# How can we end the stigma surrounding domestic and sexual violence? A modified Delphi study with national advocacy leaders

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## Abstract:

The purpose of this study was to use a modified Delphi methodology study to identify priority actions that can be taken at the individual, local, and national levels to eliminate the stigma surrounding domestic and sexual violence. An expert panel of national organizational leaders provided input about the nature of the stigma surrounding domestic and sexual violence, as well as strategies to end this stigma. The findings were organized into three themes: (a) the social context of the stigma surrounding domestic and sexual violence; (b) the impact of the stigma on resources for victims and survivors; and (c) strategies for eradicating the stigma surrounding domestic and sexual violence. Implications of the study's findings for research, practice, and advocacy are discussed.

**Keywords:** Stigma Domestic | violence | Intimate partner violence | Sexual abuse | Sexual assault

## Article:

Domestic and sexual violence remain major public health problems with serious consequences for victims, child witnesses, and society. Despite this, there remains a significant stigma surrounding these issues, and this stigma is a major barrier to preventing further violence and supporting victims and survivors. Because this stigma presents so many added challenges to addressing domestic and sexual violence at the individual and societal levels, efforts are needed to directly challenge that stigma. Therefore, the purpose of this study is to use a modified Delphi methodology study to identify priority actions that can be taken at the individual, local, and national levels to eliminate the stigma surrounding domestic and sexual violence.

### Review of the Literature

Domestic and Sexual Violence as Public Health Problems

The 2010 National Intimate Partner and Sexual Violence Survey (NISVS) demonstrated that about 35.6 % of American women and 28.5 % of American men have been the victim of intimate partner violence in the form of rape, physical violence, or stalking at some point throughout their lives (Black et al. 2011). The negative consequences of domestic and sexual violence are significant for victims, child witnesses, and society. A 2005 World Health Organization (WHO) study found that out of the countries selected, 19-55 % of women reported suffering minor or major injuries from domestic violence (World Health Organization 2005). For example, compared with women with no history of domestic or sexual violence, women with these experiences are at an increased risk for physical, emotional, and psychological symptomology (Laffaye et al.2003; World Health Organization); increased fear, concern for physical safety, and PTSD symptoms (Black et al.); and greater absenteeism at work (Black et al.; Chrisler and Ferguson 2006; Kaur and Garg 2008). Children who are exposed to domestic and/or sexual violence are at an increased risk of emotion dysregulation, externalizing and aggressive behavior, anxiety, and depression (Zarling et al. 2013). Children can also be directly affected by the way in which domestic and sexual violence affects parenting practices, as seen in Murray et al. (2012) study revealing a correlation between a mother's experience of domestic or sexual violence and an increase in the use of physical means of punishment and a decrease in parental involvement. The costs for society are significant as well, with high economic costs due to the healthcare, mental healthcare, legal services, survivors' basic needs (e.g., transportation and housing), and economic consequences of lost productivity at work (e.g., Black et al.; Chrisler & Ferguson; National Center for Inquiry Prevention and Control [NCIPC] 2003). Thus, domestic and sexual violence are significant public health issues that impact the health and well-being of survivors, children, and the broader society.

**Previous Research on Stigma and Domestic and Sexual Violence**

Although domestic and sexual violence have remained all-too-common phenomena throughout history, a stigma continues to surround these issues in modern society. Stigma is defined as a mark of disgrace associated with a person, circumstance, or quality (Byrne 2000). Terms that have been used to describe the concept include blame, "black sheep of the family" role, discrimination, isolation, labeling, loss of power and status, secrecy, separation, shame, social exclusion, and stereotypes (Crowe and Murray 2015). The stigma construct has been studied for decades by researchers across social science disciplines (Link and Phelan2001). Link and Phelan offered a five-component conceptualization of stigma designed to present a cohesive definition of the term. The five components of stigma they outlined are as follows: (a) a label is placed on differences between people; (b) the labels are associated with negative stereotypes about the characteristics of people with those labels; (c) people create a sense of separation between themselves and those with the label (i.e., "separation of 'us' from 'them'"; Link & Phelan, p. 367); (d) the people who are labeled experience diminished status and discrimination from others; and (e) people with the stigmatized label are denied access to "social, economic, and political power" (Link & Phelan, p. 367). As such, stigma can be viewed as a process that occurs among groups of people and that results in negative outcomes for the stigmatized groups.

Researchers have applied the concept of stigma to a variety of groups including individuals who are HIV-positive (Davis 2012) and individuals with serious mental illness (Smith and

Cashwell 2010, 2011); therefore, it appears to have common features across groups. However, the stigma that each unique group faces can look different, based in part on the variations between groups on the components in Link and Phelan's (2001) conceptualization described above. Thus, although there are some common processes involved in the stigmatization of various groups, it is important to consider the unique aspects of stigma that different groups face. In particular, the unique dynamics of the stigma surrounding domestic and sexual violence are just beginning to be examined.

*The Intimate Partner Violence (IPV) Stigmatization Model*

Regarding stigma and IPV, Overstreet and Quinn's (2013) IPV Stigmatization Model provided the first formal published application of the concept of stigma to IPV. Three stigma components included in their model are as follows: (a) anticipated stigma; (b) stigma internalization; and (c) cultural stigma. Each of these components represents the different levels at which IPV stigmatization can occur: individual, interpersonal, and cultural. Important to the model are the implications of each component on IPV victims' help-seeking behaviors, or the extent to which survivors seek help from others to support them in handling various consequences of their abuse.

*Anticipated stigma* describes "the degree to which people fear or expect stigmatization…if others know about their experiences" (Overstreet and Quinn 2013, p. 112). Some ways that anticipated stigma impacts survivors include believing that friends and family members will not want to help, fearing negative outcomes if their abuse experiences were to become known in their workplaces, and predicting that healthcare professionals will judge them upon disclosure. *Stigma internalization* refers to "the extent to which people internalize negative IPV beliefs" (Overstreet & Quinn, p. 117). Some self-perceptions associated with stigma internalization include self-blame, shame, embarrassment, guilt, and low self-esteem. *Cultural stigma* describes "societal ideologies that delegitimize people who experience IPV" (Overstreet & Quinn, p. 118). Cultural attitudes that contribute to IPV stigmatization include judgment, blaming, minimizing the extent of the problem, and stereotypes about the types of people who are abused. Together, these components can make it more difficult for victims to seek help, although this can vary based on the extent to which the survivors view the IPV as central to their identities and salient in their lives. The IPV Stigmatization Model provides a useful framework for understanding the different levels at which IPV survivors may experience stigma and documents support for the application of the concept of stigma to IPV.

