Common Mental Health Correlates of Domestic Violence

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This article is a review of the research literature on mental health correlates of domestic violence, with an emphasis on posttraumatic stress disorder (PTSD). It was done to develop clues, symptoms, and indicators so that practitioners in mental health or criminal justice could become alert to indicators of the onset and severity of depression, anxiety disorders, substance abuse, and/or PTSD among battered women. [*Brief Treatment and Crisis Intervention* 6:111–121 (2006)]

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Even though there is a plethora of data on domestic violence, there are only a small number of studies on the mental health effects of domestic violence. Yet, the psychological impact of domestic violence can be more debilitating than physical injuries (Gleason, 1993; Perrin, Van Hasselt, Basilio, & Hersen, 1996; Petretic-Jackson, Witte, & Jackson, 2002; Roberts, 2002; Roberts & Kim, 2005; Roberts & Roberts, 2005). The goals of this article were to determine if there was a relationship between battering and mental health, especially posttraumatic stress disorder (PTSD). I examined adult battering and victimization in relation to mental health concerns and suggest ways mental health professionals can better assist victims who experience these symptoms.

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Prevalence of Domestic Violence

Every 9 seconds a woman is abused or battered somewhere in the United States (Roberts & Roberts, 2005). Recent estimates indicate that 8 million women are battered annually. ''Intimate partner violence is the single greatest health and mental health threat to American women between the ages of 15 and 50'' (Roberts & Roberts, 2005, p. 4). According to Hamberger and Phelan (2004), intimate partner violence is strongly correlated with physical and mental disorders as well. One of the most harmful correlates of woman battering is PTSD symptoms, depressive symptoms, and suicide ideation. Several research studies have documented a significant association between ''the extent and intensity of battering experiences and the severity of PTSD symptoms''(Roberts, 2002, p. 12). Woods (2000) reported that 74% of battered women experience PTSD in various forms (Woods, 2000).

Literature Review on Mental Disorders

This review concentrates on the most common disorders associated with domestic violence

and has a specific emphasis on PTSD. Anxiety disorders are the most frequently occurring mental disorders. They also are associated with being battered. Decreased self-esteem is also associated with victimization. Next on the list is depression.

PTSD affects hundreds of thousands of people. It occurs in persons who have experienced life-threatening situations such as war, natural disasters, and terrorism; but studies show that it can also develop under other life-threatening situations such as domestic abuse and rape. The highest rates of PTSD are found among women who are victims of crime, especially rape and woman battering (Roberts & Kim, 2005; Yehuda, 1999).

There is consistent support for the contention that domestic violence is highly correlated with PTSD. PTSD is associated with an increasing likelihood of co-occurring disorders. In one study, 88% of men and 79% of women with PTSD met the criteria for another psychiatric disorder (Hamberger & Phalen, 2004; Pico-Alfonzo, 2005; Roberts & Roberts, 2005). Most common was alcohol abuse or dependence and major depressive episodes for men and major depressive disorders and simple phobias for women (http://www.ncptsd.va.gov/). Obviously, many of these diagnoses go hand in hand. A battered woman who experiences anxiety would probably be affected by bouts of PTSD, depression, and low self-esteem. Victims of rape and child abuse could also develop these symptoms. In fact, those who have experienced abuse of any sort as a child are probably at an increased risk for adult disorders. Pico-Alfonzo (2005), in particular, found a relationship between a history of child abuse and adult partner violence as the biggest forecaster of PTSD. The following studies discuss the links between each of the disorders.

Haj-Yahia (2000) found ''that significant amounts of the variances in women's low self-esteem, depression and anxiety are'' explained by their experiences with abuse (p. 453).

When examining the interaction effect of change and ethnicity in terms of depression, African American women seem to have even more depression problems than women of other ethnic groups, including depressive effects lasting beyond the end of the violence (Barbee, 1994; Richie, 1993; Vaz, 1995). Barbee (1994) studied a relatively small sample of 29 low-income Black women who were interested in discussing their experiences with dysphoria and depression in a focus group.

