Building Healthy Relationships:

Engaging Men in Prevention Strategies to End Sexual Assault and Intimate Partner Violence

October 2005

Submitted by:
Derrick M. Gordon, Ph.D.,
Amilcar N. Armmand & John Filip

Funded by the Connecticut Department of Public Health

ACKNOWLEDGEMENTS

STATE OF CONNECTICUT, DEPARTMENT OF PUBLIC HEALTH
J. Robert Galvin, M.D., M.P.H., Commissioner

PUBLIC HEALTH INITIATIVES BRANCH
Richard Edmonds, M.A., Branch Chief

FAMILY HEALTH SECTION
Lisa A. Davis, B.S.N., M.B.A., Section Chief
Sharon Tarala, B.S.N., J.D., Supervising Nurse Consultant

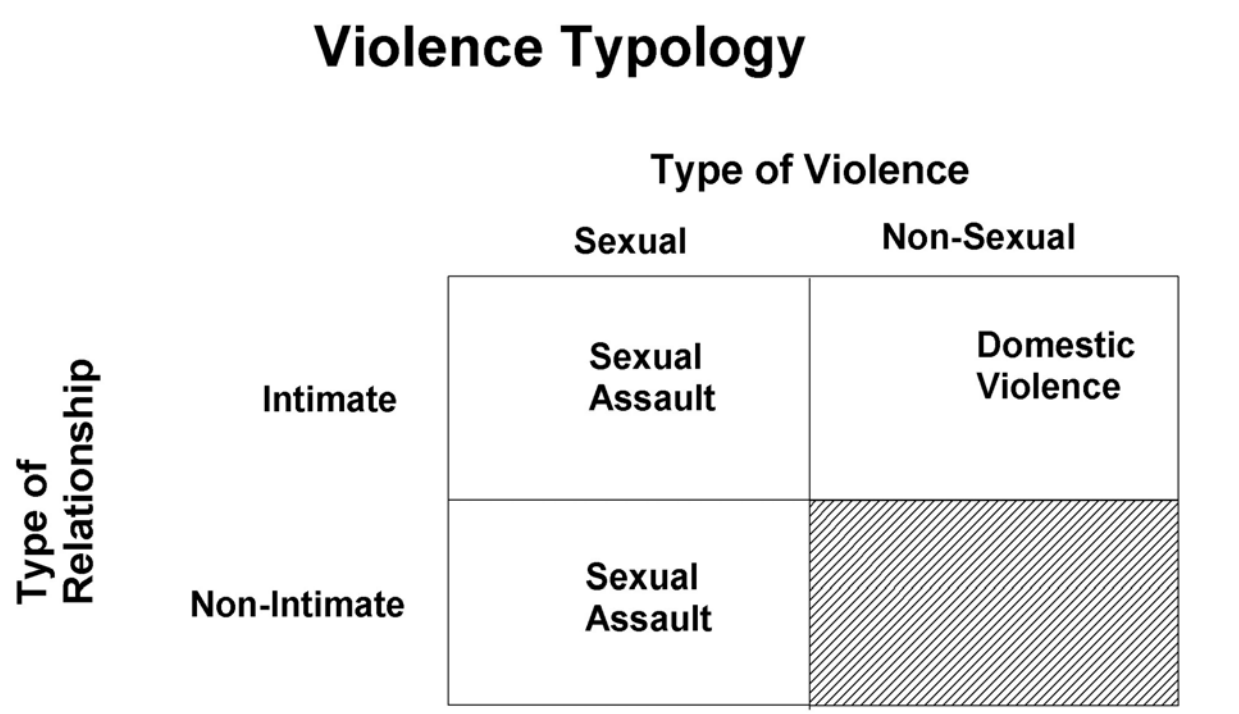
PREPARED BY:
Derrick M Gordon, Ph.D., The Consultation Center
Department of Psychiatry, Yale University School of Medicine
389 Whitney Avenue
New Haven, CT 06511

TABLE OF CONTENTS

EXECUTIVE SUMMARY

The Connecticut Department of Public Health contracted with a consultant to examine intimate partner violence, including sexual assault and domestic violence, as a public health issue and to define a best practice protocol to engage men and boys to find comprehensive strategies to develop healthy relationships and enhance intimate partner violence primary prevention efforts.

Intimate partner violence, which includes sexual assault and domestic violence, is a critical public health issue. For the purpose of this report, intimate partner violence encompasses behaviors and actions that occur in intimate relationships that put one at risk for physical harm, emotional harm, economic harm, and or psychological harm. The importance of addressing this issue from a public health and maternal and child health perspective rests in the observation that women and children are more often the victims of intimate partner violence. Even while currently on the decline, the rates of nonfatal violent victimizations perpetrated on women continue to be astounding when compared to that of men (Brecklin & Forde, 2001). In addition, the effects of intimate partner violence extend to other family and community members attached to these women and children. This report addresses intimate partner violence using a public health model that integrates prevention and social programming to reduce the effects. It also seeks to present a comprehensive approach to engaging men and boys who interface with the health care delivery system in the practice of developing healthy relationship skills. It seeks to identify and address critical areas in teaching men and boys how to develop and maintain healthy relationships that extend beyond intimate associations. Most programs designed to reduce the occurrences of domestic violence and sexual assault focus on the victims and limit the role of men in taking action to decrease the probability that violence will occur.



Sexual Assault - Unwanted sexual contact between a woman and man, in which the woman expresses concern for her safety.

Intimate Partner Violence - any behavior within an intimate relationship that causes physical, psychological, economic, or sexual harm to those in the relationship.

Domestic Violence - a range of behaviors that impact both men and women and include force, threats, intimidation, or mind games to exert one's control over another, causing them to do what the person wants. This includes stalking.

Violence, or Abuse, that ecompasses behaviors and actions that put one at risk for physical, emotional, economic, or psychological harm.

For the purpose of this report, sexual assault is defined as any unwanted sexual contact between a woman and a man where the woman feels or expresses concern for her safety (Krug, Dahlberg, Mercy, Zwi & Lozano, 2002). In this report, domestic violence describes a range of behaviors, across genders, which include force, threats, intimidation, or mind games to exert control over another (Kilpatrick & Ruggiero, 2003). Intimate partner violence is defined as the use of force, threats, intimidation, or mind games to exert your control over another, causing them to do what you want (Krug, Dahlberg, Mercy, Zwi & Lozano, 2002). It is important to

note that within the definition of intimate partner violence, a concept usually viewed as referring singularly to domestic violence, is the definition of sexual assault. Reports on sexual assault in Connecticut indicate that one in eight women will be sexually assaulted over their lifetime (Kilpatrick & Ruggiero, 2003). In 2001, the last year of comprehensive reports currently available, there were some 21,000 acts of domestic violence committed against women in the State of Connecticut (Kilpatrick & Ruggiero, 2003).

Sexual assault and domestic violence both have a considerable impact on society. Because this report focuses on sexual assault and domestic violence within the context of healthy relationship development, the term "intimate partner violence" was used to describe both sexual violence and domestic violence. The recent attention to the health related consequences of intimate partner violence and the associated financial costs to society have underscored the importance of addressing the issue in public health, health service, and community settings to reduce or change the impact of intimate partner violence.

Prevention has been identified as important in addressing healthy relationship development and intimate partner violence within individual, relationship, community, and societal contexts. This ecological framework (Bronfenbrenner, 1979) creates a synergy that builds from the individual level up to the societal level of intimate partner violence prevention.

This report catalogues risk factors associated with the perpetration of intimate partner violence, and describes the development of an intervention protocol focused on prevention, so as to reduce the social, individual, and economic impact of intimate partner violence. To understand this issue from Connecticut's perspective, eight focus group interviews were conducted to gather information on how best to involve young men and adult men in addressing healthy relationship development and reducing intimate partner violence. The focus groups

included key constituencies: domestic violence and sexual assault professionals, survivors, perpetrators, and community members.

The information shared by the focus group participants was consistent with the research literature. There was a consensus that healthy relationship development skills were important for men, young men, and boys. This is an important prevention message that should be embedded in any public health program or strategy. This report concludes with recommendations that can be incorporated into Maternal and Child Health community-based programs to promote healthy relationships. These recommendations span individual, relationship, community, and societal contexts. They cover broad themes such as: a) skill development in schools and in other settings where boys, young men and men congregate; b) the integration of these trainings and skills development strategies at the community level for access by their peers, parents, and other community members; c) consideration for how faith and spiritual leaders can be used to move this work forward; and d) curriculum development that spans peer, relationship and community perspectives.