Recent research on stigma and IPV (Crowe and Murray 2015) suggests that stigma occurs when seeking help and support from professionals. In a study involving 231 survivors of past abuse who had been out of any abusive relationship for at least 2 years, participants revealed that they experienced stigma from the following professionals from whom they sought help: mental health professionals, attorneys and judges, healthcare professionals, law enforcement, professionals in the employment or education systems, parenting-related professionals, as well as friends and family. Among a set of 279 stigma-related statements made by participants, the most frequently occurring stigma category was feeling dismissed and denied ($n = 108$), followed by blame ($n = 59$), and discrimination ($n = 38$). The participants also rated the degree to which they experienced stigma from a variety of sources on a scale from 1 (*did not experience stigma at all*) to 5 (*experienced stigma completely*). Within this sample, participants indicated experiencing the

greatest amounts of stigma from professionals in the court system and law enforcement ($M = 3.14$; $SD = 1.65$), followed by friends ($M = 2.90$; $SD = 1.41$) and family members ($M = 2.87$; $SD = 1.47$). Although disturbing and unfortunate, these results call for a deeper understanding of stigma related to IPV in order to understand more fully what can be done to eradicate it. Not only did stigma prevent participants from seeking help, it also added to the negative consequences they already faced as a result of abuse. In fact, some participants spoke of being re-victimized after having a negative experience with a professional.

Stigma may be experienced differently by different sub-groups of victims of IPV and sexual violence. For example, a growing body of research examines the unique stigma that male victims face when seeking services for IPV (e.g., Cook 2009; Tsui et al. 2010; Douglas and Hines 2011). Because many existing services are designed with female victims in mind, the unique needs of male victims may not be accounted for within certain community resources that serve victims of IPV or sexual violence. Additional social and cultural contexts that may add to the stigma surrounding these issues include sexual orientation, socioeconomic status, immigration status, language barriers, and religious norms and values. As such, victims and survivors of IPV and sexual violence may experience multiple levels of stigma from multiple sources.

Because stigma presents so many added challenges to addressing domestic and sexual violence, both at the individual and societal level, efforts are needed to directly challenge that stigma. Although research has investigated stigma from the perspectives of survivors, there is a lack of information about how professionals and experts in the field perceive this stigma. The purpose of this study is to use a modified Delphi methodology study to identify priority actions that can be taken at the individual, local, and national levels to eliminate the stigma surrounding domestic and sexual violence.

## Method

This study used Delphi methodology to solicit the perspectives of leaders of national advocacy organizations that work to address domestic and sexual violence. A decision was made to include organizations that address both domestic and sexual violence for two main reasons. First, there are significant overlaps between domestic violence and sexual assault, as IPV may involve sexual abuse, and sexual assault can occur within the context of an intimate relationship. Therefore, we were interested in learning about similarities and unique experiences for victims and survivors of both types of violence. Second, through our efforts to identify national advocacy organizations to invite to participate (as will be described below), we identified several organizations that addressed both issues; therefore, we determined that many of the professionals representing these organizations would be able to offer informed insights into both of these issues. Participants had opportunities to specify if their responses were applicable to just one or both issues when they believed that differences existed.

### Delphi Methodology

This study used modified Delphi methodology (Hsu and Sandford 2007; Stone Fish and Busby 1996; Vazquez-Ramos et al. 2007; West 2011; Yousuf 2007) to consolidate the perspectives of an expert panel of national leaders on the topic of ending the stigma surrounding

domestic and sexual violence. The Delphi method was developed by the RAND Corporation in the 1950s and has been used widely in a range of fields since then (RAND Corporation 2014; Vazquez-Ramos et al.). Delphi methodology is especially applicable to identifying priority areas for public policy and professional organizations to address complex social problems (Stone Fish & Busby; Vazquez-Ramos et al.), and it is useful when geographic or resource restrictions would prevent expert panel members from meeting face-to-face (Yousuf). The Delphi method also is well-suited for identifying future needs and trends. As Hsu and Sandford said, "Common surveys try to identify 'what is,' whereas the Delphi technique attempts to address 'what could/should be'" (p. 1).

In Delphi methodology, expert panel members complete multiple rounds of questionnaires, each moving toward consensus (Dawson and Brucker 2001; Jenkins and Smith 1994; Morrow-Howell et al. 2005; Murray et al. 2010; Stone Fish and Busby 1996; West 2011). Both qualitative and quantitative questionnaires and data analysis procedures are used, and panel members' opinions are valued throughout the study process (Hsu and Sandford 2007; Murray et al. 2010; Stone Fish and Busby 1996). Although standard procedures for Delphi methodology have been defined, researchers have used modifications to meet the unique needs of specific research studies (Vazquez-Ramos et al. 2007; Yousuf 2007).

**Participants and Recruitment**

Recruiting a quality expert panel is crucial to the success of Delphi methodology (Hsu and Sandford 2007; Stone Fish and Busby 1996; Yousuf 2007), and participants should be "highly trained and competent within the specialized area of knowledge related to the target issue" (Hsu & Sandford, p. 3). The number of panelists in Delphi studies has varied, although most studies include approximately 15 to 20 participants (Hsu & Sandford). Although there are no clear guidelines for selecting panel members, it is important to include panelists who have sufficient knowledge and experience related to the topic (Hsu & Sandford; West2011).

A benefit of Delphi methodology is it allows expert panel members to maintain anonymity yet also provide feedback on the study's topic (Hsu and Sandford 2007; Vazquez-Ramos et al. 2007; Yousuf 2007). Therefore, two reasons led to a decision to maintain participants' confidentiality, so only members of the research team knew participants' identities. First, we wanted participants to provide open and honest input throughout this study. We decided this would be most likely to occur if they were speaking on their own behalf, rather than attempting to represent the official positions or beliefs of their organizations. Second, Delphi methodology provides a forum for panel members to share thoughts without any one individual having more influence on other panel members than others (Vazquez-Ramos et al.; Yousuf). Had panel members known the identities of other participants, they may have felt pressure to share beliefs with which they felt others who they knew on the panel would agree.

Efforts were made to identify a highly qualified, diverse group of prospective participants to invite to participate in this study. The target population consisted of national leaders in the movement to end domestic and sexual violence in the United States. To identify prospective participants, we created a list of national organizations that do work in the areas of domestic and sexual violence, and we aimed to identify organizations whose work included advocacy, public

awareness campaigns, technical assistance to local service programs, training and/or educational opportunities for service providers, and/or providing direct services to people impacted by domestic and/or sexual violence. We identified these organizations through the research team members' knowledge of major national organizations, as well as by conducting Internet-based searches using search engines. Our initial list of prospective organizations included 39 organizations. From that list, we sought contact information for the most senior person in the organization (e.g., Executive Director, President). When this information was not readily available online, we called the organization's phone number to request it and/or submitted the recruitment e-mail via the organization's website contact form.

We sent study participation invitations to the designated person at each organization via e-mail ($n = 35$) or through a website contact form ($n = 4$). Individuals (or their designees) who indicated they were interested in participating were then mailed the website link to the first questionnaire, which also included the study's informed consent document. Sixteen participants completed Questionnaire 1. Only people who completed Questionnaire 1 were eligible to complete Questionnaire 2 and/or 3. A total of 10 participants completed Questionnaire 2, and 10 participants completed Questionnaire 3. At least six participants completed all three rounds of questionnaires, although two participants did not provide their names on Questionnaire 2, so it is not possible to determine whether these people completed all three rounds.