Golding (1999) assessed ''the prevalence of mental health problems among women with a history of intimate partner violence, finding the weighted mean prevalence of 47.6% in 18 studies of depression, 17.9% in 13 studies of suicidality, 63.8% in 11 studies of PTSD, 18.5% in 10 studies of alcohol abuse and 8.9%'' in 4 studies of drug abuse (Golding, 1999, p. 99). After a sexual assault, women may feel shock or confusion. A common reaction includes depression and thoughts of suicide. Kilpatrick, Saunders, Veronen, Best, and Von (1987) found 57.1% of rape victims developed PTSD. A study in North Carolina found that individuals with PTSD were almost 15 times more likely to have attempted suicide (Davidson, Hughes, Blazer, & George, 1991).

However, some studies show that neither prior history of childhood physical or sexual abuse nor severity of abuse is a significant factor in the presence of PTSD (Stoebner, Johnson, Combs, & Nash, 1999).

McCauley et al. (1997) found that 22% of their respondents reported childhood or adolescent physical or sexual abuse. Compared with women who reported no abuse, those who were abused as children but not adults had more physical symptoms and higher scores for depression, anxiety, somatization, low self-esteem, suicide, and alcohol abuse. Those who reported childhood and adult abuse had higher levels of these problems. However, they did not find significant differences in adult mental

health between women who had been sexually victimized versus those physically victimized (McCauley et al., 1997).

Lethal Results

PTSD can continue for a lifetime, especially among battered women who lethally retaliate. Relatively little attention is paid to the small number of battered women who kill their male partners. Serious and specific death threats, harming of the children, and low level of educational attainment were three of the largest predictors of homicide among 105 battered women who killed their abusive partners (Roberts, 1996). Some of these women attempted suicide before killing as a last resort, demonstrating major depression, trauma, and psychological disorders as a result of the battering. Roberts and Roberts (2005) most recent book examines the most harmful physical and emotional effects of battering among 501 battered women. Many of the chronically battered women in their study were battered from 5 to 35 years, and as a result suffered from PTSD, major depression, suicide ideation and suicide attempts, as well as traumatic brain injury. Roberts and Roberts (2005) found a strong correlation between chronically battered women who suffered from PTSD, and suicide ideation and killing their abusive partners.

With regard to the battered women who kill, to what extent do preexisting mental disorders such as PTSD lead to homicide? Some studies have examined whether PTSD may increase the likelihood of a homicide by a victim of domestic violence (Hattendorf, Otten, & Lomax, 1999; O'Keefe, 1998; Roberts & Roberts, 2005). For example, the majority of the105 homicidal battered women in Roberts and Roberts (2005) study reported preexisting sleep disturbances, flashbacks, night terrors, PTSD, depression, and suicide attempts. In another study Hattendorf et al. (1999) attempted to establish the presence of PTSD in battered women prior to the lethal event through the use of surveys and interviews. They studied 18 incarcerated Illinois women for symptoms of PTSD prior to killing their male partners, finding that 17 of 18 reported ''moderate to high levels of 16 PTSD symptoms prior to the lethal incidents. Two of the most consistently and intensely experienced symptoms were the sense of a foreshortened future and feelings of detachment. A few indicated an inability to recall the traumatic aspects of their abuse'' (Hattendorf et al., 1999, p. 302). O'Keefe (1998) examined battered women who killed/seriously assaulted their batterers, finding that these victims experienced more frequent and severe spousal abuse than those in the comparison group. The author also found each of the following variables to influence the likelihood of PTSD: physically/sexually abusive partner, PTSD symptomatology, social support, counseling in prison, and the amount of time that had elapsed since living with that abusive partner. Yet, no research has established PTSD prior to the lethal event.

The New Jersey Domestic Violence Fatality Review Board (2001) recorded 27.3% of victims of domestic violence homicide–suicide as having contact with health care providers. Interestingly, 21.3% saw mental health providers in the last 5 years (for any reason). Further, 12.1% of the perpetrators saw mental health professionals specifically about the violence in the relationship, and they saw them for other reasons in another 24.2% of cases.

