



V

Violence



Violence is a serious public health issue in Massachusetts and in the US. On average, every week in 2007 in Massachusetts, three to four people died by homicide, more than 45 spent time in the hospital, and more than 485 visited an emergency department because of an injury from an assault.¹

Although statistics from hospital data and death certificates are startling, they do not fully account for the problem. Sexual assaults, intimate partner violence, and child and elder abuse may be reported only sporadically. Injuries from assaults may be treated in a physician’s office or health center and many assaults go unreported to medical personnel and police, even when a physical injury occurs.

Regardless of how assaults are counted, deaths and injuries are only the proverbial “tip of the iceberg” in terms of the impact of violence. The hidden effects of assaults and threats can include psychological consequences that affect quality of life, physical health, and a person’s ability to function. Violence also negatively impacts society through high financial and property damage costs, reduced productivity, and a sense of fear and dread that can contribute to sedentary lifestyles and social isolation.

For many types of violence discussed in this chapter, evidence of overlap is often found. Adults who had experienced IPV were more likely to report also having been the victims of unwanted sexual contact. A similar pattern was found for dating violence victims. Children who reported witnessing family violence were more likely to report experiencing direct peer violence themselves in the forms of bullying and dating violence.

Source: MDPH BRFSS 2005-2007, MDPH Youth Health Survey 2007 and Massachusetts Department of Elementary and Secondary Education 2007 YRBS.

Figure 13.1 **Deaths and Injuries Due to Assault**



Sources: MDPH Death File, 2007; Massachusetts Division of Health Care Finance and Quality Inpatient Hospital Discharge Database, Outpatient Observation Stay Database and Outpatient Emergency Department Database, FY2007.

The good news is that violence is preventable.

Violence is complex: it is affected by individual, family, community, and societal factors. Although generally, males are at greater risk both to perpetrate and to be victims of violence, within some categories of violence, the probability of becoming a victim is reversed or nearly equal for females. For example, statistics from multiple sources and field observations indicate that females are disproportionately affected by intimate partner violence and the crimes of rape and sexual assault.

Violence also can occur in multiple forms to the same people. This fact has been documented in cases of family or domestic violence in which forms of child maltreatment may occur in the same household as intimate partner violence (IPV).^{2,3} Overlap with forms of violence that occur outside of the family has also been found.⁴ Research has shown that the risk of negative physical and mental health outcomes and of behaving in ways that put health at risk increases as the number of types of adverse experiences during childhood increases.⁵

The good news is that violence is preventable. The more we learn about factors that increase or reduce the likelihood of violence – known as risk and protective factors – the greater the probability of putting effective prevention strategies into place.

This chapter covers several types of violence, providing information about how common the problem is, who is most affected, mental and physical health outcomes and risks associated with violence.

Bullying, Harassment, and Violence in School Settings

Although we may think of our schools as safe places, many children experience violence in or on the way to or from school each year. In 2007, more than a quarter (28%) of high school students reported being in a physical fight on school property and 5% reported being threatened or injured with a weapon.⁶

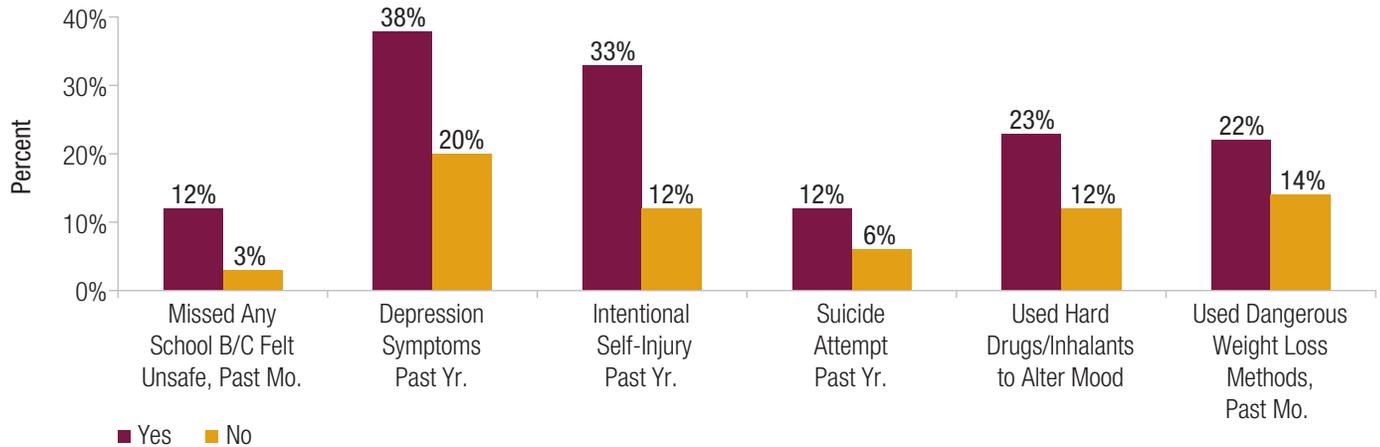
More than one in five high school students reported being bullied at school. Being bullied included being repeatedly teased, threatened, hit, kicked, shunned, or excluded by another student or group of students. Overall, 14% of high school students reported bullying others, and boys were more likely than girls to report such behavior (18% vs. 9%).⁶

