Chapter 1: Introduction and Theories

Introduction

Take a moment to think about the words “domestic violence.” What images come to mind? Do you think about a submissive, middle aged-woman being beaten by her alcoholic husband? Do you think ‘why doesn’t she just leave?’ or ‘Not in my practice, hospital or agency.’ The reality of domestic violence is that while these stereotypes fit some situations, they do not even begin to touch upon the scope of the problem. Many mental health practitioners are working with clients experiencing current domestic violence, and are unaware that it is occurring because of the shame that is often associated with it.

The National Coalition Against Domestic Violence defines domestic violence as “the willful intimidation, physical assault, battery, sexual assault, and/or other abusive behavior perpetrated by an intimate partner against another.” While there have been studies of domestic violence from a cultural perspective, domestic violence affects individuals in every community, regardless of age, economic status, race, religion, nationality or educational background. Domestic violence is often accompanied by emotionally abusive or controlling behavior, and thus is part of a systematic pattern of dominance and control. There are many consequences associated with domestic violence including physical injury, psychological trauma, and sometimes death.

There are factors that often occur co-morbidly with domestic violence, including family dysfunction, inadequate communication skills, stress and economic hardship. Alcohol abuse is present in about 50 percent of battering relationships. Personality disorders and mental illness may also compound domestic violence. While these issues are associated with the domestic abuse, they are not the cause, nor will the removal of these factors mitigate or stop it.

This course will provide an introduction to domestic violence, including prevalence and impact, laws, and the cycle of violence. The terms domestic violence, domestic abuse, and intimate partner violence will be used interchangeably throughout the text. The author has chosen to limit use of the word “battering,” which although still prevalent in the popular lexicon may suggest that domestic violence is confined to physical violence only.

Upon completion of this chapter you will be able to:

1. Define domestic violence and the term “intimate partner.”
2. Discuss prevalence of domestic violence.
3. Describe some factors associated with domestic violence.
4. Compare and contrast the various approaches to, and theories of, domestic violence.
5. List the warning signs of domestic violence.
Defining Domestic Violence

Case Vignette
Sarah Ann is consulting with Dr. Jenkins. During the intake Dr. Jenkins is aware of a number of behaviors which draw his attention to the idea that Sarah Ann may be experiencing domestic abuse. When asked about her marital status, she fearfully replies that she is married, and asks whether Dr. Jenkins will be talking to her husband. Similar concerns arise when Dr. Jenkins describes confidentiality. When Dr. Jenkins gently reflects that Sarah Ann seems scared and asks for the source of her fears, Sarah Ann breaks down and reveals that her husband had become increasingly angry and frustrated, that he had pushed her roughly, and that she was fearful that he could become violent.

Domestic violence is often called battering or wife beating, however, domestic violence is not limited to physical abuse, but most often includes other types of violence. The Introduction provided a more comprehensive definition of domestic violence (also called intimate partner violence): “the willful intimidation, physical assault, battery, sexual assault, and/or other abusive behavior perpetrated by an intimate partner against another.”

There is some variability in the use of the term “intimate partner.” This also relates to the varying perspectives of domestic violence (e.g., psychological, legal). The varying perspectives on domestic violence will be detailed in a subsequent section of this material. With regard to the legal definition, states differ on the type of relationship that qualifies under domestic violence laws. Most states require the perpetrator and victim to be current or former spouses, living together, or have a child in common. A significant number of states include current or former dating relationships in domestic violence laws. Delaware, Montana and South Carolina specifically exclude same-sex relationships in their domestic violence laws.

This training material will take a broader view of the definition of intimate partner, defining the term as a particularly close interpersonal relationship that involves physical or emotional intimacy. With this broad definition, intimate partners may be married unmarried; heterosexual, gay, or lesbian; living together, separated or dating, spouses or ex-spouses, nonmarried co-habitating partners or partners in a romantic relationship. Intimate partners can also be any age, including teens and the elderly.

While the majority of reported domestic violence occurs against women, men are also victims of domestic violence. According to a study by Tjaden and Thoennes (2000) 835,000 men in a national survey reported being victims of domestic violence. Domestic violence against men can take many forms, including emotional, sexual and physical abuse and threats of abuse. It can happen in heterosexual or same sex relationships. As with many forms of abuse, these numbers are likely underreported due to misunderstanding of the definition of
domestic violence and the shame that men may feel in identifying themselves as abuse survivors.

Examples of domestic violence include (Berry, 2000):

**Intimidation or emotional abuse.** Emotional abuse (also called psychological abuse or mental abuse) includes behaviors that make the person feel diminished or embarrassed. Emotional abuse can include verbal abuse and is defined as any behavior that threatens, intimidates, undermines the victim’s self-worth or self-esteem, or controls the victim’s freedom (Follingstad, & DeHart, 2000) This can include threatening the victim with injury or harm, telling the victim that they will be killed if they ever leave the relationship, and public humiliation. Abusers will often employ criticism and fault-finding, which may be a precursor to physical violence, but may also accompany it. This may also include withholding money or affection as a means of controlling the other person, threatening abandonment, hurting or threatening children or pets, or isolating the person from friends and family.

**Economic or financial abuse.** Abusive partners may use access to money as a means of control. Economic or financial abuse includes: withholding money or credit cards, withholding basic necessities (food, clothes, medications, shelter), sabotaging the person’s job (such as making them miss work or calling constantly), stealing from you or taking money.

**Physical violence** comprises any behaviors that injure the other person or to cause physical pain. Physical abuse can also include behaviors such as denying the person needed medical care, depriving the person of sleep or other functions necessary to live, or forcing the victim to engage in drug/alcohol use against his/her will.

**Sexual abuse** is any situation in which force or threat is used to obtain participation in unwanted sexual activity. Sexual abuse may involve a wide range of behaviors. The important component here is that the behavior is non-consensual or makes the other person feel demeaned or violated. It may include rape, forcing someone to perform sexual acts that he/she finds unpleasant, forcing someone to have sex with others or watch others, forcing someone into reproductive decisions.

**Stalking** can be defined as the willful and repeated following, watching and/or harassing of another person. While stalking does not always occur within an intimate partner relationship, it has become an area of increasing concern in the domestic violence literature.

*Case Vignette*
Jennifer has recently separated from her husband Jon and plans to file for divorce. She has been subjected to repeated phone calls, text messages, and emails telling her that Jon will “never let her go.” The content infers that he has intimate knowledge of her movements. Jennifer has been told by police that there is nothing they can do since the messages are not “threatening.” Most recently, Jennifer’s has begun to receive “gifts,” of flowers and chocolates, which appear on her apartment doorstep and car windshield. She is certain they are from Jon. Jennifer describes feeling as if she is in a constant state of panic.

Nearly 60 percent of women and 30 percent of men are stalked by a current partner (Tjaden & Thoennes, 1998.) The majority of stalking victims are women (78 percent), and the majority of offenders (87 percent) are men. (Tjaden & Thoennes, 1998).

As in the case vignette, stalking can be seen as "a course of conduct directed at a specific person that involves repeated (two or more occasions) visual or physical proximity, nonconsensual communication, or verbal, written, or implied threats, or a combination thereof, that would cause a reasonable person fear" (Tjaden & Thoennes, 1998). While there is a range of stalking behaviors, they may include leaving or sending the victim unwanted items or presents, damaging the victim’s home, car or other property, following or waiting for the victim, or leaving unwanted messages or other actions intended to control the victim.

With increasing use of technology, cyberstalking has become more prevalent. Some examples of cyberstalking are: researching the victim using public records or on-line search services, monitoring phone calls or computer use, and using technology, like hidden cameras or global positioning systems (GPS), to track the victim’s movements.

Like other forms of domestic violence, stalking usually escalates. It is a behavior that should be taken seriously and mental health clinicians may benefit from being aware of specific laws in their states of practice.
Prevalence of Domestic Violence

How widespread is domestic violence? Domestic violence is one of the most chronically underreported crimes (U.S. Department of Justice, Bureau of Justice Statistics, 2003). There is a great deal of stigma associated with intimate partner violence. While there are many reasons for stigma, Mitchell and Anglin (2009) believe that victims of domestic violence feel that the abuse is a result of a personal flaw and do not disclose the abuse due to shame. There are other reasons as well including family loyalty, fears of breaking up a family, and distrust of authority and the efficacy of authority figures.

It is believed that only one-quarter of all physical assaults, one-fifth of all rapes, and one-half of all stalkings perpetrated against females by intimate partners are reported to the police (Tjaden, & Thoennes, 2000).

Research on intimate partner violence against women has exploded in the past 20 years, but despite this increase in research, many gaps exist in our understanding of domestic violence. To further understanding of domestic violence against women, the National Institute of Justice and the Centers for Disease Control and Prevention conducted a national survey entitled The National Violence Against Women (NVAW) Survey (Tjaden, & Thoennes, 2000). The researchers sampled both women and men.

Some of the key findings are:

- Physical assault is widespread among adults: An estimated 1.9 million women and 3.2 million men are physically assaulted annually in the United States.

- Approximately 1.3 million women and 835,000 men are physically assaulted by an intimate partner annually in the United States.

- Violence against women is primarily intimate partner violence: 64.0 percent of the women who reported being raped, physically assaulted, and/or stalked since age 18 were victimized by a current or former husband, cohabiting partner, boyfriend, or date. 16.2 percent of the men who reported being raped and/or physically assaulted since age 18 were victimized by such a perpetrator.

- Stalking is more prevalent than previously thought: 8.1 percent of surveyed women and 2.2 percent of surveyed men reported being stalked at some time in their life; 1.0 percent of women surveyed and 0.4 percent of men surveyed reported being stalked in the 12 months preceding the survey. Approximately 1 million women and 371,000 men are stalked annually in the United States.
- Almost one-third of female homicide victims that are reported in police records are killed by an intimate partner. In 70-80% of intimate partner homicides, no matter which partner was killed, the man physically abused the woman before the murder (Campbell et. al., 2003).

- For both men and women, divorced or separated persons were subjected to highest rates of intimate partner victimization, followed by never-married persons (Rennison, & Welchans, 2000).

While these numbers are eye-opening, domestic violence impacts other areas as well. Intimate partner violence results in more than 18.5 million mental health care visits each year; the cost of intimate partner violence exceeds $5.8 billion each year, $4.1 billion of which is for direct medical and mental health services (CDC, 2003).

With prevalence ratings this significant, it is likely that most mental health professionals will work with a current or past victim of intimate partner violence.

### Theories on Domestic Violence

While have been many efforts to explain why domestic violence occurs, there is no one explanation. While a common understanding of the causes of domestic violence can help practitioners develop more effective responses to domestic violence, this is not an easy task with the many perspectives regarding intimate partner violence. Mitchell and Anglin (2009) summarize this in the chart below. Several of these perspectives will be detailed further.

<table>
<thead>
<tr>
<th>Group</th>
<th>Population studied</th>
<th>Conceptualization</th>
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<tbody>
<tr>
<td>Psychological/Medical</td>
<td>Patients seeking care</td>
<td>Violence as a result of frustration; as a cause of presenting symptoms; trauma response</td>
</tr>
<tr>
<td>“Family Violence” Researchers</td>
<td>College students, general population</td>
<td>Violence as a response to intermittent conflict</td>
</tr>
<tr>
<td>Domestic Violence Movement, Feminist Researchers</td>
<td>Women seeking services; men in “batterer” programs</td>
<td>Violence is part of a coercive pattern of behavior meant to establish power and control</td>
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<tr>
<td>Legal System</td>
<td>Crime victims and perpetrators</td>
<td>Violence as a criminal act</td>
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Although many of these systems may seem to offer contradictory views of domestic abuse, another perspective is that they can all provide information that increases understanding of domestic violence.

**Psychological Framework**

*Frustration-Aggression Theory*

Dollard (1939) was one of the first writers to identify a theory that was applied to intimate partner violence: the frustration-aggression theory. Simply put the theory states that when people perceive that they are being prevented from achieving a goal, their frustration is likely to turn to aggression. Aggression, then, is seen as an instinctual response to frustration. When applied to intimate partner violence, marital/dating relationships can trigger anger (justified frustration) or aggression (unjustified frustration).

*Social Learning Theory*

The Social Learning Theory is a popular way to explain violent behavior. Social learning theorists reject the idea of instinct, and instead believe that “human aggression is learned conduct that, like other forms of social behavior, is under stimulus, reinforcement, and cognitive control.”

According to social learning theory, family violence arises due to many contextual and situational factors. Examples of contextual factors include individual/couple characteristics, stress, or an aggressive personality. Situational factors include substance abuse and financial difficulties. Social learning theory also extends these factors onto the influence of children growing up in families in which these external forces exist (Domestic Violence Group Action Project).

Although the relationship is not entirely straightforward, there does seem to be some support for the learned behavior theory of violence. The strongest risk factor for males who become perpetrators of domestic violence is witnessing violence between one’s parents or caretakers (Break the Cycle, 2006). Boys who witness domestic violence are *twice as likely* to abuse their own partners and children when they become adults (Strauss, Gelles & Smith, 1990) 30% to 60% of perpetrators of intimate partner violence also abuse children in the household (Edelson, 1999). Witnessing violence in the home seems to provide these young men with lessons that validate that it’s appropriate to control women and that physically acting out is one way to do so.

The relationship between witnessing domestic violence and acting out or entering an abusive relationship is not as clear-cut for women. There have been virtually no studies of women who become domestic abusers. Research does show that women who witness domestic violence are not any more likely to be battered as
adults. Women who were physically or sexually abused as children, however, may be more likely to be abused as adults (Family Violence Prevention Fund).

**Cognitive-Behavioral Theories**

Cognitive-Behavioral theorists look at how a person perceives, interprets, and processes the events in any given situation (Todd & Bohart, 1994). Aggressive behaviors are influenced by what a person perceives and interprets prior to the aggression. Changing these thought patterns, then, will contribute to a change in behavior.

CBT also emphasizes that violence and aggression are choices. People cannot be ‘forced’ to act abusively, a cognitive-behavioral approach encourages the individual to acknowledge that they chose to behave in the way that they do.

A common CBT intervention is an *anger log*. This log encourages individuals to monitor and record the thoughts and behaviors which immediately preceded violent outbursts (Koonin, Cabarcas, & Geffner, 2002). This anger log is like other cognitive-behavioral thought logs but also includes awareness of the person’s physiology prior to aggression.

**Feminist/Domestic Violence Movement Framework**

Emphasis on the importance of addressing domestic violence dates to the 1970s, which also coincides with a boom in feminist approaches to psychology. The feminist/domestic violence movement explains domestic violence as a result of “historically created gender hierarchy and sexual division of labor in the home, in which men dominate and control women” (Messerschmidt, 1986). In addition to looking at power/gender inequalities, an important part of the feminist approach is in educating society about the problem of intimate partner violence.

Many authors have written about the link between domestic violence and power and control dynamics in the relationship. One commonly used paradigm is The *Power and Control Wheel* (Domestic Intervention Programs, Duluth, Minnesota). It was developed based on focus groups of women who had been victims of domestic abuse.

The *Power and Control Wheel* describes the different tactics that are used by abusive individuals to maintain power and control over a partner. The Wheel is depicted below.
What is significant about this depiction is that it looks at domestic violence as part of a larger pattern of behavior rather than a single (although repeated) loss of control.

As an outgrowth of other research, domestic violence professionals have attempted to look at individual and familial variables in domestic violence. Crowell (1996) was one of the first researchers to conduct a study of family violence in the United States. She correlated domestic violence with households below the poverty line, racial minority households, and heads of household being 18-30 years old. These characteristic produced high degrees of stress. Straus et al. (1990) found that in middle or upper class households, family violence was much more sheltered.

There is also a body of research and antidotal information on individual factors that may heighten the risk of potential abuse (Alabama Coalition of Domestic Violence). Males who abuse may display the following:

- Jealousy
- Controlling behavior
- Quick involvement
- Unrealistic expectations
- Isolation of victim
- Blames others for his problems
- Blames others for his feelings
- Hypersensitivity
- History of past battering
- Threats of violence
- Breaking or striking objects
- Any force during an argument
- Objectification of women
- Tight control over finances
- Minimization of the violence
- Manipulation through guilt
In addition to identifying the characteristics of abusive men, domestic violence researchers have also developed a schema for what they term the “cycle of abuse. This classic conceptualization was developed by Lenore Walker in the 1970s (Walker, 1979).

Tension Building Phase
Characterized by poor communication, tension, fear of causing outbursts. During this stage the victims try to calm the abuser down, to avoid any major violent confrontations.

Violent Episode
Characterized by outbursts of violent, abusive incidents. During this stage the abuser attempts to dominate his/her partner(victim), with the use of domestic violence.

Honeymoon Phase
Characterized by affection, apology, and apparent end of violence. During this stage the abuser feels overwhelming feelings of remorse and sadness. Some abusers walk away from the situation, while others shower their victims with love and affection.

Calm Phase
During this phase (which is often considered an element of the honeymoon/reconciliation phase), the relationship is relatively calm and peaceable. However, interpersonal difficulties will inevitably arise, leading again to the tension building phase.

Case Vignette
Anna has been attending therapy sessions, a bold move considering how fearful she is that her physically abusive husband will discover it. Following a particularly brutal encounter, she tells her therapist that she feels that her husband has “finally made a change.” He appears attentive, and has even brought her flowers, something that has not occurred since their earliest years together. Although her therapist cautions that abusive situations are very difficult to change without therapy and support, Anna is shocked when he again hurts her after an argument.
**Integrative Models**

*The Socio-Ecological Model*

The Socio-Ecological Model (Heise, 1998) attempts to integrate many of these approaches as a means of creating change. As depicted in the graphic below, this model places individual characteristics within the family/relationship, the individual and family within the community, and the individual, family and community within society.