What are the symptoms among battered women who seek shelter assistance before the situation turns lethal? Have any of these victims been diagnosed with a mental illness before being battered? Have any of these victims experienced mental illness during the abusive incidents or after coming to a shelter to escape the abuse? Does mental illness (especially depression and low self-esteem)

''predispose'' women to become victims? The question of ''which came first'' is a good one that is rarely addressed in research since most of those diagnosed with PTSD are not diagnosed until they are abused and seek assistance. It appears that the trauma is the independent variable in the relationship and that a mental illness develops after exposure to that trauma. In addition, earlier studies showed that up to 10% of otherwise healthy people experience panic attacks and other mental problems (Klerman et al., 1991), demonstrating that many persons function quite well while in need of medical treatment, as well as demonstrating that many persons with mental illness are not battered.

As a matter of logistics, the symptoms of anxiety, panic disorder, and so on make it difficult for victims to breathe and usually lead to emergency room (ER) visits, making the afflicted easy to identify by medical staff. Persons with these disorders are likely to seek medical treatment and thus would be recognized as victims of domestic violence relatively quickly. Those who experience panic and anxiety disorders also experience an urge to escape or flee. Yet, battered women usually encounter the exact opposite emotions, fearful of seeking medical treatment, exposing their battering spouse or their victimization injuries. However, other characteristics of mental health conditions are consistent with battered women. For example, low self-esteem and helplessness/hopelessness are common for victims of domestic violence and mental disorders. In addition, mental health is correlated with the development of substance abuse problems as is exposure to battering. In addition, the New Jersey Domestic Violence Fatality Review Board did find contact with mental health care providers on the part of victims and offenders before a lethal incident occurred. In all probability, PTSD is a risk factor for abuse (these are biological, psychological, or sociocultural variables that increase the probability for developing a disorder) (Gormezy, 1983; Werner & Smith, 1992). Certainly, this question is one that can be argued for years to come. The only potential way to truly solve the question is for qualified evidence-based psychotherapists and clinical researchers to conduct numerous longitudinal studies on large samples of those diagnosed with mental illnesses and assess their likelihood of being battered. This study could assist therapists and criminal justice agencies, who could then inform mental health professionals of a potentially hazardous situation before it is too late (see subsequently for a review of primary preventative efforts).

Unfortunately, as the above literature review demonstrates, many studies have a small *N* because they are qualitative and in-depth. No pretesting was done to answer the ''chicken and egg'' question of what comes first (PTSD–domestic violence or domestic violence–PTSD). These studies were beneficial, and some sacrifice in quality may be felt if newer studies are more quantitatively based, but a different methodology may solve some unanswered questions.

Experience With Shelter Victims

The author interviewed battered women in the shelter setting over the last few years and found some consistent themes: Alcohol abuse was common among the victims and the offenders, and extremely low levels of self-esteem were found among the residents. Even after ''escaping'' from their abusive partner, most victims felt terrible about themselves. Many went back to their abusers after a few months in the shelter and many met up with new abusive partners after getting out of an abusive relationship (Robertiello, 2003). Their parents also abused them when they were children, supporting the cycle theory so often discussed. The cycle of violence hypothesis suggests that a history of

abuse predisposes survivors to violence in later years.

Many of the victims I have studied, experienced abuse as children and then found abusive adult relationships with friends, boyfriends, and spouses. As adults, they allowed their children to walk all over them and bore the brunt of the blame when their abusive husbands abused their children. Yet, not one shelter victim interviewed by this researcher was diagnosed with PTSD, probably because they never sought psychological assistance before entering the shelter and hid their feelings once they left their abusers (Robertiello, 2003). Does abuse as a child lead to abusive behavior as an adult? Is this hypothesis true for domestic violence victims also? Does experiencing abuse as a child lead to experiencing further abuse as an adult?