In light of the decision to conduct this study confidentially, the IRB-approved protocol for this study does not permit the release of the names or organizational affiliations of the participants in this study. Therefore, only a summary of the participants and their organizations will be provided here. The following characteristics describe the full sample of 16 participants. Panel members were geographically diverse, with representatives from organizations that are located in states across the U.S., including Washington, DC ($n = 4$); California and New York (each with $n = 3$); Illinois and Texas (each with $n = 2$), and six other states. (Note: some participants reported that their organizations operated in multiple locations.) Participants' job titles included the following: Executive Director, CEO, President, Senior Manager, Director of Operations, and Deputy Director. All of the organizations work to address domestic and/or sexual violence, with some of the organizations addressing only one of these issues and others addressing domestic and/or sexual violence as part of efforts to address other forms of violence (e.g., child abuse and elder maltreatment) as well. All but one of the participants were female. Participants reported their ethnic/racial backgrounds as follows: White/Caucasian ($n = 11$); Latina/Latino ($n = 4$); African American ($n = 1$); and Native American ($n = 1$). The range for number of years that participants had worked in a job related to domestic and/or sexual violence was from 4 to 35 years ($M = 17.5$ years, $SD = 10.6$). All of the organizations represented on the panel had a national scope.

**Questionnaires: Format and Development**

Typically, Delphi methodology studies use three to five rounds of researcher-created questionnaires with expert panel members (Jenkins and Smith 1994; Stone Fish and Busby 1996; Vazquez-Ramos et al. 2007). The first questionnaire is open-ended, and data analyses at each phase are used to develop the next round of questionnaire, moving closer to consensus at each

phase (Vazquez-Ramos et al.; West 2011; Yousuf2007). Each questionnaire was estimated to take approximately 30 min to complete.

1. ***Questionnaire 1***

Questionnaire 1 included the following open-ended questions: (a) In your own words, how would you describe the stigma surrounding domestic and/or sexual violence? What does this stigma look like?; (b) Where do you think the stigma surrounding domestic and/or sexual violence originates? In other words, what do you think are the reasons that this stigma exists?; (c) In what ways do you think that the stigma surrounding domestic and/or sexual violence impacts survivors? What challenges does it pose to survivors at different points in their lives?; (d) In what ways does the stigma surrounding domestic and/or sexual violence impact the work that you do? In what ways does it make your work harder to do? Please consider all aspects of your work; (e) What do you think can be done to eliminate or reduce stigma at the individual level? By "individual level," we are referring to the stigma that individual survivors of domestic and/or sexual violence face; (f) What do you think can be done to eliminate or reduce the stigma surrounding domestic and/or sexual violence within local communities? By "local communities," we are referring to specific geographical regions (e.g., within a city or county) and to groups of people that identify themselves as a community (e.g., within a religious institution, neighborhood, or civic organization); (g) At the national level, what do you think can be done to eliminate or reduce the stigma surrounding domestic and/or sexual violence?; and (h) Please add any additional thoughts or feedback related to the topic of stigma and domestic and/or sexual violence that you did not provide elsewhere on this questionnaire.

Basic content analysis procedures were used to analyze participants' responses to Questionnaire 1, and the themes that emerged through the content analysis were used to develop Questionnaire 2 (Vazquez-Ramos et al. 2007). We organized Questionnaire 2 according to the themes that emerged through the content analysis (Stemler 2001), rather than on the original question structure used in Questionnaire 1 (Murray et al. 2010). The three themes that emerged in the content analysis were (a) the social context of the stigma surrounding domestic and sexual violence; (b) the impact of the stigma on resources for victims and survivors; and (c) strategies for eradicating the stigma surrounding domestic and sexual violence.

2. ***Questionnaire 2***

A typical second-round questionnaire provides participants with a list of statements derived from participants' responses to Questionnaire 1, which they are then asked to rate on a Likert-type scale (Vazquez-Ramos et al. 2007). In developing Questionnaire 2, it is important to retain a reasonable number of statements for participants to rate, and efforts are made to use participants' original language as much as possible (West 2011). All statements in each theme were presented on Questionnaire 2 in no particular order within the theme, and no efforts were made at this point to identify sub-categories. Questionnaire 2 contained a total of 105 items. Participants were asked to rate their agreement with each statement on a scale from 1 (*strongly disagree*) to 7 (*strongly agree*), with a "Not applicable" option. The survey concluded with an open-ended comment section if participants had other ideas they wanted to share. On Questionnaire 1, panel members had used different terms to describe people who have experienced domestic and sexual

violence. Thus, for consistency in Questionnaire 2, we used the term *victim* to describe someone currently experiencing abuse and the term *survivor* to describe someone who experienced abuse in the past.

3. ***Questionnaire 3***

Because there was a high level of consensus in participants' responses to Questionnaire 2, the third questionnaire involved the main modification to typical Delphi methodology in the current study. Typically, Questionnaire 3 presents the same set of statements used in Questionnaire 2 for participants to re-rate in light of fellow expert panel members' ratings, which they view in the form of median scores and interquartile ranges (Murray et al. 2010; Vazquez-Ramos et al. 2007; Yousuf 2007). However, best practices in Delphi methodology suggest the study should be stopped once consensus has been reached (Jenkins and Smith 1994). Rather than abandon the third questionnaire as some have done (see White et al. 1997), we followed the example of Murray et al. (2010) and used Questionnaire 3 as an opportunity to seek participants' feedback on our preliminary interpretations of the study's findings. This use of the third questionnaire is useful for offering a validity check on the researchers' conclusions (Murray et al. 2010; West 2011).

To develop Questionnaire 3, we first calculated the medians and 25th to 75th percentile interquartile ranges for all statements included on Questionnaire 2. Based on these figures, we identified statements that demonstrated consistent high agreement (based on the medians), along with a high level of consensus (based on the interquartile ranges). Questionnaire 3 contained only items for which participants demonstrated high consensus and high agreement on Questionnaire 2. The main themes in Questionnaire 2 (i.e., the social context of the stigma; the impact of stigma on resources; and strategies for eradicating the stigma) served as a basis for organizing the high consensus/high agreement statements in Questionnaire 3. Within each theme, Questionnaire 3 statements were organized into sub-categories. Participants read a list of statements in each subcategory, along with a summary statement, which was written in order to capture the main idea of the statements in each sub-category. Participants were instructed to do the following for each sub-category on Questionnaire 3: (a) read the list of statements; (b) read the summary statement; and (c) provide open-ended feedback about their thoughts as to how accurately the summary statement captures the ideas in the statements in each sub-category. This feedback informed the final revision of the summary statements.

## Data Collection Procedures

All communications and data collection for this study were done electronically. Questionnaires 1 and 2 were hosted on Qualtrics software, and Questionnaire 3 was created using a Google Drive form. Participants were offered a summary of the results at the end of the study as an incentive for participating. The data collection began in late August 2013 and ended in March 2014, with surveys sent on an approximately bi-monthly basis.