Certain groups of students may be more likely to be bullied. Two 2007 MA surveys found that students who identified as gay, lesbian, or bisexual, or who were unsure of their sexual orientation (39% vs. 20% of heterosexual students);⁷ students with a disability (12% vs. 3% of students who did not report a disability),⁸ and students who had been told by a medical doctor that they had a weight problem (11% vs. 4% of those who had not been told this)⁸ were more likely to be bullied.

Bullying has profound health and well-being consequences for young people. Massachusetts data parallel national studies that show that youth who are bullied are five times more likely to become depressed. Bullied girls are eight times more likely to be suicidal. Bullied boys are four times more likely to be suicidal.⁹

Bullying has profound health and well-being consequences for young people.

Figure 13.2 High School Students Bullied in Past Year: School Attendance and Emotional/Mental Health



Source: Massachusetts Department of Elementary and Secondary Education YRBS, 2007. All comparisons are statistically significant ($p \leq .05$).

Bullying can be an early warning sign of anti-social behavior that may occur in other settings and continue into adulthood. National data show that nearly 60% of those classified by researchers as bullies in grades six through nine were convicted of at least one crime by age 24. Forty percent had three or more convictions by age 24.⁹

Community Violence

Community violence affects everyone to the degree that it directly touches their lives and limits freedom of movement by making some places too dangerous to visit. For those who must live in or near places where violent crime is very common, the daily risks can take a toll on physical and emotional health.

Community violence can directly affect the outlook of children and young people who may be either victims or witnesses of crime, and it can result in an increased risk of injury, developmental disorders, youth crime, post-traumatic stress disorder (PTSD), and a number of other anxiety disorders.^{10,11,12}

Although community violence affects everyone to some degree, it affects young males most, particularly young males of color.

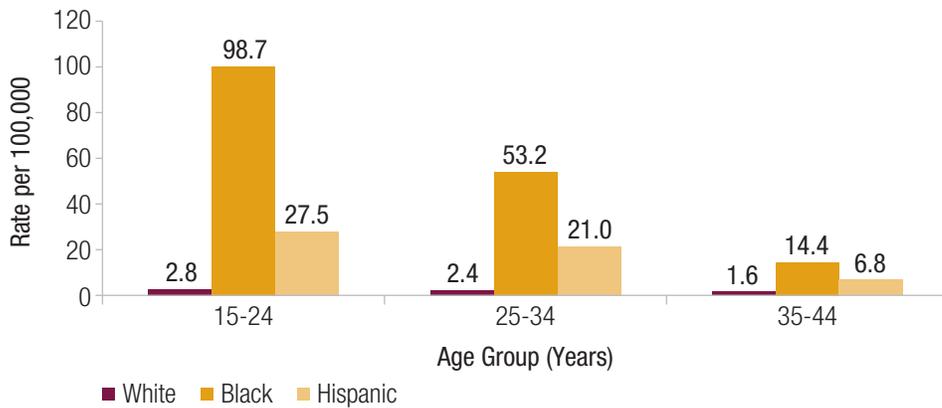
Patterns of non-fatal, assault-related injuries are similar to patterns of assault-related deaths, with the highest rates occurring among the 15-24

In 2007, young Black males (ages 15-24) were 38 times more likely to die by homicide than young White males, and young Hispanic males were 15 times more likely to die by homicide than young White males.

