous
9 sequelae should accompany assessments for victimization and
10 characterize professional responses to disclosure. One of the
11 greatest services a physician can provide to a patient is to
12 acknowledge the trauma and validate it as a threat to physical
13 and emotional well-being.³² In discussing physician's responses
14 to abused women, Anne Flitcraft, MD, notes that "the very
15 acknowledgment that domestic violence is going on, and that you
16 and she agree it is a serious problem, is a very powerful and
17 therapeutic first step."⁶²

18
19 Record-keeping regarding victimization history, observed
20 traumata potentially linked to the victimization, and referrals
21 made. Archival studies of medical records note that
22 victimization histories, if noted at all, are typically included
23 with a list of symptoms or behavioral problems--e.g., "Patient
24 presented with bruises and minor lacerations. Complaints of
25 chronic back pain, sleeplessness, and menstrual irregularity.
26 Reports marital difficulties with some hitting, some evidence of
27 substance abuse."^{60,113} More specific documentation, including
28 (a) indications of a trauma history from the initial screening,
29 (b) what the patient has disclosed about past or current
30 victimization, (c) a description of symptomatology potentially
31 linked to the victimization, and (d) referrals made, based on
32 this history provides a basis for later review of treatment
33 plans. Such a record is also useful to assess progress, or to
34 indicate the need for more intensive interventions at a later
35 contact with the patient.

36
37 Referral to within-setting and/or community trauma-specific
38 resources. After disclosure of victimization to a physician or
39 other staff, referral should be made as quickly as possible to
40 specially trained staff within the setting or, if none are
41 available (e.g., in a private practice), to outside resources.
42 Whenever possible, these resources should be "trauma-specific"--
43 e.g., rape victims would be referred to those with expertise in
44 rape crisis and/or marital or date rape; abused women would be
45 referred to resources with expertise in domestic violence, and
46 so forth.⁵⁹ Consonant with the goals stated at the beginning of
47 this section, referral and intervention procedures should take
48 into account the safety of the woman victim.

49
50 Particularly in cases of domestic violence where victims are
51 still with their abusers, protocols need to address: (a) the

1 handling of referrals when the assailant is on the premises,
2 (b) procedures for response if the immediate need of the patient
3 is for protection, and (c) the context within which the
4 "problem" of ongoing abuse and threat is to be addressed. In a
5 medical setting, such cases are most typically referred for
6 family (or couples) counseling, but are almost never referred to
7 resources designed to deal with women who are or have been
8 victimized by intimates. Physicians and other medical personnel
9 frequently do not even know what resources are available in
10 their area with expertise on wife abuse, rape and date rape, or
11 shelter. Referring a current victim to counseling with her
12 assailant is potentially dangerous. If she has no opportunity
13 to work through some issues apart from him, a victim may resist
14 discussing the issues, or completely deny that a problem exists,
15 in an attempt not to anger her partner and further endanger
16 herself.

17
18 RECOMMENDATIONS FOR POLICY

19
20 The Council on Scientific Affairs recommends:

- 21
- 22 1. That the American Medical Association, working with members
23 of the Federation and other relevant organizations,
24 undertake a campaign to alert the health care community to
25 the widespread prevalence of violence against women--that
26 the effects of such violence are likely seen on a regular
27 basis--and to sensitize them to the needs of victims of
28 violence;
 - 29
30 2. That the AMA encourage physicians to routinely incorporate
31 screening leading to identification of female patients who
32 are or have been victims of violence;
 - 33
34 3. That the AMA encourage physicians to give due validation to
35 the experience of victimization and of observed
36 symptomatology as possible sequelae;
 - 37
38 4. That the AMA encourage physicians to record a patient's
39 victimization history, observed traumata potentially linked
40 to the victimization, and referrals made;
 - 41
42 5. That the AMA encourage physicians to refer patients to
43 within-setting and/or community-based trauma-specific
44 resources as soon as possible;
 - 45
46 6. That the AMA encourage the incorporation of training on
47 interviewing techniques, risk assessment, safety planning,
48 and procedures for linking to resources into undergraduate,
49 graduate and continuing medical education programs;

- 1 7. That the American Medical Association collect and
2 disseminate protocols on identifying and treating victims
3 of violence and develop, in conjunction with other relevant
4 organizations, guidelines for treatment where protocols are
5 absent; and,
6
- 7 8. That these recommendations be adopted and the remainder of
8 this report be filed.

References

1. Kempe CH, Silverman FN, Steele BF, Droegemueller W, Silver H. The battered child syndrome. JAMA. 1962;181:107-112.
2. Steele B, Pollock C. A psychiatric study of parents who abuse infants and small children. In: Helfer R, Kempe CH, eds. The Battered Child. Chicago, IL: University of Chicago Press; 1968:103-148.
3. Gil DG. Violence Against Children. Cambridge, MA: Harvard University Press; 1970.
4. Fagan J, Browne A. Violence between spouses and intimates. Panel on the Understanding and Control of Violent Behavior. The National Research Council, National Academy of Sciences; 1991.
5. Schechter S. Women and Male Violence. Boston, MA: South End Press; 1982.
6. Finkelhor D, Yllo K. License to Rape: Sexual Abuse of Wives. New York: Holt, Rinehart, and Winston; 1985.
7. Koss MP. The hidden rape victim: Personality, attitudinal, and situational characteristics. Psychology of Women Quarterly. 1985;9:193-212.
8. Koss MP, Woodruff WJ, Koss PG. Criminal victimization among primary care medical patients: prevalence, incidence, and physician usage. Behavioral Sciences and the Law. 1991;9:85-96.
9. Langan PA, Innes CA. Preventing Domestic Violence Against Women. Washington, DC: US Dept of Justice, Bureau of Justice Statistics; 1986.
10. Russell DEH. Rape in Marriage. New York: Macmillan; 1982.
11. Browne A, Williams KR. Exploring the effect of resource availability and the likelihood of female-perpetrated homicides. Law and Society Review. 1989;23:75-94.
12. Pleck E. Domestic tyranny: The Making of American Social Policy Against Family Violence from Colonial Times to the Present. New York: Oxford University Press; 1987.
13. Council on Scientific Affairs. AMA diagnostic and treatment guidelines concerning child abuse and neglect. JAMA. 1985;254:796-800.
14. Council on Scientific Affairs. Elder abuse and neglect. JAMA. 1987;7:966-971.

15. Bienen LB. Rape III--National developments in rape reform legislation. Women's Rights Law Reporter. 1981;3:171-213.
16. Bohmer C. Acquaintance rape and the law. In: Parrot A, ed. Acquaintance Rape. New York: John Wiley; 1990.
17. Searles P, Berger RJ. The current status of rape reform legislation: an examination of state statutes. Women's Rights Law Reporter. 1987;9:25-43.
18. Koss MP, Harvey M. The rape victim: clinical and community approaches to treatment. Beverly Hills: Sage; 1991.
19. Bureau of Justice Statistics. Criminal victimization in the United States, 1987. Washington, DC: US Department of Justice; 1989.
20. Uniform Crime Reports. Washington, DC: US Dept of Justice, Federal Bureau of Investigation; 1982.
21. Bureau of Justice Statistics. Criminal victimization in the United States, 1982. Washington, DC: US Department of Justice; 1984.
22. Koss MP. The women's mental health research agenda: violence against women. Am Psychol. 1990;45:374-380.
23. Koss MP. Hidden rape: Sexual aggression and victimization in a national sample of students in higher education. In: Burgess AW, ed. Rape and Sexual Assault. New York: Garland; 1988;2:3-25.
24. Kilpatrick DG, Saunders BE, Veronen LJ, Best CL, Von JM. Criminal victimization: Lifetime prevalence, reporting to police, and psychological impact. Crime and Delinquency. 1987;33:479-489.
25. Wyatt GE. Testimony before the United States House of Representatives Select Committee on Children, Youth, and Families. June 1990.
26. Koss MP, Koss P, Woodruff WJ. Relation of criminal victimization to health perceptions among women medical patients. J Consult Clin Psychol. 1990;58:147-152.
27. Forman B. Psychotherapy with rape victims. Psychotherapy: Theory, Research, and Practice. 1980;17:304-311.
28. Burgess AW, Holmstrom LL. Rape: Crisis and Recovery. Bowie, MD: Bady; 1979.

