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Mental Health Symptoms of Women in Domestic Violence Relationships

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MENTAL HEALTH SYMPTOMS OF WOMEN IN DOMESTIC VIOLENCE
RELATIONSHIPS

by

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B.S., Southern Illinois University, 2008

A Research Paper

Submitted in Partial Fulfillment of the Requirements for the
Master of Science Degree

Department of Rehabilitation Administration and Services
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CHAPTER 1

INTRODUCTION

Need of the Study

Prior to the mid 1970's domestic violence was not considered to be a crime or even considered a social concern. Even when some women started the battered women movement during this era many communities were not supportive of the women efforts to bring awareness to domestic violence (Jackson, 2007). Many studies/research have provided sufficient evidence which demonstrates the effect of domestic violence in relation to women mental health statuses.

According to the American Bar Association, every year more than 1.3 million women are physically assaulted by their partner. Every 9 seconds a woman in the U.S. is battered. Each year, 8.7 million women are victims of intimate partner violence. Women represent more than 90% of all domestic violence cases. Every day, more than 3 women are killed as a result of intimate partner violence. The number one cause of women visitation to the emergency room is domestic violence. Nearly one in every four women in the U. S. which experience some form of domestic violence at the hands of a partner (Roberts & Roberts, 2005)

There are a number of women today who have experience some form of domestic violence at the hand of a partner. Many of the women are also at risk of developing mental health symptoms in relation to domestic violence. According to Tjaden & Thoennes, (2000) depression, Posttraumatic stress disorder (PTSD), and suicidal ideation are the most frequent mental health symptoms women of domestic violence suffer. Yet, many health/clinical professionals do not evaluate any women

mental health status in relation to their domestic violence. Many of the mental health symptoms associated with domestic violence are likely to go undiagnosed when women try to recover or receive help due to a violent encounter.

Statement of the Problem

The purpose of this project is to examine the relationship between women in domestic violence relationships and mental health symptoms/outcomes that result from domestic violence. Correctly identifying women involved in a domestic violence relationship and determining potential mental health diagnosis is a necessary part of beginning their rehabilitation process. It helps rehabilitation professional in determining the appropriate steps to take when assisting a client. Current literature detailing women of domestic violence and related mental health outcomes will be examined to determine what mental health symptoms women of domestic violence endure.

When most individuals think of domestic violence they only consider the physical state involving domestic violence. There are more forms of domestic violence than the physical act itself. Domestic violence takes many different forms: emotional and verbal abuse, isolation, threats and intimidation. For many years it was not against the law for a man to beat his wife or significant other, but due to the rising increase of homicide women have suffered at the hands of men, women have no longer been condemned as the property of a man (Sherman, 2001). Domestic violence among women has been a known problem for years and in 1994 President Clinton signed and passed into law the Violence Act Against Women (Office of the Attorney General, 2008).

Women who experience violence at the hands of a partner are more likely to be at risk of suffering mental health problems than women who do not experience violence

(Mourad, Levendosky, Bogat, & Eye, 2008). According to Mourad et al., (2008) domestic violence may not be the only undergoing problem which may relate to mental health problems, but research has shown women who have experience domestic violence are at a higher risk of being diagnosed with a mental health disorder than any other group of women. Hamberger & Phelan, (2004) stated that locating presenting factors that indicate domestic violence is sometimes difficult and the emergency room is the focal point to where women are able to receive the first step of treatment in assessing possible mental health symptoms for women in domestic violence relationships. Therefore, it is the role of the physician to ask well thought-out questions concerning suspicious of domestic violence before a diagnosis can be offered.

Significance of the Problem

Women are more likely than men to experience abuse at the hands of a partner. Mourad et al., (2008) reported that, 20.4% of American women experience domestic violence at the hands of a husband or significant other. Tjaden & Thoennes, (2000) stated that an estimated 1.3 million women are physically assaulted by the hands of a partner every year. Domestic violence & mental health policy initiative (DVMHPI) indicated that according to a 1995-1996 study by Tjaden & Thoennes, the following are the rank and percentage of domestic violence experience by women:

- “64% of women who reported being raped, physically assaulted, and/or stalked since age 18 was victimized by a current or former partner.
- 22.1% of women had been physically assaulted by a partner or date during their lifetime. Based on these data, an estimated 1.3 million women are physically assaulted by a partner every year in the US.

- 7.7% of women had experienced attempted or completed rape by a current or former partner during their lives.
- 4.8% of women had been stalked by a current or former partner” (DVMHPI, 2002).