![Socio-Ecological Model Diagram](image_url)

When applied to domestic violence prevention, this framework allows for development of specific interventions. For example, an individual factor may include use of power and control, and an appropriate strategy may be coaching. This must be viewed, however, within the larger societal context. For example, domestic violence may be associated with historical patterns that glorify violence against women and a strategy may include public education campaigns.

**Warning Signs of Abuse**

The following warning signs may alert practitioners to the possibility of abuse.

*Psychological warning signs of abuse*

- Depression, anxiety, or suicidality or post traumatic stress symptoms.
- Clients that display outbursts of anger or poor impulse control.
- Clients that display extreme hypervigilance
- Clients that have very low self-esteem, or report that they used to be confident.
- Clients that demonstrate major personality changes (e.g. an outgoing person becomes withdrawn).
General warning signs of domestic abuse

- Secrecy about entering therapy, in particular keeping the decision from a partner or spouse.
- Clients that seem overly afraid or anxious to please their partner, or who go along with everything their partner says and does.
- Clients that check in often with their partner to report where they are and what they’re doing.
- Clients that receive frequent, harassing phone calls from their partner or who are constantly checking the cell phones for messages from a partner.
- Client who talk about their partner’s temper, jealousy, or possessiveness.

Warning signs of physical abuse

- Clients that have frequent injuries, with the excuse of “accidents.”
- Frequently missing appointments without explanation.
- Clients that dress in clothing designed to hide bruises or scars (e.g. wearing long sleeves in the summer or sunglasses indoors).

Warning signs of isolation

- Clients who report being restricted from seeing family and friends.
- Clients that rarely go out in public without their partner.
- Clients that have limited access to money, credit cards, or the car.
References


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


Chapter 2: The Effects

Introduction

Case Vignette

Dr. Katz has been working with Kelly, a 46-year-old client for a month. The primary focus of counseling to this point in time has been Kelly’s anxiety. As a nurse at a local hospital, she has talked about the stresses that job entails. Dr. Katz is surprised, however, to learn that Kelly has been fired from her position. As she breaks down in Dr. Katz’s office, Kelly reveals that the termination resulted from the numerous and relentless phone calls her husband had been making to her while she was at work. Her supervisor was concerned that she was unable to focus on her patients and when she did make a relatively minor mistake with some medication, Kelly was terminated. As Dr. Katz probes, he realizes that Kelly has been dealing with domestic violence.

As the case vignette illustrates, domestic violence has many potential effects on its victims. Like Kelly, many men and women who are subjected to intimate partner violence do not disclose it, due to shame or fear. The reach of domestic violence is far: stress, economic hardship, psychological illness, and addiction. Like other forms of trauma, intimate partner violence has a number of effects on its victims. However, the impact of domestic violence varies enormously between individuals. Clinicians working with victims of domestic violence should not assume that they are one homogeneous group. In addition to individual differences, it is also important to consider whether the person who has experienced domestic violence has any prior history of trauma. There are also differences in terms of the type and severity of abuse.

While these differences are important, research indicates that there are a number of long-term effects of domestic violence. These may include (Newton, 2001):

- anxiety
- chronic depression
- chronic pain
- drug and alcohol dependence
- eating disorders
- hyper vigilance
- emotional numbing
- chronic health problems
- panic attacks
- post traumatic stress symptoms
- self-injury and self-neglect
- inconsistent parenting
While domestic violence adversely affects its victims, it is important to recognize that domestic violence is a family matter in that it also affects the children in the family. These reactions can vary depending on the child’s gender and age. Children exposed to family violence are more likely to develop social, emotional, psychological and or behavioral problems than those who are not. Recent studies indicates that children who witness domestic violence show more anxiety, low self esteem, depression, anger and temperament problems than children who grow up in homes where there is no trauma. The effects of family violence can continue into adulthood.

The National Coalition Against Domestic Violence defines domestic violence as “the willful intimidation, physical assault, battery, sexual assault, and/or other abusive behavior perpetrated by an intimate partner against another.” Domestic violence is displayed across a broad spectrum of cultural, economic, religious and racial groups. While this is not an exhaustive list, Kurst-Swanger and Petocsky (2003), have identified some behaviors indicative of intimate partner violence which include:

- Denying a person autonomy
- Isolating victims from family and friends
- Instilling fear through intimidation, threats and violence
- Manipulating behavior
- Punishing victims for challenging an abuser’s authority
- Unjustified jealousy
- Controlling financial resources
- Using children as a way to hurt, control or manipulate

This course will discuss the effects of domestic violence. The terms domestic violence, domestic abuse, and intimate partner violence will be used interchangeably throughout the text.

Upon completion of this chapter you will be able to:

1. Define domestic violence and the term “intimate partner”
2. Discuss common patterns of abusive behavior
3. Discuss chronic physical symptoms in survivors of domestic violence
4. Discuss mental health effects of domestic violence, including depression and posttraumatic stress disorder
5. Describe the effects of domestic violence on children

Common Patterns of Intimate Partner Violence

Prior to discussing the effects of domestic partner abuse, it is helpful to understand common patterns of abuse. There is also variability in the degree of chronicity with which abusive behaviors occur. Johnson and Ferraro (2000) describe these patterns of violence:
Common Couple Violence - within the context of a single issue, there is one or at most two incidents of violence, and it is not used as part of a pattern of behavior to control the partner. This is similar to the "family-only" batterer, or someone who is not violent outside the home and is the least likely to be sexually and emotionally abusive. Johnson and Ferraro report this kind of batterer is about evenly split between males (56%) and females (44%), and some studies showing that in younger samples women may use more aggression than men. However, women still tend to suffer more serious injuries compared to men.

Intimate Terrorism – this pattern of relationship violence is centered on the abuser’s need to control his/her victim. This form of violence is likely to increase over time, to involve a higher frequency of incidents, and more serious injuries.

Violent Resistance - This kind of violence occurs in response to a perceived threat, and is not part of a pattern of control and manipulation.

Mutual Violent Control - this kind of violence occurs when two parties use violence to control each other. Johnson and Ferraro note that even in these cases some gender differences remain. In 31% of these couples, the male initiated more violence, as opposed to 8% for the female.

Effects on Victims

Unexplained Physical Symptoms/Somatization

Emotional pain is often expressed through physical pain. Studies confirm an association between domestic violence and poor physical health (Hagion-Rzepka (2000; Mitchell & Anglin, 2009). While it may seem to follow that these symptoms are a result of the person having been physically assaulted, this does not appear to be the case. Often the problems appear unrelated to physical injury.

Those who have been victims of domestic violence may exhibit a wide range of physical symptoms, a greater number of symptoms, and more severe symptoms. According to Hagion-Rzepka (2000) "The stress of being in an abusive relationship often has a physiological impact, as well as the obvious physical and psychological impact: it often increases one’s vulnerability to illness." The following case study provides an example.

Case Vignette
Natalie, a 48-year-old woman, who has been in an emotionally abusive and controlling relationship is presenting for therapy. She states that she is there reluctantly, and knows that “the doctor just hasn’t found what is wrong.” Symptoms include diffuse pain, periods in which her fatigue is so great that she cannot get out of bed, shortness of breath, and blinding headaches. Natalie has consulted with several doctors, including her PCP, a neurologist and a cardiologist. Natalie believes that she must have a rare physical problem, but that it has not yet been found. She is upset that the doctor has referred her for therapy.

Patients with unexplained physical ailments generally first seek treatment in primary care settings, but may be even more common in neurologic settings. In addition to “unexplained” physical problems, such a chronic pain or migraine headaches, a number of symptom-based syndromes are also related to domestic violence. These include fibromyalgia, chronic fatigue syndrome, multiple chemical sensitivity, temporomandibular disorder, irritable bowel syndrome, and tinnitus (Richardson & Engel, 2004). These disorders share some important features, such as fatigue or pain, disability that is out of proportion to physical findings and stress or psychosocial factors. They also tend to effect women more than men.

The impact of abuse seems to be in large part biological. Abuse appears to activate the body’s stress responses, and the release of cortisol. While small increases in cortisol are not problematic, chronic stress has negative effects.

In addition to biology, chronic stress has psychological effects. Somatization is the idea that emotional pain and stress are expressed through bodily symptoms. While some victims of intimate partner violence may meet DSM criteria for Somatization Disorder, many do not meet the full criteria. It is helpful to recognize that trauma may underlie unexplained physical symptoms.
**DSM Criteria: Somatization Disorder**

A history of many physical complaints beginning before age 30 years that occur over a period of several years and result in treatment being sought or significant impairment of functioning.

Each of the following criteria must have been met, with individual symptoms occurring at any time during the course of the disturbance.

- 4 pain symptoms: a history of pain related to at least 4 different sites or functions
- 2 gastrointestinal symptoms: a history of at least 2 gastrointestinal symptoms other than pain
- 1 sexual symptom: a history of at least 1 sexual or reproductive symptom other than pain
- 1 pseudoneurological symptom: a history of at least 1 symptom or deficit suggesting a neurological condition not limited to pain

Either:

After appropriate investigation, each of the symptoms cannot be fully explained by a known general medical condition or the direct effects of a substance OR

When there is a related general medical condition, the physical complaints or resulting social or occupational impairment are in excess of what would be expected from the history, physical examination, or laboratory findings

The symptoms are not intentionally produced or feigned.

It is important for clinicians to be aware of the possibility that clients with chronic pain or unexplained physical symptoms (but especially with multiple symptoms) may have a history of abuse, and explore this sensitively. It is important that clinicians not express doubt as to the symptoms or imply that they are “imagined,” but rather to state that traumatic experiences can worsen the experience of pain or make physical symptoms more severe or difficult to handle.

**Other Mental Health Consequences of Domestic Violence**

Domestic abuse and other forms of violence are associated with increased risk for developing a range of psychiatric conditions — including depression, anxiety and posttraumatic stress disorder — or of exacerbating existing mental health concerns. Substance abuse, somatoform disorders, eating disorders, sexual difficulties and psychotic episodes have also been linked to adult and childhood
abuse (Briere et al, 1997; McCauley et al, 1995; Poirier, 2000). Partner abuse is also a significant risk factor for suicidality (Plichta & Weisman, 1995). What is also concerning is that living with a serious mental illness may increase a woman’s vulnerability to abuse.

Some of these prevalence statistics are as follows:

- Of 140 women attending an outpatient psychiatric clinic, 64% had a lifetime history of physical and/or sexual abuse (Surrey et al, 1990). On average, half of all women seen in a range of mental health settings have been abused by an intimate partner (Friedman & Lou, 2007).

- Among 153 women seen in a range of psychiatric settings, half had been sexually abused and 16% had been physically assaulted as children (Mueser et al, 1998). As adults, 64% had been sexually assaulted, 36% had been physically attacked, and 24% had witnessed severe violence.

- Out of 303 depressed women culled from a large random sample, 63% had experienced abuse at some point in their life (Scholle et al, 2008). 55% reported having been abused in adulthood by “a family member or someone they knew well, such as a boyfriend.”

Experiences of abuse and violence are especially high for women diagnosed with serious mental illness.

- 64% of female inpatients that had been physically assaulted as adults, 56% shared a home with the perpetrator (Jacobson and Richardson 2007).

- In one study with 66 female psychiatric inpatients, 44% had experienced physical assault as an adult (Bryer et al 1987). Of those, 59% had been assaulted by an intimate partner.

- Out of 93 women seen in a psychiatric emergency room 42% had been abused by a partner (Briere et al, 1997).

**Case Vignette**

Anna has been married to Mark, and has been a victim of intimate partner violence. She has been able to seek help from Dr. Frank, an outpatient psychologist. Dr. Frank has diagnosed Anna with depression, and she has begun taking medication. Anna was tearful in the last session, stating that Mark now had “more ammunition against me.” Whenever he becomes upset with her, he asks if she has taken her medication and frequently calls her “crazy.” He has also shared the fact that she is in therapy with members of her church, and is seen as a “saint” for sticking by her.
While the statistics verify the scope of mental health consequences and domestic violence, what is not reflected in the statistics is that mental illness and intimate partner violence have a circular effect. Mental illness is often cited as the impetus for incidents of family violence, particularly among those with severe mental illnesses. Additionally, abuse results in more acute symptoms of these disorders, or can be a stressor underlying the mental health concern.

**Depressive Disorders**

Chief among the mental health effects of domestic violence is depression. Prevalence rates of women who have been abused by a partner range from 37.7% to 63% (Bonomi et al., 2006). One factor that increases a victim's risk for depression is perpetrator behavior. Perpetrators often exert control, manipulate and degrade their victims, and isolate them from friends and family. When sexual abuse or assault is added to the mix, the result is even higher levels of depression.

Several studies of depression and intimate partner violence suggest that the strongest predictors of depression among abuse victims are the frequency and severity of family violence, emotional or psychological abuse, sexual violence, and lack of social support (Koopman, Ismailji & Palesh, 2007, Pico-Alfonso, 2005, Pico-Alfonso, Garcia-Linares & Celda-Navaro, 2006). These appear to be stronger predictors than cultural/demographic factors or preexisting mental illness.

The research also confirms that the incidence of depression is higher among women who reported more frequent sexual abuse by partners. Among those surveyed in the National Violence Against Women Study, twenty-five percent of women and 8 percent of men, said they were raped and/or physically assaulted by a current or former spouse, cohabiting partner, or date at some time in their life; 1.5 percent of women and 0.9 percent of all men said they were raped by a partner (Thaden & Thonnes, 1998). Although symptoms of anxiety more often predominate immediately following a sexual assault, depression quickly develops and can persist over time. Survivors of childhood abuse who are then assaulted by adult partners are at significant risk of depression (Dickinson et al., 1999).

Depression appears to be significantly associated with domestic violence. Clinicians should be aware that this may be a consequence of intimate partner violence and screen for such symptoms when working with survivors.

**Case Vignette**

Anna Louise, a 28-year-old married woman has a history of psychiatric illness. In her most recent hospitalization for a failed suicide attempt, Anna Louise disclosed that she was a victim of sexual abuse in childhood. When she initially met her husband Ken, she thought that he was “different,” but that has not
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proven to be the case. She states that he is verbally abusive and controlling. Her hospitalization was precipitated by an incident in which she felt that Ken “forced” her to have sexual intercourse despite her indications that she did not wish to. Anna Louise is despondent and hopeless that her situation will change.

Posttraumatic Stress Disorder

Like depression, posttraumatic stress disorder (at clinical or subclinical levels) is frequently a consequence of intimate partner violence. Rates of PTSD among survivors of domestic violence are estimated to be between 33% and 84% (Kemp, Rawlings & Green, 1994; Woods & Wineman, 2004). In the National Violence Against Women Study (Thaden & Thonnes, 1998), 24% of those who had experienced partner violence in the past year met full clinical criteria for PTSD.

Diagnostic criteria for PTSD include exposure to a severe stressor (such as threats to the physical integrity of oneself), a response that involved intense fear, helplessness, or horror. For a diagnosis of PTSD, the person must also have experienced symptoms of intrusive recollection, such as recurrent and intrusive distressing recollections of the event, dreams, or flashbacks; avoidant/numbing reactions, such as efforts to avoid things that arouse recollections of the trauma, diminished interest or participation in significant activities or restricted range of affect; hyperarousal, such as irritability or exaggerated startle response. Responses of men and women who have been victims of domestic violence are similar to those of other types of traumatic exposure.

Using a PTSD framework is helpful as it places symptoms squarely within the context of it being a consequence of the abuse.

As with depression, PTSD in domestic violence victims has been associated with severity of the abuse, history of repeated abuse, sexual abuse and/or assault, and psychological abuse. Stalking is also associated with the development of PTSD. The more kinds of abuse someone experiences (physical, emotional, sexual) the greater his or her risk becomes for developing PTSD (Coker, Davis & Arias, 2002).

Case Vignette

Marybeth is a 29-year-old woman presenting for an initial consultation with Dr. Arian. She states that she has been feeling overwhelmed and exhausted. She has been more irritable than normal, is having sleep problems and nightmares, and has a feeling of “dread.” Due to her current symptoms, Marybeth is increasingly isolating herself and has missed several days of work. She reports that she is separated from her husband Charlie, who is an alcoholic and often violent and unpredictable.
Domestic Violence and Children

While many past research efforts have focused on direct victims of intimate partner violence, increased attention is now being focused on the children who witness domestic violence. Between 10 to 20 percent of children nationwide are exposed to domestic violence (Carlson, 2000). That means that approximately 3.3 to 10 million children who witness the abuse of a parent or adult caregiver each year (Carlson, 1984; Straus and Gelles, 1990).

Children are affected by domestic violence in a variety of ways. Domestic violence in the household is often accompanied by other major developmental risk factors for children such as poverty, female-headed household, and low education level of primary care giver (Fantuzzo, et al, 1997).

Children who live in violent households also are at risk for physical injury both prenatally and post-natally (Peedicayil et al., 2004). Prevalence rates for domestic violence during pregnancy range from 0.9% to 20.1% depending on the definition for violence in the study (Peedicayil et al., 2004). Domestic violence is the major cause of trauma-related visits to health care providers during pregnancy (Harner, 2004).

While many children who live in homes in which there is intimate partner violence also are recipients of the violent acts, children who live in homes in which there is domestic violence are victims, whether or not they are the direct target of the violent behaviors. "Families under stress produce children under stress. If a spouse is being abused and there are children in the home, the children are affected by the abuse." (Ackerman & Pickering, 1989).

Research does indicate that children exposed to domestic violence are at an increased risk of being abused or neglected. In 30 to 60 percent of families in which there is past or present domestic violence, children are also abused (Edleson, 1999; Jaffe and Wolfe, 1990). Kaufman and Henrich (2000) estimate that approximately 40% of children who witness domestic violence are also physically abused. The severity of the domestic violence appears predictive of the severity of the child abuse (DiLauro, 2004). Mothers in domestic violence relationships are more likely to physically and/or emotionally abuse their children than are mothers in nonviolent relationships (Lutenbacher, Cohen, & Conner, 2004)

Children who grow up in families in which there is domestic violence are also four to six times more likely to be victims of sexual abuse (as cited in Wilson, 2006). This may be because abusers have a history of requiring others to meet their needs, and this may extend to sexual needs.