29. Kilpatrick DG, Veronen LJ, Best VL. Factors predicting psychological distress among rape victims. In: Figley CR, ed. Trauma and Its Wake. New York: Brunner/Mazel; 1985.
30. Resick P, Calhoun K, Atkeson B, Ellis E. Adjustment in victims of sexual assault. Journal of Consulting and Clinical Psychology. 1981;49:705-712.
31. Resick P. Sex-role stereotypes and violence against women. In: Franks V, Rothblum ED, eds. The Stereotyping of Women: Its Effects on Mental Health. New York: Springer; 1983.
32. Burge SK. Violence against women as a health care issue. Family Medicine. 1989;21:368-373.
33. Schram D. Rape. In: Chapman J, Gates G, eds. The Victimization of Women. Beverly Hills, CA: Sage Publications; 1978:53-80.
34. Finkelhor EM, Atkeson BM, Calhoun KS. An assessment of long-term reactions to rape. J Abnorm Psychol. 1981;90:263-266.
35. Resick PA, Jordan CG, Girelli SA, Hutter CK, Marhoefer-Dvorak S. A comparative outcome study of behavioral group therapy for sexual assault victims. Behavior Therapy. 1989;19:385-401.
36. Frank E, Stewart BD. Depressive symptoms in rape victims: A revisit. J Affective Disord. 1984;7:77-85.
37. Schepple KL, Bart PB. Through women's eyes: Defining danger in the wake of sexual assault. J Social Issues. 1983;39:63-81.
38. Sorenson SB, Golding JM. Depressive sequelae of recent criminal victimization. J Traumatic Stress. 1990;3:1154-64.
39. Sales E, Baum M, Shore B. Victim readjustment following assault. J Social Issues. 1984;37:5-27.
40. Koss MP, Dinero TE, Seibel C, Cox S. Stranger, acquaintance, and date rape: is there a difference in the victim's experience? Psychology of Women Quarterly. 1988;12:1-24.
41. American Psychiatric Association. Diagnostic and Statistical Manual of Mental Disorders (Third Edition-Revised). Washington, DC: American Psychiatric Association; 1987.
42. Foa EB, Olasov B, Steketee G. Treatment of rape victims. Presented at Sexual Assault Conference; 1987; Charleston, SC.
43. Golding JM, Stein JA, Siegel JM, Burnam MA, Sorenson SB. Sexual assault history and use of health and mental health services. Am J Community Psychol. 1988;16:625-644.

44. Koss MP, Woodruff WJ, Koss PG. Deleterious effects of criminal victimization on women's health and medical utilization. Arch Intern Med. 1991;51:342-347.
45. Pagelow MD. Family Violence. New York: Praeger; 1984.
46. Straus MA, Gelles RJ. Physical violence in American families: Risk factors and adaptations to violence in 8,145 families. New Brunswick, NJ: Transaction Publishers; 1990.
47. Straus MA, Gelles RJ, Steinmetz S. Behind closed doors: Violence in the American family. Garden City, NY: Anchor Press; 1980.
48. Frieze IH, Browne A. Violence in marriage. In: Ohlin L, Tonry M, eds. Family Violence: Crime and Justice, A Review of Research. Chicago, IL: University of Chicago Press; 1989:163-218.
49. Stats JE, Straus MA. Gender differences in reporting of marital violence and its medical and psychological consequences. In: Straus MA, Gelles RJ, eds. Physical violence in American families: Risk factors and adaptation to violence in 8,145 families. New Brunswick, NJ: Transaction Publishers; 1990:151-165.
50. Lentzner ER, DeBerry MM. Intimate victims: A study of violence among friends and relatives. Washington DC: US Department of Justice, Bureau of Justice Statistics; 1980.
51. Browne A, Williams KR. Trends in partner homicide: A comparison of homicides between marital and non-marital partners from 1976-1987. New York: Macmillan; In press.
52. Walker LE. The Battered Woman Syndrome. New York: Springer; 1984.
53. Browne, A. When Battered Women Kill. New York: Macmillan/Free Press; 1987.
54. US Commission on Civil Rights. Under the Rule of Thumb: Battered Women and the Administration of Justice. Washington, DC: US Government Printing Office. 1982.
55. Hotaling GT, Sugarman DB. An analysis of risk markers in husband to wife violence: the current state of knowledge. Violence and Victims. 1986;1:101-124.
56. Browne A, Finkelhor D. The impact of child sexual abuse: A review of the research. Psychol Bull. 1986;99:66-77.

57. Margolin G. Interpersonal and intrapersonal factors associated with marital violence. In: Hotaling GT, Finkelhor D, Kirkpatrick JT, Straus MA, eds. Family Abuse and Its Consequences: New Directions for Research. Newbury Park, CA: Sage; 1988:203-217.
58. Bard M, Sangrey D. The Crime Victim's Book. 2nd ed. New York: Brunner/Mazel; 1986.
59. Browne A. The victim's experience: Pathways to disclosure. Psychotherapy. 1991;28:150-156.
60. Stark E, Flitcraft A. Violence among intimates: an epidemiological review. In: Van Hasselt VB, Morrison RL, Bellack AS, Hersen M, eds. Handbook of Family Violence. New York: Plenum Press; 1988:293-318.
61. Stark E, Flitcraft A, Frazier W. Medicine and patriarchal violence: The social construction of a "private" event. Int J Health Serv. 1979;9:461-493.
62. Randall T. Domestic violence intervention calls for more than treating injuries. JAMA. 1990;264:939-940.
63. Stark E, Flitcraft A, Zuckerman D, Grey A, Robison J, Frazier W. Wife Abuse in the Medical Setting: An Introduction for Health Personnel. Monograph #7, Office of Domestic Violence, Washington, DC; 1981.
64. Jacobson A, Richardson B. Assault experiences of 100 psychiatric inpatients: evidence of need for routine inquiry. Am J Psychiatry. 1987;144:908-913.
65. Health Care Systems Committee of Tulsa, Oklahoma. Adult Abuse and Neglect: Handbook for Medical Personnel. Tulsa, OK: Health Care Systems Committee; 1984.
66. Saltzman LE. Battering during pregnancy: a role for physicians. Atlanta Medicine. 1990;64:45-48.
67. Gelles RJ. Violence and pregnancy: Are pregnant woman at greater risk of abuse? J Marriage and the Family. 1988;50:841-847.
68. Helton A, McFarlane J, Anderson E. Battered and pregnant: a prevalence study. Am J Public Health. 1987;77:1337-1339.
69. Bullock L, McFarlane J. The birthweight/battering connection. Am J Nurs. 1989;89:1153-1155.

70. Newberger EH, Lieberman ES, McCormick MC, Yllo K, Gary LT, Schechter S. Pregnant woman abuse and adverse birth outcomes: current knowledge and implications for practice. In: Fuchs F, Stubblefield PG, Fuchs AR, eds. Preterm Birth: Causes, Prevention, and Treatment. 2nd ed. Elmsford, NY: Pergamon. In 2press.
71. Sorenson S, Stein J, Seigel J, Golding J, Burnam A. The prevalence of adult sexual assault. Am J Epidemiol. 1987;126:1154-1163.
72. Helton A, McFarlane J, Anderson E. Prevention of battering during pregnancy: Focus on behavioral change. Public Health Nurs. 1987;4:166-174.
73. American College of Obstetricians and Gynecologists. The Battered Woman. Washington, DC: American College of Obstetricians and Gynecologists; 1989. (ACOG Technical Bulletin No. 124).
74. Telch CF, Lindquist C. Violent vs. non-violent couples: A comparison of patterns. Psychotherapy. 1984;21:242-248.
75. Walker LE. The Battered Woman. New York: Harper and Row; 1979.
76. Washburn C, Frieze IH. Cited in: Frieze IH, Browne A. Violence in marriage. In: Ohlin L, Tonry M, eds. Family Violence: Crime and Justice, A Review of Research. Chicago, IL: University of Chicago Press; 1989:163-218.
77. Straus MA. Ordinary violence, child abuse, and wife-beating: what do they have in common and why? In: Finkelhor D, Gelles RJ, Hotaling GT, Straus MA, eds. The Dark Side of Families. Beverly Hills, CA: Sage; 1983:213-234.
78. McKibben L, DeVos E, Newberger EH. Victimization of mothers and abused children: A controlled study. Pediatrics. 1989;84:531-535.
79. Goldberg WG, Tomlanovich MC. Domestic violence victims in the emergency department: new findings. JAMA. 1984;251:3259-3264.
80. Fagan J, Friedman E, Wexler S, Lewis V. The National Family Violence Evaluation: Final Report, Volume I-Analytical Findings. San Francisco: URSA Institute; 1984.
81. Frieze IH. Investigating the causes and consequences of marital rape. Signs. 1983;8:532-552.
82. Bowker L. Beating wife-beating. Lexington MA: DC Heath; 1983.