The traumas most women experience due to issues of domestic violence are usually categorized as anxiety disorders or posttraumatic stress disorder (Center on Crime, Communities & Culture, 1997). What are some of the other mental health issues women of domestic violence suffer? According to Prospero, (2008) women of domestic violence have a higher risk of being diagnosed with depression, PTSD, stress, or as having symptoms of being suicidal. Liebschuts, Frayne & Saxe, (2003) stated there are more mental health symptoms women experience who have been involved in domestic violence relationship, they include: feelings of helplessness and powerlessness, low self-esteem, sexual dysfunction, and self-medication with alcohol and/or other drugs.

Women who suffer from the domestic violence trauma mention above are more likely to experience some kind of mental health symptoms. According to Domestic violence and mental health policy initiative (DVMHPI, 2010), PTSD is the number one mental health symptoms suffered by women of domestic violence, percentage range from 54%-84%. Depression is ranked second between a range of 63% to 77% and anxiety ranks third between the ranges of 38% to 75%. In a research study completed by Edward et al., (2006) with a sample of 121 women involved in domestic violence affairs, result indicated at least 50.4% of the women suppressed moderate to severe depress symptoms, 32.5% had PTSD symptoms, and 14% had suicidal symptoms. The result of Edward et al. study is a little lower than DVMHPI indicates is the national average of women who

suffer such symptoms, but yet it still specifies there is a significant problem which needs to be addressed.

Purpose of this Project

The purpose of this project is to research and report the different types of mental health symptoms women of domestic violence experience. This will be determined through the evaluation of literature and different research which has conducted studies on the mental health outcomes in women of domestic violence. The following are specific question that will be addressed:

1. What role has the battered women movement and the Violence Against Women Act (VAWA) played in domestic violence?
2. How do race, culture, and social class a factor in the increasing rates of domestic violence?
3. What effect does domestic violence has on women and the possible mental health disorders?
4. What are the clinical/health factors of mental health symptoms of women in domestic violence?
5. What limitations do health professional encounter when assessing victims of domestic violence?
6. What is the feminist prospective on domestic violence?

Definition of terms

Domestic violence is defined as the behaviors used by a significant other in a relationship for the purpose of controlling or monitoring the behavior of another Tjaden & Thoennes, (2000). Domestic violence for the purpose of this project is defined as any

type of physical, psychological, economic, or emotional abuse a woman suffers by the behavior of their partner. Domestic violence and intimate partner violence (IPV) will be used interchangeably. Partner in this project is defined as a male spouse, significant other, or boyfriend (Jackson, 2007).

Limitations

The purpose of the project is to only determine the mental health symptoms women of domestic violence may endure. It is not intended to discuss any treatment options/plan for women of domestic violence. The paper does not discuss the affect and/or the role of alcohol or other substance abuse/addiction as it correlates to domestic violence. The research does not address the relationship of lesbians and/or bisexual relationship in relation to domestic violence.

Plan of Operation

For the completion of this project the resources utilized consisted of the Southern Illinois University at Carbondale library, I-Share, the internet, and government documents available online and/or through the library. The use of peer reviewed research articles will also be available for the completion of this project. The final project analysis will be completed August 2010.

CHAPTER 2

STUDIES AND RESEARCH

Battered Women Movement/Violence Against Women Act

It was not until the mid 1970's many American citizens began to realize domestic violence was a serious concern. This realization is due to the women advocating on behalf of the battered women movement (Jackson, 2007). As the concern for domestic violence began to circulate, many women of all races, culture, social statuses, and ages began to discuss their suffering (Jackson, 2007). The concern for women in domestic violence relationships led to the response and the enactment of the Violence Against Women Act (VAWA).

The VAWA is a legislation passed in 1994 as a component of Title IV of the Violent Crime Control and Law Enforcement Act (Jackson, 2007). VAWA was aimed to address and respond to violence against women (Cho & Wilke, 2005). It was implemented to advance statewide legislation against domestic violence perpetrators, enforce criminal justice against them, and assist women in intervention and social service programs. There are six different components of VAWA:

- “Safe streets for women (e.g., violence against women in the public),
- Safe homes for women (e.g., grants for domestic violence hotlines and shelters),
- Equal justice for women in the courts,
- Stalker and domestic violence reduction,
- Protection for battered immigrant women and their children, and

- Provision for strengthening existing law (Cho & Wilke, 2005).”

As a result of the VAWA domestic violence began to decline. According to Cho & Wilke, (2005) by 1997 domestic violence cases fell by 2.3% (9.8 to 7.5) per 1,000 women, but according to the authors only half on domestic violence cases are reported. In addition, reports of domestic violence cases increased from 48% to 59%. The different cases of domestic violence range from a level of physical abuse to psychological abuse.

Abuse Varieties

There are different forms of domestic violence in addition to physical violence. Other forms of domestic violence include psychological assault/violence, sexual violence, and economic control. Despite, the fact that physical violence may be viewed by society as the most brutal; all form of domestic violence is harmful within themselves.