INTRODUCTION

According to the U.S. Department of Justice, Bureau of Justice Statistics, Crime Data Brief (February 2003) there were approximately 700,000 nonfatal violent victimizations committed by current or former spouses and partners of victims during 2001. Of this number, some 600,000 nonfatal violent victimizations were perpetrated on women. Although this number represents almost a 50% decline since 1993, the rates of assault against women by spouses and partners continue to be staggering when compared to that against men. These disparate numbers illustrate the need to address the public health issue of intimate partner violence.

Over the past two decades, there has been increasing attention to the role of men in familial, community, and social functioning. However, there has been limited focus on intervening with men to address intimate partner violence, sexual assault, and overall healthy relationship development. When men have been considered, the focus has been on treating or educating offenders, after the violence has occurred. This approach, although indicated, limits the roles and responsibilities of men in taking action to change how violence impacts community and family development, and it does not address public health prevention strategies.

Within the areas of domestic violence and sexual assault, there have been calls for men to become involved in addressing and preventing violence toward women and children. Such approaches assume that men share collective responsibility for engaging each other, holding each other accountable for their actions, and communicating the inappropriateness of violence. Recently, there have been national and local campaigns urging men to stand up and be counted to support violence free and healthy relationship development with their partners, families, and community.

This report examines options, from a male perspective, to preventing sexual assault and domestic violence while fostering healthy relationship development. It also seeks to identify what key areas are important in the development of healthy relationships by young men and adult men. The work of this report will help Maternal and Child Health providers and Connecticut policy makers develop innovative, prevention-focused strategies to address the issues of intimate partner violence.

SEXUAL ASSAULT

Sexual assault continues to be a pervasive public health issue affecting our society. For the purpose of this paper, sexual assault is defined as any unwanted sexual contact between a woman and a man in which the woman expresses concern for her safety. Feltey, Ainslie & Geib (1991) estimate that between 24% and 50% of all women have been or will be sexually assaulted during their lifetime. Other researchers (Abbey, McAuslan, & Thompson-Ross, 1998; Foubert & Marriott, 1997; Hanson & Gidycz, 1993; Warshaw, 1988) call attention to what they see as a disproportionately high rate of sexual assault occurring on college campuses. Koss, Gidycz, & Winiewski (1987) reported that about 54% of college women experienced some form of sexual aggression. Koss et al. also reported that 15% of these aggressive acts were rapes. In an attempt to gather additional information about the scope of the problem, the U.S. Department of Justice (2000) commissioned a study to estimate the prevalence of sexual assault on college campuses. In this report, Fisher, Cullen & Turner (2000) estimated that the victimization rate (i.e., reaching the legal definition for rape) was about 27.7 rapes per 1,000 female students.

Reports on sexual assault in Connecticut indicate that one in eight women will be sexually assaulted over their lifetime (Kilpatrick & Ruggiero, 2003). These authors found that

risk of sexual assault was greatest for younger women (between the ages of 20-44), of Native American ancestry, with a low-income level (less than $5,000 a year). A major focus in the prevention of sexual assault has involved teaching women to reduce their exposure to sexually risky situations. Hanson & Gidycz (1993) observed that prevention efforts focused on women were effective in reducing the incidence of sexual assault for those women without a history of sexual assault. Although significant, this preventive effort failed to produce results for women with a history of sexual assault. Furthermore, such interventions were not successful in reducing the re-victimization of women with a history of sexual assault. These observations led Hanson & Gidycz (1993) to call for more prevention efforts that target men.

DOMESTIC VIOLENCE

In this report, domestic violence describes a range of behaviors that impact both men and women and include force, threats, intimidation, or mind games to exert one's control over another, causing them to do what the person wants (Krug, Dahlberg, Mercy, Zwi & Lozano, 2002). It can take the form of physical, verbal, emotional, economic, and sexual violence (Bancroft, 2002). In the previous section of this report, special attention was paid to the impact of sexual assault. For the purposes of this report, however, domestic violence will focus on the impact of physical, verbal, emotional, and economic violence, with no sexual component.

In the National Violence Against Women Survey, "Extent, Nature and Consequences of Intimate Partner Violence" (2000), the U.S. Department of Justice observed that 22.1% of women reported being physically assaulted. In this report, acts of domestic violence ranged from being slapped or hit, to using a gun. When this report considered stalking, it observed that 4.8% of women interviewed reported being stalked by a past partner sometime in their lifetime. In this

context, stalking included repeated acts of harassment and intimidation. This report concluded that although some men were victims of domestic violence from their female partners, women were significantly more likely to report being victimized by a partner.

In 2001, the last year of comprehensive reports, there were some 21,000 domestic violent acts committed in the State of Connecticut (State of Connecticut Department of Public Safety Division of State Police, Crime Analysis Unit, 2001). These incidents ranged from homicides and assaults to disorderly conduct. There were a number of weapons used in these attacks that included guns, knives, other dangerous weapons, and body parts.

One important consideration in preventing domestic violence is the extent to which perpetrators, who usually are men, use violence to maintain control. Control is reportedly the central issue experienced by individuals living in domestically violent situations. Perpetrators of domestic violence often cite a range of explanations that function as excuses for their actions. These excuses includes that he: was abused as a child, was hurt by a previous partner, loves his current partner too much, holds feelings inside too much, has an aggressive personality, loses control, is too angry, is mentally ill, hates women, is afraid of intimacy and abandonment, has low self esteem, is mistreated by others, has poor communication and conflict resolution skills, experiences abuse by women, is the victim of social oppression (like racism), and abuses alcohol or drugs (Bancroft, 2002). This extensive list catalogues the challenges faced in helping to either treat or educate men arrested for domestic violence incidents. It also underscores the "social lubrication" used to ease the responsibility that these men, and each of us, have in being responsible for our actions and closely examining the impact that our actions have on ourselves as well as others.

THE IMPACT OF INTIMATE PARTNER VIOLENCE ON HEALTH

Clearly articulated are the overarching impacts of sexual assault and domestic violence have on the functioning of any society. To this end, consideration of these social ills must take into account their similarities and reciprocal influences. Because this report considers domestic violence and sexual assault within the context of healthy relationship development, the term "intimate partner violence" will be used to describe both sexual violence and domestic violence. Intimate partner violence is seen as "any behavior within an intimate relationship that causes physical, psychological, [economic], or sexual harm to those in the relationship" (Dahlberg, Mercy, Zwi & Lozano, 2002).

In this report, much has been stated about the social consequences of intimate partner violence on the individual and others in the community and society in which they exist. Only recently has there been attention to the health related consequences of intimate partner violence and the associated financial costs. In a report completed by the World Health Organization (WHO), Krug, Dahlberg, Mercy, Zwi & Lozano (2002) underscored the health related impact of intimate partner violence. In their summary, individuals, usually women, who experience intimate partner violence, are more likely to exhibit health related consequences that extend to the physical, sexual and reproductive, psychological and behavioral, and fatal health areas (pg., 101). The catalogue of health consequences is extensive. Examples of physical health consequences include fractures, irritable bowl syndrome, and ocular damage. Examples of sexual and reproductive health consequences include infertility, pelvic inflammatory disease, and unsafe abortion. Examples of psychological and behavioral health consequences include depression and anxiety, smoking, suicidal behavior and self-harm. Examples of fatal health consequences include AIDS related mortality, homicide, and suicide (Krug, Dahlberg, Mercy,

Zwi & Lozano, 2002). Examples of financial costs include productivity lost due to being sick and medical costs for treating physical and psychological injuries (Krug, Dahlberg, Mercy, Zwi & Lozano, 2002). A March 2003 report from the National Center for Injury Prevention and Control at the Centers for Disease Control and Prevention stated that the costs of intimate partner violence exceed $5.8 billion each year, of which nearly $4.1 billion is for direct medical and mental healthcare services (National Center for Injury Prevention and Control, 2003).

For women, sharing their lives with a violent partner can have significant effects on their health status. The impact also extends to the health status of their children and other parties in the family, community, and society in which they live. Given the significant health-related impact that intimate partner violence has for society, there have been calls for garnering support and bringing attention to the issue in public health, health service, and community settings (Krug, Dahlberg, Mercy, Zwi & Lozano, 2002). One mechanism that lends itself naturally to effectively addressing the issue of intimate partner violence in these settings is prevention. Prevention, within these contexts, provides a mechanism for individuals to address and effectively intervene to reduce the impact of intimate partner violence on public health.

