

gender matters



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POLICY AND PRACTICE BRIEF

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Gender Matters in Mental Health Brief No.3: Domestic Violence

DOMESTIC VIOLENCE IS

A pattern of assaultive and coercive behaviors, including physical, sexual and psychological attacks, and economic coercion that adults or adolescents use against their intimate partners.

Prevalence Among the General Population

- Lifetime prevalence of physical and/or sexual abuse by an intimate partner is 25 percent for women and 8 percent for men.¹

Prevalence Among the Seriously Mentally Ill

- Research indicates that about 44 percent of women seen in outpatient mental health settings were physically abused as adults, and about 34 percent were sexually abused as adults.²
- In one study of 66 female psychiatric inpatients, 44 percent had experienced physical assault as an adult (Byer et al 1987). Of those, 59 percent had been assaulted by an intimate partner.³
- In another study of 69 inpatients (male and female) who had ongoing relationships with partners or family members, 63 percent reported ongoing victimization by a partner, and 48 percent reported physical abuse by a family member (Cascardi, et al 1987). Twenty-nine percent had experienced domestic abuse within the past year.⁴

Issues/Concerns

- Women who have experienced domestic violence are more likely to be diagnosed with a variety of mental health problems, including post-traumatic stress disorder,

sleep problems, depression, panic attacks, and insomnia.⁵

- Survival strategies for domestic violence survivors, who are often living in terror in their own homes, can often be misunderstood as maladjusted behavior. Such survival strategies can include, but are not limited to, self-medication, substance abuse, self-harm, depression, anxiety, extreme submission, and disassociation.
- Research on hospital emergency rooms and psychiatric evaluation centers documents that conventional screening will identify only 15 to 25 percent of the battered women entering these services.⁶

Policy Implications

- Believe the client's statements about abuse, ensure that policies require full investigation of reported abuse and/or assault.
- Develop policies that are client-centered, strength-based and empower the client.
- Develop collaborative relationships between mental health services and domestic violence advocates. This includes cross training of staff, developing referral systems, establishing channels of communication, and collaborating to share resources and expertise.
- Develop a protocol that requires routine screening and assessment for domestic violence and intimate partner abuse.
- Adopt screening tools that are closed ended, specific and concrete, can be used routinely, and offer a combination of questions about different kinds of abusive behaviors highly associated with battering.⁷ (See figure 1).



Because battered women frequently deny or minimize their abuse, experts recommend asking a range of questions that may be helpful in disclosing the abuse.

Figure 1 (taken from Gondolf, Edward G. *Assessing Woman Battering in Mental Health Services*, Sage Publications, 1998 pg. 69. The titles of these two questionnaires were changed to fit the format of this document.)

Sample Screening and Follow-up Questions

Screening Questions

1. Are you in any way fearful of your partner?
2. Does your partner have angry outbursts or temper tantrums?
3. Has your partner stopped you from going places or seeing people?
4. Has your partner threatened to harm you, your children, or your relatives?
5. Has your partner ever pushed, grabbed, slapped, or hit you?
6. Has your partner ever pressured you into sexual acts against your will?

Follow-Up Questions

NOTE: Each screening question above with a positive response should be followed with probes for the most recent incident, duration, frequency, effect, for example,

- A. When was the most recent incident?
- B. How long has this been going on?
- C. How often has it happened in the last six months?
- D. How has it made you feel? How has it hurt you physically?
- E. What help or assistance have you sought?
- F. How do you feel about calling the police or going to court to receive assistance?

Practice Implications

- Many different screening tools have been developed. Because battered women frequently deny or minimize their abuse, experts recommend asking a range of questions that may be helpful in disclosing the abuse, including questions about emotional abuse, verbal abuse, physical abuse, and sexual abuse. Positive responses to preliminary questions should be followed up with specific questions. See figure 1 for a sample of screening and follow-up questions recommended for routine use in mental health services.⁸
- Once identified, taking an abuse history is critical. It helps put the abuse in a broader context of the woman's life, helps to identify the trauma she may be suffering,

provides important information in developing a safety plan and can help the battered woman validate her experience and see the seriousness of her situation more clearly.⁹ See figure 2 for sample abuse history questions.

- If abuse is suspected, before the client leaves you must assess her level of lethality and develop a safety plan. Contact your local domestic violence agency for a lethality assessment check-list and a safety plan check-list. At a minimum, ask the client:
 - Is the abuser waiting for her at the clinic when she leaves?
 - Does the abuser have a weapon?
 - Does she feel safe leaving the clinic?
 - Does she feel safe at home?
 - Are her children safe?