Physical violence is the act of causing bodily harm/injury (Mills, 2008). Physical abuse can be as extreme as choking, kicking, and/or slapping, for example. The examples may sound minor but at the risk of many domestic violence victims it is a major concern. Physical violence is sought as the most dangerous form of domestic violence. Simply, because it can result in death at the hands of one’s partner (Mills, 2008). There is no certain characteristic which may define the looks, qualities, or actions of a physical abuser. Perhaps the most memorable case involving physical violence is the trial of O.J. Simpson. Many say the case of O.J Simpson was one of the causes leading to the legislation of VAWA (Jackson, 2007).

In 1994, O.J Simpson was accused of killing his ex-wife Nicole Brown Simpson and her friend- Ron Goldman (CNN.com). Before the death of the two there were

allegations that O.J. was physically violent with his wife and she left him due to the violence. According to CNN reports, Nicole's sister, Denise Brown reencountered stories of domestic violence her sister had endured. She recalled an incident in which O.J. picked Nicole up and threw her against the wall. She also stated the first report of domestic violence had taken place in 1977 something she later learned after reading her sister diary. Despite all the evidence/allegations of Nicole being abused, yet no one did or said anything. This is one major concern and why physical abuse is sought out as the most violent, when physical abuse escalate it may eventually result in death.

The case of Nicole and O.J. Simpson hit newlines as one of the top stories a little too late a woman's life had already been taken. In many cases of domestic violence women tend to suffer along, never disclosing the torment and terror they endure from the years of physical, emotional, sexual, or psychological abuse.

Psychological violence is also known as emotional and/or verbal abuse.

Emotional abuse is the most elusive, because it is hard to trace evidence of emotional abuse (Mills, 2008). One reason evidence is hard to trace is because emotional violence leaves no visible scars. The only thing one has to rely on is the word of the woman.

Verbal abuse is the act of using words as weapons against one's partner. Such examples of verbal abuse include cursing, threats, insults and sarcastic remarks. "You stupid little bitch!" is an example of a verbal threat used against women (Mills, 2008). Many women may tolerate verbal or emotional abuse because the attacker portrays events as if it is the woman's fault. Reflecting the blame on the women sometimes put them in the situation as if what they are doing is wrong or not good enough, and they believe they can make it better (Mills, 2008).

Sexual violence is the act of forcing or persuading one's partner to engage in sexual activities against her will (Mills, 2008). Many women are afraid of admitting to being raped by an intimate partner. They are afraid of being ridiculed or not being believed by another individual. Withholding sex is another form of sexual violence. The act of denying a partner the opportunity to fulfill their sexual desire or self-worth is very harsh. It diminishes a woman's self-esteem, and following that she begins to feel as if she is not good enough. One of the end results is the diminishing of her self-worth or the idea of doing whatever it takes to make things right: make him want/love me again (Mills, 2008).

Economic control is the act of allowing one's partner to become financial dependent on the other partner. Some forms of economic control are not allowing access to any money/bank accounts, giving one a spending limit/budget, and/or giving an allowance (Mills, 2008). In a case involving economic control a victim may even be employed and their partner may take all income and distribute it as they see fit.

Ellison et al., (2007) stated that nearly 30% of married and unmarried couples will experience some form of domestic violence within the span of their relationship. Of the 30% of women who experience intimate partner violence (IPV) they will become subject to the category of "at high risk" of developing mental health symptoms (Helfrich et al., 2008). Any form of violence is sought out as a concern because once it begins it can quickly be considered a norm for couples.

Myths vs. Facts

Myth 1: Women like to be battered or else they would leave (Richard, Letchford, & Stratton, 2008).

Fact 1: Many women of domestic violence make multiple attempts to leave their abuser, sometimes such action as, economic dependency, fear, lack of knowledge, and control from the abuser prevents willingness to leave

Myth 2: Many women of domestic violence provoke their abuser/partner.

Fact 2: No one provokes such violence. Women are not to be blamed for the actions of their partners'. Provocation is never an excuse for violence.

Myth 3: Domestic violence happens to poor/low-income women (Richard, Letchford, & Stratton, 2008).

Fact 3: Women of all social status may experience domestic violence. Police reports, service providers, and studies have proven domestic violence exists equally among all social classes.

Myth 4: Alcohol and drugs are the real causes of domestic violence

Fact 4: Some partners may use drug and alcohol during the course of a violent attack and it offers the partner an excuse to not partake in responsibility. Men who exhibit domestic violence are able to control their action, despite being drunk or high, by choosing to exhibit such behaviors in private. In addition, the two- domestic violence and substance abuse are two different issues, which should be addressed as two different concerns, receiving treatment for one- substance abuse; does not guarantee an end to the other.