Source: MDPH Violent Death Reporting System, 2007.

Note: These homicides exclude IPV/jealousy-motivated homicides and homicides where the suspect was a family member.

Figure 13.3 Homicides Among Males

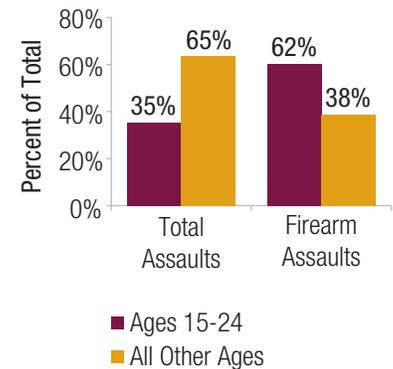


Source: MDPH Violent Death Reporting System, 2003-2007 (combined).

*The rate for Black males 15-24 was significantly higher than White and Hispanic males in this age group ($p \leq .05$). The rate for Hispanic males 15-24 was significantly higher than White males in this age group ($p \leq .05$).

Rate calculated on counts less than 20 may be unstable and should be interpreted with caution.

Figure 13.4 Nonfatal Assault-Related and Assault-Related Firearm Injuries

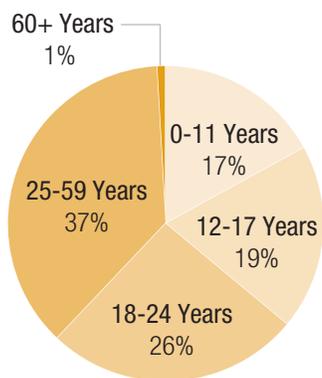


Source: Massachusetts Division of Health Care Finance and Policy, Hospital Discharge Database, 2007.

Survivors reported to the Massachusetts Rape Crisis Centers that current or ex-spouses, partners, dates, boyfriends, or girlfriends committed 26% of rapes/sexual assaults, followed by friends and acquaintances (25%), parents, step-parents, siblings, or other relatives (20%). Strangers accounted for only 14%, and persons known for less than 24 hours for only 6% of these incidents.

Source: MDPH, Rape Crisis Centers Program Data, FY2007.

Figure 13.5 Age of Sexual Assault/Rape Survivor at Time of Assault



Source: MDPH Rape Crisis Centers Program Data, FY2007.

year-old age group, followed by the 25-34 year old age group. More than a quarter (27.6%) of the assault-related injuries in the 15-24 age group during 2007 were firearm-related.¹³

Rape and Sexual Violence

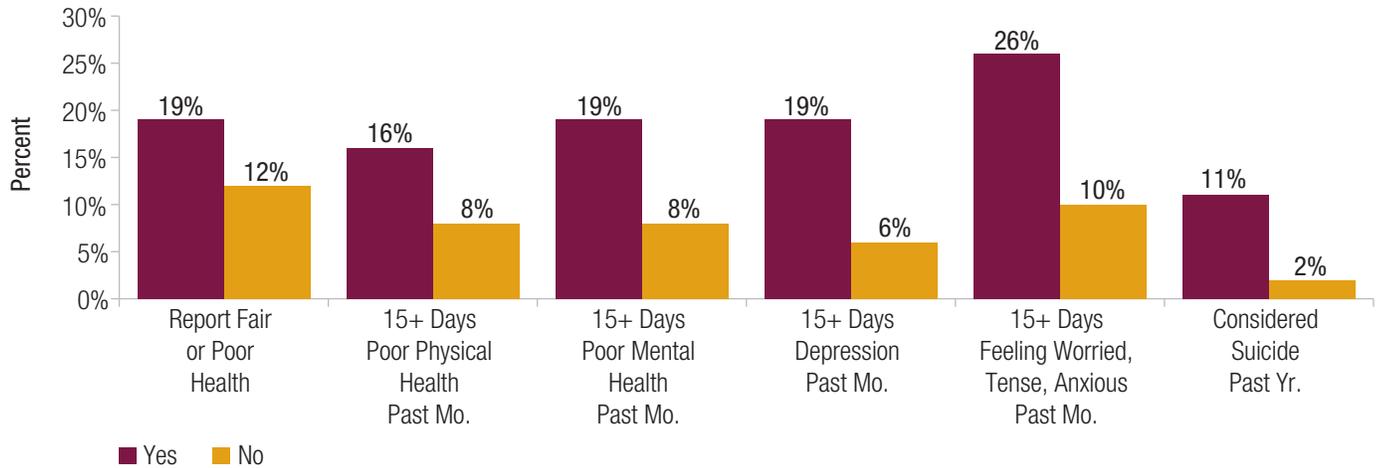
The term ‘sexual violence’ is used broadly to describe sexually violent and abusive behaviors that include but are not limited to rape, sexual assault, drug- or alcohol-facilitated sexual assault, and sexual harassment and exploitation. Most rapes and sexual assaults are committed by persons known to the victim.