The Effects of Childhood Victimization

Since the term *Battered Child Syndrome* was coined in 1962, 50,000 parents have killed their children and at least 25 million more children were abused, neglected, and/or sexually exploited (Helfer & Kempe, 1988). Recent studies have demonstrated that children growing up in violent homes (where parents are abusive) are likely to be violent and to experience abuse themselves (Widom & Maxfield, 2001). Of the 48 million children who live in two parent homes, 17.8 million may be exposed to marital violence. Although studies show that exposure to domestic violence does not have the same effect on all children, some studies have found that children exposed to domestic violence exhibited higher levels of PTSD symptomatology (Widom & Maxfield, 2001). In general, ''studies indicate that 15% to 43% of girls and 14% to 43% of boys have experienced at least one traumatic event in their lifetime. Of those children, 3% to 15% of girls and 1% to 6% of boys could be diagnosed with PTSD'' (Hamblin, 1998, p. 4). Similarly, ''90% of sexually abused children, 77% of children exposed to school shootings and 35% of urban youth exposed to community violence develop the disorder'' (Hamblin, 1998, p. 4).

Rossman (1998) explored the relationship of cognition and emotion for children exposed to severe and repetitive parental violence, arguing that the two concepts become strongly linked in guiding behavior in life-threatening circumstances. In a study of over four hundred 4- to 13-year-old children and their mothers, the PTSD subscale score from the Child Behavior Checklist was used. Families were recruited from the community, schools, and agencies, as well as shelters for battered women. Shelter children and mothers were interviewed in the shelter for their safety; community children were interviewed in the laboratory. The author determined that minority status, Conflict Tactics Scale verbal and physical aggression between caregivers, and family stressful events were all significantly higher in the shelter witness groups, and Socio-Economic Status levels were significantly lower. When these factors were controlled for, all child witness groups had significantly higher symptomatology than the nonexposed children. They also performed more poorly on cognitive tests (Rossman, 1998).

In one study of 64 children exposed to physical and emotional maltreatment of their mother, qualified PTSD was found in 13% of children (Graham-Bermann & Levendesky, 1998). Famularo, Fenton, Kinscherff, and Augustyn (1996) used structured clinical interviews to study 117 severely maltreated children and found 35% to meet the criteria for PTSD. Pediatric PTSD was significantly correlated with attention deficit/hyperactivity disorder, other anxiety disorders, the presence of suicidal tendencies, and mood disorders (Famularo et al., 1996). In addition, children who are exposed to serious domestic violence or are sexually abused appear to develop PTSD at a higher rate

than other mistreated children (Famularo, Fenton, & Kinscherff, 1993). They are also more likely to attempt suicide (Thompson et al., 1999).

According to Stoebner et al. (1999), many battered women have experienced a prior abusive relationship or witnessed marital violence as children. These experiences have a large impact on women (Brancato, 1987). Women with a history of sexual abuse in childhood are more likely to demonstrate higher scores on PTSD scales (Halle, Burghardt, Dutton, & Perrin, 1991).

Studies also show that mothers victimized during both childhood and adulthood have poorer outcomes (i.e., more depressive symptoms) than mothers victimized during either childhood or adulthood (Dobowitz, Black, Kerr, Hussey, & Newberger, 2001; Roberts, Williams, Lawrence, & Raphael, 1998). Polusny and Follette (1995) reviewed a sample of studies generated by a computerized database search of PsycLit for the years 1987–1993. In general, they found PTSD symptoms have ranged from 33% to ''86% among sexually abused victims across studies'' (Polusny & Follette, 1995, p. 144).

Another study found that ''42% of women who experienced childhood physical abuse and 35% of women who experienced childhood sexual abuse met the PTSD criteria'' (Thompson et al., 1999, p. 63) (vs. 3% and 2%, respectively, of those who did not experience the physical or sexual abuse) (Silverman, Reinherz, & Giaconia, 1996).