THE ROLE OF PREVENTION IN ADDRESSING HEALTHY RELATIONSHIP DEVELOPMENT

Intimate partner violence has a direct effect on the physical, emotional, economic, and psychological health of the victim, but also extends to health affects of their loved one(s), the perpetrator, the perpetrator's loved one(s), and the community in general. The breadth of players impacted by intimate partner violence speaks to the importance of addressing this public health issue in ways that reduce its impact on all who may be potentially affected by its occurrence. McMahon (2002) defined a public health approach as "what a society does to assure that

conditions exist in which people can be healthy." It is also dependent on collective action (Krug, Dahlberg, Mercy, Zwi, & Lozano, 2002). Any public health approach, then, calls for attention to the health of the entire population – perpetrators, bystanders, children, and victims alike. In the case of intimate partner violence, McMahon purports that improved health results from the "prevention of deaths and injuries caused by violence." To this we would also include the prevention of the emotional and psychological harm. Given this stance, any public health prevention strategy that if focused on the effects of intimate partner violence and the promotion of healthy relationships should consider how efforts will be targeted to reduce and/or redress the physical, emotional, economic, and psychological effects.

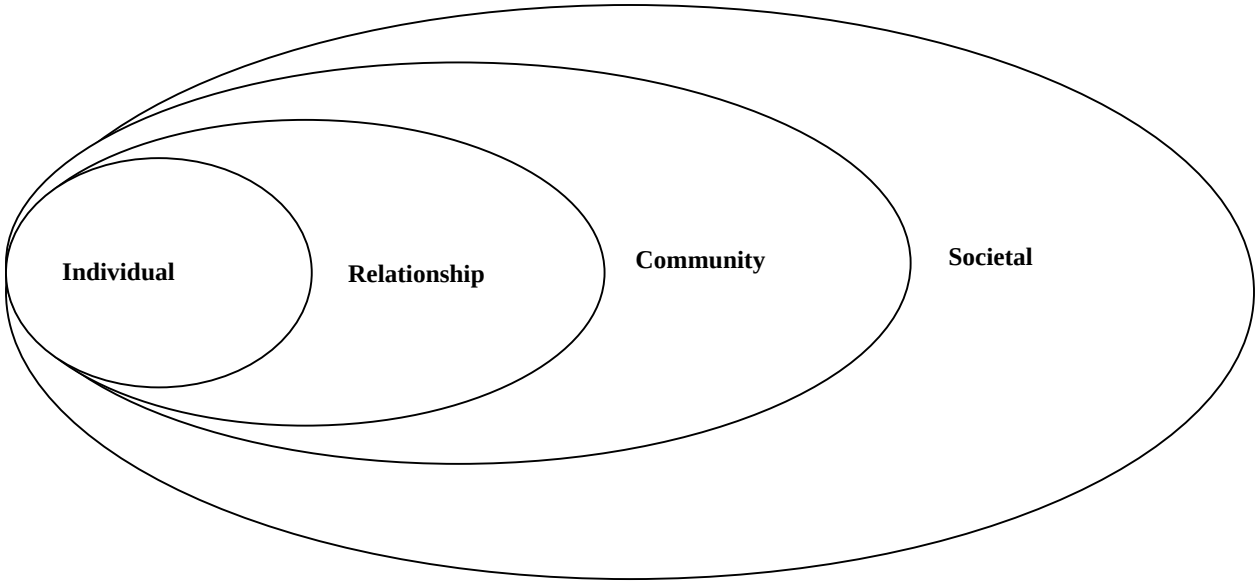
Increasingly, intimate partner violence has been conceptualized using a prevention perspective. This conceptualization seeks to "modify and or entirely eliminate the events, conditions, situations, or exposure to risk factors that result in the initiation of intimate partner violence and their associated injuries, disabilities, and deaths" (Centers for Disease Control and Prevention, 2004). There is also an emphasis on addressing the "perpetration, victimization and bystander attitudes and behaviors through the development and or enhancement of protective factors that impede the initiation of intimate partner violence" (Centers for Disease Control and Prevention, 2004).

There remains a dearth of knowledge about the types of preventive interventions that are most effective (Basile, 2003). One issue that remains unclear is the message content that positively affects the incidence and perpetration of intimate partner violence. One view is that "men must take responsibility for preventing sexual assault [and domestic violence], because most assaults are perpetrated by men against women, children, and other men" (Berkowitz, 2002, p. 163). This view also considers that a minority of men perpetrate the majority of sexual

assaults. Although most men would not be offenders of sexual assault, all men have influence on the social culture and climate that allows other men to be perpetrators (Berkowitz, 2002). Similarly, the expansive reach of domestic violence may be seen as a function of socially and individually sanctioned beliefs that nurture its expression. Individuals, researchers, and clinicians have called for men to examine their own potential for violence, and to represent a different ethos that does not condone violence. It is this examination of men's attitudes that is seen as influential as the misguided socialization messages received by men are addressed and redressed (Berkowitz, 2002).

Any discussion that considers the prevention of intimate partner violence must clearly articulate this paradigm within the context of already established frameworks used to categorize prevention initiatives. In this report, special attention will be paid to ***universal, selective*** and ***indicated*** prevention strategies within an ***individual, relationship, community, and societal*** context (see Fig 1).

Figure 1 Framework for Intimate Partner Violence Prevention (Centers for Disease Control and Prevention, 2004)



A universal prevention perspective is population-based (e.g., the role of public health. Selective prevention, however, focuses on preventing intimate partner violence by targeting a selected group of individuals who are at a heightened risk for the perpetration of or being victimized by intimate partner violence (e.g., children raised in homes where there was intimate partner violence committed). An indicated prevention perspective focuses on those individuals who have already exhibited signs that they are at risk of offending/being victimized or have been offended/victimized (Brome, Saul, Lang, Lee-Pethel, Rainford, & Wheaton, 2004). Here, the goal is to prevent future violence from occurring (e.g., incarceration, criminal supervision with psycho-education).

The context in which prevention strategies should be employed builds on the ecological framework first described by Bronfenbrenner (1979). This ecological framework has a developmental nature that builds from the individual level up to the societal level of analysis (Basile, 2003; Mercey & Hammond, 1999; Figure 1). At the individual level, the focus is on the person. Special attention is given to the attitudes, beliefs, and actions they exhibit in the expression of intimate partner violence. At the relationship level, the focus is on the interactions that occur between two or more individuals (e.g., families, friendship networks) that support the expression of intimate partner violence. At the community level, the focus is on the interactions that occur between those systems in which individuals engage, and build on these established relationships (e.g., neighborhood groups, the workplace, etc.). The societal level represents an integration of the individual, relationship, and community level systems that affect us all (e.g., race, gender norms, social policies) and that permeate our social interactions with others (Brome, Saul, Lang, Lee-Pethel, Rainford, & Wheaton, 2004). If Connecticut is considered a community

level system, then the society that we are interested in is either the East Coast or the United States of America.

There is a clear link between the public health approach that seeks health for all in our society and a prevention tool that ensures this vision. Conceptualizing the prevention of intimate partner violence within these various contexts will enhance the comprehensive public health strategies to address social health concerns (Basile, 2003).

RISK FACTORS ASSOCIATED WITH INTIMATE PARTNER VIOLENCE

The task of determining which factors are most related to intimate partner violence perpetration is difficult. Part of the problem is that, when we think about prevention initiatives, the focus usually is on the individual. Below, however, are those factors that appear to either facilitate or condone the view that intimate partner violence is normal.

One societal level factor that influences the expression and perpetration of intimate partner violence is masculinity or traditional gender norms and their expressions in social and societal contexts as boys are socialized into men. Numerous authors (see, Basile, 2003; Berkowitz, 2002; Foubert & Marriott, 1997; Hall, Sue, Narang, & Lilly, 2000; Hong, 2000; and Lonsway & Fitzgerald, 1994) have underscored the dichotomy that is evident in the definition and discourse about masculinity. From a societal perspective, masculinity is usually presented as the antithesis to femininity. It also "inculcates boys and men [into] a hegemonic [i.e., predominant influence of one state over another] and limiting code of masculinity that intimately links traditional male gender roles with violence, and that may predispose men to be perpetrators and victims of violence" (Hong, 2000, pg. 269). The devaluing of femininity and the hegemonic

masculine ideal has been described as potentially lending to the foundation of the objectification of women (Berkowitz, 2003).