Just as the Domestic Abuse Prevention Project developed a Domestic Violence Wheel, they have also developed a Child Abuse Wheel. It is significant that many
of the descriptors on the wheel mirror the Domestic Violence Wheel (see Introduction to Domestic Violence).

![Domestic Violence Wheel](image)

**Domestic Abuse Prevention Project, Duluth, MN**

Although the abused parent frequently tries to shield children from exposure to the domestic violence, 80 to 90 percent of children from households in which there is domestic violence can recount in detail the violent episodes (Doyne, Bowermaster & Meloy, 1999). They may hear the parent’s screams or crying, or the abuser’s threats. They may also see the aftermath of the abuse, such as broken furniture or windows. This results in emotional trauma, fears and guilt (Wilson, 2006).

Dynamics of domestic violence which are unhealthy for children include (Alabama Coalition Against Domestic Violence):

- control of family by one dominant member.
- abuse of a parent.
- isolation.
- protecting the "family secret".

The results of domestic violence vary, depending on the child’s age, individual personality variables, and the type and frequency of violence that they are exposed to. In general, children are more likely to develop negative psychological
effects from witnessing domestic violence if they witness severe or chronic violence, if they are younger, if the violence is frequent, and if it is perpetrated in close proximity to them (Knapp, 1998).

Overall, the trauma children experience can show up in emotional, behavioral, social and physical disturbances that effect their development and can continue into adulthood (Alabama Coalition Against Domestic Violence).

**Effects of Domestic Violence on Children**

**Emotional**

- Depression, helplessness, powerlessness.
- Shame, guilt, and self-blame.
- Confusion about conflicting feelings toward parents.
- Fear of abandonment
- Anger.
- Shame

**Behavioral**

- Acting out or withdrawing.
- Aggressive or passive.
- Refusing to go to school.
- Care taking; acting as a parent substitute.
- Lying to avoid confrontation.
- Rigid defenses.
- Excessive attention seeking.
- Bedwetting and nightmares.
- Out of control behavior.
- Reduced intellectual competency.
- Manipulation, dependency, mood swings.

**Social**

- Isolation from friends and relatives.
- Stormy relationships.
- Difficulty in trusting, especially adults.
- Poor anger management and problem solving skills.
- Excessive social involvement to avoid home.
- Passivity with peers or bullying
- Engaged in exploitative relationships as perpetrator or victim
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Physical

- Somatic complaints, headaches and stomachaches
- Nervous, anxious, short attention span
- Tired and lethargic
- Frequently illnesses
- Poor personal hygiene
- Regression in development
- High risk play
- Self abuse

While the list above documents a number of behavioral effects of domestic violence, just as with adult victims, children are at risk for depression, anxiety disorders, and posttraumatic stress disorder. The severity, duration, and proximity of an individual’s exposure to the traumatic event are the most important factors affecting the likelihood of developing PTSD (Groves, 1999). The criteria includes exposure to a traumatic event in which the person witnessed or experienced an event that involved actual or threatened death or serious injury to self or others and the individual’s response involved intense fear, helplessness, horror, or, in children, disorganized or agitated behavior. For children with PTSD re-experiencing symptoms may include repetitive play expressing a theme of the trauma.

In addition to the childhood effects of domestic violence and children, it is also important to understand the long-term effects. There is much evidence that domestic violence begets domestic violence. According to the American Psychological Association, Violence and the Family: Report of the APA Presidential Task Force on Violence and the Family (1996), A child's exposure to the father abusing the mother is the strongest risk fact for transmitting violent behavior from one generation to the next. Witnessing domestic violence as a child increases the risk for the child to be in a violent relationship as an adult (Ornduff, Kelsey, & O'Leary, 2001).

Summary

Domestic violence is an important mental health issue that affects the entire family. There are a number of long-term effects of domestic violence, including chronic anxiety and depression, inconsistent parenting and posttraumatic stress symptoms. Children that witness domestic violence are also at risk not only for mental health concerns, but also for carrying the violence forward to the next generation. It is important, then, to intervene with the whole family system.
References


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Chapter 3: Intimate partner sexual abuse

Introduction

Case Vignettes

Cami, a 38-year-old woman is married to Carl. The relationship is frequently physically abusive, and the abuse often extends to violent, forced, sexual intercourse. Cami is fearful of staying, and fearful of leaving.

Elaine, a 35-year-old married woman is seeking counseling due to severe depression. She states that her primary stressor is her marriage to Bill. The couple has one child, and Elaine is a stay-at-home mother. She feels distant from Bill, but stuck in the marriage. Elaine shares that one of the hardest parts of the relationship is that she often feels “coerced” into having sexual relations with Bill. She has clearly said no, but Bill’s guilt inducing tactics and threats to leave her and take their child leave her with no choice but to submit.

The case vignettes above illustrate the range of intimate partner sexual abuse. When most people think about sexual abuse or violence, they often think of it as an assault by a stranger on an unsuspecting victim. As clinical knowledge of sexual abuse advances, so does our understanding that sexual abuse can occur between two people who know one another, or even two people who have an intimate relationship. The term Intimate partner sexual abuse (IPSA) refers to sexual abuse or assault that occurs between two people who have or have had a consensual sexual relationship. The term Intimate Partner Sexual Violence (IPSV) is more often used in relationships where there are other forms of physical abuse, or when the sexual abuse is accompanied by violence. Partner rape is more of a legal term and is defined as sexual acts committed without a person's consent and/or against a person's will when the perpetrator is the individual's current partner (married or not), previous partner, or co-habitator. Regardless of terminology, intimate partner sexual abuse constitutes a form of power and control seen in other types of domestic violence.

While many people would look at the first case vignette and agree that it constitutes sexual abuse, some would question the second case vignette. Does coercion constitute abuse? It is helpful to look at the definition of sexual assault. Sexual assault refers to any sexual contact of a person by another without appropriate legal consent. While physical force may be present, this is not always the case. Lack of voluntary consent for sexual contact, such as through the use of intimidation or threats are equivalent to no consent (Sachs & Gomberg, 2009). Intimate partner sexual abuse can occur in dating relationships, marriages or long-term gay or lesbian relationships.
Marital rape, also known as spousal rape, is non-consensual sex in which the perpetrator is the victim's spouse. While marital rape is a recognized problem in the United States as well as internationally, a major issue is whether it has been criminalized. Marital rape is considered a criminal offense in many countries, however, cultural norms and the perceived stigma discourage women from reporting marital rape. Until 1976, marital rape was legal in every state in the United States. Marital rape is now a crime in all 50 states in the U.S., however, some states still don't consider it as serious as other forms of rape. Clinicians may want to check whether their home state is one that makes a distinction between marital rape and other forms of rape. State laws also vary with regard to the nature of acts that are considered “abusive sexual contact.”

While societal views sometimes minimize the consequences of intimate partner sexual abuse, research finds that it is as problematic, if not more problematic, than abuse by a stranger. In one of the first discussions of intimate partner sexual abuse, early researchers Finkelhor and Yllo (1985), write about the “special traumas” of this type of domestic violence and state, “It is these special traumas that we need to understand in their full and terrible reality.”

This course will examine the issue of intimate partner sexual abuse. Upon completion of this chapter you will be able to:

1. Define the terms “sexual assault” and “rape”
2. Describe the incidence and prevalence of intimate partner sexual abuse
3. Compare and contrast intimate partner sexual abuse with abuse by a non-intimate partner
4. Compare intimate partner sexual abuse with general domestic violence
5. Describe the physical and mental health effects of intimate partner sexual abuse
6. Discuss intervening in intimate partner sexual abuse, and providing trauma-informed care

Definitions, Prevalence and Incidence of Intimate Partner Sexual Abuse

Obtaining prevalence data about sexual assault in the US is problematic due to different survey methodology and definitions of what constitutes assault and/rape. Most studies are thought to grossly underestimate the incidence due to low disclosure rates. While this is true for many types of domestic violence, intimate partner sexual abuse seems to carry a particular stigma. Victims of intimate partner sexual abuse seem to also express many fears of revictimization.

Prior to looking at incidence data, it is important to look at some definitions of what constitutes sexual assault, and to expand upon those offered in the introduction. These definitions are important because they determine the scope
of inquiry and the questions included in research, affect the wording of questions and guide sample selection.

According to the American Psychological Association, sexual assault can be viewed on a continuum that ranges from forcible rape to nonphysical forms of pressure that compel people to engage in sexual acts against their wishes. Sexual assault takes many forms. It includes acts such as sexual degradation, intentionally hurting someone during sexual intercourse, the use of objects intravaginally, orally, or anally, pursuing sex when someone is not fully conscious or afraid to say no, and coercing an individual to have sex without protection against pregnancy or sexually transmitted diseases.

In contrast, rape is a legal term. Three elements characterize legal definitions of rape: lack of consent; penetration, no matter how slight or independent of whether ejaculation occurred; and compelling participation by force, threat of bodily harm, or with a person incapable of giving consent due to intoxication or mental incapacitation.

A key, population-based survey is the National Crime Victimization Survey (NCVS), which looks at the incidence of sexual assault. Data are obtained from a nationally representative sample of about 40,000 households comprising nearly 75,000 persons on the frequency, characteristics and consequences of criminal victimization in the United States. According to the 2006 NCVS survey, there were an estimated 272,350 sexual assaults against victims age 12 and older. This is a decline from previous years; sexual assault has decreased by two-thirds since 1993. The 2006 NCVS survey did not include statistics for victim and offender relationships, but past studies did. In fact, past data has revealed that an estimated 73% of all sexual assaults were committed by someone known to the victim: 38% of perpetrators were a friend or acquaintance of the victim; 28% were an intimate partner; and 7% were another relative.

Another important source of data is the CDC’s 2010 National Intimate Partner and Sexual Violence Survey (NIPSVS). This survey presents interview data obtained from 16,507 adults (9,086 women and 7,421 men). The survey found that nearly 1 in 5 women (18.3%) and 1 in 71 men (1.4%) have been raped at some time in their lives, including completed forced penetration, attempted forced penetration, or alcohol/drug facilitated completed penetration. More than half (51.1%) of female victims of rape reported being raped by an intimate partner and 40.8% by an acquaintance; for male victims, more than half (52.4%) reported being raped by an acquaintance and 15.1% by a stranger. Among victims of intimate partner violence, more than 1 in 3 women experienced multiple forms of rape, stalking, or physical violence; 92.1% of male victims experienced physical violence alone, and 6.3% experienced physical violence and stalking.

A final study that looked at intimate partner sexual abuse is the National Violence Against Women Survey (NVAWS) published in 2000. This survey looked at both
sexual assault and rape. According to the NVAWS, each year women experience about 4.8 million intimate partner related physical assaults and rapes. Men are the victims of about 2.9 million intimate partner related physical assaults. Nearly two-thirds of women who reported being raped, physically assaulted, or stalked since age 18 were victimized by a current or former husband, cohabiting partner, boyfriend, or date.

Given the statistics in these studies, it is important to address sexual assault and rape by intimate partners.

Comparing Intimate Partner Sexual Abuse to Abuse by a Non-intimate Partner

Case Vignette
Rowanna, a 42-year-old African American woman is seeking treatment. She has just left an abusive relationship with her husband Mac. Rowanna describes a long history of intimate partner physical and sexual abuse, including multiple rapes. Although she is close to her sisters, she was not able to share what was occurring in the marriage. When her 10-year-old daughter inadvertently witnessed one of the rapes, Rowanna finally had the courage to ask for her older sister’s help, and was able to leave. Rowanna reports nightmares, depression, and fears of Mac “coming to get me.”

Sexual abuse is always traumatic. The literature has shown that people who are sexually abused display a range of problems. While some may display what is considered a trauma reaction, and symptoms of posttraumatic stress disorder (PTSD), others will develop a wider range of difficulties including substance abuse, eating disorders, deliberate self-abuse, social phobias, depression, and anxiety. The aftereffects of chronic trauma may intrude on many life spheres: social and vocational; psychological or emotional; physical; sexual; family; sense of self; and relations with others. Chronic sexual abuse, whether by an intimate partner or another often results in a sense of stigmatization and powerlessness.

Logic would dictate that sexual abuse perpetrated by an intimate partner would be different from sexual abuse by a non-intimate partner, and this is the case. While some people believe that intimate partner sexual abuse doesn’t have as traumatic an impact as sexual assault by a stranger, this is not the case. In fact, intimate partner sexual abuse is in many ways more problematic than other types of sexual abuse or assault. There are a number of significant differences:

- Longer-lasting trauma: In their study of marital rape, Finkelhor & Yllo (1987) found that rape by an intimate partner often results in more chronic trauma. The researchers found that the significant reasons for this are lack of recognition that intimate partner sexual abuse is problematic and survivors’ ability to share their experiences with others.
• Higher levels of physical injury: Intimate partner sexual abuse more often involves higher levels of physical injury than other types of rape or sexual abuse. This may be because those people who are sexually abused by a partner are also physically abused (Myhill & Allen, 2002).

• Repeated traumas: Survivors of intimate partner sexual abuse suffer the highest frequency of multiple sexual assaults and repeated abuse. This results in more severe overall symptoms (Myhill & Allen, 2002).

• Different types of sexual abuse. Partner perpetrators of intimate partner sexual abuse often select abuse that is designed to humiliate and denigrate the victim. Intimate partner sexual abuse more often includes oral and anal rape when compared with other forms of sexual abuse or rape (Bergen, 1996; Arledge, 2008).

• The unclear status of intimate partner sexual abuse. While it is clear cut that rape or sexual abuse by a non-intimate partner is wrong, this is not always the case for intimate partner sexual abuse. Many survivors of intimate partner sexual abuse report being advised by church, family or friends that they should be “grateful that the rapist is a good father” or that “it’s their duty to submit” to the abuse. Women are also often socialized to see rape as involving non-consensual sex between two strangers. It may be difficult to see an intimate partner as a “rapist.” (Arledge, 2008).

• Financial dependency on the abuser. Many women who are in relationships in which there is intimate partner sexual abuse or other forms of domestic violence cannot leave the relationship due to financial issues. In many situations, domestic violence victims have been cut off from their own jobs or other means of financial support. This becomes even more difficult when there are children involved in the relationship.

• Complexity of ensuring safety. It is often difficult to work within the system of restraining orders, custody issues, etc. Even mental health professionals are not always aware of the resources available for survivors of domestic violence. Additionally, many states do not have laws that include protections for survivors of intimate partner sexual abuse. Those states that do have protections may mire them in red tape, making them difficult to access.

**Intimate Partner Sexual Abuse Compared with General Domestic Violence**

*Case Vignette*

*Janine is a 27-year-old women married to Michael. Janine has been the victim of numerous incidents of physical violence during their years together. She has also been a victim of forced sexual intercourse. While she has difficulty calling these*
episodes rape, she is quite clear that the sexual abuse is much more devastating to her than the physical violence.

Intimate partner sexual abuse often seen in relationships in which there are other forms of domestic violence. In Campbell’s (2002) study of domestic violence survivors, 46% reported sexual abuse by a physically abusive partner. Women who were also sexually abused by partners reported more negative health symptoms, gynecological problems, and increased risk of being murdered by a partner. There was also a greater likelihood that these women would experience depression, and the risk increased with the number of sexually abusive events that the women identified. Campbell theorizes that a possible mechanism of increased risk for health problems include the shame and stress reported with forced sex manifesting as especially high levels of stress and depression known to depress the immune system. Coker et. al.’s (2000) study of family practice patients found that in relationships in which there was domestic violence coupled with sexual abuse, there was a greater degree of overall violence.

Another dynamic to consider is the reason that abusers use sexual violence. More than other forms of domestic violence, sexual abuse, such as rape, has the power to violate or humiliate victims. Abusers may also rape partners to impregnate them in order to force them to remain in or return to the relationship (Easteal & McOrmond-Plummer, 2006). They may also force their partners into unprotected sex to infect them with STDs (Wilson, 2005).

These studies confirm the likelihood that perpetrators that use sexual violence are a more dangerous subgroup of abusers.
**Health Impact of Intimate Partner Sexual Abuse**

Intimate partner sexual abuse puts women at risk for a number of physical and mental health problems.

*Physical Health*

Women who are abused are frequently treated within health-care systems (Campbell, 2002). Intimate partner sexual abuse has long-term negative health consequences for survivors, even after the abuse has ended. According to several authors (El-Bassell et. al., 1998 Wingood, and Declemente, 1997), women who were victims of intimate partner sexual abuse were more likely to present with sexually transmitted illnesses. They were also less likely to use condoms and more likely to engage in other high-risk sexual behaviors.

A number of other studies also looked at physical/health consequences of intimate partner sexual violence. These studies found that some common sequelae of intimate partner violence included (McCauley et. al, 1995: Campbell, 2002, Coker et. al, 2000):

- General health problems; lowered immunity to illnesses
- Digestive
- Eating disorder symptoms Abdominal and stomach pain
- Higher incidence of urinary tract infections
- Vaginal infection discharge, and itching
- Sexually transmitted disease AIDS or HIV-1
- Vaginal bleeding, severe menstrual problems, dysmenorrhea
- Pelvic pain, genital area pain
- Fibroids or hysterectomy
- Painful intercourse and sexual dysfunction
- Headaches, migraines
- Fainting, passing out
- Seizures, convulsions
- Back pain, chronic neck pain
- Sleep disturbance, nightmares
- Temporomandibular joint disorder (TMJ)
- Hypertension

The physical effects of intimate partner sexual abuse are related to the chronic nature of this abuse and the body being under constant stress. It is similar to the effects seen in childhood survivors of sexual abuse. For both adult and childhood sexual abuse, constant stress causes the body’s natural alarm system to be on overdrive. This is often referred to as the “fight or flight response.” The body reacts by releasing adrenaline and cortisol. Long-term activation of the stress-response system, and the subsequent overexposure to cortisol and other stress hormones, can disrupt almost all the body’s processes.
Mental Health

Case Vignette
Caroline was taken by a friend to a rape crisis center following a particularly brutal sexual assault by her boyfriend. Her friend told the counselor that it was not the first time that this had occurred. Caroline appeared numb and disconnected, telling the counselor that she was not sure why her friend was concerned and that “everything was fine” and “everyone is making such a big deal about this.”