In a community sample of 391 adult females, 64% of women raped before 18 years and 33% of those molested before 18 years had PTSD. Additionally, 11% of those who experienced noncontact sexual abuse had PTSD (Saunders, Villeponteaux, Lipovsky, Kilpatrick, & Veronen, 1992).

The Co-occurrence of Abuse

Some studies suggest that persons who were victims of child abuse as a youth are likely to be victims of physical abuse as an adult. Findings of Appel and Holden (1998) suggest a median co-occurrence rate of 40%. They reviewed 31 studies and found overwhelming evidence of a co-occurrence of child abuse and later physical abuse, with numbers ranging from 10% to 100% depending on the definition of abuse used (Appel & Holden, 1998). Silvern et al. (1995) found that 8% of the 550 undergraduate students they surveyed reported that at some time in their lives they experienced physical abuse and the observation of violent acts between their parents. The rates were higher for the female victims they surveyed (Silvern et al., 1995).

McKibben, De Vos, and Newberger (1989) used hospital records of 32 cases of child abuse, determining that the same man had also abused 59% of mothers of the abused children. These findings indicate that victims of child abuse may be more likely to become adult victims of physical abuse.

Kruttschnitt and Dornfeld (1992) discussed the type of interaction that may occur in violent relationships. They suggest that ''Sequential Negative Interaction'' may spill into parent-child abuse. In other words, the husband batters the wife who then batters her child. Other authors (Moore & Pepler, 1998; Simmons, Wu, Johnson, & Conger, 1995) have suggested a more complex violent relationship interaction, where the husband and wife batter each other and the husband and wife both beat their child. The ''reactive'' behavior by a battered woman may demonstrate that she could be a violent individual, although she may not ''willingly'' beat her child.

Some battered women are coerced to batter. For example, a husband may force his wife to punish their child in an abusive manner. Another possibility is that the battered mother learns (through her own experience as a battered woman) that aggression in relationships is an effective way to control others.

Thus, studies on diverse populations show that violence begets violence. For example, Widom and Maxfield (2001) found today's abused children often become tomorrows' violent offenders. Childhood abuse and neglect increased the odds of further delinquency and adult criminality by 29%. Another concern for future generations is the possibility of PTSD among children of battered women; they witness the violence and live with a continuous ''war'' on a daily basis (Jaffe, Wolfe, & Wilson, 1990).

Summary of Correlates

PTSD in general has been associated with alcohol abuse and dependence, as well as drug abuse and dependence, headaches, immune system problems, and other mental illnesses. Overall, there are a few potential correlates that lead some individuals to develop PTSD in the first place when others do not. These correlates include

–great stressors

–surviving victimization

–betrayal

–prior vulnerability factors, including genetics, early age of onset, lack of support

–greater perceived threat of danger or fear

–social environment which produces shame or guilt (www.ncptsd.org)

The literature review shows that there are common factors in mental illness and domestic violence. These include

–fearfulness

–anxiety

–phobias

–low self-esteem

–depression

–alcohol consumption

–drug dependence

–suicide

–PTSD

–other disorders

–multiple trauma experience (i.e., physical and sexual abuse)

–emotional abuse as a child

Assessment

The information mentioned earlier should be useful in determining who is likely to develop PTSD. In fact, some of the above studies demonstrate that severity and recency of abuse, social support, religiosity, and family stressors are ''good'' indicators for someone in the helping profession to look for when attempting to detect or identify victims. In fact, Jackson, Petretic-Jackson, and Witte (2002) stressed that assessment protocols should be developed to assess PTSD, depression, trauma, alcohol abuse, and attitudes. They developed a seven-step process to follow when interviewing victims:

1. Examine the nature and circumstances of the assault
2. Postassault interaction with professionals and social support
3. Victim initial reaction (symptoms that are physical, cognitive, emotional, mental)
4. Current status (coping as well as the above mentioned)
5. Course—psychological history (i.e., suicide attempts)
6. Attributions—how do they feel they are doing?
7. Future orientation—short-term plans

Assessment can also be done in the ER. Roberts and Roberts (2002) note that ER staff should be immediately involved in discussions with the patient and her ''history.'' They should

attempt to determine the availability of supportive relatives and assist with making referrals. According to these authors, ER intervention in the past was seen as an invasion of privacy. In addition, requesting staff to ''get involved'' was seen as an added burden to ER staff, which was already overworked. Today, views have changed somewhat. Often staff do get involved and offer referrals, but they must do so consistently and convincingly (Roberts & Roberts, 2005).