According to the FBI’s Uniform Crime Reports, there were 1,634 forcible sexual assaults reported in MA in 2007.¹⁴ The BRFSS reveals that 11% of MA adult residents reported having experienced some form of sexual violence in their lifetimes.¹⁵

Women (15%) were more likely than men (6%) to have reported such experiences.¹⁶ Similarly, 18% of high school girls and 7% of high school boys reported having experienced some form of sexual violence in their lifetimes.⁷ This type of gender disparity has been found repeatedly over time in international, national, state, and local surveys. Other groups who may be at higher risk for sexual violence include those with disabilities (22% of adults with disabilities versus 9% of adults who did not report a disability), and those who identify with a sexual orientation other than heterosexual (29% compared to 12% of heterosexual adults).¹⁷

Rape and sexual assault have short- and long-term effects on victims’ physical and mental health. Three-year average BRFSS statistics (2005-2007)

Figure 13.6 Sexual Assault and Physical and Mental Health, Persons 18+



Source: MDPH BRFSS, 2005-2007.

*All comparisons are statistically significant ($p \leq .05$).

show that adults who have experienced a rape or sexual assault sometime in their lifetimes are more likely than adults without such experiences to also experience physical health symptoms, depression, suicidal thoughts, and other mental health symptoms.¹⁷

Teens who had experienced sexual assault were also more likely than those who had not to do poorly in school; miss school due to feeling unsafe on the way to, from, or in school; experience symptoms of depression; purposely injure themselves; have considered or attempted suicide in the past year, been or gotten someone pregnant in the past year; and driven after drinking.⁷

Intimate Partner Violence: Dating and Domestic Violence

Intimate partner violence (IPV), often called domestic violence, is behavior that physically hurts, arouses fear, or prevents a victim from doing what he/she wishes. It involves a pattern of coercive control directed toward the victim that is intended to undermine the will of the victim and to substitute the will of the perpetrator. IPV occurs in same-sex and heterosexual relationships.

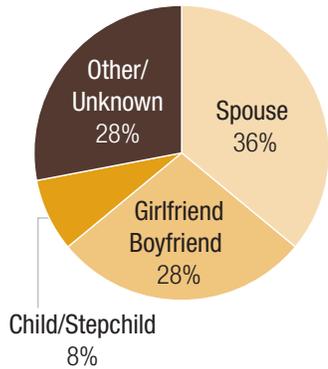
In 2005, 18% of MA adult residents reported having experienced an incident of IPV at some time in their lives.¹⁹ Women (22%) were more likely than men (14%) to have reported such experiences.²⁰ Intimate partner violence also affects youth. Eleven percent of high school students and six percent of middle school students reported being physically hurt by a date sometime in their lives.⁶

As with sexual violence, a higher percentage of adults with a disability reported having experienced IPV at some time in their lives than adults



Between fiscal year 2002 and fiscal year 2007, there were an average of 12,550 calls each year to the Massachusetts Rape Crisis Centers (RCCs) and the Spanish-language hotline service, *Llamanos y Hablemos*. RCCs also provide individual and group counseling and advocacy services for survivors, and accompany survivors to hospitals and medical clinics for medical intervention after an assault. In FY2007 Massachusetts RCCs provided 810 medical advocacy sessions to 736 individuals who sought medical services in relation to a sexual assault.¹⁸

Figure 13.7 **Victim-Suspect Relationship in Intimate Partner Violence Homicides**



Source: MDPH Violent Death Reporting System, 2003-2007.

