Domestic violence increases the risk for HIV infection, but because of its complicated and sensitive nature, domestic violence is a difficult subject to raise, discuss, and disclose. This issue of PERSPECTIVES examines the effects of domestic violence on survivors and on risks for HIV infection. The Implications for Counseling section explores ways of assessing and discussing domestic violence, and of providing appropriate referrals to clients who experience domestic violence.

Research Update

Domestic violence describes a pattern of behavior that can include battering, physical violence, psychological violence, property violence, and sexual violence. Battering refers to repeatedly subjecting a person to forceful physical and psychological behavior in order to coerce them without regard to their rights.1

Domestic violence occurs in all communities, regardless of race, socioeconomic status, ethnicity, age, sexual orientation, religion, or education level.2 According to a nationwide survey conducted between 1995 and 1996, 25 percent of women and 8 percent of men said they had been raped or physically assaulted by a current or former spouse, cohabiting partner, or date.3 Studies suggest that domestic violence occurs among same-sex partners at the same rate as in heterosexual relationships.1 Similarly, rates of domestic violence are consistent in urban and rural settings.4 It is important to note that incidents of domestic violence are generally believed to be under-reported, partly because of society’s perception that domestic violence is a private issue and is shameful.5

Although either gender is vulnerable to domestic violence, women are seven to 14 times more likely than men to report severe physical assaults by an intimate partner,3 and domestic violence is the most common cause of non-fatal injury to women in the United States.6 Of the women reporting rape or physical assault after the age of 18, 76 percent attributed the assault to a current or former husband, cohabiting partner, or date.3 In 1996, approximately 1,800 murders were committed by intimate partners, and nearly three out of every four of their victims were female.7

The Dynamics of Domestic Violence

Domestic violence is a method of gaining control, not a spontaneous act of anger. It is a pattern of perpetrated behaviors, consisting of a variety of abusive acts and occurring in multiple episodes during the course of a relationship. Perpetrators of domestic violence use a variety of abusive acts, and all parts of the pattern affect each other and can have profound physical and emotional effects on victims.8

Domestic violence often occurs in a cycle of three phases: “tension building,” in which there is an increase in tension, anger, blaming, and arguing; “acute battering,” which may include hitting, slapping, strangling, kicking, restraining, using objects or weapons, sexual abuse, and verbal threats and abuse; and the “honeymoon,” which is the calm stage, during
which the perpetrator may deny or ignore the effects of violence, make excuses, promise it will never happen again, and give presents to make up for the abuse.\textsuperscript{8}

Victims of domestic violence usually respond to the entire pattern of perpetrators’ abuse rather than simply to one episode or one tactic. An abusive episode may last anywhere from a few minutes to several days. Every episode of domestic violence builds on past episodes and sets the stage for future episodes. For instance, perpetrators may refer to past episodes or make threats about future abuse as a way to maintain control.\textsuperscript{8} Over time, relationship violence often becomes more frequent.\textsuperscript{9}

### The Effects on Victims

During an act of domestic violence, victims often focus on self-protection and survival. Common reactions include shock, denial, withdrawal, confusion, psychological numbing, and fear. As a result, victims often offer little resistance.\textsuperscript{10} Long-term victims of domestic violence often feel responsible for the abuse. Survivors may also experience a loss of self-esteem, self-respect, identity, control, initiative, decisiveness, resources, and power.\textsuperscript{2} Survivors often do not tell close friends and family about the abuse, which tends to be a source of shame and embarrassment that causes increased depression and lowered self-esteem.

In domestic violence cases, survivors often experience a breakdown of support systems. Survivors may find their own family and friends siding with the batterer, they may avoid certain social scenes because of the batterer’s presence, and they may forego medical care or counseling if the batterer has the same provider.\textsuperscript{11} In addition, the abuser may restrict and monitor the victim’s finances, transportation, activities, and telephone use.\textsuperscript{1,12}

Among the health consequences of domestic violence are risk of physical injury, psychological problems, substance abuse, negative pregnancy outcomes, and suicide. In one study, 34 percent of women who had experienced physical or sexual violence had a disability preventing them from working, compared to 16 percent of women who were not victims of violence.\textsuperscript{13} In addition, the stress of being a victim of domestic violence tends to weaken the immune system.