Brannon & David (1976; cf. Hong) present four metaphors of masculine socialization as key tools in understanding the factors that negatively impact masculinity's effect. These metaphors are: 1) "No sissy stuff" where the emphasis is on behaviors that can be construed as feminine in their expression; 2) "Be a big wheel" where the emphasis is on gaining power, dominance, wealth, and success; 3) "Be a sturdy oak" where the emphasis is on being independent, controlled, unemotional, revealing no vulnerabilities; and 4) "Give them hell" where the emphasis is on being risk-taking, daring, and aggressive – this masculine metaphor was described as being most correlated with violence. Clear in this discussion is the interplay between attitudes held and the mechanisms by which they are transmitted socially. It also brings to the fore the impact that social norms have on the expression of violence by boys and men.

There are a number of investigations that look at the causal links between the exposure to violently suggestive media and violence expression in children. Although questioned and not causally linked, reports to date suggest that children exposed to violence are more likely to perpetrate violence (Krug, Dahlberg, Mercy, Zwi, & Lozano, 2002). There also appears to be evidence supporting a link between excessive exposure to media and experience that combine arousing sexual images with violence (Krug, Dahlberg, Mercy, Zwi, & Lozano, 2002). This remark brings to the fore how we are socialized through the media and through our actions as a society. As children and young adults mature, they begin to develop relationships between sex and physical violence. When we think about larger social risk factors, we must also consider how being exposed to sexually stimulating images and violence begins to create a context whereby women's sexual cues could be misinterpreted. According to Malamuth, Sockloskie,

Koss, & Tanaka (1991) "hostile masculinity," reinforced through inaccurate media portrayals of women's sexual needs, mediates the relationship between male sexual coercion and rape myth acceptance.

Rape myths have been presented in the literature as societal-level factors to be examined and addressed in designing sexual assault prevention initiatives. These refer to attitudes and general false beliefs about rape that permeate our social fabric and that are held as truths as we try to deny and justify sexual aggression against women (Lonsway & Fitzgerald, 1994). The influence of these factors on the expression of violence toward women rests on the observation that there are "significant relations between sex and rape myth acceptance… almost all of which indicate that men are more accepting of rape myths than are women" (Lonsway & Fitzgerald, 1994, pg., 142). This stereotypical way of thinking furthers the denial and trivialization of a crime that affects a substantial proportion of the female population (cf., Brownmiller, 1975) while shifting the blame to the victim. Often when this blame is shifted, perpetrators usually report or expressly believe that women are disingenuous about their desires and are responsible for controlling their behavior, which in turn, encourages and justifies their use of violence (Abbey, McAuslan, & Ross, 1998, pg., 170). When we think about rape myths and their purpose, Lonsway & Fitzgerald (2000, cf. Hall, Howard, & Boezio, 1986) talked about three types of myths: *denial of rape's existence, excusing the perpetrator, and denial of the seriousness of the offense*. A four-factor model developed by Briere, Malamuth & Check (1985, cf. Lonsway & Fitzgerald) expanded the types of rape myths to include a category that emphasizes that *rape only happens to a certain type of woman*. This also brings to the fore the role of attitudes toward women and sex roles. Important in these discussions is how the societal-

level influences trickle down to affect the community, relationship, and individual-level values held about intimate partner violence and its perpetration.

At the community level of analysis, there are a number of factors that appear to impact intimate partner violence. Situational factors include poverty and low income (Krug, Dahlberg, Mercy, Zwi, & Lozano, 2002). Krug, Dahlberg, Mercy, Zwi, & Lozano suggest that with poverty and low income status come a number of stressors that leave individuals with fewer resources to cope, thus resulting in the use of violence. Developing targeted responses to address intimate partner violence has also been shown to impact significantly on its perpetration (Krug, Dahlberg, Mercy, Zwi, & Lozano, 2002). Counts, Brown & Campbell (1992) reported that there were lower levels of violence in societies where there are sanctions against intimate partner violence and places for women to turn and receive support. Moreover, they showed that in communities where the role of women was in the greatest transition there was more intimate partner violence. If women held the lowest status and did not indicate that they wanted to change their status, there was no need for violence. In social and societal situations where women held high status, imposed structures that positively change the "traditional gender roles" may have been present in the community (Krug, Dahlberg, Mercy, Zwi, & Lozano, 2002).

This discussion moves us to another important level of analysis in relation to addressing factors that impact the perpetration of intimate partner violence: the relationship level. A view widely held among developmental psychologists and reiterated by Basile (2003) is that "promoting positive child development has broad benefits for …society and goes beyond intimate partner violence prevention" (pg., 459). According to McMahon (2000), college men raised in hostile families where they witnessed physical violence between the parents and/or directly experienced physical or sexual abuse, are at greater risk for the perpetration of intimate

partner violence. Important in this discussion is the relationship between exposure and/or experiences of a familial history of physical violence or sexual violence with the precipitating factors that lead to violence**.** It is also important to note that within these settings there is usually a large amount of male dominance and economic stress that negatively impacts the family and its functioning.

One issue to consider is men's comfort level with intimate partner violence. Men and young men may experience challenges when they are bystanders to the expression of intimate partner violence. They are challenged because of their expressed confusion about how to intervene with peers who may be perpetrating intimate partner violence. The end result is that they remain quiet. This silence is then perceived as consent of intimate partner violence, and the cycle continues (Berkowitz, Jaffe, Peacock, Rosenbluth & Sousa, 2004). Intervention within this context dictates that we equip men and young men with the skills to be able to clearly indicate their disagreement with their peer's use of violence in their intimate relationships. One way of doing this is through the Mentoring Violence Prevention Project described in the Teen Dating Violence Information and Resources by the National Resource Center on Domestic Violence (2004).

There is also an observed link between the delinquent behavior (e.g., running away from home, friend in trouble with the law) and more socially severe actions like intimate partner violence (McMahon, 2000). Ageton (1983) observed that peer approval of sexual aggression was a precursor to the perpetuation of violence. The relationship between socially facilitative delinquent acts and aggression was presented as following two paths: 1) hostile attitudes and personality and 2) sexual promiscuity (McMahon, 2000). Data suggest that a hostile familial experience leads to a hostile orientation to the external world, which further leads to the

perpetration of delinquent acts (Krug, Dahlberg, Mercy, Zwi, & Lozano, 2002). Over time, these acts develop into the commission of intimate partner violence. McMahon also underscored other familial disruptions that appear to have some link to the perpetration of intimate partner violence. Developmental disruptions like parental divorce, large families of origin, family history of criminal behaviors, and relationship problems with their primary paternal figure are examples of familial disruptions. The relationship between male socialization and how hostile relationships between fathers and sons facilitate the maltreatment of women is also seen as a significant link to explore. The relationship between these factors and the larger macro-level factors cannot be ignored. They suggest that any intervention that targets intimate partner violence needs to incorporate interventions at multiple levels, using multiple strategies.

A number of ***individual level factors*** impact on the perpetration of intimate partner violence. As with larger social forces, individuals who have perpetrated intimate partner violence hold more "traditional" or hegemonic masculine orientations towards gender expression and role. As a result, these factors seem to increase the potential for the perpetration of intimate partner violence (Hong, 2000). Men who perpetrate sexual assault hold hostile attitudes and views that support the exploitation of women. Embedded in this orientation toward women is a hostile point of reference to women that is adversarial in nature (McMahon, 2000). This hostile orientation toward women gets redirected into violent actions because of the miscues that develop from interactions. McMahon puts it succinctly, "sexual promiscuity, which, especially in interaction with hostility, produces sexual aggression" (pg., 32). This also highlights the disconnect between the intended social communications and their interpretation – more accurately, misinterpretation – of these events (Dean & Malamuth, 1997).