Victims of intimate partner sexual assault have been violated both physically and emotionally. Due to the close nature of the relationship between victim and abuser, the mental health effects of intimate partner sexual violence are especially great. Finkelhor and Yllo (1987) state “In addition to the violation of their bodies, victims are faced with a betrayal of trust and intimacy.” They also point out the tendency for victims to blame themselves, as well as the complex dynamics that involve many victims “loving the offender but hating the offense.” As a result, intimate partner sexual assault victims often “suffer long-lasting physical and psychological injuries.”

In addition to Finkelhor and Yllo (1987), the psychological sequelae of intimate partner sexual abuse have been documented by a number of researchers (Campbell, 2002; Sachs & Gromberg, 2009; Silva et. al., 1997; Winfield et. al., 1990;). According to Sachs and Gromberg (2009) victims of intimate partner sexual abuse/rape often develop symptomatology that consists of disruptions to normal physical, emotional, cognitive, behavioral, and interpersonal characteristics. Some of these disturbances include memory impairment, dulled sensory, affective and memory functions, sleep disturbance (insomnia, wakefulness, night terrors), self-blame and guilt, and activity avoidance. Together these are termed rape trauma syndrome (RTS). This term was first used by Burgess and Holmstrom in 1974 and is similar to posttraumatic stress disorder. Additionally victims of intimate partner sexual abuse may struggle with chronic depression and suicidality, marked anxiety and panic. There may also be mood swings, obsessive qualities and somatoform disorders (physical symptoms with no identifiable cause). In terms of PTSD diagnosis, rape survivors represent the largest non-combat group of individuals with posttraumatic stress disorder. (Campbell and Wasco, 2005)

Another mental health consequence of intimate partner sexual abuse concerns lifestyle changes. Victims often experience a sense that their personal security or safety is damaged. They may have difficulty trusting others (often a challenge for clinicians) or feel hesitant to enter new relationships. They may also isolate themselves from families, friends and others.
Common coping mechanisms seen in survivors may make it difficult to initially comprehend the impact of the abuse. An example of this can be seen in the case vignette. Some common coping mechanisms/defense mechanisms include minimization (pretending that “everything is fine”), suppression (refusal to discuss the abuse) or intellectualization (detached analysis what happened, often with focus on the victim’s role in the abuse.) Victims of intimate partner sexual abuse may also rely on maladaptive coping mechanisms, such as deliberate self-harm, drug, or alcohol abuse or use of eating disorder symptoms.

Finally another dynamic seen in intimate partner sexual abuse is the Stockholm Syndrome (see de Fabrique et al., 2007). Described as a victim’s emotional “bonding” with their abuser, Stockholm Syndrome develops subconsciously and on an involuntary basis.

**Understanding the Dynamics of Intimate Partner Sexual Abuse**

While this document highlighted many of the differences between intimate partner sexual abuse and other forms of domestic violence, the dynamics of intimate partner sexual abuse is similar to other forms of domestic abuse. The National Center For the Prosecution of Violence Against Women (2005) in its publication on understanding the dynamics of intimate partner sexual abuse, does highlight an important similarity between intimate partner sexual abuse and other forms of domestic violence, namely the need for authority/power seen in perpetrators.

Sexual assault is about power, and, therefore, sex is a weapon and a means of expressing the rapist’s aggression or power. Sexual abusers do not rape out of sexual desire. While some intimate partner abusers limit their violence to sexual assault, the majority of intimate partner sexual assaults occur within a physically abusive relationship. Many intimate partner sexual assaults also involve domestic violence dynamics. One useful tool to understand this dynamic is the Power and Control Wheel created by the Domestic Abuse Intervention Project in Duluth (see Introduction to Domestic Violence).

Some relationships in which there is intimate partner sexual abuse may also include a cycle of violence. This term “cycle of violence” was developed by Lenore Walker to describe three phases in an abusive relationship: tension building, physical abuse, and the honeymoon phase.

The behaviors of victims of intimate partner sexual abuse may conflict with many sexual assault victims. They may not resist during a rape or assault; frequently delay reporting their rape; and they may continue to have contact with their assailant.

**Interventions for Victims of Intimate Partner Sexual Abuse**
Although the clinical picture for survivors in intimate partner sexual abuse clearly highlights the seriousness of the abuse, victims of intimate partner sexual abuse rarely seek treatment. When they do, it is important to provide services in an informed way.

Intimate partner sexual abuse is a complex problem. Victims’ issues are multidimensional (e.g., physical, mental, economic, legal, spiritual, emotional), and clinicians will often need to interact as part of a treatment team. This team may include psychologists, social workers, advocates and people in the legal realm.

Trauma Informed Care

“Trauma-informed” services (Laskey, 2009) refers to the idea that providers offering mental health and other services to victims of intimate partner sexual abuse should be informed about, and sensitive to, trauma-related issues present in survivors.

A “trauma-informed” system is one that includes an understanding of the role that violence plays in the lives of adults, children and adolescents and families or caregivers seeking mental health and addictions services (Harris & Fallot, 2001). One of the primary goals of a trauma informed system is to deliver service in a way that will avoid inadvertent re-traumatization and will facilitate treatment compliance.
Elements of Trauma Informed Care

Trauma informed treatment focuses on understanding the context of a person's experience. It emphasizes safety, choice, empowerment, and cultural competence. Elements of trauma informed strategies include (Laskey, 2009):

- Focus on trust and safety
- Trauma knowledge, awareness/sensitivity
- Prevention-oriented
- Strengths-based, focused on empowerment and resilience
- Collaborative
- Culturally-competent/sensitive services

An additional requirement of a trauma informed approach is safety. Providers must be aware of safety issues. Victims of intimate partner sexual abuse may need to develop a plan for physical safety. Emotional safety is also important and can be fostered through non-judgmental treatment, informed consent practices and holistic care. This helps to build trust. Additionally it is important to attend to boundary issues, such as consistency, accessibility and clear role delineation.

Vicarious Traumatization

Clinicians who work with sexual assault victims may experience vicarious trauma. Symptoms of vicarious trauma are similar to those experienced by individuals with Post Traumatic Stress Disorder and include numbing, hypervigilance, sleep difficulties and intrusive thoughts of traumas described by victims (Lassey, 2005). Trauma informed care lessen the likelihood of vicarious trauma among mental health professionals.
REFERENCES


**Chapter 4: Special Populations**

**Introduction**

**Case Vignettes**

Andrew is a 45-year-old man, who has been in a 5-year relationship with David, an emergency room physician. Andrew’s work as an artist allows him to stay home and raise Chloe, the couple’s 5-year-old daughter. David routinely holds back funds that Andrew needs to run the household, and on several occasions David has punched Andrew, the most recent time in front of Chloe.

Robert and Beatrice are 70 and 68. They have been married for 45 years. They have recently been experiencing some financial stress, and Robert has been drinking. When he drinks, he becomes very angry, and often screams at Beatrice and calls her names.

Lauren and Brent, juniors in high school, have been dating since freshman year. Brent is very jealous of Lauren, and expects her to see him every day. He keeps close tabs on her. She has lost friendships as a result of defending Brent’s actions. When Lauren and Brent fight, it often becomes physical.

While on the surface there are differences between Andrew, Beatrice and Laura, they share that they are victims of domestic or intimate partner violence. Domestic violence is “the willful intimidation, physical assault, battery, sexual assault, and/or other abusive behavior perpetrated by an intimate partner against another” (The National Coalition Against Domestic Violence). Domestic violence affects individuals from every walk of life, whether gay or straight, young or old, married or unmarried. As these cases illustrate, domestic violence is often accompanied by emotionally abusive or controlling behavior, and thus is part of a systematic pattern of dominance and control. The terms “domestic violence,” and “intimate partner violence,” are synonymous, although the later is more inclusive.

While this is not an exhaustive list, Kurst-Swanger and Petocsky (2003), have identified some behaviors indicative of intimate partner violence. These include:

- Denying a person autonomy
- Isolating victims from family and friends
- Instilling fear through intimidation, threats and violence
- Manipulating behavior
- Unjustified jealousy
- Controlling financial resources

While domestic violence researchers have focused primarily on “traditional” marriages in which there is abuse, this does a disservice to many victims. It is
important to recognize that intimate partner violence occurs in all types of partnerships.

This course will discuss the domestic violence in special populations including among gay and lesbian couples, among the elderly, and among teen dating relationships. The terms domestic violence and intimate partner violence will be used interchangeably throughout the text.

Upon completion of this chapter you will be able to:

1. Discuss prevalence and types of abuse among Gay, Lesbian, Bisexual and Transgendered (GBLT) Relationships
2. Discuss barriers to treatment and treatment recommendations for GBLT relationships
3. Discuss domestic violence in later life, including factors that may play a role
4. Describe why older men and women stay in abusive relationships
5. Discuss teen dating violence, including contributing factors and prevention

Domestic Violence in Gay, Lesbian, Bisexual and Transgendered (GBLT) Relationships

Prevalence

Intimate partner violence is a serious issue in the GLBT community. How serious? Island and Letellier (1990, 1991) suggest that intimate partner violence occurs in about 15-20% of gay male relationships. They describe intimate partner violence as “the third most severe health problem facing gay men today,” behind HIV/AIDS and substance abuse.

While study of violence in GBLT relationships is not widespread, an important source of compiling data is the National Coalition of Antiviolence Programs. Their reported prevalence data for 2010 underscores the need for clinicians to be aware of and responsive to intimate partner violence in GBLT couples. The following are some key findings:

- In 2010, NCAVP programs received 5,052 reports of intimate partner violence. While this represents an increase of 38.1% from 2009 (3,658 reports this was mainly due increased funding at the Los Angeles Gay & Lesbian Center (LAGLC) for their intimate partner violence programming.
Spousal or Partner Abuse, 45

- NCAVP documented six IPV murders/homicides in 2010 equal to the six documented murders/homicides in 2009. The majority of victims were women.
- The average age of murder/homicide victims increased. In 2009 the average age of the victims was 30, while in 2010 the average age was 39.
- Females accounted for nearly half (45.7%) of victims who reported to NCAVP member programs in 2010, while males accounted for more than a third (37%).
- 50.6% of survivors indicated they experienced intimate partner violence with a boyfriend/girlfriend or long-term partner, a decrease from 2009 (61.3%).
- More victims in 2010 (44.6%) were turned away from shelter than in 2009 (34.8%)
- More than half of victims (55.4%) experienced physical violence from their abusive partners, a substantial increase from 2009 (36.5%). Less victims called the police. In 2010 7.1% of victims called the police for support, a decrease from 2009 where 21.7% of victims called the police.

What makes these figures even more alarming is that LGBT domestic violence is vastly underreported, unacknowledged, and often reported as something other than domestic violence (National Coalition of Anti-Violence Programs, 2006). Gay men and women who are abused by a partner frequently report being afraid of revealing their sexual orientation or the nature of their relationship. Delaware, Montana and South Carolina explicitly exclude same-sex survivors of domestic violence from protection under criminal laws. Eighteen states have domestic violence laws that are gender neutral but apply to household members only. There are a number of additional barriers to reporting such abuse, and these will be discussed later in this material.

Nature of Abuse

In many ways, domestic violence in lesbian, bisexual and gay relationships is the same as in heterosexually-paired relationships. Some of these behaviors that are similar in heterosexual and GLBT relationships include (National Coalition of Antiviolence Programs, 2000):

- Verbal abuse, such as calling a partner names or belittling them in some way.
- Isolating a partner from their family or friends.
- Withholding money, shelter, food, clothing and/or medication from a partner as a means of controlling them.
- Interfering with a partner’s ability to obtain or keep employment, housing or any other benefit or service.
- Harming or attempting to harm a partner physically, or threatening to do so. Threats of harm may also extend to a partner’s family, friends, children and/or pets.
Spousal or Partner Abuse, 46

- Sexually assaulting or raping a partner.
- Threatening a partner with suicide or harm to self, if a partner tries to end a relationship or does not comply with an abuser’s demands.
- Stalking or otherwise harassing a partner.

While these types of abuse may be found in gay or straight relationships, there are some very specific forms of abuse that may be found in GBLT relationships. Some examples include (National Coalition of Antiviolence Programs, 2000):

- “Outing” or threatening to out a partner to friends, family, or employers.
- Reinforcing fears that no one will help a partner because he or she is lesbian, gay, bisexual or transgender, or that for this reason, the partner “deserves” the abuse.
- Justifying abuse with the notion that a partner is not “really” lesbian, gay, bisexual or transgender.
- Telling the partner that abusive behavior is a normal part of GBLT relationships, or that it cannot be domestic violence because it is occurring between same gender individuals.
- Portraying the violence as mutual or consensual.

According to the National Coalition of Anti-Violence Programs (2006), specific forms of abuse occur in relationships where one partner is transgendered, including:

- Using offensive pronouns such as “it” to refer to the transgender partner
- Ridiculing the transgender partner’s body and/or appearance
- Telling the transgender partner that he or she is not a real man or woman
- Denying the transgender partner’s access to medical treatment or hormones

**Case Vignette**

*Keliana and Jeanette have been in an exclusive relationship for the past two years. In the past three months, Jeanette’s behaviors have become increasingly erratic. Keliana would like to leave the relationship, but is fearful to do so because Jeanette has threatened to kill herself if Keliana leaves. She also says that if Keliana leaves her she will call members of Keliana’s very religious family and let them know that the two have been lovers.*

There is a domestic abuse power wheel specific to GBLT couples experiencing intimate partner violence:
Barriers to Seeking Services

While it is undeniable that there is a need for GBLT men and women to seek services, there are barriers to doing so. Some of these barriers include:

- The belief that domestic violence does not occur in GBLT relationships
- Societal anti-GBLT bias (homophobia, biphobia and transphobia)
- Lack of funding for research into GBLT relationship abuse
- Fear that airing of the problems among the GLBT population will detract from progress toward equality or fuel bias.
- Lack of appropriate training regarding GBLT domestic violence for service providers
- Domestic violence shelters are typically female only, thus transgender people may not be allowed entrance into shelters or emergency facilities.
Some of the factors that increase vulnerability to domestic violence in GBLT Relationships:

- Isolation of some GBLT individuals from families of origin
- Acceptance of violence in LGBT relationships from general population
- The “double closet,” need to hide sexual orientation status and need to hide the relationship abuse
- Co-Existential situations, such as low self-esteem and substance abuse
- Dismissal by police and some social service providers
- Impact of HIV in keeping couples together
- Lack of support from peers who would rather keep quiet

Recommendations for Providers

While there are a number of important issues in working with GBLT individuals who have been affected by domestic violence, the following recommendations are a few helpful ones (many excerpted from American Psychological Association recommendations):

- Increase their knowledge and understanding of homosexuality and bisexuality through continuing education, training, supervision, and consultation.
- Recognize the scope of the problem, and know that domestic violence is a “real” issue among same gender partners.
- Understand the effects of stigma (i.e., prejudice, discrimination, and violence) and its various contextual manifestations in the lives of lesbian, gay, and bisexual people.
- Understand that same-sex attractions, feelings, and behavior are normal variants of human sexuality.
- Be knowledgeable about and respect the importance of lesbian, gay, and bisexual relationships. Recognize that domestic violence should not be an acceptable part of these relationships.

Domestic Violence and Older Adults

Case Vignette
Frank and Emma have been married 50 years. While the marriage has been somewhat rocky for a number of years, it has worsened in the last several months. Recently Emma has started to develop memory problems, which have frustrated Frank. He often angrily tells her to “quit it” and calls her “stupid.” Their son David became concerned when he heard Frank asking Emma if she’d like him to “knock some sense into her.”
It is often overlooked that intimate partner violence occurs throughout the lifespan. Domestic abuse in later life is a problem that has not received the attention it deserves. It is, however, a significant problem in older men and women. The dynamics in this type of abuse are unique and require a specialized response from clinicians (Harris, 1996; US Department of Justice, 2005).

There are a number of factors that make it difficult to get an accurate picture of the scope of domestic violence in older adults. Probably the biggest factor is that intimate partner violence is often studied in conjunction with other types of elder abuse. While intimate partner violence and domestic violence share many similarities, there are differences as well. There is often not a universally agreed upon definition of what constitutes either intimate partner abuse or elder abuse. Due to these factors, and the general lack of research in this area, it is impossible to estimate prevalence.

Age versus vulnerability: Some definitions of intimate partner/elder abuse are based solely on the age of the victim. These vary from state to state, with a range of 60 to 70 as the age threshold for individuals who are victims. Many abuse in later life programs for older victims, however, identify individuals who are age 50 and older as those who are eligible to receive their support and services. Another type of definition of elder abuse includes the vulnerability of the older adult as a factor in determining whether the individual is a victim of elder abuse. In the example in the case vignette, for example, Emma’s dementia would be indicative of one such vulnerability.

Forms of abuse: The forms of elder abuse identified and defined by most states laws include physical, sexual and emotional abuse, neglect, and financial exploitation. Some definitions also include abandonment.

Abuse in later life may include physical, sexual, or psychological abuse, neglect, financial exploitation, or stalking of an older adult. The phrase “Abuse in Later Life” is often used by domestic violence and sexual assault advocates who work with older victims.

Older victims come from a variety of racial and ethnic groups and all economic levels. Many older victims are active members of the community. Some older victims are frail and live with significant health issues, physical disabilities, and/or cognitive limitations.