83. Shields N, Hanneke CR. Battered wives' reactions to marital rape. In: Finkelhor D, Gelles RJ, Hotaling GT, Straus MA, eds. The Dark Side of Families. Beverly Hills, CA: Sage; 1983:131-148.
84. Pirog-Good MA, Stets JE. Violence in dating relationships: Emerging Social Issues. New York: Praeger; 1989.
85. Yllo K, Straus MA. Interpersonal violence among married and cohabiting couples. Family Relations. 1981;30:339-347.
86. Stets JE, Straus MA. The marriage license as a hitting license: A comparison of assaults in dating, cohabiting, and married couples. In: Straus MA, Gelles RJ, eds. Physical Violence in American Families: Risk Factors and Adaption to Violence in 8,145 Families. New Brunswick, NJ: Transaction Publishers; 1990:227-244.
87. Makepeace JM. Gender differences in courtship violence. Family Relations. 1986;36:383-388.
88. Sugarman DB, Hotaling GT. Dating violence: Prevalence, context, and risk markers. In: Pirog-Good MA, Stets J, eds. Violence in Dating Relationships: Emerging Social Issues. New York: Praeger; 1989.
89. Roscoe B, Benaske N. Courtship violence experienced by abused wives: similarities in patterns of abuse. Family Relations. 1985;34:419-424.
90. Malamuth NM. Factors associated with rape as predictors of laboratory aggression against women. J Pers Soc Psychol. 1983;45:432-442.
91. Koss MP, Gidycz CA, Wisniewski N. The scope of rape: incidence and prevalence of sexual aggression and victimization in a national sample of higher education students. J Consult Clin Psychology. 1987;55:162-170.
92. Warshaw R. I Never Called it Rape. New York: Harper and Row; 1988.
93. Ageton SS. Sexual Assault Among Adolescents. Lexington, MA: DC Heath; 1983.
94. Peters SD, Wyatt GE, Finkelhor, D. Prevalence. In: Finkelhor D, ed. A Sourcebook on Child Sexual Abuse. Beverly Hills, CA: Sage; 1986:15-59.
95. Meiselman K. Incest. San Francisco: Jossey-Bass; 1978.

96. Herman JL. Father-daughter incest. Cambridge, MA: Harvard University Press; 1981.
97. Gold E. Long-term effects of sexual victimization in childhood: An attributional approach. J Consult Clin Psychol. 1986;54:471-475.
98. Bagley C, Ramsay R. Disrupted childhood and vulnerability to sexual assault: Long-term sequels with implications for counselling. Presented at the Conference on Counselling the Sexual Abuse Survivor; 1985; Winnipeg, Manitoba, Canada.
99. Briere J. The effects of childhood sexual abuse on later psychological functioning: Defining a post-sexual abuse syndrome. Presented at the Third National Conference on Sexual Victimization of Children; 1984; Washington, DC.
100. Sedney MA, Brooks B. Factors associated with a history of childhood sexual experience in a nonclinical female population. J Am Acad Child Adolesc Psychiatry. 1984;23:215-218.
101. Newberger CM, DeVos E. Abuse and victimization: Life-span developmental perspective. Am J Orthopsychiatry. 1988;58:505-511.
102. Goodwin J, McCarthy T, Divasto P. Prior incest in mothers of abused children. Child Abuse Negl. 1981;5:87-96.
103. Russell DEH. The Secret Trauma: Incest in the Lives of Girls and Women. New York: Basic Books; 1986.
104. Fromuth CJ. Cited in: Browne A, Finkelhor D. The impact of child sexual abuse: A review of the research. Psychol Bull. 1986;99:66-77.
105. Briere J. Therapy for Adults Molested as Children: Beyond Survival. New York: Springer; 1989.
106. White KN, Snyder J, Bourne R, Newberger EH. Treating Child Abuse and Family Violence in Hospitals. Lexington, MA: Lexington Books; 1989.
107. Canavan JW. Sexual child abuse. In: Ellerstein NS, ed. Child Abuse and Neglect: A Medical Reference. New York: Wiley; 1981:233-251.
108. Newberger EH. Child abuse. In: Rosenberg ML, Fenley MA, eds. Violence in America. New York: Oxford University Press; In press.

109. Miller BA, Downs WR, Gondolf DM, Keil A. The role of childhood sexual assault in the development of alcoholism in women. Violence and Victims. 1987;2:57-172.
110. Bassuk EL, Rubin L, Lauriat A. Characteristics of sheltered homeless families. Am J Public Health. 1986;76:1097-1101.
111. Craine P. Cited by: Gondolf EW. Psychiatric Responses to Family Violence: Identifying and Confronting Neglected Danger. Lexington, MA: Lexington Books; 1990.
112. Rosewater LB. Battered or schizophrenic? Psychological tests can't tell. In: Yllo K, Bograd M, eds. Feminist Perspectives on Wife Abuse. Newbury Park, CA: Sage Publications; 1988:200-216.
113. Gondolf EW. Psychiatric Responses to Family Violence: Identifying and Confronting Neglected Danger. Lexington, MA: Lexington Books; 1990.
114. Warshaw C. Gender and Society. 1989;3:506-517.
115. McLeer SV, Anwar RA. The role of the emergency physician in the prevention of domestic violence. Ann Emerg Med. 1987;16:1155-1161.
116. Patten SB, Gatz YK, Jones B, Thomas DL. Post-traumatic stress disorder and the treatment of sexual abuse. J Nat Assoc Social Workers. 1989;34:197-203.

REPORT OF THE BOARD OF TRUSTEES

Report: G
(I-91)

Subject: A Proposed AMA National Campaign Against
Family Violence

Presented by: Joseph T. Painter, MD, Chairman

Referred to: Reference Committee D
(Joseph S. Whaley, MD, Chairman)

1 Violence is one of the major public health problems facing the
2 United States today, and its sequelae touch all segments and age
3 groups of our society. Violence is broadly defined as the use of
4 physical force to inflict injury or death upon oneself or
5 another.¹ Approximately 20,000 deaths per year are attributed to
6 intentional violence perpetrated by one person on another,² with
7 12,000 of these deaths involving firearms.³ Another 30,000 people
8 die each year as a result of self-directed violence.² In
9 addition, almost 300,000 people are hospitalized every year
10 secondary to intentional violence.² According to the Federal
11 Bureau of Investigation (FBI), there were 834,322 serious assaults
12 in 1986;² these FBI figures understate the problem, since not all
13 assaults are reported.¹

14
15 According to the Centers for Disease Control, homicide and
16 suicide are among the foremost causes of premature death in the
17 United States. Together, they are the fourth leading cause of years
18 of potential life lost to Americans under the age of 65.¹
19 Violence is the major cause of death among young black males,⁴
20 whose homicide rates within extremely impoverished urban
21 neighborhoods are as high as 142 per 100,000.¹ However, violent
22 injuries are not limited to males: between 4 and 6 million women
23 are victims of violence every year,⁴ and rapes alone are estimated
24 to occur at the rate of 12 per hour (Chicago Tribune, March 22,
25 1991, Section 1, p.11). Violence costs the American economy at
26 least \$45 billion annually.¹

27
28 Interpersonal violence is a broad term used to categorize any
29 violence (be it physical or mental) between individuals, and the
30 relationship between these individuals is an important factor. When
31 violence occurs between individuals who are intimate, it is usually
32 referred to as family violence. Violence among family members has
33 reached epidemic proportions. For example, more than 2 million
34 cases of child abuse and neglect are reported annually. Most sexual
35 abuse of children is perpetrated by family members. Between 2 and 4
36 million women are battered by their spouses each year. As much as 3
37 percent of the elderly population is abused each year.¹

1 precipitate or sustain violence. Further, meaningful leadership
2 must be provided to the medical and health communities and society
3 at large as to how these factors can be altered to decrease the
4 frequency of violent behavior.

5
6 A systematic approach must also be used to develop the AMA's
7 specific role, and well-defined, achievable, and measurable goals
8 should be identified for at least a 3-5 year period. This
9 structured plan must be grounded solidly in science, since the
10 development of guidelines to aid physicians and other health
11 professionals in the identification, treatment, and prevention of
12 interpersonal violence must be built upon this foundation. This
13 information is also required to enable the development of a health
14 policy agenda to deal with violence and its victims, and to develop
15 and promote legislation that provides for the care of its victims,
16 and the prevention of future violence.

17
18 An essential component of this agenda is communication, which
19 must occur at many levels: 1) the various organizations with
20 expertise in the area of family violence must communicate with each
21 other and share their experience and knowledge in order to maximize
22 their efforts; 2) scientific information and research-based
23 interventions must be communicated to physicians, health care
24 providers, and the public health community; 3) the public must be
25 educated on the problem and the interventions that they can use to
26 protect themselves from this epidemic; 4) the public and the health
27 care community need to be made aware of what community resources are
28 available, and what other resources are needed; 5) legislators need
29 to understand the problem and develop practical solutions.