A recent study found that a large health plan’s annual cost of treating women experiencing intimate partner violence was nearly $2,000 higher than the cost of treating female enrollees in general. Significant contributions to this higher cost were general clinic ambulatory visits, mental health clinic visits, and out-of-plan referrals or visits.\textsuperscript{14} Abusive partners may prevent victims from receiving regular health care and medical attention to injuries, or victims may not seek care because they have become unable to recognize bodily signals of distress.\textsuperscript{15}

The impacts of battering on a person may manifest in various ways. Physical signs of possible battering include missing or broken-off patches of hair, circular punch marks or finger marks, defensive injuries of the forearms, human bites, intentional burns, dental trauma, chronic abdominal, pelvic, or chest pain, and repeated or chronic injuries. Some psychological signs are reluctance to discuss home life, frequent references to the partner’s anger, hesitation to speak or disagree in the presence of the abusive partner, hyper-vigilance, desire for isolation, shame, anxiety, and depression.\textsuperscript{1,12}

Behavioral signs that could indicate that a person is a victim of domestic violence include delaying seeking medical care, canceling appointments, offering illogical explanations for injuries, wearing high-necked or long-sleeved clothing to cover injuries even in hot weather, having trouble adhering to treatment, and self-medicating with over-the-counter drugs, home remedies, alcohol, or other drugs.\textsuperscript{16}
Why Survivors Stay and Leave

Domestic violence survivors stay in relationships for various reasons: fear, love for the batterer, the presence of children or pets, economic restrictions, social isolation, language barriers, fear of damage to reputation, fear of deportation, feeling undeserving of a “better” partner, equating partner jealousy and abuse as love, and hope that the abuser will change.¹ Some survivors believe that leaving will not necessarily make their lives or their children’s lives safer, a feeling that is substantiated by reports of women being at greatest risk of injury or murder at the time they end a relationship.¹⁷ Survivors of domestic violence in same-sex relationships may also face blackmail to keep them in the relationship. For example, the batterer may threaten to reveal the survivor’s homosexuality to family or employers. Survivors may also fear confronting homophobia or that their experience will be labeled as “mutual abuse,” although in most cases, only one partner is the batterer.¹⁸

Research suggests that the most likely predictor of whether a survivor will permanently separate is whether or not he or she has enough financial resources to live without the abuser’s support.¹⁹ According to one study, the most common reason among survivors for remaining in violent marriages is the ideological pressure of staying married.²⁰ Survivors often leave when they feel empowered, have gained knowledge, support, and available resources, have seen the impact on their children, or have realized that they cannot change the abuser. It takes an average of five to seven attempts at leaving an abusive relationship before a survivor can maintain independence.¹

Survivor Needs

Most victims of domestic violence benefit from counseling, access to a safe place, support, realistic options, and the knowledge that others who have been in similar positions have improved their circumstances.² Research indicates that most domestic violence survivors hope that health workers will ask, in a caring manner,
whether they have been abused.12

Finding a safe place to stay is especially difficult for men and lesbians who have been battered. Men’s homeless shelters, often the only recourse for battered gay men, are particularly dangerous settings where violence and theft are common. For people who are ill, physical injury or theft of essential goods such as medication is such a concern that they may resist shelter placement even in an emergency. Furthermore, gay men or lesbians who stay at men’s or women’s shelters face security risks from their partners, who may not be restricted from the shelters because they are of the same gender.21

**Risks for HIV Infection**

A study conducted at a women’s shelter found that psychological abuse was strongly associated with multiple risks for HIV exposure. Of the 40 women in the study, 75 percent had multiple risk factors for HIV infection, including 98 percent who reported that their partner never or rarely used a condom. Eighty-five percent of these did not perceive themselves to be at risk for infection, and 80 percent reported never having asked their abusive partner to wear a condom. The researchers concluded that the respondents’ inability to realistically assess their vulnerability to HIV is comparable to the failure of people diagnosed with acute stress disorder to recognize their basic health and safety needs.22 Furthermore, research indicates that batterers are likely to impose verbal and emotional abuse and threats of physical violence if their partners request condom use.23,24