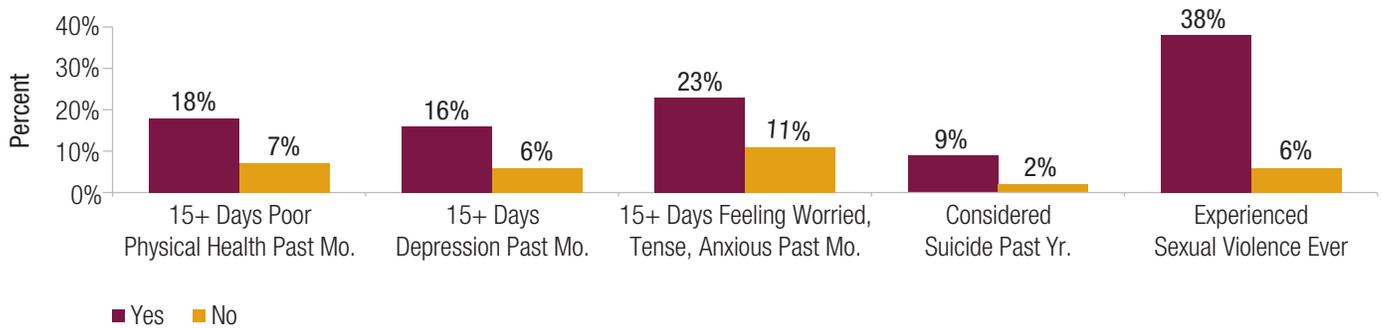
with no disability (30% vs.15%), and, 47% of gay, lesbian, and bisexual adults reported such experiences compared to 19% of heterosexual adults.¹⁹

At its most extreme, IPV can lead to death. Between 2003 and 2007, 125 IPV-related homicides were recorded statewide.²¹ Although the IPV victim is most often the target of IPV homicide, other people close to the IPV victim, including one or more children, may be killed as well or instead.²¹

Historically, many homicide-suicides happen as part of IPV dynamics. Between 2003 and 2007, more than 80% of the 41 homicide-suicide cases in Massachusetts were IPV/jealousy-motivated. These homicide-suicides took the lives of 70 people.²¹

In addition to the increased risk of injury and death, victims of IPV experience a variety of increased health risks.

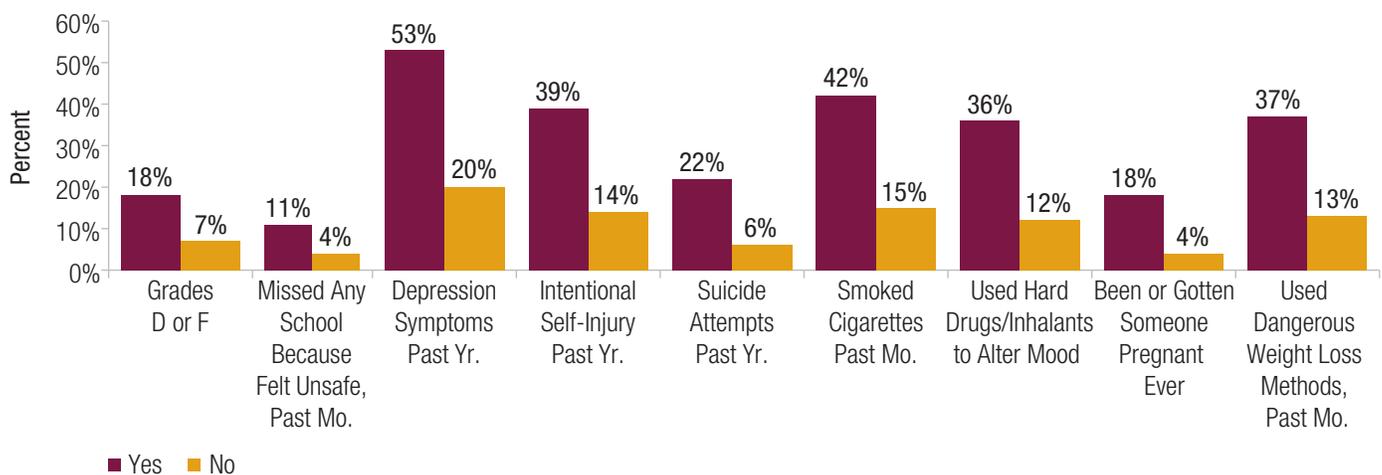
Figure 13.8 **Experienced IPV: Emotional/Mental Health and Sexual Violence Victimization History**