30 31 Content Considerations and Implications for Policy

32
33 Unlike the child abuse movement where physicians have played a
34 vital role, physicians have had minimal involvement in addressing
35 other forms of family violence such as sexual abuse, domestic
36 violence, and elder abuse. Yet, as they have in the area of child
37 abuse, physicians can make significant contributions to the
38 advancement of knowledge, practice, and policy. Rosalie Wolf⁵ in
39 a special review article discussed the role of physicians in
40 relation to the problem of elder abuse. Her recommendations,
41 applicable to all forms of abuse, outline the several vital roles
42 demanding the attention and participation of the physician community:

- 43
44 1. Physicians must become aware and knowledgeable about the
45 diagnosis and treatment of family violence.
- 46
47 2. All physicians must become familiar with applicable abuse
48 reporting laws and other legal requirements as well as
49 appropriate procedures for dealing with and referring
50 suspected cases of abuse.

1 include the development of local resource directories, distribution
2 of guidelines, protocols, model programs or conducting educational
3 programs (see Appendix).
4

5 Medical Resource Center: A resource center could be designed to
6 provide leadership, resource information and materials, technical
7 assistance and professional consultation in the prevention,
8 identification, diagnosis and treatment of family violence; train
9 professionals in the field of family violence; and identify, verify,
10 and disseminate treatment models (see Appendix). The resource
11 center agenda and activities would be determined by an AMA national
12 advisory group of experts in the field of family violence. The
13 advisory group would periodically meet with a coalition of national
14 organizations dedicated to addressing issues of family violence.
15

16 Conference: In 1985, then Surgeon General C. Everett Koop, MD,
17 convened the Surgeon General's Workshop on Violence and Public
18 Health. The focus of the so-called Leesburg Conference was directed
19 primarily at interpersonal violence within the family, placing
20 emphasis on the need for a multidisciplinary approach to the problem
21 and underscoring the fact that family violence is a public health
22 problem. Dr. Koop hoped this meeting would be the first of many and
23 recommended another workshop that would focus on the partnership
24 between health and justice.
25

26 As a result of increasing interest in this topic, it is
27 suggested that the Leesburg Conference be reconvened under the joint
28 sponsorship of the American Medical Association, the Surgeon
29 General, the Centers for Disease Control, and the American Bar
30 Association.
31

32 Recommendations for Policy

33

34 The Board of Trustees recommends that the following statements
35 be adopted and that the remainder of this report be filed. A
36 detailed action plan addressing the implementation of these
37 recommendations is attached as an appendix to this report. To
38 accomplish its goal, the American Medical Association should:
39

- 40 1. Develop a media campaign that announces and elaborates the AMA's
41 efforts to address family violence;
42
- 43 2. Establish a national coalition of Physicians Against Violence;
44
- 45 3. Establish a national medical resource center or clearinghouse
46 for the prevention of family violence; and,
47
- 48 4. Host a national conference to address family violence in
49 conjunction with other relevant organizations.

APPENDIX

NATIONAL COALITION OF PHYSICIANS AGAINST VIOLENCE:
MEMBER ACTIVITIES AND BENEFITS

Member Activities

- provide leadership at national, state, and local levels in the diagnosis, prevention, and treatment of family violence
- support AMA efforts to lobby for changes in federal and state legislation that supports children and families
- share information on policies and practices designed to diagnose, treat, and prevent family violence
- help disseminate practice guidelines, training materials, and other publications developed by the AMA's Resource Center on Family Violence
- assist in designing and carrying out a public information/education campaign aimed at preventing family violence by displaying posters and distributing educational materials
- encourage the development of state and local chapters on family violence

Member Benefits

- access to the Resource Center's newsletters and other publications
- participation in a national physicians' network that includes colleagues with similar interests and concerns
- timely notification of AMA-sponsored training events and conferences on family violence, as well as related events and conferences sponsored by other organizations and agencies
- listing in the Resource Center's directory of physicians concerned with family violence
- access to Resource Center information and services upon request
- receipt of a poster and membership certificate that can be used to alert patients to the physician's interest in and concern for this problem
- access to public education materials (pamphlets, brochures) that can be displayed or handed to patients

Clearinghouse Functions

- develops and maintains databases that contain bibliographic and programmatic information dealing with family violence
- responds to written, telephone, and in-person requests for materials and information, including standard requests for Clearinghouse materials and publications, as well as customized requests for information
- develops and disseminates publications and other resources for professionals and the general public, including bibliographies, state of the art papers, research briefs, directories of programs and people, catalogs of in-house materials, etc.
- develops and maintains a computerized mailing list, including various special interest categories for targeted mailings
- attends, presents, and exhibits at national conferences on family violence
- provides support to the AMA Board and House of Delegates on issues of family violence; assists in preparing AMA responses to requests on this topic from the White House, various government agencies, and/or Congress
- establishes networking relationships with government agencies, other resource centers and clearinghouses, professional associations, and other national organizations concerned with family violence

Establishing state and local medical society violence prevention committees	Science* Auxiliary Medical Society Relations	1/92-1/93
AMA Advisory Group on Family Violence	Science*	1/92, 9/93
Coalition of national organizations on family violence	Science*	9/92
AMA Work Groups on Family Violence	Science*	
Child Abuse		1/92
Domestic Violence		1/92
Sexual Abuse		3/92
Elder Abuse		6/92
Family Violence & the Workplace	Ongoing	
Leesburg Conference planning group		6/93

To assist physicians in diagnosing, treating and preventing family violence.

**AMA National Resource Center/
Clearinghouse on Family Violence**

Providing technical assistance to state and county medical society violence prevention committees	Science* Auxiliary	1/92- Ongoing
Collecting and disseminating guidelines and protocols for physicians and medical practice areas	Science*	10/1/91 Ongoing
Newsletters to members of the National Coalition, Auxiliary members, state, county and specialty societies	Science*	1/92, 6/93 10/92
Council on Scientific Affairs Activities		
<u>Reports:</u>	Science*	
Violence Against Women		Completed
Violence to and by Adolescents		10/91
Neuroscience of Violence		10/91
The Impact of Family Violence on Mental Health		2/92
Substance Abuse and Violence		6/92
Abuse of Pregnant Women and Adverse Birth Outcomes		6/92
Relationship of family violence to the workplace		6/92
The media and violence - an update		8/92

1. The first part of the document discusses the importance of maintaining accurate records of all transactions and activities.

2. The second part of the document discusses the importance of maintaining accurate records of all transactions and activities.

TESTIMONY FOR THE PUBLIC HEARING ON VIOLENCE AGAINST WOMEN

Sponsored by the State of New Jersey
Commission on Sex Discrimination in the Statutes
March 20, 1992

Submitted by Courtney N. Esposito
Womanspace, Inc.
Lawrenceville, N.J.

Senator Lipman, Ms. Griffin, Members and Staff. of the Commission
and colleagues:

Good afternoon. My name is Courtney Esposito. I am a domestic violence consultant and educator, have worked in the field of domestic violence prevention since 1978, am a survivor of abuse and serve on the Boards of Womanspace in Mercer County, the National Woman Abuse Prevention Center in Washington, DC, and on the New Jersey Advisory Council on Domestic Violence.

I would like to begin my testimony with an excerpt from a letter to the editor of Ms. Magazine in response to that magazine's national readership survey on violence against women. Mary Bryant of Fulton, MO. wrote:

"...The fear is always there--on the street, in the workplace and at home. We avert our eyes, refuse ground floor hotel/motel rooms. We lock doors and windows. We stand to one side and act as if we're waiting for someone rather than get on an elevator alone with a man. We walk quickly through dim parking garages with keys gripped in one hand and a mace cartridge in the other. Sometimes we ridicule ourselves for being paranoid. Then we read the morning paper."

A broad definition of violence, or abuse, would be any behavior which treats a person like a thing. More specifically, violent or abusive behavior is behavior which physically harms, like battering, rape or incest; behavior which arouses fear, like threats of physical harm, threats to kidnap or kill the children, sexual harassment on the street, on the job, in a bar or in an elevator; behavior which prevents a woman from doing what she wishes, like wearing a certain color, seeing family or friends, going to school, properly feeding and adequately clothing her children or herself, applying for a certain job or running for public office, having the right to choose to have an abortion, to preach a sermon or to lead a congregation; or behavior which forces a woman to behave in ways she does not want to, like only wearing one color, forcing her to have sex with his friends every Friday night in front of a video camera, or returning to live with an abusive husband because he can afford a good lawyer but she cannot, or because there is no decent affordable housing available for her and her children to move in to.