Gender. Abuse in later life affects older women more often than older men, although some men may be victims. Although older women often experience more significant violence and are more apt to change their lives to stay safe or accommodate the abuser, some older men are also victims of abuse, neglect, and exploitation.

Dynamics. In later life, another dynamic that is important to note is the length of
the relationship. Spousal or partner relationships may sometimes be new, following the death of a previous partner. In these relationships there is not a history, and perpetrators will rarely disclose that violence had also been present in a prior relationship.

Another type of intimate partner abuse is late-onset abuse. In this situation long-term relationship that had not been abusive previously becomes so in later life. What is significant about late-onset abuse is that a medical or mental health condition may have led to aggressive or violent behavior (more later). In other there where there has been ongoing abuse, medical or mental health conditions are likely not present (US Department of Justice, 2005).

*What causes abuse in later life?*

Like other forms of domestic violence, many cases of abuse in later life involve dynamics of power and control. Even if physical abuse is not present, the threat of harm is often enough to persuade the older person to capitulate to the abuser's demands. The types of abuse seen in later life include physical abuse, emotional and psychological abuse, threats of physical violence or abandonment, isolating the individual from family and friends, limiting the victim’s use of the telephone, denying the person finances to manage their needs, breaking assistive devices, and denying health care. The abusing partner can be very persuasive, and often try to convince family, friends, and professionals that they are only trying to help.

Many issues co-occur with abuse in later life including anger, stress, caregiver issues, medical conditions, mental health issues, substance abuse, or prior poor relationships. While these do not *cause* the abusive behavior, they can present the catalyst that may result in the violence. It is important that clinicians intervene to support resolution of these underlying problems and do not focus only on the abuse.

Because of the strong connection between caregiving and domestic violence, it is important to look at this in terms of domestic abuse. Many theories of domestic abuse in later life center on the stress of caring for a physically or mentally impaired partner. Certainly providing care for an ill or frail older person can be stressful, but there are many instances in which caregivers do not become abusive. Research has borne out the idea that caregiver stress is not a primary cause of elder abuse (www.ncall.us.)

In older adults it is important to consider that violent behavior may occur as a symptom of some medical or mental conditions or as a side effect of combinations of medications. These conditions include various dementias (Alzheimer's, Vascular Dementia, Lewy body disease, and other degenerative dementias.) Alzheimer's disease and related disorders account for more than 90% of dementia cases in the elderly. Delirium is another medical condition that
can account for violent behavior. Medication side effects should also be considered.

As in other populations, use of drugs and alcohol may intensify situations and cause escalation into abuse. Alcohol abuse and alcoholism are common but under recognized problems among older adults. One third of older alcoholic persons develop a problem with alcohol in later life, while the other two thirds grow older with the medical and psychosocial sequalae of early-onset alcoholism. Physiologic changes related to aging can alter the presentation of medical complications of alcoholism (Rigler, 2000). Substance abuse among those 60 years and older (including misuse of prescription drugs) currently affects about 17 percent of this population. By 2020, the number of older adults with substance abuse problems is expected to double (Hazeldon, 2012). Mental health clinicians should include a screening for these disorders when working with older adult perpetrators.

Case Vignette
Mary and John, both in their 70s, have been married for 51 years. Mary is seeking counseling due to depression. In assessing Mary, Dr. Cox asked about relationships and supports. Mary tearfully reports that her husband John had always been her biggest supporter, but lately it seemed like he was “a different person.” He has seemed “distracted,” and has been short-tempered, often raising his voice when he becomes frustrated with something, and these outbursts often seem to be directed at Mary. When Dr. Cox asks if Mary and John have seen their physician recently, Mary says that they have not, and agrees to schedule appointments for them both.

Domestic Violence Wheel Older Adults
Why do victims stay?

As with domestic violence in people younger than 60, many older victims choose to remain in the relationship. Some of the reasons for this are similar to younger victims, but some are age-related. Victims sometimes stay in violent relationships because: (National Center on Elder Abuse, 2005; US Department of Justice, 2005).

- Fear of the unknown of fears of being alone
- Economic dependence
- Fear of institutionalization
- Values and culture that frown upon separation
- Shame and guilt
- Not wanting to leave behind cherished possessions or pets
- Medical conditions and disabilities
- Fear of loss of autonomy

Mandated reporting
Please be aware of your state’s mandated reporting laws, and whether elder abuse is a mandated reporting issue.

Teen Dating Violence

When we think of intimate partner violence, teens are another population that often are overlooked. Unhealthy relationships often start as an early pattern, and can last a lifetime. Consider the following scenario:

Case Vignette
Anna, a 23-year-old college student is seeking counseling at the student-counseling center. She presents as anxious and tells the intake counselor that she has been “a mess” since the end of her last relationship. Anna reports that when she first met Brent, she thought he was “different,” but that he “just likes all the others.” She describes a pattern of abuse that began early in the relationship. When asked about prior relationships, Anna described a 5-year relationship that began in high school and lasted until her sophomore year of college. She described her former boyfriend Connor as “controlling” and “jealous,” and shared that he would often follow her to know her whereabouts. Connor would also hack into her social networking site. She feels that much of her anxiety began during those years and as a result of those experiences.

Teen dating violence is defined as the physical, sexual, or psychological or emotional violence within a dating relationship, as well as stalking. It can occur in person or electronically and may occur between a current or former dating partner (CDC).

Just how prevalent is teen dating violence? A comparison of Intimate Partner Violence rates between teens and adults reveals that teens are at higher risk of intimate partner abuse (Silverman et. al, 2001). Females ages 16-24 are more vulnerable to intimate partner violence than any other age group – at a rate almost triple the national average (U.S. Department of Justice, 2001).

In 2009 the CDC conducted a nationwide survey in order to look at teen dating violence. 9.8 percent of high school students reported being hit, slapped, or physically hurt on purpose by their boyfriend or girlfriend in the 12 months prior to the survey. (Centers for Disease Control and Prevention, 2009 Youth Risk Behavior Survey). About 1 in 5 women and nearly 1 in 7 men who ever experienced rape, physical violence, and/or stalking by an intimate partner, first experienced some form of partner violence between 11 and 17 years of age (Centers for Disease Control and Prevention, 2010 National Intimate Partner and Sexual Violence Survey).

Despite the prevalence of teen dating violence, it is rarely reported to authorities, rather teens confide in peers, who are not equipped to help them handle the
situation. Zwicker (2002) conducted a survey of female high school students. When asked who they would talk to if someone they dates was attempting to control them, insulted them, or physically harmed them, 86% percent said they would confide in a friend, while only 7% said they would talk to police. In another survey conducted on behalf of the Claiborne Foundation (2005), only 33% of teens who were in an abusive relationship ever told anyone about the abuse. The prevalence of dating violence in teen relationships is similar to that of opposite gender relationships (Halpern et al., 2004).

Consequences of dating violence

One of the biggest overall influences for teens are relationships, dating and otherwise. Teens that are exposed to healthy relationship behaviors experience positive emotional affects. Conversely, unhealthy, abusive or violent relationships can cause negative effects.

Violent relationships in adolescence can have serious ramifications for victims. Teens who are victims are more likely to be depressed and do poorly in school. Many teens that are abused will continue to be abused in their adult relationships. Teens experiencing teen dating violence are also at higher risk for substance abuse, eating disorders, risky sexual behavior, and suicide (Silverman et. al, 2001). The severity of violence among intimate partners has been shown to increase if the pattern has been established in adolescence (Field & Strauss, 2001).

Why does teen dating violence happen?

Violence is related to certain risk factors. According to the CDC, the risks of having an unhealthy relationship increase for teens who:

- Believe it's okay to use threats or violence to get their way or to express frustration or anger.
- Use alcohol or drugs.
- Can't manage anger or frustration.
- Hang out with violent peers.
- Have multiple sexual partners.
- Have a friend involved in dating violence.
- Are depressed or anxious.
- Have learning difficulties and other problems at school.
- Don't have parental supervision and support.
- Witness violence at home or in the community.
- Have a history of aggressive behavior or bullying.

Attitudes about violence/contributing factors
Teen dating violence does not happen in a vacuum. It can be traced to attitudinal factors and beliefs that many adolescents and adults alike have about relationships. First, many adults do not recognize the teen relationships can be violent, or believe that physical or emotional violence can be attributed to a lack of “maturity.” There is also the societal tendency to blame the victim. Lavoie (2003) conducted a qualitative study of teens. She found that the teens’ explanatory models still attribute part of the responsibility to victims and is caused by: provocation by the girl; the victim’s personality type; the girl’s need for affection; communication problems; and peer group influence. The teens also pointed out the influence of pornography. Jackson et. al. (2000) also found that many high school students (77% of female and 67% of males) endorse some form of sexual coercion, including unwanted kissing, hugging, genital contact, and sexual intercourse. Clearly educational efforts are needed.

Prevention

Working with teens who have experienced abuse is similar to other populations. It is helpful, however, to implement prevention strategies that will enable us to stop teen violence before it begins. Prevention programs focus on strategies that promote healthy relationships. The teen years are ones in which learning the skills of relationships, whether friendships or romantic, are crucial. The ultimate goal of prevention programs is to avert patterns of dating violence that can last into adulthood. Prevention programs change the attitudes and behaviors linked with dating violence.

One example is Safe Dates, a school-based program. The goals of this program are to:

- Raise students’ awareness of what constitutes healthy and abusive dating relationships.
- Raise students’ awareness of dating abuse and its causes and consequences.
- Equip students with the skills and resources to help themselves or friends in abusive dating relationships.
- Equip students with the skills to develop healthy dating relationships, including positive communication, anger management, and conflict resolution.
REFERENCES


National Center on Elder Abuse (2005). Domestic violence: Older women can be victims too.


Chapter 5: Motivational Interviewing and Stages of Change

Introduction

Case Vignette

Kelly Sykes, LSW, is working with Lauren, an adolescent client. Lauren has been dating Nick for 6 months, and thinks that he is “the one.” Lauren’s mother is concerned about Nick’s severe verbal abuse towards her daughter, and Kelly has been working hard to educate Lauren about healthy relationships. They have worked together on assertiveness skills, and Kelly has enlisted Lauren’s mom as a positive, supportive influence.

Kelly is relieved when Lauren tearfully tells her that she and Nick are “over.” In their next session, Lauren joyfully tells Kelly that she and Nick are together again, and that Nick has promised not to yell at her or call her names. Two weeks later, Nick shoves Lauren against a wall. Kelly is extremely disappointed, feeling that she has somehow failed Lauren.

This case vignette may sound familiar to many working with intimate partner violence. While there are numerous therapeutic issues in working with men and women who are in abusive partnerships, many of the challenges in domestic violence counseling can be summed up by a single word: change.

As evidenced in Kelly’s interventions, traditional behavior change interventions have focused on increasing skills and reducing barriers. While both of these things are important, they are not always enough. Telling people what to do, or how to do it, is rarely effective in supporting change. This is especially true in working with domestic violence, where change may be synonymous with endings.

In partnerships touched by domestic violence, what does genuine change look like? Is it even possible? How can clinicians motivate someone to make changes? How can you determine if someone is embarking on this process?
One of the main contributions of the Transtheoretical Model (Prochaska & DeClemente, 1984) is its utility in helping clients to make changes. Motivational Interviewing is an empathic, gentle, and skillful style of counseling that allows clinicians to have productive conversations with clients. While widely used with clients with addictive and co-occurring disorders, this approach is applicable to a wide range of behaviors and is well-suited to working with domestic violence issues (Prochaska & DeClemente, 1984; Prochaska, DeClemente & Norcross, 1992).

Much of the evidence base for the transtheoretical model comes from addictions treatment and practice. Alcohol and drug-dependent clients are often resistant to making changes, and traditional methods of treatment that were appropriate for self-motivated clients did not always work. In the mid 1990s, researchers first began looking at the potential applicability of the TTM in understanding the change process for both perpetrators (Daniels & Murphy, 1997) and victims (Brown, 1997) of domestic abuse. With regard to perpetrators, resistance to change is often apparent. There may be a tendency to deny or minimize problems or to blame others for their actions. They also often fail to attend even court-mandated treatment and are noncompliant with interventions intended to change behavior (Murphy & Maiuro, 2009). Victims often need to change existing values, thinking processes, and relationship skills and may not be ready to do so.

It is important to review the definition of domestic violence. The National Coalition Against Domestic Violence defines domestic violence as “the willful intimidation, physical assault, battery, sexual assault, and/or other abusive behavior perpetrated by an intimate partner against another.” Domestic violence is displayed across a broad spectrum of cultural, economic, religious and racial groups. The terms “domestic violence” and “intimate partner violence” will be used interchangeably in this training material.

This course will provide an overview of the transtheoretical model of behavior change. It will also include motivational interviewing skills and techniques and their applicability to working with domestic violence.
Upon completion of this chapter you will be able to:

1. Discuss the overall goals of the transtheoretical model of behavior change, including the stages of change
2. Discuss the research base regarding the applicability of the transtheoretical model to domestic violence
3. List the components and strategies of motivational interviewing and describe how these are used to promote change
4. Discuss the applicability of motivational interviewing in work with perpetrators and victims of domestic violence

**Goals of the Transtheoretical Model**

**Case Vignette 1**

Tom and Mary are presenting for couples counseling. The two describe periods of intense conflict that often escalates to physical violence. Tom is clearly angry to be attending the session, and states “if she wouldn't provoke me all the time, things would be fine.” Mary becomes enraged, stating, “I provoke him? Let me tell you what he says to me.” Tom angrily stalks out of the room, slamming the door in his wake.

**Case Vignette 2**

Kevin and Louise are also in couples counseling. They have frequent, physical altercations. When asked what he sees as the reason that their fights, Kevin states “I know it gets bad at times.” Louise angrily retorts, “that’s what you always say, but we can never get past this. Last time you only came with me to counseling for two sessions. I’ve had it with this.” Kevin states “I’m here aren’t I?”

The transtheoretical model of behavior change is aptly named. It is a treatment model centered on the premise that clients can change otherwise dysfunctional behaviors. Although this idea is at the heart of the transtheoretical model, the model does not assume that maladaptive behaviors are immediately amenable to change. As with many clients, a degree of ambivalence may be apparent. As Kevin says “I’m here, aren’t I?” Being “here” is not necessarily equivalent to being ready to dive into treatment and make changes.

In contrasting the two cases presented above, it’s apparent that each of these
couples is in a very different place in terms of readiness to make changes. But significant changes do need to be made. Some of these changes include the couple communicating more effectively, the abusive partners using anger management strategies, and both parties recognizing that abuse in any form is not allowable. How, then, does the therapist collaborate with the client to move them forward?

Assessment of Readiness

Case Vignette

Carla is a 45-year-old woman in a relationship with Bob. Carla works for a pharmaceutical company is a fast-paced position. In her first session with Dr. David, Carla reveals a history of long-term emotional abuse. Dr. Davis states that in order to heal, Carla will need to end the relationship with Bob, and points out that in her work life she often has to make difficult decisions. Carla angrily responds that she does not need anyone else “browbeating me” and does not return for a subsequent session.

A central tenet of the transtheoretical model is the assessment of an individual's readiness to act on a new healthier behavior. According to Wahab (2005), the intention behind assessing motivation, readiness and confidence levels for change is to tailor the intervention accurately to the client’s stage of change at any given moment. As the case above illustrates, there are times that therapists do not take into consideration a client’s readiness for change.

The transtheoretical model conceptualizes behavior change as a process with various stages. The stages represent distinct categories along a continuum of motivational readiness. The stages include precontemplation, contemplation, preparation, action, maintenance and relapse.

According to Prochaska and DiClemente (1982) precontemplation is the state in which an individual is not yet considering the possibility of change. People who are in this stage may classically be labeled as “resistant” or “unmotivated.” In the case study, for example, Tom’s verbalizations and actions are suggestive of a person at the precontemplation stage of change.
The next stage in the continuum is *contemplation*. People in the contemplation stage have the intention or express the desire to change and existing behavior or to initiate a new behavior. While people in this stage are contemplating change, there is no clear plan of how or when to initiate changes. Kevin fits the profile of someone in the contemplation stage. He recognizes that changes need to be made, but his “plan” of simply being there in the sessions is not indicative of immediate action.

*Preparation* is a state characterized by an intention to change in the immediate future, usually within the next month. There is a clear plan in place that includes steps that will facilitate change. This generally leads to *action*, the stage where the person takes action in order to achieve a behavior change. In the examples at the beginning of this section, an example of action would be actively practicing anger management strategies, such as identifying triggers or taking a time-out.

*Maintenance* is the stage where the individual strives to maintain and integrate a behavior that has been successfully started or changed. This stage is one in which fosters the consistency of newly developed behaviors. People at this stage report greater self-efficacy and resistance to relapse.

At any point in the change process, a person may exhibit signs of *relapse*. Relapse is not exactly synonymous with the definition from the additions field. A person is considered to be in the stage of relapse when he or she re-engages the undesired behavior and/or stops the desired behavior. For example, a goal of change may be for a client to communicate feelings to his or her partner rather than using alcohol to self-medicate. If a client has mastered this skill, but then begins to isolate and not communicate feelings, this would be considered indicative of relapse, whether or not substance use is involved.

The transtheoretical model employs a specific set of techniques, known as motivational interviewing, to move people from one stage of change to the next. These techniques are supportive in nature, but also focus on pointing out the dissonance between what a person desires or knows to be productive and the current behaviors he or she is exhibiting. A discussion of motivational
interviewing is contained in the next section of this training material.

**Motivational Interviewing Strategies**

Motivational interviewing is a therapeutic approach based on the recognition that clients who need to make changes are at different levels of readiness to change. Motivational interviewing strategies engage clients in the therapeutic process, mobilizing intrinsic motivation by developing cognitive and behavioral discrepancies and by exploring and resolving sources of ambivalence that inhibit change.