## Results

*Medians and Interquartile Ranges of Items on Questionnaire 2*

To identify statements from Questionnaire 2 on which participants had high agreement and high consensus, we calculated the medians and 25th to 75th percentile interquartile ranges for each statement. Adapting criteria from Murray et al. (2010) and Stone Fish and Busby (1996), items were considered to have high agreement if they had a median of 5.5 or higher on the scale from 1 (*strongly disagree*) to 7 (*strongly agree*), and items were considered to demonstrate high consensus if their 25th to 75th percentile interquartile ranges were 1.25 or less. The items demonstrating high consensus and high agreement, which were retained for Questionnaire 3, are presented in Table 1, along with their medians and interquartile ranges.

**Table 1** Medians and 25th to 75th Percentile Interquartile Ranges (IQR) of Questionnaire 2 items

| Item | Median | 25th-75th %ile IQR |
|---|---|---|
| Theme 1: The social context of the stigma surrounding domestic and sexual violence | | |
| Sub-category #1 | | |
| Stigma looks like blame—both from others and what victims/survivors put on themselves. | 6 | 0.75 |
| Blame becomes even more intense if the victim/survivor has engaged in any "risky" behavior—such as drinking, drug use, hanging out with the "wrong people," not leaving quickly enough, or being a sex worker. | 7 | 0 |
| Blame becomes even more intense if the victim/survivor is a mother and there is a perception that children have been harmed. | 6 | 1 |
| Victims/survivors are often made to feel that it is their fault. | 6.5 | 1 |
| Victims are often stigmatized once they share their story through judgmental questions, such as "How did you get into an abusive relationship?;" "Why didn't you leave?;" "Why didn't you think of your children?;" and "Why did you wear that outfit (if the survivor was raped)?". | 7 | 1 |
| Victims of domestic violence and sexual assault are singularly different than perceptions held of other types of victims. No other crime victim has to face constant implications that they are somehow responsible for the crimes committed against them. | 7 | 0.75 |
| Responsibility for domestic and sexual violence is not placed on the offenders as it should be. | 7 | 1 |
| Society believes that victims are granting permission to be treated in this manner, and therefore there is something wrong with THEM. | 6 | 0.75 |
| Society ranks and classifies victims by how "innocent" they are, so that some (e.g., those who are not white, those who are over the age of 6 or 8) are somehow less "real" victims and less deserving of our support or outrage against their perpetrators. | 7 | 0.75 |
| Victims' self-blame often leads to self-destructive behaviors, such as alcohol and drug addiction, eating disorders, suicidality, and depression as coping mechanisms. | 7 | 0.75 |
| Even survivors forget that many years ago, they were victims, too, and now criticize other people currently in abusive relationships. | 5.5 | 1 |
| Survivors do not want to be blamed for breaking up their homes by their family members, clergy, other professionals, and sometimes even by their children. | 7 | 1 |
| Sub-category #2 | | |
| There is a general belief in society that a survivor can just get up and leave an abusive relationship. | 7 | 0 |
| Many people believe that it is a sign of weakness or lack of education to be a victim of abuse or assault. | 7 | 1 |
| There is a belief that stigmatizes victims of sexual violence that "it's just sex," so you should get over it right away, as in, "It's no big deal, so you shouldn't need support in any way." | 6.5 | 1 |
| Some people are not even aware that domestic violence is a crime, so while they view assault against a man as wrong and as a crime, if they witness a man beating a woman, they see it as "a private matter," and not a crime. | 5.5 | 1 |
| People have perceptions about what victims are supposed to act like, and when they don't present the way they expect them to and when the facts don't "look right" they fail to believe or support victims. | 7 | 0 |
| Sexual violence is still seen as a crime NOT occurring at epidemic proportions. Even in light of institutional sexual violence such as military, campus, and faith-based organizations, questions are still being asked if the number accurate, rather than acknowledging sexual violence as a real problem in the US. | 6.5 | 1 |
| Most people are not aware of the dynamics of domestic and sexual violence, and this lack of awareness contributes to more violence. | 7 | 0 |
| Many people are still in agreement with "traditional" gender roles that value men and male privilege and women as subservient. | 6 | 0 |
| The origin of the stigmas surrounding sexual and domestic violence is in the patriarchal social structures that consider women as property of men, without agency and credibility. | 6.5 | 1 |
| The stigma surrounding domestic and sexual violence is codified in our language, our cultural norms, the media (including social media), pop culture, our laws, and public policy. | 7 | 1 |
| Sub-category #3 | | |
| Victims' isolation is a consequence of both the actual abuse tactics and the shame surrounding them. | 7 | 0 |
| Victims often suffer alone in their shame. | 7 | 0.75 |
| Survivors are afraid to have others find out that they are being abused because they feel ashamed and weak. | 6.5 | 1 |
| People want to distance themselves from the experience of victimization, and so they create barriers between themselves and people who are victimized. | 7 | 1 |
| Stigma can create divisions in families and friendships. | 7 | 1 |

**Table 1** (continued)

| Item | Median | 25th-75th %ile IQR |
|---|---|---|
| Sub-category #4 | | |
| Employers and co-workers see victims/survivors as liabilities. | 6 | 1 |
| Landlords see victims/survivors as a danger because they might put other tenants in jeopardy. | 6 | 0 |
| Political leaders show their indifference to domestic and sexual violence when funding is cut for shelter, hotlines, housing, and employment assistance for victims and survivors. | 6 | 1 |
| The stigma is a barrier to outside visibility or financial support for the issues of domestic and sexual violence. | 6.5 | 1.25 |
| Sub-category #5 | | |
| There is a lot of stigma attached to survivors in the LGBTQ community (e.g., "a person of your same sex should not be able to overpower you. You should be able to fight back"). | 6.5 | 1 |
| For the deaf and hard of hearing, there are additional stigmas as they are a close knit and smaller community. | 7 | 1 |
| The stigma can be pretty painful for male victims since they are socialized to be strong and never show any signs of vulnerability (e.g., they have been told they are weak or sissies, that a woman or same-sex partner cannot overpower them or hurt them, and that they should be embarrassed to call a hotline or reach out for help). | 7 | 1 |
| An additional layer of mother-blaming in our society often holds mothers to unrealistic standards, and they may be stigmatized for failing to protect their children. | 6 | 0 |
| Theme 2: The Impact of the Stigma on Resources for Victims and Survivors | | |
| Sub-category #1 | | |
| Even when victims and survivors seek help, the stigma can still come from practitioners, the justice system, or social service system. | 6.5 | 1 |
| Bad experiences with law enforcement or the courts, where many men have prejudiced views and behaviors, serve as deterrents to effective support for victims/survivors. | 7 | 0.75 |
| CPS workers can be very harsh on DV survivors and remove their children because s/he did not leave the relationship as quickly as possible. | 6 | 1 |
| Stigmas are even present in our domestic and sexual violence services. | 6 | 1 |
| Sub-category #2 | | |
| Survivors are wary in seeking assistance because they might be questioned by friends, family members, and service providers as to why they did not leave sooner. | 6 | 1 |
| Survivors are less likely to seek help if they perceive the stigma, and this is even worse for men, marginalized women, or women from other cultures besides Euro-American. | 6 | 1 |
| When victims are not believed and judged, they are less likely to reach out for services. | 6 | 0.75 |
| Survivors are left questioning themselves, their decision-making processes, and their self-worth. | 7 | 0.75 |
| Theme 3: Strategies for Eradicating the Stigma Surrounding Domestic and Sexual Violence | 6 | 1 |
| Sub-category #1 | | |
| We must ensure that services provided to victims and survivors are survivor-driven, empowering, trauma-informed, and culturally-relevant. | 7 | 0 |
| Service providers must convey an appreciation for how big a deal it is for many victims/survivors to tell ANYONE what is happening when clients seek their help. | 7 | 0 |
| Advocacy and service organizations should validate survivors' fears and frustrations. | 7 | 0 |
| Service providers should offer support groups and educational materials that help survivors shed their feeling of shame and embarrassment; lessen their feelings of helplessness & hopelessness; regain their self-esteem and self-confidence; and help them strengthen their feelings of empowerment. | 7 | 0 |
| Service providers can create forums that provide survivors with the time and space to share their stories. | 7 | 0 |
| Every organization working in this field should work constantly at challenging our own stereotypes and biases so that we can correct those that are embedded within us. | 7 | 0 |
| Providing resources (e.g., web-sites, blogs, and groups) that survivors can find and make use of that are supportive of them can be helpful. | 7 | 0 |
| Service providers and advocacy organizations should educate and empower survivors to tell their stories. | 7 | 1 |
| We should do more to reach victims/survivors out there who have never sought help because of stigma, and because they are not aware that there are laws, resources, and services. | 7 | 0.75 |
| We should make sure our messages are culturally relevant, in all the different meanings of culture (ethnicity, language, geography, etc.). | 7 | 0 |