Although the Women's Movement has assisted victims of domestic violence and continues to do so, these efforts are limited in that the provision of services is ''reactive.'' That is, service providers intervene when women (or others on their behalf) request assistance (Abbott & Williamson, 1999). Their study confirms previous research that has indicated that health care professionals receive little, if any, training/education in domestic violence.

The American College of Obstetricians and Gynecologists has suggested a four-part program for physicians education, the provision of materials that keep them up-to-date on resources, campaigning for the provision of adequate services, and working to raise public awareness (Jones, 1993). Health care professionals do not see domestic violence as an issue where they can play a major role. They are not screening for it or supporting and empowering women. In addition, assessment is not routine (McGrath et al., 1997). Most primary care physicians do not inquire at annual visits about abuse. In fact, one study found that only 6% of women were asked personal questions about their safety (Hamberger, Saunders, & Houg, 1992).

To assist in assessment, a ''proactive'' stance must be taken. The American Medical Association says that all female patients entering ERs, surgery, primary care facilities, pediatric, prenatal, and mental health facilities should be screened for domestic violence. The goal should be to assess all women entering the health care system and screen for domestic violence, even for those without a history of abuse. This effort at ''primary and secondary prevention'' can stop the onset and escalation of intimate partner violence (Boes & McDermott, 2002).

Conclusions

Although it is difficult to establish PTSD prior to a lethal incident, mental health and health care professionals should learn to identify the typical characteristics of a battered woman experiencing symptoms and diagnosis it as soon as possible. In order to do so, victims of domestic violence must go to health care providers for assistance. Thus, police, prosecutors, and judges need to be aware of programs for these women and stress that victims utilize these services. In recent years, police training academies have included 8–20 hr on domestic violence issues and responses for all new police officers. But, in-service training is also needed for experienced police officers and prosecutors. Unfortunately, it is rare that law schools require a course in domestic violence for future attorneys and prosecutors. Mental health professionals need a lot more training since only a small group of graduate programs in social work as well as clinical psychology have a required family violence intervention course. With the millions of dollars allocated through the federal Violence Against Women Act to the 50 statewide domestic violence coalitions and police departments, criminal justice professionals have become more aware of the plight of a battered woman, legal advocacy needs, and victim services.

Shelter staff especially need to be trained to recognize PTSD, depression, and suicide ideation. Family background should be thoroughly examined because a link between child physical and/or sexual abuse increases the risk of

developing PTSD. Furthermore, laws regarding police handling of domestic violence situations and training need to be continuously updated and examined. Finally, those in the ''helping'' professions need to realize that they can make a difference.

The earlier listed correlates of PTSD and mental illness, as well as the studies that summarize the comorbidity between certain factors, are a start in attempting to prevent, recognize, and treat victims. Overall, detecting PTSD and domestic abuse as early as possible should be the goal. Identification and detection should involve combining findings from structured and open-ended interviews and questionnaires with psychological and physical assessment measures. Detection of domestic abuse involves intervention at the earliest stages of a relationship that is violent. In order to intervene, early identification of a victim must be determined. Improved pre-service and in-service training of police, social workers, mental health providers, and ER workers can help. We are not talking about 1 hr of training, instead we are recommending one to three full days annually in specialized continuing education training on mental health assessment and crisis intervention with battered women. Danger and safety assessments are always conducted first. However, once the battered woman is in a safe place, screening immediately for mental disorders and offering other psychological interventions as soon as possible can play a major role in early detection, crisis stabilization, and recovery.

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