Batterers may also coerce victims into unprotected sex and force them to have sex with other people. During episodes of sexual violence, the forced nature of vaginal or anal penetration during an assault may result in tissue trauma.25 In addition, batterers may engage in sexual relationships with other partners. Each of these factors increases the victim’s risk for HIV infection. According to anecdotal evidence, some abusers may intentionally infect a partner with HIV so that the partner becomes more dependent upon the abuser.1

**Effects of HIV on Domestic Violence**

The presence of HIV infection can increase the risk or severity of domestic violence. A Maryland study that surveyed 136 health care providers working with HIV-infected women found that 18 percent of clients feared physical violence in response to disclosing their HIV infection to their partners, 29 percent feared emotional abuse, and 35 percent feared abandonment. Among female participants who disclosed their infections to their partners, 8 percent experienced physical violence, 23 percent experienced emotional abuse, and 19 percent experienced abandonment. Reported incidents include being threatened, harassed, spit on, hit, kicked, raped, stabbed, left homeless, and shot by partners.26

A 1996 nationwide study of adults in treatment for HIV infection found that 13 percent reported being victims of domestic violence since receiving their diagnosis, with women reporting twice as much violence as men. Almost 45 percent of these participants stated that the physical aggression was prompted by their HIV infection status.27

Research on HIV-infected people indicates that the elevated stress associated with living in constant fear of abuse can significantly accelerate HIV disease progression.28 In cases where perpetrators of domestic violence are themselves infected with HIV, uninfected partners may experience survivor guilt, making it emotionally confusing and difficult to leave the abuser alone to cope with the illness.29

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**Implications for Counseling**

It is imperative that HIV counselors understand the role of domestic violence in HIV risk, and that they feel both prepared and willing to assess whether or not domestic violence is an issue in a client’s life. At the same time, HIV counselors must remember their limited role and use the assessment session to facilitate appropriate referrals. In some cases, referrals to domestic violence shelters may be appropriate, but it is important to consider other options. It may be more appropriate to listen and to offer other listening resources such as counseling referrals. Accurate assessment of the client’s situation and his or her stage in the continuum of behavior change is critical to making the right interventions and referrals.

Regardless of the client’s gender or sexual preference, there is a chance that he or she could be a victim or perpetrator of domestic violence. No one category of person is immune from domestic violence. Counselors should recognize the role of power, control, shame, guilt, and substance abuse in domestic violence situations and be prepared to explore these areas and provide referrals as appropriate.

**Assessing and Exploring Risks**

In assessing for domestic violence, counselors should be prepared for a variety of scenarios. Some clients may not hesitate to reveal instances of domestic violence from past or ongoing relationships. Others may share more limited information, which can
help the counselor begin an exploration of risk and incidence of domestic violence. These are the cases that require the most in-session counseling work related to domestic violence.

The question, “Are you in a safe living situation?” may prompt a client to disclose that he or she experiences some form of domestic violence, and this is a good question to include in a general history taking. It is also important to know whether or not the client has had a history of domestic violence in past relationships and, if so, how those situations were resolved. A history of domestic violence, either as a survivor or as a perpetrator, often indicates risk for future recurrences if the client has not received appropriate counseling. A client may not consider domestic violence to be an issue of safety, and he or she may not associate domestic violence with HIV risk. It is the counselor’s task to assess the situation and to make these connections for clients who may not have already done so. Keep in mind that the presence of substance abuse increases the chances of domestic violence.

In responding to a client’s disclosure of domestic violence, consider the issue of control. Does the client see him or herself as having control in his or her life, or does the client present scenarios that suggest a lack of control over personal decisions and activities? Clients who experience domestic violence are likely to feel a lack of control. These clients are vulnerable to engaging in risky activities because of the threat of violence they see as inevitable and out of their control, and for which they have no “future story” other than the recurrent story of abuse. Future stories are the narratives people tell themselves about the way they perceive what will happen to them. Inviting clients to tell their future stories about their relationships can help counselors assess whether or not clients feel power to change their circumstances, and it may help clients begin to imagine different outcomes.

Future stories may be rooted in the past or present, and they may be based on either a realistic or skewed sense of reality. Assessing whether or not the client has a sense of a future at all—a future without violence, and the related HIV risks—can guide the counselor toward an appropriate referral.