A prominent comic jokes that it's OK for men to have sex with their daughters because they pay for their tuition, and boasts on video that he'll burn a woman with a cigarette if she doesn't screw him with enough enthusiasm. This is violence against women.

In 1980, while commenting on pending marital rape legislation, California State Senator Bob Wilson asked "If you can't rape your own wife, who can you rape?" This is violence against women.

Heavy metal and rap musicians harmonize to the world and to our children about raping a woman with a flashlight, suggest that women be "smoked" with an Uzi submachinegun, and brag "I used to love her, but I had to kill her....And now I'm happier this way." This is violence against women.

A video game called "Custer's Revenge" shows a naked General Custer raping an Indian woman tied to a post. This is violence against women.

Congresswoman Pat Schroeder maintains that most women are one man away from poverty. And this is violence against women.

25% of college men in one survey experienced rape or attempted rape. 15% of the college men in another study admitted they had forced a woman to have sex. 51% of college men in a third survey said they would rape if they were certain they could get away with it. This is violence against women.

Dr. Gloria Bachman of Robert Wood Johnson Medical Center found that one in four women she surveyed had been sexually assaulted as children. This is violence against women.

31% of all female homicide victims in 1988 were killed by their husbands or boyfriends, and 25% of all pregnant women are being abused. In pregnant battered women, dominant targets of assault are the breasts, abdomen and genitalia. This is violence against women.

In 1987, approximately 375,000 women and children sought refuge in some 1,200 shelters and safe homes across the country. But nearly 40% of women seeking immediate shelter were turned away because of a lack of space. The same dilemma is faced daily by New Jersey's domestic violence programs. And this is violence against women.

I could go on and on and on with alarming statistics and horrifying examples of violence perpetrated against women in our society. Instead, I submit to the Commission the following documents:

- Violence Against Women: A MS. Report on Life in Our Times
- American Medical News, January 6, 1992 edition entitled "Seeing the Pain - America's Physicians Confront Family Violence"
- The American Medical Association's Report on Violence Against Women, with statistical data and study reviews concerning rape, physical and sexual assaults by marital or dating partners, and the long-term effects of child sexual molestation in adult women. This report also contains recommendations for policy for its individual members and state and local member organizations.
- The American Medical Association's Policy and Planning Report for a National Campaign Against Family Violence

I would like to focus now on personal, professional and institutional minimization, avoidance and denial of the systematic violence against women. I begin with victim-blaming as a national pasttime.

Most often, exhortations to women concerning their personal safety are based on a "blame the victim" mentality. We are told not to go out alone at night (a clear predicament if you work the 3PM - 11PM shift at the hospital), not to wear attractive clothing, not to be friendly on the street or make eye contact with strangers. The underlying assumption is that what we do is decisive--our demeanor, our wardrobe, our carelessness, the visibility of our curves or the mere existence of our body parts--these invite violence or allow it to happen. From the flawed premise that being a woman must equal being victimized comes the conclusion that it is up to us, by changing our behavior, to prevent our own victimization. Truth be told, what we do does not decrease the incidence of men's attempts at violent acts against women. As one battered woman said of her husband's violence, "I may be his excuse, but I have never been his reason."

Men must stop committing violence against women, take away permission from each other to commit it, stop condoning it in others and stop blaming women for it. When Israeli legislators proposed a curfew on women in order to lower the incidence of rape, Golda Meir protested, "But it is the men who are attacking women. If there is to be a curfew, let the men stay home."

I submit also for your consideration a summary sheet of myths that support violence against women and contaminate our ability to help victims of violence. By assigning fault to the victim, we distance ourselves from the issue. The victim, not the violence, becomes the problem--a problem we will never solve should we accept this falsehood. As a pattern of power and coercive control, violence works--and it works particularly well when our response of choice to it is to neglect, stigmatize and even punish its victims. Violent behavior against women and children both within the family and within the fabric of society has historically been accepted and tolerated as a natural and inevitable dynamic. It has thus been legitimated by the community and its social and legal institutions. I believe it's time for a major change.

The process of change can only begin if we recognize violence against women as pervasive, redefine it as illegitimate and intolerable and provide safety and support for its victims. This is going to cost money, folks. Don't think for a moment that it isn't costing us more to not address violence and its prevention. Family violence researchers alone, including the American Medical Association and the Centers for Disease Control, believe that domestic violence may in fact be the primary drain on the American economy. By denying that violence against women exists, minimizing the extent to which it occurs, avoiding the real fact that it can and has happened to any one of us who is female, we might be able to feel untouched, safe and healthy for a time. This self-protective technique, which plays itself out on both individual and institutional levels, initiates and perpetuates a dynamic which increases the isolation of every

victim and ultimately and inevitable leads to her entrapment-- be it physical, social, legal or financial.

I offer you this definition of entrapment: Entrapment is repeated and consistent trauma (the rapist, the abusive husband, the incest perpetrator do that) coupled with negative outside treatment (we do that). When we refuse to recognize, hear or help women victimized by any and all forms of violence, we ensure that their lot will never change.

I would like to give you two major national examples of Denial with a capital D.

Despite the fact that we have known for a decade that as many as half of the women murdered in this country each year are killed by a male partner or ex-partner, and that battering is the single major cause of injuries to women, the original draft of the U.S. Department of Health and Human Services' document "Promoting Health/Preventing Disease: Year 2000 Objectives for the Nation" omitted the following four words: domestic violence, battered women. Although violent and abusive behavior was discussed, women as its primary victims were never even mentioned.

And the Hate Crimes Statistics Act, signed by President Bush, directs the U.S. Department of Justice to collect statistics on crimes motivated by a victim's race, religion, ethnicity, or sexual orientation. The Act purposefully ignored gender-biased crimes. Women as "lightning rods" for male abuse were again officially rendered invisible.

As my mother used to say, there is simply no excuse for this. This is just not good enough. The costs to our society, to this state, to individual women and their families, of this far-from-benign neglect are inestimable. It is time to talk prevention, to follow that talk with action, and to include dollar signs in the action. Survivors of violence against women want the beginnings of their fair share in the fiscal scheme of things.

I implore you to move and to shake the powers that be in this state to do better by women:

- * Advocate for every effort that proposes to assist victims and educate and sensitize the general public and helping professionals about the prevalence and effects and prevention of violence against women.
- The governing bodies of this state can and should, holistically and in a coordinated fashion, formulate and create policies and programs around the issue of violence against women. The New Jersey Advisory Council on Domestic Violence has had not a penny allocated to its voluminous and crucial work over the past five years. The Division on Women in 1984 had \$350,000 to conduct a public awareness campaign, and to train health care professionals, educators and the clergy on domestic violence awareness and intervention. That dollar figure is now zero. I

challenge the specious reasoning that our state cannot afford stationery, let alone staff, to deal effectively with this issue.

* Move and approve every law that you can that will in any way ease the physical, emotional and financial devastation of women.

The newly-amended Prevention of Domestic Violence Act is one of the best of its kind in the nation. Victims of family violence are being assisted greatly by the expanded provisions of this statute. Yet it was not easy to pass. The Marriage License Surcharge Bill never came to a vote. Domestic violence programs are forced to serve more and more clients at frozen funding levels. Additional resources that could be provided by this legislation are desperately needed in every county in the state.

* Encourage every study, stimulate every research effort that you can that will bring this problem out of the shadows and expose it to the light of public scrutiny.

* Initiate and support every appropriation possible to empower women and their children to live lives free from fear and violence.

I can assure you that all of us who work to prevent violence against women will continue to bring opportunities to safeguard our clients to your attention. I appreciate the opportunity to speak before you today, and I would be happy to answer any questions you may have. Thank you for your time and attention.

SUMMARY OF MYTHS THAT SUPPORT VIOLENCE AGAINST WOMEN

Type of myth	How the myth gets applied to each specific form of violence			
	Rape	Battering	Sexual harassment	Child sexual assault
Victim-blaming.	Women invite by their dress or behavior; women lead men too far; women want it and/or enjoy being raped.	Women invite by their behavior; women pick violent partners; women stay so they must like it.	Women invite by their dress or behavior; women sleep their way to the top or for good grades.	Little girls are seductive; mothers set up incestuous relationships by their own failure as sexual partners.
Not a common problem or not a real issue.	It's only done by perverts leaping from bushes.	Wives are violent, too.	It's just mutual attraction.	It isn't harmful to girls.
Male perpetrator isn't responsible for his actions.	Rapists are psychopaths; rapists are provoked.	Batterers are alienated at work or unemployed or grew up in violent homes, or are alcoholic.	Most harassers don't intend harm; they're just complimenting women.	Male relatives had no choice because their sexual needs were unmet by their wives, or they're psychopaths.
Racist assumptions.	Black men rape white women; black women are looser about their sexuality; Hispanic women are hot lovers.	Black and Hispanic families condone violence.	Black women are looser; Hispanic women are hot lovers.	Black and Hispanic families condone sexual activity between adults and children.