There are also a number of individual factors that impact the perpetration of intimate partner violence. These include being young in age and connected romantically to a significant partner. Alcohol and other substance use have also been linked to the perpetration of intimate partner violence. Important here is the co-occurring influence that substance use/abuse has on the expression and use of violence. Other factors intrinsic to the individual, such as their mental health status (e.g., depression) and personality functioning, have been shown to impact one's decision to use violence in intimate relationships. Economic status has also been shown to influence the use of intimate partner violence (Dean & Malamuth, 1997; Krug, Dahlberg, Mercy, Zwi, & Lozano, 2002). Although all these factors are important in our understanding of the perpetration of intimate partner violence, there are a number of authors (Krug, Dahlberg, Mercy, Zwi, & Lozano, 2002; McMahon, 2000) who assert that these factors in-and-of themselves cannot be used to explain away one's choice to use violence.

With an understanding of the factors that impact the perpetration of intimate partner violence and sexual assault as well as those factors associated with the prevention of these public health issues, key community constituents were engaged to inform the development of prevention strategies with men. The key constituents were also asked to think about, engage, and suggest strategies that involve men, young men, and boys at all levels of the prevention intervention strategies. The section that follows presents a clear description of how the focus group protocol was developed, who participated, and a summary of the themes presented in these groups.

DEVELOPMENT OF FOCUS GROUPS PROTOCOLS

The focus groups began with an invitation to local experts in the areas of domestic violence and sexual assault. These individuals were asked to meet with the principal investigator and staff members of the Department of Public Health at the Department of Public Health. The experts came from Connecticut Sexual Assault Crisis Services (CONNSACS), Connecticut Coalition Against Domestic Violence (CCADV), and the Non-Violence Alliance (NOVA). In these key informant interviews, the intent of this project was reviewed and the process was described. Participants were asked to review and respond to a series of questions developed by the principal investigator of this project, with input from key staff at the Connecticut State Department of Public Health (see Appendix I). The experts were then asked to provide feedback, suggest strategies for primary prevention, and give their expert opinion on how best to involve men to develop healthy relationships. A total of three key informant interviews were conducted with a total of two women and one man participating in these interviews. After these interviews were arranged, a total of five focus groups were conducted with key community constituents.

Focus groups are group interviews on a specific topic, in which a moderator guides the discussion occurring between small numbers of individuals. The information shared in these group interviews represents the data of the focus groups. Within the context of this work, the area of concern for these focus groups was to better understand from key constituents how best to involve young men and adult men in addressing healthy relationship development, identifying key strategies, and underscoring areas of concern in this approach.

Beginning in the fall of 2004 and through the spring of 2005, five (5) focus groups were conducted to better assess their views and comments regarding sexual violence issues and

prevention efforts. Three focus groups with community members and survivors took place at CONNSACS office in East Hartford, Connecticut. Two focus groups with individuals incarcerated with sexual assault and domestic violence histories took place at the Brooklyn Correctional Facility. All of the participants consented to participate in these focus groups. They were informed of their rights and it was made clear that their participation was voluntary. If they wished not to participate, they were told that this would not adversely impact them. Refer to Appendix I and II for a copy of the questions posed in each of the focus groups.

Focus Group	**Totals**	Women	Men
CONNSACS Staff	11	10	1
Adult Group	8	7	1
Adolescent Group	5	4	1
Incarcerated Men (2 groups)	20	0	20
Totals	44	21	23

GENERAL SUMMARY OF FOCUS GROUPS

SERVICE PROVIDERS, CONSUMERS, & INTERESTED COMMUNITY PARTNERS

In general, the motivation for intimate partner violence perpetration was seen as a function of: control and power by men, the cycle of violence and the control that it gives to men, a lack of respect for women, and low self-esteem. The participants stressed how miscommunication plays a role in inaccurate interpretation of social cues for men who perpetrate sexual assault and domestic violence. This led to numerous discussions about the experience of

the men who perpetrate these acts and the perception that they were solely concerned with what was going on for themselves, with little concern for the other parties involved. Lack of information and education about what are the ingredients of a healthy relationship involving sexual intimacy and how to develop a healthy relationship that includes sexual intimacy impacted the perpetration of intimate partner violence. The image of masculinity and conforming to stereotypical gender roles were identified as contributing factors to the development of poor relationships skills. It is clear that one's social context affects one's understanding of, and attention to, what constitutes a healthy relationship. Specifically, the participants discussed a number of instances where adults could have addressed behaviors that were negative but ignored them because "boys will be boys." This position minimizes the consequences of sexual assault and domestic violence. Cultural pressures to be silent about healthy sexuality were seen as another factor that impacts the perpetration of sexual assault and domestic violence. This led to stories that underscored the dichotomy between sexuality being seen from either an abstinence only perspective, or a sexual assault only perspective, with no middle ground.

The important areas identified in addressing sexual assault and domestic violence included being in a comfortable setting where all can learn about healthy relationship development, creating contexts where men and women can talk to each other about healthy relationship development, and breaking down the stereotypes about men, sexuality, and healthy relationship development. One area that seemed to be omnipresent in these discussions dealt with the role of prevention strategies and their impact on the already developed strategies. As the participants talked, they expressed concern about the reallocation of resources that would diminish the foundations already laid. The participants also stressed the importance of healthy

relationship development among middle and upper middle class segments of our society. This assertion was described as growing out of the view that the issues of sexual assault and domestic violence do not occur within those settings. The participants were, however, clear about the inaccuracy of this view. Some consideration called for understanding or identifying how substance use affects healthy relationship development. This encouraged a discussion about the community's response to issues that indicate a less than ideal relationships and healthy ideas of relationships. Specifically, they talked about law enforcement and its role in either perpetrating the myths related to these areas or neglecting the impact of these myths on those affected.

The proposed need to attend to, and focus on the value of addressing sexual assault and domestic violence prevention with men was met with a resounding yes. All participants agreed that to adequately address the issue of healthy relationship development, attention needs to be paid to men, and men need to be integrated into the solution through enhanced roles as peer mentors and as advocates in modeling how healthy relationships are established and sustained. This discussion led to excitement for bringing the issues of sexual assault and domestic violence to the community and having the community cooperate in the eradication of these issues. In these discussions, participants talked about bringing women's groups to men, young men, and boys' groups to begin a dialogue about how healthy relationships are developed and the responsibilities of each participant in ensuring that these skills are developed.

When asked about their concerns in addressing sexual assault and domestic violence prevention with men in an effort to increase healthy relationships, the participants said there were a number of factors to consider. One factor identified was the context in which young men live. Delineation of this factor brought attention to positive socialization, healthy relationship modeling by primary caretakers and other significant models, and juvenile justice and school

systems response to perpetrators. A second factor was the issue of collective responsibility. The participants acknowledged that all men should model healthy relationships between the sexes, rather than ascribe special credit for those who engage in behaviors that contribute to the healthy development of a society. A third factor related to men and their involvement in the areas of sexual assault prevention, domestic violence prevention, and healthy relationship development had to do with the potential that men might reject the feminist ideals about these issues and their social impact. Specifically, the participants were adamant that men not be allowed to be "the voice" of these issues and ignore the voice of women. Men must also attend to the sexist language that men can take for granted, which negatively impacts these issues.

When asked how best to bring these issues to men, young men, and boys, the participants were clear that men had to be a significant part of the solution. Specifically, they asked that women not be used to "lecture at" men about healthy relationship development or the impact of sexual assault and domestic violence. They did, however, ask that the voice of women not be lost in this process. They called for men, young men, and boys to be the agents of change to determine how best to advance the idea of healthy relationship development with themselves. Community involvement was seen as another area in which men could change the culture that exists around healthy relationship development. The participants went on to talk about the development of community supports that allow individuals to dialogue about healthy relationships and provide a context whereby community members are accountable to each other for their actions. Added to this discussion was the role of culture and ethnicity and ensuring that all discussions, promotions, and interventions consider the impact of culture and ethnicity on how this issue is understood and addressed. The participants felt that attention needed to be paid

to the context in which these discussions occurred. This included the impact that socio-economic status had on how we defined what comprises a healthy relationship.

Incarcerated Men

When individuals incarcerated for perpetrating sexual assault and domestic violent acts were interviewed, the responses were comparable to those received from service providers, consumers, and interested community partners. In general, there was broad support for the promotion of healthy relationship development with men and boys. There were however, special considerations that the participants suggested.