While the idea of therapeutic alliance is important with all clients, with men and women affected by domestic violence it is key. Clients may seek therapy unwillingly, or with little real hope for change. They may also have been in domestic violence systems that have contributed to the already disempowered way that they feel. Motivational interviewing uses empathic listening, affirming client’s autonomy and choice and matching interventions to the clients own level of readiness to change. As such it is nonjudgmental. Clients therefore feel “accepted” despite “unacceptable behavior.”

According to Murphy and Maiuro (2009), Motivational interviewing involves four therapeutic principles:

1. Assessment of client’s stage of change, which allows the therapist to better communicate understanding, empathy and congruence.
2. Development of cognitive/attitudinal discrepancies. How does the client want to live their life? What is their life currently like? What are the potential benefits of change?
4. Support of self-efficacy by allowing the client his or her autonomy

Some of the characteristics of Motivational interviewing include:

- Expressing empathy through reflective listening
- Noting discrepancies between current and desired behavior
- Evocation; drawing out rather than imposing ideas
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- Avoiding argumentation
- Collaboration to build rapport and facilitate trust
- Encouraging belief in the ability to change
- Communicating respect for and acceptance of people and their feelings
- Establishing a nonjudgmental relationship
- Developing and action plan to which the client can commit
- Using affirmations and language that affirms clients’ strengths
- Providing summaries that highlight important aspects of the discussion, shift the direction of conversations that become "stuck"
- Communicating interest and understanding of an individual's perspective
- Belief in the autonomy of the client rather than the authority of the therapist

Specific techniques include:

- Use of open-ended questions
- Asking permission to explore topics
- Affirmation of client strengths
- Expressing appreciation of client difficulties
- Reflections to express empathy and facilitate change
- Summaries

Sample client conversation and use of techniques

-Therapist: Hello Maria, it is nice to meet you. I imagine based on what we discussed in our phone call that you may have some mixed feelings about being here. Could we spend some time exploring your situation (ask permission)?

Maria: Yes, it’s very hard to be here.

-Therapist: I’m sure it is. Could you tell me about the specific incident that brought you here (open-ended question)?

Maria: Well, my husband hit me. He was angry. He likes for me to have the kids in bed before her comes home and to have dinner on the table waiting. The kids were so crazy, and time got away from me. I could tell as soon as he walked in that he was mad.
Therapist: He came home and was angry that the kids were up and dinner wasn't ready? What happened next?

Maria (crying): I hate for my kids to see that. It was right in front of them. He promised to stop (crying harder). He pushed me down and was screaming and hitting. I would hear them crying in the background. I was begging him to stop. I was scared the neighbors would hear, and that they would call the police again.

Therapist: You were concerned about the kids because you hate for them to see that? And also that the police may come (reflecting emotion)?

Maria: Yes. I love him. I didn’t want him to get into trouble, I didn’t want the kids to be scared.

Therapist: It sounds like even though your husband has hit you, you love him (reflection).

There are a number of differences apparent in this conversation. First, although the therapist may be concerned about the information she is learning about Maria’s situation, she is non-reactive, and takes time to explore Maria’s situation. The therapist does not use words like “abuse,” or jump immediately to safety planning. The therapist is also respectful of the fact that Maria loves her husband, even though her husband is violent. While conducting this conversation, he therapist would be aware of some of the targets for change and where the client is in terms of readiness for change.

Sample assessment of readiness for change:

Therapist: It sounds like even though your husband has hit you, you love him (reflection/summary).

Maria: Yes. We’ve been together since we were both 16 (laughs). Things were so different then. Then the kids came along. He’s a good provider and loves the children. He has never laid a hand on
them. My friend tells me I should leave him, but I could never do that.

Therapist: You have a long, complicated history together. He has many qualities that are important to you. Tell me a little more about why you would never leave him. What are the benefits of staying (assess pros/cons of present behavior)?

Maria: When this happened before, he didn’t hit me for a long time. He was so sweet to the kids. If I stay I don’t need to worry about money, or getting a job. I can stay home and be a good mom to my children.

Therapist: So now that he’s hit you, things will be better. It’s also more financially secure for you and for the children. Is there anything else?

Maria: Nothing that comes to mind.

Therapist: Are there any disadvantages to staying with your husband?

Maria: Next time may be worse. He could even kill me. I know it probably sounds crazy to you, but I still think that staying is better than leaving.

Therapist: On the positive side the finances are taken care of if you stay. You wouldn’t have to worry about looking for work or not being home for the kids. On the other hand, your husband may kill you someday. It’s a risk you are willing to take (summarize, create discrepancy.)

Therapist: Where does this leave you now (support self-efficacy.)

Maria: I’m not sure. I know all the reasons I should leave, just pack up the kids and leave. I often want to leave. But I stay. Crazy, right?
Change Talk

An important aspect of motivational interviewing is the clinician’s reinforcement of change talk. Change Talk refers to the client’s mention and discussion of his or her Desire, Ability, Reason, and Need to change behavior and Commitment to changing. Clearly Maria is aware of the need to change. She may even desire to leave. It is not fully clear from the session, however, how much of the focus on change is self-motivated, versus coming from her well-meaning friend or a response to what Maria thinks her new therapist would like to hear. It makes sense that when people talk about change themselves; they are more likely to change than if someone else talks about it.

Listening for and appreciating the client’s ambivalence about change is a significant aspect of motivational interviewing. While many of us may be ambivalent when confronted with the need for life changes, for clients affected by domestic violence not making changes is often dangerous.

Change talk is divided in five categories: Desire, Ability, Reason, Need, and Commitment:

- Desire: Why would you want to make this change?
- Ability: How would you do it if you decided?
- Reason: What are the three best reasons?
- Need: How important is it? And why?
- Commitment: What do you think you’ll do?

Central to motivational interviewing is the consistent emphasis on client autonomy and self-determination. This is helpful for victims of domestic violence, who often feel as if systems, including the mental health system, are autocratic and reinforce dependency. Perpetrators of domestic violence also benefit from feeling as if changes are those they want to make, rather than are forced to make. With motivational interviewing, the client has the freedom and responsibility to contemplate and engage in change.
Working with Perpetrators of Domestic Violence

While the case example provided above dealt with a victim of domestic violence, Motivational Interviewing is also an effective technique for working with perpetrators of domestic abuse.

Researchers have looked at the utility of using Motivational interviewing with this group. Kistenmacher & Weiss (2008) conducted a small-scale study of the potential effectiveness of motivational interviewing in changing the way perpetrators think about their violent behavior. They studied thirty-three men who were court-mandated to treatment for domestic violence. The motivational interviewing group demonstrated generally more improvement on stages of change as well as a significantly greater decrease in the extent to which they blamed their violence on external factors. Similarly Musser et al. (2008) studied motivational interviewing as a pre-group intervention with perpetrators. They found that the motivational intake led to more constructive in-session behavior during the early phase of group CBT, greater compliance with group CBT homework assignments, higher late session therapist ratings of the working alliance, and more help seeking outside of the domestic violence program. Alexander et al. (2010) also looked at motivational interviewing and compared it with standard CBT approaches when working with perpetrators. They found that motivational interviewing led to significant reductions in female partners’ reports of physical aggression at follow-up.

These studies demonstrate that motivational interviewing is an effective technique. While some of the challenges of working with this group are apparent from the literature, it is helpful to review these prior to looking at a case example. According to Worden (2000), some of the challenges and areas of intervention with perpetrators of domestic violence include:

1) System Blaming: Many perpetrators of domestic violence believe that the systems (such as the criminal justice system, child services, etc) treat men unfairly in domestic violence cases and that women abuse the laws.
2) Problems with Partner/Partner Blaming: Perpetrators of domestic violence and blame the partner for the violence.

3) Problems with Alliance: Use of direct confrontation in therapy results in and inability to help the clients who have been abusive to feel understood, safe, and supported.

4) Social Justification: Perpetrators of domestic violence often believe that change would be difficult—or impossible—in one’s environment, given social and religious norms and expectations.

5) Hopelessness: Perpetrators of domestic violence often feel hopeless, overwhelmed, depressed or anxious about making changes.

6) Isolation: Perpetrators of domestic violence often lack support from family and friends because of social isolation, distrust, or discomfort seeking help.

7) Psychological Reactance: Perpetrators of domestic violence often respond to pressure to change with an angry stance.

8) Passive Reactance: Perpetrators of domestic violence may respond with pressure to change by participating only superficially, without meeting expectations or responding appropriately.

Motivational interviewing can help to support change by addressing many of these issues. The following example demonstrates its utility in working with this population. Note that the therapist does not confront or challenge Tom, but instead allows his story to unfold. While doing so the therapist assess Tom’s readiness to change his behavior.

**Therapist: Hello Tom, it is nice to meet you. Could you tell me a little bit about why you’re here (ask permission)?**
Tom: My wife thinks I need anger management.

Therapist: You’re here at the request of your wife? Is there a reason that she thinks you need anger management (open-ended question)?

Tom: I know that I get really angry sometimes. All the men in my family have tempers.

Therapist: You’re aware of your tendency to get angry. Could you tell me more about what happens when you get angry (restatement, open-ended question)?

Tom: She can be a bitch too you know.

Therapist: You feel like your wife can also be angry?

Tom: You got that right. One time she was angry because I stayed out late. She raised her voice right in front of my son, disrespecting me.

Therapist: What happened then?

Tom: Well, I had to be a role model for my son. I popped her one. She shut up real fast. Didn’t want to do that, you know, but all that disrespecting.

Therapist: You want to be a role model for your son, and to feel like your wife respects you (reflection).

Tom: You got that right.

Therapist: So when you hit your wife, you feel more respected. Are there any negatives about taking that action?

Tom: She gets really upsets and cries and says she’ll leave me. This time she packed the kids up. She’s at her mom’s now.
haven’t seen her or my boys in a week. I miss them.

Therapist: So, even though putting her in her place felt good, your wife leaving has been a negative. You miss your wife and kids (summarize, create discrepancy).

Tom: That’s why I’m here. I want them back. Maybe I do need to work on my anger.

Working with Victims of Domestic Violence

Domestic violence victims can also benefit from motivational interviewing strategies. While victims of domestic violence often need to make a number of changes in behavior, a continuing theme is that they do not recognize the dangers of remaining with an abusive partner.

Several researchers have looked at the use of motivational interviewing in working with victims of domestic violence. These have included Simmons et al. (2008), Burke et al (2001) and Burkitt & Larkin (2008). These studies have been small in scale but have demonstrated promising effects on victims’ use of community resources, cessation of ongoing abuse, and utilization of mental health and social supports.

Burke et al. (2001) conducted research into the transtheoretical model as a conceptual framework for understanding how women end abuse in their intimate relationships. In-depth interviews were conducted with 78 women who were either currently in or had recently left abusive relationships. Women talked about the following five stages of behavior change:

<table>
<thead>
<tr>
<th>Stage</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Precontemplation</td>
<td>The woman does not recognize abuse as a problem and is not interested in change</td>
</tr>
<tr>
<td>Contemplation</td>
<td>The woman recognizes abuse as a problem and has an increasing awareness of the pros and cons of change</td>
</tr>
<tr>
<td>Preparation</td>
<td>The woman recognizes abuse as a problem, intends to change, and has developed a plan</td>
</tr>
</tbody>
</table>
Spousal or Partner Abuse, 72

<table>
<thead>
<tr>
<th>Action</th>
<th>The woman is actively involved in making changes related to ending the abuse</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maintenance</td>
<td>The abuse has ended and the woman is taking steps to prevent relapse</td>
</tr>
</tbody>
</table>

In the example we viewed earlier involving Maria, Maria was in the contemplation stage. While Maria may not yet be ready to develop a plan or take action

Maria: I’m not sure. I know all the reasons I should leave, just pack up the kids and leave. I often want to leave. But I stay. Crazy, right?

Therapist: This is a hard time for you. There are advantages and disadvantages to leaving. Whatever you decide to do is your choice. I’m confident that you will make the best choice for yourself (support self-determination).

While Maria does not yet appear to be ready to leave her husband, there may be other avenues to explore, such as why she may want to make this change, or how she could do it if she decided to do so:

Therapist: I’m confident that you will make the best choice for yourself (support self-determination). If you did decide that leaving was the best choice, what steps would you need to take?

Maria: Remember, my friend I told you about? She told me I could stay with her. My husband would never try to interfere if I went there. He’d be too embarrassed. I’d feel bad about asking her for help, but I know she would help me.

Summary

This training material reviewed some of the strategies of motivational interviewing in supporting change in victims and perpetrators of domestic violence. While the complexity of target behavior in this group is readily apparent, research indicates that many of these behaviors are amenable to these supportive strategies, which affirming client autonomy and empower them to make changes in their lives.
Spousal or Partner Abuse, 73
References


Chapter 6: Legal and Ethical Issues

Introduction

Case Vignettes

Carrie is a 38-year-old mother of two preteen children. She has been dating Jack for the past year. When they initially met, she felt that she had finally met the man of her dreams, but now it seems like a constant nightmare. Shortly after the start of the relationship, Jack became physically abusive. Her children have recently witnessed the violence, and her youngest has urged her to call the police. Carrie is fearful of police involvement, however, many of the fears centering around whether her children will be removed from the household.

Domestic violence is a pattern of coercive tactics perpetrated by one person against an intimate partner, with the goal of establishing and maintaining power and control. Domestic violence includes physical, psychological, sexual, economic, and emotional abuse. Domestic violence occurs across a spectrum of intimate relationships, including married couples, dating couples, couples who live together, people with children in common, same-sex partners, people who were formerly in a relationship with the person abusing them, and teen dating relationships.

Carrie’s story is not an isolated one. Given the prevalence of intimate partner violence, mental health clinicians will likely encounter a survivor in his or her practice. An estimated 5.3 million cases of intimate partner violence are reported each year (CDC, 2003). These incidents result in 486,000 emergency room visits and 18.5 million therapy sessions each year (CDC, 2003). While these numbers may seem high, and they certainly are, they are gross underestimates. According to 2006 Bureau of Justice statistics, less than one-fifth of victims reporting an injury from intimate partner violence sought medical treatment following the injury. Similarly, many domestic violence victims do not report incidents of abuse to law enforcement due to perceived risks of removal of children, dual arrest policies, homelessness, embarrassment or deportation.

Mental health clinicians may be placed in the role of helping to facilitate such reports. They may serve as a lifeline for patients, providing them with information on resources, advocacy and helping them negotiate the justice system. While clinicians cannot be experts on all fronts, it is important to have an understanding of the systems in which victims may need to operate. Additionally it is critical that clinicians be aware of their ethical obligations to domestic violence victims and their children.

This is not always easy. According to the American Psychological Association Task Force on Violence and the Family, the legal system is fraught with numerous problems. The report states: “Most victims of family violence will have
some contact with the legal system that is not well designed to handle such cases. In addition, inequities in the application of the law, racial and class bias, and inadequate investigations have harmed rather than helped many families. The low priority given to funding for implementation of child protection laws results in a legal system that frequently fails to work. Many battered women find themselves in dangerous positions because the courts often do not give credence or sufficient weight to a history of partner abuse in making decisions about child custody and visitation. Racial bias often influences the court's decision about whether to order treatment or to imprison offenders.

It is important that mental health professionals find ways to negotiate sometimes faulty systems. The first step is in understanding needs of the victim and clinicians' professional obligations.

This course will provide an overview of risks, a discussion of why survivors are reluctant to disclose abuse, the legal resources available to clients and ethical obligations. It will also contain an appendix with helpful information, including a summary of state laws on mandatory arrest and a sample safety plan.

The terms “domestic violence” and “intimate partner violence” will be used interchangeably in this training material.

Upon completion of this chapter you will be able to:

1. Discuss the scope of the problem, including intimate partner homicide, lethality assessment and nonfatal injuries
2. Discuss reasons why victims often fail to report intimate partner violence
3. Define “mandatory arrest” and “dual arrest” and describe the implications of each
4. Describe issues related to empowerment and advocacy
5. Discuss navigating the various systems related to domestic violence
6. Discuss ethical and legal issues related to domestic violence

**Scope of the Problem**

Prior to looking at the legal aspects of intimate partner violence, it is helpful to look at the history in the impact of domestic violence and its connection to the criminal justice system. While domestic violence is certainly not new, it is only recently that it has been considered a violation of the law. Prior to about the 1970s (and sometimes even currently), domestic violence was seen as a "normal" part of marriage or intimate relationships.
A significant factor in why the criminal justice system has undergone reforms is how dangerous domestic violence is. The statistics cited in the introduction tell only part of the story. Domestic violence presents a number of concerns related to safety. Mental health providers should be careful not to minimize safety concerns, and assessment of safety and risks should be an ongoing component of therapy.

**Intimate Partner Homicide**

April 4, 2011 – Orlando, Florida. Police arrested a man they said killed two people at an Orlando apartment complex on Sunday night. Officers said 45-year-old Eligio Isalgue shot his estranged wife and her new boyfriend. Isalgue was arrested in the complex’s parking lot. Investigators said they found a gun inside the apartment. Two other people, including Isalgue’s 13-year-old daughter, were in the apartment. The others were not injured. Investigators said the husband and wife had not lived together for about two months.

Intimate partner homicide is defined as a homicide perpetrated against a current or former spouse, cohabitant, or romantic partner by his or her intimate partner. Here is a summary of some key findings (Catalano et al., 2009):

- In 2007 intimate partners committed 14% of all homicides in the U.S. The total estimated number of intimate partner homicide victims was 2,340, including 1,640 females and 700 males.

- Females were killed by intimate partners at twice the rate of males. Females are generally murdered by people they know. In 64% of female homicide cases, females were killed by a family member or intimate partner. 24% of female homicide victims were killed by a spouse or ex-spouse; 21% were killed by a boyfriend or girlfriend; and 19% by another family member.

- Men were more likely than women to be killed by strangers. Among male homicide victims, 16% were murdered by a family member or intimate partner. Of male homicide victims, 2% were killed by a spouse or ex-spouse and 3% were killed by a girlfriend or boyfriend. Over half (54%) were killed by others they knew, and 29% were killed by strangers.