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Figure 2: Abuse History

Below is a list of the critical categories to include when taking an abuse history

Isolation

- Keeping the victim from going to a job, school, church, or from seeing family and friends,
- Taking away the victim's ID cards or driver's license,
- Following the victim around,
- Opening the victim's mail,
- Monitoring phone calls or removing the telephone.

Financial Control

- Denying access to money,
- Forcing the victim to beg and plead for money,
- Lying about money or hiding it,
- Preventing the victim from working,
- Stealing the victim's money,
- Not providing sufficient money for expenditures,
- Ruining or preventing the woman from getting credit,
- Threatening to jeopardize her receipt of AFDC.

Intimidation

- Frightening the woman by certain gestures and looks,
- Smashing or throwing things,
- Destroying the woman's possessions,
- Hurting or killing pets,
- Playing with weapons to scare the woman,
- Threatening to kill the woman, children, or himself,
- Threatening to have the woman deported, if immigrant or refugee status.

Emotional Abuse

- Putting the woman down,
- Calling the woman names,
- Humiliating the woman in front of family and friends,
- Making the woman feel stupid,
- Blaming the woman for what he did wrong.

Sexual Abuse

- Ridiculing the woman's sexual performance or response,
- Pressuring the woman to do sex acts that make her uncomfortable,
- Threatening to sexually molest the children,
- Pressuring the woman to copy pornographic magazines,
- Pressuring the woman to watch pornographic videos,
- Raping or threatening to rape.

Physical Abuse

- Pushing, shoving, grabbing, arm twisting,
- Slapping, punching, choking, burning, beating up,
- Use of objects or weapons against the woman.



If abuse is suspected, before the client leaves you must assess her level of lethality and develop a safety plan.



*California Women's Mental Health
Policy Council*

CALIFORNIA INSTITUTE FOR
MENTAL HEALTH
2125 19TH STREET, 2ND FLOOR
SACRAMENTO, CA 95818
(916) 556-3480
WWW.CIMH.ORG



California Institute for Mental Health
2125 19th Street, 2nd Floor
Sacramento, CA 95818

- Documentation is critical for women seeking legal protection, redress or custody of their children.¹⁰
 - Documentation of abuse should be detailed and specific, highlighting circumstances, tactics, time, place, effect, and injury of battering incidents. Include information derived from the abuse history, a lethality checklist and a safety plan.¹¹
 - Other than post-traumatic stress disorder, any diagnosis should be made cautiously. Diagnosis can be used against the client by the batterer, particularly related to child custody issues.¹²
 - Documentation should also include the client's strengths in surviving the abuse and important cultural factors as they affect the individual client.
- For additional screening tools, see the following Web sites:
 - <http://www.aafp.org/aafp/20040515/poc.html>
 - http://www.femalepatient.com/html/arc/sig/screening/articles/029_04_039.asp

DOMESTIC VIOLENCE RESOURCES

- California Partnership to End Domestic Violence, <http://www.cpedv.org>; helpline, M–F 9:00 a.m.–5:00 p.m., (800) 524-4765; business phone, (916) 444-7163
- National Domestic Violence Hotline (800) 799-SAFE (7233).

ENDNOTES

- ¹ Chamberlain, Linda, PhD, MPH, *Making The Connections: Domestic Violence and Public Health, The Family Violence Prevention Fund, 2004*,
- ² Lehmann, Christine, Psychiatrists Urged to Ask About Domestic Violence, *Psychiatr News* 2002 37: 8
- ³ Warshaw, Carol, MD., Barnes, Holly, MA, *Domestic Violence, Mental Health and Trauma: Research Highlights*, April 2003. <http://www.dvmhpi.org/Publications.htm>, March 23, 2006.
- ⁴ Ibid
- ⁵ Chamberlain, Linda.
- ⁶ Gondolf, Edward W. *Assessing Woman Battering in Mental Health Services*, Sage Publications, Thousand Oaks, California 1998, pg.68.
- ⁷ Ibid.
- ⁸ Gondolf, Edward W. pg. 68-69.
- ⁹ Ibid, pg. 73.
- ¹⁰ Warshaw, Carol
- ¹¹ Gondolf, Edward W. pg 90-91.
- ¹² Ibid pg. 89.