The incarcerated men involved in these focus groups were able to identify a number of factors: a) lack of respect, b) being unable to manage feelings, c) issues with control, d) minimization of a man's responsibility in engaging in consensual sexual and intimate relations with others, and e) not having appropriate models for relationships as factors that contributed to the expression of violence in their intimate relationships. Important in this discussion were the large number of rein forcers that suggest that women are objects and present only to gratify their needs. The role of men in relation to women was another factor that was presented as significantly important in their understanding of the expression of intimate partner violence in their lives. This declaration appeared to be related to their view that, for men, there is a great deal of social pressure to demonstrate that they are "in charge," and or responsible for those attached to them. Any indication that they were not living up to the expectation was seen as tantamount to admitting that they were not man enough. Specifically, the men talked about their frustrations with behaviors from their partners that suggested they were not the "authority" in their homes. This led to a discussion about the role that self-esteem has on how men develop and maintain healthy relationships. Integrated into this discussion was the respondents'

acknowledgement that there are times when they felt hurt by their partners and they wanted to retaliate and hurt them also. The relationship between these behaviors and their use of illicit substances and alcohol was presented as a mitigating factor. The men involved in these focus groups all underscored their lack or lowered self-control while under the influence of drugs and alcohol.

When the men were asked to discuss what areas should be addressed in developing healthy relationships, they disclosed that special attention should be paid to the way men are socialized. Specifically, the men underscored the importance of engaging young men in schools and at home, and talking, teaching, and engaging them in strategies that would ultimately lead to healthy relationships. This discussion also underscored how words and attitudes influence the expression of physical violence. Making a direct connection between what we say or feel and what we do was seen as important in understanding how healthy relationships are fostered. The participants talked about the tightrope that exists between knowledge and self-control. They felt that self control and managing their need to control could be enhanced with knowledge and skill development. Another area of concern for the men was teaching them how to ask for help. Most of the men confessed that admitting that they had a problem was difficult for them and that socially there was an inordinate amount of pressure for them to deny the presence of problems or deficits. An outgrowth of this discussion was the identification of places where men and boys can access help, safely. Places where this was seen as most relevant included churches, extended families, schools, counselors, and hotlines. The creation of services within these contexts was not a sufficient remedy to the issues at hand. The men felt that within these contexts, significant changes needed to be made in how they received and welcomed men and boys into services being offered. They also talked about families as a socializing agent needing to be involved in

reshaping the messages being delivered to men and boys – to one that facilitated their healthy development without conflicting expectations.

As this focus group progressed, the men expressed hope that all young men and women receive consistent messages about healthy relationships. They were clear that these messages needed to be delivered, but were concerned that older men may be too cemented in their ways to make the requisite changes. When challenged, given their status, the men took pause and reiterated that they truly believed that change was possible.

In looking to the hope for the future in this work, the men claimed that they did not want their sons and daughters to be plagued with the same challenges they faced in their intimate relationships. They were concerned that their modeling may have predisposed their children to fail in the future. The men indicated that healthy relationship skills should be first taught in the elementary schools because they were concerned that once you have been labeled as an offender, that label would remain with you forever. As we approached these issues, the men indicated that it was important for us to create a safe and open environment in which these issues could be explored and addressed. There was some realization that the group context was instrumental in assisting them to identify strategies and behaviors that negatively impacted healthy relationship development, while providing an avenue to learn alternative skills. As this discussion continued the men asserted their view that men should be central in the teaching of these skills to men, young men, and boys. They were also clear that to more fully illustrate the impacts of intimate partner violence, it is critical to involve men who were arrested and have since made concrete efforts to change their behaviors, in group work with young men and men. There was some call for more time-intensive interventions for men, young men, and boys who have been identified as committing intimate partner violence.

Overall, the men interviewed were very supportive of the idea of sustaining and building capacity in men to develop and maintain healthy relationships with their intimate partners. To this end, they asked that supports be established prior to the manifestation of intimate partner violence, and that, if a man engages in intimate partner violence, services be provided to teach him how to develop and maintain healthy relationships. There was great consensus that men, young men, and boys can and need to learn, practice, and receive support for healthy relationship skills. The men also talked about the impact of time and socialization on their experience. Specifically, they talked about being acutely aware of how their views about these issues changed the longer they were involved in the programs. This revelation alerted them to the power of time as they worked on developing these skills and resulted in them asking that men, young men, and boys be afforded the time needed to make that transformation. This discussion paralleled the work developed by Prochaska, DiClemente & Norcross (1992) in their stages of change model.

RECOMMENDATIONS

In general, the information shared by participants of the focus groups was consistent with the academic literature and reiterated some of the action steps identified. The recommendations spanned the ***societal, community, relationship, and individual level*** perspectives and integrated ***universal, selective, and indicated*** prevention approaches that were ***primary, secondary, and tertiary*** in focus. All interviewed called for a restructuring of how men are viewed and socialized within the community of Connecticut from the individual-level to the societal-level. These recommendations ask that we think about how to collaborate with key constituents to achieve the goal of socializing and teaching men, young men, and boys how to form and build

0healthy relationships. Important partners for this work will be the girls, young women, and women connected to these boys, young men, and men.

The focus of this report is on boys, young men, and men. Special attention needs to be given to the unique challenges that this segment of the population faces. As a result, any intervention needs to clearly identify the focus population and outcomes. A number of researchers (e.g., Berkowitz, 1994, 2002, 2004; Berkowitz, Jaffe, Peacock, Rosenbluth & Sousa, 2004; Fabiano, Perkins, Berkowitz, Linkenbach, & Stark, 2003) have argued that this work needs to be comprehensive, intensive, relevant, employ positive messages, be participatory, interactive, geared towards the learning styles of men, consider the impact of race, class, and culture, and be sustained over time in order for the intended audience to fully receive and be able to use the information presented. These interventions should also clearly articulate what a healthy relationship is, how to negotiate and develop an egalitarian relationship, and include reward systems that supports these skills. This solution-focused approach will help us to achieve the desired outcomes, and should lead to social change in which each man holds the other accountable for his use or misuse of violence in his intimate personal relationships.

The recommendations provided represent strategies that the State of Connecticut Department of Public Health or Maternal and Child Health providers could undertake to address the issue of intimate partner violence and sexual assault.

CONNECTICUT DEPARTMENT OF HEALTH LEVEL INTERVENTIONS

- Establish and/or support existing programs that teach men/boys healthy relationship skills in the places that they most often socialize (e.g., schools, church, home, sporting events, gyms, etc).
- Develop and conduct statewide public education campaigns on healthy relationships skills. Utilize federal resources (Rape Prevention Education funds) to conduct campaign activities.

- Develop targeted prevention campaigns that address specific groups (e.g., college students, high school students) on the impact of alcohol and other illicit drug use on the expression of intimate partner violence.

- Replicate trainings currently offered by DPH contractors (i.e., CONNSACS) in other parts of the state that focus on positive male behaviors.

- Provide basic materials (e.g., brochures, videos) that deliver strategies for boys, young men, and men on healthy relationship skills and where they can receive assistance to get help when it is needed.

- Provide basic materials (e.g., brochures, videos) that deliver strategies for girls, young women, and women on healthy relationships with boys, young men, and men and where they can receive assistance to get help when it is needed.

- Broadly disseminate recently developed male engagement brochure to places where men congregate.

- Translate DPH male engagement brochures into other languages (Spanish).

- Develop and disseminate to MCH providers culturally and age-appropriate materials that support the work of healthy relationship development with men. This includes development of materials in languages other than English.

- Distribute promotional materials where men congregate (barber shops, sporting events, parks, car wash, hardware stores).

- Partner with other public and private entities to display and disseminate promotional materials (e.g., Department of Social Services Regional Offices, Home Depot, sporting events).

- Conduct a comprehensive needs assessment of MCH funded programs that identify how they support the development of healthy relationships with boys, young men, and men.

- Work with State Department of Education, School Based Health Centers (SBHC) to integrate strategies into health curricula in elementary, middle and high schools that promote healthy relationship development (i.e., Mentoring Violence Prevention).

- Work with SBHCs to develop and implement trainings for at-risk boys regarding positive relationship building.

- Review DPH Strategic Adolescent Health Plan for inclusion of skill building opportunities for teen males regarding healthy relationships.

- Work with United Way/Infoline to determine statewide resources available for callers regarding positive male relationships- skill trainings.

- Disseminate and post on DPH website *Building Healthy Relationships: Engaging Men in Prevention Strategies to End Sexual and Intimate Partner Violence* to appropriate community partners.

- Collaborate with community partners to develop and implement asset-based evaluation in schools to enhance development of positive, successful relationships.

- Include healthy relationship skills as part of strategies in the prevention of Violence Against Women statewide plan that is currently being developed.