Prior domestic violence is a strong risk factor for intimate partner homicide. Campbell and Glass (2009), who conducted a study of female victims of intimate partner homicide, found that approximately 80% of women had been a victim of physical and/or sexual intimate partner violence or stalking prior to their murder and 42% were seen in the healthcare system the year before they were killed. While the women themselves are not always good at assessing their own risk,
Campbell and Glass state that healthcare professionals, including those in the mental health fields, can be a resource for identifying women who are at risk.

Currently about 20 states have fatality review teams, which comprehensively look at each death. These teams promote prevention and track patterns of homicides and suicides resulting from intimate partner homicide.

Collectively these review teams have found some common warning signs of intimate partner homicide. These include (Campbell et al., 2003):

- A prior history of domestic violence and injuries
- Attempts to break away from the abusive partner (such as a protective order, pending divorce, or moving out of the house
- Stalking or threatening behaviors
- Previous police involvement
- History of mental illness
- History of drug or alcohol abuse (abusive partner or victim)

Assessing Safety

Safety planning is an important component of treatment. Experts on trauma work such as Herman (1997) and Bloom (1997) state that creating safety for trauma survivors is key to recovery. With survivors of domestic violence, this often involves assessing lethality and developing a safety plan. This training material will discuss safety planning later in this chapter. Mental health professionals can use the warning signs of intimate partner homicide in their safety assessment. Additionally safety assessments involve asking clients about:

- Increases in frequency of violence
- Means of violence (physical violence, presence of guns)
- Threats of violence
- Presence of a child that is not the abuser’s
- Control
- Threats of suicide
- Stalking or spying behavior

Other Losses

Case Vignette
A case making breaking news in New York is that of the death of Mary Kennedy, who committed suicide. Her death came on the heels of husband Bobby Kennedy filing for divorce. Bobby Kennedy alleges that he was the victim of domestic violence. Mary’s family alleges that she was a victim.
In addition to homicide of victims of intimate partner violence, there are also other losses. Suicide attempts/completed suicide is another loss associated with domestic violence. Suicide.org estimates one out of every four women who are the victims of domestic violence attempt suicide.

**Non-fatal Injuries**

While the discussion of intimate partner homicide provides a frightening picture, in terms of sheer numbers, the number of men and women who suffer non-fatal injuries is significantly higher. In 2008 females age 12 or older experienced about 552,000 nonfatal violent victimizations (rape/sexual assault, robbery, or aggravated or simple assault) by an intimate partner (a current or former spouse, boyfriend or girlfriend). In the same year, men experienced 101,000 nonfatal violent victimizations by an intimate partner. About two-thirds of reported victimizations occur at home. After the incident, less than one-fifth of victims seek medical care (Catalano et al., 2009).

**Reporting Intimate Partner Violence**

Many victims of domestic violence fail to report abuse to the police. Research has show gender differences in reporting rates, as well as some of the reasons that victims choose not to make a police report. Males victims of domestic abuse are actually more likely to report violent conflicts. In 2008, 72% of the intimate partner violence against males and 49% of the intimate partner violence against females was reported to police. Stalking victimization was equally likely to be reported to police whether the victim was male or female. Thirty-seven percent of male and 41% of female victimizations were reported to the police by the victim or another person aware of the crime (Catalano et al., 2009).

A recent study from the Bureau of Justice statistics found that the major reasons for not reporting abuse to police were: fear of reprisal (15%), belief that police cannot help (6%), and a feeling that violence is “private” (28%). Additionally many victims of intimate partner violence are extremely isolated from sources of support, and lack the support networks to leave abusive environments. They may be faced with the prospect of homelessness or family separation.

This distrust of the legal system also extends to healthcare professionals. This may be particularly true when children are involved or children witness or are victims of family violence. One source of controversy are “failure to protect” statutes. These statutes may be enforced if victims choose to remain with abusers as they place children in harm’s way. In some states, children can be removed from the family in this situation.

Many victims of domestic violence also hide the abuse from health care providers. What is unfortunate is that by doing so they may be cutting themselves
off from potential resources and sources of help. It is important that mental health professionals be aware of signs of domestic violence and include questions about the possibility of domestic violence in their screenings. It is important to ask these questions outside the presence of the potentially abusive partner.

**Mandatory and Dual Arrest Policies**

In understanding domestic violence and the law it is important to understand the legal context of domestic violence. The U.S. Department of Justice defines domestic abuse or violence as, "a pattern of abusive behavior in any relationship that is used by one partner to gain or maintain power and control over another intimate partner."

Since the 1970s, many states have implemented so called “warrantless arrest policies” in an effort to deter domestic violence. While these laws have been helpful in increasing rates of arrest, prosecution, and conviction of perpetrators of domestic violence (National Research Council, 2004), they have led to some problems. State laws vary with regard to circumstances under which warrantless arrests can be made. For example, some stipulate that arrests can be made in cases of felonies, within a certain number of hours of the incident, and/or if the persons involved are married, blood-related, living together or have a child together. A listing of these policies can be found in the appendix of this training material.

*Mandatory arrest policies* mean the police officers are required by law to make arrests based on probable cause that domestic violence was committed. Some states that have mandatory arrest provisions include: Alaska, Arizona, Colorado, Connecticut, Iowa, Kansas, Louisiana, and the District of Columbia. *Preferred arrest policies* are less strict; they encourage but do not mandate arrest as the favored action when probable cause exists. States with preferred arrest provisions include: Arkansas, California, Massachusetts, Montana, North Dakota and Tennessee. *Discretionary arrest Policies* allow greatest leniency when confronted with domestic violence. The statutes stipulate that the officer "may" arrest under certain circumstances where probable cause is evident. Those states with discretionary arrest provisions include: Michigan, Minnesota, Nebraska, New Hampshire, New Mexico, North Carolina, Oklahoma, Pennsylvania, Texas, Vermont, West Virginia and Wyoming.

With these policies, an important (but subjective) determination is the idea of “primary aggressor.” Responding officers often have to sort out varying stories of what occurred. In situations where there is a lack of clarity, officers make a *dual arrest*. In this instance, both victim and perpetrator are arrested, and the court makes the determination. These policies have come under fire by domestic violence advocates, such as Eleanor Pence, developer of the Duluth Model of intervention. She states that contemporary domestic violence intervention, far too
often, is “one-size-fits-all,” and can allow some chronic violent abusers to avoid proper punitive sanctions for their long-term violent behavior.

Buel and Hirst (2009) believe that healthcare professionals can be instrumental in helping victims to advocate for themselves when threatened with dual arrest. They can serve as “translators” to help victims of domestic violence to voice what occurred. While this role is an important one, the overall feeling is that dual arrest policies can be detrimental to victims of intimate partner abuse.

**Advocacy**

As Buel and Hirst’s (2009) comments suggest, one role that mental health professionals can play in working with domestic violence is advocacy. Victims of intimate partner violence generally feel disempowered and overwhelmed by the many systems and legalities associated with trauma. They may be struggling to create physical and emotional safety.

What is empowerment? Wilson and Martin (2006) define the word “empower” as “increasing the control people have over their lives.” They include components of feeling powerful, competent and worthy of self-esteem. These authors also states that there needs to be a modification of the structural conditions in order to reallocate power.

The *Advocacy Wheel* for domestic violence (The Missouri Coalition Against Domestic Violence, n.d.) follows. Based on the *Duluth Wheels*, this graphic provides a schema that describes the role of the clinician-advocate. The central goal of the wheel is to help promote empowerment for victims of domestic violence.
While clinicians will have differing roles with regard to advocacy, this wheel is broad enough to cover many of these. A synopsis and explanation of each follows:

**Confidentiality:** As a first step, the clinician must establish confidentiality. Discussing the possibility of victimization must occur in private. A victim of domestic abuse will not typically disclose a history of violence in the presence of her perpetrator or other family members. If she discloses the violence in his presence, it is likely she will suffer retaliation. When there may be limits to confidentiality (discussion will follow), these must be verbalized at the outset. It is helpful to emphasize that the goal of any intervention is providing help.

One area that can be particularly tricky is balancing the role of advocating from a victim of abuse and the mandate to report child abuse.

**Case Vignette**

Maureen Quinto, a licensed social worker, is employed at a community mental health center. She completed an intake with
Mary, a new client seeking help for depression. Mary reported to Maureen that her husband would often beat her and the children. Maureen complied with agency procedures, and reported the child abuse. She received a distraught and angry phone call from Mary, stating that her children had been removed from the house.

Case Vignette
Trudi Hayes, a licensed social worker, is employed at a community mental health center. She meets with a new client, Maribeth. Prior to the intake, she discusses confidentiality, including the limits around child abuse reporting. Maribeth states that she is frightened to tell her what has been happening at home because “I don’t want to lose my kids.” Trudi explains that if a parent initiates a call to Child Protective Services, they are less likely to take the children, stressing that there are resources that can help her. She does not make any guarantees. Maribeth tearfully describes how her husband Tom beats her and the kids. Together they call Child Protective Services, who supports Maribeth in her efforts to take the children to a domestic violence shelter.

These two cases illustrate the importance of managing confidentiality issues in a way that is sensitive and also affirms the role of the non-abusing parent as an integral role.

**Validation**: Validating that violence perpetrated against the victim is true. Victims of domestic violence may be fearful that they will not be believed if they report abuse. In many households where there is domestic violence, and abusive partner can look very “normal” or be considered by others to be an “upstanding citizen.”

**Acknowledge the Injustice**: Victims of domestic violence often feel that abuse is their fault. Be aware of blaming statements and respond appropriately. There is often a great deal of self-doubt and blame.

**Autonomy**: Empowering advocacy is based on the core belief that victims of domestic violence have the right to control their own lives. In the process of victimization, control has been taken away from them. Clinicians should provide victims with autonomy by guiding, but allowing victims to make their own decisions.

**Safety Planning**: What are the victim’s options? Safety is critical. According to the American Psychological Task Force on Violence and the Family (1996) (as summarized by Wilson & Martin, 2006) the following strategies will help ensure safety:
Spousal or Partner Abuse, 84

- Calling the police
- Calling a shelter
- Leaving the home or scene
- Superficially complying with the abuser’s demands
- Talking to friends
- Hiding
- Avoiding the abuser
- Seeking professional help
- Avoiding conflict and keeping the peace

It is also important to remember that the victim is often the ultimate expert on how an abuser will respond. For example, leaving the house may not be an option because it will further incense the abuser. According to Wilson and Martin (2006), two important questions to ask are: “What are some of the cues or behaviors that are present before a violent incident occurs?” and “What have you done in the past to successfully protect yourself and your children.”

Clinicians can also use the sample safety plan (contained in the appendix), a detailed roadmap for victims. It is important to discuss safety procedures, and review them frequently.

*Promote Access To Community Services*: Know the resources in your community. If you are able to do so, provide victims with a written list that they can refer to.

**Navigating the Systems**

A key component in working with domestic victims is in helping them to navigate the various systems they encounter. In addition to the mental health system, some of these systems include: legal, medical, social service, and child protective. When making a referral to any of these systems it is helpful to provide victims with a sense of what they can expect.

While each state varies with regard to the systems in place to prevent and respond to domestic violence, there are some similar agencies that many states have in common. The following is a summary of some of these systems. It is important to know the resources in your home state.

**Offices for the Prevention of Domestic Violence**

These systems support local and state domestic violence efforts. While many of their efforts have to do with grants and funding, they can be a resource for
learning about availability of domestic violence training and a clearinghouse of other services.

**Offices of Victim Services**

Many states have offices of Victims Services. These can be invaluable in supporting victims. Victims Services compensates victims of crime for unreimbursed out-of-pocket expenses, which can include expenses for mental health counseling (including counseling for children and relatives). These systems provide funding to victims of spousal abuse, sexual assault and child abuse. In some states these program includes other victims of violent crime.

In addition to victim compensation, most offices of victim services provide advocates help victims of violent crime by notifying them of their rights and by providing information and assistance. These advocates:

- Provide information to the victim about the criminal case and criminal justice system
- Act as a liaison between victims and court personnel
- Escort victims and their family members to court proceedings
- Advocate for victims during court proceedings
- Provide victims with social service referrals
- Assist victims and their family members in preparing and delivering a victim impact statement

**Criminal And Civil Courts**

This system is the legal arm of domestic violence. Many states have dedicated domestic violence courts that act on criminal complaints pertaining to domestic violence. This ensures consistent responses to domestic violence. Domestic violence is no longer treated as a simple battery. Consequently, our system imposes enhanced and specialized sentences for these offenses.

One important function of civil courts involves the issuance of protective orders. An order of protection (also called a restraining order) is an official document that outlines provisions that limit contact between an abusive partner and the victim. There are generally two types of protective orders: protection from abuse (PFA) and protection from harassment (PFH). According to Buel & Hirst (2009) the orders may include provisions that:

- Prohibit future abuse against victims and any children in the home
- Maintain a 100-yard distance from the victim, home, workplace or other appropriate location
- Refrain from contacting the victim in any way
- Determine who may stay in residence
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- Pay compensation for damages
- Award custody of the child
- Require supervised visitation
- Enforce payment of spousal and child support
- Prohibit purchase of a gun and relinquishment of guns during the enforcement of the protective order
- Require appropriate counseling or treatment for the abusive partner

While the process for filing a protective order will vary from state to state, there are some similarities. In most places, once appropriate paperwork is completed, a temporary (“ex parte”) protective order is issued. This order keeps the abusive partner away from the victim for a specified period of days (usually about 5-7) until a formal hearing is held. At the hearing, the judge decides if the protection order will be canceled or continued.

While it is not mandatory that the victim bring any “proof” with her to court, it is generally helpful. Proof of abuse or harassment may include:

- Photographs of injuries (and if possible the person who took the photographs)
- Threatening notes, email, phone messages.
- A witness who saw or overheard the abuse, even though in some courts only the parties are allowed to testify.

A victim advocate may be helpful to provide additional support.

Once a protection order has been issued, its effectiveness in ensuring the continuing safety of the protected person depends in large measure on the enforcement of that order. Enforcement must occur smoothly and routinely in order to work as a deterrent to continued domestic violence. States and municipalities establish rules around the enforcement of protective orders. The Federal Violence Against Women Act (VAWA) makes protection orders enforceable across state lines. If a victim believes that an order of protection has been violated, he or she should call police immediately. In many states, violators of protective orders are immediately arrested and jailed.

Family Courts

Intimate partner violence is a common issue in custody, visitation, and divorce cases. Family courts are often called upon to assess the impact of family violence with regard to these types of court cases. Since custody and visitation cases often involve mental health issues, expert testimony from mental health providers may be required.

Departments of Health
These systems include direct medical services. Rape crisis centers are also housed within departments of health. These systems generally also provide direct crisis counseling.

**Child Protective Services (CPS)**

While most clinicians know the term “child protective services”, it is often not until a client is involved in this system that CPS functions are truly understood. Many women who have been abused by an intimate partner are also involved with CPS, and by extension, treating clinicians will be involved as well. In defining CPS, the Family Violence Prevention Fund states: “The child protection system is a bureaucratic government institution responsible for ensuring that various laws, regulations and policies regarding the protection of children are enforced.”

While state laws vary with regard to what is reportable to CPS, in many states clinicians are mandated to report to CPS any reasonable suspicion of child abuse or neglect.

Most women fear the possibility of a report being filed with CPS. While there are cases in which children are removed from an abusive household, more often efforts are made to keep children with a non-abusing parent. This may mean that a parent is referred to a shelter or short-term housing. CPS often also runs support groups and can refer women to additional resources. The following types of services are available:

*Family support services* are community-based services that assist and support parents in their role as caregivers. Family support services promote parental competence and healthy child development by helping parents enhance their strengths and resolve problems that can lead to child maltreatment, developmental delays, and family disruption.

*Family preservation services* are short-term, family-focused, and community-based services designed to help families cope with significant stresses or problems that interfere with their ability to nurture their children. The goal of family preservation services is to maintain children with their families or to reunify them, whenever it can be done safely.

**Ethical Considerations: Confidentiality**

*Dr. Markin is working with Patricia, a registered nurse, who has recently separated from her husband Gerald. Patricia has two daughters, ages 8 and 10. Gerald sees his daughters on weekends. Gerald has been abusive to Patricia in the past, but she denies any current incidents. Patricia has worked hard to*
increase her autonomy, and has stated that she will not condone any type of abuse to herself or her daughters. Following the separation, Patricia purchased a handgun and has taken shooting lessons. Patricia phones Dr. Markin for an emergency session. She tells Dr. Markin that her older daughter came home from a weekend visit with bruises, stating that her father had hit her because of her “foul mouth.” Patricia is incensed, stating that she plans to “kill that son of a bitch.”

What are Dr. Markin’s obligations here? Should she report Gerald to child protective services? Does she have a duty to warn Gerald about the threat to his safety?

Mental health professionals are confronted with a wide range of ethical and legal issues concerning their treatment of victims of domestic violence. As the case above illustrates, many ethical issues arise as a result of balancing the roles of therapist, advocate, and mandated reporter. Mental health functions frequently intersect with other disciplines, which can lead to conflicts in maintaining confidentiality. For example, a common issue that arises in treatment of domestic violence victims is the need to interact with the various systems discussed in this material, such as the criminal justice system, child protective services, etc. The case vignette provided an example of potential disclosure of confidential therapy discussions to child protective services. Questions may arise regarding whether clinicians can maintain the confidentiality of patient information or whether they must comply with police or court requests for access to health records or reports. Another common issue is whether mental health professionals should breach confidentiality in relation to patients they consider at risk of harming themselves or others. This section will discuss several of these issues. It is important, however, to be aware of the specific guidelines of the state in which you practice.

To begin, let’s look at the obligation to maintain confidentiality, a standard shared by all professional codes. An example of this guideline is contained in National Association of Social Workers (NASW) standard 1.07, which states: “Social workers should respect clients’ right to privacy. Social workers should not solicit private information from clients unless it is essential to providing services or conducting social work evaluation or research. Once private information is shared, standards of confidentiality apply.”