**Table 1** (continued)

| Item | Median | 25th-75th %ile IQR |
|---|---|---|
| Local programs must be vigilant about their printed materials to make sure that the message they present is empowering and devoid of judgment. | 7 | 0 |
| Advocates must work consistently to undermine negative messages that victims may be hearing in other areas of their life. | 7 | 0 |
| We should ensure that there is a safe place in every community where a survivor can reach out for help and feel genuine support. | 7 | 0 |
| Sub-category #2 | | |
| Public awareness campaigns can let survivors know they don't have to deal with their pain on their own. | 7 | 0 |
| Service providers and advocacy organizations should educate communities about the real reasons people stay and how to be an effective ally. | 7 | 0 |
| Society cannot downplay the severity of what victims and survivors have experienced or continue to experience and how horrible any form of violence is against anyone. | 7 | 0 |
| Advocacy organizations should teach positive bystander strategies. | 7 | 0.75 |
| Advocates should create campaigns that let survivors know that people care about them. | 7 | 1 |
| Advocacy organizations should have large public awareness campaigns addressing the stigma. | 7 | 1 |
| No one message will resonate with every person or in every place, so the more conversations that we have going, the more likely it is that someone will hear something that clicks for them. | 7 | 1 |
| Advocacy organizations should engage celebrities, sports figures, newscasters, and political leaders in the conversation and ensure that they understand the influence their attitude and words have on our society. | 7 | 0.75 |
| Involving the national media responsibly in the conversations about domestic and sexual violence is important. | 7 | 0 |
| We have to hold journalists accountable for how they present stories of domestic violence and sexual assault. | 7 | 0 |
| So many attacks are unreported that we don't have the data to understand the true scope of the problem. | 7 | 1 |
| We're talking about a cultural shift, so much of the work to create it has to come from the ground up. | 7 | 1 |
| We should develop community-based, prevention-focused programs to promote change in community members' attitudes and beliefs that perpetuate the stigma surrounding abuse. | 7 | 0 |
| Sub-category #3 | | |
| Parents can raise sons and daughters to value human rights for all. | 7 | 0 |
| We should educate children in our school system from an early age as to what a healthy relationship should look like. | 7 | 0 |
| Sub-category #4 | | |
| Advocates must work toward undoing harmful policies that perpetuate domestic and sexual violence. | 7 | 0.75 |
| We should work on legislation that is more supportive of survivors and that holds perpetrators more accountable. | 7 | 0 |
| Groups working together in local communities should come together on a regular basis to discuss what strategies would be best for their communities and then implementing those. | 7 | 1 |
| We should implore leaders (mayors, coaches, teachers, business leaders) to take a stand against domestic and sexual violence. | 7 | 0 |
| We should work toward more consistent and clear penalties for abusers (e.g., jail time, fees, compliance with batterer treatment programs, and taking responsibility for their actions). | 6.5 | 1 |
| We should ensure that coordinated community responses are not just focused around victim services, but also perpetrator accountability. | 7 | 0 |
| Sub-category #5 | | |
| Survivors need to be portrayed as 3-dimensional human beings. They are not only "victims;" they are parents, family members, friends, workers, students, members of congregations, people with multiple skills, talents, attributes. | 7 | 0 |
| We need to create opportunities for survivors to have a voice in public awareness campaigns—including PSAs, radio and TV talk shows, posters, and other literature. | 7 | 1 |
| We need to publicize success stories that feature survivors, instead of only portraying them as "victims" to be pitied. | 7 | 0.75 |
| It is important for survivors who have not sought help to see other survivors who have been able to leave their abusive situations behind and are now living violence free lives and even built successful lives. | 7 | 1 |

**Table 1** (continued)

| Item | Median | 25th-75th %ile IQR |
|---|---|---|
| Sub-category #6: Professionals and other groups should be trained to ensure that they are equipped to provide support to survivors. | 7 | 0 |
| We should work to educate those who impact survivors, such as church groups, school administrators, and law enforcement. | 7 | 0 |
| We should ensure that religious leaders understand how domestic violence impacts the home and safety of victims and children and have them on board with supporting the victim in getting to a safe place. | 7 | 0 |
| We should ensure that law enforcement is doing everything possible to support survivors. | 7 | 0 |
| We should ensure that medical professionals screen for domestic and sexual violence and provide information, education, and resources to patients on this. | 7 | 0 |
| Sub-category #7 | | |
| We must make sure that we are including all people in our fight, and not just white women of privilege. | 7 | 0 |
| We need to understand and challenge the cultural beliefs in EVERY culture that have been used to excuse gender-based violence, and instead identify and promote those cultural strengths and resilience factors that are protective. | 7 | 0 |

Reported means are based on a scale from 1 (*strongly disagree*) to 7 (*strongly agree*), with a "Not applicable" option available to participants.

## Major Areas of Consensus and Participant Feedback on Questionnaire 3

Questionnaire 3 provided the opportunity for participants to provide feedback to help refine and clarify the researchers' initial interpretations of the findings of this study. Again, the statements contained within each sub-category are provided in Table 1. In this section, we present the original summary statement that was included on Questionnaire 3 for each sub-category, followed by a summary of participants' feedback about the sub-category summary statements. For each sub-category, revisions were made to the summary statements based on participants' feedback. Thus, the final, revised versions of the summary statements are provided.

***Theme 1:*** The social context of the stigma surrounding domestic and sexual violence

This theme contained five sub-categories, which are described below. These sub-categories addressed victim-blaming, societal beliefs, separation and isolation, barriers to seeking help, and multiple layers of stigma for non-minority groups.