MCH COMMUNITY-BASED PROVIDER PROGRAM INTERVENTIONS

- Distribute educational materials when boys and men present for program services.

- Distribute educational materials where boys and men congregate (barber shops, sporting events, parks, car wash, hardware stores).

- Conduct an annual self-assessment of the program's ability to meet the demands of male clients if they present for services. Assessment should ensure that:

    - Female to male staff ratios reflect an interest and requisite skills for working with men.

    - Physical setting is welcoming to men as well as women.

    - Program is staffed by individuals who clearly understand expectations of interventions and are competent in using the skills set that program wants to develop in others.

    - All intake and assessment instruments are not biased against men because of their exclusion from them or minimal inquiry about them.

    - Program has resources, staff, and competence in addressing issues of healthy relationship development.

    - Interventions targeted at community are held in places where they are easily accessible by community.

- Program and interventions need to elicit support and form allies in faith communities to support and affirm boys, young men, and men in developing healthy relationships skills that are based on their faith principles/values.

- Integrate egalitarian relationship skills into existing program curricula or trainings.

- Identify and/or create opportunities (i.e., home visits) to educate children and their parents about sexual abuse/domestic violence and give them skills to address them in the context of intimate partner relationships.

- Offer, identify, and or support existing mentoring programs to children who are either at risk or express having difficulties establishing egalitarian and healthy relationships. Pair these children with adults who have these skills and can be models to develop and maintain healthy relationships (i.e., Big Brothers' programs).

- Create opportunities for boys, young men, and men to learn and identify how miscommunication about relationships, sex, and sexuality impacts the miscommunication that often occurs between males and both genders.

- Work with local school districts to create parallel trainings and/or resource materials for parents about healthy relationship development in order to ensure that the skills and expectations taught to students in schools are reinforced at home.

- Create partnerships with and provide community awareness about DPH programs, with organizations that serve boys, young men, and men to further the work of healthy relationship development and engaging boys and men in the health care delivery system (i.e., Boy Scouts, fraternal organizations, Boys & Girls clubs, and faith-based organizations).

- Identify community-based resources and provide referrals to individuals who have, through their actions, demonstrated that they have problems maintaining healthy relationships that are egalitarian to learn new skills in settings that are not mandated by the courts or probation.

- Develop a list of community-based resources for men who are interested in developing and learning healthy relationship skills that are community specific.

- Develop strategies to ensure that girls, young women, and women are allies in this work.

- Collaborate with local board of educations to develop and implement asset-based evaluation into schools to enhance positive, successful relationships.

CONCLUSION AND SUMMARY

Intimate partner violence is a social issue that continues to plague our state and society. Strategies to address this issue have often singularly targeted women or men only after the issue had been identified in the criminal justice system.. Calls have been made for the integration of men in this work. These calls however, have been met with inconsistent responses. Although some consideration have been made of the impact that universal, selected and or indicated

prevention interventions can have on addressing this issue, these considerations often times neglect men. This report catalogued a consensus among individuals working in the areas of domestic violence and sexual assault, victims of sexual assault and domestic violence, community members, and men incarcerated who have a history of domestic violence and sexual assault. Simply stated, they agreed that for there to be true change in the way we address the issue of intimate partner violence we must adopt a prevention perspective that includes men as a part of the solution. The role of men in this effort cannot simply be relegated to being participants of psycho-educational groups after they have perpetrated violence against their intimate partner, be it physical, psychological, emotional, or sexual.

This report summarizes the views of focus group members about the importance of including men, young men, and boys in the teaching and learning of healthy relationship skills. They also underscored the importance of modeling and clearly integrating all aspect of society as key partners in creating a context where healthy relationship skills are developed, modeled, and reinforced for men, young men, and boys. What was reassuring in this report was the consistency of views across all the groups interviewed.

Clearly, there is a great deal of work to be done in order to create the change suggested in this report. Nevertheless, one finds hope in the knowledge that even those most significantly impacted by the issues of intimate partner violence (its victims and perpetrators) see a need for men, young men, and boys to be involved in the solution.

REFERENCES

Abbey, A., McAuslan, P., & Thomson-Ross, L. (1998). Sexual assault perpetration by college men: The role of alcohol, misperception of sexual intent, and sexual beliefs and experiences. *Journal of Social and Clinical Psychology*. *17*, 167-195.

Ageton, S. S. (1983) Sexual assault among adolescents. New York: Lexington Books

Bancroft, Lundy. (2002) Is it Real? Assessing and Fostering Change in Batterers as Parents Thousand Oaks, SAGE Publications.

Bancroft, Lundy. (2002) Why does he do that? Inside the minds of angry and controlling men. New York, New York. Berkley Books

Basile, K.C. (2003). Implications of public health for policy on sexual violence. *Annals of the New York Academy of Sciences. 989,* 446-63.

Berkowitz, A.D. (1994b). A model acquaintance rape prevention program for men. In A. Berkowitz (Ed.), *Men and rape: Theory, research, and prevention programs in higher education* (pp. 35-42). San Francisco, CA: Jossey-Bass.

Berkowitz, A.D. (2002). Fostering men's responsibility for preventing sexual assault. In Schewe, P.A., (Ed.), *Preventing violence in relationships: Interventions across the life span*. (pp. 163-196). Washington, DC: American Psychological Association.

Berkowitz, A. D. (2004) The social norms approach to violence prevention. National Electronic Network on Violence Against Women. Available from National Electronic Network on Violence Against Women website: http://www.vawnet.org/

Berkowitz, A. D. (2004) Working with Men to Prevent Violence Against Women: An Overview. National Electronic Network on Violence Against Women. Available from National Electronic Network on Violence Against Women website: http://www.vawnet.org/

Berkowitz, A.D., Burkhart, B.R., & Bourg, S.E. (1994). Research on men and rape. In A. Berkowitz (Ed.), *Men and rape: Theory, research, and prevention programs in higher education* (pp. 67-71). San Francisco, CA: Jossey-Bass.

Berkowitz, A. D., Jaffe, P., Peacock, D., Rosenbluth, B., Sousa, C. (2004) Young Men as Allies in Preventing Violence and Abuse: Building Effective Partnerships with Schools. National Electronic Network on Violence Against Women. Available from National Electronic Network on Violence Against Women website: http://www.vawnet.org/

Black, B., Weisz, A., Coats, S., & Patterson, D. (2000). Evaluating a psychoeducational sexual assault prevention program incorporating theatrical presentation, peer education, and social work. *Research on Social Work Practice*. *10*, 589-607.

Brannon R, David D. (1976) The Forty-Nine Percent Majority: The Male Sex Role. Reading, MA: Addison-Wesley.

Brecklin, L.R., & Forde, D.R. (2001). A meta-analysis of rape education programs. *Violence and Victims. 16,* 303-321.

Briere, J., & Malamuth, N. M. (1983) Self-reported likelihood of sexually aggressive behavior: Attitudinal versus sexual explanations. Journal of Research in Personality, 17, 315-323.

Bronfenbrenner U. (1979) The Ecology of Human Development: Experiments by Nature and Design. Cambridge, MA Harvard University Press

Brownmiller, S. (1975). Against our will: Men, women and rape. New York: Simon and Schuster.

Centers for Disease Control and Prevention, (2004). Sexual Violence Prevention: Beginning the Dialogue. Atlanta, GA: Centers for Disease Control and Prevention.

Feltey, Kathryn M; Ainslie, Julie J; Geib, Aleta (1991). Sexual coercion attitudes among high school students: The influence of gender and rape education. *Youth & Society. Vol 23(2),* 229-250.

Fisher, Cullen & Turner (2000) The Sexual Victimization of College Women. National Institute of Justice. NCJ 182369

Foubert, J.D., & Marriott, K.A. (1997). Effects of a sexual assault peer education program on men's belief in rape myths. *Sex Roles*. *36*, 259-268.

Hall, E. R., Howard, J. A., & Boezio, S. L. (1986) Tolerance of rape: A sexist or antisocial attitude. *Psychology of Women Quarterly*, 10, 101-118.

Hall, G.C.N., Sue, S., Narang, D.S., & Lilly, R.S. (2000). Culture-specific models of men's sexual aggression: Intra- and interpersonal determinants. *Cultural Diversity and Ethnic Minority Psychology. 6,* 252-267.

Hanson, K.A., & Gidyez, C.A. (1993). Evaluation of a sexual assault prevention program. *Journal of Consulting & Clinical Psychology. 61,* 1046-1052.