Source: MDPH BRFSS, 2005.

*All comparisons are statistically significant (p<.05).

Figure 13.9 **Dating Violence, High School Students: School Attendance, Emotional/Mental Health and Risk Behaviors**



Source: Massachusetts Department of Elementary and Secondary Education YRBS, 2007.

*All comparisons are statistically significant (p<.05).

Like adults, teens who experience dating violence report a variety of risk-taking behaviors and mental and emotional states that might negatively affect their long-term health and put them in danger of injury or death.⁷

Child Maltreatment and Witnessing Family Violence

Violence against infants and children is most often perpetrated by parents, or other family members. Child victims of sexual violence, are usually the victims of either family members or authority figures in child-serving or community organizations. Eighty four percent of perpetrators of child-directed sexual violence are male.²³

Children are also harmed by witnessing violence in the home, as bystanders to bullying and harassment in schools and communities and as witnesses to violent crime. Effects on children range from death or injury to long-range psychological harm and health risks.

In 2007, 11% of MA high school students reported witnessing violence in their families in the past year. Certain students were more likely than others to report such experiences, including: female students (14% vs. 9% of male students); students who identified as Hispanic or with a race other than White (16% vs. 9% of White students); students who identified as gay, lesbian, or bisexual (28% vs. 10% of heterosexual students), and students who reported a disability (18% vs. 8% of students without a disability).⁸

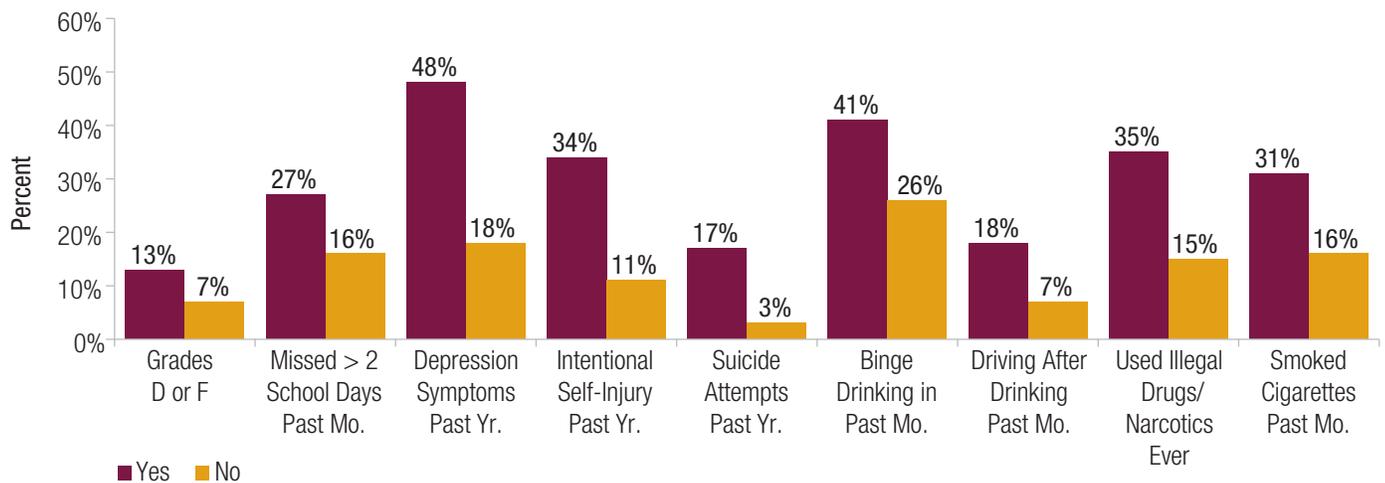
Students who reported witnessing family violence in the past year were doing more poorly than students who did not on a variety of measures of school performance, mental health, and general distress. They were also