Myth 5: Most assaults are just a couple of slaps, nothing serious.

Fact: A quarter of violent crimes are due to domestic violence. Domestic violence is the largest cause for female homicides cases. Any form of assault is serious and should be seen as a precaution in domestic violence cases (Richard, Letchford, & Stratton, 2008).

Barriers

There are many barriers which contribute to different causes of domestic violence. Many research articles explore the issue of race/culture and social class as it contributes to different domestic violence awareness. In relation to race being a factor in cases of domestic violence, there has been a lot of empirical evidence which supports reality or fiction in determining if race may be a factor in the percentage of domestic violence incidents.

African American women are seen among all ethnicity as women who experience the highest rates of intimate partner violence. Despite, the fact that white women are more likely to report crimes of domestic violence, the annual rate of non-physical domestic violence by the year 2004 was 8.2 per 1,000 for African American women and 6.3 per 1,000 White women. In comparison to Caucasian counter partners African American women are exposed to domestic violence 35% higher than White women (Mansley, 2009). Although it is understood that non-minorities women are exposed to domestic violence at the hands of a partner, there is limited research published within the last five years which hold accounts of Caucasian women and domestic violence. One justification may be that much of the growing research has focused on women in “ethnically diverse families” (Sokoloff, 2005). Despite the fact, there are limited recent studies completed on the relationship between Caucasian women and domestic violence, the relationship between African American women and domestic violence tends to be well documented (Sokoloff, 2005).

According to Sokoloff, (2005), African American couples reported a higher rate of domestic violence, a rate of 23%, followed by Hispanics at a rate of 17% and Caucasians 11%. When taking into consideration the level of severe violence, African

American women/wives were commonly subjected to domestic violence. In addition, Sokoloff, (2005) also stated that homicide is one of the top causes of death for African American women. Jackson (2007) stated that HIV is another consequence is association of domestic violence within African American women. The author goes on to state, in a First and Second National Family Violence Survey, African American men reported higher rates of spousal abuse than white men. Cases of severe act of violence were reported at 113 per1000 for black males versus 30 per 1000 for white males. Jackson (2007) also noted a study by Straus and his colleagues which reported wife-to-husband abuse between African American males and White males. The author also stated that, the increase of domestic violence within African American may be due to the lack of economic and socially disadvantage factors. The fact that many African American women are marginalized also exposes them to multiple traumatic experiences. The stereotype that a black woman are supposed to be strong and courageous limits many of them from displaying any signs of abuse at the hands of a partner and prevents them from seeking some forms of treatment (Jackson, 2007). Some other factors associated with domestic violence are believed to be culturally expected by some members of society.

Jackson (2007) noted a study by Staples 1982, in which he expressed the idea that racial discrimination by black men lead to the increased rates of domestic violence within their relationships. Staples goes on to state that, “anger and frustration” within the African American men toward society becomes displayed in their actions and their wives and girlfriends pay the cost by being abused. Staples also suggested that because men are unable to become the primary providers, something a man should do to establish their man hood, they find an alternative way to establish man hood which is through domestic

violence. The ability to provide financial stability is sought as the male responsibility in the African American culture and when he cannot live up to his manhood, he may see himself or believe others view him as not being a man (Jackson, 2007). Other publisher have documented that a shortage of men and women fear of being along causes African American women to give a man power over them or prevent her from leaving when he become abusive. Despite the fact that African American women appear to be more exposed to domestic violence at a high percentage they are not alone.

According to a recent study Hispanic women are 1.4 times more likely to be in relationships involving intimate partner violence. That is 53.2% compared to 51.8% for other ethnic groups. Welland & Ribner (2008) stated that previous research indicated there are three factors which play an important role in the stages of domestic violence in the Hispanic culture: urban city of residence, low income, and youthfulness regression. A Hispanic U. S. native was also found to be a high factor in the discovery of increased, resulting in an increase of 17.9%. According to Welland & Ribner (2008) previous research also indicated that the highest cases involving intimate partner violence were among Puerto Ricans at a rate of 20.4%, then Mexicans 10.5%, followed by Cuban 2.5%. One last factor considered was unemployment. Unemployment is seen as a factor because it may contribute to the male losing his supremacy/control and can cause disruption in the care he is suppose to provide for his family. The lost of employment results in tension among men in the Hispanic ethnic group.