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new jersey women and aids network

THE UNTIMELY DEATHS OF WOMEN DUE TO AIDS
IS VIOLENCE AGAINST WOMEN

Testimony before the
Commission on Sex Discrimination in the Statutes
March 20, 1992
Presented by Marion Banzhaf, Coordinator, NJWAN

AIDS is the leading cause of death for New Jersey African-American women and the second leading cause of death among all New Jersey women between the ages of 18-44. If women were diagnosed with HIV disease earlier and had access to health care, women would have longer lives and a higher quality of life. Discrimination against women in the AIDS epidemic has resulted in undercounting of AIDS cases among women, misdiagnosis of AIDS in women, and exclusion from potentially life saving treatments by virtue of having a uterus and/or by lack of access to primary health care.

The New Jersey Women and AIDS Network was founded in May 1988 to advocate for the needs of women in the AIDS epidemic. NJWAN is a statewide, independent membership organization representing 350 agencies and individuals concerned with increasing women's visibility in the AIDS crisis and with advocating for appropriate public policies specific to women. We have worked to educate health care providers, state officials, and the general public about AIDS prevention for women and care and treatment issues specific to women. In June 1990, NJWAN published 'Me First: Medical Manifestations of HIV in Women', directed to health care providers and educators, and a companion brochure, 'Me First', written for lay women. We have distributed over 23,000 of these publications across the country.

New Jersey has the highest percentage of AIDS cases among women in the country: 23 percent compared to 11 percent nationally. In Essex County, women are 35 percent of AIDS cases. Nationally, as many women were diagnosed with AIDS in the last two years as in the first eight years of the epidemic. Women are the fastest growing new group of people with AIDS, and the state is not prepared to meet their needs.

The Department of Health estimates that 25,000 women in New Jersey may be infected with HIV. This number may be low since women have been undercounted by being excluded from the AIDS case definition. The federal Centers for Disease Control continues to discriminate against women by refusing to add women-specific opportunistic infections and cancers to the AIDS case definition. The male-based AIDS case definition results in lack of education to health care providers about women-specific presentations of HIV disease and contributes to the untimely deaths of women. HIV disease in women usually presents itself first by chronic, recurring vaginal yeast infections. Women with HIV and cervical cancer may have died due to AIDS but were not counted as having AIDS.

In New Jersey, 62% of the women with AIDS were infected through unsafe injection drug use; 32% contracted the disease through unprotected sexual behaviors. Heterosexual transmission of HIV is nearly equal to transmission by injection drug use in women in Essex County, and already accounts for over half of the AIDS cases among Hispanic women.

Women of color and low income women have been disproportionately affected by the AIDS crisis: 68% of women with AIDS in New Jersey are African-American, 21% are white, and 11% are Latina. The majority of women with HIV have little access to the sparse network of available AIDS-related education and health programs. There are only two AIDS clinics for women in the state and although support groups for women have expanded, no support groups exist in many areas of the state. Institutionalized racism and sexism, as well as the gross inadequacy of health care services for low income people, are significant contributing factors to the incidence of AIDS and HIV infection in women.

Several factors have impeded effective action on HIV disease in women. These include:

- o Women are grossly underrepresented in cohort studies and clinical drug trials. Women are excluded from experimental clinical trials based on pharmaceutical liability fears due to the potential risk to women's reproduction. However, the same standard is not applied to fear of an adverse reaction to sperm and men's reproductive capacity.
- o The emphasis on women has been as vectors of transmission, especially to their infants, rather than as women needing care themselves.
- o Women are generally held responsible for infection prevention during sexual encounters even if they do not have power in their relationships.
- o Many women are isolated in their homes or are in other ways outside the mainstream of currently directed prevention efforts.
- o Women are the primary caretakers of infected men and children, often postponing their own health. Even if no one else in a woman's family is infected, she is still the primary caretaker.
- o There is a paucity of research on the progression of HIV infection in women, and that which does exist is discounted because it is smaller than the body of research on men: a classic catch-22.

While services are beginning to address the needs of women and AIDS, most concern women only as potential transmitters of HIV infection and bearers of infected children. Services are needed for all women, regardless of their reproductive capacity or intent. Due to continued emphasis on risk groups instead of risk behaviors, most women do not consider themselves at risk for HIV infection. Conducting non-judgmental, thorough risk assessments are necessary if women are to be diagnosed early, therefore increasing life expectancy. Services for women must include comprehensive medical and psychosocial care, as well as the protection of their legal and human rights.

Recommendations

1. **Medical Services:** Medical programs which address the HIV-related needs of all women, regardless of childbearing status, must be established. Most family planning, sexually transmitted disease, and prenatal clinics now include some HIV risk assessment in their services. However, the elimination of anonymous testing in these sites restricts women's access to choice of medical services. Anonymous testing should be reinstated at all locations. These programs should include staff who are knowledgeable about the medical manifestations of HIV in women and who have been specifically trained to counsel and assist women.

2. Comprehensive Care centers: Ideally, comprehensive treatment centers should be developed which offer medical, psychosocial, legal and mental health services to HIV infected women. These facilities would provide direct care, in addition to being a resource for other women's centers throughout the state. The Children's Hospital AIDS Program (CHAP), which offers direct care for children with AIDS and provides additional services for the family affected, is an example of a comprehensive care program. All Treatment and Assessment Programs should establish women's clinics so that women with HIV have access to gynecologic care. Gynecologists and infectious disease doctors must talk to each other. When desired by the woman, all efforts should be made to schedule pediatric visits and mothers' visits at the same time so that child care and transportation are lesser barriers to women's access to health care.

3. Education and Prevention: Culturally sensitive prevention and education, counseling, and voluntary HIV screening programs for women must be available. These programs need to reach poor, minority, and drug using women, particularly women who are uninfected but at risk. Education and counseling aimed at altering risky behaviors, such as the sharing of needles for injection drug use and unprotected sex, are critical. Drug treatment programs must expand to be accessible to women, including pregnant women, and to allow women flexibility in maintaining family relations. Threatened with losing their children, women may not seek out treatment they need. Policies must reflect support of the family unit, and not be punitive against a mother.

Programs directed at teenage girls, college students, divorcees, women whose husbands engage in risky behaviors, and lesbians and bisexual women should also be developed and supported. Outreach efforts should be conducted in places women go: beauty parlors, nail salons, aerobic and fitness centers, bars, laundromats, and malls.

4. Health Care Workers: restrictions on health care workers, as well as calls for mandatory testing of health care workers, disproportionately effect women as the majority of all health care workers. Mandatory testing for any population must be opposed as counter to the public health interest since mandatory testing only drives people away from being tested.

All health care providers in the state should become familiar with HIV disease because of the continually expanding population of men, women, and children infected with HIV. Training for gynecologists is essential. A protocol for the treatment of women with HIV disease should be developed (currently, only protocols for treating HIV+ men, pregnant women, and children have been developed by the State Department of Health). Training and education in HIV disease should be mandated for all health care providers. This education must be culturally sensitive and gender-specific.

5. Reproductive Rights: The current policy of the CDC is for HIV-positive women to postpone and avoid pregnancy. This policy results in limiting women's choices. HIV-positive women have the same rights to bear children as do all other women. At the same time, HIV-women's access to abortion services are limited and/or denied based on hysteria and fear by some abortion providers.

New Jersey's AIDS epidemic is a harbinger of things to come for the nation. We have the opportunity to lead the country in providing humane, compassionate and comprehensive care to women. The New Jersey Women and AIDS Network is committed to advocating for such leadership. We hope you will join us in our efforts. Thank you.

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Before: The New Jersey Commission On Sex Discrimination
In The Statutes

At ; Trenton, New Jersey

Date: March 20, 1992

Members of the Commission, ladies and gentlemen, I would like to thank you for the opportunity to contribute information and recommendations for new or revised legislation which would help to overcome existing obstacles to the legal equality of the sexes in the context of violence directed primarily toward women. As definrd by the Commission, these acts of violence include the crime of incest. This most heinous of crimes is often the first, but rarely the last act of violence directed primarily toward women as young girls, aschildren, and yes, as babies.

Child sexual abuse is a sexual act imposed upon a child. Children lack the emotional, maturational and cognitive development to consent to such acts. Sexual abuse is defined in most states as any non-consensual sexual contact, and in most states a child less than seventeen years old is held to be incapable of consent to such an act.