Approximately 2,200 people attended Massachusetts Certified Batterer Intervention Programs each year between fiscal years 2003 and 2007.²⁴

Over a six-year period, IPV offenders who completed MA certified batterer intervention programs were less likely than those who did not to have a subsequent arraignment of any kind (47.7% vs. 83.6%), an arraignment for a subsequent violent offense (33.7% vs. 64.2%), or one for a subsequent restraining order violation (17.4% vs. 41.8%). Those who completed batterer intervention programs also had lower new arraignment rates than IPV offenders who completed anger management or substance abuse treatment. Other types of programs studied did not decrease IPV offenders likelihood to have additional restraining order violations or arraignments.

Source: Office of the Commissioner of Probation's 2004 study *Restraining Order Violators, Corrective Programming, and Recidivism*.²²

Figure 13.10 Witnessing Family Violence, High School Students: School Attendance, Emotional Distress and Risk Behaviors



Source: MDPH Youth Health Survey, 2007.

•All comparisons are statistically significant (p≤.05).

Since 2000, more than 33,500 reports of child maltreatment have been supported by the Department of Children and Families each year.²³

more likely than their peers to have engaged in risky behaviors that could affect their safety or their long-term health.⁸

Since 2000, more than 33,500 reports of child maltreatment have been supported by the Department of Children and Families (DCF) each year.²³ In 2007, DCF labeled as supported 853 cases of child sexual abuse and 4,593 cases of child physical abuse.²³ These numbers do not represent all of these types of abuse, since not all incidents are reported to DCF. There are also obstacles to confirming such reports, particularly of the sexual abuse of young children.²³

FIGURE NOTES

Figure 13.3: Homicides exclude intimate partner violence and jealousy-motivated homicides and homicides where the suspect was a family member. Rate calculated on counts less than 20 may be unstable and should be interpreted with caution; counts of less than 20 include ages 0-14 for *all* race and ethnicities, Black residents ages 45+, Hispanic residents ages 35-44, 45+ and all Asian age groups.

Figure 13.4: Data shown are injuries requiring hospitalization. Residents ages 15-24 years accounted for 34.7% of total nonfatal assault-related injury hospital discharges, but 61.7% of all firearm assaults in 2007.

Figure 13.7: "Other" may include people like the IPV victim's family members, a new boyfriend, girlfriend, or spouse, friend, or a colleague.

Figure 13.8: Reports based on lifetime experience.

END NOTES

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- 7 Previously unpublished statistics from the 2007 Youth Risk Behavior Survey which is administered for the Massachusetts Departments of Elementary and Secondary Education and Public Health by the Center for Survey Research at the University of Massachusetts, Boston.
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- 14 US Department of Justice, Federal Bureau of Investigation. FBI Uniform Crime Reports: *Crime in the United States, 2007, Table 5: Crime in the United States by State, 2007*, September 2008.
- 15 Overall percentage is a previously unpublished statistic from the 2007 Massachusetts Behavioral Risk Factor Surveillance System, which is administered via the Health Survey Program, Bureau of Health Information, Statistics, Research, and Evaluation, MDPH.

- 16 MDPH, Bureau of Health Information, Statistics, Research, and Evaluation, Health Survey Program. *A Profile of Health among Massachusetts Adults, 2007*, December 2008.
- 17 Previously unpublished statistics from combined 2005 through 2007 Massachusetts Behavioral Risk Factor Surveillance System data sets. The MA BRFSS is administered via the Health Survey Program, Bureau of Health Information, Statistics, Research, and Evaluation, MDPH.
- 18 MDPH, Bureau of Community Health Access and Promotion, Division of Violence and Injury Prevention, Sexual Assault Prevention and Survivor Services data sets.
- 19 Previously unpublished statistics from the 2005 Massachusetts Behavioral Risk Factor Surveillance System, which is administered via the Health Survey Program, Bureau of Health Information, Statistics, Research, and Evaluation, MDPH.
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