That does not mean, however, that social worker, psychologists, and counselors cannot share confidential information. When an appropriate authorization is in place, and clients consent to sharing information, this is allowable. Examples that may apply to domestic violence cases are: interacting on the patient’s behalf to obtain housing, sharing information with courts to support an order of protection, or coordinating with a child’s school teacher or counselor.
Compelling Reasons to Break Confidentiality

Professional codes of ethics allow disclosure of confidential information when there are “compelling professional reasons.” These reasons include “serious, foreseeable, and imminent harm to a client or other identifiable person.” This is a broad dictate, and can include (but is certainly not limited to) harm to a minor child, harm to an elder, harm to oneself, or harm to others. Should a clinician be required to break confidentiality, he or she should disclose “the least amount of confidential information necessary to achieve the desired purpose; only information that is directly relevant to the purpose for which the disclosure is made should be revealed” and when possible, inform clients of the disclosure in advance.

While the confidentiality standards discussed in the previous paragraph are ethical mandates, a closely related legal function is the clinician’s role as a mandated reporter. Simply put, being a mandated reporter means that an individual is required to report suspected cases of abuse. All states have passed some form of mandatory child abuse and neglect reporting law in order to qualify for funding under the Child Abuse Prevention and Treatment Act (CAPTA). In addition to child abuse reporting laws, many states also have laws pertaining to mandatory reporting of elder abuse (for more about older adults and domestic violence please see “Issues in Domestic Violence: Special Populations.”) The laws apply to mental health providers working both in private practice and institutional settings.

One common question is how certain about clinicians need to be in order to make a report of abuse. Although this is something that each clinician needs to decide for his or herself, Pass (2007) observes that if a clinician witnesses only behavioral symptoms of child abuse (e.g., sudden changes in behavior or school performance, hypervigilance, concentration problems) it is best for the clinician to document their observations and continue to assess the situation. When a professional observes physical symptoms (e.g., bruises or other marks) it is best to consult with a colleague and also to speak with a parent or guardian. When a clinician notices a combination of physical and behavioral symptoms, however, an immediate report is indicated. On a therapeutic level it is important to consider the potential consequences of reporting, and thoroughly assess the situation. There is no timeframe; a 2-3 week assessment is ok if the child is not in immediate danger.

In addition to issues regarding suspected child abuse, clinicians are ethically bound to disclose information in situations in which they believe a client will harm themselves or another identifiable person. With the link between domestic violence and suicidal thoughts/attempts (see Devries et al., 2011) it is important to keep in mind that a clinician may need to seek help for a client, even if it means breaking confidentiality. Additionally they may be compelled to seek help for an intended victim, even if that victim is an abusive partner. The treating
professional’s duty to warn is discussed in a subsequent section.

Confidentiality and Privilege

Case Vignette
Carla Varnis, a clinical social worker, is working with Pamela. Pamela has been a victim of domestic abuse. Carla receives subpoena for medical records from Pamela’s husband’s attorney. Pamela’s husband has filed for custody, stating that Pamela is “crazy” and “unfit to be a parent.” Carla recognizes that her therapy notes likely do have some information about Pamela’s past mental health history that could be prejudicial. What should she do?

As this case illustrates, the intersection of the court system and mental health system can prove to be challenging. In some cases, such as when a clinician is providing information that a client has requested that a court representative receive, it is simple. For example, if a client requests that her own lawyer receive a summary of therapy sessions, such information can be provided by having the client sign a release form authorizing this disclosure. This is covered by NASW ethical standard 1.07b “Social workers may disclose confidential information when appropriate with valid consent from a client or a person legally authorized to consent on behalf of a client” and by similar standards with the other professions. It is still important, however, to explain to the client the potential consequences of the disclosure prior to releasing the records to a third party. NASW ethical standard 1.07d states “Social workers should inform clients, to the extent possible, about the disclosure of confidential information and the potential consequences, when feasible before the disclosure is made.” The standard goes on to clarify that clinicians should still educate the client about the potential effects of disclosures “on the basis of a legal requirement or client consent.” While other ethical codes (such as the APA code) are not as specific about the need to provide psychoeducation, it is good clinical practice.

A question that frequently arises is the distinction between confidentiality, an ethical and legal requirement, and privilege, a legal term. Psychotherapists have an ethical and legal requirement to maintain the confidentiality of disclosures made by clients during the course of treatment.

In the case of the vignette presented at the outset of this section, in which an attorney subpoenas treatment records a clear conflict exists for the clinician. The therapist in the vignette, Carla, has several duties to Gloria, one of which is to maintain the confidentiality of their communications. In order to do so, Carla must assert psychotherapist-patient privilege. By asserting privilege, Carla is communicating to the court that she recognizes her duty to respond to the subpoena asking her to provide information to the Court (which is a legal obligation), but that she has a competing duty to the patient to keep her therapy disclosures confidential. Further by invoking privilege Carla is asserting the belief that her duty to maintain patient confidentiality outweighs the duty to provide
information that could be used as evidence. Asserting privilege acts as a request to the court to be exempted from the duty to provide this confidential information (Clinical Lawyer, n.d.)."

While the opposing lawyer can continue to fight to see Gloria’s records, most courts err on the side of privilege. It is helpful to speak to legal experts from the state licensing board that governs your profession.

**Treating Professional’s Duty to Warn**

Another ethical issue is the treating professional’s duty to warn. Let’s return now to the case vignette that introduced this section:

*Dr. Markin is working with Patricia, a registered nurse, who has recently separated from her husband Gerald. Patricia has two daughters, ages 8 and 10. Gerald sees his daughters on weekends. Gerald has been abusive to Patricia in the past, but she denies any current incidents. Patricia has worked hard to increase her autonomy, and has stated that she will not condone any type of abuse to herself or her daughters. Following the separation, Patricia purchased a handgun and has taken shooting lessons. Patricia phones Dr. Markin for an emergency session. She tells Dr. Markin that her older daughter came home from a weekend visit with bruises, stating that her father had hit her because of her “foul mouth.” Patricia is incensed, stating that she plans to “kill that son of a bitch.”*

What are Dr. Markin’s obligations here? Should she report Gerald to child protective services? Does she have a duty to warn Gerald about the threat to his safety?

There are clearly a number of issues involved in this case, including therapeutic, ethical and legal concerns. Let’s take each of these duties separately. From a therapeutic standpoint, Dr. Markin has a duty to provide a safe environment in which Patricia can work through her feelings about her relationship with Gerald. Such safety is especially critical to allow victims of domestic violence to heal from their traumas and to move forward with their lives. According to the Advocacy Wheel depicted earlier it is critical to respect confidentiality, promote safety and validate the victim’s experiences. Given these important concerns, it is important that any decision that would involve breaking confidentiality be fully considered.

Ethically, Dr. Markin could, if he feels it is indicated, make a disclosure based on the limited details of the case. According to APA Ethical Standard 4.05B Psychologists disclose confidential information without the consent of the individual only as mandated by law, or where permitted by law for a valid purpose such as to (3) protect the client/patient, psychologist, or others from harm. While Dr. Markin could disclose information for the reason of protecting Gerald, it would clearly come into conflict with his ability to act in a therapeutic manner.
Tarasoff v. Regents of the University of California (1976) is the case that established the duty to warn in California and iterations of the “duty to warn/duty to protect” laws have been passed in most states across the country. The idea behind these laws is that by accepting responsibility for the care of a client in need of mental health treatment, the clinicians may owe a duty to protect third parties from harm threatened by the client. The Tarasoff ruling states: “When a therapist determines, or pursuant to the standards of his profession should determine, that his patient presents a serious danger of violence to another, he incurs an obligation to use reasonable care to protect the intended victim against such danger” (Tarasoff, 1976, p. 340).

What makes the question of what Dr. Markin should do even more confusing is that there are state variations in duty to warn requirements. The following categories apply (NASW):

**Mandatory Duty to Warn.** Some states establish a mandatory duty to warn. These are: Arizona, California, Colorado, Delaware, Idaho, Illinois, Indiana, Kentucky, Louisiana, Maryland, Massachusetts, Michigan, Minnesota, Montana, Nebraska, New Hampshire, New Jersey, Ohio, Tennessee, Utah, Virginia, and Washington. A number of these states also have court decisions that have interpreted the duty to warn laws.

**“Permissive” Standard.** Some states give permission in state statutes for therapists to warn of serious threats. These states are: Alaska, Arkansas, District of Columbia, Florida, Hawaii, Iowa, Mississippi, Missouri, New Mexico, New York, Oklahoma, Oregon, Rhode Island, South Carolina, South Dakota, Texas, Virgin Islands, West Virginia, and Wyoming. In some states, such as Texas, the permission to warn is limited to notifying medical or law enforcement personnel, not the threatened person or persons.

**No Statutory Standard.** A third set of states does not provide any statutory language addressing the duty to warn, but some of these have implemented the duty through court decisions. Connecticut, Pennsylvania, Vermont and Wisconsin do not have statutory provisions, but have established a duty to warn through court decisions. States that are silent as to the social worker’s duty to warn are Georgia, Kansas, Maine, Nevada, North Dakota, and Puerto Rico.
While these variations make it hard to determine a one-size fits-all approach to what to do in the case study, there are some recommended standards for decision making. According to the NASW publication *Social Workers and State Duty to Warn Laws*, some of the key issues to review in a case involving a possible duty to warn are:

- Whether the client is the individual who represents a threat to self or others
- Who has disclosed the threat and under what circumstances
- How much time has passed since the threat was made
- Whether the client possesses the means and capacity to carry out the threat
- Whether the duty to warn has been established as a mandatory requirement in state law
- Whether the threat of harm is to a specific individual or represents a general threat to the public at large
- Whether the criteria for involuntary commitment may apply
- Whether the state permits disclosure of a threat even if it is not mandatory
- Who needs to be warned to effectively discharge the duty to warn (e.g. Law enforcement, the intended target, the department of motor vehicles, a treating physician, a responsible family member).

Sample conversation with Patricia (state variations will occur)

After allowing Patricia time to talk about feelings:

Dr. Markin: I am concerned about some things that you said earlier. You said that you wanted to “kill that son of a bitch.” Do you still feel that way?

Patricia: I don’t want to see my daughter being abused the same way I was.

Dr. Markin: That’s understandable. But meeting violence with violence is not the answer. If you went to prison, your daughters would have no one to care for them.

Patricia: I know that. I just feel so powerless.

Dr. Markin: I think that one thing that may help is to make a call together to Child Protective Services. They will help us to make sure that both you and the girls stay safe.
Patricia: I know you’re right. I’m angry, that’s all. Let’s make the phone call.

In this situation, Dr. Markin used his clinical judgment to diffuse a potentially dangerous situation. Had Patricia been less cooperative and he felt that a credible threat still existed, enlisting the support of the authorities may have been necessary.

Summary

This training material discussed many of the legal and ethical issues related to supporting victims of domestic abuse. While clinicians cannot be “experts” on all facets of domestic violence competent care is grounded in the ethics and standards of the profession. Mental Health professionals need to be aware of ethical and legal standards and they also need to develop and maintain the professional skills necessary to work with victims and families affected by domestic violence.
Appendix

Domestic Violence Safety Plan

Victims of domestic violence need to plan in advance for safety. The following considerations are important ones, and can be discussed in a therapy session.

Things to think about and have ready:

1. Important phone numbers. These may include hotlines, clergy, school contacts, friends and the local domestic violence resources and shelters.
2. Friends or neighbors that could seek help on your behalf. Ask them to call the police if they hear angry or violent noises. If you have children, teach them how to dial 911. Make up a code word that you can use when you need help.
3. Safe exit from home. Practice ways to get out quickly if need be.
4. Safer places within home. Think about places where victims can go to be away from the abuser.
5. Remove all weapons from the house if possible.
6. Even if clients are not open to the idea of leaving, it is still important to have them consider where they could go. An “exit strategy” is also helpful. This strategy may involve a way to leave the house, such as walking the dog or going to the store. It is also helpful to have a bag of everyday items packed, but well hidden.
7. Encourage clients to go over their safety plan often.

Other considerations:

1. Have clients think of three or four places they could go if they leave home.
2. Have clients think about people who might help if they left. These may include people who could keep a bag for them, who could loan them money, or who could help with children. It is also important to make plans for pets.
3. Clients may consider getting a prepaid cell phone to pack in a bag.
4. Clients may consider opening a bank account or getting a credit card in their name only.
5. Clients should consider issues regarding children. There may be times when it is safer to leave without children.

Things to take
- Order of protection
- Money
- Keys to car, house, work
Extra clothes
Medicine
Important papers
Birth certificates
Social security cards
School and medical records
Bankbooks, credit cards
Driver's license
Car registration
Welfare identification
Passports, green cards, work permits
Lease/rental agreement
Pictures, jewelry, things that are meaningful
Items for children (toys, blankets, etc.)
## States with Mandatory Arrest Provisions

<table>
<thead>
<tr>
<th>State</th>
<th>Condition</th>
</tr>
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<tbody>
<tr>
<td>Alaska</td>
<td>Probable cause to believe that a crime of domestic violence was committed within past 12 hours.</td>
</tr>
<tr>
<td>Arizona</td>
<td>Domestic violence involving infliction of physical injury or use/threatening use deadly weapon.</td>
</tr>
<tr>
<td>Colorado</td>
<td>Probable cause to believe a crime of domestic violence was committed.</td>
</tr>
<tr>
<td>Connecticut</td>
<td>Speedy information that family violence was committed in jurisdiction.</td>
</tr>
<tr>
<td>District of Columbia</td>
<td>Probable cause to believe that an intrafamily offense was committed that resulted in physical injury including pain or illness or caused or was intended to cause reasonable fear of imminent serious physical injury or death.</td>
</tr>
<tr>
<td>Iowa</td>
<td>Probable cause to believe that domestic abuse assault committed that resulted in bodily injury, or was committed with intent to inflict serious injury, or with use or display of dangerous weapon.</td>
</tr>
<tr>
<td>Kansas</td>
<td>Probable cause to believe a crime has been committed.</td>
</tr>
<tr>
<td>Louisiana</td>
<td>Reason to believe family or household member has been abused and (1) probable cause exists to believe that aggravated/second degree battery was committed or (2) aggravated or simple assault or simple battery committed and reasonable belief in impending danger to abused.</td>
</tr>
<tr>
<td>Maine</td>
<td>Probable cause to believe there has been a violation of aggravated assault statute between members of same family or household.</td>
</tr>
<tr>
<td>Mississippi</td>
<td>Probable cause to believe that within 24 hours offender knowingly committed a misdemeanor act of domestic violence.</td>
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<tr>
<td>Missouri</td>
<td>Called to same address within 12 hours</td>
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<tr>
<td>State</td>
<td>Conditions</td>
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</tr>
<tr>
<td>Nevada</td>
<td>Probable cause to believe that within 24 hours battery was committed.</td>
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<tr>
<td>New Jersey</td>
<td>Probable cause to believe that domestic violence has occurred and either victim shows signs of injury or probable cause that a weapon was involved.</td>
</tr>
<tr>
<td>New York</td>
<td>Probable cause to believe a felony has been committed against a member of the same family or household or, unless victim requests otherwise, a misdemeanor family offense committed.</td>
</tr>
<tr>
<td>Ohio</td>
<td>Reasonable cause to believe that offender committed felonious assault.</td>
</tr>
<tr>
<td>Oregon</td>
<td>Probable cause to believe that a felonious assault or an assault resulting in injury occurred or action has placed another to reasonably fear imminent serious bodily injury or death.</td>
</tr>
<tr>
<td>Rhode Island</td>
<td>Probable cause to believe the following: felonious assault; assault resulting in injury; action was intended to cause fear of imminent serious bodily injury or death.</td>
</tr>
<tr>
<td>South Carolina</td>
<td>If physical injury is present and probable cause to believe person is committing or has freshly committed a misdemeanor/felony assault or battery.</td>
</tr>
<tr>
<td>South Dakota</td>
<td>Probable cause to believe that within previous 4 hours, there has been an aggravated assault, an assault resulting in bodily injury, or an attempt by physical menace to place in fear of imminent serious bodily injury.</td>
</tr>
<tr>
<td>Utah</td>
<td>Probable cause to believe that an act of domestic violence was committed and there will be continued violence or evidence perpetrator has recently caused serious bodily injury or used a dangerous weapon.</td>
</tr>
<tr>
<td>Virginia</td>
<td>Probable cause to believe assault or</td>
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Spousal or Partner Abuse, 98
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<th>Spousal or Partner Abuse, 99</th>
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<tr>
<td>__________________________</td>
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<tr>
<td>battery on family or household member.</td>
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<tr>
<td>Washington</td>
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<td>__________________________</td>
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<tr>
<td>Probable cause to believe a person 16 years or older within the previous 4 hours assaulted a family or household member <em>and</em> believes (1) felonious assault occurred, or (2) assault resulting in bodily injury occurred whether injury is visible or not, or (3) any physical action occurred which was intended to cause reasonable fear of imminent serious bodily injury or death.</td>
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<td>Wisconsin</td>
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<tr>
<td>Probable cause to believe a person 16 years or older within the previous 4 hours assaulted a family or household member <em>and</em> believes (1) felonious assault occurred, or (2) assault resulting in bodily injury occurred whether injury is visible or not, or (3) any physical action occurred which was intended to cause reasonable fear of imminent serious bodily injury or death.</td>
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<tr>
<td><strong>Coded Relationships</strong>: (A) current/former spouse, (B) current/former cohabitant, (C) child in common, (D) Dating relationship, (E) related by marriage or blood</td>
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<tr>
<td>__________________________</td>
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<tr>
<td>Source: U.S. Department of Justice</td>
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</tbody>
</table>
Spousal or Partner Abuse, 100

References