Despite the fact that Asian American make up only 4.2% of the U.S. population, there have been a reported finding that at least 38% of Asians have identified knowing an Asian woman who has been shoved, pushed, or hit in some form. This rate may not be

alarming to other Asian Americans considering the fact that in the Asian culture, “hitting is a common type of discipline,” (Nguyen, 2005). Even though hitting may be seen as a type of discipline, in a study by Sokoloff (2005), only 12% of Asian American women reported any form of domestic violence, representing the lowest domestic violence rate of any cultural ethnic group. The study also considers factors, such as, Asians women presumed as hard working “model minorities” who could not be exposed to high rates of domestic violence Sokoloff (2005). The results of another study completed by Nguyen (2005), indicated that in an anonymous survey 81.1% of 178 Asian women reported experiencing some form of intimate partner violence and another 67% reported experiencing some form of partner domination (Nguyen, 2005). Is there just not enough research to determine the true rate of intimate partner violence in the Asian American culture, or are Asian American women truly the lowest ethnic group to experience any form of domestic violence? According to Sokoloff (2005), in a national study Asian American women reported being the least ethnic group exposed to domestic violence, which may be due to underreporting, but based on many self- reports domestic violence does appear to be a serious problem.

According to Sokoloff (2005), Native Americans are among the highest group of ethnic minorities to suffer from insufficient education, high unemployment, and other health related issues (i.e., diabetes and high mortality rates). Due to these factors the rate of domestic violence among Native Americans has increased at an alarming percentage. Hart & Lowther (2008) noted that Native American women are exposed to domestic violence 50% more often than African American. Despite having limited studies pertaining to domestic violence among Native American culture, there is evidence

domestic violence is a serious problem (Jones, 2008). The author also stated, that evidence from the National Violence Against Women survey revealed that 30% of Native American women have experience some form of domestic violence at the hands of a partner. In another study administered at the Indian Health Service it revealed that out of 347 women, (52%), had reported at least one incident of domestic violence (Jones, 2008). Jones (2008) also noted another study in which 91% of Southwestern Indians reported being abused by an intimate partner. This statistics suggest that domestic violence within the Native American community is more likely to occur within the ethnic group than individuals may perceive.

As noted, domestic violence cases are not shaped by race, but race can define the intensity of domestic violence incidents (Sokolof, 2005). While race is one factor in determining the percentage of domestic violence women of different ethnic groups may be exposed to, there are others. A different factor is a woman's social status. According to Sokolof (2005) many minorities are faced not only with the disadvantages place on them by society because of their ethnicity, but they also live in a world where their social class can define nearly everything. Even though race/culture and social class are two different factors in determining raters of domestic violence incidents it is a hard task to separate race and class in relation to domestic violence (Jackson, 2007).

Social class

Many researchers have expressed the idea that women living in extreme poverty are at higher risk of being in relationship resulting in domestic violence. In society when we hear the words domestic violence, we tend to paint a picture of low-income women,

minority woman, why? Does social class really determine the level/forms of domestic violence?

Some research has indicated that poverty and homelessness display some major factors in the evidence of intimate partner violence. According to Hattery, (2009) women of domestic violence come from different social status and all ethnic groups. Jackson (2007) stated that existing literature place higher cases of domestic violence within the middle and upper class, despite the fact, that majority of research suggest a high correlation between lower class women and domestic violence. However, women of higher social status cases of domestic violence are not accumulated in the data of domestic violence because we rely on the victims stories through biographies, court records, or therapy transcripts. Domestic violence in the upper class ranks from Anna Quindie-writer for the New York Times to Farrah Fawcett- actress and sex symbol (Hattery, 2009). Due to the fact, they are upper class women many of their stories are never heard outside of therapy sessions or close friends/family. The same response is not given to low-income, poor women.

Hattery, (2009) stated that one factor of domestic violence cases is a woman's second class status. Many women who have been exposed to domestic violence did not have a high school diploma or GED, and limited access to financial resources. According to Mansley, (2009) different researches suggest high levels of poverty within African American are one of the main factors they are exposed to a higher rate of domestic violence. The author also stated that because poorer women have limited resources it is hard for them to keep their abuse private and not have police officers involved. They do not have to money to pay for hotels or private medical services; therefore they only have

shelter and emergency rooms to seek for help. This may be seen as one of the main reason women of lower social economic status are thought of as having the highest incidents of domestic violence assaults, despite what some recent literature may suggest.

Jackson (2007) examined a research completed by Wyke, Benson, and Fos in 2003. The research suggested that factors within a woman's neighborhood were related with increased rates of domestic violence. Another study conducted by the same authors verified there is a correlation between social disorganization and domestic violence. The study also suggested that neighborhoods which were socially and economically deprived were exposed to higher rates of violence between women and their partners. Social class has been associated with higher rates of domestic violence incidents prior to the grassroots of the domestic violence movement (Jackson, 2007). Different research and literature suggest that incidents of domestic violence occurs throughout all levels social class, yet society only paint the picture of poor minority women and domestic violence.