Abusers often attempt to control their partners by using insults or shame, threatening to kill themselves or to harm children or pets, using manipulative lies, taking control of finances and friends, or threatening to reveal the partner’s sexual behaviors to others. Counselors should listen for these kinds of concerns as clues of domestic violence, and follow-up with appropriate questions about how the client views these experiences.

Sexual Risk and Domestic Violence

The prospect of being psychologically or physically abused by a partner can overshadow what may seem like a more abstract risk for HIV infection. It is important for the counselor to follow the client’s lead in terms of concerns and priorities. If HIV risk is the client’s primary concern, explore with the client how staying in the cycle of violence perpetuates risk for infection. If domestic violence is of primary concern to the client, assess the client’s understanding of how domestic violence affects his or her HIV risks. If the client is reluctant to explore domestic violence, set it aside for a few minutes or abandon it completely. However, if the client expresses only mild resistance or is open to discussion, explicitly point out how domestic violence may lead to HIV-related risk.

Following the client’s lead, ask him or her to describe a typical violent scenario. For example, the client may say that violent episodes often include forced sex. Or the client may say that shortly after a violent incident occurs, the violent partner apologizes and wants to “make up,” and sex is often part of this process. It may be that the client usually practices safer sex, but for a variety of reasons, does not in either of these scenarios. Help the client to understand this HIV risk situation and to decide how he or she wants to respond in the future.

Counseling the Abuser

Counselors often think of assessing domestic violence in terms of the client who is abused. Yet some clients are abusers, and abusers are also at increased risk for HIV infection. Although it may be unlikely, some batterers may raise the topic of their abusive behaviors and be open to considering its consequences. For example, a man who
has begun to experience the negative consequences of being a batterer, such as losing friends or experiencing decreased self-esteem, may be prepared to discuss some of his feelings if the counselor can create an emotionally safe environment in which to do so. In this situation, clarifying HIV risk issues may help move the client from a stage of seriously considering the implications of his behavior toward a state of readiness to make a change.

Making the session emotionally safe for such a discussion does not mean being neutral to spousal abuse: spousal abuse is never a positive or healthy response to problems. It is never appropriate to rationalize a client’s abusive behavior as an acceptable or appropriate response. Rather, express understanding for the client’s painful, angry, or shameful feelings, and suggest ways he or she can get help in finding alternative responses to inflicting psychological and physical abuse and engaging in HIV risk behaviors. The tone and words the counselor uses to discuss the behavior can either support the client in making an honest assessment of the situation, or it can collude with the client’s own desire to minimize the significance of the abusive behavior.

References
Counselor Issues

It is important for counselors to acknowledge that assessing risk of domestic violence presents a number of personal challenges. Perhaps the most important challenge for the counselor to confront is his or her own feelings about the issues of hope and despair, about power and powerlessness in relationships, and about addressing domestic violence issues with clients.

A counselor who has had personal experiences with domestic violence must explore the related feelings, values, and beliefs in a safe environment. In this way, counselors can increase their ability to approach the issue from a neutral stance. As with many issues HIV test counselors must face with their clients, this neutral stance is not about embracing unacceptable behavior; it is about remaining non-judgmental to better assist the client.

HIV test counselors should also be aware of the legal issues involved in working with clients who experience domestic violence. Depending on the type of counseling setting, counselors may be required by law to report any wounds or physical injuries they know or suspect to be caused by domestic violence. Counselors are also required to report any threats of domestic violence. At confidential testing sites, counselors are not obligated to report domestic violence. Counselors at confidential testing sites, however, may be required to make a report. It is essential for counselors to know their obligations regarding mandated reporting; counselors who are unclear about their legal responsibilities should discuss this issue with their supervisors.

Counseling Intervention

Give John support for seeking an HIV antibody test. Explore what he means when he says that Mike “flies into rages.” If the rages refer to verbal abuse—such as name calling, accusations, or threats—explore with John if Mike has ever been physical during these episodes. Ask John how he feels about the abuse and if he feels “safe” in this relationship, especially if John says Mike’s abuse has been physical.