Statistics indicate that one in four females is likely to be sexually victimized before she is eighteen years old.¹ Reported cases of all types of child abuse increased from 416,000 in 1976 to 1.7 million in 1984. The percentage of child sexual abuse cases increased from 3% of all child abuse to 13% in 1984. Thus, the number of reported child sexual abuse cases rose from 12,480 cases in 1976 to 220,000 in 1984.² At least 90% of abusers are male. Fifty percent of the sexual abuse perpetrators in the 1984 sample were natural parents, and 32% were either step-parents, foster-parents or adopted parents. Therefore, 82% of child sexual abuse is committed by parents, or parent-figures in the child's life.⁴

A large number of child sexual abuse cases are never reported to information gathering organizations that produce statistics, such as the American Humane Association and the National Center For Child Abuse and Neglect,⁹ and the unreported incidents may compose the majority of the cases.⁶

Any act of alleged intrafamily sexual abuse is viewed by our society as inherently unbelievable because it is difficult to believe that any parent would seek sexual gratification by exploiting their own child. This choice not to believe is reinforced by deeply rooted taboos against incest.⁷ Most cases of child sexual abuse are processed through the criminal justice system, initiated by criminal complaints, or through the juvenile justice system, initiated by abuse and neglect petitions. The majority of these cases can never be proven because there are no witnesses other than the child and the abuser. The truth is hard to determine as well when the allegations are raised in the context of civil cases, such as divorce, custody or visitation disputes.⁸

A child who is sexually abused by a parent may be the most vulnerable of all victims. Most children are dependent upon their parents for virtually all physical and emotional sustenance. In addition, they are subject to their parent's authority and control. A child is ill-equipped to defend herself from a parent's sexual abuse, therefore, the society and the legal system must provide adequate protection.⁹ The reported cases of child sexual abuse increased by the thousands, indicating recognition of the problem, and indicating that those who become aware of the problem are turning to the legal system for relief. However, the rate at which the courts are making findings of sexual abuse is disproportionately low to the actual incidence.¹⁰

When allegations of sexual abuse are raised during a divorce, custody or visitation dispute, the burden of proof is on the accuser. Since these allegations are so difficult to prove many such allegations are found to be unsubstantiated. This does not mean that the allegations are untrue, or fabricated, merely that there is not enough evidence to overcome the burden of evidentiary proof. The final result, however, is that the final finding is a finding of no abuse.

As stated above, 90% of child sexual abuse is perpetrated by males, therefore, when allegations of child sexual abuse arise, they are nearly always raised by the mother. In these instances equal justice is denied to females as child victims, and as mothers of the victims seeking to protect them through the courts. Generally, these allegations are not believed by the courts. Even though there is not enough evidence to substantiate the allegations the abuse, in fact, may have occurred. In the ensuing custody or visitation litigation the child's right to be

free from abuse is subsumed in the process. Sending a child who has actually been abused into a dangerous environment may merely be incidental to a court order, instead of the child's interest being the primary focus of the court's decision.

Mothers who otherwise would be awarded custody because they had been the primary caregivers of the children before the separation, generally lose custody if they raise allegations of sexual abuse.¹¹ These mothers bring their case to the legal system first, but the legal system does not believe them, and orders them to turn the children over to the alleged abuser. Out of sheer frustration and desperation, some mothers place the children in hiding, or go underground with them.¹² In these situations everyone loses. The protecting parent and the children become fugitives, the other parent, who might even be innocent, loses all contact with the child, and the legal system is viewed by all as a failure.

Judge Charles B. Schudson, a Wisconsin Circuit Court judge, is a member of the faculties of the National Council of Juvenile and Family Court Judges and the National Judicial College, and is considered the nation's foremost expert on new laws and techniques that affect children in the courtroom. In a book he recently co-authored with Billie Wright Dziech, entitled On Trial: America's Courts and their Treatment of Sexually Abused Children, he advocates for legislative reform. He states that the best defense against false allegations of sexual abuse is implementation of procedures that will increase children's participation in the legal system. To those who claim that innocent defendants are being prosecuted because of malicious stories from devious children, Judge Schudson points out that one must first allow the children to tell their stories, even if it means telling that story while seated in the lap of the other parent's lap while testifying, using puppets in the courtroom, or television cameras, it is better than no testimony at all, because the child has frozen up at the sight of a crowded courtroom, the presence of her rapist, and a man in a black robe towering over her.

"There is no validity to the claim by VOCAL and other opponents of legal reform that attention to child victim's rights somehow threatens the constitutional rights of defendants. Child advocates have not argued that American courts should abandon traditional protections for defendants. Responsible professionals have not advocated rejecting the constitutional principle that the accused is innocent until proven guilty. They have not maintained that defendants be denied the right to confront their accusers. They have argued only that sometimes in order to facilitate discovery of truth, confrontation of a child must occur in ways not usually employed in courtrooms. Child advocates have not maintained that that admittance of hearsay evidence should be the rule in sexual abuse trials. They have argued only that in special instances, certain hearsay statements by children should be considered

under the long-accepted category of exceptions to the hearsay rule. Respect for the rights of child victims does not limit the rights of defendants; it helps balance the scales of justice so that the system can foster the quest for the truth."¹³

A comprehensive review of the rules of evidence and court rules and procedures should take place, with an eye toward reforms which could be implemented to augment the "quest for truth", and indeed better balance the scales of justice." Other reforms should require an immediate halt to a custody or visitation proceeding when allegations of sexual abuse are raised, and an investigation initiated by the court. If a child alleges that a parent has abused her, the child should remain in the custody of the nonabusive parent during the investigation. We must stop punishing children for disclosing sexual abuse of a parent by tearing them from the only safe relationship they may have. Obviously, in weighing the conflicting harms, it is far more equitable that a parent only visit with the child in a supervised setting during the investigation, than that a child who has in fact been raped be forced to submit to the control of her rapist. Custody or visitation should never be decided until the investigation has been conducted and a report submitted.¹⁴

In every child sexual abuse case an attorney should be appointed to represent the interests of the child as opposed to the interest of both or either of the parents. This appointment however should not be made as a meaningless gesture as it is in most cases today. Standards must be implemented in order that these Guardians Ad Litem know what is expected of them who they are accountable to, and the standards to which they are to be held. Judges must be encouraged to appoint qualified, neutral attorneys and must enforce standards requiring aggressive representation of the interests of the child. It is imperative that these standards or guidelines be applicable throughout the State of New Jersey, and that they be enforced just as uniformly.

Equal treatment of women in the courts, fair and unbiased investigation of allegations of child sexual abuse and procedural reforms in the way in which these cases are tried, would make parental abduction in civil child sexual abuse cases unnecessary.

Other concerns exist in the area of gender bias in the courts. New Jersey was the first state to appoint a task force to study the issue, and is still the forerunner in evaluating and making recommendations to alleviate the problems.¹⁵

It was not only determined that gender bias did exist in the judicial system, but that it had a particular negative impact on women who were victims of domestic violence and women who were victims of rape. The study did not address civil child sexual abuse cases, but it does not take a large leap in logic to determine that women are not believed because first and foremost, they are women. It would help to remedy many problems

in these cases if a study was undertaken to discover exactly how, and in what context gender bias in the courts has a negative impact on this type of case. AS concluded in the evaluation, recommendations and implications of the task force study:

Some judges appear to believe that once they eliminate gender bias in matters such as forms of address and appointments to fee-generating cases, they have eliminated gender bias in the courts. They are reluctant to move beyond court interaction to the complexities of gender bias in substantive decision-making. Although reducing gender bias in the court environment creates conditions favorable to its reduction in the more difficult area of case outcome, an understanding of one aspect of the problem does not necessarily lead to an understanding of the other.

"A second problem is that many judicial acts and omissions that are manifestations of gender bias are not understood as such. A primary duty of a task force is to explain why indifference to spouse abuse in custody awards, failure to enforce child support and de minimus awards to the family of a homemaker in a wrongful death suit, to cite three examples, constitute gender bias, and why gender bias is inimical to fundamental fairness."

Thus, equal justice cannot be achieved for victims of child sexual abuse cases until the impact of gender bias is addressed as an integral part of the outcome of these cases. Our Center has just begun to analyze each of the components of civil child sexual abuse cases, and to set our own objectives so that we may better serve our clients. We are interested in any reforms that will improve the current failures in the system.

In closing I would like to quote Judge Schudson who states:

"At the very heart of the American experience lies the conviction that that when laws and traditions are unjust, they must be changed. That theme dominates our legal traditions from the Declaration of Independence to the Constitutional Convention to countless Supreme Court decisions and reminds us -- indeed requires us -- to re-examine our laws to assure that they provide justice for all. We cannot forsake that history; if in our passion to protect one individual's rights, we ignore those of another, especially those of a child, we cannot claim to be a just society."