CHAPTER 3

RESULTS, RECOMMENDATION, CONCLUSION

Limitations in the clinical health setting

Many abusers attempt to prevent the women whom they abused from seeking health care. Prevention is one mechanism partner's used to remain in control (Plat-Jones, 2006). Prevention is also a serious concern given the thought of what may happen to a woman if she returns to her partner after seeking medical attention.

Women exposed to IPV frequently seek assistance, safety, and shelter at a clinical setting/emergency room. Yet, health professionals generally lack the knowledge and services provided needed to assist women of domestic violence. The lack of knowledge and training has made it hard for health professionals to address the issues and concern of women in domestic violence relationships (Plat-Jones, 2006). It also makes it difficult to address the mental health concerns many of the women may be suffering. Therefore, it is necessary for health professionals to provide care and develop assessments to recognize mental health symptoms associated with domestic violence. Health care professionals should be alerted to the possibility of mental health consequences if they are treating a patient suffering from domestic violence. Training sessions for health professional has been advocated to distinguish the characteristics between a woman of domestic violence and non domestic violence relationship in a medical facility/emergency room (Hamberger & Phelan, 2004). The training sessions will provide health care professionals with the skills and ability to act on their observations, preparation to ask necessary questions, and give appropriate responses.

Plat-Jones (2006) noted that a 2000 article by Massa et al. suggested that healthcare professionals often fail to address the issue of domestic violence fearing that other problems may arise which they do not have the time to address. Health professional who fail to address the issue domestic violence contribute to the risk of the victims returning to their abuser, increased exposure to domestic violence, and a higher risk of developing mental health issues (Plat-Jones, 2006). In addition, to health professionals not wanting to intervene, there are additional concerns as to what methods they should go about in trying to intervene in the treatment process of women suffering from abuse.

One hundred forty-four women in a domestic violence shelter were surveyed in a study by Thakeray et al., (2007). The surveyed asked 17 multiple choice, Likert questions including, how the victims heard of and was referred to the shelter- including assistance from the clinical health settings. Responses revealed that women are more comfortable disclosing domestic violence in the present of another woman. Even though the race of the professional woman did not display a significant difference, some victims did indicate they would prefer a professional of the same race. The study also revealed 67% of women in IPV prefer optional questions or a health history form be administered by health professionals (Thakeray et al., 2007). The second type of preferred method was handouts detailing available information or additional places to seek assistance.

Health professionals have a responsibility to treat patients within their facility. In addition professionals should acknowledge domestic violence as a serious mental health concern. The longer women in domestic violence relationship mental health status remain untreated the longer it takes for the women to receive treatment and live an

independent and normal life. Due to the empirical evidence showing women mental health status tend to go undetected many women live years and are undiagnosed with the possible mental health symptoms women of domestic violence experience.

Mental health symptoms

Victims of domestic violence experience a wide variety of physical injuries, mental health symptoms and/or death (Ellison et al., 2007). For the purpose of this paper the focus will be on the variety of mental health issues incurred by women of intimate partner violence. PTSD, depression, and suicidal ideation are three common mental health symptoms found in women who have been exposed to intimate partner violence. According to the American Bar Association, 56% of women who are exposed to IPV are diagnosed with a mental health disorder, 45% suffer from PTSD, 46% are diagnosed with an anxiety disorder, 37% of IPV women suffer from symptoms of depression and 29% of all women who attempt suicide were victims of domestic violence.

PTSD is a diagnostic of a mental disorder The DSM-IV defines PTSD as a mental disorder which is often used in reference of women suffering from domestic abuse (Jackson, 2007). The criteria for being diagnosed with PTSD include:

- “A history of exposure to traumatic events,
- intrusive recollection (i.e., experiencing the traumatic event),
- avoidant/numbing (i.e., denial or dissociation),
- hyperarousal (i.e., anxiety, panic attacks, or fearfulness) (Jackson, 2007).”

PTSD in relation to women of domestic violence does not focus on the generalization of women being helpless or ineffective. The alternative focus of PTSD in correlation to battered women is the psychological disturbance experienced by the

woman due to exposure of domestic violence (Jackson, 2007). A person suffering from PTSD and remembers the exposure to a traumatic events is a major psychological experience that remind victims of the pain, terror, grief, or despair. PTSD can limit a woman ability to develop and maintain daily life skills, which are necessary for her to become self-sufficient and independent (Helfrich et al., 2008). PTSD makes it impossible for women to perform work task and be consistent on any assignment. In addition, women of domestic violence experiencing PTSD often avoid the public scenery, resulting in their isolation and dependency.