***Subcategory #1:*** Victim-blaming is a big part of the stigma.

Several participants indicated they believed this summary statement accurately reflected the statements in this sub-category (e.g., "Accurate summary statement;" "It's fine;" and "I believe it summarizes it very well"). (Note: from this point forward, we will not indicate when participants made statements similar to these basic indications of agreement, and rather our focus will be on the suggestions to refine each summary statement in the sub-categories below.) Several participants offered suggestions for clarifying or adding to this statement, such as "'Big part' seems very vague to me. What does that mean?"; "I would add that even advocates and other well-meaning social service providers…use language that is victim blaming;" and "I would recommend broadening the statement so that it is clear that victim blaming comes from many sources, including the internalized aspects of victim blaming that is rooted in the societal aspects." We consolidated the feedback to capture the participants' feedback in the following

final, revised version of this statement: *Victim-blaming (by society, perpetrators, other survivors, and even the survivors themselves) fuels the stigma surrounding domestic and sexual violence.*

***Subcategory #2:*** Societal beliefs add to the stigma

Several expert panel members suggested this statement should be revised to be less vague and more concrete, and they offered suggestions for doing so (e.g., "Maybe add perceptions;" "I think it would be valuable to include the last statement about how these beliefs are part of our laws, pop culture, media, etc.;" and "I would agree but hone in: 'Societal beliefs, fueled by misinformation, beliefs, and traditional gender roles, add to the perceived stigma'"). Others suggested wording changes (e.g., "Don't societal beliefs…drive the stigma rather than add to it?"). Therefore, the final version of this sub-category's summary statement is as follows: *Societal beliefs and perceptions—fueled by misinformation, beliefs, traditional gender roles, and other factors (*e.g.*, religious beliefs, racism, and classism) that are part of our laws, popular culture, and the media—drive the stigma surrounding domestic and sexual violence.*

***Subcategory #3:*** Victims/survivors are separated and isolated from others

Participants' suggestions for refining this statement related to the source of the separation and isolation (e.g., "Victims/survivors are often separated and isolated - either as a battering tactic or through self-isolation - from friends, family or other service providers who can provide help") and the nature of them (e.g., "The isolation can be both physical and emotional, literal and perceived"). Thus, the final version of this summary statement is as follows: *Victims/survivors are separated and isolated from others—physically and/or emotionally—due to the dynamics of the abuse and the stigma. The separation and isolation may be intensified by geographic isolation (*e.g.*, in rural areas or when victims/survivors do not live nearby friends or family members).*

***Subcategory #4:*** Victims/survivors face stigma that makes it harder for them to attain economic security, basic needs, and personal safety

Feedback focused on barriers that survivors may face when they attempt to seek services. For example, one participant said:

> I would add the community in general shows their indifference to victims when they turn a blind eye to abuse happening in public. And when victims try to access services, many times they feel more stigmatized when they may have to produce proof of DV such as when getting a TRO [temporary restraining order], public assistance, help at the school, trying to get protection at their apartment. This at times causes some victims to not seek services to avoid the questions and shame. Even getting into a DV shelter can be a challenge as many of assessments can be long and tiring and questions can be posed in a victim blaming manner.

Thus, the final, revised version of this summary statement is as follows: *Victims/survivors face systemic and societal-wide stigma and institutional obstacles that create barriers and make it harder for them to attain economic security, basic needs, and personal safety.*

***Subcategory #5:*** Specific non-majority groups may experience multiple layers of stigma

Panel members suggested the term "non-majority" groups was limiting (e.g., "I feel we all suffer multiple levels of stigma" and "Is it correct to say that mothers are a non-majority group? Maybe by actual numbers, but I wouldn't think of mothers as included if I only saw the summary statement"). They also suggested focusing on "intersectionality" by "list[ing] out some examples like racism, classism, homophobia, etc." To address this, we adapted a participant's suggested wording as the final version of this statement: *Characteristics of victims'/survivors' identity (*e.g.*, race, ethnicity, disability, and family status) can add multiple layers of stigma.*

***Theme 2:*** The impact of the stigma on resources for victims and survivors

Two sub-categories address the potential impact of the stigma on the accessibility of services and resources. These subcategories addressed the stigma that may be experienced from resources designed to help victims of abuse and the impact of the stigma on help-seeking.

***Subcategory #1:*** Victims may experience stigma and discrimination from resources that are designed to help them

Most panel members supported this statement, as most feedback addressed one specific statement in the list ("…where many men have prejudiced views and behaviors"), and they address the gender bias in that statement and suggested that "this is a problem, many women also have prejudiced views." One participant said that this issue was addressed in the summary statement ("…especially as its presentation does not include the sex of the provider"). Two suggested revisions (e.g., "systems *and resources*" and "I think it would be helpful to include that it's not always intentional and may be the result of the system itself rather than an individual"), however, were incorporated into the following revised summary statement: *Victims may experience stigma and discrimination from systems and resources that are designed to help them, and this stigma can be unintentional and/or the result of institutional policies.*

***Subcategory #2:*** The stigma makes survivors feel less willing to seek help

Most participants agreed with this summary statement. A few wording suggestions were made, such as "may make survivors feel less willing to seek help" and "I tried taking out the word 'feel' which seems to make it stronger but changes the meaning." Therefore, the final version of this statement is as follows: *The stigma may make survivors less willing to seek help.*

***Theme 3:*** Strategies for eradicating the stigma surrounding domestic and sexual violence

The seven sub-categories in this theme offer suggested strategies that can be taken at different levels to end the stigma surrounding domestic and sexual violence. The topics addressed in these categories included the needs for responsive and non-stigmatizing services, education and outreach in communities, preventive interventions beginning in childhood, supportive public and organizational policies, models of survivors who have overcome abuse, professional training, and culturally-relevant resources.

***Subcategory #1:*** We need responsive services that work proactively to support survivors in non-stigmatizing environments

Participants suggested modifying this statement to "add that we should allow the victim to decide what is best for her/him and to meet them where they are at in their process of change" and to be inclusive "of both prevention and intervention." Another said, "Responsive services seems very passive to me. I think you mean it in terms of responsive to survivor needs? I believe the services need to be proactive as you then say." Yet another panel member suggested the term "driven by survivor understanding." To address these suggestions, the final version of this statement was as follows: *We need proactive and responsive prevention and intervention services driven by survivor understanding in non-stigmatizing environments.*

***Subcategory #2:*** We need broad-based efforts to educate and engage the public so that, through greater knowledge, the stigma will be reduced

Most panelists agreed with this summary. One said, "It's through community engagement and not the professionals that the most change will happen." Two other suggestions were to say "diverse" instead of "broad-based" and to increase not only "knowledge but also about increasing the volume of public discussion on the topic." Therefore, the final version of this statement is: *We need diverse and broad-based efforts to educate and engage the public so that, through greater knowledge and dialogue, the stigma will be reduced*.