Recognize that shame plays a large part in abusive relationships. Tell John that he is not alone, that other people are and have been in similar situations, and that there is support available to help clients like himself improve their circumstances. Support and praise John for his recovery from substance use. Explore with him how his relationship with his partner benefits his recovery and in what ways it has contributed to stress in his life and in his recovery.

Ask John about sexual risk taking. Be sure to ask how conflicts with Mike are resolved. If sexual violence or sexual “make-ups” are common, assess how or if HIV risk taking in these situations is similar to or different from John’s usual sexual behavior.

Explore with John his level of concern about HIV risk, his recovery, and the kind of abuse—verbal, physical, or both—he is experiencing. Do not decide for John, for instance, that if Mike physically abuses him, he must leave Mike. This is a common counseling error that can cause setbacks in the client’s progress toward making needed changes. Instead, ask John what he thinks about the situation and what he might want to do. In part, asking these questions helps the counselor and potentially the client hear just how hopeful or despairing John is about the situation, how much control he feels he has in the situation, or how much he feels the situation is “out of his hands.”

If John does not express concern, he may be denying the seriousness of the situation. In this case, gently but clearly explain the risks John may be facing, given the information he has shared, particularly addressing any contradictions he may have presented. For example, tell John, “You have just told me how Mike forces you to have unsafe sex when he’s angry, and you said earlier that you are concerned about HIV risk. Yet now you say that Mike’s rages aren’t a problem. What do you make of that?”

If John expresses concern either directly or indirectly, validate this response. Assess whether John is still in a contemplative stage of behavior change or if he seems ready to take some kind of action to change this behavior. It may be that a referral to a peer support group, to a counseling intervention providing a safe place to discuss the issues further, or to a telephone hotline for domestic violence issues can be most helpful for John to take his next step.

Case Study

John is a 32-year-old man who, for the past three months, has been in a relationship with a man who abuses alcohol. John has been in recovery from alcohol and other drug abuse for six months and says that he has been at risk for HIV in the past and feels ready to take an HIV test. The counselor asks John about his relationship and if his partner, Mike, knows he is testing. John is hesitant at first but then says that he is afraid to tell Mike because, “He flies into rages.”
Test Yourself

Review Questions

1. True or False: Victims of domestic violence perceive every abusive act as independent of any other.

2. True or False: In the United States, domestic violence is the most common cause of non-fatal injury to women.

3. Which of the following are signs of domestic violence? a) chronic pain; b) feeling shame, anxiety, or depression; b) missing or broken-off patches of hair; d) all of the above.

4. Survivors of domestic violence may be at increased risk for HIV infection because of which of the following reasons? a) they have difficulty negotiating condom use with the abuser; b) they may be subjected to sexual violence; c) they may be forced into having sex with other people; d) all of the above.

5. True or False: Once survivors leave their violent relationships, they are finally safe from their partners' abuse.

6. Which of the following statements characterize domestic violence? a) a battering episode can last anywhere from a few minutes to several days; b) domestic violence is a strategy to gain control; c) domestic violence can profoundly impact the survivor's physical, psychological, and emotional health; d) all of the above.

7. True or False: Research indicates that an estimated 25 percent of women and 8 percent of men in the United States have been raped or physically assaulted by an intimate partner or date.

8. What are some needs of a domestic violence survivor? a) compassionate counseling; b) realistic options; c) probing into what they may have done to cause the abuse; d) a and b.

Discussion Questions

1. How can counselors decide whether or not to ask a client if he or she has ever experienced domestic violence?

2. How can counselors be aware of appropriate referrals for clients who experience domestic violence?

3. What should counselors do if they suspect that a client is a victim of domestic violence but the client is unwilling to discuss the issue?

4. What are some strategies for initiating a discussion of domestic violence in a counseling session?

5. How can counselors assess and address their own assumptions about domestic violence?

6. How can counselors stay abreast of current legal issues related to counseling clients who are victims or perpetrators of domestic violence?

Answers

1. False. Acts of domestic violence build on one another, and survivors tend to respond to the combined threat.

2. True.

3. d.

4. d.

5. False. Domestic violence survivors may be at greatest risk of injury or death after they end their relationships.

6. d.

7. True.

8. d.
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