A study by Helfrich et al., (2008) stated that 55%-92% of women exposed to domestic violence within their relationship will experience mild to severe PTSD. The level (mild or severe) of PTSD among abused women has been correlated to the harshness and level of regularity in domestic violence. Women who may have endured domestic violence for years may be at risk of being diagnosed with severe PTSD in comparison to a woman who may have been exposed to IPV for only a month.

In a research article by Pico-Alfonso et al. (2006) 182 women were sampled in the study. 130 of the 182 women were victims of domestic violence the remaining 52 women were examined as the control group and were in a nonviolent relationship. The study was an interview given by four trained psychologist, who asked the women about their life and health. The three mental health symptoms assessed were depression, anxiety, and PTSD (for now only PTSD will be discussed). The extent of PTSD was evaluated with Echeburua's Severity of Symptoms Scale of PTSD. "Echeburua's Severity of Symptoms Scale is a structured interview based on the DSM-IV criteria of a PTSD disorder (Pico-Alfonso et al., 2006). The results of the study revealed that all of

the women who were exposed to some form of domestic violence also suffered from a psychological disorder. The severity of PTSD and the other mental health disorders were all correlated to exposure of domestic violence, higher than expected at a rate of 62.5% (Pico-Alfonso et al., 2006). There was positive correlation of IPV and PTSD ($r=0.69$, $n=182$, $p<.001$). The result of the Pico-Alfonso et al. study indicated that domestic violence has a negative effect on women's mental health status and increases the risk of being diagnosed with PTSD or depression. The study also revealed that majority of women exposed to domestic violence with a diagnosis of PTSD also have some symptoms of depression.

Depression is common mental health disorder associated with women of IPV. Helfrich et al., (2008) stated that 35-70% of domestic violence victims are at risk of developing depressive symptoms. Depression is a concern for women of domestic violence, due to, the frequency, persistence, and interference with daily life activities. Depression may affect a woman's ability to maintain a healthy relationship, resulting in social isolation and limited financial support. Women suffering from IPV are six to seven times more likely to be diagnosed with depression (Jackson, 2007). The frequency of abuse also increases the possibility of depression diagnosis. Depressed victims require time and patience when accessing the root of the problem, not just prescribed medication, because a treatment of the disorder alone does not eliminate the victims' doubt of not being at fault (Jackson, 2007).

A study by Filson et al., (2010) explores the correlation between IPV and depression. The study sampled 327 female college students. The Revised Conflict Tactic Scale (CTS) was used to evaluate the level of dating violence. Dating violence refers to

whenever a female goes out on a date with a male and experience violence, also known as premarital violence (Jackson, 2007). The Center for Epidemiological Study Depression Scale (CES-D) was used to evaluate symptoms of depression among the women. In relation to ethnicity 51.7% were Caucasian 18.0% were Hispanic, 18.0% were Asian, 7.3% were Other, and 4.9% were African American. A twenty item questionnaire in a Likert-Scale format was used to ask a variety of question related to the women current mood. The internal reliability of the scale was .91 (Filson et al., 2010). The hypothesis explored by the authors is “does different meditational pathways explain the powerlessness in intimate violence-depression link.

The results of the study indicated there was a significant correlation between CTS and CES-D, $r(1, 324) = .214, p < .001$, revealing that more violence creates more depression. The finding of the current study expanded on what many other authors suggested, revealing that IPV has an influence on the mental health status of women. In addition, the findings found that are connections between domestic violence, powerlessness, and depression (Filson et al., 2010). Filson et al., (2010) noted there was also a meditational relationship among the three variables (powerless, violence, and depression). The findings revealed that high levels of violence lead to powerlessness, which resulted in depression. The authors also noted that the findings unveiled the more levels of violence the women reported, the higher levels of depression they encountered. The researchers also founded that women who lacked power in their violent relationships were more depressed than women who may have had a little control. Many authors have research the linkage between women in domestic violence relationships and depression. Researchers have exposed there is a correlation between IPV and depression and others

stated there may be a correlation between depressed domestic violence victims and suicide or suicidal ideation.

Women exposed to domestic violence also experience suicidal ideation. Suicidal ideation is defined as the contemplation of killing yourself (Chan et al., 2008). Women exposed to domestic violence are eight times more likely to commit suicide or suicide attempts than women of non-violent relationships (Jackson, 2007). The rate of suicide can also depend on the relationship status. Married women in violent relationship are at an increase level of suicide attempts, but pregnant women have a higher rate of suicidal ideation than married women. Chan et al., (2008) stated that suicidal ideation in battered women are higher than non-battered women, ranging from 20%-26%. According to Jackson (2007) women who suffer physical and psychological abuse at the hands of a partner commonly consider suicide. Jackson and other researchers have stated that women in domestic violence relationship may have other contributing factors that lead to suicidal ideation, for example, nervous breakdowns, depression, low self-esteem, or PTSD. The author also states that women are more likely to consider suicide when they are in a domestic violent relationship, feels powerless, and lacks social support.