***Subcategory #3:*** Prevention and educational efforts should begin with children

Several panelists indicated enthusiastic agreement with this statement (e.g., "Absolutely!" and "Yes!"). However, two revisions were suggested. First, one participant said, "I would capture healthy relationships in this statement. I think most people will only think of good touch/bad touch and instead of focusing on the negative/harm, we need to talk about positive relationships." Two others noted the importance of focusing on the family and/or parents (e.g., "Prevention and education efforts should be aimed at parents first and children second" and "It's working with the entire family…to change the dynamics of abuse"). To address these concerns, the final version of this sub-category's summary statement became: *Prevention and educational efforts should support children and families in learning about and building healthy, safe relationships*.

***Subcategory #4:*** We need to work to ensure that public and organizational policies support survivors and don't add to the stigma that survivors face

One panel member suggested using the term "Communities" instead of "We" to start the sentence. Three participants mentioned the need to address perpetrators (e.g., "Add something about holding perpetrators accountable too"), and another addressed the need for policies to also avoid adding "to the various forms of stigma that survivors might face including all of the 'isms' mentioned before." Therefore, the final version of this summary statement is as follows: *Communities need to work to ensure that public and organizational policies hold offenders accountable, support survivors, address multiple layers of stigma, and don't add to the stigma that survivors face*.

***Subcategory #5:*** We need positive models of survivors that share empowering stories of overcoming abuse

One participant noted, "I don't think it is necessary to use the term positive models of survivors … can be misunderstood – are there negative models of survivors?" Another participant suggested addressing this as follows: "Could be: We need survivors to publicly share their empowering stories of abuse." Another said, "It's more than just sharing stories, it's supporting them to become leaders in their communities where they can become role-models based on what they want." Still another participant said, "I realize this isn't part of the statements above, but I feel like this summary statement feeds the stigma that you 'should' leave your relationship and that there's something wrong with you if you don't. So I would add to the end of this statement: '… so that when survivors are ready to leave, and have made that decision for themselves, they will have role models to look to.'" Another noted that "I would also add that service providers should really focus their attention on celebrating even the small accomplishments made by survivors such as calling a hotline, going to a counseling session, etc." All of this feedback was incorporated into the following final version of the statement: *Communities need to support survivors in publicly sharing their empowering stories of overcoming abuse and becoming leaders in their communities, as well as to celebrate survivors on their private accomplishments, such as calling a hotline or going to a counseling session.*

***Subcategory #6:*** Professionals and other groups should be trained to ensure that they are equipped to provide support to survivors

The suggestions in response to this summary statement address the wording of the term "professionals and other groups", which a participant suggested was "very open-ended." Another said, "I think the summary statement should make it clear that we're referring to professionals who encounter victims/survivors in their work, not just those who work in DV/SA services." Another suggested making the wording more succinct (i.e., "…should be trained to support survivors"), while another suggested adding the importance of providing the type of support that a particular survivor needs and wants (i.e., "I think it is important to point out that professionals and other groups should be trained to ensure they are equipped to provide support to survivors based on what support looks like for that particular survivor."). Therefore, the final version of this statement was revised to be: *Professionals who encounter victims and survivors in their work (including domestic and sexual violence service providers, law enforcement, medical professionals, and others) should be trained to provide multiple forms of support and resources that meet the unique needs of each survivor*.

***Subcategory #7:*** Unique cultural issues must be addressed in efforts to end the stigma surrounding abuse

All but one of the participants indicated full agreement with this statement. The one participant who expressed concerns said, "And even when other non-white people are included, they should be made to feel as an important and valuable part of the group with their input/feedback taken seriously. It is equally important that they be treated with dignity and respect and not held to a white privilege view of the world as that would not add to the richness or value of the

discussion." In an effort to capture this feedback, the final version of this summary statement is as follows: *Unique cultural issues must be addressed in efforts to end the stigma surrounding abuse and ensure that all people are treated with dignity and respect regardless of their background characteristics*.

## Discussion

The purpose of this study was to identify potential solutions for addressing the stigma that surrounds domestic and sexual violence. To that end, Delphi methodology was used to gain the perspectives of a panel of national advocacy experts who work to address domestic and sexual violence. A summary of this study's findings is provided in Table 2.

**Table 2** Summary statements for sub-categories within each theme

| |
|---|
| The social context of the stigma surrounding domestic and sexual violence |
| 1. Victim-blaming (by society, perpetrators, other survivors, and even the survivors themselves) fuels the stigma surrounding domestic and sexual violence. |
| 2. Societal beliefs and perceptions—fueled by misinformation, beliefs, traditional gender roles, and other factors (e.g., religious beliefs, racism, and classism) that are part of our laws, popular culture, and the media—drive the stigma surrounding domestic and sexual violence. |
| 3. Victims/survivors are separated and isolated from others—physically and/or emotionally—due to the dynamics of the abuse and the stigma. The separation and isolation may be intensified by geographic isolation (e.g., in rural areas or when victims/survivors do not live nearby friends or family members). |
| 4. Victims/survivors face systemic and societal-wide stigma and institutional obstacles that create barriers and make it harder for them to attain economic security, basic needs, and personal safety. |
| 5. Characteristics of victims' and survivors' identities (e.g., race, ethnicity, disability, and family status) can add multiple layers of stigma. |
| The impact of the stigma on resources for victims and survivors |
| 6. Victims may experience stigma and discrimination from systems and resources that are designed to help them, and this stigma can be unintentional and/or the result of institutional policies. |
| 7. The stigma may make survivors less willing to seek help. |
| Strategies for eradicating the stigma surrounding domestic and sexual violence |
| 8. We need proactive and responsive prevention and intervention services driven by survivor understanding in non-stigmatizing environments. |
| 9. We need diverse and broad-based efforts to educate and engage the public so that, through greater knowledge and dialogue, the stigma will be reduced. |
| 10. Prevention and educational efforts should support children and families in learning about and building healthy, safe relationships |
| 11. Communities need to work to ensure that public and organizational policies hold offenders accountable, support survivors, address multiple layers of stigma, and don't add to the stigma that survivors face. |
| 12. Communities need to support survivors in publicly sharing their empowering stories of overcoming abuse and becoming leaders in their communities, as well as to celebrate survivors on their private accomplishments, such as calling a hotline or going to a counseling session. |
| 13. Professionals who encounter victims and survivors in their work (including domestic and sexual violence service providers, law enforcement, medical professionals, and others) should be trained to provide multiple forms of support and resources that meet the unique needs of each survivor. |
| 14. Unique cultural issues must be addressed in efforts to end the stigma surrounding abuse and ensure that all people are treated with dignity and respect regardless of their background characteristics. |

## Statement of Limitations

As a Delphi methodology study, this research was limited by common disadvantages of this approach. In particular, by focusing on achieving consensus, beliefs that are unique or outliers, which may be important to understanding the overall phenomenon, may be eliminated in the final analysis (Vazquez-Ramos et al. 2007; Yousuf 2007). Also, because the composition of the panel is so critical to the success of the study (Vazquez-Ramos et al. 2007), it is possible that the current study was biased due to the non-participation of some of the national leaders who declined the invitation to be part of the study (Yousuf). As leaders of national organizations, all participants likely have busy and demanding schedules, which may have made it difficult for them to find time to participate fully due to the time demands of Delphi research (Vazquez-Ramos et al.; Yousuf). This may explain the attrition of some participants between phases of the study (Hsu and Sandford 2007).