ENDNOTES

1. B.W. Dziech and C.B. Schudson, On Trial: America's Courts and their Treatment of Sexually Abused Children, Beacon Press, Boston (1989) (hereinafter Dziech and Schudson)
2. American Humane Association, Highlights of Official Child Neglect and Abuse Reporting, Devner, American Humane Association, (1986)
3. D. Finkelhor, A Sourcebook on Child Sexual Abuse, Saga Publications, London (1986) at 126
4. D.A. Duquette, Advocating for the Child in Protection Proceedings: A Handbook for Lawyers and Court Appointed Special Advocates, University of Michigan Law School, Lexington Books, (1990), citing Faller, Child Sexual Abuse: An Interdisciplinary Manual for Diagnosis, Case Management, and Treatment, New York Columbia University Press (1988) at 131
5. D. Finkelhor, "How Widespread is Child Abuse?" Children Today, July-August (1984) at 19.
6. Note, "The Testimony of Child Victims in Sex Abuse Prosecutions: Two Legislative Innovations, 98 Harvard Law Review 809 (1985)
7. La Fontaine, "Child Sexual Abuse and the Incest Taboo: Practical Problems and Theoretical Issues, 23 Man 1" 11 (March 1988)
8. M.S. Fahn, "Allegations of Child Sexual Abuse in Custody Disputes: Getting the Truth of the Matter," Vol. 25, No. 2 Family Law Quarterly, (Summer 1991) at 194.
9. id, See also S. Sgroi, "Validation of Child Sexual Abuse" in Handbook of Clinic Intervention in Child Sexual Abuse, Lexington Books (1982); reprinted in Sexual Abuse Allegations in Custody and Visitation Cases, (Nicholson, Buckley eds.) American Bar Association (1988)
10. id
11. See Chrissy F. by her Next Friend and Guardian Ad Litem Donna Medley v. Mississippi Department of Public Welfare Et Al, WL 261615 (S.D. Miss. 1991); Newsome v Newsome, 557 So. 2d 511 (1987); Morgan v. Foretich, 546 A2d 407, 408 (D.C. 1988) cert den 109 S. C. 790 (1989); In the Interest of A.H., No. 88-1503; 89-4070-CAE Cir. Ch. App, 5th Dist., Marion County, Ala, (1990); Brothers v. Brothers, DR-86-200107. 02 Cir. Ct., Marshall County, Ala. (1989); and Murabito v. Murabito, No. 85-M-1041 Sup. Ct. of New Hampshire, Rockingham County (1990).

12. Galtney, "Mothers On The Run", U.S. News and World Report, June 13, 1988, and Milloy, "The Conductor of the Underground", New York Newsday, May 8, 1990, Pt. 2 at 2.
13. Dziech and Schudson, supra, at 19.
14. See N. Copeland-Aldridge, W. Dow and J. Straton "Should Survivors of Sexual Assault Visit Their Rapist on Weekends?" Vol. 3, No. 2 Journal of the Task Group on Child Custody Issues, National Organization for Men Against Sexism Fall 1991.

STATEMENT OF THE DIVISION OF YOUTH AND FAMILY SERVICES
NEW JERSEY DEPARTMENT OF HUMAN SERVICES
TO THE
COMMISSION ON SEX DISCRIMINATION IN THE STATUTES
SUBMITTED MARCH 20, 1992

The Division of Youth and Family Services (DYFS) is the public child protection and child welfare agency for New Jersey. It operates 24 hours a day, seven days a week, to provide protective and supportive social services to all New Jersey children and families who request or require them. DYFS services are provided through a network of 45 field office sites, four residential treatment centers, four group care homes for older youths, and 15 child day care centers.

DYFS receives some 86,000 referrals and requests for services each year. The majority of these referrals allege child abuse or neglect. For example, in Calendar Year 1990 -- the latest year for which complete information is available -- the Division received 54,366 reports alleging child abuse and neglect; 19,546 (36 per cent) were substantiated upon investigation. This substantiation rate has remained fairly stable at about one-third over the past several years.

The most frequent sources of abuse and neglect referrals are: anonymous (17.7 per cent); schools (17.3 per cent); and friends and neighbors (12.3 per cent).

Most often, the report alleges neglect (52.6 per cent), followed by abuse (35.3 per cent), sexual abuse (7.6 per cent) and multiple types of maltreatment (4.5 per cent). The overwhelming majority -- over 96 per cent -- of child maltreatment that is reported to the Division is alleged to occur in the child's own home.

The current DYFS caseload is 49,847 children. The majority of these children, 41,396 (or 83 per cent), live at home with their biological or adoptive families. The remaining 8,451 (17 per cent) reside in a variety of out-of-home placements, primarily foster family care. The Division's primary effort is to serve children, whenever possible, in their own homes and thus reduce its reliance on out-of-home placement.

The Division also contracts with local public and private not-for-profit provider agencies to deliver a wide range of supportive services, including child care, legal services, community mental health services and advocacy, and services to victims of domestic violence.

Public child welfare agencies, such as DYFS, are concerned with the high overall incidence of domestic violence. It is not logic alone that indicates that there is evidence that a considerable relationship exists between domestic violence and child maltreatment or endangerment. Statistics from the New Jersey State Police Uniform Crime Reporting Unit bear this out.

For example, in 1990, there were 50,823 domestic violence offenses reported by local police agencies. Children were involved or present in over one-half (53 per cent) of the reported offenses for this time frame. Of particular interest to the Commission is the fact that the Division of Youth and Family Services receives some 2,600 referrals on children each year who were living in a home where domestic violence was identified at the time of the referral.

Recognizing that family violence is also a child welfare concern, the Division also performs a role in the provision of services to victims of domestic violence and their families. By contracting for domestic violence shelter and counselling services, the Division complements the community education and awareness efforts of the Division on Women's Domestic Violence Prevention Program.

Specifically, for many years, DYFS has worked in cooperation with the New Jersey Coalition for Battered Women to develop 24-hour emergency shelters and related supportive services for victims of domestic violence throughout the State. At present, DYFS is funding emergency shelters for victims of domestic violence and their families in 19 of the 21 counties.

In October, 1991, DYFS awarded grants to develop domestic violence shelters in the two remaining counties that do not now have these services: Cumberland and Cape May Counties. These grants were two-fold in nature: capital bond issue funds of approximately \$450,000 each to cover facility costs, and operational funds of \$50,000 each. The opening of these two shelters will complete the Division's commitment to funding and supporting a network of domestic violence shelters statewide.

At the close of Calendar Year 1991, the Legislature and the Governor enacted legislation that takes a large step in recognizing even further the relationship between domestic violence and the risk of child abuse. The Prevention of Domestic Violence Act (Senate Bill 2230) attempts to decrease the incidence of domestic violence and to increase the enforcement of laws to protect victims.

Specifically, it expands the definition of domestic violence to apply to a person 18 years of age or older, or an emancipated minor, who has been subjected to violence by a spouse, former spouse, or any other person who is a present or former household member or a person with whom the victim has a child. The law also emphasizes that the primary duty of a law enforcement officer, when responding to a domestic violence call, is to enforce the laws allegedly violated and to protect the victim.

Further, the measure expands the requirements for court orders to include consideration of certain information reflecting the safety and welfare of the victim and of any child(ren) involved in the incident. For example, in situations where a restraining order has been issued, the law requires the Court to consider a request by the victim for an evaluation by the appropriate agency to assess the risk of harm to the child before a visitation order is issued. To that end, the law requires that an assessment tool be developed. Counties are required to designate the agency responsible for developing a plan for an completing assessments related to visitation. DYFS has been cooperating with staff of the judiciary at the county level by sharing information that may prove helpful in developing the required assessment tool.

Finally, the law requires the Department of Law and Public Safety to ensure that all law enforcement officers receive training in domestic violence issues and its Division of Criminal Justice must develop and distribute to all local police agencies training courses and curricula on the handling, investigation, and response procedures concerning reports of domestic violence.

Domestic violence presents a risk not only to the family members, but also to the police officers responding to complaints of domestic violence and to DYFS staff investigating child abuse referrals in a violent household. This is no better illustrated than by the oft-cited statistic wherein more than half of all police officer injuries occur during responses to domestic violence complaints. The training provisions of the new law will provide important skills to law enforcement officers that will, hopefully, assist in the initial stages of intervention.

In closing, the Division of Youth and Family Services -- in pursuing its mandates of protecting children, preventing abuse, and strengthening family life -- supports the work of the Commission and will cooperate within the limits of its authority and resources to preventing violence against women and children.