A study by Seedat et al., (2005) researched the correlation of domestic violence in a sample of 637 women. The demographic are as followed: 52.7% White, 45.9% African American. The majority of women in IPV was White, married, high school graduate, and employed. The women were given telephone surveys and the final response was 71%. The hypothesis was to test the relevance of IPV in a sample of women and to explore its correlation with childhood maltreatment, substance misuse, PTSD, and suicidal ideations.

Results of the study were explained separately; therefore the discussion will only focus on suicidal ideation.

The results revealed that 23% of the women in domestic violent relationships reported having suicidal thoughts at one time during their violent relationship ($p < .0001$, $OR = 4.07$). The results indicated what other studies have noted; there is a correlation between IPV and suicidal ideation. Seedat (2005) researched a study conducted in 2000 by Kaslow and colleagues on African American women in domestic violent relationships. The study indicated that African American women in domestic violent relationship had a higher rate of suicide attempts than women in non-violent relationship. Seedat et al. and Kaslow's research have extended empirical research on the correlation between domestic violence and suicidal ideation. Even though there is evidence that women in domestic violent relationship experience high level of suicidal ideation, there is not many intervention program implemented to help women of domestic violence face the coping mechanism.

Naved & Akhtar (2008) stated that understanding the factors correlated with suicidal ideation is an important aspect to address the problem related to women of IPV and suicide. The authors advocate a need to implement suicide prevention programs for victims of domestic violence. In addition, suicidal ideation is a reflection of other mental health disorders, suicide itself and other mental health issues is worthy of an intervention process starting in the clinical health setting.

Recommendation

Medical institutions implement protocols for screening and referring domestic violence victims, such protocols include:

- Training/increased awareness/educate (Thackeray et al., 2007);
- Assess for symptoms of domestic violence;
- Create a victim-centered and pleasant atmosphere;
- Begin the conversation with domestic violence victims (Jackson, 2007);
- Implement a screening protocol/review client's history (Thackeray et al., 2007);
- Determine risk assessment (Humphreys, C., 2008);
- Develop strategy for suitable care;
- Document all findings;
- Provide referral sources- for counseling, shelter, or other social services agencies (Thackeray et al., 2007);
- Provide follow-up care (Plat-Jones, 2006);

According to Jackson (2007) it is easier to begin a conversation with a victim of domestic violence if the clinical setting has posters or other visible messages displayed throughout the clinical setting. Having messages displayed throughout the environment is a good way to phase important questions that need to be addressed. Unfortunately if there are no visible messages a professional can start a friendly conversation with a patient, for example they may start by saying, "As you may know, abuse by a partner- is unfortunately very common in our society, including in my own practice. Because of this I am now asking every patient if she/he is safe at home and in her/his relationship (Jackson, 2007)." This frame of response allows the victim to begin to feel comfortable with talking to the professional and allows the health professional to start an assessment and possibly expose any mental health disorder.

Conclusion

Domestic violence among women has been a serious health and social concern prior to the 1970's. Because of the action taken by women in the 1970's it led to the first Battered Women Movement. As of today there is still no quick solution to fix the problem of domestic violence. As rehabilitation professionals we face the daily task of helping individuals with a disability. While being a victim of domestic violence is not considered a disability, the trauma and possible mental health disorders women may incur are among the many different types of disabilities. Working in the field of rehabilitation we have to understand and acknowledge that even though mental health diagnosis (i.e. PTSD, depression, etc.) are the primary disability, domestic violence is still a secondary concern. It is difficult to address the primary concern without addressing the secondary concern as well.

The intention of this research paper was to address the mental health issues of women in domestic violent relationship. This was achieved by analyzing research article, books, and online publications. The implication of this paper suggested that women of domestic violence are at a higher risk of being diagnosis with three common mental health disorders; PTSD, depression, and suicidal ideation. Yet, many healthcare professional does not want to address the issue of domestic violence when assistant patient. Some professionals believe assisting women of domestic violent relationships is a waste of time. They believe they will return to their abuser anyway, so why assist them. Other professional just does not feel comfortable with addressing the issue of domestic violence, the fear tearing apart a family. One way to overcome the fear of simply carelessness in the profession is to implement a mandatory assessment process for

all victims believe to have encountered any form of domestic violence. If the healthcare professionals do not take the time to assess the women and determine their possible mental health diagnosis, how can we as rehabilitation professional begin to address the issue? We cannot, since domestic violence is not a disability in accordance with the DSM-IV some of the women may never seek the assistance need to overcome a disability they are not certain they have.

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