A related limitation of this study is the small sample size, although the size of the sample was typical of Delphi methodology. Further, although national leaders have a unique vantage point for understanding the stigma surrounding domestic and sexual violence, their views may differ from other key stakeholders impacted by domestic and sexual violence, especially survivors and direct service providers in local communities.

**Implications for Research**

Although the concept of stigma has been studied for many years as it applies to other issues (e.g., mental illness and HIV), the stigma surrounding domestic and sexual violence has only recently begun to be studied (Crowe and Murray 2015; Overstreet and Quinn 2013). Therefore, additional research is needed to add to scholars' and practitioners' understanding of this stigma, including its causes, impact on victims and survivors, and strategies for challenging, reducing, and eliminating it. The findings of the current study support findings of previous research, which show that victim-blaming is a major component of the stigma surrounding domestic and sexual violence (Bryant and Spencer 2003; Gover et al. 2011). Further, expert panel members confirmed both that the stigma victims and survivors face can come from many sources at different levels, and that the stigma adds to the barriers survivors face in seeking help and moving toward violence-free lives (Crowe and Murray 2015; Overstreet & Quinn). Building on the IPV Stigmatization Model (Overstreet & Quinn), additional research is needed to further refine a conceptual model for understanding and addressing the stigma surrounding domestic and sexual violence. In particular, it is important to gain a greater understanding of how the stigma impacts survivors, such as their help-seeking behaviors and their perceptions of their ability to receive support from others (Overstreet & Quinn).

An additional fruitful direction for future research involves examining similarities and differences in the stigma surrounding domestic violence and sexual violence. In the current study, we combined both of these forms of violence, which may overlap (e.g., sexual assault within an intimate relationship) or be entirely distinct (e.g., sexual assault that is not in the context of an intimate relationship). Therefore, it is likely that there are some aspects of stigma common to both forms of violence, but there are also likely components of stigma unique to each one. The findings of this study make clear that the stigma surrounding domestic and sexual violence exists at many different levels and within many different social systems. Therefore, more research is needed to understand how this stigma is perceived and experienced by different

stakeholders, including survivors and local service providers. Furthermore, future research can identify how the stigma is manifest in specific social systems and intervention and prevention resources (e.g., law enforcement and healthcare settings). Also, the expert panel members in this study frequently mentioned the intersections of multiple layers of stigma survivors may face, including racial, ethnic, ability, family, and socioeconomic statuses. Thus, the intersections of multiple layers of stigma, and how they uniquely combine to impact survivors, are an important area for future research.

## Implications for Practice and Advocacy

Expert panel members suggested several practical steps that can be taken at different levels to reduce, and ultimately eliminate, the stigma surrounding domestic and sexual violence. These strategies involve actions that can be taken to improve direct services and prevention and advocacy initiatives within communities.

### *Direct Services*

Panel members emphasized the importance of every potential organization and professional that works with victims, survivors, and even perpetrators of domestic and sexual violence of ensuring they are proactively creating non-stigmatizing environments. Training is critical, especially for professionals working in fields that may receive limited training on working with victims and survivors. Previous research suggests that victims and survivors may face stigma from professionals in virtually any field, including law enforcement, mental health and healthcare professionals, the criminal justice system, and even domestic and sexual violence agencies (Crowe and Murray 2015).

Some specific implications for direct service providers that can be drawn from this study's findings are as follows. First, professionals should ensure that their own practices, as well as policies and practices within their organizations, are grounded in a solid understanding of the needs of survivors that reflect their experiences with abuse. One potentially useful framework is that of trauma-informed care, through which organizations examine every aspect of their practices to ensure they meet the unique needs of clients who have experienced trauma (SAMHSA 2014). Organizations also may develop and use protocols to ensure their organizations are responsive to survivors' needs (e.g., Daire et al. 2014). Second, all services should be designed to be responsive to clients' unique needs based on their cultural and other background characteristics. This may involve offering tangible resources, such as having translation services available for non-English-speaking clients or ensuring that resources are available for partners in same-sex couples. However, it also goes beyond basic tangible support to ensure that all professionals who encounter victims and survivors not only avoid stigmatizing survivors, but also to ensure they are treated with dignity and respect. Professionals also should consider how their clients' stigma-related experiences may be compounded by their background characteristics, such as male victims who may find that services are primarily designed to reflect the needs of women (Cook 2009; Tsui et al. 2010).

Third, national, state, and local organizations can work to deliver training programs that equip interdisciplinary professionals to provide services competently, ethically, and respectfully. Many

professionals are under-trained to address domestic and sexual violence (Daire et al. 2014), and therefore this remains a critical need to prevent further stigmatization of victims and survivors. Finally, the findings offer a reminder that professionals and organizations can "celebrate survivors on their private accomplishments." Survivors face many major barriers within and following an abusive relationship—including the stigma, but also the safety risks, the risk of injury and emotional distress, judgment from others, fears and anxieties, and more. Thus, even acts that may seem minor (e.g., calling a hotline) may represent major efforts to overcome barriers and take a chance on moving a step closer to safety and peace. Professionals can honor these acts by validating them as courageous and significant acts of progress.

*Prevention and Advocacy Initiatives*

Beyond direct supports and resources provided to victims and survivors on an individual level, this study's findings highlight the need to support ongoing and new initiatives to prevent further domestic and sexual violence, raise awareness of these issues in the community, and directly challenge the stigma surrounding them. One useful resource for identifying prevention programs addressing domestic violence can be found through the PreventIPV web-site (http://www.preventipv.org/). Preventive initiatives should be directed to the general community, not only to raise awareness of domestic and sexual violence within the general population, but also to promote ongoing dialogue about these issues. Prevention initiatives aimed at helping children learn how to create healthy, safe relationships are especially important, although expert panel members emphasized the importance of focusing efforts on reaching children through their parents and families. Some panel members focused especially on ensuring that all children are able to grow up in safe, non-violent homes, where they have models of healthy relationships from the adults in their lives. This is consistent with research demonstrating the potential lasting negative effects of childhood exposure to family violence (Zarling et al. 2013).

The voices of survivors should be an ongoing part of prevention and advocacy initiatives, especially so that communities can see and learn from people who have overcome abuse. Leadership training programs for survivors may be especially useful in helping survivors learn ways to share their stories, advocate for change, and provide input into public and organizational policies that impact victims and survivors. Of course, it is important that survivors be able to choose for themselves if and how they want to share their stories publicly, as it may not be safe for some survivors to do so. Therefore, prevention and advocacy organizations can work to create ways that survivors can share their stories, both publicly and/or anonymously, to add to the public dialogue about domestic and sexual violence. One potential approach to doing this is through the use of Photovoice, which can be used as a support group format but also result in a community awareness event to highlight survivors' stories (Haymore et al. 2012). Ultimately, highlighting survivors' stories of overcoming abuse can both be empowering for the survivors themselves and also provide a direct challenge to many of the negative stereotypes and judgments that contribute to the stigma surrounding domestic and sexual violence (Crowe and Murray 2015; Overstreet and Quinn 2013).

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