Hong, L. (2000). Towards a transformed approach to prevention: Breaking the link between masculinity and violence. *Journal of American College Health. 48*, 269-279.

Kilpatrick, D. G., & Ruggiero K. J. (2003). Rape in Connecticut: A report to the State. Charleston, SC: National Violence Against Women Prevention Research Center, Medical University of South Carolina.

Koss, M.P., & Gidycz, C.A. (1987). Sexual experiences survey: Reliability and validity. *Journal of Consulting & Clinical Psychology. 53,* 422-423.

Krug E.G., Dahlberg L. L., Mercy, J. A., Zwi, A. and Lozano, R. for the World Health Organization (Eds). (2002). World Report on Violence and Health. Geneva. World Health Organization

Loh, C. (2003). Sexual assault perpetration in college men: Support for an integrative model of sexual assault and acquaintance rape. *Dissertation Abstracts International: Section B: the Sciences and Engineering*. *63*, 3978.

Lonsway, K.A., & Fitzgerald, L.F. (1994). Rape myths: A review. *Psychology of Women Quarterly. 18,* 133-164.

Malamuth, Neil M; Sockloskie, Robert J; Koss, Mary P; Tanaka, JS. (1991) Characteristics of aggressors against women: Testing a model using a national sample of college students. Journal of Consulting & Clinical Psychology. Vol 59(5) 670-681.

McMahon, P.M. (2000). The public health approach to the prevention of sexual violence. *Sexual Abuse: Journal of Research & Treatment. 12*, 27-36.

National Center for Injury Prevention and Control. Costs of Intimate Partner Violence Against Women in the United States. Atlanta (GA): Centers for Disease Control and Prevention; 2003.

National Resource Center on Domestic Violence (2004). Teen Dating Violence Information and Resources. Harrisburg, PA.

State of Connecticut Department of Public Safety, Crime Analysis Unit. (2001) Crime in Connecticut. Retrieved from State of Connecticut Department of Public Safety, Crime Analysis Unit site: http://www.state.ct.us/dps/Crime_Analysis/Crime_Analysis.asp

Thoennes, N. and Tjaden, P. (2000) Extent, Nature, and Consequences of Intimate Partner Violence: Findings from the National Violence Against Women Survey. National Institute of Justice. NCJ 181867

ADDITIONAL REFERENCES

Abbey, A. (2002). Alcohol-related sexual assault; a common problem among college students. *Journal of Studies on Alcohol – Supplement. 14*, 118-228.

Barzelatto, J. (1998). Understanding sexual and reproductive violence: an overview. *International Journal of Gynecology & Obstetrics. 63 Suppl. 1,* S13-8.

Becker, J.V., & Hicks, S.J. (2003). Juvenile sexual offenders: characteristics, interventions, and policy issues. *Annals of the New York Academy of Sciences. 989,* 397-410.

Black, B., Weisz, A., Coats, S., & Patterson, D. (2000). Evaluating a psychoeducational sexual assault prevention program incorporating theatrical presentation, peer education, and social work. *Research on Social Work Practice*. *10*, 589-607.

Brannon R, David D. (1976) The Forty-Nine Percent Majority: The Male Sex Role. Reading, MA: Addison-Wesley.

Brecklin, L.R., & Forde, D.R. (2001). A meta-analysis of rape education programs. *Violence and Victims. 16,* 303-321.

Briere, J., & Malamuth, N. M. (1983) Self-reported likelihood of sexually aggressive behavior: Attitudinal versus sexual explanations. Journal of Research in Personality, 17, 315-323.

Dean, Karol E; Malamuth, Neil M. (1997) Characteristics of men who aggress sexually and of men who imagine aggressing: Risk and moderating variables. Journal of Personality & Social Psychology. Vol 72(2), 449-455.

Foubert, J.D. (2000). The longitudinal effect of a rape-prevention program on fraternity men's Attitudes, behavioral intent, and behavior. *Journal of American College Health. 48,* 158-163.

Foubert, J.D., & McEwen, M.K. (1998). An all-male rape prevention peer education program: Decreasing fraternity men's behavioral intent to rape. *Journal of College Student Development. 39*, 548-556.

Heppner, M.J., Neville, H.A., Smith, K., Kivlighan, D.M., & Gershuny, B.S. (1999). Examining Immediate and long-term efficacy of rape prevention programming with racially diverse college men. *Journal of Counseling Psychology. 46*, 16-26.

Mahlstedt, D., & Corcoran, C. (1999). Preventing dating violence. In Crawford, C., David, S., & Sebrechts, J., (Eds.), *Coming into her own* (pp. 311-327). San Francisco, CA: Jossey Bass.

McCall, G.J. (1993). Risk factors and sexual assault prevention. *Journal of Interpersonal Violence, 8,* 277-295.

Mendoza, J., & Cummins, A. (2001). Help-seeking and male gender-role attitudes in male batterers. *Journal of Interpersonal Violence. 16*, 833-840.

Mersey, J. A. & Hammond, W. R. (1999). Preventing homicide: A public health perspective. In M.D. Smith & M.A. Zahn (Eds.), Studying and preventing homicide: Issues and challenges (pp. 274-294). Thousand Oaks: Sage Publications.

Morrison, T. (2001). Surveying the terrain: Current issues in the prevention and management of sexually abusive behavior by males. *Journal of Sexual Aggression*. *7*, 19-39.

National Resource Center on Domestic Violence (2004). Teen Dating Violence Information and Resources. Harrisburg, PA.

Parrot, A.. (1998). Meaningful sexual assault prevention programs for men. In Anderson, P.B., & Struckman-Johnson, C., (Eds.) *Sexually aggressive women: Current perspectives and controversies.* (pp. 205-223).

Prentky, R.A. (2003). A 15-year retrospective on sexual coercion: advances and projections. *Annals of the New York Academy of Sciences. 989,* 13-32.

Shapiro, D.L., & Rinaldi, A. (2001). Achieving successful collaboration in the evaluation of sexual assault prevention programs: A case study. *Violence Against Women. 7,* 1186-1202.

Schewe, P.A., & O'Donohue, W.T. (1996). Rape prevention with high-risk males: Short-term outcome of two interventions. *Archives of Sexual Behavior. 25,* 455-471.

Warshaw, R. (1988) I never called it rape: The "Ms." report on recognizing, fighting, and surviving date and acquaintance rape. New York, NY, US: Harper & Row Publishers, Inc.

Appendix I

PROTOCOL FOR ENGAGING MEN IN HEALTHY BEHAVIORS
Department of Public Health

Focus Group Questions for Consumers and Community Groups

1. What do you understand as being the motivation for sexual assault/domestic violence?

2. What matters most to you in addressing the issue of sexual assault/domestic violence?

3. Is there any value to addressing the issue of sexual assault/domestic violence with men?

4. What are some of your key concerns in addressing issues related to sexual assault/domestic violence prevention with men?

5. What are the ideas that you think would be most important in addressing sexual assault/domestic violence prevention with men?

6. Given your experience, what are some of the strategies you think would be most important in addressing the issue of sexual assault/domestic violence with men?

FORMAT OF FOCUS GROUPS:

These groups were structured in free format that allowed participants to talk openly about their reactions to this work and identify what they see as being the key components to accomplishing this work. All responses were recorded, transcribed, and kept confidential. No names or comments were attached to the transcribed notes.

Appendix II

PROTOCOL FOR ENGAGING MEN IN HEALTHY BEHAVIORS
Department of Public Health

Offender Focus Group Questions

1. Why do you think that sexual assault/domestic violence happens?

2. What is the biggest issue that we must look at in talking about sexual assault/domestic violence?

3. Should we be talking about sexual assault/domestic violence with men?

4. Do you think it will make a difference talking about sexual assault/domestic violence with men?

5. Do you worry about talking about sexual assault/domestic violence prevention (stopping sexual assault/domestic violence before it happens) with men?

6. What issues do you think would be most important in talking about sexual assault/domestic violence prevention with men?

7. Given your experience, what would be important to talk about in sexual assault/domestic violence with men?

FORMAT OF FOCUS GROUPS:

These groups were structured in free format that allowed participants to talk openly about their reactions to this work and identify what they see as being the key components to accomplishing this work. All responses were recorded, transcribed, and kept confidential. No names or comments were attached to the transcribed notes.